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Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan; Notice

DEPARTMENT OF VETERANS AFFAIRS

Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: This document concerns VA's health care planning process known as CARES, or Capital Asset Realignment for Enhanced Services. The CARES process was designed to enable the veterans health care system to more effectively use its resources to deliver more care, to more veterans, in places where veterans need it most. We are providing interested persons the opportunity to review and submit written comments to the independent CARES Commission concerning the draft National CARES Plan of the Under Secretary for Health.

DATES: Comments must be submitted by October 20, 2003.

ADDRESSES: Written comments can be mailed to Richard E. Larson, Executive Director, CARES Commission, 00CARES, 810 Vermont Avenue, NW., Washington, DC 20480; or faxed to (202) 501–2196; or e-mail to *www.carescommission.va.gov.* Comments should indicate that they are submitted in response to the ''Notice; Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan.''

FOR FURTHER INFORMATION CONTACT: Janice R. Sloan, CARES Commission, at (202) 501–2000.

SUPPLEMENTARY INFORMATION: VA's mission to provide quality health care for America's veterans has not changed since its inception. But how that care is provided—at what kind of facilities, where they are located and which types of procedures are used—has been subject to dynamic change. Medical advances, modern health care trends, and veteran migrations all have an impact on the medical care landscape. In a dynamic health care environment, VA must plan to embrace change so it can best serve veterans health care needs in the future.

The draft National CARES Plan embodies the plan for managing a vital element of that change: The Department's capital infrastructure. The plan is based on a systematic, national assessment of the future needs of veterans and the present location and condition of the physical plant that delivers their health care. The draft National CARES Plan identifies gaps where there is an imbalance between current infrastructure and future needs. It then makes recommendations to solve these imbalances and assure that VA is best positioned to meet veterans health care needs into the future.

The draft Plan incorporates new community-based primary and specialty outpatient clinics. Additionally, four new Spinal Cord Injury and Disorders Units have been proposed, along with two new Blind Rehabilitation Centers. Other enhancements include expansion of numerous existing outpatient clinics, renovations of inpatient beds, diagnostic and ancillary services, as well as two new hospitals.

This notice includes the draft National CARES Plan, including an appendix that summarizes individual network plans, which was prepared by VA's Under Secretary for Health after review of present and projected user data, as well as input from a wide range of sources and stakeholders and the individual network plans. The full plan, all appendices, and related information can be viewed at *www.va.gov/CARES.*

The independent CARES Commission, appointed by the VA Secretary, is evaluating this draft National CARES Plan, which incorporates individual network Market Plans. Members of the Commission include individuals with special knowledge or interest relating to VA health care, as well as representatives from stakeholders' groups.

This notice provides interested persons an opportunity to submit written comments concerning the draft National CARES Plan to the CARES Commission. The Commission will consider these comments in developing its recommendations to the VA Secretary. Under the CARES process, the Secretary will either accept or reject the Commission's recommendations, without modification.

Dated: August 5, 2003.

Tim S. McClain,

General Counsel.

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Introduction

Environment of Change Surrounds VA Mission

The mission so nobly described by Abraham Lincoln as ''Caring for those who shall have borne the battle'' represents a single constant, surrounded by constant change.

The one, unchanging feature attending Mr. Lincoln's charge to provide health care for America's veterans is that the nation regards it as a duty of the highest priority. But how that job is done—at what kind of facilities, where they are located, and which types of procedures are used—has been subject to dynamic change, as a function of medical advances, modern health care trends, regional migration and other factors.

