VISN 7 Follow Up Information for CARES Commission
October 3, 2003

A. Charleston hearing follow up:

- Access to primary and hospital care/supporting data for SC locations: *Selection of new CBOC and contract hospital locations was based on 1) relative enrollee concentrations, and 2) distance to nearest site of VA care. A sufficient number of new sites were selected in order to meet the 70% (primary care) and 65% (hospital care) access thresholds. Only enough new care locations were selected to meet the recommended thresholds. Please note that the National CARES Planning Office assigned all 15 of VISN 7's proposed new CBOCs to the highest priority group. Nationwide, 48 CBOCs were assigned to the high priority group. VISN 7 had 15 of the 48. The 48 CBOCs were selected based on their satisfying both access and capacity gaps, and their "productivity" in bringing enrollees within a 30-minute drive of primary care. The file that lists enrollee data by county is attached.*
- Outpatient primary care, specialty care, and mental health:
  Primary care: *see above response*
  Specialty care: *Since VISN 7 treated each new CBOC as a discrete facility in the CARES IBM software, all workloads, by CARES category, are identifiable for each CBOC. Generally speaking, specialty care workloads were mapped to new CBOCs 1) as needed to meet capacity gaps in specialty care for that market, and 2) based on the feasibility of attracting specialists to work at those geographic locations. As we develop our CARES implementation plan, we will spend more time in identifying the specific specialty services that should be offered at our CBOCs, considering such factors as the feasibility of offering that specialty in a non-VAMC location (based on supporting equipment requirements, for example) and potential telemedicine solutions (for dermatology consultations, for example). VISN 7 has used the term "super clinic" to denote a CBOC that offers specialty care services on site in addition to primary care and mental health services.*
  Mental Health: *All of VISN 7's new CBOCs will offer mental health services. Our "rule of thumb" for current and new CBOCs was to plan mental health services at the rate of 20% of planned primary care service volume, or actual historical rate, whichever was higher. Please note that VISN 7 exceeds performance expectations on the "CBOC access to mental health services" performance monitor.*
- Inpatient medicine and psychiatry contract feasibility: *VISN 7 is planning to add hospital contract solutions in the Greenville and Savannah areas in order to bring hospital access to 65%. Preliminary contacts indicate readily available community hospital capacity. We have no plans to contract for inpatient psychiatry care in this market.*
- Extended care: *VISN 7 plans renovations for NHCUs where the FCA (Facility Condition Assessment) was less than 3.0. These capital investments do not address gaps in service.*

- Enhanced Use/Homeless Vets: *A total 433 beds are currently available for homeless veterans in VISN 7 either in our homeless domiciliaries (in Dublin, CAVHCS, and Augusta) or in the community. VISN 7 facilities reported a need for 351 more homeless beds based on demand in 2002. Please note that domiciliary needs will be addressed in the next CARES planning cycle.*
- VBA Collaboration: *The VARO co-location on the grounds of the VAMC Columbia SC has been ranked as a "high priority" VHA/VBA collaborative initiative in the Draft National CARES Plan. Of 17 VHA/VBA initiatives nationwide, six are identified as "high priority" and the remaining eleven as "medium priority". Should VBA remain in GSA-leased space in downtown Columbia, SC, annual rent is estimated at $1,800,000. Collocation of the Regional Office to the Columbia VA Medical Center through an Enhanced Use Lease should, based on previous Enhanced Use projects, yield an annual rent of $1,650,000. VBA estimates a rental savings of $150,000 per year. Other, less tangible benefits, include:*
    - *Accessibility to veterans through better parking,*
    - *One-stop service,*
    - *More functional space design that promotes better employee performance,*
    - *Modern building with state-of-the-art communication, HVAC, lighting, energy conservation, etc.*
- DoD Collaboration: *A copy of Appendix I, "Department of Defense Collaborations", Draft National CARES Plan, is attached. Each VISN 7 collaboration is updated as follows:*
    - *Page 2, Maxwell AFB and Montgomery VAMC collaboration is still under development. The collaboration should be revised to state " Air Force will provide space to VA for ambulatory surgery, eye, podiatry on Maxwell AFB. Maxwell AFB and VA plan to consolidate breast care services at Maxwell AFB. Additionally, Maxwell AFB and CAVHCS are in the process of identifying providers to be jointly credentialed."*
    - *Page 3, Navy Hospital/Charleston collaboration should be revised to say that the Navy clinic planned for Goose Creek, SC has potential to address VA capacity and access needs for a new CBOC in that area. Discussions between the VA and the Navy for a collocated clinic are underway.*
    - *Page 5, Navy Clinic/Beaufort: The small VA clinic is currently collocated in the current Navy clinic in Beaufort and the arrangement works well. The planned replacement Navy clinic will be at the Marine Air Station and VA is reviewing the option of relocating to the new site, approximately five miles from the current location.*
    - *Page 6, Hunter Army Air Field/Savannah: VA clinic collaboration option is no longer feasible. The new Army clinic cannot accommodate the Savannah VA clinic and the Army plans to demolish their former clinic.*

- *Page 7, Robbins AFB/Dublin: This should be revised to say, "Dublin may provide mental health and substance abuse services to active duty airmen, and RAFB may provide optometry services to veterans."*
- *Page 9, no changes for current sharing agreements at Augusta.*
- *Page 10, no changes for current sharing agreements at Columbia or Montgomery. Delete the Ft. Stewart/Dublin item.*
- *Page 11, no change for Atlanta and Ft. McPherson.*

- Facility Condition: A description of the facility condition assessment process can be found at http://vaww.va.gov/facmgt/consulting/.
- Proximity: *VISN 7's complete proximity analysis is posted on the CARES portal and is attached for your convenience.*

B. Atlanta hearing follow up:

- CBOC numbers and locations, and lease/build/contract decisions for CBOCs: *Please see response above regarding number and location decision process. Lease/build/contract decisions considered local factors including proximity to a VAMC, size of the CBOC, staffing considerations and community resources. For example, CAVHCS now contracts with Southeast Alabama Medical Center for its CBOC in Dothan, AL. A good solution would be to expand this contract to add a site of care to meet the needs in nearby Enterprise. The new Opelika CBOC is planned as a VA-staffed operation, since the proximity of Opelika to the Tuskegee VA facility would facilitate VA staffing and support. The new (replacement) Huntsville CBOC is planned to be a VA-constructed, VA-staffed, large multi-specialty clinic. Construction is planned instead of a lease since a market survey found nothing available that met the needs for space, parking, and ground level entrance. It was also determined to be more economical to build ($12,000,000) rather than lease ($4,000,000/year) in Huntsville since lease costs for a facility that size would exceed the build costs after just three years. All multi-specialty clinics are planned as VA-staffed clinics in leased space.*
- Rome GA CBOC: *As discussed earlier, new sites for CBOCs were selected based on identifying where we had the largest concentrations of enrollees outside of a 30-minute drive time to primary care. Seven new CBOCs are planned for the Georgia market, to achieve the recommended 70% access threshold by 2012. We added sites of care, one at a time, in order of enrollee population, until we met the 70% target. Rome would have been the eighth new CBOC.*
- Reduction of vacant space: *Our CARES Plan shows 1.4 million square feet of vacant space by 2022, with all but 20% planned for elimination by demolition (456,021), out lease (619,604), or enhanced use (24,911). We are not sure where the 57% figure in your question comes from.*
- SCI needs analysis and ADC information: *SCI projection models were developed through the combined efforts of VA SCI&D SHG officials and the Office of the Actuary in collaboration with the National CARES Program Office. We recommend you contact Dr. Chang for details on the projection model.*

The Augusta SCI Unit has 60 operating beds. Due to construction, 8 beds have been out of service since March 2002. These 8 beds will be reactivated on October 6, 2003, when the newly renovated space will be occupied. There is currently a wait list (30) for admissions and these 8 beds will be filled immediately.

ADC for the Augusta SCI Unit:

- *FY 03: 46.6 (46.2/52 beds = 90% occupancy; 85% occupancy is the target rate)*
- *FY 02: 45.9 (45.9/52 beds = 88% occupancy)*

VISN 7 South Carolina Market

			Data								
Visn	Market	County	Fy01act Enr	Enroll2	Enroll12	Enroll22	Vp2001	Vp2002	Vp2012	Vp2022	
	South Carolina	ABBEVILLE (45001)	766	847	718	587	2,425	2,390	1,986	1,602	
		ANDERSON (45007)	**2,975**	**3,292**	**3,590**	**3,518**	**17,481**	**17,237**	**14,794**	**12,488**	
		BAMBERG (45009)	302	334	314	273	1,447	1,410	1,113	877	
		BEAUFORT (45013)	**3,381**	**3,931**	**4,292**	**4,556**	**17,136**	**17,211**	**17,256**	**15,978**	
		BERKELEY (45015)	5,003	5,453	6,150	6,207	19,411	19,351	18,145	16,394	Near Charleston VAMC
		BRYAN (13029)	488	565	799	915	2,533	2,559	2,704	2,723	
		CALHOUN (45017)	237	267	297	287	1,401	1,378	1,187	1,005	
		CHARLESTON (45019)	10,985	11,978	12,327	11,981	35,525	35,443	33,677	30,482	Charlestown VAMC
		CHATHAM, GA (13051)	**5,783**	**6,358**	**7,015**	**6,715**	**26,585**	**26,085**	**22,022**	**18,747**	
		CHEROKEE (45021)	843	959	1,132	1,108	4,896	4,831	4,152	3,513	
		CHESTER (45023)	850	947	811	685	2,949	2,889	2,362	1,899	
		CHESTERFIELD (45025)	848	923	815	721	3,384	3,331	2,788	2,306	
		CLARENDON (45027)	848	924	781	673	2,737	2,715	2,394	2,026	
		COLLETON (45029)	1,265	1,340	1,194	1,014	3,877	3,815	3,243	2,696	
		DARLINGTON (45031)	1,351	1,483	1,378	1,230	5,842	5,737	4,781	3,972	
		DORCHESTER (45035)	**3,896**	**4,232**	**4,570**	**4,616**	**13,267**	**13,251**	**12,678**	**11,744**	
		EFFINGHAM (13103)	681	784	1,078	1,158	4,271	4,234	3,874	3,480	
		FAIRFIELD (45039)	641	682	553	456	2,031	1,993	1,655	1,359	
		FLORENCE (45041)	**3,237**	**3,558**	**3,115**	**2,841**	**11,174**	**11,082**	**9,927**	**8,728**	
		GEORGETOWN (45043)	1,680	1,852	1,666	1,555	6,072	6,051	5,840	5,247	
		GREENVILLE (45045)	**6,174**	**6,706**	**7,166**	**7,270**	**36,580**	**36,216**	**32,393**	**28,353**	
		GREENWOOD (45047)	1,474	1,698	1,472	1,238	5,792	5,675	4,654	3,742	
		HAMPTON (45049)	536	582	489	438	1,769	1,743	1,539	1,340	
		HART (13147)	377	453	496	452	2,255	2,214	1,867	1,516	
		HORRY (45051)	**7,313**	**8,038**	**6,812**	**6,376**	**25,251**	**25,355**	**24,969**	**22,829**	
		JASPER (45053)	395	439	452	438	1,813	1,795	1,611	1,466	
		KERSHAW (45055)	1,654	1,793	1,601	1,389	5,828	5,745	4,914	4,102	
		LANCASTER (45057)	1,707	1,821	1,447	1,294	5,887	5,809	5,027	4,321	
		LAURENS (45059)	989	1,133	1,221	1,155	6,254	6,166	5,210	4,359	
		LEE (45061)	230	271	330	331	1,598	1,578	1,350	1,111	
		LEXINGTON (45063)	4,813	5,313	6,167	6,760	23,619	23,755	24,029	23,235	Near Columbia VAMC
		LIBERTY, GA (13179)	**2,248**	**2,486**	**2,934**	**3,068**	**7,589**	**7,616**	**7,459**	**6,839**	
		LONG (13183)	156	194	295	314	1,161	1,148	1,002	880	
		MARION (45067)	864	947	835	706	2,737	2,683	2,172	1,735	
		MCINTOSH (13191)	285	322	337	304	1,248	1,232	1,055	916	
		NEWBERRY (45071)	751	851	793	712	3,176	3,135	2,761	2,326	
		OCONEE (45073)	1,180	1,340	1,412	1,323	7,783	7,683	6,572	5,473	
		ORANGEBURG (45075)	**2,561**	**2,779**	**2,352**	**2,000**	**7,694**	**7,596**	**6,575**	**5,577**	
		PICKENS (45077)	1,919	2,119	2,363	2,447	10,448	10,406	9,672	8,666	
		RICHLAND (45079)	11,973	12,829	12,752	12,128	35,462	35,390	32,853	29,348	Columbia VAMC
		SALUDA (45081)	318	351	331	293	1,597	1,559	1,273	1,037	
		SPARTANBURG (45083)	**3,764**	**4,226**	**4,844**	**4,845**	**24,134**	**23,802**	**20,481**	**17,364**	
		SUMTER (45085)	**3,838**	**4,166**	**3,854**	**3,409**	**11,842**	**11,700**	**10,114**	**8,602**	
		UNION (45087)	589	680	653	550	2,533	2,481	1,976	1,532	
		WILLIAMSBURG (45089)	672	719	650	563	2,382	2,339	1,973	1,633	
		YORK (45091)	**3,175**	**3,652**	**4,245**	**4,541**	**16,660**	**16,591**	**15,597**	**14,299**	
	South Carolina Total *		106,015	116,619	118,898	115,444	437,534	434,408	395,675	349,866	

