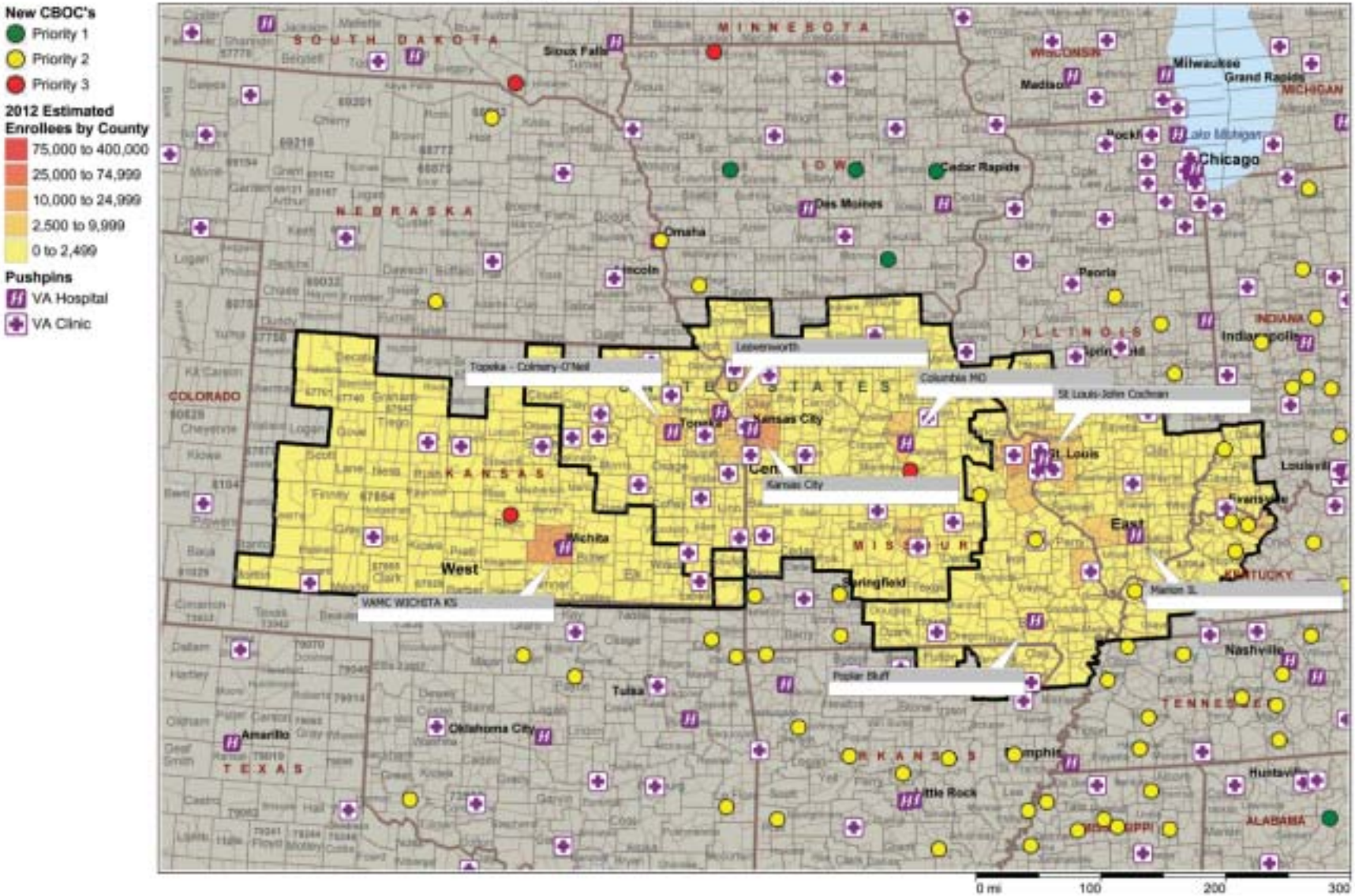
VISN 15 – VA Heartland Network



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VISN 15, VA Heartland Network

VISN Overview

VISN 15, VA Heartland Network, is an integrated, comprehensive health care system that provided medical services to approximately 199,000 of the 286,000 veterans enrolled in VA's health care system in this VISN in FY 2003.[322] The total veteran population VISN is 969,000. Geographically, the VISN is located in six Midwestern states: Indiana, Kentucky, Arkansas, Illinois, Missouri, and Kansas. Ninety-two percent of the counties in the Western Market are considered highly rural or rural, as are 88 percent of the counties in the Eastern Market. With a staff of 6,852 FTEs,[323] VISN 15 delivers health care services through eight medical centers, one outpatient clinic, and 22 community-based outpatient clinics (CBOCs). Additionally, VA operates four Vet Centers in VISN 15's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 15.