This document embodies the plan for managing a vital element of that change: the capacity and placement of facilities, their accessibility and the acute care infrastructure necessary to meet the current and future needs of veterans. The underlying planning process is entitled ''Capital Asset Realignment for

Enhanced Services (CARES), and the foundational CARES Plan includes:

- Findings from an objective comparison of data on future needs versus current capabilities;
- A comprehensive assessment of the adequacy of all current VHA health care space to meet these needs;
- An investment strategy to guide the allocation of capital resources to meet those space needs;
- Exploration of alternative use of campuses to benefit veterans, such as assisted living facilities or other compatible uses, with revenues used to invest in veteran services;
- Adopting the Critical Access Hospital (CAH) model developed by the Centers for Medicare and Medicaid Services for small facilities as a guide to ensure that quality of care is maintained in the future;
- A description of consolidations of services and realignments to replace inefficient, aged campuses with modern facilities to improve quality and cost effectiveness;
- A description of internal collaborations between the three VA administrations and external collaborations with the Department of Defense (DoD) to maximize joint utilization of capital resources; and
- A description of stakeholder involvement in the CARES process.

Background Includes Transformational Changes

A brief word of background on the federal entity charged with caring for America's veterans may help to place the CARES process and this plan into perspective. This entity is the Department of Veterans Affairs (VA). Many changes in VA's health care system have come through gradual evolution, but there also have been instances of remarkable transformation. After World War II, for example, VA astounded critics by accomplishing a dramatic and highly successful expansion to meet the needs of millions of World War II veterans.

VA's health care system—in modern parlance, the Veterans Health Administration (VHA)—was transformed again in the 1990's. Having initially lagged behind the national trend of placing greater reliance on primary care and outpatient settings, VHA accomplished a reinvention of major proportions.

In just seven years—from 1995 to 2002—VA changed from an inpatient model of care characterized by a limited number of specialized facilities, to an outpatient model with more than 1,300 access sites in veterans' communities across the United States. Acute operating beds were reduced from 52,000 to about 19,000, and the inpatient average daily census dropped about 60 percent in this period. Most telling, by 2002, the VA was treating more than 1.5 million additional veterans annually—an increase greater than 50% since the beginning of the period.[1]

A key element of the reorganization was dividing the VA system into strategic networks. There are currently 21 of these Veterans Integrated Service Networks, commonly referred to as ''VISNs.'' VISNs are focal points for coordinating medical services in a population-based approach to care. In a few short years, VISNs guided VA's transformation into a system of highly efficient, ambulatory-based care, backed by a highly integrated system of tertiary care and other services.

Echoes of Change: Reverberations Linger

Reverberations can linger in the wake of such remarkable changes in the VA health care system. For example, when VA geared up to care for World War II veterans, medical staffs were augmented virtually overnight (through affiliation with the nation's medical schools). Necessary expansion of the infrastructure took much longer—with site selection, design, funding, and construction of VA facilities around the country stretching through the 1950's and 60's.

The more recent reformation of VA health care during the 1990's—creating today's efficient, primary care focused, outpatient-based system—was also followed by reverberations. While making strong progress in refining primary care modalities and expanding access through investments in community based clinics, VA had limited success in securing capital to maintain its acute care infrastructure.

Initial restructurings, such as reducing bed numbers, closing staffed wards, changing specific use of buildings, etc., were accomplished with dispatch. But further steps were problematic, since disposition of capital assets traditionally has been a difficult process in the Federal sector in general, and in the VA, in particular. In addition, vacant space may be scattered and not concentrated in specific locations amenable to closure or re-use. To some extent, the lack of concentrated space simply reflects the nature of physical plant entities, *i.e.*, vacant and underutilized buildings (many of which have historic value) cannot be moved around like most other resources. Disposing of such assets can be a complex process for any department or agency. For VA, periodic, vigorous opposition from local interest groups who object to the proposed re-use of the facility or land has complicated this difficult task.