New & old CBOCs are in bold.
New CBOCs are in yellow: Summerville (Dorchester Co.), Spartanburg, and Hinesville (Liberty Co.).

EXECUTIVE SUMMARY

Proximity Planning Initiative – VISN 7
(Charleston-Columbia and Augusta-Columbia)

Background

VISN 7 has 2 Proximity Planning Initiatives involving 3 facilities. This analysis addresses the proximity of Columbia to Charleston (116 miles) and Columbia to Augusta (82 miles). There is no PI between Augusta and Charleston. The continued provision of tertiary-level services at Columbia is the focus of this narrative. The mission statement for each facility is provided in Appendix A.

Environmental Assessment - All three facilities have affiliations in medicine and surgery, have affiliations in the allied health disciplines, and have established sharing agreements and/or joint ventures with DoD. There is currently a considerable amount of movement between facilities for inpatient services. Following is an analysis of the where the services are provided; at the preferred facility (closest to the veteran's home address) or Other.

Facility	Inpatient Preferred Care	Inpatient Other Facility
Augusta	37%	63%
Columbia	42%	58%
Charleston	51%	49%

A review of similar outpatient visit information indicates that approximately 65% of the patients receive their outpatient care at the Preferred Facility and 35% receive their care at an Other facility for the three facilities considered.

These numbers clearly show the referral relationships among the 3 facilities, due to their complementary tertiary missions.

The VISN 7 Clinical Inventories were reviewed and no significant potential for further integration of services exists. The three facilities have already consolidated tertiary-level clinical services and VISN 7 is a VHA leader in consolidating administrative services.

One problem encountered when conducting the proximity review is the lack of clear definition of tertiary facility and services. Assuming tertiary services are on a continuum, Columbia is at the very minimal end with Augusta and Charleston in the middle. VISN 7 considers a transplant center on the high end of the continuum. Columbia does not provide cardiovascular surgery or neurosurgery, two recognized indicators when discussing tertiary facility. Veterans needing these services are referred to Augusta or Charleston VAMCs.

Alternative Option A (Recommended): Maintain all 3 facilities (Columbia, Augusta and Charleston) as no additional consolidations of services are feasible. Most of the

tertiary programs have already been integrated using a network-managed care approach with benchmarks and performance measures. Most of the administrative services have already been consolidated to ensure operational efficiencies and standardization of services and products. Furthermore, a review of outpatient demand shows a steady increase in specialty care workload for each of these facilities. Therefore, the likelihood that the tertiary component of one of these facilities could be reduced is not feasible if the VA plans to meeting waiting time standards for care, access standards and maintain quality of care without significant new construction or expensive contract care. The evaluation of growth in inpatient and outpatient demand between FY 2012 and FY 2022 supports this decision. These facilities can manage inpatient workload by "right sizing" inpatient unit beds. This right sizing includes flexibility in designating beds as medicine or surgery (as needed) and the cross training of nursing staff in medicine and surgery. The high cost/low volume services are already consolidated at two of the three facilities thereby avoiding duplication of these services and improving efficiency and quality.

Alternative Option B: Maintain only one of the two facilities. VISN 7 focused on eliminating inpatient services at the Columbia VAMC due to it's almost equidistance between Charleston and Augusta VAMCs. Issues evaluated include: 1) Impact on Augusta 2) Impact on Charleston 3) Impact on Columbia. The outcome of the evaluation indicates that eliminating inpatient care at Columbia VAMC would create an acute hospital access PI for the South Carolina market (54.2%), require costly contracting out of hospital care, generate a lack of support for the extensive outpatient (specialty and primary care) services in Columbia and impact continuity of care for veterans.

Alternative Option C: Maintain all facilities and consolidate the specific tertiary specialty services at one of the three sites based on referral patterns, facility capabilities (space, staffing, equipment) and existing affiliate partnerships in the delivery of specific tertiary specialty care. This has been accomplished to a major degree as depicted in Table 5 with only eye, vascular, orthopedic surgeries and radiology offered at all three facilities. Complete clinical consolidation will negatively impact medical and DoD affiliate programs and, most importantly, veterans' access to care.

VISN 7

Proximity Planning Initiatives
Augusta, Columbia, and Charleston

Background

Three tertiary care facilities in VISN 7 are within the 120-mile standard for a Proximity Planning Initiative (PI). These facilities are Augusta, Columbia, and Charleston VA Medical Centers. Columbia is geographically located between the other two facilities, with Augusta 82 miles to the west and Charleston 116 miles east. The basis for this PI is the proximity of Columbia to Charleston and Columbia to Augusta. (The distance between Charleston and Augusta is greater than 120 miles and does not create a tertiary proximity PI.) One problem encountered when conducting the proximity review is the lack of clear definition of tertiary facility and services. Assuming tertiary services are on a continuum, Columbia is at the very minimal end with Augusta and Charleston in the middle. VISN 7 considers a transplant center on the high end of the continuum. Historically, the presence of an open-heart surgery program and neurosurgery were two major determining indicators for a facility to be designated tertiary. Columbia does not provide either in-house with veterans needing these services referred to Augusta or Charleston VAMCs. The three facilities that make up this Proximity PI have overlapping acute care roles but do not overlap tertiary care services. The Columbia VAMC, while it has a full range of consultative services, does not meet other criteria for providing advanced acute care that are important for a tertiary classification.

Assessment of Current Environment

Mission and Access

The three facilities involved have overlapping acute care missions, but the overlap does not exist for tertiary care services. All three facilities provide medical and surgical inpatient care and outpatient specialty care in most of the subspecialties. These missions are detailed in Attachment A. All three facilities have strong affiliations in medicine and surgery, have affiliations in the allied health disciplines, and have established sharing agreements and/or joint ventures with DoD.

There are no tertiary care access PI concerns since 100% of the enrollees meet the access drive standards. Additionally, if any one of the three facilities changed its mission from tertiary care to acute care, an Access PI for tertiary care would not exist.

The existing use value of all the facilities is much greater than the market value of the land without the facilities.

	Existing Use	Market Value
Augusta (Uptown)	$161 million	$10 million
Augusta (Downtown)	$214 million	$ 1.5 million
Charleston	$ 62 million	$ 8.4 million
Columbia	$149 million	$ 5 million

Columbia and Charleston VAMCs are in need of ward renovations for inpatient services.

Enrollment and Utilization

NOTE: Enrollment and Utilization data in this section were extracted from the KLF Menu on March 12, 2003. These data include enrollment data as of January 2003, and include specific parameters to capture workload associated with the Preferred Facility. As such, this data cannot be reconciled to VISTA, which may show higher numbers of enrollees in FY 2002.

FY 2002 Enrollment Data, extracted from the KLF Menu, for the three facilities is shown below. An analysis of these data shows that, of the three facilities, Columbia has the largest number of unique enrollees and also the largest number of users in FY 2002. A comparison of Unique Enrollees to Users in FY 2002 shows that almost 56% of the veterans enrolled at Augusta actually used the services. At Charleston, 47% enrolled and utilized the services, and 52% in Columbia. For ease of review purposes, an evaluation of growth by Enrollment Priority will be reviewed as two overall groups: Categories 1 through 4, being the first and having a higher enrollment priority and Categories 5 through 7C, as the second group having a lesser enrollment priority. The data show that at each facility, approximately 25% of the New Users in FY 2002 were in the higher priority groups, Categories 1 – 4, and 75% were enrolled in Priority Categories 5 – 7C.

Table 1	**Augusta**			**Charleston**			**Columbia**		
Enrollment Priority	**Unique Enrollees**	**Users in FY 2002**	**New Users in FY 2002**	**Unique Enrollees**	**Users in FY 2002**	**New Users in FY 2002**	**Unique Enrollees**	**Users in FY 2002**	**New Users in FY 2002**
1	3,810	3,057	33	4,496	3,311	24	7,174	5,804	37
2	2,527	1,352	33	3,827	1,918	49	5,338	3,035	66
3	4,519	2,036	92	7,722	3,083	129	10,029	4,756	240
4	1,524	1,194	13	1,535	1,115	13	2,598	1,731	122
5	11,097	6,803	334	16,345	8,672	259	20,432	11,385	641
6	854	257	15	1,614	441	22	1,336	356	18
7A	368	155	1	642	241	8	1,115	459	35
7C	7,029	2,821	306	15,758	5,825	225	18,961	7,308	627
TOTAL	**31,728**	**17,675**	**827**	**51,939**	**24,606**	**729**	**66,983**	**34,834**	**1,786**

The enrollment data in Table 2 may be used to assess inpatient utilization by reviewing Inpatient Bed Days of Care (BDOC) at the "Preferred Facility" vs. BDOC at the "Other Facility". The facility in which a patient is enrolled is considered the patient's "Preferred Facility". When the patient receives treatment at another VA, this facility is identified as "Other Facility". Where the patient receives inpatient care is primarily influenced by two factors: 1) the availability of the specialty services at the preferred facility, and 2) patient preference.

