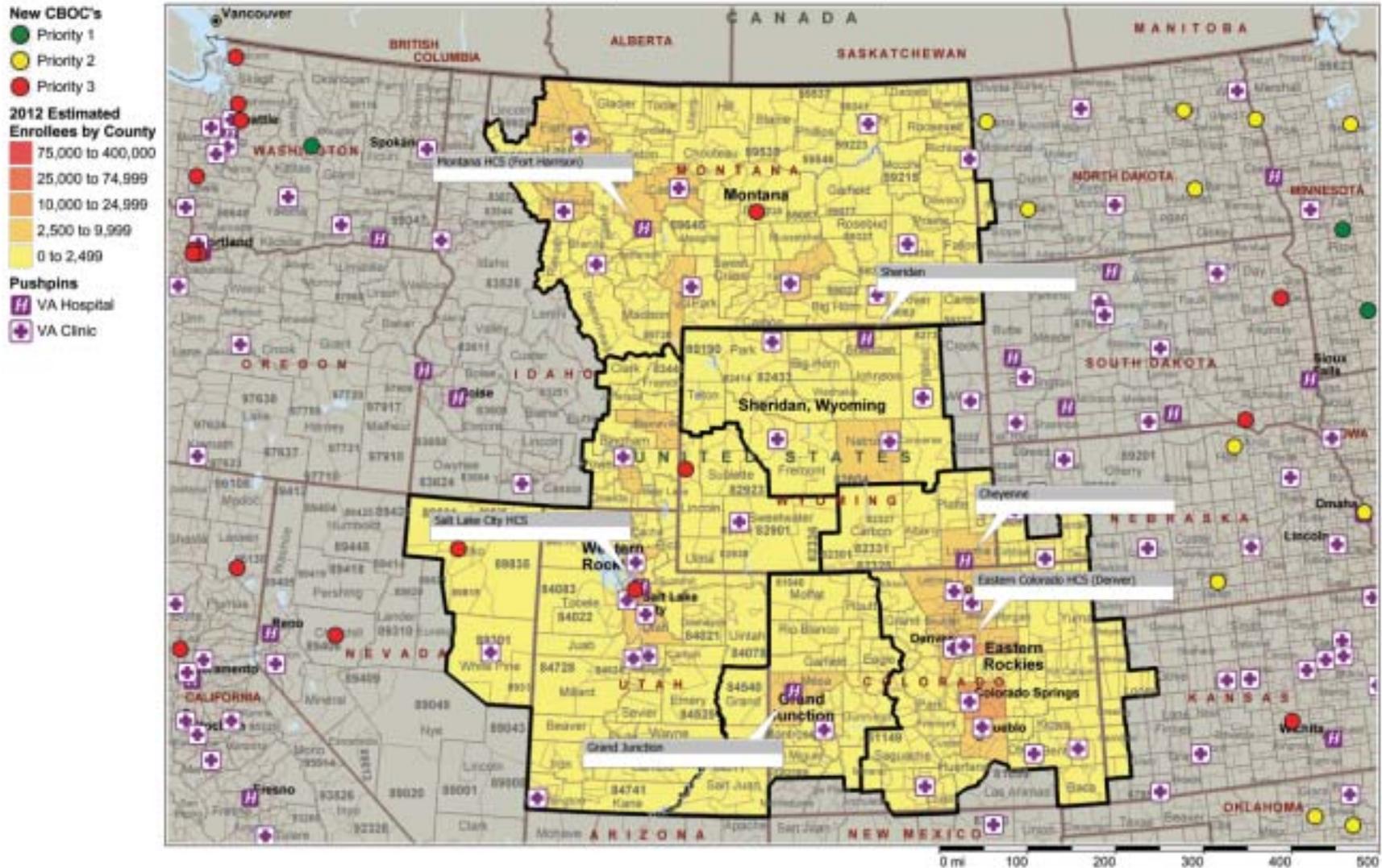


VISN 19 – Rocky Mountain Health Care System



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VISN 19, Rocky Mountain Network

VISN Overview

VISN 19, the Rocky Mountain Network, is the largest VISN in terms of geographic area in the 48 contiguous states, spanning nearly all counties in four western states: Colorado, Montana, Utah and Wyoming, with counties in an additional five states: Idaho, Kansas, Nebraska, Nevada and North Dakota. This large geographic area covers approximately 450,000 square miles and is classified as rural or highly rural, with only two truly urban centers at Denver and Salt Lake City.

This health care system has a total veteran population of 777,000 and provided medical services to approximately 125,000 of the 194,000 veterans enrolled in its system in FY 2003.⁴⁵²

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 19.

