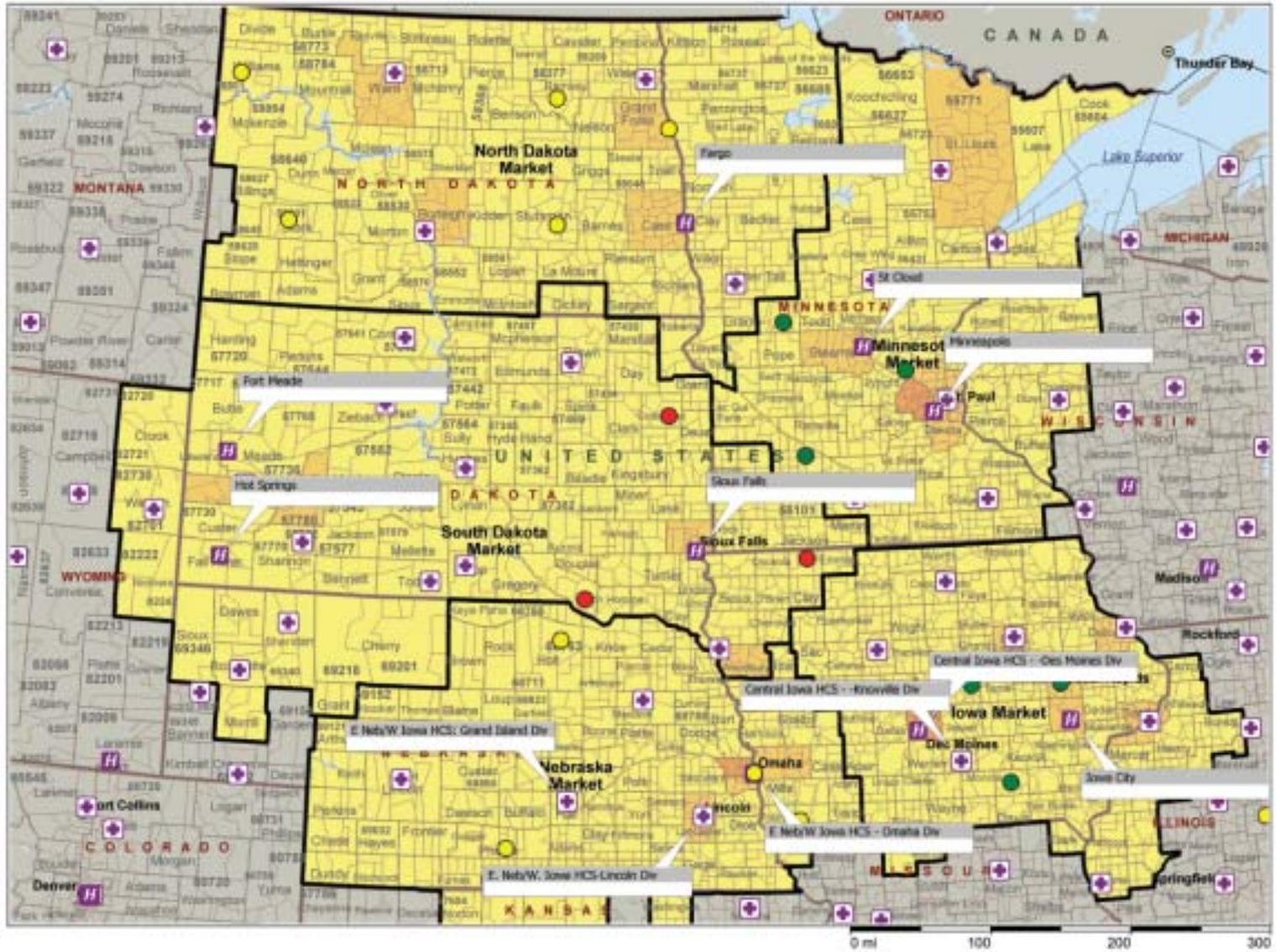


VISN 23 - VA Upper Midwest Health Care System

- 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 23, VA Midwest Health Care Network

VISN Overview

VISN 23, VA Midwest Health Care Network, is an integrated, comprehensive health care system that geographically spans nearly 390,000 square miles and includes a veteran population of approximately 1.16 million. The majority of the VISN is rural with only three large urban areas (Minneapolis-St. Paul, MN; Des Moines, IA; and Omaha, NE). The VISN covers nearly all of Iowa, Minnesota, Nebraska, North Dakota, and South Dakota and includes some counties in Wisconsin, Illinois, Missouri, Kansas, and Wyoming. In FY 2003, the 8,907 FTEs⁵⁷⁰ for this VISN provided services to approximately 232,000 and, as of September 30, 2003, there were a total of approximately 344,000 enrollees, 32,500 of whom were new to VA in FY 2003.⁵⁷¹ VISN 23 delivers health care services through nine medical centers, seven nursing homes, four domiciliaries, and 35 community-based outpatient clinics (CBOCs). Additionally, VA operates 12 Vet Centers in VISN 23'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 23.

