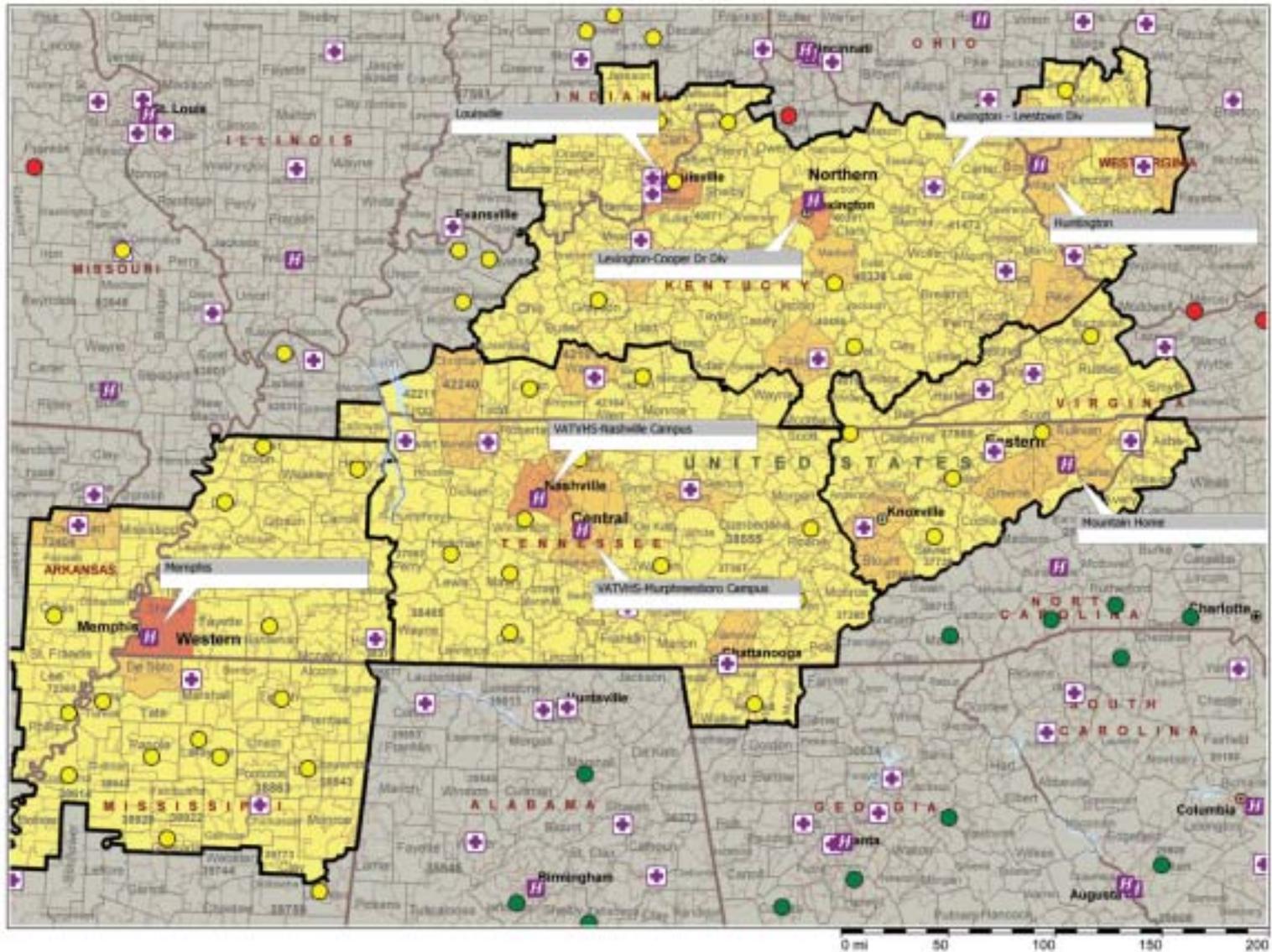


VISN 9 - MidSouth Health Care System

- 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



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VISN 9, VA MidSouth Health Care Network

VISN Overview

VISN 9, the VA MidSouth Health Care Network, is an integrated, comprehensive health care system that provided health care services to approximately 204,000 of the 313,000 veterans enrolled in VA's health care system in FY 2003.²¹⁰ Geographically, this VISN spans about 150,000 square miles and covers Kentucky, Tennessee, and parts of Indiana, Ohio, West Virginia, Virginia, North Carolina, Georgia, Mississippi, and Arkansas. It includes a total veteran population of 1.1 million. With a VA staff of approximately 8,582 FTEs,²¹¹ VISN 9 delivers health care services through seven medical centers, three satellite outpatient clinics, 16 community-based outpatient centers (CBOCs), three nursing homes, one domiciliary unit, and one spinal cord injury (SCI) center. Additionally, VA operates nine Vet Centers in VISN 9's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the DNCP to identify the levels of need for services in VISN 9.