Table 2

	Augusta			Charleston			Columbia		
Enrollment Priority	**Users in FY 2002**	**BDOC Preferred Facility**	**BDOC Other Facility**	**Users in FY 2002**	**BDOC Preferred Facility**	**BDOC Other Facility**	**Users in FY 2002**	**BDOC Preferred Facility**	**BDOC Other Facility**
1	3,057	1905	3,719	3,311	1,282	1,724	5,804	4,527	4,752
2	1,352	492	431	1,918	327	379	3,035	648	563
3	2,036	343	836	3,083	490	496	4,756	332	1,433
4	1,194	2035	3,415	1,115	916	942	1,731	914	2,129
5	6,803	1617	3,142	8,672	1,703	1,036	11,385	1,622	2,189
6	257	7	11	441	30	4	356	46	33
7A	155	10	11	241	17	0	459	42	85
7C	2,821	469	322	5,825	424	357	7,308	256	372
TOTAL	**17,675**	**6,878**	**11,887**	**24,606**	**5,189**	**4,938**	**34,834**	**8,387**	**11,556**

In FY 2002, there were a total of 77,115 Users of VA Services among the three facilities -- Augusta, Charleston, and Columbia – of which 63% (48,835) used inpatient services. Of these inpatient users, 42% (20,454) used a Preferred Facility and 58% (28,381) received inpatient care at another VA Facility.

An analysis by facility indicates of the 18,765 patients receiving inpatient care (Preferred and Other Users) in FY 2002 at Augusta, 37% (6,878) received care at the Preferred Facility and 63% (11,887) received care at another VA facility. In Charleston, 10,127 patients utilized inpatient services in FY 2002. Of this total, 51% (5,189) utilized the Preferred Facility and the remaining 49% (4,938) received care at another VA. In Columbia, 19,943 patients received inpatient care and 42% (8,387) receive their care at the Preferred Facility and almost 58% (11,556) were treated at another VA facility. This indicates that referral to adjacent facilities for specific care is already occurring to a large degree.

A comparison of Total Outpatient Visits by Facility to the number of patients receiving care at the Preferred Facility vs. Other Facility indicates that approximately 65% of the patients receive their outpatient care at the Preferred Facility and 35% receive their care at another facility for each of the three Proximity PI facilities. Utilization by facility and Preferred vs. Other Facility users are detailed in Table 3 below:

Table 3	Augusta		Charleston		Columbia	
Enrollment Priority	Visits Preferred Facility	Visits Other Facility	Visits Preferred Facility	Visits Other Facility	Visits Preferred Facility	Visits Other Facility
1	8,261	10,887	9,932	5,328	20,889	8,037
2	3,119	2,060	3,863	2,381	7,363	3,007
3	4,309	2,630	5,916	3,219	10,061	5,010
4	3,428	3,725	4,517	1,553	4,174	2,327
5	15,918	7,945	19,518	8,261	23,885	13,666
6	429	144	766	285	575	349
7A	281	98	360	186	836	339
7C	4,654	1,052	8,211	3,906	11,134	5,780
TOTAL	**40,399**	**28,541**	**53,083**	**25,119**	**78,917**	**38,515**

Inpatient Demand

Augusta VA Medical Center (VAMC) provides specialty care services in all medical and surgical specialties and subspecialties. It is the tertiary referral facility for Dublin VA Medical Center and the community-based outpatient clinics (CBOCs) located in Macon and Albany, GA. The VAMC is strongly affiliated with the Medical College of Georgia (MCG) and enjoys a close working relationship with Dwight David Eisenhower Army Medical Center through its unique Joint Venture for Shared Services agreement.

The Columbia VA Medical Center provides primary care, specialty care, extended care, and related social support services to the veteran population. The medical center's inpatient facility encompasses acute medical, surgical, psychiatric, and long-term care. The medical center operates a Nursing Home Care Unit adjacent to the hospital. The medical center is recognized for its tertiary-level pain clinic and provides this service for patients residing in the Augusta and Charleston catchment areas. There is a large CBOC located in Greenville and smaller CBOCs in Florence, Rock Hill, Sumter, Orangeburg, and Anderson, SC. There is a strong affiliation with the University of South Carolina (USC) School of Medicine, which is located on the VA campus in VA buildings. The medical school does not have its own medical center, relying on the VA and community hospitals for resident training. The VA medical center is designated as the Clinic of Jurisdiction for the state of South Carolina. Further, it provides administrative support for the Florence, SC National Cemetery and has a strong relationship with Moncrief Army Hospital at Fort Jackson. Columbia VAMC's National Inpatient Customer Satisfaction scores have been consistently good with an average of 1 - 2% above the National Average. In 2002, Columbia averaged 4% higher than the VISN average in each of the Customer Service Standards.

In Charleston, if the proposed replacement facility venture with the affiliate, Medical University of South Carolina (MUSC), comes to fruition the space issues may be alleviated; however, additional space alone will not resolve these large gaps -- staffing and overall infrastructure are still a major concern. In spite of the space shortage at

Charleston, the facility manages to maintain very high patient satisfaction scores, especially in its surgery program, which significantly exceeded the national average scores in FY 2002 and, overall, patient satisfaction scores for all bed sections exceed the national average.

Charleston and Columbia both have a relatively high projected demand for inpatient medicine beds in FY 2012, with a positive gap of 24 beds and 16 beds, respectively. This diminishes by FY 2022 to 17 beds and 6 beds, respectively. Projected in Augusta are 6 excess beds in FY 2012 and an excess of 15 beds in FY 2022.

In surgery, the number of inpatient beds for each facility seems sufficient, or within a manageable range at the facility level, for the projected workload by FY 2012. By FY 2022, Augusta and Columbia show a slight decline in the need for inpatient surgery beds, with a projections of an excess of 4 beds in Columbia by FY 2022 and as many as 11 excess beds in Augusta by this same time. At Charleston, the surgery gap shows a need for an additional 17 beds in FY 2012 and 2 beds by FY 2022.

Outpatient Specialty Demand

If the demand for outpatient specialty care workload increases as projected by the CARES data, the medical centers will not have the capacity to provide specialty care and primary care within the physical space available at most medical centers. This is especially true of Charleston where space is already a limiting factor.

Referred workload to the Augusta VA Medical Center from the Dublin VA Medical Center and its associated CBOCs accounted for a total of 13,591 and 14,892 clinic stops/visits in FY 2001 and FY 2002, respectively. Of this workload, the percent breakdown by category of service is as follows: 13% Cardiology, 4% Audiology, 3% Neurology, and remaining 80% Other Medical/Surgical Subspecialties. Specialty patient referrals from Dublin and the Macon and Albany, GA CBOCs are expected to grow by an estimated 5% per year.

Although the specialty care workload gap in Augusta increases as we approach FY 2012 (18% gap), this gap is relatively small as compared to the gap in the overall Georgia market. The workload gap in Augusta is unlikely to be resolved within the Georgia market due the geographic proximity of Augusta to other tertiary facilities in this market and because of the large gaps in the other medical centers in this market. Since sufficient space is available, and given the availability of staffing resources, the gaps for Augusta can be easily resolved. In South Carolina, the specialty workload gaps for Charleston and Columbia are near or above a 100% gap at each facility in FY 2012 and in FY 2022.

Patient Satisfaction

Table 4 shows Patient Satisfaction data extracted from the Office of Quality and Performance Programs and Services, Survey of Healthcare Experiences of Patients (SHEP) data. The data is a comparison of Patient Satisfaction Trends by Bed Section, for calendar years 2000 through 2002 (2nd Quarter), for Augusta, Columbia, and Charleston. The VISN 7 Average and National Average have also been included for comparison purposes.

Table 4 **Overall Patient Satisfaction Trends by Bed Section**

	All Bed Sections			**Medicine**			**Surgery**		
	2000	**2001**	**2002**	**2000**	**2001**	**2002**	**2000**	**2001**	**2002**
Augusta	54.92	59.18	65.50	52.57	62.30	70.29	71.81	71.21	68.53
Columbia	64.47	69.33	66.60	64.12	73.94	67.11	62.47	73.10	82.85
Charleston	66.22	66.06	73.37	71.81	71.21	68.53	67.44	71.65	80.75
VISN7 Avg.	60.60	61.28	67.75	61.13	63.66	66.86	68.60	66.98	77.98
National Avg.	64.44	64.53	71.11	65.95	67.95	72.53	73.14	73.84	79.50

An analysis of the Patient Satisfaction data in Table 4 indicates that Augusta has an overall patient satisfaction score that is lower than the VISN 7 and National Average each year for All Bed Sections. Columbia scored very well almost across the board relative to national and VISN averages. Charleston has exceptional Overall Patient Satisfaction scores as compared to the VISN7 averages.

Evaluation of Clinical Inventory and Services

The VISN 7 Clinical Inventories for Augusta, Columbia, and Charleston were reviewed and evaluated to identify any duplication of tertiary/specialty services in the three facilities. The three facilities have already consolidated specialty clinical services to increase efficiency, improve cost-effectiveness, and optimize quality of patient care. For example, the Columbia VAMC sent 31 cardiothoracic surgery cases to Augusta and 82 cases to Charleston in FY 2002. Columbia neurosurgery patients are transferred to Augusta and Charleston. Additionally, the Charleston Neurosurgeons hold one pre/post operative clinic per month at the Columbia. Augusta and Charleston utilize the tertiary-level Pain Clinic in Columbia. The Charleston VA Medical Center is also the referral center for Columbia for invasive/interventional Cardiology, such as PTCAs and Stents, and complex Urological procedures. Other services are shared among the three facilities on an as needed basis, to include orthopedics, general and vascular surgery, pulmonary, and oncology.

Consolidation/Integration of Administrative Services

The Atlanta Network has been a leader within VHA in consolidating administrative services. The Network Business Office concept includes the consolidation of Prosthetics (April 2001), Human Resources (April 2002), Infrastructure, and Logistics (July 2002). All of the consolidations have generated economies of scale.

The consolidation of all of the Network Logistics Offices into one Logistics organization provides for the increase standardization of products, services, and Logistics policies among the eight medical centers in VISN 7. The Network Logistics Office now manages the centralized monitoring of the National Performance Standards. This includes, but is not limited to, inventory management benchmarks, standardization compliance and Socio-Economic Procurement. Consolidation of contracting will raise the service level for contract administration, award, and compliance while creating efficiencies by reducing the total number of contracts required for meeting the needs in VISN 7.

Implementation plans were approved to centralize VISN 7 accounting functions at the Augusta VA Medical Center. The Centralized Accounting Office began operations in January 2002. The centralization of employee travel functions began May 2001 at the Tuscaloosa VA Medical Center. The VISN 7 DSS office remains virtual; however, we have standardized DSS processes and position descriptions. A "One-Team Structure" is used whereby duties are shared between staff and facilities. There are many benefits to the centralization of these fiscal functions, and after training of all the staff associated with the centralized functions is accomplished, a decrease in the number of employees required to manage the workload is expected. Other benefits include, but are not limited to:

- Standardization of accounting processes: will eventually alleviate some of the redundancy in the overall accounting arena.
- Centralization of travel: will result in better customer service and more timely preparation of travel authorities and travel claims.
- Standardization of DSS: has resulted in the development of a standardized methodology for accomplishing audits and providing feedback to facility managers.