VISN 23	FY 2001	FY 2012	FY 2022
Enrollees	290,458	289,143	257,068
Veteran Population	1,160,866	938,152	757,962
Market Penetration	25.02%	30.82%	33.92%

For the CARES process, this VISN is divided into five markets: the Iowa Market (*facilities*: Iowa City, Knoxville, and Des Moines, IA); the Minnesota Market (*facilities*: Minneapolis and St. Cloud, MN); the Nebraska Market (*facilities*: Omaha and Grand Island, NE); the North Dakota Market (*facility*: Fargo, ND); and the South Dakota Market (*facilities*: Sioux Falls, Hot Springs, and Fort Meade, SD).

⁵⁷⁰ VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

⁵⁷¹ VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

Information Gathering

The CARES Commission visited four sites in VISN 23 and conducted two public hearings.

The Commission received 357 public comments regarding VISN 23.

- ▶ *Site Visits:* Hot Springs, SD; Fort Meade, SD; Knoxville, IA; and Des Moines, IA, on July 8 through 11.
- ▶ *Hearings:* Minneapolis, MN, on September 3; and Omaha, NE, on September 4.

Summary of CARES Commission Recommendations:

I Small Facility and Campus Realignment – Knoxville and Des Moines, IA

- 1 The Commission concurs with the DNCP proposal to move all inpatient services to Des Moines and to retain outpatient services at Knoxville, provided there are safeguards in place to ensure that no VA-operated long-term care (LTC) in the VISN is lost nor the capacity to care for the patients now being treated at Knoxville.
- 2 The Commission recommends that acute inpatient mental health services should be provided with other acute inpatient services whenever feasible.
- 3 The Commission recommends that:⁵⁷²
 - a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
 - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
 - c Domiciliary care programs should be located as close as feasible to the population they serve.
 - d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-390)

II Small Facility and Campus Realignment – Hot Springs, SD

- 1 The Commission does not concur with the DNCP proposal to change the mission of the Hot Springs campus to that of a critical access hospital (CAH). The Commission recommends that VA establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this designation.

⁵⁷² Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

- 2 The Commission recommends that Hot Springs retain its current mission to provide acute inpatient medical, domiciliary and outpatient services.

(see page 5-393)

III Small Facility – St. Cloud

- 1 The Commission concurs with the DNCP proposal to maintain inpatient acute psychiatry, domiciliary, nursing home, and outpatient services at St. Cloud. The Commission concurs with transferring medicine beds from St. Cloud to Minneapolis and with contracting in the community.
- 2 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-395)

IV Inpatient Care

- 1 The Commission concurs with the DNCP proposal to contract for acute hospital and tertiary hospital care in the community to improve access to hospital and tertiary care for veterans in this VISN.
- 2 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
- 3 The Commission concurs with the DNCP proposal that construction and renovation for the purpose of modernization proceed at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities.

- 4 The Commission concurs with the DNCP proposal regarding the need to upgrade the existing LTC unit at Grand Island. The Commission recommends that:⁵⁷³
- a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
 - b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
 - c Domiciliary care programs should be located as close as feasible to the population they serve.
 - d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-397)

V Outpatient Care

- 1 The Commission recommends that:⁵⁷⁴
- 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.

⁵⁷³ Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

⁵⁷⁴ Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

- 2 The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space needs at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities.

(see page 5-400)

VI Enhanced Use and Collaboration with VBA

- 1 The Commission concurs with the DNCP proposal for enhanced use leasing (EUL) projects for VISN 23.
- 2 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-403)

VII Special Disability Programs – Spinal Cord Injury/Disorder Unit at Minneapolis

- 1 The Commission concurs with the DNCP proposal to build a new 30-bed SCI/D unit in Minneapolis.
- 2 VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

(see page 5-404)

I Small Facility and Campus Realignment – Knoxville and Des Moines

DNCP Proposal

“Knoxville will maintain outpatient services, and all inpatient care, including acute care, long-term care, and domiciliary will be transferred to the Des Moines campus. A new 120-bed nursing home is proposed at Des Moines to replace the 226 nursing home beds at Knoxville.”

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 VA Medical Centers (VAMCs).