VISN 9	FY 2001	FY 2012	FY 2022
Enrollees	266,890	307,836	286,015
Veteran Population	1,096,205	950,707	812,264
Market Penetration	24.35%	32.38%	35.21%

For the CARES process, this VISN is divided into four markets: Northern Market (*facilities*: Louisville, Huntington, Lexington 2-Division – Cooper Drive and Leestown); Central Market (*facilities*: Tennessee Valley Health Care System – Nashville and Murfreesboro); Eastern Market (*facility*: Mountain Home); and Western Market (*facility*: Memphis).

²¹⁰ VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

²¹¹ VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002-September 2003.

Information Gathering

The CARES Commission visited five sites in VISN 9 and conducted two public hearings. The Commission received 10,322 public comments regarding VISN 9.

- ▶ *Site Visits:* Lexington, KY, VA Medical Center (VAMC); Wilmore (KY) State Veterans Home; Louisville, KY, VA Medical Center; and Ireland Army Hospital at Fort Knox (KY) U.S. Army Base, July 22 and 23.
- ▶ *Hearings:* Lexington, KY, September 8; and Nashville, TN, September 10.

Summary of CARES Commission Recommendations

I Evaluate Building a Replacement Hospital for Louisville VAMC

- 1 The Commission concurs with the DNCP proposal that VA study the feasibility of building a replacement medical center for the Louisville VAMC in proximity to the University of Louisville, including the possibility of shared infrastructure with the medical school and the VBA office.
- 2 Due to the poor environment of care and overcrowding at the current medical center, the Commission recommends the study commence immediately, focus on building a replacement hospital near the University of Louisville, and be completed within a short time so that corrective actions can begin in the very near future.

(see page 5-162)

II Campus Realignment – Lexington

- 1 The Commission does not concur with the DNCP proposal on transferring current outpatient care and nursing home care services from Leestown to Cooper Drive. The Commission recommends that the Lexington-Leestown campus remain open and continue to provide nursing home, outpatient care, and administrative services.
- 2 The Commission recommends that the VA move swiftly to secure an enhanced use lease with Eastern State Hospital and/or the Kentucky Department of Veterans Affairs, as VA would not have to move from the Leestown campus in order for Eastern State Hospital (ESH) to begin using this space. The Commission recommends that plans be developed to make the footprint of the Leestown campus smaller, making most of the campus available for disposition and/or enhanced use leasing (EUL).

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

(see page 5-164)

III Campus Realignments – Nashville and Murfreesboro

- 1 The Commission concurs with the DNCP proposal to consolidate services at Murfreesboro and Nashville, and recommends that the VISN proceed with its plan for providing outpatient surgical services at both campuses.

(see page 5-167)

IV Inpatient Medicine and Surgery

- 1 The Commission concurs with the DNCP proposals to increase inpatient medicine services in the Central and Western markets through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central Market and in outlying areas as available in the Western Market).
- 2 The Commission concurs with the DNCP proposal on contracting for excess demand, particularly in the Charleston, WV, area.
- 3 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-169)

V Outpatient Primary and Specialty Care

- 1 The Commission concurs with the DNCP proposal to expand services at current sites of care, to expand the use of telemedicine, and to use community contracts, but notes that this is not an adequate solution to the substantial access and capacity deficiencies in this VISN, which cannot be met without additional sites of care.
- 2 The Commission recommends that:²¹²
 - a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
 - b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
 - c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
 - d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
 - e Whenever feasible, CBOCs provide basic mental health services.
 - f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.
- 3 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-171)

²¹² Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

VI Mental Health Care

- 1 The Commission does not concur with the DNCP proposal and recommends maintaining inpatient psychiatric and outpatient mental health services in at least all current locations until mental health services VISN-wide have been reevaluated.
- 2 The Commission recommends that VISN 9 leadership complete a thorough review of mental health services in the VISN, including in CBOCs, and develop and implement a plan to provide an appropriate level of services.
- 3 The Commission recommends that acute inpatient mental health services be provided with other acute inpatient services whenever feasible.
- 4 The Commission recommends that additional enhanced use lease opportunities with the Commonwealth of Kentucky be explored.

(see page 5-174)

VII VA/DoD Sharing

- 1 The Commission concurs with expansion of space for primary care and outpatient mental health services at the Fort Knox CBOC.

(see page 5-178)

VIII Special Disability Programs – Spinal Cord Injury/Disorder (SCI/D)

- 1 The Commission concurs with the DNCP proposal on the expansion of SCI/D beds at Memphis. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-179)

I Evaluate Building a Replacement Hospital for Louisville VAMC

DNCP Proposal

“Construction of a new or fully renovated facility sized to meet service delivery requirements and projected demand will be studied. Options include construction of a new medical center, full renovation of the current facility, and the potential for a collaborative hospital within a hospital arrangement with University of Louisville Medical School affiliate. Opportunities exist for VBA collocation as well as enhanced DoD sharing should a new facility option be selected.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Louisville VAMC, a tertiary care center closely affiliated with the University of Louisville, provides a full range of services for veterans in central Kentucky and southern Indiana. The VAMC is authorized for 83 medical beds, with 43 operating medical beds and an average daily census (ADC) of 46, an intermediate medical unit used for short-term rehabilitation with 15 operating beds (ADC 5), an inpatient surgical program with 23 operating beds (ADC 16), and an inpatient acute psychiatric unit with 26 operating beds (ADC 15).²¹³ During FY 2003, more than 378,000 outpatient stops were provided on the campus, covering a broad array of outpatient services including primary care, specialty medical care, outpatient surgeries, mental health care, and support services. A large number of additional primary care and mental health outpatient services are provided at a separate Louisville location due to space limitations at the main campus.²¹⁴

The condition of the hospital buildings is poor at this 50-year-old facility, and according to the Director, Mr. Tim Shea, the facility is landlocked, making expansion at the current site difficult.²¹⁵ It is currently located in a residential neighborhood five miles north of its medical affiliate, the University of Louisville.