GAO Paints Challenge in Stark Terms

In view of this background, it was not particularly surprising when, in 1999, the General Accounting Office (GAO) gave VA poor marks, for its record in divesting itself of vacant and underutilized buildings. Some details in the GAO comments were noteworthy, such as the contention that, unless VA implemented more effective capital investment planning and budgeting, it could ''spend billions of dollars operating hundreds of unneeded buildings over the next 5 years or more.''[2]

Although the GAO financial estimate were based upon complete campus closures (not closing/demolishing individual buildings at over 150 sites), which are not fully achievable, VA embraced the recommendation to strengthen capital investment planning—because the GAO's conclusion was in perfect accord with VA's own goals for the direction of its health care system. This GAO conclusion was that ''VA could enhance veterans'' health care benefits if it reduced the level of resources spent on underused or inefficient buildings, and used these resources instead to provide health care more efficiently in existing locations or closer to where veterans live.''[3]

Congressional authorizing, appropriating and oversight committees had also expressed concern over the lack of a long-term capital planning process.

Designing a Tool of Unprecedented Precision

In designing the CARES process, VA explicitly followed GAO recommendations, such as working to eliminate subjective judgments, developing methods to quantify the benefits of locations and facilities, and seeking the best-defined measurement standards. The completed CARES design therefore differed from previous planning and budgeting efforts in several important respects. CARES was:

[1] Source: Department of Veterans Affairs Program Statistics, April 17, 2003.

[2] *VA Health Care: Capital Asset Planning and Budgeting Need Improvement* (GAO/T–HEHS–99–83, Mar. 10, 1999).

[3] *VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting,* GAO/HEHS–99–145 (Washington, DC: Aug. 13, 1999), p. 4.

Comprehensive—the systematic assessment of the condition and functionality of current space and requirements to meet projected changes in the demand for services was applied throughout the VA system.

Data driven—the use of market-specific actuarial projections brought a new level of credibility to the assessment of future veterans' needs in well-defined health care markets.

Objective—''gaps'' in service (disparities between current capabilities and future needs) were identified based solely on clear-cut application of ''threshold criteria.''

Systematic—planning initiatives and their resolution in market plans followed a set of system-wide assessment and projection methodologies and tools based upon national data sources.

Most Distinguishable Characteristic—Stakeholder Involvement

One piece of GAO advice, in particular, led to one of the defining characteristics of CARES. This area of GAO commentary involved the diverse groups of publics with whom VA health care is intimately involved at many levels.

GAO asserted that these groups have not always had an appropriate role in dealing with VA capital assets. According to the GAO, these publics should be involved in an active advisory role in developing procedures, criteria, etc., for CARES. GAO pointed out that the involvement of these public groups not only facilitates receiving valuable perspectives from them, the GAO stated, but also enhances understanding of and builds support for the process.[4]

The importance VA placed on these publics was reflected by the fact that they were termed ''stakeholders'' in the CARES process. The resources and policies devoted to ensure that they were part of the process further attested to their importance. Stakeholders included veterans service organizations, VA employees, academic affiliates, Department of Defense sharing partners, and the congressional delegations that represent all the other publics. Chapter 3 of this plan details the unprecedented level of interaction between VA and these stakeholders during the design and application of CARES.

Meeting the CARES Deadline

The ''roll out'' of CARES began on June 5, 2002, when Secretary of Veterans Affairs Anthony J. Principi announced the initiation of the CARES process. Fourteen months later, on August 1, 2003, this Draft National CARES Plan was presented to the CARES Commission. (The role of the Commission and the overall CARES timetable are explained in Chapter 2.)

This relatively short development period for such a complex planning process reflects that the CARES timetable had an absolute deadline: to have an approved National CARES Plan in time to meet congressional target dates for capital funding proposals for FY 2005 and FY 2006.

At the time this draft was published, it was anticipated that the completed and fully reviewed National CARES Plan would be ready for the Secretary's decision by the end of December 2003—which would meet the stipulated deadline for the first of these fiscal year budget cycles.

In building a virtual roadmap for veterans' health care in the future, the CARES process combined state-of-the-art statistical methodologies with thorough, pragmatic planning analyses. This complex undertaking was the first comprehensive, long-range assessment of the VA health care system's capital requirements since 1981, when a multi-year effort known as the Medical District Initiated Planning Process (MEDIPP) conducted a similar, if less sophisticated, system-wide appraisal.

