Chapter 3

National Crosscutting Recommendations

Introduction

Through its public meetings, site visits, hearings and informal meetings with individual veterans and stakeholders, the Commission developed an appreciation for the complexity of the system-wide issues confronting VA and the significance of the changes proposed in the DNCP. Relying on its collective expertise, the Commission identified a variety of issues that are critical to VA's success as it continues on its path to realign and transform its health care system. Resolution of these issues is essential to achieve the desired changes. Of these, the issues that arose in all or nearly all VISNs were designated as "Crosscutting Issues" and are as follows:

- Facility Mission Changes
- Community-Based Outpatient Clinics (CBOCs)
- Mental Health Services (Acute Inpatient and Outpatient Services)
- Long-Term Care (Including Geriatric and Seriously Mentally Ill Services)
- Excess VA Property
- Contracting for Care

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Each is important to VA achieving the necessary changes to accomplish CARES goals. Facility Mission Changes and managing excess property concentrate on the realignment of capital assets. The prioritization and placement of CBOCs and contracting for care in local communities focus

on developing equitable access to quality health care. Similarly, the issues of Mental Health Services and Long-Term Care, subjects that were not fully incorporated into this phase of CARES, deal with providing access to quality services.

The Commission determined that for VA to reach a successful outcome from the CARES process, it was essential that recommendations be developed for these crosscutting issues. These issues and related recommendations, while appearing at times to be discrete from one another, are in fact interdependent, and require careful integration and prudent application across VA to ensure an effective outcome.

Accordingly, the Commission developed recommendations for each issue. Initially, these recommendations served to guide the Commission's decision-making as it reviewed the DNCP proposals for, and with sensitivity to the particular circumstances in, each VISN. These recommendations are not intended to resolve all questions that may be raised on the subject in the context of specific VISNs. Therefore, although the Commission did not necessarily apply them identically in each VISN, the recommendations were considered and did influence the outcome.

Additionally, the Commission believes that these recommendations should be the basis for the development of national policy guidance on the issues addressed.

This chapter describes these issues and provides underlying rationale for the Commission's recommendations regarding each of the crosscutting issues. Chapter 5 details how the recommendations were applied in the specific VISNs.

Facility Mission Changes

Issue

Did the DNCP adequately establish and consistently apply criteria regarding proposed mission changes at VA facilities?

Background

The primary goal of the CARES process is to realign resources in order to enhance access to health care services for our nation's veterans. To accomplish this goal, it is critical to eliminate duplicate clinical and administrative services at VA facilities, increase efficiencies, and allow reinvestment of financial savings. To this end, the DNCP proposed consolidation of services at three types of facilities: facilities with

small workload volume ("small facilities"); facilities within close geographic proximity of other facilities ("proximity"); and facilities with multiple campuses ("campus realignment").[1]

The guidance to the VISNs stipulated that "proximity" of two separate tertiary and acute hospitals located within a defined distance of the other be a basis for evaluating whether to consolidate the facilities or services at the facilities. After the USH reviewed the VISN's proximity initiatives and recommendations, he expanded the proximity review with a campus realignment review. This latter analysis focused primarily on VA facilities with two or more campuses.

The DNCP identified 18 facilities meeting criteria for small facilities[2] and 22 facilities meeting the criteria for proximity or campus realignment[3]. The Commission combined the recommended changes to these facility types and describes them as "facility mission changes."

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Small Facilities

The DNCP states that a VA facility was selected as a small facility for purposes of a mission change review when the facility met all of the following criteria:

- The facility provided acute hospital bed services.
- The facility had acute medicine beds.
- The facility was projected to have less than 40 total acute beds for medicine, surgery, and psychiatry in FY 2012 and FY 2022.[4]

[1] Draft National CARES Plan (DNCP), *Chapter 8: Strategic Directions of Small Facilities*, *Chapter 9: Proximity and Campus Realignments,* [*http://www1.va.gov/cares/*]

[2] The total of facilities discussed as small facilities differs slightly from that shown in the DNCP in Table 8.2, Small Facility Recommendations, which lists 19 facilities. Two of those included in Table 8.2 – Knoxville and Des Moines, IA – are two campuses of one health care system and the consolidation of services from Knoxville to Des Moines is included in Table 9.1, Campus Realignment Proposals. These facilities are not included as small facilities. In additions, Roseburg, OR, is described as a small facility in the VISN 20 Executive Summary in the DNCP, but was not included in Table 8.2.

[3] The total of facilities discussed as proximity or campus realignments differs from that shown in the DNCP in Table 9.1, Campus Realignment Proposals, which includes 26 facilities. Four of the facilities included in Table 9.1 – Montrose, NY; Kerrville, TX; Walla Walla, WA; and Hot Springs, SD – are also included in Table 8.2 as small facilities and are discussed under that category in this report.

[4] Draft National CARES Plan (DNCP), *Chapter 8: Strategic Directions of Small Facilities*, [*http://www1.va.gov/cares/*]

In this evaluation, acute care included intermediate medicine and psychiatry services; however, long-term care was not included. Based on the above criteria, the Commission considered the following 18 facilities as small facilities for a possible mission change:

VISN	VAMC
3	Castle Point, NY
4	Butler, Erie, and Altoona, PA
6	Beckley, WV
7	Dublin, GA
11	Ft. Wayne, IN; Saginaw, MI
15	Poplar Bluff, MO
16	Muskogee, OK
17	Kerrville, TX
18	Prescott, AZ
19	Cheyenne, WY; Grand Junction, CO
20	Walla Walla, WA; Roseburg, OR
23	Hot Springs, SD; St. Cloud, MN

The DNCP recommended that 11 of these 18 small facilities retain acute beds, with limited "scope of practice" restricting inpatient surgical and intensive care beds. Seven of these 11 facilities would convert to a new type of facility modeled after the Centers for Medicare and Medicaid Services (CMS) designation of a critical assess hospital (CAH). Seven facilities were proposed to close acute hospital beds over the next several years – six as soon as possible and one by FY 2012 – and manage demand through community contracts, referral, or consolidation with another facility.

Campus Realignments

Campus realignment focused primarily on facilities with multiple campuses. The Commission considered the following 22 facilities that met the criteria for campus realignment:

VISN	Facility
1	Bedford and Jamaica Plain, MA
2	Canandaigua, NY
3	Lyons, NJ; St. Albans, Montrose, and Manhattan, NY
4	Pittsburgh (Highland Drive Division), PA
5	Perry Point, MD
7	Augusta (Uptown Division), GA; Montgomery, AL
8	Lake City, FL
9	Lexington (Leestown Division), KY
10	Brecksville, OH
15	Leavenworth, KS
16	Gulfport, MS
17	Waco, TX
18	Big Spring, TX
20	Vancouver, WA; White City, OR
21	Livermore, CA
23	Knoxville, IA

Analysis

For small facilities, VISNs were required to analyze options for changing the mission of the facility. These options were: 1) retain acute hospital beds; 2) close acute beds and reallocate workload to another VA facility; 3) close acute beds and contract with a local provider, or initiate a joint venture for workload; or, 4) a combination of 1, 2, or 3.