²¹³ VSSC KLF Menu Database, *Bed Control Data, Occupancy Rates*, FY 2003.

²¹⁴ M. Scott Stamper, Assistant Supervisor, National Service Office, Disabled American Veterans, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 89.

²¹⁵ VISN 9, Site Visits, Lexington/Wilmore/Fort Knox/Louisville, July 22-23, 2003, page 6, available from [<http://www.carescommission.va.gov/SiteVisits.asp>].

The University of Louisville Medical School's Vice Dean for Clinical Affairs testified that he sees value in building a replacement VAMC adjacent to the six-hospital area downtown. He indicated that the school campus could accommodate a new VAMC and that the school is open to being a flexible partner, for example, by leasing tertiary services to VA. He outlined some options for the Louisville VA:

The greatest asset is, in fact, the acreage. It is the highest real estate valued area in the state of Kentucky, across the street from the highest per capita income neighborhood in the state of Kentucky, in a beautiful, wooded hilltop. If the VA were to locate to the downtown medical center, it would be joining a 26 block, six-hospital medical center. There is space on the east end for that, and the medical center also includes a biopark. This could be whatever the VA would like it to be. A hospital within a hospital...a new building in that area with some shared facilities, things as boring as parking garages... there are great synergies when medical schools and VA's are located in the same facility.²¹⁶

Collocating the current VBA office, which is currently housed in inadequate space, with the Louisville VAMC would only be possible if a replacement hospital were built. This collocation should increase the cost advantage of building a new facility rather than attempting to renovate the current hospital building.

Commission Findings

- 1 The Louisville VAMC currently has space deficits and is providing services off campus.
- 2 The current buildings are in poor condition and landlocked. Construction of a replacement hospital at a site near the University of Louisville Medical School would enhance clinical care, improve accessibility, and strengthen the academic affiliation.
- 3 There is opportunity to collocate the VAMC near the University of Louisville Medical School campus.
- 4 Collocating the VBA office to a new replacement hospital site is likely to provide further financial advantage to VA.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal that VA study the feasibility of building a replacement medical center for the Louisville VAMC in proximity to the University of Louisville, including the possibility of shared infrastructure with the medical school and the VBA office.

²¹⁶ Mark Pfeiffer, Vice Dean, University of Louisville Medical School, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, pages 146-147.

- 2 Due to the poor environment of care and overcrowding at the current medical center, the Commission recommends the study commence immediately, focus on building a replacement hospital near the University of Louisville, and be completed within a short time so that corrective actions can begin in the very near future.

II Campus Realignment – Lexington

DNCP Proposal

“Current services of outpatient care and nursing home care will be transferred to Cooper Drive. Due to possible space limitations at Cooper Drive, it may be necessary to relocate some outpatient primary care and outpatient mental health psychiatric services to alternative locations other than Cooper Drive. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Enhanced use opportunities for the majority of the Leestown campus with the commonwealth of Kentucky appears to exist with Eastern State Hospital (ESH). Any revenues or in-kind services will remain in the VISN to invest in services for veterans. Plans also include the pursuit of collaborative opportunities between the Louisville and Lexington VAMCs.”

DNCP Alternatives

- 1 *Status quo*
- 2 *Original Market Plan*: Contracting out of inpatient acute care, some outpatient specialty care and consolidating the remainder of outpatient specialty, ancillary/diagnostic, mental health, and primary care at the Leestown division with eventual divestiture of the Cooper Drive Division. Addition of CBOCs at Berea, Hazard, and Morehead, KY.
- 3 *100 Percent Contracting*
- 4 *Alternative 1 [The VISN's preferred alternative]*: Development of major construction project to renovate existing space, construct two additional floors and add an 800-space parking facility at the Cooper Drive division. Discontinue all VA operations at the Leestown division and pursue enhanced use program with the Commonwealth of Kentucky for select space at Leestown. Unused space would be demolished or divested as appropriate. Development of CBOCs at Berea, Hazard, and Morehead, KY.

- 5 *Alternative 2:* Retain operations at both Cooper Drive and Leestown with consolidation of 24x7 operations to Cooper Drive and movement of Leestown to a five-day-a-week operation. Development of Cooper Drive for acute inpatient and nursing home care services as well as outpatient specialty and ancillary/diagnostic services.

