

SITE VISIT REPORT VISN 21

- I. VISN: VISN 21
- II. Date of Visits: July 22-23, 2003
- III. Sites Visited During Trip:
 - Palo Alto
 - Menlo Park
 - Livermore
- IV. Commissioners/Staff in Attendance
 - COMMISSIONER PATRICIA VANDENBERG
 - COMMISSIONER ROBERT RAY
 - COMMISSION STAFF: CAROLYN ADAMS

- V. Overview of Visit:
 - Commissioner/Staff Impressions of Tour**

VA Palo Alto Health Care System is an integrated delivery system encompassing 3 main divisions: Palo Alto, Menlo Park and Livermore. These three divisions along with six Community Based Outpatient Clinics (CBOC's) deliver the primary and specialty care to the veterans in that catchment area.

Palo Alto Division is the site of all tertiary care and the site of all acute inpatient care in psychiatry, medicine and surgery. It is also the site to VA special emphasis programs in blind and spinal cord rehabilitation as well as traumatic brain injury services and Hospice.

Menlo Park Division is the site of nursing home units, gero-psychiatry and VA specialty programs in PTSD, homelessness and the treatment of chronic mental illness.

Livermore Division has a wide range of primary and specialty clinics, which offer an array of outpatient services. A 120-bed nursing home unit and a 30 bed sub-acute unit are also located at Livermore.

Total operating beds within the three divisions remains at 903 with an average daily census of 723 and occupancy rate of approximately 80%. Care for the veteran is accomplished with approximately 3000 staff members and 1550 volunteers.

This healthcare system has a strong affiliation with Stanford University School of Medicine and has 528 Stanford University Residents and Fellows and 157 Medical Students. In total there are 145 active affiliations with better than 1300 trainees.

VA Palo Alto Healthcare System is the third largest research program in the VHA and was awarded six Centers of Excellence in FY 02. These Centers include: Autopsy, Cardiac Surgery, Comprehensive Medical Rehabilitation, Domiciliary Care for Homeless Veterans, Human Immunodeficiency Virus and Spinal Cord Injury.

The Commissioners felt this was an excellent healthcare system. Staff interaction at all facilities was very good. There was positive Leadership and relationships within the management team. There was demonstration of a good consolidation of the three medical centers.

Palo Alto is a new facility with good infrastructure. The Commissioners toured the Medical/Surgical ICU, Hospice, GI Suite, Ambulatory Care Clinic, Spinal Cord Injury (SCI) and Blind Rehabilitation Center (BRC). The SCI was of particular interest as the Director of the unit had input on the design and throughout his tour showed his enthusiasm and positive impact on the program. The BRC was very impressive, involving the family in many aspects of the rehabilitation process.

Menlo Park is an older facility located in a residential area. There is an existing parking shortage. If beds were relocated to Menlo Park there would definitely be a need for a new Nursing Home. Space for this construction would be acquired by demolishing existing buildings. The Commissioners toured the Nursing Home Care Unit in Building 324. The PTSD program at this facility has acquired national attention and was utilized to help the Military response to the September 11, 2002 at the Pentagon.

Livermore is on 113 acres in a rural setting. The facility is older and has had renovation in some patient areas with planned renovations for the remaining Nursing Home facility. Livermore is in a spectacular setting with beautiful grounds. The Commissioners toured the Sub-Acute area, GI Suite, Primary Care and Nursing Home Care Unit. Sub-acute care at this facility is essential to the Palo Alto Healthcare System keeping patients out of the needed acute care beds and providing the rehabilitation the Veteran needs prior to returning home or to another institution.

Summary of Meeting(s) with VISN Leadership

Names and titles of Attendees:

Robert Wiebe, M.D., Director, VA Sierra Pacific Network

Larry Janes, VISN CARES Coordinator

Diana Struski, VISN Public Affairs

Lisa Freeman, Director, VAPAHCS

John Sisty, Acting COO VISN, Associate Director

Javaid Sheikh, M.D., Chief of Staff

Ellen Shibata, M.D., Deputy Chief of Staff, Livermore

Stephen Ezeji-Okoye, Acting Chief, Medical Service
Alice Naqvi, ACOS for Nursing
Shirley Paulson, Chief Nurse
Debra Grizzard, Chief Nurse
Sandy Parkes, Chief nurse
Dwight Wilson, Chief Nurse
Lisa Rogers, Staff Assistant to the Director
Lori Peery, Staff Assistant to the Chief of Staff
Robert Goldman, Staff Assistant to the Deputy Chief of Staff
Jason Nietupski, Facility Planner
William Ball, Communications Officer
Nora Lynn Buluran, Health Systems Specialist, COS

Meeting Forum

This was an informal meeting. The VISN Director, Robert Wiebe reviewed the overall VISN Market Plans. Lisa Freeman, Director, VAPAHCS reviewed the South Coast Market Plan which encompasses the Palo Alto Healthcare System. These reviews were facilitated with superior storyboards that highlighted facility attributes and the CARES Planning Initiatives (PI's).

