

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 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.
- 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 Care*, 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)

I 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

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

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.

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 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.
- 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 decreasing 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.