

VISN 20 – VA Northwest Network Alaska

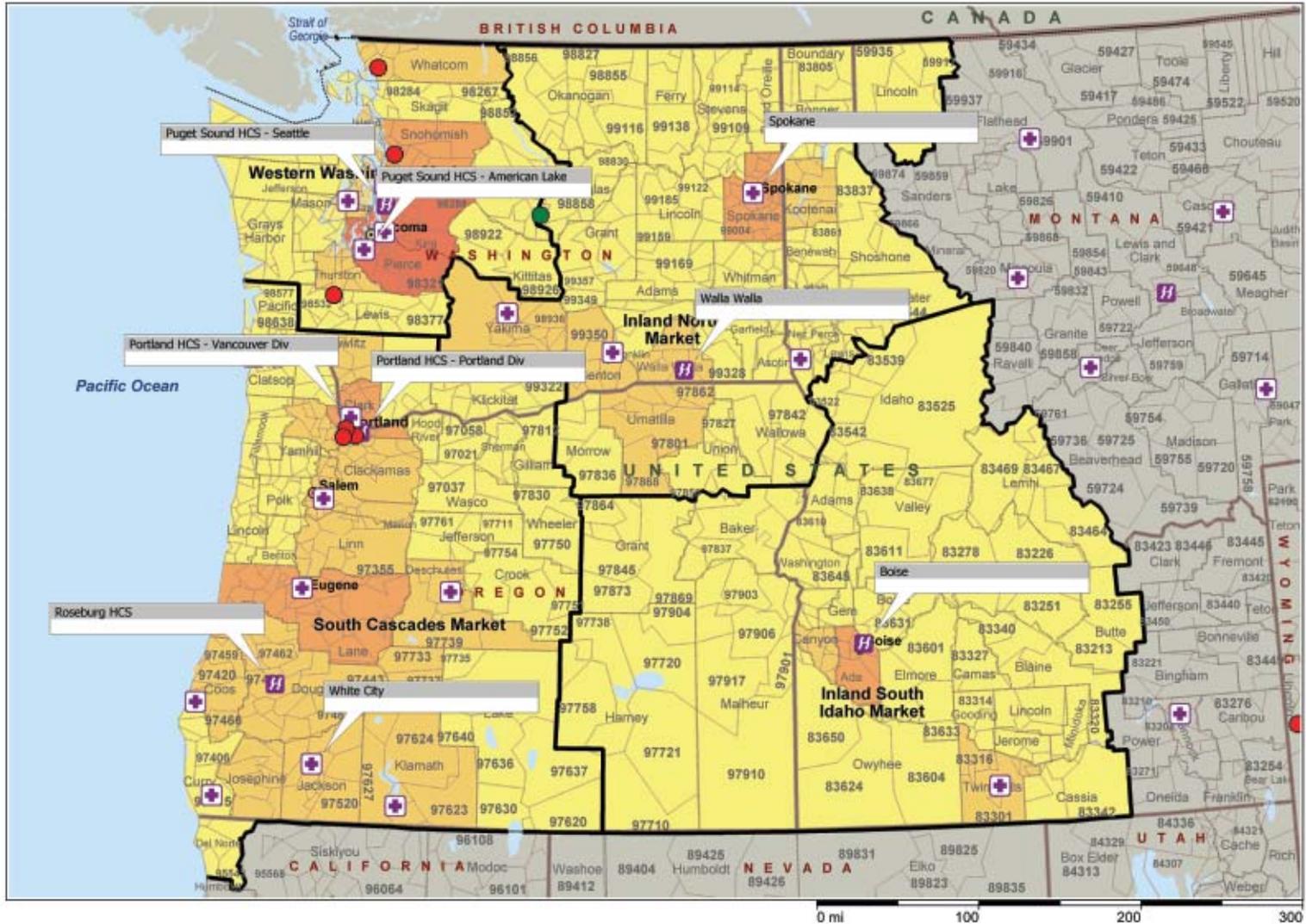
- New CBOC's**
- Priority 1
- Priority 2
- Priority 3
- 2012 Estimated Enrollees by County**
- 75,000 to 400,000
- 25,000 to 74,999
- 10,000 to 24,999
- 2,500 to 9,999
- 0 to 2,499
- Pushpins**
- 🏥 VA Hospital
- 🏥 VA Clinic



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VISN 20, Northwest Network

VISN Overview

VISN 20, Northwest Network, includes the states of Alaska, Oregon, Washington, most of the state of Idaho, and counties in northwest California and northwest Montana. The VISN facilities are spread over a geographic area that encompasses approximately 22 percent of the United States landmass. The VISN covers approximately 788,500 square miles, of which 72 percent is the state of Alaska.