Commission Analysis

The Lexington VAMC is a two division, tertiary care facility – Cooper Drive and Leestown. The Cooper Drive Division is located adjacent to the University of Kentucky Medical Center, and operates medical inpatient units with 67 operating beds and an ADC of 45, an acute inpatient psychiatry unit with 19 operating beds and an ADC of 12, and an inpatient surgical program with 21 operating beds and an ADC of 14. During FY 2003, more than 309,000 outpatient clinic stops were provided at the Cooper Drive campus for a full array of primary care, specialty medical and surgical care, and support services.²¹⁷

The Leestown Division provides nursing home services with 61 operating beds (ADC 56) and, during FY 2003, provided more than 61,000 outpatient stops, predominantly for primary care, home-based primary care, podiatry, optometry, and mental health services, including specialized substance abuse and post-traumatic stress disorder (PTSD) services. The majority of the outpatient mental health services offered by the Lexington VAMC for area veterans are provided at the Leestown campus.²¹⁸

At the Lexington hearing, VISN leadership described Cooper Drive as a landlocked facility with significant parking problems. They proposed adding two floors to the Cooper Drive facility to absorb services from Leestown.²¹⁹ But as Dr. Roth, VISN 9 CARES co-chair, testified:

The consolidation of Cooper is predicated on the fact that we would be able to offload primary care and outpatient mental health to CBOCs that are located in outlying areas in Southeastern Kentucky. Because even with building two floors on Cooper, there is not going to be enough space.²²⁰

There is very limited potential for expansion at the Cooper Drive location, and that the proposal to move nursing home beds to Cooper Drive would place the nursing home unit above the first floor, which would limit access to outdoor space for patients.

²¹⁷ John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 28.

²¹⁸ VSSC KLF Menu Database, *Bed Control, Occupancy Rates and FYTD CBOC VAST and Workload Report*.

²¹⁹ John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 28.

²²⁰ Dr. Dan Roth, VISN 9 CARES Committee Co-Chair, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 34.

The realignment proposal includes a life cycle cost analysis that appears to be incomplete. For example, although parking is identified as a current problem, no analysis is presented as to the extent of the current problem. Construction of an 800-space garage is recommended, but no indication is included as to how much of the garage would solve the existing problem and how much is intended to accommodate the proposed consolidation of Leestown, and the likely construction costs of around \$18 million were not included in the VISN's cost analysis. New construction and renovation costs are included in all alternatives, even the 100 Percent Contracting Alternative.²²¹

The DNCP proposal to transfer the substantial primary care and mental health workload currently provided at the Leestown campus for Lexington area residents to CBOCs far away from the greater Lexington metropolitan area does not seem reasonable, since these services need to be easily accessible to veterans.

There appear to be EUL opportunities for the majority of the Leestown campus with ESH, the Commonwealth of Kentucky's acute and long-term psychiatric institution. Medical center management has been working with the Commonwealth of Kentucky on leasing opportunities for approximately 18 months, and the Commonwealth wants to acquire a lease as soon as possible.

In addition to the above proposal, the Kentucky Department of Veterans Affairs also has proposed a 60- to 80-bed domiciliary and a 40-bed transition/homeless shelter in conjunction with Volunteers of America. These enhanced use options are not contingent on moving the current services from the Leestown campus.

Commission Findings

- 1 The Cooper Drive Division is a landlocked facility with significant parking issues and has no expansion capacity without major construction. The proposal to move the nursing home to this site would place the nursing home above the first floor.
- 2 There is a good EUL opportunity involving ESH or the Kentucky Department of Veterans Affairs that would not require VA to move from the Leestown campus.
- 3 To successfully implement the EUL opportunities, a new footprint would be required for the Leestown campus that would make the majority of the 135 acres available for enhanced use leasing and/or disposition.
- 4 The consolidation of space at Cooper Drive requires the movement of outpatient primary care and mental health services, which would further decrease access to care.

²²¹ Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

Commission Recommendations

- 1 The Commission does not concur with the DNCP proposal on transferring current outpatient care and nursing home care services from Leestown to Cooper Drive. The Commission recommends that the Lexington-Leestown campus remain open and continue to provide nursing home, outpatient care, and administrative services.
- 2 The Commission recommends that the VA move swiftly to secure an enhanced use lease with Eastern State Hospital and/or the Kentucky Department of Veterans Affairs, as VA would not have to move from the Leestown campus in order for ESH to begin using this space. The Commission recommends that plans be developed to make the footprint of the Leestown campus smaller, making most of the campus available for disposition and/or EUL.
- 3 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

III Campus Realignments – Nashville and Murfreesboro

DNCP Proposal

“Maintain both facilities and develop complementary missions through consolidation of services. Nashville will provide inpatient acute medicine and surgery programs while retaining a minimum number of medicine beds at Murfreesboro to support demand generated from the long-term programs. Murfreesboro will provide acute and long-term inpatient psychiatry and nursing home care services.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN Director testified that the proposal to address service delivery options for the Alvin C. York facility (Murfreesboro) and the Nashville campuses was developed to decrease the duplication of services. During the hearing, Mr. David Pennington, Director of the VA Tennessee Valley Health Care System,

clarified the plans for the provision of surgical services. He indicated that the current plan is to move all inpatient surgery to Nashville, but to retain outpatient surgery at both Murfreesboro and Nashville, which would require changes to space at Murfreesboro to create an outpatient surgical center. Mr. Pennington indicated that some patients might have to drive further for surgery, but the benefit would be an improved timeliness in surgery.²²²

