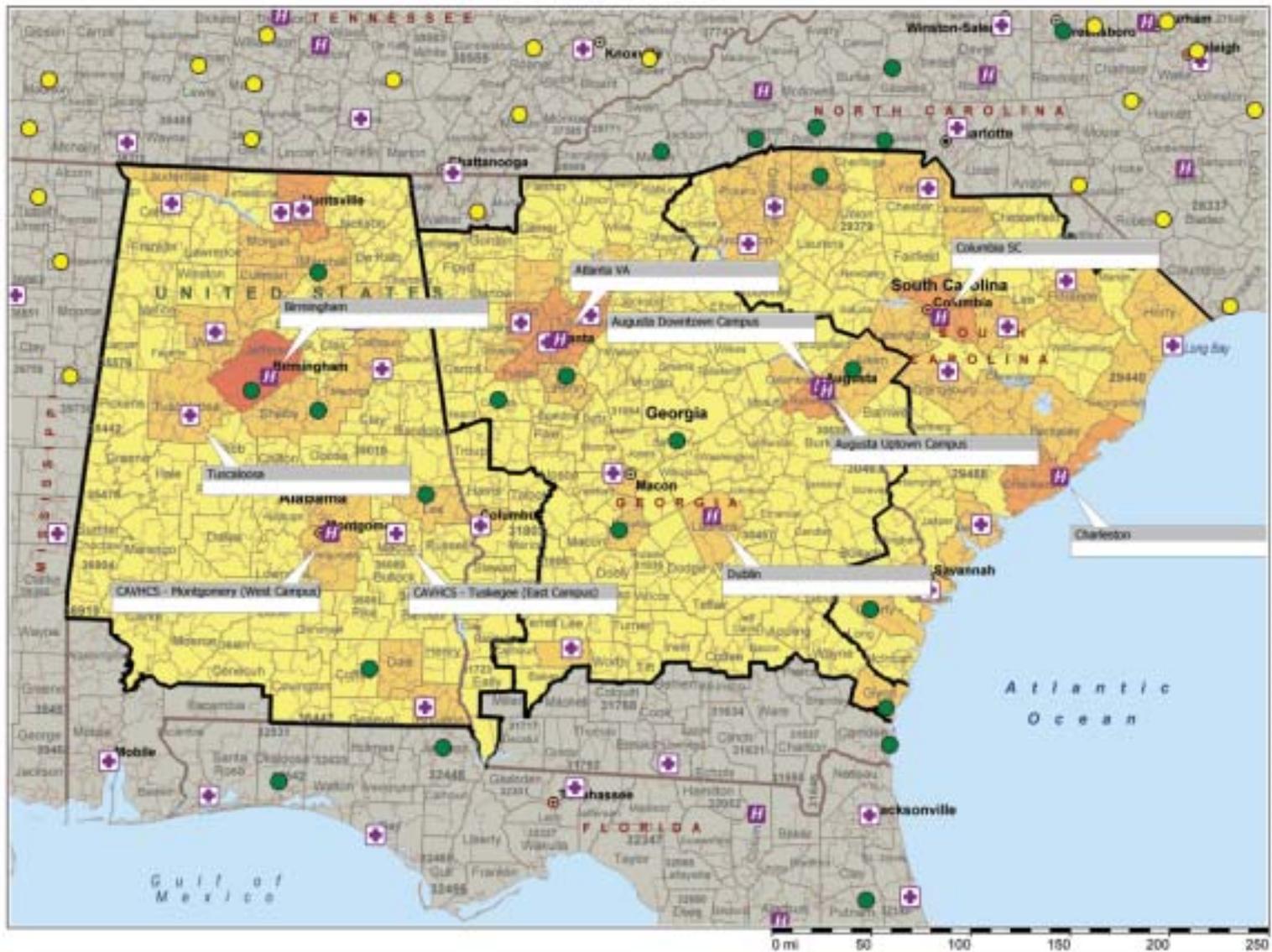


VISN 7 – VA Atlanta Network

- Pushpins**
-  VA Hospital
-  VA Clinic
- 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



Copyright © 1988-2001 Microsoft Corp. and/or its suppliers. All rights reserved. <http://www.microsoft.com/mappoint>
 © Copyright 2000 by Geographic Data Technology Inc. All rights reserved. © 2000 Navigation Technologies. All rights reserved. The data includes information taken with permission from Canadian authorities. © Her majesty the Queen in Right of Canada. © Copyright 2000 by CompuSearch Micromarketing Data and Systems Ltd.

VISN 7, Atlanta Network

VISN Overview

VISN 7, the Atlanta Network, is an integrated, comprehensive health care system that provided medical services to approximately 245,000 of the 400,000 veterans enrolled in VA's health care system in FY 2003.¹⁴⁴ Geographically, this VISN spans about 80,000 square miles and includes all or part of South Carolina, Georgia, and Alabama. The total veteran population is approximately 1.5 million.