Commission Analysis

Both Knoxville and Des Moines were identified as small facilities, as both are projected to need fewer than 40 acute inpatient beds in FY 2012 and FY 2022. These facilities were also selected for campus realignment as they are under a single leadership and are both part of the Central Iowa Health Care System (HCS). There are currently 260 authorized beds at Knoxville with an average daily census (ADC) of about 217. This includes an ADC of six intermediate medicine, eight acute psychiatry, 32 domiciliary, and 171 nursing home patients.⁵⁷⁵ Knoxville is projected to need 26 acute beds in FY 2012 and 20 in FY 2022.⁵⁷⁶ Knoxville also includes a 30-bed acute rehabilitation unit that is Commission for Accreditation of Rehabilitation Facilities (CARF) accredited. In FY 2003, Des Moines had an ADC of 23 for inpatient medicine, and is projected to need 34 acute beds in FY 2012 and 24 in FY 2022. Workload is projected to decrease to an ADC of 14 by FY 2022. Workload in Knoxville for inpatient medicine was projected to peak in FY 2003 with an ADC of 10, and to decrease to an ADC of 6 by FY 2022. Workload for inpatient psychiatry is projected to peak in FY 2004 at an ADC of 14, and to taper off to 10 by FY 2022.⁵⁷⁷

⁵⁷⁵ Appendix D, *Data Tables*, page D-105.

⁵⁷⁶ Appendix D, *Data Tables*, page D-105.

⁵⁷⁷ CARES Portal, VISN 23, Workload by Year Report.

During the site visit, the Commission noted that many of the current recipients of care at Knoxville are from the Des Moines metropolitan area. Also, the Commission noted that many of the current patients in Knoxville are very ill and have multiples diagnoses, including longstanding psychiatric disorders. These patients would be very difficult to place in the community or in State Veterans Homes.⁵⁷⁸ During the site visit, the State Home Director indicated that she could take more VA patients, but when questioned, indicated that the State Home does not accept many of the kinds of patients currently cared for at the Knoxville facility.⁵⁷⁹ No other VA facility in the Iowa Market provides long-term mental health services. Many patients at Knoxville come from larger urban areas including Des Moines, Iowa City, Sioux Falls, and Omaha.

Donald Cooper, Director of the Central Iowa HCS, indicated that he was convinced there would be significant savings and a significant payback if facilities were moved from Knoxville and built in Des Moines.⁵⁸⁰ Dr. Bruce Sieleni, Director of the Mental Health Service Line, stated that in order to improve coordination and quality of care, both acute and long-term psychiatry, should be located with other acute services in Des Moines.⁵⁸¹ A number of concerns with the condition of the Knoxville buildings, including life safety and environment of care issues, were identified during the site visit. Also, nursing home care units do not meet community standards, and privacy standards are minimally met. Many patient care buildings do not have air conditioning,⁵⁸² have JCAHO waivers for life safety standards, and do not meet JCAHO psychiatric safety standards for suicide prevention.

Life-cycle costs indicate that there would be about \$114 million in net savings in life-cycle costs by moving Knoxville inpatient and nursing home services to Des Moines and building a new 120-bed nursing home at Des Moines. Construction and renovation costs of \$31.3 million are estimated for Des Moines.

There likely will be an economic impact on the community of Knoxville if inpatient services are moved to Des Moines. Jeffrey LuGarce, the City Manager of Knoxville, said in testimony that “the Knoxville VA is our second-largest employer.”⁵⁸³ A number of other stakeholders in and around Knoxville and employees from Knoxville were opposed to closing inpatient services in Knoxville. According to medical center leadership, most Knoxville VAMC employees would be offered jobs in Des Moines. The Des Moines campus is slightly more than 35 miles from Knoxville.

⁵⁷⁸ CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 4.

⁵⁷⁹ CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 5.

⁵⁸⁰ Donald Cooper, Director, Central Iowa Health Care System, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, page 33.

⁵⁸¹ CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 2.

⁵⁸² CARES Site Visit Report; Knoxville and Des Moines, IA, July 10-11, 2003, page 3.

⁵⁸³ Jeffrey LuGarce, City Manager of Knoxville, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, page 67.

Veterans service organizations (VSOs) and stakeholders, including Senator Grassley’s office and employees from Des Moines, noted concerns related to ensuring that access is maintained. Commissioners agreed that moving inpatient services from Knoxville to Des Moines was in keeping with the principle regarding access, but expressed concern that the DNCP calls for the construction of fewer LTC beds than are currently being used.