The VISN delivers care through six medical centers, one independent domiciliary, one independent outpatient clinic, a mobile clinic, and 18 community-based outpatient clinics (CBOCs) with a staff of approximately 7,883 FTEs.⁴⁸⁶ The VA Northwest Network provided medical services to approximately 174,000 of the 294,000 veterans enrolled in the system in FY 2003.⁴⁸⁷ Additionally, VA operates 14 Vet Centers in VISN 20's catchment area. Total veteran population for this VISN is 1.2 million.

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 20.

VISN 20	FY 2001	FY 2012	FY 2022
Enrollees	251,090	296,944	282,121
Veteran Population	1,226,278	1,050,949	892,760
Market Penetration	20.48%	28.25%	31.60%

For the CARES process, this VISN is divided into five markets: Alaska Market (*facility*: Anchorage, AK); Inland North Market (*facilities*: Spokane and Walla Walla, WA); Inland South Market (*facility*: Boise, ID); South Cascades Market (*facilities*: Portland, Roseburg, and White City, OR); and Western Washington Market (*facilities*: Seattle and American Lake, WA).

Information Gathering

The CARES Commission visited three sites in VISN 20 and conducted three public hearings. The Commission received 6,536 public comments regarding VISN 20.

⁴⁸⁶ VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

⁴⁸⁷ VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

- ▶ *Site Visits:* Vancouver, WA, on July 16; Walla Walla, WA, on July 18; and White City, OR, on October 3.
- ▶ *Hearings:* Portland, OR, on September 26; Walla Walla, WA, on September 29; White City, OR, on October 3.

Summary of CARES Commission Recommendations

I Realignment – Vancouver

- 1 The Commission does not concur with the DNCP proposal to vacate the Vancouver campus. The Commission recommends maintaining the current mission at the Vancouver facility, while reducing the campus footprint.
- 2 The Commission recommends that VA explore options to expand Vancouver’s function, particularly with regard to relocating services from the Portland VA Medical Center.

(see page 5-322)

II Small Facility – White City Southern Oregon Rehabilitation Center Clinic

- 1 The Commission does not concur with the DNCP proposal to transfer the domiciliary and Compensated Work Therapy (CWT) programs from White City to other VAMCs. The Commission agrees with the VISN-recommended alternative that the White City SORCC maintain its current mission.
- 2 The Commission concurs with the DNCP proposal that White City should retain its outpatient services.

(see page 5-324)

III Small Facility – Walla Walla

- 1 The Commission concurs with the DNCP proposal to close the Walla Walla VAMC and, where appropriate, contract for acute inpatient medicine and psychiatry care and nursing home care in the Walla Walla geographic area. 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.

- 2 The Commission concurs with the DNCP proposal to maintain outpatient services and recommends that outpatient care be moved off the Walla Walla VAMC campus after inpatient services have been relocated.⁴⁸⁸

(see page 5-326)

IV Small Facility – Roseburg

- 1 The Commission concurs with the DNCP proposal on converting surgical beds to 24-hour surgical observation beds at Roseburg.

(see page 5-329)

V Inpatient Care

- 1 The Commission concurs with the DNCP proposal to move 15 inpatient beds from American Lake to Madigan Army Medical Center.

(see page 5-330)

VI Outpatient Care

- 1 The Commission concurs with the DNCP proposal to add a new CBOC in the Inland North Market; to increase primary care services in three other markets through VA/DoD joint ventures, new construction, and converting in-house space; to meet increased demand for mental health services in the Inland North Market in-house and through contracting; and to increase outpatient specialty care services in all five markets through two new CBOCs, new construction, in-house expansion, and contracting.
- 2 The Commission recommends that:⁴⁸⁹
 - 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.

⁴⁸⁸ General Counsel (024), Request for Opinion Regarding Legal Effect of Public Law 100-71 Provision, Under Secretary of Health (10).

