Chapter 5

VISN Recommendations

Introduction

Chapter 5 provides the Commission's response to the Draft National CARES Plan (DNCP) proposals for the individual VISNs.

The Commission, during its review of the DNCP, developed a deep appreciation for the complexity of the VISN and national issues confronting VA as well as the significance of the many DNCP proposals. The Under Secretary for Health (USH), National CARES Program Office (NCPO), and each VISN, in carrying out the most comprehensive review ever undertaken of VA's health care system's capital assets, worked conscientiously to develop solutions to address issues they identified. Because of the size and complexity of the project, VA designed CARES to be a macro-level assessment of the resources necessary to meet veterans' future health care needs. This work, resulting in the issuance of the DNCP, forms the basis for making significant and far-reaching changes in the delivery of health care to our nation's veterans.

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The Commission recognizes and commends this enormous effort. The process was managed by the USH with nine full-time staff in VA Central Office (VACO) and 12 field support staff. VISN planning teams, field advisory groups, facility planners, engineers, and public affairs officers involved at least another 400 to 500 VISN and facility staff.

In responding to the DNCP proposals for each VISN, the Commission followed a format that provides an introductory overview of the VISN. Included are descriptions of geographic location, size, demographics, the "markets" developed for the CARES process, and a synopsis of the Commission's information gathering in the VISN. The DNCP proposals and alternatives, or lack thereof, are quoted at the outset of each topic in the VISN review, followed by a summary of the Commission's analysis, and then its findings and recommendations for each topic.

The "CARES projections" generated by the CARES model are also included in the VISN analyses. The information noted in the table on page one of each VISN discussion is based on data collected in FY 2001.[1] These projections supply the percentage in increases or decreases in need, or demand, by FY 2012 and by FY 2022, for various health care services in comparison to the FY 2001 baseline. The projections may show increases over the baseline by FY 2012 that thereafter decrease, by FY 2022, but which still indicate demand above the FY 2001 baseline. These projections are briefly explained in the individual VISN analyses.

In the introductory paragraph for each VISN, the actual enrollee population in the most recent fiscal year, FY 2003, is identified. As will be noted, the FY 2003 enrollee population increased significantly over the FY 2001 baseline; indeed, the number of FY 2003 enrollees is higher than the FY 2012 and FY 2022 projections even in those VISNs in which the enrollee projections would otherwise appear to be trending downward from the FY 2001 baseline level. There could be a number of explanations for this growth in the number of enrollees, such as improved access to care through newly opened community-based outpatient clinics (CBOCs), success of VA outreach efforts, veterans turning to VA for lower cost pharmaceuticals in response to increased costs outside of VA, and continued word-of-mouth advocacy from veterans satisfied with their care from VA. This anomalous result may lead to some questions about the validity of the CARES projections, which advocates for an ongoing calculation of the present and projected demand for services through the next phases of the CARES process.

It is important to understand the parameters given to the Commission in making its recommendations about DNCP VISN proposals. As mandated by the Charter and following the Secretary's guidance, the Commission's work was to review the DNCP proposals. The Commission was not charged with generating proposals. In some instances, however, the Commission considered alternative proposals

The Commission's work was to review the DNCP proposals. The Commission was not charged with generating proposals. In some instances, however, the Commission considered alternative proposals.

[1] VA used the model developed by VA and its contractor, Milliman USA, for the CARES program. The output of the model used in each VISN summary is identified as the "CARES Scenario Milliman USA projections."

to those in the DNCP. These were raised by the VISNs earlier in the CARES process or in the course of hearings.[2] Where alternatives were provided in the DNCP or by the VISNs, the Commission indicates what they are in the section labeled "DNCP Alternatives" and considered them during its review. If no alternatives were provided, the Commission so indicates.

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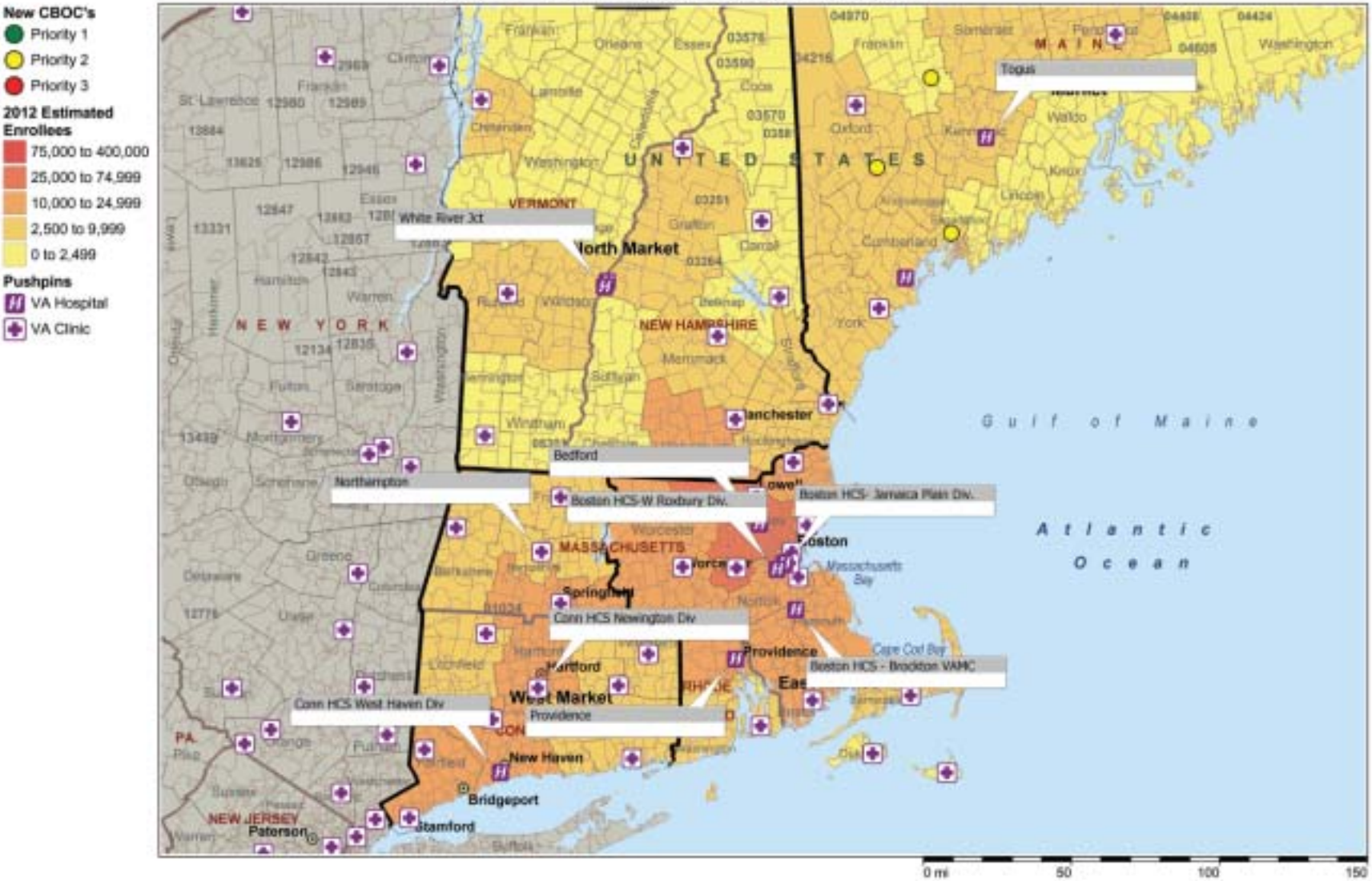
There are some instances, based on information the Commission was given, when the Commission took the initiative to recommend a somewhat different course of action than that proposed in the DNCP or the alternatives. In other instances, it was clear after the Commission completed its information gathering, that certain DNCP proposals had already been implemented or approved for implementation. The report does not address those proposals. The Commission has no objection to any DNCP proposal not discussed in this report.

The Commission's subject-by-subject analysis of the proposals for the VISNs as set forth in the DNCP, with related findings and recommendations resulting from the Commission's deliberations on each VISN, follows.

[2] VISNs developed market plans delineating alternatives prior to the issuance of the DNCP and, in the Fall of 2003, submitted alternatives in response to the NCPO "data call".

VISN 1 – VA New England Health Care System



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VISN 1, VA New England Health Care System

VISN Overview

VISN 1, VA New England Health Care System, is an integrated, comprehensive health care system that provided medical services to approximately 206,000 of the 325,000 veterans enrolled in VA's health care system in FY 2003.[3] Geographically, this VISN spans about 68,700 square miles and consists of the six New England states of Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut. It includes a total veteran population of 1.2 million.

With a VA staff of 8,892 FTEs,[4] VISN 1 delivers health care services through eight medical centers, 38 community-based outpatient clinics (CBOCs), six nursing homes, and two domiciliary care facilities. Additionally, VA operates 18 veterans outreach counseling centers (hereinafter referred to as Vet Centers) in VISN 1's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 1.

VISN 1	FY 2001	FY 2012	FY 2022
Enrollees	280,850	281,126	232,102
Veteran Population	1,281,914	935,188	686,577
Market Penetration	21.91%	30.06%	33.81%

This VISN consists of four markets: the Far North Market (*facility:* Togus, ME); the North Market (*facilities:* White River Junction, VT, and Manchester, NH); the West Market (*facilities:* West Haven and Newington, CT, and Northampton, MA); and the East Market (*facilities:* Bedford, MA; Providence, RI; and Brockton, Jamaica Plain, and West Roxbury, MA).

[3] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[4] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The Commission visited seven sites in VISN 1 and conducted one public hearing. The Commission received 15,602 public comments regarding VISN 1.

- *Site Visits:* Bedford, Brockton, and West Roxbury on July 8; Bedford, Brockton, and West Roxbury medical centers, the VA Causeway Outpatient Clinic, and the Jamaica Plain campus in Boston, MA, and the Providence, RI, and Manchester, NH, medical centers on September 15 and 16.
- *Hearing:* Billerica, MA, on August 25.

Summary of CARES Commission Recommendations

I Mission Change, Campus Realignment – Edith Nourse Rogers Memorial VA Medical Center in Bedford

1. The Commission does not concur with the DNCP proposal to change the mission of the Bedford VA Medical Center (VAMC).
2. The Commission recommends that VA conduct a thorough feasibility study of building a single, appropriately sized replacement medical center in the Boston area for acute and sub-acute inpatient services, residential rehabilitation services, and administrative and research support. This medical center would replace all such existing functions at the West Roxbury, Jamaica Plain, and Brockton campuses of the Boston Health Care System (HCS) and the Bedford VAMC.
3. As part of the planning for a possible replacement medical center in the Boston area, the Commission recommends that:
   - a. The VISN develop a strategic plan to determine the appropriate size and location for coordinated long-term care (LTC) services, including nursing home care and the Geriatric Research, Education and Clinical Center (GRECC) clinical and research services that are integrated with them, and ensure there is no loss of capacity and specialty programs.
   - b. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities, VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.[5]
   - c. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - d. Domiciliary care programs should be located as close as feasible to the population they serve.

[5] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

e Freestanding LTC facilities should be permitted as an acceptable care model.

4 The Commission concurs with the DNCP proposal for a feasibility study for the Jamaica Plain campus and recommends that it be done in conjunction with the feasibility study of a single replacement medical center in the Boston area.

(see page 5-9)

II Inpatient Care

1 The Commission concurs with the DNCP proposal to use contracting to improve access for hospital care in the North and Far North markets, and to pursue telemedicine opportunities.

2 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3 The Commission concurs with the DNCP proposal to meet increasing inpatient demand in the East and West markets through in-house expansions at Providence and West Haven. Expansion at West Roxbury should be considered as part of the feasibility study for a replacement facility for Boston.

(see page 5-15)

III Outpatient Care

1 The Commission recommends that:[6]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

[6] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

2 The Commission concurs with the DNCP proposal to use telemedicine programs at existing sites of care and at proposed new CBOCs to help address access issues.

3 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-17)

IV Extended Care

1 The Commission recommends that:[7]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-20)

[7] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

Mission Change, Campus Realignment – Edith Nourse Rogers Memorial VA Medical Center in Bedford

DNCP Proposals

"*Bedford* – Outpatient services will be maintained at the Bedford campus. Current services of inpatient psychiatry, domiciliary, nursing home, and other workload from the Bedford campus will be transferred to Brockton, West Roxbury, and other appropriate campuses (Manchester). The remainder of the Bedford campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans. *Jamaica Plain* – Study the feasibility of designing the Jamaica Plain campus to consolidate services into building for operational savings and to maximize the enhanced use lease (EUL) potential of the campus for assisted living or other compatible types of use. Retain multidisciplinary outpatient clinic."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Retain inpatient capacity at Bedford.
3. *100 Percent Contracting*
4. *Alternative 1 [The VISN's preferred alternative]:* Transfer 75 inpatient psychiatry beds, 40 domiciliary beds, 240 nursing home beds, minimal amount primary care, and mental health care workload and research associated with inpatient programs to Brockton. Transfer 30 nursing home beds to Manchester. This option reflects a reduction of approximately $838 million compared to the status quo.
5. *Alternative 2:* Consolidate all inpatient and outpatient programs from both the Bedford facility and the VA Boston Health Care System (Brockton, Jamaica Plain, and West Roxbury campuses) to one large replacement medical complex located in Boston.

Commission Analysis

At the time of the initial site visit to the Boston area medical facilities in July 2003, including the Bedford facility, the DNCP proposal for the Bedford facility was uncertain. The visit revealed that many facilities, including Brockton, which would receive some of Bedford's inpatient services, were in need of renovations to improve patient areas. The buildings are aesthetically unappealing and the mechanical infrastructures, such as air conditioners in several of the buildings toured, were malfunctioning. In spite of this, on the day of the visit to the Bedford nursing home and Alzheimer's unit, Commissioners observed many family

members involved in the ongoing care of patients. These observations support maintaining Bedford's long-term care operations. Proximity and quality of care allow the families immediate access to loved ones and relocating patients to another facility would not only disrupt the family connection, but might mean disruption of the family's ability to assist in the veteran's care. As one family member wrote, "We chose Bedford due to its proximity to our family (especially my mom). Dealing with my dad having Alzheimer's disease has been an excruciating time in my life. If you care to visit the facility any day at noontime, you will see many of the veterans' wives and/or children there feeding their loved ones lunch. I make it a habit of spending one or two lunchtimes a week there."[8]

The hearing record also indicated that a change in Bedford's mission would negatively impact research on Alzheimer's disease and psychiatry, as well as the medical education of medical students and residents. As Dr. Aram V. Chobanian, Dean of Boston University's School of Medicine and Provost of the Boston University Medical Campus, testified:

> I also have serious concerns about the potential impact of the proposed National CARES Plan on Bedford's nationally recognized Center of Excellence in Alzheimer's disease. The current program integrates the inpatient activities with those involved in ambulatory care, adult day care, hospice care, and research. Many of the clinical and research staff work on several of these components and moving part of the program some 35 miles away would create serious logistic issues for this outstanding center.[9]

In response to the hearing, the Commission determined that further study of the proposal was required. This included additional analysis of data and a second, more comprehensive site visit, this time to all Boston area facilities, and also to the VAMCs in Manchester, NH, and Providence, RI.

On the follow-up site visit to VISN 1, a special consultant on hospital construction and renovation with extensive experience both in VA and the private sector accompanied Commission members. The Commissioners and consultant concurred that all four major campuses in the Boston area are in need of significant construction to improve medical and patient areas, to meet infrastructure requirements (including mechanical, privacy, and safety), and to enhance the aesthetic value of the buildings. Inpatient areas at West Roxbury are very congested, space is cramped, and the older construction does not provide adequate ceiling height and is not configured to accommodate new technologies. This requires additional staff time and effort to maintain the quality of care and results in inefficiencies and an unattractive environment of care for patients and staff. Acute and intermediate psychiatry as well as residential rehabilitation areas at Brockton and Bedford are aging. The spinal cord injury (SCI) unit at Brockton particularly is below accepted standards.

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[8] Meg Anderson, Written Public Comment submitted on VISN 1.

[9] Aram V. Chobanian, MD, Dean, Boston University School of Medicine, Boston, MA. Transcribed Testimony from the Bedford, MA, Hearing on August 25, 2003, page 171.

The VHA Office of Facility Management Facility Condition Database indicates that the "correction costs" necessary to upgrade the four Boston area campuses exceeds $300 million.[10] For VA to be a competitive employment option in the Boston area, which is known for its modern health care with state-of-the art medical facilities and technologies, and its strong, prominent academic institutions that attract extra-ordinarily skilled professionals, it would need to upgrade the infrastructure of its Boston area facilities.

Services provided in the greater Boston area are dispersed among four sites. An average daily census (ADC) of approximately 75 acute medical beds, 35 surgical beds, and 20 intermediate care beds are sited at the West Roxbury campus. Spinal cord injury beds are split between the West Roxbury (ADC 19) and Brockton (ADC 24) campuses. Acute psychiatry beds are divided between the Brockton (ADC 51) and Bedford (ADC 10) campuses. Sub-acute psychiatry beds are split between Brockton (ADC 64) and Bedford (ADC 50). Residential rehabilitation beds (psychiatric residential rehabilitation treatment program [PRRTP] and domiciliary) are split between the Brockton and Jamaica Plain campuses (with combined ADC 71) and Bedford (ADC 89). Nursing home care beds are divided between Brockton (ADC 124) and Bedford (ADC 256).[11] Outpatient services also are offered at numerous sites including the West Roxbury, Jamaica Plain, Brockton, Bedford campuses, at a large outpatient clinic in downtown Boston (Causeway Clinic), and in area CBOCs.

Travel between these geographically dispersed sites of care is generally through congested Boston city streets. Thus, access to care is less than optimal due to the dispersion of services and the locations of the current sites of care. Furthermore, acute psychiatry services, including substance abuse detoxification, are on different campuses than are acute medical services, though the Commission heard in repeated testimony across the country that quality of care is enhanced when acute psychiatry and acute medical services are on the same campus. Acute psychiatry services are also best located in close proximity to intermediate psychiatric care. The separation of the acute and longer-term SCI units limits the flexibility of the SCI staff in caring for patients.

Operating on four campuses in the Boston area, the VISN must maintain a large amount of acreage and a number of aging buildings, including the large, former main hospital building at Jamaica Plain. This requires large expenditures for maintenance personnel and for recurring maintenance projects and utilities. The wide-spread dispersion of staff and services also results in inflated transportation costs and lost time for staff traveling between campuses. Old space originally configured for inpatient services at the Jamaica Plain campus is being used for outpatient care, to house research centers, and for administrative functions, which is inefficient and wasteful.

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[10] VISN 1, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo.*

[11] VSSC KLF Menu Database, *Workload from AMIS Report*, as of the end of FY 2003.

However, when following the hearing in Boston, the VISN was required to conduct a cost benefit analysis to compare the long-term cost of various alternatives,[12] these costs did not seem to be considered. Though the VISN's alternatives included constructing a 600-bed replacement medical center at a cost of $609 million, the VISN did not recommend this alternative. Instead, the VISN recommended transferring Bedford's inpatient services to Brockton and Manchester, with estimated renovation and construction costs for the four Boston facilities at $57.3 million and for Manchester at $150.2 million.

The VISN cost analysis for a replacement facility was counterintuitive in that the life cycle costs presented were higher than the recommended alternative by $2.3 billion. In the realignment proposal study, the VISN estimated that life cycle recurring costs for staffing and maintaining a newly constructed facility would exceed the life cycle cost of maintaining the current dispersed aging facilities. This is inconsistent with past experiences in VA and with other proposed mergers of campuses in the DNCP, which invariably project substantial savings in operating costs from the merger of campuses into new construction. These savings should include:

- Substantial savings in the approximately $38 million spent annually on buildings and ground maintenance for the current aging campuses with large numbers of buildings and acreage.
- Savings in other administrative overhead costs from the merger of the Bedford and Boston HCS leadership offices, from reduced security needs for a single campus; from the further merger of other administrative services such as human resources, medical administration, acquisition and fiscal; and from efficiencies in transportation costs and lost time due to staff travel.
- Savings in clinical costs, for example, clinical after-hours' supervision should be more efficient, and savings should accrue from more modern, well-organized clinical space.

Review of the cost benefit analysis suggests no projected appreciable operational savings from transferring services to the newly constructed hospital. This is despite a statement in the narrative portion of the analysis that indicates, "Provision of inpatient and outpatient care at a modern facility located on a single site would significantly improve staff and operational efficiencies by offering 'one stop care for veterans'. ... Duplication of services/equipment between campuses would be eliminated. Bedford, Brockton, Jamaica Plain and West Roxbury campuses could be sold to offset the cost of constructing a replacement facility."[13]

The Commission, based on hearing testimony and personal observations at the site visits, noted that nursing home services need to be well better distributed across the Boston area to ensure that there is adequate access for patients and their families, who need the opportunity to be involved in the patients' ongoing care. The Bedford facility has recently completed significant renovations at its nursing home and is currently in

[12] VISN 1, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo.*
[13] VISN 1, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo.*

the process of making additional renovations to make the nursing home unit a state-of-the-art treatment center. In addition to improving the infrastructure for patient care services, it would appear that the capital improvements might be a step toward improving the facility's aesthetic quality. To abandon these capital investments would not appear to be reasonable or cost effective and would move away from improving VA's competitive edge in the employment arena.

Commission Findings

1. Quality of care and access for families of LTC and nursing home patients at Bedford would not improve under the VISN's preferred alternative.
2. Nearly 15,500 public comments were received that favored maintaining Bedford's LTC operations.
3. Affiliate relationships may suffer under the DNCP plan for Bedford.
4. The Boston area is known for its modern health care with state-of-the-art medical facilities and technologies and strong, prominent academic institutions. It is a highly competitive employment area for medical professionals. For VA to compete, it needs to upgrade the infrastructure of its Boston area facilities.
5. Site visit observations, including those from a special consultant on hospital construction and renovation, indicate that virtually every Boston area facility requires renovations to improve medical and patient areas to meet infrastructure requirements (including mechanical, privacy, and safety) and to enhance the aesthetic values of the buildings.
6. Acute and sub-acute inpatient care is currently fragmented and dispersed in the Boston area on multiple, aging campuses, leading to less than optimal access, coordination of care, and staff efficiencies.
7. Consolidation of services into a newly constructed, centrally located facility would correct deficiencies in the environment of care, improve staff efficiency, improve access to care, and increase coordination of care.
8. The cost benefit analysis comparing the cost of maintaining the current facilities versus building a new single facility contains inconsistencies.
9. There is a high probability that a well-conceived plan to consolidate all acute and sub-acute inpatient services, many outpatient services, administrative functions, research functions, residential rehabilitation services, and a portion of the LTC services onto a single, modern

campus would improve the quality and coordination of care, improve access for most users in the Boston area, and increase efficiencies.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to change the mission of the Bedford VAMC.
2. The Commission recommends that VA conduct a thorough feasibility study of building a single, appropriately sized replacement medical center in the Boston area for acute and sub-acute inpatient services, residential rehabilitation services, and administrative and research support. This medical center would replace all such existing functions at the West Roxbury, Jamaica Plain, and Brockton campuses of the Boston HCS and the Bedford VAMC.
3. As part of the planning for a possible replacement medical center in the Boston area, the Commission recommends that:
   - a. The VISN develop a strategic plan to determine the appropriate size and location for coordinated LTC services, including nursing home care and the Geriatric Research, Education and Clinical Center (GRECC) clinical and research services that are integrated with them, and ensure there is no loss of capacity and specialty programs.
   - b. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.[14]
   - c. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - d. Domiciliary care programs should be located as close as feasible to the population they serve.
   - e. Freestanding LTC facilities should be permitted as an acceptable care model.
4. The Commission concurs with the DNCP proposal for a feasibility study for the Jamaica Plain campus and recommends that it be done in conjunction with the feasibility study of a single replacement medical center in the Boston area.

[14] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

II Inpatient Care

DNCP Proposals

"*Hospital Care/Access* – Access in the North and Far North markets is being met through community contracts. In addition, telemedicine and telecare programs will be used across the VISN to improve quality and access for primary care and specialty care. The Maine Telemedicine program for the private sector will be used to provide cost-effective care to the Maine veterans in collaboration with the VA. *Medicine/Inpatient Services* – Increasing inpatient medicine demand and access gaps in the Far North and North markets is being met through community contracts, also needed to resolve access gaps. Increasing inpatient medicine demand in the East and West markets is being met through in-house expansion at West Roxbury, Providence, and West Haven. *Psychiatry* – Decreasing inpatient psychiatry demand in the East market is being met through the consolidation of acute psychiatry at Bedford, Brockton, and Providence."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In the Far North and North Markets, less than 60 percent of enrolled veterans are currently within the VA's access standards for hospital care. The CARES standard is 60 minutes for urban areas; 90 minutes in rural areas; and 120 minutes in highly rural areas. Inpatient medicine workload is projected to increase in all markets by at least 70 percent over the FY 2001 baseline by FY 2012, and remain at least 26 percent over baseline by FY 2022. The Far North Market has the largest projected increase, with 209 percent over baseline by FY 2012, declining to 151 percent over baseline by FY 2022.[15]

CARES space management reports indicate space deficits for inpatient service areas at West Haven and Newington (West Market), West Roxbury and Providence (East Market), and Manchester (North Market). In-house expansions and improvements are the recommended remedies for access and workload gaps. As noted during discussions with VISN leadership and as observed at the specific facilities visited during Commission site visits, improvements are needed for inpatient care areas in every VA medical center in VISN 1 in order to respond to both access and workload gaps.

The DNCP recommends expanding inpatient areas at the Togus VA Medical Center (Far North Market), the only VA medical center in Maine, to respond to growing demand for inpatient services. In order to

[15] Appendix D, *Data Tables*, page D-1.

do this, however, Togus needs to reclaim the facility's inpatient areas by moving some outpatient services out of the medical center and into satellite locations. Once this has been done, the inpatient areas would undergo renovations. At the same time, the relocated outpatient services would be able to expand to include mental health services and specialty care, where appropriate. Additionally, at meetings with VISN leadership during the site visits, the Commission learned that the state of Maine has integrated a statewide telemedicine program to serve the medical needs of the general population. Leadership at the Togus VAMC has engaged the state leadership in developing a partnership whereby VA may use the telemedicine capabilities presently in place in Maine to serve the medical needs of veterans, particularly those in areas where access to VA health care is less than optimal.

As to contracting for health care, the hearing record indicated that this option to health care delivery is presently used, well received, and will continue to be used to augment VA health care when access to care or peak workload demands hinder timely health care delivery by VA.

Commission Findings

1. The Far North Market and the North Market have significant gaps for access to hospital care.
2. Inpatient medicine workload is projected to increase in all markets of VISN 1.
3. In-house expansions appear to be a partial and reasonable solution to workload gaps but may not improve access gaps in rural areas.
4. All the VAMCs in this VISN require improvements and enhancements to their physical plants to meet access and workload gaps.
5. VA may be able to partner with the state of Maine to use telemedicine technology.
6. Contracting for care is reasonable to maintain or improve access to health care.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to use contracting to improve access for hospital care in the North and Far North Markets, and to pursue telemedicine opportunities.
2. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3 The Commission concurs with the DNCP proposal to meet increasing inpatient demand in the East and West markets through in-house expansions at Providence and West Haven. Expansion at West Roxbury should be considered as part of the feasibility study for a replacement facility for Boston.

III Outpatient Care

DNCP Proposals

"*Primary Care/Access* – The DNCP attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. *Primary Care/ Outpatient Services* – Increasing primary care demand in the Far North, East, and West markets is being met primarily through community contracts, telemedicine, and expansion of existing CBOCs. Some in-house expansion is planned for Brockton, Togus, and Newington. Excess outpatient demand from West Roxbury and from the Causeway Clinic will be moved to Jamaica Plain. *Mental Health* – Increasing demand for mental health in the Far North and North markets is being met through community contracts, telemedicine, and expansion of existing CBOCs that will include mental health services. *Specialty Care* – Increasing specialty care demand in all four markets is being met using community contracts to the extent feasible, telemedicine, shifting selected services to CBOCs and in-house expansion through significant new construction and conversion of vacant space. Northampton will lease 50,000 square feet in the Springfield area. West Roxbury and Providence have replacement operating room projects in their special care expansions."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

CARES workload projections indicate that all markets in VISN 1 will experience increasing demand for primary care and/or specialty care outpatient services creating gaps in the VISN's ability to deliver services. Primary care workload is projected to increase in the West Market by 38 percent over the FY 2001 baseline by FY 2012 and significantly decrease to four percent over the baseline in FY 2022. For specialty care in the West Market, projections indicate an increase 84 percent by FY 2012 and 44 percent by FY 2022.

In the East Market, primary care is projected to increase by 54 percent by FY 2012 and 18 percent by FY 2022. Specialty care for the East Market is projected to increase by 75 percent by FY 2012 and 41 percent by FY 2022.

The North Market will experience significant increases in specialty care of 79 percent by FY 2012 and 56 percent by FY 2022, and only nominal increases in primary care (21 percent by FY 2012, and 0 percent by FY 2022).

The fourth market, Far North, is projected to see a 59 percent increase in primary care by FY 2012 and 28 percent by FY 2022. Specialty care for the Far North is projected to increase by 136 percent by FY 2012 and 104 percent by FY 2022.

Increasing demand for outpatient mental health services is projected in the North and Far North markets, and the levels of projected demand are likely to further increase once the corrected CARES outpatient mental health data is run. The North Market is projected to see a 55 percent increase in demand for outpatient mental health services by FY 2012 and a 17 percent increase by FY 2022.[16]

The Far North Market is of special note. This market is projected to have substantial increases in mental health care by at least 38 percent by FY 2012 and three percent by FY 2022. In addition, the Far North Market is currently below the standard set for access to primary care. Currently only 59 percent of the veterans residing in this largely rural market are within the CARES guidelines set for access to primary care services.[17] The Commission heard testimony regarding access for care in the Far North Market. For example, Mr. John Wallace, representing the Vietnam Veterans of America in that market, provided testimony on the difficulties of accessing care, particularly during harsh Maine winters, when travel is problematic.[18] Mr. Roland La Pointe, Director of the Bureau of Veterans Services for Maine, testified that VA staff conducted Town Hall meetings across Maine and through this collaborative effort a market plan was developed that included new CBOCs in rural areas to improve access, patterned after the successful existing CBOCs in five rural areas of the state.[19]

The DNCP proposes to address this projected demand for services and access by expanding services at existing sites of care, including existing medical centers and CBOCs. Consequently the DNCP does not include any of the VISN's proposed additional CBOCs in the high priority group slated for early activation. The VISN had proposed five new CBOCs, all in the Far North Market. These new CBOCs would be located

[16] Appendix D, *Data Tables*, page D-2.
[17] VISN 1 CARES Planning Initiatives from VISN 1, VA New England Health Care System, submitted April 15, 2003.
[18] John Wallace, State Council President, Vietnam Veterans of America. Transcribed Testimony from the Bedford, MA, Hearing on August 25, 2003, page 84.
[19] Roland La Pointe, Director of the Bureau of Veterans Services for the State of Maine. Transcribed Testimony from the Bedford, MA, Hearing on August 25, 2003, page 117.

across Maine in order to improve access to care and thus address the current deficiencies in access in this market as well as projected needs for increased demand for all types of outpatient care. These CBOCs are also crucial to the VISN's plan to expand inpatient capacity at Togus, by reclaiming old inpatient space that has been converted to outpatient services. Telemedicine is currently being used in the Far North Market in association with Maine's statewide telemedicine program, and would be a valuable adjunct to care at new proposed CBOCs. The proposed new CBOCs would have a relatively smaller staff than an average CBOC and not require the expenditure of large amounts of money to establish. The DNCP proposal to merely expand services at existing sites of care in the Far North Market will not improve access in the market.

The VISN currently provides outpatient services in downtown Boston at the Causeway Clinic, which is located next to a public transportation hub, making it easily accessible for metropolitan area patients. The VISN does not propose to renew the lease on this clinic, but rather proposes to transfer the outpatient services to underutilized space at the Jamaica Plain campus. Staff at the Causeway Clinic acknowledged that this will cause a hardship for many patients since public transportation to Jamaica Plain is much more difficult.

Commission Findings

1. Increases in demand for outpatient services are projected across the VISN.
2. Access to primary care services is well below CARES access standards in the Far North Market.
3. Expansion of services at current sites of care will partially address projected demand for services in the North, West, and East Markets, but will not address access deficiencies in the Far North Market.
4. The VISN's original plan to improve access to care in the Far North Market through deployment of new CBOCs throughout Maine is a well-conceived plan to improve access to care.
5. No new CBOCs are in the DNCP's priority group one for VISN 1.
6. To the extent possible, use of telemedicine and contract care is a reasonable response to access issues, especially in rural areas of Maine.

Commission Recommendations

1. The Commission recommends that:[20]
   a. The Secretary and Under Secretary for Health utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

[20] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

2 The Commission concurs with the DNCP proposal to use telemedicine programs at existing sites of care and at proposed new CBOCs to help address access issues.

3 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

IV Extended Care

DNCP Proposal

"For extended care, the DNCP proposed capital investments to remedy space deficiencies in nursing homes including renovation of 51,289 existing square feet in the West Market (Northampton and West Haven) and the renovation of 43,017 square feet in the Far North Market (Togus)."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Commission heard little specific testimony regarding plans to renovate long-term care space at Northampton, West Haven, and Togus VAMCs. The VISN does seem to have a relatively large complement of nursing home beds.

This VISN may be impacted by the upcoming long-term care model projections. Final decisions regarding any change to the number and location of long-term care beds in VISN 1 need to await the model's projections. However, the Commission recognizes the need to upgrade the environment of care in older VA nursing homes.

Commission Findings

1. Several VISN facilities require some level of upgrade and modernization to inpatient areas.
2. The VISN may be impacted by the upcoming long-term care model projections.

Commission Recommendations

1. The Commission recommends that:[21]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.

[21] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

VISN 2 – VA Health Care Network Upstate New York

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VISN 2, VA Health Care Network Upstate New York

VISN Overview

VISN 2, VA Health Care Network Upstate New York, is an integrated, comprehensive health care system that provided medical services to approximately 115,000 of the 206,000 veterans enrolled in VA's health care system in FY 2003.[22] While the estimated veteran population for VISN 2 is 547,000, it is projected to decrease by 32 percent by FY 2012. Geographically, this VISN spans 42,925 square miles in most of New York and parts of Pennsylvania.

With a VA staff of 5,240 FTEs,[23] VISN 2 delivers health care services through five medical centers, 27 community-based outpatient clinics (CBOCs), six nursing homes, and two domiciliary units in Upstate New York. In addition, there are four Vet Centers in VISN 2.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 2.

VISN 2	FY 2001	FY 2012	FY 2022
Enrollees	187,408	162,667	124,582
Veteran Population	585,805	396,811	287,638
Market Penetration	31.99%	40.99%	43.31%

For the CARES process, this VISN is divided into four markets: the Eastern Market (*facility:* Albany, NY); the Central Market (*facility:* Syracuse, NY); the Finger Lakes Market (*facilities:* Canandaigua and Bath, NY); and the Western Market (*facilities:* Buffalo and Batavia, NY).

[22] VSSC KLF Menu Database, *Enrollment Priority and Status by* Gender, as of the end of FY 2003.
[23] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited three sites and conducted one public hearing in VISN 2. It received 108,996 comments regarding VISN 2. Site visits and hearing(s) were held as follows:

- *Site Visits:* Buffalo, Batavia, and Canandaigua, NY, on July 9 and 10; Canandaigua, NY, on October 19.
- *Hearing:* Canandaigua, NY, on October 20.

Summary of CARES Commission Recommendations

I Mission Change, Campus Realignment – Canandaigua and Finger Lakes Market

1. The Commission does not concur with the DNCP proposal on transferring services from Canandaigua to other VA Medical Centers (VAMCs) within the VISN.
2. The Commission recommends that Canandaigua retain long-term care, including the nursing home, psychiatric nursing home care, and the domiciliary.
3. The Commission concurs with the DNCP proposal to transfer acute inpatient psychiatric beds.
4. The Commission also concurs with the DNCP proposal that Canandaigua retain its ambulatory care.
5. The Commission recommends that the VISN develop another strategic plan for the challenges it faces in Canandaigua with high overhead costs, unused or underutilized buildings, and the impact on the community and on employees.
6. In line with Recommendation 5 above, the Commission recommends that the VISN involve stakeholders and the community to help resolve these challenges.

(see page 5-26)

II Inpatient Care

1. The Commission concurs with the DNCP proposal to contract for the projected increase in inpatient medicine care with community providers in markets with increased need, given the relatively small increase in beds and the benefit of providing such care nearer to patient residences.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-31)

III Outpatient Care

1 Given projected increases in workload in primary and specialty care, the Commission recommends that the need for either expanded and/or additional CBOCs be part of the strategic plan for VISN 2.

(see page 5-32)

IV Special Disability Programs – Spinal Cord Injury Center

1 The Commission concurs with the DNCP proposal to build a new Spinal Cord Injury (SCI) Center in Syracuse.

2 VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-34)

Mission Change, Campus Realignment – Canandaigua and Finger Lakes Market

DNCP Proposal

"Current services of acute inpatient psychiatry, nursing home, domiciliary, and residential rehabilitation services at Canandaigua will be transferred to other VAMCs within the VISN. Outpatient services will be provided in Canandaigua's market. The campus will be revaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues of in-kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Maintain baseline workload at medical center; contract for projected growth in workload, acute services, and expanded specialty care in the Rochester area.
3. *100 Percent Contracting*
4. *[The VISN's preferred alternative]:* Realign inpatient services with other VISN VAMCs. Open new CBOC in Canandaigua area; expand Rochester CBOC. Divest campus.

Commission Analysis

The Canandaigua VAMC was established in 1932 and consists of 23 buildings on 171 acres of land. Of the 664,248 square feet of space at Canandaigua, 26 percent is vacant or underutilized; an additional 8 percent of square footage is leased for non-VA purposes and provides a revenue stream for the hospital. According to a periodic study conducted by VA's Office of Facilities Management dated November 1, 2000, the estimated cost to correct deficiencies at the Canandaigua VAMC is approximately $50.7 million. Since 1998, Canandaigua has installed air conditioning and renovated two buildings. Following completion of this work in early 2004, a gero-psychiatric unit for elderly psychiatric patients was planned. The number of current enrollees in the Finger Lakes Market (Rochester, Canandaigua, and Bath areas) is 41,000 and is projected to decline to 36,000 by FY 2012 and to 28,000 by FY 2022.[24]

[24] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

At its peak, the Canandaigua VAMC had approximately 1,700 operational beds.[25] Inpatient medicine and surgery services were discontinued 3 years ago. Today, Canandaigua's 700 employees[26] maintain its 276 beds: 138 nursing home beds, 88 psychiatric beds (50 inpatient psychiatry and 38 residential rehabilitation), and 50 domiciliary beds. The average daily census (ADC) on these 276 beds is 159 (occupancy rate of 58 percent).[27] Customer satisfaction scores for this facility are above the national average. Canandaigua also has 270 patients in community placement residential care.[28] The nearest acute care VAMCs are located in Buffalo (approximately 1½ hours away) and Syracuse (approximately 1¼ hours away).

Outpatient care services for the Finger Lakes Market are provided through the Rochester CBOC and at Canandaigua. Of the approximately 15,000 users of outpatient services in this market, more than half receive at least a part of their outpatient care at the Rochester CBOC and the remainder use the Canandaigua VAMC. The driving time between these two facilities is about 40 minutes and probably longer in winter conditions. In addition, data show that Rochester has the greatest concentration of veterans (50 percent) in the market and is the only major city in the VISN without a VA hospital. VISN 2 proposed adding a five-bed triage area to the Rochester CBOC for acute psychiatric patients. Enhancing Rochester and Canandaigua outpatient services and maintaining some capability for emergent acute psychiatric inpatient care are important components of the VISN's plan for providing services to more veterans.

At the stakeholders' meeting during the site visit in July, there was no discussion of closing Canandaigua. Instead, hospital staff focused on the lack of funds to maintain the facility. After submission of the VISN plan, the Under Secretary of Health asked VISN 2 to consider realigning Batavia's mission to an outpatient clinic and relocating long-term care (LTC) beds to Buffalo or Canandaigua. Instead, VISN 2 proposed to evaluate changing the mission at Canandaigua. After analysis of both Batavia and Canandaigua, the VISN selected Canandaigua based on its greater potential savings to reinvest in direct patient care. The DNCP proposed that Canandaigua's inpatient services be relocated to other facilities. The inpatient psychiatric care units would be split between Syracuse and Buffalo; residential rehabilitation services would be moved to Batavia; domiciliary beds would be moved to Bath; and nursing home beds would be moved to Buffalo, Batavia, Bath, and contracted for in the community. The revised proposal also calls for outpatient services being provided in Canandaigua's market and for the campus to be reevaluated for alternative uses, such as enhanced use leasing (EUL).

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[25] Bill Feeley, VISN 2 Director, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, page 94.
[26] Bill Feeley, VISN 2 Director, Written Testimony submitted at the Canandaigua, NY, Hearing on October 20, 2003, Attachment G.
[27] Appendix D, *Data Tables*, page D-8.
[28] Bill Feeley, VISN 2 Director, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, page 66.

While the quality of inpatient psychiatric care at Canandaigua appears to be high,[29] there is no evidence to suggest that either the quality of care or patient safety would be adversely affected by the transfer of the inpatient psychiatry beds to the tertiary care hospitals at Syracuse and Buffalo. The transfer of inpatient psychiatric patients, especially those requiring acute psychiatric care, closer to tertiary care hospitals would likely result in enhanced clinical care and coordination in terms of psychiatric research and the education of psychiatric caregivers. Although Commissioners did note that a transfer would leave the Fingers Lakes Market with no inpatient acute psychiatric beds, travel times would remain within the one-hour standard.

Historically, Canandaigua has been a long-term care hospital. It has been downsized considerably in the past 10 years as the paradigm for psychiatric care has changed to one stressing reintegration into society. Today, 270 former inpatients currently reside in foster homes supervised by the Canandaigua Community Residential Care staff. Others are in the community under the care of Canandaigua's Intensive Community Case Management program. Outpatient support services for seriously mentally ill patients in the Canandaigua area would be retained. The transfer of the residential rehabilitation beds to Batavia would not significantly change access for patients needing such care.

The proposal to transfer 90 of Canandaigua's 138 nursing home beds to Bath, which is approximately 75 miles away from Rochester, would unnecessarily hamper access for a market that has an enrollment and patient base predominately from the Rochester metropolitan area. Also, separating the nursing home from adult day care would also be a loss for dementia patients and would reduce the capacity for respite care for families. While the traditional model for nursing homes in VA indicates that it is optimal for a nursing home to be collocated with an acute care facility, the private sector model for nursing homes is primarily a freestanding nursing home. The Commission believes that VA nursing homes need not always be collocated with inpatient psychiatric hospitals or acute inpatient hospitals, and this includes the nursing home at Canandaigua.

The 50 domiciliary care beds at Canandaigua are used primarily to provide residential rehabilitation services for homeless veterans, most of whom are from the greater Rochester metropolitan area. These patients receive care and rehabilitation for their medical and mental health disorders, and are then provided comprehensive psychosocial and vocational rehabilitation services to enable them to successfully reintegrate into their community. These services should be provided in as close proximity as is feasible to the metropolitan area from which the patients come. The proposal to move these services to Bath, which is a largely rural area and significantly farther from the Rochester metropolitan area, would be

[29] Performance Measures Quadrants, FY 2003, Mental Health. Available at [*vaww.oqp.med.va.gov*].

inconsistent with the mission of this program, would decrease access, and potentially would impair the effectiveness of these services. In addition, Commissioners learned at the hearing that relocating services to Bath would mean additional travel times of more than an hour for patients and their families.[30]

A cost analysis was evaluated to justify divestiture of the Canandaigua campus, establish a new multi-specialty outpatient clinic, and realign the workload to other VISN 2 medical facilities. The analysis was inconclusive and did not provide an adequate basis for decision among alternatives. For example, demolition costs were not identified; new construction costs were inappropriately included in the contracting alternative; capital costs of $8.5 million for an SCI unit in Syracuse were included in all alternatives but are immaterial to the choice among alternatives; inconsistent operating costs were included; and annual operating savings of $20.8 million are cited but are not substantiated in the cost analysis.[31]

The transfer of Canandaigua's workload to other VISN 2 facilities would have an impact on employees. It is not clear, however, exactly how many employees would lose their jobs or would retire. In testimony, the VISN Director stated, "Canandaigua employees will be given first chance for any position that may open in the VISN for which they are qualified,"[32] although this is not a guarantee and may not be attractive to many employees, as nearly 50 percent reside in the Canandaigua area.

The complete divestiture of the Canandaigua VAMC would have a severe negative impact on the community. There was extensive testimony against transferring services out of Canandaigua. Congressman Walsh expressed the concerns of many people, "…closing the Canandaigua VA hospital would …have a staggering impact on the economy of the Finger Lakes region."[33]

Commission Findings

1. Overall, the facility appears to be in good condition, but is underutilized or unused due to the large decline in inpatient psychiatry care.
2. While the cost analysis for Canandaigua is inconclusive at this time, maintaining such a large campus with a vastly reduced inpatient population requires a large overhead that might be better directed to veterans' medical care.

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[30] Colleen Combs, President of AFGE Local 3306, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, page 294.

[31] Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

[32] Bill Feeley, VISN 2 Director, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, pages 60-61.

[33] The Honorable James Walsh, Congressman from New York, 25th District, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, page 17.

3 The transfer of inpatient psychiatry patients to a tertiary level hospital would increase the level of overall care for such patients.

4 Closure would likely have a negative impact on the community and possibly on employees.

5 Workload has declined in all of Canandaigua's medical service areas; 3 years ago, inpatient medicine and surgery services were discontinued in-house and contracted to the local community.

6 Moving domiciliary-based residential rehabilitation units with a large vocational program farther from the Rochester metropolitan area is not consistent with the principles of improving access and providing care near urban areas.

7 Moving nursing home units to other facilities further away from Rochester would add a transportation burden for family members, particularly in winter.

8 Separating nursing home from adult day care would also be a loss for dementia patients and would reduce respite care for families, as well as comprehensive outpatient services.

9 As stated by Mr. Feeley in his testimony on October 20, 2003, the VISN needs to partner with the community and other stakeholders to explore ways to minimize the negative financial impact on the Canandaigua area and to develop alternative uses of the unused or underutilized portions of the campus.

10 There was a lack of timeliness, forewarning, and stakeholder awareness and involvement in the DNCP proposal of August 4, 2003, to realign the Finger Lakes Market.

11 Almost all of the 108,996 written comments (including petitions with 106,575 signatures) received by the Commission for VISN 2 opposed closing the Canandaigua facility.

Commission Recommendations

1 The Commission does not concur with the DNCP proposal on transferring services from Canandaigua to other VAMCs within the VISN.

2 The Commission recommends that Canandaigua retain LTC, including the nursing home, psychiatric nursing home care, and the domiciliary.

3 The Commission concurs with the DNCP proposal to transfer acute psychiatric beds.

4 The Commission also concurs with the DNCP proposal that Canandaigua retain its ambulatory care.

5 The Commission recommends that the VISN develop another strategic plan for the challenges it faces in Canandaigua with high overhead costs, unused or underutilized buildings, and the impact on the community and on employees.

6 In line with Recommendation 5 above, the Commission recommends that the VISN involve stakeholders and the community to help resolve these challenges.

II Inpatient Care

DNCP Proposal

"Increased inpatient medicine services are projected for both the Central and the Finger Lakes/Southern Tier Markets. The VISN proposes to move workload from the Western or Central Market to the Finger Lakes and Southern Tier Market and utilize contracting for services in the counties where the patient resides. This includes utilizing fee basis and contracts for inpatient medicine services. Additional contract services will need to be established for the increased projected workload especially in the Monroe County area. Projected increase at Bath can be handled in the current space."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Review of data reveals no gaps in access to hospital and tertiary care, and only minimal increased capacity needs for inpatient medicine services. The Eastern Market has a projected increase of 48 percent (18 beds) above the FY 2001 baseline by FY 2012 for medicine beds and returns to the baseline figures by FY 2022. The Finger Lakes Market projects an increase of 57 percent (eight beds) by FY 2012, while the Western Market projects an 18 percent increase (11 beds). Projections for the Finger Lakes Market return to the baseline figures by FY 2022, while the Western Market is projected to have a 22 percent decrease for medicine beds over the FY 2001 baseline by FY 2022.

To ensure inpatient care is provided in close proximity to the veterans' homes, the VISN plans to contract for some inpatient care. The VISN Director testified, "[T]he Network has a rich history of successful partnerships with community providers. Such partnerships need to be considered as alternatives in addressing any planning initiatives."[34] He indicated that the contracting for inpatient medical services in the local Canandaigua community, which has been ongoing for several years, has been a successful example of contracting.

Commission Finding

VISN 2 currently contracts for inpatient services and has the ability to meet projected increases in demand through local contracting.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to contract for the projected increase in inpatient medicine care with community providers in markets with increased need, given the relatively small increase in beds and the benefit of providing such care nearer to patient residences.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

III Outpatient Care

DNCP Proposals

"*Primary Care* – Increased primary care outpatient services has been identified in the Finger Lakes and Southern Tier Markets. There is a significant increase in primary care workload, especially in Monroe County. The VISN proposes to utilize contractual services in close proximity to the patients' homes

[34] Bill Feeley, VISN 2 Director, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, page 55.

to address increased outpatient primary care demand. *Specialty Care* – Increasing specialty care outpatient services has been identified in three markets (all but the Western Market). The VISN is proposing a combination of approaches tailored to the individual needs of each market. These approaches include utilizing fee basis; contracting for services in the counties where the patient lives; maintaining existing current workload at the existing medical center and existing CBOCs, and renovating CBOC space."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

As an early proponent of CBOCs, VISN 2 has already provided 80 to 90 percent access to primary care for its veterans across all four markets. For FY 2012, the projected increase in primary care workload for the Finger Lakes Market is 66 percent above the FY 2001 baseline. The workload for specialty care is expected to increase by 117 percent in the Eastern Market, by 90 percent in the Central Market, and by 173 percent in the Finger Lakes Market. By FY 2022, the projected increase in primary care workload for the Finger Lakes Market is still 26 percent above the FY 2001 baseline. The workload for specialty care by 2022 shows increases of 69 percent in the Eastern Market, 44 percent in the Central Market, and by 111 percent in the Finger Lakes Market.[35]

Proposals to address workload increases for all facilities show: 1) construction and conversion of 67,000 square feet for additional outpatient care, and 2) contracting for some primary and specialty care with 31,000 square feet of leased space. The only new CBOC site being proposed in the DNCP is in the Canandaigua area (Finger Lakes Market), to enhance outpatient services following the proposed closure of the facility. The VISN also recognizes the importance of the Rochester CBOC, as there is no VA hospital in the community. VISN testimony called for expansion of outpatient services in Rochester.[36] However, the DNCP did not address expansion of the Rochester CBOC.

Commission Findings

1. Projected workload in the Finger Lakes Market indicates that additional services will be needed in this VISN, particularly for specialty care.

[35] Appendix D, *Data Tables*, page D-8.
[36] Bill Feeley, VISN 2 Director, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, page 58.

2 The DNCP proposes to address gaps in outpatient care through a mix of contracting and expansion of services at current sites of care.

Commission Recommendation

Given projected increases in workload in primary and specialty care, the Commission recommends that the need for either expanded and/or additional CBOCs be part of the strategic plan for VISN 2.

IV Special Disability Programs – Spinal Cord Injury Center

DNCP Proposal

"Build a new 30-bed Spinal Cord Injury (SCI)/Disorders unit at the Syracuse VAMC."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

SCI plans were developed on a national basis using actuarial modeling. Currently, patients go to VISN 3 (Castle Point, East Orange, Bronx) or VISN 10 (Cleveland). During the site visit, the Commissioners learned that VISN 2 had evaluated both Albany and Syracuse for the new SCI Center. After study and consultation with concerned stakeholder groups, Syracuse was selected, due to both its central location within the state and clinical expertise in managing the care of spinal cord injured patients.[37]

Mr. Richard DeNoyer from Paralyzed Veterans of America testified, "…PVA supports the CARES construction plan for a 30-bed SCI Center with an additional 18 long-term care beds…[W]e feel this new facility must be located on the Syracuse campus with easy access to all tertiary care services offered at the Syracuse facility."[38]

[37] Bill Feeley, VISN 2 Director, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, page 56.
[38] Richard DeNoyer, Paralyzed Veterans of America, Transcribed Testimony from the Canandaigua, NY, Hearing on October 20, 2003, pages 250-251.

Commission Finding

Adding an SCI Center in Syracuse will improve access and eliminate transportation hardships into New York City or Cleveland for patients and their families.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to build a new SCI Center in Syracuse.
2. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

VISN 3 – New York/New Jersey Integrated Service Network

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VISN 3, VA New York/New Jersey Veterans Health Care Network

VISN Overview

VISN 3, the VA New York/New Jersey Veterans Health Care Network, is an integrated, comprehensive health care delivery system that provides care to 381,000 enrolled veterans, with a total veteran population of 1.1 million. In FY 2003, the VISN furnished services to 181,000 veterans.[39] This VISN covers the most densely populated area in the nation and provides service to veterans from the Hudson Valley of New York, the metropolitan New York area, Long Island, and much of New Jersey. With a staff of 10,326 FTEs,[40] VISN 3 delivers health care services through three health care systems (made up of two or more medical facilities), two additional medical centers, six nursing homes, four domiciliary care facilities, and 32 community-based outpatient clinics (CBOCs). Additionally, VA operates 11 Vet Centers in VISN 3.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 3.

VISN 3	FY 2001	FY 2012	FY 2022
Enrollees	342,920	282,076	212,260
Veteran Population	1,179,101	804,514	568,541
Market Penetration	29.08%	35.06%	37.33%

For the CARES process, the VISN is divided into three markets: the New Jersey Market (*facilities:* East Orange and Lyons, NJ); the Metro New York Market (*facilities:* Castle Point, Montrose, Brooklyn, Manhattan, St Albans, and Bronx, NY); and the Long Island Market (*facility:* Northport, NY).

[39] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[40] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited five sites and conducted three public hearings in VISN 3. The Commission received 264 public comments regarding VISN 3.

- *Site Visits:* The St. Albans and Manhattan campuses of the New York Harbor Health Care System, the Montrose and Castle Point campuses of the Hudson Valley Health Care System, and the Lyons campus of the New Jersey Health Care System between July 22 and 24.
- *Hearings:* Lyons, NJ, on September 15; Bronx, NY, on September 17; and Montrose, NY, on October 21.

Summary of CARES Commission Recommendations

I Study Feasibility of Consolidating Manhattan and Brooklyn

1. The Commission concurs with the DNCP proposal that a feasibility study should be carried out before any proposal to consolidate the Manhattan campus of the New York Harbor Health Care System (HCS) with the Brooklyn campus is put forward.

(see page 5-42)

II Mission Change – Montrose and Castle Point Campuses of the Hudson Valley HCS

1. The Commission does not concur with the DNCP proposal to move all inpatient beds from Montrose to Castle Point.
2. The Commission recommends that the inpatient psychiatry beds be moved from the Montrose campus to the Castle Point campus.
3. The Commission recommends that the nursing home care beds be moved from the Montrose campus to the Castle Point campus.
4. The Commission recommends that the domiciliary-based residential rehabilitation programs and ambulatory care services remain at the Montrose campus.
5. The Commission recommends that:[41]
   a. Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

[41] Chapter 3, *National Crosscutting Recommendations: Long-Term Ca*re, contains additional information on this topic.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

6 The Commission recommends that the enhanced use leasing (EUL) proposals for the Montrose campus that have been held in abeyance pending the completion of the CARES process now go forward as soon as is feasible.

(see page 5-44)

III Campus Realignment – St. Albans Campus of the New York Harbor HCS

1 The Commission concurs with the DNCP proposal for changing the St. Albans campus subject to completion of a cost-benefit analysis.

2 The Commission recommends that:[42]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

3 The Commission concurs with the DNCP proposal to make land available at St. Albans for potential EUL opportunities, such as assisted living facility, transitional housing for homeless veterans, and veterans housing.

(see page 5-48)

[42] Chapter 3, *National Crosscutting Recommendations: Long-Term Ca*re, contains additional information on this topic.

IV Inpatient Care

1. The Commission concurs with the DNCP proposal to address the increased demand by FY 2012 in the Metro New York Market for inpatient services through absorption at the Brooklyn and New York campuses along with some contracting in the community.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to meet the increased demand in the New Jersey Market for inpatient services through expansion of in-house space via new construction and conversion of vacant space.

(see page 5-50)

V Primary and Specialty Outpatient Care

1. The Commission concurs with the DNCP proposal to meet the increase in demand for outpatient care through new construction to expand in-house space, conversion of vacant space, and using contracting in the community.
2. The Commission recommends that:[43]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

[43] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs),* contains additional information on this topic.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service setting.

(see page 5-51)

VI Special Disability Programs – Relocation of SCI Centers from East Orange, New Jersey, and Castle Point, New York, to the Bronx

1 The Commission concurs with the DNCP proposal to relocate the spinal cord injury/disorder (SCI/D) beds from Castle Point to the Bronx and with the DNCP proposal not to relocate the SCI beds from East Orange to the Bronx at this time.

2 The Commission recommends that VA direct inter-VISN coordination and action in order that the VISN 3's proposed consolidation at the Bronx facility of all the VISN's SCI/D beds can take place as soon as is feasible.

3 VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-54)

Study Feasibility of Consolidating Manhattan and Brooklyn

DNCP Proposal

"Develop a plan to consider the feasibility of consolidating acute inpatient care at the Brooklyn and incorporate the proposed outpatient care improvements for Brooklyn in the current plan. Maintain a significant outpatient primary and specialty care presence in Manhattan at the current site or another appropriate location in Manhattan."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The veteran enrollment for the New York metropolitan area is projected to decline over the next 20 years, to 80 percent of FY 2001 baseline enrollment by FY 2012 and 60 percent by FY 2022. Workload projections indicate that the need for inpatient medicine and surgery in the New York area will still be substantial to FY 2012 with a 16 percent increase over baseline in demand for medicine beds and no change in demand for surgical beds, based on the FY 2001 baseline. By FY 2022, these projections decline to 79 and 68 percent of baseline. The projections for inpatient psychiatry show an increase of 10 percent by FY 2012, followed by a decline to 85 percent of baseline in FY 2022. The workload projections for outpatient primary and specialty care show an increase in both by FY 2012 of 44 and 41 percent, respectively, with the increases tapering off to 4 and 3 percent by FY 2022.[44] For FY 2003, the average daily census at Brooklyn, which has 147 operating beds, was approximately 118, and approximately 135 at Manhattan, which has 166 operating beds.[45]

The Commission took note of a significant degree of input at the hearing and in comments in direct opposition to the potential shifting of work to Brooklyn. Dr. Robert Glickman, Dean of the New York University School of Medicine, the academic affiliate of the Manhattan facility, described the range and quality of services available at the Manhattan facility. He made the point that "[i]t is a mistake to think that the centers of excellence that now exist at the Manhattan VA can be replicated in Brooklyn without great cost to the Department and to the veterans who live in the community."[46]

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[44] Appendix D, *Data Tables*, page D-11.

[45] Stephen Gonzenbach, Chief of Audiology, VA NYHHCS, E-mail to William E. Brew, January 7, 2004.

[46] Robert Glickman, MD, Dean, New York University School of Medicine, Transcribed Testimony from the Bronx, NY, Hearing on September 17, 2003, page 111.

Many witnesses at the Bronx hearing testified about the difficulties of transportation in New York City, with a number of witnesses suggesting that public transportation between the Manhattan and Brooklyn facilities would be very challenging and time-consuming for veteran patients and nearly impossible for those veterans with disabilities that impact their mobility. Mr. Paul Wekenmann, representing the Disabled American Veterans, noted:

> …the plan to relocate services from the Manhattan 23rd Street VA Medical Center to the Brooklyn VA Medical Center (VAMC) has just made it so a veteran who by way of mass transit to the 23rd Street facility, now has to take two trains and two buses, and this now equates to an hour and a half commute.[47]

Commission Findings

1. Enrollment projections for the Metro New York Market are declining.
2. Workload projections for the Metro New York Market are declining over the period from FY 2012 to FY 2022.
3. Current occupancy rates at both Brooklyn and Manhattan are about 80 percent.
4. Veterans and stakeholders indicate that consolidation would hurt affiliations and veterans' access to VAMCs in the New York area.
5. A cost-benefit analysis has not been prepared.

Commission Recommendation

The Commission concurs with the DNCP proposal that a feasibility study should be carried out before any proposal to consolidate the Manhattan campus of the New York Harbor HCS with the Brooklyn campus is put forward.

[47] Paul A. Wekenmann, Supervisor National Service Officer, Disabled American Veterans, Written Testimony submitted at the Bronx, NY, Hearing on September 17, 2003, page 2.

II Mission Change – Montrose and Castle Point Campuses of the Hudson Valley HCS

DNCP Proposals

"*Montrose* – Current services of domiciliary beds and all other inpatient units including psychiatry, medicine, and nursing home will be transferred to Castle Point. Maintain outpatient services on the Montrose campus at a location that maximizes the EUL potential of the site. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans. *Castle Point* – Current inpatient services will be transferred from Montrose to Castle Point. The SCI unit would be relocated to the Bronx. Castle Point campus will maintain an SCI outpatient unit. Castle Point will convert to a critical access hospital."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The current CARES data indicate that the Montrose campus of the Hudson Valley HCS currently has 105 psychiatry beds, 148 domiciliary beds and 244 nursing home beds. The Castle Point campus of the Hudson Valley HCS has 25 inpatient medicine beds and 53 nursing home beds.[48] In connection with the Montrose hearing, Mr. Michael Sabo, Director, Hudson Valley Health Care System, indicated that the number of operating beds had changed and that the number of current beds at Montrose has been reduced to 70 psychiatry beds (average daily census [ADC] 54), 116 domiciliary beds (ADC 89), and 105 nursing home care beds (ADC 87); at Castle Point, the number of currently active beds is 27 medicine beds (ADC 18), and 75 nursing home care beds (ADC 66).[49]

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[48] Appendix D, *Data Tables*, page D-14.

[49] Michael Sabo, Director, VA Hudson Valley Health Care System, E-mail to William E. Brew, October 14, 2003.

At the Montrose hearing, Mr. Sabo described the rationale for the proposal to move acute and long-term psychiatric beds and nursing home beds to Castle Point. He noted that, since the Montrose and Castle Point campuses have been integrated into the Hudson Valley HCS, the "catchment area, or our market area in terms of the veterans we serve, has expanded beyond Westchester and Rockland County, which essentially Montrose served."[50] He went on to indicate "geographically speaking, Castle Point is about the midpoint in between the Bronx and the Albany VA."[51] Thus, the acute psychiatric beds would serve the northern portion of VISN 3, being well placed between similar beds at Bronx and Albany.

This plan would also enhance the emergency and general acute medical care for the inpatients on psychiatry and in the nursing home. Commissioners concur that while integrating acute and long-term psychiatry care at Castle Point enhances patient care, they reject the designation of a critical access hospital, and instead refer to Castle Point as a small hospital.

On the other hand, the Commission believes, based on testimony at the Montrose hearing and a review of information on the patients served, that the domiciliary-based residential rehabilitation programs should remain on the Montrose campus. These residential programs provide an integrated set of substance abuse, PTSD, and vocational rehabilitation services for veterans, many of whom come from the New York City metropolitan area. These programs are designed to reintegrate patients, including homeless veterans, into their home community, and need to be as close to the metropolitan area as possible. As Mr. Sabo noted, in describing the Montrose residential programs, "We serve as a resource not only for the veterans in the Hudson Valley, but for those folks in Yonkers and the northern Bronx," adding "many of our referrals come from the Bronx VA Medical Center, for those veterans requiring longer substance abuse treatment and for homelessness."[52] The Commission, recognizing the importance of access, believes it is appropriate to keep the residential rehabilitation program at Montrose, which is closer to metropolitan New York City.

The Commission recognizes that relocating the inpatient psychiatry and nursing home beds from Montrose to Castle Point could have some financial impact on the community but believes that the clinical benefits of the relocation justify the action. Moving the nursing home from Montrose to Castle Point, while potentially disruptive for the families of some veterans, has the advantage of combining two nursing homes, now each in space that does not meet current criteria, into one, new nursing home facility. A New York State-run veterans nursing home will remain at the Montrose campus.

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[50] Michael Sabo, Director, VA Hudson Valley Health Care System, Transcribed Testimony from the Montrose, NY, Hearing on October 21, 2003, page 60.

[51] Michael Sabo, Director, VA Hudson Valley Health Care System, Transcribed Testimony from the Montrose, NY, Hearing on October 21, 2003, page 60.

[52] Michael Sabo, Director, VA Hudson Valley Health Care System, Transcribed Testimony from the Montrose, NY, Hearing on October 21, 2003, page 66.

The Commission also recognizes that there may be a negative impact on some Montrose employees from the relocation. Mr. Sabo estimated that between 50 and 75 jobs presently at Montrose would not move to Castle Point and would no longer be needed following the move. Given the relative proximity of the two facilities (less than 30 miles apart, approximately 45 minutes driving time), the timeframe involved before any changes take place, the fact that, according to the facility leadership, nearly two-thirds of the employees at Montrose actually live closer to Castle Point, and the expressed willingness of the VISN and facility leadership to work with employees who might be relocated, either by moving them to other positions at Montrose, placing them with the relocated programs at Castle Point, or providing retraining, the Commission believes that such impact can be minimized. The Commission notes the necessity for the VISN to enhance transportation systems between the two campuses.

At the Montrose hearing, Mr. Sabo described the potential at the Montrose campus for an EUL. He noted that a project, which was put on hold when the current phase of the CARES process began, was originally for a 60-acre parcel, later reduced to 20 acres, that would be developed by an outside entity for senior housing and assisted living facilities.[53]

The Commission heard strong opposition from witnesses at the hearing in Montrose to the proposal in the DNCP to leave only ambulatory care at Montrose. There was however, general support, especially from veterans who testified at the hearing, for transferring the psychiatry and nursing home beds to Castle Point if, in addition to the ambulatory care, the residential rehabilitation beds were maintained at the Montrose campus. For example, Ralph DeMarco, the Executive Legislative Director for the New York State Council of Veterans Organizations, which consists of nearly 40 organizations, testified that the Council had helped develop the original plan that would have retained the domiciliary care at Montrose, and supported it.

Commission Findings

1. Moving acute and long-term psychiatric beds to Castle Point would improve access for inpatient psychiatric care for veterans in the northern sectors of the VISN.
2. The residential rehabilitation beds serve the northern New York Metro area and should remain as close to the patient population they serve as possible to facilitate reentry into productive community living.
3. Moving nursing home beds from Montrose to Castle Point will require a new nursing home facility to combine the existing nursing homes.

[53] Michael Sabo, Director, VA Hudson Valley Health Care System, Transcribed Testimony from the Montrose, NY, Hearing on October 21, 2003, page 91.

4. There would likely be some economic impact on the Montrose community.
5. An estimated 50 to 75 employee positions at Montrose would no longer be required after services are transferred to Castle Point, and the VISN has indicated its willingness to minimize the impact on employees.
6. Stakeholders are generally opposed to the proposed change in mission, but supportive of the proposal if the domiciliary-based residential rehabilitation programs and ambulatory care services are maintained at Montrose
7. Castle Point's inpatient workload has been stable over the past 4 years but is projected to decline to 10 and 13 beds in FY 2012 and FY 2022, respectively.[54]
8. Montrose appears to have excess space as workload has declined for the past 4 years.
9. Montrose has the potential for an EUL for the development of the excess property, which has not been realized pending the completion of the CARES process.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to move all inpatient beds from Montrose to Castle Point.
2. The Commission recommends that the inpatient psychiatry beds be moved from the Montrose campus to the Castle Point campus.
3. The Commission recommends that the nursing home care beds be moved from the Montrose campus to the Castle Point campus.
4. The Commission recommends that the domiciliary-based residential rehabilitation programs and ambulatory care services remain at the Montrose campus.
5. The Commission recommends that:[55]
    a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

[54] Appendix D, *Data Tables*, page D-14.
[55] Chapter 3, *National Crosscutting Recommendations: Long-Term Ca*re, contains additional information on this topic.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

6 The Commission recommends that the EUL proposals for the Montrose campus that have been held in abeyance pending the completion of the CARES process now go forward as soon as is feasible.

III Campus Realignment – St. Albans Campus of the New York Harbor HCS

DNCP Proposal

"Build new facilities for outpatient, nursing home, and domiciliary care. Demolish old facilities and design new construction on site to maximize the area for an enhanced use lease project such as assisted living facility or other compatible uses to benefit veterans. Any revenues or in-kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The large main building on the St. Albans campus of the New York Harbor HCS was built and used by U.S. Navy following World War II. For the purposes of patient care, it is costly to operate and is inefficient for health care delivery with corridors without air conditioning. The VISN's proposed plan for this campus, which furnishes only extended care services and outpatient care, is to raze all the buildings on its more than 60 acres and replace them with a 180-bed LTC facility and a 50-bed domiciliary, as well as a building for outpatient treatment.

The VISN also suggests an EUL opportunity to create veteran housing or an assisted living facility on the remainder of this campus. The Commission notes that the VISN did not provide any specific information on the cost of razing the existing buildings and constructing the replacements. Workload for the domiciliary has been steady with a 47 ADC in FY 2001, 47 in FY 2002, and 43 in FY 2003. Nursing home workload was similar in that it went from a 170 ADC in FY 2001, to 172 in FY 2002, and 159 in FY 2003.[56]

[56] Appendix D, *Data Tables*, page D-12.

The community supports this change. For example, Dr. Eugene Feigelson, Dean of the Downstate Medical School of the State University of New York, testified at the hearing in the Bronx: "As nearly two-thirds of the New York Harbor Health Care System enrollees reside in Brooklyn, Queens, and Richmond counties, and nearly 50 percent are over 65 years [old], we believe that continuing and upgrading services to the Brooklyn-Saint Albans' area is highly desirable."[57]

Commission Finding

Workload data for the domiciliary and nursing home have been stable for the past few years.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for changing the St. Albans campus.
2. The Commission recommends that:[58]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.
3. The Commission concurs with the DNCP proposal to make land available at St. Albans for potential EUL opportunities, such as assisted living facility, transitional housing for homeless veterans, and veterans housing.

[57] Eugene Feigelson, MD, Dean, Downstate Medical School of the State University of New York, Transcribed Testimony from the Bronx, NY, Hearing on September 17, 2003, page 107.

[58] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

IV Inpatient Care

DNCP Proposals

"*Medicine* – Decreasing demand identified in the Metro New York market will be absorbed at the Brooklyn and New York campuses with some contracting in the community. Increasing demand projected for the New Jersey market will be accommodated in-house through new construction (50,000 square feet) and conversion of vacant space (77,200 square feet). *Psychiatry* – Decreasing demand identified in the Metro New York market will be absorbed at the Brooklyn and New York campuses. Increasing demand projected for the New Jersey market will be met through the expansion of in-house services with new construction (107,000 square feet) and the conversion of vacant space (129,000 square feet)."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In the Metro New York Market, there is a projected increase in demand over the FY 2001 baseline for inpatient medicine (16 percent increase) and psychiatry beds (10 percent increase) by FY 2012. Workload projections then decline to 21 percent below baseline for medicine and 15 percent below baseline for psychiatry by FY 2022.[59] Pending completion of the feasibility study recommended on the possible consolidation of the Brooklyn and Manhattan VAMCs, the VISN proposes to meet current projected demand through FY 2012 by providing services at the Brooklyn and Manhattan VAMCs, with some contracting in the community to handle the immediate increases in demand.

There is a projected increase in demand for inpatient services in the New Jersey Market, with the demand for inpatient medicine increasing by 84 percent over the FY 2001 baseline by FY 2012 and decreasing to 33 percent above baseline by FY 2022. Demand for inpatient surgery is projected to increase by 65 percent by FY 2012 and then decline to 18 percent by FY 2022. The projection for inpatient psychiatry is a 27 percent increase by FY 2012, decreasing to 13 percent over baseline by FY 2022.[60] The VISN proposes to address the increase in demand with modifications of in-house capacity through either new construction or the conversion of vacant space.

[59] Appendix D, *Data Tables*, page D-11.
[60] Appendix D, *Data Tables*, page D-11.

Commission Findings

1. The inpatient demand projections for the Metro New York Market rise slightly by FY 2012.
2. By FY 2022, there is a projected decrease in demand for all inpatient services in the Metro New York Market.
3. There is a projected increase in demand for all inpatient services in the New Jersey Market.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to address the increased demand by FY 2012 in the Metro New York Market for inpatient services through absorption at the Brooklyn and New York campuses along with some contracting in the community.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to meet the increased demand in the New Jersey Market for inpatient services through expansion of in-house space via new construction and conversion of vacant space.

V Primary and Specialty Outpatient Care

DNCP Proposals

"*Primary Care* – Increased primary care outpatient demand has been identified in all three of the VISN's markets. The VISN proposes to meet the majority of this need through expansion of in-house space via new construction (138,000 square feet), conversion of vacant space (70,000 square feet), and utilization of community contracts. A new joint VA/DoD CBOC is proposed for Ft. Monmouth, NJ. A new CBOC for Passaic County, NJ, is included in the plan but is not in the high implementation priority group. *Specialty Care* – All three of the VISN's markets are projected to experience increased

outpatient specialty care demand. The VISN proposes to meet the majority of this need through the expansion of in-house services with new construction (457,000 square feet), vacant space conversion (114,000 square feet) and some utilization of community contracts."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Mr. Farsetta, VISN Director, testified that the CARES process identified an increase in demand for outpatient services by FY 2022 at all locations in the VISN.[61] Demand for primary care in the Long Island Market is projected to increase by 84 percent over the FY 2001 baseline by FY 2012 and to decrease to 30 percent over baseline by FY 2022. The projected demand for specialty care in this market is projected to increase by 103 percent over baseline by FY 2012 and to decrease to 45 percent over baseline by FY 2022. In the Metro New York Market, there is also a projected increase in demand for primary care by 44 percent by FY 2012, decreasing to just above the baseline by FY 2022. There is also a projected increase in demand for specialty care by 41 percent by FY 2012, again deceasing to just above the baseline by FY 2022.[62]

The greatest projected growth in demand for outpatient services in this VISN is in the New Jersey Market, with a projected increase of 88 and 39 percent for primary care by FY 2012 and FY 2022, respectively, and 146 and 88 percent increases for specialty care by FY 2012 and FY 2022, respectively.[63]

The VISN proposes to meet this increased demand largely through expansion of in-house capacity. Two new CBOCs – one joint with DoD – were proposed for the New Jersey Market, but neither was included in the DNCP's priority group one, although the Passaic County CBOC was opened early in 2003, prior to the completion of the CARES process.

[61] James Farsetta, VISN 3 Director, Transcribed Testimony from the Lyons, NY, Hearing on September 15, 2003, page 13.
[62] Appendix D, *Data Tables*, page D-11.
[63] Appendix D, *Data Tables*, page D-11.

Commission Findings

1. There is a projected increase in demand for outpatient services, including both primary care and specialty care, at all locations in the VISN.
2. The Passaic County CBOC opened in early 2003.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to meet the increase in demand for outpatient care through new construction to expand in-house space, conversion of vacant space, and using contracting in the community.
2. The Commission recommends that:[64]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service settings.

[64] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs),* contains additional information on this topic.

VI Special Disability Programs – Relocation of SCI Centers from East Orange, NJ, and Castle Point, NY, to the Bronx

DNCP Proposal

"The LTC spinal cord injury unit will be consolidated from Castle Point to the Bronx. The SCI unit at the East Orange campus will remain. Outpatient SCI services will be maintained at Castle Point."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Mr. Farsetta, VISN Director, testified regarding the VISN's plan to consolidate SCI inpatient services at the Bronx facility:

> We feel it would be more appropriate to relocate the inpatient portion of that [the East Orange SCI beds] to the Bronx, where we really have a state-of-the-art, high-quality program. It is not to say we don't have that at East Orange, but the Bronx runs an average daily census of between 42 and 50 … We think that would provide for continued high-quality programs with a real concentration.[65]

East Orange's current ADC for its SCI unit is seven and Castle Point has an ADC of 12. The SCI Center at the Bronx currently has an ADC of 40 for 62 operating beds, which means that this facility could meet the needs of the East Orange and Castle Point patients. Thus, Commissioners are satisfied that this proposal is the correct outcome for the VISN.

The Commission appreciates, however, that VISN 3 is receiving SCI/D patients on referral from neighboring VISNs (primarily VISN 4) and believes that, until an inpatient unit is available in VISN 4, there will be a need to maintain an inpatient SCI/D capacity at East Orange.

Ultimately, relocating the SCI/D beds from both East Orange and Castle Point to the Bronx or to the appropriate neighboring VISN is the correct decision. This would allow VISN 3 to establish a single, highly effective and efficient SCI Center at the Bronx VAMC.

[65] James Farsetta, VISN 3 Director, Transcribed Testimony from the Bronx, NY, Hearing on September 17, 2003, page 45.