Commission Findings

- 1 Placing acute psychiatry with other acute care services will improve the coordination of care.
- 2 Moving the domiciliary patients to Des Moines will increase the percentage of residents who are closer to their homes and families.
- 3 Site visits to Knoxville indicated that the condition of some of the buildings is poor and there are JCAHO waivers for life safety and psychiatric issues.
- 4 Moving inpatient care to Des Moines would have some impact on the community of Knoxville, as VA is the second largest employer in town.
- 5 VSOs and stakeholders’ concerns are related to ensuring that access is maintained.
- 6 The plans to build a 120-bed nursing home to replace the existing long-term care beds at Knoxville that currently have an ADC of 171 calls into question where the VISN plans to provide the 80 additional VA operated inpatient beds.
- 7 Many of the patients currently cared for in the Knoxville VAMC will be difficult, if not impossible, to place in a community setting.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to move all inpatient services to Des Moines and to retain outpatient services at Knoxville, provided there are safeguards in place to ensure that no VA-operated LTC beds in the VISN is lost nor the capacity to care for the patients now being treated at Knoxville.
- 2 The Commission recommends that:⁵⁸⁴
 - 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.

⁵⁸⁴ Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

- 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 Small Facility and Campus Realignment – Hot Springs

DNCP Proposal

“The Hot Springs division of the Black Hills HCS identified the concept of the critical access hospital (CAH) in their small facilities proposal. The National CARES Program Office fully endorsed the CAH concept where Hot Springs would begin converting their hospital length of stay to no greater than 96 hours, maintain bed levels below 15, and maintain a strong link to their referral network.”

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

By 2022, the inpatient workload in the South Dakota Market (Hot Springs, Fort Meade, and Sioux Falls) is projected to decrease by about 45 percent. Hot Springs, which is a part of the Black Hills HCS, was identified as a small facility as it is projected to need 23 acute beds by FY 2012 and 20 by FY 2022. The Hot Springs ADC was 10 in FY 2003 and has shown a steady decrease since FY 2000 when the ADC was slightly higher than 17. The facility is authorized for one surgical bed but has had no inpatient surgical census since FY 2000, though Hot Springs does do about ten ambulatory surgeries per day.⁵⁸⁵ Additionally, the facility has 160 domiciliary beds with an ADC of 143 in FY 2003, which is an increase

⁵⁸⁵ CARES Site Visit Report; Hot Springs and Fort Meade, SD, July 8-9, 2003, page 3.

from the 130 ADC in FY 2000.⁵⁸⁶ Quality of care and customer satisfaction scores are generally higher than the national average for Fort Meade and Hot Springs.⁵⁸⁷

Native Americans are the largest minority in the VISN and are medically underserved. Many have multiple health problems and difficulty with transportation to care. One area of focus of Hot Springs is outreach to reservations. About 25 percent of Hot Springs' patients are Native American. One CBOC is located between two reservations and serves a primarily Native American Community. A new PTSD clinic has recently been opened on the Rosebud Reservation. Market penetration for Fall River County where the Hot Springs facility is located is about 77 percent and is similar in the counties just to the south where the Pine Ridge and the Rosebud Indian Reservations are located. Indian Health Service provides only primary care services and contracts for all specialty care. Native American veterans in the area are very dependent on the Hot Springs VA for their care.⁵⁸⁸

The nearest community hospital is in Rapid City, more than 60 miles away, and the nearest VA facility, Fort Meade, is more than 100 miles away. The only other medical center in Hot Springs was closed and, though it reopened recently, the Director of the Black Hills Health Care System said:

The community hospital once existed in Hot Springs, closed in 1998. Once critical access was recognized and funded by Medicare, it reopened in 2001. Currently, it's a ten-bed critical access hospital, does not have a 24-hour emergency room. Number one, they're not JCAHO accredited as many small critical access hospitals aren't.⁵⁸⁹

About 40 percent of Hot Springs' enrollees come from northwestern Nebraska and receive most of their care in Hot Springs. Should Hot Springs change its mission, they would have to travel another 100 miles for services. The Hot Springs campus provides services for the community, including all dialysis and some emergency care, and inpatient and outpatient health care services on a contracted basis for the Hot Springs State Veterans Home, the only State Veterans Home in South Dakota. VSOs and stakeholders, including the Governor's office and VA employees, testified that changing the mission of the Hot Springs campus would have a negative impact on the community and the availability of health care in the Hot Springs area. Mr. Dennis Foell, Director of the South Dakota Division of Veterans Affairs, stated:

We have concerns about the Hot Springs VA Medical Center in western South Dakota. This facility serves rural veterans in southwest South Dakota, northwestern Nebraska and

⁵⁸⁶ Appendix D, *Data Tables*, page D-111.

⁵⁸⁷ Appendix D, *Data Tables*, page D-112.

⁵⁸⁸ CARES Site Visit Report; Hot Springs and Fort Meade, SD, July 8-9, 2003, page 3.