The Deans of the School of Medicine at Meharry and Vanderbilt testified at the Nashville hearing that they had a very effective alliance, had been apprised of the CARES process, and had been involved in the early discussions on the surgical programs at Murfreesboro and Nashville. The Dean of Meharry raised concerns about the impact of removing inpatient surgery on acute medical service. However, VISN leadership indicated that this service and the ambulatory surgical service at Murfreesboro would be enhanced. The Dean of Vanderbilt indicated that Vanderbilt would work with Meharry and address any educational shortcomings that might develop as a result of the changes in services at the Murfreesboro VAMC.²²³

Commission Findings

- 1 The surgical portion of the plan for consolidation of services at Nashville and Murfreesboro has been changed by the VISN since the DNCP was published.
- 2 Plans relating to inpatient medicine, long-term psychiatry, and nursing home care remain unchanged.

Commission Recommendation

The Commission concurs with the DNCP proposal to consolidate services at Murfreesboro and Nashville, and recommends that the VISN proceed with its plan for providing outpatient surgical services at both campuses.

²²² David Pennington, Director, VA Tennessee Valley Health Care System, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 58.

²²³ Steven Gabbe, MD, Dean School of Medicine, Vanderbilt University, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 75.

IV Inpatient Medicine and Surgery

DNCP Proposals

“*Medicine* – Increase inpatient medicine services in the Central and Western markets to meet demand through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central market and in outlying areas as available in the Western market). *Surgery* – Consolidate inpatient surgery at Murfreesboro to Nashville, along with contracting for some surgical beds within the Chattanooga community. Contract for excess demand, particularly in the Charleston, WV, area.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Workload projections and space inventories indicate that both Nashville and Murfreesboro need additional space for inpatient medicine and surgery. While inpatient surgery did not meet criteria as a planning initiative for this market, the viability of the surgical program at Murfreesboro was selected as an initiative by the VISN and was addressed previously in the discussion on consolidation of services at Murfreesboro and Nashville.

The VISN proposed to contract for inpatient surgery beds (approximately three) in order to provide those services for veterans served by the Chattanooga outpatient clinic. This is a large clinic that provided a full range of outpatient services to 9,271 veterans during FY 2003. The VISN Director testified at the Nashville hearing that some inpatient care would be provided through contracts. He said, “A strong consideration was placed on enhancing access, rather than expanding existing medical centers. If expansion was necessary, contracting was considered a preferable alternative.”²²⁴ The VISN Director also testified that Chattanooga is in need of an acute surgical presence. Chattanooga presently has a CBOC that makes surgery referrals to the Nashville VAMC. The VISN has determined the best solution for Chattanooga is to contract for surgical care in the community.²²⁵

²²⁴ John Dandridge, VISN 9 Director, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, pages 23-24.

²²⁵ John Dandridge, VISN 9 Director, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 26.

Workload projection data indicate that Memphis will have a large increase in demand for inpatient medicine. Memphis currently operates 75 medicine beds with an ADC of 54 in inpatient medicine, and they are projected to have a need for an additional 40 beds over the FY 2001 baseline by FY 2012, decreasing to a need for an additional 22 beds over baseline by FY 2022.²²⁶

The available space at the Huntington VAMC would be used for inpatient care in FY 2012, and the Huntington VAMC would use contracted services as a solution.²²⁷ Patients from the Charleston, WV, area are referred to the Huntington VAMC for inpatient surgical care.

Commission Findings

- 1 CARES projections indicate small to moderate increases in need for inpatient medicine and surgical services in FY 2012, and most markets demonstrate a decreased need by FY 2022.
- 2 The VISN's strategic approach to addressing projected increases in inpatient care is by providing services through contracts rather than by construction.
- 3 While inpatient surgery did not meet criteria as a planning initiative for this market, the viability of the surgical program at Murfreesboro was selected as an initiative by the VISN. Based on the VISN's data review, they elected to continue ambulatory surgery at the Murfreesboro campus and to move inpatient surgery to Nashville.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposals to increase inpatient medicine services in the Central and Western markets through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central Market and in outlying areas as available in the Western Market).
- 2 The Commission concurs with the DNCP proposal on with contracting for excess demand, particularly in the Charleston, WV, area.
- 3 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

²²⁶ VSSC KLF Menu Database, *Occupancy Rates*, as of FY 2003.

²²⁷ Linda Godleski, MD, VISN 9 Mental Health Program Manager, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, pages 28-29.

