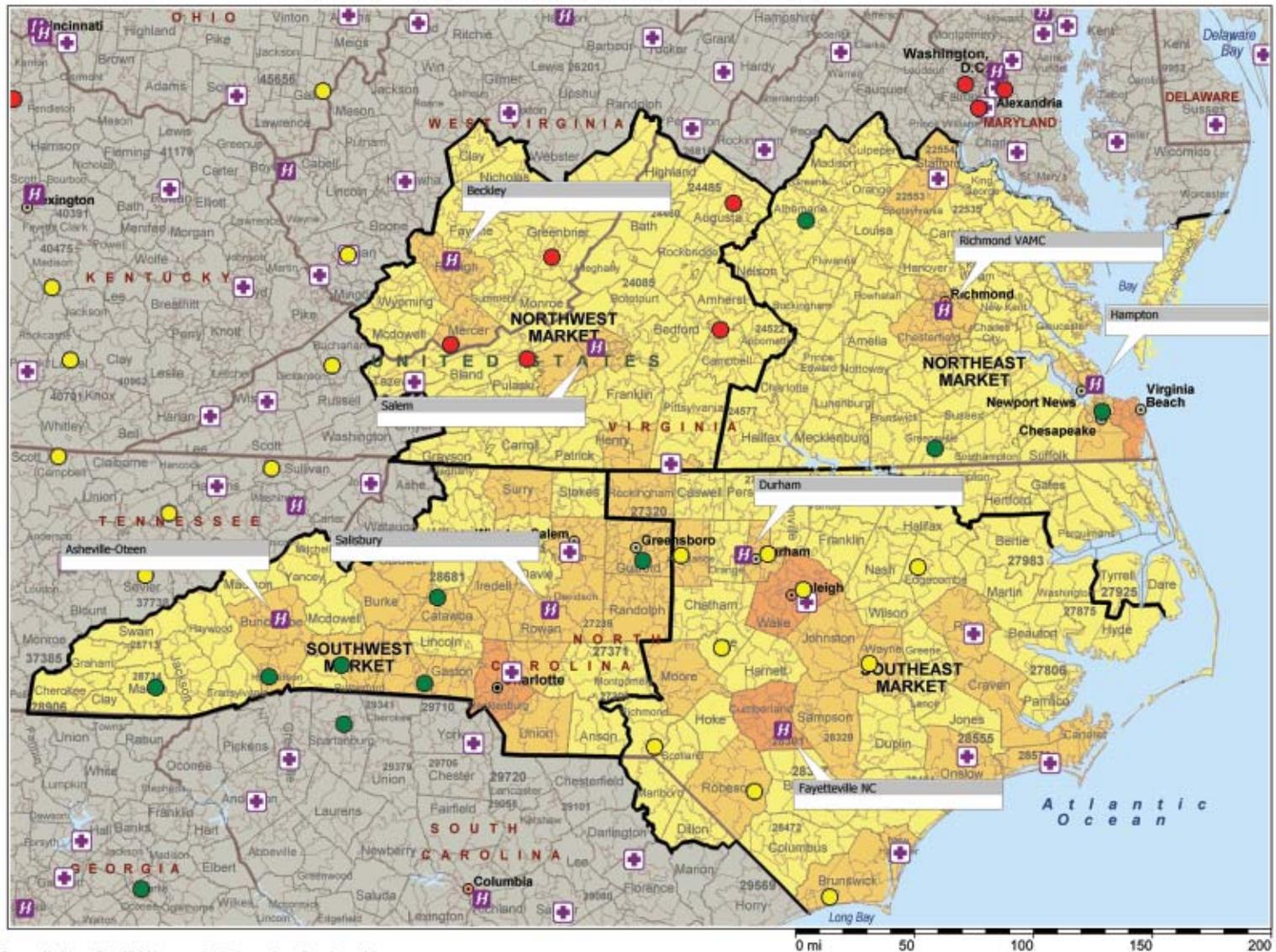


### VISN 6 – VA Mid-Atlantic Health Care Network

- New CBOC's**
- Priority 1
- Priority 2
- Priority 3
- 2012 Estimated Enrollees by County**
- 75,000 to 400,000
- 25,000 to 74,999
- 10,000 to 24,999
- 2,500 to 9,999
- 0 to 2,499
- Pushpins**
- H VA Hospital
- + VA Clinic



