

CARES COMMISSION
POST HEARING SUMMARY

VISN 23 Minneapolis Hearing
September 3, 2003

- I. Commissioners in Attendance:
 - 1. John Vogel, Vice Chairman
 - 2. John Kendall, M.D., Hearing Chair
 - 3. Vernice Ferguson, R.N.
 - 4. Robert Ray

- II. Market Areas Addressed in Hearing
 - 1. Minnesota Market
 - 2. North Dakota Market
 - 3. South Dakota Market

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III. Market Area Summary

Market	Planning Initiative	Market Plan Recommendation	DNCP Recommendation
Minnesota	Access to Primary Care: 53% vs. 70% goal	<ul style="list-style-type: none"> ➤ Open 4 CBOCs ➤ Increase primary care at main facilities 	4 new CBOCs not included in high priority group
Minnesota	Access to Hospital Care: 64% vs. 65% goal	Provide contracted care in community facilities	Provide contracted care in community facilities
Minnesota	Outpatient Primary Care 2012 – 43% increase 2022 – 19% increase	<ul style="list-style-type: none"> ➤ Move care to CBOCs ➤ Reconfigure/build ➤ Outsource high vol/low cost procedures 	Specifics not given, plan said 171K sq ft new construction to be added in VISN, other solutions included contracting and in-house expansion
Minnesota	Outpatient Specialty Care: 2012 – 40% increase 2022 – 24% increase	<ul style="list-style-type: none"> ➤ Move care to CBOCs ➤ Reconfigure/build ➤ Outsource high vol/low cost procedures ➤ Reconfigure some wards for specialty care 	Specifics not given, plan said 171K sq ft new construction to be added in VISN, other solutions included contracting and in-house expansion
Minnesota	Inpatient Medicine 2012 – 6% decrease 2022 – 30% decrease	<ul style="list-style-type: none"> ➤ Close St Cloud acute medicine beds, transfer care to Minneapolis or contract in community ➤ Reconfigure existing wards for outpatient care 	Increase flexibility of remaining beds by making significant capital investment to reconfigure beds, upgrade ICU's and increase number of monitored beds
Minnesota	Inpatient Surgery 2012 – 33% decrease 2022 – 51% decrease	<ul style="list-style-type: none"> ➤ Close St Cloud acute medicine beds, transfer care to Minneapolis or contract in community ➤ Reconfigure existing wards for outpatient care 	Specifics not given, realign space from inpatient to outpatient specialty clinics
Minnesota	Special Programs	<ul style="list-style-type: none"> ➤ Build new 20 bed SCI unit with outpatient clinic ➤ Build 20 more beds on 3rd floor as need arises 	Build new 30 bed SCI inpatient unit
Minnesota	Enhanced Use	<p>Minneapolis proposals:</p> <ul style="list-style-type: none"> ➤ SRO ➤ Federal Credit Union ➤ Co-location with VBA <p>St Cloud proposal:</p> <ul style="list-style-type: none"> ➤ 90 homeless beds 	<p>Three Minneapolis proposals are included in DNCP but no specifics given</p> <p>St Cloud proposal not included in DNCP</p>
Minnesota	Small Facility – St Cloud	Close acute medicine beds and transfer care to Minneapolis or contract; retain inpatient psych and nursing home unit	Proposed capital investments for nursing home construction and renovation in Lebanon and Coatesville

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N Dakota	Access to Primary Care: 37% vs. 70% goal	Open 5 CBOCs	Not in high priority group
N Dakota	Access to Hospital Care: 37% vs. 65% goal	Contract at Bismarck and Minot, SD	Contract at Bismarck and Minot, SD
N Dakota	Access to Tertiary Care: 32% vs. 65% goal	Contract at Bismarck and Minot, SC	Contract at Bismarck and Minot, SD
N Dakota	Outpatient Specialty Care 2012 – 120% 2022 – 82%	Proposed new construction at Fargo; plan indicated no room for renovation or possibility of leasing	Did not specify where new construction is planned, but identified 171K sq ft new space to be built in network
S Dakota	Access to Primary Care: 52% vs. 70% goal	Open 3 CBOCs	Not in high priority group
S Dakota	Access to Hospital Care: 59% vs. 65% goal	Contract at Pierre, SD and Scottsbluff, NE	Contract at Pierre, SD and Scottsbluff, NE
S Dakota	Outpatient Primary Care: 2012 – 15% decrease 2022 – 31% decrease	Does not address projected decrease, particularly in light of need to improve access	Not addressed
S Dakota	Inpatient Medicine Decrease Workload: 2012 – 22% decrease 2022 – 51% decrease	Due to underserved nature of market they will make adjustments to decrease beds as needs arise	Noted decreased need for inpatient medicine services over time, but no specific plans given
S Dakota	Small Facility – Hot Springs	Change mission to Critical Access Hospital, decrease to 15 beds and 96 hr LOS	Change mission to Critical Access Hospital, decrease to 15 beds and 96 hr LOS