Following submission of VISN analyses on small facilities, VA applied the CAH designation to seven small facilities that furnish acute hospital care in rural or less densely populated areas.[5] VA has yet to develop a clear definition of a CAH in the VA system or criteria for the establishment of a CAH. In the USH's presentation to the Commission on August 7, 2003, he noted that CAH is a new concept in the context of VA health care.[6] The essential characteristics are: 1) that the hospital is remote with no other inpatient facility nearby, 2) the facility would have no intensive care unit or inpatient surgical services, and 3) it would be primarily an intake point for other facilities or for relatively minor illnesses.

The Commission did not receive supporting data for many of the proposed mission changes, particularly as to the 22 campus realignment proposals, until more than two months after the release of the DNCP and after the Commission had completed virtually all of its site visits and hearings. To evaluate these supplemental data, the Commission received assistance from an independent team made up of staff from VA's Office of Policy and Planning, Office of Capital Asset Enterprise Management, and VHA's Office of Facilities Management. This team analyzed the information submitted by the VISNs in response to a data call from the NCPO and provided the Commission with an analysis of the data's quality and reliability. The team's overall view on this information was:

> Twenty-one[7] realignment proposals were reviewed by the team. There was wide variability in the quality of the realignment studies. At best, the proposals provide a broad overview of the possible alternatives available at the 21 locations. However, numerous inconsistencies and errors in data were found in the proposals. The life cycle costs presented contain many apparent weaknesses and could mislead decision makers. The relative cost effectiveness of alternatives in each proposal may change dramatically after more detailed analyses are completed.[8]

The review team also concluded that life cycle costs did not reflect the anticipated implementation dates of the various alternatives. Construction costs generally included "building-only" costs and omitted site preparation and other costs. Demolition costs were often not estimated or were questionable. Capital costs were sometimes included in contracting alternatives that should not incur capital costs. In some cases, capital costs for construction at facilities with increasing workload were included even though

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[5] DNCP, *Appendix F: Small Facilities Planning Initiatives and Recommendations*, page 1. [*http://www1.va.gov/cares/*]

[6] Roswell, Robert, Under Secretary for Health, CARES Commission Meeting Summary, August 7, 2003. [*http://www.carescommission.va.gov/MeetingMinutes.asp*]

[7] This reflects the number of proposals in NCPO's data call in September 2003. There were 22 proposed campus realignments in the DNCP.

[8] Appendix E, *Financial Review of CARES Realignment Proposals*, page 2.

these costs had no direct correlation to the increasing workload. Contracting was not always considered as an option. Contracting portions of workload, such as inpatient care rather than all workload, could have resulted in more meaningful and cost-effective comparisons.

The review team highlighted other problem areas. For example, it found that policy regarding providing nursing home care to veterans with psychiatric diagnoses was applied inconsistently – some VISNs did not contract with community nursing homes for such care under any circumstances, while other VISNs were willing to contract all nursing home care, including for veterans with psychiatric diagnoses. The team noted that enhanced use leasing was not well understood by VISNs and proposals did not reflect the potential savings of this approach. The team also observed many facilities acknowledged having historic buildings, yet presented no solutions as to how to manage them. State Veterans Homes and homeless grant programs were not seriously considered as options. Veterans Benefits Administration collocations were cited as reasons for selecting alternatives even when this option had been rejected by VBA as unacceptable.

Commission Evaluation

As discussed earlier, the Commission applied the following factors in its evaluation of each DNCP proposal for a mission change to assess the proposal's reasonableness:

- Impact on veterans' access to care
- Impact on health care quality
- Veteran and stakeholder views
- Impact on the community
- Impact on VA missions and goals
- Cost to government

In applying these factors, the Commission relied on the broad expertise and experience of Commission members and utilized data in the following areas when available:

- *Workload:* VA workload, average daily census, and other applicable data over the past four years;[9] CARES workload projections for FY 2012 and FY 2022.[10]

[9] VISN Service Support Center (VSSC) KLF Menu Database, *Financial: General Reports*.
[10] CARES Portal, VISN Market Plans – Small Facilities.

- *Access to Care:* VA facilities within 30- and 60-minute drive times of the facility selected for possible mission change.[11]
- *Community Alternatives:* JCAHO-accredited non-VA facilities with available capacity within 30- and 60-minute drive times of a facility with potential mission change.[12]
- *Quality of Care:* Quality scores relating to surgical and medical services.[13]
- *Costs:* Comparison of inpatient, outpatient, and contracting alternatives against national averages. Contracting costs are based on VA's current average costs for contracted care.[14]
- *Customer Satisfaction:* Overall satisfaction scores from customer feedback surveys for inpatient and outpatient services compared to national scores.[15]
- *Financial Analysis:* Cost analysis of VISN-provided data conducted by the independent team, described above.[16]
- *Impact on the Community:* Impact on the local economy and on community health care services.[17]
- *Facility Condition:* Average facility condition scores for patient buildings.[18]
- *Impact on VA Missions:* Effects of proposed changes on VA's other missions, including education and training, research, homeland security, and support to the Department of Defense.[19]

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[11] DNCP, *Chapter 9: Proximity and Campus Realignments*, page 2. [*http://www1.va.gov/cares/*]

[12] VSSC Spreadsheets and George Washington University (GWU) Analyses regarding non-VA facilities. [Data were compiled by GWU based on published reports of the American Hospital Association for the years 1999 and 2003. These data are self reports of hospitals to AHA and as such may be subject to error. For example, programs may close within a hospital or licensed beds may change from year to year. Because of time requirements of the data request, GWU accepted the AHA report to have met the scrutiny of AHA and therefore to be valid. A sample of hospitals was not called to check the validity of the reported data. To measure the reliability of the GWU abstraction process, a 25 percent random sample of the cases were selected for a comparison abstraction and 94 percent of the data were found to be identical. With this high percentage the researchers at GWU School of Public Health and Health Services are confident that the abstraction method also yielded reliable results.]

[13] Office of Quality and Performance, Department of Veterans Affairs, *Performance Measurement*, November 4, 2003. [*http://vaww.oqp.med.va.gov*]

[14] VSSC KLF Menu Database, Decision Support Service (DSS), *National Data Extracts (NDE) Reports*, using NPC and PTF files, Fiscal Year 2002. Prepared by VHA's Allocation Resource Center. Costs adjusted to remove depreciation and National/VISN overhead.

[15] Office of Quality and Performance, Department of Veterans Affairs, *Performance Measurement*, November 4, 2003. [*http://vaww.oqp.med.va.gov*]

[16] Appendix E, *Financial Review of CARES Realignment Proposals*.

[17] Hearing Records and Public Comments.

[18] VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

[19] Hearing Records and Public Comments; NCPO Campus Realignment Studies; VISN Narratives.

- *Veteran and Stakeholder Input:* Veteran and stakeholder views received during site visits, hearings, and in written comments.[20]

The Commission considers access and quality of care to be the primary drivers in meeting the health care needs of veterans. In some cases, Commission conclusions differ from the DNCP recommendations for small facilities and campus realignments. Due to a lack of supporting data for the DNCP's proposals on facilities with a potential mission change, the Commission evaluated each facility using its own factors and available data but took into account the unique issues in the various VISNs and issues associated with urban and rural areas. Individual recommendations are included in the specific VISN summaries, found in Chapter 5 of this report.