VISN 19	FY 2001	FY 2012	FY 2022
Enrollees	164,392	185,705	180,272
Veteran Population	790,355	701,306	610,613
Market Penetration	20.80%	26.48%	29.52%

With a staff of 4,307 FTEs,⁴⁵³ the Rocky Mountain Health Care System is composed of seven medical centers, six nursing homes, and 33 community-based outpatient clinics (CBOCs). Additionally, VA operates 11 Vet Centers in VISN 19’s catchment area.

This VISN is divided into five markets: the Eastern Rockies Market (*facilities*: Denver, CO, and Cheyenne, WY); the Grand Junction Market (*facility*: Grand Junction, CO); the Montana Market (*facilities*: Fort Harrison and Miles City, MT); the Western Rockies Market (*facility*: Salt Lake City, UT); and the Wyoming Market (*facility*: Sheridan, WY).

Information Gathering

The CARES Commission visited five sites in VISN 19 and conducted three public hearings. The Commission received 1,234 public comments regarding VISN 19.

⁴⁵² VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

⁴⁵³ VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

- ▶ *Site Visits:* Miles City, MT, on July 21; Wyoming facilities, including Sheridan and Riverton CBOCs, on July 23 and 24; Colorado facilities, including the Rifle Veterans State Nursing Home, Grand Junction VA Medical Center (VAMC), and Montrose CBOC, on July 23, 24, and 25.
- ▶ *Hearings:* Denver, CO, on September 22; Billings, MT, on September 24; and Cheyenne, WY, on October 23.

Summary of CARES Commission Recommendations

I Replacement VAMC at Denver

- 1 The Commission concurs with the DNCP proposal for building a replacement medical center with DoD on the Fitzsimmons campus and recommends that it be made a high priority.
- 2 The Commission concurs in principle with the DNCP proposal to build a replacement nursing home unit.
- 3 The Commission recommends that:⁴⁵⁴
 - a Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
 - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
 - c Domiciliary care programs should be located as close as feasible to the population they serve.
 - d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-299)

II Special Disability Programs – Spinal Cord Injury Center

- 1 The Commission concurs with the DNCP proposal to add a 30-bed SCI Center at Denver.

(see page 5-301)

III Small Facility – Cheyenne

- 1 The Commission does not concur with the DNCP proposal that Cheyenne’s mission should be changed. The Commission recommends that Cheyenne retain its current mission due to its significant

⁴⁵⁴ Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

distance from other VAMCs; the high quality of care, including surgical care; the excellent condition of its buildings; the cost-effectiveness of operations; and the negative impact a mission change would have on the affiliation with the University of Wyoming and the DoD collaboration.

(see page 5-302)

IV Small Facility – Grand Junction

- 1 The Commission does not concur with the DNCP proposal that Grand Junction’s mission should be changed. The Commission recommends that Grand Junction retain its current mission due to its significant distance from other VAMCs and the high quality of care.

(see page 5-305)

V Small Facility and Seismic – Fort Harrison

- 1 The Commission concurs with the DNCP proposal to maintain the current mission of the Fort Harrison VAMC.
- 2 The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

(see page 5-307)

VI Inpatient Care

- 1 The Commission concurs with the DNCP proposal to improve acute hospital access by contracting for inpatient care in the Eastern Rockies, Montana, and Wyoming markets and for tertiary care in the Montana and Wyoming markets.

(see page 5-308)

VII Outpatient Care

- 1 The Commission concurs with the DNCP proposal to meet part of the future demand for more primary care, mental health, and specialty outpatient care through construction and conversion of space at current sites of care, and to increase specialty care at selected current sites of care, as well as contracting in high-peak periods of growth. The Commission notes, however, that merely increasing services at existing sites of care will not resolve access gaps in some markets.

- 2 The Commission recommends that:⁴⁵⁵
- 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 5-310)

VIII Enhanced Use – Salt Lake City

- 1 The Commission concurs with the DNCP proposal for the Phase II enhanced use project at Salt Lake City.

(see page 5-314)

⁴⁵⁵ Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

I Replacement VAMC at Denver

DNCP Proposal

“*Replacement Facility Study at Denver* – The Denver replacement hospital is included in the plan.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

During the Denver hearing, the Commission was advised that, in line with the Eastern Rockies Market’s plans for construction of a new replacement hospital at Denver, the proposal for this replacement facility includes a new 30-bed SCI unit, a 60-bed replacement nursing home unit, and 20-bed, sub-acute rehabilitation unit.

The current Denver VAMC space projections indicate that there is a deficit of 41,000 square feet of inpatient space.⁴⁵⁶ Denver also has a space deficit of 201,000 square feet for outpatient care. The tour of the Denver facility inpatient space revealed that this building is old and has patient privacy problems.