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IV. Brief Description of Hearing Testimony

1. Network Leadership – Dr. Petzel, Network Director

Dr. Petzel presented the CARES plan for the Minnesota, North and South Dakota markets. Access to care is the biggest issue in these highly rural areas. North Dakota, at 37%, has the lowest primary care access in the VA. These rural markets also have some of the highest market share in the VA.

The network has 36 CBOCs and 12 proposed CBOCs for these three markets. The eight proposed CBOCs for North and South Dakota were not in the highest priority group. None of the current CBOCs are closed to enrollment, although some have very limited services and openings.

Dr. Petzel discussed converting Hot Springs to a Critical Access Hospital (CAH), using the Medicare definition. The community hospital is not considered a viable alternative. It closed in 1998, reopening in 2001 with 10 beds averaging 3 patients/day. It is not JCAHO accredited, has an old physical plant and strained financial resources. The VA dialysis program is a community resource treating 18 patients/week. The network sees an opportunity to collaborate with the community hospital and create a combined CAH for veterans and community patients, at the current VAMC campus.

Dr. Petzel discussed plans for a new \$6.4M building housing a 20 bed SCI unit with attached outpatient clinic. When asked if he could convert existing beds to an SCI unit, if funding was not forthcoming, the network analysis showed the current space could not accommodate all the SCI-related accessories at the desired VACO size of 30 beds. Current space could accommodate about 10 beds.

Dr. Petzel discussed the unique aspects of the Fargo and Sioux Falls VAMCs, which were taken off the small facility list following revised projections. Unlike other “small facilities” both have teaching affiliations and a considerable drive time to other VA facilities.

Dr. Petzel stated VISN 23’s top three needs are: 1) opening CBOCs, 2) renovation of Omaha ICU, and 3) construction of a new nursing home in Des Moines to handle the transfer of services from Knoxville. Commissioners learned VISN 23 has started grant applications to develop an Institute of Rural Medicine in conjunction with medical affiliates.

2. Veterans Organizations

Mr. Ballard, Paralyzed Veterans of America

Mr. Pearson, Disabled American Veterans

Mr. Hanson, Veterans of Foreign Wars

Mr. Harkema, North Dakota Department of Veterans Affairs

Mr. Ludwig, The American Legion

Mr. Olson, Minnesota Department of Veterans Affairs

Mr. Scocos, Wisconsin Department of Veterans Affairs

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Representatives discussed involvement in the CARES process. They stressed the need to improve access in these highly rural markets, with large numbers of veterans per capita. They were disappointed eight proposed CBOCs were not in the first priority group. The Governor of North Dakota also sent a letter to be entered in the record.

The American Legion does not support contracting out for care while closing beds in Hot Springs and St Cloud. The Minnesota Department of Veteran Affairs is concerned about the source of funds to implement recommendations, the need to review nursing home care units, and shifting acute care from St Cloud to Minneapolis. PVA supports construction of a 30 bed SCI unit, with an additional 10 beds at a later date. DAV stressed the importance of continued communication with stakeholders. VFW is also concerned about transferring acute care from St Cloud. They want to keep ambulatory surgery at St Cloud, increase the number of nursing home beds and CBOCs, and co-locate VBA at the Minneapolis campus. Wisconsin Department of Veterans Affairs wants a CBOC in western Wisconsin, more contracting in the community, and review of VA services at the Chippewa Falls site.