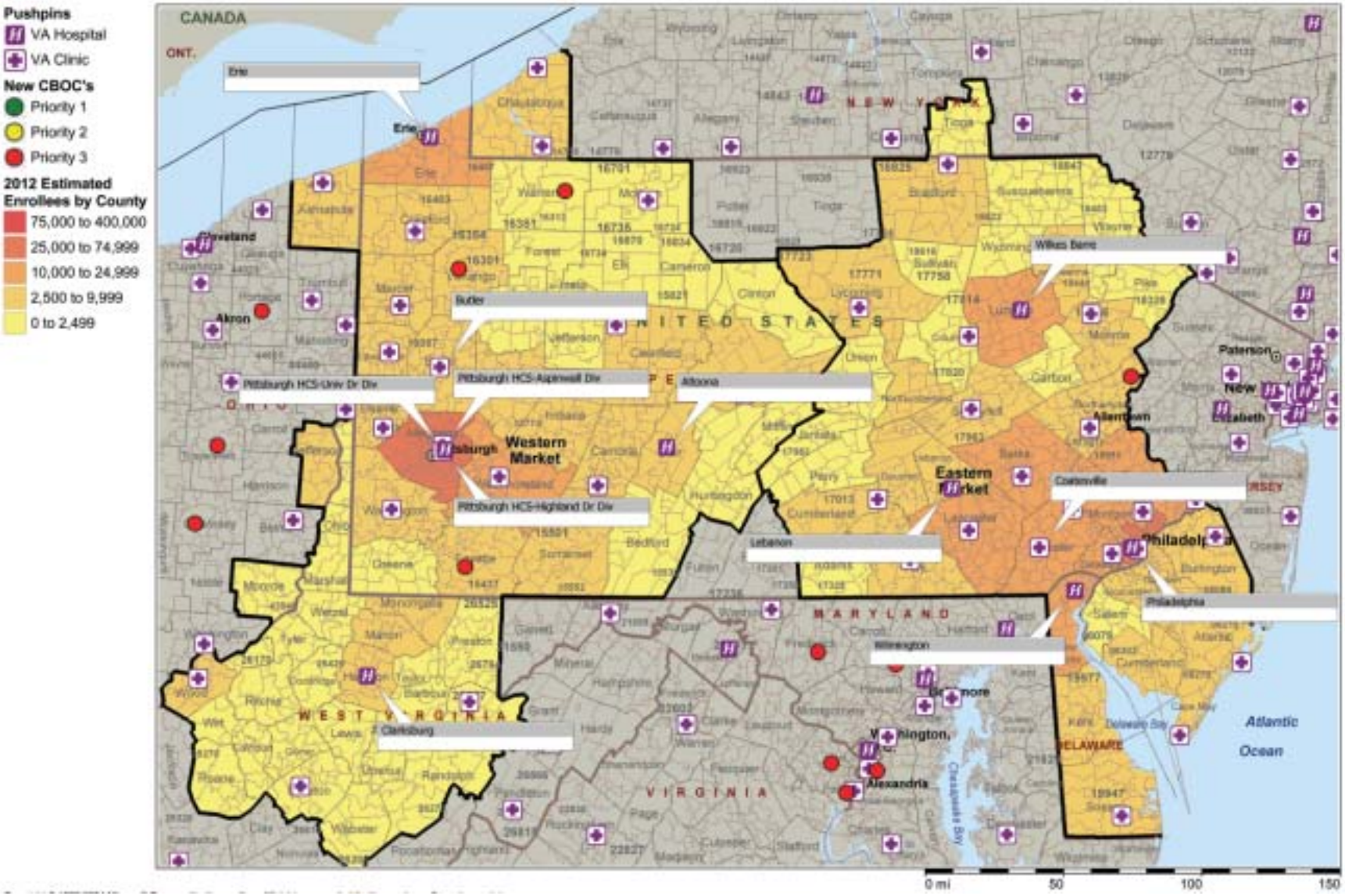
Commission Findings

1. The East Orange SCI/D unit provides care to veterans from neighboring VISNs, particularly veterans from VISN 4.
2. The VISN's proposal to relocate the SCI/D beds from both East Orange and Castle Point to the Bronx would allow the VISN to establish a single, highly effective and efficient SCI Center.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to relocate the SCI/D beds from Castle Point to the Bronx and with the DNCP proposal not to relocate the SCI/D beds from East Orange to the Bronx at this time.
2. The Commission recommends that VA direct inter-VISN coordination and action so that VISN 3's proposed consolidation at the Bronx facility of all the VISN's SCI beds can take place as soon as is feasible.
3. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

VISN 4 – VA Stars and Stripes Health Care Network



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VISN 4, VA Stars and Stripes Health Care Network

VISN Overview

VISN 4, VA Stars and Stripes Health Care Network, is an integrated, comprehensive health care system that provided medical services to approximately 262,000 of the 428,000 veterans enrolled in VA's health care system in FY 2003.[66] Geographically, this VISN spans about 59,000 square miles, which consists of all or part of Pennsylvania, Delaware, Ohio, West Virginia, New York, and New Jersey.

With a staff of approximately 9,647 FTEs[67], VISN 4 delivers health care services through 10 medical centers, 40 community-based outpatient clinics (CBOCs), 10 nursing homes, and three domiciliary facilities. Additionally, VA operates 12 Vet Centers in VISN 4's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA Projections and represent end of year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 4.

VISN 4	FY 2001	FY 2012	FY 2022
Enrollees	370,476	354,744	288,366
Veteran Population	1,582,854	1,172,269	887,670
Market Penetration	23.41%	30.26%	32.49%

For the CARES process, this VISN was divided into two markets: the Western Market (*facilities:* Clarksburg, WV; and Butler, Erie, Altoona, Highland Drive, University Drive, and Heinz (formerly Aspinwall), PA); and the Eastern Market (*facilities:* Philadelphia, Coatesville, Lebanon, and Wilkes-Barre, PA, and Wilmington, DE).

[66] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[67] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited five sites and held two public hearings in VISN 4. The Commission received 50 comments regarding VISN 4.

- *Site Visits:* Pittsburgh Health Care System's (HCS) University Drive and Highland Drive divisions and the Butler VA Medical Center (VAMC) on July 9; the Philadelphia and Wilmington VAMCs on July 10.
- *Hearings:* Pittsburgh on August 27; and Coatesville on August 28.

Summary of CARES Commission Recommendations

I Mission Change, Campus Realignment – Pittsburgh's Highland Drive Division

1. The Commission concurs with the DNCP proposal to consolidate services at the Highland Drive Division of the Pittsburgh HCS with the University Drive Division and the Heinz Progressive Care Center. The Commission, however, recommends that VA conduct an improved life cycle cost analysis.
2. The Commission recommends that VA consider the appropriateness of the current renovation of inpatient units at the Highland Drive Division in light of the DNCP proposal for consolidation.
3. The Commission recommends that VA consider enhanced use leasing (EUL) or divesture of the Highland Drive Division property. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-62)

II Mission Change, Small Facilities – Butler, Erie, and Altoona

Butler

1. The Commission concurs with the DNCP proposal to close acute care services at Butler. The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Butler area veterans and that the VISN pursue available resources in the Butler community, particularly with regard to Butler Memorial Hospital. The Commission further recommends that Butler VAMC maintain its outpatient and long-term care (LTC) programs.

Altoona

2 The Commission concurs with the DNCP proposal that Altoona maintain its outpatient services as well as its LTC programs.

3 The Commission does not concur with the DNCP proposal for Altoona to close its acute care services by FY 2012 and recommends that acute care beds be closed at Altoona as soon as reasonable.

4 The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Altoona area veterans and that the VISN pursue available resources in the Altoona community.

Erie

5 The Commission concurs with the DNCP proposal that Erie close its inpatient surgical services and retain outpatient (including outpatient surgery) and its LTC programs.

6 The Commission does not concur with the DNCP proposal that Erie maintain the remainder of its current inpatient services and recommends that all acute care beds be closed as soon as reasonable.

7 The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Erie area veterans and that the VISN pursue available resources in the Erie community.

Butler, Altoona, and Erie

8 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-65)

III Enhanced Use – Butler

1 The Commission concurs with the DNCP proposals regarding EUL leasing opportunities at the Butler VAMC. The Commission also recommends that the EUL proposal with Butler Memorial Hospital be made a high priority for VA and that the evaluation of this EUL opportunity be completed within six to nine months.

2 The Commission concurs with the EUL proposal with Butler County for a new 16-bed intermediate mental health facility on VA grounds.

(see page 5-70)

IV Inpatient Care

1. The Commission concurs with the DNCP proposals to improve inpatient care through in-house expansions and community contracts, where appropriate.
2. The Commission recommends that:
   - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission recommends that the Philadelphia and Wilmington VAMCs proceed with further consolidation of services.

(see page 5-72)

V Outpatient Care

1. The Commission concurs with the DNCP proposal to meet increased demand through in-house expansion, contracting out, enhanced use arrangements, and increased use of CBOCs.
2. The Commission recommends that: [68]
   - a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

[68] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-74)

VI Special Disability Programs – Spinal Cord Injury Outpatient Clinic at the Philadelphia VAMC

1 The Commission concurs with the DNCP proposal to establish a certified spinal cord injury/disorder (SCI/D) outpatient clinic in Philadelphia.

2 The Commission recommends that inter-VISN coordination and planning for SCI/D patients be improved, especially between VISN 3 and VISN 4. Once this inter-VISN coordination has been improved, the Commission recommends that VA reevaluate the current and projected SCI/D bed needs for VISN 4 in order to determine whether a 30-bed SCI Center should be established in the eastern part of VISN 4.

(see page 5-76)

VII Extended Care

1 The Commission recommends that: [69]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-78)

[69] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

Mission Change, Campus Realignment – Pittsburgh's Highland Drive Division

DNCP Proposal

"Current services at Highland Drive will be transferred to University Drive and Heinz (formerly Aspinwall) campuses, with new facilities for psychiatry, mental health, and related research and administrative services. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans. A major construction project to accommodate services at the University Drive and Aspinwall campuses is required."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan [The VISN's preferred alternative]:* Over 500,000 square feet of new space and additional parking at University Drive must be added to the two remaining divisions to fit all essential services now housed at Highland Drive. The plan also adds space for the projected increases in demand in care as well as the proposed collocation of VBA.
3. *100 Percent Contracting:* All care provided at the Highland Drive division would be sent to an outside health care facility. Those services include inpatient psychiatry, inpatient PRRTP, outpatient specialty care, and ancillary and diagnostics. Administrative space would be leased.

Commission Analysis

The Pittsburgh HCS has three facilities: the University Drive and Highland Drive divisions and the Heinz Progressive Care Center. The University Drive Division consists of 146 medicine, surgery, neurology, and critical care beds. It also has primary and specialty care outpatient clinics and ambulatory surgery. The Heinz facility has 336 nursing home beds, primary care, adult day care, and hospice care. The third, the Highland Drive Division, has 210 psychiatry beds, including 101 patients in a homeless veteran domiciliary unit.[70]

The consolidation of the Highland Drive and University Drive divisions has been ongoing for a number of years, and much of the Highland Drive Division has unused buildings. The proposed change would consolidate Highland Drive's psychiatry services (average daily census [ADC] 60) at the University Drive Division, which, as stated, currently provides acute medicine services. Consolidating Highland Drive's

[70] VISN 4, Pittsburgh HCS, *Trip Pack Data* Submitted for the July 9, 2003 Commission Site Visit.

residential rehabilitation (ADC 31) and domiciliary services (ADC 58) to the Heinz facility would not adversely affect the mission of these two services nor veterans' access to them.

Lawrence Biro, VISN Director, testified on the impact of the consolidation on inpatient and outpatient services and research space:

> The most reasonable location for the addition of most outpatient care and research space is the University Drive Division, which is adjacent to the affiliate and nearest to the urban center of Pittsburgh. Veterans expressed a strong preference to have their outpatient care provided at the University Drive location. Consolidation of behavioral health and medical care functions and collocation of administrative functions would be possible in this scenario.[71]

The Highland Drive Division is a 50-year-old, campus-style setting situated on approximately 168 acres. The main patient care buildings are in good condition overall, while some areas are functionally and aesthetically antiquated. The inpatient units are currently under renovation, and all the beds will be grouped in one of the more than 20 existing buildings within the next few years. Most of the remaining space is in moderate-to-poor condition and houses administrative and patient care support functions. The Highland Drive Division has the most vacant space of the three divisions in the Pittsburgh Health Care System. One building is in good condition and has a large, vacant floor, which could be used for enhanced use alternatives. Another building has vacant wings that would make excellent office space and are also available for enhanced use opportunities.

The Commission's review of the life cycle cost data raised questions about the validity of the data. For example, construction costs for the garage and addition to University Drive are estimated as approximately $100 million but past experiences in constructing similar garages indicate the cost could be $200 million. Also, demolition costs of $286,000 are cited but, again, similar experiences would indicate that the costs could be as high as $11 million.[72]

Veterans and stakeholders expressed support for the enhancement of services that the proposed consolidation would bring, but raised two key concerns. First, they seek assurances that there would be no loss of

[71] Lawrence Biro, VISN 4 Director, Written Testimony submitted at the Pittsburgh, PA, Hearing on August 27, 2003, page 18, available from [*http://www.carescommission.va.gov/Documents/PittsburghPanel1Part2.pdf*].

[72] Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

services while construction is being completed. Second, they discussed the funding issues. As Senator Rick Santorum stated:

> I remind the Commission of the difficulty of delivering on these construction funds and that it not undermine the delivery of care to those in need.[73]

The academic affiliation with the University of Pittsburgh School of Medicine will benefit from the proposed consolidation of services. Dr. Loren Roth, Associate Vice Chancellor for Health Services at the University of Pittsburgh School of Medicine, testified:

> Of particular interest to the University of Pittsburgh, as an affiliate partner, is the proposal to consolidate the three divisions of the VA Pittsburgh Health Care System into two. We do support this proposal, if fully funded, for several critical reasons. The modern facilities that this plan proposes are an essential precursor to the delivery of excellent care. Patient confidence and comfort are enhanced when it is delivered in an aesthetically appealing environment designed to meet modern space, privacy standards, technology requirement, and so forth.[74]

Commission Findings

1. Consolidation of Highland Drive Division's inpatient services to the University Drive campus over the past few years has resulted in vacant buildings at the Highland Drive campus.
2. The proposed consolidation of Highland Drive Division's psychiatry services to the University Drive campus would align psychiatry services with acute medicine services.
3. To accommodate the consolidation of Highland Drive Division's services to the other two facilities, VA would need to construct more than 500,000 square feet of additional clinical and administrative space at the two receiving divisions and a 900-car parking garage at the University Drive Division.
4. Since considerable consolidation of services has already taken place at the Highland Drive Division and the facilities are in close proximity, there should be less impact on veterans' access to care, on the community, and on employees.

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[73] The Honorable Rick Santorum, U.S. Senator from Pennsylvania, Written Testimony submitted at the Pittsburgh, PA, Hearing on August 27, 2003, page 5, available from [*http://www.carescommission.va.gov/Documents/PittsburghCongressionalStatementsPart1.pdf*].

[74] Dr. Loren Roth, Associate Vice Chancellor for Health Services at the University of Pittsburgh School of Medicine, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, page 56.

5 There are inpatient units at the Highland Drive Division currently under renovation.

6 From a clinical perspective, additional consolidation appears to be appropriate.

Commission Recommendations

1 The Commission concurs with the DNCP proposal to consolidate services at the Highland Drive Division of the Pittsburgh Health Care System with the University Drive Division and the Heinz Progressive Care Center. The Commission, however, recommends that VA conduct an improved life cycle cost analysis.

2 The Commission recommends that VA consider the appropriateness of the current renovation of inpatient units at the Highland Drive Division in light of the DNCP proposal for consolidation.

3 The Commission recommends that VA consider EUL or divesture of the Highland Drive Division property. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

II Mission Change, Small Facilities – Butler, Erie, and Altoona.

DNCP Proposals

Butler – "Butler will maintain nursing home and outpatient services and close its hospital acute care services."

Altoona – "Altoona will maintain outpatient services and close its hospital acute care services by FY 2012 as the need for acute care beds declines."

Erie – "Erie will maintain its current services except it will close its inpatient surgical services and retain outpatient surgery and observation beds. The inpatient demand from these programs will be referred to Pittsburgh or contracted out to the community."

DNCP Alternatives

1 Retain acute hospital beds

2 Close acute hospital beds and reallocate workload to another VA facility

3. Close acute hospital beds and implement contracting, sharing or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

Three of the five medical centers in VISN 4's Western Market – Butler, Altoona, and Erie – were identified through the CARES process as small facilities. The Commission evaluated these three medical centers by first reviewing current and projected workload data, the facilities' relationship to the Pittsburgh HCS, and identifying resources available in the communities as alternatives to VA care.

Butler VAMC. The Butler VAMC has eight acute medicine beds (ADC 3, 42 percent occupancy), a 97-bed nursing home care unit (NHCU) (ADC 60, 62 percent occupancy), and 56 domiciliary beds (ADC 45, 81 percent occupancy). It also provides outpatient primary care, specialty care, and mental health services. Workload data indicate that Butler has three inpatient psychiatry beds with an ADC of zero. CARES projections indicate that the Butler VAMC will need 11 acute beds by FY 2012 and eight by FY 2022.[75] Patients requiring complex health care services are referred to the Pittsburgh HCS, which is approximately 39 miles away, and veterans who are unable to be transported to Pittsburgh use Butler Memorial Hospital for emergent care. There are at least four hospitals with JCAHO accreditation within 60 minutes of the Butler VAMC, and all appear to have excess capacity.[76]

Altoona VAMC. The Altoona VAMC has 28 acute medicine beds (ADC 17, 60 percent occupancy) and 40 NHCU beds (ADC 31, 77 percent occupancy). It also provides outpatient primary care, specialty care, and mental health services, and ambulatory surgery. CARES projections indicate that Altoona will need 19 acute beds by FY 2012 and 13 by FY 2022.[77] Patients requiring complex health care services are referred to the Pittsburgh HCS, which is approximately 92 miles from Altoona, and veterans who are unable to be transported to Pittsburgh use local hospitals for emergent care. There are 10 community medical centers with JCAHO accreditation that are within 60 minutes of the Altoona VAMC. Six of these 10 community medical centers appear to have excess capacity.[78] Altoona VAMC currently uses community resources for urgent care services, MRI services, as well as employing 60 to 70 community physicians for specialty services.[79]

[75] Appendix D, *Data Tables*, page D-21.
[76] Appendix D, *Data Tables*, page D-21.
[77] Appendix D, *Data Tables*, page D-21.
[78] Appendix D, *Data Tables*, page D-22.
[79] Gerald Williams, Director Altoona VAMC, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, page 32.

Erie VAMC. The Erie VAMC has 26 acute medicine beds (ADC 9, 34 percent occupancy), nine surgery beds (ADC 2, 26 percent occupancy), and 52 transitional care/NHCU beds (ADC 37, 71 percent occupancy). It also provides outpatient primary care, specialty care, and mental health services, and ambulatory surgery. CARES projections indicate that this facility will need 14 acute beds by FY 2012 and 10 by FY 2022.[80] Patients requiring complex health care services are referred to the Pittsburgh HCS, approximately 135 miles from Erie. Veterans who are unable to be transported to Pittsburgh use local hospitals for emergent care. There are four JCAHO medical centers within 60 minutes of Erie, three of which indicate excess capacity.[81] Erie VAMC currently uses community resources for urgent care services, as well as employing a group of community physicians for specialty and subspecialty services, such as neurology and cardiology.[82]

While Pennsylvania's veteran population will decline over the next eight years, the number of veterans projected to enroll for medical care in the Western Market served by Pittsburgh, Erie, Butler, Altoona, and Clarksburg, WV, will increase from 161,000 in FY 2002 to 192,000 in FY 2012. In addition, the VISN 4 Director testified that in FY 2012, this area would need to be prepared to handle a 20 percent increase in inpatient medical care services for veterans from FY 2001.[83] The need for inpatient surgery services is decreasing due to improved ambulatory surgical care and new non-invasive treatments.

The Western Market is built on a hub-and-spoke system in which the Pittsburgh HCS, the hub, provides a full array of acute inpatient services. Erie, Butler, Altoona, and Clarksburg are the spokes that have a strong referral relationship with Pittsburgh, as well as ensuring collaboration and coordination among the five facilities on individual patient care.

The DNCP proposes consolidation of the Highland Drive Division of the Pittsburgh HCS with new construction to affect the consolidation effort. Closing the Highland Drive Division at the Pittsburgh HCS would not appear to negatively impact the referral patterns for these small facilities for two reasons. First, the consolidation effort has been underway for a number of years. Second, the VISN Director testified that the Pittsburgh HCS would convert decreasing surgery beds to medicine beds to absorb the workload referred from Butler, Erie, and Altoona.[84]

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[80] Appendix D, *Data Tables*, page D-21.

[81] Appendix D, *Data Tables*, page D-22.

[82] James Palmer, Director Erie VAMC, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, page 33.

[83] Lawrence Biro, VISN 4 Director, Written Testimony submitted at the Pittsburgh, PA, Hearing on August 27, 2003, page 9, available [*http://www.carescommission.va.gov/Documents/PiitsburghPanel1Part1.pdf*].

[84] Lawrence Biro, VISN 4 Director, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, page 1.

Describing the current situation, Mr. Biro, VISN Director, testified:

> This option [referring to the VISN's proposals for Butler, Erie, and Altoona] ensures that inpatient care will be provided in hospitals that have, at the very least, full secondary inpatient services and that generate volume, which can maintain provider/staff competency. It should be noted that all three medical centers work closely with their respective community hospitals and have a strong referral relations with VA Pittsburgh. This past experience helps to substantiate the quality of care received at the community hospitals and VA Pittsburgh and will ease the implementation of closing the VA beds. The use of community hospitals can also increase access for veterans.[85]

The Commission notes that the three small facilities currently use community resources to augment VA health care services including inpatient services. The Commission believes that expanded use of community resources may be in order. In keeping with VA's high standards of health care, however, the Commission would urge the VISN to proceed to expand use of community resources only if such resources ensure veterans access to quality care.

Commission Findings

1. The number of veterans projected to enroll for medical care in the Western Market of VISN 4, the area served by Pittsburgh, Erie, Butler, Altoona, and Clarksburg, WV, will increase from 161,000 in FY 2002 to 192,000 in FY 2012.
2. The Western Market of VISN 4 is built on a hub-and-spoke system in which the Pittsburgh HCS is the hub.
3. Butler, Altoona, and Erie have low acute inpatient ADC and occupancy rates. CARES projections indicate all three will be well below the 40-bed threshold for small facilities.
4. There are JCAHO-accredited hospitals within 60 minutes of each of the three facilities that appear to have excess capacity.
5. The three facilities currently use community providers.
6. The VISN Director acknowledged that, in conjunction with the Pittsburgh HCS, local hospitals could absorb the workload and provide quality care.

[85] Lawrence Biro, VISN 4 Director, Written Testimony submitted at the Pittsburgh, PA, Hearing on August 27, 2003, page 13, available from [*http://www.carescommision.va.gov/Documents/PittsburghPanel1Part2.pdf*].

7 The simultaneous reduction or elimination of inpatient services at the Erie and Altoona VAMCs may have a combined negative effect on the delivery of VA care in the Western Market of VISN 4 that cannot be calculated.

Commission Recommendations

Butler

1 The Commission concurs with the DNCP proposal to close acute care services at Butler. The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Butler area veterans and that the VISN pursue available resources in the Butler community, particularly with regard to Butler Memorial Hospital. The Commission further recommends that Butler VAMC maintain its outpatient and LTC programs.

Altoona

2 The Commission concurs with the DNCP proposal that Altoona maintain its outpatient services as well as its LTC programs.

3 The Commission does not concur with the DNCP proposal for Altoona to close its acute care services by FY 2012 and recommends that acute care beds be closed at Altoona as soon as reasonable.

4 The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Altoona area veterans and that the VISN pursue available resources in the Altoona community.

Erie

5 The Commission concurs with the DNCP proposal that Erie close its inpatient surgical services and retain outpatient (including outpatient surgery) and its LTC programs.

6 The Commission does not concur with the DNCP proposal that Erie maintain the remainder of its current inpatient services and recommends that all acute care beds be closed as soon as reasonable.

7 The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Erie area veterans and that the VISN pursue available resources in the Erie community.

Butler, Altoona and Erie

8 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

III Enhanced Use – Butler

DNCP Proposal

"Butler is exploring a number of potential enhanced use proposals. The proposals include: adult residential living program, 16-bed intermediate psychiatry facility, administrative space for DOD, and community diagnostic services center. In addition, the local community hospital (Butler Memorial) and Butler have explored enhance use opportunities on the VA campus to expand specialty care. This innovative proposal would enhance services to veterans in the Butler area and could results in replacing older buildings with more state-of-the-art, energy efficient space."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Mr. Michael Finegan, Director of the Butler VAMC, indicated that Butler Memorial Hospital and the Butler VAMC have been working together for a number of years and currently share some services, such as computerized tomography services. He said that Butler Memorial Hospital has expressed an interest in locating part or all of its health care system on the VA campus. This would provide a more desirable location and better transportation for its patients and would also benefit VA, which then could maintain some services in Butler that might not otherwise be available.[86]

Mr. Joseph Stewart, the CEO of Butler Memorial Hospital, testified that Butler Memorial Hospital has outgrown its present campus and that, as part of its long-term plan, there is a need to consider

[86] Michael Finegan, Director Butler VAMC, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, pages 28-31.

creating a new campus elsewhere. Mr. Stewart would support establishing a partnership with the Butler VAMC.[87]

At the site visit to Butler, Mr. Finegan noted that Butler Memorial Hospital is anxious to move forward on the EUL opportunity. Mr. Stewart raised concerns, however, about the potential delay in the EUL process noting during the Pittsburg hearing, "I hope this can be achieved in the timeframe that benefits all. Frankly, we are, the community sector, staggered sometimes by the government timelines."[88]

At the Pittsburgh hearing, Mr. Finegan also indicated that the Secretary of Veterans Affairs has approved an EUL project with Butler County to build a 16-bed intermediate mental health facility on VA grounds. Two of these beds would be dedicated to veterans.

Commission Findings

1. The Butler VAMC and Butler Memorial Hospital presently share services such as computerized tomography services.
2. Butler Memorial Hospital has outgrown its present campus and is aggressively searching for a new location.
3. The CEO from Butler Memorial Hospital and the Butler VAMC Director believe the EUL proposal in Butler represents an opportunity that would benefit both veterans and the community.
4. The current EUL opportunity with Butler Memorial Hospital is time-critical and, if it is not approved, the opportunity may disappear.
5. VA Central Office has indicated that the Butler VAMC should proceed with an EUL project with Butler County for a new 16-bed intermediate mental health facility on VA grounds.

Commission Recommendations

1. The Commission concurs with the DNCP proposals regarding EUL opportunities at the Butler VAMC. The Commission also recommends that the EUL proposal with Butler Memorial Hospital be made a high priority for VA and that the evaluation of this EUL opportunity be completed within six to nine months.
2. The Commission concurs with the EUL proposal with Butler County for a new 16-bed intermediate mental health facility on VA grounds.

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[87] Joseph Stewart, CEO Butler Memorial Hospital, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, pages 119-120.

[88] Joseph Stewart, CEO Butler Memorial Hospital, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, pages 120-121.

IV Inpatient Care

DNCP Proposal

"Inpatient medicine demand is increasing the Eastern Market while inpatient surgery demand is decreasing in the Western Market. The Eastern Market increase will be managed by in-house expansion, contracting out, and enhanced use at all five hospital sites. The Pittsburgh HCS in the Western Market will convert the decreasing surgery beds to medicine beds to absorb part of the workload from Butler, Altoona, and Erie."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The inpatient growth in VISN 4 is primarily in the Eastern Market, which is projected to experience a 32 percent increase in inpatient medicine workload over the FY 2001 baseline by FY 2012. Western Market's inpatient medicine workload is projected to increase by 20 percent over baseline by FY 2012, but is projected to decrease by 13 percent from baseline by FY 2022. On the other hand, the Western Market's inpatient surgery workload is projected to decrease by 13 percent from baseline by FY 2012 and to further decrease by 38 percent from baseline by FY 2022. Projections for inpatient psychiatry for FY 2012 include some increased workload for both markets (9 percent for Eastern Market; 7 percent for Western Market).

There has been consolidation of health care and administrative services between the Wilmington and Philadelphia VAMCs to maximize the VISN's use of available resources. As Mr. Lawrence Biro, VISN Director, testified:

> There are a lot of things going on between Philadelphia and Wilmington. Philadelphia is our tertiary center, and they take the serious cases and the additional diagnostic work. They're the ones that have the MRI and the full range of tertiary services. So Wilmington has mission critical services, and they work together to make sure that there's that continuum of care. There are consolidations. Philadelphia is the laboratory…and a lot of laboratory work from Wilmington, in fact a great amount, goes to Philadelphia.[89]

[89] Lawrence Biro, VISN 4 Director, Transcribed Testimony from the Coatesville, PA, Hearing on August 28, 2003, pages 67-68.

CARES Workload Reports[90] and the hearing record indicate that most of the projected increases throughout the VISN are in inpatient medicine. Since the Western Market's surgery demand is decreasing, the increased demand for inpatient medicine care in that market will be managed by converting the decreasing surgery beds to medicine beds. Doing this will also enable the Pittsburgh HCS to absorb workload from Butler, Erie, and Altoona. In the Western Market, increased demand for inpatient medicine will be managed in-house by'"using the space vacated through declines in admissions to support the projected increases in medicine and specialty care."[91] Further, the VISN indicated that it would like to reclaim inpatient space by moving some specialty care services into outpatient clinic settings.

Commission Findings

1. Inpatient medicine workloads are projected to increase in VISN 4, but significantly in its Eastern Market.
2. Inpatient surgery in the Western Market is projected to decrease, which will allow the Pittsburgh HCS to mange its increasing workload through conversion of surgery beds to medicine beds. It also enables the Pittsburgh HCS to absorb the workload from Erie, Butler, and Altoona.
3. Philadelphia and Wilmington have been consolidating health care and administrative services to maximize the VISN's use of available resources.
4. Inpatient capacity at the VAMCs will be achieved by reallocating specialty care to CBOC settings.
5. Contracting for care is a reasonable approach to maintaining or improving access to health care.

Commission Recommendations

1. The Commission concurs with the DNCP proposals to improve inpatient care through in-house expansions and community contracts, where appropriate.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission recommends that the Philadelphia and Wilmington VAMCs proceed with further consolidation of services.

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[90] VISN 4 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=35*].

[91] Lawrence Biro, VISN 4 Director, Written Testimony submitted at the Pittsburgh, PA, Hearing on August 27, 2003, page 9, available from [*http://www.carescommission.va.gov/Documents/PittsburghPanel1Part1.pdf*].

V Outpatient Care

DNCP Proposal

"Specialty care is increasing in demand for both markets and primary care in the Eastern Market. In-house expansion, contracting out, and enhanced use arrangements will handle the specialty care workload. Space for additional in-house specialty clinics will be achieved through increased use of CBOCs for primary care to free up specialty care space at VAMCs. These CBOCs are proposed but are not in the national high priority category."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

There are five new CBOCs proposed, but none in VISN 4 are in priority group one. Growth in outpatient demand in this VISN is primarily in the Eastern Market, where outpatient primary care workload is projected to increase by 50 percent over the FY 2001 baseline by FY 2012 and, for this same period of time, specialty care will increase by 117 percent. By FY 2022, demand for primary care in the Eastern Market is projected to have decreased from the 2012 projections at 19 percent over the baseline of FY 2001, and specialty care will be only 79 percent over baseline. In the Western Market, outpatient specialty care is the primary growth area, and this workload is projected to increase by 43 percent over the baseline by FY 2012 and then drop to 11 percent over baseline by FY 2022.

In the Eastern Market, increased demand for outpatient specialty care services will be managed in-house by reclaiming inpatient space vacated through declines in admissions or when appropriate through outside contracts. Testimony from one academic affiliate at the Coatesville hearing described how the VISN furnishes specialty care services through contracts with the medical school:

> Specialty contracts with PSUCOM/MSHMC [Penn State University College of Medicine, Milton S. Hershey Medical Center] have allowed VAMC [Lebanon] to provide needed specialty services to veterans. Current specialty contracts with PSU/MSHMC include the following: anesthesia, cardiology, dermatology, ophthalmology, and urology. Without these specialty agreements, veterans would be required to travel a minimum of two hours for care to the VISN 4 eastern hub facility.[92]

[92] R. Kevin Grigsby, D.S.W., Vice Dean for Faculty and Administrative Affairs Milton S. Hershey Medical Center at Penn State University, Written Testimony Submitted at the Coatesville, PA, Hearing on August 28, 2003, page 2, available from [*http://www.carescommission.va.gov/Documents/CoatesvillePanel6.pdf*].

The VISN Director testified that the VISN can establish new CBOCs within allocated resources.[93] Veterans and stakeholders strongly support the expansion of services through CBOCs.

> At present, our veterans and their dependents must travel 40-46 miles to reach the nearest medical facility (outpatient clinic) located at 3100 Hamilton Blvd., Allentown, PA. In addition, if a veteran were in need of more advanced medical care, the nearest VA medical hospital is 72-83 miles from Bangor Borough. Average travel times for veterans from Bangor to Wilkes-Barre = 1 hour 55 minutes. Average travel time Bangor to Allentown – 1 hour 5 minutes.[94]

In the Western Market, a new CBOC was requested by the VISN for Morgantown, WV, in order to redistribute workload from the parent facility, the Clarksburg VAMC. This CBOC would promote the affiliate relationship between VA and the University of West Virginia Medical School, which has expressed a willingness to place residents in medical and surgical specialties in the CBOC.[95]

The Commission also heard testimony on how best to include specialty care for women veterans:

> It is of importance that each VISN keep in mind the growing number of women veterans who will be knocking on the door to access the VA in the future. An additional concern of women veterans is the uncertain outcome of the possibility of mainstreaming women veterans' health care into general primary care clinics. We fear if these clinic areas are lost or if a total mainstreaming is accomplished, the attention to the interplay of the medical conditions of women will take a step back in time.[96]

Commission Findings

1. Outpatient primary and specialty care workloads are projected to increase in the Eastern Market.
2. The VISN plans to increase specialty care services in CBOC settings.
3. The VISN Director stated that the VISN can establish new CBOCs within allocated resources.
4. In the Eastern Market, the VISN has been successful in involving a medical affiliate to provide specialty care.

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[93] Lawrence Biro, VISN 4 Director, Transcribed Testimony from the Coatesville, PA, Hearing on August 28, 2003, page 67.

[94] The Honorable Joseph Capozzolo, Mayor of Bangor, PA, Written Testimony submitted at the Coatesville, PA, Hearing on August 28, 2003, page 1, available from [*http://www.carescommission.va.gov/Documents/CoatesvillePanel7.pdf*].

[95] Glen Struchtemeyer, Director Clarksburg, WV, VAMC, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, page 49.

[96] Marsha Four, Program Director Homeless Veterans, Written Testimony submitted at the Coatesville, PA, Hearing on August 28, 2003, pages 2 and 3, available from [*http://www.carescommission.va.gov/Documents/CoatesvillePanel4.pdf*].

5 A medical affiliate in the Western Market has expressed a willingness to train students and residents in CBOCs.

Commission Recommendations

1 The Commission concurs with the DNCP proposal to meet increased demand through in-house expansion, contracting out, enhanced use arrangements, and increased use of CBOCs.

2 The Commission recommends that: [97]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

VI Special Disability Programs – Spinal Cord Injury Outpatient Clinic at the Philadelphia VAMC

DNCP Proposal

"Add a new outpatient SCI clinic at Philadelphia."

[97] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

VISN 4 does not have a SCI Center. Veterans requiring care at a SCI Center are referred to VISNs 3, 6, and 10. In VISN 4's Western Market, the Pittsburgh VA HCS has a SCI outpatient clinic.

According to information provided by VISN 4, it had 588 SCI users in FY 2001 who used approximately 5,800 bed days of care. This workload equates to 19 beds. Projections indicate that VISN 4 would need 47 acute and 66 LTC beds dedicated to SCI/D by FY 2022.[98]

VISN 4 refers the greatest number of its SCI veterans to VISN 3.[99] This suggests that Philadelphia may be an appropriate location to provide SCI services. However, the Philadelphia VAMC does not currently have a certified SCI outpatient clinic where staff are appropriately trained to serve the unique needs of SCI patients.

The Commission notes the need for improved inter-VISN coordination and planning, particularly with regard to SCI care for VISN 3 and VISN 4 veterans.

Commission Findings

1. The need for SCI specialty care is increasing in VISN 4.
2. The Philadelphia VAMC does not currently have a certified SCI outpatient clinic.
3. VISN 4 refers the majority of its SCI patients to VISN 3.
4. Because VA planning for SCI services is done at a national level, inter-VISN coordination needs to be improved, especially between VISN 3 and VISN 4.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to establish a certified SCI/D outpatient clinic in Philadelphia.

[98] Michael W. Neusch, FACHE, VISN 4 Assistant Director, Email to Kathy Collier received on September 3, 2003.
[99] Michael W. Neusch, FACHE, VISN 4 Assistant Director, Email to Kathy Collier received on September 3, 2003.

2 The Commission recommends that inter-VISN coordination and planning for SCI/D patients be improved, especially between VISN 3 and VISN 4. The Commission recommends that VA reevaluate the current and projected SCI/D bed needs for VISN 4 in order to determine whether a 30-bed SCI Center should be established in eastern part of VISN 4.

VII Extended Care

DNCP Proposal

"Proposed capital investments for nursing home care to remedy space deficiencies are included for Altoona, Butler, Coatesville, Lebanon, and Clarksburg."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP did not provide specific data on these space deficiencies. Further, information on the particular sites was not gathered at the relevant hearings. Therefore, the Commission cannot evaluate this proposal.

Commission Findings

1 In some cases, especially for existing LTC and chronic psychiatric units, infrastructure and safety improvements are needed to improve the quality of space for patients and to modernize medical settings. No data were provided as to Altoona, Butler, Coatesville, Lebanon, and Clarksburg.

Commission Recommendations

1. The Commission recommends that: [100]

   a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

   b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

   c. Domiciliary care programs should be located as close as feasible to the population they serve.

   d. Freestanding LTC facilities should be permitted as an acceptable care model.

[100] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

VISN 5 – VA Capitol Health Care Network

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VISN 5, VA Capitol Health Care Network

VISN Overview

VISN 5, the VA Capitol Health Care Network, is an integrated, comprehensive health care system that provides care to 178,000 enrolled veterans. In FY 2003, the VISN furnished services to 103,000 veterans from Maryland, Washington, DC, eastern West Virginia, northern Virginia, and two counties in Pennsylvania. The total veteran population of the VISN is approximately 778,000.[101]

With a staff of more than 5,735 FTEs,[102] VISN 5 delivers health care services through three medical centers, four nursing homes, two domiciliary care facilities, and 15 community-based outpatient clinics (CBOCs). Additionally, there are six Vet Centers in VISN 5.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 5.

VISN 5	FY 2001	FY 2012	FY 2022
Enrollees	149,549	166,490	156,136
Veteran Population	805,564	659,428	545,599
Market Penetration	18.56%	25.25%	28.62%

For the CARES process, the VISN is divided into three markets: the Martinsburg Market (*facility:* Martinsburg, WV); the Baltimore Market (*facilities:* Baltimore and Perry Point campuses and the Baltimore Rehabilitation and Extended Care Center); and the Washington DC Market (*facility:* Washington, DC).

Information Gathering

The CARES Commission visited four sites and conducted one public hearing in VISN 5 and received five public comments.

- *Site Visits:* Baltimore and Perry Point on June 30; Washington, DC, on July 1; and Martinsburg on July 2.
- *Hearing:* Baltimore, MD, on August 12.

[101] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[102] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Summary of CARES Commission Recommendations

I Campus Realignment, Extended Care – Perry Point

1. The Commission recommends that:[103]
   - a. Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.
2. The Commission concurs with the DNCP proposal to redesign the Perry Point campus, including enhanced use leasing (EUL), subject to the preparation and approval of a strategic plan.

(see page 5-84)

II Inpatient Acute Psychiatry and Residential Rehabilitation Care

1. The Commission concurs with the DNCP proposal to move 77 domiciliary beds from Martinsburg VA Medical Center (VAMC) to Washington, DC.
2. In view of the fact that there are a large number of homeless veterans in the Washington, DC, area, the Commission recommends that consideration be given to transferring more residential rehabilitation beds to the Washington, DC, area.
3. The Commission concurs with the DNCP proposal to move 22 acute psychiatry beds from Perry Point to the Washington DC VAMC.

(see page 5-86)

III Outpatient Care

1. The Commission concurs with the DNCP proposal to address the need for increased space for outpatient primary, mental health, and specialty care through in-house expansion, new construction, and leases.

[103] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

2 The Commission recommends that:[104]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-88)

IV VA/DoD Sharing

1 The Commission concurs with the DNCP proposal on developing joint ventures with DoD at Fort Meade, Fort Detrick, and Fort Belvoir.

2 The Commission recommends that the DNCP proposal for the VISN 5 VA/DoD collaborative opportunities include clear, written evidence of a joint commitment.

(see page 5-90)

V Enhanced Use

1 The Commission concurs with the DNCP proposal for an EUL project at Fort Howard.

(see page 5-92)

[104] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

I Campus Realignment, Extended Care – Perry Point

DNCP Proposals

"*Campus Realignment* – While maintaining the current mission, redesign the campus to maximize the enhanced use lease potential of the campus. The campus will be evaluated for alternatives uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues of in-kind services will remain in the VISN to invest in services for veterans. The redesign of the campus should include the current proposed new nursing home, other required new buildings to consolidate services, and preservation of the histories sites: the Mansion, Grist Mill, and five acres of Indian burial grounds. *Extended Care* – Proposed capital investments for nursing home care units to remedy space deficiencies include…new construction of 67,000 square feet in the Baltimore Market (Perry Point)."

DNCP Alternatives

1. *Status quo*
2. *Alternative 1 [The VISN's preferred alternative]:* Construct new nursing home and renovate four patient care buildings.
3. *Alternative 2:* Maintain the three most recently constructed patient care buildings and new construction that will address the workload and bed requirements.
4. *Alternative 3:* Vacate all current buildings and constructs a complete replacement facility that relocates all inpatient and outpatient services to the northwestern corner of the campus.

Commission Analysis

The Perry Point VAMC, located in Maryland on 364 acres on the banks of the Susquehanna River and the Chesapeake Bay, offers long and short-term inpatient mental health care, including an inpatient alcohol and substance abuse treatment program. A new, state-of-the-art inpatient psychiatric care facility offers specialized treatment programs, rehabilitation services, and enhanced patient privacy for veterans. The medical center also offers a full range of inpatient medical, intermediate, and LTC programs, including a nursing home, a chronic ventilator care unit, and a specialized unit for patients with Alzheimer's disease. A newly renovated 50-bed domiciliary care facility houses a program which helps to rehabilitate homeless veterans through counseling, job assistance, and home placement. The Perry Point VAMC provides primary care and specialty outpatient services in a new outpatient care facility.

The nursing home at Perry Point is housed in a 79-year-old building that VISN leadership noted during site visits and in formal testimony is no longer appropriate for furnishing health care services. The VISN Director, Dr. James Nocks, testified, "The nursing home at Perry Point is a building that is very, very old. Despite attempts in the Network and at the medical center to keep it functioning, that building has probably emerged as our number-one replacement priority in the Network."[105]

Changing the footprint of the Perry Point campus and construction of a replacement nursing home at Perry Point would have little impact on the community in the near term. The VISN realignment proposal would retain approximately 100 to 135 acres for VA use and free the remainder of the 364 acres for EUL. It is unlikely that VA jobs would be lost as a result of this change as there is no plan to decrease the services offered. In the long run, using the vacated space for an EUL project is likely to result in a positive impact on the community, as new jobs would be generated.

The realignment would also include a building to consolidate outlying patient care functions, a 23-bed compensated work therapy (CWT) transitional residence, and renovation of four buildings. Workload in the nursing home care unit (NHCU) has increased from an average daily census (ADC) of 77 in FY 2000 to about 112 in FY 2003, an increase of 40 percent. As LTC projections were not included in the current phase of CARES, there are no data to support the number and types of nursing home care unit beds needed at Perry Point.

There are very few details in the DNCP with respect to redesigning the Perry Point campus to maximize its enhanced use lease potential. Senator Barbara Mikulski suggested a cautious approach, stating:

> Any changes to Perry Point must remain true to the principles of VA health care: open access to care, quality care, and timely care. However, before changes are made at Perry Point, I believe we should learn from experience. VA shouldn't try to get new things at Perry Point until we learn the lessons at Fort Howard. Let's get that done, do it right, and look at lessons learned before moving forward.[106]

Commission Findings

1. The DNCP proposal to redesign the campus appears to have merit and alternatives have been offered. There is no specific plan.

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[105] James Nocks, MD, VISN 5 Director, Transcribed Testimony from the Baltimore, MD, Hearing on August 12,2003, page 42.

[106] The Honorable Barbara Mikulski, Senator, Written Statement submitted at the Baltimore, MD, Hearing on August 12, 2003, page 2, available from [*http://www.carescommission.va.gov/Documents/BaltimoreCongressionalStatements.pdf*].

2. The nursing home at Perry Point needs to be replaced as it is no longer an appropriate facility for furnishing service; however, it is not clear, in the absence of specific data on LTC demand, whether it should be replaced at the present location or what the number of beds should be.
3. Many of the facilities at Perry Point are old, unused, underutilized, and in need of major renovation or demolition.
4. The campus is a prime location and adequate in size to accommodate EUL in direct benefit to veterans, such as assisted living, transitional housing for homeless veterans, or veterans housing.
5. It is unlikely any VA jobs will be lost at Perry Point as a result of the change in the campus footprint. In the longer-term, it is likely that jobs would be added to the community as a result of the EUL project.

Commission Recommendations

1. The Commission recommends that:[107]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.
2. The Commission concurs with the DNCP proposal to redesign the Perry Point campus, including EUL, subject to the preparation and approval of a strategic plan.

II Inpatient Acute Psychiatry and Residential Rehabilitation Care

DNCP Proposals

"*Mental Health* – 77 domiciliary beds are being shifted from Martinsburg to Washington to establish a domiciliary presence in DC area and to obviate the need for replacement of poor quality space at Martinsburg.

[107] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

Psychiatry – Decreasing inpatient psychiatric demand in the Baltimore market has been met through the downsizing of beds at Baltimore in FY 2002. Increasing inpatient demand in the Washington Market is being met through a shift of beds from Perry Point to Washington with in-house space expansion."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Martinsburg VAMC is a 107-bed medical and surgical facility, with a 148-bed nursing home and 312 domiciliary beds. The domiciliary unit serves patients from throughout the VISN. During the Baltimore hearing, the VISN leadership outlined the benefits of moving 77 domiciliary beds to Washington, DC, by noting that many of these veterans are from the DC metropolitan area. The Washington DC Market currently has no domiciliary beds. Overall, service to these veterans would be improved by moving the facility closer to the community in which they live. In addition, of the 312 domiciliary beds in Martinsburg, 77 beds are currently housed in pre-World War II structures that are not suitable for renovation. At the Baltimore hearing, the VISN leadership presented the results of a data review that identified these structures as inadequate for providing health care per current standards and not conducive to renovation. Patient privacy was also noted as a concern, as many of these facilities still have communal bathrooms. There was general support for this initiative at the hearing, although union representatives expressed concern over potential impact on employees at Martinsburg.

In the Washington DC Market, demand for inpatient psychiatry is expected to increase 40 percent over the FY 2001 baseline by FY 2012 and then to significantly decrease to two percent over the baseline by FY 2022. In the Baltimore Market, demand is projected to decrease by two percent from the baseline by FY 2012 and by 31 percent by FY 2022.[108] Perry Point currently has 214 inpatient psychiatry beds. The movement of 22 acute psychiatry beds from Perry Point to Washington, DC, addresses the projected increase in demand for inpatient psychiatric services in the Washington DC Market and the decreased demand in Baltimore.

The VISN's written testimony noted that "by shifting inpatient mental health beds to Washington, the Network will greatly improve access to inpatient psychiatry services for veterans living in the Washington DC Market area. These veterans are often currently transferred significant distances to receive that type of care in our Network."[109] VISN leadership indicated that space on one of the inpatient wards at the Washington DC VAMC would be renovated to accommodate the expansion of the 22 additional psychiatry beds.

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[108] Appendix D, *Data* Tables, page D-26.

[109] James Nocks, MD, VISN 5 Director, Written Testimony submitted at the Baltimore, MD, Hearing on August 12, 2003, page 17, available from [*http://www.carescommission.va.gov/Documents/BaltimorePanel1.pdf*].

Commission Findings

1. The realignment of acute inpatient psychiatric and domiciliary-based residential rehabilitation services within VISN 5 would likely meet projected demand for care, move care closer to where veterans live, and increase access to care in the DC metropolitan area. The Commission believes that there is a strong need for domiciliary beds in the Washington, DC area, especially to address homeless veterans' needs for care, training, employment, and reintegration into society.
2. This realignment places more psychiatric patients in an acute care facility where the medical needs of psychiatric patients can be more readily met.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to move 77 domiciliary beds from the Martinsburg VAMC to Washington, DC.
2. In view of the fact that there are a large number of homeless veterans in the Washington, DC, area, the Commission recommends that consideration be given to transferring more residential rehabilitation beds to the Washington, DC, area.
3. The Commission concurs with the DNCP proposal to move 22 acute psychiatry beds from Perry Point to the Washington DC VAMC.

III Outpatient Care

DNCP Proposals

"*Primary Care and Mental Health* – Increasing primary care and mental health demand is being met in all three markets through a combination of in-house expansion, expansion of existing CBOCs, and the establishment of DoD joint ventures. Outpatient mental health is being integrated with primary care at all sites. *Specialty Care* – Increasing specialty care demand at Martinsburg, Baltimore, and Washington is being met using a combination of in-house expansion (new construction and leases), offering selected high volume specialty care services at larger CBOCs, and community contracts. Perry Point will use primarily community contracts for specialty care expansion."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

During the Baltimore hearing, Dr. Nocks, the VISN Director, noted that the CARES data "reflects significant workload increases in outpatient care throughout VISN 5 as the national shift from inpatient to outpatient care continues."[110] The reconciled CBOC list provided by NCPO includes six CBOCs for this VISN, three of which are DoD joint ventures and three of which were classified in the lowest priority group. Outpatient workload projections for the VISN grow from 1.4 million clinic stops in FY 2001 to 2.3 million stops in FY 2012.[111] The VISN proposes to meet this increased demand for ambulatory care services in various ways in each market. During site visits to VISN 5, Commissioners noted that the current configuration of space for outpatient services in the Martinsburg, Washington, DC, and Baltimore medical centers was less than optimal. Space that was once inpatient wards is being used to provide outpatient services. There are an inadequate number of exam rooms, limiting the efficiency of patient flow through the clinic space. There are current space deficits for outpatient care in all three markets. Martinsburg has a deficit of 64,000 square feet; Washington, DC, has a deficit of 101,000 square feet; and Baltimore has a deficit of more than 100,000 square feet for outpatient primary and specialty care.[112]

At both Martinsburg and Washington, DC, the DNCP proposes new construction. The addition of a 31,000 square foot outpatient clinic at Martinsburg, and a 155,000 square foot addition at the Washington, DC VAMC, will provide expanded primary, mental health, and specialty care, as well as support services.

At the Baltimore VAMC, due to the absence of available space and land for construction, VISN 5 proposes to move all outpatient primary and mental health services into leased space in close proximity to the medical center and to use the vacated space within the facility for outpatient specialty care to improve workflow and resolve space deficiencies.

Commission Findings

1. VISN 5 is projected to experience a significant increase in demand for outpatient care services and the VISN's plan to respond to this demand appears appropriate.
2. In view of the absence of projection data for outpatient mental health, it is unclear what the space and staffing demands will be for this service.
3. The VISN needs to have the flexibility to shift some services from the Baltimore VAMC to a new location to relieve its space deficiencies.

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[110] James Nocks, MD, VISN 5 Director, Transcribed Testimony from the Baltimore, MD, Hearing on August 12, 2003, page 18.
[111] VISN 5 CARES Portal; VISN 5 Detailed Planning Initiative Report, dated March 21, 2003.
[112] Management of CARES Space Report received from the VISN Support Services Center (VSSC) dated September 23, 2003.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to address the need for increased space for outpatient primary, mental health, and specialty care through in-house expansion, new construction, and leases.
2. The Commission recommends that:[113]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

IV VA/DoD Sharing

DNCP Proposals

"The DNCP recommends further development of joint ventures with the Department of Defense at Fort Meade and Fort Detrick, MD, and at Fort Belvoir, VA, to address expansion of outpatient services."

[113] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

VISN 5 plans to address expansion of outpatient services in all markets through the development of collaborative partnerships with DoD facilities (Fort Meade/Baltimore; Fort Detrick/Martinsburg; Fort Belvoir/Washington, DC).

Dr. Nocks, VISN Director, testified about the proposed collaboration with Fort Meade as follows:

> To resolve the workload gaps in outpatient primary and mental health care…a collaborative partnership with the Department of Defense will enable [Baltimore] to expand outpatient services to veterans living in Anne Arundel County with the opening of a VA outpatient clinic at Fort Meade military base.[114] Demand for outpatient primary care in the Baltimore Market is projected to increase by 29 percent over the FY 2001 baseline by FY 2012 and six percent by FY 2022. A new outpatient access point at Fort Meade would help alleviate issues associated with overcrowding at the Glen Burnie CBOC and resultant "wait lists." Efforts are also underway for the construction of a new VA CBOC at the replacement hospital at Fort Belvoir.

Veterans service organizations agreed with the overall concept of collaboration for outpatient care, although some expressed concern over locating a VA facility on a military post due to potential difficulties in accessing the CBOC, particularly in a time of deployment and/or heightened security on military bases. Concerns also were expressed by stakeholders on the wisdom of locating CBOCs on military bases in light of ongoing military base restructuring, changes of base missions, and changes in command that result in potential changes of policy regarding support for joint collaboration.

VISN leadership also addressed two other proposed collaborations with Fort Detrick and Fort Belvoir in the Baltimore hearing. The Fort Detrick site would open a new access point for veterans living in the Frederick, MD area, and the Fort Belvoir proposal would expand outpatient clinical services and improve access for veterans living in the Washington, DC, metropolitan area.

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[114] James Nocks, MD, VISN 5 Director, Written Testimony submitted at the Baltimore, MD, Hearing on August 12, 2003, page 17, available from [*http://www.carescommission.va.gov/Documents/BaltimorePanel1.pdf*].

Commission Finding

The proposed collaborations with DoD appear appropriate; however, the Commission remains concerned that there are unresolved questions concerning policy and implementation of these joint activities and about the degree to which veterans can be guaranteed access to clinics located on military bases.

Commission Recommendations

1. The Commission concurs with the DNCP proposal on developing joint ventures with DoD at Fort Meade, Fort Detrick, and Fort Belvoir.
2. The Commission recommends that the DNCP proposal for the VISN 5 VA/DoD collaborative opportunities include clear, written evidence of a joint commitment.

V Enhanced Use

DNCP Proposals

From the DNCP – "An enhanced use lease has been approved for Ft. Howard that targets 297,613 square feet to develop a retirement community for veterans and non-veterans. Revenues will remain in the VISN to invest in services for veterans."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Fort Howard initiative was developed prior to CARES and is being implemented separate from CARES process. The project includes the leasing of vacant space on the Fort Howard campus to a private developer to create a retirement community for veterans and non-veterans. The developer has the option of renovating or demolishing any or all existing space. The estimated cost for demolishing existing buildings is $3.8 million; however, in an EUL scenario, these costs would be borne by developer. The new facility will consist of independent living, assisted living, and skilled nursing. Additionally, as part of the proposal, a replacement VA outpatient clinic is to be built. The request for proposals was released in early FY 2003 and has now been approved by the Secretary.

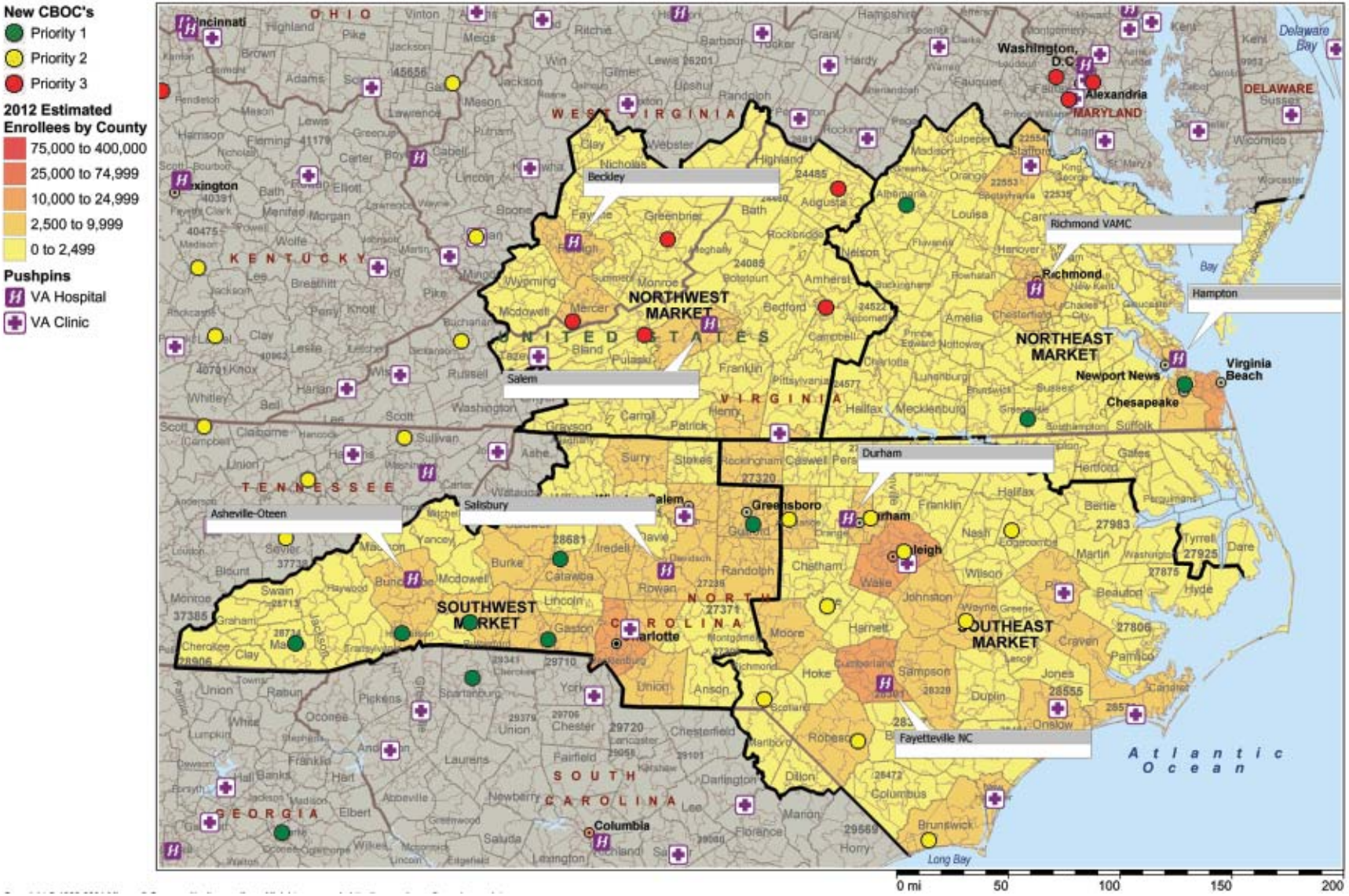
Commission Findings

This enhanced use project has been approved and a contractor selected. Work is beginning.

Commission Recommendations

The Commission concurs with the DNCP proposal for an EUL project at Fort Howard.

VISN 6 – VA Mid-Atlantic Health Care Network



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VISN 6, Mid-Atlantic Health Care Network

VISN Overview

VISN 6, Mid-Atlantic Health Care Network, encompasses the state of North Carolina and portions of Virginia, West Virginia, and South Carolina. The VISN is the home to 1.3 million veterans and covers 88,306 square miles. Census data from 2000 reveals that seven of the top ten cities of 100,000 or more with the highest density veteran populations are in VISN 6. The VISN provided medical services to approximately 216,000 of the 347,000 veterans enrolled in VISN 6's health care system in FY 2003.[115] With a staff of approximately 9,274 FTEs,[116] VISN 6 delivers health care services through eight medical centers, a domiciliary, eight nursing homes, and 18 community-based outpatient clinics (CBOCs). It also has two spinal cord injury (SCI) centers and one of the four VA traumatic brain injury centers. Additionally, VA operates ten Vet Centers in VISN 6's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 6.

VISN 6	FY 2001	FY 2012	FY 2022
Enrollees	286,182	334,444	321,971
Veteran Population	1,351,973	1,184,663	1,020,278
Market Penetration	21.17%	28.23%	31.56%

For the CARES process, this VISN is divided into four markets: the Northeast Market (*facilities:* Hampton and Richmond, VA); the Northwest Market (*facilities:* Beckley, WV, and Salem, VA); the Southeast Market (*facilities:* Durham and Fayetteville, NC); and the Southwest Market (*facilities:* Asheville and Salisbury, NC).

Information Gathering

The CARES Commission visited one site and conducted one public hearing in VISN 6. The Commission received 18 comments regarding VISN 6.

- *Site Visit:* Beckley, WV, on July 1.
- *Hearing:* Durham, NC, on September 12.

[115] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[116] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002-September 2003.

Summary of CARES Commission Recommendations

I Small Facility – Beckley

1. The Commission recommends that VA establish a clear definition and clear policy on the critical access hospital (CAH) designation prior to making a decision on the use of this designation.
2. The Commission does not concur with the DNCP proposal to convert Beckley into a CAH and recommends closing the acute inpatient hospital beds and contracting for acute care in the community as soon as reasonable.
3. The Commission recommends that:
   - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
4. The Commission recommends that Beckley retain its multi-specialty outpatient services and nursing home.

(see page 5-99)

II Extended Care – Beckley

1. The Commission concurs with the DNCP proposal to improve nursing home space at Beckley.
2. The Commission recommends that:[117]
   - a Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities, VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c Domiciliary care programs should be located as close as feasible to the population they serve.
   - d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-101)

[117] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

III Inpatient Care

1. The Commission concurs with the DNCP proposal to increase the access for hospital care in the Southeast Market by providing limited inpatient care at the naval hospital at Camp Lejeune.
2. The Commission concurs with the DNCP proposal for new construction and renovation of inpatient space throughout this VISN, but notes that converting current outpatient space into inpatient wards will increase current deficits in outpatient space.

(see page 5-103)

IV Outpatient Care

1. The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space gaps in Hampton, Richmond, Durham, Fayetteville, Asheville, and Salisbury.
2. The Commission recommends that:[118]
   - a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e Whenever feasible, CBOCs provide basic mental health services.
   - f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-105)

[118] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

V Enhanced Use

1. The Commission concurs with the DNCP proposal for Durham's enhanced use leasing (EUL) project and further recommends that specific target dates for implementation be set and final actions defined.
2. If the EUL plan does not materialize, the Commission recommends that the VISN quickly develop an alternative approach to meet shortfalls in its outpatient primary and specialty care, research, and parking space needs.

(see page 5-110)

Small Facility – Beckley

DNCP Proposal

"Retain acute medicine beds. Convert their bed designation to critical access hospital model. Close inpatient surgery beds and utilize observation beds, local contracting, or transfer to other VAMCs to meet surgical needs."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

Beckley was identified as a small facility for conversion to a critical access hospital (CAH) because it has less than 40 beds. In FY 2003, Beckley's average daily census (ADC) for acute care was 20: 26 operating internal medicine beds (ADC 15), 12 operating intermediate medicine beds (ADC 4), and two operating surgery beds (ADC 1). In addition, there is a 50-bed nursing home (ADC 36). The facility also furnishes primary and ambulatory nursing care. The Commission did not accept the CAH designation for small facilities because VA does not have a standardized definition for CAH. Instead, the Commission evaluated facilities that the DNCP proposed converting to CAHs as small hospitals.

Workload projections for Beckley indicate a need for 15 acute inpatient beds in FY 2012 and 11 in FY 2022.[119] Inpatient ADC has been declining in the past four years; it was 36 in FY 2000, 34 in FY 2001, 27 in FY 2002, and 20 in FY 2003.

The veteran population for this VISN is projected to decrease from 1.4 million in FY 2001 to 1.02 million in FY 2022. While three markets in this VISN are expected to have growth in both enrollees and workload, projections for the Northwest Market, which includes Beckley, show decreases in enrollment from 53,000 veterans in FY 2001 to 48,000 in FY 2012 to 39,000 in FY 2022.[120]

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[119] Appendix D, *Data Tables*, page D-29.

[120] *Management of CARES Enrollment and VetPop Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

During the site visit, Commissioners heard that the health status of the population in West Virginia is one of the worst in the nation. The economy is very depressed, with coal mining being the primary source of employment in southern West Virginia. Veterans experience significant geographic barriers that can cause a five-hour driving time to a VA tertiary medical center. Although most of the surgeries at Beckley are currently conducted on an outpatient basis, the VISN leadership believes that there should be surgical beds in case it is necessary to keep a patient overnight.

Stakeholders at the site visit were concerned that, if Beckley closed, care would be handled through referral to Salem, Durham, or Richmond, and that this would be too far to allow family participation. They also expressed concern about the quality of the health care available in the community and indicated that the local hospitals have waiting lists.[121] Most testimony during hearings expressed a strong wish for Beckley to retain its current mission. On the other hand, according to published report from the American Hospital Association, there are 11 JCAHO accredited non-VA facilities with excess capacity within 60 minutes of Beckley, two of which are in Beckley.[122]

Therefore, although the DNCP only calls for closure of Beckley's two inpatient surgery beds as part of making Beckley a CAH, the Commission believes that given the decreased workload projections and the projected decreases in enrollment, the VISN should closely consider closing all inpatient services at Beckley and contracting for care in the community or providing referrals to other VAMCs.

Commission Findings

1. There is a small ADC and the declining projections for FY 2012 and FY 2022.
2. There are 11 JCAHO accredited hospitals within 60 minutes of Beckley VAMC, two of which are in Beckley. Therefore, there are enough community alternatives in and around Beckley to absorb the acute inpatient workload without affecting veterans' ability to get the services they need.
3. Workload has decreased over past four years for medicine, surgery, and intermediate medicine.

Commission Recommendations

1. The Commission recommends that VA establish a clear definition and clear policy on the critical access hospital (CAH) designation prior to making a decision on the use of this designation.

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[121] VISN 6 Site Visit Report, Beckley, West Virginia, July 1, 2003 available from [*http://www.carescommission.va.gov/SiteVisits.asp.pdf*].

[122] Appendix D, *Data Tables*, page D-31.

2. The Commission does not concur with the DNCP proposal to convert Beckley into a CAH and recommends closing the acute inpatient hospital beds and contracting for acute care in the community as soon as reasonable.
3. The Commission recommends that:
   a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
4. The Commission recommends that Beckley retain its multi-specialty outpatient services and nursing home.

II Extended Care – Beckley

DNCP Proposal

"Proposed capital investments in nursing homes to remedy space deficiencies include new construction of 40,000 square feet in the Northwest market (Beckley) for a replacement facility."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The nursing home at Beckley is authorized for 50 beds and currently has an ADC of 36 (72 percent occupancy), down from 46 in FY 2000, 45 in FY 2001, and 43 in FY 2002.[123] During the site visit to Beckley, Commissioners noted that the nursing home is old, has privacy issues, and needs renovation. The LTC model, which will provide workload projections and help identify how many nursing home care unit beds are needed and where they should be located, has not been run.

The veteran population for this VISN is projected to decrease from 1.4 million in FY 2001 to 1.02 million in FY 2022. Projections for the Northwest Market, which includes Beckley, show decreases in enrollment from 53,000 veterans in FY 2001 to 48,000 in FY 2012 to 39,000 in FY 2022.[124]

[123] Appendix D, *Data Tables*, page D-30.
[124] *Management of CARES Enrollment and VetPop Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

The DNCP proposal indicates that the proposed nursing home is a replacement facility, but when a Commissioner asked whether the plan was to replace the nursing home or to add more long-term care beds, Mr. Husson, the medical center director, indicated that they were planning to increase the number of beds. Mr. Husson indicated that the population is getting older and many patients need long-term care. He said, "What is proposed is to take a jump from the 50 current beds to 120; 80 long-term care, 20 rehabilitation, and 20 in an Alzheimer's dementia unit."[125] Mr. Husson indicated that the architectural engineering phase has already been completed for the new nursing home and that they are awaiting construction funds.

Commission Findings

1. Current LTC workload at Beckley is decreasing and does not indicate that more nursing home care beds are needed.
2. The plan to build a nursing home at Beckley is underway, and the first phase has been completed.
3. The current nursing home care unit at Beckley needs improvement.
4. Given that the veteran population is decreasing in this market and the LTC model has not been run, there is no accurate information about the numbers of nursing home care unit beds needed at Beckley or other places in the market.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to improve nursing home space at Beckley.
2. The Commission recommends that:[126]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities, VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.

[125] Jerry Husson, Director of the Beckley VAMC. Transcribed Testimony from the Durham, NC Hearing on September 12, 2003, pages 33-34.

[126] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

III Inpatient Care

DNCP Proposals

"*Access to Hospital Care* – Increase the access for hospital care in the Southeast Market by providing limited inpatient care at a DoD site located in the eastern part of the market that will enable this market to meet the hospital access guidelines. *Medicine* – Increased inpatient medicine services have been identified for both the Southeast and the Southwest markets. This will require constructing new space, renovating existing space and using telemedicine links with out-station locations to augment coordination, timeliness and quality of care. Community contracts for projected peak year usage will also be employed as appropriate. *Surgery* – Increased inpatient surgery services have been identified for both the Southeast and the Southwest markets. This will require a combination of ward renovations projects and new construction. To create enough space for these projects, outpatient functions currently located in inpatient areas will be relocated to the proposed outpatient additions. The projects will be supplemented by sharing agreements for acute care, as appropriate. There is a slight decrease in demand at Salisbury. Therefore, no significant changes are planned at this time beyond an increased reliance on in-house versus contract services and a focus on increased productivity. *Psychiatry* – Increase inpatient psychiatry services have been identified for the Southeast market. This will require ward renovation projects that will provide space and address patient privacy and efficiency issues at each facility. To create sufficient space for these projects, outpatient functions currently located in inpatient areas will be relocated to the proposed outpatient additions. Decreased inpatient psychiatry services will be addressed through the elimination of 47 beds by FY 2022."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Southeast Market (Durham, Fayetteville) has a hospital gap. Currently, 64 percent of veterans in the market have access to a tertiary facility within the travel guidelines, and the standard is 65 percent. Workload in this market is projected to increase for inpatient medicine, surgery, and psychiatry.[127] According to the VISN's plan, access to hospital care will be addressed through a sharing agreement with the naval hospital at Camp Lejeune, which will provide medical and surgical inpatient care for patients from Onslow, Duplin, and Jones counties. This will increase the percentage of enrolled veterans with access to hospital care from 64 percent to 75.4 percent in FY 2012 and to 75.6 percent in FY 2022.[128]

[127] Appendix D, *Data Tables*, page D-29.
[128] CARES Portal, VISN 6 Market Plan.

The VISN also has planning initiatives in the Southeast and Southwest markets related to increased workload in medicine, surgery, and psychiatry. In the Southeast Market, workload is projected to increase in medicine by 46 percent over the FY 2001 baseline, in surgery by 58 percent, and in psychiatry by 72 percent, which translates to needing 114 more inpatient beds in Durham and Fayetteville by FY 2012. By FY 2022, these figures are 27 percent over baseline for inpatient medicine, 40 percent over baseline for surgery, and 49 percent over baseline for inpatient psychiatry.[129] This market is projected to still require 74 more beds in FY 2022 than current levels. The CARES Space Report indicates that Durham currently has space gaps of about 54,000 square feet and that there is a plan to build an additional 29,000 square feet.[130] Additionally, some inpatient wards at Durham had been converted into outpatient clinics to address the increased outpatient workload and must now be converted back to inpatient space. According to the Space Report, Fayetteville has current space gaps of about 40,000 square feet, and the plan calls for construction of 13,000 square feet of new medicine and psychiatry space.

In the Southwest Market, inpatient workload is projected to increase in medicine by 76 percent, in surgery by 61 percent, and in psychiatry by three percent. This translates into needing 75 more inpatient beds in Asheville and Salisbury by FY 2012. This market is projected to still require 38 more beds than current levels in FY 2022.[131] The CARES Space Report indicates that Asheville currently has space gaps of about 51,000 square feet, and the plan calls for construction of about 29,000 square feet of new space. Salisbury's current space gap is about 38,000 square feet, and the plan calls for converting 13,000 square feet of existing space.[132]

Commission Findings

1. Portions of the Southeast Market do not meet the CARES standard for access to hospital care, and this market is projected to grow significantly.
2. There are currently an inadequate number of inpatient beds to meet the projected demand, and the demand is large enough that each market (Southeast and Southwest) will need to add beds.
3. Plans to address the projected need for inpatient space through new construction and conversion of space seems appropriate, although conversion of existing space is likely to increase the current significant deficits in outpatient space.

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[129] Appendix D, *Data Tables*, page D-29.
[130] *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.
[131] Appendix D, *Data Tables*, page D-29.
[132] *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to increase the access for hospital care in the Southeast Market by providing limited inpatient care at the naval hospital at Camp Lejeune.
2. The Commission concurs with the DNCP proposal for new construction and renovation of inpatient space throughout this VISN but notes that converting current outpatient space into inpatient wards will increase current deficits in outpatient space.

IV Outpatient Care

DNCP Proposals

"*Primary Care Access* – Increase primary care access points in two markets by adding nine new CBOCs: six in the Southwest Market and three in the Northeast Market. The DNCP attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, new access points in the Southeast and Northwest markets are not included in the DNCP, but they are not in the high priority implementation category. *Outpatient Services/Primary Care* – Increase primary care services in all of the four markets to meet increased demand and access guidelines. VISN 6 will use a combination of approaches tailored to the individual needs of each market. Approaches include establishing new CBOCs using a mix of VA-staffed clinics in leased space and contract-model clinics in the Southwest and Northeast markets; expanding existing CBOCs; establishing new satellite outpatient clinics (SOPC) in certain former CBOC sites; and renovating and/or constructing new outpatient space. *Specialty Care*- Increase specialty care services at six care sites and in three markets with the exception of the Northwest market. VISN 6 will use a combination of approaches tailored to individual needs of each market. Approaches included providing specialty care services at multiple SPOCs/CBOCs; as a major component of outpatient additions; and using community contracts for the early years before lease/construction and for peak years. *Mental Health* – Increase the mental health outpatient services in three markets with the exception of the northwest market due to increased demand and primary care in all four markets. The VISN will use a combination of approaches tailored to the individual needs of each market. These approaches included incorporating Mental Health into CBOCs; renovating and construction new outpatient space at the parent facilities; and providing some limited workload by contract."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The CARES workload reports, testimony presented at the public hearing, and public comments indicate that improvements are needed for outpatient access in every VISN 6 market. Three of the four markets (Northeast, Southeast, and Southwest) are projected to have large increases in demand for primary care, specialty care, and mental health outpatient services. The projected increases in the Southeast and Southwest markets are among the largest in the nation for mental health and specialty care, as projections indicate that the amount of care currently provided will need to be more than doubled. All four markets in this VISN have gaps in access to primary care. The VISN Director testified, "In North Carolina, we have seen significant growth in areas of Raleigh-Durham, the I-85 corridor from Greensboro and Winston-Salem to Charlotte and Fayetteville."[133] The CBOC list provided by NCPO includes 23 CBOCs for this VISN: nine in the highest priority group and 14 in the second and third groups. The nine CBOCs in the highest priority group include the three proposed CBOCs in the Northeast Market and the six proposed CBOCs in the Southwest Market.

To address specialty care and mental health gaps, the VISN plans include renovation of existing space, new construction, and expansion of some CBOCs to include specialty and mental health services. According to the CARES Space Report, there are current space deficits for primary and specialty care in Richmond, Hampton, Durham, Fayetteville, Asheville, and Salisbury.[134]

The three CBOCs proposed in the Northeast Market are included in the high priority group. Overall workload is projected to increase in primary care in this market by 79 percent over the FY 2001 baseline by FY 2012. Specialty care is projected to grow 76 percent and mental health by 38 percent during this same period.[135] The CARES Space Report indicates there is a current space deficit in Hampton of 113,000 square feet, which is projected to grow to 152,000 square feet by FY 2012. The Space Report also reports a current space deficit in Richmond of about 93,000 square feet, which is projected to grow to 144,000 square feet by FY 2012.[136] Plans to address this include new construction and leasing of space.