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Findings

1. There was a lack of adequate supporting data to justify many of the DNCP's mission change recommendations.
2. VA established a new model for health care delivery using the designation of a "critical access hospital" without clearly defining the concept.

Recommendations

1. Access and quality of care should be the primary drivers in recommending changes to meet the health care needs of veterans.
2. VA should establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this designation.

[20] Hearing Records and Public Comments.

The following table presents information regarding the CARES Commission's response to the DNCP's recommendations for small facilities and campus realignment facilities.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
1	Bedford, MA	Campus Realignment	Transfer Bedford's inpatient services to Brockton, domiciliary to Northampton, and nursing home care to Manchester, Brockton and community. Outpatient services remain at Bedford. Explore enhanced use leasing (EUL) for remainder of the Bedford campus.	The Commission does not concur with DNCP to change the mission at Bedford. The Commission recommends a more thorough study of the feasibility of building a single, 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.
1	Jamaica Plain, MA	Campus Realignment	Study the feasibility of consolidation into fewer buildings for operational savings and to maximize the EUL potential.	The Commission concurs with the DNCP. This study should be done in conjunction with the feasibility study of a single replacement medical center in the Boston area.
2	Canandaigua, NY	Campus Realignment	Transfer Canandaigua's inpatient psychiatry, nursing home care, domiciliary and residential rehabilitation services to other VAMCs in the VISN. Outpatient services will be provided in the Canandaigua Market. Explore EUL at Canandaigua.	The Commission does not concur with the DNCP on transferring services from Canandaigua to other VAMCs within the VISN. The Commission concurs with the DNCP proposal to transfer acute inpatient psychiatric beds. The Commission recommends that Canandaigua retain long-term care, including the nursing home, psychiatric nursing home care, and the domiciliary. The Commission also concurs with the DNCP proposal that Canandaigua retain its ambulatory care. 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 and that the VISN involve stakeholders and the community to help resolve these challenges.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
3	St. Albans, NY	Campus Realignment	Build new facilities for outpatient, nursing home, and domiciliary care. Demolish old facilities. Design new construction to maximize area available for EUL project.	The Commission concurs with the DNCP proposal for changing the St. Albans campus subject to completion of a cost-benefit analysis. 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.
3	Lyons, NJ	Campus Realignment	Campus remains open with current mission.	The Commission concurs with the DNCP.
3	Montrose, NY	Campus Realignment	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 campus at a location that maximizes the EUL potential.	The Commission does not concur with the DNCP proposal to move all inpatient beds from Montrose to Castle Point. The Commission recommends that the inpatient psychiatry beds and nursing home care beds be moved from the Montrose campus to the Castle Point campus and that the domiciliary-based residential rehabilitation programs and the ambulatory care services remain at the Montrose campus.
3	Castle Point, NY	Small Facility	Current inpatient services will be transferred from Montrose to Castle Point. Transfer Castle Point's spinal cord injury beds to the Bronx. Retain SCI outpatient clinic. Convert to a CAH.	The Commission concurs with the proposal to transfer the SCI beds to the Bronx. The Commission does not concur with designating the facility a CAH.
3	Manhattan, NY	Campus Realignment	Develop plan to study the feasibility of consolidating all inpatient services from Manhattan to Brooklyn. Retain outpatient primary and specialty care in the Manhattan area.	The Commission concurs with the DNCP proposal.
4	Pittsburgh–Highland Drive, PA	Campus Realignment	Current services at Highland Drive will be transferred to University Drive and Aspinwall (Heinz) campuses, with new facilities for psychiatry, mental health, and related research and administrative services. VA will no longer operate health care services at the Highland Drive campus. Evaluate Highland Drive campus for EUL.	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. 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. The Commission recommends that VA consider EUL or divesture of the Highland Drive Division property.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
4	Butler, PA	Small Facility	Maintain nursing home and outpatient services and close hospital acute care services. Inpatient demand will be referred to the Pittsburgh HCS or contracted out in the community.	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.
4	Altoona, PA	Small Facility	Maintain outpatient services and close hospital acute care services by FY 2012. In the interim, convert to CAH. Inpatient demand will be referred to the Pittsburgh HCS or contracted out in the community.	The Commission concurs with the DNCP proposal that Altoona maintain its outpatient services, as well as its LTC programs. 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. 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.
4	Erie, PA	Small Facility	Maintain current services except close inpatient surgical services and retain outpatient surgery and observation beds. Inpatient demand will be referred to the Pittsburgh HCS or contracted out in the community.	The Commission concurs with the DNCP proposal that Erie close its inpatient surgical services and retain outpatient (including outpatient surgery) and its LTC programs. 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. 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.
5	Perry Point, MD	Campus Realignment	While maintaining the current mission, redesign the campus to maximize the EUL of the campus. The redesign of the campus should include the current proposed new NHCU, other required new buildings to consolidate services, and preservation of the historic sites: the Mansion, Grist Mill, and 5 acres of Indian burial grounds.	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.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
6	Beckley, WV	Small Facility	Retain acute medicine beds. Convert to CAH. Close inpatient surgery beds and utilize observation beds, local contracting, or transfer to other VAMCs to meet surgical needs.	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. The Commission recommends that Beckley retain its multi-specialty outpatient services and the nursing home.
7	Montgomery, AL	Campus Realignment	The proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study.	The Commission concurs with the DNCP proposal.
7	Augusta-Uptown Division, GA	Campus Realignment	Study the feasibility of realigning the campus footprint including the feasibility of consolidating selected current services at the Uptown Division to the Downtown Division or other VAMCs and contracting with the community. The campus will be evaluated for EUL.	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. 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 program.
7	Dublin, GA	Small Facility	Retain 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.	The Commission concurs with the DNCP proposal.
8	Lake City, FL	Campus Realignment	Transfer inpatient surgery services to Gainesville. Inpatient medicine transfer will be reevaluated when Gainesville has expanded inpatient capacity (with construction of a proposed new bed tower). NHCU and outpatient services will remain.	The Commission does not concur with the DNCP proposal to move Lake City's inpatient surgery services to Gainesville at the present time. 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 after FY 2012. The Commission concurs with the DNCP proposal to maintain nursing home care and outpatient services at Lake City.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
9	Lexington-Leestown, KY	Campus Realignment	The Lexington-Leestown campus's current outpatient and nursing home care will be transferred to Cooper Drive Campus. Due to possible space limitations at Cooper Drive, it may be necessary to relocate some outpatient primary care and outpatient mental health psychiatry services to alternative locations other than Cooper Drive. VA will no longer operate health care services at the Leestown campus. Leestown will be evaluated for EUL with the majority of the Leestown campus with the Commonwealth of Kentucky's Eastern State Hospital. Plans also include the pursuit of collaborative opportunities between the Louisville and Lexington VAMCs.	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. The Commission recommends that VA move swiftly to secure an EUL 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.
10	Cleveland, OH	Campus Realignment	Current services at the Brecksville Division will be transferred to the Wade Park Division. VA will no longer operate health care services at the Brecksville campus. Proposal includes EUL of 102 acres at Brecksville in exchange for property adjacent to Wade Park.	The Commission concurs with the DNCP proposal to relocate current psychiatric care, nursing home care, domiciliary, and residential services from Brecksville to Wade Park, provided the existing level of services can be maintained. The Commission concurs with the DNCP proposal to pursue EUL opportunities at Brecksville in exchange for property adjacent to Wade Park.
11	Ft. Wayne, IN	Small Facility	Maintain outpatient services; acute medicine services will be transferred to Indianapolis, together with partial contracting out for inpatient/emergent care services.	The Commission concurs with the DNCP proposal.
11	Saginaw, MI	Small Facility	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. Ann Arbor HCS must be upgraded prior to any bed consolidation to address the transfer of projected medicine patients to this facility.	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. The Commission concurs with the DNCP proposal to maintain nursing home and outpatient care at Saginaw.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
15	Leavenworth, KS	Campus Realignment	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, psychiatry and outpatient surgery. Under this plan Leavenworth would maintain acute beds. Also, Leavenworth will provide additional primary care capacity for Kansas City, and both Leavenworth and Topeka would retain 24/7 emergency services at both campuses.	The Commission concurs with the DNCP proposal.
15	Poplar Bluff, MO	Small Facility	Maintain acute care beds. This facility currently operates as a CAH and will continue as such when VHA develops its CAH criteria.	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. The Commission recommends that, regardless of the decision on inpatient services, outpatient services and long-term care remain at Poplar Bluff. The Commission does not concur with designating the facility a CAH.
16	Gulfport, MS	Campus Realignment	Current patient care services will be transferred to the Biloxi division and possibly to Keesler AFB. VA will no longer operate health care services at the Gulfport campus. Evaluate for EUL.	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. 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.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
16	Muskogee, OK	Small Facility	Maintain inpatient medicine program, with possible expansion of inpatient psychiatry. Inpatient surgery and ICU beds are proposed for closure due to low volume of selected major procedures. Ambulatory surgery would continue with surgery observation beds available.	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. 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
17	Kerrville, TX	Small Facility	Continue to provide nursing home care and outpatient services. Acute care services will be transferred to San Antonio VAMC as space becomes available from the proposed inpatient construction at San Antonio. In the interim, Kerrville would convert to a CAH. An EUL for assisted living for veterans is under development.	The Commission does not concur with the DNCP proposal to convert the Kerrville VAMC to a critical access hospital. 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. The Commission recommends clarification of proposed construction and renovation costs at San Antonio. The Commission concurs with the DNCP proposal that the nursing home and outpatient services remain at Kerrville.
17	Marlin, TX	Campus Realignment	Remaining outpatient services will be transferred to a new and more accessible location in the Marlin and Waco area. VA will no longer provide health care services at this campus. Evaluate for EUL.	The Commission concurs with DNCP proposal.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
17	Waco, TX	Campus Realignment	Transfer services to other VAMCs and community contracts. Inpatient psychiatry services will be met primarily at Temple. The VISN will also lease 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 sub market. The balance of inpatient psychiatry, all of Blind Rehab and a third of Waco's NHCU services will be transferred to the Temple VAMC. The balance of NHCU needs will be contracted out in the community. Outpatient services will be transferred to a new location more strategically placed to improve access for patients from both Waco and Marlin. VA will no longer operate health care services at this campus. Evaluate for EUL.	The Commission concurs with the DNCP proposal to transfer services from the Waco campus to appropriate locations within the VISN as follows: 1) A portion of acute care inpatient psychiatry to Austin; 2) The balance of acute care and all the long-term inpatient psychiatry to the Temple VAMC; and 3) PTSD residential rehabilitation services to the Temple VAMC, with no decrease in capacity. The Commission does not concur with the DNCP proposal to transfer Waco nursing home services to the community. 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. The Commission concurs that a new multi-specialty outpatient clinic be established in the Waco area. 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.
18	Prescott, AZ	Small Facility	Medicine workload 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.	The Commission concurs with the DNCP proposal.
18	Big Spring, TX	Campus Realignment	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 CAH or acute care hospital for the Odessa/Midland area that would include a nursing home and expansion of an existing clinic to a multi-specialty outpatient clinic.	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. The Commission does not concur with designating the facility a CAH.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
19	Cheyenne, WY	Small Facility	Maintain acute bed sections. 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). Convert to CAH.	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. The Commission does not concur with designating the facility a CAH.
19	Grand Junction, CO	Small Facility	Maintain acute bed sections. 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). Convert to CAH.	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. The Commission does not concur with designating the facility a CAH.
20	Vancouver, WA	Campus Realignment	Study/develop plan to enhance use lease the campus by contracting for nursing home care and relocating outpatient services. The campus will be evaluated for EUL.	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. The Commission recommends that VA explore options to expand Vancouver's function, particularly with regard to relocating services from the Portland VAMC.
20	White City, OR	Campus Realignment	White City will maintain outpatient services. The domiciliary care and CWT programs will be transferred to other VAMCs in VISN 20. The balance of the campus will be evaluated for EUL.	The Commission does not concur with the DNCP proposal to transfer the domiciliary and Compensated Work Therapy programs from White City to other VAMCs. The Commission agrees with the VISN-recommended alternative that the White City SORCC maintain its current mission. The Commission concurs that White City should retain its outpatient services.