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

V Outpatient Primary and Specialty Care

DNCP Proposals

“The DNCP attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. *Primary Care and Mental Health* – Outpatient demand is increasing in three of the four markets for primary care and in two of the four markets for mental health care. Increased capacity for these services is being addressed through a combination of in-house expansion (renovations and leases) and expansion of existing CBOCs. In addition, outpatient mental health is being integrated with primary care at all sites. *Specialty Care* – Increase the capacity for outpatient specialty care in all four markets. The plan is to use a mix of in-house expansion, telemedicine, inclusion of selected high volume specialty services at larger CBOCs and through the use of community contracts.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

As part of the CARES process, standards were set for how far enrolled veterans should have to drive to see their primary care provider, with different standards for urban, rural, and highly rural settings. A gap in access to primary care was identified if less than 70 percent of enrolled veterans are within the acceptable drive times. All four markets in this VISN have access gaps to primary care. Current access ranges from 51 percent in the Eastern Market to 60 percent in the Northern Market.²²⁸ More than 160 public comments received by the Commission regarding VISN 9 concerned travel distances to primary and hospital care. The Commission also heard testimony from veterans service organizations that veterans were required to drive long distances to receive care, often over country roads that are especially treacherous during winter months.

²²⁸ VSSC KLF Menu Database, *CARES Reports*.

The Central Market has a 79 percent projected gap for primary care capacity by FY 2012, which decreases to 60 percent over the FY 2001 baseline by FY 2022. The Western Market has a primary care gap of 52 percent over baseline by FY 2012, which declines to 34 percent over baseline by FY 2022. The Eastern and Northern markets have smaller gaps in FY 2012 (25 and 23 percent, respectively) and are projected to return near to FY 2001 baseline levels by FY 2022.²²⁹

The VISN currently provides primary care services at 25 CBOCs. At two of these sites (Knoxville and Chattanooga), additional specialty services are also provided. There also are plans to expand specialty care at CBOCs. Mr. Pennington, the VAMC Director VA Tennessee Valley Health Care System, indicated that they have recently added 13 exam rooms in the Chattanooga clinic with the objective of pulling as much specialty care to the clinic as possible.²³⁰

Some of these CBOCs are VA staffed and some are contracted with community resources. At the Nashville hearing, Dr. Roth testified that the VISN uses business criteria to evaluate service delivery options; “Once we came to the site, then the decision had to be made whether or not we were either going to have a VA presences and staff it, own the building infrastructure, or to go ahead and lease space and/or to contract [that].”²³¹ He cited as an example that 1,600 veterans in East Tennessee receive care at eight CBOC sites through a rural health care consortium contract. Veterans testified that additional sites of care had improved access, particularly for those residing in more rural areas in the VISN.

In its original CARES market plan, the VISN had proposed opening an additional 40 CBOCs to further improve access to primary care throughout the VISN, with a mix of contract and VA-staffed sites. A proposed CBOC in eastern Kentucky (Hazard) is of particular note for several reasons. Patients from that area currently must travel three hours to Lexington for primary care, a new State Veterans Home is opening in Hazard, and the University of Kentucky is offering family practice training in Hazard. This would allow the VISN to collaborate with one of their major affiliates in improving access for veterans residing in a remote area. The VISN also has planned to address a portion of its projected increase in outpatient specialty care through CBOCs. According to Mr. Dandridge, “a strong consideration was placed on enhancing access, rather than expanding existing medical centers. If expansion was necessary, contracting was considered a preferable alternative.”²³²

²²⁹ Appendix D, *Data Tables*, page D-46.

²³⁰ David Pennington, Director, VA Tennessee Valley Health Care System, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 32.

²³¹ Richard Roth, MD, VISN 9 CARES Committee Co-Chair, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 44.

²³² John Dandridge, VISN 9 Director, Transcribed Testimony from the Nashville, TN, Hearing on September 10, 2003, page 23.

None of the proposed new CBOCs are in priority group one in the DNCP. Although expanding services at existing CBOCs, as proposed in the DNCP, may reduce projected capacity gaps for primary care and specialty care, it will not address the substantial deficiencies for access, as measured by travel time, that are prevalent across the VISN.

It is also not clear that facilities will be able to identify either space or contract arrangements at the current sites of care to meet their projected outpatient demand. Available data suggest that all existing primary care, mental health, and specialty care sites in all markets either need additional space now or will in the future. It is not clear whether capacity can be increased to the level necessary to meet the demand without additional CBOCs being activated.

Commission Findings

- 1 No CBOCs in this VISN are in the DNCP's priority group one and, without the ability to add CBOCs, the VISN is unlikely to optimally meet projected increases in the need for primary care and specialty services, or to correct current deficiencies in access to primary care and specialty care services.
- 2 In-house expansions and expansions at existing CBOCs may address only a portion of the increased workload projected across the VISN. There does not appear to be capacity in many facilities in the VISN to absorb this workload without construction.
- 3 All markets are projected to increase their need for specialty care, and the VISN's strategy for addressing projected increases in specialty care is by contracting specialty services in communities and CBOCs close to where the veteran lives.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to expand services at current sites of care, to expand the use of telemedicine, and to use community contracts, but notes that this is not an adequate solution to the substantial access and capacity deficiencies in this VISN, which cannot be met without additional sites of care.
- 2 The Commission recommends that:²³³
 - a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