Workload at the Denver VAMC for inpatient medicine is projected to increase by 46 percent in FY 2012 over the FY 2001 baseline and to decline to 27 percent over the baseline by FY 2022. The surgical inpatient workload is projected to peak in FY 2009 at about 10 percent above current workload and to then decline by about eight percent above current workload by FY 2022. Psychiatric inpatient workload was projected to have peaked in FY 2002 and to decline about 30 percent by FY 2022.

The Commissioners viewed the general building plan for the new University of Colorado site and saw the proposed site of the Federal facility at the Fitzsimmons campus. Under the proposed plan, VA and DoD would each have their own designated Federal facility and patients, but would share certain areas, such as operating rooms, radiology, labs, and special procedure rooms with the University Medical Center.

The replacement university medical center is currently under construction and the university will be moving to the new site as soon as the bed tower has been completed in 2004. Section 213 of Public Law 108-170 authorizes VA to conduct advanced planning for a major medical facility project at Denver, not to exceed \$30 million; \$26 million from VA and \$4 million from DoD. The Conference Public Law 108-199 directs

⁴⁵⁶ VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

continuing efforts and planning to collocate the Denver VAMC with the University of Colorado hospital and a DoD medical facility at the Fitzsimmons campus. The University needs a clear commitment from VA to proceed with the next phase of the campus plan to include the proposed Federal facility.

Testimony from the Disabled American Veterans, The American Legion, AFGE VISN 19 Liaison of the Rocky Mountain Unified Union Presidents, the University of Colorado, DoD partners, Congressman Beauprez, and the Governor of Colorado all support the plan to build a Federal facility at the Fitzsimmons site. The Denver AFGE, however, while supportive of a replacement facility, is not in favor of having the two facilities adjacent to each other, citing concerns about veterans continuing to receive priority care and the possible loss of jobs.

When the VISN Director was asked during the Denver hearing about alternatives if the replacement facility were not approved, he indicated that there were no good alternatives. He stated that the current facility could be improved, but that it would still be a 50-year-old building.⁴⁵⁷ Denver's Medical Center Director indicated that, if the proposal were not approved, VISN staff would do the best they could, which would be to build yet another addition. He also indicated that this would be a temporary solution and a very costly one.⁴⁵⁸

Commission Findings

- 1 The Denver VAMC is old and has patient privacy problems.
- 2 The Space and Functional Report indicates that the Denver VAMC has a significant current space deficit in inpatient and outpatient areas, which is projected to increase.
- 3 There are no good alternatives for further construction or renovation at the Denver VAMC.
- 4 The plan calls for the VA and DoD to collaborate on building a new Federal facility and for some shared services with the University of Colorado.
- 5 The proposed replacement facility also would include a new 30-bed SCI unit, a 60-bed replacement nursing home, and a 20-bed, sub-acute rehabilitation unit.
- 6 All stakeholders support the proposal for building a new replacement facility near the University of Colorado Medical Center.
- 7 The timeframe for action is short.

⁴⁵⁷ Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 26.

⁴⁵⁸ Ed Thorsland, Medical Center Director of the Denver VAMC, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 51.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal for building a replacement medical center with DoD on the Fitzsimmons campus and recommends that it be made a high priority.
- 2 The Commission concurs in principle with the DNCP proposal to build a replacement nursing home unit.
- 3 The Commission recommends that:⁴⁵⁹
 - 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.

II Special Disability Programs – Spinal Cord Injury Center

DNCP Proposal

“Build a new Spinal Cord Injury (SCI) Center located with the replacement facility at Denver.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Currently, there are no SCI Centers close to Denver. Among the nearest SCI Centers are those in Milwaukee, Albuquerque, Long Beach, and Seattle, which causes significant access problems for veterans in this VISN. The model used to project the need for SCI beds indicated that VISN 19 could support a 30-bed unit. Dr. Anderson, Acting Chief Medical Officer for VISN 19, reported:

As we looked at the expansion of the Denver facility out at Fitzsimmons, we asked Dr. Margaret Hammond, who is the chief consultant for the spinal cord injury health group in Washington,

⁴⁵⁹ Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

to look at our population of spinal cord injury. It was determined we have substantial portions of SCI and SCD spinal cord injury patients in this area, and that we could easily support a 30-bed inpatient acute unit at the Denver facility.⁴⁶⁰

Commission Finding

The Denver VAMC could support a 30-bed inpatient SCI Center at Denver, which would significantly improve access to care.

Commission Recommendation

The Commission concurs with the DNCP proposal to add a 30-bed SCI Center at Denver.