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[133] Daniel Hoffman, VISN 6 Director. Transcribed Testimony from the Durham, NC, Hearing on September 12, 2003, page 10.
[134] *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.
[135] Appendix D, *Data Tables*, page D-30.
[136] *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

Five additional CBOCs for the Northwest Market (not in the high priority group) were proposed to improve primary care access from 39 percent to 73 percent, with the majority of the needed additional access in the Lynchburg, VA, area. Mr. Stafford, a member of the West Virginia VISN 6 Veterans Advisory Council, testified:

> Beckley, West Virginia, has a problem that most VAs do not have, accessibility to veterans. If we've got at least 40 miles – it can take an hour or more to reach a VAMC. Some veterans live 70, 100 miles away, and it can take 2½ hours to get there. Most specialized appointments take the veteran away from home, one, two, or three days. The long travel time and hospital stay will not allow the family to have support, or have the veteran have support at his time of illness.[137]

The Southeast Market has a current access gap for primary care, as only 50 percent of the enrolled veterans meet the CARES driving time standards. In addition, workload in this market is projected to increase in primary care by 78 percent, in specialty care by 109 percent, and in mental health by 193 percent by FY 2012.[138] The CARES Space Report includes a current space deficit in Durham of 157,000 square feet, which is projected to grow to 254,000 square feet by FY 2012. The Space Report also indicates that Fayetteville has a current space gap of 155,000 square feet, which is projected to grow to 192,000 square feet by FY 2012.[139] Plans to address these space deficiencies include construction of new space and moving workload into Satellite Outpatient Clinics (SOC) and CBOCs.

The Durham VAMC is landlocked, and there is little or no possibility for further construction. Some inpatient wards at Durham had been converted into outpatient clinics to address the increased outpatient workload and must now be converted back to inpatient space to address the increased need for inpatient beds. This will make the existing large space deficit for outpatient care even worse. The space deficiencies may be compounded by the increasing possibility that the approved EUL initiative at Durham, which included outpatient space, will not materialize (See the discussion on the Enhanced Use Lease). The VISN Director and the medical center director of the Durham VAMC indicate that there is a critical need to move some primary and specialty care off campus and into some outpatient sites around Durham. They believe this will improve access and convenience to patients and will improve the current space deficits at the Durham VAMC.

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[137] Mr. Stafford, Disabled American Veterans, Department of West Virginia. Transcribed Testimony from the Durham, NC, Hearing on September 12, 2003, pages 80-81.

[138] Appendix D, *Data Tables*, page D-30.

[139] *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

Though none of the nine CBOCs proposed for the Southeast Market fell in the DNCP's high priority group, these CBOCs would improve access in primary care from 50 percent to 72 percent by reaching veterans in outlying areas and in the high population areas between Fayetteville, NC, and Durham, NC. The VISN also proposed expansion of two existing CBOCs and to build new outpatient facilities at both Durham and Fayetteville medical centers. Both medical centers are at capacity, having converted all available space to outpatient care. Mr. Hunt Moore, County Veterans Service Officer, testified:

> You know, this VISN has done some heroic things to get the numbers down of patients waiting for care. But if we don't do something in the Southeast Market, it's going to overwhelm us before we know what to do with it. And I think you know we need those additional CBOCs. I guess that's my message to you today.[140]

The Southwest Market also currently has a gap on access to primary care, as only 47 percent of the enrolled veterans meet the CARES driving time standards. By FY 2012, workload in the Southwest Market is projected to increase in primary care by 51 percent, in specialty care by 130 percent, and in mental health by 104 percent. By FY 2022, these figures are 39 percent over baseline for primary care, 125 percent over baseline for specialty care, and 81 percent over baseline for mental health.[141] Asheville currently has a space deficit of 93,000 square feet, which is projected to grow to 123,000 square feet by FY 2012. Salisbury has a current space gap of 78,000 square feet, which is projected to grow to 124,000 square feet by FY 2012.[142]

Plans to address these space deficits include renovation of space, new construction, and moving workload to SOCs and CBOCs. There is a specific proposal to expand the current CBOC to a satellite outpatient clinic in Charlotte, which has the greatest shortfalls in VISN 6.

Commission Findings

1. CBOCs to improve access in the Northeast and Southwest markets are included in the high priority group in the DNCP.
2. The five CBOCs proposed in the Northwest Market to improve access for primary care to 73 percent were not included in the high priority group.

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[140] George Hunt, Moore County Veterans Service Officer. Transcribed Testimony form the Durham, NC, Hearing on September 12, 2003, page 83.

[141] Appendix D, *Data Tables*, page D-30.

[142] *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

3. The nine CBOCs proposed for the Southeast Market to improve access for primary care to 72 percent and help address very large capacity gaps for all outpatient care were not included in the DNCP.
4. The Durham and Fayetteville medical centers are both at capacity for outpatient care. Proposals to expand CBOCs and build new outpatient facilities are included in the DNCP, but the CBOCs are not in the high priority group, which will hinder the VISN's efforts to meet future demand.
5. To provide needed inpatient space at Durham, existing clinic space will need to be converted back into inpatient wards, which will make the need for more outpatient space at Durham critical. There is no more room to add outpatient space at the landlocked Durham facility.
6. Clinic space deficits at Durham are likely to become worse that originally predicted if the EUL proposal that includes increased outpatient clinic space does not materialize.
7. As all three markets with projected increases in outpatient workload have current space deficits and are projected to grow more, there is a need to increase outpatient clinic space.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space gaps in Hampton, Richmond, Durham, Fayetteville, Asheville, and Salisbury.
2. The Commission recommends that:[143]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

[143] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

V Enhanced Use

DNCP Proposal

"Durham has an approved enhanced use project in which a real estate development company will finance, build, operate, and maintain on the VA grounds a mixed-use development (approximately 650,000 square feet) consisting of a hotel, retail space, office buildings, and parking garage addition for non-VA use."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

According to the VISN market plan, the EUL venture consists of ambulatory care space, research space, a hotel, retail space, office buildings, and a parking garage with some spaces allocated for VA. The project, although approved by VA Central Office, is uncertain and has been progressing slowly for two years. This EUL project appears to be an essential component of the VISN's plan to address some of the Durham VAMC's space requirements for research, parking, and its projected growth in workload. In October, the Commission learned from staff in the Office of Asset Enterprise Management that the economic situation in Durham has changed and that the EUL partner has not gone forward with action necessary to meet its requirements under the lease and has missed one deadline. The DNCP included no alternatives for addressing the need for more outpatient clinic space to address increasing workload if the enhanced use proposal does not materialize.

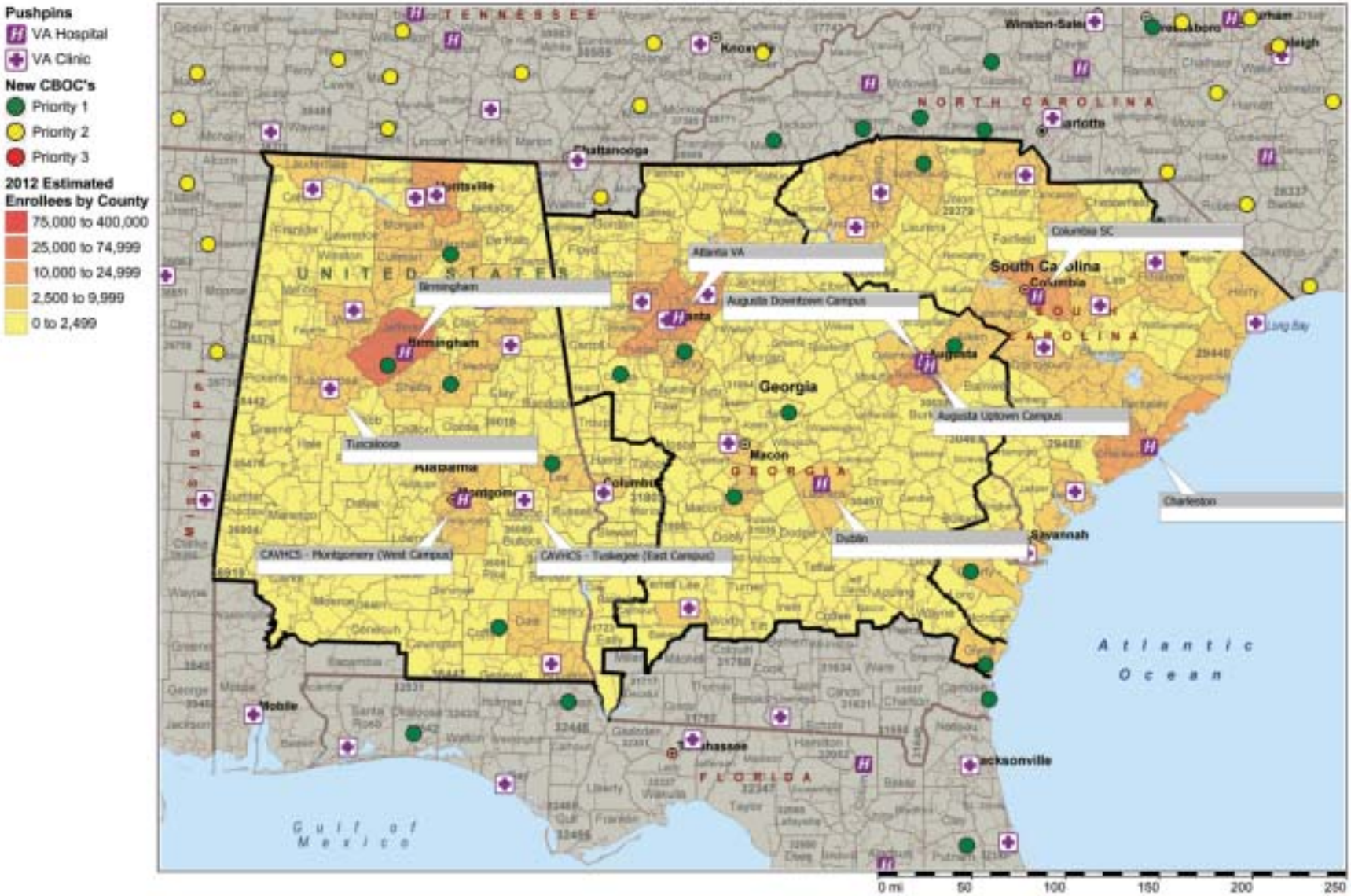
Commission Finding

Although previously approved, the enhanced use project in Durham seems highly unlikely to be completed.

Commission Recommendation

1. The Commission concurs with the DNCP proposal for Durham's enhanced use project and further recommends that specific target dates for implementation be set and final actions defined.
2. If the EUL plan does not materialize, the Commission recommends that the VISN quickly develop an alternative approach to meet shortfalls in its outpatient primary and specialty care, research, and parking space needs.

VISN 7 – VA Atlanta Network



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VISN 7, Atlanta Network

VISN Overview

VISN 7, the Atlanta Network, is an integrated, comprehensive health care system that provided medical services to approximately 245,000 of the 400,000 veterans enrolled in VA's health care system in FY 2003.[144] Geographically, this VISN spans about 80,000 square miles and includes all or part of South Carolina, Georgia, and Alabama. The total veteran population is approximately 1.5 million.

With a VA staff of approximately 10,000 FTEs,[145] VISN 7 delivers health care services through eight medical centers, 23 CBOCs, seven nursing homes, and three domiciliary facilities. Additionally, VA operates six Vet Centers in VISN 7.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 7.

VISN 7	FY 2001	FY 2012	FY 2022
Enrollees	335,208	395,912	388,621
Veteran Population	1,483,559	1,332,516	1,182,659
Market Penetration	22.59%	29.71%	32.86%

The VISN is divided into three markets: the Alabama Market (*facilities:* Birmingham, Tuscaloosa, Montgomery and Tuskegee, AL); the Georgia Market (*facilities:* Atlanta, Augusta, and Dublin, GA); and the South Carolina Market (*facilities:* Columbia and Charleston, SC).

Information Gathering

The CARES Commission visited five VA sites and one DoD site, and held two public hearings in VISN 7. The Commission received 15 public comments regarding VISN 7.

- *Site Visits:* Augusta VA Medical Center (VAMC) Uptown and Downtown Divisions on June 30; Dwight D. Eisenhower Army Medical Center at Fort Gordon, GA, and Columbus, GA,

[144] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[145] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Outpatient Clinic on July 1; and the Central Alabama Veterans Health Care System (CAVHCS), Montgomery and Tuskegee campuses, on July 2.

- *Hearings:* Atlanta, GA, on August 8; Charleston, SC, on September 8.

Summary of CARES Commission Recommendations

I Mission Change – Augusta

1. The Commission does not concur with the DNCP proposal to study the feasibility of consolidating selected current services at the Uptown Division to the Downtown Division because the proposed realignment is not practical.
2. The Commission concurs with the DNCP proposal to realign the footprint at the Uptown Division campus and to evaluate that campus for alternative uses under the enhanced use leasing (EUL) program. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-117)

II Mission Change – Dublin

1. The Commission concurs with the DNCP proposals that the Dublin VAMC should retain its inpatient programs, with intensive care unit (ICU) beds subject to a VHA-directed external evaluation; that transition surgery beds be changed to observation beds; and that Dublin refer complex or non-emergent surgery to other VAMCs, and contract with local community hospitals for emergent surgery.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-120)

III Mission Change – Montgomery, Alabama (Central Alabama Veterans Health Care System [CAVHCS], West Campus)

1. The Commission concurs with the DNCP that the proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study.

(see page 5-122)

IV Inpatient Care

1. The Commission concurs with the DNCP proposals on the use of contract hospital sites, conversion of vacant space, new construction, renovation, and leasing as required in the Alabama and South Carolina markets to meet access and capacity issues in these markets.
2. The Commission recommends that:
   - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-124)

V Outpatient Care

1. The Commission concurs with the DNCP proposals to add CBOCs; to expand existing CBOCs via contracting, leasing and new construction; and to realign the use of space at the VAMCs via renovation, conversion of vacant space, new construction and leasing.
2. The Commission recommends that:[146]
   - a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

[146] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-126)

VI Enhanced Use, Collocation with the Veterans Benefits Administration, and Collaboration with Academic Affiliate

1 The Commission concurs with the DNCP proposal on the VBA collocation and enhanced use lease proposal at Columbia.

2 The Commission supports the concept of cooperative partnering and recommends promptly evaluating the Medical University of South Carolina (MUSC) and VA joint venture proposal.

(see page 5-128)

VII Special Disability Programs – Spinal Cord Injury/Disorder Beds

1 The Commission concurs with the DNCP proposal to add 11 beds immediately at the Augusta VAMC and increase to the projected 20 Spinal Cord Injury/Disorder (SCI/D) beds needed by FY 2012.

2 VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-130)

VIII VA/DoD Sharing Opportunities

1 The Commission concurs with maximizing space utilization and services among the VA and DoD health care operations to provide enhanced services for veterans.

(see page 5-131)

IX Extended Care

1 The Commission concurs with the DNCP proposal on the need for renovations to the nursing home care units at Charleston and Columbia.

2 The Commission recommends that:[147]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-132)

X Facility Condition

1 The Commission concurs with the DNCP proposal to renovate inpatient wards at the Atlanta, Columbia, and Charleston VAMCs.

(see page 5-134)

I Mission Change – Augusta

DNCP Proposal

"Study the feasibility of realigning the campus footprint, including the feasibility of consolidating selected current services at Uptown Division (UD) to the Downtown Division (DD). The campus will be evaluated for alternative uses to benefit veterans, such as enhanced use leasing for an assisted living facility or other compatible uses. Any revenues or in-kind services will remain in the VISN to invest in services for veterans. Explore with DoD the feasibility of greater coordination with DoD services at either VA division."

DNCP Alternatives

1 *Status quo*

2 *Original Market Plan:* One primary care team would relocate from Downtown Division (DD) to Uptown Division (UD). Demolish some buildings.

[147] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

3 *Alternative [The VISN's preferred alternative]:* This alternative adds buildings to the list of buildings at UD planned for demolition. All primary care teams are relocated from DD into converted vacant space at UD.

Commission Analysis

The Augusta VAMC is a two-division medical center. Most acute medical and surgery services are offered at the Downtown Division. Extended care, rehabilitation, and mental health services are offered at the Uptown Division. Located three miles apart, the Downtown and Uptown Divisions both provide outpatient primary care, specialty care, and mental health services, with the Uptown Division being the primary location for outpatient mental health services. The Downtown Division has a 60-bed SCI/D unit (average daily census [ADC] 42), 58 acute medicine beds (ADC 40), and 37 surgery beds (ADC 23).[148] The Uptown Division maintains 10 rehabilitation medicine beds (ADC 6), a 15-bed blind rehabilitation center (ADC 14), a 132-bed nursing home unit (ADC 107), 68 inpatient psychiatry beds (ADC 47), and 60 domiciliary beds (ADC 53).[149]

The Downtown Division is connected both physically and functionally to the Medical College of Georgia (MCG). More than 500 MCG residents, interns, and students are trained at the Augusta VAMC each year. There are also nursing school affiliations as well as other allied health training programs. Additionally, the Augusta VAMC and the Dwight D. Eisenhower Army Medical Center at Fort Gordon, GA, have a longstanding joint venture to share health care services such as cardio-thoracic surgery, neurosurgery, sleep laboratory studies, laboratory testing, physical therapy, and imaging services. Presently, the Augusta VAMC provides temporary lodging space for active duty personnel in the Eisenhower substance abuse program in exchange for DoD providing professional reading of PET scans. This VA/DoD sharing of vacant space for Eisenhower's substance abuse program generates $90,000 per year for VA and creates greater privacy for soldiers.[150]

To relieve overcrowded inpatient areas at the Downtown Division and in an effort to enhance specialty care services there as well, the VISN recently consolidated some primary care services from the Downtown Division into vacant space at the Uptown Division.

During site visits, the Commission observed that the Downtown Division is landlocked with no room to expand, and that the buildings at the two divisions are well-kept and use state-of-the-art medical equipment. The CARES space management report indicates that the Downtown Division has space deficiencies for its

[148] VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.
[149] VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.
[150] VISN 7, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo*.

inpatient medicine areas. There are also sizeable space deficiencies at the Uptown Division for inpatient psychiatry areas and for outpatient primary and specialty care areas.

Stakeholders' comments reflected their concern about the proposed realignment by noting that the two locations have distinct and complementary missions. Consideration of the Augusta VAMC's Uptown Division campus realignment is complicated by the fact that the medical center has buildings and areas that are either designated national historic landmarks or are listed in the National Register of Historic Places. Many of these historic buildings have structural, asbestos abatement and lead paint problems. Although the VISN had offered these buildings to the public, there has been no interest in taking ownership of these buildings. When asked whether the City of Augusta was in any way prepared to assume the care of the historic buildings at the Augusta VAMC, Mayor Bob Young indicated:

> We are prepared to search high and low for potential uses for buildings with nonprofit and faith-based organizations in our community that deal with homeless people and displaced folks and other services.[151]

In VISN 7's campus realignment proposal, the VISN's preferred alternative is to demolish 15 buildings at the Uptown Division. For any of these buildings that have historical significance, there are specific regulations applicable to how they can be handled. Because of the aforementioned safety issues and because thus far the VISN has been unable to obtain an alternative steward for these buildings, the VISN has proposed demolition. The VISN's campus realignment proposal indicates that the demolition would be the most cost-effective approach and would have net present value savings of $199.4 million over the life cycle.[152]

Commission Findings

1. The Downtown and Uptown Divisions have very distinct and complementary missions.
2. Realignment of inpatient services from the Uptown Division to the Downtown Division of the Augusta VAMC is not practical because there is a lack of space at the Downtown Division to adequately consolidate services.
3. Stakeholders expressed concern regarding disruption of services.
4. Some of the buildings at the Uptown Division are historically significant. Many of these historic buildings have structural, asbestos abatement and lead paint issues. The VISN has been unable to obtain an alternative steward for these historic buildings.

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[151] The Honorable Bob Young, Mayor of Augusta, GA, Transcribed Testimony from the Atlanta, GA, Hearing on August 29, 2003, page 109.

[152] VISN 7, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo*.

5. The VISN's proposal indicates that demolition would be the most cost-effective approach and would have savings of a net present value of $199.4 million over the life cycle.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to study the feasibility of consolidating selected current services at the Uptown Division to the Downtown Division because the proposed realignment is not practical.
2. The Commission concurs with the DNCP proposal to realign the footprint at the Uptown Division campus and to evaluate that campus for alternative uses under the EUL program. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

II Mission Change – Dublin

DNCP Proposal

"Dublin VAMC to retain its inpatient program, but ICU beds will be subject to a VHA-directed external evaluation. Transition surgery beds to observation beds. Refer complex, non-urgent, or non-emergent surgery to other VAMCs. Contract with local community hospitals for emergent surgery."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The Dublin VAMC was identified as a small facility due to the size of its acute inpatient program. Workload data for FY 2003 indicate that the medical center had 30 medicine beds (ADC 22) and six surgery beds (ADC 2). CARES projected workload indicates that the VAMC will need 36 acute medicine beds in FY 2012 and 30 in FY 2022. The Dublin VAMC also has 164 nursing home beds (ADC 145) and 145 domiciliary beds (ADC 64), and provides outpatient primary and specialty care and mental health care services.[153]

Quality outcome ratings for medicine services indicate that the Dublin VAMC was rated higher than the national average in seven of the 18 areas measured. Surgery quality outcome ratings indicate that the medical center is within the normal range for mortality. Customer satisfaction scores for both inpatient and outpatient care are below the national average for VHA medical centers.[154]

The nearest VAMC is the Augusta VAMC, which is approximately 90 miles from Dublin. The Atlanta VAMC is also an alternative facility for Dublin area veterans, though it is farther away (approximately 140 miles). Within the Dublin community, there is one JCAHO accredited medical center that appears to have ample excess capacity, if needed.[155]

Inpatient care costs data for Dublin indicate that medicine, surgery, and nursing home costs are all lower than the national average. Contracted medicine care costs are higher than the national average while contracted surgery costs are lower. Additionally, outpatient care costs for primary care, specialty care, and mental health services are all lower than the national average.

VISN Acting Director Kenneth Ruyle testified that the Dublin VAMC inpatient program was recommended to remain intact based on quality of care, access, and costs.[156]

The hearings revealed community concerns about the potential change in mission at Dublin. Dr. Peter Makaya, Director at Middle Georgia College, testified regarding the many positive sharing arrangements that are in place between the Dublin VAMC and Middle Georgia College. The college allows VA employees to attend Middle Georgia College tuition-free, and most employees availing themselves of this educational opportunity are majoring in nursing. In January 2004, the college also plans to move its nursing program to the grounds of the VAMC in order to provide training to more nurses.

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[153] Appendix D, *Data Tables*, page D-36.
[154] Appendix D, *Data Tables*, page D-37.
[155] Appendix D, *Data Tables*, page D-37.
[156] Kenneth Ruyle, Acting VISN 7 Director, Written Testimony submitted at the Atlanta, GA, Hearing on August 28, 2003, page 8, available from [*http://www.carescommission.va.gov/Documents/AtlantaPanel1.pdf*].

Commission Findings

1. CARES projected data indicate the Dublin VAMC will need 36 acute medicine beds in FY 2012 and 30 acute medicine beds in FY 2022.
2. The Dublin VAMC is approximately 90 miles from the nearest VAMC in Augusta. It is approximately 140 miles from the Atlanta VAMC.
3. There is one JCAHO accredited community hospital in the Dublin area. This medical center does appear to have excess capacity.
4. The Dublin VAMC has partnered with the local college to provide educational and training opportunities for VA employees, especially in the area of nursing.

Commission Recommendations

1. The Commission concurs with the DNCP proposal that the Dublin VAMC should retain its inpatient programs, with ICU beds subject to a VHA-directed external evaluation; that transition surgery beds be changed to observation beds; and that Dublin refer complex or non-emergent surgery to other VAMCs, and contract with local community hospitals for emergent surgery.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

III Mission Change – Montgomery, Alabama (Central Alabama Veterans Health Care System [CAVHCS], West Campus)

DNCP Proposal

"The proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* New construction to accommodate the significant increase in overall projected inpatient and outpatient workload.
3. *100 Percent Contracting*
4. *[The VISN's preferred alternative]:* The CAVHCS/DoD sharing alternative facilitates the sharing of federal resources (space, equipment and manpower). This allows CAVHCS to increase its capacity and accommodate projected workload without significant capital investment. CAVHCS gains state-of-the-art space from Maxwell AFB, while Maxwell AFB gains high quality care for its service members and backup inpatient capacity from CAVHCS.

Commission Analysis

The Montgomery campus is 52 acres, located in a residential community adjacent to city school property, and is approximately five miles from downtown Montgomery, AL. The four buildings that make up the Montgomery campus were built in 1939, though Commissioners noted that the buildings are in good physical condition. Workload data for Montgomery over the past 3 years indicate significant changes in services including indications that there are available beds in certain care areas. Both inpatient and outpatient customer satisfaction scores at the Montgomery facility are below the national averages for these patient care areas.[157]

Testimony from VISN leadership revealed that the Montgomery realignment scenario had not been in the VISN's original CARES plan. Rather, the VISN was asked to consider the realignment of the Montgomery campus after the DNCP had been developed. At the time of the hearings in VISN 7, a fully developed analysis had not yet been completed. In October 2003, the VISN submitted to the USH its preferred alternative for realigning the Montgomery campus, which is a plan to accommodate projected growth in demand for veterans' medical services while minimizing VA resources (construction and maintenance costs, operational costs and staffing). The VISN would accomplish this by sharing space, equipment, and staffing with the 42nd Medical Group at Maxwell Air Force Base (AFB), which is 7 miles away. Under the VISN proposal, VA would retain and slightly expand the inpatient medicine and surgery services at the Montgomery campus, while continuing a partnership with Maxwell AFB. Constructed in 2000, Maxwell AFB has a significant amount of underutilized space that the VISN would use to increase its outpatient care capacity and to free up space at Montgomery for inpatient conversion and improvement to outpatient space.

[157] Appendix D, *Data Tables*, page D-41.

While the VISN's realignment proposal recommended a VA/DoD collaboration with Maxwell AFB and this recommended alternative appears to be promising, a more thorough life cycle cost analysis should be conducted to take into consideration any other VA/DoD sharing opportunities. The VISN's preliminary analysis included only the workload and costs associated with sharing with Maxwell AFB, and did not include the workload and costs associated with any other VA/DoD sharing opportunities.

Commission Findings

1. There has been a limited analysis of the impact of a possible mission change at the Montgomery campus of the Central Alabama Veterans Health Care System.
2. Although the Montgomery facility was built in 1939, the Commission observed that buildings were in good physical condition.
3. Workload data for the Montgomery campus indicate reductions in inpatient services provided at that medical center.
4. Montgomery's inpatient and outpatient customer satisfaction scores are lower than the national average.
5. While the proposal to provide services in conjunction with Maxwell AFB looks advisable based on the cost data provided, the basis of those costs is unclear.

Commission Recommendation

The Commission concurs with the DNCP that the proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study.

IV Inpatient Care

DNCP Proposal

"Increasing demand for medicine in both Alabama and South Carolina markets, surgery in Alabama, and psychiatry in the South Carolina Market will be met by contract hospital sites, conversion of vacant space, new construction, renovation, and leasing as required by each site of care."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Alabama Market's inpatient medicine demand is expected to increase by 66 percent above the FY 2001 baseline by FY 2012 and decrease to 34 percent above baseline in FY 2022. Surgery for the Alabama Market will increase by 65 percent in FY 2012 and 34 percent in FY 2022.[158] The Alabama Market does not meet the CARES standard for access to hospital care.

Workload projections indicate that 90 percent of the increased demand for inpatient medicine and surgery services in the Alabama Market will come from veterans living in northern Alabama counties. The Birmingham VAMC, which serves these counties, is space-constrained and landlocked, and plans to contract with a community hospital in Huntsville, AL, beginning in FY 2004. This would address access to hospital care in this market. Birmingham plans to transfer some medicine and surgery workload to the Huntsville hospital. It will retain complex inpatient services.

The South Carolina Market is projected to have a 79 percent increase in its inpatient psychiatry workload by FY 2012 and 43 percent increase by FY 2022.[159] Additionally, the South Carolina Market does not meet the CARES standard for access to hospital care.

In South Carolina, the VISN plans to manage increased inpatient workload, as well as improve access to hospital care, by contracting with a Greenville hospital for a portion of the medicine, psychiatry, and surgery workload.

Commission Findings

1. Inpatient care and access gaps exist in the Alabama and South Carolina markets.
2. The use of community contracts, reconfiguration, renovation, and conversion of excess space for peak workload years would address inpatient care and access gaps.

Commission Recommendations

1. The Commission concurs with the DNCP proposal on the use of contract hospital sites, conversion of vacant space, new construction, renovation, and leasing as required in the Alabama and South Carolina markets to meet access and capacity issues in these markets.

[158] Appendix D, *Data Tables*, page D-33.
[159] Appendix D, *Data Tables*, page D-33.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

V Outpatient Care

DNCP Proposal

"Increasing demand for primary care and specialty care in all three markets and mental health in the South Carolina Market will be met by addition of 15 new CBOCs, expansion of existing CBOCs via contract, lease, and new construction. Demand will also be met by reconfiguration of space at the VAMCs via renovation, conversion of vacant space, new construction, and leasing."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

CARES workload data indicate that all three markets will see significant increases in workload. The VISN proposed 15 new CBOCs to address access and workload gaps. Testimony presented at both hearings support the expansion of outpatient services through the opening of the 15 CBOCs included in the DNCP's highest priority category. The VISN also completed an in-depth analysis to address specific market populations in order to strategically plan the CBOC locations.

In an effort to meet access standards and respond to increasing workloads, the VISN intends to expand services at certain CBOCs that have the space and staff to accept additional workload and to contract for services in various locations.

Kenneth Ruyle, Acting VISN Director, discussed the growth that would occur in workload in VISN 7. "All CBOCs plan to deliver mental health services at the rate of either the benchmark of 20 percent of primary care workload volume or actual historical volume, whichever is greater."[160]

[160] Kenneth Ruyle, Acting VISN 7 Director, Written Testimony submitted at the Atlanta, GA, Hearing on August 28, 2003, page 5, available from [*http://www.carescommission.va.gov/Documents/AtlantaPanel1.pdf*].

The VISN indicated that primary care would be moved from the VAMCs to CBOCs. Once accomplished, the parent VAMCs plan to convert vacated space to enhance specialty care clinics. This may require some renovations to VAMCs in order to reconfigure the vacated space.

Commission Findings

1. All 15 CBOCs requested by the VISN are included in the DNCP's priority one group.
2. Access to care gaps exist in all three markets in the VISN.
3. Workload projections indicate gaps in primary care, specialty care, and mental health care services.
4. The proposed CBOCs should improve access to care as well as address increased workload.
5. The VISN plans to reclaim some primary care space in VAMCs for specialty care clinics once primary care workload is relocated to CBOC settings. This outpatient care space may require reconfiguration and renovations to accommodate delivery of other health care services.

Commission Recommendations

1. The Commission concurs with the DNCP proposals to add CBOCs; to expand existing CBOCs via contracting, leasing and new construction; and to realign the use of space at the VAMCs via renovation, conversion of vacant space, new construction and leasing.
2. The Commission recommends that:[161]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.

[161] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

VI Enhanced Use, Collocation with the Veterans Benefits Administration, and Collaboration with Academic Affiliate

DNCP Proposals

"*Enhanced Use* – Columbia has an enhanced use project utilizing 26 acres. *VBA Collaboration* – The VBA will collocate on Columbia VAMC as part of the enhanced use project."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Mr. Kenneth Ruyle, Acting VISN Director, said in testimony that "VBA has agreed to collocate their regional office on the Columbia campus to an enhanced use construction project with a private developer."[162] He indicated that this facility would be built on unoccupied land within the 26 acres that the medical center has designated as an EUL site. Other potential uses for the space include a fire station for the city of Columbia, a South Carolina Law Enforcement Assistance Program, and relocated and consolidated medical center administrative functions.[163] According to the DNCP, collocation of the VBA Regional Office at the Columbia VAMC is one of six initiatives on VBA's high priority list.[164]

At the Charleston hearing, the Commission heard from Charleston's medical affiliate about another opportunity for VA to engage in partnership, although this proposal was outside the DNCP. Dr. Raymond Greenberg, President of the Medical University of South Carolina (MUSC), testified that MUSC would like to partner with the Ralph A. Johnson VAMC in Charleston as part of the MUSC long-range plan to build a replacement medical center.

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[162] Kenneth Ruyle, Acting VISN 7 Director, Written Testimony submitted at the Charleston, SC, Hearing on September 8, 2003, page 4, available from [*http://www.carescommission.va.gov/Documents/CharlestonPanel1.pdf*].

[163] Kenneth Ruyle, Acting VISN 7 Director, Written Testimony submitted at the Charleston, SC, Hearing on September 8, 2003, page 4, available from [*http://www.carescommission.va.gov/Documents/CharlestonPanel1.pdf*].

[164] Draft National CARES Plan (DNCP), *Appendix H - VBA and NCA Collaborations by VISN,* page 1, available from [*http://www1.va.gov/cares/docs/DNP_appH.pdf*].

The project proposal from MUSC includes incremental phasing, with the first phase being MUSC leasing land from VA for access purposes. Subsequent proposed phases include the construction of a shared structure between VA and MUSC for all core support services such as laboratory, radiology, operating room, and other support services. The third phase, in concept, would include construction of a separate bed tower for use by VA connected to the shared support structure. The latter two phases have no set timeline. The process has already begun with the proposal for the initial phase having been sent to the VA Central Office for expedited approval.[165]

There is tremendous support from MUSC and the City of Charleston to further strengthen the strong partnership with VA. Dr. Greenberg stated, "If the VA entered into an agreement with us [MUSC], they [VA] would almost be in a no-lose position because if it turned out that they didn't really need the bed capacity in the long term, MUSC could just turn over the beds that they didn't want to utilize."[166]

The Commission believes that the MUSC proposal represents a fine example of how future partnerships might be handled.

Commission Findings

1. VBA views moving its Columbia Regional Office to the Columbia VAMC campus as a high priority.
2. The MUSC partnership proposal with the Ralph H. Johnson VAMC is under review in the VA Central Office.
3. The proposed cooperative arrangement between MUSC and VA is a possible framework for future partnerships.

Commission Recommendations

1. The Commission concurs with the DNCP proposal on the VBA collocation and enhanced use lease proposal at Columbia.
2. The Commission supports the concept of cooperative partnering and recommends promptly evaluating the MUSC and VA joint venture proposal.

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[165] Dr. Raymond Greenberg, President, Medical University of South Carolina, Transcribed Testimony submitted at the Charleston, SC, Hearing on September 8, 2003, page 113.

[166] Dr. Raymond Greenberg, President, Medical University of South Carolina, Transcribed Testimony submitted at the Charleston, SC, Hearing on September 8, 2003, page 113.

VII Special Disability Programs – Spinal Cord Injury/Disorder Beds

DNCP Proposal

"Increase the number of Spinal Cord Injury (SCI) beds at the Augusta VAMC by adding 11 beds now and increase to the projected 20-bed need by 2012."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

SCI plans were developed on a national basis using actuarial modeling. Currently, the Augusta VAMC is a referral SCI Center for patients in VISN 7 and from other states in the Southeast.

Augusta is a 60-bed SCI Center with ADC of 42.[167] The Commission noted during its site visit that the Augusta SCI Center is in the process of renovations to respond to patient environmental issues, and this may account for the low ADC of 42. CARES projections indicate that by FY 2012, VISN 7 will need 71 acute SCI beds and by FY 2022, the VISN will need 86 acute SCI beds. For long-term care (LTC) SCI beds, the CARES projections indicate a need for 99 LTC beds by FY 2012 and 121 LTC beds by FY 2022.[168] The additional beds projected for the Augusta SCI Center will accommodate the increased workload projected due to demographic shifts in veteran population to the southeastern part of the United States.

Mr. James Trusley, VAMC Augusta Medical Center Director, indicated that the medical center operates in a hub and spoke model, with the spokes being outpatient evaluation centers at each of the feeder medical centers.

Commission Findings

1. The Augusta VAMC SCI program is a center of excellence and serves as an integral component of SCI care in that geographic area.
2. The additional SCI beds do not meet the projected need.

[167] Appendix D, *Data Tables*, page D-34.

[168] DNCP, *Appendix Q – Special Disability Program Planning Initiatives*, page 7, available from [*http://www1.va.gov/cares/docs/DNP_appQ.pdf*].

Commission Recommendations

1. The Commission concurs with the DNCP proposal to add 11 beds immediately at the Augusta VAMC and increase to the projected 20 SCI/D beds needed by FY 2012.
2. VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

VIII VA/DoD Sharing Opportunities

DNCP Proposal

"1) Atlanta is exploring the possibility of locating their new South Fulton County CBOC at Joel Army Medical Clinic (Ft. McPherson). 2) Charleston plans to construct a new Savannah CBOC at Hunter Army Airfield. 3) A new Hinesville, GA, CBOC will be either on the Fort Stewart Army Base or in the Hinesville community. 4) Plans to contract for hospital care in the Savannah community may be met by purchasing DoD care from nearby Fort Stewart. 5) Montgomery realignment will examine opportunities to purchase inpatient care from Maxwell AFB as part of studying the realignment of inpatient services. 6) Central Alabama Veterans Health Care System is pursuing options with Fort Rucker (Enterprise, AL, area) and Fort Benning (Columbus, GA). VISN 7/DoD has a Tiger Team in place to evaluate additional sharing opportunities including possible application for a demonstration site for the VA/DoD Health Care Resources Sharing Project (NDAA)."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

There are numerous opportunities identified in VISN 7 for possible DoD and VA collaboration.

In regard to the VISN 7 VA/DoD current collaboration and opportunities for further sharing Mr. Glen Sigafoose, a spokesperson for the Eisenhower Army Medical Center, testified:

> We have had a shared joint venture since 1992. In 1993, we began a neurosurgery program and, recently, we instituted a cardio-thoracic program at Eisenhower where all VA patients who need open-heart surgery come to our campus, because of the involvement of the Southeast Regional Medical Command. [W]e have a broad arrangement and relationship

> with others. The Tiger team has been operating since last year. Just in the initial six months, we have helped identify many of the sharing opportunities across the region and have also sent forward five proposals for the VA/DoD joint sharing [opportunities].[169]

A joint VA/DoD staffing and assignments demonstration project between the Augusta VAMC and the Dwight D. Eisenhower Army Medical Center was announced on November 3, 2003. This demonstration project will test the capabilities of the two departments to provide a seamless delivery of benefits and services to military members and veterans by sharing information and other efficiencies.

Commission Findings

1. There are many opportunities to maximize space utilization and services among the VAMCs and DoD health care operations to enhance health care for veterans.
2. The Augusta VAMC and the Eisenhower Army Medical Center will participate in a joint VA/DoD staffing and assignments demonstration project. This demonstration project will test the capabilities of the two departments to provide a seamless delivery of benefits and services to military members and veterans by sharing information and other efficiencies.

Commission Recommendation

The Commission concurs with maximizing space utilization and services among the VA and DoD health care operations to provide enhanced services for veterans.

IX Extended Care

DNCP Proposal

"Proposed capital investments for nursing home care units (NHCU) to remedy space deficiencies include the renovation of 67,247 existing square feet in the South Carolina market (Charleston and Columbia)."

DNCP Alternatives

None provided in the DNCP.

[169] Glen Sigafoose, Chief, Managed Care, Eisenhower Army Medical Center, Transcribed Testimony from the Atlanta, GA, Hearing on August 28, 2003, page 106.

Commission Analysis

The Charleston VAMC's nursing home unit was established in 1997, when a 40-bed ward was converted to a 28-bed nursing home care unit. Because it is located in a hospital bed tower, the nursing home space is less than optimal, as it does not provide amenities that would generally be expected for quality nursing home settings.

The Charleston VAMC nursing home maintains 28 beds with an ADC of 24. The Columbia VAMC's nursing home consists of 107 beds with an ADC of 80.[170]

CARES space projections for Charleston and Columbia did not clearly identify space deficiencies in the nursing home care units. The CARES process identified inpatient space in the Charleston and Columbia VAMCs in need of renovations. Additionally, the NCPO indicated that both VAMCs' extended care units have space with environmental issues.

At the hearing in Charleston, Acting VISN Director Ruyle did not specifically speak to the nursing home care units in the two medical centers, but did indicate that neither Charleston, built in 1965, nor Columbia, built in1979, had had any significant renovations to their inpatient wards since they were built, with the exception of Columbia's surgical ward.[171]

Commission Findings

1. The Charleston VAMC's nursing home is in a hospital bed tower, a less than optimal setting for a nursing home.
2. Specific data relating to nursing home space is not available, but inpatient space deficits do exist.
3. Neither the Charleston VAMC nor Columbia VAMC has had significant renovations to inpatient wards since they were built, except Columbia's surgical ward.

Commission Recommendations

1. The Commission concurs with the DNCP proposal on the need for renovations to the nursing home care units at Charleston and Columbia.

[170] VSSC KLF Menu Database, *Occupancy Rate Report thru September 2003*.

[171] Kenneth Ruyle, Acting VISN 7 Director, Transcribed Testimony from the Charleston, SC, Hearing on September 8, 2003, page 22.

2 The Commission recommends that:[172]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

X Facility Condition

DNCP Proposal

"The inpatient ward conditions at the Atlanta, Columbia, and Charleston VAMCs were identified as a VISN Planning Initiative."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP proposal was clarified at the hearing to mean that the USH approved the VISN planning initiatives to renovate the inpatient wards at Atlanta and Charleston. The Georgia Market is projected to have a 19 percent (32 beds) increase over the FY 2001 baseline in the need for inpatient medicine beds by FY 2012. This partly offsets projected declines of 6 percent in the need for both psychiatry and surgery beds (ten beds). The Atlanta VAMC's inpatient medicine, psychiatry, and surgery units are areas that were identified through the CARES process as having poor quality space and therefore needing renovations.

The South Carolina Market is projected to have a 40-percent growth in medicine beds (40 beds), a 10-percent growth in surgery beds (five beds), and a 79-percent growth in psychiatry beds (23 beds) by FY 2012. While projections indicate some decline by FY 2022, there will still be a need for 31 beds above current levels.

[172] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

Mr. Ruyle indicated that the Columbia and Charleston VAMCs have not had any significant renovations to their inpatient wards since they were built, with the exception of Columbia's surgical ward. Through the CARES process, Charleston was identified as meeting the threshold for renovation. While the Columbia VAMC did not meet the threshold for renovation under the CARES process, it was identified as needing some improvements to address environmental and space issues. Columbia has proposed construction for its medical inpatient unit, and Charleston will begin the renovation of its inpatient units in 2004 and 2005.

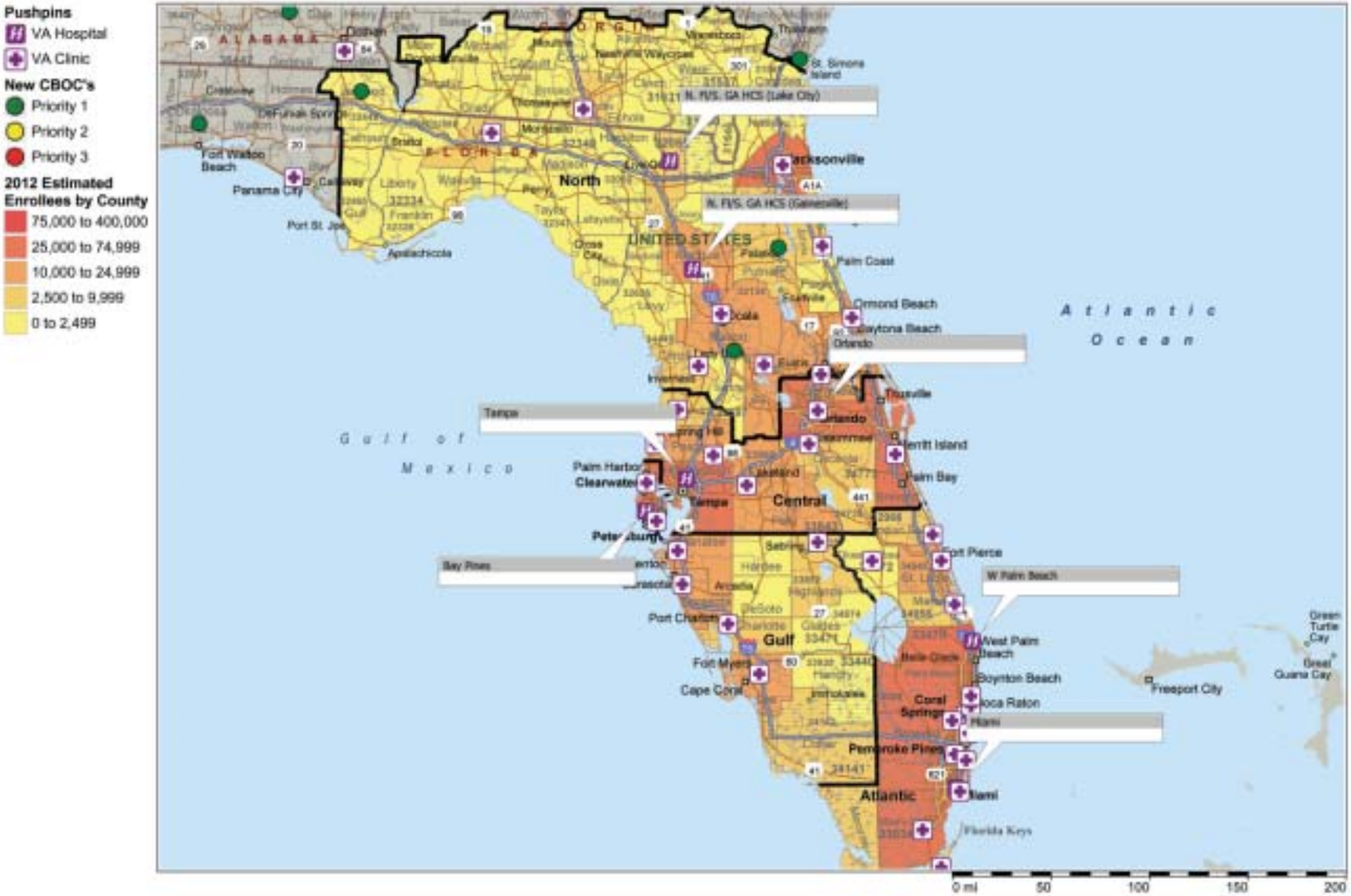
Commission Findings

1. The need for inpatient beds is projected to grow in Atlanta, Columbia, and Charleston.
2. The CARES process identified areas within the Atlanta and Charleston VAMCs as meeting the threshold for renovations. The Columbia VAMC was identified as needing renovation to improve environmental and limited space issues.
3. The VISN has begun renovating inpatient wards in Charleston and Columbia, using VISN minor construction dollars.

Commission Recommendation

The Commission concurs with the DNCP proposal to renovate inpatient wards at the Atlanta, Columbia, and Charleston VAMCs.

VISN 8 – VA Sunshine Health Care Network



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VISN 8, VA Sunshine Health Care Network

VISN Overview

VISN 8, VA Sunshine Health Care Network, is an integrated, comprehensive health care system that provided medical services to approximately 453,000 of the 655,000 veterans enrolled in VA's health care system in FY 2003.[173] Geographically, this VISN spans about 63,400 square miles and includes a total veteran population of 1.9 million. The VISN includes Florida (except seven Panhandle counties), 19 rural counties in South Georgia, the U.S. Virgin Islands, and Puerto Rico.

According to testimony of Dr. Elwood Headley, VISN 8 Director, "the greatest challenge in VISN 8, operational and strategic, continuous to be the tremendous growth in users in our health care system resulting from the continuous influx of veterans to Florida from other parts of the country."[174] Over the past five years, VISN 8 experienced a 67 percent workload increase.

With a VA staff of approximately 15,000 FTEs,[175] VISN 8 delivers health care services through seven medical centers (the two campuses in North Florida are integrated under one director), 10 multi-specialty outpatient clinics, 34 community-based outpatient clinics (CBOCs), eight nursing homes, and two domiciliary facilities. In addition, VA operates 14 Vet Centers in VISN 8.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 8.

VISN 8	FY 2001	FY 2012	FY 2022
Enrollees	516,951	554,882	499,972
Veteran Population	1,919,414	1,653,416	1,384,515
Market Penetration	26.93%	33.56%	36.11%

For the CARES process, the VISN is divided into five markets: North Market (*facilities:* Gainesville and Lake City, FL); Atlantic Market (*facilities:* West Palm Beach and Miami, FL); Puerto Rico Market (*facility:* San Juan, PR); Gulf Market (*facility:* Bay Pines, FL); and Central Market (*facility:* Tampa, FL).

[173] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.

[174] Elwood Headley, MD, VISN 8 Director. Written Testimony submitted at the Orlando, FL, Hearing on September 10, 2003, page 1, available from [*http:www.carescommission.va.gov/Documents/OrlandoPanel2.pdf*].

[175] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited ten different locations in VISN 8 and held one public hearing. The Commission received 5,435 public comments regarding VISN 8.

- *Site Visits:* The VA Medical Center (VAMC) in San Juan and the Ponce multi-specialty clinic, Roosevelt Roads Naval Hospital, and the Army's Fort Buchanan on July 7; Lake City VAMC and the Fort Augustine, FL, CBOC on July 9; Tampa VAMC, Fort Myers CBOC, Miami VAMC, and an Orlando CBOC on September 11.
- *Hearing:* Orlando, FL, on September 10.

Summary of CARES Commission Recommendations

I New Hospital (Access) – Orlando

1. The Commission concurs with the DNCP proposal on the construction of a new inpatient facility in Orlando and recommends the number of beds in the proposal be validated in relation to the proposed new Tampa VAMC bed tower.

(see page 5-141)

II Mission Change – Lake City

1. The Commission does not concur with the DNCP proposal to move Lake City's inpatient surgery services to Gainesville at the present time.
2. In light of the projected growth of enrollees and the access gap in the North Market, the Commission further recommends that any consideration of a transfer of inpatient services from Lake City to Gainesville be delayed until FY 2012.
3. The Commission concurs with the DNCP proposal to maintain nursing home care and outpatient services at Lake City.

(see page 5-142)

III Inpatient Care – Tampa VAMC

1. The Commission concurs with the DNCP proposal for construction of an inpatient bed tower at the Tampa VAMC primarily on the basis of infrastructure and safety issues.
2. The Commission recommends that as the planning for the bed tower at Tampa proceeds, the number of beds in the proposal be validated in relation to the proposed new Orlando inpatient facility.

(see page 5-144)

IV Other Inpatient Care – Gulf South and North Markets

1. The Commission concurs with the DNCP proposal to address the access gap for inpatient services in the Gulf South Market (Bay Pines VAMC) by contracting for care. The Commission also concurs with the VISN proposal to realign the number of operating beds in the Gulf South Market. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
2. The Commission concurs with the DNCP proposal for a DoD/VA joint venture with the Naval Air Station Hospital at Jacksonville and a contractual arrangement with University of Florida/Shands and new construction at Gainesville to meet inpatient demand in the North Market.
3. The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care in the Panhandle of Florida.

(see page 5-146)

V Outpatient Care

1. The Commission concurs with the DNCP proposal for adding four new points of primary care in the North Market and by expansion of existing CBOCs in all five markets.
2. The Commission recommends that:[176]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-148)

[176] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

VI VA/DoD Sharing

1. The Commission recommends that the VISN plans for the DoD collaborative opportunities in VISN 8 include clear, written evidence of a joint commitment.

(see page 5-150)

VII Special Disability Programs – Spinal Cord Injury/Disorder Beds at Tampa

1. The Commission does not concur with the DNCP on the addition of 30 Spinal Cord Injury/Disorder (SCI/D) beds in Tampa. The Commission recommends that, prior to a final decision to increase the number of SCI/D beds at Tampa, VA's Chief Consultant for SCI/D consider alternative locations in or near VISN 8 for an additional SCI Center.
2. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-151)

VIII Excess VA Property

1. The Commission concurs with the DNCP proposal for further exploration of enhanced use leasing (EUL) project opportunities at Bay Pines and Miami.
2. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-152)

IX Infrastructure and Safety

1. The Commission recommends the expeditious construction of a new seismically safe bed tower in San Juan. The Commission recommends the VISN validate the bed, space, and cost requirements given the projected decreasing demand for inpatient care in that market.

(see page 5-154)

New Hospital – Orlando

DNCP Proposals

"Acute hospital access in Central market will be increased by adding a new VA owned and operated site for hospital care in Orlando (Gulf market)."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Veterans in the Orlando area receive inpatient care mainly at the Tampa VAMC, since there is no inpatient facility in the mid- and eastern portion of the Central Market. Today, only 45 percent of veterans living in the Central Market area are within the CARES travel access standard for hospital care; the requirement is 65 percent. CARES data identified the Central Market as having the largest workload gap and greatest infrastructure need of any single market in the country.

VISN 8's Director, Dr. Elwood Headley, indicated at the Orlando hearing that "in the Central Market, access to acute hospital care will be met through the construction of a VA hospital in Orlando and a new bed tower in Tampa."[177] In response to a question about the need for a new hospital in Orlando and the number of beds required, Dr. Headley indicated that, based on projections, about 100 inpatient beds were needed "however we are not far enough along in this process to have any concrete plans."[178]

While a large outpatient clinic in Orlando is adequately serving veterans' outpatient needs, there is a clear access gap that supports constructing an inpatient facility in Orlando. As the Tampa VAMC currently provides services to veterans from the Orlando area and given the geographic proximity of these two areas, the size of the new Orlando VAMC and the new bed tower at Tampa need to be validated in relation to each other.

Public comments strongly support the need for a new acute inpatient facility in Orlando. Florida State Representative John Quinones submitted the following in written comments: "I am concerned about the lack of adequate health care for our veterans in Central Florida. As one of the fastest growing populations of veteran retirees, the demand for services has not kept pace with the supply."[179] Veterans report long driving distances (90 minutes to two hours) and wait times to receive care at the Tampa facility.

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[177] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, pages 23-24.

[178] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 62.

[179] The Honorable John Quinones, Florida House of Representatives. Written Letter dated August 5, 2003, for the CARES Commission Hearing, Orlando, FL, September 10, 2003, page 1.

Commission Finding

Access requirements and increasing inpatient demand support the establishment of a new inpatient facility in Orlando. Data to support the number of beds has not been substantiated.

Commission Recommendation

The Commission concurs with the DNCP proposal on the construction of a new inpatient facility in Orlando and recommends the number of beds in the proposal be validated in relation to the proposed new Tampa VAMC bed tower.

II Mission Change – Lake City

DNCP Proposals

"Transfer of current inpatient surgery services to Gainesville now. Inpatient medicine services transfer to Gainesville will be reevaluated when Gainesville has expanded inpatient capacity (due to construction of a proposed new bed tower). Nursing home care and outpatient services will remain at Lake City."

DNCP Alternatives

1. *Status quo*
2. *100 Percent Contracting*
3. *[The VISN's preferred option]:* Transfer inpatient surgery services to Gainesville and reevaluate inpatient medicine once Gainesville has expanded its inpatient capacity.

Commission Analysis

The North Florida/South Georgia Veterans Health Care System is composed of the Lake City and Gainesville facilities. Commissioners learned that the Gainesville facility is operating at capacity and does not currently have the ability to absorb the inpatient workload from Lake City. VA data support this contention. Access to hospital care in the North Market is currently at 35 percent and enrollment is projected to grow from 130,000 in FY 2001 to 169,000 in FY 2012 and 140,000 in FY 2022.[180] The proposed bed tower at Gainesville would increase its capacity, improve patient flow, and correct fire and safety issues, allowing for greater opportunity to absorb some of the Lake City workload.

[180] CARES VISN Web Site.

Because of the capacity issues at Gainesville, VISN leadership developed an alternative plan to relocate only inpatient surgery from Lake City to Gainesville at a later date. The remaining inpatient medicine workload would be relocated pending completion of the bed tower in Gainesville. The rationale for this shift includes the ability to retain "highly qualified surgical practitioners"[181] at Lake City. According to Fred Malphus, Director of the Gainesville VAMC, inpatient surgical cases currently comprise seven to eight percent of total surgical cases at Lake City.[182] The vast majority of surgical care is completed on an outpatient basis. Lake City currently operates six inpatient surgery beds.[183]

Rather than addressing their preferred alternative, the VISN submitted a realignment proposal that considered alternatives of a) transferring inpatient programs, b) transferring only inpatient surgery to Gainesville, or c) contracting for those services. However, the proposal did not provide a life cycle analysis and did not provide sufficient information with which to make a decision.

The Lake City facility is in good condition and has traditionally served the southern Georgia and Florida Panhandle area, much of which is medically underserved. Stakeholder groups and the local community overwhelmingly oppose shifting inpatient services to Gainesville, due to concerns over the rapidly growing Florida population and the associated influx of veterans, as well as the added access gap imposed by the need to travel to Gainesville.

Commission Findings

1. The Gainesville facility currently does not have the capacity to absorb the Lake City inpatient workload. The proposed patient tower in Gainesville would help alleviate capacity issues and improve overall facility quality.
2. VISN leadership supports the transfer of inpatient surgical cases to Gainesville, citing the difficulty of retaining "highly qualified surgical practitioners" in Lake City.
3. Stakeholders overwhelmingly advocate the retention of the current Lake City inpatient services.
4. Access gaps for inpatient medicine and surgery in the North Market would increase if these services were moved to Gainesville.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to move Lake City's inpatient surgery services to Gainesville at the present time.

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[181] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 30.
[182] Mr. Fred Malphus, Director, Gainesville VAMC. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 32.
[183] VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.

2 In light of the projected growth of enrollees and the access gap in the North Market, the Commission further recommends that any consideration of a transfer of inpatient services from Lake City to Gainesville be delayed until FY 2012.

3 The Commission concurs with the DNCP proposal to maintain nursing home care and outpatient services at Lake City.

III Inpatient Care – Tampa VAMC

DNCP Proposals

"Tampa (West Central Florida submarket) will build a new inpatient bed tower above the new spinal cord injury (SCI) center to meet medical, surgical, and psychiatry inpatient workload."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Due to current infrastructure issues in the Central Market (Tampa), as well as the impact of growth from the Orlando area, the Tampa VAMC currently operates at capacity, with considerable overcrowding. In FY 2003, the inpatient occupancy rate for Tampa was 75 percent (ADC 226), and the nursing home occupancy rate was 85 percent (ADC 254).[184] During the Commission site visit, VISN leadership described the deteriorating infrastructure situation at the Tampa facility and indicated that insufficient capital investment and improvements have resulted in space inadequacies. An assessment made by the VA's Office of Facilities Management[185] shows poor code compliance, patient privacy issues, and infrastructure problems, with an estimated cost of repair of $100 to $150 million. Specifically, inpatient wards still operate with four-bed patient rooms, and the bed tower lacks such safety measures as an adequate sprinkler system. The current bed tower also contains asbestos.[186] To resolve overcrowding in Tampa and to improve overall quality and patient safety, the DNCP proposes construction of a new inpatient bed tower, without providing construction or life cycle information.

[184] VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.
[185] VISN 8, Background Information Requested by CARES Commission for Orlando, FL, Hearing, September 10, 2003.
[186] CARES Portal, VISN 8, Proximity Narrative, Bay Pines and Tampa VAMC.

The Tampa VAMC is a major tertiary care hospital in an area with a large and growing number of enrollees. It is more than 1 hour from the Bay Pines VAMC, through congested traffic. In addition, though CARES projections indicate that demand at Bay Pines for inpatient medicine and surgery is declining, testimony reflected a need for development of more subspecialty care and increased workload in specialty care services,[187] as well as increased demand for inpatient psychiatry. Even though these two VAMCs are in close proximity, VISN leadership stated "given the large complex nature of both facilities. [and] the separation of the two cities' urban areas by the bay the population is better served by maintaining two health systems."[188]

Commissioners note, however, that there was no indication of consideration being given to the impact of a new inpatient medical center in Orlando on the Tampa VAMC workload.

Commission Findings

1. The Tampa facility currently operates at capacity, with considerable overcrowding.
2. Tampa has significant space deficiencies, poor code compliance, and infrastructure problems.
3. To resolve space inadequacies and quality issues, the VISN proposes to develop an inpatient bed tower at the Tampa facility.
4. The Bay Pines VAMC is 44 miles from Tampa, is geographically separated from Tampa by the bay, and provides complementary services to those provided at Tampa.
5. There was no indication of review of the impact of the new Orlando inpatient medical center on the Tampa VAMC workload.
6. No construction or life cycle cost information was provided for the Tampa bed tower project.

Commission Recommendation

1. The Commission concurs with the DNCP proposal for construction of an inpatient bed tower at the Tampa VAMC primarily on the basis of infrastructure and safety issues.
2. The Commission recommends that as the planning for the bed tower at Tampa proceeds, the number of beds in the proposal be validated in relation to the proposed new Orlando inpatient facility.

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[187] Smith Jenkins, Director of the Bay Pines VAMC. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 59.

[188] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 26.

IV Other Inpatient Care – Gulf South and North Markets

DNCP Proposals

"*Access* – by adding new contract sites for hospital care in the Gulf South market area (Ft. Myers) and for North market, by adding two new points of acute medical care at Jacksonville Shands (contract) and Jacksonville DoD (joint venture). *Inpatient Services* – Increasing psychiatry demand in the North Market will be met through new construction at Gainesville."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In the Gulf South Market, the DNCP proposes to improve inpatient access by contracting for services, as currently only 50 percent of veterans meet the CARES access standard (which is 65 percent) for inpatient care. This market has a projected declining workload in medical and surgical inpatient care, and an increasing need for acute psychiatric beds,[189] that the VISN Director plans to address by adjusting the number of beds at the Bay Pines VAMC. A veterans service organization representative cautioned against excessive contracting for care for fear of VA becoming a purchaser of care rather than a provider of care.[190]

In the North Market, only 35 percent of the veterans meet the CARES access standard for inpatient care. Workload projections reflect an increased need for medical and psychiatry beds through FY 2012, and continued growth in demand for inpatient psychiatry through FY 2022.[191] Growing inpatient needs in the Jacksonville part of the North Market will be met through a proposed VA/DoD joint venture. In testimony, the VISN Director stated, "We are looking to establish relationships with both the Naval Air Station for inpatient hospitalization and with the Shands University of Florida presence in Jacksonville."[192] In addition, new construction has been proposed for the Gainesville facility to meet the increased demand for inpatient psychiatry. There was general stakeholder support for these initiatives, particularly to meet peak-year workload needs.

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[189] Appendix D, *Data Tables*, page D-42.

[190] Reggie Beverly, Department Commander, The American Legion of Florida. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 166.

[191] Appendix D, *Data Tables*, page D-42.

[192] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 55.

The Florida Panhandle is divided between two VISNs, with the western portion being part of VISN 16 and the eastern portion being part of VISN 8. In VISN 16 hearing in Biloxi, there was discussion about the need to address inpatient access in the Panhandle.[193] Similarly, at the VISN 8 hearing, Dr. Headley testified:

> We need to do more work with VISN 16 in addressing inpatient needs in the Panhandle I am not totally satisfied that this has been completely hammered out. The Panhandle has been a very rural area historically, but is beginning to build up a bit now. But providing services to veterans in the Panhandle has been and continues to be an area we will continue to address.[194]

General comments from the public reflect a need for VA to address veteran health care needs in Florida's Panhandle. The delineations imposed by the VISN structure that divides the area into two separate VISNs creates special issues and highlights the greater need for inter-VISN coordination in the planning process.

Commission Findings

1. There are sufficient private JCAHO medical centers that have capacity to meet inpatient workload needs in the Gulf South Market.
2. Establishing relationships with both the Jacksonville Naval Station and with the Shands University of Florida, combined with current referral patterns to the Gainesville facility, would likely adequately address the inpatient needs of the North Market.
3. New construction at Gainesville will help address increased demand for inpatient psychiatry in the North Market.
4. Issues relating to access to care for veterans living in the Florida Panhandle must be addressed through inter-VISN cooperation with VISN 16.

Commission Recommendation

1. The Commission concurs with the DNCP proposal to address the access gap for inpatient services in the Gulf South Market (Bay Pines VAMC) by contracting for care. The Commission also concurs with the VISN proposal to realign the number of operating beds in the Gulf South Market. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

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[193] The Honorable Bill Nelson, Florida Senator. Written Testimony Submitted at the Biloxi, MS, Hearing on August 26, 2003, page 1, available from [*http://www.carescommission.va.gov/Documents/BilioxiPanel3.pdf*].

[194] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 53.

2 The Commission concurs with the DNCP proposal for a DoD/VA joint venture with the Naval Air Station Hospital at Jacksonville and a contractual arrangement with University of Florida/Shands and new construction at Gainesville to meet inpatient demand in the North Market.

3 The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care in the Panhandle of Florida.

V Outpatient Care

DNCP Proposals

"*Access* – VISN 8 has a primary care access gap in the North market and an acute hospital gap in Central, Gulf, and North markets. Primary care access in the North market will be met by adding four new points of primary care. *Outpatient Services* – Increasing demand for primary care and specialty care in all five markets and mental health in two markets will be met by addition of four new CBOCs (North market only), expansion of existing CBOCs via contract, lease, and new construction."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The overall outpatient workload in the VISN, including primary, specialty, and mental health, is projected to increase 67 percent over the FY 2001 baseline by FY 2012 and to increase 65 percent over baseline by 2022.[195] There is increased demand for mental health care in all four Florida markets, not just in two noted in the DNCP.[196] To address this expected workload increase in all markets, VISN 8 recommended activation of five new CBOCs and two multi-specialty outpatient clinics.[197]

The need for primary care in the North Market is projected to increase in FY 2012 by 39 percent.

[195] Management of CARES Workload Report received from the VISN Support Service Center (VSSC) dated September 25, 2003, *Management Report*, page 2.
[196] Management Report, op cit.
[197] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 24.

This market also has the greatest number of current and projected enrollees for this VISN: near 170,000 in FY 2012 and 141,000 in FY 2022. The specialty care gaps are 115 percent by FY 2012 and 96 percent in FY 2022. The mental health care gaps are 70 percent in FY 2012 and 43 percent in FY 2022.[198] The VISN proposed to rectify these access gaps and address outpatient workload projections for this market by adding three new CBOCs and one multi-specialty outpatient clinic, which met the DNCP priority group criteria.

In the Puerto Rico Market, the VISN recommended the addition of two CBOCs, to be located in western and eastern Puerto Rico. The outpatient primary care workload is expected to increase by 21 percent over the FY 2001 baseline in FY 2012 and then decrease by 11 percent below baseline in FY 2022, while the need for specialty care is projected to increase by 98 percent by FY 2012 and by 51 percent by FY 2022.[199]

Additionally, VISN 8 plans expanding current CBOCs in other markets and adding one multi-specialty clinic in the Gulf Market.[200] During the Orlando hearing, VISN 8 Director, Dr. Headley, also outlined VISN plans to add mental health at existing and new CBOCs in compliance with the VA directive.[201]

Public comments support increased access to all types of outpatient care services and, given the significant growth in demand, that outpatient care services be provided in areas with high veteran population concentrations. VISN and public comments also question the accuracy of workload projections beyond two years, given the rapid growth in population and migration to Florida. The Commission believes that additional CBOCs are needed given the increasing veteran population in this VISN.

Commission Findings

1. Demand in this VISN for outpatient care has grown and is projected to grow.
2. Three of the VISN's proposed CBOCs and one multi-specialty clinic in the North Market are in the DNCP's priority group one.
3. The two CBOCs proposed by the VISN for the Puerto Rico Market are not in the priority group one.
4. The multi-specialty clinic proposed by the VISN for the Gulf Market is not in the priority group one.

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[198] Appendix D, *Data Tables*, page D-42.
[199] Appendix D, *Data Tables*, page D-42.
[200] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, pages 24-25.
[201] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 25.

Commission Recommendation

1. The Commission concurs with the DNCP proposal for adding four new points of primary care in the North Market and by expansion of existing CBOCs in all five markets.
2. The Commission recommends that:[202]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

VI VA/DoD Sharing

DNCP Proposals

"*DoD* – Outpatient joint ventures in the Puerto Rico market with Fort Buchanan and in the Gulf Market with McDill AFB, inpatient joint venture in the North market with Jacksonville Navy Hospital. *NCA* – NCA is interested in acreage for a cemetery along with any proposed construction in the Sarasota or Fort Myers area."

DNCP Alternatives

None provided in the DNCP.

[202] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

Commission Analysis

The VISN Director testified that VISN 8 will work to develop outpatient joint ventures in the Puerto Rico Market with Fort Buchanan, in the Gulf Market with McDill Air Force Base, and an inpatient joint venture with the Jacksonville Naval Air Hospital.[203]

Dr. Headley testified that at the Jacksonville clinic, there are ongoing collaborations in outpatient areas with the Naval Air Station and with the Shands University of Florida, but that inpatient discussions are in the "very preliminary stages."[204]

Commission Findings

1. The proposed collaborations are in early planning stages and the levels of commitment are unclear.
2. With the 35 percent access gap for hospital care in the North Market (discussed under "Inpatient Care"), the need for an acceleration of DoD collaboration is apparent.

Commission Recommendation

The Commission recommends that the VISN plans for the DoD collaborative opportunities in VISN 8 be accelerated and agreements include clear, written evidence of a joint commitment.

VII Special Disability Programs – Spinal Cord Injury Beds at Tampa

DNCP Proposals

"Increase the number of long-term SCI beds at Tampa by adding a 30-bed wing to the current SCI building."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Hearing testimony outlined the overall need within VA to establish long-term care beds for patients with spinal cord injury, so as to ensure appropriate care by specialized SCI medical professionals for an

[203] Elwood Headley, MD, VISN 8 Director. Written Testimony submitted at the Orlando, FL, Hearing on September 10, 2003, page 7, available from [*http://www.carescommission.va.gov/Documents/OrlandoPanel2.pdf*].

[204] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 56.

aging veteran population. However, in discussions for an additional 30-bed wing, alternative site proposals were not mentioned, and the DNCP does not provide specific rationale for increasing services at the Tampa location. The ADC for SCI beds at Tampa is 45 with an occupancy rate of 79 percent.[205] Wheelchair-bound, SCI/D veterans have great difficulties traveling far for care and thus locating a new SCI/D center in closer proximity to veterans' homes would be beneficial to their initial rehabilitation during which veterans' families play an important role. Another site, in addition to the existing Tampa site, would improve access for all subsequent admissions and outpatient care.

Because of the similarities in staffing and construction, VA's Chief Consultant for SCI Programs has the flexibility to designate SCI/D beds as initial rehabilitation, sustaining, or long-term care beds.

Commission Finding

Insufficient data has been provided on the proposal to increase the number of SCI/D beds at Tampa VAMC.

Commission Recommendation

1. The Commission does not concur with the DNCP on the addition of 30 SCI/D beds in Tampa. The Commission recommends that, prior to a final decision to increase the number of SCI/D beds at Tampa, VA's Chief Consultant for SCI/D consider alternative locations in or near VISN 8 for an additional SCI Center.
2. VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

VIII Excess VA Property

DNCP Proposals

"Potential enhance use projects are being explored for Bay Pines. None have been developed for inclusion in this cycle of CARES. University of Miami enhanced use lease project proposals is in development. University of Miami will pay for construction cost of adding three additional floors to existing research building at estimated cost of $8 million. Miami will address interior needs at estimated cost of $10 million. Project identified for design in FY 2005 and construction in FY 2006–2007."

[205] KLF menu, *Bed Control Data, Occupancy Rates*, FY 2003.

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Dr. Headley indicated in his testimony that "the Miami VAMC and the University of Miami are considering an enhanced use project proposal in which the university will fund construction of three floors above the existing research building on the VA medical center campus. The Miami VAMC will address interior needs in this space. If approved, the project will be designed in FY 2005 with construction to follow."[206]

While Dr. Headley noted in his testimony that EUL projects are being explored at the Bay Pines facility, no plans have been put forth for review. Bay Pines has ample grounds for EUL projects.

Commission Findings

1. It appears that the plans for the Miami VAMC project are early in the planning stages. The Commission is unaware of any study on this proposal or any cost and benefit analysis associated with it for the VA.
2. Bay Pines has ample grounds for EUL proposals, but no concrete plans are in place.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for further exploration of EUL project opportunities at Bay Pines and Miami.
2. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

[206] Elwood Headley, MD, VISN 8 Director. Written Testimony submitted at the Orlando, FL, Hearing on September 10, 2003 page 7, available from [*http://www.carescommission.va.gov/Documents/OrlandoPanel2.pdf*].

IX Infrastructure and Safety

DNCP Proposals

"The San Juan, PR facility is among the seismic correction projects within VA; estimated cost $85 million."[207]

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The San Juan VAMC was built in 1968. Since that time, new construction requirements that protect infrastructure and patients from potential seismic activity have been developed. The San Juan VAMC's seismic risk is significant. Extensive seismic studies have been conducted that indicate there are concerns regarding the structure's ability to provide health care in the event of an earthquake. Dr. Ramirez-Gonzalez, VAMC Director, testified about the clinical implications of an earthquake and the impact on care at the medical center. He indicated that since the present structure is made of steel, research has shown that it may withstand an earthquake but would become nonfunctional.

An in-depth study was performed sampling the welding through the building. They sampled a significant amount of sites and concluded that they meet the life safety code that meant the hospital would be standing after a major earthquake, but it will be nonfunctional. There would be no electricity, no power, and no water.[208]

During site visits, Commissioners learned that the VA facility also serves as a formal backup facility for all DoD and private sector medical care in San Juan. To correct the seismic issues and meet other patient safety and environmental issues, as well as to manage capacity, the VISN plans to use the $45 million already allocated from previous appropriations and is requesting an additional $25 million to construct a six-story bed tower. Dr. Headley indicated that the VISN wants to "complete a six-story tower that will allow us to put all of the inpatient beds in seismically safe environment."[209] During site visits, the Commissioners observed that the current facility had small, cramped patient rooms, an outdated intensive care unit with inadequate hand washing facilities, an SCI center in poor condition, and significant patient privacy issues.

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[207] DNCP, Chapter 11, Table 11.2.

[208] Rafael Ramirez-Gonzalez, MD, Director, San Juan VAMC. Transcribed Testimony from the Orlando, FL, Hearing on September 10,2003, page 34.

[209] Elwood Headley, MD, VISN 8 Director. Transcribed Testimony from the Orlando, FL, Hearing on September 10, 2003, page 36.

Construction of the new bed tower would serve the dual purpose of improving the facility's seismic performance and improving its space deficiencies. The significance of these improvements is highlighted by the important role VA plays in the San Juan community for overall health care delivery.

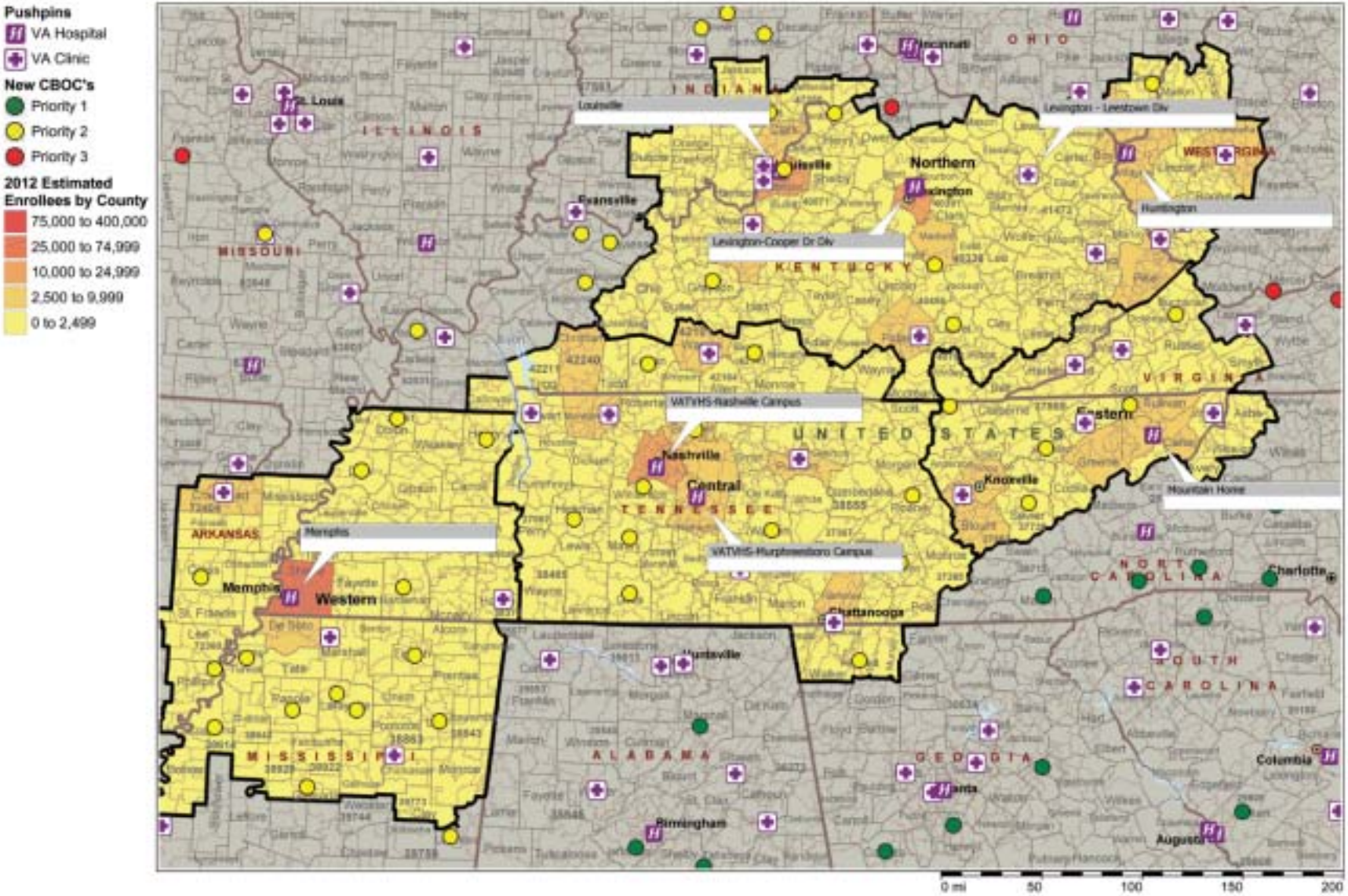
Commission Findings

1. The San Juan VAMC has significant seismic and patient safety issues that must be expeditiously addressed.
2. In addition to the correction of seismic issues, the proposed plan represents an opportunity for replacement of inpatient beds to correct patient privacy and safety issues and to enhance its SCI center.
3. $50 million was appropriated by the Congress to correct the seismic problem; $45 million has not been obligated.