VISN	Facility	Type of Change	DNCP Proposal	CARES Commission Recommendation
20	Walla Walla, WA	Small Facility	Walla Walla will maintain outpatient services and contract for acute inpatient medicine and psychiatry (will improve hospital access in the Inland North Market) and nursing home care. Evaluate for EUL	The Commission concurs with the DNCP proposal to close and, where appropriate, contract for acute inpatient medicine and psychiatry care and nursing home care in the Walla Walla geographic area. 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.
20	Roseburg, OR	Small Facility	Converting surgical beds to 24-hour surgical observation beds is underway in Roseburg.	The Commission concurs with the DNCP proposal.
21	Livermore, CA	Campus Realignment	Current nursing home care services will be transferred to Menlo Park campus and community contracts. Outpatient services are to be transferred to an expanded San Joaquin Valley CBOC and a new East Bay CBOC closer to where the patients live. VA will no longer operate health care services at this campus. Evaluate campus for EUL.	The Commission does not concur with the DNCP proposal that nursing home care at Livermore be transferred to Menlo Park and the community. The Commission concurs with the DNCP proposal to transfer sub-acute beds to Palo Alto, and that outpatient care should be shifted to CBOCs. The Commission recommends that the long-term care services (nursing home beds) at Livermore be retained as a freestanding nursing home care unit.
23	Hot Springs, SD	Small Facility	Remain open as Critical Access Hospital.	The Commission does not concur with the DNCP proposal to change the mission of the Hot Springs VAMC to that of a critical access hospital. The Commission recommends that Hot Springs retain it current mission to provide acute inpatient medical, domiciliary and outpatient services.
23	Knoxville, IA	Campus Realignment	Maintain outpatient services. All inpatient care, including acute care, LTC 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.	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 in the VISN is lost nor the capacity to care for the patients now being treated at Knoxville.
23	St. Cloud, MN	Small Facility	Maintain acute psychiatry, domiciliary, other mental health, and outpatient services. Acute medicine is transferred to Minneapolis and contracts in local community.	The Commission concurs with the DNCP proposal.