III Small Facility – Cheyenne

DNCP Proposals

“Maintain acute bed sections and develop appropriate parameters (more restrictive) for types of in-house surgery procedures. Complete an evaluation to determine if ICU beds could be closed (VA external review survey).”

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).

⁴⁶⁰ Dr. Leigh Anderson, VISN 19 Acting Chief Medical Officer, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 102.

Commission Analysis

While the DNCP recommended that Cheyenne retain its current mission, in the Under Secretary for Health's August 6, 2003, presentation to the Commission, he indicated that he had asked the VISN to consider converting Cheyenne to a critical access hospital (CAH) and transferring some inpatient services to Denver, or contracting for care. The Cheyenne VAMC is projected to require fewer than 20 beds in FY 2012 and FY 2022.⁴⁶¹

Cheyenne is more than 100 miles from Denver, the nearest acute care VAMC. In addition, many patients from Sheridan, WY, use the Cheyenne VAMC for their inpatient care. If Cheyenne were to change its mission, these patients would have to travel to Denver, which is more than 400 miles from Sheridan.

Further, testimony at the Cheyenne hearing by VISN leadership indicated that both the quality of care as measured by the External Peer Review Program (EPRP) and the patient satisfaction scores are above average for nearly all measures. Surgical performance data also indicate that the Cheyenne VAMC's observed-to-expected ratio for surgical performance is better than expected. Recently, a full-time orthopedic surgeon was hired, which is expected to increase the scope of services provided and the inpatient census. Additionally, the facility does not have any difficulty recruiting and retaining staff. On a site visit to Cheyenne, Commissioners observed that the buildings at the facility are in excellent condition.

From the hearing, the Commissioners learned that closing surgery and ICUs and contracting in the community or sending patients to Denver would actually be more expensive than maintaining the current mission. Regarding the cost-effectiveness of changing the mission of the Cheyenne facility to a CAH, Dr. Michael Kilpatrick, Director of the Cheyenne VAMC, indicated that the data currently showed the Cheyenne facility provides inpatient care at below the Medicare rates. He testified that:

if we could contract for care at TriCare rates, which I think is extremely problematic, it would cost an additional \$250,000 to provide the care we provided that year. If we could contract for Medicare rates, it would cost an additional \$1.25 million for the same amount of care we provided. And, parenthetically, for just those DRGs that we treated, not for tertiary level of care, which is where Cheyenne truly excels, we would have cost the system an additional \$500,000 if we sent the patients to Denver.⁴⁶²

⁴⁶¹ Appendix D, *Data Tables*, page D-84.

⁴⁶² Dr. Michael Kilpatrick, Director of the Cheyenne VAMC, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 46.

The facility also has an affiliation agreement to train family practice residents for the University of Wyoming. During his testimony, Dr. Page, Associate Dean for Clinical Affairs at the University of Wyoming, testified, “The proposed changes in the mission of the Cheyenne VAMC would seriously damage the University of Wyoming residency training program and potentially threaten their accreditation. The Cheyenne facility has been a partner in training physicians to practice in rural Wyoming and other rural states.”⁴⁶³

Witnesses noted that there are 21 hospitals in Wyoming, 11 of which have 25 beds or less. Senator Enzi testified that using the term “critical access hospital” in Wyoming had created a significant issue in his state,⁴⁶⁴ as this is the average size of hospitals in Wyoming.

In addition, the Cheyenne VAMC has a highly effective collaboration with DoD and has provided an office in the primary care treatment area for a TriCare coordinator to facilitate the seamless treatment of active duty personnel and dependents’ authorized use of the VAMC. This collaboration includes a premier women’s clinic, which is headed by a female staff OB-GYN. In FY 2002, this clinic provided care to approximately 1,500 women: active duty, DoD dependents, and veterans. The clinic provides health care in a private and secure environment that focuses solely on womens’ health issues and is viewed as a positive addition for the medical center by patients and staff.

Veterans service organizations (VSOs) and stakeholders including the Governor’s office, both U.S. Senators, U.S. Representative, the University of Wyoming, and employees testified that changing the mission of the Cheyenne facility would have a negative impact on the community and the availability of health care in the region.

Commission Findings

- 1 Overall, workload has decreased slightly over the past 4 years. CARES projections indicate a need for 17 acute beds in FY 2012 and 14 acute beds in FY 2022.
- 2 The recent hiring of a full-time orthopedic surgeon will increase the inpatient surgical workload.
- 3 Performance on VHA quality of care measures is above average and surgical quality scores are normal.
- 4 Care at the Cheyenne VAMC is more cost-effective than either contracting or sending patients to Denver.