In June 2002, a centralized Informatics Service Line for VISN 7 was established. The mission of the VISN 7 Informatics Service Line is to identify ideas of common need, develop plans and priorities for implementation, and oversee implementation VISN-wide consistent with the values of the VISN 7 Executive Leadership Council and the One VA concept. All Informatics, Medical Media and Library staffs are supervised network-wide and this in itself has led to a more consistent approach to customer support across VISN 7. The physical location of most services has remained at the individual medical centers with the exception of a centralized Help Desk, which was consolidated using contractor support at the Dublin VAMC. The Help Desk was established to improve IT customer service across the network. The VISN 7 Informatics Help Desk assures effective 24 x 7 support of all Information Technology services/equipment in the Network, e. g. the Computerized Patient Record System (CPRS), BCMA, Imaging, VISTA, Telecommunications, PC Desktop Applications, etc. The Informatics Service Line has created an integrated informatics infrastructure that allows the VISN to truly function as a network of medical centers.

Augusta, Columbia, and Charleston VA Medical Centers only minimally meet the criteria based on distance for a Proximity PI. Due to the distances involved, additional

consolidations of administrative functions are not feasible. For example, the distance between these facilities means maintaining a consolidated warehouse or shared Supply, Processing, and Distribution (SPD) services would not be cost-effective and would adversely impact patient care support. Highly specialized supplies and equipment need to be immediately available.

One patient-related service that is consolidated is laundry services, located at Augusta. The Augusta location serves Columbia and Charleston. This arrangement has worked extremely well.

Quality of Care

All VISN 7 facilities were surveyed by JCAHO in August 2001. The Augusta VA Medical Center was awarded Accreditation with a Hospital Accreditation Program (HAP) Score of 92. The facility does not have any outstanding OSHA issues and receipt of the OIG CAP Report is pending. All physicians are board certified in their respective subspecialty.

The Columbia VAMC was awarded Accreditation with a HAP Score of 94. In February 2003, the Columbia received an OSHA Citation related to the development and implementation of an emergency response plan to handle and anticipated emergency regarding the potential spill of hazardous chemicals during transport between the inpatient lab and the hazardous waste storage trailer in an outlying building. This citation has been corrected. In other review areas, such as the American College of Surgeons and the Commission on Accreditation of Rehabilitation Facilities, the Columbia has met and exceeded the standard.

The Charleston VAMC was awarded Accreditation with a HAP Score of 93. There are no outstanding issues with OSHA, CAP, or any other external review body.

Table 5 shows an assessment by the National Surgical Quality Improvement Program (NSQIP) for the three-year period, October 1, 1998 – September 30, 2001. This data provides a quality assessment indicator for the ratio of patients treated where the morbidity was higher or lower than expected.

Table 5: Morbidity Observed/Expected (O/E) Ratios Over Time
October 1, 1998 - September 30, 2001

Surgical Subspecialty	Augusta O/E = Ratio	Charleston O/E = Ratio	Columbia O/E = Ratio
General	142/123 = 1.15	069/062 = 1.11	110/108 = 1.02
Vascular	NA	051/048 = 1.06	054/035 = 1.54
Non-Cardiac Thoracic	026/027 = 0.96	NA	NA
Orthopedic	041/045 = 0.91	026/027 = 0.96	029/028 = 1.04
Neurosurgery	069/391 = 0.18	016/087 = 0.18	NA
Urology	029/023 = 1.26	027/022 = 1.23	024/015 = 1.60
Otolaryngology	015/012 = 1.25	NA	NA
Plastic	NA	NA	NA

A review of Augusta's data above, comparing observed to expected morbidity, shows that Augusta has a slightly higher morbidity rate in three of the six subspecialties evaluated. In Charleston, the morbidity was higher in three of the five areas, and in Columbia every subspecialty evaluated shows a higher than expected morbidity ratio.

Using NSQIP data for the same period, October 1, 1998 – September 30, 2001, the ratio of observed vs. expected deaths is also evaluated in Table 6:

Table 6: Mortality Observed/Expected (O/E) Ratios Over Time
October 1, 1998 - September 30, 2001

Surgical Subspecialty	Augusta O/E = Ratio	Charleston O/E = Ratio	Columbia O/E = Ratio
General	039/031 = 1.25	014/010 = 1.40	036/030 = 1.20
Vascular	NA	011/007 = 1.57	004/006 = 0.67
Non-Cardiac Thoracic	008/009 = 0.89	NA	NA
Orthopedic	011/009 = 1.22	008/005 = 1.60	007/007 = 1.00
Neurosurgery	011/013 = 0.85	002/003 = 0.67	NA
Urology	001/003 = 0.33	003/003 = 1.00	001/002 = 0.50
Otolaryngology	004/003 = 1.33	NA	NA
Plastic	NA	NA	NA

Source: NSQIP Annual Report, Table 8

At Augusta and Columbia, half of the subspecialties evaluated show a mortality rate greater than expected and the other 50% show a rate lower than expected. In Charleston, four of the five subspecialties evaluated show a mortality rate higher than expected. There does seem to be some correlation between morbidity and the mortality ratio – where the morbidity is higher than expected, the mortality ratio is also higher than expected. However, the only exception to this correlation is Urology, where

the morbidity is higher than expected and the mortality is significantly lower than expected or in Charleston where the ratios are equal. This trend reversal is not entirely surprising considering the high demand for Urological procedures among our patient population and the system-wide expertise in this subspecialty.

Cost of Care

Per Table 7, the average cost per Bed Day of Care (BDOC) is lower at Columbia than at Augusta, Charleston, or the VISN average. Also, the Columbia cost per BDOC is substantially lower than Augusta in Medicine, and substantially lower than Charleston in Surgery.

Table 7	VISN Average	Augusta VAMC	Charleston VAMC	Columbia VAMC
Medicine	$1,240	$1,400	$1,278	$1,140
Surgery	$1,871	$1,678	$2,018	$1,570
Average Cost	$1,556	$1,539	$1,648	$1,355

(source: VSSC CARES Cost Calculator)

In FY 2012, the Columbia VAMC projected BDOC are 22,099 for Medicine and 6,571 for Surgery. Using these figures, and the cost per BDOC from Table 7, the cost to treat patients in FY 2012 at each facility is depicted in Table 8:

Table 8	VISN Average	Augusta VAMC	Charleston VAMC	Columbia VAMC
Medicine	$27,402,760	$30,938,600	$28,242,522	$25,192,860
Surgery	$12,294,341	$11,026,138	$13,260,278	$10,316,470
Average Cost	$19,848,551	$20,982,369	$20,751,400	$17,754,665

Table 8 shows that Columbia VAMC could provide care 22,099 BDOC at a cost of $25.2 million, which is 11% ($28.2 million) less than Charleston and 18% ($30.9 million) less than Augusta.

Assuming that BDOC is constant over a five-year period, this translates into $126.0 million at Columbia as compared to approximately $150 million at Charleston or Augusta over the same five-year period – which is 16% more than providing the care at Columbia. The increase in costs for the same workload may be attributed to the complexity and level of inpatient care at Augusta and Charleston, as compared to Columbia.

ANALYSIS

<u>ALTERNATIVE OPTION A</u>: Maintain all facilities (Columbia, Augusta and Charleston)

A review and evaluation of the Clinical Inventory for the three Proximity facilities shows that most of the acute care workload has already been integrated and many of the administrative services are already consolidated. No significant additional specialty services could be integrated without disruption of the teaching affiliation program and impairment to access for the discontinued service at the remaining VAMCs. A review of outpatient demand shows a steady increase in specialty workload for each of these facilities, especially Columbia and Charleston; therefore, the likelihood that the tertiary component of one of these facilities could be closed is not feasible if the VA plans to address demand for care. A tertiary care presence, or a combination of tertiary and acute presence, between the three Proximity facilities is needed to maintain access and quality of care. The evaluation of growth in inpatient and outpatient demand between FY 2012 and FY 2022 supports this decision.

Some of the acute and specialty integrations are as follows:

- Columbia VAMC sent 31 cardiothoracic surgery cases to Augusta and 82 cases to Charleston in FY 2002.
- Neurosurgery patients are transferred from Columbia to Augusta and Charleston, and the Charleston specialists hold one pre/post operative clinic per month at the Columbia VAMC.
- Augusta and Charleston utilize the tertiary-level Pain Clinic in Columbia.
- Charleston VA Medical Center is also the referral center for Columbia for invasive/interventional Cardiology, such as PTCAs and Stents, and complex urological procedures.
- Other services, shared between the three facilities on an as needed basis, include orthopedics, general and vascular surgery, pulmonary, and oncology.

Charleston has a significant shortage of inpatient medicine beds and aggressive strategies for addressing this gap must be developed. The number of inpatient surgery beds for all three facilities is sufficient and does not require consideration as a CARES PI, even though Charleston is just below the range for consideration.

Table 9 is a comparison of high cost services as identify by the CARES process.

Table 9: Comparison of High Cost Services and Capacity by Facility

Description	Augusta	Charleston	Columbia
Cardio-thoracic surgery	Sharing arrangement with DoD. Excess Capacity exists during non-war times.	In-house. Excess Capacity: Yes	***Not available.*** Workload transferred to Charleston, Augusta or Asheville (VISN 6)
Invasive/Interventional Cardiology	In-house. 72 cases in first 6 months of FY 2003. Excess capacity: two referrals/week.	In-house. The team performed 869 procedures at affiliate. Excess capacity: None	***Not available.*** 82 were referred to Charleston; 31 to Augusta. Excess capacity: N/A
Hemodialysis	Contract with Fresenius. Excess capacity: Available via contractor.	In-house. Excess capacity: None	In-house. 3,175 chronic & 639 acute treatments Excess capacity: None.
Joint Replacement	In-house. Excess Capacity: None.	In-house. Excess capacity: Dependent upon the procedure & complexity.	In-house. Surgeon did 51 VA joints & 94 affiliate joints. Total ortho cases were 221. Significant component of affiliation. Excess capacity: None.
Vascular Surgery	In-house. Excess capacity: None.	In-house. Excess capacity: Dependent upon the procedure & complexity.	In-house. 277 procedures Excess capacity: 5 - 10 cases per month.
Neurosurgery	In-house. Joint Venture with DoD. Excess capacity: None.	In-house. Excess capacity: None.	***Not Available.*** Referred to Charleston. Excess capacity: N/A
Interventional Radiology	Contract with Vascular Associates. Excess capacity: Available via contractor.	In-house. Excess capacity: None.	In-house. 462 angiograms; 127 interventional procedures in FY 2002. Excess capacity: None.
Transplant Programs	***Not Available.*** Workload referred to VA approved sites: Nashville, Richmond, Seattle, and Chicago	Contract with VA Affiliate, MUSC.	***Not Available.*** Workload referred to VA approved sites: Nashville, Richmond, Seattle, and Chicago
Eye Surgery	In-house. 330 procedures	In-house. 339 procedures	In-house. 363 procedures

As shown by in Table 9, many of the high cost/low volume services are already being transferred from Columbia to another VA facility, avoiding duplication of these services and improving efficiency.