Commission Recommendation

The Commission recommends the expeditious construction of a new seismically safe bed tower in San Juan. The Commission recommends the VISN validate the bed, space, and cost requirements given the projected decreasing demand for inpatient care in that market.

VISN 9 – MidSouth Health Care System



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VISN 9, VA MidSouth Health Care Network

VISN Overview

VISN 9, the VA MidSouth Health Care Network, is an integrated, comprehensive health care system that provided health care services to approximately 204,000 of the 313,000 veterans enrolled in VA's health care system in FY 2003.[210] Geographically, this VISN spans about 150,000 square miles and covers Kentucky, Tennessee, and parts of Indiana, Ohio, West Virginia, Virginia, North Carolina, Georgia, Mississippi, and Arkansas. It includes a total veteran population of 1.1 million. With a VA staff of approximately 8,582 FTEs,[211] VISN 9 delivers health care services through seven medical centers, three satellite outpatient clinics, 16 community-based outpatient centers (CBOCs), three nursing homes, one domiciliary unit, and one spinal cord injury (SCI) center. Additionally, VA operates nine Vet Centers in VISN 9's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the DNCP to identify the levels of need for services in VISN 9.

VISN 9	FY 2001	FY 2012	FY 2022
Enrollees	266,890	307,836	286,015
Veteran Population	1,096,205	950,707	812,264
Market Penetration	24.35%	32.38%	35.21%

For the CARES process, this VISN is divided into four markets: Northern Market (*facilities:* Louisville, Huntington, Lexington 2-Division – Cooper Drive and Leestown); Central Market (*facilities:* Tennessee Valley Health Care System – Nashville and Murfreesboro); Eastern Market (*facility:* Mountain Home); and Western Market (*facility:* Memphis).

[210] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[211] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002-September 2003.

Information Gathering

The CARES Commission visited five sites in VISN 9 and conducted two public hearings. The Commission received 10,322 public comments regarding VISN 9.

- *Site Visits:* Lexington, KY, VA Medical Center (VAMC); Wilmore (KY) State Veterans Home; Louisville, KY, VA Medical Center; and Ireland Army Hospital at Fort Knox (KY) U.S. Army Base, July 22 and 23.
- *Hearings:* Lexington, KY, September 8; and Nashville, TN, September 10.

Summary of CARES Commission Recommendations

I Evaluate Building a Replacement Hospital for Louisville VAMC

1. The Commission concurs with the DNCP proposal that VA study the feasibility of building a replacement medical center for the Louisville VAMC in proximity to the University of Louisville, including the possibility of shared infrastructure with the medical school and the VBA office.
2. Due to the poor environment of care and overcrowding at the current medical center, the Commission recommends the study commence immediately, focus on building a replacement hospital near the University of Louisville, and be completed within a short time so that corrective actions can begin in the very near future.

(see page 5-162)

II Campus Realignment – Lexington

1. The Commission does not concur with the DNCP proposal on transferring current outpatient care and nursing home care services from Leestown to Cooper Drive. The Commission recommends that the Lexington-Leestown campus remain open and continue to provide nursing home, outpatient care, and administrative services.
2. The Commission recommends that the VA move swiftly to secure an enhanced use lease with Eastern State Hospital and/or the Kentucky Department of Veterans Affairs, as VA would not have to move from the Leestown campus in order for Eastern State Hospital (ESH) to begin using this space. The Commission recommends that plans be developed to make the footprint of the Leestown campus smaller, making most of the campus available for disposition and/or enhanced use leasing (EUL).

3 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-164)

III Campus Realignments – Nashville and Murfreesboro

1 The Commission concurs with the DNCP proposal to consolidate services at Murfreesboro and Nashville, and recommends that the VISN proceed with its plan for providing outpatient surgical services at both campuses.

(see page 5-167)

IV Inpatient Medicine and Surgery

1 The Commission concurs with the DNCP proposals to increase inpatient medicine services in the Central and Western markets through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central Market and in outlying areas as available in the Western Market).

2 The Commission concurs with the DNCP proposal on contracting for excess demand, particularly in the Charleston, WV, area.

3 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-169)

V Outpatient Primary and Specialty Care

1. The Commission concurs with the DNCP proposal to expand services at current sites of care, to expand the use of telemedicine, and to use community contracts, but notes that this is not an adequate solution to the substantial access and capacity deficiencies in this VISN, which cannot be met without additional sites of care.

2. The Commission recommends that:[212]

   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

   b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

   c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

   d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

   e. Whenever feasible, CBOCs provide basic mental health services.

   f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

3. The Commission recommends that:

   a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

   b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-171)

[212] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

VI Mental Health Care

1. The Commission does not concur with the DNCP proposal and recommends maintaining inpatient psychiatric and outpatient mental health services in at least all current locations until mental health services VISN-wide have been reevaluated.
2. The Commission recommends that VISN 9 leadership complete a thorough review of mental health services in the VISN, including in CBOCs, and develop and implement a plan to provide an appropriate level of services.
3. The Commission recommends that acute inpatient mental health services be provided with other acute inpatient services whenever feasible.
4. The Commission recommends that additional enhanced use lease opportunities with the Commonwealth of Kentucky be explored.

(see page 5-174)

VII VA/DoD Sharing

1. The Commission concurs with expansion of space for primary care and outpatient mental health services at the Fort Knox CBOC.

(see page 5-178)

VIII Special Disability Programs – Spinal Cord Injury/Disorder (SCI/D)

1. The Commission concurs with the DNCP proposal on the expansion of SCI/D beds at Memphis. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-179)

Evaluate Building a Replacement Hospital for Louisville VAMC

DNCP Proposal

"Construction of a new or fully renovated facility sized to meet service delivery requirements and projected demand will be studied. Options include construction of a new medical center, full renovation of the current facility, and the potential for a collaborative hospital within a hospital arrangement with University of Louisville Medical School affiliate. Opportunities exist for VBA collocation as well as enhanced DoD sharing should a new facility option be selected."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Louisville VAMC, a tertiary care center closely affiliated with the University of Louisville, provides a full range of services for veterans in central Kentucky and southern Indiana. The VAMC is authorized for 83 medical beds, with 43 operating medical beds and an average daily census (ADC) of 46, an intermediate medical unit used for short-term rehabilitation with 15 operating beds (ADC 5), an inpatient surgical program with 23 operating beds (ADC 16), and an inpatient acute psychiatric unit with 26 operating beds (ADC 15).[213] During FY 2003, more than 378,000 outpatient stops were provided on the campus, covering a broad array of outpatient services including primary care, specialty medical care, outpatient surgeries, mental health care, and support services. A large number of additional primary care and mental health outpatient services are provided at a separate Louisville location due to space limitations at the main campus.[214]

The condition of the hospital buildings is poor at this 50-year-old facility, and according to the Director, Mr. Tim Shea, the facility is landlocked, making expansion at the current site difficult.[215] It is currently located in a residential neighborhood five miles north of its medical affiliate, the University of Louisville.

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[213] VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.

[214] M. Scott Stamper, Assistant Supervisor, National Service Office, Disabled American Veterans, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 89.

[215] VISN 9, Site Visits, Lexington/Wilmore/Fort Knox/Louisville, July 22-23, 2003, page 6, available from [*http://www.carescommision.va.gov/SiteVisits.asp*].

The University of Louisville Medical School's Vice Dean for Clinical Affairs testified that he sees value in building a replacement VAMC adjacent to the six-hospital area downtown. He indicated that the school campus could accommodate a new VAMC and that the school is open to being a flexible partner, for example, by leasing tertiary services to VA. He outlined some options for the Louisville VA:

> The greatest asset is, in fact, the acreage. It is the highest real estate valued area in the state of Kentucky, across the street from the highest per capita income neighborhood in the state of Kentucky, in a beautiful, wooded hilltop. If the VA were to locate to the downtown medical center, it would be joining a 26 block, six-hospital medical center. There is space on the east end for that, and the medical center also includes a biopark. This could be whatever the VA would like it to be. A hospital within a hospital...a new building in that area with some shared facilities, things as boring as parking garages… there are great synergies when medical schools and VA's are located in the same facility.[216]

Collocating the current VBA office, which is currently housed in inadequate space, with the Louisville VAMC would only be possible if a replacement hospital were built. This collocation should increase the cost advantage of building a new facility rather than attempting to renovate the current hospital building.

Commission Findings

1. The Louisville VAMC currently has space deficits and is providing services off campus.
2. The current buildings are in poor condition and landlocked. Construction of a replacement hospital at a site near the University of Louisville Medical School would enhance clinical care, improve accessibility, and strengthen the academic affiliation.
3. There is opportunity to collocate the VAMC near the University of Louisville Medical School campus.
4. Collocating the VBA office to a new replacement hospital site is likely to provide further financial advantage to VA.

Commission Recommendations

1. The Commission concurs with the DNCP proposal that VA study the feasibility of building a replacement medical center for the Louisville VAMC in proximity to the University of Louisville, including the possibility of shared infrastructure with the medical school and the VBA office.

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[216] Mark Pfieffer, Vice Dean, University of Louisville Medical School, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, pages 146-147.

2 Due to the poor environment of care and overcrowding at the current medical center, the Commission recommends the study commence immediately, focus on building a replacement hospital near the University of Louisville, and be completed within a short time so that corrective actions can begin in the very near future.

II Campus Realignment – Lexington

DNCP Proposal

"Current services of outpatient care and nursing home care will be transferred to Cooper Drive. Due to possible space limitations at Cooper Drive, it may be necessary to relocate some outpatient primary care and outpatient mental health psychiatric services to alternative locations other than Cooper Drive. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Enhanced use opportunities for the majority of the Leestown campus with the commonwealth of Kentucky appears to exist with Eastern State Hospital (ESH). Any revenues or in-kind services will remain in the VISN to invest in services for veterans. Plans also include the pursuit of collaborative opportunities between the Louisville and Lexington VAMCs."

DNCP Alternatives

1 *Status quo*

2 *Original Market Plan:* Contracting out of inpatient acute care, some outpatient specialty care and consolidating the remainder of outpatient specialty, ancillary/diagnostic, mental health, and primary care at the Leestown division with eventual divesture of the Cooper Drive Division. Addition of CBOCs at Berea, Hazard, and Morehead, KY.

3 *100 Percent Contracting*

4 *Alternative 1 [The VISN's preferred alternative]:* Development of major construction project to renovate existing space, construct two additional floors and add an 800-space parking facility at the Cooper Drive division. Discontinue all VA operations at the Leestown division and pursue enhanced use program with the Commonwealth of Kentucky for select space at Leestown. Unused space would be demolished or divested as appropriate. Development of CBOCs at Berea, Hazard, and Morehead, KY.

5 *Alternative 2:* Retain operations at both Cooper Drive and Leestown with consolidation of 24x7 operations to Cooper Drive and movement of Leestown to a five-day-a-week operation. Development of Cooper Drive for acute inpatient and nursing home care services as well as outpatient specialty and ancillary/diagnostic services.

Commission Analysis

The Lexington VAMC is a two division, tertiary care facility – Cooper Drive and Leestown. The Cooper Drive Division is located adjacent to the University of Kentucky Medical Center, and operates medical inpatient units with 67 operating beds and an ADC of 45, an acute inpatient psychiatry unit with 19 operating beds and an ADC of 12, and an inpatient surgical program with 21 operating beds and an ADC of 14. During FY 2003, more than 309,000 outpatient clinic stops were provided at the Cooper Drive campus for a full array of primary care, specialty medical and surgical care, and support services.[217]

The Leestown Division provides nursing home services with 61 operating beds (ADC 56) and, during FY 2003, provided more than 61,000 outpatient stops, predominantly for primary care, home-based primary care, podiatry, optometry, and mental health services, including specialized substance abuse and post-traumatic stress disorder (PTSD) services. The majority of the outpatient mental health services offered by the Lexington VAMC for area veterans are provided at the Leestown campus.[218]

At the Lexington hearing, VISN leadership described Cooper Drive as a landlocked facility with significant parking problems. They proposed adding two floors to the Cooper Drive facility to absorb services from Leestown.[219] But as Dr. Roth, VISN 9 CARES co-chair, testified:

> The consolidation of Cooper is predicated on the fact that we would be able to offload primary care and outpatient mental health to CBOCs that are located in outlying areas in Southeastern Kentucky. Because even with building two floors on Cooper, there is not going to be enough space.[220]

There is very limited potential for expansion at the Cooper Drive location, and that the proposal to move nursing home beds to Cooper Drive would place the nursing home unit above the first floor, which would limit access to outdoor space for patients.

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[217] John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 28.
[218] VSSC KLF Menu Database, *Bed Control*, *Occupancy Rates* and *FYTD CBOC VAST and Workload Report.*
[219] John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 28.
[220] Dr. Dan Roth, VISN 9 CARES Committee Co-Chair, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 34.

The realignment proposal includes a life cycle cost analysis that appears to be incomplete. For example, although parking is identified as a current problem, no analysis is presented as to the extent of the current problem. Construction of an 800-space garage is recommended, but no indication is included as to how much of the garage would solve the existing problem and how much is intended to accommodate the proposed consolidation of Leestown, and the likely construction costs of around $18 million were not included in the VISN's cost analysis. New construction and renovation costs are included in all alternatives, even the 100 Percent Contracting Alternative.[221]

The DNCP proposal to transfer the substantial primary care and mental health workload currently provided at the Leestown campus for Lexington area residents to CBOCs far away from the greater Lexington metropolitan area does not seem reasonable, since these services need to be easily accessible to veterans.

There appear to be EUL opportunities for the majority of the Leestown campus with ESH, the Commonwealth of Kentucky's acute and long-term psychiatric institution. Medical center management has been working with the Commonwealth of Kentucky on leasing opportunities for approximately 18 months, and the Commonwealth wants to acquire a lease as soon as possible.

In addition to the above proposal, the Kentucky Department of Veterans Affairs also has proposed a 60- to 80-bed domiciliary and a 40-bed transition/homeless shelter in conjunction with Volunteers of America. These enhanced use options are not contingent on moving the current services from the Leestown campus.

Commission Findings

1. The Cooper Drive Division is a landlocked facility with significant parking issues and has no expansion capacity without major construction. The proposal to move the nursing home to this site would place the nursing home above the first floor.
2. There is a good EUL opportunity involving ESH or the Kentucky Department of Veterans Affairs that would not require VA to move from the Leestown campus.
3. To successfully implement the EUL opportunities, a new footprint would be required for the Leestown campus that would make the majority of the 135 acres available for enhanced use leasing and/or disposition.
4. The consolidation of space at Cooper Drive requires the movement of outpatient primary care and mental health services, which would further decrease access to care.

[221] Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal on transferring current outpatient care and nursing home care services from Leestown to Cooper Drive. The Commission recommends that the Lexington-Leestown campus remain open and continue to provide nursing home, outpatient care, and administrative services.
2. The Commission recommends that the VA move swiftly to secure an enhanced use lease with Eastern State Hospital and/or the Kentucky Department of Veterans Affairs, as VA would not have to move from the Leestown campus in order for ESH to begin using this space. The Commission recommends that plans be developed to make the footprint of the Leestown campus smaller, making most of the campus available for disposition and/or EUL.
3. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

III Campus Realignments – Nashville and Murfreesboro

DNCP Proposal

"Maintain both facilities and develop complementary missions through consolidation of services. Nashville will provide inpatient acute medicine and surgery programs while retaining a minimum number of medicine beds at Murfreesboro to support demand generated from the long-term programs. Murfreesboro will provide acute and long-term inpatient psychiatry and nursing home care services."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN Director testified that the proposal to address service delivery options for the Alvin C. York facility (Murfreesboro) and the Nashville campuses was developed to decrease the duplication of services. During the hearing, Mr. David Pennington, Director of the VA Tennessee Valley Health Care System,

clarified the plans for the provision of surgical services. He indicated that the current plan is to move all inpatient surgery to Nashville, but to retain outpatient surgery at both Murfreesboro and Nashville, which would require changes to space at Murfreesboro to create an outpatient surgical center. Mr. Pennington indicated that some patients might have to drive further for surgery, but the benefit would be an improved timeliness in surgery.[222]

The Deans of the School of Medicine at Meharry and Vanderbilt testified at the Nashville hearing that they had a very effective alliance, had been apprised of the CARES process, and had been involved in the early discussions on the surgical programs at Murfreesboro and Nashville. The Dean of Meharry raised concerns about the impact of removing inpatient surgery on acute medical service. However, VISN leadership indicated that this service and the ambulatory surgical service at Murfreesboro would be enhanced. The Dean of Vanderbilt indicated that Vanderbilt would work with Meharry and address any educational shortcomings that might develop as a result of the changes in services at the Murfreesboro VAMC.[223]

Commission Findings

1. The surgical portion of the plan for consolidation of services at Nashville and Murfreesboro has been changed by the VISN since the DNCP was published.
2. Plans relating to inpatient medicine, long-term psychiatry, and nursing home care remain unchanged.

Commission Recommendation

The Commission concurs with the DNCP proposal to consolidate services at Murfreesboro and Nashville, and recommends that the VISN proceed with its plan for providing outpatient surgical services at both campuses.

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[222] David Pennington, Director, VA Tennessee Valley Health Care System, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 58.

[223] Steven Gabbe, MD, Dean School of Medicine, Vanderbilt University, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 75.

IV Inpatient Medicine and Surgery

DNCP Proposals

"*Medicine* – Increase inpatient medicine services in the Central and Western markets to meet demand through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central market and in outlying areas as available in the Western market). *Surgery* – Consolidate inpatient surgery at Murfreesboro to Nashville, along with contracting for some surgical beds within the Chattanooga community. Contract for excess demand, particularly in the Charleston, WV, area."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Workload projections and space inventories indicate that both Nashville and Murfreesboro need additional space for inpatient medicine and surgery. While inpatient surgery did not meet criteria as a planning initiative for this market, the viability of the surgical program at Murfreesboro was selected as an initiative by the VISN and was addressed previously in the discussion on consolidation of services at Murfreesboro and Nashville.

The VISN proposed to contract for inpatient surgery beds (approximately three) in order to provide those services for veterans served by the Chattanooga outpatient clinic. This is a large clinic that provided a full range of outpatient services to 9,271 veterans during FY 2003. The VISN Director testified at the Nashville hearing that some inpatient care would be provided through contracts. He said, "A strong consideration was placed on enhancing access, rather than expanding existing medical centers. If expansion was necessary, contracting was considered a preferable alternative."[224] The VISN Director also testified that Chattanooga is in need of an acute surgical presence. Chattanooga presently has a CBOC that makes surgery referrals to the Nashville VAMC. The VISN has determined the best solution for Chattanooga is to contract for surgical care in the community.[225]

[224] John Dandridge, VISN 9 Director, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, pages 23-24.
[225] John Dandridge, VISN 9 Director, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 26.

Workload projection data indicate that Memphis will have a large increase in demand for inpatient medicine. Memphis currently operates 75 medicine beds with an ADC of 54 in inpatient medicine, and they are projected to have a need for an additional 40 beds over the FY 2001 baseline by FY 2012, decreasing to a need for an additional 22 beds over baseline by FY 2022.[226]

The available space at the Huntington VAMC would be used for inpatient care in FY 2012, and the Huntington VAMC would use contracted services as a solution.[227] Patients from the Charleston, WV, area are referred to the Huntington VAMC for inpatient surgical care.

Commission Findings

1. CARES projections indicate small to moderate increases in need for inpatient medicine and surgical services in FY 2012, and most markets demonstrate a decreased need by FY 2022.
2. The VISN's strategic approach to addressing projected increases in inpatient care is by providing services through contracts rather than by construction.
3. While inpatient surgery did not meet criteria as a planning initiative for this market, the viability of the surgical program at Murfreesboro was selected as an initiative by the VISN. Based on the VISN's data review, they elected to continue ambulatory surgery at the Murfreesboro campus and to move inpatient surgery to Nashville.

Commission Recommendations

1. The Commission concurs with the DNCP proposals to increase inpatient medicine services in the Central and Western markets through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central Market and in outlying areas as available in the Western Market).
2. The Commission concurs with the DNCP proposal on with contracting for excess demand, particularly in the Charleston, WV, area.
3. The Commission recommends that:
    a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

[226] VSSC KLF Menu Database, *Occupancy Rates*, as of FY 2003.

[227] Linda Godleski, MD, VISN 9 Mental Health Program Manager, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, pages 28-29.

b The Commission recommends VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

V Outpatient Primary and Specialty Care

DNCP Proposals

"The DNCP attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. *Primary Care and Mental Health* – Outpatient demand is increasing in three of the four markets for primary care and in two of the four markets for mental health care. Increased capacity for these services is being addressed through a combination of in-house expansion (renovations and leases) and expansion of existing CBOCs. In addition, outpatient mental health is being integrated with primary care at all sites. *Specialty Care* – Increase the capacity for outpatient specialty care in all four markets. The plan is to use a mix of in-house expansion, telemedicine, inclusion of selected high volume specialty services at larger CBOCs and through the use of community contracts."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

As part of the CARES process, standards were set for how far enrolled veterans should have to drive to see their primary care provider, with different standards for urban, rural, and highly rural settings. A gap in access to primary care was identified if less than 70 percent of enrolled veterans are within the acceptable drive times. All four markets in this VISN have access gaps to primary care. Current access ranges from 51 percent in the Eastern Market to 60 percent in the Northern Market.[228] More than 160 public comments received by the Commission regarding VISN 9 concerned travel distances to primary and hospital care. The Commission also heard testimony from veterans service organizations that veterans were required to drive long distances to receive care, often over country roads that are especially treacherous during winter months.

[228] VSSC KLF Menu Database, *CARES Reports*.

The Central Market has a 79 percent projected gap for primary care capacity by FY 2012, which decreases to 60 percent over the FY 2001 baseline by FY 2022. The Western Market has a primary care gap of 52 percent over baseline by FY 2012, which declines to 34 percent over baseline by FY 2022. The Eastern and Northern markets have smaller gaps in FY 2012 (25 and 23 percent, respectively) and are projected to return near to FY 2001 baseline levels by FY 2022.[229]

The VISN currently provides primary care services at 25 CBOCs. At two of these sites (Knoxville and Chattanooga), additional specialty services are also provided. There also are plans to expand specialty care at CBOCs. Mr. Pennington, the VAMC Director VA Tennessee Valley Health Care System, indicated that they have recently added 13 exam rooms in the Chattanooga clinic with the objective of pulling as much specialty care to the clinic as possible.[230]

Some of these CBOCs are VA staffed and some are contracted with community resources. At the Nashville hearing, Dr. Roth testified that the VISN uses business criteria to evaluate service delivery options; "Once we came to the site, then the decision had to be made whether or not we were either going to have a VA presences and staff it, own the building infrastructure, or to go ahead and lease space and/or to contract [that]."[231] He cited as an example that 1,600 veterans in East Tennessee receive care at eight CBOC sites through a rural health care consortium contract. Veterans testified that additional sites of care had improved access, particularly for those residing in more rural areas in the VISN.

In its original CARES market plan, the VISN had proposed opening an additional 40 CBOCs to further improve access to primary care throughout the VISN, with a mix of contract and VA-staffed sites. A proposed CBOC in eastern Kentucky (Hazard) is of particular note for several reasons. Patients from that area currently must travel three hours to Lexington for primary care, a new State Veterans Home is opening in Hazard, and the University of Kentucky is offering family practice training in Hazard. This would allow the VISN to collaborate with one of their major affiliates in improving access for veterans residing in a remote area. The VISN also has planned to address a portion of its projected increase in outpatient specialty care through CBOCs. According to Mr. Dandridge, "a strong consideration was placed on enhancing access, rather than expanding existing medical centers. If expansion was necessary, contracting was considered a preferable alternative."[232]

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[229] Appendix D, *Data Tables,* page D-46.

[230] David Pennington, Director, VA Tennessee Valley Health Care System, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 32.

[231] Richard Roth, MD, VISN 9 CARES Committee Co-Chair, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 44.

[232] John Dandridge, VISN 9 Director, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 23.

None of the proposed new CBOCs are in priority group one in the DNCP. Although expanding services at existing CBOCs, as proposed in the DNCP, may reduce projected capacity gaps for primary care and specialty care, it will not address the substantial deficiencies for access, as measured by travel time, that are prevalent across the VISN.

It is also not clear that facilities will be able to identify either space or contract arrangements at the current sites of care to meet their projected outpatient demand. Available data suggest that all existing primary care, mental health, and specialty care sites in all markets either need additional space now or will in the future. It is not clear whether capacity can be increased to the level necessary to meet the demand without additional CBOCs being activated.

Commission Findings

1. No CBOCs in this VISN are in the DNCP's priority group one and, without the ability to add CBOCs, the VISN is unlikely to optimally meet projected increases in the need for primary care and specialty services, or to correct current deficiencies in access to primary care and specialty care services.
2. In-house expansions and expansions at existing CBOCs may address only a portion of the increased workload projected across the VISN. There does not appear to be capacity in many facilities in the VISN to absorb this workload without construction.
3. All markets are projected to increase their need for specialty care, and the VISN's strategy for addressing projected increases in specialty care is by contracting specialty services in communities and CBOCs close to where the veteran lives.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to expand services at current sites of care, to expand the use of telemedicine, and to use community contracts, but notes that this is not an adequate solution to the substantial access and capacity deficiencies in this VISN, which cannot be met without additional sites of care.
2. The Commission recommends that: [233]
   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

[233] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

3 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

VI Mental Health Care

DNCP Proposals

"*Psychiatry* – To meet inpatient psychiatry demand in the Northern Market, acute inpatient psychiatry services will be centralized to one site within the Northern Market or refer patients to the Mufreesboro, TN, program. Options to centralize services within the Northern Market include provision of these services as part of the enhanced use agreement with the Commonwealth of Kentucky on the Leestown campus or consolidating services to the Louisville VAMC. *Primary Care and Mental Health* – Outpatient demand is increasing in three of the four markets for primary care and in two of the four markets for mental health care. Increased capacity for these services is being addressed through a combination of in-house expansion (renovations and leases) and expansion of existing CBOCs. In addition, outpatient mental health is being integrated with primary care at all sites."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP proposal for providing inpatient psychiatry, particularly in the Northern Market, does not adequately address the needs for psychiatric inpatient care. Acute inpatient psychiatric services are currently provided in efficient units at both major tertiary care centers – in Louisville, with 26 operating inpatient psychiatric beds and a current ADC of 15, and in Lexington, with 19 operating psychiatric beds and a current ADC of 12.[234] The plan to consolidate Lexington and Louisville's services or to send patients to Murfreesboro (located three and a half to four hours away)[235] would put veterans who are currently within the CARES access (travel time) standards outside the CARES standard. This move would also leave one of the tertiary-level VA medical centers without an acute inpatient psychiatric service. There is a projected need for an additional 34 acute psychiatric beds in this market (an increase of 96 percent over the FY 2001 baseline) by FY 2012, decreasing to 18 beds (a gap of 51 percent over baseline) by FY 2022.[236] This is one of the largest projected gaps for acute inpatient psychiatry in the country. It is illogical to address a large projected gap by closing one of the two existing units serving this market. In fact, the data would suggest that both current acute units will need to expand to meet demand, and that contracting for acute inpatient services in the Huntington area may also be advisable to improve access for veterans in the far eastern portion of the market.

There is a projected increase of 54 percent for inpatient acute psychiatric services over baseline by FY 2012 in the Western Market (Memphis). The DNCP does not address this gap in any way.

Although the DNCP indicates that outpatient mental health demand is increasing in only two of the four markets in this VISN, it is projected that all four markets have large gaps. Data indicate that all four markets also meet the thresholds for inclusion as planning initiatives for outpatient mental health services in both FY 2012 and FY 2022.[237] The VISN, however, selected only two markets for inclusion and the DNCP reflects the VISN's selections.[238]

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[234] VSSC KLF Menu Database, *Bed Control, Occupancy Rates.*
[235] John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 47.
[236] Appendix D, *Data Tables*, page D-46.
[237] VISN 9 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=49*].
[238] VISN 9 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=49*].

Only six of the 25 CBOCs currently open in the VISN have mental health visits that account for more that two percent of their workload.[239] VISN 9 has the worst record in VHA for providing access to basic mental health services at CBOCs. This means that high priority patients with severe mental disorders must often travel large distances to access VA mental health outpatient services. At the Lexington hearing, the VISN Director stated that CARES has put this deficit under the microscope. He acknowledged that it needs to be addressed by putting mental health providers at current and future CBOCs.[240]

As with primary care and outpatient specialty care, the DNCP proposal to not open new CBOCs in the VISN would significantly limit the VISN's ability to close the very large gaps that are projected for outpatient mental health services.

Commissioners expressed concern that this VISN shows a deficiency in the availability of mental health services, compared to most other VISNs, for a number of reasons:[241]

- The projected gaps for inpatient and outpatient mental health services across the VISN are among the largest in the nation, although there is only a modest projected increase of seven percent in enrollment in the VISN. Since most of the gaps for mental health capacity approach or exceed 100 percent, this indicates that the VISN is currently providing less than half the level of mental health services required by the currently enrolled population.[242]
- Of the 3,867 seriously mentally ill patients in active intensive case management (as of June 2003), a modality strongly supported as crucial by VA's practice guidelines, only six were from this VISN.[243]
- There has been a decline in treatment of Post-Traumatic Stress Disorder (PTSD) patients for this VISN that is not in keeping with national trends. While VA has seen a 56 percent increase in PTSD services nationwide since 1996, this VISN provides PTSD services to fewer patients than it did six years ago.
- Finally, while the DNCP suggests there are additional EUL opportunities between the VA and the Commonwealth of Kentucky that could include a domiciliary and/or a transitional/homeless shelter, this opportunity has not been explored.[244]

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[239] VSSC KLF Menu Database *FYTD CBOC VAST and Workload Report*, FY 2003, accessed on October 13, 2003.

[240] John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 53.

[241] CARES Commission Hearing Summary: Lexington, KY, page 7, available from [*http://www.carescommission.va.gov/Documents/V09LexingtonHearingSummary.pdf*].

[242] VISN 9, *Market Plans,* available from [*http://www1.va.gov/cares*].

[243] VHA National Mental Health Evaluation Center (NEPEC) *Quarterly Report, Second Quarter FY 2003 on Mental Health Intensive Case Management Team Implementation*.

[244] Leslie E. Beavers, Brigadier General (Ret.), Commissioner, Kentucky Department of Veterans Affairs, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 126.

Commission Findings

1. While plans were developed to address the projected outpatient mental health gaps in two markets, data indicate there are significant projected gaps in all four markets.
2. Although there is a VHA directive that CBOCs provide mental health services,[245] most CBOCs in this VISN do not provide mental health services.[246]
3. The plan to consolidate Lexington and Louisville's psychiatric units and move workload to Murfreesboro would decrease the current level of access to inpatient services and would leave a tertiary care facility without acute inpatient psychiatric service. No plans were offered for addressing future needs for additional acute inpatient care in the Western Market.
4. The VISN has large gaps in the levels of mental health care provided, including for particularly high priority groups of veterans such as the seriously mentally ill and patients with war-related PTSD.
5. There are additional enhanced use opportunities between the VA and the Commonwealth of Kentucky that have not been explored.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal and recommends maintaining inpatient psychiatric and outpatient mental health services in at least all current locations until mental health services VISN-wide have been reevaluated.
2. The Commission recommends that VISN 9 leadership complete a thorough review of mental health services in the VISN, including in CBOCs, and develop and implement a plan to provide an appropriate level of services.
3. The Commission recommends that acute inpatient mental health services be provided with other acute inpatient services whenever feasible.
4. The Commission recommends that additional enhanced use lease opportunities with the Commonwealth of Kentucky be explored.

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[245] VHA Directive 2001-60, *Veterans Health Administration Policy for Planning and Activating Community Based Outpatient Clinics*, Attachment A: *Minimum Standards for Community Based Outpatient Clinics (CBOCs)*, page A-1.

[246] VSSC KLF Menu Database *FYTD CBOC VAST and Workload Report*, FY 2003.

VII VA/DoD Sharing

DNCP Proposal

"*DoD* – Expansion of space for primary care and outpatient mental health services at Fort Knox CBOC. There were no DoD initiatives developed between Millington Naval Base and VAMC Memphis now but opportunities will continue to be pursued in the future."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

During the site visit in July 2003, Commissioners learned that the Louisville VAMC and the Fort Knox Ireland Army Hospital established a sharing program in 1996 that is a revenue-neutral initiative. In return for receiving a CBOC site providing access for veterans, VA provides about 50 percent of Fort Knox's outpatient care. With this arrangement, VA and DoD improved access and lowered costs. VA and DoD are considering expanding the sharing agreement to allow for the sharing of space for primary care along with outpatient mental health services.[247]

Commission Finding

The VA/DoD sharing agreement between Fort Knox and the Louisville VA has been mutually beneficial, and both parties are working on expanding the sharing agreement.

Commission Recommendation

The Commission concurs with expansion of space for primary care and outpatient mental health services at the Fort Knox CBOC.

[247] VISN 9, *Site Visit Report*, Lexington/Wilmore/Louisville/Fort Knox, dated July 22-23, 2003, page 7, available from [*http://www1.va.gov/cares/docs*].

VIII Special Disability Programs – Spinal Cord Injury/Disorder (SCI/D)

DNCP Proposal

"Add 20 long-term care SCI beds within the current spinal cord injury unit at Memphis."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN plan indicates that an existing ward can be renovated to accommodate the SCI unit, at a cost of $1.8 million. VA data show that Memphis has 70 authorized SCI/D beds, 60 of which are operating, with an ADC of 53.[248] It is projected that this facility will need 54 acute and 66 long-term SCI/D beds in FY 2012, and 63 acute and 78 long-term beds in FY 2022.[249]

Commission Finding

Occupancy of the current SCI unit is fairly high, though it is noted that 10 beds are closed.

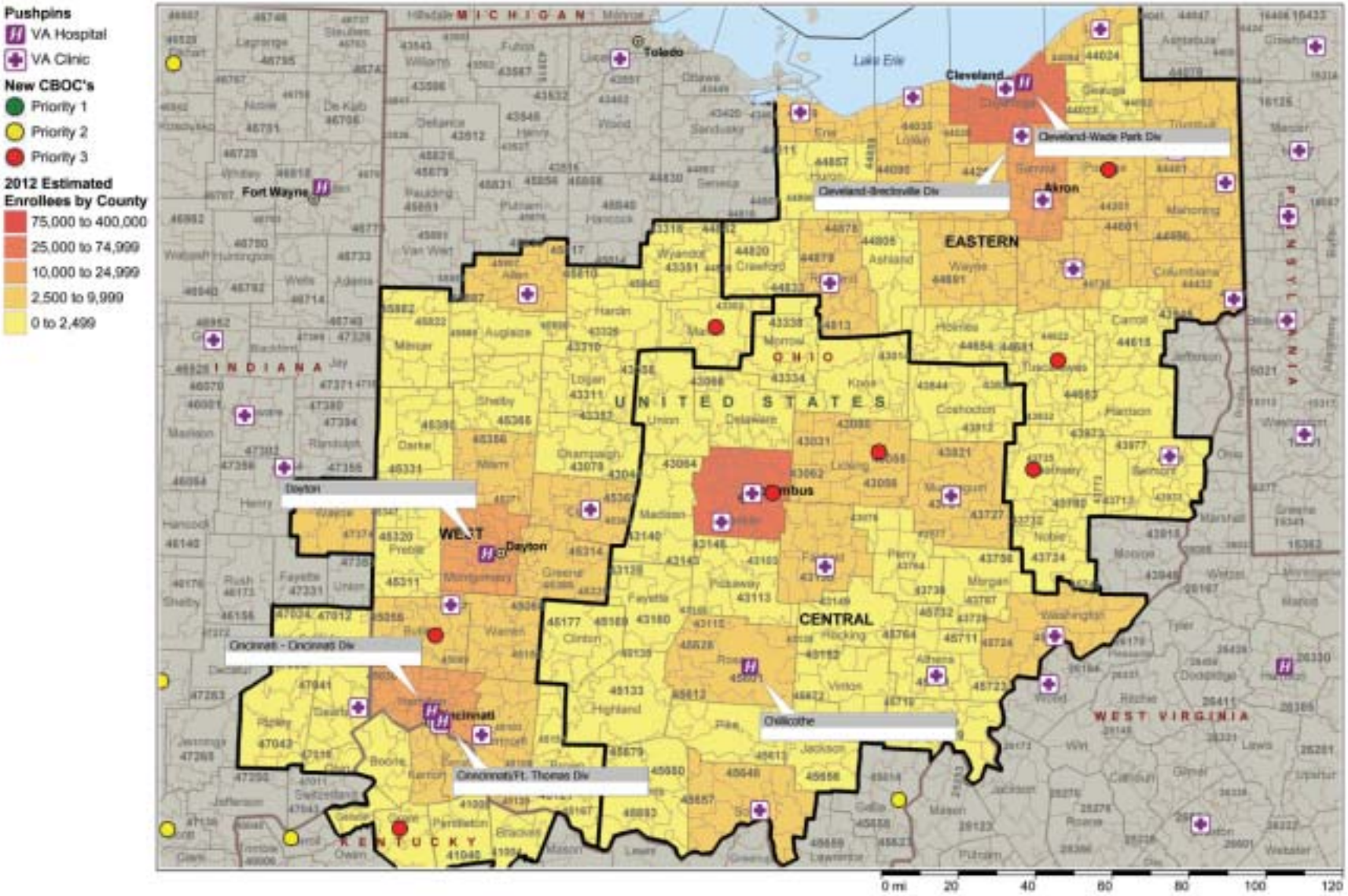
Commission Recommendation

The Commission concurs with the DNCP proposal on the expansion of SCI/D beds at Memphis. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

[248] VSSC KLF Menu Database, *Bed Control, Occupancy Rates,* thru May 2003.

[249] Draft National CARES Plan (DNCP), *Appendix Q – Special Disability Program Planning Initiatives*, page 7, available from [*http://www1.va.gov/cares/docs/DNP_appQ.pdf*].

VISN 10 – VA Health Care System of Ohio



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VISN 10, VA Health Care System of Ohio

VISN Overview

VISN 10, VA Health Care System of Ohio, is an integrated, comprehensive health care system that provided medical services to approximately 156,000 of the 261,000 veterans enrolled in VA's health care system in FY 2003.[250] Geographically, this VISN spans about 86,000 square miles and consists of all or part of Ohio, Indiana, and Kentucky.

With a VA staff of approximately 7,200 FTEs,[251] VISN 10 delivers health care services through four medical centers, four nursing homes, four domiciliary care facilities, and 23 CBOCs. Additionally, VA operates four Vet Centers in VISN 10's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 10.

VISN 10	FY 2001	FY 2012	FY 2022
Enrollees	217,036	237,796	211,827
Veteran Population	1,035,268	810,404	655,570
Market Penetration	20.96%	29.34%	32.31%

For the CARES process, this VISN is divided into three markets: Eastern (*facilities:* 2-Division Cleveland Medical Center at Wade Park and Brecksville, OH); Central (*facility:* Chillicothe, OH); and Western (*facilities:* Cincinnati, which operates two campuses in Cincinnati and Ft. Thomas, KY, and Dayton, OH).

Information Gathering

The CARES Commission visited two sites and conducted two public hearings in VISN 10. The Commission received 201 comments regarding VISN 10.

- *Site Visits:* Cleveland on July 1; and Dayton on July 2.
- *Hearings:* Cleveland on August 12; and Columbus on August 19.

[250] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[251] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Summary of CARES Commission Recommendations

I Mission Change and Campus Realignment – Brecksville and Wade Park Divisions of the Cleveland VA Medical Center

1. The Commission concurs with the DNCP proposal to relocate current psychiatric, nursing home, domiciliary, and residential services from Brecksville to Wade Park, provided the existing level of services can be maintained.
2. The Commission concurs with the DNCP proposal to pursue enhanced use leasing (EUL) opportunities at Brecksville in exchange for property adjacent to Wade Park.
3. The Commission recommends that disposal pursuits should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-185)

II Access to Hospital Care and Inpatient Medicine Services

1. The Commission concurs with the DNCP proposal to contract for inpatient care with local hospitals in Columbus and Canton.
2. The Commission recommends analysis of the impact on other facilities of adding services in Columbus, particularly on Chillicothe.
3. The Commission recommends that:
   - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-188)

III Replacement Outpatient Specialty Care Clinic

1. The Commission concurs with building an expanded 260,000 square foot replacement outpatient specialty care center in Columbus, OH, on Federal land donated by DoD Defense Supply Center.

2 The Commission recommends that the new Columbus outpatient specialty care center be a high priority.

(see page 5-190)

IV Outpatient Primary and Mental Health Care

1 The Commission recommends that: [252]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-192)

[252] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

V Special Disability Program – Spinal Cord Injury Center

1. The Commission concurs with the DNCP proposal to add 20 long-term care beds to the Cleveland Spinal Cord Injury (SCI) Center.
2. The Commission recommends that VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-195)

VI Enhanced Use

1. The Commission concurs with the DNCP proposal relating to enhanced use leasing (EUL) projects at Cincinnati to lease quarters and use the proceeds for additional parking.
2. The Commission concurs with the DNCP proposal relating to EUL of Dayton's empty buildings.
3. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-196)

Mission Change and Campus Realignment – Brecksville and Wade Park Divisions of the Cleveland VAMC

DNCP Proposals

"Current services at the Brecksville Division will be transferred to the Wade Park Division. This project will require new construction of 500,730 square feet and renovation of existing space at the Wade Park Division of 140,400 square feet. This project includes the enhanced use lease of 102 acres at Brecksville in exchange for property adjacent to Wade Park. This consolidation will result in a reduction of 548,363 square feet of the Brecksville Division."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan [The VISN's preferred alternative]:* Consolidate all clinical and administrative functions of a two-division medical center at Wade Park. All current services and programs provided at Brecksville will be provided at Wade Park. In addition, there will be a comprehensive rehabilitation center and blind rehabilitation center at the Wade Park campus. This plan will enhance use the Brecksville campus.
3. *100 Percent Contracting*

Commission Analysis

Commissioners toured both the Brecksville and Wade Park facilities at their site visit in July and heard directly from stakeholders about the proposal. Brecksville operates 192 nursing home beds, 25 psychiatric beds, and 168 domiciliary beds on 102 acres.[253] Although workload reports combine data for the Brecksville and Wade Park campuses, these reports indicate that for the past 4 years, there have been noticeable increases in demand for internal medicine services and noticeable decreases in demand for psychiatry services.[254] Inpatient customer satisfaction scores for Wade Park exceed those for Brecksville and exceed the national average for inpatient care. Outpatient customer satisfaction scores show just the opposite in that Brecksville's outpatient scores exceed the outpatient scores for both Wade Park and the national average.[255]

[253] VSSC KLF Menu Database, *Workload, Inpatient, Occupancy*, as of November 13, 2003.
[254] Appendix D, *Data Tables*, page D-51.
[255] Appendix D, *Data Tables*, page D-52.

In the past 2 years, the realignment plan has been widely discussed with stakeholders. Most favor the plan, although some individual veterans spoke against it at a meeting in July. The plan also received support from municipal and state elected officials. At the hearing, Cleveland Mayor Jane Campbell testified. "The proposed consolidation of the Brecksville and Wade Park facilities will both increase the benefits to area veterans and provide VA an opportunity to improve cost efficiency." [256] Bill Montague, Director of the Cleveland VAMC, testified, "With this proposal, every inpatient program or veteran service located at the current Brecksville campus will be available at the consolidated Wade Park campus. Not only will every existing service remain available but also the rehabilitative and inpatient programs can expand and serve a greater number of veterans."[257]

Further, efficiencies are expected both in terms of access to services and operating costs. For example, Brecksville's inpatient mental health patients requiring emergency care are now transported by ambulance to a facility with such services. Consolidation, as proposed, provides these patients with immediate access to a state-of-the-art emergency room at Wade Park and eliminates the costs associated with transporting patients to other facilities. The consolidation effort also would generate significant savings in maintenance and infrastructure costs, which the VISN estimates at $27 million.[258]

Consolidation would take place over a period of about 5 years. During this time, no services would be disrupted at the Brecksville campus. This timeframe allows for appropriate consideration to design and for construction at Wade Park as well as planning for the transfer of patients. It provides the VISN with the ability to determine alternative uses under the EUL program or other methods for disposing of the vacated campus at Brecksville. It further provides the VISN with an opportunity to consider using community partners, should alternative services be an appropriate response to health care needs (for example, for domiciliary patients). Furthermore, moving domiciliary beds to Wade Park would mean that these services are located closer to an urban setting, which is in keeping with the Commission's overarching principle of providing domiciliary care in the urban areas from which patients come and to which they will return.

The VISN submitted a realignment proposal that provided a sound justification for the recommended alternative over the Status quo. The cost analysis indicated a sizable net present value of $708 million for the recommended alternative with reasonable new construction and renovation costs of $220 million.

The realignment proposal, however, did contain some inconsistencies in recording certain costs that need clarification and refinement. Examples of apparent inconsistencies are: the proposal included heavy emphasis

[256] The Honorable Jane Campbell, Mayor of Cleveland, OH, Transcribed Testimony from the Cleveland, OH, Hearing, August 12, 2003, page 110.

[257] William Montague, Director, Cleveland VA Medical Center, Paraphrase of Transcribed Testimony from the Cleveland, OH, Hearing, August 12, 2003, pages 11-15.

[258] Clyde Parkis, VISN 10 Director, Transcribed Testimony from the Cleveland, OH, Hearing, August 12, 2003, page 9.

on a collocation with VBA although VBA has declined this opportunity because of a lack of public transportation for employees and veterans; the 100 Percent Contracting Alternative was dismissed with little justification even though the net present value is calculated as $98.4 million higher than the recommended alternative; and $162.4 million in new construction and renovation are added to the 100 Percent Contracting Alternative for no apparent reason.

Commission Findings

1. Brecksville's inpatient customer satisfaction score is lower than the national average but its outpatient score is higher. Wade Park's inpatient customer satisfaction score is higher than the national average but its outpatient score is lower.[259]
2. Workload data for Brecksville and Wade Park cannot be separated for analysis; however, data for the past 4 years indicate noticeable increases in demand for internal medicine services and noticeable declines in demand for psychiatry services.
3. The proposed consolidation would improve health care quality, safety, and environment while having minimal impact on patient travel time, research, and affiliations.
4. The proposals take advantage of improvements already completed at Wade Park.
5. Veterans are currently being transported by ambulance from Brecksville to other facilities with services. Consolidating Brecksville and Wade Park should result in savings of these transportation costs.
6. Realignment would provide efficiencies in operations.
7. The campus realignment plan is dependent on construction of replacement units. The life-cycle cost analysis in the realignment proposal contained some cost inconsistencies that would need clarification and refinement.
8. The Commission had questions about the VISN's ability to provide enough domiciliary services to maintain the level currently available at Brecksville.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to relocate current psychiatric, nursing home, domiciliary, and residential services from Brecksville to Wade Park, provided the existing level of services can be maintained.

[259] Appendix D, *Data Tables*, page D-52.

2 The Commission concurs with the DNCP proposal to pursue EUL opportunities at Brecksville in exchange for property adjacent to Wade Park.

3 The Commission recommends that disposal pursuits should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

II Access to Hospital Care and Inpatient Medicine Services

DNCP Proposals

"*Hospital Care* – Improve access to acute hospital care in the Central and Eastern markets to ensure that at least 65 percent of veteran enrollees are within the driving time guidelines. This would be achieved by contracting for acute hospital care in the local community of Columbus, OH, which would increase the percentage of veterans within the access standard from 39 percent to 83 percent in FY 2012 and to 84 percent in FY 2022. Currently, the Eastern Market is within the guidelines for access to hospital care. The Eastern Market would provide hospital care utilizing contracts in Canton, OH, allowing the market to stay within the hospital access guidelines. *Medicine* – Increasing inpatient medicine services in the Eastern Market is being met through the consolidation of the Brecksville division to Wade Park. This will require new construction and renovation of existing space for Medicine at the Wade Park division. The Central Market will utilize community hospital contracts and other arrangements within the Columbus metropolitan area to provide local inpatient services."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Only 39 percent of central Ohio veterans (Central Market) are within 60 minutes of a VA hospital; the CARES access standard is for 65 percent of veterans to have access. The VA facility nearest to the Columbus metropolitan area is approximately 50 miles away in Chillicothe. Because of Chillicothe's limited services, however, many patients in Columbus must travel either 82 miles to the Dayton VAMC or 100 miles to the Cincinnati VAMC.

At the site visit, however, the Commissioners heard that the projected need for less than 40 beds at Columbus does not support building a new VA hospital. Furthermore, since enrollment projections peak

in FY 2010[260] and a new hospital would take time to get approval and be built, a new VA hospital would not be operational until after enrollment had started to decline. At the Columbus hearing, Congresswoman Pryce noted that the previous 3-year contract with Ohio State University Hospital East for emergency and stabilization care had expired.[261] As Congressman Hobson stated in his testimony before the Commission on August 19:

> In conjunction with this new clinic [referring to replacement outpatient specialty care center in Columbus], it is imperative that the Central Market simultaneously addresses the inpatient hospital care access gap. There are many hospitals in the Columbus area, many of which have empty beds. I, along with others in the Ohio delegation, have written urging that an agreement exist with an area hospital to address these issues. Today, I am once again urging VA to pursue a long-term contract with a local hospital willing to dedicate space to the veterans of central Ohio.[262]

Commissioners noted that the outpatient clinic for Columbus should be a top priority, as veterans are currently being transported on buses to the nearest VAMC. The Commission notes that there are numerous facilities in Columbus with extra beds that could be used for veterans' care, a result that is consistent with the DNCP proposal.

In the Canton area in the Eastern Market, contracting for inpatient care is used for emergency purposes and during peak workload periods. As the VISN Director stated in his testimony:

> It is our intent to get more efficient as we go forward. But, if there is care beyond what we can – the capacity that we have – [the] default response in the planning model is [to contract for care]. That would in my mind not be the ideal choice. I would much rather that we manage our capacity in a way to meet those needs.[263]

Commission Findings

1. Inpatient access gaps exist in the Central Market, particularly in the Columbus area.
2. Contracting for inpatient care in the Columbus and Canton areas is a cost-effective response to inpatient access gaps as it is not dependent on capital funds.
3. Contracting for inpatient services in the Columbus area may reduce the workload at other VA facilities, such as at Chillicothe.

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[260] VSSC, *Management of CARES Workload Report* received from the VISN Support Services Center (VSSC) dated September 26, 2003.

[261] The Honorable Deborah Pryce, Congresswoman, Ohio 15th District, Transcribed testimony from the Columbus, OH, Hearing on August 19, 2003, page 22.

[262] The Honorable Dave Hobson, Congressman, Ohio 7th District, Written Testimony submitted at the Columbus, OH, Hearing, August 19, 2003, page 4.

[263] Clyde Parkis, VISN 10 Director, Transcribed Testimony from the Cleveland, OH, Hearing, August 12, 2003, page 34.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to contract for inpatient care with local hospitals in Columbus and Canton.
2. The Commission recommends analysis of the impact on other facilities of adding services in Columbus, particularly on Chillicothe.
3. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

III Replacement Outpatient Specialty Care Clinic

DNCP Proposals

"A new expanded 260,000 square foot outpatient specialty care center would be built on the DoD Defense Supply Center site located in Columbus, Ohio. DoD has up to 200 acres available at this location at no cost to VA. At the completion of this project, 150,000 square feet of leased space will be terminated."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Columbus, OH, is the only major metropolitan area in VISN 10 that does not have a VA Medical Center. Rather, the Chalmers P. Wylie Outpatient Clinic is the only VA facility in Columbus, and it has outgrown its space. Lillian Thome, Director, Columbus Outpatient Clinic testified, "the clinic moved to the existing 118,000 square foot [facility] located on Taylor, which you also heard was designed for 135,000 annual visits, and this year we expect to finish with greater than 205,000 visits."[264] The data available for FY 2003 shows the Columbus clinic with greater than 209,000 visits.[265] The clinic's current location is in leased space and on land

[264] Lillian Thome, MD, Columbus Outpatient Clinic Director, Transcribed Testimony from the Columbus, OH, Hearing on August 19, 2003, pages 56-57.

[265] VSSC KLF Menu Database, *Workload: Outpatient, FY-OPC Visit Report, FY 2003, as of December 28, 2003.*

that is not owned by the Federal government. The proposed new outpatient specialty care center would be built on land donated by DoD Defense Supply Center, which eliminates the costs associated with land acquisition. The new facility provides 260,000 square feet of space in a three-story structure, as well as parking space to accommodate 1,000 vehicles.

CARES workload data indicate that in FY 2002, the Columbus outpatient clinic had 153,000 primary and specialty care stops, with a mix of medical specialties and surgical care. The CARES data projected that in FY 2012 primary care, specialty care, and mental health care stops will increase to 263,000. By FY 2022, demand for these services will decline to 240,000.[266]

Hearing testimony indicated that in addition to primary and specialty care and mental health services, the proposed outpatient specialty care center in Columbus would provide enhanced and expanded services to veterans, such as ambulatory surgery with 12- to 23-hour observation beds.

VISN 10 has studied the accessibility to impatient and outpatient special health services not offered in the Central Market. Clyde Parkis, VISN 10 Director testified:

> It was noted [in the study] that about 320 veterans each week, aged up to 85 years old, some very frail, travel an average of an almost 200 miles round trip. This computes to 62,500 patient travel miles every week. About a fourth of it is in the same kind of bus that you rode in here this morning. It is a rough ride. Three-fourths of it are patients traveling on their own. A veteran spends an average of 12 hours and may have only a 20 to 30 minute clinic appointment to show for it. And the 12 hours doesn't include their time coming to the clinic and leaving the clinic. We want to change that. Many of the veterans that travel are older, have chronic illness[es], [and] have difficulty getting around. The yearly cost of transportation exceeds a million dollars.[267]

Improving access to care in the Columbus area is a major issue for VISN 10. At the CARES Commission hearing, the VISN Director testified that terminating the old lease for 150,000 square feet would save $1.3 million annually.[268] The proposed ambulatory care center will provide 50 percent more services by FY 2010, including outpatient surgery.[269]

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[266] VSSC, *Management of CARES Workload Report* received from the VISN Support Services Center dated September 26, 2003.
[267] Clyde Parkis, VISN 10 Director, Transcribed Testimony form the Columbus, OH, Hearing on August 19, 2003, pages 52-53.
[268] Clyde Parkis, VISN 10 Director, Written Testimony form the Columbus, OH, Hearing on August 19, 2003, page 13.
[269] VSSC, *Management of CARES Workload Report* received from the VISN Support Services Center dated September 26, 2003.

Commission Findings

1. Columbus, OH, is the only major metropolitan area in VISN 10 that does not have a VAMC.
2. The current outpatient clinic in Columbus has outgrown its space. It was constructed for 135,000 annual visits; however, in FY 2003 the clinic had better than 209,000 annual visits.
3. The clinic is located in leased space, and is located on land that is not owned by the Federal government.
4. Building a replacement outpatient clinic in Columbus on donated federally owned land would eliminate current expenses associated with leasing space and is the fastest, most cost-effective means to improve outpatient access and workload gaps in the Central Market.
5. Veterans often travel 12 hours for a 20 to 30 minute clinic appointment.
6. Workload projection data indicate increasing demand for outpatient services in the Columbus area.
7. Adding a new outpatient specialty care center in Columbus would provide enhanced and expanded services to veterans.
8. There is strong congressional support for the new facility in Columbus, including support from members of the VA/HUD Appropriations Committee.

Commission Recommendations

1. The Commission concurs with building an expanded 260,000 square foot replacement outpatient specialty care center in Columbus, OH, on Federal land donated by DoD Defense Supply Center.
2. The Commission recommends that the new Columbus outpatient specialty care center be a high priority.

IV Outpatient Primary and Mental Health Care

DNCP Proposals

"Increasing primary care outpatient services is being addressed in all three markets through a combination of in-house expansion (leases and new construction), use of telemedicine, and expansion of existing CBOCs, in addition to new CBOCs. Outpatient mental health services have been an integral part of the existing CBOC and the Network will continue to support the expansion of mental health services in all Network CBOCs. Overall, VISN 10 is increasing specialty care outpatient services in all three markets and at all six care sites.

The need is being met by utilizing a combination of in-house expansion (new construction and leases), offering selected high volume specialty care services at larger CBOCs, and through community contracts."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Though VISN 10's markets currently meet the criteria for access to primary care, by FY 2012, primary care workload is expected to increase in the Eastern Market by 53 percent, in the Central Market by 22 percent, and in the Western Market by 43 percent. The workload for specialty care in the Eastern Market is expected to increase by 107 percent, in the Central Market by 96 percent, and in the Western Market by 45 percent.[270] Projections for all facilities show: 1) construction of 167,000 square feet for additional outpatient care; and 2) contracting for some primary and specialty care over peak enrollment years.[271]

Specialty care demand throughout the entire VISN is projected to increase. In the Central Market, there is a 76 percent projected increase over the FY 2001 baseline in FY 2012, and a 77 percent projected increase in FY 2022. The Eastern Market's projected increase in FY 2012 is 45 percent over the FY 2001 baseline, and is 32 percent in FY 2022. The greatest overall increase in specialty care demand will be in the Eastern Market, with increases of 101 percent in FY 2012 and 76 percent in FY 2022 over the FY 2001 baseline.[272]

From the hearing record, the Commission learned that this VISN has taken innovative steps to address the past demand for outpatient health care services and is prepared to address future demand. As indicated in testimony, the VISN has included in some CBOCs a mental health intensive case management program, which consists of ten or 15 people. Doing this allows the VISN "to care for many seriously mentally ill patients in the community."[273] The VISN also intends to add additional outpatient space through construction projects, particularly when the Brecksville and Wade Park divisions have been consolidated. This will ensure that access to health care services is maintained.

Projected workload for the seven proposed CBOCs in FY 2012 is 87,000 clinic stops.[274] All of the proposed CBOCs would provide mental health care, and three of the proposed CBOCs would provide specialty care.

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[270] VSSC, *Management of CARES Workload Report* received from the VISN Support Services Center dated September 26, 2003.
[271] VSSC, *Management of CARES Workload Report* received from the VISN Support Services Center dated September 26, 2003.
[272] Appendix D, *Data Tables*, page D-50.
[273] William Montague, Director, Cleveland VA Medical Center, Transcribed Testimony from the Cleveland, OH, Hearing on August 12, 2003, pages 27-28.
[274] VSSC, *Management of CARES Workload Report* received from the VISN Support Services Center dated September 26, 2003.

Commission Findings

1. Outpatient workload is increasing in all markets.
2. The VISN has already integrated mental health services in CBOCs and intends to continue this integration in future CBOCs.
3. The VISN has established service sites to meet access and increasing demand for outpatient services.
4. Construction is needed to respond to changes resulting from consolidation of the Brecksville and Wade Park divisions to ensure access to health care.
5. Some contracting for care in the community may be needed to resolve gaps in demand for outpatient services.

Commission Recommendations

1. The Commission recommends that: [275]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

[275] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

V Special Disability Program – Spinal Cord Injury Center

DNCP Proposals

"DNCP recommends adding 20 long-term care beds to the Cleveland SCI Center."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

SCI plans were developed on a national basis. The DNCP indicates that, in FY 2001, VISN 10 had 38 acute-SCI beds, 32 of which were staffed. Projections indicate a decline in the need for acute-SCI beds from the current level of beds. The projections for FY 2012 show a need for 21 acute-SCI beds, and for 24 acute-SCI beds in FY 2022.

The DNCP also indicates that, in VISN 10, ten SCI beds are currently designated as long-term care SCI beds. Projections for long-term care SCI beds show that 43 long-term care SCI beds will be needed in FY 2012 and that this need increases to 48 long-term care SCI beds in FY 2022.[276]

Commission Findings

1. The need for acute-SCI beds is declining.
2. Workload projections indicate increasing need for long-term care SCI beds.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to add 20 long-term care beds to the Cleveland SCI Center.
2. The Commission recommends that VA conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

[276] Draft National Cares Plan (DNCP), *Appendix Q-Special Disability Program Planning Initiatives*, page 7. Available from [*http://www1.va.gov/cares/docs/DNP_appQ.pdf*].

VI Enhanced Use

DNCP Proposals

"Enhanced use is proposed for 690,669 square feet of space. The vast majority (548,363 square feet or 79 percent) is associated with the consolidation of activities of the Brecksville Division to Cleveland/Wade Park. The remaining space (142,306 square feet) is associated with proposed enhanced use lease projected at Cincinnati (leasing of Quarters and use proceeds for additional adjacent parking) and Dayton (leasing of empty building)."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Decisions regarding EUL at the Brecksville Division are contingent on the realignment of services at that facility to the Wade Park Division. The Commission concurs with the DNCP proposal to consolidate services at Wade Park and agrees that, once completed, the VISN should move forward with finding alternative uses for the vacated space at Brecksville or divesting the property.[277]

Regarding the Cincinnati and Dayton EUL opportunities, the Commission heard testimony that the VISN wants to build on partnering ventures already in place in those communities. At the Cincinnati VAMC, significant parking space shortage currently exists and this will be exacerbated as workload increases. The Cincinnati VAMC owns 832 parking spaces, including all the handicapped spaces. It also owns or leases 1,242 parking spaces. According to the VISN, there is a parking deficit of 447 spaces using the FY 2001 patient workload data at the medical centers. The VISN's plan to resolve this parking deficit is to use the EUL process to lease 11 unused living quarters buildings at Cincinnati's Fort Thomas campus and to use the funds generated from this EUL to develop a parking garage on land that is owned by the Cincinnati Zoo.[278]

The Dayton VAMC, the third oldest VAMC in the country, was established pursuant to legislation signed by President Abraham Lincoln creating the National Home for Disabled Volunteer Soldiers. The Dayton VAMC currently has an excess number of buildings and an outdated infrastructure that pose many financial challenges, including the financial drain to maintain buildings not currently used for patient care. Many of the

[277] Chapter 3, *National Crosscutting Recommendation: Facility Mission Changes*, contains additional information on this topic.
[278] Clyde Parkis, VISN 10 Director, Written Testimony submitted at the Columbus, OH, Hearing on August 19, 2003, pages 17-18, available from [*http://www.carescommission.va.gov/Documents/ColumbusPanel2Part3.pdf*].

buildings on the Dayton campus are historically significant and there is strong opposition from the community to their demolition. The VISN has worked with the community, in particular, the American Veterans Heritage Center (AVHC), a nonprofit organization, to preserve these historic buildings. At the Columbus hearing, Brigadier General Dennis Samic (USAF, Ret.), a member of the Board of AVHC, described the effort as follows:

> We have such a partnership in Dayton and look forward to getting our campus added to the historic register to rehabilitating the first permanent chapel built by the United States Government; and in the long-term, turning Dayton's historic VA facilities into a National Veterans Hall of Fame to honor veterans and educate the nation's youth on the value of patriotism.[279]

This partnering effort resulted in a $130,000 grant from the National Historic Treasures Program through the National Park Service, which the AVHC plans to match.

Commission Findings

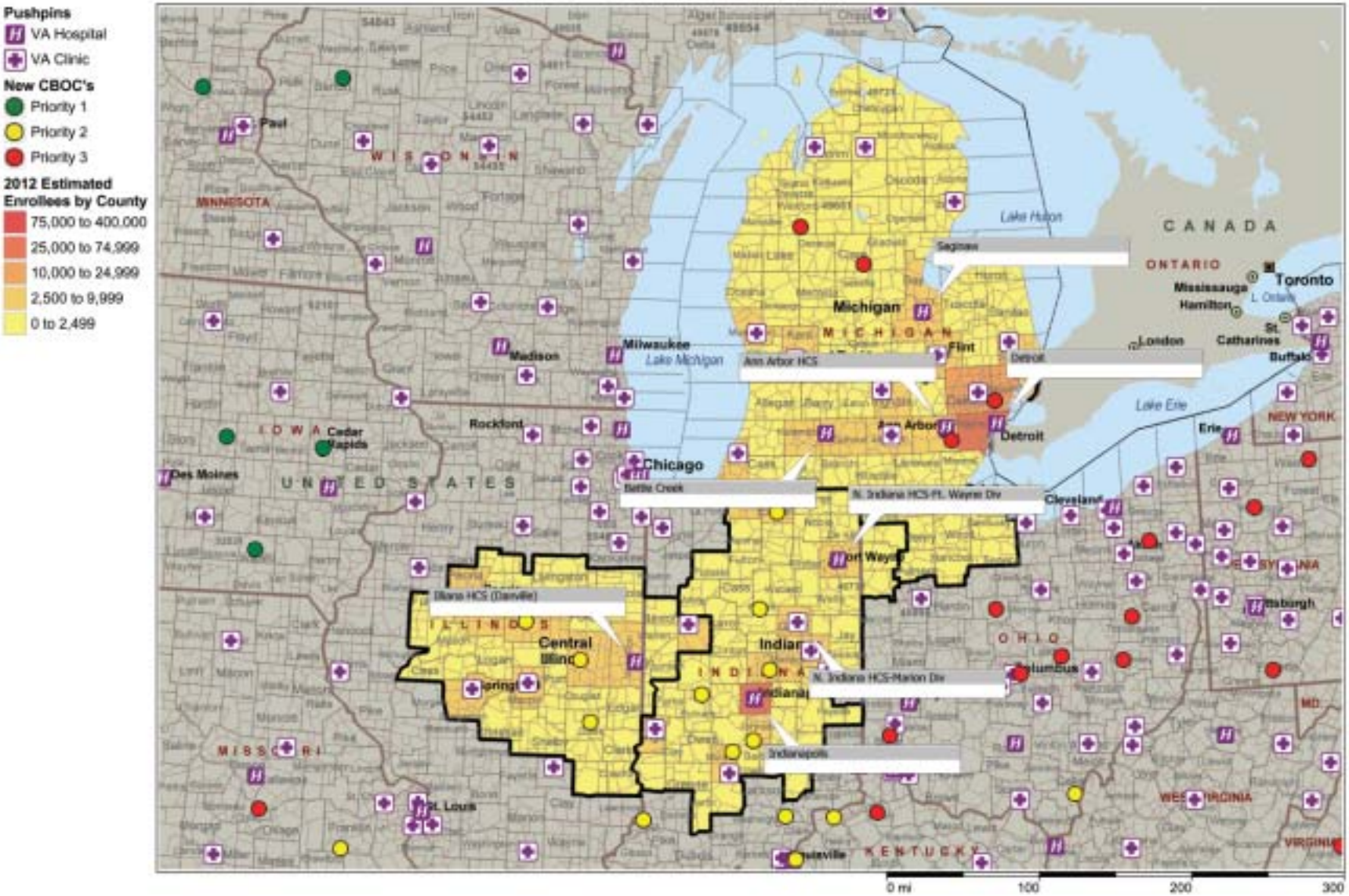
1. The Cincinnati VAMC has a parking deficit of 447 spaces. The VISN plans to use the EUL process to lease unused living quarters in exchange for funding to support development of a parking garage.
2. The Dayton VAMC has a number of historically significant buildings, which are not used for patient care. The VISN has established creative partnerships with community leaders, particularly the AVHC, to assist the VISN in maintaining historic buildings at the Dayton VAMC.

Commission Recommendations

1. The Commission concurs with the DNCP proposal relating to EUL projects at Cincinnati to lease quarters and use the proceeds for additional parking.
2. The Commission concurs with the DNCP proposal relating to EUL of Dayton's empty buildings.
3. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

[279] Brigadier General Dennis Samic, Treasurer American Veterans Heritage Center, Transcribed Testimony from the Columbus, OH, Hearing on August 19, 2003, pages 159-160.

VISN 11 – Veterans in Partnership



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VISN 11, Veterans in Partnership

VISN Overview

VISN 11, Veterans in Partnership, is an integrated, comprehensive health care system that provided medical services to approximately 189,000 of the 298,000 veterans enrolled in VA's health care system in FY 2003.[280] Geographically, this VISN spans about 90,100 square miles in Lower Michigan, Indiana, and Central Illinois, and includes a total veteran population of 1.4 million.[281] With a VA staff of approximately 8,066 FTEs,[282] VISN 11 delivers health care services through eight medical centers, 21 community-based outpatient clinics (CBOCs), and six nursing homes. In addition, VA operates six Vet Centers in VISN 11.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 11.

VISN 11	FY 2001	FY 2012	FY 2022
Enrollees	249,012	275,868	248,315
Veteran Population	1,485,477	1,147,624	915,903
Market Penetration	16.76%	24.04%	27.11%

For the CARES process, this VISN is divided into three markets: Michigan Market (*facilities:* Ann Arbor, Detroit, Battle Creek, and Saginaw); Indiana Market (*facilities:* Fort Wayne, Marion, and Indianapolis); and Central Illinois Market (*facility:* Illiana).

Information Gathering

The CARES Commission visited two sites and conducted two public hearings in VISN 11. The Commission received 2,238 comments regarding VISN 11.

- *Site Visits:* Fort Wayne and Marion, IN, on July 14.
- *Hearings:* Fort Wayne, IN, August 20; Detroit, MI, August 22.

[280] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[281] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[282] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Summary of CARES Commission Recommendations

I Small Facility – Fort Wayne Campus of the Northern Indiana Health Care System (HCS)

1. The Commission concurs with the DNCP proposal to close acute care at Fort Wayne and transfer these services to other VA facilities or contract in the local community.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to maintain outpatient care at Fort Wayne.

(see page 5-203)

II Small Facility – Saginaw VA Medical Center (VAMC)

1. The Commission concurs with the DNCP proposal to discontinue acute medical services at Saginaw, but does not concur with adding beds at the Ann Arbor VAMC to accommodate additional workload from Saginaw (see Inpatient Care).
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to maintain nursing home and outpatient care at Saginaw.

(see page 5-205)

III Inpatient Care

1. The Commission does not concur with the DNCP proposal to add additional beds at Ann Arbor to accommodate additional workload from Saginaw.

2 The Commission recommends that the inpatient workload projections be validated. If validated, the Commission supports the DNCP proposal for construction of beds at Ann Arbor and opening the unused unit at Detroit.

(see page 5-208)

IV Improve Access to Hospital Care in Central Illinois

1 The Commission concurs with the DNCP proposal to contract with hospitals in Central Illinois for inpatient care.

2 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-209)

V Outpatient Care

1 The Commission concurs with the DNCP proposal for outpatient care.

2 The Commission recommends that: [283]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

[283] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service settings.

(see page 5-211)

VI Proximity of Ann Arbor and Detroit VAMC Services

1 The Commission concurs with the DNCP proposal to maintain tertiary facilities in Michigan at both Ann Arbor and Detroit, with continued consolidation of services.

2 The Commission recommends shifting appropriate Post-Traumatic Stress Disorder (PTSD) and substance abuse services from Battle Creek to Detroit.

(see page 5-213)

VII Pursue Enhanced Use Leasing for Danville and Battle Creek Excess Space

1 With respect to the proposed enhanced use lease at the Illiana VAMC for a replacement nursing home, the Commission recommends that: [284]

a Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

2 The Commission concurs with pursuing enhanced use leasing (EUL) opportunities at the Battle Creek VAMC.

(see page 5-215)

[284] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

I Small Facility – Fort Wayne Campus of the Northern Indiana HCS

DNCP Proposal

"The Fort Wayne VAMC, a division of the Northern Indiana Health Care System, will maintain outpatient services. Acute medicine services will be transferred to Indianapolis, together with partial contracting out for inpatient/emergent care services. Patient transfer protocols will be upgraded to address these significant changes. The Indianapolis VAMC does not require renovation prior to the consolidation."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The Fort Wayne facility, part of the Northern Indiana Health Care System, currently operates 26 inpatient medicine beds (with an average daily census [ADC] of 22).[285] The Marion campus has inpatient psychiatry beds and nursing home care beds.

At the Fort Wayne hearing, Ms. Linda Belton, the VISN Director, described the rationale for the proposed closure of the inpatient capacity at Fort Wayne, noting:

> The Fort Wayne campus of Northern Indiana anticipates a Fiscal Year 2012 average daily census of 11 in acute medicine, with an average daily census of 10 in FY 2022. VISN 11 proposes to close the remaining 26 acute medical beds, increase contract hospitalization, and continue to transfer appropriate patients to Indianapolis.[286]

[285] Appendix D, *Data Tables*, page D-56.
[286] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 20.

When asked about VA's ability to contract for care in the Fort Wayne community and about the quality of care in the community, Dr. Michael Murphy, the Director of VA's Northern Indiana Health Care System, noted that "Fort Wayne is a rather substantial medical community with two tertiary facilities – Parkview and Lutheran – and those hospitals are generally within the top 100 hospitals in the country in their category."[287] The Commission notes that these two facilities are among the nine JCAHO-accredited community hospitals within 60 minutes of Fort Wayne, which all appear to have the ability to contract with VA for needed services for veterans.[288]

In response to a question about the economic implications of the DNCP proposal to move acute medicine services and contract out inpatient and emergent care, Mr. Craig Anderson, VISN 11 CARES Coordinator, testified:

> There are some savings that are being projected with this move. We should not forget about the cost being provided by Indianapolis, and we've also calculated those costs. But the savings that are being projected for the closure of beds at Fort Wayne, which will assist us in expanding other programs, is approximately 2.1 million dollars per annum.[289]

With respect to the impact on employees now at Fort Wayne, Ms. Belton indicated that there were 29.4 FTEs associated with the inpatient program and that these employees would be reassigned or retrained.[290] Ms. Belton added that the VISN "has made a commitment not to use reductions in force, except as a last resort" and that, "in eight years, we have not had to resort to that."[291] There was, however, no guarantee that all who might lose their jobs will be reemployed.

There was strong opposition from veterans service organizations (VSOs) and employee organizations to the proposed closure of acute medicine at the Fort Wayne facility.

Commission Findings

1. There are nine JCAHO-accredited community hospitals within 60 minutes of Fort Wayne.

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[287] Michael W. Murphy, PhD, Director, Northern Indiana Health Care System, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 26.
[288] Appendix D, *Data Tables*, page D-57.
[289] Craig Anderson, VISN 11 CARES Coordinator, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 32.
[290] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 32.
[291] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 33.

2. The VISN projects savings of approximately $2.1 million with the closure of beds at Fort Wayne.
3. The VISN testified that, based on available data, the major health care providers in Fort Wayne, identified in VISN testimony, along with the Indianapolis VAMC, could absorb Fort Wayne's workload.
4. Fort Wayne's ADC is projected to decline from the current ADC of 20 to 11 by FY 2012 and to 10 by FY 2022.[292]

Commission Recommendations

1. The Commission concurs with the DNCP proposal to close acute care at Fort Wayne and transfer these services to other VA facilities or contract in the local community.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to maintain outpatient care at Fort Wayne.

II Small Facility – Saginaw VAMC

DNCP Proposal

"Saginaw VAMC will maintain outpatient and nursing home services. Acute medicine services will be transferred to Ann Arbor and Detroit. There will be partial contracting out for inpatient/emergent care services and to improve the access for patients in the northern sectors of Lower Michigan. Patient transfer protocols will be upgraded to address these significant changes, and the Ann Arbor HCS must be upgraded prior to any bed consolidation to address the transfer of projected medicine patients to this facility. The Detroit VAMC does not require renovation prior to the consolidation."

[292] Appendix D, *Data Tables*, page D-56.

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The Saginaw VAMC currently operates 27 medicine beds (ADC 11), six intermediate beds (ADC 5), and 81 nursing home care beds (ADC 67). The Saginaw VAMC is located approximately 100 miles from the Ann Arbor and Detroit VAMCs.

At the Detroit hearing, Ms. Belton, addressing the plans for the Saginaw VAMC, testified as follows:

> The Saginaw campus anticipates an FY 2012 average daily census [ADC] of 18 in acute medicine with an ADC of 17 by FY 2022. To meet the small facility standards, VISN 11 proposes to close acute beds at this facility, to maintain 6 to 8 intermediate observation, transition-type beds, to increase contract hospitalization in Saginaw and the northern part of lower Michigan; for example, Traverse City, Charlevoix, Cheboygan, and Presque Isle and to also transfer some acute bed capacity to both Ann Arbor and Detroit. We believe that these actions will improve the access and quality of care.[293]

At the same hearing, the Saginaw VAMC Director, Mr. Gabriel Perez, in response to a question as to how VA would meet the needs of veterans now served by the Saginaw facility, testified:

> That's part of our plan as well, especially depending on the emergent nature and the medical status of the patient, to have them be treated at one of those facilities within our community. And even more, to set up contracts with our northern tier areas, Traverse City, Gaylord, Oscoda areas. So that way, the veteran will have better access than what they have right now.[294]

[293] Linda Belton, VISN 11 Director, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 14.
[294] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 26.