⁴⁸⁹ Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

- 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 5-331)

VII VA/DoD Collaboration

- 1 The Commission concurs with the DNCP proposal on DoD initiatives and recommends the Elmendorf Air Force Base proposal be expedited due to the expiration of the lease space currently occupied by the Alaska VA Health Care System (HCS) in FY 2007.

(see page 5-334)

VIII Infrastructure and Safety

- 1 The Commission concurs with the DNCP proposal for the seismic/life safety projects in VISN 20. 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 5-336)

I Realignment – Vancouver

DNCP Proposals

“Study/develop a plan to enhance use lease the campus by contracting for nursing home care and relocating outpatient services to another location to maintain or improve access. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans.”

DNCP Alternatives

- 1 *Status quo*
- 2 *Original Market Plan*: Demolition of most of the old buildings, EUL unused acreage.
- 3 *100 Percent Contracting*
- 4 *Alternative 1*: Vacate Vancouver campus. Relocate some services to Portland, lease new space in the community, contract for some care.
- 5 *Alternative 2 [The VISN's preferred alternative]*: Demolition of old buildings creating 19.6 acres for EUL. Leave clinical services at Vancouver.

Commission Analysis

The VISN did not choose the DNCP-recommended alternative and submitted a realignment proposal that recommends maintaining current services at the Vancouver campus (rehabilitation, long-term care, outpatient primary care, mental health, and substance abuse treatment), but reducing the current campus footprint by demolishing old cantonment structures to reduce operating costs. This demolition would make 19.6 acres available for enhanced use leasing on this campus.

Vancouver is a 72-bed rehabilitation and extended care center that serves the Portland/Vancouver metropolitan area. The center's services include extended care rehabilitation, physical medicine activities (occupational therapy, physical therapy, cardiac rehabilitation, etc.), nursing home care, a skilled nursing care unit, and a new outpatient clinic that offers primary care, mental health, and substance abuse treatment. These services are not duplicated at the Portland VAMC and could not be transferred there, as the Portland VAMC is landlocked and has a significant parking deficit. Information received at site visits by the Commission and testimony from veterans and stakeholders support the data regarding the lack of capacity at the Portland VAMC, travel congestion, and limited parking at the Portland site. As the VISN Director indicated, “Vancouver

is a key component to decompressing and expanding Portland’s specialty and tertiary care capability that supports all of Oregon and to a limited extent, facilities in eastern Washington and Idaho as well.”⁴⁹⁰

The Vancouver campus also has the first enhanced use lease in VA for a single-room occupancy transitional housing unit that serves hundreds of veterans. Further EUL opportunities exist with public entities to support health care related programs and to provide housing for VISN administrative functions.

The Commission received multiple comments concerning the possible reduction of services at the Vancouver facility. The comments indicated that veterans are pleased with the service provided at Vancouver, would be harmed by the facility’s removal, and that a hardship would be caused by the need to travel to another facility.

Commission Findings

- 1 The Portland VAMC is dependent on Vancouver for providing patient care capacity.
- 2 Vancouver’s capacity continues to allow Portland to expand its specialty and tertiary care capacity and provide service for multiple markets.
- 3 Vancouver provides rehabilitation, extended care services, and other programs that the Portland VAMC does not.
- 4 The Portland campus is landlocked with significant parking deficits and topographical issues, making expansion of that facility a challenge.
- 5 The Vancouver campus provides space for outpatient services, has parking available, and decreases travel time for some veterans.
- 6 Extraneous buildings on the Vancouver campus could be demolished, making land available for the enhanced use lease program.
- 7 Traffic congestion impacts on travel time to the Portland VAMC.

Commission Recommendations

- 1 The Commission does not concur with the DNCP proposal to vacate the Vancouver campus. The Commission recommends maintaining the current mission at the Vancouver facility, while reducing the campus footprint.
- 2 The Commission recommends that VA explore options to expand Vancouver’s function, particularly with regard to relocating services from the Portland VAMC.

⁴⁹⁰ Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

II Small Facility – White City Southern Oregon Rehabilitation Center Clinic (SORCC)

DNCP Proposal

“The domiciliary and CWT programs will be transferred to other VAMCs. Maintain outpatient services. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans.”