Highlights of the South Coast Market:

Inpatient care demand:

Surgery Inpatient (decrease of 26 beds in 2022) will convert one acute surgical unit to sub-acute beds. There will be no impact on Capital Assets.

Psychiatry Inpatient (-25 beds in 2012, -41 beds in 2022) Reduce Psychiatric Beds as demand decreases. Shift care to mental Health outpatient setting.

Outpatient care demand:

Primary Care: CBOC's at Modesto/Stockton, Fremont/Hayward and New South San Mateo will expand Primary Care capacity. Expand Monterey and San Jose CBOCs and open a new CBOC in San Mateo. New Ambulatory Care Center in Palo Alto will also expand Primary Care. Will require Capital Leases and 2 Minor projects and a Major Project.

Specialty Care: Expand the Emergency Room and Ambulatory Care at Palo Alto. Construct new Ambulatory Care Center at Palo Alto and expand the Modesto/Stockton CBOC. Open a new Fremont/Hayward CBOC. Will Require 2 minor projects and a Major Project with a Capital Lease (All Mentioned above).

Access to primary care, acute hospital care, tertiary care :
Acute Hospital Access: Only 53% of Enrollees are within the Access Standard. Plans are to expand fee basis contracts with community hospitals. No impact on Capital Assets.

Proximity (60-mile, 120-mile)

Palo Alto Medical Center and San Francisco Medical Center are 45 miles apart. The medical centers have proposed consolidations of administrative and clinical programs. Neither facility has the bed capacity, infrastructure nor clinical staff to accommodate the full workload of the other. They have proposed the following:

Administrative consolidations:

San Francisco: Reproduction, HRM Classification Position Service.

Palo Alto: Warehouse Operations, Disposal of Government Property, Recycle Program, Management of Grounds and Transportation, Prosthetics and Sensory Aids Purchasing Agents, IRM Help Desk and Police Training.

VISN: Finance, Asset Management and Acquisition Operations.

Clinical Consolidations:

San Francisco: Parkinson Disease/Epilepsy Surgery/Brain Mapping, portions of Neurosurgery including Stereotactic Radiosurgery, Brain Stem Auditory Evoked Responses, Somatosensory Evoked Potentials, All surgery requiring Spinal cord and root monitoring, Brachytherapy for Prostate Cancer, all Dental Surgery, portions of radiology through increased use of PACS, portions of Laboratory Services, Electronystagmographs, Endovascular embolism of AVM Moh's surgery.

Palo Alto: Long term inpatient care for Dementia and Neurobehavioral problems including substance abuse, Electroconvulsive Therapy, LTC for Chronically Mentally Ill, certain laboratory contract testing.

Collaborations:

DoD: DoD sharing in this market would be to evaluate the feasibility of a joint venture to construct a single facility that would adequately support both VA and DoD missions at the Monterey Clinic.

There are no VBA or NCA collaboration possibilities in this market.

Special Populations :

Palo Alto has a 43-bed SCI unit. The Director of this facility is using telemedicine and desires to move what SCI care he can to the outpatient setting.

Palo Alto also has a 32-bed Blind Rehabilitation Center and has incorporated computer training for enhanced independent living.

Other:

Infrastructure: This VISN has major seismic safety issues. Of the top 77 Exceptionally High Risk buildings in VHA, 3 VISN 21 structures rank 1st, 2nd and 3rd with regard to seismic deficiencies.

1st: San Francisco's Bldg 203 (Main Hospital Bed Tower)

2nd: Palo Alto Division's Bldg 2 (Acute Inpatient Psychiatry)

3rd: Palo Alto Division's Bldg 4 (Consolidated Research Activities)

Vacant Space: The VHA Goal for Vacant space is a reduction of at least 10% beginning in FY 04 and 30% in FY 05. The actual VISN 21 Space reduction will be 30% in FY 04 and 43% in FY 05.

Mission Change Analysis:

VISN 21 was tasked to "evaluate a strategy to convert from a 24-hour operation to an 8 hour operation" at the Livermore Division. In order to effectively realign the Livermore Division, existing and projected outpatient and inpatient workload would be redistributed. Many San Francisco Bay area residents migrate out of the region and locate in the Central Valley. The majority of veterans who use Livermore reside in the Central Valley and the East Bay. Veterans increasingly use specialty care services at the Livermore Division enhancing primary care and mental health services at the Stockton, Modesto and Sonora CBOC's would be needed. In 2002, nearly 10,500 veterans obtained medical care at Livermore. The following realignments are proposed:

Livermore's Outpatient Services:

Establish a new 35,000 GSF ambulatory care clinic in the Central Valley, which would enhance primary care, selected specialty care and ancillary services. Relocate the ambulatory care functions from the Livermore Division to a new site in East Bay improving primary care, specialty care, outpatient procedures, ancillary and diagnostic services.