VISN 7 has been a leader in establishing a Network Business Office, which includes Prosthetics, Human Resources, Infrastructure, and Logistics as previously discussed as part of the Environmental Assessment under the "Consolidation/Integration of Administrative Services". These consolidated arrangements have proved effective. The Centralized Accounting, Decision Support Services, and Travel consolidation has been very successful and the IT Service Line consolidation is effective.

The track record proves that consolidations, both clinically and administratively, have already occurred without compromising quality patient care and efficiency of administrative services.

The consolidation of administrative functions into the Network Business Office in VISN 7 maximizes the use of excess space at the Augusta VA and creates system efficiency by standardizing processes and developing network wide expertise. These efficiencies are realized in human resources, centralized accounting, logistics, travel, and especially information technology.

ALTERNATIVE OPTION B: Maintain only one of the two facilities (Eliminate one facility).

The Proximity PI consists of two pairs: Columbia-Augusta and Columbia-Charleston. Since Columbia is geographically located between the other two facilities, with Augusta 82 miles to the west and Charleston 116 miles east, it seems reasonable to consider the closure of the tertiary component of the Columbia facility. The assumption is that 50% of Columbia's acute inpatient care would shift to each of the other two facilities, Augusta and Charleston. Additionally, the closure of Augusta is evaluated since the geographic concentration of unique enrollees is significantly lower at this facility than at Columbia and Charleston.

Impact on Augusta if Columbia Closed Acute Inpatient Services:
Assuming that Augusta VAMC absorbed 50% of Columbia's acute inpatient workload, the impact to Augusta would be as follows:

Medicine	FY 2012 BDOC	FY 2022 BDOC
Augusta VAMC	16,757	14,105
Columbia VAMC	11,161	9,550
Total	27,918	23,655
Needed Beds for Total Workload (85% occupancy rate)	**89**	**76**

Surgery	FY 2012 BDOC	FY 2022 BDOC
Augusta VAMC	9,129	7,938
Columbia VAMC	3,302	2,847
Total	12,431	10,785
Needed Beds for Total Workload (85% occupancy rate)	**51**	**43**
Grand Total Beds Needed	**140**	**119**

Augusta currently has a total of 95 med/surg beds. To accommodate the 140 beds in 2012, we would need to open two additional wards. The cost of renovation as estimated by the facility engineer would be roughly $4 million per ward for a total of $8 million. An administrative building to house the displaced administrative functions is required at an estimated cost of $2.5 million.

Augusta has space that could be converted to inpatient use, however Augusta is expected to have significant increases in both primary and specialty care outpatient workload in 2012. Unit 6D is currently being utilized for spinal cord injury inpatients while the SCI unit is being renovated and expanded. Unit 6C is being utilized for pulmonary function testing and administration of chemotherapy. Unit 6C is also where the majority of negative pressure rooms are located for the facility. The remaining space contains administrative functions. While tapering off somewhat, the workload in 2022 would still be greater than that of the base year, 2001. The impact of taking on Columbia's workload would limit available space for expansion of the specialty care and primary care clinics. Another factor to consider is that CARES indicates that Augusta would have to add 26 additional acute Spinal Cord Injury beds by 2022. Spinal cord injury patients are heavy users of ancillary care resources. It is not feasible for Augusta to absorb workload beyond that indicated without either renovating for 2 inpatient wards, contracting out workload (inpatient & outpatient), or leasing/constructing significant new space.

If Augusta were to absorb 50% of the surgical workload from Columbia there is sufficient space in the Operating Room Suite and the main Recovery Room to treat these patients.

Total elimination of the Columbia facility would displace such a high volume of workload that this scenario is not feasible. The Columbia facility is the 2nd largest facility, behind Atlanta, when considering the number of veterans managed.

Impact on Charleston if Columbia Closed Acute Inpatient Services:
Assuming that Charleston VAMC absorbed the remaining 50% of Columbia's acute inpatient workload, the impact to Charleston would be as follows:

Medicine	FY 2012 BDOC	FY 2022 BDOC
Charleston VAMC	21,405	19,221
Columbia VAMC	11,161	9,550
Total	32,566	28,771
Needed Beds for Total Workload (85% occupancy rate)	**105**	**93**

Surgery	FY 2012 BDOC	FY 2022 BDOC
Charleston VAMC	9,872	8,789
Columbia VAMC	3,302	2,847
Total	13,174	11,636
Needed Beds for Total Workload(85% occupancy rate)	**42**	**38**
Grand Total Beds Needed	**147**	**131**

Charleston currently has a total of 83 med/surg beds. To accommodate the need for 147 beds by 2012, the facility would need to open one additional medicine ward and half of a surgery ward. The goal would be to absorb the surgical workload into existing space by maintaining flexibility between acute medicine and surgery beds. The cost of new construction and required renovations to existing space would total approximately $5.3 million.

If Charleston were to absorb 50% of Columbia's workload there would be significant concerns in a number of areas. There is currently no room in the Charleston facility for expansion of medicine or surgery programs; however, new construction could address this situation. The shift of 50% of Columbia's inpatient workload would impact Charleston's outpatient workload.

As described earlier, total elimination of the Columbia facility would shift such a large volume of outpatient workload to Charleston that this scenario is not feasible.

Charleston's ability to accommodate the increased workload in surgery and PACU is dependent upon the complexity and number of cases. There are proposed plans for an OR expansion project; however the goal is to modernize, not add more rooms. An

increase in inpatient workload could provide a greater opportunity to support the teaching component of the Charleston VAMC's mission and could further strengthen the affiliation with the Medical University of South Carolina.

Impact on Columbia if Acute Inpatient Services are Closed:
Consideration was also given to the impact of closing acute inpatient services at Columbia VAMC. If Columbia were to close acute inpatient services, there would be a tremendous impact on the Research, Safety and Environment, Academic Affairs, Staffing and Community, Support to other Missions of VA (VBA, NCA, and DoD), and on the ability to optimize the use of VA resources.

Closure of inpatient services at Columbia VAMC would preclude the delivery of timely health care services to the veterans of South Carolina. There is no VA capacity to accommodate the tremendous workload and growth Columbia VAMC has experienced. The mission of the Columbia VAMC (with its six clinics) is to provide an integrated delivery system, which improves the health of the veteran population by providing primary care, specialty care, extended care and related social support services.

South Carolina is a medically-underserved state, facing an extreme shortage of nurses, but also a shortage of physicians and other clinical support staff, as well as health care facilities. The Columbia VAMC plays a vital role in the provision of teaching facilities and experiences to trainees in South Carolina. Closure of inpatient services would severely impact the integrity of the University of South Carolina School of Medicine as well as the economy of the midlands of South Carolina. This closure would dramatically impact the culture of the medical center. Most of the staff and faculty would no longer be required, thereby, destroying the academic environment of the medical center. The USC School of Medicine was created with VA funding after Congress passed the Teague-Cranston Act, which provided significant VA support for the formation of new medical schools. Closure of inpatient services would severely impact the future physician and nurse workforces for the state of South Carolina. The Schools of Medicine and Nursing depend on Columbia VAMC for clinical rotations for students and clinical preceptors and faculty. The numbers graduating from the state schools would decline and further contribute to an even greater shortage of health care professionals. If the acute care services were eliminated, the School of Medicine would literally be faced with possible closure since their long-term lease of the former VA hospital is predicated on the continuation of the medical affiliation. There would be no legal basis for the lease since the medical residency program would no longer be viable or meet medical education accreditation standards.

The loss of these inpatient services will affect 63 affiliation agreements in various disciplines with 27 institutions. These include the University of South Carolina School of Medicine, Palmetto Health Richland, Midlands Technical College, the University of South Carolina College of Pharmacy, and the University of South Carolina College of Nursing. The Columbia VA Medical Center provides training to over 680 trainees per year. We currently have 49 resident and fellow positions and approximately 175 residents/fellows rotate through the VAMC annually. If removal of inpatient services

occurs at Columbia VAMC and precipitates closure of the USC School of Medicine, approximately 75 less physicians would graduate annually.

Closure of inpatient services would severely impair the continuity and spectrum of care for the veterans served in the Columbia, South Carolina catchment area. This closing of services would have a domino effect on the stability of the medical center, the School of Medicine, and the care provided to the veterans served. Remaining options for inpatient care would include:

a. Transfer of healthcare to other VA Medical Centers (requiring significant travel and expense, plus lack of capacity to pick up the workload).
b: Contractual care in the private sector (financially not feasible).
c: Elimination of essential patient care services.

Eliminating inpatient care at Columbia VAMC would create a significant geographic gap in services, resulting in a failure to meet another CARES guideline to provide acute hospital care within 60-minutes. Columbia VAMC is already working to address access to acute hospital care in the upstate of South Carolina. Additionally, this would significantly impact access to acute hospital care in the Metropolitan Augusta area, which would require significant contracting of services to resolve.

The Research Program is an integral part of the Columbia VAMC Strategic Plan for academic improvement. All of Columbia's major goals for implementation require an active and vibrant research program (Recruitment and Retention, Magnet Hospital Status, and Centers of Excellence in Oncology and Geriatrics). A lack of inpatient services would compromise the Human Research Program since many research projects require inpatients. It would severely impact new initiatives with the School of Public Health, Departments of Chemistry and Biology, and current research grants with USC. There would also be a negative impact on clinical study enrollment and follow up.

Columbia VAMC has developed a premier working relationship with DoD through sharing agreements. This resulted in cost savings/avoidance in excess of $2 million in FY 2002 (blood products, sleep laboratory services and MRI). In addition to these existing programs, Columbia VAMC is proceeding with a pilot program to provide operating room services and personnel to DoD beginning with one day per week.

Columbia VAMC performed 3,773 surgical cases in the OR, second in volume only to Atlanta in VISN 7. There is no capacity to handle this workload elsewhere. The Columbia VAMC is unique in several important areas. The Molecular Pathology Department provides analyses for HIV-1 Viral Loads (1,972); HCV Quantitative (1,691); HCV Quantitative (2,362); and HCV Genotype (1,474) for the other VA facilities in the Atlanta Network. This resulted in a cost savings of $386,868 for the Columbia VAMC and a savings of $1,350,770 for VISN 7 in FY01. Additionally, no other VISN 7 facility provides this service. Columbia operates a tertiary-level Pain Clinic two days per week, with 2,767 patient visits and 299 anesthesia injections in FY 2002. Additionally 35 pain implants (infusion pumps and stimulators) were surgically inserted. Both Augusta and Charleston refer veterans to Columbia for this specialized pain clinic.

In summary, it is fiscally irresponsible and geographically impractical to consider transfer of inpatient services at other medical centers. Columbia is the most rapidly growing facility within the Atlanta network. The Columbia VAMC is a thriving medical center whose growth, productivity and rapidly increasing workload warrant expansion. Additionally, the fact that Charleston VAMC is just 4 miles under, and Augusta VAMC is just 38 miles under the 120-mile threshold weakens arguments for closing beds at any of these facilities. A decision to reduce inpatient services at any of these facilities is not in the best interest of veterans in South Carolina.

Impact on Augusta if Acute Inpatient Services are Closed at Augusta:
Based on the CARES data, if Augusta were to eliminate their inpatient acute services it would not create an Access PI; however, there would be a tremendous negative impact upon the Research, Safety and Environment, Academic Affairs, Staffing and Community, Support to other Missions of VA (VBA, NCA, and DoD) issues, and to the ability to optimize the use of VA resources.