VISN 15	FY 2001	FY 2012	FY 2022
Enrollees	239,574	242,560	211,555
Veteran Population	1,005,240	805,573	655,816
Market Penetration	23.83%	30.11%	32.26%

For the CARES process, this VISN is divided into three markets: Eastern (*facilities:* St. Louis, MO; Poplar Bluff, MO; and Marion, IL), Central (*facilities:* Kansas City, MO; Topeka, KS; Columbia, MO; and Leavenworth, KS), and Western (*facility:* Wichita, KS).

[322] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[323] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited three sites in VISN 15 and conducted two public hearings. The Commission received 11 public comments regarding VISN 15.

- *Site Visits:* John J. Pershing VA Medical Center (VAMC), Poplar Bluff, MO, on June 30; and Kansas City, MO, and Leavenworth, KS, facilities on July 1.
- *Hearings:* Leavenworth, KS, on August 18; and Poplar Bluff, MO, on August 20.

Summary of CARES Commission Recommendations

I Consolidation of Services/Proximity – Kansas City and Leavenworth VAMCs

1. The Commission concurs with the DNCP proposal to implement the recommendations of the Secretary's Advisory Board.

(see page 5-222)

II Small Facility – Poplar Bluff

1. The Commission does not concur with the DNCP that Poplar Bluff currently operates as a critical access hospital (CAH).
2. The Commission recommends that VA establish a clear definition and clear policy on CAH designation prior to making a decision regarding the Poplar Bluff VAMC.
3. The Commission recommends that a target date be set for making a full cost-benefit analysis of sustaining inpatient services versus contracting for such services. The Commission further recommends that, based on the results of that assessment, a decision be made regarding whether or not to close inpatient services at Poplar Bluff.
4. The Commission recommends that, regardless of the decision on inpatient services, outpatient services and long-term care (LTC) remain at Poplar Bluff.

(see page 5-224)

III Inpatient Services – Psychiatry

1. The Commission concurs with the DNCP proposal on shifting workload between the Central and Western markets to meet inpatient psychiatry workload.

(see page 5-226)

IV Outpatient Care

The Commission concurs with the DNCP proposal on expansion of in-house services, new construction, space conversion, and utilization of community contracts to address capacity gaps for outpatient care. However, it notes that substantial access gaps and many of the capacity gaps are unlikely to be resolved without additional sites of care.

1. The Commission recommends that:[324]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-227)

V Excess VA Property/Enhanced Use Lease for Historic Buildings at Leavenworth

1. The Commission concurs with the DNCP proposal to pursue an enhanced use lease (EUL), including the assisted living project, at the Leavenworth campus.
2. The Commission recommends that VA develop a viable plan for funding this proposal.
3. The Commission further 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 5-229)

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

Consolidation of Services/Proximity – Kansas City and Leavenworth VAMCs

DNCP Proposal

"Continuation of the Secretary's Advisory Board recommendations. The Secretary's Advisory Board was created prior to CARES to consider realignments within VISN 15. The Advisory Board developed a comprehensive plan for realignment and consolidation of services between Topeka and Leavenworth that was approved by the USH and incorporated into the VISN's CARES plan. It included realignments of nursing home care unit, psychiatry, and outpatient surgery. Under this plan, Leavenworth would maintain acute beds. In addition, Leavenworth will provide additional primary care capacity for Kansas City, and both Leavenworth and Topeka would retain 24/7 emergency services at both campuses."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The data support that Kansas City, Leavenworth, and Topeka serve different populations, with only a 2.9 percent overlap between Kansas City and Leavenworth, and a 4.9 percent overlap between Kansas City and Topeka. In testimony, Dr. Peter L. Almenoff, VISN Director, described the changes already underway:

> The plan capitalizes on the strengths of Leavenworth and Topeka's integration and the relationship with the Kansas City VA as a tertiary care facility through the implementation of the Advisory Board recommendations authorized by the Secretary of Veterans Affairs and recently approved by the Under Secretary for Health. These include realignment of psychiatry and nursing home beds between the Leavenworth and Topeka campuses, realignment of intensive substance abuse treatment programs, continuation of urgent care services at both campuses 24 hours, 7 days a week, 365 days a year, maintaining up to 38 acute inpatient beds at Leavenworth, establishment of a same-day surgi-center at the Leavenworth and Topeka campuses, and referral of complex major surgical procedures would be performed in Kansas City. All the facilities will continue to provide support for the DoD installations, including Fort Leonard Wood, Fort Leavenworth, Fort Riley, Whiteman Air Force Base, and McConnell Air Force Base.[325]

[325] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 11.

Leavenworth (Dwight D. Eisenhower VA Medical Center) is a part of the Eastern Kansas Health Care System and has 393 beds: 103 inpatient beds (internal medicine, intermediate medicine, rehabilitation, surgery, and psychiatry), 183 domiciliary, 82 nursing home, and 25 residential care. The FY 2003 total average daily census (ADC) was 264, with an inpatient ADC of 60, domiciliary ADC of 167, and nursing home ADC of 37.[326]

The site visit revealed that many of the buildings at the Leavenworth facility are of the post-Civil War era and are historic in nature. The Commissioners noted the presence of the Centralized Mail Out Pharmacy (CMOP) program on the Leavenworth campus. In addition, 85 percent of counties in the area are designated as medically underserved in the Department of Health and Human Service medically underserved listing.[327]

The Kansas City VAMC is a 165-bed tertiary care facility with an ADC of 120. A referral center for VAMCs in Leavenworth, Topeka, and Wichita, KS, and Fayetteville, AR, it is located in the heart of Kansas City. During the stakeholders' meeting at the Leavenworth VAMC, stakeholders expressed concerns about the possible closure of the Leavenworth location given the driving distance to Kansas City, an urban area. Leavenworth is approximately 34 miles from Kansas City and 64 miles from Topeka. Testimony provided by a union official, who is a registered nurse, indicated that such a driving distance is disruptive for veterans and may create additional costs such as mileage reimbursement as well as the cost of hardship for families who may have to travel an additional 70 miles to see their family members.[328]

Additionally, testimony indicated that Leavenworth supports the DoD with a variety of sharing agreements with the U.S. Army at Fort Leavenworth and Fort Riley. These agreements support active duty soldiers with emergency room care, inpatient and outpatient care, psychiatry services, readiness physicals, and laboratory testing.

Commission Findings

1. The Leavenworth and Kansas City medical centers serve separate and distinct missions.
2. There is minimal overlap in patient population served by the two medical centers.
3. The Leavenworth VAMC provides substantial health care for VA's DoD partners at Fort Leavenworth and Fort Riley.

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[326] VSSC KLF Menu Database, Cumulative Average Daily Census (ADC) 5-Year Report, FY 2003.

[327] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 9.

[328] Sandy Bond, President, National Federation of Federal Employees Local 1765, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 121.

4 Eighty-five percent of the counties in the area are designated as medically underserved.

Commission Recommendation

The Commission concurs with the DNCP proposal to implement the recommendations of the Secretary's Advisory Board.

II Small Facility – Poplar Bluff

DNCP Proposal

"Poplar Bluff will maintain acute care beds. This facility currently operates as a critical access hospital (CAH) and will continue as such when VHA develops its CAH criteria."

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 53-year-old John J. Pershing VA Medical Center (Poplar Bluff VAMC) has 16 acute care beds and a 40-bed nursing home unit. The facility has an ADC of 16 acute patients, which is projected to decrease to 15 in FY 2012 and to 11 in FY 2022. No inpatient surgery is performed at this site. The nursing home unit has an ADC of 37. Outpatient primary care and mental health services are provided. Subspecialty services are provided by local consultants and/or referral to VA tertiary care facilities.[329] Commissioners also noted that the Poplar Bluff VAMC is located near a major earthquake fault. In September 1984, VA completed a $6.9 million construction project to correct seismic deficiencies in four buildings. There is a hospital in the Poplar Bluff community that is reported to have excess capacity.[330]

[329] Facility Fact Sheet: *John J. Pershing, VA Medical Center, Poplar Bluff, MO.* [*http://vaww.poplar-bluff.med.va.gov/VA*]
[330] Appendix D, *Data Tables*, page D-60.