DNCP Alternatives

- 1 *Status quo*
- 2 *Original Market Plan*: Maintain White City residential beds based on CARES projections for VISN 20 (plus Northern California and Nevada) and expand outpatient services
- 3 *100 Percent Contracting*
- 4 *Alternative 1*: Close White City campus and relocate all residential beds to American Lake. Move outpatient services to new clinic in Medford.
- 5 *Alternative 2*: Close White City campus and relocate residential beds to Roseburg. Move outpatient services to new clinic in Medford.
- 6 *Alternative 3 [The VISN’s preferred alternative]*: Maintain current programs at White City similar to the initial VISN 20 Market Plan; decrease operating beds to 500.

Commission Analysis

The White City Southern Oregon Rehabilitation Center & Clinics (SORCC) focuses on intensive psychosocial rehabilitation for patients who have failed at other rehabilitation efforts. Use of admission criteria, motivational assessment, needs-based programming, and case managers to improve outcomes has been in place since 2000. White City became a VISN referral point following the closure of the inpatient domiciliary and substance abuse programs at Portland.

Testimony at the Livermore, CA, hearing indicates that VISN 21 refers 40 percent of its domiciliary patients to the White City SORCC and has no way to provide alternative care for these patients.⁴⁹¹ In public comment by James A. Prevatt, a veteran and volunteer at the White City SORCC facility, he stated, “I have personally

⁴⁹¹ Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

witnessed people’s lives saved because of the mental health treatment there.”⁴⁹² Many other comments were received that echoed this sentiment. Max McIntosh, PhD, Deputy Director of White City, stated, “Last year, people came to us from 40 states, and we are greatly relied upon by Nevada and California, as well as the Northwest VISN.”⁴⁹³ All of the affiliate-related witnesses at the White City hearing spoke to the importance of White City in the VA health profession’s educational mission. Ms. Donna Markle, MSN, Associate Professor, Oregon Health Sciences University Nursing School (OHSU), stressed the need for clinical experiences outside acute settings to educate future nurses. She indicated that training sites like SORCC are critical if the school is to double nursing enrollment in the next five years. She also noted that OHSU recently received a grant to bring the nurse practitioner mental health program to SORCC for clinical rotations.⁴⁹⁴

The Commission noted that White City provides care for patients who have dual diagnoses and often have failed at other domiciliary programs. While the metropolitan locations are often preferable for domiciliaries, in this case, the Commission believes that the sheltered workshops provided at White City would be hard to replicate in an urban setting. The Commission also observed that the local community is very supportive of the White City SORCC.

Commission Findings

- 1 The treatment model established at White City demonstrates clinical innovation for this difficult patient population.
- 2 Rehabilitation services provided at White City are unique and provide services for veterans who have not been successful in other domiciliary programs.
- 3 The White City SORCC is a referral center for a number of VISNs.

Commission Recommendations

- 1 The Commission does not concur with the DNCP proposal to transfer the domiciliary and CWT programs from White City to other VAMCs. The Commission agrees with the VISN-recommended alternative that the White City SORCC maintain its current mission.
- 2 The Commission concurs with the DNCP proposal that White City should retain its outpatient services.

⁴⁹² James Prevatt, Veteran and SORCC Volunteer, Written Public Comment submitted on VISN 20.

⁴⁹³ Max E. McIntosh, Ph.D., Deputy Director, VA Domiciliary, Transcribed Testimony from the White City, OR, Hearing on September 26, 2003.

⁴⁹⁴ Donna Markle, MSN, Associate Professor, Oregon Health Sciences University Nursing School, Transcribed Testimony from the White City, OR, Hearing on September 26, 2003, page 59.

III Small Facility – Walla Walla

DNCP Proposal

“Maintain outpatient services and contract for acute inpatient medicine and psychiatry care (will improve hospital access in the Inland North Market) and nursing home care. The campus will be evaluated for alternative uses to benefit veterans, such as EUL for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans.”

DNCP Alternatives

- 1 *Status quo*
- 2 *Alternative 1:* Contract inpatient medicine and emergency room; inpatient mental health – limited capacity within the service area so 50 percent transfer to Spokane VAMC to outpatient and 50 percent contract. Convert residential rehabilitation and substance abuse to outpatient and lease space for programs. Lease space in community for nursing home; contract food services and laundry.
- 3 *Alternative 2:* Construct new space for ten-bed inpatient psychiatric unit. Contract inpatient medicine, emergency room, and nursing home; lease space for outpatient residential rehabilitation and substance abuse program.