The Augusta VA Medical Center (VAMC) provides specialty care services in all medical and surgical specialties and subspecialties. It is the primary tertiary referral facility for Dublin VA Medical Center and the community-based outpatient clinics (CBOCs) located in Macon and Albany GA. The VAMC is strongly affiliated with the Medical College of Georgia (MCG) and enjoys a close working relationship with Dwight David Eisenhower Army Medical Center through its unique Joint Venture for Shared Services agreement.

The two-division Augusta medical center's inpatient facility encompasses acute medical, surgical, psychiatric, and long-term care. The closing of such a large tertiary, medical school affiliated program would have a significant impact on its teaching, research and patient care missions and would cripple its ability to support the Dublin VAMC and its Community-Based Outpatient Clinics (CBOCs) located in Macon and Albany.

The closing of the inpatient program would severely curtail the facility's ability to attract high caliber and funded physicians to conduct research. Physicians recruited jointly by the VAMC and MCG conduct approximately 50% of the ongoing research at the Augusta VAMC. At present, these physicians bring in a total of $1.5 million of research dollars to support Augusta's research efforts. Without this source of funding the research program would not be able to support administrative staff, the animal facility and other critical resources that have allowed Augusta to attract and retain top researchers. In addition, without acute inpatient services no inpatient research protocols could be conducted. It is expected that within a very short period of time the research program in Augusta, without an active acute inpatient function, would fold.

The loss of inpatient services will affect more than 115 affiliation agreements with a multitude of teaching institutions. The largest of these is with the Medical College of Georgia (MCG). Augusta VAMC provides training for over 350 residents from MCG. Funding for this program is as follows: $3.0 million for medical residents, $130,000 for medical students, $80,000 for dental students, $65,000 for podiatry students. The absence of a VA inpatient service would significantly damage the teaching program. In

all likelihood, MCG's School of Medicine would not be able to support its current level of medical student enrollment. The VA funding and facility are vital to their survival. Without the VA 's support it is doubtful whether MCG would be able to maintain a viable School of Medicine. Any drastic reduction in the numbers of physicians MCG is able to train and graduate would have vast repercussions in the community and the healthcare field in general. In addition, the School of Nursing also depends on the Augusta VAMC for clinical rotations for students and clinical preceptors and faculty. The numbers graduating from the state schools would decline and further contribute to an even greater shortage of health care professionals such as nurses during a critical time of need.

The termination of the teaching program at the Augusta VAMC would have ramifications for all of the attending physician staff as well. Since it is a teaching facility, many of the physicians are part-time VA and MCG. In the event, that an alternative to close inpatient services is pursued literally hundreds of physicians employed by the VA would lose their jobs.

The Augusta facility has global missions of teaching, research and patient care. The specific missions and/or functions hit hardest by a closure of their inpatient services would be the acute/specialty care, spinal cord injury, long-term care and emergency services. The other area that would be totally disseminated by a decision to close inpatient services is the productive relationship Augusta has with their Department of Defense (DoD) partner, the Eisenhower Army Medical Center (EAMC).

The Augusta VAMC's long-term care chronic mental health, nursing home and domiciliary programs depend on having access to an acute facility. It is absolutely essential that these patients have ready access to acute care services for acute changes or other urgent and/or emergent medical problems. If these services were not available the VA would have to contract out with local healthcare providers for this care.

The Augusta VAMC has enjoyed a long-standing and productive relationship with the EAMC. It has been recognized nationally as having one of the most progressive VA/DoD collaborative models for delivering healthcare to active military and VA beneficiaries. Without acute inpatient services, the Joint Venture Shared Services (JVSS) for Neurosurgery, Thoracic, Open Heart and proposed Sleep Study Programs would come to an abrupt halt. The VA and EAMC have had much success in pooling resources and building collaborative programs because of their mutual ability to exchange the provision of tertiary services. However, without an acute program and the availability of specialty services there would be no incentive for EAMC to continue in any kind of relationship with the Augusta VAMC. Augusta would no longer be in a position to share their strength in various clinical areas with the EAMC or vice versa. Another great loss would be the Augusta VAMC's ability to carry out its mission in the event of war. Through the VA/DoD Contingency Plan, the Augusta VA currently provides inpatient backup and overflow beds for active military that cannot be accommodated by the EAMC. Unfortunately, this key function would be lost with the loss of inpatient services. The Augusta VAMC is a TriCare provider.

The Augusta VAMC is home to one of the largest Acute Spinal Cord Injury Units (SCIU) in the country. This 60-bed SCIU depends upon having access to an intensive care unit (ICU) and specialty services such as neurosurgery, pulmonary, plastic surgery and orthopedics. It just simply could not survive without acute inpatient services. There is no spinal cord injury facility in the southeast that could accommodate the Augusta workload. This includes Tampa, Miami, Richmond, Memphis and Houston. The local community does not have the ability to care for the numbers of acute spinal cord injuries that utilize this program. If the Augusta SCIU were to vanish, patients would have to travel in excess of 5 or more hours; and more importantly, another 60-beds would have to be added to one of the other VAMCs in our VISN. Obviously, the Paralyzed Veterans Association (PVA) would have much to say about such a plan. The political ramifications of such a plan would be quite severe. Augusta just completed a $3.9 million renovation of 48 patient rooms with another $3.5 million earmarked to update and renovate the remaining patient rooms on this unit. The $3.9 million is a sunk cost that could not be recouped in the event that a decision was made to close this acute SCIU program and move it to another locale.

Workload transferred to the Augusta VA Medical Center from the Dublin VA Medical Center and its associated CBOCs accounted for a total of 13,591 and 14,892 clinic stops/visits in FY 2001 and FY 2002, respectively. Of this workload, the percent breakdown by category of service is as follows: 13% Cardiology, 4% Audiology, 3% Neurology, and remaining 80% Other Medical/Surgical Subspecialties. Specialty patient referrals from Dublin and the Macon and Albany CBOCs are expected to grow by an estimated 5% per year. The loss of Augusta's inpatient program would be catastrophic for Dublin who depends upon this facility as its primary tertiary referral center. Services that would have to be absorbed by another Network facility or contracted out would include all medical and surgical specialty care, Audiology, ophthalmology and acute psychiatry. The obvious referral site for Dublin patients would be the Atlanta VAMC. It does not have any excess capacity in which to care for these patients. The cost would be exorbitant whether one is considering contract costs or the cost of new construction at the Atlanta VAMC to expand their facility to support the Dublin workload.

The Columbia VAMC would be affected by the closure of inpatient services in Augusta. The Columbia VAMC does not have neurosurgery, thoracic surgery or interventional cardiology. In FY 2002, Columbia sent 42 open-heart cases to Augusta. It also utilizes Augusta's neurosurgery and interventional cardiology programs. The Augusta VAMC is one of the few hospitals that can offer cardiac electrophysiology (EP) services in-house. These services include EP Studies, pacemaker, ICD placement and cardiac ablations.

The Downtown Division of the Augusta VAMC consists of 670,468 SF of space. The estimated price of the building if sold would be $201,140,400 based on a $300 cost per square foot to build a similar facility.

In summary, it is fiscally irresponsible to consider consolidation of inpatient services at other VA Medical Centers. The impact upon the Augusta community, including the Medical College of Georgia, and Dwight David Eisenhower Army Medical Center would

be especially traumatic. The referral of patients from Dublin needing tertiary services would be negatively affected, as the Atlanta VAMC does not have the resources available to meet this increased need. The monetary and political costs of such a move would be difficult for VHA to overcome.

ALTERNATIVE OPTION C: Maintain all facilities (Columbia, Augusta and Charleston), but consolidate services/integrate facilities.

As describe thoroughly in Alternative Options A & B, the recommendation is to maintain all facilities status quo. Columbia is considered a minimally tertiary facility, maintaining only those tertiary functions necessary to continue the affiliation with the University of South Carolina School of Medicine. Further removal of tertiary services would devastate this affiliate to the point of where the affiliation would end.

The high cost/low volume tertiary services have already been consolidated away from Columbia. This includes organ transplants, cardio-thoracic surgery, neurosurgery, invasive/interventional cardiology, etc. The remaining tertiary services - eye, vascular, orthopedics, and radiology, are critical if the affiliation is to continue.

The network has completed the consolidation of many of the business functions, including Informatics , Human Resources, Logistics and Fiscal. The approximately 2-hour travel time from Columbia to the two adjacent facilities negates the potential for sharing services such as warehouse or SPD.

RECOMMENDATION

VISN 7 recommends Alternative Option A (maintain tertiary services at all sites) as the best option for this Proximity PI. The affiliations in place at each medical center have distinct specialty teaching programs and DoD sharing agreements that would be negatively impacted if the limited remaining tertiary clinical programs (i.e. eye surgery, orthopedic joint replacement and vascular surgery) were consolidated at remote VA medical centers. Therefore, it is recommended that all three facilities continue their current specialty programs. Please review Appendix B – Impact on CARES Criteria for further supporting evidence for this recommendation.

Appendix A - Mission Statements for CARES Proximity PI – VISN 7

Augusta

The Augusta VA Medical Center (VAMC) is a two-division medical center that provides tertiary care in medicine, surgery, neurology, psychiatry, rehabilitation medicine, and spinal cord injury. Augusta is the primary tertiary care referral center for the Dublin VA Medical Center and the Macon and Albany, GA Community-Based Outpatient Clinics (CBOCs). The Downtown Division has 58 medicine, 37 surgery, and 60 spinal cord injury beds. The Uptown Division located approximately 3 miles away, houses a 132 Nursing Home Care Unit beds; a 15-bed Blind Rehabilitation Center; 10 medical rehabilitation beds, and outpatient rehabilitation unit; 68 Mental Health & Behavioral Science beds; and a 60-bed domiciliary. Included in the Nursing Home Care Unit are special programs for Alzheimer's patients, and a unit developed to meet the needs of patients with advanced dementia. Additional designated special programs that have evolved to meet specialized needs prevalent in the veteran population include treatment of the spinal cord injured, blinded veterans, chronically mentally ill and homeless, traumatic brain injuries, substance abuse, and veterans with amputated limbs, among other programs.

The Augusta VAMC continues to be one of VHA's forerunners in building successful collaborative healthcare delivery partnerships with the Department of Defense (DoD). The Medical Center and Eisenhower Army Medical Center (EAMC) at Fort Gordon entered into a Joint Venture for Shared Services in 1993, which provides for the cost-effective sharing of resources between these two federal health care facilities. Among the many Joint Venture business agreements between the two Federal facilities are consolidations of Cardio-thoracic surgery and Neurosurgery. Department of the Army surgeons perform all Cardio-thoracic surgery for VA and DoD beneficiaries at Eisenhower Army Medical Center. The same surgeons provide cardio-thoracic clinics and follow-up care at the VA Medical Center. Department of the Army neurosurgeons provide all neurosurgical services for VA and DoD beneficiaries at the VA Medical Center. Affiliated with the Medical College of Georgia, which is physically connected to the downtown division. The Medical College of Georgia presently provides radiation therapy for Augusta VA Medical Center patients through a contractual relationship. The Medical College of Georgia also provides general thoracic surgery services and back-up emergency cardio-thoracic surgery services through a contractual relationship.