²³³ Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

- b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
 - c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
 - d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
 - e Whenever feasible, CBOCs provide basic mental health services.
 - f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.
- 3 The Commission recommends that:
- a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

VI Mental Health Care

DNCP Proposals

Psychiatry – To meet inpatient psychiatry demand in the Northern Market, acute inpatient psychiatry services will be centralized to one site within the Northern Market or refer patients to the Mufreesboro, TN, program. Options to centralize services within the Northern Market include provision of these services as part of the enhanced use agreement with the Commonwealth of Kentucky on the Leestown campus or consolidating services to the Louisville VAMC. *Primary Care and Mental Health* – Outpatient demand is increasing in three of the four markets for primary care and in two of the four markets for mental health care. Increased capacity for these services is being addressed through a combination of in-house expansion (renovations and leases) and expansion of existing CBOCs. In addition, outpatient mental health is being integrated with primary care at all sites.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The DNCP proposal for providing inpatient psychiatry, particularly in the Northern Market, does not adequately address the needs for psychiatric inpatient care. Acute inpatient psychiatric services are currently provided in efficient units at both major tertiary care centers – in Louisville, with 26 operating inpatient psychiatric beds and a current ADC of 15, and in Lexington, with 19 operating psychiatric beds and a current ADC of 12.²³⁴ The plan to consolidate Lexington and Louisville’s services or to send patients to Murfreesboro (located three and a half to four hours away)²³⁵ would put veterans who are currently within the CARES access (travel time) standards outside the CARES standard. This move would also leave one of the tertiary-level VA medical centers without an acute inpatient psychiatric service. There is a projected need for an additional 34 acute psychiatric beds in this market (an increase of 96 percent over the FY 2001 baseline) by FY 2012, decreasing to 18 beds (a gap of 51 percent over baseline) by FY 2022.²³⁶ This is one of the largest projected gaps for acute inpatient psychiatry in the country. It is illogical to address a large projected gap by closing one of the two existing units serving this market. In fact, the data would suggest that both current acute units will need to expand to meet demand, and that contracting for acute inpatient services in the Huntington area may also be advisable to improve access for veterans in the far eastern portion of the market.

There is a projected increase of 54 percent for inpatient acute psychiatric services over baseline by FY 2012 in the Western Market (Memphis). The DNCP does not address this gap in any way.

Although the DNCP indicates that outpatient mental health demand is increasing in only two of the four markets in this VISN, it is projected that all four markets have large gaps. Data indicate that all four markets also meet the thresholds for inclusion as planning initiatives for outpatient mental health services in both FY 2012 and FY 2022.²³⁷ The VISN, however, selected only two markets for inclusion and the DNCP reflects the VISN’s selections.²³⁸

²³⁴ VSSC KLF Menu Database, *Bed Control, Occupancy Rates*.

²³⁵ John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 47.

²³⁶ Appendix D, *Data Tables*, page D-46.

²³⁷ VISN 9 CARES Planning Initiatives, *Power Point slide show*, available from [<http://www1.va.gov/cares/page.cfm?pg=49>].

²³⁸ VISN 9 CARES Planning Initiatives, *Power Point slide show*, available from [<http://www1.va.gov/cares/page.cfm?pg=49>].

Only six of the 25 CBOCs currently open in the VISN have mental health visits that account for more than two percent of their workload.²³⁹ VISN 9 has the worst record in VHA for providing access to basic mental health services at CBOCs. This means that high priority patients with severe mental disorders must often travel large distances to access VA mental health outpatient services. At the Lexington hearing, the VISN Director stated that CARES has put this deficit under the microscope. He acknowledged that it needs to be addressed by putting mental health providers at current and future CBOCs.²⁴⁰

As with primary care and outpatient specialty care, the DNCP proposal to not open new CBOCs in the VISN would significantly limit the VISN's ability to close the very large gaps that are projected for outpatient mental health services.

Commissioners expressed concern that this VISN shows a deficiency in the availability of mental health services, compared to most other VISNs, for a number of reasons:²⁴¹

- ▶ The projected gaps for inpatient and outpatient mental health services across the VISN are among the largest in the nation, although there is only a modest projected increase of seven percent in enrollment in the VISN. Since most of the gaps for mental health capacity approach or exceed 100 percent, this indicates that the VISN is currently providing less than half the level of mental health services required by the currently enrolled population.²⁴²
- ▶ Of the 3,867 seriously mentally ill patients in active intensive case management (as of June 2003), a modality strongly supported as crucial by VA's practice guidelines, only six were from this VISN.²⁴³
- ▶ There has been a decline in treatment of Post-Traumatic Stress Disorder (PTSD) patients for this VISN that is not in keeping with national trends. While VA has seen a 56 percent increase in PTSD services nationwide since 1996, this VISN provides PTSD services to fewer patients than it did six years ago.
- ▶ Finally, while the DNCP suggests there are additional EUL opportunities between the VA and the Commonwealth of Kentucky that could include a domiciliary and/or a transitional/homeless shelter, this opportunity has not been explored.²⁴⁴

²³⁹ VSSC KLF Menu Database *FYTD CBOC VAST and Workload Report*, FY 2003, accessed on October 13, 2003.