Commissioners recognize the challenge for veterans to access acute care in Poplar Bluff. It is a highly rural area. There is minimal public transportation. There are no VA facilities within 60 minutes, and the St. Louis, MO and Memphis, TN VAMCs are 150 miles away.

At the time of the hearing, CAH criteria were used to address the Poplar Bluff VAMC. The Commission has not accepted the DNCP's use of such criteria.

Commission Findings

1. Poplar Bluff has a 16-bed acute medicine unit with an ADC of 16, which is projected to decline to 15 in FY 2012 and to 11 in FY 2022.
2. There are no VA facilities within 60 minutes of Poplar Bluff. The St. Louis and Memphis VAMCs are 150 miles away.
3. Poplar Bluff is in a highly rural area with minimal public transportation.
4. There is one non-VA hospital in the Poplar Bluff community, which has excess capacity.
5. There are established relationships with community specialty care providers as reflected by referral of specialty patients.

Commission Recommendations

1. The Commission does not concur with the DNCP that Poplar Bluff currently operates as a CAH.
2. The Commission recommends that VA establish a clear definition and clear policy on CAH designation prior to making a decision regarding the Poplar Bluff VAMC.
3. The Commission recommends that a target date be set for making a full cost-benefit analysis of sustaining inpatient services versus the potential for contracting such services. The Commission further recommends that, based on the results of that assessment, a decision be made regarding whether or not to close inpatient services.
4. The Commission recommends that, regardless of the decision on inpatient services, outpatient services and LTC remain at Poplar Bluff.

III Inpatient Services – Psychiatry

DNCP Proposal

"Decreasing demand in the Central Market will be offset by increased workload from the Western Market. Inpatient workload will be met through a combination of in-house and community contracts. New construction is proposed to meet projected space needs."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The inpatient psychiatry workload is projected to increase in the Eastern Market with an additional 30 beds over the FY 2001 baseline needed by FY 2012, and six beds over baseline needed by FY 2022. Likewise, the Western Market was projected to need an increase of two beds over baseline by FY 2012, decreasing to one bed over baseline by FY 2022. In the Central Market by FY 2012, a decrease of 15 beds over baseline and, by FY 2022, a decrease of 40 beds over baseline was projected. Dr. Almenoff noted in his testimony that the VISN would manage inpatient psychiatry needs using a combination of in-house capacity and community contracts. Additionally, there would be realignment of psychiatry services between Leavenworth and Topeka in the Central Market.

Commission Finding

Need for increased inpatient psychiatry services will be met through use of shifting of workload and a combination of in-house capacity adjustment and community contracts.

Commission Recommendation

The Commission concurs with the DNCP proposal on shifting workload between the Central and Western markets to meet inpatient psychiatry workload.

IV Outpatient Care

DNCP Proposals

"*Primary Care* – Increased primary care outpatient demand has been identified in all three of the Network's markets. The majority of this need will be met through expansion of in-house space via new construction, conversion of vacant space, lease space, and utilization of community contracts. The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. While new access points in the Central and the East markets are included in the National plan, they are not in the high implementation priority category at this time. *Specialty Care* – All three of the Network's markets are projected to experience increased outpatient specialty care demand. The VISN proposes to meet the majority of this need through expansion of in-house services with new construction, vacant space conversion, lease space, and utilization of community contracts. In addition, some shifting of care between facilities is proposed."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Data on access to primary care indicate that only 62 percent of enrolled veterans in the Eastern Market are within the access guidelines, and that the Western Market is at only 56 percent. The standard is 70 percent. Large increases in specialty care needs are projected for all three markets. By FY 2012, the average increase in demand for specialty care over the FY 2001 baseline is projected to be 128 percent for this VISN: 107 percent for the Central Market, 188 percent for the Western Market, and 91 percent for the Eastern Market.[331] However, the seven proposed CBOCs for this VISN were all in the DNCP's lowest priority group.[332]

Dr. Almenoff testified that construction of primary care and specialty care clinics, conversion of vacant space, use of leased space, and community contracts would be used to meet demand. In addition, CBOCs have also been placed in state homes in Missouri. The VISN also uses medical outreach clinics, which go

[331] Appendix D, *Data Tables*, page D-59.