Commission Analysis

The Walla Walla VAMC is located in southern Washington and sits on the grounds of what was once Fort Walla Walla. Buildings from the original fort date from the period between 1877 and 1906. Fifteen of the original buildings are still in use on the 88-acre campus. Since the campus’ infrastructure is integrated, the VISN must provide services for all of the buildings, not just those that are in use. Maintaining these excess buildings requires the use of funds that could otherwise be used for patient services. In addition, the compound, together with the remaining original fort buildings, was placed on the National Historic Register in 1974, and the realignment proposal submitted by the VISN does not indicate what could be done with these buildings. Further, the VISN Director, Dr. Leslie Burger, indicated that several of the buildings are seismically unsafe and would require millions of dollars to bring up to current standards. Finally, there is lead-based paint in the housing on the grounds. For all of these reasons, the Walla Walla campus has a very-low potential for EUL.

Walla Walla has five operating medicine beds with an ADC in FY 2003 of four, provides inpatient psychiatry with 31 operating beds with a census of 21, and operates a nursing home unit with 30 beds with an ADC of 22.⁴⁹⁵ The acute psychiatric unit includes 15 patients in residential rehabilitation and five who are acutely ill.⁴⁹⁶ Walla Walla also provides outpatient services, and in FY 2001, provided approximately 32,000 stops for primary care, 11,000 stops for specialty care, and 11,000 stops for mental health.⁴⁹⁷

Dr. Burger's testimony regarding the Walla Walla site mission change reflected the challenges of providing access to care given the highly rural nature of this area. He emphasized the importance of maintaining or improving the level of care given the change in mission at the Walla Walla site.⁴⁹⁸ Accordingly, when it comes to inpatient medicine and nursing home care, the local community in Walla Walla has options for providing this care. Dr. Burger further stated that VA staff could be accommodated in the local nursing home to which the veterans would be moved.

There would be more of a challenge in providing care for Walla Walla's psychiatric patients, as psychiatric services in the immediate Walla Walla area are presently not available. However, the Commission believes that the VISN leadership has not been aggressive enough in pursuing possible alternatives. Because the patients cared for in acute psychiatry at Walla Walla come evenly from the Tri-Cities area (Richland, Kennewick, and Pasco), Yakima, and Walla Walla,⁴⁹⁹ testimony indicated that additional exploration is needed to identify opportunities for inpatient psychiatric care. The Commission noted that a combination of solutions would probably be needed. For example, although there are two JCAHO accredited hospitals in Walla Walla and neither currently provides inpatient psychiatric care, the possibility of working with these facilities to add psychiatric care was not explored. There are also JCAHO accredited hospitals in Tri-Cities that provide psychiatric care, and the Spokane VAMC has an inpatient psychiatric unit as well.

Commission Findings

- 1 Walla Walla has a small patient census, with an ADC of four for inpatient medicine and an ADC of 21 for inpatient psychiatry. About five of these inpatient psychiatry patients are acutely ill.
- 2 Inpatient psychiatry patients come evenly from three areas: Walla Walla, Yakima, and Tri-Cities.
- 3 Alternatives to providing psychiatric care for Walla Walla's patients do not appear to have been fully explored.

⁴⁹⁵ Appendix D, *Data Tables*, page D-96.

⁴⁹⁶ Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

⁴⁹⁷ VSSC, *FY01 Baseline Workload by Treating Facility VISN 20*, Data as Provided by Milliman USA with VSSC Re-Allocation of FEE Workload to Planning Categories, updated as of December 20, 2002.

⁴⁹⁸ Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

⁴⁹⁹ Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

- a Although there are JCAHO-accredited community hospitals in Walla Walla and none provide acute psychiatric care,⁵⁰⁰ further exploration of community resources is needed regarding provision of the small amount of inpatient psychiatric services provided at the Walla Walla VAMC.
 - b Tri-Cities has JCAHO-accredited facilities that provide psychiatric care.
 - c Spokane has an inpatient psychiatric unit.
- 4 Some buildings at the Walla Walla VAMC site are seismically unsafe, and many of the buildings will require millions of dollars to renovate.
 - 5 The Walla Walla campus is not a good candidate for EUL.
 - 6 Outpatient services currently provided at the Walla Walla campus are essential to meeting access standards in this market.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to close the Walla Walla-VAMC and, where appropriate, contract for acute inpatient medicine and psychiatry care and nursing home care in the Walla Walla geographic area. 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.
- 2 The Commission concurs with the DNCP proposal to maintain outpatient services and recommends that outpatient care be moved off the Walla Walla VAMC campus after inpatient services have been relocated.⁵⁰¹

⁵⁰⁰ Appendix D, *Data Tables*, page D-96.