²⁴⁰ John Dandridge, VISN 9 Director, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 53.

²⁴¹ CARES Commission Hearing Summary: Lexington, KY, page 7, available from [<http://www.carescommission.va.gov/Documents/V09LexingtonHearingSummary.pdf>].

²⁴² VISN 9, *Market Plans*, available from [<http://www1.va.gov/cares>].

²⁴³ VHA National Mental Health Evaluation Center (NEPEC) *Quarterly Report, Second Quarter FY 2003 on Mental Health Intensive Case Management Team Implementation*.

²⁴⁴ Leslie E. Beavers, Brigadier General (Ret.), Commissioner, Kentucky Department of Veterans Affairs, Transcribed Testimony from the Lexington, KY, Hearing on September 8, 2003, page 126.

Commission Findings

- 1 While plans were developed to address the projected outpatient mental health gaps in two markets, data indicate there are significant projected gaps in all four markets.
- 2 Although there is a VHA directive that CBOCs provide mental health services,²⁴⁵ most CBOCs in this VISN do not provide mental health services.²⁴⁶
- 3 The plan to consolidate Lexington and Louisville’s psychiatric units and move workload to Murfreesboro would decrease the current level of access to inpatient services and would leave a tertiary care facility without acute inpatient psychiatric service. No plans were offered for addressing future needs for additional acute inpatient care in the Western Market.
- 4 The VISN has large gaps in the levels of mental health care provided, including for particularly high priority groups of veterans such as the seriously mentally ill and patients with war-related PTSD.
- 5 There are additional enhanced use opportunities between the VA and the Commonwealth of Kentucky that have not been explored.

Commission Recommendations

- 1 The Commission does not concur with the DNCP proposal and recommends maintaining inpatient psychiatric and outpatient mental health services in at least all current locations until mental health services VISN-wide have been reevaluated.
- 2 The Commission recommends that VISN 9 leadership complete a thorough review of mental health services in the VISN, including in CBOCs, and develop and implement a plan to provide an appropriate level of services.
- 3 The Commission recommends that acute inpatient mental health services be provided with other acute inpatient services whenever feasible.
- 4 The Commission recommends that additional enhanced use lease opportunities with the Commonwealth of Kentucky be explored.

²⁴⁵ VHA Directive 2001-60, *Veterans Health Administration Policy for Planning and Activating Community Based Outpatient Clinics*, Attachment A: *Minimum Standards for Community Based Outpatient Clinics (CBOCs)*, page A-1.

²⁴⁶ VSSC KLF Menu Database *FYTD CBOC VAST and Workload Report*, FY 2003.

VII VA/DoD Sharing

DNCP Proposal

“DoD – Expansion of space for primary care and outpatient mental health services at Fort Knox CBOC. There were no DoD initiatives developed between Millington Naval Base and VAMC Memphis now but opportunities will continue to be pursued in the future.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

During the site visit in July 2003, Commissioners learned that the Louisville VAMC and the Fort Knox Ireland Army Hospital established a sharing program in 1996 that is a revenue-neutral initiative. In return for receiving a CBOC site providing access for veterans, VA provides about 50 percent of Fort Knox’s outpatient care. With this arrangement, VA and DoD improved access and lowered costs. VA and DoD are considering expanding the sharing agreement to allow for the sharing of space for primary care along with outpatient mental health services.²⁴⁷

Commission Finding

The VA/DoD sharing agreement between Fort Knox and the Louisville VA has been mutually beneficial, and both parties are working on expanding the sharing agreement.

Commission Recommendation

The Commission concurs with expansion of space for primary care and outpatient mental health services at the Fort Knox CBOC.

²⁴⁷ VISN 9, *Site Visit Report*, Lexington/Wilmore/Louisville/Fort Knox, dated July 22-23, 2003, page 7, available from [<http://www1.va.gov/cares/docs>].

VIII Special Disability Programs – Spinal Cord Injury/Disorder (SCI/D)

DNCP Proposal

“Add 20 long-term care SCI beds within the current spinal cord injury unit at Memphis.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN plan indicates that an existing ward can be renovated to accommodate the SCI unit, at a cost of \$1.8 million. VA data show that Memphis has 70 authorized SCI/D beds, 60 of which are operating, with an ADC of 53.²⁴⁸ It is projected that this facility will need 54 acute and 66 long-term SCI/D beds in FY 2012, and 63 acute and 78 long-term beds in FY 2022.²⁴⁹

Commission Finding

Occupancy of the current SCI unit is fairly high, though it is noted that 10 beds are closed.

Commission Recommendation

The Commission concurs with the DNCP proposal on the expansion of SCI/D beds at Memphis. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

²⁴⁸ VSSC KLF Menu Database, *Bed Control, Occupancy Rates*, thru May 2003.

²⁴⁹ Draft National CARES Plan (DNCP), *Appendix Q – Special Disability Program Planning Initiatives*, page 7, available from [http://www1.va.gov/cares/docs/DNP_appQ.pdf].