The Augusta VAMC actively supports a robust research program. The Medical Center's success stems from our ongoing efforts to recruit seasoned physician researchers with our medical school affiliate and our ability to provide excellent research facilities and assistance to researchers applying for VA Merit Review Funding. The Medical Center also provides training opportunities for more than 900 students and residents annually. Additional health training affiliations exist with approximately 50 academic institutions.

Columbia

The WJB Dorn VA Medical Center (Columbia VAMC) provides primary care, specialty care, extended care, and related social support services to our veteran population. The medical center's inpatient facility encompasses acute medical, surgical, psychiatric, and long-term care. The medical center operates a Nursing Home Care Unit adjacent to the hospital. The medical center is recognized for its tertiary-level Pain Clinic and provides care for patients residing in the Augusta and Charleston catchment areas. There is a large CBOC in Greenville and smaller CBOCs in Florence, Rock Hill, Sumter, Orangeburg, and Anderson, SC. The medical center is also designated as the Clinic of Jurisdiction for the state of South Carolina, and provides administrative support for the Florence, SC National Cemetery. Vet Centers are located in Greenville and Columbia, SC and the VA Regional Office, also located in Columbia, is being co-located on the Columbia VA campus through the Enhanced Use Lease program. Specialized services include a Comprehensive Homeless Program with a Compensated Work Therapy Program, PACE (Program for All-Inclusive Care for the Elderly), and an expanded toll free Telephone Advice Program to allow 24-hour access. An affiliation is held with the University of South Carolina (USC) School of Medicine, which is located on the VA campus. Other affiliations include the USC College of Nursing, Midlands Technical College, School of Nursing and South Carolina State University, Orangeburg, SC. There are a total of 42 affiliated agreements, in various disciplines, with 24 institutions. Columbia VA Medical Center provides training to 688 trainees per year and currently has 48.6 resident positions, and rotate about 155 residents through VA annually.

Columbia VA Medical Center (Columbia VAMC) and Moncrief Army Hospital at Fort Jackson have a Joint Venture for Sharing. Currently, we co-own an MRI that is located on the VA Campus and a Sleep Lab that is located in their hospital. We also have sharing agreements which cover blood products, Audiology exams, ENT physician services, Critical Care Nurses Training, Reserve Army physicals, GYN physician services, NDMS/emergency preparedness, full range of laboratory tests, Pathology Back-up coverage, EEG technician back-up coverage, Military separation physicals, C&P exams, CT scans, Radiology back-up and Nuclear Medicine back-up services and Operating Room back-up.

Columbia's funded research and development program includes studies in chronobiology and oncology, all of which enhance their ability to provide state-of-the-art medical techniques and treatments to our veteran patients.

Charleston

The Ralph H. Johnson VA Medical Center, located in historic Charleston, SC, is a 126-bed acute care facility that provides comprehensive primary, secondary, and tertiary level care. For FY 2001, Charleston served approximately 33,000 unique veterans in South Carolina and Georgia and serves as the referral center from other VA Medical Centers for such clinical services as cardiothoracic (open-heart) surgery, invasive/interventional cardiology, neurosurgery, and complex urological procedures. Demand for services and the veteran population in specific SC counties continue to increase. Charleston also operates Community Based Outpatient Clinics (CBOCs) in Savannah, GA, Myrtle Beach, SC, and Beaufort, SC, and provides administrative support to the Vet Centers in North Charleston, SC and Savannah, GA, as well as the Beaufort, SC National Cemetery.

The 126 operational beds are compromised of 48 Medicine, 8 Medical intensive care, 19 Surgery, 8 SICU, 15 Psychiatry and 28 Nursing Home Care Unit (NHCU) beds.

The Medical Center is highly affiliated with the Medical University of South Carolina (MUSC) and supported 87.5 paid Resident positions for Academic Year 2002. All major medical, surgical and mental health residents and students rotate through the Charleston VA Medical Center. In addition, the Charleston VA Medical Center has numerous allied health institutions (including MUSC) that rotate students to VA as part of their training and education. The VA has many scare medical specialty contracts with MUSC for the following specialties:

- Cardiothoracic surgery
- Perfusion services for open-heart surgeries
- Neurosurgery
- Orthopedics
- Vascular surgery
- Gastrointestinal services
- Radiation Therapy
- Anesthesia
- Dental services

The Charleston VA enjoys a close relationship with the DoD and has sharing agreements with the Naval Hospital in Charleston, SC for inpatient and outpatient services; Naval Hospital Beaufort, SC, where VA manages a CBOC in leased space; and Charleston Air Force Base for outpatient services. A sharing relationship between the VA and Fort Stewart/Hunter Army Airfield in Savannah, GA is currently in the developmental stages. The Charleston VA is also a TRICARE provider for Medical/Surgical as well as Mental Health services.

In FY 2001, the Research Service had 68 funded investigators with a total of $11.7 million in funded research. Major areas of funding include diabetes, lipid disorders, heart disease, hematology, fetal alcohol syndrome, kidney disease, and rheumatology. In addition to a nationally recognized research program, two of Charleston's research

programs have been awarded the highly prestigious and competitive REAP (Research Enhancement Award Programs) awards for FY 2003.

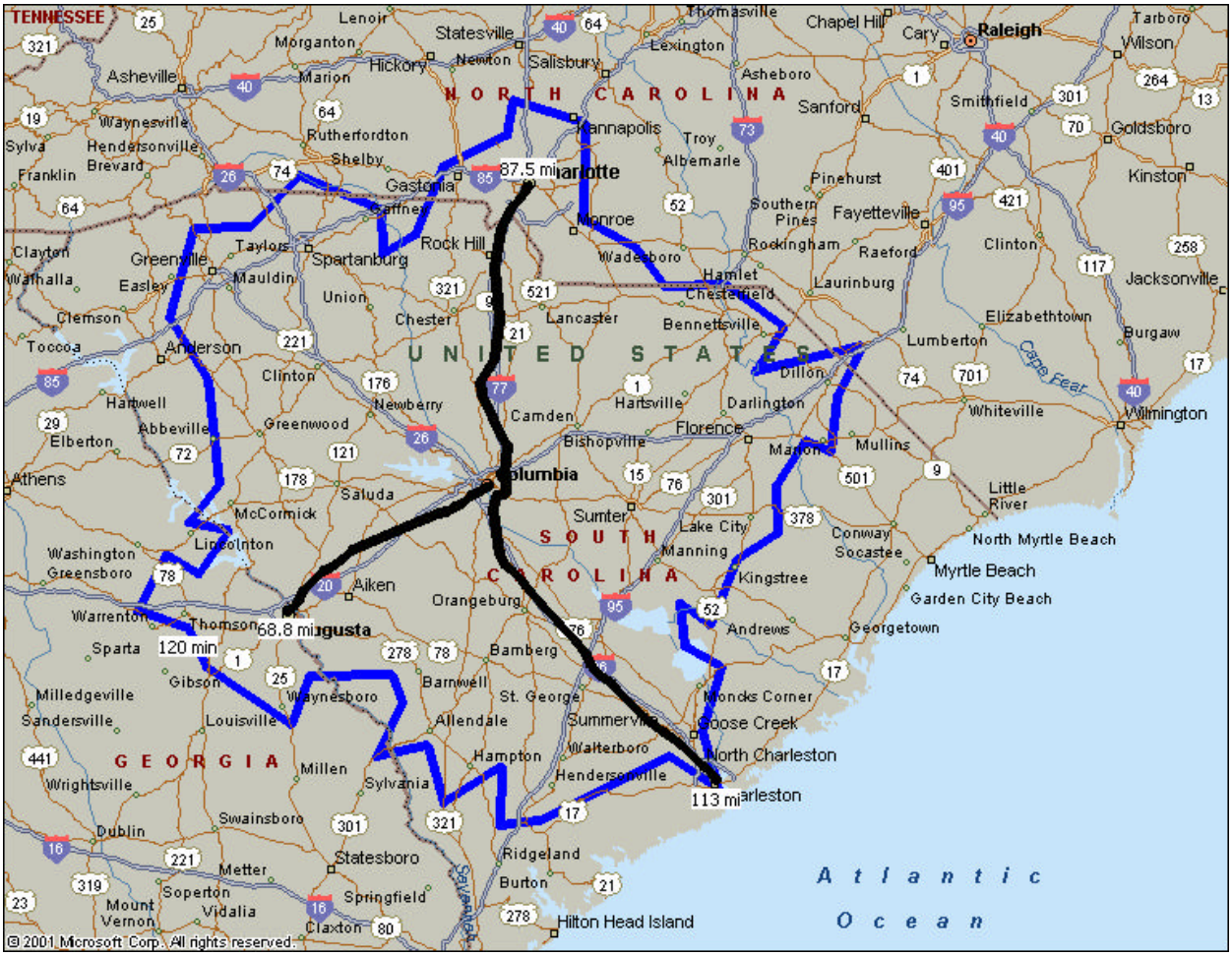
APPENDIX B - IMPACT ON CARES CRITERIA FOR PROXIMITY PI - VISN 7

Criteria	Healthcare Quality and Need	Safety & Environment	Healthcare Quality as Measured by Access	Impact on Research and Academic Affairs	Impact on Staffing and Community	Support other Missions of VA	Optimizing Use of Resources In-house
Alternative A	Positive: Workload data and projected demand support retaining services at current levels at all three facilities. Strong QA results by reviewing bodies.	Positive: Infrastructure and equipment is adequate at all sites.	Positive: There are no Access PIs for tertiary care since 100% of the enrollees meet the Access standards for care.	Positive: All three facilities have strong affiliations in medicine and surgery as well as in other disciplines.	Positive: Some of the clinical services have already been consolidated.	Positive: Maintaining a tertiary care presence in the three facilities provides support to VA's commitment to its teaching mission and its commitment to provide specialized services to veterans for service connected conditions.	Positive: This current option is the more optimal to sending expensive specialty care to the community under contract.
	Strategy to min. negative: Promote "right-sizing" of tertiary care in the three facilities to meet projected demand.	Strategy to min. neg. impact: Use flexible beds to have med/surg wards where possible.	Strategy to min. neg. impact: Work with affiliates to maintain adequate clinic size.	Strategy to min. neg. impact: Maintain the close relationship with the affiliate to meet the growing demand for specialized services.	Strategy to min. neg. impact: Existing consolidations have been accomplished through attrition, rather than reductions in force.	Strategy to min. neg. impact: The tertiary component needed to support the delivery of specialized services is not compromised. The teaching mission of the VA will be maintained.	Strategy to min. neg. impact: The previous clinical consolidations were driven by solid decisions for VISN 7 and implemented before the initiation of CARES. The CARES initiative provides a framework for further supporting these decisions.

Criteria	Healthcare Quality and Need	Safety & Environment	Healthcare Quality as Measured by Access	Impact on Research and Academic Affairs	Impact on Staffing and Community	Support other Missions of VA	Optimizing Use of Resources In-house
Alternative B	Positive: Increases some case volume for quality purposes.	Positive: Reduces operating wards.	Positive: Establishes center of excellence	Positive: Reallocates resident slots and more funds for specialty training.	Positive: Will ease staffing requirements in hard to recruit categories.	Positive: Reallocates funds to fewer sites.	Positive: Reallocates funds to fewer VA sites.
	Strategy to min. neg. impact: Collaborate with the affiliates on workload management.	Strategy to min. neg. impact: Further develop intra-facility transfer system.	Strategy to min. neg. impact: Work closely with specialty providers on appropriateness of scheduling. May shift workload to other VISNs or care settings.	Strategy to min. neg. impact: R&D and some clinical programs will be phased out.	Strategy to min. neg. impact: Transfer limited resources to the specialty centers of excellence.	Strategy to min. neg. impact: Concentrates resources based on priority.	Strategy to min. neg. impact: Review workload projections for capacity plan.