⁴⁶³ Dr. James A. page, Associate Dean for Clinical Affairs at the University of Wyoming, Written Testimony submitted at the Cheyenne, WY, hearing on October 23, 2003, page 3, available from [<http://www.carescommission.va.gov/Documents/CheyennePanel4.pdf>].

⁴⁶⁴ The Honorable Mike Enzi, Senator of Wyoming, Written Testimony submitted at the Cheyenne, WY, Hearing on October 23, 2003, page 1, available from [<http://www.carescommission.va.gov/Documents/CheyennePanel1.pdf>].

- 5 Changing the mission of the Cheyenne VAMC would cause many patients from Cheyenne to have to travel more than 100 miles and patients from Sheridan to travel more than 400 miles to receive care at the Denver VAMC.
- 6 The Cheyenne VAMC buildings are in excellent condition.
- 7 VISN leadership indicates recruitment and retention of professional staff are excellent, and the facility is sufficiently staffed to maintain the scope of services.
- 8 Changing the mission of the facility would have a negative impact on the University of Wyoming Health Sciences residency training programs.
- 9 Stakeholders are uniformly opposed to changing the mission of the facility.

Commission Recommendation

The Commission does not concur with the DNCP proposal that Cheyenne’s mission should be changed. The Commission recommends that Cheyenne retain its current mission due to its significant distance from other VAMCs; the high quality of care, including surgical care; the excellent condition of its buildings; the cost-effectiveness of operations; and the negative impact a mission change would have on the affiliation with the University of Wyoming and the DoD collaboration.

IV Small Facility – Grand Junction

DNCP Proposal

“Maintain acute bed sections and develop appropriate parameters (more restrictive) for types of in-house surgery procedures. Complete an evaluation to determine if ICU beds could be closed (VA external review survey).”

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

While the DNCP recommended that Grand Junction VAMC retain its current mission, the Under Secretary for Health, in his August 6, 2003 presentation to the Commission, indicated that he asked the VISN to consider converting Grand Junction to a critical access hospital. CARES data project that Grand Junction will need 24 beds in FY 2012 and 18 beds in FY 2022.⁴⁶⁵

Grand Junction is approximately 250 miles from either Denver or Salt Lake City, over mountain ranges. It is not clear that the Denver or Salt Lake City VAMCs could easily absorb the surgical or ICU workload from Grand Junction. On a site visit to the Grand Junction facility, Commissioners observed that the medical center is in good condition.

The patient satisfaction scores for this facility are higher than the national average. Grand Junction's performance is better than the average for nearly all quality measures.⁴⁶⁶ The outpatient surgical workload includes between five and eight cases per day that require general anesthesia. Grand Junction also serves as the main resource for mental health care in western Colorado. Approximately 25 percent of all inpatient episodes of care at Grand Junction are psychiatric admissions, managed on a small, efficient acute psychiatry unit. Cost data for inpatient medicine and surgical services indicate that Grand Junction's costs are lower than Medicare unit costs.⁴⁶⁷ In FY 2001, Grand Junction won the President's National Quality Award for its levels of performance outcomes.

Veterans service organizations and stakeholders testified that changing Grand Junction's mission would have a negative impact on the community and the availability of health care in the region. Mr. Todd White, National Vice Commander, The American Legion, said Grand Junction is an excellent facility and it provides care to 38,000 veterans in a 17-county area in western Colorado and eastern Utah.⁴⁶⁸

Commission Findings

- 1 Inpatient workload has generally been stable over the past four years, except for surgery, which has decreased slightly over the past three years. CARES data project that Grand Junction will need 24 beds in FY 2012 and 18 beds in FY 2022.
- 2 Performance on VHA quality of care measures is above average, and surgical quality scores are normal.

⁴⁶⁵ Appendix D, *Data Tables*, page D-87.

⁴⁶⁶ Appendix D, *Data Tables*, page D-88.

⁴⁶⁷ VISN 19, *Small Facility Analysis, Grand Junction, CO*, prepared as backup to the VISN 19 Market Plan, page 2.

⁴⁶⁸ Todd White, National Vice Commander, The American Legion, Written Testimony submitted at the Denver, CO, Hearing on September 22, 2003, page 4, available from [<http://www.carescommission.va.gov/Documents/DenverPanel3.pdf>].

- 3 Grand Junction provides mental health services, including acute inpatient services, for veterans in the western Colorado area.
- 4 Grand Junction VAMC is approximately 250 miles from the Denver and Salt Lake VAMCs.
- 5 The Grand Junction VAMC buildings are in good condition.
- 6 Stakeholders are uniformly opposed to changing the facility’s mission.