Community-Based Outpatient Clinics (CBOCs)

Issue

Does the methodology used in the DNCP to prioritize the VISNs' proposed CBOCs enhance veterans' access to outpatient services?

Background

CBOCs gained prevalence in VA over the last decade, following the health care industry's shift to a largely outpatient model, with fewer and shorter hospital stays. This model for delivering care has been successful in enhancing access to health care services in the community, including mental health services. Currently, approximately two-thirds of existing CBOCs provide basic mental health services.[21] Additionally, this model shifts outpatient workload away from parent VA facilities, relieving space constraints and allowing these facilities to accommodate more patients.

Access to outpatient care is an important component of the CARES process. "Access" in the context of CARES is defined as the time veterans must travel to receive care. NCPO established standard travel times. In urban and rural areas, veterans should not be required to travel more than 30 minutes to receive primary care. In highly rural areas, the maximum travel time should be no more than 60 minutes. During the planning process, if 70 percent of veterans in a specific VISN market area did not fall within these standards, an access shortfall was identified and the VISN proposed solutions to improve access to care. Often the solution was to establish additional CBOCs. In addition, in order to address space deficits at parent facilities, some VISNs also proposed establishing CBOCs to increase the capacity for primary and mental health care workload.

"Access" in the context of CARES is defined as the time veterans must travel to receive care.

Analysis

As part of the CARES process, VISNs submitted plans outlining needs for additional CBOCs. Of the 242 proposed new CBOCs, 175 are related to access and 67 address projected workload demand and the inability of existing space to manage both current and future workload.[22] Following VISN submissions, the USH developed criteria to organize proposed CBOCs into three priority groups.

[21] VSSC KLF Menu Database, CBOC, General Reports, *CBOC Workload and VAST Data*, last updated November 16, 2003.

[22] National CARES Planning Office (NCPO), Department of Veterans Affairs, *CBOC Analysis*, provided to the Commission on December 11, 2003.

Priority group one, which consists of 48 CBOCs, includes CBOCs proposed in markets meeting the following criteria: 1) an access gap; 2) projected future increases in workload; and 3) more than 7,000 projected enrollees, currently residing outside of access standards, per proposed CBOC.[23] Additionally, there are five VA/DoD CBOCs designated as priority group one, although they do not necessarily meet these three criteria. Priority group two contains 122 CBOCs that meet access and workload criteria, but projected average enrollment per CBOC is less than 7,000.[24] Priority group three consists of 67 CBOCs that do not address access shortfalls, but rather have current or future increased workload.[25]

The DNCP describes the rationale for the priority groupings by stating that:

> increases in new access points historically have generated new users to the VHA health care systems beyond forecasted utilization. This new demand for care, if not cautiously approached in the National CARES Plan, could increase acute inpatient needs before a systematic infrastructure improvement process is in place to ensure that the expected new demand can be met in a quality inpatient environment.[26]

GAO reinforced the concept of CBOCs generating new demand for care in a 2001 report finding that in CBOCs opened after 1995, the percent of new enrollees at each of these new CBOCs ranged from 16 percent to 42 percent. [27]

The USH advised the Commission on October 7 that priority groups were established in order to limit new enrollees who strain the inpatient infrastructure. The Commission notes, however, that this has the effect of limiting access to outpatient care, which is contrary to the goal of CARES to better serve veterans today and in the future.

The methodology used in the DNCP to determine priority groups was to divide the projected number of enrollees in a specific market who fall outside access guidelines by the total number of proposed CBOCs. If the result was greater than 7,000 enrollees – a number selected with no supporting rationale – then all proposed CBOCs in the market were included in the first priority group. If the result was less than 7,000 enrollees, none of the proposed CBOCs was included in the first priority group, even if one or more of the proposed CBOCs was projected to have more than 7,000 enrollees. CBOCs in priority group one are

[23] DNCP, *Chapter 4: Enhancing Access to Healthcare Services*, page 4. [*http://www1.va.gov/cares/*]

[24] National CARES Planning Office (NCPO), Department of Veterans Affairs, *CBOC Analysis*, provided to the Commission on December 11, 2003.

[25] National CARES Planning Office (NCPO), Department of Veterans Affairs, *CBOC Analysis*, provided to the Commission on December 11, 2003.

[26] DNCP, *Chapter 4: Enhancing Access to Healthcare Services*, page 3. [*http://www1.va.gov/cares/*]

[27] Government Accounting Office (GAO), GAO Reports, *VA Health Care: Community-Based Clinics Improve Primary Care Access* (02- May-01, GAO-01-678T). [*http://www.gao.gov*]

proposed to be opened between 2004-2010. The DNCP does not provide any timeframe for establishing CBOCs in priority groups two and three, but the Commission understands that these would follow after priority group one.

This approach generally led to CBOCs in rural areas being placed in the second priority group based on the relatively small veteran populations in these markets. At Commission hearings, many stakeholders noted that the CBOC priority groups created a bias against rural veterans, many of whom report traveling over 100 miles to receive care.

This calculation also resulted in certain large markets with low access not having new CBOCs included in the first priority group. This was the result in the Durham area of VISN 6, for example, where current access is 50 percent for a veteran population of 104,000. The projection model indicated that this market required seven new CBOCs to bring access standards up to 70 percent. However, when the number of enrollees falling outside access guidelines was divided by the seven CBOCs, the calculation yielded fewer than the required 7,000 enrollees per CBOC. As a result, none of the proposed CBOCs was included in the first priority category.

VISNs also proposed new CBOCs to address overall workload issues and space capacity issues at parent facilities and existing CBOCs. The Commission learned that several facilities, including Baltimore, Atlanta, Salt Lake City and Portland, are currently operating at capacity for outpatient care. Proposed CBOCs that address space issues associated with increased workload are in the third priority group. Without timely development of new sites of care, whether designated as CBOCs or otherwise, there will be greater demand on existing clinic space and on the exam rooms per provider, leading to inefficient workflow and a reduction in the total number of patients that can be seen in a given day. This in turn could lead to increased wait times at the parent facility. Several VISNs have undertaken creative solutions to make efficient use of existing resources at parent facilities and CBOCs, including expanding hours of operation, although this cannot resolve capacity issues in all cases.

Some parent facilities also have projected growth in inpatient workload, requiring conversion of outpatient space back to its original inpatient purpose. Without the timely establishment of new CBOCs, many facilities will require construction to accommodate workload increases. A potential consequence of placing all workload-related CBOCs in priority group three is the requirement for new construction at the parent facilities, a more costly solution with longer-term ramifications.

Finally, the CARES model is an integrated, data-driven approach for predicting inpatient and outpatient demand. If measures are taken to limit enrollment by restricting the number of new CBOCs, then all of the model projections, including those for inpatient care may not accurately reflect future needs.