⁵⁰¹ General Counsel (024), Request for Opinion Regarding Legal Effect of Public Law 100-71 Provision, Under Secretary of Health (10).

IV Small Facility – Roseburg

DNCP Proposal

“Converting surgical beds to 24-hour surgical observation beds is underway in Roseburg.”

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 Roseburg VAMC serves veterans in the southern Oregon and northern California area with 88 authorized acute beds and an ADC of 67 patients. Surgical ADC has been one patient. Roseburg also has a 75-bed nursing home care unit with an ADC of 70 patients. The Roseburg VAMC provides acute care services to the White City SORCC.

In response to a question about the efficiency of having two surgical beds at Roseburg, the medical center director, Mr. George Marnell, indicated that “there is an active outpatient surgical program, and we have moved many of the procedures that ordinarily would require an inpatient stay into an outpatient setting.”⁵⁰² He also reported that they use the two beds as the exception to that rule when there are cases that “need an overnight stay in conjunction with their surgery.”⁵⁰³ When a question was raised as to whether staffing efficiency and costs allow for that, Mr. Marnell indicated that it is not a burden because surgical patients are integrated into beds on the medical wards and the same nursing staff is used, which also allows staff to keep up their competencies for surgical recovery.⁵⁰⁴

⁵⁰² George Marnell, Director of the Roseburg VAMC, Transcribed testimony at the Portland, OR, Hearing on September 26, 2003.

⁵⁰³ George Marnell, Director of the Roseburg VAMC, Transcribed testimony at the Portland, OR, Hearing on September 26, 2003.

⁵⁰⁴ George Marnell, Director of the Roseburg VAMC, Transcribed testimony at the Portland, OR, Hearing on September 26, 2003.

Commission Finding

Using available inpatient beds for the occasional surgical patient who requires a higher level of services has no negative impact on either efficiency or staffing as patients are admitted to existing empty beds on the medicine ward.

Commission Recommendation

The Commission concurs with the DNCP proposal on converting surgical beds to 24-hour surgical observation beds at Roseburg.

V Inpatient Care**DNCP Proposal**

“Western Washington Market will need to increase inpatient medicine services. VA Puget Health Care System, and Seattle, will absorb additional workload through increased in-house contract and joint venture options. A joint venture with Madigan Army Medical Center (MAMC) will involve closure of American Lake acute beds and referral of inpatient care to MAMC. Capital investments are not required.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In the Western Washington Market, the VA Puget Sound Health Care System has had an increase in demand for inpatient tertiary care and has limited room to expand. Solutions include renovation, contracting, and partnering with affiliates and other Federal agencies. The VISN Director testified, “Opportunities to partner with DoD in the South Puget Sound area cry out to be accomplished.”⁵⁰⁵

⁵⁰⁵ Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

A joint venture with MAMC involves the closure of 15 American Lake acute beds. This will free up 8,500 square feet of space at American Lake to meet outpatient service requirements. The proposal that the American Lake campus transfer its acute care patients to the tertiary care medical center at Madigan was recently selected by the VA/DoD Executive Council as a demonstration project for collaboration, and as such has support at the top levels of both departments.

Commission Finding

The collaboration agreement between MAMC and the American Lake campus of the Puget Sound VAMC is a sound approach to address the market's need for increased inpatient medicine services.

Commission Recommendation

The Commission concurs with the DNCP proposal to move 15 inpatient beds from American Lake to Madigan Army Medical Center.

VI Outpatient Care

DNCP Proposals

Primary Care – VISN 20 will increase primary care access points in the Inland North Market by adding a new CBOC site in central Washington state and enhancing the Spokane mobile clinic. This will help achieve access for more than 20 percent of veterans who will be within a 30-minute drive time of primary care. Increase the primary care outpatient services in three markets and at all care sites through planned CBOC and DoD joint ventures, new construction, and converting in-house space. *Mental Health* – Increased demand for mental health in the Inland North Market will be managed in-house and through increased contracting. Mental health and primary care services are integrated into all new CBOCs. *Specialty Care* – All five markets and all care sites will need to increase outpatient specialty care services. In all cases, approaches include expanding specialty care in-house services and contracting in high peak periods of growth. Additionally, two CBOCs will offer selected high volume specialty care services. New construction of 228,467 square feet is planned to meet access, environment of care concerns, and the increasing workload demand. Other solutions include a combination of renovation, conversion of existing space, and leasing.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Increasing primary care outpatient capacity in three markets and at all care sites in the markets will require significant recurring funding, both capital and leasing. Patients must travel great distances for care, which prompted this VISN to use telemedicine to encourage communication among staff and to provide health care services in areas such as dermatology, cardiology, mental health, spinal cord injury, and geriatrics. As VISN 20 is mostly rural, this is an effective way to provide access. The VISN Director testified:

Our greatest challenge will be to continue delivering efficient, quality health services to an ever-growing population of veterans across a very large geographic area. I would like to [also] highlight that VISN 20, at the present time, has the largest waiting list of the 21 networks, despite the fact that we have taken over 40,000 veterans off the waiting list since July of last year.⁵⁰⁶

Of the nine CBOCs proposed for this VISN, only one is classified in priority group one in the DNCP.

In the South Cascades Market, the Portland VAMC proposes to relieve the overcrowded conditions at the facility and move primary care services off the main campus by developing CBOCs in the Portland metropolitan area. Two of these CBOCs have been approved by VA Central Office, outside of the CARES process, and one in the South Metro area has yet to be approved. The Portland VAMC would then have the ability to expand inpatient and outpatient specialty care at the Portland campus. Moving outpatient workload to the Vancouver facility would allow Portland to expand its specialty and tertiary care capacity. Additionally, testimony from stakeholders regarding the Portland VAMC reflected difficulty with parking availability and travel due to the location of the medical center.

In the Western Washington Market, the VA Puget Sound Health Care System is projected to have a 120 percent increase over the FY 2001 baseline by FY 2012 and 123 percent increase by FY 2022 for outpatient specialty care with limited room to expand. Solutions include renovation, contracting, and partnering with affiliates and other Federal agencies. Stakeholder testimony reflected that either Olympia or Bellingham would be an appropriate location for a CBOC due to traffic congestion and long travel times to the Seattle VAMC.

⁵⁰⁶ Dr. Leslie Burger, VISN 20 Director, Transcribed Testimony from the Portland, OR, Hearing on September 26, 2003.

The Inland South Market also projects growth in outpatient care of approximately 12 percent over the FY 2001 baseline in FY 2012 decreasing to 6 percent over baseline in FY 2022. The DNCP calls for expansion of outpatient capacity through internal expansion and community partnering.

The Inland North Market has access gaps for primary care of 23 percent over the FY 2001 baseline by FY 2012 and decreasing to 6 percent by FY 2022, and projected growth for outpatient mental health. The only CBOC in priority group one for this VISN is in the Inland North Market. This CBOC would target a five-county area in central Washington, where veterans drive more than 150 miles to obtain care. Testimony also claimed that the area is medically underserved and that access to care can only be met through the use of CBOCs because of electronic limitations in these geographic locations.

The Spokane VAMC operates a mobile clinic and currently has no CBOCs. The need for outpatient mental health care is projected to grow in the Inland North Market by 42 percent, with 21,000 additional or 71,000 total stops by FY 2012 and then decrease to 13 percent over baseline by FY 2022. This mobile clinic represents an alternative method for delivering health care to rural communities, but does not replace the need for CBOCs in this market.

Commission Findings

- 1 All five markets will expand outpatient specialty care capacity through expansion of in-house capacity and contracting.
- 2 The Portland VAMC in the South Cascades Market needs to move primary care services off the main campus. Two CBOCs have been approved for the metropolitan Portland area and one CBOC in the South Metro area remains to be approved outside the CARES process.
- 3 The Western Washington Market has an increase in demand for outpatient specialty care. Veterans in Olympia and Bellingham in particular are faced with traffic congestion problems that enhance the need for CBOCs in these areas.
- 4 The Inland North Market has a primary care access gap.
- 5 The Spokane VAMC operates a mobile clinic to help meet the needs of this highly rural area.
- 6 Mental health services are currently provided in some CBOCs.
- 7 The VISN uses telemedicine to encourage staff communication and to provide health care services.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to add a new CBOC in the Inland North Market; to increase primary care services in three other markets through VA/DoD joint ventures, new construction, and converting in-house space; to meet increased demand for mental health services in the Inland North Market in-house and through contracting; and to increase outpatient specialty care services in all five markets through two new CBOCs, new construction, in-house expansion, and contracting.
- 2 The Commission recommends that:⁵⁰⁷
 - 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.