⁵⁸⁹ Joseph Dalpiaz, Director of the Black Hills Health Care System, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, pages 33-34.

eastern Wyoming, besides the care provided to the rural veterans in these area, Hot Springs also provides care for the 130 to 150 residents at the Michael J. Fitzmaurice South Dakota State Veterans Homes.⁵⁹⁰

Commission Findings

- 1 There is one non-JCAHO-accredited private sector facility within 60 minutes of the Hot Springs VAMC, with little capacity. No VAMCs are within 60 minutes of Hot Springs.
- 2 The Hot Springs VAMC currently provides dialysis and some emergency care for the community.
- 3 The Hot Springs community, the State Veterans Home, Native American veterans, and residents of the VA domiciliary are dependent on the Hot Springs VAMC beds for critical services.
- 4 Customer satisfaction scores and quality of care scores for inpatient and outpatient services at Hot Springs are above the national average.
- 5 VSOs and stakeholders are opposed to changing the mission at Hot Springs.

Commission Recommendations

- 1 The Commission does not concur with the DNCP proposal to change the mission of the Hot Springs campus to that of a CAH. The Commission recommends VA establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this designation.
- 2 The Commission recommends that Hot Springs retain its current mission to provide acute inpatient medical, domiciliary, and outpatient services.

III Small Facility – St. Cloud

DNCP Proposal

“Maintain acute psychiatry, domiciliary, other mental health, and outpatient services. Acute medicine is transferred to Minneapolis and contracts in local community.”

DNCP Alternatives

- 1 Retain acute hospital beds.

⁵⁹⁰ Dennis Foell, Director of the South Dakota Division of Veterans Affairs, Written Testimony submitted at the Minneapolis, MN, Hearing on September 3, 2003, page 2.

- 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 St. Cloud VAMC, which is primarily an extended care facility, was identified as a small facility as it is projected to require 26 acute beds in FY 2012 and 18 in FY 2022. St. Cloud is approximately 70 miles from the Minneapolis VAMC over an interstate highway. Overall acute inpatient workload in the Minnesota Market (Minneapolis and St. Cloud) is projected to decrease 6 percent by 2012, and 30 percent by FY 2022 over the FY 2001 baseline.

For the past 2 years, as a part of a pilot program, all inpatient medicine beds have been closed at St. Cloud and about one-half of these patients have been transferred to Minneapolis for care; the other half are treated under a contract in the local community. In St. Cloud, there are 40 operating beds in psychiatry, with an ADC of 39 (98 percent occupancy).⁵⁹¹ Approximately ten of these beds appear to be acute psychiatry beds, and the other 30 have longer lengths of stay. The VISN market plan indicated that there is a need to retain the acute psychiatry beds in St. Cloud because the Minneapolis VAMC does not have the capacity to absorb this work. The St. Cloud VAMC also has 123 authorized VA domiciliary beds, and its ADC has decreased from 107 in FY 2000 to fewer than 93 in FY 2003. It also has 220 authorized nursing home care unit beds, and the ADC has decreased from 211 in FY 2000 to about 204 in FY 2003.⁵⁹² Inpatient psychiatry is projected to increase in this market by 29 percent (nine beds) in FY 2012 and to then decrease by about 13 percent (four beds) from the FY 2001 baseline in FY 2022. At the Minneapolis VAMC, there are currently 25 operating beds in acute psychiatry, with an ADC of 15 (60 percent occupancy).⁵⁹³

Quality of care scores for outpatient medicine indicate that St. Cloud is better than the national average on most quality measures. Its inpatient customer satisfaction scores are below the national average, while its outpatient satisfaction scores are above the national average.

There would be no economic impact on employees or the community from this DNCP proposal because the changes have been in place for 2 years as a part of a pilot project. Testimony and comments encourage further contracting in the community.

⁵⁹¹ Appendix D, *Data Tables*, page D-108.

⁵⁹² Appendix D, *Data Tables*, page D-108.

⁵⁹³ Appendix D, *Data Tables*, page D-108.