In describing the community health care facilities in Saginaw with which VA might contract for care, Mr. Perez noted that there are "two very strong tertiary care facilities that are competitive, Covenant Health Care System and St. Mary's Health Care System."[295] Mr. Perez added, "They both have level 1 emergency rooms, open heart surgery in both. So, they can handle anything in the community."[296] The Commission notes that there are 11 JCAHO accredited community hospitals within 60 minutes of Saginaw and that there appears to be sufficient capacity in the community to provide services to those veterans who could not be referred to either the Ann Arbor or Detroit medical centers.[297]

With regard to the potential impact on employees at the Saginaw facility from the proposed mission change, Mr. Perez noted that the increasing workload in the outpatient care area would result in jobs for all employees, adding, "Some people may not have the same positions they had before, like on the ward. They have to shift to the outpatient area."[298]

Commission Findings

1. The Ann Arbor and Detroit VAMCs are approximately 100 miles from Saginaw.
2. There are 11 JCAHO accredited community hospitals within 60 minutes of Saginaw, which appear to have excess capacity and could provide services through contracting.
3. Saginaw's ADC for acute care is projected to increase to 21 by FY 2012 and then to decline to 16 by FY 2022.[299]

Commission Recommendations

1. The Commission concurs with the DNCP proposal to discontinue acute medical services at Saginaw, but does not concur with adding beds at the Ann Arbor VAMC to accommodate additional workload from Saginaw (see Inpatient Care).
2. The Commission recommends that:
    a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

[295] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 25.
[296] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 25.
[297] Appendix D, *Data Tables*, page D-54.
[298] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 39.
[299] Appendix D, *Data Tables*, page D-54.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3 The Commission concurs with the DNCP proposal to maintain nursing home and outpatient care at Saginaw.

III Inpatient Care

DNCP Proposal

"Increase inpatient medicine beds in the Michigan market to meet the projected demand. The Ann Arbor HCS and the Detroit VAMC will need to increase their compliment of medicine beds to meet that projected demand and to add additional beds to meet the change in acute beds from Saginaw (small facility) and the consolidation of five beds from the Battle Creek VAMC."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In addition to the impact of the proposed closure of the Saginaw VAMC and of the closing of acute medicine beds at the Battle Creek VAMC, the CARES process projected an increased demand for medicine beds in the Michigan Market, with an additional 84 beds over the FY 2001 baseline needed by FY 2012, decreasing to 40 beds over baseline by FY 2022.[300] To meet this increased demand, the VISN proposed adding, by FY 2012, 43 beds at the Ann Arbor HCS and 32 beds at the Detroit VAMC. The increase in demand for medicine beds is based on a projected increase in market penetration. At present, the VISN's market penetrations of 14 percent is one of the lowest in the VA system; the CARES model projects an increase to a 25 percent market penetration.

At the Detroit hearing, Ms. Linda Belton, the VISN Director, testified that the projected increase is based on "seeing an increase in market share over the last couple of years as there are changes in the local industries, layoffs, some decrease in benefits…"[301] She noted that the increased demand could be met at

[300] Appendix D, *Data Tables*, page D-53.
[301] Linda Belton, VISN 11 Director, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 38.

Ann Arbor by converting "vacated space through minor construction" and at Detroit by activating "an existing unutilized nursing unit."[302] The Director of the Detroit VAMC said that the unutilized nursing unit is on the 7th floor of the bed tower at Detroit and is space that has not been used since the facility was opened.[303]

Commission Findings

1. There is an increase in demand projected for inpatient medicine beds in the Michigan market based on a significant increase in the VISN's market penetration. It is not clear that this increase will occur.
2. There is significant vacant space at the Detroit VAMC.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to add additional beds at Ann Arbor to accommodate additional workload from Saginaw.
2. The Commission recommends that the inpatient workload projections be validated. If validated, the Commission supports the DNCP proposal for construction of beds at Ann Arbor and opening the unused unit at Detroit.

IV Improve Access to Hospital Care in Central Illinois

DNCP Proposal

"Increase access for hospital care in the Central Illinois Market by contracting with community providers at two new sites on the western side of the market."

DNCP Alternatives

None provided in the DNCP.

[302] Linda Belton, VISN 11 Director, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 15.
[303] Michael Wheeler, Director, Detroit VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 47.

Commission Analysis

Only 36 percent of Central Illinois veterans live within 60 minutes of a VA hospital. Since the nearest VA facility is the Illiana VAMC in Danville, veterans on the west side of the market fall outside the CARES guidelines for access to hospital care (the standard is 65 percent).[304] The Commission notes that there is a significant demand for services in this part of the state as the two existing CBOCs, one in Peoria and one in Springfield, furnished services to more than 10,000 individual veterans in FY 2003.[305]

To address this gap in access to hospital care, the VISN proposes to contract for care in the western side of the Central Illinois Market. As Ms. Linda Belton, VISN Director, testified:

> With the Danville Medical Center located at the far eastern end of the [Central Illinois] market, veterans in Peoria and Springfield have to travel two hours for hospital care. So to meet the CARES access standard, VISN 11 will contract with community providers in those areas for inpatient medical and surgical care. This action will bring access to hospital care from 36 percent to 85 percent.[306]

Dr. William P. Marshall, the Chief of Medicine at the Illiana VAMC, testified at the Fort Wayne hearing on behalf of the College of Medicine at the University of Illinois where he holds a faculty appointment as the Chairman of Internal Medicine. Addressing the proposed contracting for hospital care in the western side of the market, Dr. Marshall noted that this change "would negatively impact to a certain degree" on the number of admissions to the Illiana VAMC, but that the "critical number of patients" needed by Illiana to attract staff would be maintained.[307]

Commission Findings

1. Contracting with the community hospitals in Peoria and Springfield will improve access to hospital care to 85 percent of the veterans in the Central Illinois Market.
2. Contracting for hospital care in the western portion of the market may have an impact on the demand for care at the Illiana VAMC; however, that impact is not anticipated to affect the ability to attract staff at the Illiana VAMC.

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[304] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 18.
[305] Craig Anderson, VISN 11 CARES Coordinator, Email to William E. Brew, January 13, 2004.
[306] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 18.
[307] William P. Marshall, MD, Chief of Medicine, Danville VAMC / Chairman, Internal Medicine, College of Medicine of the University of Illinois, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 101.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to contract with hospitals in Central Illinois for inpatient care.
2. The Commission recommends that:
   a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

V Outpatient Care

DNCP Proposals

"*Primary Care* – Increase primary care in two markets and at all care sites except the Illiana HCS at Danville, IL. *Specialty* Care – Increase the specialty outpatient care in all three markets and at all eight cares sites to include selected CBOCs. Three innovative telemedicine networking systems located at the tertiary level facilities are also proposed. These new systems can provide care and consultation services to the veteran in either another VHA facility or at his/her home. These systems will particularly assist the older veteran with ambulation issues, dementia, Alzheimer's, Parkinson's, and the SCI patient. These systems have shown that they can increase patient satisfaction and significantly reduce the number of emergency room, and other visits, and future hospitalizations."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Currently, two markets fall below the CARES 70 percent standard for providing access to primary care within 30 minutes of veterans' homes: Central Illinois (54 percent) and Indiana (63 percent).[308] The CARES model projects that, by FY 2012, primary care workload will increase significantly, by

[308] VISN 11 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=53*].

58 percent over the FY 2001 baseline in Indiana and by 76 percent over baseline in Michigan. Likewise, there is a projected increase by FY 2012 in demand for specialty care, with the workload in Central Illinois projected to increase by 139 percent over baseline, in Indiana by 60 percent over baseline, and in Michigan by 154 percent over baseline.[309] The VISN plans to expand existing sites of care through conversion or renovation of existing space or leasing additional space. There are also plans to increase the use of telemedicine and to contract for care.[310]

During the Fort Wayne site visit, Commissioners learned two Northern Indiana CBOCs are closed to new enrollment. They were also told that Fort Wayne wants to submit a proposal to the VISN 11 Clinical Leadership Board to add specialty care in selected CBOCs, such as the South Bend and Muncie clinics.[311]

As part of its CARES submission, VISN 11 proposed adding 14 new CBOCs by FY 2006.[312] Although 10 of the proposed CBOCs are in the two markets with access gaps – Central Illinois and Indiana – none is in the DNCP priority group one. As Congressman Evans noted about proposed CBOCs in Central Illinois, "…omitting these clinics means that the VISN continues to fail to meet its national access standard for almost half (46 percent) of the [Central Market] enrolled veterans, relegating veterans… to a much lower standard of access than most of the nation's veterans enjoy. "[313]

Commission Findings

1. The establishment of three CBOCs in Lower Michigan and two in Northern Indiana will enhance services in areas that will be impacted by the proposed closure of inpatient services at the Saginaw and Fort Wayne VAMCs.
2. The establishment of three new CBOCs in Illinois and five additional new CBOCs in Indiana will address deficiencies in meeting access standards.
3. It is not clear that merely expanding existing CBOCs will adequately address access gaps.

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[309] Appendix D, *Data Tables*, page D-53.

[310] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 6.

[311] VISN 11, Site Visits Marion/ Fort Wayne on July 14, 2003, page 3, available from [*http://www.carescommission.va.gov/Documents/SiteVisitVISN11MarionFortWayne.pdf*].

[312] National CARES Planning Office (NCPO), Department of Veterans Affairs, CBOC Analysis, provided to the Commission on December 11, 2003.

[313] The Honorable Lane Evans, Congressman from Illinois, Written Testimony submitted at Wayne, IN, Hearing on August 20, 2003, pages 1-2, available from [*http://www.carescommission.va.gov/Documents/FortWayneCongressionalStatements.pdf*].

Commission Recommendations

1. The Commission concurs with the DNCP proposal for outpatient care.
2. The Commission recommends that:[314]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service settings.

VI Proximity of Ann Arbor and Detroit VAMC Services

DNCP Proposal

"The Ann Arbor and Detroit facilities currently have several services that they have consolidated and they include: cardiac, surgery, neurosurgery, interventional cardiology, cochlear implant, gynecologic cytopathology, nuclear medicine, sleep laboratory, GRECC, HSR&D, contract administration, prosthetic management. Future consolidations to be considered are: home oxygen management and radiology interpretation."

DNCP Alternatives

None provided in the DNCP.

[314] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

Commission Analysis

Ann Arbor and Detroit are 46 miles apart, and are affiliated with the University of Michigan (UMHS) and Wayne State, respectively. Internal medicine occupancy in FY 2002 was 90 percent at Ann Arbor and 72 percent at Detroit. Combined surgery admissions were 36 patients a day, with two-thirds of these patients at Ann Arbor.[315] Projected inpatient workload peaks by FY 2008, gradually declining through FY 2022.[316] As discussed earlier, both facilities will absorb some workload if the DNCP proposal to close inpatient care at the Saginaw VAMC is implemented.

Commissioners reviewed a patient Zip code analysis that showed different referral patterns at each facility. Detroit serves its local community, with 80 percent of the patients from two counties. Ann Arbor is a statewide referral center, with 80 percent of the patients from 17 counties.[317] In recent years, VISN 11 has consolidated high-tech, high-cost care at Ann Arbor, including open-heart surgery and neurosurgery.

The post-traumatic stress disorder (PTSD) residential program is located in Battle Creek, 125 miles from Detroit. As Mr. Bob Rasche from The American Legion testified, "Veterans from the Detroit area needing post traumatic stress disorder (PTSD) treatment and therapy for some other mental health needs would be disadvantaged by having to travel to Battle Creek."[318] As noted in the analysis of Inpatient Care (above), there is significant unused and underutilized space at the new Detroit VAMC. The Commission has consistently based its decisions on the principle that residential rehabilitation services should be placed as close to the populations they serve as feasible. The availability of space at Detroit raises the question of why veterans with PTSD, a high priority for VA, need to travel great distances and because of these distances, have it more difficult for their family to be involved in treatment, when VA has already invested in providing clinical space in downtown Detroit that is underutilized.

Commission Findings

1. A significant VA presence is needed in both Detroit and Ann Arbor; neither facility could absorb the total services from the other facility.

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[315] VSSC KLF Menu Database, *Occupancy Rates Report,* October 2001 through September 2002.

[316] VISN 11 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=53*].

[317] CARES Portal, VISN 11, Michigan Market County-Facility Workload Allocation Workbook.

[318] Bob Rasche, Department Service Officer, The American Legion, Written Testimony submitted at the Detroit, MI, Hearing on August 22, 2003, page 4, available from [*http://www.carescommission.va.gov/Documents/DetroitPanel2PART1.pdf*].

2 Residential rehabilitation services should be provided close to the hometown of the majority of the patients in such programs.

Commission Recommendations

1 The Commission concurs with the DNCP proposal to maintain tertiary facilities in Michigan at both the Ann Arbor and Detroit, with continued consolidation of services.

2 The Commission recommends shifting appropriate PTSD and substance abuse services from Battle Creek to Detroit.

VII Pursue Enhanced Use Leasing for Danville and Battle Creek Excess Space

DNCP Proposal

"There are several enhanced use lease projects planned by the Network to address significant space issues to meet the projected primary and specialty outpatient care workload. There are significant enhanced use projects planned at the Battle Creek (new mental health building and Vet Center), the Illiana HCS for the new nursing home care unit, and at NIHCS – Fort Wayne Division to relocate their outpatient services and dispose of their inpatient building to a community provider."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

VISN 11 has a successful EUL at the former Cold Spring Road facility of the Indianapolis VAMC, generating a trust fund for innovative VISN 11 programs. In FY 2002, $1.9 million from the fund was designated for telehealth programs, an important VISN 11 initiative.[319]

Currently, most VISN vacant space is in Danville (at the Illiana VAMC), Marion, and Battle Creek; VISN 11 is actively consolidating services at all campuses to reduce overhead costs.

[319] Craig Anderson, VISN 11 CARES Coordinator, as reported in the July 14, 2003 Fort Wayne Site Visit, page 3, available from [*http://www.carescommission.va.gov/Documents/SiteVisitVISN11MarionFortWayne.pdf*].

Three vacant buildings at the Illiana VAMC were converted to senior housing through enhanced lease agreements. There are longstanding issues relating to the environment for care at the 280-bed Illiana VAMC nursing home, which is housed in a 40-year-old building. It does not meet standards under the Americans with Disabilities Act or VA patient privacy standards and has space and functional issues.[320]

For Battle Creek, the DNCP describes using the EUL process for a new mental health building and a Vet Center. During the Detroit hearing, Ms. Alice Wood, Director of the Battle Creek VAMC, provided more detail about these proposals. With respect to the mental health building, Ms. Wood indicated that "the simplest and the cleanest [arrangement] would be to simply build the mental health facility that we need with an outside developer coming in, building it for us and then leasing it to us." With respect to the other proposed EUL prospect, Ms. Wood clarified that the proposal was for a "Vet Village" which would be a "privately-owned and operated assisted living" facility on the grounds of the medical center that would be available to veterans.

At the Fort Wayne hearing, the VISN Director noted that some unused buildings on the Marion Campus were proposed for demolition and that other vacant space will be converted to provide ambulatory care. She also discussed the possibility of ceding nine acres of land at Marion to NCA for use as a cemetery.

Commission Findings

1. The existing nursing home at the Illiana VAMC does not meet standards under the ADA, does not meet VA patient privacy standards, and has space and functional issues.
2. In light of the VISN's experience with the EUL process, the DNCP proposal to use the process for a new mental health building and 'Vet Village' in Battle Creek may be achievable, though it is not clear there are developers interested in these projects.

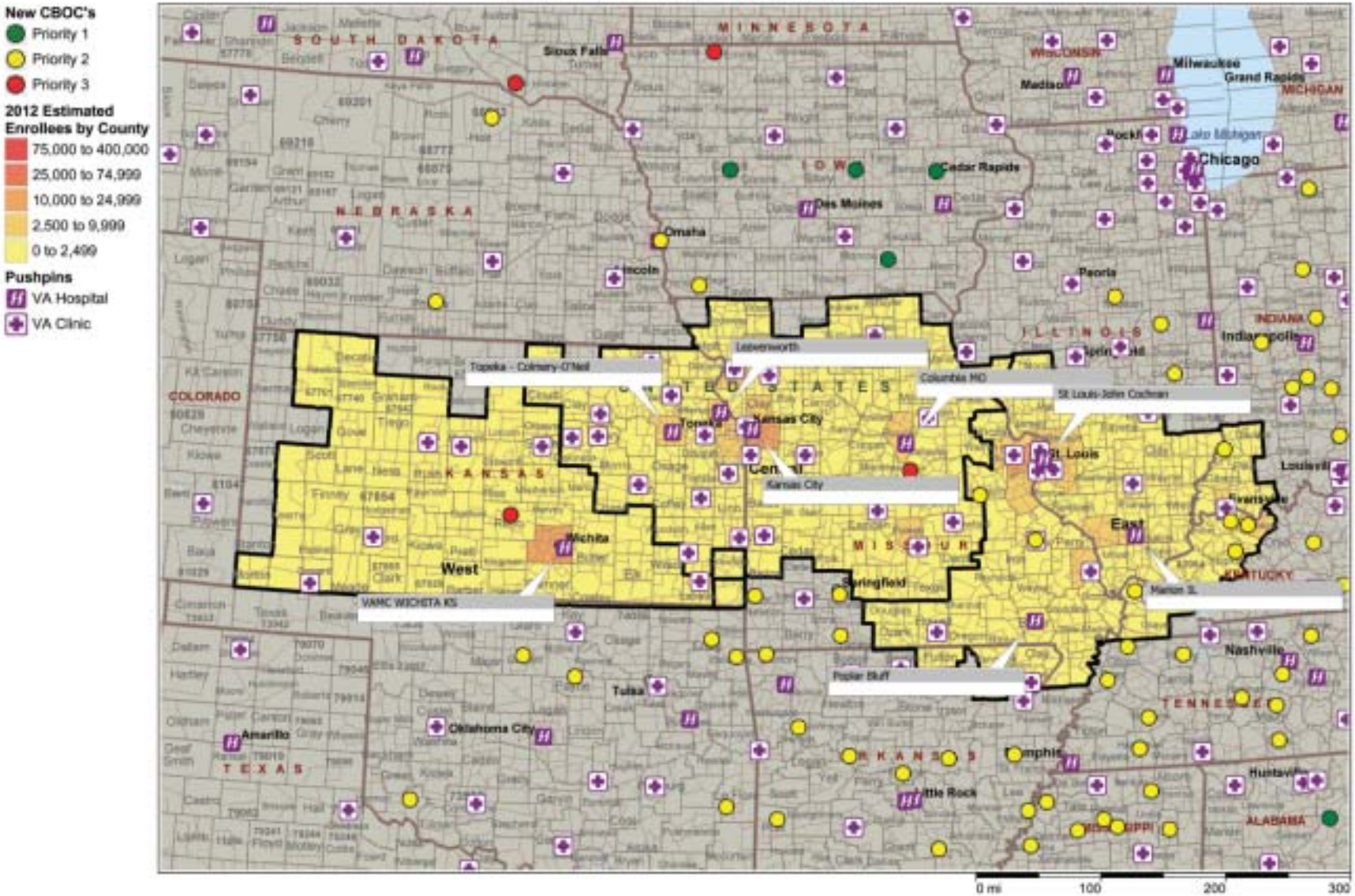
[320] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 18.

Commission Recommendations

1. With respect to the proposed enhanced use lease at the Illiana VAMC for a replacement nursing home, the Commission recommends that: [321]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.
2. The Commission concurs with the DNCP proposal to pursue EUL opportunities at the Battle Creek VAMC.

[321] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

VISN 15 – VA Heartland Network



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VISN 15, VA Heartland Network

VISN Overview

VISN 15, VA Heartland Network, is an integrated, comprehensive health care system that provided medical services to approximately 199,000 of the 286,000 veterans enrolled in VA's health care system in this VISN in FY 2003.[322] The total veteran population VISN is 969,000. Geographically, the VISN is located in six Midwestern states: Indiana, Kentucky, Arkansas, Illinois, Missouri, and Kansas. Ninety-two percent of the counties in the Western Market are considered highly rural or rural, as are 88 percent of the counties in the Eastern Market. With a staff of 6,852 FTEs,[323] VISN 15 delivers health care services through eight medical centers, one outpatient clinic, and 22 community-based outpatient clinics (CBOCs). Additionally, VA operates four Vet Centers in VISN 15's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 15.

VISN 15	FY 2001	FY 2012	FY 2022
Enrollees	239,574	242,560	211,555
Veteran Population	1,005,240	805,573	655,816
Market Penetration	23.83%	30.11%	32.26%

For the CARES process, this VISN is divided into three markets: Eastern (*facilities:* St. Louis, MO; Poplar Bluff, MO; and Marion, IL), Central (*facilities:* Kansas City, MO; Topeka, KS; Columbia, MO; and Leavenworth, KS), and Western (*facility:* Wichita, KS).

[322] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[323] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited three sites in VISN 15 and conducted two public hearings. The Commission received 11 public comments regarding VISN 15.

- *Site Visits:* John J. Pershing VA Medical Center (VAMC), Poplar Bluff, MO, on June 30; and Kansas City, MO, and Leavenworth, KS, facilities on July 1.
- *Hearings:* Leavenworth, KS, on August 18; and Poplar Bluff, MO, on August 20.

Summary of CARES Commission Recommendations

I Consolidation of Services/Proximity – Kansas City and Leavenworth VAMCs

1. The Commission concurs with the DNCP proposal to implement the recommendations of the Secretary's Advisory Board.

(see page 5-222)

II Small Facility – Poplar Bluff

1. The Commission does not concur with the DNCP that Poplar Bluff currently operates as a critical access hospital (CAH).
2. The Commission recommends that VA establish a clear definition and clear policy on CAH designation prior to making a decision regarding the Poplar Bluff VAMC.
3. The Commission recommends that a target date be set for making a full cost-benefit analysis of sustaining inpatient services versus contracting for such services. The Commission further recommends that, based on the results of that assessment, a decision be made regarding whether or not to close inpatient services at Poplar Bluff.
4. The Commission recommends that, regardless of the decision on inpatient services, outpatient services and long-term care (LTC) remain at Poplar Bluff.

(see page 5-224)

III Inpatient Services – Psychiatry

1. The Commission concurs with the DNCP proposal on shifting workload between the Central and Western markets to meet inpatient psychiatry workload.

(see page 5-226)

IV Outpatient Care

The Commission concurs with the DNCP proposal on expansion of in-house services, new construction, space conversion, and utilization of community contracts to address capacity gaps for outpatient care. However, it notes that substantial access gaps and many of the capacity gaps are unlikely to be resolved without additional sites of care.

1. The Commission recommends that:[324]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-227)

V Excess VA Property/Enhanced Use Lease for Historic Buildings at Leavenworth

1. The Commission concurs with the DNCP proposal to pursue an enhanced use lease (EUL), including the assisted living project, at the Leavenworth campus.
2. The Commission recommends that VA develop a viable plan for funding this proposal.
3. The Commission further recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-229)

[324] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

Consolidation of Services/Proximity – Kansas City and Leavenworth VAMCs

DNCP Proposal

"Continuation of the Secretary's Advisory Board recommendations. The Secretary's Advisory Board was created prior to CARES to consider realignments within VISN 15. The Advisory Board developed a comprehensive plan for realignment and consolidation of services between Topeka and Leavenworth that was approved by the USH and incorporated into the VISN's CARES plan. It included realignments of nursing home care unit, psychiatry, and outpatient surgery. Under this plan, Leavenworth would maintain acute beds. In addition, Leavenworth will provide additional primary care capacity for Kansas City, and both Leavenworth and Topeka would retain 24/7 emergency services at both campuses."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The data support that Kansas City, Leavenworth, and Topeka serve different populations, with only a 2.9 percent overlap between Kansas City and Leavenworth, and a 4.9 percent overlap between Kansas City and Topeka. In testimony, Dr. Peter L. Almenoff, VISN Director, described the changes already underway:

> The plan capitalizes on the strengths of Leavenworth and Topeka's integration and the relationship with the Kansas City VA as a tertiary care facility through the implementation of the Advisory Board recommendations authorized by the Secretary of Veterans Affairs and recently approved by the Under Secretary for Health. These include realignment of psychiatry and nursing home beds between the Leavenworth and Topeka campuses, realignment of intensive substance abuse treatment programs, continuation of urgent care services at both campuses 24 hours, 7 days a week, 365 days a year, maintaining up to 38 acute inpatient beds at Leavenworth, establishment of a same-day surgi-center at the Leavenworth and Topeka campuses, and referral of complex major surgical procedures would be performed in Kansas City. All the facilities will continue to provide support for the DoD installations, including Fort Leonard Wood, Fort Leavenworth, Fort Riley, Whiteman Air Force Base, and McConnell Air Force Base.[325]

[325] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 11.

Leavenworth (Dwight D. Eisenhower VA Medical Center) is a part of the Eastern Kansas Health Care System and has 393 beds: 103 inpatient beds (internal medicine, intermediate medicine, rehabilitation, surgery, and psychiatry), 183 domiciliary, 82 nursing home, and 25 residential care. The FY 2003 total average daily census (ADC) was 264, with an inpatient ADC of 60, domiciliary ADC of 167, and nursing home ADC of 37.[326]

The site visit revealed that many of the buildings at the Leavenworth facility are of the post-Civil War era and are historic in nature. The Commissioners noted the presence of the Centralized Mail Out Pharmacy (CMOP) program on the Leavenworth campus. In addition, 85 percent of counties in the area are designated as medically underserved in the Department of Health and Human Service medically underserved listing.[327]

The Kansas City VAMC is a 165-bed tertiary care facility with an ADC of 120. A referral center for VAMCs in Leavenworth, Topeka, and Wichita, KS, and Fayetteville, AR, it is located in the heart of Kansas City. During the stakeholders' meeting at the Leavenworth VAMC, stakeholders expressed concerns about the possible closure of the Leavenworth location given the driving distance to Kansas City, an urban area. Leavenworth is approximately 34 miles from Kansas City and 64 miles from Topeka. Testimony provided by a union official, who is a registered nurse, indicated that such a driving distance is disruptive for veterans and may create additional costs such as mileage reimbursement as well as the cost of hardship for families who may have to travel an additional 70 miles to see their family members.[328]

Additionally, testimony indicated that Leavenworth supports the DoD with a variety of sharing agreements with the U.S. Army at Fort Leavenworth and Fort Riley. These agreements support active duty soldiers with emergency room care, inpatient and outpatient care, psychiatry services, readiness physicals, and laboratory testing.

Commission Findings

1. The Leavenworth and Kansas City medical centers serve separate and distinct missions.
2. There is minimal overlap in patient population served by the two medical centers.
3. The Leavenworth VAMC provides substantial health care for VA's DoD partners at Fort Leavenworth and Fort Riley.

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[326] VSSC KLF Menu Database, Cumulative Average Daily Census (ADC) 5-Year Report, FY 2003.

[327] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 9.

[328] Sandy Bond, President, National Federation of Federal Employees Local 1765, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 121.

4 Eighty-five percent of the counties in the area are designated as medically underserved.

Commission Recommendation

The Commission concurs with the DNCP proposal to implement the recommendations of the Secretary's Advisory Board.

II Small Facility – Poplar Bluff

DNCP Proposal

"Poplar Bluff will maintain acute care beds. This facility currently operates as a critical access hospital (CAH) and will continue as such when VHA develops its CAH criteria."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The 53-year-old John J. Pershing VA Medical Center (Poplar Bluff VAMC) has 16 acute care beds and a 40-bed nursing home unit. The facility has an ADC of 16 acute patients, which is projected to decrease to 15 in FY 2012 and to 11 in FY 2022. No inpatient surgery is performed at this site. The nursing home unit has an ADC of 37. Outpatient primary care and mental health services are provided. Subspecialty services are provided by local consultants and/or referral to VA tertiary care facilities.[329] Commissioners also noted that the Poplar Bluff VAMC is located near a major earthquake fault. In September 1984, VA completed a $6.9 million construction project to correct seismic deficiencies in four buildings. There is a hospital in the Poplar Bluff community that is reported to have excess capacity.[330]

[329] Facility Fact Sheet: *John J. Pershing, VA Medical Center, Poplar Bluff, MO.* [*http://vaww.poplar-bluff.med.va.gov/VA*]
[330] Appendix D, *Data Tables*, page D-60.

Commissioners recognize the challenge for veterans to access acute care in Poplar Bluff. It is a highly rural area. There is minimal public transportation. There are no VA facilities within 60 minutes, and the St. Louis, MO and Memphis, TN VAMCs are 150 miles away.

At the time of the hearing, CAH criteria were used to address the Poplar Bluff VAMC. The Commission has not accepted the DNCP's use of such criteria.

Commission Findings

1. Poplar Bluff has a 16-bed acute medicine unit with an ADC of 16, which is projected to decline to 15 in FY 2012 and to 11 in FY 2022.
2. There are no VA facilities within 60 minutes of Poplar Bluff. The St. Louis and Memphis VAMCs are 150 miles away.
3. Poplar Bluff is in a highly rural area with minimal public transportation.
4. There is one non-VA hospital in the Poplar Bluff community, which has excess capacity.
5. There are established relationships with community specialty care providers as reflected by referral of specialty patients.

Commission Recommendations

1. The Commission does not concur with the DNCP that Poplar Bluff currently operates as a CAH.
2. The Commission recommends that VA establish a clear definition and clear policy on CAH designation prior to making a decision regarding the Poplar Bluff VAMC.
3. The Commission recommends that a target date be set for making a full cost-benefit analysis of sustaining inpatient services versus the potential for contracting such services. The Commission further recommends that, based on the results of that assessment, a decision be made regarding whether or not to close inpatient services.
4. The Commission recommends that, regardless of the decision on inpatient services, outpatient services and LTC remain at Poplar Bluff.

III Inpatient Services – Psychiatry

DNCP Proposal

"Decreasing demand in the Central Market will be offset by increased workload from the Western Market. Inpatient workload will be met through a combination of in-house and community contracts. New construction is proposed to meet projected space needs."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The inpatient psychiatry workload is projected to increase in the Eastern Market with an additional 30 beds over the FY 2001 baseline needed by FY 2012, and six beds over baseline needed by FY 2022. Likewise, the Western Market was projected to need an increase of two beds over baseline by FY 2012, decreasing to one bed over baseline by FY 2022. In the Central Market by FY 2012, a decrease of 15 beds over baseline and, by FY 2022, a decrease of 40 beds over baseline was projected. Dr. Almenoff noted in his testimony that the VISN would manage inpatient psychiatry needs using a combination of in-house capacity and community contracts. Additionally, there would be realignment of psychiatry services between Leavenworth and Topeka in the Central Market.

Commission Finding

Need for increased inpatient psychiatry services will be met through use of shifting of workload and a combination of in-house capacity adjustment and community contracts.

Commission Recommendation

The Commission concurs with the DNCP proposal on shifting workload between the Central and Western markets to meet inpatient psychiatry workload.

IV Outpatient Care

DNCP Proposals

"*Primary Care* – Increased primary care outpatient demand has been identified in all three of the Network's markets. The majority of this need will be met through expansion of in-house space via new construction, conversion of vacant space, lease space, and utilization of community contracts. The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. While new access points in the Central and the East markets are included in the National plan, they are not in the high implementation priority category at this time. *Specialty Care* – All three of the Network's markets are projected to experience increased outpatient specialty care demand. The VISN proposes to meet the majority of this need through expansion of in-house services with new construction, vacant space conversion, lease space, and utilization of community contracts. In addition, some shifting of care between facilities is proposed."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Data on access to primary care indicate that only 62 percent of enrolled veterans in the Eastern Market are within the access guidelines, and that the Western Market is at only 56 percent. The standard is 70 percent. Large increases in specialty care needs are projected for all three markets. By FY 2012, the average increase in demand for specialty care over the FY 2001 baseline is projected to be 128 percent for this VISN: 107 percent for the Central Market, 188 percent for the Western Market, and 91 percent for the Eastern Market.[331] However, the seven proposed CBOCs for this VISN were all in the DNCP's lowest priority group.[332]

Dr. Almenoff testified that construction of primary care and specialty care clinics, conversion of vacant space, use of leased space, and community contracts would be used to meet demand. In addition, CBOCs have also been placed in state homes in Missouri. The VISN also uses medical outreach clinics, which go

[331] Appendix D, *Data Tables*, page D-59.

[332] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

from town to town in Western Kansas once a month, to meet the primary care needs of rural populations. Dr. Almenoff further testified regarding use of televideo to provide for specialty services: "if you are in a clinic out in Western Kansas and you had an x-ray in the system, I can see the x-ray in Kansas City. I can talk to the provider to discuss care and treatment."[333] Written testimony from Congressman Lane Evans stated, "The Central Market might consider putting in primary care services in one of the under-served rural counties in Missouri, northeast of Columbia, to create better access for these veterans in addition to the veterans of Pike County, Illinois. Undoubtedly, more veterans would seek primary care if such services were more accessible."[334] Testimony from stakeholders reflected support of additional access points for CBOCs, though there was concern about contracting for providers versus use of VA-staffed clinics.

Commission Findings

1. No proposed CBOCs were recommended to be included in priority group one. While in-house expansions and expansions at existing CBOCs will address increased workload, these actions will not improve access to primary care or address the distances veterans must travel for care.
2. Access to primary care in the Eastern and Western markets is below the CARES 70 percent standard.
3. All three markets are projected to have large increases in primary and specialty care workload.
4. VISN 15 is using televideo and other technology to address access to care issues in rural areas in Kansas.

Commission Recommendations

1. The Commission concurs with expansion of in-house services, new construction, space conversion, and utilization of community contracts to address capacity gaps for outpatient care. However, it notes that substantial access gaps and many of the capacity gaps are unlikely to be resolved without additional sites of care.

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[333] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 26.

[334] Lane Evans, United States Congress, Written Testimony submitted at the Leavenworth, KS, Hearing on August 18, 2003, page 2.

2 The Commission recommends that:[335]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

V Excess VA Property/Enhanced Use Lease for Historic Buildings at Leavenworth

DNCP Proposal

"The Network is developing a project at the Leavenworth campus that would rehabilitate 39 historic buildings for mixed use, including an assisted living facility. In addition, there would be an expansion of the Leavenworth National Cemetery. The second project is the out-leasing of approximately 2.5 acres of land to a commercial developer in exchange for the construction of a parking garage adjacent to the St. Louis-John Cochran facility."

[335] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

At both the site visit and the public hearing, there was discussion of possible EUL options for the Leavenworth campus. As Dr. Almenoff testified at the Leavenworth hearing:

> It is still in development. What they are planning on doing is through a grant from the Historical Society, which I think is about $50 to $75 million, they will be renovating anywhere between 37 and 39 of the current buildings that we have on the campus that we originally had on slate for demolition. With those specific enhancements and redevelopment of those buildings, an assisted living program would be developed which veterans would have a priority to get into. In addition, it's really going to be multi-use.[336]

Several stakeholders encouraged VA to pursue this opportunity, though they noted the EUL process is problematic. It was noted that VA does not have a definition for assisted living facilities, which could affect using this campus for that purpose. "Although no commitment to an operator of such senior facilities has been made (including assisted living facilities) this remains a service that fits well with several of these historic buildings."[337] Additional support from stakeholders revealed community involvement and partnering with VA in use of some of the Leavenworth campus buildings. There is concern, however, that there is no demonstrable plan for funding. Plans rely on an historical society to provide a grant for $50 to $75 million in order to move forward.

Commission Findings

1. The Leavenworth community supports the proposed project to renovate vacant buildings and create an assisted living facility for area residents including veterans.
2. The Leavenworth EUL proposal makes beneficial use of buildings no longer suitable for VA's mission while removing VA's current operating costs and providing revenue to VA to enhance services.
3. There is no demonstrable plan for funding. Plans rely on an historical society to provide a grant for $50 to $75 million in order to move forward.
4. VA does not have either a policy or guidelines that specifically address assisted living.

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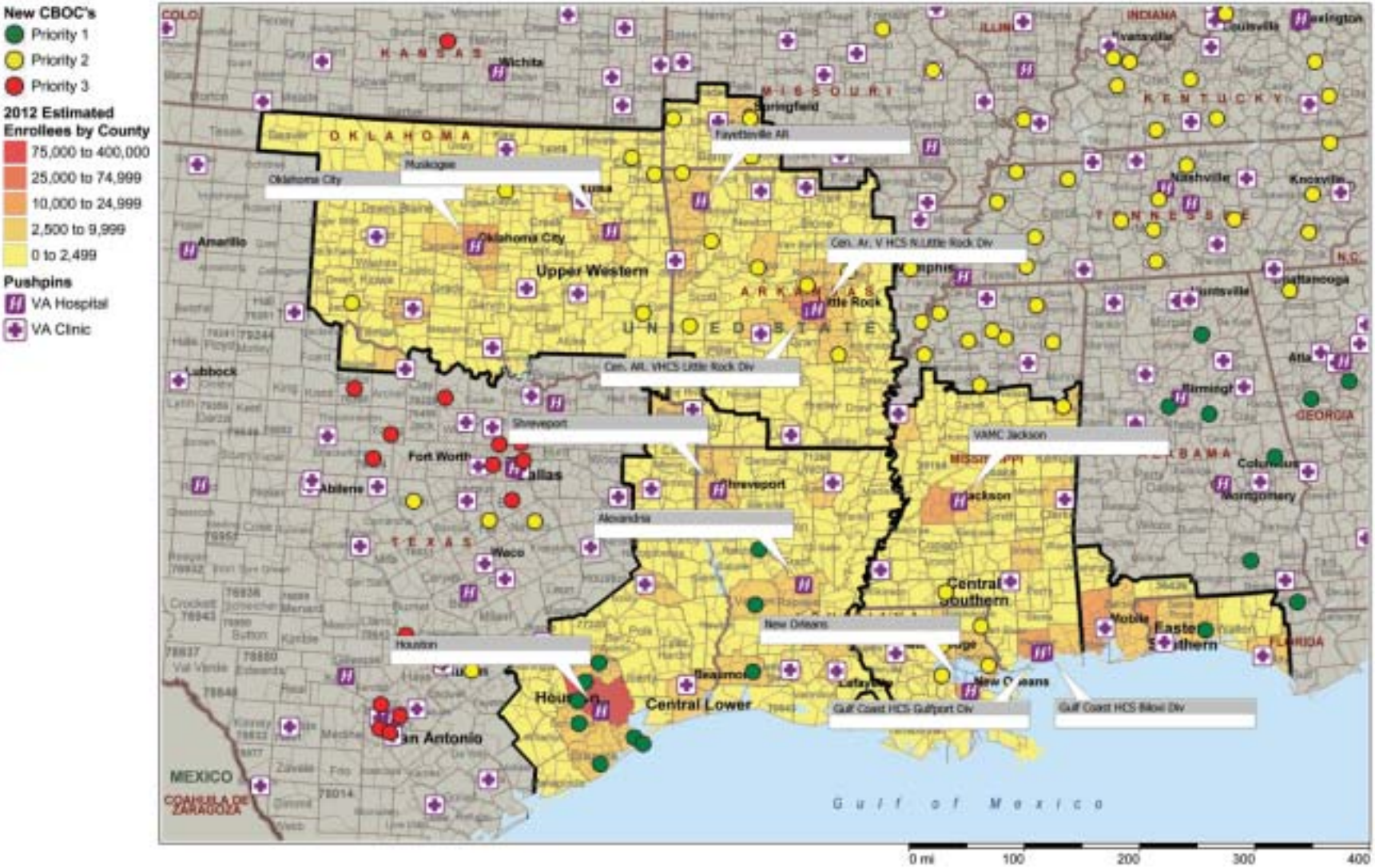
[336] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 31.

[337] Richard C. Gervasini, VALOR, Written Public Comment on VISN 15, submitted August 27, 2003.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to pursue an EUL, including the assisted living project, at the Leavenworth campus.
2. The Commission recommends that VA develop a viable plan for funding this proposal.
3. The Commission further recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

VISN 16 – South Central VA Health Care Network



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VISN 16, South Central VA Health Care Network

VISN Overview

VISN 16, South Central VA Health Care Network, is an integrated, comprehensive health care system that provided health care services to 382,000 of the 574,000 veterans enrolled in VA's health care system in FY 2003.[338] Geographically, this VISN spans nearly 170,000 square miles.

With a VA staff of 14,869 FTEs,[339] VISN 16 delivers health care services through ten medical centers, 30 CBOCs, seven nursing homes, and two domiciliary units. Additionally, VA operates 11 Vet Centers in VISN 16's catchment area. The VISN includes all or part of Florida, Alabama, Mississippi, Louisiana, Arkansas, Missouri, Oklahoma, and Texas.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for the veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify levels of need for services in VISN 16.

VISN 16	FY 2001	FY 2012	FY 2022
Enrollees	482,234	543,624	510,862
Veteran Population	1,917,259	1,670,716	1,459,861
Market Penetration	25.15%	32.54%	34.99%

For the CARES process, VISN 16 was divided into four markets: Central Lower Market (*facilities:* Houston, TX, and Alexandria and Shreveport, LA); Central Southern Market (*facilities:* New Orleans, LA, and Jackson, Gulfport, and Biloxi, MS); Upper Western Market (*facilities:* Oklahoma City and Muskogee, OK, and Fayetteville, Little Rock, and North Little Rock, AR); Eastern Southern Market (*facilities:* none).

[338] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[339] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited five sites and conducted three public hearings in VISN 16. The Commission received 3,090 comments regarding VISN 16.

- *Site Visits:* Biloxi and Gulfport on July 2; Muskogee on July 22; and Little Rock and North Little Rock on September 3.
- *Hearings:* Muskogee on August 22; Biloxi on August 26; and Shreveport on August 27.

Summary of CARES Commission Recommendations

I Consolidation/Realignment – Gulfport

1. The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life cycle cost analysis for the Gulfport campus.
2. The Commission recommends that there be a clear commitment from DoD for the utilization of Keesler Air Force Base (AFB) as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing health services.
3. The Commission concurs with the DNCP proposal to develop enhanced use lease (EUL) opportunities at Gulfport.
4. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-237)

II Small Facility – Muskogee

1. The Commission concurs with the DNCP proposal to maintain the inpatient medicine program at Muskogee. The Commission recommends that a more thorough study be conducted of meeting health care needs of the population through the Muskogee VAMC versus using community resources in the Muskogee/Tulsa area. A target date should be set for completion of this study. In the short term, inpatient medical services should be sustained. A decision to expand inpatient psychiatry should consider results of the study.

2 The Commission concurs with the DNCP proposal to close inpatient surgery and ICU beds at Muskogee and that ambulatory surgery should continue with surgery observation beds available.

(see page 5-240)

III Inpatient Care and VA/DoD Sharing

1 The Commission concurs with the DNCP proposal regarding VA/DoD sharing in the Eastern Southern Market with Pensacola Naval Hospital and Eglin AFB to provide inpatient services.

2 The Commission recommends contracting in the community to ensure essential inpatient care in the underserved Eastern Southern Market.

3 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as having the availability of trained staff to negotiate cost-effective contracts.

4 The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care from veterans in the Florida Panhandle.

(see page 5-243)

IV Outpatient Care

1 The Commission concurs with the DNCP proposals to add CBOCs in VISN 16 to resolve access to primary care gaps as well as gaps in capacity to meet demand for outpatient services.

2 The Commission recommends that:[340]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

[340] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-245)

V Special Disability Programs – Blind Rehabilitation Center

1 The Commission concurs with the DNCP proposal to establish a blind rehabilitation center (BRC) in Biloxi. The Commission recommends further analysis to determine the size of the center.

(see page 5-248)

VI Special Disability Programs – Spinal Cord Injury Center

1 The Commission concurs with the DNCP proposal to establish a 30-bed Spinal Cord Injury (SCI) Center in VISN 16, but does not concur with locating it at North Little Rock.

2 The Commission recommends that VA further study where an SCI Center should be located, taking into consideration referral patterns and excess capacity at the closest SCI Centers.

(see page 5-249)

VII Excess VA Property

1 The Commission concurs with the DNCP proposal for an EUL cooperative arrangement to construct a high-rise medical arts building at the Houston VAMC.

2 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-250)

Consolidation/Realignment – Gulfport

DNCP Proposal

"Gulfport's current patient care services will be transferred to the Biloxi campus and possibly Keesler AFB. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility or other compatible uses to benefit veterans. Any revenues or in-kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Close Gulfport division and enter into an enhanced use leasing agreement for the majority of the property. Enter into a sharing agreement for provision of clinical services with Keesler Air Force Base.
3. *Alternative 1:* Close Gulfport division and enter into an EUL for the majority of the property. Construct new facilities at Biloxi to accommodate patient workload from Gulfport and Keesler AFB, and new expanded programs from the CARES planning initiatives.
4. *Alternative 2:* Close Gulfport and enter into an EUL agreement for the majority of the property. Enter into a sharing agreement for provision of clinical services with Keesler AFB. Additional space will be provided at Biloxi via minor and nonrecurring maintenance (NRM) construction.

Commission Analysis

The Gulfport and Biloxi VAMCs are located eight miles apart, and their services have been consolidated for more than 30 years. The DNCP would provide for additional consolidation of inpatient care by maximizing the use of vacant space at Biloxi to construct new facilities to absorb Gulfport's inpatient workload. Further, because of the close proximity of the two campuses and the enhanced services, neither veterans, veterans' families, nor VA employees would be negatively impacted.[341]

Services at the Biloxi VAMC consist of 45 internal medicine beds (average daily census [ADC] 33), 12 surgery beds (ADC 8), a 171-bed domiciliary facility (ADC 148), 104 nursing home beds (ADC 99), and 20 intermediate care beds (ADC 18). Additionally, the Biloxi VAMC provides outpatient primary, specialty care, and mental health services.[342]

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[341] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 16.
[342] VSSC KLF Menu Database, *Bed Control, Occupancy Rates,* and *CBOC Workload and VAST Report*.

Services at the Gulfport VAMC consist of 144 inpatient psychiatry beds (ADC 67) and 56 nursing home beds (ADC 48). Outpatient primary, specialty care, and mental health services are provided as well.[343]

The Gulfport campus encompasses approximately 90 acres, 50 of which are desirable beachfront property. While touring the Gulfport campus in July, Commissioners learned that many buildings are of historical significance. However, they also learned that many of these historic buildings are vacant or used only for storage. The VISN's market plan includes long-term EUL agreements that would preserve these historic buildings but provide for appropriate reuse of the grounds.

Keesler AFB is likewise only a few miles from the Gulfport VAMC and actually abuts the Biloxi VAMC. Presently, VA provides inpatient psychiatric health care to Keesler's active duty military personnel with non-adjustment/stress-type mental health illnesses. During the Commission's site visit in July, Brigadier General David Young indicated that his primary goal through collaboration with VA is to support VA's infrastructure by meeting veterans' acute hospitalization, surgery, and rehabilitation needs. In return, General Young would like to engage in joint clinical research with VA as well as joint psychiatric services.

VISN leadership provided testimony that moving to a single facility will have a positive impact on patients at Gulfport. Ms. Julie Cattelier, Director of the VA Gulf Coast Veterans Health Care System, testified:

> We believe that it is most critical to establish a single standard of care for our patients receiving mental health and long-term care, and that means that in the case of a medical crisis…they would receive exactly the same level of care and level of clinical support that any patient in a comprehensive health care system would receive.[344]

According to Dr. Robert Lynch, Director of VISN 16, "Veterans will not lose services. There will be more services here in the Biloxi/Gulfport area than there currently are."[345] Stakeholders at the public hearing and site visits were generally supportive of the consolidation. The proposed timeline for implementing this closure is FY 2009.

The VISN realignment proposal contained a life cycle cost analysis with some inconsistencies, including $44.6 million in new construction and renovation in the 100 Percent Contracting Alternative. If the costs are adjusted to correct for that error, the four alternatives to the Status quo are close in net present value.

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[343] VSSC KLF Menu Database, *Bed Control, Occupancy Rates,* and *CBOC Workload and VAST Report*.

[344] Julie Cattelier, VA Gulf Coast Veterans Health Care System Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 31.

[345] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 16.

The preferred alternative would require $60.5 million in new construction and renovation and would achieve a net present value savings of $436.8 million. Although the net present value in excess of $400 million is cited, the proposal states that enhanced lease revenue of $44 million is expected and cost savings at Gulfport from reductions in staff and operating costs would save another $48 million. Explanations for monetary savings are confusing if non-existent. A more thorough life cycle cost analysis must be completed.[346]

Commission Findings

1. The Gulfport and Biloxi VAMCs are 8 miles apart.
2. The Gulfport Division has 90 acres, 50 of which are desirable beachfront.
3. New construction is needed for Biloxi to absorb Gulfport's workload.
4. The life-cycle cost analysis in the realignment proposal contains inconsistencies.
5. The VISN is currently in discussions with Keesler AFB to assess feasibility of entering into a sharing agreement to resolve space issues at Biloxi.
6. VISN leadership and stakeholders support consolidation.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life-cycle cost analysis for the Gulfport campus.
2. The Commission recommends there be a clear commitment from DoD for the utilization of Keesler AFB as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing DoD and VA health services.
3. The Commission concurs with the DNCP proposal to develop EUL opportunities at Gulfport.
4. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

[346] Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

II Small Facility – Muskogee

DNCP Proposal

"Muskogee maintains its inpatient medicine program, with possible expansion of inpatient psychiatry. Inpatient surgery and ICU beds are recommended for closure due to low volume of selected major procedures. Ambulatory surgery would continue with surgery observation beds available."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

Located in the Upper Western Market of VISN 16, the Muskogee VAMC is a primary and secondary level medical center providing services in medicine, surgery, and mental health. The Muskogee VAMC has been in operation since 1923 and has, in recent years, undergone extensive renovations to upgrade inpatient medicine and surgery services and outpatient primary and specialty care services.

The Muskogee VAMC was probably overbuilt. This is evident by 33,709 square feet of vacant space.[347] This situation would be exacerbated if surgical beds were closed vacating an additional 100,000 square feet.

Muskogee's inpatient ADC has been constant at 44. While the total number of patients treated has increased, ADC is projected to decline to 36 in FY 2012, and to 27 in FY 2022.[348]

The Upper Western Market is projected to need 84 additional acute psychiatric beds by FY 2012. Currently, there are ten acute psychiatric beds at the Fayetteville VAMC, 30 acute psychiatric beds at the Oklahoma City VAMC, and 50 acute psychiatric beds at the Little Rock campus. The Muskogee VAMC does not currently have any inpatient acute psychiatry beds.[349]

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[347] Management of CARES Space Report received from the VISN Support Services Center (VSSC) dated September 2, 2003.
[348] Appendix D, *Data Tables*, page D-66.
[349] VSSC KLF Menu Database, *Bed Control, Occupancy Rate.*

Approximately 4,800 patients are provided outpatient mental health services at the Muskogee VAMC and the Tulsa CBOC.[350] The number of mental health patients in the Muskogee/Tulsa area has been increasing steadily in the past few years (e.g., by 10 percent from FY 2001 to FY 2002). When these patients require acute psychiatric hospitalization, they are treated on an emergent basis in private facilities in the Tulsa area or more commonly transported to the Oklahoma City VAMC 140 miles away. The VISN Director testified that an average of five patients in the Oklahoma City VAMC's acute psychiatric unit are from Muskogee/Tulsa. VISN leadership indicated that as part of the proposal to maintain the inpatient program at the Muskogee VAMC, the VISN would reallocate inpatient psychiatry workload to the Muskogee VAMC, which currently does not have inpatient psychiatry.[351]

Inpatient psychiatry workload data for these VAMCs reflect the following: Fayetteville has ten inpatient psychiatry beds. Little Rock has 85 acute and long-term psychiatric beds. In FY 2003, there was a slight ADC increase for Fayetteville to 11. Little Rock had an increase to 72. With operating beds of 39, Oklahoma City's ADC was 37 in FY 2000, 42 in FY 2001, 43 in FY 2002, and 45 in FY 2003.[352] The CARES inpatient psychiatry projection data do not project inpatient bed needs for each facility.[353]

The VISN plans to meet the projected demand for the 84 additional acute inpatient psychiatric beds in the Upper Western Market by increasing the size of the three current units. This is particularly appropriate at Fayetteville, which has experienced a 22.5 percent increase from FY 2001 to FY 2002.[354] The VISN also plans to establish a new, small acute inpatient psychiatric unit at the Muskogee VAMC. This would provide easier access for the growing population in the Muskogee/Tulsa area. While the Muskogee unit would be small, it would be similar to Fayetteville.

The VISN Director indicated that Muskogee's current inpatient space, which was configured for medical/surgical units, is not properly set up to handle psychiatric patients. Minor renovations would be required.

There are 12 non-VA, JCAHO-accredited medical facilities within 60 minutes of the Muskogee VAMC. Six offer inpatient psychiatric care and have excess capacity.

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[350] VSSC KLF Menu Database, *CBOC Patients Receiving Mental Health Services*.

[351] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Muskogee, OK, Hearing on August 22, 2003, page 18.

[352] VSSC KLF Menu Database, *Bed Control, Occupancy Rate*.

[353] VSSC CARES Portal, VISN 16 Analysis: Psychiatry Inpatient Needs in the Upper Western Market, South Central VA Health Care Network.

[354] Department of Veterans Affairs National Mental Health Performance Monitoring System, FY 2002 Report (Table 5.7).

At the Muskogee hearing, Commissioners and witnesses discussed the growing veteran population in Tulsa. The Tulsa CBOC provided services to 14,255 patients in FY 2003, approximately half of the patients seen at the outpatient clinic at Muskogee VAMC and its other CBOC in McAlester, OK.[355] The Commission discussed that a hospital in Tulsa would be ideal. However, the Muskogee facility provides inpatient care for the Tulsa population. If the Muskogee inpatient services were closed, the next nearest VAMC is Oklahoma City, 140 miles away.

Commission Findings

1. The Muskogee VAMC has been underutilized.
2. Muskogee has significant vacant space, and closing surgical beds would increase the amount of vacant space.
3. Muskogee's inpatient workload has been constant for the past few years. Medicine workload projections indicate that 36 beds would be needed in FY 2012 and 27 beds would be needed in FY 2022.
4. There are 12 non-VA, JCAHO-accredited medical facilities within 60 minutes of the Muskogee VAMC. Six offer psychiatric care and have excess capacity.
5. Adding a small inpatient psychiatry unit at the Muskogee VAMC would be a reasonable part of a broader plan to increase inpatient psychiatry capacity in the Upper Western Market to meet projected demand for 84 additional beds by FY 2012.
6. Renovations would be needed at the Muskogee VAMC and the other three medical centers in the Upper Western Market to accommodate increases in inpatient psychiatry workload.
7. Tulsa is the second largest veteran catchment area in the Upper Western Market and VA operates a Tulsa CBOC. This CBOC and Muskogee facilities provide outpatient mental health services to approximately 4,800 patients annually. When these patients require acute inpatient psychiatry care, they are hospitalized in Tulsa under contracted care or are transported to the Oklahoma City VAMC 140 miles away.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to maintain the inpatient medicine program at Muskogee. The Commission recommends that a more thorough study be conducted of meeting

[355] VSSC KLF Menu Database, *CBOC Workload and VAST Data*.

health care needs of the population through the Muskogee VAMC versus using community resources in the Muskogee/Tulsa area. A target date should be set for completion of this study. In the short term, inpatient medical services should be sustained. A decision to expand inpatient psychiatry should consider results of the study.

2 The Commission concurs with the DNCP proposal to close inpatient surgery and ICU beds at Muskogee and that ambulatory surgery should continue with surgery observation beds available.

III Inpatient Care and VA/DoD Sharing

DNCP Proposal

"The acute hospital gap will be met in Eastern Southern market through a sharing agreement with Eglin AFB, adding a point of care in Panama City, continued contracting with the University of South Alabama in Mobile and expanding services currently provided by Pensacola Naval Hospital via a joint venture."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Eastern Southern Market is the only market in VISN 16 without a VA medical center. Only four percent of the veterans in this market meet the CARES hospital access criteria. The requirement is 65 percent.[356] Geographically, this market area includes the western portion of the Florida Panhandle. The eastern portion of the Panhandle is in VISN 8 and is also experiencing gaps in access to hospital care. Both the VISN 16 and 8 leaderships testified as to the need to address access to hospital care in this area.[357]

VISN 16 hearing testimony and access data highlight the underserved nature of this population and the importance of continuing to partner with the DoD on inpatient care. Congressman Jeff Miller testified, "Florida's First Congressional District represents what is arguably the most striking example of access to care challenges in the nation. … I am pleased that CARES recognizes the Federal medicine partnering opportunities that already exist…and the potential savings through sharing by the expansion of current agreements."[358]

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[356] VISN 16, CARES Market Plan, submitted April 15, 2003.

[357] For more information on the Panhandle of Florida, please see the report on VISN 8.

[358] The Honorable Jeff Miller, Congressman, Written Testimony submitted at the Biloxi, MS, Hearing on August 26, 2003 page 1, available from [*http://www.carescommission.va.gov/Documents/BiloxiPanel3.pdf*].

During the Commission's site visit to Biloxi and Gulfport, stakeholders shared their concerns about the distances veterans in the Eastern Southern Market must travel to receive VA care. VISN leadership indicated that inpatient care of veterans from this market area is provided in Biloxi and Gulfport, unless community-based services are available. This means that some veterans may travel 6 to 8 hours to the nearest VAMC.

Additionally, 13 VA/DoD sharing agreements are in place between the Gulf Coast Veterans Health Care System and six military facilities. More sharing agreements are in various planning stages. Among these is a plan to expand arrangements with the naval hospital (Correy Station) in Pensacola, Florida. At the time of the Commission's visit, this hospital had 60 beds with an average daily census of 25. In addition to overnight stays, this facility has a large volume of same day surgery and other procedures that occupy their beds.[359] Further, the VISN currently has an agreement with Eglin AFB to provide outpatient primary care. VISN leadership would like to expand this agreement to include inpatient services.[360]

Commission Findings

1. Only 4 percent of veterans living in the Eastern Southern Market meet CARES access standards for inpatient care.
2. The Florida Panhandle is divided between VISNs 16 and 8. Both VISNs have similar gaps in access to hospital care for veterans in the Panhandle.
3. The Eastern Southern Market relies on DoD collaboration and contracting for inpatient care.
4. VISN 16 currently has several sharing agreements with DoD.

Commission Recommendations

1. The Commission concurs with the DNCP proposal regarding VA/DoD sharing in the Eastern Southern Market with Pensacola Naval Hospital and Eglin AFB to provide inpatient services.
2. The Commission recommends contracting in the community to ensure essential inpatient care in the underserved Eastern Southern Market.
3. The Commission recommends that:
    a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

[359] VISN 16, Site Visit Report, Biloxi-Gulfport, July 2, 2003, page 3.
[360] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 19.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

4 The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care from veterans in the Florida Panhandle.

IV Outpatient Care

DNCP Proposals

"*Primary Care* – VISN 16 has a primary care access gap in all four markets and an acute hospital gap as well in the Eastern Southern market.[361] The plan includes as a high implementation priority category, 11 CBOCs for the Eastern Southern and Central Lower markets. The National CARES Plan attempts to balance meeting national access guidelines while ensuring the current and future viability of its acute care infrastructure. Consequently, while new access points in the Upper Western and the Central Southern markets in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. *Outpatient Services* – Increasing demand for primary care and specialty care in all four markets will be met by the addition of 11 new CBOCs in the Eastern Southern and the Central Lower markets, expansion of existing CBOCs via contract, lease, and new construction. In addition, it will be met by reconfiguration of space at the VAMCs via renovation, conversion of vacant space, and new construction."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Significant gaps were found in access to outpatient primary care in all four markets in VISN 16. In the Upper Western Market area, only 54 percent of veterans met the access to primary care criteria (requirement is 70 percent). The Central Lower Market shows that only 55 percent of veterans met the access criteria. The Eastern Southern Market has a primary care access gap of 60 percent, and the Central Southern Market has a primary care access gap of 58 percent.[362]

[361] The gap in acute hospital care in the Eastern Southern Market is discussed in the Inpatient Access section.
[362] VISN 16, CARES Market Plan, submitted April 15, 2003.

In addition to access for primary care, the CARES workload projections indicate increased demand for outpatient specialty care in all of VISN 16's markets. In the Central Lower Market, outpatient care is projected to increase by 95 percent in FY 2012 and 80 percent in FY 2022. In the Central Southern Market, demand is projected to increase by 100 percent over the FY 2001 baseline in FY 2012, decreasing to 87 percent in FY 2022. For the Eastern Southern Market, demand is projected to be 159 percent over the baseline by FY 2012 and 154 percent in FY 2022. Additionally, the Upper Western Market's demand is projected to be 103 percent in FY 2012, decreasing to 86 percent in FY 2022. These data indicate the increased demand for outpatient specialty care will primarily occur between now and FY 2012.[363]

In response to the primary care access gaps and the increasing demand for specialty services, the VISN proposed adding 16 additional CBOCs, 11 of which are included in the DNCP's priority group one. These are for the Central Lower and the Eastern Southern Markets. The CBOCs slated for the Central Lower Market would accommodate 31,000 new enrollees and would increase access to above 70 percent.[364] Further, one of them would include a joint venture site at Fort Polk.[365] Dr. Robert Lynch, VISN 16 Director, testified, "We are proposing a major clinical addition at the Overton Brooks VA Medical Center in Shreveport" to address the outpatient specialty care in the Central Lower Market.[366] In the Eastern Southern Market, the proposed new CBOCs also would increase access to above 70 percent. VISN leadership anticipates similar enhancements to outpatient care services in the other market areas.[367]

The Commission is concerned that the DNCP fails to address projected workload gaps in outpatient mental health services in VISN 16. In the Eastern Southern Market, there is projected to be a gap of 89 percent by FY 2012 and 63 percent by FY 2022. There are also substantial projected gaps by FYs 2012 and 2022, including in the Central Lower Market (48 and 21 percent, respectively) and the Upper Western Market (42 and 16 percent, respectively), which again are not addressed in the DNCP.[368]

The VISN currently has sharing agreements with DoD to provide primary care services. Agreements exist at Tyndall and Eglin AFBs in Florida, and the VISN would like to establish a CBOC at Eglin AFB.[369]

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[363] Appendix D, *Data Tables*, page D-63.

[364] VSSC CARES Portal, *Access Planning Initiatives for the Central Lower Market.*

[365] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Shreveport, LA, Hearing on August 21, 2003, page 17.

[366] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Shreveport, LA, Hearing on August 21, 2003, page 15.

[367] Robert Lynch, MD, VISN 16 Director, Written Testimony submitted at the Biloxi, MS, Hearing on August 26, 2003, page 3, available from [*http://www.carescommission.va.gov/Documents/BiloxiPanel2pdf*].

[368] Appendix D, *Data Tables*, page D-63.

[369] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 18.

Commission Findings

1. The VISN proposed a total of 16 new CBOCS to resolve gaps in outpatient care services. Eleven CBOCs for the Central Lower and Eastern Southern markets of VISN 16 are in the DNCP's priority group one.
2. The Central Southern and Upper Western markets have access and workload gaps in primary and specialty care, but proposed CBOCs are not in priority group one.
3. A clinical addition is proposed in Shreveport to address increased outpatient specialty care needs in the Central Lower Market.
4. There are large projected gaps in outpatient mental health care, which have not been addressed in the DNCP.
5. The VISN has a sharing agreement with DoD to provide outpatient care to veterans and would like to establish a CBOC at Eglin AFB, Florida.

Commission Recommendations

1. The Commission concurs with the DNCP to add CBOCs in VISN 16 to resolve access to primary care gaps as well as gaps in capacity to meet demand for outpatient services.
2. The Commission recommends that:[370]
   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   e. Whenever feasible, CBOCs provide basic mental health services.
   f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

[370] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

V Special Disability Programs – Blind Rehabilitation Center

DNCP Proposals

"*Appendix A, Executive Summary for VISN 16* – Build a new 20-bed blind rehabilitation center at Biloxi. *Chapter 7: Enhancing Access to Special Disability Programs* – 36-bed blind rehabilitation center in Biloxi."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP sets forth two proposals relating to the number of blind rehabilitation beds recommended for VISN 16. Current estimates indicate that approximately 2,700 veterans who are legally blind are enrolled in VISN 16. CARES data indicate the VISN will need 36 beds for blind patients in FY 2012 and 37 beds in FY 2022. Currently, patients are referred to Birmingham, AL (VISN 7), Tucson, AZ (VISN 18), and Waco, TX (VISN 17), as VISN 16 does not have a BRC. According to the hearing record, the VISN leadership reviewed their referral patterns and expects to continue referring to VISN 17 for veterans residing in the western portion of VISN 16. However, they believe that the balance of veterans in VISN 16 would be better served by a BRC in Biloxi.[371]

Commission Findings

1. VISN 16 does not currently have a BRC.
2. Blind veterans residing in VISN 16 are referred to one of three other VISNs for care.
3. The DNCP indicates that VISN 16 will need 36 beds for blind veterans by FY 2012 and 37 beds by FY 2022.

Commission Recommendation

The Commission concurs with the DNCP proposal to establish a BRC in Biloxi. The Commission recommends further analysis to determine the size of the center.

[371] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing, on August 26, 2003, page 15.

VI Special Disability Programs – Spinal Cord Injury Center

DNCP Proposals

"*Appendix A Executive Summary for VISN 16* – Construct a new 25-bed Spinal Cord Injury (SCI) Center at the Central Arkansas Healthcare System-North Little Rock division. *Appendix Q* – 25 to 34 bed SCIU at North Little Rock."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP sets forth two proposals relating to the number of SCI beds proposed for VISN 16. Appendix Q of the DNCP indicates that VISN plans recommend location of the SCI Center be at North Little Rock. Appendix Q proposes that this location be reconsidered and the VISN's choice justified.

In FY 2001, VISN 16 had 34 acute SCI beds. By FY 2012, acute bed projections indicate 74 beds would be needed, increasing to 90 beds by FY 2022. Further, in FY 2001, VISN 16 had nine long-term care (LTC) SCI beds. Projections indicate that by FY 2012, 128 LTC SCI beds would be needed, increasing to 155 in FY 2022.[372]

According to VISN leadership, North Little Rock was selected as the proposed location for the new SCI Center because this campus has significantly larger grounds and available space. The Commission notes, however, that the North Little Rock Division is not a tertiary care hospital. On the other hand, both the Little Rock Division and the Shreveport VAMC provide tertiary care. The Commission believes either of these hospitals would be a more appropriate location.

SCI occupancy data for VISN 16 indicate that the Houston VAMC (446 miles from North Little Rock) has 40 inpatient SCI beds and an ADC of 30 (74 percent). The next closest medical centers with inpatient SCI beds are the Memphis (138 miles) and Dallas (329 miles) VAMCs. The Memphis SCI Center has 70 beds with an ADC of 53 (76 percent occupancy rate). The Dallas SCI Center has 30 beds with an ADC of 22 (73 percent occupancy rate).[373]

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[372] Appendix Q, DNCP.
[373] VSSC KLF Menu Database, *Bed Control, Occupancy Rate,* as of the end of FY 2003.

VISN leadership indicated that a new SCI Center in VISN 16 might have a negative impact on inpatient units in Houston, Memphis, and Dallas based on referral patterns. Veterans' organizations voiced opposition to establishment of this center at North Little Rock, in favor of a more southern location collocated with a tertiary care VAMC.[374]

Commission Findings

1. SCI projection models indicate need for additional inpatient SCI beds in VISN 16.
2. SCI data for inpatient SCI Centers in Houston (446 miles), Memphis (138 miles), and Dallas (329 miles) indicate excess capacity.
3. North Little Rock does not have tertiary care services. However, the Little Rock Division and the Shreveport VAMC do provide tertiary care.
4. VISN leadership and veterans service organizations expressed concern about the placement of the SCI Center at North Little Rock, specifically due to the absence of tertiary care.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to establish a 30-bed SCI Center in VISN 16, but does not concur with locating it at North Little Rock.
2. The Commission recommends that VA further study where an SCI Center should be located, taking into consideration referral patterns and excess capacity at the closest SCI Centers.

VII Excess VA Property

DNCP Proposal

"Houston has the potential for an enhanced use lease cooperative arrangement with the private sector to construct a high-rise medical arts building."

DNCP Alternatives

None provided in the DNCP.

[374] VISN 16, Site Visit Report, Little Rock, AR, September 3, 2003.

Commission Analysis

In the Lower Central Market, only 55 percent of veterans meet the CARES travel guidelines for access to primary care. This market also identified a large increase in outpatient specialty care of 95 percent above the FY 2001 baseline by FY 2012 and 80 percent above baseline by FY 2022. An EUL was proposed to address the access gaps in primary and specialty care in the Houston area. Ed Tucker, VA Medical Center Director at Houston, testified that Houston has huge demands for services and that VA would need an additional 200,000 square feet of space. As a partial solution, the Houston VAMC is exploring a collaborative arrangement with its primary affiliate, Baylor College of Medicine, to build a 180,000 square foot ambulatory care center. Dr. Lynch, VISN 16 VISN Director, stated:

> The emphasis here is enhanced use. VA does not give up title to the land. We [use a] long-term 75-year lease. The scenario in Houston is the Baylor College of Medicine would build a large medical arts building with a couple of hundred thousand square feet of space for our use, which would cost us nothing but would be in the area of $40 million dollars… It's a benefit to the taxpayer.[375]

Commission Findings

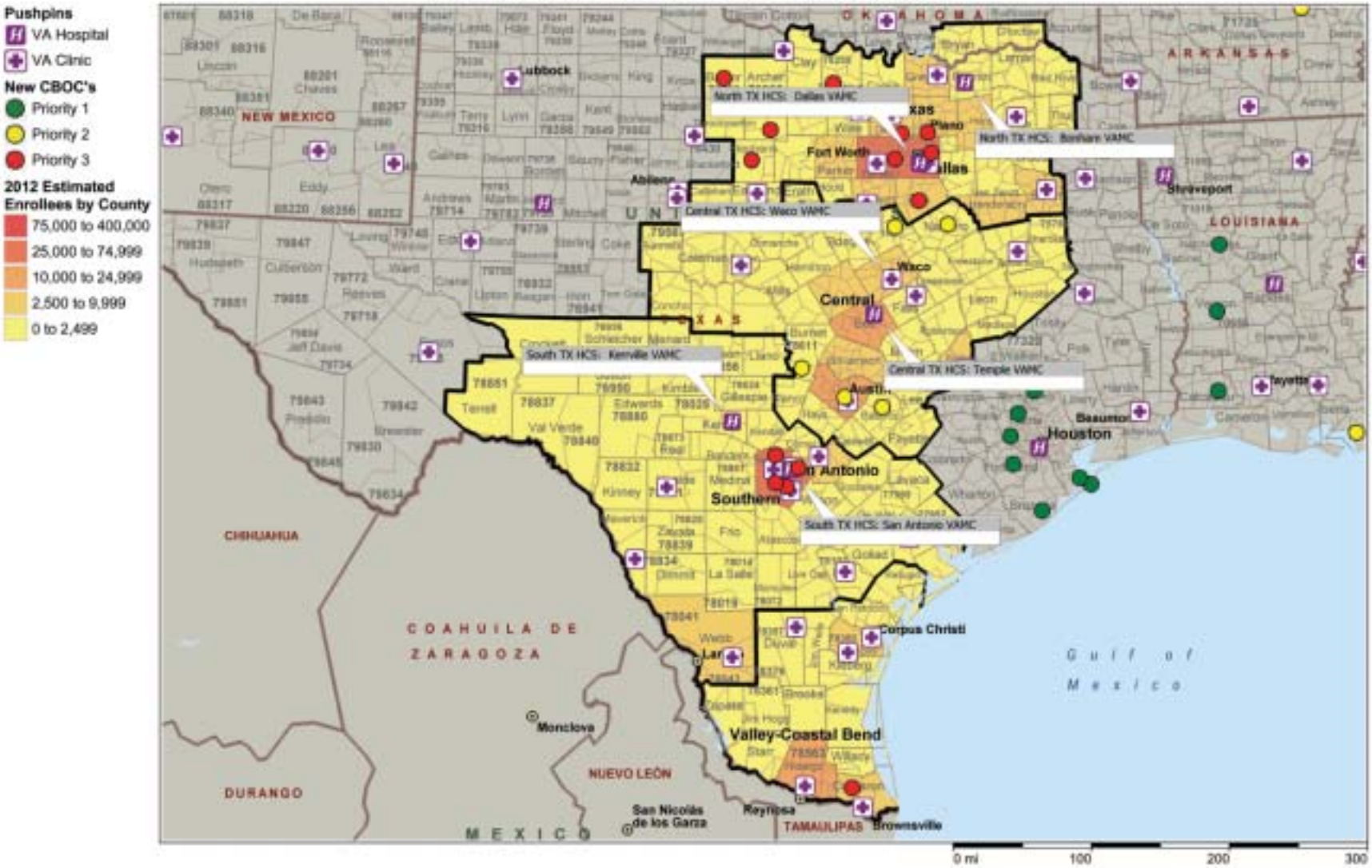
1. There is an access gap and an increasing demand for outpatient services in the Houston area.
2. An EUL agreement with Baylor College of Medicine on the Houston VAMC campus would provide additional space to meet this demand.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for an EUL cooperative arrangement to construct a high-rise medical arts building at the Houston VAMC.
2. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

[375] Robert Lynch, MD, VISN 16 Director, Transcribed Testimony form the Shreveport, LA, Hearing on August 27, 2003, pages 27-28.

VISN 17 – VA Heart of Texas Health Care Network



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VISN 17, VA Heart of Texas Health Care Network

VISN Overview

VISN 17, VA Heart of Texas Health Care Network, is an integrated, comprehensive health care system spanning 131,534 square miles and stretching from the Oklahoma border on the North, to the lower Rio Grande Valley in the South. Of the 1.1 million veterans in VISN 17, approximately 302,000 are enrolled in the VA health care system.[376] In FY 2003, VISN 17, with a staff of 8,582 FTEs,[377] provided health care services to approximately 193,000 unique patients who reside in 134 counties. The VISN delivers care through six medical centers, one large independent outpatient clinic in Austin, six nursing homes, three domiciliary, and 28 community-based outpatient clinics (CBOCs). Additionally, VA operates seven Vet Centers in VISN 17.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 17.

VISN 17	FY 2001	FY 2012	FY 2022
Enrollees	246,102	285,392	276,578
Veteran Population	1,075,173	952,546	843,631
Market Penetration	22.89%	29.96%	32.78%

For the CARES process, this VISN is divided into four markets: The North Market (*facilities:* Dallas and Bonham, TX); Central Market (facilities: Temple and Waco, TX); Southern Market (*facilities:* San Antonio and Kerrville, TX); and the Valley-Coastal Bend Market (*facilities:* none).

Information Gathering

The CARES Commission visited five sites and conducted two public hearings. The Commission received 35,457 public comments regarding VISN 17, with the majority addressing the Waco mission change.

- *Site Visits:* Kerrville VA Medical Center (VAMC) on July 14; San Antonio on July 15; Austin Outpatient Clinic on July 16; Temple VAMC on July 16; and Waco VAMC on July 16.
- *Hearings:* San Antonio on October 1; and Waco on October 3.

[376] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[377] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Summary of CARES Commission Recommendations

I Mission Change – Waco

1. The Commission concurs with the DNCP proposal to transfer services from the Waco campus to appropriate locations within the VISN as follows:
   - a A portion of acute care inpatient psychiatry to Austin;
   - b The balance of acute care and all the long-term inpatient psychiatry to the Temple VAMC; and
   - c PTSD residential rehabilitation services to the Temple VAMC, with no decrease in capacity.
2. The Commission does not concur with the DNCP proposal to transfer Waco nursing home services to the community.
3. The Commission recommends that: [378]
   - a Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c Freestanding LTC facilities should be permitted as an acceptable care model.
   - d Access for families of patients and clinical relationships between institutional and non-institutional LTC programs must be considered.
4. The Commission concurs with the DNCP proposal to transfer the blind rehabilitation center (BRC) from Waco, but recommends that the VISN determine an appropriate location taking into account access and the BRC's role as a regional rehabilitation referral center.
5. The Commission concurs that a new multi-specialty outpatient clinic be established in the Waco area.
6. The Commission recommends that time be provided for the transition to allow an orderly transfer with minimal disruption to patients and families and for the VISN to involve veterans, stakeholders, and the community in a plan for the Waco campus that is most beneficial to veterans.

(see page 5-257)

[378] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

II Mission Change – Kerrville

1. The Commission does not concur with the DNCP proposal to convert the Kerrville VAMC to a critical access hospital (CAH). VA should establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this description.
2. The Commission concurs with the DNCP proposal to transfer the Kerrville VAMC's acute inpatient services and recommends that the VISN contract with community health care providers for these acute inpatient services, including urgent care services, in lieu of or until space is available at the San Antonio facility.
3. The Commission recommends clarification of proposed construction and renovation costs at San Antonio.
4. The Commission concurs with the DNCP proposal that the nursing home and outpatient services remain at Kerrville.