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

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

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

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

Information Gathering

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

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

¹⁴⁴ VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

¹⁴⁵ VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

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

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

Summary of CARES Commission Recommendations

I Mission Change – Augusta

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

(see page 5-117)

II Mission Change – Dublin

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

(see page 5-120)

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

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

(see page 5-122)

IV Inpatient Care

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

(see page 5-124)

V Outpatient Care

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

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

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

(see page 5-126)

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

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

(see page 5-128)

VII Special Disability Programs – Spinal Cord Injury/Disorder Beds

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

(see page 5-130)

VIII VA/DoD Sharing Opportunities

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

(see page 5-131)

IX Extended Care

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

- 2 The Commission recommends that:¹⁴⁷
 - a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
 - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
 - c Domiciliary care programs should be located as close as feasible to the population they serve.
 - d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-132)

X Facility Condition

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

(see page 5-134)

I Mission Change – Augusta

DNCP Proposal

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

DNCP Alternatives

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

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

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

Commission Analysis

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

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

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

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

¹⁴⁸ VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.

¹⁴⁹ VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.

¹⁵⁰ VISN 7, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo*.

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

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

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

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

Commission Findings

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

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

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

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

Commission Recommendations

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

II Mission Change – Dublin

DNCP Proposal

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

DNCP Alternatives

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

Commission Analysis

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

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

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

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

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

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

¹⁵³ Appendix D, *Data Tables*, page D-36.

¹⁵⁴ Appendix D, *Data Tables*, page D-37.

¹⁵⁵ Appendix D, *Data Tables*, page D-37.

¹⁵⁶ Kenneth Ruyle, Acting VISN 7 Director, Written Testimony submitted at the Atlanta, GA, Hearing on August 28, 2003, page 8, available from [<http://www.carescommission.va.gov/Documents/AtlantaPanel1.pdf>].

Commission Findings

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

Commission Recommendations

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

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

DNCP Proposal

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

DNCP Alternatives

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

Commission Analysis

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

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

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

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

Commission Findings

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

Commission Recommendation

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

IV Inpatient Care

DNCP Proposal

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

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Alabama Market’s inpatient medicine demand is expected to increase by 66 percent above the FY 2001 baseline by FY 2012 and decrease to 34 percent above baseline in FY 2022. Surgery for the Alabama Market will increase by 65 percent in FY 2012 and 34 percent in FY 2022.¹⁵⁸ The Alabama Market does not meet the CARES standard for access to hospital care.

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

The South Carolina Market is projected to have a 79 percent increase in its inpatient psychiatry workload by FY 2012 and 43 percent increase by FY 2022.¹⁵⁹ Additionally, the South Carolina Market does not meet the CARES standard for access to hospital care.

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

Commission Findings

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

Commission Recommendations

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

¹⁵⁸ Appendix D, *Data Tables*, page D-33.

¹⁵⁹ Appendix D, *Data Tables*, page D-33.

- 2 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

V Outpatient Care

DNCP Proposal

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

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

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

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

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

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

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

Commission Findings

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

Commission Recommendations

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

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

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

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

DNCP Proposals

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

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

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

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

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

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

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

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

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

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

Commission Findings

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

Commission Recommendations

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

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

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

VII Special Disability Programs – Spinal Cord Injury/Disorder Beds

DNCP Proposal

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

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

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

Augusta is a 60-bed SCI Center with ADC of 42.¹⁶⁷ The Commission noted during its site visit that the Augusta SCI Center is in the process of renovations to respond to patient environmental issues, and this may account for the low ADC of 42. CARES projections indicate that by FY 2012, VISN 7 will need 71 acute SCI beds and by FY 2022, the VISN will need 86 acute SCI beds. For long-term care (LTC) SCI beds, the CARES projections indicate a need for 99 LTC beds by FY 2012 and 121 LTC beds by FY 2022.¹⁶⁸ The additional beds projected for the Augusta SCI Center will accommodate the increased workload projected due to demographic shifts in veteran population to the southeastern part of the United States.

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

Commission Findings

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

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

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

Commission Recommendations

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

VIII VA/DoD Sharing Opportunities

DNCP Proposal

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

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

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

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

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

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

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

Commission Findings

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

Commission Recommendation

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

IX Extended Care

DNCP Proposal

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

DNCP Alternatives

None provided in the DNCP.

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

Commission Analysis

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

The Charleston VAMC nursing home maintains 28 beds with an ADC of 24. The Columbia VAMC's nursing home consists of 107 beds with an ADC of 80.¹⁷⁰

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

At the hearing in Charleston, Acting VISN Director Ruyle did not specifically speak to the nursing home care units in the two medical centers, but did indicate that neither Charleston, built in 1965, nor Columbia, built in 1979, had had any significant renovations to their inpatient wards since they were built, with the exception of Columbia's surgical ward.¹⁷¹

Commission Findings

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

Commission Recommendations

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

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

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

- 2 The Commission recommends that:¹⁷²
- a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
 - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
 - c Domiciliary care programs should be located as close as feasible to the population they serve.
 - d Freestanding LTC facilities should be permitted as an acceptable care model.

X Facility Condition

DNCP Proposal

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

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

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

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

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

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

Commission Findings

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

Commission Recommendation

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