Commission Findings

- 1 The plan as recommended in the DNCP has already been implemented at the St. Cloud VAMC on a pilot basis with few problems or concerns.
- 2 Workload is generally increasing in psychiatry in St. Cloud and remains about the same in Minneapolis. Both domiciliary and nursing home workload has decreased slightly over the past four years.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to maintain inpatient acute psychiatry, domiciliary, nursing home, and outpatient services at St. Cloud. The Commission concurs with transferring medicine beds from St. Cloud to Minneapolis and with contracting in the community.
- 2 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

IV Inpatient Care

DNCP Proposals

“Hospital Care – Access to VA hospital care will improve in the Iowa, Minnesota, North Dakota, and South Dakota markets through community contracts at 11 sites. *Tertiary Care* – Tertiary care access will improve for veterans in the North Dakota Market by contracting for care in Bismarck and Minot. *Medicine* – The VISN will also transfer some medicine from in-house care to contract care to improve hospital access for veterans. The VISN proposes significant capital investments for tertiary care ICUs, monitored beds, and overall facility conditions. *Surgery* – Inpatient surgery services will decrease in the Minnesota Market, resulting in a tremendous shift from inpatient to outpatient care. As a result, space will be realigned from inpatient to outpatient specialty care at VAMC Minneapolis. *Extended Care Grand Island* – The renovation of 26,806 square feet in Nebraska market (Grand Island) is planned.”

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Four of the five markets in this VISN do not meet the CARES standard at 65 percent for access to hospital care. Access ranges from 37 percent in North Dakota to 70 percent in Nebraska, though the latter meets the standard.⁵⁹⁴ Dr. Petzel, VISN Director, testified that the plan is to provide emergent hospitalization at the inpatient facility closest to the veteran's home and tertiary care at the nearest advanced care facility, and to transfer the patient to a VA facility as soon as he/she is stable. The North Dakota Market also has a gap in access to tertiary care, with only 32 percent of enrollees having access within the driving guidelines (the threshold is 65 percent).⁵⁹⁵

Compounding the issue for a need to increase access to hospital care is the concurrent projected decrease in the need for overall inpatient beds in all five markets. Inpatient medicine and surgery are projected to decrease from the FY 2001 baseline by FY 2012, and to decrease further by FY 2022. Inpatient psychiatry is projected to increase in all five markets by FY 2012, and to return to FY 2001 baseline levels by FY 2022.

Renovation or new construction of inpatient space is planned at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities. Renovation of inpatient space at Fargo is nearing completion.⁵⁹⁶ With the exception of Des Moines, life-cycle costs were not provided for renovation or new construction.

The VISN has identified the need to renovate the nursing home care unit at Grand Island as one of its top priorities. The workload report at Grand Island for intermediate and LTC indicates the current ADC is 54 with 76 operating beds. No workload projections were provided for LTC. The VISN Director testified that the VISN is:

...in the process of renovating the nursing home in Grand Island. It's at the top of the list right now of projects; we're expecting the funding to come shortly. So that's a viable program; it's going to be there for as far in the future as we can see and there is no plan to diminish it, and right now there are no plans to expand it either.⁵⁹⁷

⁵⁹⁴ VISN 23 Market Plan for Capital Asset Realignment for Enhanced Services; VISN Level Information; Section 5-e.

⁵⁹⁵ VISN 23 Market Plan for Capital Asset Realignment for Enhanced Services; VISN Level Information; Section 5-e.

⁵⁹⁶ Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 14. Also from the Omaha, NE, Hearing on September 4, 2003, pages 17-18.

⁵⁹⁷ Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, pages 31-32.

Commission Findings

- 1 There are access-to-hospital-care gaps in four of the five markets and a simultaneous projected overall decrease in the need for acute inpatient beds. There is a need to balance improved access with maintaining an adequate inpatient census to sustain the viability and cost-effectiveness of some of this VISN's medical centers.
- 2 There is a reasonable plan to provide hospital and tertiary care to address access through contracts in the VISN.
- 3 Much of the inpatient space in many of the medical centers in the VISN have not been updated or renovated for many years.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to contract for acute hospital and tertiary hospital care in the community to improve access to hospital and tertiary care for veterans in this VISN.
- 2 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
- 3 The Commission concurs with the DNCP proposal that construction and renovation for the purpose of modernization proceed at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities.
- 4 The Commission concurs with the DNCP proposal regarding the need to upgrade the existing LTC unit at Grand Island. The Commission recommends that:⁵⁹⁸
 - 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.

⁵⁹⁸ Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

V Outpatient Care

DNCP Proposal

“*Primary Care* – Primary care access will be improved in two markets with seven new CBOCs for the Iowa and the Minnesota markets included in the plan. The DNCP attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, new access points in the Nebraska, North Dakota, and South Dakota markets are in the National Plan; however, they are not in the high implementation priority category at this time. *Primary Care Workload* – Primary care outpatient services will increase in five markets. Planned CBOCs in the Iowa and Minnesota markets, new construction and internal conversion will help improve access. The new CBOCs planned will be leased sites or contract care. In-house expansions will occur through capital investments in renovation, conversion, and new construction. *Specialty Care* – Specialty care outpatient services will increase in four markets and at all care sites. Contracting is utilized in high peak periods of growth. New construction of 171,000 square feet is planned in VISN 23 to meet access initiatives, 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