(see page 5-265)

III Inpatient Care

1. The Commission concurs with the DNCP proposal to correct inpatient access gaps in the Central and Valley-Coastal Bend markets through contracting or leasing of beds in the local community.
2. The Commission concurs with the proposal to expand in-house services at the Dallas VAMC through construction and renovation.
3. The Commission recommends that:
   - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-269)

IV Outpatient Care

1. The Commission concurs with the DNCP proposal to expand services at current sites of care as proposed by the DNCP, but notes that this is not an adequate solution to the access and capacity gaps in the VISN.
2. In the Valley-Coastal Bend Market, the Commission concurs with moving the Brownville CBOC to Harlingen in affiliation with the University of Texas.
3. The Commission recommends that:[379]
   - a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e Whenever feasible, CBOCs provide basic mental health services.
   - f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-271)

V VA/DoD Sharing

1. The Commission concurs with the DNCP proposal that VISN 17 pursue collaborative and sharing opportunities with DoD.

(see page 5-274)

[379] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

Mission Change – Waco

DNCP Proposal

"Current services will be transferred to Temple and community contracts and leases used to provide these services. Current inpatient psychiatry services will be met primarily at Temple. The VISN will also lease 27 inpatient psychiatry beds in Austin. The CARES market-based demand data projected a need for 28-inpatient medicine and 10 inpatient surgery beds for the Austin submarket. Blind rehabilitation and a third of Waco's nursing home care services will be transferred to the Temple VAMC. The balance of nursing home care needs will be contracted out in the Waco Central Texas market area. Outpatient services will be moved to a new location more strategically placed to improve access for patients from both Waco and Marlin."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Inpatient and outpatient services at Waco continue, no inpatient psychiatric services in Austin or Temple.
3. *100 Percent Contracting*
4. *Alternative 1 [The VISN's preferred alternative]:* Inpatient psychiatric services moved to Temple and leased beds in Austin. Balance of nursing home beds will be contracted in the Waco community. Outpatient services provided off-campus.
5. *Alternative 2:* Inpatient psychiatric services moved to Temple and Austin, Outpatient services provided on Waco campus.

Commission Analysis

The Central Market's total veteran population is approximately 237,000, of which 72,000 are currently enrolled in the VA health care system. The Central Market has two active medical centers, Waco and Temple (Olin E. Teague Veterans' Center); the former Marlin VAMC now provides outpatient services only. These medical facilities come under the single management of the Director of the Central Texas Veterans Health Care System (CTVHCS). The CTVHCS provides a range of services to veterans in 32 counties through Temple's tertiary care medical center, the Waco VAMC, and six outpatient clinics.

In the CARES process, the VISN identified the Austin area as a sub-market in the Central Market. The Austin sub-market is the largest in the Central Market and is growing rapidly. It currently has a veteran population of approximately 109,000 and an enrollment of approximately 19,088, which represents 26 percent of the total market enrollment.[380] VA maintains a large outpatient clinic in Austin that provided care to 15,244 unique veterans during FY 2003.[381] A full array of primary care, specialty care, and mental health services is offered at the clinic.

Enrollment in the Austin sub-market is projected to increase 36 percent over the FY 2001 baseline by FY 2012 and to further increase to 56 percent over baseline by FY 2022.[382] The majority of the veterans in the Austin sub-market do not meet the CARES standard for access to hospital care.[383]

Built in 1932,Waco VAMC's campus encompassed 508 acres. Today, the medical center is located on 126 acres of VA property and has 30 buildings, seven of which are unoccupied, five of which are underutilized, and 29 of which are historically registered. While none are leased for commercial use, a portion of one building, 40,000 square feet of space, is leased to the VA Austin Finance Center. Of the total square footage at the Waco VAMC, 251,000 square feet is unoccupied and 49,000 square feet is underutilized.[384] This represents approximately 26 percent of the total space at the Waco VAMC. As VISN Director Tom Stranova testified:

> Well, currently…there is a large amount of unused space on the Waco campus, and that's approximately 250,000 square feet. So that we believe that we are carrying a lot of overhead in infrastructure that, if we can realign these services, we can continue to provide high-quality services, and the resources that are put out to support infrastructure that is not being used can be redirected to patient care. We can buy drugs and provide direct services.…We're operating at a loss. In fact, in terms of our annual budget, we do subsidize, and have been, the facilities in the Central Market. We take resources for the North and Central, from their budget, because do have underutilized assets.[385]

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[380] Jeff Milligan, Staff Assistant to the Director, VISN 17 CTVHCS, January 13, 2004, Email Response to January 12, 2004, *Austin Sub-market Enrollment* inquiry.

[381] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

[382] Jeff Milligan, Staff Assistant to the Director, VISN 17 CTVHCS, January 13, 2004, Email Response to January 12, 2004, *Austin Sub-market Projection Data* inquiry.

[383] Jeff Milligan, Staff Assistant to the Director, VISN 17 CTVHCS, January 13, 2004, Email Response to January 12, 2004, *Austin Sub-market Enrollment* inquiry.

[384] Jeff Milligan, Staff Assistant to the Director, VISN 17 CTVHCS, January 5, 2004, Email Response to January 5, 2004, *Waco Unused Space* inquiry.

[385] Tom Stranova, VISN 17 Director, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, pages 47-48.

The Waco VAMC is primarily an inpatient psychiatric care hospital. At its peak, it had more than 2,000 beds. In FY 2003, it had 346 inpatient beds, with an average daily census (ADC) of 214.[386] Commissioners learned during the site visit to Waco that the buildings are in good repair, but that the facility has a declining referral base and a markedly decreased need for space. The Waco VAMC currently provides all of the acute and long-term psychiatric inpatient care for the Central Market. Its inpatient psychiatry ADC of 128 includes both short-term acute stays and a substantial number of longer-term patients.[387] At the end of FY 2003, 71 patients had been in a psychiatric bed longer than six months, and 48 of these 71 patients had been in a psychiatric bed more than one year.[388] Waco also is the site for the Central Market's specialized Residential Rehabilitation Program for patients with Post Traumatic Stress Disorder (PTSD; ADC 17), the inpatient blind rehabilitation center (BRC; ADC 14), and a nursing home with an ADC of 58.[389]

The Waco VAMC also provides a full range of outpatient services, including services for the seriously mentally ill. The VISN leadership testified that there would be no impact on the 94 percent of patients currently using Waco for outpatient services since a proposed new outpatient clinic would remain in the Waco area.[390]

Located approximately 34 miles south of the Waco VAMC is the Temple VAMC. Built in the early 1940s, with additions over the years, Temple is a tertiary medical center that provides a full range of patient care services except for inpatient psychiatry. It is affiliated with the Texas A&M Medical School. It is also the site of a State Veterans Home. There are 40 buildings with a total of 1.2 million square feet on 166 acres. The Temple VAMC has the capacity to address the DNCP's proposals to relocate programs from the Waco campus and inpatient and specialty services are available at Temple to support those programs.

The DNCP proposes transferring all inpatient psychiatric services off the Waco campus. Twenty-seven of the 107 acute psychiatric beds would be transferred to Austin to meet the acute care needs of veterans residing in the Austin metropolitan area. Mr. Tom Stranova, VISN 17 Director, testified at the Waco hearing:

> To meet the inpatient health care needs of veterans in the Austin sub-market, the Draft National CARES Plan calls for approximately 27 medicine beds, 10 surgical beds, and 27 psychiatric beds in the Austin sub-market. This can be accomplished by lease, lease-to-own, or new construction.[391]

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[386] Patient Treatment File, Gains and Losses Report.
[387] Patient Treatment File, Gains and Losses Report.
[388] Department of Veterans Affairs, *National Mental Health Performance Monitoring System*, FY 2003, Table 3-14.
[389] Michael Dunfee, VISN 17 Strategic Planner, January 27, 2004 Email Response to January 23, 2004, *Waco ADC* inquiry.
[390] Tom Stranova, VISN 17 Director, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, pages 34-36.
[391] Tom Stranova, VISN 17 Director, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, page 33.

This transfer would bring inpatient care in the market in line with clinical best practices, as compared to now where currently Austin area patients who require acute inpatient psychiatric care are transferred 105 miles to the Waco VAMC.

The majority of the acute psychiatric beds would transfer to the Temple VAMC, where they would be more centrally located in the market, where essential inpatient medical services can be more readily provided, and where the coordination of medical and mental health services can be enhanced.

The DNCP also proposes that approximately one-third of the nursing home beds move to Temple and the remainder of the services be contracted locally in the community. The Commission is concerned by the proposal to contract locally for nursing home beds in view of the fact that VA nursing homes provide care for many psychiatry patients, often with co-occurring mental disorders, who are generally difficult to place in the community nursing homes. Furthermore, the Commission expressed concern that long-term care (LTC) services for Waco area veterans, including the seriously mentally ill, not be diminished by the proposed realignment.

For the Blind Rehabilitation Services Program, the DNCP proposes to move the BRC from the Waco VAMC to the Temple VAMC. There was no unanimity among the individuals who testified on behalf of blinded veterans regarding the location of the BRC should it be moved out of the Waco VAMC. The chief concern for these veterans was access. Ms. Rebecca Vinduska, Director of Government Relations of the Blinded Veterans Association, shared this concern indicating that the location of specific facilities is a local decision.[392]

The fate of the PTSD residential rehabilitation unit is not specifically addressed in the DNCP, but the Commission understands from the site visit that it would also be transferred, intact, to the Temple VAMC.

The VISN leadership indicated that the transition proposed in the DNCP would take place over a three- to five-year period in a manner that would minimize disruption to patients and families, and not before facilities are prepared and staff at Temple are trained. From a clinical and patient safety standpoint, the Commission believes that such a transition can be completed successfully, in time, with minimal impact on patients and their families.

VISN leadership stated that the transfer of inpatient services to the Temple VAMC and Austin will not adversely impact the current affiliation between the CTVHCS and the University of Texas and may, in fact, enhance the relationship with the University's Department of Psychiatry.[393]

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[392] Rebecca Vinduska, Director, Governmental Relations, Blinded Veterans Association, CARES Commission Meeting in Washington, DC, on October 7, 2003, pages 6-7.

[393] Kathryn Kotrla, MD, VISN 17 Clinical Director for Mental Health Services, Waco VAMC, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, pages 70-71.

A VISN cost analysis indicates that $910 million could be saved over the life cycle were the Waco VAMC and the Marlin campus to close. This is based on estimated net savings over a 19-year period. It assumes a complete closure of the Waco and Marlin campuses starting in FY 2004 and not locating a new outpatient clinic on the Waco campus. The estimate includes the costs of construction and renovation at Temple, a new outpatient clinic in the Waco area, and the lease costs for Austin.[394]

Consultants from the City of Waco VA Task Force Commission [hereafter referred to as the Task Force] noted that the calculations were inadequate and did not account for all costs associated with new services at other sites.[395] The Commission is concerned about the lack of detailed data upon which to make a complete analysis. Capital costs were provided only in summary form. Cost information is not provided for the status quo or alternatives. The Commission also believes that it would be unreasonable to expect closure to occur in FY 2004 and for savings to begin to accrue in that year.

In addition, the VISN Director testified that he was required to redirect funds allocated to other medical centers to Waco in order to maintain that facility.[396]

Given the Waco VAMC's location, its size, the good condition of the facilities, the legal mechanism to enter into enhanced use leases (EULs), and the willingness of city officials to assist, VA should be able to achieve considerable savings that can be redirected to medical care.

VISN leadership stated that there would be no economic impact on the community if Waco's inpatient programs were transferred; other stakeholders indicated that an economic impact was likely. According to the Task Force, the Waco VAMC "annually contributes approximately $203 million to the local economy and directly and indirectly accounts for about 2,000 jobs throughout central Texas."[397] Neither the Task Force nor the VISN provided data to support its view.

During the Commission hearing in Waco, Mr. Tom Stranova, the VISN Director, "guaranteed" that no jobs would be lost.[398] The VISN leadership discussed the need to retain current staff to support an outpatient clinic, including mental health services, in the Waco and Marlin area and the additional services that will be needed in Temple and Austin. Tom Kelly, a PhD economist and a member of the Task Force, testified that he conducted an independent survey of Waco VAMC employees and found that nearly 43 percent plan

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[394] Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

[395] Enid Wade, member of the City of Waco VA Task Force Commission, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, page 130.

[396] Tom Stranova, VISN 17 Director, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, page 55.

[397] Texas State House of Representatives Resolution #111, September 22, 2003, Presented by the City of Waco VA Task Force Commission, CARES Hearing, Waco, Texas, October 3, 2003.

[398] Tom Stranova, VISN 17 Director, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, pages 61-62.

to commute to the Temple VAMC, and 18 percent plan to leave Waco and locate closer to their new VA employer. About 22 percent plan to seek alternative employment, 10 percent were undecided, and seven percent plan to cease work or retire. A copy of the survey was provided to the Commission.[399] Dr. Kelly further testified that, at least in the short run, the economic loss to the community of closing Waco would be mitigated by the decision of a number of Waco VA employees to continue to live or retire in Waco.

Veterans service organizations (VSOs) and stakeholders, including the mayor's office, both U.S. Senators, four members from the House of Representatives, and employee representatives, testified that changing the mission of Waco would have a negative impact on the VISN's ability to provide care, particularly long-term mental health care and blind rehabilitation services.

The DNCP proposal to transfer current services from the Waco VAMC was put forward without any prior consultation with local stakeholders. The Task Force may not have had sufficient time to evaluate the revised proposal. Task Force members have requested sufficient time to work with VA officials to develop alternatives for the Waco VAMC. The Task Force has been well organized, reasonable, and has offered to assist in the marketing and economic development of the unused space on the campus using EUL. The Commission believes that the VISN understands that any transition will take time and that partnering with the local community can result in a positive outcome for both entities.

Commission Findings

1. Transferring a portion of the acute inpatient psychiatric beds from Waco to Austin would significantly improve the access to inpatient psychiatric care for veterans residing in Austin.
2. Transferring a portion of the acute inpatient psychiatric beds and all the long-term psychiatric beds from Waco to Temple would provide these patients with immediate access to inpatient medical and tertiary care services. If the needs are emergent, patients at Waco requiring such services are currently transported to the Temple VAMC or community facilities.
3. The proposal to move the BRC to the Temple VAMC would improve access and would enhance coordination with medical and specialty care. The unit serves several markets, however, and thus could also effectively be relocated to another VISN 17 medical center.
4. It is not clear that it will be possible to contract for nursing home services for the complex patients treated at Waco. Community nursing homes are seldom willing or able to accommodate patients requiring psychiatric nursing home services.

[399] Written Submission of the Results of a Survey of Future Plans of Waco VA Hospital Employees, page 3, part of the Submission of the City of Waco VA Task Force Commission.

5 Ninety-four percent of the veterans receiving care at the Waco VAMC are treated on an outpatient basis. Outpatient services, including specialized mental health outpatient services to support the population of deinstitutionalized seriously mentally ill patients in the Waco community, are proposed to remain in the Waco area. The location, size, cost, and services at the proposed new CBOC have not been fully determined or articulated.

6 The current and projected need for a large inpatient psychiatric medical center campus has changed considerably from the past when nearly 2,000 beds were required for psychiatric patients who are now best treated in the community.

7 The VISN 17 Director testified that he has been required to redirect funds allocated to other medical centers in the VISN to Waco in order to maintain that VAMC.

8 The cost analysis submitted by the VISN on this proposal is incomplete and a more thorough cost analysis is required. While a thorough cost analysis has not been completed, the campus is no longer being fully utilized. Funds that may benefit veterans' health care are being expended for unnecessary overhead.

9 Employee representatives and some stakeholders expressed concern that jobs will be lost at the Waco campus. The VISN Director, Tom Stranova, "guaranteed" that no jobs would be lost.

10 An independent survey conducted by Tom Kelly, PhD, a member of the Task Force, indicated that 43 percent of the employees at the Waco VAMC plan to continue to work for the VA and commute to Temple, 18 percent plan to leave Waco and locate near their new VA employer, and 10 percent are undecided. Approximately 22 percent of the current workers plan to seek alternative employment, and the remaining seven percent will cease work or retire.

11 Closing the Waco VAMC would likely have some impact on the local economy.

12 The Waco community is well organized and has offered to help alleviate the medical center's overhead and assist in leasing unused buildings and property.

13 Twenty-nine of the 30 buildings on the Waco campus are historically registered.

14 The buildings on the Waco campus are in good repair and approximately $80 million in capital improvements have been made to the campus over the past 10 years.

15 The lack of inpatient medicine beds and specialty medical coverage at Waco require that patients requiring such services be transported to a local hospital or the Temple VAMC.

16 There was a lack of timeliness, forewarning, and stakeholder awareness and involvement in the DNCP proposal of August 4, 2003, to realign the Waco VAMC.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to move services from the Waco campus to appropriate locations within the VISN as follows:
   - a. A portion of acute care inpatient psychiatry to Austin;
   - b. The balance of acute care and all the long-term inpatient psychiatry to the Temple VAMC; and
   - c. PTSD residential rehabilitation services to the Temple VAMC, with no decrease in capacity.
2. The Commission does not concur with the DNCP proposal to transfer Waco nursing home services to the community.
3. The Commission recommends that:[400]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Freestanding LTC facilities should be permitted as an acceptable care model.
   - d. Access for families of patients and clinical relationships between institutional and non-institutional LTC programs must be considered.
4. The Commission concurs with the DNCP proposal to transfer the BRC from Waco, but recommends that the VISN determine an appropriate location taking into account access and the BRC's role as a regional rehabilitation referral center.
5. The Commission concurs that a new multi-specialty outpatient clinic be established in the Waco area.
6. The Commission recommends that time be provided for the transition to allow an orderly transfer with minimal disruption to patients and families and for the VISN to involve veterans, stakeholders, and the community in a plan for Waco campus that is most beneficial to veterans.

[400] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

II Mission Change – Kerrville

DNCP Proposal

"Kerrville will continue to provide nursing home and outpatient services. Acute inpatient services will be transferred to San Antonio as space becomes available from the proposed inpatient construction at San Antonio. In the interim, Kerrville would convert to a CAH. In addition, inpatient services will be contracted for in Harlingen and Corpus Christi. A major enhanced use project for assisted living in Kerrville has been submitted for approval."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Close acute beds, relocate to other VAMCs.
3. *100 Percent Contracting*
4. *Alternative 1 [The VISN's preferred alternative]:* Beds relocate to San Antonio as space becomes available at San Antonio.

Commission Analysis

The Kerrville and San Antonio VAMCs are in the Southern Market and are managed by the South Texas Veterans Health Care System (STVHCS). The Kerrville VAMC, which began its operation in 1947, is approximately 61 miles northwest of the San Antonio VAMC. The Kerrville campus is composed of 26 buildings that require considerable infrastructure maintenance, estimated by VA to cost a total of $4,101,522 for FY 2003. The STVHCS annual operating budget for FY 2003 was $342,944,043. The Kerrville budget is included in this amount.[401]

Kerrville was once a 300-bed acute inpatient care facility but today is a 25-bed facility (including five intensive care unit [ICU] beds). It also houses a 154-bed nursing home that has a relatively steady ADC at 123. Additionally, the facility maintains a 24/7 urgent care area that is fully staffed. The VISN leadership stated that on average it has five to seven after-hour visits per evening with varying degrees of illness severity and that approximately 33 percent of these visits result in a direct admission to an ICU or acute medicine.

Kerrville provides acute medical, primary, and LTC services to approximately 16,000 veterans and has approximately 430 FTEs.[402] The facility has an eroding patient base and an inpatient medicine ADC

[401] VISN 17 January 21, 2004, Email Response to January 2004 Kerrville Operating Budget memo.

[402] VISN 17, Site Visits, San Antonio/Kerrville, July 14-15, 2003, page 2, available from [*http://www.carescommision.va.gov/SiteVisits.asp*].

that has declined from 18 in FY 2000 to 12 in FY 2003. CARES projections for FY 2012 and FY 2022 are 15 and 12, respectively.[403]

The San Antonio VAMC currently has 126 internal medicine beds with an ADC of 85. It also has 59 surgical beds with an ADC of 40, and 79 psychiatric beds with an ADC of 68. The total inpatient operating beds at San Antonio is 294 with an ADC of 213.[404] San Antonio also maintains spinal cord injury beds.

Contrary to this data, which indicates that the San Antonio VAMC has inpatient bed capacity, Mr. Stranova testified that the San Antonio VAMC is operating at capacity and that, on many days, the VISN must divert patients to community facilities. He added that about half of the medical and surgical beds at the San Antonio VAMC are not compliant with current privacy standards; many have four beds to a room, some are not handicap accessible, and most do not have private showers.[405]

Community resources in Kerrville include two JCAHO accredited hospitals in the immediate vicinity and a third JCAHO accredited hospital within 60 minutes of the Kerrville VAMC, all of which appear to have excess capacity. The driving time between the Kerrville and the San Antonio VAMCs is more than one hour. During the site visit, Mr. Stranova also stated a transportation system was established to transport patients, lab specimens, medical records, etc., between San Antonio and Kerrville.[406]

The transfer of the Kerrville VAMC's inpatient beds can be completed with minimal disruption to the quality of patient care and safety due to the small ADC. Less clear is whether San Antonio has current capacity or whether such a transfer must await the proposed new construction. There appears to be capacity in the Kerrville community's two JCAHO accredited hospitals, though the VISN proposal did not discuss contracting Kerrville VAMC inpatient services in the community.

In the campus realignment study, the VISN estimated costs for new construction at San Antonio of $21.4 million require clarification to identify what contributes to this total cost. Additionally, the campus realignment study indicates renovation at San Antonio would be needed to accommodate Kerrville's inpatient workload. The cost associated with this is $2.6 million for a total of 27,000 square feet. These costs appear too low and may require clarification.[407]

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[403] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

[404] Appendix D, *Data Tables*, page D-74.

[405] Tom Stranova, VISN 17 Director, Transcribed Testimony from the Waco, TX, Hearing on October 3, 2003, pages 12-13.

[406] VISN 17, Site Visits, San Antonio/Kerrville, July 14-15, 2003, page 2, available from [*http://www.carescommision.va.gov/SiteVisits.asp*].

[407] Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

Commissioners noted during the site visit to the Kerrville VAMC that the outpatient areas of the facility are constrained and that moving inpatient services out of the facility would give the VISN increased space to provide outpatient services.[408]

Commissioners also learned during the site visit that veterans requiring medical services at San Antonio are transported by either the Kerrville VA shuttle system or the Kerrville EMS system. While ambulatory patients can be transferred by the VA shuttle system, a Kerrville city ordinance requires the use of the city ambulance service for transporting patients who require care beyond what is available to Kerrville VAMC. The cost of these services is $500 per patient for local moves and $1,000 per patient transported to San Antonio.[409]

Another Kerrville service highlighted by the STVHCS Director during the site visit is the laundry facility. Kerrville has a state-of-the-art computerized laundry facility that services this health care system (Kerrville does not provide this service for the VISN). Kerrville has a sharing agreement with Brooke Army Medical Center (BAMC), which is their largest customer and also provides laundry services to the Cancer Therapy Treatment (CTRC) located across the street from Audie L. Murphy, the Austin School of the Deaf and the Big Spring VAMC in VISN 18. The laundry is one of the division's revenue generating services and was described by the STVHCS Director as another viable part of the Kerrville facility.

Proposed plans for Kerrville would not adversely impact other VA missions or academic affiliations. However, in general, stakeholders do not favor moving inpatient services from Kerrville though most were supportive of providing increased services at the San Antonio facility. Walter Schellhase, president of the Hill Country Veterans Council, said:

> In Kerrville, we have a large facility available. At one time it consisted of over 300 beds. Now [it is] down to 20 beds and five ICU beds. In addition, Kerrville has the cost per day basis per patient of $870, which is far less than most of South Texas as a whole, and much lower than Audie Murphy. So the question remains why should we close 20 beds in Kerrville, and build facilities in San Antonio? It makes no sense whatsoever.[410]

Employee representatives testified at the hearing in favor of the continuation of the current services at Kerrville as they feel the San Antonio VAMC cannot accommodate the full complement of patients who need care nor do they feel the local hospitals can handle the overflow of patients the San Antonio VA

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[408] VISN 17, Site Visits, San Antonio/Kerrville, July 14-15, 2003, page 2, available from [*http://www.carescommision.va.gov/SiteVisits.asp*].

[409] VISN 17, Site Visits, San Antonio/Kerrville, July 14-15, 2003, page 2, available from [*http://www.carescommision.va.gov/SiteVisits.asp*].

[410] Walter Schellhase, President of the Hill Country Veterans Council, Transcribed Testimony from the San Antonio, TX, Hearing on October 1, 2003, page 105.

often experiences. Mr. Dean Ward, President AFGE Local 2281, indicated that the CARES plan could mean the destruction of almost 400 good jobs held by veterans. In his testimony, Mr. Ward, states, "The Kerrville VA…It's projected that the population of elderly veterans will grow by 500,000 over the next seven years in our nation …[T]he number of veterans anticipated to live in our area is expected to increase…at least the next 20 years."[411] He further stated, "Thousands of veterans will lose their jobs. Taxpayers will lose. Veterans will lose. Kerrville and Kerr County will lose."[412] On the other hand, the VISN Director noted that 28 clinical personnel plus urgent care physician staff currently service the inpatient workload.[413]

Commission Findings

1. While there are three JCAHO accredited community hospitals within 60 minutes of Kerrville that appear to have excess capacity, there is no indication that the VISN or the DNCP gave serious consideration to contracting for inpatient medicine services.
2. Cost data for proposed new construction and renovations at San Antonio is in need of clarification.
3. Kerrville City Ordinance mandates the cost of transporting medical emergencies from Kerrville to San Antonio. The cost to the VA for such services in FY 2003 amounted to $210,788.[414]
4. The impact on the community and employees would be mitigated by the fact that outpatient services, long-term/nursing home care, and the laundry facility would remain. Further, the local Kerrville hospital(s) would benefit from the increased utilization of VA contracted beds.
5. There would be no impact on VA missions.
6. Stakeholders support more services in San Antonio but do not wish to see Kerrville close its acute care services.
7. Employee representatives believe the CARES plan could mean the loss of 400 jobs that are currently held by a significant number of veterans. On the other hand, the VISN states that 28 clinical personnel plus the urgent care physician staff currently service the inpatient workload.
8. Workload for acute inpatient care and nursing home has decreased over the past four years. Inpatient workload is projected to be 15 beds by FY 2012 and 12 beds by FY 2022.[415]

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[411] Dean Ward, President AFGE Local 2281, Transcribed Testimony from the San Antonio, TX, Hearing on October 1, 2003, page 140.
[412] Dean Ward, President AFGE Local 2281, Transcribed Testimony from the San Antonio, TX, Hearing on October 1, 2003, page 143.
[413] VISN 17, STVHCS, January 16, 2004, Email Response to January 14, 2004, *Inpatient Personnel Support* inquiry.
[414] VISN 17, STVHCS, January 16, 2004, Email Response to January 14, 2004, *Kerrville Emergency Transportation Cost* inquiry.
[415] Appendix D, *Data Tables*, page D-69.

9 The state-of-the-art laundry service at Kerrville, in addition to generating revenue, also provides services to VA, DoD, and other organizations.

10 A portion of the Kerrville VAMC is being renovated for the establishment and operation of an assisted living program.

11 The DNCP proposes that Kerrville would convert to a CAH until services have been transferred.

Commission Recommendations

1 The Commission does not concur with the DNCP proposal to convert the Kerrville VAMC to a critical access hospital (CAH). VA should establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this description.

2 The Commission concurs with the DNCP proposal to transfer the Kerrville VAMC's acute inpatient services and recommends that the VISN contract with community health care providers for these acute inpatient services, including urgent care services, in lieu of or until space is available at the San Antonio facility.

3 The Commission recommends clarification of proposed construction and renovation costs at San Antonio.

4 The Commission concurs with the DNCP proposal that the nursing home and outpatient services remain at Kerrville.

III Inpatient Care

DNCP Proposals

"*Hospital* – Deficiencies in hospital access in Austin, Lower Rio Grande Valley, are being met through contracting or leasing beds in local communities. *Medicine and Psychiatry* – Increasing demand in the north market will be met by expanding in-house services at the Dallas VAMC through construction and renovation projects. In addition, contracts for hospital care in Austin, Harlingen, and Corpus Christi will increase services in the remaining three markets."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Workload data highlight the growing need for more access to inpatient medicine services in the North Market, which is served by the Dallas VAMC. The demand for inpatient medicine in the North Market is projected to increase by 39 percent over the FY 2001 baseline by FY 2012, with a decrease to 25 percent over baseline by FY 2022. Likewise, demand for inpatient psychiatry in this market is also projected to increase: to 30 percent over baseline in FY 2012 and to 24 over baseline in FY 2022.[416] The remedy for inpatient care access at the Dallas VAMC is in-house expansion of existing space and space that will be vacated once some of Dallas' outpatient services are relocated to an outpatient setting.

Data indicate that a significant portion of the veteran population served in the Central Market reside in and near the Austin metropolitan area, which is one of the fastest growing areas in the nation. Currently, veterans in this area travel to Temple and Waco for inpatient medicine services. As discussed previously in the mission change to the Waco VAMC, leasing space to establish VA-operated medical and psychiatric inpatient units in Austin will improve access for Austin veterans, possibly in partnership with the affiliate, the University of Texas Health Science Center.

While projections for inpatient care in the Valley-Coastal Bend Market indicate that 10 beds were needed in FY 2001,[417] the demand is not sufficient to justify building a VA-staffed facility. At present, the San Antonio VAMC is used to meet a portion of that demand. However, this represents only a partial solution as it is proposed that the San Antonio VAMC will absorb some of the Kerrville VAMC's inpatient demand. Given the level of inpatient demand and the availability of community resources in the Valley-Coastal Bend Market, veterans' access to inpatient care in the Harlingen and Corpus Christi areas would be better served through contract providers. Therefore, the VISN plans to expand current contracts and initiate additional contracts with affiliated hospitals in Harlingen and Corpus Christi. These plans will allow access to inpatient care in the Valley-Coastal Bend Market to reach 90 percent.

Commission Findings

1. Construction is underway at the Dallas VA (North Market) to meet inpatient care needs.
2. The Austin area shows a deficiency in access to hospital care, which would be addressed by contracting or leasing beds in Austin. The VISN proposes to pursue an affiliation relationship with the University of Texas for inpatient services in the Austin area.

[416] Appendix D, *Data Tables*, page D-69.
[417] Appendix D, *Data Tables*, page D-69.

3. There is an access gap for veterans requiring hospital care in the Valley-Coastal Bend Market as there are no VAMCs in this market.
4. The VISN proposes to contract for inpatient beds in the Valley-Coastal Bend Market in the Harlingen and Corpus Christi communities.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to correct inpatient access gaps in the Central and Valley-Coastal Bend markets through contracting or leasing of beds in the local community.
2. The Commission concurs with the proposal to expand in-house services at the Dallas VAMC through construction and renovation.
3. The Commission recommends that:
   a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

IV Outpatient Care

DNCP Proposals

"*Primary Care and Mental Health* – Increasing demand for primary care and mental health outpatient services is being met across the Network primarily through expansion of CBOCs. Outpatient mental health is being integrated with primary care at all sites as well as being expended in-house at parent facilities. *Specialty Care* – Increasing specialty care services in all four markets is being met using a combination of in-house expansion (new construction, renovation, and leases), which offer selected high volume specialty care services at larger CBOCs and community contracts."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

According to the CARES workload reports, the demand for primary and mental health outpatient services is increasing markedly across the entire VISN as enrollment is projected to increase 27 percent and 13 percent by the years FY 2012 and FY 2022, respectively.[418] In addition to the large capacity gaps, only 63 percent of veterans residing in the Central Market meet the driving time access standard for primary care services. The DNCP proposes to address these deficiencies by expanding services only at current sites of care. The VISN had proposed 19 new CBOCs, 10 of which would predominantly serve veterans currently living outside of the primary care travel access standard. None of the proposed CBOCs in this VISN were included in the first priority group targeted for early implementation.

The VISN leadership outlined at the October 3, 2003, hearing several alternative measures to address outpatient demand. These included establishing satellite clinics near parent facilities and population centers such as in Dallas and Austin, in-house expansions at VAMCs, retaining outpatient services at Kerrville and the Marlin and Waco areas, as well as continuing collaboration with DoD and medical school affiliates.

Additionally, VISN leadership noted that in the North Market, increased demand for outpatient services is coupled with the problem of the Dallas Medical Center operating at near capacity. There is a need to move some outpatient services into clinic settings to improve the Dallas VAMC inpatient area. As such, establishing additional satellite clinics and CBOCs in this market would serve an additional purpose of managing other workload at the parent facility. At the hearing, the VISN 17 Director testified that he proposed that six of the 19 new CBOCs be activated throughout the Dallas/Fort Worth metropolitan area.

To meet the projected increased demand for outpatient specialty care, the DNCP proposes to increase high volume specialty care services at larger outpatient clinics in the Southern Market. The VISN proposed to meet primary and specialty outpatient needs through the establishment of new CBOCs in the greater San Antonio area. In the Central Market, four new CBOCs were proposed to provide primary and mental health services. The proposed CBOCs are not in the priority listing in the DNCP.

In the Valley-Coastal Bend Market, VISN leadership plans to replace the Brownville clinic with a larger VA–staffed clinic in Harlingen. The Harlingen Clinic is being planned in partnership with the University of Texas Health Science Center at San Antonio,[419] where a specialist is available to CBOCs for services and consultation.

Commission Findings

1. Demand for outpatient services is increasing in all of VISN 17's markets.

[418] Appendix D, *Data Tables*, page D-70.

[419] Tom Stranova, VISN 17 Director, Transcribed Testimony from the San Antonio, TX, Hearing on October 1, 2003, page 10.

2. None of the VISN's proposed CBOCs was in the DNCP's recommended priority group one.
3. VISN leadership has outlined various approaches to meet outpatient demand including establishing satellite clinics and CBOCs, and expanding existing CBOCs to accommodate increased demand for outpatient services.
4. Mental health services would be integrated into primary care clinics.
5. A VA-staffed clinic in Harlingen would replace a contracted clinic in Brownville and would allow VA to partner with University of Texas Health Science Center, where a specialist would be available.
6. While expanding outpatient services at current sites as proposed in the DNCP may meet a portion of projected capacity requirements, it will not address access deficiencies, especially in the Central Market.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to expand services at current sites of care as proposed by the DNCP, but notes that this may not be an adequate solution to the access and capacity gaps in the VISN.
2. In the Valley-Coastal Bend Market, the Commission concurs with moving the Brownville CBOC to Harlingen in affiliation with the University of Texas.
3. The Commission recommends that:[420]
   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

[420] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

V VA/DoD Sharing

DNCP Proposal

"*DoD-North Market* – Sharing opportunity with Joint Reserve Base in North Forth Worth for possible CBOC. *Central Market* – Sharing opportunities between Fort Hood and the Temple Medical Center (telemedicine, orthopedics, psychiatry, sleep lab, training). *South Market* – Inpatient/outpatient sharing and enhanced use among San Antonio, Brooke Army Medical Center and Wilford Hall Air Force Medical Center including CBOCs, consolidating reference labs, domiciliary, Consolidated Mail Out Pharmacy (CMOP), discharge physicals, sleep lab, consolidation of bone marrow transplant programs at VA."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The STVHCS has identified the need to improve veteran access to care in the northeast section of San Antonio. Since there are two sizeable DoD medical centers in that section of San Antonio, Brooke Army Medical Center (BAMC) and Wilford Hall Air Force Medical Center (WHMC), the VISN is presently working with DoD to identify health care services that might be shared among the three facilities. The VISN's plans include collaborating with the BAMC to provide primary care and specialty care, such as dermatology, so that veterans do not have to travel across San Antonio to receive care. The BAMC currently has telemedicine capability and the VISN is exploring the possibility of using that technology to care for veterans. Similar discussions are underway with the Air Force leadership at WHMC.[421]

The VISN has also identified the need to improve veterans' access to care in the northwest section of San Antonio. The VISN has begun exploring with DoD the possibility of establishing new outpatient sites of care at Randolph Air Force Base, Brooks City Base and Kelly Air Force Base. The VISN leadership

[421] Tom Stranova, VISN 17 Director, and Jose Coronado, Director, South Texas Veterans Health Care System, Transcribed Testimony from the San Antonio, TX, Hearing on October 1, 2003, pages 22-39.

testified that approximately 7,000 patients currently in contracted sites of care would move to these new sites, which would be staffed by VA employees.[422]

VA and DoD have further identified areas for possible collaboration and sharing of resources. Some of these other areas are adding WHMC and BAMC to the VA/DoD CMOP pilot; establishing a sleep lab at BAMC, which would receive approximately 10 percent of the sleep lab population; and consolidating the bone marrow transport units at BAMC and WHMC with the VISN's bone marrow transplant unit at San Antonio VAMC. The Commission is aware that the Director of the STVHCS and the Commanding Officer of the Naval Hospital in Corpus Christi have signed a Memorandum of Understanding and a formal Sharing Agreement to implement short-term initiatives in minor procedures, audiology and optometry services. The Commission notes that the San Antonio VAMC has recently been selected as a demonstration project site along with the BAMC and WHMC to test sharing of medical information and information technology systems.[423]

While the Commission did not hear testimony on other potential collaborative opportunities with DoD facilities in the North and Central Markets, the Commission reviewed information indicating that joint ventures may be possible. For example, in North Market, the Carswell Joint Reserve Base is located in northwest Fort Worth. The VISN would like to enter into a joint venture with DoD to establish an outpatient site of care on the base. In the Central Market, the VISN would like to partner with DoD at Ft. Hood to share telemedicine technology as well as specialty services, such as orthopedics, psychiatry and sleep lab.

Commission Findings

1. Numerous VA/DoD opportunities exist in VISN 17 that would improve access to care as well as capitalize on existing resources.
2. The VISN appears to be taking an aggressive approach to pursuing opportunities with DoD as evidenced by a signed Memorandum of Understanding between VA and the Naval Hospital in Corpus Christi.
3. The San Antonio VAMC has been selected as a demonstration project site to test sharing of medical information and information technology systems with BAMC and WHMC.

Commission Recommendation

The Commission concurs with the DNCP proposal that VISN 17 pursue collaborative and sharing opportunities with DoD.

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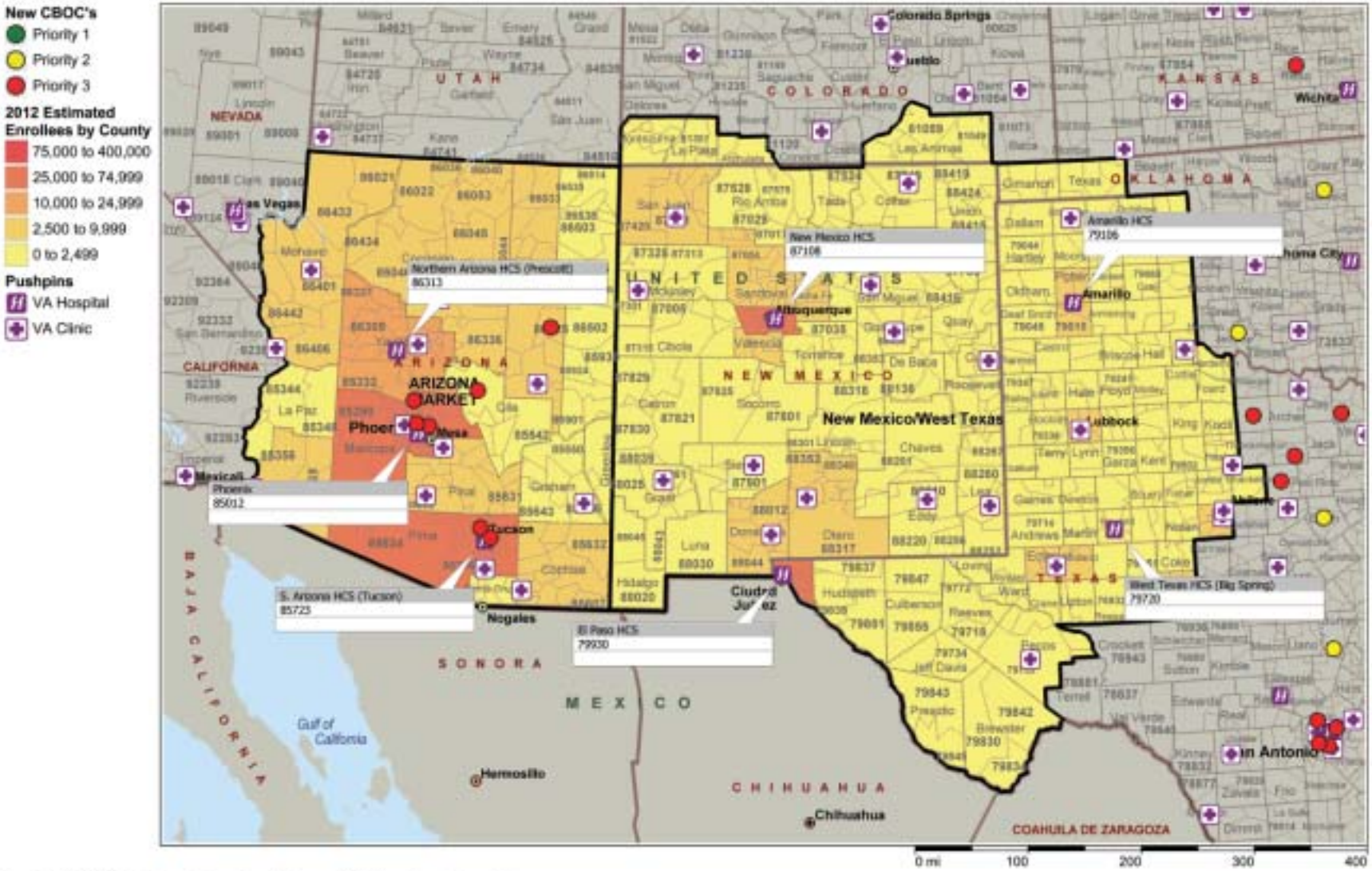
[422] Richard Bauer, MD, Chief of Staff at the San Antonio VAMC, Transcribed Testimony from the San Antonio, TX, Hearing on October 1, 2003, page 65.

[423] VA News Release dated November 3, 2003, "VA and DoD Select Eight Medical Demonstration Sites".

VISN 18 – VA Southwest Health Care Network



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VISN 18, VA Southwest Health Care Network

VISN Overview

VISN 18, VA Southwest Health Care Network, is an integrated, comprehensive health care system that provided medical services to approximately 190,000 of the 291,000 veterans enrolled in VA's health care system in FY 2003.[424] Geographically, this VISN spans 352,000 square miles in Arizona, New Mexico, and West Texas. It is geographically diverse, including fast growing urban areas such as Phoenix, Tucson, Albuquerque, and El Paso, and large, sparsely populated areas. Eighty-two percent of Arizona is tribal or public land, home to 25 Native American Nations living in extremely rural areas. It has a total veteran population of 931,000.

With a VA staff of 7,318 FTEs,[425] VISN 18 delivers health care services through six medical centers, one independent outpatient clinic, 36 community-based outpatient clinics (CBOCs), six nursing homes, one mobile clinic, and one domiciliary unit. Additionally, VA operates five Vet Centers in VISN 18.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 18.

VISN 18	FY 2001	FY 2012	FY 2022
Enrollees	244,414	261,550	243,210
Veteran Population	944,370	839,651	719,803
Market Penetration	25.88%	31.15%	33.79%

For the CARES process, this VISN is divided into two markets: Arizona Market (*facilities:* Prescott, Phoenix, and Tucson, AZ); and the New Mexico and West Texas Market (*facilities:* Albuquerque, NM, and Amarillo, and Big Spring, TX).

[424] VSSC KLF Menu Database, Enrollment Priority and Status by Gender, as of the end of FY 2003.
[425] VSSC KLF Menu Database, FMS Annual Salary Report, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited one site and conducted two public hearings. The Commission received 12,789 public comments regarding VISN 18.

- *Site Visit:* Albuquerque, NM, on July 22.
- *Hearings:* El Paso, TX, on September 18; Prescott, AZ, on September 19.

Summary of CARES Commission Recommendations

I Small Facility – Prescott

1. The Commission concurs with the DNCP proposal to retain patients at Prescott who would have been referred to Phoenix.

(see page 5-281)

II Mission Change – Study Feasibility of Closing Big Spring

1. The Commission concurs with the DNCP proposal insofar as it relates to studying the possibility of no longer providing health care services at Big Spring. The study should take into account the input of stakeholders regarding access to care.
2. The Commission recommends that VA establish a clear definition and clear policy on the critical access hospital (CAH) designation prior to making a decision on the use of this designation.

(see page 5-283)

III Inpatient Care

1. The Commission concurs with the DNCP proposal to address inpatient medicine access and capacity issues through renovation, reopening closed units, and contracting for care.
2. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to cost-effective contracts.
3. The Commission concurs with the DNCP proposal to meet increasing demand for inpatient psychiatry by expanding services at Phoenix, Tucson, and Albuquerque.

(see page 5-285)

IV Outpatient Care

1. The Commission concurs with expanding services at existing sites of care, but notes that this is only a partial solution to capacity and access issues in VISN 18.
2. The Commission recommends that:[426]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-287)

V VA/DoD Sharing

1. The Commission recommends that there be a clear commitment from DoD to expand the existing VA/DoD joint venture with William Beaumont Army Medical Center. Predicated upon VA having this commitment, the Commission concurs with expanding the VA/DoD joint venture, including inpatient beds staffed and operated by VA and additional outpatient services.
2. The Commission concurs with the DNCP proposal to collaborate with DoD in providing primary care services for DoD personnel at the Mesa CBOC.

(see page 5-289)

[426] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

VI Extended Care

1. The Commission concurs with the DNCP proposal on the need for renovation of nursing homes in VISN 18.
2. The Commission recommends that:[427]
   - a. Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-291)

VII Enhanced Use

1. The Commission concurs with the DNCP proposal for the Phoenix and Albuquerque enhanced use leasing (EUL) projects.

(see page 5-292)

VIII Research

1. The Commission concurs with the DNCP proposal on the need to improve research capabilities to enhance patient care and physician recruitment.

(see page 5-293)

[427] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

Small Facility – Prescott

DNCP Proposal

"Medicine workload at Prescott will increase by taking patients who would have been referred to Phoenix. This will also enhance the ability to recruit specialists at Prescott to meet the need for outpatient specialty care. Utilization review will ensure that lengths of stay are comparable to Medicare guidelines."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

Both Phoenix VAMC and the North Arizona VA Health Care System (Prescott) have projected increases in workload for inpatient and outpatient care. In comparison to the FY 2001 baseline, demand for inpatient medicine in the Arizona Market is expected to increase by 29 percent by FY 2012; inpatient psychiatry by 53 percent; outpatient primary care by 26 percent; and outpatient mental health care by at least 55 percent. By FY 2022, demand in the market declines to 13 percent over the FY 2001 baseline for inpatient medicine, 30 percent for inpatient psychiatry, 14 percent for outpatient primary care, and 32 percent for outpatient mental health.[428] Both the Prescott facility and the Phoenix VAMC have experienced substantial increases in workload over the past five years. During FY 2003, Prescott provided health care services to 19,796 unique patients, an increase of 85 percent over FY 1998 levels. During FY 2003, Phoenix provided care to 58,535 unique patients, an increase of 54 percent over FY 1998 levels.[429]

[428] Appendix D, *Data Tables*, page D-77.
[429] VSSC KLF Menu Database, Enrollment & Workload Preferred Facility & Priority.

The VISN's plan to move 20 beds from Phoenix to the Prescott will address capacity issues and allow space at Phoenix for expanded specialty care. At the Prescott hearing, Ms. McKlem, VISN Director, explained:

> referring outpatient specialty care and inpatient medical care to the Carl T. Hayden Medical Center [Phoenix] has become increasingly difficult because the Phoenix population and resultant workload has increased much faster...than capacity. Part of the Phoenix increased demand results from referral workload from Prescott while at the same time, the Phoenix workload continues to grow. Pulling most of the specialty workload back to Prescott, allowing veterans in northern Arizona to avoid traveling an extra 100 miles into the center of a large city, provides better patient access for outpatient specialty care and inpatient care. It also addresses increased demand at the Carl T. Hayden Medical Center and reduces the need for additional beds and construction at that facility.[430]

Moreover, because Prescott has not supported large specialty medical programs, many patients were transferred to Phoenix. Physicians increasingly have been attracted to the area, however, and contracting with specialists, such as general surgeons, ophthalmologists, and urologists, is no longer a problem.[431] Therefore, Prescott is able to expand its in-house inpatient and outpatient medical specialty care by attracting specialists to work at the facility on a part-time or consultant basis, supplementing the efforts of full-time VA professional staff, and Prescott's veterans will be better served.

Commission Findings

1. Workload is increasing for both Phoenix and Prescott, and is projected to increase further.
2. The DNCP proposal would have a positive economic impact on the Prescott community.
3. Reallocating the Phoenix VAMC's workload to the Prescott facility improves access to hospital care and outpatient services, particularly specialty care services, for veterans residing in Prescott's catchment area.
4. Medical professionals are available to work at the Prescott facility under contract.

Commission Recommendation

The Commission concurs with the DNCP proposal to retain patients at Prescott who would have been referred to Phoenix.

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[430] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the Prescott, AZ, Hearing on September 19, 2003, pages 18-19.
[431] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the Prescott, AZ, Hearing on September 19, 2003, page 52.

II Mission Change – Study Feasibility of Closing Big Spring

DNCP Proposal

"Close surgery and contract for care in communities nearest to patients. Study the possibility of no longer providing health care services at Big Spring by development of a critical access hospital for the Odessa-Midland area that would include a nursing home and expansion of an existing clinic to a multi-specialty outpatient clinic. Also as part of the study, consider the possible need for acute hospital care in the area."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The VISN Director testified that the feasibility study requested by the VA Central Office (VACO) to determine the best way to deliver care in the Big Spring catchment area was added after the April 2003 submission of the VISN's market plan. The VISN did not receive guidance from VACO on how the study was to be conducted or by whom.

The VISN Director testified that inpatient surgical services at the Big Spring facility had already closed. This occurred in April 2003.

The FY 2003 workload data for the Big Spring facility shows the following average daily census (ADC) for its inpatient bed sections: internal medicine 13; intermediate care 2; and VA nursing home 36.[432] Except for the inpatient psychiatry workload, which declined in FY 2002 and is shown as zero in FY 2003, and inpatient surgery, which was closed in FY 2003, Big Spring's inpatient workload from FY 2000 to FY 2003 has been consistent. There are five community alternatives to VA services within 60 minutes from the Big Spring facility.[433]

[432] Appendix D, *Data Tables*, page D-80.
[433] Appendix D, *Data Tables*, page D-81.

On the other hand, representatives of local veterans' groups and veterans who receive care at Big Spring raised concerns about the proposed movement of inpatient services to Odessa/Midland, particularly for veterans living east of Big Spring. Cited were issues with the impact that a mission change at the Big Spring VAMC would have on the local economy, as well as access as it relates to health issues that may prevent the ability to travel farther. In his written testimony, Congressman Randy Neugebauer stated that "of the veteran population within the market area, 57 percent reside closer to Big Spring than they do to the Midland/Odessa area." Congressman Neugebauer also added his testimony on the impact on access to veterans by stating:

> The presence of the Big Spring facility was a required component of the state of Texas' decision and commitment to locate a new nursing home facility there called the Lamun-Lusk-Sanchez Texas State Veterans Home in Big Spring. It's dependent on the Big Spring facility to provide health care services to those veterans. The State Veterans Home would not have been built in Big Spring if the VA hospital did not have a presence there.[434]

Commission Findings

1. Inpatient surgical services at Big Spring closed in April 2003.
2. There are five non-VA community alternatives within 60 minutes of Big Spring.
3. Most stakeholders who testified are opposed to changing Big Spring's mission and raised concerns about access that need to be carefully addressed in any study of moving services from Big Spring.
4. The State of Texas relied on the presence of the Big Spring VAMC in its decision and commitment to locate a new nursing home facility in Big Spring.
5. VA applied the CAH model to the proposed Odessa/Midland hospital without clearly defining the concept.

Commission Recommendation

1. The Commission concurs with the DNCP proposal insofar as it relates to studying the possibility of no longer providing health care services at Big Spring. The study should take into account the input of stakeholders regarding access to care.
2. The Commission recommends that VA establish a clear definition and clear policy on the CAH designation prior to making a decision on the use of this designation.

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[434] Randy Naugebauer, United States Congress, Transcribed Testimony from the El Paso, TX, Hearing on September 18, 2003, page 11.

III Inpatient Care

DNCP Proposal

"*Access* – The gap in hospital and tertiary care access in the New Mexico/West Texas Market is being met through expanding the joint venture with DOD in El Paso and contracting in Midland/Odessa, Lubbock, and Roswell. *Inpatient Services – Medicine:* Increasing demand in the Arizona Market will be met by expanding in-house services at all three facilities using renovation projects. In the New Mexico/West Texas Market, by expanding the joint venture at the William Beaumont Army Medical Center adjacent to the El Paso OPC as well as contracting for care in Lubbock, Roswell, and local communities in West Texas and New Mexico for Emergency Care will meet demand. *Psychiatry* – The increasing demand for inpatient psychiatry will be met by expanding services at Phoenix, Tucson, and Albuquerque Contracting for emergency care will also be implemented in New Mexico and West Texas."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The CARES workload projections for inpatient care show that both markets (Arizona and New Mexico/West Texas) will experience a 29 percent increase in medicine demand and a two percent increase in surgical demand over the FY 2001 baseline in FY 2012.[435] By FY 2022, demand for inpatient medicine is projected to decrease in both markets: 13 percent over FY 2001 baseline in the Arizona Market and 25 percent for the New Mexico/West Texas Market. Demand for inpatient surgery will also decrease by FY 2022 by 10 percent below FY 2001 baseline for the Arizona Market and 12 percent below baseline for the New Mexico/West Texas Market.[436]

In the New Mexico/West Texas Market, only 57 percent of enrolled veterans have access to hospital care within the CARES two-hour rural guideline.[437] VA provides outpatient care at a large community outpatient clinic in Lubbock, TX, where 9,769 veterans received care in FY 2003.

[435] CARES Portal, VISN 18 Market Plan: Planning Initiatives for Gaps.
[436] Appendix D, *Data Tables*, page D-77.
[437] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the El Paso, TX, Hearing on September 18, 2003, page 30.

At the El Paso hearing, Ms. McKlem testified:

> Additional beds will be acquired through reactivating or contracting 24 inpatient medical beds at the New Mexico Health Care System and reactivating 13 beds at Amarillo when demand dictates. We also plan to contract for three beds in Lubbock, TX, and two beds in Roswell, NM, as need occurs.[438]

In the Arizona Market, Ms. McKlem stated that renovations at current facilities would be used to address increasing demand for inpatient services.

The CARES projections for FY 2012 indicate that VISN 18 will see an increase in inpatient psychiatry workload of 53 percent in the Arizona Market and 49 percent in the New Mexico/West Texas Market. By FY 2022, demand for inpatient psychiatry will decrease to 30 percent above baseline in the Arizona Market and to 18 percent above baseline in the New Mexico/West Texas Market.[439] At the Prescott hearing, Ms. McKlem, the VISN Director, explained the plan to address the demand in the Arizona Market:

> VISN 18 will reactivate a psychiatric inpatient unit at the [Phoenix] medical center, which will provide 30 additional beds, and expand the psychiatric unit at [Tucson] by seven beds as demand indicates. Additional long-term psychiatric inpatient resources are provided through a contract with the Big Spring State Hospital.[440]

Commission Findings

1. Renovating current facilities, reactivating closed areas, or contracting for care will increase access to hospital care and address capacity gaps.
2. The VISN has planning initiatives to address projected inpatient psychiatry workload increases for both the Arizona and New Mexico/West Texas Market areas.

Commission Recommendation

1. The Commission concurs with the DNCP proposal to address inpatient medicine access and capacity issues through renovation, reopening closed units, and contracting for care.
2. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

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[438] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the El Paso, TX, Hearing on September 18, 2003, pages 31-32.
[439] CARES Portal, VISN 18 Market Plan: Planning Initiatives for Gaps.
[440] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the Prescott, AZ, Hearing on September 19, 2003, pages 21-22.

3 The Commission concurs with the DNCP proposal to meet increasing demand for inpatient psychiatry by expanding services at Phoenix, Tucson, and Albuquerque.

IV Outpatient Care

DNCP Proposal

"*Primary Care and Mental Health* – Increasing primary care and mental health outpatient service is being addressed in both markets primarily through expansion of existing CBOCs as well as increasing services at parent facilities. Outpatient mental health is being integrated with primary care at all sites. *Specialty Care* – Increasing specialty care services in both markets will be met using a combination of in-house expansion (new construction, renovation, and leases) and by offering selected high volume specialty care services at larger CBOCs and through community contracts."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

VISN 18 is highly rural, with 104 of the 136 counties identified as medically underserved. Eighty-two percent of Arizona is tribal or public land, and the northern portion of New Mexico also has many Native Americans living on tribal land. Arizona has approximately 25 Native American Nations with a large portion living in extremely rural areas. Public transportation is nonexistent in these highly rural areas.

By FY 2012, primary care workload in the Arizona Market is projected to increase over the FY 2001 baseline by 26 percent, decreasing to a 14 percent increase above baseline by FY 2022. The specialty care workload in Arizona is expected to increase by 56 percent and in the New Mexico/West Texas Market by 52 percent over baseline by FY 2012, declining to 48 and 30 percent over baseline, respectively, by FY 2022. The workload for outpatient mental health in Arizona is expected to increase by 55 percent, and in New Mexico/West Texas by 49 percent over baseline by FY 2012, declining to 32 and 17 percent, respectively, by FY 2022.[441]

[441] Appendix D, *Data Tables*, page D-77.

VISN 18 was a pioneer in establishing CBOCs, and both markets meet the access to primary care criteria largely due to the deployment of the existing 36 CBOCs.[442] The National CARES Program Office (NCPO) indicates that one new CBOC, at New Pasyon, AZ, opened in November 2003. The VISN had proposed nine other new CBOCs. One of these proposed sites, New Holbrook, AZ, is identified to serve the needs of Native Americans in northern Arizona. The other CBOCs are in the metropolitan Phoenix and Tucson areas, and were intended to improve accessibility in these increasingly congested cities, as well as taking some workload from the crowded medical centers so that space could be freed up for expanded specialty services. The DNCP does not put any of these nine new CBOCs in priority group one.

At the El Paso hearing, Commissioners learned that mental health services are being added to existing CBOCs and that telepsychiatry at smaller CBOCs has been well accepted by patients.[443] The VISN also has a $9 million major construction proposal to build a VISN 18 telepsychiatry center of excellence in Tucson.[444] VISN 18 already has a successful teleradiology arrangement.

Commission Findings

1. The DNCP proposes to meet the increased need for primary care in this VISN only through expansion at current sites of care.
2. The DNCP strategy did not address access to care in Northern Arizona, where many Native Americans live.
3. Capacity/space needed for specialty care can best be addressed by moving primary care workload into leased space and then using the space at the parent facility to provide expanded specialty care.
4. The VISN proposes to increase access to mental health care at existing CBOCs and, where possible, increase the use of telemedicine.

Commission Recommendation

1. The Commission concurs with expanding services at existing sites of care, but notes that this is only a partial solution to capacity and access issues in VISN 18.
2. The Commission recommends that:[445]
    a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

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[442] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the Prescott, AZ, Hearing on September 19, 2003, page 11.
[443] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the El Paso, TX, Hearing on September 18, 2003, page 33.
[444] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the Prescott, AZ, Hearing on September 19, 2003, page 36.
[445] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

V VA/DoD Sharing

DNCP Proposal

"The VISN is pursuing expansion of the joint venture with William Beaumont Army Medical Center in El Paso as well as a primary care clinic with Luke AFB at the Mesa CBOC."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

El Paso has the fastest growing workload in the New Mexico/West Texas Market. During FY 2003, El Paso provided health care services to 15,577 patients.[446] Inpatient care in El Paso is provided via contract with the William Beaumont Army Medical Center (WBAMC). Plans envisioned a shared physical and programmatic arrangement between VA and DoD. In 1995, a four-story, 254,000 square foot VA outpatient clinic opened next to WBAMC. The clinic is connected to the hospital on all four floors, allowing easy access between each area. In addition, working with specialists at WBAMC has enabled VA to reduce the number of patients sent to Albuquerque. Today, there are less than 1,000 consults sent to Albuquerque, compared to more than 3,000 in 1995. Conversely, in FY 2002, there were 3,200 consults to WBAMC.[447]

[446] VSSC KLF Menu Database, Enrollment Priority and Status by Gender, as of the end of FY 2003.

[447] Byron Jacqua, Director, El Paso VA Health Care System, Transcribed Testimony from the El Paso, TX, Hearing on September 18, 2003, page 37.

At the hearing, the VISN Director discussed plans to expand the existing relationship by having VA staff 33 acute medical beds within the WBAMC and share ancillary services with DoD. This scenario also includes establishing a 27-bed, VA-staffed and -operated inpatient psychiatric unit within the WBAMC that would serve VA and DoD patients, expanding outpatient specialty care, and expanding outpatient mental health services to meet projected workload for those categories of care. Because of deployment issues, WBAMC has experienced changes in clinical staffing levels. VISN leadership believes VA should staff any new inpatient units.

The Phoenix VAMC operates a large community-based outpatient clinic in Mesa, AZ. During FY 2003, this clinic provided 32,944 outpatient visits to 8,923 patients.[448] Primary care, mental health, and some specialty care were provided. This substantial clinic would seem an ideal venue for a joint venture to provide primary care services for DoD personnel in the Mesa area.

Commission Findings

1. Most inpatient health care for veterans served by the El Paso VA Health Care System is provided by contract or through the Army at the WBAMC.
2. Increased inpatient capacity in the El Paso area will be achieved through expansion of an existing joint venture with WBAMC to establish 33 VA-staffed and operated acute medical beds and 27 VA-staffed and operated inpatient psychiatry beds.
3. While expansion of the VA/DoD joint venture with WBAMC in El Paso is the cornerstone of this plan, there was a noticeable absence of a clear commitment from DoD senior commanders for the initiative and no written agreement. Should the expansion of the joint venture fail, other DNCP proposals for this VISN will not be achieved.
4. The Mesa CBOC seems well positioned to enter into a joint venture with DoD to provide primary care services to DoD personnel.

Commission Recommendations

1. The Commission recommends that there be a clear commitment from DoD to expand the existing VA/DoD joint venture with William Beaumont Army Medical Center. Predicated upon VA having this commitment, the Commission concurs with expanding the VA/DoD joint venture, including inpatient beds staffed and operated by VA and additional outpatient services.
2. The Commission concurs with the DNCP proposal to collaborate with DoD in providing primary care services for DoD personnel at the Mesa CBOC.

[448] VSSC KLF Menu Database, Enrollment Priority and Status by Gender, as of the end of FY 2003.

VI Extended Care

DNCP Proposal

"Proposed capital investments for nursing homes include the renovation of 58,314 square feet in the New Mexico/West Texas Market (Albuquerque and Amarillo) and the renovation of 124,209 square feet in the Arizona Market (Phoenix, Prescott, and Tucson)."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Southwest is increasingly a retirement destination for many aging veterans, who tend to use VA health care services at higher rates than do younger veterans. This partially accounts for the high market penetration in VISN 18 (244 per 1,000 veteran population in FY 2003, compared to VA national average of only 177 per 1,000). Because most VHA nursing home construction occurred decades ago, before the large migration to the Southwest, there is a relative paucity of VA nursing home beds in the VISN. During FY 2003, the VISN had 469 nursing home operating beds with an ADC of 407 (87 percent occupancy). There were beds at Albuquerque (18 ADC), Amarillo (116 ADC), Big Spring (36 ADC), Phoenix (81 ADC), Prescott (81 ADC), and Tucson (75 ADC).[449] This makes it reasonable to upgrade the current nursing home environments of care to better accommodate ongoing increasing demand from aging veterans in this part of the country.

Commission Findings

This VISN is likely to have increased need for nursing home beds into the future.

Commission Recommendations

1. The Commission concurs with the DNCP proposal on the need for renovation of nursing homes in VISN 18.
2. The Commission recommends that:[450]
    a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

[449] VSSC KLF Menu Database, Workload Report, as of the end of FY 2003.
[450] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

VII Enhanced Use

DNCP Proposal

"A major enhanced use leasing project at Phoenix is being pursued which will make office space available on its campus in downtown Phoenix to affiliates, as well as DoD and the private sector. Albuquerque is pursuing a multi-use project that includes collocation of the VARO, a hoptel, and an assisted living facility."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Excess land at the Phoenix campus is high on VA's list of land most likely to produce revenue that can be used to enhance VA health care services.

The Albuquerque VAMC provides tertiary inpatient surgical services to veterans from a large catchment area that covers most of New Mexico and large portions of Texas and other nearby states. A hoptel unit would provide veterans and their families traveling a long distance for such services with a comfortable, affordable place to live while undergoing the preparatory and recovery portions of the surgery. It would also permit the VAMC to be more efficient by reducing unnecessary lengths of stay on high demand surgical and medical beds.

Commission Findings

1 Land at the Phoenix campus has high potential for EUL.

2 The establishment of a hoptel at the Albuquerque VAMC will enhance services for veterans in the market.

Commission Recommendation

The Commission concurs with the DNCP proposal for the Phoenix and Albuquerque EUL projects.

VIII Research

DNCP Proposal

"The VISN will join with Arizona State University (ASU) to establish an Arizona Biomedical Institute. In addition, the VISN is working with both ASU and University of Arizona to establish a Molecular Diagnostics and Research Laboratory. Albuquerque also has a very active research program that has numerous space and functional deficiencies. All of these initiatives will require construction and/or enhanced use projects."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

As patient care services have expanded, funded research has also expanded in this VISN. In her written testimony at the El Paso hearing, the VISN Director said, "In the New Mexico/West Texas Market, the New Mexico VA Health Care System [Albuquerque] is affiliated with the University of New Mexico. At that facility, research has increased by 57 percent. This increase has not been accompanied by a comparable increase in renovation and construction for research."[451]

Commission Findings

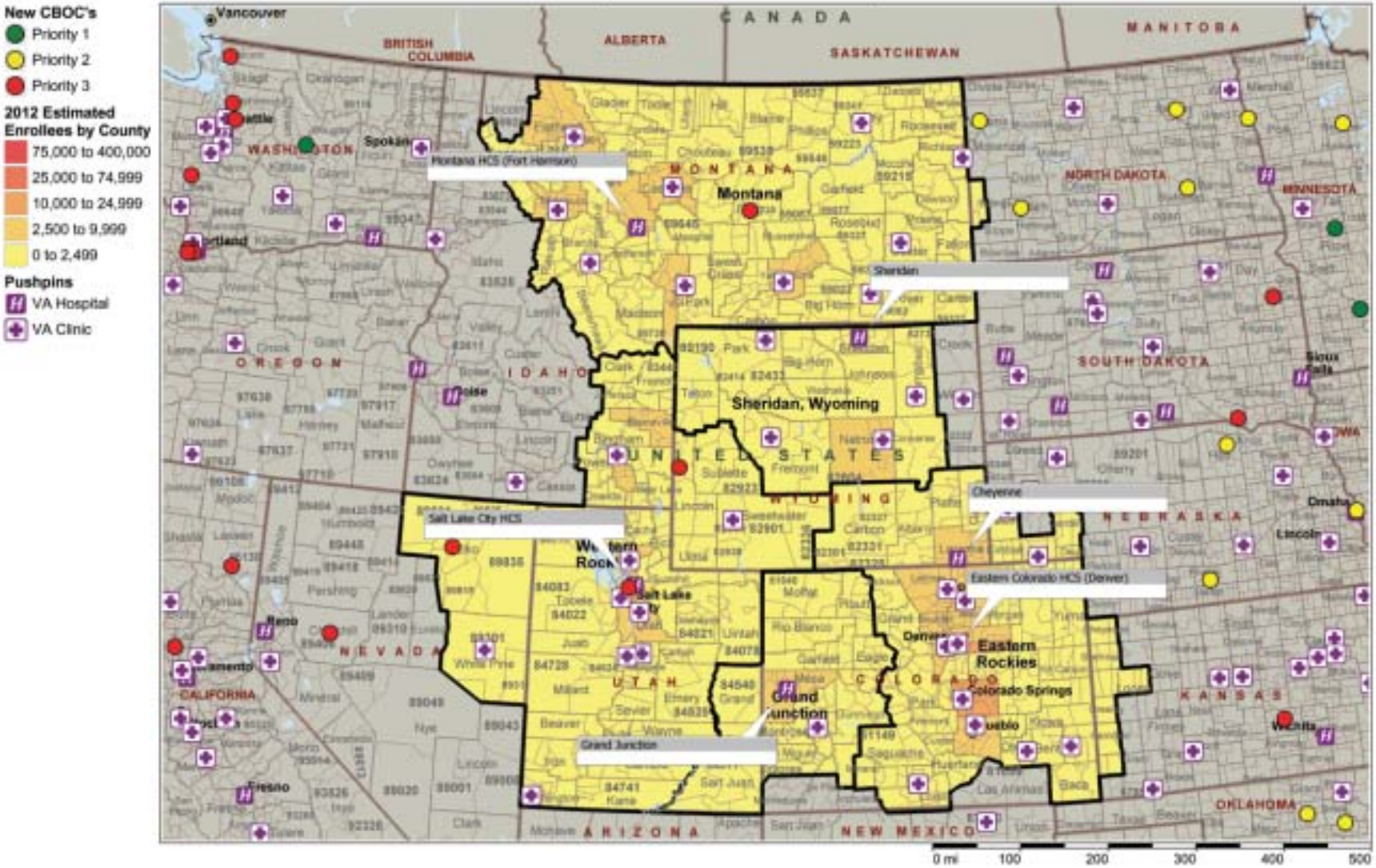
1. VA's clinical services are expanding rapidly in this VISN.
2. Increased collaboration with educational affiliates is crucial to expanding VA clinical services.
3. Expanding research programs in the VISN strengthens the relationship with affiliates and aids in recruiting highly qualified clinical staff.

Commission Recommendation

The Commission concurs with the DNCP proposal on the need to improve research capabilities to enhance patient care and physician recruitment.

[451] Patricia McKlem, VISN 18 Director, Transcribed Testimony from the El Paso, TX, Hearing on September 18, 2003, page 34.

VISN 19 – Rocky Mountain Health Care System



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VISN 19, Rocky Mountain Network

VISN Overview

VISN 19, the Rocky Mountain Network, is the largest VISN in terms of geographic area in the 48 contiguous states, spanning nearly all counties in four western states: Colorado, Montana, Utah and Wyoming, with counties in an additional five states: Idaho, Kansas, Nebraska, Nevada and North Dakota. This large geographic area covers approximately 450,000 square miles and is classified as rural or highly rural, with only two truly urban centers at Denver and Salt Lake City.

This health care system has a total veteran population of 777,000 and provided medical services to approximately 125,000 of the 194,000 veterans enrolled in its system in FY 2003.[452]

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 19.

VISN 19	FY 2001	FY 2012	FY 2022
Enrollees	164,392	185,705	180,272
Veteran Population	790,355	701,306	610,613
Market Penetration	20.80%	26.48%	29.52%

With a staff of 4,307 FTEs,[453] the Rocky Mountain Health Care System is composed of seven medical centers, six nursing homes, and 33 community-based outpatient clinics (CBOCs). Additionally, VA operates 11 Vet Centers in VISN 19's catchment area.

This VISN is divided into five markets: the Eastern Rockies Market (*facilities:* Denver, CO, and Cheyenne, WY); the Grand Junction Market (*facility:* Grand Junction, CO); the Montana Market (*facilities:* Fort Harrison and Miles City, MT); the Western Rockies Market (*facility:* Salt Lake City, UT); and the Wyoming Market (*facility:* Sheridan, WY).

Information Gathering

The CARES Commission visited five sites in VISN 19 and conducted three public hearings. The Commission received 1,234 public comments regarding VISN 19.

[452] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[453] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

- *Site Visits:* Miles City, MT, on July 21; Wyoming facilities, including Sheridan and Riverton CBOCs, on July 23 and 24; Colorado facilities, including the Rifle Veterans State Nursing Home, Grand Junction VA Medical Center (VAMC), and Montrose CBOC, on July 23, 24, and 25.
- *Hearings:* Denver, CO, on September 22; Billings, MT, on September 24; and Cheyenne, WY, on October 23.

Summary of CARES Commission Recommendations

I Replacement VAMC at Denver

1. The Commission concurs with the DNCP proposal for building a replacement medical center with DoD on the Fitzsimmons campus and recommends that it be made a high priority.
2. The Commission concurs in principle with the DNCP proposal to build a replacement nursing home unit.
3. The Commission recommends that:[454]
   - a. Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-299)

II Special Disability Programs – Spinal Cord Injury Center

1. The Commission concurs with the DNCP proposal to add a 30-bed SCI Center at Denver.

(see page 5-301)

III Small Facility – Cheyenne

1. The Commission does not concur with the DNCP proposal that Cheyenne's mission should be changed. The Commission recommends that Cheyenne retain its current mission due to its significant

[454] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

distance from other VAMCs; the high quality of care, including surgical care; the excellent condition of its buildings; the cost-effectiveness of operations; and the negative impact a mission change would have on the affiliation with the University of Wyoming and the DoD collaboration.

(see page 5-302)

IV Small Facility – Grand Junction

1. The Commission does not concur with the DNCP proposal that Grand Junction's mission should be changed. The Commission recommends that Grand Junction retain its current mission due to its significant distance from other VAMCs and the high quality of care.

(see page 5-305)

V Small Facility and Seismic – Fort Harrison

1. The Commission concurs with the DNCP proposal to maintain the current mission of the Fort Harrison VAMC.
2. The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

(see page 5-307)

VI Inpatient Care

1. The Commission concurs with the DNCP proposal to improve acute hospital access by contracting for inpatient care in the Eastern Rockies, Montana, and Wyoming markets and for tertiary care in the Montana and Wyoming markets.

(see page 5-308)

VII Outpatient Care

1. The Commission concurs with the DNCP proposal to meet part of the future demand for more primary care, mental health, and specialty outpatient care through construction and conversion of space at current sites of care, and to increase specialty care at selected current sites of care, as well as contracting in high-peak periods of growth. The Commission notes, however, that merely increasing services at existing sites of care will not resolve access gaps in some markets.

2 The Commission recommends that:[455]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-310)

VIII Enhanced Use – Salt Lake City

1 The Commission concurs with the DNCP proposal for the Phase II enhanced use project at Salt Lake City.

(see page 5-314)

[455] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

Replacement VAMC at Denver

DNCP Proposal

"*Replacement Facility Study at Denver* – The Denver replacement hospital is included in the plan."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

During the Denver hearing, the Commission was advised that, in line with the Eastern Rockies Market's plans for construction of a new replacement hospital at Denver, the proposal for this replacement facility includes a new 30-bed SCI unit, a 60-bed replacement nursing home unit, and 20-bed, sub-acute rehabilitation unit.

The current Denver VAMC space projections indicate that there is a deficit of 41,000 square feet of inpatient space.[456] Denver also has a space deficit of 201,000 square feet for outpatient care. The tour of the Denver facility inpatient space revealed that this building is old and has patient privacy problems.

Workload at the Denver VAMC for inpatient medicine is projected to increase by 46 percent in FY 2012 over the FY 2001 baseline and to decline to 27 percent over the baseline by FY 2022. The surgical inpatient workload is projected to peak in FY 2009 at about 10 percent above current workload and to then decline by about eight percent above current workload by FY 2022. Psychiatric inpatient workload was projected to have peaked in FY 2002 and to decline about 30 percent by FY 2022.

The Commissioners viewed the general building plan for the new University of Colorado site and saw the proposed site of the Federal facility at the Fitzsimmons campus. Under the proposed plan, VA and DoD would each have their own designated Federal facility and patients, but would share certain areas, such as operating rooms, radiology, labs, and special procedure rooms with the University Medical Center.

The replacement university medical center is currently under construction and the university will be moving to the new site as soon as the bed tower has been completed in 2004. Section 213 of Public Law 108-170 authorizes VA to conduct advanced planning for a major medical facility project at Denver, not to exceed $30 million; $26 million from VA and $4 million from DoD. The Conference Public Law 108-199 directs

[456] VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

continuing efforts and planning to collocate the Denver VAMC with the University of Colorado hospital and a DoD medical facility at the Fitzsimmons campus. The University needs a clear commitment from VA to proceed with the next phase of the campus plan to include the proposed Federal facility.

Testimony from the Disabled American Veterans, The American Legion, AFGE VISN 19 Liaison of the Rocky Mountain Unified Union Presidents, the University of Colorado, DoD partners, Congressman Beauprez, and the Governor of Colorado all support the plan to build a Federal facility at the Fitzsimmons site. The Denver AFGE, however, while supportive of a replacement facility, is not in favor of having the two facilities adjacent to each other, citing concerns about veterans continuing to receive priority care and the possible loss of jobs.