Criteria	Healthcare Quality and Need	Safety & Environment	Healthcare Quality as Measured by Access	Impact on Research and Academic Affairs	Impact on Staffing and Community	Support other Missions of VA	Optimizing Use of Resources In-house
Alternative C	Positive: Workload data and projected demand support retaining services at current levels at all three facilities.	Positive: There are no safety or environmental issues at the three facilities.	Positive: There are no Access PIs for tertiary care since 100% of the enrollees meet the Access standards for care.	Positive: All three facilities have strong affiliations in medicine and surgery, as well as affiliation agreements in other disciplines.	Positive: Some of the clinical services have already been consolidated with increased efficiency of service delivery.	Positive: Maintaining a tertiary care presence in the three facilities provides support to VA's commitment to its teaching mission and to its commitment to provide specialized services to SC veterans.	Positive: Through the consolidation of administrative services, resources are used more efficiently through standardization and the development of VISN-wide expertise.
	Strategy to min. negative: Promote "right-sizing" of tertiary care services in the three facilities to meet projected demand. Evaluate any new programs from a Network perspective.	Strategy to min. neg. impact: Program ward renovations based on workload volume.	Strategy to min. neg. impact: Maintain at current levels.	Strategy to min. neg. impact: Maintain a close relationship with the affiliate to meet the growing demand for specialized services.	Strategy to min. neg. impact: Existing consolidations have been accomplished through attrition, rather than reductions in force. Look for appropriate involvement of stakeholders.	Strategy to min. neg. impact: The tertiary component needed to support the delivery of specialized services is not compromised. The teaching mission of the VA will be maintained.	Strategy to min. neg. impact: The administrative consolidations were driven by solid business decisions for VISN7 and implemented before the initiation of CARES. The CARES initiative provides a framework for further supporting these decisions.

Appendix C – 120-Minute Drive Time Map for CARES Proximity PI – VISN 7



Appendix D - Questions and Answers – CARES Proximity PI – VISN 7: These questions were raised during the CARES review of Proximity Planning Initiatives, April 22, 2003.

1. **Why does each facility maintain a cardiovascular surgery program in view of potential economies of scale and volume-related quality issues?**

    - Columbia does not have a cardio-thoracic program; it is limited to diagnostic heart caths. It currently sends its CT workload to Charleston, Augusta and a few cases to Asheville (VISN 6).

    - Charleston has a fully affiliated CT program with Medical University of South Carolina. This program has the best outcomes and has lower costs than the other CT programs in VISN 7, except Augusta as described below. The service area is the majority of South Carolina and the coastal area of Georgia. Due to the affiliate workload (869), the CT team's open-heart workload (82+869=951) is sufficient to meet all VA surgical quality standards.

    - The Augusta VAMC program is unique in that the surgeons are provided by the Department of Defense, the CT surgery is done at Eisenhower Army Medical Treating Facility, the VA provides nursing FTEE at Eisenhower and the VA supplies workload. The surgeons are recognized by our affiliate (Medical College of Georgia), therefore complimenting our residency program. This arrangement increases the workload volume (projected 96 cases for this FY) for the DoD surgeons so that they stay at "ready-status" and eliminates for the VA the overhead and FTEE (other than nursing) costs (or contract costs) for this high-cost program. Although this program has only been in place for 1 year, the preliminary costing data indicates the arrangement is cost effective, as the surgeon's costs are free. The social value/patient satisfaction of having this surgery done in the veterans community is significant.

2. **Is there a more complete justification for not consolidating other high risk, low volume services?**

    - The only high risk, low volume service that Columbia provides is Ophthalmic surgery. Charleston performed 339 eye surgery cases last year. Augusta performed 330 eye procedures in FY 2002 and has done 185 procedures in FY 2003 thru 4/30/03 while Columbia did 369 cases. This is too much workload to consolidate between two sites and would disrupt an important teaching program at Columbia. The other unique program at Columbia is a full, tertiary-level Pain Clinic, including surgical implants. This is not available at Augusta or Charleston.

3. **Why should not all tertiary services be removed from Columbia, making it an acute hospital?**

   - One problem encountered when conducting the proximity review is the lack of clear definition of tertiary facility and services. Assuming tertiary services are on a continuum, Columbia is at the minimal end with Augusta and Charleston in the middle. We would consider a transplant center on the high end of the continuum. Columbia does not provide cardiovascular surgery or neurosurgery, two recognized indicators when discussing tertiary facility. An important fact is that Columbia VAMC is the primary site for residents for the University of South Carolina School of Medicine. There is no quality of care issues to suggest the need to alter or modify the services provided in Columbia.

   - We cannot move these services to Charleston as they do not have sufficient current space and not if the CARES workload projections come to fruition. Their campus does not have the capacity for expansion.

   - If we move the workload to Augusta, they will be required to construct additional space. The Augusta tertiary campus (downtown campus) does not have expansion capability. The Augusta mental health and long term care campus (uptown campus) has space. To make room at the tertiary campus would require the probable relocation of the current 60-bed SCI center (expanding to 86 beds due to CARES). The costs involved for this construction would be huge, as well as the significant decrease in quality of SCI care due to the separate of this acute SCI center from the tertiary services located at the tertiary campus. Although this would not be outside of the 4-hour access timeframe, it would certainly impact patient satisfaction.

4. **There was discussion in the group of a possible consolidation of Charleston with the medical school or the Navy. What is the role of this issue in the proximity initiative? Why was this issue omitted from the narrative? How was planning for this consolidation coordinated with the CARES criteria/process?**

   - VA has received a proposal from the Medical University of South Carolina (MUSC) to replace the VAMC as part of MUSC's strategic plan to replace their hospital. To meet their future needs, MUSC needs the VA property. Their proposal has been reviewed and not accepted. A counter proposal has been given and negotiations are occurring. Any VA facility constructed will not be a consolidated facility, but a freestanding facility with a distinct VA identity. Although there may be some sharing of services, the risk is too high to include shared services in the preliminary evaluation of capital considerations.

- Although this concept is very interesting to the VA, there are significant hurdles to address, specifically the huge funding costs to the VA (replacement cost estimates are $132-185 million), legislative actions are required for this to occur and the concept of a long-term financial commitment from the VA. Due to these issues and the fact we are still in the feasibility study process, we do not consider this a valid option. This may change within the next 2-3 years.

- As part of the CARES process, we considered the affiliate opportunity into our market plan. We did not include it as is still being evaluated for feasibility. Two specific issues were considered critical if the replacement facility concept evolved. Both issues involved space. The current facility needs to increase square footage due to workload and essentially double in size to meet the CARES projections. A major portion of the market plan is to develop a CBOC in Summerville SC, which is about 40 miles from the VAMC, although still considered in metro Charleston. We anticipate pushing approximately 42% of the primary care workload to this new CBOC. This will generate space that is needed for projected doubling of specialty and ancillary services. Even with this new location, VA will need to construct a clinical addition to hand the outpatient workload. Both the new clinic and the expansion will come into play if we should build a replacement facility. We determined that we would still need to the Summerville clinic due to acreage limitations. The clinical expansion (major construction project) would be eliminated if the facility were replaced. The problem is that the VA needs this new space prior to the probably timetable of the construction of the replacement facility. Although we included the major construction as far out as possible, we can very quickly change to a short-term solution of contracting or leasing if the replacement project is approved.

- The Navy has closed their Medical Treating Facility in Charleston due to the lack of workload and is planning an outpatient clinic in North Charleston. The scope of care there will not allow for the provision of tertiary medical services at that site.

APPENDIX A
ACCESS/SMALL FACILITY/PROXIMITY

Criteria **Alternative**	**Healthcare Quality and Need**	**Safety & Environment**	**Healthcare Quality as Measured by Access**	**Impact on Research and Academic Affairs**	**Impact on Staffing and Community**	**Support other Missions of VA**	**Optimizing Use of Resources In-house**
Alternate A	Positive: Workload data and projected demand support retaining services at current levels at all three facilities.	Positive: N/A	Positive: There are no Access PIs for tertiary care since 100% of the enrollees meet the Access standards for care.	Positive: All three facilities have strong affiliations in medicine and surgery as well as in other disciplines.	Positive: Some of the clinical services have already been consolidated. An extensive consolidation of administrative services across VISN7 has already been implemented with increased efficiency of service delivery.	Positive: Maintaining a tertiary care presence in the three facilities provides support to VA's commitment to its teaching mission and its commitment to provide specialized services to veterans for service connected conditions.	Positive: Through the consolidation of administrative services, resources are used more efficiently through standardization and the development of VISN-wide expertise.

	Strategy to min. negative: Promote “right-sizing” of tertiary care in the three facilities to meet projected demand.	Strategy to min. neg. impact: N/A	Strategy to min. neg. impact: N/A	Strategy to min. neg. impact: Maintain the close relationship with the affiliate to meet the growing demand for specialized services.	Strategy to min. neg. impact: Existing consolidations have been accomplished through attrition, rather than reductions in force.	Strategy to min. neg. impact: The tertiary component needed to support the delivery of specialized services is not compromised. The teaching mission of the VA will be maintained.	Strategy to min. neg. impact: The administrative consolidations were driven by solid business decision for VISN7 and implemented before the initiation of CARES. The CARES initiative provides a framework for further supporting these decision.
Alternate B	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:

Alternate C	Positive: Workload data and projected demand support retaining services at current levels at all three facilities.	Positive: There are no safety or environmental issues at the three facilities.	Positive: There are no Access PIs for tertiary care since 100% of the enrollees meet the Access standards for care.	Positive: All three facilities have strong affiliations in medicine and surgery, as well as affiliation agreements in other disciplines.	Positive: Some of the clinical services have already been consolidated. An extensive consolidation of administrative services across VISN7 has already been implemented with increased efficiency of service delivery.	Positive: Maintaining a tertiary care presence in the three facilities provides support to VA's commitment to its teaching mission and to its commitment to provide specialized services to veterans for service connected conditions.	Positive: Through the consolidation of administrative services, resources are used more efficiently through standardization and the development of VISN-wide expertise.

	Strategy to min. negative: Promote “right-sizing” of tertiary care services in the three facilities to meet projected demand.	Strategy to min. neg. impact: N/A	Strategy to min. neg. impact: N/A	Strategy to min. neg. impact: Maintain a close relationship with the affiliate to meet the growing demand for specialized services.	Strategy to min. neg. impact: Existing consolidations have been accomplished through attrition, rather than reductions in force.	Strategy to min. neg. impact: The tertiary component needed to support the delivery of specialized services is not compromised. The teaching mission of the VA will be maintained.	Strategy to min. neg. impact: The administrative consolidations were driven by solid business decisions for VISN7 and implemented before the initiation of CARES. The CARES initiative provides a framework for further supporting these decisions.