Findings

1. VA rationale for prioritizing the implementation of new CBOCs is to control new demand for care, particularly to ensure that an infrastructure improvement process is in place prior to generating new users to the VA health care system.
2. Controlling demand for inpatient services by limiting the establishment of new CBOCs is contrary to the goal of CARES. VA must address inpatient capacity issues to ensure availability of services for veterans through other means.
3. The methodology for determining the priority of CBOCs led to either all or none of the CBOCs proposed in a market area being designated in priority group one.
4. The proposed use of priority groups disproportionately disadvantage rural veterans.
5. The DNCP places all CBOCs addressing increased workload needs in priority group three. If the DNCP timetables prevail, many VAMCs will require new construction to accommodate increasing numbers of patients and an increased need for space, resulting in greater costs to VA.
6. Approximately one-third of existing CBOCs do not provide basic mental health services.

Controlling demand for inpatient services by limiting the establishment of new CBOCs is contrary to the goal of CARES. VA must address inpatient capacity issues to ensure availability of services for veterans through other means.

Recommendations

The Commission recommends that:

1. 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.
2. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
3. 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.
4. 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.

5 Whenever feasible, CBOCs provide basic mental health services and multi-specialty outpatient services.

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

Mental Health Services

ISSUE

Does the DNCP adequately address acute inpatient and outpatient mental health services?

Background

The care of veterans with mental disorders is a high priority component of VA's health care mission. Nearly a half million veterans have a service-connected mental disorder.[28]

During the 1950s and 1960s, consistent with common practices of the time, VA often separated the care of the mentally ill, establishing inpatient facilities located away from metropolitan areas and the nearest VA acute medical facility. Today, due to changes in care in VA as well as in the non-VA sector, the majority of these veterans are treated on an outpatient basis, many in CBOCs. While primary care providers generally treat veterans suffering from simple depression and anxiety disorder, those with psychoses, PTSD, and substance abuse issues require intervention by specialized mental health professionals.

Analysis

To project future need for inpatient and outpatient mental health services in VA, the CARES model used private sector actuarial data from inpatient and outpatient diagnostic, procedure and treatment codes. These data were compared with 2001 VA utilization data to calculate projected gaps in service. Where gaps existed, VISNs developed solutions to ensure the provision of needed services.[29]

The NCPO recognized early in the process that the data for outpatient mental health projections were flawed. The model projected decreasing requirements for mental health services while national projections included significant increases in outpatient primary and specialty care needs. Many of the mental health

[28] Unique individuals by Mental Health Diagnosis (Mental Health ICD-9 Diagnostic Codes: 299-304, 308-309) VA Outpatient Clinic Fiscal Year 2002.

[29] CARES Guidebook Phase II, Chapter 2: CARES Directive 2002-032: Capital Asset Realignment for Enhanced Services (CARES) Program, June 5, 2002.

services provided by VA are not included in private sector databases, as insurance companies and Medicare do not cover services such as vocational rehabilitation programs and outreach to homeless veterans. According to VA data, these services accounted for approximately one-third of VA mental health services, leading to the underestimation of future outpatient mental health needs.[30]

NCPO is currently reworking enrollment forecasts in collaboration with the CARES Mental Health Group. Proposed changes to the model include ensuring that VA actual workload and projected workload data are comparable and account for the needed mental health services for Vietnam era veterans. The forecasts should be completed in 2004 inclusion into the CARES process.

Because VA's inpatient psychiatry database does not separate acute and long-term psychiatry patients, the model defined acute length of stay to be under 75 days. The CARES Mental Health Group and NCPO redefined acute length of stay to be under 45 days. The Commission understands that VA plans to apply this 45 day definition when reworking CARES forecasts for mental health services.

On site visits and at hearings, the Commission observed the current state of mental health services across the VISNs. The Commission learned that the provision of mental health services, particularly outpatient care, varies from VISN to VISN. Currently, approximately two-thirds of existing CBOCs provide basic mental health services.[31] The Commission recognized that some CBOCs are small and serve very few veterans, making it impractical to provide mental health services.

The Commission also noted that although several VAMCs continue to locate acute psychiatry on a separate campus, along with long-term psychiatric services, it believes it is optimal to locate acute mental health services in a medical setting. In this regard, several CARES initiatives propose to close or alter the mission of traditional psychiatric facilities, moving these services to the same campus as other acute care services. For example, the Commission heard during site visits in Knoxville and Des Moines, Iowa, that one reason to move Knoxville services to Des Moines is the benefit of locating acute mental health services near other acute inpatient services.[32]

Findings

1. Initial CARES projections underestimated the demand for outpatient mental health services.
2. Problems with the outpatient mental health data and projections can be corrected quickly.

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[30] VSSC KLF Menu Database, Workload, Outpatient, *Clinic Stops and Persons*.
[31] VSSC KLF Menu Database, CBOC, General Reports, *CBOC Workload and VAST Data*, last updated November 16, 2003.
[32] CARES Commission Site Visit Report, *VISN 23 VA Central Iowa Health Care System*. [*http://www.carescommission.va.gov*]

3. The CARES model, with proposed adjustments, is expected to better assess the acute and long-term mental health workload.
4. The Commission observed variation in the current provision of mental health services across the VISNs.
5. One-third of existing CBOCs do not provide basic mental health services.[33]

The CARES model, with proposed adjustments, is expected to better assess the acute and long-term mental health workload.

Recommendations

1. The outpatient mental health model should be rerun as soon as possible, utilizing corrected VA data. Once the new results are available, VISNs should develop plans to address identified gaps and these plans should be incorporated into CARES.
2. VA should take action to ensure consistent availability of mental health services to veterans across the VISNs.
3. CBOCs should provide basic mental health services whenever feasible.
4. Acute inpatient mental health services should be provided with other acute inpatient services whenever feasible.

Long-Term Care (LTC)
(Including Geriatric and Seriously Mentally Ill Services)

ISSUE

Does the DNCP consistently address long-term care services?

Background

The Commission learned from NCPO presentations in the spring of 2003 that LTC, including nursing home, domiciliary and non-acute inpatient and residential mental health services, was not included in the current CARES projections due to the absence of an adequate model to project future need for these services. VA workgroups are currently developing these models, which they expect to complete and have approved in 2004.

[33] VSSC KLF Menu Database, CBOC, General Reports, *CBOC Workload and VAST Data*, last updated November 16, 2003.

Despite the absence of an adequate planning model and data, the DNCP includes a number of initiatives that directly impact nursing home care, domiciliary care, and residential and long-term mental health care. These include proposals to:

- Replace or upgrade buildings housing these programs,
- Construct new nursing homes,
- Move LTC programs to other facilities or campuses, and
- Close LTC beds and contract for services in the community.

Analysis

Nursing home care units vary in mission and case mix. Some operate as short-term medical rehabilitation units and some operate as traditional LTC units. Some provide care for seriously mentally ill patients who also have care needs related to medical illnesses and dementia. During site visits and hearings, the Commission noted that these patients are extremely difficult to place in community nursing homes, as most do not admit patients with psychiatric diagnoses. SCI/D LTC is addressed in Chapter 4 in the discussion on Special Disability Programs. The Commission also noted that LTC and residential beds are not distributed across the VISNs in a manner consistent with current veteran demographics. Overall, there is a lack of consistency across VISNs in the types of LTC they provide and in their plans for LTC.