VII VA/DoD Collaboration

DNCP Proposal

“The proposed collaborations between VA and DoD include: 1) a pilot VA/DoD demonstration site with American Lake Division, VA Puget Sound Health Care System, and Madigan Army Medical Center;

⁵⁰⁷ Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

2) ongoing collaboration efforts with Everett Naval Hospital, Bremerton Naval Hospital, and Oak Harbor Naval Hospital; and 3) VA Alaska HCS is planning for expanded sharing/integration with both Bassett Army Community Hospital and Elmendorf Air Force Base in order to meet demand projections in both Fairbanks and Anchorage.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

During testimony, the Commission heard about the close working relationship between VA and DoD in this VISN.

The American Lake campus of the Puget Sound Health Care System has proposed a pilot collaboration with MAMC. The plan calls for the relocation of 15 American Lake medicine beds and all emergency room services to MAMC. In return, VA staff will provide service at Madigan. (See Inpatient Care, above, for a fuller discussion.)

Ongoing collaboration with Everett Naval Hospital, Bremerton Naval Hospital, and Oak Harbor Naval Hospital includes partnering to provide medical and surgical outpatient and inpatient care, emergency medical care, mental health services, geriatrics, gynecology services, and pharmacy, radiology, and laboratory services.

In the Alaska Market, Dr. Burger testified that VA has outgrown its leased space in Anchorage. The lease was very expensive, and it will expire in 2007. This facility coordinates care for the whole state. A major construction project is proposed as a joint venture collocation with the Air Force at Elmendorf Air Force Base (AFB), including constructing a building adjacent and connected to the Elmendorf Hospital. This new facility would increase primary care space by 75 percent, specialty care space by 100 percent, and mental health space by 100 percent.⁵⁰⁸ The Commission heard repeatedly through testimony that expeditious action must be taken on this proposal due to the expiring lease at the current location.

The Army provides VA space at the Bassett Army Community Hospital in Fairbanks, AK, where VA operates the Fairbanks CBOC. Bassett also provides pharmacy support for the CBOC. The Army is constructing a new hospital facility scheduled for completion in FY 2005. The VA clinic will gain an additional 1,100 square feet for a total of 3,000 square feet as part of this construction.

⁵⁰⁸ CARES Commission Site Visit Report, VISN 20, VA Northwest Health Network, Vancouver, WA, available from [<http://www.carescommission.va.gov/Documents/SiteVisitVISN20PortlandVancouver.pdf>].

Commission Findings

- 1 There is ongoing collaboration with Everett Naval Hospital, Bremerton Naval Hospital, and Oak Harbor Naval Hospital to provide selected care.
- 2 The Alaska Market has outgrown its leased space and a joint venture has been proposed at Elmendorf AFB in Anchorage, AK. Expeditious action must be taken on this joint venture to address the leased space issue in Anchorage.
- 3 The Army is constructing a new facility at the Bassett Army Community Hospital in Fairbanks, AK, and the VA clinic will gain space for its outpatient clinic with this new construction.
- 4 The American Lake campus, in collaboration with MAMC, plans to relocate 15 American Lake medicine beds and all emergency room services to MAMC.
- 5 The VA/DoD collaboration in this VISN is very effective.

Commission Recommendation

The Commission concurs with the DNCP proposal on DoD initiatives and recommends the Elmendorf Air Force Base proposal be expedited due to the expiration of the lease space currently occupied by the Alaska VA HCS in 2007.

VIII Infrastructure and Safety**DNCP Proposal**

“Seismic conditions will be improved through proposed construction projects at Portland, American Lake, Seattle, White City, and Roseburg.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN has seismic construction issues at Roseburg (inpatient), White City (residential domiciliary), American Lake (NHCU, research, outpatient mental health, and main hospital building), Seattle (ambulatory/administration building and research), and Portland (main hospital building and administration/research building). Complete cost data is not available for seismic improvements at all facilities.

Commission Finding

Seismic construction projects are needed at Roseburg, White City, American Lake, Seattle, and Portland.

Commission Recommendation

The Commission concurs with the DNCP proposal for the seismic/life safety projects in VISN 20. 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.