All five markets in this VISN do not meet the CARES standard for access to primary care. Gaps range from a high of 53 percent of enrolled veterans who have access within the driving distance standard in the Minnesota Market to a low of 37 percent in the North Dakota Market.⁵⁹⁹ The DNCP includes a total of 21 CBOCs for this VISN, eight of which are in the DNCP’s priority group one: the four proposed CBOCs in the Minnesota Market and the four in the Iowa Market. The six CBOCs proposed in the North Dakota Market, the three in the South Dakota Market, and three of the four proposed in the Nebraska Market are included in the priority group two. Two of the CBOCs, including the Offutt clinic, are proposed to address capacity issues at Minneapolis and Omaha. The others are proposed to improve access in all markets. A fourth proposed CBOC in the Nebraska Market at Bellevue, while identified as included in priority group two, is actually a collaboration with DoD at Offutt AFB, which automatically elevates this CBOC to priority group one.

⁵⁹⁹ VISN 23 Market Plan for Capital Asset Realignment for Enhanced Services; VISN Level Information; Section 5-e.

In Nebraska, North Dakota, and South Dakota, many veterans currently must travel more than 100 miles to receive primary care. Mr. David Parr, Veterans of Foreign Wars: “There’s a large segment of the population of South Dakota made up of veterans who are entitled to VA health care services. Because South Dakota is generally a rural area, many veterans must travel as far as 250 miles one way in order to receive that care.”⁶⁰⁰

When the VISN Director was asked in hearings to delineate his top three priorities under CARES, he said, “Community-based outpatient clinics would be number, [one] two, three, four, and five.”⁶⁰¹ During the site visits, the VISN Director indicated that he did not believe that the VISN would be able to meet the CARES access standards even if all the CBOCs were opened nor did he believe that it was practical to be able to meet the guidelines given the highly rural nature of some counties in the VISN.⁶⁰² Commissioners also were advised that much of North Dakota, South Dakota, and western Nebraska is designated as medically underserved.

Local VSOs stated that they travel 100 to 150 miles one-way to see a primary care provider. They also reported that some CBOCs in South Dakota and northwestern Nebraska are closed to new enrollees and that they would like to see more staff hired in those clinics so that they would not have to travel to Hot Springs for primary care.

More than 85 percent of the 357 public comments received for this VISN concern access, including the addition of new CBOCs and where they should be placed. Complicating the issue of increased access to primary care, however, is the concurrent projected decrease in the need for overall primary care in three of the five markets in this VISN. Outpatient workload for primary care is projected to decrease in both the North Dakota and the South Dakota Markets in both FY 2012 (by 1 and 15 percent over the FY 2001 baseline, respectively) and FY 2022 (by 22 and 31 percent, respectively). Primary care workload is projected to decrease in the Nebraska Market by 11 percent by FY 2022. In addition, while outpatient mental health is projected to increase by 73 percent by FY 2012 in the North Dakota Market, it is expected to remain generally flat or decrease in other markets.⁶⁰³ The VISN Director indicated that mental health services would be added to CBOCs when feasible but also noted that some of the contracted CBOCs include only a small number of veterans.⁶⁰⁴

However, outpatient workload for specialty care is projected to increase at each of the VAMCs in this VISN, except in the South Dakota Market. North Dakota is projected to have the largest increase in specialty care demand at 120 percent over baseline by FY 2012, and 82 percent over baseline by FY 2022.

⁶⁰⁰ David Parr, Veterans of Foreign Wars, Transcribed Testimony from the Omaha, NE, Hearing on September 4, 2003, page 96.

⁶⁰¹ Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 29.

⁶⁰² CARES Site Visit Report; Hot Springs and Fort Meade, SD, July 8-9, 2003, page 1.

⁶⁰³ Appendix D, *Data Tables*, page D-105.

⁶⁰⁴ Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 23.

In the Iowa Market, specialty care is expected to increase by 65 percent over baseline in FY 2012, and to still be 39 percent over baseline by FY 2022. Projections for Minnesota include an increase to 40 percent over baseline by FY 2012, with a decrease to 24 percent over baseline by FY 2022. Specialty care in the Nebraska Market is projected to increase by 35 percent over baseline by FY 2012, with a decrease to 15 percent over baseline by FY 2022.⁶⁰⁵

The CARES Space Report indicates that there are space deficits in most facilities in the VISN,⁶⁰⁶ which are to be addressed either through new construction or the conversion of existing space. Many facilities also plan construction and renovation of existing space to address problems with the condition of their space.