Veterans and stakeholders consistently expressed strong views that access to LTC is a critical issue. Relatives of aging veterans are concerned about driving long distances to LTC facilities. Concern was also consistently expressed over the physical condition of VA LTC facilities, many of which need upgrades for safety, clinical, and patient privacy reasons.

The Commission heard conflicting rationale for moving current LTC beds. On the one hand, the USH and certain VISN officials contended that LTC beds should be located on the same campus as a tertiary care center to enhance overall medical care. Some DNCP proposals are consistent with that view. On the other hand, several DNCP proposals call for moving LTC beds to campuses without medical beds, or for contracting with community nursing homes not connected to a hospital. The Commission noted that freestanding nursing homes are the norm in the private sector.

In addition, inconsistent views have been expressed by VISNs concerning the extent to which community nursing homes can adequately provide care for veterans with serious psychiatric needs.

Veterans and stakeholders consistently expressed strong views that access to LTC is a critical issue.

Some VISNs expressed a willingness to contract for all nursing home beds, while others argued strongly that a sizable portion of VA nursing home patients could not be adequately cared for in community nursing homes.

Through its grant and per diem programs, VA collaborates with states in the funding of State Veterans Homes. These homes are a critical part of the continuum of LTC for veterans and for their families.

Domiciliary care and residential care units provide comprehensive services to high priority veterans, including specialized treatment for PTSD, substance abuse, and psychosocial rehabilitation services for homeless veterans. These programs are at times unique and not readily available in the private sector. They most often serve veterans in urban areas, and are ideally located as close to the urban area as feasible in order to facilitate reentry into independent community living.

Through its grant and per diem programs, VA collaborates with states in the funding of State Veterans Homes. These homes are a critical part of the continuum of LTC for veterans and for their families. In developing a strategic plan, VA should consider broader collaboration with states to leverage VA and other public funding through the State Veterans Home programs.

Findings

1. Developing a model for the deployment of LTC beds across VA is a complex undertaking that VA has yet to complete.
2. Strategic planning for LTC has not adequately addressed the needs of aging, seriously mentally ill patients for whom community resources are scarce.
3. VA has not developed a consistent rationale for the placement of LTC units that addresses stakeholder concerns regarding access to care.
4. DNCP proposals for the movement of residential rehabilitation and domiciliary beds are inconsistent, at times recommending that programs designed to rehabilitate urban homeless veterans be moved away from the metropolitan area.
5. Seriously mentally ill patients currently cared for in VA nursing homes located in VA's LTC facilities are extremely difficult to place in community nursing homes.
6. There appears to be opportunity for greater collaboration between VA and State Veterans Homes.
7. Freestanding nursing homes are the norm in the private sector.

Recommendations

1. 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.
2. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
3. Domiciliary care programs should be located as close as feasible to the population they serve.
4. Freestanding LTC facilities should be permitted as an acceptable care model.
5. As discussed in Chapter 5, VA should implement the VISN-specific recommendations 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.

Excess VA Property

Issue

Can VA's approach to managing excess property be made more effective?

Background

The intent of the CARES process is to realign the VA infrastructure so as to enhance access to health care services for our nation's veterans. One method to achieve this result is to reduce the level of resources spent on excess VA property.

To evaluate the ability of existing capital assets to meet future demand, VA conducted a comprehensive survey of its current infrastructure. The Space and Functional Report evaluated both the quantity and the quality of the physical infrastructure owned or leased by VA.[34] This information was used to develop the inventory of existing space, including approximately 8.5 million square feet of vacant space.[35] This vacant space is comprised of buildings, as well as pockets of space scattered throughout buildings, on VA campuses. In addition, there is an unspecified amount of acreage that is not currently in use.

The DNCP proposals, if implemented, are projected to result in a 42 percent reduction of vacant space from 8.5 million square feet in 2001 to 4.9 million in 2022.[36] Reductions in vacant space proposed in

[34] DNCP, *Chapter 12: Reducing Vacant Space*, page 1. [*http://www1.va.gov/cares/*]
[35] DNCP, *Chapter 12: Reducing Vacant Space*, page 1. [*http://www1.va.gov/cares/*]
[36] DNCP, *Chapter 12: Reducing Vacant Space*, page 2. [*http://www1.va.gov/cares/*]

The DNCP proposals, if implemented, are projected to result in a 42 percent reduction of vacant space from 8.5 million square feet in 2001 to 4.9 million in 2022.

the DNCP do not include a prioritized and comprehensive plan for elimination of specific buildings and acreage. The DNCP, however, does outline potential cost savings of $165,977 per day in 2022 due to the 42 percent reduction in vacant space.[37]

The DNCP outlines demolition and divestiture, particularly in the early years of the CARES implementation phase, as the primary methods to reduce vacant space. The DNCP projects that additional vacant space will be created through mission changes and consolidations and suggests additional demolition and divestiture as these initiatives are implemented. Use of demolition and divestiture decreases in later years, when complete units have been removed and remaining vacant space exists in pockets not configured for elimination.

In the DNCP, there is also significant reliance on the enhanced use lease (EUL) process to address excess space or property. The EUL process was first authorized in 1991.[38] Under the initial law, VA could lease underutilized or unused property to an outside entity if the agreement enhanced the use of the property and provided direct benefit to VA. In 1999, the EUL law was amended to allow VA to enter into such leases if the consideration received under the agreement, such as the direct lease payment for the property, would result in an improvement of services to veterans in the VISN in which the property is located. [39] This represented a fundamental change in the EUL process by allowing a lease to go forward with no benefit to VA beyond monies received for the lease. The Office of Asset Enterprise Management within VA supports the EUL process. Since the inception of the EUL process, VA has implemented 30 initiatives, 27 of which remain active.[40]

Analysis

In the DNCP and through the hearing process, the Commission learned that much of VA's vacant space is not contiguous, but consists of pockets of space scattered throughout the campuses, rendering it useless for other purposes.[41] The DNCP does not provide the methodology for the 42 percent reduction number,

[37] DNCP, *Chapter 12: Reducing Vacant Space*, page 5. [*http://www1.va.gov/cares/*]

[38] *Veterans Benefits Programs Improvement Act of 1991*, Public Law 102-86, Section 401 added a new subchapter V to Chapter 81, Title 38 US Code, *Enhanced Use Leases of Real Property*.

[39] *Veterans Millennium Health Care and Benefits Act*, Public Law 106-117, Section 208, 106th Congress.

[40] Office of Asset Enterprise Management, Department of Veterans Affairs, Jim Sullivan, CARES Commission Meeting, May 2003. [*www.carescommission.va.gov/MeetingMinutes.asp*]

[41] DNCP, *Chapter 12: Reducing Vacant Space*, page 2. [*http://www1.va.gov/cares/*]

except for outlining that capital investment and alternative uses for vacant space cannot be accurately predicted beyond five years. Since the DNCP predicts that overall workload demand begins decreasing after 2012, space needs will decrease as well, leading to additional increases in vacant space by 2022.