Developing the Draft National CARES Plan in such a short time period was a formidable task. Despite the fact that a detailed ''CARES Guide and Operating Plan'' was prepared and distributed to VA planning teams in advance, full implementation of the process required many adaptations and temporary solutions. Ultimately, some limitations in the CARES process had to be accepted, with the understanding that improvements would be made when the process was integrated with VHA's regular strategic planning process. While the CARES pilot was instructive in demonstrating the importance of stakeholder participation, it was a contracted study performed by a consultant in a single VISN.[5]

The CARES pilot did not provide the tools, technical methodologies or processes to extend the process to the entire VA health care system. These tools had to be developed in real time, without benefit of full testing. Implementation began with unfamiliar databases, and an incomplete understanding of the interrelationships and policy implications of a complex set of data, methodologies and processes.

As indicated in the succeeding chapters, many improvements were made as the plan developed and the knowledge base improved. At the time this Draft National CARES Plan was published, improvements in the process were still underway, notably including those required to develop credible forecasts of the need for Nursing Home Care, Domiciliary Care and selected mental health components. Inclusion of these three program areas was therefore postponed until the next VHA strategic planning cycle.

CARES Plan Had Numerous Authors

Credit for the CARES process and for this plan is due literally hundreds of men and women across the nation who devoted a great deal of time and energy to this effort.

Some contributors devoted long hours of complex, diligent work—in addition to regular job responsibilities. Yet all of those involved—from the designers of the process, to the statisticians who ran the data, to the program experts who constructed models for special disabilities, to the network planning teams comprised of planners, clinicians and administrators who brought the numbers to life—gave CARES the attention and the respect it deserved as a key element in the future of VA medical programs.

The largest group of contributors was comprised of the many stakeholders in the VA system, prominently including America's veterans service organizations. Their active participation—learning about CARES, providing advice at various stages of the process, and commenting on findings and proposals—was fundamental to the program's integrity.

Because of the collective involvement of these numerous ''authors'' of this CARES Plan, the Department of Veterans Affairs stands poised to fulfill its long term planning mission: ''to improve access to, and the quality and cost effectiveness of, veterans health care.''

Chapter 1: CARES

Continuing VA's Improvement Process

CARES is a systematic planning process to prepare VA's facilities and campuses to meet the future veterans health care needs through a methodical, system-wide assessment of the current existing and future needs for space, and of the size, mission and locations of facilities, compared to the number of projected enrollees and forecasts of their anticipated utilization of medical

[4] VA Health Care: VA is Struggling to Address Asset Realignment Challenges, GAO/HEHS–00–88 (Washington, DC: April 5, 2000), p. 5.

[5] The role of the pilot program in VISN 12 as the first step in the phased implementation of CARES is discussed in Chapter 2.

services. The changes described will occur over an extended period. In particular, the complexity of realigning clinical services and campuses necessitate careful planning in order to ensure a seamless transition in services. The Draft National CARES Plan contains the capital requirements to enhance the current infrastructure so that VA health care services are delivered in a modern functional health care environment. CARES is another step in the dynamic improvement process that characterizes the VA health care system. The CARES process follows the many improvements achieved in the processes and outcomes by the VA.