Commission Findings

- 1 Access to primary care is a significant problem in this VISN.
- 2 Access to primary care will be improved with the addition of the priority group one CBOCs. These new clinics, however, will not address the VISN's access problems in three of the five markets: Nebraska, North Dakota, and South Dakota.
- 3 All markets have projected increases in specialty care workload, and two markets also have projected increases in primary care workload.
- 4 According to the Space Report, there is inadequate outpatient space for most facilities in the VISN.
- 5 The quality of space at Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities is in need of renovation.

Commission Recommendations

- 1 The Commission recommends that:⁶⁰⁷
 - 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.

⁶⁰⁵ Appendix D, *Data Tables*, pages D-104 and D-105.

⁶⁰⁶ VSSC CARES Space Report based upon the Office of Facilities Management Space & Functional Database as extracted from the IBM Market Planning Template.

⁶⁰⁷ 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.
- 2 The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space needs at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities.

VI Enhanced Use and Collaboration with VBA

DNCP Proposals

Enhanced Use – Three enhanced use lease projects are proposed: 1) Single Room Occupancy Initiative Concept plan (approval pending); 2) Federal Credit Union Concept Plan (approved), public hearing completed requires approximately an acre of property on medical center campus; and 3) a St. Paul VARO enhanced use initiative with a private developer to collocate onto the Minneapolis campus. *Collaboration VBA* – The VARO in St. Paul would relocate to new construction on land at the VAMC Minneapolis campus through an EUL proposal (high priority).”

Commission Analysis

The Minneapolis campus is one of 20 locations with high potential for EUL. Three separate EUL projects are underway on this campus: building a federal credit union, a transitional housing project, and the collocation of VBA to the Minneapolis campus. The EUL plan that includes VBA has not progressed past the planning stage, and although VBA has identified the project as a high priority project with plans for completion by FY 2010, it has not submitted a formal proposal.⁶⁰⁸

⁶⁰⁸ Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 16.

VISN 23 reported in early January 2004 that the Minneapolis VAMC held a public hearing on the proposed construction project for the transitional housing project and is currently waiting for the conclusion of a 90-day review period by Congress. The VISN hopes to start construction in the spring of 2004.

A hearing was also held for the federal credit union project a year ago, and a private sector partner was selected. The 90-day Congressional review process has been completed. The VISN reports that VA Regional Counsel is currently reviewing the proposed lease under negotiation between the builder and the credit union management.⁶⁰⁹

Commission Findings

- 1 While no data are available for review, the narrative in the VISN's market plan, the VISN Director's testimony at the Minneapolis hearing, and his replies to questions from Commissioners on the topic appear to provide reasonable support for the VISN's EUL initiatives.
- 2 Two of the three EUL efforts have VA Central Office approval.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal for EUL projects in VISN 23.
- 2 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

VII Special Disability Programs – Spinal Cord Injury/Disorder Unit at Minneapolis

DNCP Proposal

“Build a new SCI/D unit at Minneapolis.”

DNCP Alternatives

None provided in the DNCP.

⁶⁰⁹ E-mail received from VISN 23 Network Office on January 9, 2004.

Commission Analysis

The plan for the new SCI/D unit is for new construction of a two- or three-story building that would include outpatient space and one or two floors for inpatient care. The VISN Director testified that new construction would be required as only about ten beds could be converted if existing space were utilized:

We came to the conclusion that we could not accommodate [the SCI/D unit] within the space that we have right now, not at the size that's required by the Central Office and PVA criteria for a spinal cord injury unit. We could do something like ten beds, but we couldn't do 20 beds or 30 beds, which is what they're talking about.⁶¹⁰

In testimony, Oscar Ballard, National Service Officer for the Paralyzed Veterans of America said, "The Minnesota Chapter of PVA supports the construction of a 30-bed SCI center with plans for an additional ten beds at a later date at the Minneapolis VAMC."⁶¹¹

The Commission agreed that an SCI/D inpatient unit appears to be indicated, and although the number of beds was uncertain, noted that 30 SCI/D beds is the minimum that should be placed in any center but that these beds could be a mix of acute and long-term beds depending on the needs in the area.

Commission Findings

- 1 There are no SCI Centers between Milwaukee and Seattle along the northern section of the country.
- 2 Stakeholders support the building of a new SCI/D unit in Minneapolis.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to build a new 30-bed SCI/D unit in Minneapolis.
- 2 VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce wait times.

⁶¹⁰ Robert Petzel, MD, VISN 23 Director, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 30-31.

⁶¹¹ Oscar Ballard, National Service Officer for the Paralyzed Veterans of America, Transcribed Testimony from the Minneapolis, MN, Hearing on September 3, 2003, page 60.