When the VISN Director was asked during the Denver hearing about alternatives if the replacement facility were not approved, he indicated that there were no good alternatives. He stated that the current facility could be improved, but that it would still be a 50-year-old building.[457] Denver's Medical Center Director indicated that, if the proposal were not approved, VISN staff would do the best they could, which would be to build yet another addition. He also indicated that this would be a temporary solution and a very costly one.[458]

Commission Findings

1. The Denver VAMC is old and has patient privacy problems.
2. The Space and Functional Report indicates that the Denver VAMC has a significant current space deficit in inpatient and outpatient areas, which is projected to increase.
3. There are no good alternatives for further construction or renovation at the Denver VAMC.
4. The plan calls for the VA and DoD to collaborate on building a new Federal facility and for some shared services with the University of Colorado.
5. The proposed replacement facility also would include a new 30-bed SCI unit, a 60-bed replacement nursing home, and a 20-bed, sub-acute rehabilitation unit.
6. All stakeholders support the proposal for building a new replacement facility near the University of Colorado Medical Center.
7. The timeframe for action is short.

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[457] Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 26.

[458] Ed Thorsland, Medical Center Director of the Denver VAMC, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 51.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for building a replacement medical center with DoD on the Fitzsimmons campus and recommends that it be made a high priority.
2. The Commission concurs in principle with the DNCP proposal to build a replacement nursing home unit.
3. The Commission recommends that:[459]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.

II Special Disability Programs – Spinal Cord Injury Center

DNCP Proposal

"Build a new Spinal Cord Injury (SCI) Center located with the replacement facility at Denver."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Currently, there are no SCI Centers close to Denver. Among the nearest SCI Centers are those in Milwaukee, Albuquerque, Long Beach, and Seattle, which causes significant access problems for veterans in this VISN. The model used to project the need for SCI beds indicated that VISN 19 could support a 30-bed unit. Dr. Anderson, Acting Chief Medical Officer for VISN 19, reported:

> As we looked at the expansion of the Denver facility out at Fitzsimmons, we asked Dr. Margaret Hammond, who is the chief consultant for the spinal cord injury health group in Washington,

[459] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

to look at our population of spinal cord injury. It was determined we have substantial portions of SCI and SCD spinal cord injury patients in this area, and that we could easily support a 30-bed inpatient acute unit at the Denver facility.[460]

Commission Finding

The Denver VAMC could support a 30-bed inpatient SCI Center at Denver, which would significantly improve access to care.

Commission Recommendation

The Commission concurs with the DNCP proposal to add a 30-bed SCI Center at Denver.

III Small Facility – Cheyenne

DNCP Proposals

"Maintain acute bed sections and develop appropriate parameters (more restrictive) for types of in-house surgery procedures. Complete an evaluation to determine if ICU beds could be closed (VA external review survey)."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

[460] Dr. Leigh Anderson, VISN 19 Acting Chief Medical Officer, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 102.

Commission Analysis

While the DNCP recommended that Cheyenne retain its current mission, in the Under Secretary for Health's August 6, 2003, presentation to the Commission, he indicated that he had asked the VISN to consider converting Cheyenne to a critical access hospital (CAH) and transferring some inpatient services to Denver, or contracting for care. The Cheyenne VAMC is projected to require fewer than 20 beds in FY 2012 and FY 2022.[461]

Cheyenne is more than 100 miles from Denver, the nearest acute care VAMC. In addition, many patients from Sheridan, WY, use the Cheyenne VAMC for their inpatient care. If Cheyenne were to change its mission, these patients would have to travel to Denver, which is more than 400 miles from Sheridan.

Further, testimony at the Cheyenne hearing by VISN leadership indicated that both the quality of care as measured by the External Peer Review Program (EPRP) and the patient satisfaction scores are above average for nearly all measures. Surgical performance data also indicate that the Cheyenne VAMC's observed-to-expected ratio for surgical performance is better than expected. Recently, a full-time orthopedic surgeon was hired, which is expected to increase the scope of services provided and the inpatient census. Additionally, the facility does not have any difficulty recruiting and retaining staff. On a site visit to Cheyenne, Commissioners observed that the buildings at the facility are in excellent condition.

From the hearing, the Commissioners learned that closing surgery and ICUs and contracting in the community or sending patients to Denver would actually be more expensive than maintaining the current mission. Regarding the cost-effectiveness of changing the mission of the Cheyenne facility to a CAH, Dr. Michael Kilpatrick, Director of the Cheyenne VAMC, indicated that the data currently showed the Cheyenne facility provides inpatient care at below the Medicare rates. He testified that:

> if we could contract for care at TriCare rates, which I think is extremely problematic, it would cost an additional $250,000 to provide the care we provided that year. If we could contract for Medicare rates, it would cost an additional $1.25 million for the same amount of care we provided. And, parenthetically, for just those DRGs that we treated, not for tertiary level of care, which is where Cheyenne truly excels, we would have cost the system an additional $500,000 if we sent the patients to Denver.[462]

[461] Appendix D, *Data Tables,* page D-84.

[462] Dr. Michael Kilpatrick, Director of the Cheyenne VAMC, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 46.

The facility also has an affiliation agreement to train family practice residents for the University of Wyoming. During his testimony, Dr. Page, Associate Dean for Clinical Affairs at the University of Wyoming, testified, "The proposed changes in the mission of the Cheyenne VAMC would seriously damage the University of Wyoming residency training program and potentially threaten their accreditation. The Cheyenne facility has been a partner in training physicians to practice in rural Wyoming and other rural states."[463]

Witnesses noted that there are 21 hospitals in Wyoming, 11 of which have 25 beds or less. Senator Enzi testified that using the term "critical access hospital" in Wyoming had created a significant issue in his state,[464] as this is the average size of hospitals in Wyoming.

In addition, the Cheyenne VAMC has a highly effective collaboration with DoD and has provided an office in the primary care treatment area for a TriCare coordinator to facilitate the seamless treatment of active duty personnel and dependents' authorized use of the VAMC. This collaboration includes a premier women's clinic, which is headed by a female staff OB-GYN. In FY 2002, this clinic provided care to approximately 1,500 women: active duty, DoD dependents, and veterans. The clinic provides health care in a private and secure environment that focuses solely on womens' health issues and is viewed as a positive addition for the medical center by patients and staff.

Veterans service organizations (VSOs) and stakeholders including the Governor's office, both U.S. Senators, U.S. Representative, the University of Wyoming, and employees testified that changing the mission of the Cheyenne facility would have a negative impact on the community and the availability of health care in the region.

Commission Findings

1. Overall, workload has decreased slightly over the past 4 years. CARES projections indicate a need for 17 acute beds in FY 2012 and 14 acute beds in FY 2022.
2. The recent hiring of a full-time orthopedic surgeon will increase the inpatient surgical workload.
3. Performance on VHA quality of care measures is above average and surgical quality scores are normal.
4. Care at the Cheyenne VAMC is more cost-effective than either contracting or sending patients to Denver.

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[463] Dr. James A. page, Associate Dean for Clinical Affairs at the University of Wyoming, Written Testimony submitted at the Cheyenne, WY, hearing on October 23, 2003, page 3, available from [*http://www.carescommission.va.gov/Documents/CheyennePanel4.pdf*].

[464] The Honorable Mike Enzi, Senator of Wyoming, Written Testimony submitted at the Cheyenne, WY, Hearing on October 23, 2003, page 1, available from [*http://www.carescommission.va.gov/Documents/CheyennePanel1.pdf*].

5. Changing the mission of the Cheyenne VAMC would cause many patients from Cheyenne to have to travel more than 100 miles and patients from Sheridan to travel more than 400 miles to receive care at the Denver VAMC.
6. The Cheyenne VAMC buildings are in excellent condition.
7. VISN leadership indicates recruitment and retention of professional staff are excellent, and the facility is sufficiently staffed to maintain the scope of services.
8. Changing the mission of the facility would have a negative impact on the University of Wyoming Health Sciences residency training programs.
9. Stakeholders are uniformly opposed to changing the mission of the facility.

Commission Recommendation

The Commission does not concur with the DNCP proposal that Cheyenne's mission should be changed. The Commission recommends that Cheyenne retain its current mission due to its significant distance from other VAMCs; the high quality of care, including surgical care; the excellent condition of its buildings; the cost-effectiveness of operations; and the negative impact a mission change would have on the affiliation with the University of Wyoming and the DoD collaboration.

IV Small Facility – Grand Junction

DNCP Proposal

"Maintain acute bed sections and develop appropriate parameters (more restrictive) for types of in-house surgery procedures. Complete an evaluation to determine if ICU beds could be closed (VA external review survey)."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

While the DNCP recommended that Grand Junction VAMC retain its current mission, the Under Secretary for Health, in his August 6, 2003 presentation to the Commission, indicated that he asked the VISN to consider converting Grand Junction to a critical access hospital. CARES data project that Grand Junction will need 24 beds in FY 2012 and 18 beds in FY 2022.[465]

Grand Junction is approximately 250 miles from either Denver or Salt Lake City, over mountain ranges. It is not clear that the Denver or Salt Lake City VAMCs could easily absorb the surgical or ICU workload from Grand Junction. On a site visit to the Grand Junction facility, Commissioners observed that the medical center is in good condition.

The patient satisfaction scores for this facility are higher than the national average. Grand Junction's performance is better than the average for nearly all quality measures.[466] The outpatient surgical workload includes between five and eight cases per day that require general anesthesia. Grand Junction also serves as the main resource for mental health care in western Colorado. Approximately 25 percent of all inpatient episodes of care at Grand Junction are psychiatric admissions, managed on a small, efficient acute psychiatry unit. Cost data for inpatient medicine and surgical services indicate that Grand Junction's costs are lower than Medicare unit costs.[467] In FY 2001, Grand Junction won the President's National Quality Award for its levels of performance outcomes.

Veterans service organizations and stakeholders testified that changing Grand Junction's mission would have a negative impact on the community and the availability of health care in the region. Mr. Todd White, National Vice Commander, The American Legion, said Grand Junction is an excellent facility and it provides care to 38,000 veterans in a 17-county area in western Colorado and eastern Utah.[468]

Commission Findings

1. Inpatient workload has generally been stable over the past four years, except for surgery, which has decreased slightly over the past three years. CARES data project that Grand Junction will need 24 beds in FY 2012 and 18 beds in FY 2022.
2. Performance on VHA quality of care measures is above average, and surgical quality scores are normal.

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[465] Appendix D, *Data Tables*, page D-87.
[466] Appendix D, *Data Tables*, page D-88.
[467] VISN 19, *Small Facility Analysis, Grand Junction, CO*, prepared as backup to the VISN 19 Market Plan, page 2.
[468] Todd White, National Vice Commander, The American Legion, Written Testimony submitted at the Denver, CO, Hearing on September 22, 2003, page 4, available from [*http://www.carescommission.va.gov/Documents/DenverPanel3.pdf*].

3. Grand Junction provides mental health services, including acute inpatient services, for veterans in the western Colorado area.
4. Grand Junction VAMC is approximately 250 miles from the Denver and Salt Lake VAMCs.
5. The Grand Junction VAMC buildings are in good condition.
6. Stakeholders are uniformly opposed to changing the facility's mission.

Commission Recommendation

The Commission does not concur with the DNCP proposal that Grand Junction's mission should be changed. The Commission recommends that Grand Junction retain its current mission due to its significant distance from other VAMCs and the high quality of care.

V Small Facility and Seismic – Fort Harrison

DNCP Proposals

"*Small Facility* – Fort Harrison maintains current services. *Seismic* – The seismic condition will be improved by the construction projects at Fort Harrison."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Fort Harrison has 30 inpatient medicine beds, 10 surgery beds, and five inpatient psychiatry beds, with a current ADC of 39 that is not expected to significantly decline until at least FY 2022.[469] Fort Harrison is more than 200 miles from any other VAMC. Fort Harrison is also 17th on the list of national seismic projects. Patient buildings identified at risk include the ambulatory care building and the main hospital building. During testimony, the facility director indicated that the corrections to the ambulatory care building had essentially been completed. He also indicated that, with the exception of the analysis of what needs to be done and related estimated costs, no work has been done to correct identified deficiencies in the hospital building. The projected costs for correcting problems in the main hospital are about $24 million.

[469] VSSC KLF Menu Database, *Occupancy Rate Report thru May 2003*.

Commission Findings

1. The main hospital building has been identified as being of Exceptionally High Risk on the list of national seismic projects.
2. While seismic corrections have been completed for the ambulatory care building, no work has yet begun on the main hospital building.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to maintain the current mission of the Fort Harrison VAMC.
2. The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

VI Inpatient Care

DNCP Proposals

"*Hospital Care* – Increased access for hospital care in the Eastern Rockies, Montana, Wyoming, Grand Junction, and Western Rockies markets by contracting at seven sites in VISN 19. *Tertiary Care* – Increased access for hospital care in the Eastern Rockies and Montana markets by contracting for care at three sites. *Medicine* – Increase inpatient medicine services in the Eastern Rockies market. The majority of the increasing demand will be absorbed at VAMC Denver. This is part of the replacement facility (new construction) proposal at Denver. Excess space will be demolished."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Three of the markets in this VISN have travel access gaps for hospital care: the Eastern Rockies Market, the Montana Market, and the Wyoming Market. The Grand Junction, Montana, and Wyoming markets also have gaps in access to tertiary care.

A VISN meets the travel guidelines for access to hospital care if 65 percent of veterans in a market can get to a hospital within the required timeframes. Access to hospital care for the Eastern Rockies Market

at 54 percent, the Montana Market at 20 percent, and the Wyoming Market at 34 percent do not meet the CARES standard for hospital access. The Grand Junction Market is at 70 percent and the Western Rockies Market is at 65 percent, which meet the access guidelines. In written testimony, the VISN Director indicated that there was an error in the Montana data, and the numbers should indicate current access to hospital care is 46 percent, not 20 percent, for this market.[470] Tertiary care guidelines have been established at 65 percent of enrolled veterans, and the Grand Junction Market is at 61 percent, the Montana Market is at 2 percent, and the Wyoming Market is at 1 percent.[471]

The VISN Director testified that access standards in the Eastern Rockies Market could be reached with a plan to purchase care through a sharing agreement with the DoD in El Paso County (Colorado Springs).[472] This market has a projected workload gap in inpatient medicine. Overall hospital workload for this market is projected to increase by 47 percent from the FY 2001 baseline by FY 2012. In FY 2022, medicine is projected to be 27 percent higher than the FY 2001 baseline, while surgery and psychiatry are projected to decrease 8 and 17 percent, respectively, from the FY 2001 baseline. The plan to address this increased workload is through the replacement facility at Denver.

The Montana Market's plan is to contract for inpatient care in Billings and Great Falls, MT. To improve hospital and tertiary access in Sheridan in the Wyoming Market, the VISN will contract in Billings, MT. Additionally, the VISN plans to continue to provide some inpatient care services at the Denver and Salt Lake VAMCs.

Commission Findings

1. The VISN will contract for hospital and/or tertiary care in the Eastern Rockies, Montana, and Wyoming markets.
2. Contracting will improve tertiary care access in the Montana and Wyoming markets.

Commission Recommendation

The Commission concurs with the DNCP proposal to improve acute hospital access by contracting for inpatient care in the Eastern Rockies, Montana, and Wyoming markets and for tertiary care in the Montana and Wyoming markets.

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[470] Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Billings, MT, Hearing on September 24, 2003, page 20.

[471] VISN 19 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=63*].

[472] Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Billings, MT, Hearing on September 24, 2003, page 40.

VII Outpatient Care

DNCP Proposals

"*Primary Care Access* – The National CARES Plan attempts to balance meeting national guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. *Primary Care Workload* – Increasing the primary care outpatient services in one market, and highly rural care in all markets requires new construction and conversion of space. The replacement hospital at Denver will include a large outpatient care project and a VA/DOD joint venture. *Specialty Care* – Increase specialty care outpatient services in all five markets and at all care sites. Contracting is utilized in high peak periods of growth. New construction of 359,600 square feet is planned to meet environment of care concerns and the increasing workload demand. Other solutions include renovation, conversion of existing space and leasing alternatives."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

None of the seven CBOCs proposed for this VISN were in the DNCP's first priority group. Overall, outpatient specialty care in the VISN is projected to increase by 87 percent in FY 2012 and by 78 percent in FY 2022.[473] All markets have a projected increase in workload in specialty care. The Eastern Rockies Market projects an increase in primary care workload. Grand Junction, Montana, and Wyoming markets fall below access to primary care requirements.

The Eastern Rockies Market has a projected increase in workload in primary and specialty care. The Denver VAMC has a current space deficit of 132,000 square feet for specialty care, a 44,000 square feet deficit for primary care, and a 25,000 square feet deficit for mental health.[474] To address this, the VISN plans to construct 453,000 square feet of new outpatient space as a part of the Denver hospital replacement project.

In the Grand Junction Market, there is a projected workload increase for outpatient specialty care and the CARES Space Report indicates that there is a current space deficit of 19,000 square feet for outpatient specialty

[473] VISN 19 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=63*].
[474] VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

care. This report also indicates that there is a current 5,000 square feet deficit in primary care and a 2,000 square feet deficit in mental health.[475] The plan is to add about 20,000 square feet of space at Grand Junction.

Access to primary care is 62 percent for the Montana Market, compared to the guidelines established at 70 percent.[476] There are also projected increases in workload in primary and specialty care. Primary care access standards would have been improved with the proposed Cut Bank and Lewistown, MT, CBOCs. Even with these, the access standards would be difficult to achieve. Outpatient specialty care demand will be met through a combination of renovation and new construction. The Montana Market has projected increase in workload in mental health. Outpatient mental health demand will be met through contractual arrangements with local providers. Contracting will improve veteran access to care in the highly rural areas of the state. Most of the CBOCs proposed in this VISN have been proposed in order to improve access, as this VISN is a highly rural area.

Though access to primary care in the Western Rockies Market is 74 percent, which exceeds the 70 percent access standards, in testimony from the hearing, VSOs and Congressman Jim Gibbons expressed support for a CBOC in Elko, NV. In the Congressman's statement, he indicated that he could not "overstate the need for a community-based outpatient clinic in Elko, not only to serve the residents of the City of Elko and Elko County, but the surrounding area as well."[477] This CBOC would be supported by the Salt Lake City VAMC and would also serve veterans from the far eastern portion of VISN 21. The nearest VA service to Elko, NV, is 230 miles. VISN testimony indicated, "The Elko, Nevada, CBOC would serve the largest number of veterans of any of our proposed clinics. Elko County has a veteran population of approximately 4,800 veterans."[478] During the Sheridan, WY, site visit, the VSOs also strongly supported placing a CBOC in Afton, WY. Afton is approximately 200 miles from Salt Lake and 400 miles from Sheridan.[479]

The Western Rockies Market also has a projected increase of 72 percent in outpatient specialty care workload. The Salt Lake City VAMC has a large space deficiency of 118,000 square feet for specialty care, which is projected to increase to 137,000 square feet.[480] The plan is to lease space and for new construction and conversion of existing space. In testimony, Dr. Maffet indicated that in order to address the current space gap,

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[475] VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

[476] VISN 19 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=63*].

[477] The Honorable Jim Gibbons, Congressman from Nevada, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 17.

[478] Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 46.

[479] CARES Commission Site Visit Report, VISN 19, Rocky Mountain Network, Sheridan, WY, available from [*http://www.carescommission.va.gov/Documents/SiteVisitVISN19MilesCitySheridanRivertonRifleGrandJunctionMontrose.pdf*].

[480] VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

there is a critical need to open the CBOC in the West Valley of Salt Lake City to move some of the primary care and specialty care workload from the main facility. He indicated that if this CBOC were not approved, there would be need for further construction at the Salt Lake VAMC, which would be expensive,[481] though no cost data were provided.

The Wyoming Market's current access to primary care is 67 percent, which is slightly below the 70 percent standard. There is also a projected increase in specialty care workload. In Sheridan, there is a current gap of about 17,000 square feet for specialty care and an excess of about 9,000 square feet for primary care and mental health. The facility will convert about 6,000 square feet of existing space to support specialty outpatient care. In testimony, the VISN Director indicated that there is also a need to contract for a number of specialty services in the Sheridan community. He indicated that this, along with contracting to improve access to hospital services, had been proposed in the VISN market plan, though he noted that the DNCP did not include these plans and instead called for providing services in Denver and Salt Lake City.[482]

Commission Findings

1. There are projections for growth in specialty care in all five markets in the VISN, and there are current space deficits in all facilities that are projected to have increased workload. Plans are to address these gaps through CBOCs and/or new construction and renovation of space.
2. The Montana Market, even with the inclusion of the two proposed CBOCs, will have difficulty reaching access standards.
3. Outpatient mental health demand in the Montana Market will be met through contracting with local providers.
4. A CBOC in the city of Elko, NV, would serve residents in the surrounding area, which has a veteran population of approximately 4,800.
5. There is a very large outpatient space deficit at the Denver VAMC and if the plan to build a replacement facility is not realized, it is not clear how the need for increased outpatient space would be resolved. It is also not clear how the VISN will address its current space shortages until a replacement facility becomes available.
6. A CBOC in Afton, WY, would serve veterans who are more than 200 miles from the Sheridan VAMC and 400 miles from the Salt Lake City VAMC.

[481] Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 46.

[482] Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 28.

7. The Western Rockies Market needs to move some of the outpatient care out of the Salt Lake City VAMC to avoid having to do construction at that facility. Salt Lake City has a significant current space deficit of 125,000 square feet for outpatient care and, without the ability to lease space at a new site, there appears to be no expeditious way to address the problem.

8. To prevent patients from having to travel significant distances one-way to see a specialist, there is a need to contract for specialty care in rural communities, such as Sheridan, Grand Junction, and Miles City.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to meet part of the future demand for more primary care, mental health, and specialty outpatient care through construction and conversion of space at current sites of care, and to increase specialty care at selected current sites of care, as well as contracting in high peak periods of growth. The Commission notes, however, that merely increasing services at existing sites of care will not resolve the access gaps in some markets.

2. The Commission recommends that:[483]

   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

   b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

   c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

   d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

   e. Whenever feasible, CBOCs provide basic mental health services.

   f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

[483] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

VIII Enhanced Use – Salt Lake City

DNCP Proposal

"*Enhanced use leasing* is being explored at Salt Lake (Phase 2). Proposal was submitted to demolish old VA buildings and replace buildings with a new building. VA will occupy some of the space."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Phase I of an enhanced use project in Salt Lake City has been completed, and planning is underway for Phase II. Phase I consisted of the construction of an office building at the Salt Lake City medical center campus, which is currently occupied by VBA and VHA. Other renters are also being sought to occupy the remaining space in the Phase I building.

In Phase II, the proposal is to construct a 125,000 square foot joint research facility for VA and the University of Utah, which would consolidate research to one location.

In response to questions, Mr. James Floyd, Director of the Salt Lake City VAMC, indicated that although it took three to four years to work through the details to get the Phase I projects approved, he thought Phase II would go faster as some hurdles had already been cleared. He believed they would begin construction in spring 2004.[484] In testimony, Dr. Lorris Betz, Dean of the University of Utah Medical School, indicated that they are looking at leasing space and doing joint research with VA at the new enhanced use site.[485]

Commission Findings

1. Salt Lake City has successfully completed one enhanced use lease project and is well underway with Phase II, using the same developer.

[484] James Floyd, Medical Center Director, Salt Lake City VAMC, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 61.

[485] Dr. Lorris Betz, Dean University of Utah Medical School, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 210.

2 The University of Utah is supportive of building a single research facility and moving their research activities to the new building on the VA grounds.

Commission Recommendation

The Commission concurs with the DNCP proposal for the Phase II enhanced use project at Salt Lake City.

VISN 20 – VA Northwest Network Alaska

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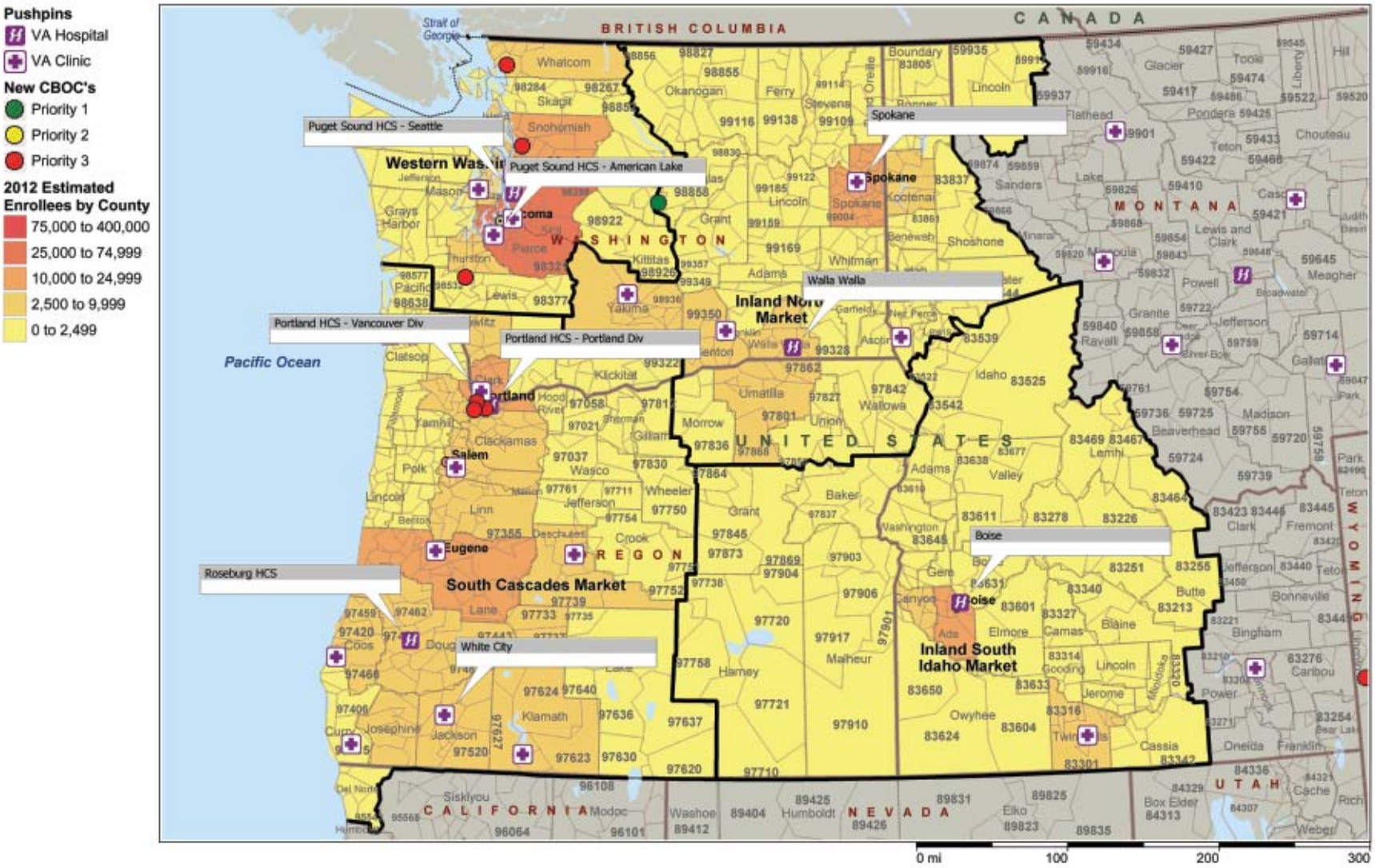
VISN 20 – VA Northwest Network



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VISN 20, Northwest Network

VISN Overview

VISN 20, Northwest Network, includes the states of Alaska, Oregon, Washington, most of the state of Idaho, and counties in northwest California and northwest Montana. The VISN facilities are spread over a geographic area that encompasses approximately 22 percent of the United States landmass. The VISN covers approximately 788,500 square miles, of which 72 percent is the state of Alaska.

The VISN delivers care through six medical centers, one independent domiciliary, one independent outpatient clinic, a mobile clinic, and 18 community-based outpatient clinics (CBOCs) with a staff of approximately 7,883 FTEs.[486] The VA Northwest Network provided medical services to approximately 174,000 of the 294,000 veterans enrolled in the system in FY 2003.[487] Additionally, VA operates 14 Vet Centers in VISN 20's catchment area. Total veteran population for this VISN is 1.2 million.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 20.

VISN 20	FY 2001	FY 2012	FY 2022
Enrollees	251,090	296,944	282,121
Veteran Population	1,226,278	1,050,949	892,760
Market Penetration	20.48%	28.25%	31.60%

For the CARES process, this VISN is divided into five markets: Alaska Market (*facility:* Anchorage, AK); Inland North Market (*facilities:* Spokane and Walla Walla, WA); Inland South Market (*facility:* Boise, ID); South Cascades Market (*facilities:* Portland, Roseburg, and White City, OR); and Western Washington Market (*facilities:* Seattle and American Lake, WA).

Information Gathering

The CARES Commission visited three sites in VISN 20 and conducted three public hearings. The Commission received 6,536 public comments regarding VISN 20.

[486] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.
[487] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.

- *Site Visits:* Vancouver, WA, on July 16; Walla Walla, WA, on July 18; and White City, OR, on October 3.
- *Hearings:* Portland, OR, on September 26; Walla Walla, WA, on September 29; White City, OR, on October 3.

Summary of CARES Commission Recommendations

I Realignment – Vancouver

1. The Commission does not concur with the DNCP proposal to vacate the Vancouver campus. The Commission recommends maintaining the current mission at the Vancouver facility, while reducing the campus footprint.
2. The Commission recommends that VA explore options to expand Vancouver's function, particularly with regard to relocating services from the Portland VA Medical Center.

(see page 5-322)

II Small Facility – White City Southern Oregon Rehabilitation Center Clinic

1. The Commission does not concur with the DNCP proposal to transfer the domiciliary and Compensated Work Therapy (CWT) programs from White City to other VAMCs. The Commission agrees with the VISN-recommended alternative that the White City SORCC maintain its current mission.
2. The Commission concurs with the DNCP proposal that White City should retain its outpatient services.

(see page 5-324)

III Small Facility – Walla Walla

1. The Commission concurs with the DNCP proposal to close the Walla Walla VAMC and, where appropriate, contract for acute inpatient medicine and psychiatry care and nursing home care in the Walla Walla geographic area. The Commission recommends that:
    a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
    b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

2 The Commission concurs with the DNCP proposal to maintain outpatient services and recommends that outpatient care be moved off the Walla Walla VAMC campus after inpatient services have been relocated.[488]

(see page 5-326)

IV Small Facility – Roseburg

1 The Commission concurs with the DNCP proposal on converting surgical beds to 24-hour surgical observation beds at Roseburg.

(see page 5-329)

V Inpatient Care

1 The Commission concurs with the DNCP proposal to move 15 inpatient beds from American Lake to Madigan Army Medical Center.

(see page 5-330)

VI Outpatient Care

1 The Commission concurs with the DNCP proposal to add a new CBOC in the Inland North Market; to increase primary care services in three other markets through VA/DoD joint ventures, new construction, and converting in-house space; to meet increased demand for mental health services in the Inland North Market in-house and through contracting; and to increase outpatient specialty care services in all five markets through two new CBOCs, new construction, in-house expansion, and contracting.

2 The Commission recommends that:[489]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

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[488] General Counsel (024), Request for Opinion Regarding Legal Effect of Public Law 100-71 Provision, Under Secretary of Health (10).

[489] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-331)

VII VA/DoD Collaboration

1 The Commission concurs with the DNCP proposal on DoD initiatives and recommends the Elmendorf Air Force Base proposal be expedited due to the expiration of the lease space currently occupied by the Alaska VA Health Care System (HCS) in FY 2007.

(see page 5-334)

VIII Infrastructure and Safety

1 The Commission concurs with the DNCP proposal for the seismic/life safety projects in VISN 20. The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

(see page 5-336)

Realignment – Vancouver

DNCP Proposals

"Study/develop a plan to enhance use lease the campus by contracting for nursing home care and relocating outpatient services to another location to maintain or improve access. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Demolition of most of the old buildings, EUL unused acreage.
3. *100 Percent Contracting*
4. *Alternative 1:* Vacate Vancouver campus. Relocate some services to Portland, lease new space in the community, contract for some care.
5. *Alternative 2 [The VISN's preferred alternative]:* Demolition of old buildings creating 19.6 acres for EUL. Leave clinical services at Vancouver.

Commission Analysis

The VISN did not choose the DNCP-recommended alternative and submitted a realignment proposal that recommends maintaining current services at the Vancouver campus (rehabilitation, long-term care, outpatient primary care, mental health, and substance abuse treatment), but reducing the current campus footprint by demolishing old cantonment structures to reduce operating costs. This demolition would make 19.6 acres available for enhanced use leasing on this campus.

Vancouver is a 72-bed rehabilitation and extended care center that serves the Portland/Vancouver metropolitan area. The center's services include extended care rehabilitation, physical medicine activities (occupational therapy, physical therapy, cardiac rehabilitation, etc.), nursing home care, a skilled nursing care unit, and a new outpatient clinic that offers primary care, mental health, and substance abuse treatment. These services are not duplicated at the Portland VAMC and could not be transferred there, as the Portland VAMC is landlocked and has a significant parking deficit. Information received at site visits by the Commission and testimony from veterans and stakeholders support the data regarding the lack of capacity at the Portland VAMC, travel congestion, and limited parking at the Portland site. As the VISN Director indicated, "Vancouver

is a key component to decompressing and expanding Portland's specialty and tertiary care capability that supports all of Oregon and to a limited extent, facilities in eastern Washington and Idaho as well."[490]

The Vancouver campus also has the first enhanced use lease in VA for a single-room occupancy transitional housing unit that serves hundreds of veterans. Further EUL opportunities exist with public entities to support health care related programs and to provide housing for VISN administrative functions.

The Commission received multiple comments concerning the possible reduction of services at the Vancouver facility. The comments indicated that veterans are pleased with the service provided at Vancouver, would be harmed by the facility's removal, and that a hardship would be caused by the need to travel to another facility.

Commission Findings

1. The Portland VAMC is dependent on Vancouver for providing patient care capacity.
2. Vancouver's capacity continues to allow Portland to expand its specialty and tertiary care capacity and provide service for multiple markets.
3. Vancouver provides rehabilitation, extended care services, and other programs that the Portland VAMC does not.
4. The Portland campus is landlocked with significant parking deficits and topographical issues, making expansion of that facility a challenge.
5. The Vancouver campus provides space for outpatient services, has parking available, and decreases travel time for some veterans.
6. Extraneous buildings on the Vancouver campus could be demolished, making land available for the enhanced use lease program.
7. Traffic congestion impacts on travel time to the Portland VAMC.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to vacate the Vancouver campus. The Commission recommends maintaining the current mission at the Vancouver facility, while reducing the campus footprint.
2. The Commission recommends that VA explore options to expand Vancouver's function, particularly with regard to relocating services from the Portland VAMC.

[490] Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

II Small Facility – White City Southern Oregon Rehabilitation Center Clinic (SORCC)

DNCP Proposal

"The domiciliary and CWT programs will be transferred to other VAMCs. Maintain outpatient services. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Maintain White City residential beds based on CARES projections for VISN 20 (plus Northern California and Nevada) and expand outpatient services
3. *100 Percent Contracting*
4. *Alternative 1:* Close White City campus and relocate all residential beds to American Lake. Move outpatient services to new clinic in Medford.
5. *Alternative 2:* Close White City campus and relocate residential beds to Roseburg. Move outpatient services to new clinic in Medford.
6. *Alternative 3 [The VISN's preferred alternative]:* Maintain current programs at White City similar to the initial VISN 20 Market Plan; decrease operating beds to 500.

Commission Analysis

The White City Southern Oregon Rehabilitation Center & Clinics (SORCC) focuses on intensive psychosocial rehabilitation for patients who have failed at other rehabilitation efforts. Use of admission criteria, motivational assessment, needs-based programming, and case managers to improve outcomes has been in place since 2000. White City became a VISN referral point following the closure of the inpatient domiciliary and substance abuse programs at Portland.

Testimony at the Livermore, CA, hearing indicates that VISN 21 refers 40 percent of its domiciliary patients to the White City SORCC and has no way to provide alternative care for these patients.[491] In public comment by James A. Prevatt, a veteran and volunteer at the White City SORCC facility, he stated, "I have personally

[491] Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

witnessed people's lives saved because of the mental health treatment there."[492] Many other comments were received that echoed this sentiment. Max McIntosh, PhD, Deputy Director of White City, stated, "Last year, people came to us from 40 states, and we are greatly
relied upon by Nevada and California, as well as the Northwest VISN."[493] All of the affiliate-related witnesses at the White City hearing spoke to the importance of White City in the VA health profession's educational mission. Ms. Donna Markle, MSN, Associate Professor, Oregon Health Sciences University Nursing School (OHSU), stressed the need for clinical experiences outside acute settings to educate future nurses. She indicated that training sites like SORCC are critical if the school is to double nursing enrollment in the next five years. She also noted that OHSU recently received a grant to bring the nurse practitioner mental health program to SORCC for clinical rotations.[494]

The Commission noted that White City provides care for patients who have dual diagnoses and often have failed at other domiciliary programs. While the metropolitan locations are often preferable for domiciliaries, in this case, the Commission believes that the sheltered workshops provided at White City would be hard to replicate in an urban setting. The Commission also observed that the local community is very supportive of the White City SORCC.

Commission Findings

1. The treatment model established at White City demonstrates clinical innovation for this difficult patient population.
2. Rehabilitation services provided at White City are unique and provide services for veterans who have not been successful in other domiciliary programs.
3. The White City SORCC is a referral center for a number of VISNs.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to transfer the domiciliary and CWT programs from White City to other VAMCs. The Commission agrees with the VISN-recommended alternative that the White City SORCC maintain its current mission.
2. The Commission concurs with the DNCP proposal that White City should retain its outpatient services.

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[492] James Prevatt, Veteran and SORCC Volunteer, Written Public Comment submitted on VISN 20.

[493] Max E. McIntosh, Ph.D., Deputy Director, VA Domiciliary, Transcribed Testimony from the White City, OR, Hearing on September 26, 2003.

[494] Donna Markle, MSN, Associate Professor, Oregon Health Sciences University Nursing School, Transcribed Testimony from the White City, OR, Hearing on September 26, 2003, page 59.

III Small Facility – Walla Walla

DNCP Proposal

"Maintain outpatient services and contract for acute inpatient medicine and psychiatry care (will improve hospital access in the Inland North Market) and nursing home care. The campus will be evaluated for alternative uses to benefit veterans, such as EUL for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Alternative 1:* Contract inpatient medicine and emergency room; inpatient mental health – limited capacity within the service area so 50 percent transfer to Spokane VAMC to outpatient and 50 percent contract. Convert residential rehabilitation and substance abuse to outpatient and lease space for programs. Lease space in community for nursing home; contract food services and laundry.
3. *Alternative 2:* Construct new space for ten-bed inpatient psychiatric unit. Contract inpatient medicine, emergency room, and nursing home; lease space for outpatient residential rehabilitation and substance abuse program.

Commission Analysis

The Walla Walla VAMC is located in southern Washington and sits on the grounds of what was once Fort Walla Walla. Buildings from the original fort date from the period between 1877 and 1906. Fifteen of the original buildings are still in use on the 88-acre campus. Since the campus' infrastructure is integrated, the VISN must provide services for all of the buildings, not just those that are in use. Maintaining these excess buildings requires the use of funds that could otherwise be used for patient services. In addition, the compound, together with the remaining original fort buildings, was placed on the National Historic Register in 1974, and the realignment proposal submitted by the VISN does not indicate what could be done with these buildings. Further, the VISN Director, Dr. Leslie Burger, indicated that several of the buildings are seismically unsafe and would require millions of dollars to bring up to current standards. Finally, there is lead-based paint in the housing on the grounds. For all of these reasons, the Walla Walla campus has a very-low potential for EUL.

Walla Walla has five operating medicine beds with an ADC in FY 2003 of four, provides inpatient psychiatry with 31 operating beds with a census of 21, and operates a nursing home unit with 30 beds with an ADC of 22.[495] The acute psychiatric unit includes 15 patients in residential rehabilitation and five who are acutely ill.[496] Walla Walla also provides outpatient services, and in FY 2001, provided approximately 32,000 stops for primary care, 11,000 stops for specialty care, and 11,000 stops for mental health.[497]

Dr. Burger's testimony regarding the Walla Walla site mission change reflected the challenges of providing access to care given the highly rural nature of this area. He emphasized the importance of maintaining or improving the level of care given the change in mission at the Walla Walla site.[498] Accordingly, when it comes to inpatient medicine and nursing home care, the local community in Walla Walla has options for providing this care. Dr. Burger further stated that VA staff could be accommodated in the local nursing home to which the veterans would be moved.

There would be more of a challenge in providing care for Walla Walla's psychiatric patients, as psychiatric services in the immediate Walla Walla area are presently not available. However, the Commission believes that the VISN leadership has not been aggressive enough in pursuing possible alternatives. Because the patients cared for in acute psychiatry at Walla Walla come evenly from the Tri-Cities area (Richland, Kennewick, and Pasco), Yakima, and Walla Walla,[499] testimony indicated that additional exploration is needed to identify opportunities for inpatient psychiatric care. The Commission noted that a combination of solutions would probably be needed. For example, although there are two JCAHO accredited hospitals in Walla Walla and neither currently provides inpatient psychiatric care, the possibility of working with these facilities to add psychiatric care was not explored. There are also JCAHO accredited hospitals in Tri-Cities that provide psychiatric care, and the Spokane VAMC has an inpatient psychiatric unit as well.

Commission Findings

1. Walla Walla has a small patient census, with an ADC of four for inpatient medicine and an ADC of 21 for inpatient psychiatry. About five of these inpatient psychiatry patients are acutely ill.
2. Inpatient psychiatry patients come evenly from three areas: Walla Walla, Yakima, and Tri-Cities.
3. Alternatives to providing psychiatric care for Walla Walla's patients do not appear to have been fully explored.

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[495] Appendix D, *Data Tables*, page D-96.
[496] Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.
[497] VSSC, *FY01 Baseline Workload by Treating Facility VISN 20*, Data as Provided by Milliman USA with VSSC Re-Allocation of FEE Workload to Planning Categories, updated as of December 20, 2002.
[498] Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.
[499] Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

a Although there are JCAHO-accredited community hospitals in Walla Walla and none provide acute psychiatric care,[500] further exploration of community resources is needed regarding provision of the small amount of inpatient psychiatric services provided at the Walla Walla VAMC.

b Tri-Cities has JCAHO-accredited facilities that provide psychiatric care.

c Spokane has an inpatient psychiatric unit.

4 Some buildings at the Walla Walla VAMC site are seismically unsafe, and many of the buildings will require millions of dollars to renovate.

5 The Walla Walla campus is not a good candidate for EUL.

6 Outpatient services currently provided at the Walla Walla campus are essential to meeting access standards in this market.

Commission Recommendations

1 The Commission concurs with the DNCP proposal to close the Walla Walla-VAMC and, where appropriate, contract for acute inpatient medicine and psychiatry care and nursing home care in the Walla Walla geographic area. The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

2 The Commission concurs with the DNCP proposal to maintain outpatient services and recommends that outpatient care be moved off the Walla Walla VAMC campus after inpatient services have been relocated.[501]

[500] Appendix D, *Data Tables*, page D-96.

[501] General Counsel (024), Request for Opinion Regarding Legal Effect of Public Law 100-71 Provision, Under Secretary of Health (10).

IV Small Facility – Roseburg

DNCP Proposal

"Converting surgical beds to 24-hour surgical observation beds is underway in Roseburg."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The Roseburg VAMC serves veterans in the southern Oregon and northern California area with 88 authorized acute beds and an ADC of 67 patients. Surgical ADC has been one patient. Roseburg also has a 75-bed nursing home care unit with an ADC of 70 patients. The Roseburg VAMC provides acute care services to the White City SORCC.

In response to a question about the efficiency of having two surgical beds at Roseburg, the medical center director, Mr. George Marnell, indicated that "there is an active outpatient surgical program, and we have moved many of the procedures that ordinarily would require an inpatient stay into an outpatient setting."[502] He also reported that they use the two beds as the exception to that rule when there are cases that "need an overnight stay in conjunction with their surgery."[503] When a question was raised as to whether staffing efficiency and costs allow for that, Mr. Marnell indicated that it is not a burden because surgical patients are integrated into beds on the medical wards and the same nursing staff is used, which also allows staff to keep up their competencies for surgical recovery.[504]

[502] George Marnell, Director of the Roseburg VAMC, Transcribed testimony at the Portland, OR, Hearing on September 26. 2003.
[503] George Marnell, Director of the Roseburg VAMC, Transcribed testimony at the Portland, OR, Hearing on September 26. 2003.
[504] George Marnell, Director of the Roseburg VAMC, Transcribed testimony at the Portland, OR, Hearing on September 26. 2003.

Commission Finding

Using available inpatient beds for the occasional surgical patient who requires a higher level of services has no negative impact on either efficiency or staffing as patients are admitted to existing empty beds on the medicine ward.

Commission Recommendation

The Commission concurs with the DNCP proposal on converting surgical beds to 24-hour surgical observation beds at Roseburg.

V Inpatient Care

DNCP Proposal

"Western Washington Market will need to increase inpatient medicine services. VA Puget Health Care System, and Seattle, will absorb additional workload through increased in-house contract and joint venture options. A joint venture with Madigan Army Medical Center (MAMC) will involve closure of American Lake acute beds and referral of inpatient care to MAMC. Capital investments are not required."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In the Western Washington Market, the VA Puget Sound Health Care System has had an increase in demand for inpatient tertiary care and has limited room to expand. Solutions include renovation, contracting, and partnering with affiliates and other Federal agencies. The VISN Director testified, "Opportunities to partner with DoD in the South Puget Sound area cry out to be accomplished."[505]

[505] Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

A joint venture with MAMC involves the closure of 15 American Lake acute beds. This will free up 8,500 square feet of space at American Lake to meet outpatient service requirements. The proposal that the American Lake campus transfer its acute care patients to the tertiary care medical center at Madigan was recently selected by the VA/DoD Executive Council as a demonstration project for collaboration, and as such has support at the top levels of both departments.

Commission Finding

The collaboration agreement between MAMC and the American Lake campus of the Puget Sound VAMC is a sound approach to address the market's need for increased inpatient medicine services.

Commission Recommendation

The Commission concurs with the DNCP proposal to move 15 inpatient beds from American Lake to Madigan Army Medical Center.

VI Outpatient Care

DNCP Proposals

"*Primary Care* – VISN 20 will increase primary care access points in the Inland North Market by adding a new CBOC site in central Washington state and enhancing the Spokane mobile clinic. This will help achieve access for more than 20 percent of veterans who will be within a 30-minute drive time of primary care. Increase the primary care outpatient services in three markets and at all care sites through planned CBOC and DoD joint ventures, new construction, and converting in-house space. *Mental Health* – Increased demand for mental health in the Inland North Market will be managed in-house and through increased contracting. Mental health and primary care services are integrated into all new CBOCs. *Specialty Care* – All five markets and all care sites will need to increase outpatient specialty care services. In all cases, approaches include expanding specialty care in-house services and contracting in high peak periods of growth. Additionally, two CBOCs will offer selected high volume specialty care services. New construction of 228,467 square feet is planned to meet access, environment of care concerns, and the increasing workload demand. Other solutions include a combination of renovation, conversion of existing space, and leasing."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Increasing primary care outpatient capacity in three markets and at all care sites in the markets will require significant recurring funding, both capital and leasing. Patients must travel great distances for care, which prompted this VISN to use telemedicine to encourage communication among staff and to provide health care services in areas such as dermatology, cardiology, mental health, spinal cord injury, and geriatrics. As VISN 20 is mostly rural, this is an effective way to provide access. The VISN Director testified:

> Our greatest challenge will be to continue delivering efficient, quality health services to an ever-growing population of veterans across a very large geographic area. I would like to [also] highlight that VISN 20, at the present time, has the largest waiting list of the 21 networks, despite the fact that we have taken over 40,000 veterans off the waiting list since July of last year.[506]

Of the nine CBOCs proposed for this VISN, only one is classified in priority group one in the DNCP.

In the South Cascades Market, the Portland VAMC proposes to relieve the overcrowded conditions at the facility and move primary care services off the main campus by developing CBOCs in the Portland metropolitan area. Two of these CBOCs have been approved by VA Central Office, outside of the CARES process, and one in the South Metro area has yet to be approved. The Portland VAMC would then have the ability to expand inpatient and outpatient specialty care at the Portland campus. Moving outpatient workload to the Vancouver facility would allow Portland to expand its specialty and tertiary care capacity. Additionally, testimony from stakeholders regarding the Portland VAMC reflected difficulty with parking availability and travel due to the location of the medical center.

In the Western Washington Market, the VA Puget Sound Health Care System is projected to have a 120 percent increase over the FY 2001 baseline by FY 2012 and 123 percent increase by FY 2022 for outpatient specialty care with limited room to expand. Solutions include renovation, contracting, and partnering with affiliates and other Federal agencies. Stakeholder testimony reflected that either Olympia or Bellingham would be an appropriate location for a CBOC due to traffic congestion and long travel times to the Seattle VAMC.

[506] Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

The Inland South Market also projects growth in outpatient care of approximately 12 percent over the FY 2001 baseline in FY 2012 decresing to 6 percent over baseline in FY 2022. The DNCP calls for expansion of outpatient capacity through internal expansion and community partnering.

The Inland North Market has access gaps for primary care of 23 percent over the FY 2001 baseline by FY 2012 and decreasing to 6 percent by FY 2022, and projected growth for outpatient mental health. The only CBOC in priority group one for this VISN is in the Inland North Market. This CBOC would target a five-county area in central Washington, where veterans drive more than 150 miles to obtain care. Testimony also claimed that the area is medically underserved and that access to care can only be met through the use of CBOCs because of electronic limitations in these geographic locations.

The Spokane VAMC operates a mobile clinic and currently has no CBOCs. The need for outpatient mental health care is projected to grow in the Inland North Market by 42 percent, with 21,000 additional or 71,000 total stops by FY 2012 and then decrease to 13 percent over baseline by FY 2022. This mobile clinic represents an alternative method for delivering health care to rural communities, but does not replace the need for CBOCs in this market.

Commission Findings

1. All five markets will expand outpatient specialty care capacity through expansion of in-house capacity and contracting.
2. The Portland VAMC in the South Cascades Market needs to move primary care services off the main campus. Two CBOCs have been approved for the metropolitan Portland area and one CBOC in the South Metro area remains to be approved outside the CARES process.
3. The Western Washington Market has an increase in demand for outpatient specialty care. Veterans in Olympia and Bellingham in particular are faced with traffic congestion problems that enhance the need for CBOCs in these areas.
4. The Inland North Market has a primary care access gap.
5. The Spokane VAMC operates a mobile clinic to help meet the needs of this highly rural area.
6. Mental health services are currently provided in some CBOCs.
7. The VISN uses telemedicine to encourage staff communication and to provide health care services.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to add a new CBOC in the Inland North Market; to increase primary care services in three other markets through VA/DoD joint ventures, new construction, and converting in-house space; to meet increased demand for mental health services in the Inland North Market in-house and through contracting; and to increase outpatient specialty care services in all five markets through two new CBOCs, new construction, in-house expansion, and contracting.
2. The Commission recommends that: [507]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

VII VA/DoD Collaboration

DNCP Proposal

"The proposed collaborations between VA and DoD include: 1) a pilot VA/DoD demonstration site with American Lake Division, VA Puget Sound Health Care System, and Madigan Army Medical Center;

[507] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

2) ongoing collaboration efforts with Everett Naval Hospital, Bremerton Naval Hospital, and Oak Harbor Naval Hospital; and 3) VA Alaska HCS is planning for expanded sharing/integration with both Bassett Army Community Hospital and Elmendorf Air Force Base in order to meet demand projections in both Fairbanks and Anchorage."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

During testimony, the Commission heard about the close working relationship between VA and DoD in this VISN.

The American Lake campus of the Puget Sound Health Care System has proposed a pilot collaboration with MAMC. The plan calls for the relocation of 15 American Lake medicine beds and all emergency room services to MAMC. In return, VA staff will provide service at Madigan. (See Inpatient Care, above, for a fuller discussion.)

Ongoing collaboration with Everett Naval Hospital, Bremerton Naval Hospital, and Oak Harbor Naval Hospital includes partnering to provide medical and surgical outpatient and inpatient care, emergency medical care, mental health services, geriatrics, gynecology services, and pharmacy, radiology, and laboratory services.

In the Alaska Market, Dr. Burger testified that VA has outgrown its leased space in Anchorage. The lease was very expensive, and it will expire in 2007. This facility coordinates care for the whole state. A major construction project is proposed as a joint venture collocation with the Air Force at Elmendorf Air Force Base (AFB), including constructing a building adjacent and connected to the Elmendorf Hospital. This new facility would increase primary care space by 75 percent, specialty care space by 100 percent, and mental health space by 100 percent.[508] The Commission heard repeatedly through testimony that expeditious action must be taken on this proposal due to the expiring lease at the current location.

The Army provides VA space at the Bassett Army Community Hospital in Fairbanks, AK, where VA operates the Fairbanks CBOC. Bassett also provides pharmacy support for the CBOC. The Army is constructing a new hospital facility scheduled for completion in FY 2005. The VA clinic will gain an additional 1,100 square feet for a total of 3,000 square feet as part of this construction.

[508] CARES Commission Site Visit Report, VISN 20, VA Northwest Health Network, Vancouver, WA, available from [*http://www.carescommission.va.gov/Documents/SiteVisitVISN20PortlandVancouver.pdf*].

Commission Findings

1. There is ongoing collaboration with Everett Naval Hospital, Bremerton Naval Hospital, and Oak Harbor Naval Hospital to provide selected care.
2. The Alaska Market has outgrown its leased space and a joint venture has been proposed at Elmendorf AFB in Anchorage, AK. Expeditious action must be taken on this joint venture to address the leased space issue in Anchorage.
3. The Army is constructing a new facility at the Bassett Army Community Hospital in Fairbanks, AK, and the VA clinic will gain space for its outpatient clinic with this new construction.
4. The American Lake campus, in collaboration with MAMC, plans to relocate 15 American Lake medicine beds and all emergency room services to MAMC.
5. The VA/DoD collaboration in this VISN is very effective.

Commission Recommendation

The Commission concurs with the DNCP proposal on DoD initiatives and recommends the Elmendorf Air Force Base proposal be expedited due to the expiration of the lease space currently occupied by the Alaska VA HCS in 2007.

VIII Infrastructure and Safety

DNCP Proposal

"Seismic conditions will be improved through proposed construction projects at Portland, American Lake, Seattle, White City, and Roseburg."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN has seismic construction issues at Roseburg (inpatient), White City (residential domiciliary), American Lake (NHCU, research, outpatient mental health, and main hospital building), Seattle (ambulatory/administration building and research), and Portland (main hospital building and administration/research building). Complete cost data is not available for seismic improvements at all facilities.

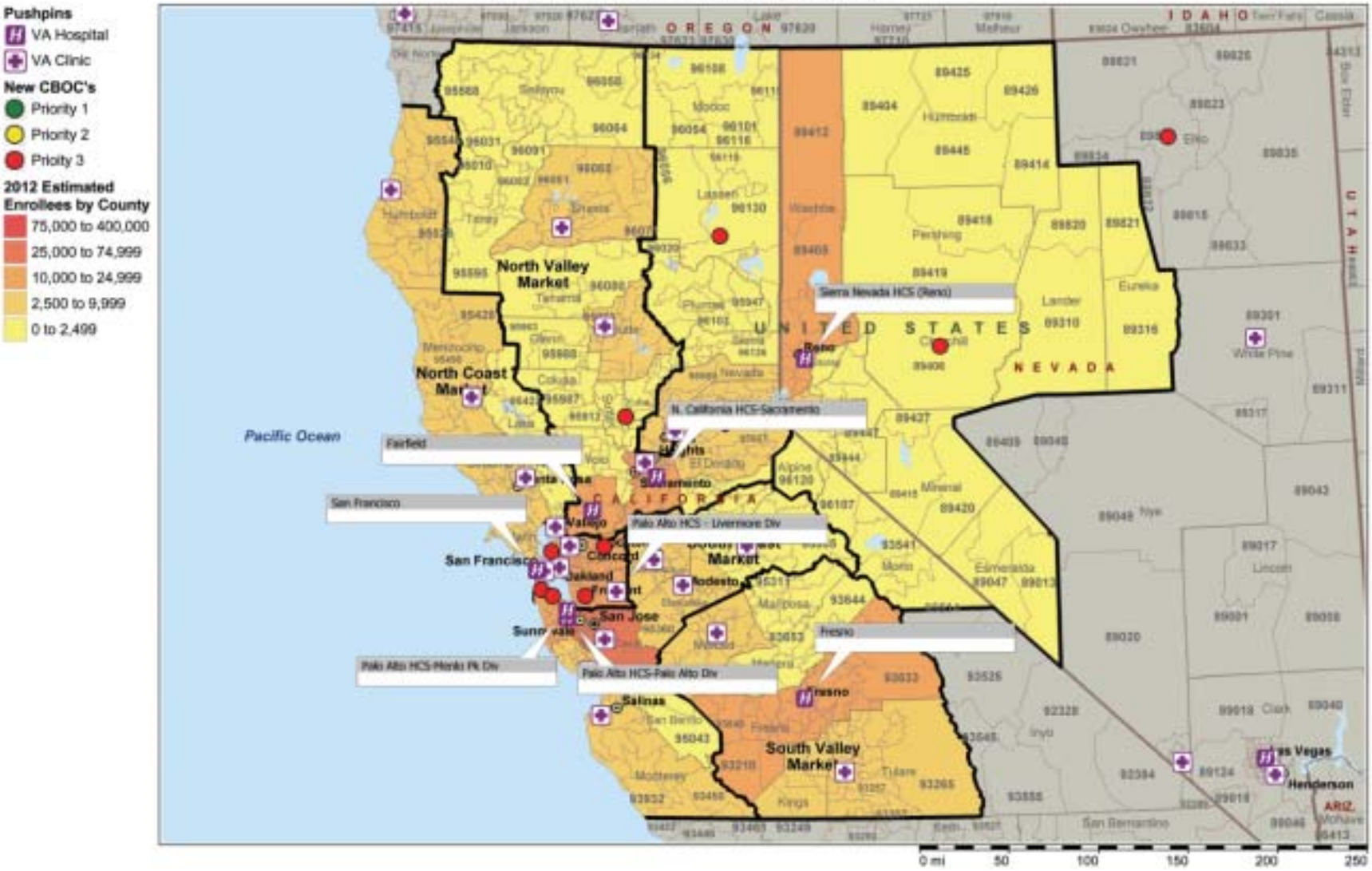
Commission Finding

Seismic construction projects are needed at Roseburg, White City, American Lake, Seattle, and Portland.

Commission Recommendation

The Commission concurs with the DNCP proposal for the seismic/life safety projects in VISN 20. The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

VISN 21 – VA Sierra Pacific Network



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VISN 21 – VA Sierra Pacific Network Hawaii

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VISN 21, Sierra Pacific Network

VISN Overview

VISN 21, Sierra Pacific Network, is an integrated, comprehensive health care system that provided medical services to approximately 188,000 of the 316,000 veterans enrolled in the VISN in FY 2003.[509] Geographically, this VISN spans more than 472,000 square miles. The service area includes central and northern California, northern Nevada, Hawaii, the Philippines, and several Pacific Islands including Guam and American Samoa, and has a total veteran population of 1.2 million. Counties in this VISN range from highly urban to highly rural. VISN 21, with a staff of 7,896 FTEs,[510] delivers health care services through six medical centers, seven nursing homes, 26 community-based outpatient clinics (CBOCs), and a VA CBOC and Regional Office Center (VARO/OC). Additionally, the VA operates 14 Vet Centers in VISN 21's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 21.

VISN 21	FY 2001	FY 2012	FY 2022
Enrollees	253,799	257,471	216,224
Veteran Population	1,234,254	936,134	716,508
Market Penetration	20.56%	27.50%	30.18%

For the CARES process, this VISN is divided into six markets: North Coast Market (*facilities:* San Francisco and Martinez, CA); South Coast Market (*facilities:* Palo Alto, Livermore and Menlo Park, CA); North Valley Market (*facility:* Sacramento, CA); South Valley Market (*facility:* Fresno, CA); Sierra Nevada Market (*facility:* Reno, NV); and Pacific Island Market (*facility:* Honolulu-OPC).

[509] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[510] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002-September 2003.

Information Gathering

The CARES Commission visited three sites in VISN 21 and conducted one public hearing. The Commission received 961 public comments regarding VISN 21.

- *Site Visits:* Palo Alto Health Care System, which includes Palo Alto, Menlo Park, and Livermore facilities, on July 22 and July 23.
- *Hearing:* Livermore, CA, on October 1.

Summary of CARES Commission Recommendations

I Campus Realignment – Livermore

1. The Commission does not concur with the DNCP proposal that nursing home care at Livermore be transferred to Menlo Park and the community.
2. The Commission recommends that the long-term care (LTC) services (nursing home beds) at Livermore be retained as a freestanding nursing home care unit.
3. The Commission concurs with the DNCP proposal to transfer sub-acute beds to Palo Alto.
4. The Commission concurs with the DNCP proposal to shift outpatient care to CBOCs.

(see page 5-344)

II Inpatient Care and Access

1. The Commission concurs with the DNCP proposal for expansion of services at the Reno VA Medical Center (VAMC) and contracting for services in South Coast and Sierra Nevada markets as needed to meet inpatient access demands.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-346)

III Outpatient Care

1. The Commission recommends that VA open a new CBOC closer to the residences of patients who now receive outpatient care at Livermore.

2. The Commission recommends that:[511]

   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

   b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

   c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

   d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

   e. Whenever feasible, CBOCs provide basic mental health services.

   f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-348)

IV VA/DoD Sharing

1. The Commission concurs with the DNCP proposals on DoD collaborations.

(see page 5-352)

[511] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

V Infrastructure and Life Safety

1. The Commission concurs with the DNCP proposals for seismic construction projects at facilities in the North Coast, South Coast, and South Valley markets.
2. The Commission recommends that patient and employee safety should be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

(see page 5-354)

VI San Francisco/Palo Alto Consolidation of Services

1. The Commission concurs with the DNCP proposal to maintain both San Francisco and Palo Alto as separate facilities and to realign and consolidate services as the VISN is able to do so.

(see page 5-355)

VII Enhanced Use

1. The Commission concurs with the DNCP proposal to provide a research facility at San Francisco.

(see page 5-357)

Campus Realignment – Livermore

DNCP Proposal

"Current nursing home services will be transferred to Menlo Park campus and contracts in the community. Outpatient services are proposed to transfer from the Livermore campus to an expanded Central Valley CBOC and a new East Bay CBOC closer to where the patients live. Both CBOCs will offer primary care, specialty services and mental health services. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Livermore Division (LVD) largely Status quo. Some primary and specialty care shifted to new East Bay and Central Valley clinics and Palo Alto Division. All NHCU and sub-acute care remains at Livermore.
3. *100 Percent Contracting*
4. *Alternative 1 [The VISN's preferred alternative]:* Consolidate all Livermore programs to other sites (NHCU 80 to Menlo Park, 30 sub-acute to Palo Alto, 52 to contract) new East Bay Clinic; expand Central Valley Clinic, realign some specialty care to PA. Reuse Livermore for EU project consistent with veterans' health needs.
5. *Alternative 2:* Livermore retains NHCU and small primary care and mental only; new East Bay Clinic; Palo Alto absorbs specialty outpatient and 30 sub-acute medicine beds.

Commission Analysis

During the hearing, the Commission received information on the details underlying the realignment proposal. The DNCP recommends transferring Livermore's current services to other VA sites, primarily to Palo Alto, Menlo Park, the new East Bay CBOC, and Central Valley areas as follows:

- Relocate 80 nursing home care unit (NHCU) beds from Livermore to the Menlo Park Division;
- Relocate 30 sub-acute beds from Livermore to the Palo Alto Division;
- Contract for 40 NHCU beds in the community;
- Develop a new, expanded (multi-specialty) San Joaquin Valley CBOC; and

- Develop a new East Bay CBOC.[512]

Information provided at the Livermore hearing by VISN leadership indicates that most of the patients seeking LTC at Livermore are from Modesto (100 miles from Menlo Park), Stockton (in the Livermore area), Livermore, Manteca, and Pleasanton (more than 30 miles away). Lisa Freeman, Director, Palo Alto Health Care System, testified, " There were a total of 180 sub-acute admissions to the Livermore division and 445 long-term care admissions, that's of the 10,407 unique veterans that were treated at the Livermore Division. So admittedly, certainly when you look at the map for those veterans and their families that would have to travel to Menlo Park versus Livermore, that is a disadvantage."[513] Linda Barton, Livermore City Manager, testified:

> A consideration certainly in the Bay Area is if [Livermore services are] relocated, the veterans and their families will have to travel considerable distances in heavy traffic in order to receive service or to visit their relatives from Livermore at Menlo Park. Public transportation is not a very good option for people who are elderly. It would take them at least two and a half hours.[514]

In addition, some stakeholders were concerned about the provision of nursing home services within VA. Bill Lutrell, President of AFGE Local2110, provided a copy of a study prepared for the California Health Care Foundation, "The Financial Health of the California Nursing Home Industry," (May 2003) and stated:

> California's supply of nursing home beds is among the lowest in the country at 31 beds per 1,000, compared to the nationwide ratio of approximately 49 beds per 1,000 elderly. Moreover, there is a striking imbalance in bed supply across counties within the state. This is of great concern as the state's elderly population is projected to grow significantly over the coming decades.[515]

Numerous witnesses testified on the approximately $20 million in renovations that have already been completed at the Livermore nursing home.

The Commission believes a freestanding nursing home should be retained at Livermore, rather than moving its nursing home care to Menlo Park, as most of the nursing home residents come from the Stockton area. Access to care for those veterans and their family members would be negatively impacted, due to travel distance, traffic congestion, and the lack of available public transportation, if the beds were

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[512] Robert Weibe, MD, VISN 21 Director, Written Testimony submitted at the Livermore, CA, Hearing on October 1, 2003, page 8, available from [*http://www.carescommission.va.gov/Documents/LivermorePanel2 Part2.pdf*]

[513] Lisa Freeman, Director, Palo Alto Health Care System, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, pages 74-75.

[514] Linda M. Barton, Livermore City Manager, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, pages 54-55.

[515] Bill Lutrell, President of AFGE Local 2110, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 182.

moved. The Commission also discussed the lack of clear evidence on the availability and the quality of care provided in community nursing home beds and the cost that may be associated with those beds. The Commission agrees with the proposal to move 30 sub-acute beds to Palo Alto from Livermore where acute services are available. The Commission also agrees with the CBOCs planned for East Bay and San Joaquin Valley, as this will address outpatient access gaps in the South Coast Market. The proposed location of these clinics is along major highway, which will facilitate improved access to care.

Commission Findings

1. Access to care for some veterans and access for family members of some veterans would be negatively impacted if long-term care beds were moved.
2. There is no clear evidence to determine whether nursing home care beds are available in the community.
3. Palo Alto and Livermore's workload is combined, but data indicate steady increases in nursing home beds and consistent growth in other care services.
4. The Commission received 938 public comments that oppose the closure of Livermore.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal that nursing home care at Livermore be transferred to Menlo Park and the community.
2. The Commission recommends that the LTC services (nursing home beds) at Livermore be retained as a freestanding nursing home care unit.
3. The Commission concurs with the DNCP proposal to transfer sub-acute beds to Palo Alto.
4. The Commission concurs with the DNCP proposal to shift outpatient care to CBOCs.

II Inpatient Care and Access

DNCP Proposals

"*Tertiary Care* – Sierra Nevada Market will expand services at Reno VAMC and contract locally. *Hospital Care* – South Coast Market will contract locally to meet demand and improve access. *Surgery* – Decreasing demand in South Coast Market is being managed by reducing in-house services at Palo Alto. *Psychiatry* – Decreasing demand in South Coast Market is being managed by reducing in-house services."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Sierra Nevada Market has a gap for access to tertiary care, as only 30 percent of the enrollees in this market are within the tertiary care access guidelines. The Sierra Nevada Market has proposed to address this gap by expanding telemedicine between the Reno VAMC, Palo Alto VAMC, and the San Francisco VAMC and by developing tertiary care contracts within the Reno community.

The DNCP proposal for the South Coast Market to contract for care will allow the market to meet the CARES access-to-hospital standard that requires that 65 percent of veterans be able to reach a hospital in 60 minutes. The South Coast Market's affiliation with Stanford University enables veterans to obtain medical, surgical, and psychiatric treatment. There is a projected decrease of 26 beds in surgery from the FY 2001 baseline by FY 2022 (53 percent below baseline) and a decrease of 41 beds in psychiatry by FY 2022 (34 percent below baseline).[516] The Palo Alto VAMC plans to address these decreases as they materialize by shifting and reducing in-house services. Commissioners note that the South Coast Market has a 50-bed national Post-Traumatic Stress Disorder (PTSD) center, which serves as a resource for PTSD patients nationwide. Thus, 50 of the 112 inpatient psychiatry beds at Palo Alto are from this program, which may not have been taken into account by the CARES projections.

Commission Findings

1. To meet existing tertiary care gaps, the Sierra Nevada Market is expanding its telemedicine capabilities and expanding its community contracts.
2. To meet existing hospital care gaps, the South Coast Market has contracted for care within the community and thus no longer has a gap in this area.
3. Projected decreases in demand for surgical and psychiatric beds will be addressed by shifting and reducing in-house services.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for expansion of services at the Reno VAMC and contracting for services in South Coast and Sierra Nevada markets as needed to meet inpatient access demands.

[516] Appendix D, *Data Tables*, page D-98.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

III Outpatient Care

DNCP Proposals:

"*Primary Care* – Increasing primary care demand in all six markets is being met primarily through expansion of existing CBOCs, as well as increasing services at parent facilities. In some cases, expanded hours are planned to increase capacity. A multi-specialty expanded CBOC in the Central Valley and a new CBOC are in the plan as high priorities to meet the outpatient requirements associated with the closure of Livermore. However, since the DNCP attempts to balance meeting national access guidelines, while other access points are included in the DNCP, they are not in the high implementation priority category at this time. *Specialty Care* – Increasing specialty care demand in all six markets is being met by using in-house expansion (new construction, renovation, and leases), utilizing telehealth options for select clinics, and offering selected high volume specialty care service on site at larger CBOCs."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN proposed 12 additional CBOCs in its CARES plan – one new CBOC in the East Bay area in conjunction with the Livermore realignment and 11 new CBOCs to address capacity gaps. In addition, most markets have proposed expansions in outpatient care capacity at existing CBOCs and medical centers. Robert Wiebe, MD, VISN Director, testified:

> The new New East Bay CBOC and the expansion of CBOC services in the Central Valley are critical and our highest priority. These initiatives will directly support the effective realignment of the Livermore campus. The VISN also feels that the establishment of the

> other 11 proposed new CBOCs is essential to meet the increased number of enrollees as projected through the CARES methodology.[517]

None of the new CBOCs were included in the DNCP priority group one.

According to CARES planning data, the North Valley Market, Sierra Nevada Market, North Coast Market, and the South Coast Market will have shortfalls in both primary and specialty care in FY 2012, with these gaps projected to decrease by FY 2022. For the North Valley Market, primary and specialty care are projected to increase by 16 percent and 44 percent over the FY 2001 baseline by 2012, respectively. The Sierra Nevada Market is projected to have an increase in demand for primary and specialty care of 26 and 42 percent over baseline, respectively. For the North Coast Market, these figures are 63 and 32 percent over baseline, respectively. For the South Coast Market, projections are 42 and 46 percent over baseline, respectively, for these types of care. These projections decrease by FY 2022 in all markets.[518] To address these shortfalls, the VISN proposed expansion of existing and additional CBOCs as well as the expanded use of telemedicine.

The primary care workload is projected to increase by 67 percent over baseline by FY 2012 for the Pacific Islands Market with a gradual decline in demand of 46 percent over baseline by FY 2022, and this market's specialty care workload demand is projected to increase by 212 percent over baseline by FY 2012, with a very slight decline to 192 percent by FY 2022.[519] The market proposal included expanding the existing CBOCs on the neighbor islands of Hawaii, establishing three new CBOCs at Kaneohe and Waianae on Oahu and in American Samoa, expansion of the joint venture at Tripler Army Medical Center/VAMC Honolulu to provide an ambulatory surgical and invasive procedure suite, and expanding the CBOC capacity in Guam through participation in a VA/DoD joint venture with the Navy.

Congressman Eni Faleomavaega testified:

> According to a survey conducted by U.S. Army Reserve during a four-month period in 2001, 2 years ago, American Samoa now has over 5,000 veterans, although only 1,000 are registered in the Veterans Administration due the lack of information by the administration process. American Samoa also has 19,806 military dependents. American Samoa's total population is approximately 60,000. About 20,000 of these residents are foreign and, of a native population of 40,000, approximately 15,000 are under the age of 18. This means that roughly 25,000 U.S. Nationals and citizens over the age of 18

[517] Robert Weibe, MD, VISN 21 Director, Written Testimony submitted at the Livermore, CA, Hearing on October 1, 2003, page 5, available from [*http://www.carescommission.va.gov/Documents/LivermorePanel2 Part1.pdf*].
[518] Appendix D, *Data Tables*, page D-99.
[519] Appendix D, *Data Tables*, page D-99.

> live in American Samoa, and of this number, 5,000 are veterans. … many should qualify for VA services.[520]

H. David Burge, Director of the VA Pacific Islands Health Care System, testified that determining the number of veterans in American Samoa has been problematic. Though the census indicates that there are about 1,000 veterans, when VA sent a team to do a count, it found the number to be about 800. Mr. Burge indicated that, of the 800, most would be high users, but recognized that this population would not meet the threshold for a CBOC. He indicated that they are trying to build a critical mass by working with DoD and the Army Reserves. VA is currently negotiating with the Army Reserves for it to give VA a building. With construction costs of a little more than $1 million, the building could be converted to a clinic that would serve DoD beneficiaries as well as veterans.[521]

Congresswoman Madeleine Bordallo testified concerning the veterans of Guam:

> I am also concerned that like other facilities dependent on the Department of Defense, construction in Guam will be delayed, causing the 2008 time frame to slip. While I am deeply grateful that this project is designated as a "high priority" under the Draft National Plan, I am not aware of how the VA can hold the Navy firm to the 2008 timeline.[522]

Dr. Weibe, VISN Director, testified, "It's not a new CBOC, but again, working with the Department of Defense to maintain a clinic on the naval site in Guam is high priority."[523]

Commission Findings

1. The VISN proposed 12 additional CBOCs in its plan, one of which was to address the proposed mission change at Livermore. None of the 11 new CBOCs is in the DNCP's priority group one.
2. Four of the markets had projected increases in demand in both specialty and primary care by FY 2012, with declining demand for both areas by FY 2022.
3. The Pacific Islands Market expects an increase in primary care demand by FY 2012, with a decrease in demand by FY 2022. Specialty care in this market significantly increases in FY 2012, and there is only a slight decrease by FY 2022.

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[520] The Honorable, Eni F.H. Faleomavaega, Congressman, American Samoa, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 24-25.

[521] H. David Burge, Director, VA Pacific Islands Health Care System, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 80.

[522] The Honorable Madeleine Z. Bordallo, Congresswoman, California, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 18.

[523] Robert L. Weibe, MD, VISN 21 Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 83.

4. Though the veteran population on American Samoa does not appear to meet the threshold for a CBOC, the Director of the Pacific Island HCS is moving forward with a possible joint venture with the Army Reserves.
5. The Guam CBOC is a high priority for the VISN. The VISN will continue to work with DoD for inclusion of a new clinic in the DoD replacement hospital.
6. The South Valley Market projects an increased demand in specialty care in FY 2012, with this demand diminishing over the next 10 years.

Commission Recommendations

1. The Commission recommends that VA open a new CBOC closer to the residences of patients who now receive outpatient care at Livermore.
2. The Commission recommends that:[524]
   a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   e. Whenever feasible, CBOCs provide basic mental health services.
   f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

[524] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

IV VA/DoD Sharing

DNCP Proposal

"The VISN is developing the following collaborative opportunities with DoD: In Pacific Island Market, enhancing access to tertiary and acute care and to meet primary and specialty care outpatient needs through expanded agreements with Tripler Army Medical Center. There may be opportunities of collaboration in medical research with DoD in Hawaii, particularly given DoD's anticipation of a new research facility on Oahu. In addition, there are opportunities with DoD in the North Valley Market at Travis AFB to provide enhanced access to inpatient care, primary care, and specialty care. Also working with DoD on joint ventures for both inpatient and outpatient care in Monterey."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Sierra Pacific Network is actively engaged in DoD collaborative initiatives in four of the six markets. Several of these collaborative efforts have been ongoing for years and are associated with large and successful VA/DoD sharing agreements.

The joint venture with Air Force's David Grant Medical Center (DGMC) at Travis AFB in Fairfield, CA, is well established. This venture currently provides veterans with 24-hour emergency care, specialty care service for selected diagnostic procedures, and inpatient hospitalization. VA also has an outpatient clinic on the DGMC campus. Under discussion are plans to provide an inpatient psychiatry unit as well as the feasibility of opening a DoD-operated joint pharmacy at the VA Sacramento outpatient clinic.

Colonel James Collier, MC, testified:

> We feel our unique position as a well-manned graduate medical training center gives us excess capacity in several medical and surgical specialties that may allow us to help with any increase in specialty care needs resulting from the increased access the VA proposes through this plan, so, to summarize my opinion: Region 10, we greatly support the CARES initiatives for the North Coast and the South Coast.[525]

[525] Colonel James Collier, MC, Region 10, TRICARE Lead Agent, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, pages 156-157.