Quality is an essential component in any assessment. A recent judgment presented in an authoritative medical journal provided a definitive indication of how VA care compares with the medical community at large. Simply stated, VA care was found to be significantly better than care provided in the fee-for-service program paid for through Medicare. This conclusion was reported in a study published in the New England Journal of Medicine, which compared VA care with the Medicare fee-for-service program on 11 similar quality indicators for the period from 1997 to 1999. VA scores were better in all 11 categories. The study noted that VA outperformed Medicare again in 2000, this time on 12 of 13 indicators.[6] Calling the study's findings ''robust,'' a Journal editorial confirmed, ''VA care appears to be better.''[6a]

Along the way to achieving high scores in quality, the VA established a position of health care industry leadership in patient safety and electronic medical records. In 2002, for example, two VA facilities received the first John M. Eisenberg Patient Safety Awards, sponsored by the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations.[6b] And VA's electronic medical record system and Bar Code Medication Administration (BCMA) program have been widely recognized as groundbreaking tools for improving health care quality and patient safety. The BCMA program won the 2002 Pinnacle Award, a top honor presented by the American Pharmaceutical Association Foundation.

Today, numerous other innovative management practices sustain the pace of VA clinical improvements, including:

- Preventive measures such as pneumococal vaccinations and diabetic foot examinations, which demonstrably reduced the incidence of illness and infection in VA's patient population.
- A morbidity and mortality monitoring system, which ensures that quality improvement in VA surgical programs is ongoing.
- Telemedicine initiatives, which not only bring diagnostic support and specialist consultation to remote delivery sites, but allow monitoring of patients in their own homes, in a new ''Telehealth care'' program.

All of these actions were stimulated and supported through a continuous improvement philosophy instilled throughout the organization, based on the principles of the Malcolm Baldrige National Quality Award.

The most significant element of VA's management re-invention—one which directly facilitated and accelerated positive change in the system—was the creation of decentralized health care delivery systems called Veterans Integrated Service Networks (VISNs). Networks implemented challenging system alterations, such as dramatic reductions in inpatient hospital beds, closures of redundant campuses, and consolidation of services. Under VISN management, the transformed VA system achieved extensive improvements in access and enrolled millions of new veterans (a measure of success which, nonetheless, has put new strains on VA's capital assets). These changes must be incorporated into CARES planning as well as future challenges to be anticipated in the planning for capital assets.

Clearly, the systematic assessment and improvement of quality that has characterized the VA health care system since the early 1990's has produced dramatic results. VHA's determination to emulate this success in the systematic planning for capital assets had an excellent starting place in the CARES process.

The timing for improved capital asset planning is right. The forecasted decrease in the veteran population, though offset in part by increasing numbers of enrollees and aging of the veteran population, is raising questions regarding the size and distribution of VA facilities and outpatient services. VHA planners and leaders must assure that facilities are in the right place and have the physical plant necessary to provide quality care to the aging veteran population. The CARES planning process and the National CARES Plan will prepare VHA to meet that challenge of the provision of veterans' health care in the 21st century.

What Did CARES Assess?

CARES focused on capital requirements at a macro level by using projections of beds and outpatient visits by broad categories such as inpatient medicine, surgery and psychiatry, and outpatient primary care, mental health and specialty care. CARES did not develop plans at the diagnostic or service line level (cardiovascular disease, diabetes, etc.) These lower level plans will be considered as part of VHA's revised strategic planning process.

The CARES process systematically assessed the critical components that determine the future need for capital and services. CARES comprised the first detailed system-wide assessment and integration of the following elements:

- *Physical Plant*—CARES developed and used assessments of the current condition and functionality of all space that provides and supports the delivery of health care services. A comprehensive evaluation and database were developed to determine the amount of space that did not meet current standards and that should be improved.
- *Enrollment*—CARES utilized enrollment forecasts by priority group, based upon the Secretary's enrollment decisions and Presidential budget requests.
- *Utilization*—CARES developed the expected utilization of enrollees for bed days of care and outpatient visits for all priority groups by age and gender, and the specific needs of the SCI and Blind Rehabilitation Program.
- *Management of Utilization*—CARES prompted VISN decisions on managing utilization changes from a range of alternatives, such as new construction, renovations, leases, contracts and other mechanisms.
- *Vacant Space*—CARES brought about the evaluation of all vacant space, including determination of potential use in meeting future expected utilization, and all possible disposition alternatives including lease, building demolition, and other divestiture measures.
- *Realignments*—CARES facilitated a systematic assessment of the potential for realignment of services and campuses. The capital costs and savings of these realignments are not yet fully integrated into the National CARES Plan because their complexity requires more detailed analysis (in the event they are approved.)
- *Access*—CARES determined driving times to primary outpatient and acute

[6] NEJM, *Effect of the Transformation of the Veterans Affairs Health Care System on the Qaulity of Care,* Ashish Jha, Vol. 348:2218–2227, May 29, 2003.