There are numerous historic properties in VA's inventory, many of which can no longer be used to furnish medical care services. The historic importance of these properties varies widely, with some property of great historical significance to VA and the nation, while some other property may be considered historic primarily because of its age. The historic designation of some VA property presents challenges to VA. First, it is necessary for VA to utilize medical care appropriations that could otherwise be used to provide direct medical care to pay for the upkeep and maintenance of property that no longer has a medical purpose. Second, a historic designation often impedes disposal of the property when it is deemed excess to VA's needs. The Commission notes the successful public-private partnership involving VA and the American Veterans Heritage Center, among others, that is working to protect and preserve historic property at the Dayton VAMC. This partnership is a prime example, and the Commission recommends that VA replicate this approach at other sites with historic properties.

The Commission understands the potential value in the EUL process, particularly as it allows VA to work collaboratively with local communities to determine beneficial uses for vacant VA space. This process can preserve and make use of historic properties. VA can also use the EUL process to reallocate resources from the maintenance of excess space to a direct benefit for veterans and achieving significant cost savings. Another option may be to utilize vacant space to provide transitional housing and supportive services to homeless veterans.

The EUL process as it currently exists has been fraught with delays, resulting in lost opportunities, and pointing to the need to reform the process. The lack of demonstrated confidence in the process from field managers, and the relatively small number of successful EUL initiatives since the process was first authorized in 1991, call into question the ability of VA to support the significant number of EUL proposals within the DNCP. Across the country, Commissioners consistently heard testimony on the structural problems with the EUL process. In the field, there often is insufficient expertise or resources to attract potential investors or to navigate local zoning and land use requirements. Within VA, the review and approval process is arduous and time-consuming.

The EUL process as it currently exists has been fraught with delays, resulting in lost opportunities, and pointing to the need to reform the process.

The potential outcome of this arduous process is a lost opportunity to better serve veterans. An example of this is the Butler VAMC. At the Commission's hearing in Pittsburgh, there was significant testimony about the EUL process, particularly with respect to the

Proceeds from sale or transfer will not be available to VA for health care or any other purpose. VA, however, would receive a benefit from avoiding the maintenance costs of these buildings.

Butler VAMC. This testimony specifically referenced an initiative in which VA and Butler Memorial Hospital would enter into an agreement under which Butler Memorial Hospital would build a replacement facility on VA grounds. Mr. Joseph Stewart, the CEO of Butler Memorial Hospital, raised concerns about the potential delay in the EUL process, noting "I hope this can be achieved in the time frame that benefits all. Frankly, we are, the community sector, staggered sometimes by the government timelines."[42]

There are viable options other than the EUL process for disposing of unused buildings and land, such as outright sale of the asset or transferring the asset to another public entity. The Commission notes that these options were seldom considered in the DNCP. If VA uses these other available processes, the proceeds from sale or transfer will not be available to VA for health care or any other purpose. VA, however, would receive a benefit from avoiding the maintenance costs of these buildings.

Findings

1. Maintaining excess buildings and land requires VA to use medical care appropriations that could otherwise be used to provide direct medical care.
2. Historic designations of VA facilities often impede disposition of the property.
3. The 42 percent reduction in vacant space by 2022, as proposed in the DNCP, seems low. Because the DNCP lacks details on the reduction plan and timeline, the Commission cannot thoroughly assess the validity of this figure.
4. The DNCP relies heavily on the EUL process, to the exclusion of other alternatives to dispose of the property.
5. The EUL process is in need of reform.
6. The EUL process can be used to provide needed services to homeless veterans.

Recommendations

1. The EUL process should be reformed to ensure timely action on proposals.
2. VA should develop a more efficient process, perhaps even create a separate organization, to aggressively pursue disposal of excess VA property and land.

[42] Joseph Stewart, Chief Executive Officer of Butler Memorial Hospital, Transcribed Testimony from the Pittsburgh, PA, Hearing on August 27, 2003, pages 120-121.

3. 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.
4. VA should ensure that adequate expertise in the disposal of capital assets is available to and utilized by VA officials at the local and national level. Private sector expertise should be utilized where appropriate.
5. VA should request a separate appropriation for historic preservation funds to stabilize and maintain historic property, rather than rely on medical care appropriations for such purposes.

Contracting for Care

ISSUE

Should contracting for care in the community be considered a viable option to meet veteran health care needs?

Background

Over the past decade, VA transformed from a system of discrete medical centers to a health care system marked by improving access by providing services closer to where veterans reside. VA uses contracting as one vehicle for improving access to care. During FY 2003, VA spent $245.5 million on contracts for community nursing home care, and $346.8 million on contracts for inpatient hospital care.[43] As one example of increased contracting, VA has significantly expanded access to care with community-based outpatient clinics (CBOCs). While most of the more than 700 CBOCs are staffed by VA employees, in approximately 180 CBOCs, care is provided through contracts with community providers.[44] In FY 2003, VA spent more than $594 million on contract CBOCs and on other fee-basis outpatient care.[45] The CARES projections for many markets show modest increases in demand for health care services in FY 2012, and then decreasing demand to FY 2022.[46]

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[43] Nursing Home Care Unit (NHCU) Cost vs. Fee File Report for FY 2003 and Contract Hospital Cost vs. Fee Files for FY 2003.
[44] VSSC KLF Menu Database, CBOC, General Reports, *CBOC Workload and VAST Data*, last updated November 16, 2003.
[45] Outpatient Cost – Source Files – 1) FY 2003 Outpatient Notation Data Extract, SAS Dataset from Contract CBOC. Listing generated from VAST Database as of January 20, 2004. 2) Outpatient Fee File, SAS Dataset "Amount" Variable. Summarized by STA3N.
[46] Kathy Patterson, Milliman USA/CACI, *Enrollee Healthcare Projection Model*, CARES Commission Briefing, March 2003.

Analysis

The benefits of contracting for care in the community are: 1) it can add capacity and improve access faster than can be accomplished through a capital investment; 2) it provides flexibility to add and discontinue services as needed; and 3) it allows VA to provide services in areas where the small workload may not support a VA infrastructure, such as in highly rural areas.

Some veterans service organizations and stakeholders, however, believe that contracting for care shifts VA's role away from that of a health care provider. Veterans service organizations and local unions also expressed concerns about the quality of care veterans might receive at a private facility unaccustomed to serving veterans. The Commission believes that these concerns are based on a fear that contracting for care is possibly the first step toward a voucher system. During hearings, the Commission heard little dissatisfaction with contracted care. In fact, the Commission received testimony that contracted care improves access.

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Findings

1. Contracting for care provides VA with the flexibility to quickly add and subtract services to meet changing veteran needs, contingent on the availability of viable alternatives in the community.
2. By using local providers, rather than undertaking new construction, VA can meet access and capacity needs.
3. In order to assure quality care to veterans, contracted care must be closely monitored to ensure compliance to VA standards.

Recommendations

1. The Commission concurs with the DNCP proposal to utilize contracts for care in the community to enhance access to health care services.
2. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
3. The Commission recommends that the Secretary ensure that VA has quality criteria and procedures for contracting, and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.