Colonel James Meyers further testified:

> Medical treatment facility (MTF) Commanders will receive three types of funding: funds for readiness operations, funds for other operations, like Graduate Medical Education, and a capitated fund allocation based on the MTF's enrolled population. While the details are still being worked out, the basic concept is fixed, an MTF Commander will pay for all care provided to her enrolled population, whether provided in-house, by the health service and support contact or, most importantly for this discussion, provided by any other source to include the VA. We believe this is one more great reason to collaborate with the VA.[526]

The Pacific Island Market has a joint venture between the Honolulu VA and Tripler Army Medical Center. Current plans call for a new joint-use ambulatory surgical center and specialty clinic pavilion and to integrate and expand research through a new clinical research center. Plans also include an addition to an existing parking structure. This VISN will participate as a demonstration site for budget and financial management as mandated by the Fiscal Year 2003 National Defense Authorization Act. Colonel Frederick Gargiulo, Chief of Staff for Tripler Army Medical Center, testified:

> The project would include structure and processes to jointly assess, execute, and evaluate health care forecasting demand management and resource tracking, coordinated referral management, fee authorization, revenue management utilizing a joint charge description master and document management. The most exciting aspect of this proposal is that these products will be designed in such a way that they would be exportable to other VA/DoD collaborative sites.[527]

In Guam, VA is working to include a VA outpatient clinic at the Navy's replacement hospital.[528] In American Samoa, VA is working to obtain an Army Reserves building that VA would convert to an outpatient clinic that would serve VA and DoD beneficiaries.

Commission Findings

1. The Sierra Pacific Network has several large, successful, existing VA/DoD sharing agreements.
2. VA has an outpatient clinic on the DGMC campus and is exploring the feasibility of expanding this sharing agreement to include inpatient psychiatry and a joint pharmacy at the VA Sacramento Outpatient Clinic.

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[526] Colonel James Meyers, Region 10, TRICARE Executive Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 159.

[527] Colonel Frederick Gargiulo, Chief of Staff, Tripler Army Medical Center, Transcribed Testimony from the Livermore, CA, Hearing on October 2003, page 150.

[528] Appendix I, page 4, of the DNCP.

3. Tripler Army Medical Center and VA Pacific Islands Health Care System, Hawaii have been selected to be one of the demonstration sites for budget and financial management by the DoD/VA Health Executive Council.
4. A VA outpatient clinic is proposed at the Navy's replacement hospital in Guam.
5. In American Samoa, VA is proposing to build an outpatient clinic to be used by both VA and DoD beneficiaries.

Commission Recommendation

The Commission concurs with the DNCP proposals on DoD collaborations.

V Infrastructure and Life Safety

DNCP Proposal

"The VISN has proposed seismic construction projects at facilities in the North Coast, South Coast, and South Valley markets, including VA facilities in Palo Alto, San Francisco, Menlo Park, and Fresno."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The North Coast Market has six buildings with seismic construction projects from the Exceptionally High Risk list – the main acute inpatient hospital at San Francisco; four buildings that house specialty clinics, administration, and research; and the Martinez division, which has a seismic construction project for its laboratory and research building.

The South Coast Market's psychiatry building, research, and the gero-psychiatric nursing home care building are on the VA Exceptionally High Risk seismic inventory list.

The South Valley Market has five buildings with seismic issues. The buildings are currently used for a mixture of outpatient mental health and administrative functions. Two of the buildings are on the VA seismic list; three are not because they are not used for patient care.

At the Livermore hearing, the VISN Director testified, "The Network has identified $196 million in seismic correction major and minor construction projects, which include the three top seismic risk projects on the VA's exceptionally high risk listing. Correction of these seismic deficiencies is seen as the top priority in the Network."[529]

Commission Finding

Construction to correct seismic deficiencies is needed at Fresno, San Francisco, Martinez, Palo Alto, and Menlo Park.

Commission Recommendations

1. The Commission concurs with the DNCP proposals for seismic construction projects at facilities in the North Coast, South Coast, and South Valley Markets.
2. The Commission recommends that patient and employee safety should be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

VI San Francisco/Palo Alto Consolidation of Services

DNCP Proposal

"Services to be consolidated at San Francisco include the following: *Administrative Services:* Reproduction services (i.e., copies) and HR classification. *Clinical Services:* Parkinson's disease and epilepsy surgery and brain mapping, potions of neurosurgery including stereotactic radiosurgery (including Gamma Knife), Brainstem auditory evoked responses, Somato sensory evoked potentials, All surgery requiring intra-operative spinal cord and root monitoring, electronystagmographs, bachytherapy for prostate cancer, endovascular, embolism of AVM, Hohs surgery, portions of radiology including neuroradiology through increased use of PACS, all dental surgery including dental implantology, and portions of laboratory services.

Services to be consolidated at Palo Alto include the following: *Administrative Services:* Warehousing opera tions, disposal of government property program, recycling program, management of grounds and transportation services, prosthetics and sensory aids purchasing agents, IRM help desk and police training. *Clinical Services:* Long-term inpatient care for dementia, neurobehavioral problems and substance abuse, electroconvulsive therapy (ECT), long-term care for chronically mentally ill, and selected laboratory contract testing."

[529] Robert Weibe, MD, VISN 21 Director, Written Testimony submitted at the Livermore, CA, Hearing on October 1, 2003, page 4, available from [*http://www.carescommission.va.gov/Documents/LivermorePanel2 Part1.pdf*].

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

As part of the CARES process, VAMCs in close proximity (within 60 miles) were required to evaluate whether their services could be consolidated. VISN 21 is supported by two tertiary care facilities, San Francisco and Palo Alto, which are within 40 miles of one another. Both are highly affiliated medical centers: San Francisco is affiliated with the University of California, San Francisco, and Palo Alto is affiliated with Stanford University. Both of these sites serve as referral centers for other facilities within the VISN, and consolidation of most clinical programs into a single site would be impractical. Some consolidation of services has already occurred – primarily in highly specialized, low-volume, high-cost clinical services and for selected administrative functions. A review of the CARES space data indicates that neither facility would have the ability to absorb the workload of the other and that both have several seismically unsafe buildings on the Extremely High Risk list.

The VISN Director, Dr. Robert Weibe, testified that after a comprehensive analysis of the two facilities, "We concluded that it is not feasible or desirable to close or fully consolidate either site. We based this on the surrounding veteran population, historical referral patters, capacity of each facility and the critical role each facility plays."[530]

Commission Findings

1. If San Francisco and Palo Alto were to consolidate into one medical center, there would be the only one tertiary care site available for both the North Coast and South Coast Markets. Although they are only 40 miles from one another, they are located in a highly urban, congested setting.
2. If the two facilities were to consolidate into one medical center, it is likely a gap in access to hospital care would be created.
3. Neither VAMC has the capacity to absorb the workload of the other.

Commission Recommendation

The Commission concurs with the DNCP proposal to maintain both San Francisco and Palo Alto as separate facilities and to realign and consolidate services as the VISN is able to do so.

[530] Robert Weibe, MD, VISN 21 Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 64.

VII Enhanced Use

DNCP Proposal

"Proposals are being developed involving research at San Francisco and long-term care at Sacramento. Joint venture for ambulatory and long-term care with Alameda County and assisted living facility at the Menlo Park Division of Palo Alto Health Care System."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN Director, Dr. Robert Weibe, testified that there are several new enhanced use leasing (EUL) projects designed to further the VISN's long-term care and research programs. One of these projects is a 100-bed LTC facility on the campus of the new VA medical center in Sacramento, CA. This project at Sacramento is on hold awaiting resolution of the Department's assisted living policy.

Another project is an EUL project at the San Francisco VAMC, which will provide critically needed research space.[531] The proposed EUL project would provide for a new 200,000 square foot research facility and a parking structure. The VISN is awaiting approval from VA Central Office. The project is anticipated for completion by FY 2007.

Commission Finding

The proposed EUL projects are in the early- to mid-planning stages.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to provide a research facility at San Francisco.

[531] Robert Weibe, MD, VISN 21 Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 66.

VISN 22 – VA Desert Pacific Health Care Network

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VISN 22, Desert Pacific Health Care Network

VISN Overview

VISN 22, the Desert Pacific Health Care Network, is an integrated, comprehensive health care delivery system that provided medical services to 223,000 of the 397,000 veterans enrolled in the VA's health care system in FY 2003.[532] This VISN covers a service area of 110,000 square miles and provides services to veterans located in the southern parts of California and Nevada. The service area includes Las Vegas in Clark County, NV, one of the fastest growing areas in the United States. The total veteran population of the VISN is approximately 1.5 million. With a staff of 9,520 FTEs,[533] VISN 22 delivers health care services through five medical centers, including the Mike O'Callaghan Federal Hospital (MOFH) at Nellis Air Force Base, a VA/DoD joint venture medical center in Las Vegas, four nursing homes, one domiciliary care facility, and 30 community-based outpatient clinics (CBOCs). Additionally, there are 11 Vet Centers in VISN 22.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 22.

VISN 22	FY 2001	FY 2012	FY 2022
Enrollees	322,931	334,440	282,238
Veteran Population	1,575,939	1,159,413	869,863
Market Penetration	20.49%	28.85%	32.45%

For the CARES process, the VISN is divided into two markets: the California Market (*facilities:* Long Beach, Loma Linda, West Los Angeles, and San Diego); and the Nevada Market (*facility:* Las Vegas).

Information Gathering

The CARES Commission conducted three site visits to VISN 22 and two public hearings. The Commission received 1,822 public comments regarding VISN 22.

- *Site Visits:* Long Beach and West Los Angeles on July 14 and 15; walkthroughs of three sites and a driving tour of the other seven locations making up VA's ten outpatient sites in Las Vegas and the MOFH at Nellis AFB on July 16.
- *Hearings:* Las Vegas, NV, on September 26; and Long Beach, CA, on September 29.

[532] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[533] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003.

Summary of CARES Commission Recommendations

I New Hospital – Las Vegas; VA/DoD Sharing

1. The Commission recommends that VA continue the joint venture with MOFH at Nellis AFB in Las Vegas for inpatient beds and that the partnership be expanded to meet VA's increased need for acute care services. This partnership allows for shared services that support inpatient beds and will reduce redundancies and be more cost-efficient than operating two separate hospital facilities.
2. The Commission recommends that VA provide a collocated multi-specialty outpatient clinic and nursing home care unit in the Las Vegas area.
3. The Commission recommends that, given the uniqueness of the Las Vegas situation and the increased need for VA inpatient care in southern Nevada, if DoD cannot continue the partnership by fulfilling the medical needs of veterans, the VA should exercise the option of constructing a new VA hospital in Las Vegas, as recommended in the DNCP.

(see page 5-364)

II Realignment/Consolidation of Services Due to Proximity – West LA Campus and Long Beach

1. The Commission concurs with the DNCP proposal to maintain existing facilities at Long Beach and West LA campus, and to integrate services where appropriate.

(see page 5-368)

III Inpatient Care

1. The Commission concurs with the DNCP proposal to address the need for additional inpatient medicine beds in the California Market through the conversion and renovation of existing space and to use contracted services to meet demand during peak periods.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-369)

IV Outpatient Care

1. The Commission concurs with the DNCP proposal to address capacity gaps through new construction, shifting workload, and expansion of services.
2. The Commission recommends that:[534]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs at teaching sites to enhance quality of care in community-based service settings.

(see page 5-371)

V Special Disability Programs

1. The Commission concurs with the DNCP proposal to establish a new blind rehabilitation center (BRC) on the Long Beach campus.
2. The Commission concurs with the DNCP proposals for Long Beach to realign 30 beds from acute spinal cord injury/disorder (SCI/D) to long-term SCI/D. The Commission recommends that VA conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-373)

[534] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

VI Infrastructure and Life Safety

1. The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

(see page 5-374)

VII Excess Land Use – West LA Campus

1. The Commission concurs with the DNCP proposal for the Network Land Use Planning Committee to address the use of VA land, especially the property on the West LA campus, with stakeholder input. The Commission recommends, however, that the committee be augmented with the addition of stakeholder representation on the committee in an advisory capacity.
2. The Commission concurs with the DNCP proposal for construction of a new clinical addition to consolidate clinical services.
3. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed enhanced use leasing (EUL) process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-376)

VIII Long-Term Care/Facility Condition

1. The Commission concurs with the DNCP proposal for upgrading existing long-term care (LTC) and chronic psychiatric care units recognizing that some renovations are needed to improve the safety and maintenance of the facilities' infrastructure and to modernize patient areas.
2. The Commission recommends that VA provide for nursing home care, collocated with a multi-specialty outpatient clinic, in the Las Vegas area.
3. The Commission recommends that:[535]
   a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities, VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

[535] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

b An integral part of the strategic plan should be maximizing the use of Sate Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-378)

IX Research

1 The Commission concurs with the DNCP proposal for new research facilities at Loma Linda, San Diego, and West LA locations.

(see page 5-380)

X VA/DoD Sharing and Other Collaborations

1 The Commission recommends that VA/DoD collaboration should be a major consideration in addressing health care needs in a local area.

2 The Commission concurs with collocating the VBA office to West LA campus and providing VBA space in the proposed outpatient clinic in Las Vegas, NV.

3 The Commission concurs with collocating an NCA columbarium on 20 acres of the West LA campus.

(see page 5-381)

New Hospital – Las Vegas; VA/DoD Sharing

DNCP Proposals

"*Inpatient Services* – Develop a plan for a new hospital in Las Vegas that would include the current plans for a multi-specialty outpatient clinic. *Extended Care* – Capital investments consist of new construction of 95,000 square feet in the Nevada market (Las Vegas). *DoD* – DoD collaboration opportunities included in the plan are through the Mike O'Callaghan Federal Hospital [Nellis AFB] in Las Vegas…"

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The demand for inpatient services in the Nevada Market is projected to increase: inpatient medicine – 91 percent over the FY 2001 baseline by FY 2012, and 70 percent over baseline by FY 2022; surgery – 28 percent over baseline by FY 2012, and 15 percent over baseline by FY 2022; and inpatient psychiatry – 21 percent over baseline by FY 2012, but decreasing to 8 percent below baseline by FY 2022. Likewise, there are projected increases in demand for outpatient specialty care (120 percent over the FY 2001 baseline by FY 2012, decreasing to 112 percent by FY 2022), primary care (49 percent by FY 2012, 35 percent by FY 2022), and mental health outpatient care (69 percent by FY 2012, 40 percent by FY 2022).[536]

During the site visit, Commissioners noted that the current arrangement for outpatient services to veterans in Las Vegas is fragmented, with care being furnished at ten separate sites. Commissioners were given a tour of the MOFH on the Nellis AFB and heard some concerns expressed by Air Force staff about VA's projected need for increased beds and outpatient services. VA's need might be impacted by DoD's plans to increase the troop strength at Nellis and DoD's need for additional beds to support that increase. The importance of Nellis AFB to DoD and the growing needs of VA to respond to an increasing veteran population in southern Nevada makes the VA/Nellis joint venture a unique situation.

Following the MOFH tour, Commissioners were shown one of the possible locations for a new VA outpatient clinic and nursing home initiative. The DNCP proposes a new hospital for the Las Vegas community, which would end the 9-year VA/DoD collaboration at the MOFH.

[536] Appendix D, *Data Tables*, page D-103.

At the Las Vegas hearing, Colonel Rank, Commander of the MOFH, testified on the nature of the joint venture:

> The Mike O'Callaghan Federal Hospital is a successful joint venture between the Department of Veterans Affairs, the Department of Defense…specifically the Department of the Air Force. Air Force and Veterans Affairs jointly operate the 94-bed facility sharing the surgical suites and intensive care units, emergency department, and several ancillary and support services. The Veterans Affairs currently staffs 52 of the 94 beds to support veteran patients, and Air Force staffs 42 beds supporting DoD patients. The VA Draft CARES Plan identifies a requirement for 81, and now 90, acute care and 120 long-term care beds by the year 2012. The 99th Medical Group supports meeting the Veterans Affairs acute care requirement and maintaining the existing joint venture.[537]

Colonel Rank noted that there will be capacity to add 28 acute care beds without construction when the VA surgical clinics are moved to a new VA ambulatory care center [earlier possible CARES consideration], and that another six beds are projected to be available in FY 2005 when MOFH's emergency room project is scheduled for completion. Colonel Rank added:

> The 99th Medical Group and the Air Force Medical Service maintain the current joint venture to meet the Veterans Affairs acute care bed requirement. However, a long-term care facility is beyond our capability and incompatible with our mission, and there is insufficient space to accommodate the facility…The 99th Medical Group regrets that the inability of Nellis [AFB] to support a [VA] long-term care facility has led [VA] to consider terminating the entire joint venture after nine successful years of a true win/win partnership.[538]

Colonel Rank described the VA/DoD collaboration at Nellis AFB as a premier model for other joint ventures and identified several disadvantages to severing that partnership including:

- It would be a tremendous loss and contrary to the transformation initiatives to increase VA/DoD integration of the President of the United States and Secretary of Defense;
- There would be decreased opportunity for Air Force personnel to build and maintain wartime medical skills due to fewer critically ill patients;

[537] Melissa A. Rank, Colonel, 99th Medical Group, Mike O'Callaghan Federal Hospital, Nellis Air Force Base, Las Vegas, NV, Transcribed Testimony from the Las Vegas, NV, Hearing on September 26, 2003, pages 44-45.

[538] Melissa A. Rank, Colonel, 99th Medical Group, Mike O'Callaghan Federal Hospital, Nellis Air Force Base, Las Vegas, NV, Transcribed Testimony from the Las Vegas, NV, Hearing on September 26, 2003, page 46.

- DoD care at Nellis may not support an intensive care unit, and Nellis may be in jeopardy of losing inpatient status;
- It might require 54 additional full-time equivalents to replace VA staff in integrated areas;
- The Air Force would lose $7 million in operations reimbursement from VA; and
- The loss of the VA psychiatric unit would cost $147,000 per year for active duty referrals to the community.[539]

Dr. David S. Chu, Under Secretary of Defense for Personnel and Readiness, expressed his deep concern about the DNCP proposal that VA discontinue its longstanding and successful partnership at the MOFH, stating: "The consequences of losing one of our most prominent and successful collaboration sites could be severe."[540] He added, "While we recognize that the veteran population in the Las Vegas area is growing, the model of collaboration …at Nellis can and should be reshaped to reflect this evolving demand."[541]

The Commission was informed that VA did ask DoD/Air Force for clarification on the commitment of Nellis AFB to continue its joint venture with VA, but that there has yet not been a response from DoD. VA has a dire need to address the growing veteran population and to bring a continuum of health care closer to southern Nevada veterans. VA must position itself so that if changing circumstances preclude a continuation of the joint venture with DoD at Nellis, it can seek an independent site for a medical center as proposed by the DNCP. Congresswoman Shelley Berkley shared testimony with the Commission about the growing veteran numbers in Southern Nevada:

> Let me tell you about the situation…in southern Nevada. We have one of the fastest growing veterans population in the United States, close to 200,000 veterans are [in] southern Nevada [with] anywhere from a few World War I vets, World War II vets, Korean War vets, Vietnam vets, [and] Gulf War vets are all here and keep coming in. …I understand according to your studies that we will have half-a-million veterans in this community by 2020, and we don't even have a single hospital or clinic or long-term care center to help these people out.[542]

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[539] Melissa A. Rank, Colonel, 99th Medical Group, Mike O'Callaghan Federal Hospital, Nellis Air Force Base, Las Vegas, NV, Transcribed Testimony from the Las Vegas, NV, Hearing on September 26, 2003, pages 65-66.

[540] David S. C. Chu, Ph.D., Under Secretary of Defense for Personnel and Readiness, Written Testimony submitted at the Stakeholder Meeting in Washington, DC, on October 7, 2003, page 2.

[541] David S. C. Chu, Ph.D., Under Secretary of Defense for Personnel and Readiness, Written Testimony submitted at the Stakeholder Meeting in Washington, DC, on October 7, 2003, page 5.

[542] Shelley Berkley, United States Congress, Transcribed Testimony from the Las Vegas, NV, Hearing on September 26, 2003, pages 10-11, 18.

Congresswoman Berkley also acknowledged the joint venture with Nellis AFB for inpatient care as, "The Mike O'Callaghan Hospital [has] been a temporary fix …[However] 1,500 of my veterans have to leave southern Nevada to get care down in Southern California. …These are older people…[and] it's very difficult for the rest of the family to go down to Southern California and care for them."[543]

The Commission determined that continuing the relationship with DoD at the MOFH was important. The Commission noted that with the continuation of the VA/DoD partnership, it would be reasonable to develop an outpatient clinic collocated with a nursing home at a location other than on Nellis AFB, possibly close to the base to ensure ease of access to inpatient care, but also possibly in conjunction with the University of Nevada, Las Vegas. The Commission suggested that working with the University of Nevada, would provide an opportunity for the medical school to provide residents' training at the VA sites, particularly as the medical school currently does not have a hospital in Las Vegas.

Commission Findings

1. The need for additional VA capacity in Las Vegas, including inpatient, outpatient, and nursing home care, is clear.
2. The Commission believes that VA and DoD should be able to find a way to build on the existing joint venture at MOFH to help address VA's inpatient needs without impairing that partnership.
3. Maintaining and expanding the partnership between VA and the MOFH reduces costs and redundancies, and increases efficiencies within both agencies.
4. The additional space needed for a multi-specialty outpatient clinic and a new nursing home should be located, outside Nellis AFB, in the Las Vegas area.
5. Realizing the uniqueness of the Las Vegas situation and the increased need for VA inpatient care in southern Nevada, in the absence of a continued VA/DoD partnership, VA should look at an independent site for a full-service medical center and nursing home care unit.

Commission Recommendations

1. The Commission recommends that VA continue the joint venture with MOFH at Nellis AFB in Las Vegas for inpatient beds and that the partnership be expanded to meet VA's increased need for acute care services. This partnership allows for shared services that support inpatient beds and will reduce redundancies and be more cost-efficient than operating two separate hospital facilities.

[543] Shelley Berkley, United States Congress, Transcribed Testimony from the Las Vegas, NV, Hearing on September 26, 2003, page 16.

2 The Commission recommends that VA provide a collocated multi-specialty outpatient clinic and nursing home care unit in the Las Vegas area.

3 The Commission recommends that, given the uniqueness of the Las Vegas situation and the increased need for VA inpatient care in southern Nevada, if DoD cannot continue the partnership by fulfilling the medical needs of veterans, the VA should exercise the option of constructing a new VA hospital in Las Vegas, as recommended in the DNCP.

II Realignment/Consolidation of Services Due to Proximity – West LA Campus and Long Beach

DNCP Proposal

"The two facilities will continue to refer patients for interventional cardiology/cardiac surgery and neurosurgery as well as implementing extensive collaboration in the areas of laboratory, radiation therapy, and radiology. Other opportunities for consolidation, integration and cooperation are anticipated in geriatrics and extended care and mental health."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

As part of the CARES process, VA Medical Centers (VAMCs) within 60 miles of each other were required to evaluate whether their services could be consolidated. VISN 22 has two tertiary care facilities in this category, Long Beach and the West LA campus. These facilities are 27 miles apart, with varying drive times depending on traffic patterns. Both facilities offer comprehensive health care services and are highly affiliated teaching hospitals. Long Beach operates several VISN-wide special emphasis programs, and the West LA campus is the referral center for some services from other facilities in the VISN. Some consolidation of services has already occurred, mainly in the clinical support, prosthetics, and administrative functions. Certain complex services, not offered at Long Beach, are done at the West LA campus, such as neurosurgery, interventional cardiology, and cardiac surgery. Each facility contracts workload in the community and each fully uses its respective clinical capacity for inpatient acute care.

The VISN Director, Mr. Ken Clark, testified that while the VISN did not recommend any mission changes for the two facilities to address proximity issues, the VISN did recognize the need to continue the consolidation of services to enhance patient care and improve efficiency in the VISN. Mr. Terry Tracy, Department Service Officer for The American Legion, expressed agreement, "Long Beach and the Greater Los Angeles facility are currently referring patients for interventional cardiology and cardiac surgery and neurosurgery…The American Legion believes that if further consolidation of services will enhance veterans health care, then it should be pursued, cautiously."[544]

Commission Findings

1. Despite the short distance, 27 miles, between Long Beach and West LA campus facilities, their location in highly urban, congested settings may create extended travel times.
2. The VISN has already undertaken some consolidations of clinical support and administrative functions to reduce redundancies and improve access to care for veterans.
3. The VISN is currently implementing additional integrations of services including geriatrics and mental health.

Commission Recommendation

The Commission concurs with the DNCP proposal to maintain existing facilities at Long Beach and West LA campus, and to integrate services where appropriate.

III Inpatient Care

DNCP Proposal

"Increasing demand for inpatient medicine beds in the California and Nevada markets will be met by VA/DoD sharing, conversion of vacant space and renovation of existing space. The peak demand, which occurs between 2004 and 2012, will be addressed through contracting. The majority of decreasing demand for inpatient psychiatry will be addressed through the downsizing of beds at all California market facilities between FY 2012 and 2022."

[544] Terry Tracy, Department Service Officer, The American Legion, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 109.

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

According to data projections for the California Market, inpatient medicine beds are projected to increase by 33 percent by FY 2012 and to decrease to four percent over the FY 2001 baseline by FY 2022. Surgery beds are projected to decrease by four percent below baseline by FY 2012 and to further decrease to 24 percent over the baseline by FY 2022.[545] At the Long Beach hearing, the VISN Director testified that the new clinical addition on the West LA campus would allow outpatient functions currently housed in inpatient space to move, and that space would be used for the expansion of inpatient medicine beds. Similarly, an administrative addition is proposed at the Long Beach VAMC to address space and seismic deficiencies, which would allow for expansion of the inpatient services in that space.[546]

Inpatient psychiatry projections indicate a decrease to 12 percent below baseline by FY 2012, and a further decrease to 34 percent below baseline by FY 2022. The VISN Director, Ken Clark testified that the gap in inpatient medicine beds at all facilities would be addressed through downsizing the psychiatry beds and that, during peak periods, services would be contracted as needed to accommodate the demand.[547]

Commission Findings

1. The VISN plans to address the need for additional inpatient medicine beds in the California Market through the conversion and renovation of existing space.
2. The VISN plans to utilize contracted services as needed to meet the demand during the peak period between FY 2004 to FY 2012.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to address the need for additional inpatient medicine beds in the California Market through the conversion and renovation of existing space and to use contracted services to meet demand during peak periods.

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[545] Appendix D, *Data Tables*, page D-103.
[546] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 52.
[547] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 52.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

IV Outpatient Care

DNCP Proposal

"Increasing demand for primary care and specialty care services in both the California and Nevada markets will be met by expansion of existing CBOCs via clinical services contracts, replacement leases, and new construction and reconfiguration of space at the VAMCs via enhanced use leases, renovations, conversion of vacant space, and new construction."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The CARES projections indicate that the California Market will have capacity gaps by FY 2012 for primary care of 71 percent above the FY 2001 baseline and for specialty care of 79 percent. Projected capacity gaps for the California Market by FY 2022 for primary care are 38 percent over baseline, and for specialty care are 54 percent over baseline. Projections for the Nevada Market indicate capacity gaps by FY 2012 in primary care of 49 percent, and in specialty care of 120 percent. Projected capacity gaps for the Nevada Market by FY 2022 for primary care are 35 percent over baseline, and for specialty care are 112 percent.[548] The Commission notes that the CARES data indicate a 69 percent gap by FY 2012, and a 40 percent gap by FY 2022 for outpatient mental health services for the Nevada Market,[549] which was not addressed in the DNCP. Data also indicate that the two largest CBOCs in the Nevada Market (Henderson and Pahrump) do not currently provide a substantial level of basic mental health services.[550]

[548] Appendix D, *Data Tables*, page D-103.
[549] Appendix D, *Data Tables*, page D-103.
[550] VSSC KLF Menu Database *FYTD CBOC VAST and Workload Report*, FY 2003.

The VISN Director, Ken Clark, testified that the VISN plans to address patient care capacity and space planning needs through new construction for additional space, shifting workload and expanding current sites of care: "While our plan does not include establishing new community clinics, we plan on addressing future growth in primary care by expanding capacity at medical centers and at existing community clinics."[551]

Commission Findings

1. There are large capacity gaps for primary care and specialty care services in the California Market by FY 2012.
2. There are large capacity gaps for primary care, specialty care, and mental health in the Nevada Market by FY 2012.
3. The VISN plan will address capacity gaps through new construction, shifting workload, and expansion of services at existing CBOCs.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to address capacity gaps through new construction, shifting workload, and expansion of services.
2. The Commission recommends that:[552]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

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[551] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 52.

[552] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs at teaching sites to enhance quality of care in community-based service settings.

V Special Disability Programs – Blind Rehabilitation Center and Spinal Cord Injury Beds

DNCP Proposal

"A new 24-bed blind rehabilitation center (BRC) and conversion of 30 acute spinal cord injury/disorder (SCI/D) beds to long-term SCI/D beds are planned."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

At the site visit and during the Long Beach hearing, VSO representatives agreed that there is a need for a BRC in Southern California to reduce travel and waiting times for blinded veterans who are seeking treatment and rehabilitation services. The only disagreement on this issue related to the center's location. The VISN Director identified the Long Beach campus as the best site for the new BRC, noting "its central location and because it fits well with the Long Beach focus on special populations."[553] During the site visit, he explained that the Long Beach campus currently houses the largest SCI/D facility and the addition of a BRC would be a natural fit with its mission of treating special populations.

Mr. Earl Ivie, representing the Blinded Veterans Association, disagreed with the Long Beach location, recommending that the BRC be established at the West LA VA. Ms. Rebecca Vinduska, Director, Governmental Relations, Blinded Veterans Association, when asked, indicated that the location of specific facilities is a local decision.[554]

With respect to the proposal to convert SCI/D beds at Long Beach from acute to long-term care, the VISN Director testified that "…[t]he spinal cord injury special disability program population data show

[553] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 53.
[554] Rebecca Vinduska, Director, Governmental Relations, Blinded Veterans Association, CARES Commission Meeting in Washington, DC, on October 7, 2003, page 7.

a decrease in acute bed need and an increase in need for long-term care beds over time."[555] Mr. William Rollins, appearing on behalf of a number of organizations that represent paralyzed veterans, voiced support for 30 long-term care SCI beds at Long Beach but did not "support the sacrifice of current acute bed capacity to achieve this goal."[556] The recommendation would not result in a decrease of SCI/D beds, but would allow existing acute SCI/D beds to be made available for SCI/D patients who are admitted with no definite/planned date of discharge.

Commission Finding

The need for both a BRC and LTC SCI/D beds in the California Market of VISN 22 is supported by the available data and the testimony of VA and key stakeholders.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to establish a new BRC on the Long Beach campus.
2. The Commission concurs with the DNCP proposals for Long Beach to realign 30 beds from acute SCI/D to long-term SCI/D. The Commission recommends that VA conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

VI Infrastructure and Life Safety

DNCP Proposal

"The plan addresses seismic issues through new construction and demolition of old buildings at West LA campus and Long Beach, and through renovation at San Diego, Long Beach and West LA. Costs for seismic improvements are $39 million for Long Beach, $49.1 million for San Diego, and $64.4 million for West LA."

[555] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 53.
[556] William Rollins, Cal Diego Paralyzed Veterans Association, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 103.

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN Director noted that:

> …[t]he main patient care buildings at San Diego and West Los Angeles need correction of seismic structural deficiencies. Both are considered Exceptionally High Risk (EHR) buildings. The West Los Angeles building is the largest at-risk building in VA. …Outpatient and other critical patient care spaces in Long Beach are also in need of seismic correction. …These are critical needs for our Network that must remain a priority.[557]

The Commission, during both the site visit and the Long Beach hearing, heard discussion on seismic/life safety issues for employees housed in structures other than direct patient care buildings that also need reinforcing/retrofitting. In the VISN's prepared statement, this point was addressed as follows:

> "Other seismic correction projects at the West Los Angeles and Long Beach campus total $70 million."[558]

Commission Findings

1. The Commission supports patient and employee safety as the highest priority.
2. The need for seismic corrections in this VISN is clear.

Commission Recommendation

The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

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[557] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, pages 55-56.

[558] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, pages 55-56.

VII Excess Land Use – West LA Campus

DNCP Proposals

"*Land* – VISN 22 has developed an Excess Land Use Policy that provides a process to address excess land. Upon review by the CARES Commission and approval by the Secretary of Veterans Affairs, the Land Use Planning process will guide local VA leadership when recommending reuse initiatives to the Secretary. *Vacant Space* – The Network CARES Market Plan proposes that a majority of the vacant space be reduced through demolition of vacated buildings on the north side of the West LA campus and at the Sepulveda campus. The plan includes a strategy to consolidate all care, with the exception of long-term care, on the south side of the West Los Angeles campus as part of building a new clinical addition on the south side. This project would be in addition to collocation project with VBA. A wide variety of outpatient mental health programs and support staff would also be located within this new clinical addition to accommodate the rising workload. The proposed clinical addition would also consolidate other clinical services currently in buildings on the north campus and free up a majority of the north campus for demolition of old buildings and construction of a State Nursing Home, expansion of the Los Angeles National Cemetery or other veteran-focused projects. This consolidation would also improve the efficiency of care delivery and improve patient access to services on the West Los Angeles campus."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Veterans, stakeholders, and community members expressed interest in the future use of VA land, particularly the land on the West LA campus, and reserving the park-like quality of that space.

The Acting Director, Mr. Charles Dorman, emphasized that given the size of the West LA campus and its location in the city, efforts have been ongoing to maintain the aesthetic integrity of the grounds. He identified the historical buildings on the campus, Centers of Excellence programs, current and planned VA construction projects and many of the other land use initiatives, including a proposed 500-bed State Veterans Home; collocation of the Los Angeles VBA office; Center for Ulcer Research and Education (CURE); a proposal for an enhanced use lease (EUL); a proposal to develop a 400-unit Senior Veterans Housing project; and a proposal for a columbarium to supplement burial operations.[559]

[559] VISN 22, Trip Pack, Executive Summary: VA Greater Los Angeles Health Care System, May 2003.

At the Long Beach hearing, elected officials and members of the West Los Angeles community addressed concerns about protecting the environmental integrity of the area. Testimony by Councilwoman Cindy Miscikowski, 11th District, City of Los Angeles, stated the general concern on this issue:

> I am pleased in general to support the CARES concept…to determine what our country's veterans' needs are and to best deliver effective health care, but I am vitally concerned about how this concept is applied and is planned to be applied to the VA West LA campus specifically regarding the issue of land use…The West LA property is a truly unique resource in the entire Southern California region. Approximately 400 acres gifted through a deed over 100 years ago expressly to be used for an old soldiers home. I am concerned that the Market Plan developed for the West LA campus and the lack of stakeholder outreach and the input from both impacted veterans and the communities, which surround the campus…The veterans rightly demand that this land remain theirs, and not [be] made excess, and be devoted to their use.[560]

They focused on the decision-making process for the use of the land, specifically the membership of the land use committee, which currently excludes stakeholder representation. Ms. Catherine Barrier, representing the Los Angeles Conservancy, testified:

> While we do not doubt that these administrators are superlative health care professionals, we feel strongly that planning for this important site will require the development of a comprehensive long-term land use master plan, prepared with the assistance of planning and historic preservation professionals and the input of community stakeholders, including veterans, community groups, and elected officials.[561]

VISN leadership also testified about plans to demolish older buildings and consolidate services on the campus with the construction of a new clinical addition.

Commission Findings

1. The VISN has demonstrated its commitment to maintain the West LA campus in a manner to benefit veterans.

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[560] The Honorable Cindy Miscikowski, Councilmember, 11th District, City of Los Angeles, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, pages 10, 12.

[561] Catherine Barrier, Los Angeles Conservancy, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, pages 190-191.

2. The strong community interest in the West LA land and the importance of that land suggests that veterans and community representatives be involved as decisions are made about the future of the land.
3. VISN planning includes new construction on the West LA campus that will allow for functions to be relocated into new space, and those vacated older buildings considered for demolition.
4. West LA campus also has several collocation initiatives with VBA, NCA, and the State of California that will utilize vacant land on the campus, bringing improved/expanded services to the veterans.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for the Network Land Use Planning Committee to address the use of VA land, especially the property on the West LA campus, with stakeholder input. The Commission recommends, however, that the committee be augmented with the addition of stakeholder representation on the committee in an advisory capacity.
2. The Commission concurs with the DNCP proposal for construction of a new clinical addition to consolidate clinical services.
3. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

VIII Long-Term Care/Facility Condition

DNCP Proposal

"Improvement and expansion of nursing home space is achieved mainly through renovation and new construction. Capital investments consist of renovation of 64,000 square feet at Long Beach and 16,000 square feet at San Diego, new construction of 95,000 square feet at Las Vegas and construction of a 130,000 square feet replacement facility at the West LA campus."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN Director testified that the existing nursing home units on the West LA campus are substandard due to the age and design of the buildings. The current buildings, originally built in 1938, have physical limitations, are narrow and multilevel, and not appropriate for VA's nursing home care. A new facility is needed to address fire/life safety improvements, as well as accommodations for persons with disabilities. The Commission notes that the State of California has an approved proposal to build a new 500-bed California State Veterans Home on the campus of the West LA site. The VISN Director also identified a need for facility condition improvements at the nursing homes located on the Long Beach and San Diego VAMCs.[562]

The plan to respond to a shortage of nursing home beds in the Nevada Market is to construct a new 120-bed unit. The need for a VA nursing home care unit in southern Nevada is supported by the rapid growth in the veterans population in that area, a lack of community and VA nursing home capabilities, and the age of veterans treated in that market (42 percent are age 65 and over).[563]

Commission Findings

1. The facility condition of existing LTC units in the California Market is considered to be inadequate due to age and design.
2. Replacement of the buildings is needed to address updated fire/life safety codes and handicapped accessibility requirements.
3. The rapid growth of veteran population in the Nevada Market, along with a lack of available nursing home beds and the age of the veterans treated, combine to support the need for a VA nursing home facility in the Nevada Market.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for upgrading existing LTC and chronic psychiatric care units recognizing that some renovations are needed to improve the safety and maintenance of the facilities infrastructure and to modernize patient areas.

[562] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 55.
[563] Ken Clark, VISN 22 Director, Transcribed Testimony from the Las Vegas, NV, Hearing on September 26, 2003, page 26.

2 The Commission recommends that the VA provide for nursing home care, collocated with a multi-specialty outpatient clinic, in the Las Vegas area.

3 The Commission recommends that:[564]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

IX Research

DNCP Proposal

"Improvement and expansion of research space is achieved mainly through new construction. Capital investments consist of construction of 45,000 square feet at Loma Linda 260,000 square feet at San Diego, and 245,000 square feet at the West LA campus. Existing space will be demolished at West LA, and backfilled in San Diego and Loma Linda."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The utilization and demand for VHA health services has grown in VISN 22 and is projected to continue to increase through FY 2012. In order to meet the needs of veterans residing and migrating to this part of the country and in markets where competition for high quality health care providers is great, VHA must maximize its dedication to, and contributions in, medical services research. The VISN Director, Ken Clark, testified, "…So clearly, as we are able to provide state-of-the-art research facilities, it enhances

[564] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

our ability to attract people who are academically oriented, interested in research as well as patient care."[565] VISN 22 has a very active research program, with funding in excess of $100 million annually. Research functions, however, are housed in old buildings in need of improvement or replacement to address work and safety concerns. The VISN is planning a new research addition at Loma Linda that will move the research functions out of the main building (Building 1), where they currently reside, into a separate building designated specifically for research. Current research space in Building 1 is not contiguous and will be backfilled by adjacent administrative and/or clinical services. The VISN Director, Ken Clark, testified that "…Greater Los Angeles and San Diego have significant research space and functional deficiencies. The CARES Plan includes new research buildings at each of these two sites."[566]

Commission Finding

The VISN has a very active research program, which often is housed in older buildings that need to be replaced.

Commission Recommendation

The Commission concurs with the DNCP proposal for new research facilities at Loma Linda, San Diego, and West LA locations.

X VA/DoD Sharing and Other Collaborations

DNCP Proposals

"*DoD* – DoD collaboration opportunities included in the plan are through the Mike O'Callaghan Federal Hospital [Nellis AFB] in Las Vegas, Balboa Naval Hospital in San Diego and with Medical Treatment Facilities throughout southern California. *VBA* – VBA collaborations include construction of a new VARO building at the West LA campus. Space in this building will be included for VHA administrative functions. This will be accomplished through an enhanced-use lease project. In the Nevada market, the plan included collocation of VBA space at the new site of the Las Vegas OPC. *NCA* – Utilize 20 acres of West LA campus land for a columbarium."

[565] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 60.
[566] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 56.

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Commissioners heard testimony on the history of the partnership with DoD in Las Vegas at Nellis AFB, and the interest DoD has in maintaining/expanding that inpatient relationship to the benefit of the veterans and both agencies. The outpatient and long-term care needs of the Nevada Market are proposed to be addressed through a separate outpatient clinic and collocated nursing home care unit that will include space (14,065 square feet) for a VBA Regional Office. This collaboration in the Nevada Market is on VBA's high priority listing.

The VISN Director testified that, in the California Market, expanding VA/DoD sharing is a goal of the VISN. "Each of the four California facilities have active sharing agreements, and …we will continue to explore possible initiatives as a way of addressing our gaps in primary and specialty care as well as inpatient medical bed needs."[567]

Commissioners also heard testimony about expanding and new proposed collaborations between this VISN and VBA, NCA, and the State of California. Testimony from community representatives included comments by Joseph Smith, Director, Department of Military and Veterans Affairs, County of Los Angeles, who voiced his full support of the collocation of VBA and NCA facilities on a single VA site. "Clearly this helps provide cost efficiencies and resolves space utilization problems."[568] Testimony from service organizations included, "There's a proposal to build a columbarium at West LA. We really support that concept…. Also, we in The American Legion…strongly support the collaboration between the [VA] and the State of California in their partnering to make a State Veterans Home a reality on the Greater LA campus."[569]

Commission Findings

1. VA/DoD partnership initiatives currently exist in this VISN and will continue to be pursued energetically by all facilities as a possible way of addressing continued growth and capacity issues for delivering care to veterans.

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[567] Ken Clark, VISN 22 Director, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 55.

[568] Joseph Smith, Director, Department of Military and Veterans Affairs, County of Los Angeles, Transcribed Testimony from the Long Beach, CA, Hearing on September 29, 2003, page 168.

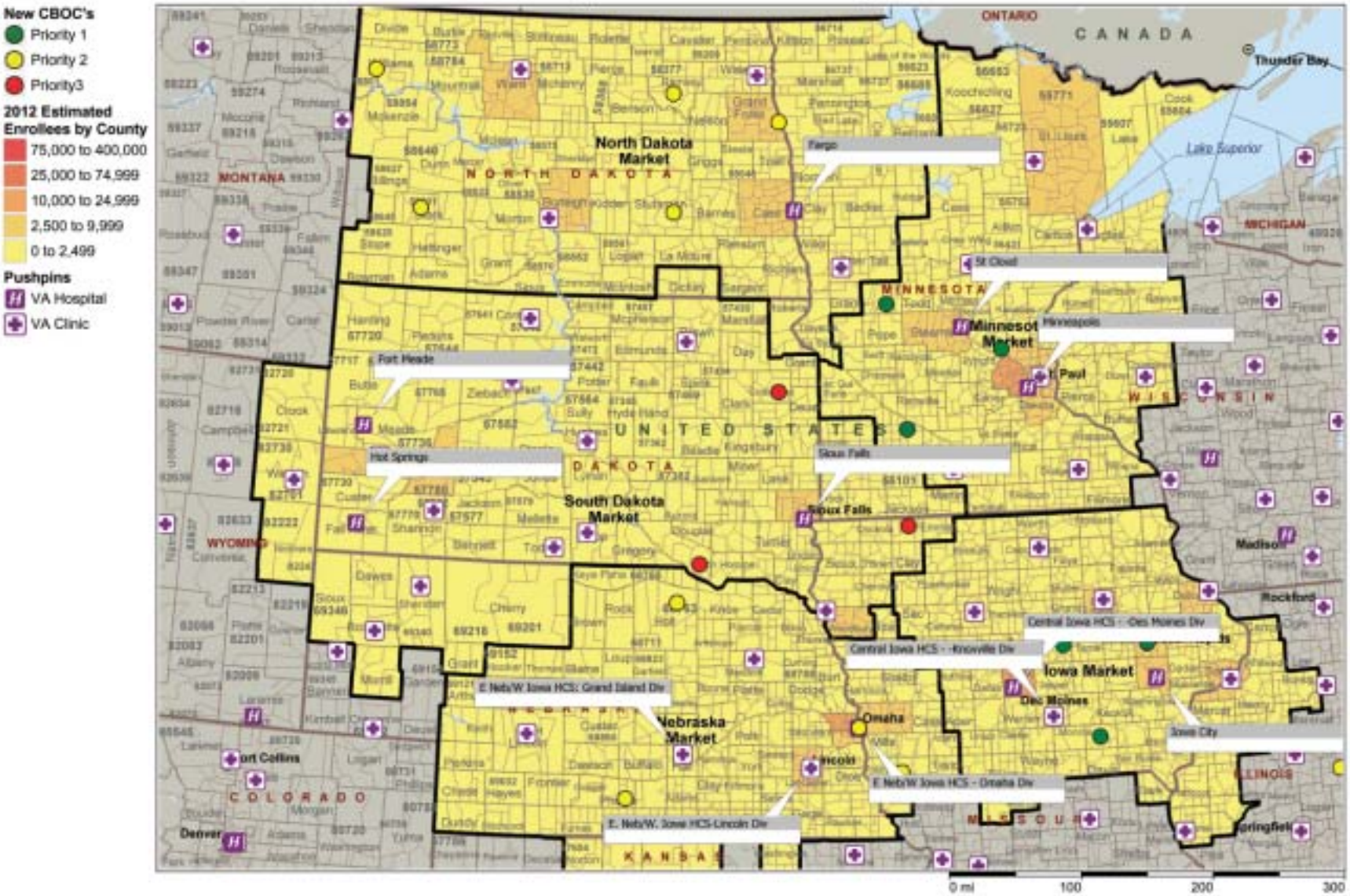
[569] Terry Tracy, Department Service Officer, The American Legion, Transcribed Testimony from Long Beach, CA, Hearing on September 29, 2003, page 114.

2. Collocation initiatives with VBA and NCA are clearly viewed as positive steps to consolidate VA services to central locations to improve access to veterans and families, and be more cost efficient.

Commission Recommendations

1. The Commission recommends that VA/DoD collaboration should be a major consideration in addressing health care needs in a local area.
2. The Commission concurs with collocating the VBA office to West LA campus and providing VBA space in the proposed outpatient clinic in Las Vegas, NV.
3. The Commission concurs with collocating an NCA columbarium on 20 acres of the West LA campus.

VISN 23 – VA Upper Midwest Health Care System



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VISN 23, VA Midwest Health Care Network

VISN Overview

VISN 23, VA Midwest Health Care Network, is an integrated, comprehensive health care system that geographically spans nearly 390,000 square miles and includes a veteran population of approximately 1.16 million. The majority of the VISN is rural with only three large urban areas (Minneapolis-St. Paul, MN; Des Moines, IA; and Omaha, NE). The VISN covers nearly all of Iowa, Minnesota, Nebraska, North Dakota, and South Dakota and includes some counties in Wisconsin, Illinois, Missouri, Kansas, and Wyoming. In FY 2003, the 8,907 FTEs[570] for this VISN provided services to approximately 232,000 and, as of September 30, 2003, there were a total of approximately 344,000 enrollees, 32,500 of whom were new to VA in FY 2003.[571] VISN 23 delivers health care services through nine medical centers, seven nursing homes, four domiciliaries, and 35 community-based outpatient clinics (CBOCs). Additionally, VA operates 12 Vet Centers in VISN 23's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 23.

VISN 23	FY 2001	FY 2012	FY 2022
Enrollees	290,458	289,143	257,068
Veteran Population	1,160,866	938,152	757,962
Market Penetration	25.02%	30.82%	33.92%

For the CARES process, this VISN is divided into five markets: the Iowa Market (*facilities:* Iowa City, Knoxville, and Des Moines, IA); the Minnesota Market (*facilities:* Minneapolis and St. Cloud, MN); the Nebraska Market (*facilities:* Omaha and Grand Island, NE); the North Dakota Market (*facility:* Fargo, ND); and the South Dakota Market (*facilities:* Sioux Falls, Hot Springs, and Fort Meade, SD).

[570] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.
[571] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.

Information Gathering

The CARES Commission visited four sites in VISN 23 and conducted two public hearings.
The Commission received 357 public comments regarding VISN 23.

- *Site Visits:* Hot Springs, SD; Fort Meade, SD; Knoxville, IA; and Des Moines, IA, on July 8 through 11.
- *Hearings:* Minneapolis, MN, on September 3; and Omaha, NE, on September 4.

Summary of CARES Commission Recommendations:

I Small Facility and Campus Realignment – Knoxville and Des Moines, IA

1. The Commission concurs with the DNCP proposal to move all inpatient services to Des Moines and to retain outpatient services at Knoxville, provided there are safeguards in place to ensure that no VA-operated long-term care (LTC) in the VISN is lost nor the capacity to care for the patients now being treated at Knoxville.
2. The Commission recommends that acute inpatient mental health services should be provided with other acute inpatient services whenever feasible.
3. The Commission recommends that: [572]
   - a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c Domiciliary care programs should be located as close as feasible to the population they serve.
   - d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-390)

II Small Facility and Campus Realignment – Hot Springs, SD

1. The Commission does not concur with the DNCP proposal to change the mission of the Hot Springs campus to that of a critical access hospital (CAH). The Commission recommends that VA establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this designation.

[572] Chapter 3, *National Crosscutting Recommendations: Long-Term Ca*re, contains additional information on this topic.

2 The Commission recommends that Hot Springs retain it current mission to provide acute inpatient medical, domiciliary and outpatient services.

(see page 5-393)

III Small Facility – St. Cloud

1 The Commission concurs with the DNCP proposal to maintain inpatient acute psychiatry, domiciliary, nursing home, and outpatient services at St. Cloud. The Commission concurs with transferring medicine beds from St. Cloud to Minneapolis and with contracting in the community.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-395)

IV Inpatient Care

1 The Commission concurs with the DNCP proposal to contract for acute hospital and tertiary hospital care in the community to improve access to hospital and tertiary care for veterans in this VISN.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3 The Commission concurs with the DNCP proposal that construction and renovation for the purpose of modernization proceed at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities.

4 The Commission concurs with the DNCP proposal regarding the need to upgrade the existing LTC unit at Grand Island. The Commission recommends that: [573]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-397)

V Outpatient Care

1 The Commission recommends that:[574]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service settings.

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[573] Chapter 3, *National Crosscutting Recommendations: Long-Term Ca*re, contains additional information on this topic.

[574] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs),* contains additional information on this topic.

2 The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space needs at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities.

(see page 5-400)

VI Enhanced Use and Collaboration with VBA

1 The Commission concurs with the DNCP proposal for enhanced use leasing (EUL) projects for VISN 23.

2 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-403)

VII Special Disability Programs – Spinal Cord Injury/Disorder Unit at Minneapolis

1 The Commission concurs with the DNCP proposal to build a new 30-bed SCI/D unit in Minneapolis.

2 VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-404)

Small Facility and Campus Realignment – Knoxville and Des Moines

DNCP Proposal

"Knoxville will maintain outpatient services, and all inpatient care, including acute care, long-term care, and domiciliary will be transferred to the Des Moines campus. A new 120-bed nursing home is proposed at Des Moines to replace the 226 nursing home beds at Knoxville."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VA Medical Centers (VAMCs).

Commission Analysis

Both Knoxville and Des Moines were identified as small facilities, as both are projected to need fewer than 40 acute inpatient beds in FY 2012 and FY 2022. These facilities were also selected for campus realignment as they are under a single leadership and are both part of the Central Iowa Health Care System (HCS). There are currently 260 authorized beds at Knoxville with an average daily census (ADC) of about 217. This includes an ADC of six intermediate medicine, eight acute psychiatry, 32 domiciliary, and 171 nursing home patients.[575] Knoxville is projected to need 26 acute beds in FY 2012 and 20 in FY 2022.[576] Knoxville also includes a 30-bed acute rehabilitation unit that is Commission for Accreditation of Rehabilitation Facilities (CARF) accredited. In FY 2003, Des Moines had an ADC of 23 for inpatient medicine, and is projected to need 34 acute beds in FY 2012 and 24 in FY 2022. Workload is projected to decrease to an ADC of 14 by FY 2022. Workload in Knoxville for inpatient medicine was projected to peak in FY 2003 with an ADC of 10, and to decrease to an ADC of 6 by FY 2022. Workload for inpatient psychiatry is projected to peak in FY 2004 at an ADC of 14, and to taper off to 10 by FY 2022.[577]

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[575] Appendix D, *Data Tables*, page D-105.
[576] Appendix D, *Data Tables*, page D-105.
[577] CARES Portal, VISN 23, Workload by Year Report.

During the site visit, the Commission noted that many of the current recipients of care at Knoxville are from the Des Moines metropolitan area. Also, the Commission noted that many of the current patients in Knoxville are very ill and have multiples diagnoses, including longstanding psychiatric disorders. These patients would be very difficult to place in the community or in State Veterans Homes.[578] During the site visit, the State Home Director indicated that she could take more VA patients, but when questioned, indicated that the State Home does not accept many of the kinds of patients currently cared for at the Knoxville facility.[579] No other VA facility in the Iowa Market provides long-term mental health services. Many patients at Knoxville come from larger urban areas including Des Moines, Iowa City, Sioux Falls, and Omaha.

Donald Cooper, Director of the Central Iowa HCS, indicated that he was convinced there would be significant savings and a significant payback if facilities were moved from Knoxville and built in Des Moines.[580] Dr. Bruce Sieleni, Director of the Mental Health Service Line, stated that in order to improve coordination and quality of care, both acute and long-term psychiatry, should be located with other acute services in Des Moines.[581] A number of concerns with the condition of the Knoxville buildings, including life safety and environment of care issues, were identified during the site visit. Also, nursing home care units do not meet community standards, and privacy standards are minimally met. Many patient care buildings do not have air conditioning,[582] have JCAHO waivers for life safety standards, and do not meet JCAHO psychiatric safety standards for suicide prevention.

Life-cycle costs indicate that there would be about $114 million in net savings in life-cycle costs by moving Knoxville inpatient and nursing home services to Des Moines and building a new 120-bed nursing home at Des Moines. Construction and renovation costs of $31.3 million are estimated for Des Moines.

There likely will be an economic impact on the community of Knoxville if inpatient services are moved to Des Moines. Jeffrey LuGarce, the City Manager of Knoxville, said in testimony that "the Knoxville VA is our second-largest employer."[583] A number of other stakeholders in and around Knoxville and employees from Knoxville were opposed to closing inpatient services in Knoxville. According to medical center leadership, most Knoxville VAMC employees would be offered jobs in Des Moines. The Des Moines campus is slightly more than 35 miles from Knoxville.

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578 CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 4.
579 CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 5.
580 Donald Cooper, Director, Central Iowa Health Care System, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, page 33.
581 CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 2.
582 CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 3.
583 Jeffrey LuGarce, City Manager of Knoxville, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, page 67.

Veterans service organizations (VSOs) and stakeholders, including Senator Grassley's office and employees from Des Moines, noted concerns related to ensuring that access is maintained. Commissioners agreed that moving inpatient services from Knoxville to Des Moines was in keeping with the principle regarding access, but expressed concern that the DNCP calls for the construction of fewer LTC beds than are currently being used.

Commission Findings

1. Placing acute psychiatry with other acute care services will improve the coordination of care.
2. Moving the domiciliary patients to Des Moines will increase the percentage of residents who are closer to their homes and families.
3. Site visits to Knoxville indicated that the condition of some of the buildings is poor and there are JCAHO waivers for life safety and psychiatric issues.
4. Moving inpatient care to Des Moines would have some impact on the community of Knoxville, as VA is the second largest employer in town.
5. VSOs and stakeholders' concerns are related to ensuring that access is maintained.
6. The plans to build a 120-bed nursing home to replace the existing long-term care beds at Knoxville that currently have an ADC of 171 calls into question where the VISN plans to provide the 80 additional VA operated inpatient beds.
7. Many of the patients currently cared for in the Knoxville VAMC will be difficult, if not impossible, to place in a community setting.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to move all inpatient services to Des Moines and to retain outpatient services at Knoxville, provided there are safeguards in place to ensure that no VA-operated LTC beds in the VISN is lost nor the capacity to care for the patients now being treated at Knoxville.
2. The Commission recommends that: [584]
   a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

[584] Chapter 3, *National Crosscutting Recommendations: Long-Term Ca*re, contains additional information on this topic.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

II Small Facility and Campus Realignment – Hot Springs

DNCP Proposal

"The Hot Springs division of the Black Hills HCS identified the concept of the critical access hospital (CAH) in their small facilities proposal. The National CARES Program Office fully endorsed the CAH concept where Hot Springs would begin converting their hospital length of stay to no greater than 96 hours, maintain bed levels below 15, and maintain a strong link to their referral network."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

By 2022, the inpatient workload in the South Dakota Market (Hot Springs, Fort Meade, and Sioux Falls) is projected to decrease by about 45 percent. Hot Springs, which is a part of the Black Hills HCS, was identified as a small facility as it is projected to need 23 acute beds by FY 2012 and 20 by FY 2022. The Hot Springs ADC was 10 in FY 2003 and has shown a steady decrease since FY 2000 when the ADC was slightly higher than 17. The facility is authorized for one surgical bed but has had no inpatient surgical census since FY 2000, though Hot Springs does do about ten ambulatory surgeries per day.[585] Additionally, the facility has 160 domiciliary beds with an ADC of 143 in FY 2003, which is an increase

[585] CARES Site Visit Report; Hot Springs and Fort Meade, SD, July 8-9, 2003, page 3.

from the 130 ADC in FY 2000.[586] Quality of care and customer satisfaction scores are generally higher than the national average for Fort Meade and Hot Springs.[587]

Native Americans are the largest minority in the VISN and are medically underserved. Many have multiple health problems and difficulty with transportation to care. One area of focus of Hot Springs is outreach to reservations. About 25 percent of Hot Springs' patients are Native American. One CBOC is located between two reservations and serves a primarily Native American Community. A new PTSD clinic has recently been opened on the Rosebud Reservation. Market penetration for Fall River County where the Hot Springs facility is located is about 77 percent and is similar in the counties just to the south where the Pine Ridge and the Rosebud Indian Reservations are located. Indian Health Service provides only primary care services and contracts for all specialty care. Native American veterans in the area are very dependent on the Hot Springs VA for their care.[588]

The nearest community hospital is in Rapid City, more than 60 miles away, and the nearest VA facility, Fort Meade, is more than 100 miles away. The only other medical center in Hot Springs was closed and, though it reopened recently, the Director of the Black Hills Health Care System said:

> The community hospital once existed in Hot Springs, closed in 1998. Once critical access was recognized and funded by Medicare, it reopened in 2001. Currently, it's a ten-bed critical access hospital, does not have a 24-hour emergency room. Number one, they're not JCAHO accredited as many small critical access hospitals aren't.[589]

About 40 percent of Hot Springs' enrollees come from northwestern Nebraska and receive most of their care in Hot Springs. Should Hot Springs change its mission, they would have to travel another 100 miles for services. The Hot Springs campus provides services for the community, including all dialysis and some emergency care, and inpatient and outpatient health care services on a contracted basis for the Hot Springs State Veterans Home, the only State Veterans Home in South Dakota. VSOs and stakeholders, including the Governor's office and VA employees, testified that changing the mission of the Hot Springs campus would have a negative impact on the community and the availability of health care in the Hot Springs area. Mr. Dennis Foell, Director of the South Dakota Division of Veterans Affairs, stated:

> We have concerns about the Hot Springs VA Medical Center in western South Dakota. This facility serves rural veterans in southwest South Dakota, northwestern Nebraska and

[586] Appendix D, *Data Tables*, page D-111.
[587] Appendix D, *Data Tables*, page D-112.
[588] CARES Site Visit Report; Hot Springs and Fort Meade, SD, July 8-9, 2003, page 3.
[589] Joseph Dalpiaz, Director of the Black Hills Health Care System, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, pages 33-34.

eastern Wyoming, besides the care provided to the rural veterans in these area, Hot Springs also provides care for the 130 to 150 residents at the Michael J. Fitzmaurice South Dakota State Veterans Homes.[590]

Commission Findings

1. There is one non-JCAHO-accredited private sector facility within 60 minutes of the Hot Springs VAMC, with little capacity. No VAMCs are within 60 minutes of Hot Springs.
2. The Hot Springs VAMC currently provides dialysis and some emergency care for the community.
3. The Hot Springs community, the State Veterans Home, Native American veterans, and residents of the VA domiciliary are dependent on the Hot Springs VAMC beds for critical services.
4. Customer satisfaction scores and quality of care scores for inpatient and outpatient services at Hot Springs are above the national average.
5. VSOs and stakeholders are opposed to changing the mission at Hot Springs.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to change the mission of the Hot Springs campus to that of a CAH. The Commission recommends VA establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this designation.
2. The Commission recommends that Hot Springs retain it current mission to provide acute inpatient medical, domiciliary, and outpatient services.

III Small Facility – St. Cloud

DNCP Proposal

"Maintain acute psychiatry, domiciliary, other mental health, and outpatient services. Acute medicine is transferred to Minneapolis and contracts in local community."

DNCP Alternatives

1. Retain acute hospital beds.

[590] Dennis Foell, Director of the South Dakota Division of Veterans Affairs, Written Testimony submitted at the Minneapolis, MN, Hearing on September 3, 2003, page 2.

2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The St. Cloud VAMC, which is primarily an extended care facility, was identified as a small facility as it is projected to require 26 acute beds in FY 2012 and 18 in FY 2022. St. Cloud is approximately 70 miles from the Minneapolis VAMC over an interstate highway. Overall acute inpatient workload in the Minnesota Market (Minneapolis and St. Cloud) is projected to decrease 6 percent by 2012, and 30 percent by FY 2022 over the FY 2001 baseline.

For the past 2 years, as a part of a pilot program, all inpatient medicine beds have been closed at St. Cloud and about one-half of these patients have been transferred to Minneapolis for care; the other half are treated under a contract in the local community. In St. Cloud, there are 40 operating beds in psychiatry, with an ADC of 39 (98 percent occupancy).[591] Approximately ten of these beds appear to be acute psychiatry beds, and the other 30 have longer lengths of stay. The VISN market plan indicated that there is a need to retain the acute psychiatry beds in St. Cloud because the Minneapolis VAMC does not have the capacity to absorb this work. The St. Cloud VAMC also has 123 authorized VA domiciliary beds, and its ADC has decreased from 107 in FY 2000 to fewer than 93 in FY 2003. It also has 220 authorized nursing home care unit beds, and the ADC has decreased from 211 in FY 2000 to about 204 in FY 2003.[592] Inpatient psychiatry is projected to increase in this market by 29 percent (nine beds) in FY 2012 and to then decrease by about 13 percent (four beds) from the FY 2001 baseline in FY 2022. At the Minneapolis VAMC, there are currently 25 operating beds in acute psychiatry, with an ADC of 15 (60 percent occupancy).[593]

Quality of care scores for outpatient medicine indicate that St. Cloud is better than the national average on most quality measures. Its inpatient customer satisfaction scores are below the national average, while its outpatient satisfaction scores are above the national average.

There would be no economic impact on employees or the community from this DNCP proposal because the changes have been in place for 2 years as a part of a pilot project. Testimony and comments encourage further contracting in the community.

[591] Appendix D, *Data Tables*, page D-108.
[592] Appendix D, *Data Tables*, page D-108.
[593] Appendix D, *Data Tables*, page D-108.

Commission Findings

1. The plan as recommended in the DNCP has already been implemented at the St. Cloud VAMC on a pilot basis with few problems or concerns.
2. Workload is generally increasing in psychiatry in St. Cloud and remains about the same in Minneapolis. Both domiciliary and nursing home workload has decreased slightly over the past four years.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to maintain inpatient acute psychiatry, domiciliary, nursing home, and outpatient services at St. Cloud. The Commission concurs with transferring medicine beds from St. Cloud to Minneapolis and with contracting in the community.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

IV Inpatient Care

DNCP Proposals

"*Hospital Care* – Access to VA hospital care will improve in the Iowa, Minnesota, North Dakota, and South Dakota markets through community contracts at 11 sites. *Tertiary Care* – Tertiary care access will improve for veterans in the North Dakota Market by contracting for care in Bismarck and Minot. *Medicine* – The VISN will also transfer some medicine from in-house care to contract care to improve hospital access for veterans. The VISN proposes significant capital investments for tertiary care ICUs, monitored beds, and overall facility conditions. *Surgery* – Inpatient surgery services will decrease in the Minnesota Market, resulting in a tremendous shift from inpatient to outpatient care As a result, space will be realigned from inpatient to outpatient specialty care at VAMC Minneapolis. *Extended Care Grand Island* – The renovation of 26,806 square feet in Nebraska market (Grand Island) is planned."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Four of the five markets in this VISN do not meet the CARES standard at 65 percent for access to hospital care. Access ranges from 37 percent in North Dakota to 70 percent in Nebraska, though the latter meets the standard.[594] Dr. Petzel, VISN Director, testified that the plan is to provide emergent hospitalization at the inpatient facility closest to the veteran's home and tertiary care at the nearest advanced care facility, and to transfer the patient to a VA facility as soon as he/she is stable. The North Dakota Market also has a gap in access to tertiary care, with only 32 percent of enrollees having access within the driving guidelines (the threshold is 65 percent).[595]

Compounding the issue for a need to increase access to hospital care is the concurrent projected decrease in the need for overall inpatient beds in all five markets. Inpatient medicine and surgery are projected to decrease from the FY 2001 baseline by FY 2012, and to decrease further by FY 2022. Inpatient psychiatry is projected to increase in all five markets by FY 2012, and to return to FY 2001 baseline levels by FY 2022.

Renovation or new construction of inpatient space is planned at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities. Renovation of inpatient space at Fargo is nearing completion.[596] With the exception of Des Moines, life-cycle costs were not provided for renovation or new construction.

The VISN has identified the need to renovate the nursing home care unit at Grand Island as one of its top priorities. The workload report at Grand Island for intermediate and LTC indicates the current ADC is 54 with 76 operating beds. No workload projections were provided for LTC. The VISN Director testified that the VISN is:

> …in the process of renovating the nursing home in Grand Island. It's at the top of the list right now of projects; we're expecting the funding to come shortly. So that's a viable program; it's going to be there for as far in the future as we can see and there is no plan to diminish it, and right now there are no plans to expand it either.[597]

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[594] VISN 23 Market Plan for Capital Asset Realignment for Enhanced Services; VISN Level Information; Section 5-e.

[595] VISN 23 Market Plan for Capital Asset Realignment for Enhanced Services; VISN Level Information; Section 5-e.

[596] Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 14. Also from the Omaha, NE, Hearing on September 4, 2003, pages 17-18.

[597] Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, pages 31-32.

Commission Findings

1. There are access-to-hospital-care gaps in four of the five markets and a simultaneous projected overall decrease in the need for acute inpatient beds. There is a need to balance improved access with maintaining an adequate inpatient census to sustain the viability and cost-effectiveness of some of this VISN's medical centers.
2. There is a reasonable plan to provide hospital and tertiary care to address access through contracts in the VISN.
3. Much of the inpatient space in many of the medical centers in the VISN have not been updated or renovated for many years.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to contract for acute hospital and tertiary hospital care in the community to improve access to hospital and tertiary care for veterans in this VISN.
2. The Commission recommends that:
   - a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   - b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal that construction and renovation for the purpose of modernization proceed at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities.
4. The Commission concurs with the DNCP proposal regarding the need to upgrade the existing LTC unit at Grand Island. The Commission recommends that: [598]
   - a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   - b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   - c. Domiciliary care programs should be located as close as feasible to the population they serve.
   - d. Freestanding LTC facilities should be permitted as an acceptable care model.

[598] Chapter 3, *National Crosscutting Recommendations: Long-Term Ca*re, contains additional information on this topic.

V Outpatient Care

DNCP Proposal

"*Primary Care* – Primary care access will be improved in two markets with seven new CBOCs for the Iowa and the Minnesota markets included in the plan. The DNCP attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, new access points in the Nebraska, North Dakota, and South Dakota markets are in the National Plan; however, they are not in the high implementation priority category at this time. *Primary Care Workload* – Primary care outpatient services will increase in five markets. Planned CBOCs in the Iowa and Minnesota markets, new construction and internal conversion will help improve access. The new CBOCs planned will be leased sites or contract care. In-house expansions will occur through capital investments in renovation, conversion, and new construction. *Specialty Care* – Specialty care outpatient services will increase in four markets and at all care sites. Contracting is utilized in high peak periods of growth. New construction of 171,000 square feet is planned in VISN 23 to meet access initiatives, environment of care concerns, and the increasing workload demand. Other solutions include renovation, conversion of existing space and leasing alternatives."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

All five markets in this VISN do not meet the CARES standard for access to primary care. Gaps range from a high of 53 percent of enrolled veterans who have access within the driving distance standard in the Minnesota Market to a low of 37 percent in the North Dakota Market.[599] The DNCP includes a total of 21 CBOCs for this VISN, eight of which are in the DNCP's priority group one: the four proposed CBOCs in the Minnesota Market and the four in the Iowa Market. The six CBOCs proposed in the North Dakota Market, the three in the South Dakota Market, and three of the four proposed in the Nebraska Market are included in the priority group two. Two of the CBOCs, including the Offutt clinic, are proposed to address capacity issues at Minneapolis and Omaha. The others are proposed to improve access in all markets. A fourth proposed CBOC in the Nebraska Market at Bellevue, while identified as included in priority group two, is actually a collaboration with DoD at Offutt AFB, which automatically elevates this CBOC to priority group one.

[599] VISN 23 Market Plan for Capital Asset Realignment for Enhanced Services; VISN Level Information; Section 5-e.

In Nebraska, North Dakota, and South Dakota, many veterans currently must travel more than 100 miles to receive primary care. Mr. David Parr, Veterans of Foreign Wars: "There's a large segment of the population of South Dakota made up of veterans who are entitled to VA health care services. Because South Dakota is generally a rural area, many veterans must travel as far as 250 miles one way in order to receive that care."[600]

When the VISN Director was asked in hearings to delineate his top three priorities under CARES, he said, "Community-based outpatient clinics would be number, [one] two, three, four, and five."[601] During the site visits, the VISN Director indicated that he did not believe that the VISN would be able to meet the CARES access standards even if all the CBOCs were opened nor did he believe that it was practical to be able to meet the guidelines given the highly rural nature of some counties in the VISN.[602] Commissioners also were advised that much of North Dakota, South Dakota, and western Nebraska is designated as medically underserved.

Local VSOs stated that they travel 100 to 150 miles one-way to see a primary care provider. They also reported that some CBOCs in South Dakota and northwestern Nebraska are closed to new enrollees and that they would like to see more staff hired in those clinics so that they would not have to travel to Hot Springs for primary care.

More than 85 percent of the 357 public comments received for this VISN concern access, including the addition of new CBOCs and where they should be placed. Complicating the issue of increased access to primary care, however, is the concurrent projected decrease in the need for overall primary care in three of the five markets in this VISN. Outpatient workload for primary care is projected to decrease in both the North Dakota and the South Dakota Markets in both FY 2012 (by 1 and 15 percent over the FY 2001 baseline, respectively) and FY 2022 (by 22 and 31 percent, respectively). Primary care workload is projected to decrease in the Nebraska Market by 11 percent by FY 2022. In addition, while outpatient mental health is projected to increase by 73 percent by FY 2012 in the North Dakota Market, it is expected to remain generally flat or decrease in other markets.[603] The VISN Director indicated that mental health services would be added to CBOCs when feasible but also noted that some of the contracted CBOCs include only a small number of veterans.[604]

However, outpatient workload for specialty care is projected to increase at each of the VAMCs in this VISN, except in the South Dakota Market. North Dakota is projected to have the largest increase in specialty care demand at 120 percent over baseline by FY 2012, and 82 percent over baseline by FY 2022.

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[600] David Parr, Veterans of Foreign Wars, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, page 96.

[601] Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 29.

[602] CARES Site Visit Report; Hot Springs and Fort Meade, SD, July 8-9, 2003, page 1.

[603] Appendix D, *Data Tables*, page D-105.

[604] Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 23.

In the Iowa Market, specialty care is expected to increase by 65 percent over baseline in FY 2012, and to still be 39 percent over baseline by FY 2022. Projections for Minnesota include an increase to 40 percent over baseline by FY 2012, with a decrease to 24 percent over baseline by FY 2022. Specialty care in the Nebraska Market is projected to increase by 35 percent over baseline by FY 2012, with a decrease to 15 percent over baseline by FY 2022.[605]

The CARES Space Report indicates that there are space deficits in most facilities in the VISN,[606] which are to be addressed either through new construction or the conversion of existing space. Many facilities also plan construction and renovation of existing space to address problems with the condition of their space.

Commission Findings

1. Access to primary care is a significant problem in this VISN.
2. Access to primary care will be improved with the addition of the priority group one CBOCs. These new clinics, however, will not address the VISN's access problems in three of the five markets: Nebraska, North Dakota, and South Dakota.
3. All markets have projected increases in specialty care workload, and two markets also have projected increases in primary care workload.
4. According to the Space Report, there is inadequate outpatient space for most facilities in the VISN.
5. The quality of space at Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities is in need of renovation.

Commission Recommendations

1. The Commission recommends that:[607]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

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[605] Appendix D, *Data Tables*, pages D-104 and D-105.

[606] VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

[607] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs),* contains additional information on this topic.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service settings.

2 The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space needs at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities.

VI Enhanced Use and Collaboration with VBA

DNCP Proposals

"*Enhanced Use* – Three enhanced use lease projects are proposed: 1) Single Room Occupancy Initiative Concept plan (approval pending); 2) Federal Credit Union Concept Plan (approved), public hearing completed requires approximately an acre of property on medical center campus; and 3) a St. Paul VARO enhanced use initiative with a private developer to collocate onto the Minneapolis campus. *Collaboration VBA* – The VARO in St. Paul would relocate to new construction on land at the VAMC Minneapolis campus through an EUL proposal (high priority)."

Commission Analysis

The Minneapolis campus is one of 20 locations with high potential for EUL. Three separate EUL projects are underway on this campus: building a federal credit union, a transitional housing project, and the collocation of VBA to the Minneapolis campus. The EUL plan that includes VBA has not progressed past the planning stage, and although VBA has identified the project as a high priority project with plans for completion by FY 2010, it has not submitted a formal proposal.[608]

[608] Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 16.

VISN 23 reported in early January 2004 that the Minneapolis VAMC held a public hearing on the proposed construction project for the transitional housing project and is currently waiting for the conclusion of a 90-day review period by Congress. The VISN hopes to start construction in the spring of 2004.

A hearing was also held for the federal credit union project a year ago, and a private sector partner was selected. The 90-day Congressional review process has been completed. The VISN reports that VA Regional Counsel is currently reviewing the proposed lease under negotiation between the builder and the credit union management.[609]

Commission Findings

1. While no data are available for review, the narrative in the VISN's market plan, the VISN Director's testimony at the Minneapolis hearing, and his replies to questions from Commissioners on the topic appear to provide reasonable support for the VISN's EUL initiatives.
2. Two of the three EUL efforts have VA Central Office approval.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for EUL projects in VISN 23.
2. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

VII Special Disability Programs – Spinal Cord Injury/Disorder Unit at Minneapolis

DNCP Proposal

"Build a new SCI/D unit at Minneapolis."

DNCP Alternatives

None provided in the DNCP.

[609] E-mail received from VISN 23 Network Office on January 9, 2004.

Commission Analysis

The plan for the new SCI/D unit is for new construction of a two- or three-story building that would include outpatient space and one or two floors for inpatient care. The VISN Director testified that new construction would be required as only about ten beds could be converted if existing space were utilized:

> We came to the conclusion that we could not accommodate [the SCI/D unit] within the space that we have right now, not at the size that's required by the Central Office and PVA criteria for a spinal cord injury unit. We could do something like ten beds, but we couldn't do 20 beds or 30 beds, which is what they're talking about.[610]

In testimony, Oscar Ballard, National Service Officer for the Paralyzed Veterans of America said, "The Minnesota Chapter of PVA supports the construction of a 30-bed SCI center with plans for an additional ten beds at a later date at the Minneapolis VAMC."[611]

The Commission agreed that an SCI/D inpatient unit appears to be indicated, and although the number of beds was uncertain, noted that 30 SCI/D beds is the minimum that should be placed in any center but that these beds could be a mix of acute and long-term beds depending on the needs in the area.

Commission Findings

1. There are no SCI Centers between Milwaukee and Seattle along the northern section of the country.
2. Stakeholders support the building of a new SCI/D unit in Minneapolis.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to build a new 30-bed SCI/D unit in Minneapolis.
2. VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

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[610] Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 30-31.

[611] Oscar Ballard, National Service Officer for the Paralyzed Veterans of America, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 60.