Responses were varied when asked about the quality of care at VA-staffed vs. contract CBOCs. VA staffing is preferred and differences may be real or perceived. A suggestion was made to systematically study quality and patient satisfaction between staffing models.

3. Affiliates and Collaborative Partners

Mr. Crawford, VBA

Dr. Edwardson, University of Minnesota School of Nursing

Dr. Moldow, University of Minnesota School of Medicine

Witnesses presented testimony on their involvement in the CARES process. Commissioners heard from Dean Edwardson about the Minneapolis VAMC nurse anesthetist and radiology technician training programs. Dr. Kendall quizzed panelists on when the U. of Minnesota established the second affiliation in the VA. Dr. Moldow mentioned the challenge of integrating the medical school's educational mission into CBOCs.

4. Employee Organizations

Dr. Lawrence, Physicians Association, Minneapolis

Ms. Nygard, AFGE 3669 (Minneapolis)

Mr. Russell, AFGE 1539 (Hot Springs)

Representatives indicated they were involved in the CARES process. Kathy Maynard, AFGE 2342, submitted written testimony. Dr. Lawrence expressed concerns about market-sensitive provider compensation and understated projections for specialty care. The VA needs to develop strategies to increase both the number and efficiency of specialists. She cited an Annals of Surgery article stating linear increases in primary care lead to exponential increases in specialty care, including increasing need for surgical services.

Mr. Russell raised concerns about the urbanization of healthcare, to the detriment of rural veterans. AFGE 1539 does not support contract CBOCs or converting Hot Springs to a

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CAH. He shared anecdotal stories about community hospitals holding VA patients as “cash cows”, and contract CBOCs raising rates after two years. Employees are concerned about going from CAH to losing ambulatory surgery and dialysis services to closure.

Ms. Nygard stated the Commission needs to review psychiatric and long term care needs. With a projected need for 17,000 nursing home beds by 2022 she asked why the VA is not converting unused beds to long term care.

V. Commissioner Views

Market Area	Planning Initiative	DNCP Recommendation	Commissioner Views
Minnesota	Access to Primary Care: 53% vs. 70% goal	4 new CBOCs not included in high priority group	Commissioners recommended the 4 CBOCs be re-evaluated for inclusion in the first priority group in this rural market.
Minnesota	Access to Hospital Care: 64% vs. 65% goal	Provide contracted care in community facilities	Commissioners agreed with the need to improve access to hospital care in rural areas, but they did not have a clear idea of the types of services or community hospitals targeted for contracting.
Minnesota	Outpatient Primary Care 2012 – 43% increase 2022 – 19% increase	Specifics not given, plan said 171K sq ft new construction to be added in VISN, other solutions included contracting and in-house expansion	Commissioners agreed with the need for more infrastructure for outpatient care, but would like to see a breakdown of the 171K sq ft by network facility.
Minnesota	Outpatient Specialty Care: 2012 – 40% increase 2022 – 24% increase	Specifics not given, plan said 171K sq ft new construction to be added in VISN, other solutions included contracting and in-house expansion	See above. After hearing Dr Lawrence’s talk about national projections for more surgery as baby boomers age Commissioners asked to see the Annals of Surgery article, and verify the NCPO model assumes a constant ratio of surgical beds.
Minnesota	Inpatient Medicine 2012 – 6% decrease 2022 – 30% decrease	Increase flexibility of remaining beds by making significant capital investment to reconfigure beds, upgrade ICU’s and increase monitored beds	Commissioners agreed with the need to maintain flexibility in light of projected declines in workload, but they did not hear any specific testimony on the need for more monitored beds.
Minnesota	Inpatient Surgery 2012 – 33% decrease 2022 – 51% decrease	Specifics not given, realign space from inpatient to outpatient	Commissioners felt Dr Petzel’s construction projects were well prioritized across the network.
Minnesota	Special Programs	Build new 30 bed SCI inpatient unit	Commissioners thought the SCI inpatient unit appears indicated, although the number of beds is uncertain. Given changes in protocols and patient preference they felt 20 initial beds may be appropriate.
Minnesota	Enhanced Use (EU)	Three Minneapolis proposals are included in DNCP but no specifics given	Commissioners agreed with the enhanced use proposals and felt they were ambitious and worthwhile projects. Since the Network Director did not understand why the St Cloud