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## VISN 6, Mid-Atlantic Health Care Network

### VISN Overview

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

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

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

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

### Information Gathering

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

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

<sup>115</sup> VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

<sup>116</sup> VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002-September 2003.

## Summary of CARES Commission Recommendations

### I Small Facility – Beckley

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

*(see page 5-99)*

### II Extended Care – Beckley

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

*(see page 5-101)*

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<sup>117</sup> Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

### III Inpatient Care

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

*(see page 5-103)*

### IV Outpatient Care

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

*(see page 5-105)*

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

**V Enhanced Use**

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

*(see page 5-110)*

## I Small Facility – Beckley

### DNCP Proposal

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

### DNCP Alternatives

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

### Commission Analysis

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

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

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

<sup>119</sup> Appendix D, *Data Tables*, page D-29.

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

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

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

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

### Commission Findings

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

### Commission Recommendations

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

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

<sup>122</sup> Appendix D, *Data Tables*, page D-31.

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

## II Extended Care – Beckley

### DNCP Proposal

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

### DNCP Alternatives

None provided in the DNCP.

### Commission Analysis

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

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

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<sup>123</sup> Appendix D, *Data Tables*, page D-30.

<sup>124</sup> *Management of CARES Enrollment and VetPop Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

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

### Commission Findings

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

### Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to improve nursing home space at Beckley.
- 2 The Commission recommends that:<sup>126</sup>
  - 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.

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

<sup>126</sup> Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

### III Inpatient Care

#### DNCP Proposals

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

#### DNCP Alternatives

None provided in the DNCP.

#### Commission Analysis

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

<sup>127</sup> Appendix D, *Data Tables*, page D-29.

<sup>128</sup> CARES Portal, VISN 6 Market Plan.

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

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

### Commission Findings

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

<sup>129</sup> Appendix D, *Data Tables*, page D-29.

<sup>130</sup> *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

<sup>131</sup> Appendix D, *Data Tables*, page D-29.

<sup>132</sup> *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

### Commission Recommendations

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

## IV Outpatient Care

### DNCP Proposals

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

### DNCP Alternatives

None provided in the DNCP.

### Commission Analysis

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

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

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

<sup>133</sup> Daniel Hoffman, VISN 6 Director. Transcribed Testimony from the Durham, NC, Hearing on September 12, 2003, page 10.

<sup>134</sup> *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

<sup>135</sup> Appendix D, *Data Tables*, page D-30.

<sup>136</sup> *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

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

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

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

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

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

<sup>138</sup> Appendix D, *Data Tables*, page D-30.

<sup>139</sup> *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

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

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

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

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

### Commission Findings

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

<sup>140</sup> George Hunt, Moore County Veterans Service Officer. Transcribed Testimony from the Durham, NC, Hearing on September 12, 2003, page 83.

<sup>141</sup> Appendix D, *Data Tables*, page D-30.

<sup>142</sup> *Management of CARES Space Report* received from the VISN Support Services Center (VSSC) dated September 23, 2003.

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

#### **Commission Recommendations**

- 1 The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space gaps in Hampton, Richmond, Durham, Fayetteville, Asheville, and Salisbury.
- 2 The Commission recommends that:<sup>143</sup>
  - 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.

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

- d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
- e Whenever feasible, CBOCs provide basic mental health services.
- f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

## **V Enhanced Use**

### **DNCP Proposal**

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

### **DNCP Alternatives**

None provided in the DNCP.

### **Commission Analysis**

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

### **Commission Finding**

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

### **Commission Recommendation**

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