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

from town to town in Western Kansas once a month, to meet the primary care needs of rural populations. Dr. Almenoff further testified regarding use of televideo to provide for specialty services: "if you are in a clinic out in Western Kansas and you had an x-ray in the system, I can see the x-ray in Kansas City. I can talk to the provider to discuss care and treatment."[333] Written testimony from Congressman Lane Evans stated, "The Central Market might consider putting in primary care services in one of the under-served rural counties in Missouri, northeast of Columbia, to create better access for these veterans in addition to the veterans of Pike County, Illinois. Undoubtedly, more veterans would seek primary care if such services were more accessible."[334] Testimony from stakeholders reflected support of additional access points for CBOCs, though there was concern about contracting for providers versus use of VA-staffed clinics.

Commission Findings

1. No proposed CBOCs were recommended to be included in priority group one. While in-house expansions and expansions at existing CBOCs will address increased workload, these actions will not improve access to primary care or address the distances veterans must travel for care.
2. Access to primary care in the Eastern and Western markets is below the CARES 70 percent standard.
3. All three markets are projected to have large increases in primary and specialty care workload.
4. VISN 15 is using televideo and other technology to address access to care issues in rural areas in Kansas.

Commission Recommendations

1. The Commission concurs with expansion of in-house services, new construction, space conversion, and utilization of community contracts to address capacity gaps for outpatient care. However, it notes that substantial access gaps and many of the capacity gaps are unlikely to be resolved without additional sites of care.

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[333] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 26.

[334] Lane Evans, United States Congress, Written Testimony submitted at the Leavenworth, KS, Hearing on August 18, 2003, page 2.

2 The Commission recommends that:[335]

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.

V Excess VA Property/Enhanced Use Lease for Historic Buildings at Leavenworth

DNCP Proposal

"The Network is developing a project at the Leavenworth campus that would rehabilitate 39 historic buildings for mixed use, including an assisted living facility. In addition, there would be an expansion of the Leavenworth National Cemetery. The second project is the out-leasing of approximately 2.5 acres of land to a commercial developer in exchange for the construction of a parking garage adjacent to the St. Louis-John Cochran facility."

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

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

At both the site visit and the public hearing, there was discussion of possible EUL options for the Leavenworth campus. As Dr. Almenoff testified at the Leavenworth hearing:

> It is still in development. What they are planning on doing is through a grant from the Historical Society, which I think is about $50 to $75 million, they will be renovating anywhere between 37 and 39 of the current buildings that we have on the campus that we originally had on slate for demolition. With those specific enhancements and redevelopment of those buildings, an assisted living program would be developed which veterans would have a priority to get into. In addition, it's really going to be multi-use.[336]

Several stakeholders encouraged VA to pursue this opportunity, though they noted the EUL process is problematic. It was noted that VA does not have a definition for assisted living facilities, which could affect using this campus for that purpose. "Although no commitment to an operator of such senior facilities has been made (including assisted living facilities) this remains a service that fits well with several of these historic buildings."[337] Additional support from stakeholders revealed community involvement and partnering with VA in use of some of the Leavenworth campus buildings. There is concern, however, that there is no demonstrable plan for funding. Plans rely on an historical society to provide a grant for $50 to $75 million in order to move forward.

Commission Findings

1. The Leavenworth community supports the proposed project to renovate vacant buildings and create an assisted living facility for area residents including veterans.
2. The Leavenworth EUL proposal makes beneficial use of buildings no longer suitable for VA's mission while removing VA's current operating costs and providing revenue to VA to enhance services.
3. There is no demonstrable plan for funding. Plans rely on an historical society to provide a grant for $50 to $75 million in order to move forward.
4. VA does not have either a policy or guidelines that specifically address assisted living.

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[336] Peter L. Almenoff, MD, VISN 15 Director, Transcribed Testimony from the Leavenworth, KS, Hearing on August 18, 2003, page 31.

[337] Richard C. Gervasini, VALOR, Written Public Comment on VISN 15, submitted August 27, 2003.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to pursue an EUL, including the assisted living project, at the Leavenworth campus.
2. The Commission recommends that VA develop a viable plan for funding this proposal.
3. The Commission further 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.