Commission Recommendation

The Commission does not concur with the DNCP proposal that Grand Junction’s mission should be changed. The Commission recommends that Grand Junction retain its current mission due to its significant distance from other VAMCs and the high quality of care.

V Small Facility and Seismic – Fort Harrison

DNCP Proposals

“*Small Facility* – Fort Harrison maintains current services. *Seismic* – The seismic condition will be improved by the construction projects at Fort Harrison.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Fort Harrison has 30 inpatient medicine beds, 10 surgery beds, and five inpatient psychiatry beds, with a current ADC of 39 that is not expected to significantly decline until at least FY 2022.⁴⁶⁹ Fort Harrison is more than 200 miles from any other VAMC. Fort Harrison is also 17th on the list of national seismic projects. Patient buildings identified at risk include the ambulatory care building and the main hospital building. During testimony, the facility director indicated that the corrections to the ambulatory care building had essentially been completed. He also indicated that, with the exception of the analysis of what needs to be done and related estimated costs, no work has been done to correct identified deficiencies in the hospital building. The projected costs for correcting problems in the main hospital are about \$24 million.

⁴⁶⁹ VSSC KLF Menu Database, *Occupancy Rate Report thru May 2003*.

Commission Findings

- 1 The main hospital building has been identified as being of Exceptionally High Risk on the list of national seismic projects.
- 2 While seismic corrections have been completed for the ambulatory care building, no work has yet begun on the main hospital building.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to maintain the current mission of the Fort Harrison VAMC.
- 2 The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

VI Inpatient Care

DNCP Proposals

“Hospital Care – Increased access for hospital care in the Eastern Rockies, Montana, Wyoming, Grand Junction, and Western Rockies markets by contracting at seven sites in VISN 19. *Tertiary Care* – Increased access for hospital care in the Eastern Rockies and Montana markets by contracting for care at three sites. *Medicine* – Increase inpatient medicine services in the Eastern Rockies market. The majority of the increasing demand will be absorbed at VAMC Denver. This is part of the replacement facility (new construction) proposal at Denver. Excess space will be demolished.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Three of the markets in this VISN have travel access gaps for hospital care: the Eastern Rockies Market, the Montana Market, and the Wyoming Market. The Grand Junction, Montana, and Wyoming markets also have gaps in access to tertiary care.

A VISN meets the travel guidelines for access to hospital care if 65 percent of veterans in a market can get to a hospital within the required timeframes. Access to hospital care for the Eastern Rockies Market

at 54 percent, the Montana Market at 20 percent, and the Wyoming Market at 34 percent do not meet the CARES standard for hospital access. The Grand Junction Market is at 70 percent and the Western Rockies Market is at 65 percent, which meet the access guidelines. In written testimony, the VISN Director indicated that there was an error in the Montana data, and the numbers should indicate current access to hospital care is 46 percent, not 20 percent, for this market.⁴⁷⁰ Tertiary care guidelines have been established at 65 percent of enrolled veterans, and the Grand Junction Market is at 61 percent, the Montana Market is at 2 percent, and the Wyoming Market is at 1 percent.⁴⁷¹

The VISN Director testified that access standards in the Eastern Rockies Market could be reached with a plan to purchase care through a sharing agreement with the DoD in El Paso County (Colorado Springs).⁴⁷² This market has a projected workload gap in inpatient medicine. Overall hospital workload for this market is projected to increase by 47 percent from the FY 2001 baseline by FY 2012. In FY 2022, medicine is projected to be 27 percent higher than the FY 2001 baseline, while surgery and psychiatry are projected to decrease 8 and 17 percent, respectively, from the FY 2001 baseline. The plan to address this increased workload is through the replacement facility at Denver.

The Montana Market's plan is to contract for inpatient care in Billings and Great Falls, MT. To improve hospital and tertiary access in Sheridan in the Wyoming Market, the VISN will contract in Billings, MT. Additionally, the VISN plans to continue to provide some inpatient care services at the Denver and Salt Lake VAMCs.

Commission Findings

- 1 The VISN will contract for hospital and/or tertiary care in the Eastern Rockies, Montana, and Wyoming markets.
- 2 Contracting will improve tertiary care access in the Montana and Wyoming markets.

Commission Recommendation

The Commission concurs with the DNCP proposal to improve acute hospital access by contracting for inpatient care in the Eastern Rockies, Montana, and Wyoming markets and for tertiary care in the Montana and Wyoming markets.

⁴⁷⁰ Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Billings, MT, Hearing on September 24, 2003, page 20.

⁴⁷¹ VISN 19 CARES Planning Initiatives, *Power Point slide show*, available from [<http://www1.va.gov/cares/page.cfm?pg=63>].