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		St Cloud proposal for 90 transitional beds not included in DNCP	proposal was not in the DNCP the Commissioners asked for clarification of its omission.
Minnesota	Small Facility – St Cloud	Close acute medicine beds in St Cloud; transfer care to Minneapolis or contract in community; retain inpatient psych and nursing home	Commissioners agreed with the current pilot program for closing acute medicine beds at St Cloud. They asked for confirmation on the type of patients, LOS and size of the nursing home sub-acute unit.
N Dakota	Access to Primary Care: 37% vs. 70% goal	5 proposed CBOCs not in high priority group	Commissioners recommended the 5 CBOCs be re-evaluated for inclusion in the first priority group, particularly two on the western side of the state, since N Dakota has the lowest access to primary care of any VHA market.
N Dakota	Access to Hospital Care: 37% vs. 65% goal	Contract at Bismarck and Minot, SD	Commissioners agreed with the need to improve access to hospital care in rural areas and would encourage the network to contract for complete care in outlying communities. They asked to see more information on the type of services to be contracted.
N Dakota	Access to Tertiary Care: 32% vs. 65% goal	Contract at Bismarck and Minot, SD	See above.
N Dakota	Outpatient Specialty Care 2012 – 120% 2022 – 82%	Did not specify where new construction is planned, but identified 171K sq ft new space to be built in network	Commissioners agreed with the need for more infrastructure for outpatient care, but would like to see a breakdown of the 171K sq ft by network facility.
S Dakota	Access to Primary Care: 52% vs. 70% goal	3 CBOCs not in high priority group	Commissioners recommended the 3 CBOCs be re-evaluated for inclusion in priority group since S Dakota has one of the lower access to primary care of any VHA market
S Dakota	Access to Hospital Care: 59% vs. 65% goal	Contract at Pierre, SD and Scottsbluff, NE	Commissioners agreed with the need to improve access to hospital care in rural areas and would encourage the network to contract for complete care in outlying communities. They asked to see more information on the type of services to be contracted.
S Dakota	Outpatient Primary Care: 2012 – 15% decrease 2022 – 31% decrease	Not addressed	While the testimony did not specifically address this issue the Commissioners agreed with the network plans to maintain flexibility by contracting in the community.
S Dakota	Inpatient Medicine Decrease Workload: 2012 – 22% decrease 2022 – 51% decrease	Noted decreased need for inpatient medicine services over time, but no specific plans given	Again the testimony did not specifically address this issue but Commissioners would encourage the network to maintain beds, given the problems with access to care.

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S Dakota	Small Facility – Hot Springs	Change mission to Critical Access Hospital (CAH), decrease to 15 beds and 96 hr LOS	Commissioners agreed with the plan to convert Hot Springs to a CAH and felt VISN 23 was following the CMS definition of CAH, unlike other areas which appear to have picked up the CAH label for more populated areas.
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VI. Other Comments

- The VISN 23 site visit and hearings gave Commissioners a greater appreciation for the challenges of rural healthcare. They agreed the DNCP’s 7,000 enrollment threshold is an artificial barrier for rural markets and suggest development of more applicable criteria for highly rural markets, e.g., mileage between CBOCs.
- Commissioners stressed the importance of developing one definition of a Critical Access Hospital to use consistently at the VA. VISN 23 appears to be following the CMS definition while other networks are modifying it to justify their situation.
- Commissioners also discussed the need for consistent bed type nomenclature and definitions, e.g., monitored beds, step down unit, intermediate beds, sub acute beds.
- Commissioners heard about contract CBOC staff that could not answer questions on VA eligibility rules, referrals, etc. They felt contract CBOCs could upgrade customer service through written education materials, VBA 800#’s, and information on special disorders affecting veterans such as PTSD and agent orange.

VII. Follow-up questions for VHA/VISN

1. What types of services and community hospitals are targeted for contracting in Minnesota, Bismarck and Minot, ND, Pierre, SD, and Scottsbluff, NE.
2. Provide a breakdown by facility of the proposed 171,000 sq ft for outpatient services.
3. Provide information on why St Cloud EU proposal was not included in DNCP.
4. Provide information on St Cloud sub-acute unit, including number of beds, types of patients and length of stay.