Livermore's Inpatient Services:

Relocate Livermore Division's 30 sub-acute/intermediate medicine beds to Palo Alto Division. Use vacant ward space in the new Building 100 bed tower to consolidate all sub-acute/intermediate medicine beds within the Health Care System. Extended care would be addressed by relocating 80 NHCU beds from Livermore to Menlo Park (dementia, respite, hospice and extended care). Construct a new 200-bed extended care nursing home a Menlo Park incorporating the 80 beds from Livermore and 120 beds for the seismically deficient Menlo Park. Contract remaining 40 NHCU beds to facilities in the community (Stockton, Modesto and Sonora) to reduce the hardship on veterans who reside in outlying Central Valley communities.

The proposed plan would eliminate unneeded buildings from the VA inventory, streamline operations and reallocate resources to direct patient care, reduce redundant operations and consolidate duplicative functions. There may be an opportunity for an Enhanced Use Lease at the Livermore Division. That would have to be investigated.

Summary of Stakeholder Meeting(s):**Palo Alto:**

Thirty-two were in attendance (see attachment)

Dr. Wiebe provided welcoming remarks to all stakeholders and introduced the Commissioners and Commission Staff. He gave an overview of the purpose of the meeting and asked each attendee to introduce him/herself. Some member participation was through teleconference.

Commissioner Vandenberg thanked everyone for attending the meeting. She gave a brief background description of the CARES experience and the role of the Commission.

Commissioner Ray emphasized the importance of the stakeholders input not only in terms of the present but also in terms of what the future needs of the veteran would be.

Topics of Discussion:

A general question was asked about when the final report would be due. The Commissioner's reviewed the CARES time line and when the Commission report was due to the Secretary.

Employee representation was most concerned about the change of mission at the Livermore Division. They felt the VISN plan had been submitted and that with changes then coming from the Under Secretary there was now questions about the whole CARES process in the mind of the employees. CARES needed to be mindful of the employees and why should employees stay if the hospital was going to close.

Veteran Service Organizations were also concerned with keeping the families involved in the veterans care. There is a movement of veterans out of the urban area into the valley due to the cost of living and they felt the migration had not been reflected in the CARES model.

Congressional representation indicated there are access issues. There are clinics but not in the northern area and there needs to be inpatient services for elderly, fragile veterans.

Seismic issues were of great concern. Many projects have been approved but not funded by Congress. They do not want these projects lost in the CARES process.

There was discussion if the Long Term Care needs could be met through State Homes. Three homes have been planned for California, one in Los Angeles, one in Fresno and one in Redding.

There was also concern on what criteria would be used to evaluate what would actually end up in the National CARES Plan.

Livermore:

Names and Titles of Attendees:

Ellen Shibata, M.D.
Robert Goldman
Dwight Wilson, RN
Jon Fuller, M.D.
Donna Heinle, M.D.
Sandy Parkes, RM
Anita Straley, RN
Myrna Muzni, RN
Vic Allyn, President Local 1620
Bill Luttrell, President Local 2110

Topics of Discussion:

Employee representation was most concerned about the staff at Livermore and the change of the Mission. This is affecting recruitment and retention. Why stay or come if the place is closing. Things seem to change week to week and the stakeholder voice is not being heard. The initial CARES planning involved the Union and Local Management and they were much more in tune and then after the plan was submitted it was decided by the Under Secretary to close Livermore. Why did the Under Secretary decide on Livermore? Had they done something to upset him?

Concern was expressed about the reduction in number of beds and the Millennium Bill. How would the VISN meet its bed numbers? It is also recognized that on any given day there were patients in contract beds because the health care system did not have beds for them and asked how could there be a further reduction of beds. Access to acute beds was also recognized as an issue so it was stated eliminating sub-acute beds will only compound the problem of admissions of patients.

There was discussion about the care the aging Viet Nam Veteran would require and that those patients would not be candidates for contract beds. There were no beds in the private sector that meet those patient's needs. It was said that the National CARES Model did not address the needs of these patients or really the Long Term Care needs of any veterans so, it was asked, how could Livermore be targeted?

Livermore is a secondary hub for the CBOC's. Concern was expressed that if Livermore goes away many of the programs will die. The staff indicated they have been building access; quality is access. They said the veterans will vote with their feet and they will not go down the road for care. Travel is terrible. The traffic is so bad from 6-10 a.m. you cannot get to Palo Alto or Menlo Park. Continuity of care will be missing when you chop off extended care. A large portion of the veterans needs will be gone. Veterans refuse now to go to have test at Palo Alto because of the travel and the need to stay overnight on occasions. They will not take three days from their schedules for tests.

There was concern that specialists would not be available at the CBOC's. The private sector struggles now for specialists. There was discussion on how the VA would attract these individuals.

Clear, consistent messages need to be provided in discussions with stakeholders concerning the Livermore options.

Attachments:

Attendance for Stakeholder Meeting: Palo Alto