⁴⁷² Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Billings, MT, Hearing on September 24, 2003, page 40.

VII Outpatient Care

DNCP Proposals

“*Primary Care Access* – The National CARES Plan attempts to balance meeting national 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 Workload* – Increasing the primary care outpatient services in one market, and highly rural care in all markets requires new construction and conversion of space. The replacement hospital at Denver will include a large outpatient care project and a VA/DOD joint venture. *Specialty Care* – Increase specialty care outpatient services in all five markets and at all care sites. Contracting is utilized in high peak periods of growth. New construction of 359,600 square feet is planned to meet environment of care concerns and the increasing workload demand. Other solutions include renovation, conversion of existing space and leasing alternatives.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

None of the seven CBOCs proposed for this VISN were in the DNCP’s first priority group. Overall, outpatient specialty care in the VISN is projected to increase by 87 percent in FY 2012 and by 78 percent in FY 2022.⁴⁷³ All markets have a projected increase in workload in specialty care. The Eastern Rockies Market projects an increase in primary care workload. Grand Junction, Montana, and Wyoming markets fall below access to primary care requirements.

The Eastern Rockies Market has a projected increase in workload in primary and specialty care. The Denver VAMC has a current space deficit of 132,000 square feet for specialty care, a 44,000 square feet deficit for primary care, and a 25,000 square feet deficit for mental health.⁴⁷⁴ To address this, the VISN plans to construct 453,000 square feet of new outpatient space as a part of the Denver hospital replacement project.

In the Grand Junction Market, there is a projected workload increase for outpatient specialty care and the CARES Space Report indicates that there is a current space deficit of 19,000 square feet for outpatient specialty

⁴⁷³ VISN 19 CARES Planning Initiatives, *Power Point slide show*, available from [<http://www1.va.gov/cares/page.cfm?pg=63>].

⁴⁷⁴ VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

care. This report also indicates that there is a current 5,000 square feet deficit in primary care and a 2,000 square feet deficit in mental health.⁴⁷⁵ The plan is to add about 20,000 square feet of space at Grand Junction.

Access to primary care is 62 percent for the Montana Market, compared to the guidelines established at 70 percent.⁴⁷⁶ There are also projected increases in workload in primary and specialty care. Primary care access standards would have been improved with the proposed Cut Bank and Lewistown, MT, CBOCs. Even with these, the access standards would be difficult to achieve. Outpatient specialty care demand will be met through a combination of renovation and new construction. The Montana Market has projected increase in workload in mental health. Outpatient mental health demand will be met through contractual arrangements with local providers. Contracting will improve veteran access to care in the highly rural areas of the state. Most of the CBOCs proposed in this VISN have been proposed in order to improve access, as this VISN is a highly rural area.

Though access to primary care in the Western Rockies Market is 74 percent, which exceeds the 70 percent access standards, in testimony from the hearing, VSOs and Congressman Jim Gibbons expressed support for a CBOC in Elko, NV. In the Congressman's statement, he indicated that he could not "overstate the need for a community-based outpatient clinic in Elko, not only to serve the residents of the City of Elko and Elko County, but the surrounding area as well."⁴⁷⁷ This CBOC would be supported by the Salt Lake City VAMC and would also serve veterans from the far eastern portion of VISN 21. The nearest VA service to Elko, NV, is 230 miles. VISN testimony indicated, "The Elko, Nevada, CBOC would serve the largest number of veterans of any of our proposed clinics. Elko County has a veteran population of approximately 4,800 veterans."⁴⁷⁸ During the Sheridan, WY, site visit, the VSOs also strongly supported placing a CBOC in Afton, WY. Afton is approximately 200 miles from Salt Lake and 400 miles from Sheridan.⁴⁷⁹

The Western Rockies Market also has a projected increase of 72 percent in outpatient specialty care workload. The Salt Lake City VAMC has a large space deficiency of 118,000 square feet for specialty care, which is projected to increase to 137,000 square feet.⁴⁸⁰ The plan is to lease space and for new construction and conversion of existing space. In testimony, Dr. Maffet indicated that in order to address the current space gap,

⁴⁷⁵ VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

⁴⁷⁶ VISN 19 CARES Planning Initiatives, *Power Point slide show*, available from [<http://www1.va.gov/cares/page.cfm?pg=63>].

⁴⁷⁷ The Honorable Jim Gibbons, Congressman from Nevada, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 17.

⁴⁷⁸ Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 46.

⁴⁷⁹ CARES Commission Site Visit Report, VISN 19, Rocky Mountain Network, Sheridan, WY, available from [<http://www.carescommission.va.gov/Documents/SiteVisitVISN19MilesCitySheridanRivertonRifleGrandJunctionMontrose.pdf>].

⁴⁸⁰ VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

there is a critical need to open the CBOC in the West Valley of Salt Lake City to move some of the primary care and specialty care workload from the main facility. He indicated that if this CBOC were not approved, there would be need for further construction at the Salt Lake VAMC, which would be expensive,⁴⁸¹ though no cost data were provided.

The Wyoming Market's current access to primary care is 67 percent, which is slightly below the 70 percent standard. There is also a projected increase in specialty care workload. In Sheridan, there is a current gap of about 17,000 square feet for specialty care and an excess of about 9,000 square feet for primary care and mental health. The facility will convert about 6,000 square feet of existing space to support specialty outpatient care. In testimony, the VISN Director indicated that there is also a need to contract for a number of specialty services in the Sheridan community. He indicated that this, along with contracting to improve access to hospital services, had been proposed in the VISN market plan, though he noted that the DNCP did not include these plans and instead called for providing services in Denver and Salt Lake City.⁴⁸²

Commission Findings

- 1 There are projections for growth in specialty care in all five markets in the VISN, and there are current space deficits in all facilities that are projected to have increased workload. Plans are to address these gaps through CBOCs and/or new construction and renovation of space.
- 2 The Montana Market, even with the inclusion of the two proposed CBOCs, will have difficulty reaching access standards.
- 3 Outpatient mental health demand in the Montana Market will be met through contracting with local providers.
- 4 A CBOC in the city of Elko, NV, would serve residents in the surrounding area, which has a veteran population of approximately 4,800.
- 5 There is a very large outpatient space deficit at the Denver VAMC and if the plan to build a replacement facility is not realized, it is not clear how the need for increased outpatient space would be resolved. It is also not clear how the VISN will address its current space shortages until a replacement facility becomes available.
- 6 A CBOC in Afton, WY, would serve veterans who are more than 200 miles from the Sheridan VAMC and 400 miles from the Salt Lake City VAMC.

⁴⁸¹ Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 46.

⁴⁸² Dr. Ken Maffet, Acting VISN 19 Director, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 28.

- 7 The Western Rockies Market needs to move some of the outpatient care out of the Salt Lake City VAMC to avoid having to do construction at that facility. Salt Lake City has a significant current space deficit of 125,000 square feet for outpatient care and, without the ability to lease space at a new site, there appears to be no expeditious way to address the problem.
- 8 To prevent patients from having to travel significant distances one-way to see a specialist, there is a need to contract for specialty care in rural communities, such as Sheridan, Grand Junction, and Miles City.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to meet part of the future demand for more primary care, mental health, and specialty outpatient care through construction and conversion of space at current sites of care, and to increase specialty care at selected current sites of care, as well as contracting in high peak periods of growth. The Commission notes, however, that merely increasing services at existing sites of care will not resolve the access gaps in some markets.
- 2 The Commission recommends that:⁴⁸³
 - 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.

⁴⁸³ Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

VIII Enhanced Use – Salt Lake City

DNCP Proposal

“*Enhanced use leasing* is being explored at Salt Lake (Phase 2). Proposal was submitted to demolish old VA buildings and replace buildings with a new building. VA will occupy some of the space.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Phase I of an enhanced use project in Salt Lake City has been completed, and planning is underway for Phase II. Phase I consisted of the construction of an office building at the Salt Lake City medical center campus, which is currently occupied by VBA and VHA. Other renters are also being sought to occupy the remaining space in the Phase I building.

In Phase II, the proposal is to construct a 125,000 square foot joint research facility for VA and the University of Utah, which would consolidate research to one location.

In response to questions, Mr. James Floyd, Director of the Salt Lake City VAMC, indicated that although it took three to four years to work through the details to get the Phase I projects approved, he thought Phase II would go faster as some hurdles had already been cleared. He believed they would begin construction in spring 2004.⁴⁸⁴ In testimony, Dr. Lorris Betz, Dean of the University of Utah Medical School, indicated that they are looking at leasing space and doing joint research with VA at the new enhanced use site.⁴⁸⁵

Commission Findings

- 1 Salt Lake City has successfully completed one enhanced use lease project and is well underway with Phase II, using the same developer.

⁴⁸⁴ James Floyd, Medical Center Director, Salt Lake City VAMC, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 61.

⁴⁸⁵ Dr. Lorris Betz, Dean University of Utah Medical School, Transcribed Testimony from the Denver, CO, Hearing on September 22, 2003, page 210.

- 2 The University of Utah is supportive of building a single research facility and moving their research activities to the new building on the VA grounds.

Commission Recommendation

The Commission concurs with the DNCP proposal for the Phase II enhanced use project at Salt Lake City.