[6a] NEJM, *Editorial: The Right Care,* Stephen Jencks, M.D., Vol. 348:2218–2227, May 29, 2003.

[6b] Modern Healthcare, *The Week in Healthcare, VA Captures Two Awards, Eisenbergs Reward Patient Safety,* Sept. 16, 2002.

inpatient care, based upon the current locations of VA sites of care, to gauge the percentage and number of veterans who are within travel time guidelines.

• *Collaborations*—CARES identified opportunities to jointly meet VBA, NCA and DoD needs for space, and the information regarding potential collaborations will be integrated into future assessments of space needs at VHA delivery sites.

CARES Strategic Emphasis

The VA health care delivery system of the future requires a capital investment strategy, which is based upon a systematic assessment of the future needs of veterans and the present location and condition of the physical plant that delivers these services to veterans. Because of the dynamic nature of health care delivery in the 21st century, VA's planning tools must be flexible enough to accommodate changes in the projected veterans' health care needs, in medical technology, and in departmental policy. Thus, the National CARES Plan must be seen as a beginning, linked to redesigned strategic planning and a capital asset prioritization process.

Balancing the System

Outpatient Care

The National CARES Plan must ensure that VA is a balanced health care system that has adequate acute inpatient capacity to meet the acute care needs of an aging veteran enrollee population. The inpatient-oriented approach of the 1980's has been replaced by a system with a strong outpatient orientation, as demonstrated by expansion to more than 600 Community Based Outpatient Clinics (CBOCs), and an increase of 14.5 million annual outpatient visits from 1997 through 2002. A ''snapshot'' picture of the result may be seen in the fact that, in 2001, VA provided accessible primary care to 67% of enrollees who live within 30 minutes driving time of a primary care delivery site.

The CARES forecasting model projected continued growth in outpatient care, and VISN market plans proposed 234 CBOCs to meet that strategic need. In order to achieve a functional balance between acute care and outpatient services, the National CARES Plan recognized a fundamental tenet of modern health care—*i.e.*, that outpatient demand must be supported by a viable acute and tertiary care component. Achieving this balance is particularly important to VA with respect to the acute and rehabilitation needs of special disability populations such as veterans with spinal cord injury, blindness, and traumatic brain injury.

The National CARES Plan reinforced VA's strategy of ensuring that continued growth in outpatient care would be supported by a high quality, appropriately sized and appropriately located acute care inpatient system. In order to move in the direction of a more balanced system, the National CARES Plan identified the capital requirements needed to expand to meet the growing forecasted demand for outpatient services. Improvements in access to outpatient care (which experience indicates will increase demand) must be balanced against strengthening the inpatient acute infrastructure in order to provide high quality services across the continuum of care.

The investment strategy for outpatient access sites is described in greater detail in Chapter 4. The Draft National CARES Plan proposed a system-wide consideration of potential new access points or CBOCs and a selective process for identifying markets in the plan with new CBOC access sites to be prioritized for early implementation. The highest priority markets are those having predictions of large future demand gaps (by clinic visits), co-existing with large access gaps (by driving time), and also where the number of enrollees per proposed CBOC that fell outside access guidelines met efficiency standards (developed in the review process—*i.e.*, greater than 7,000 enrollees). The second priority group is comprised of markets where large demand gaps co-exist with large access gaps, but the number of enrollees would not meet efficiency standards. The third group consists of CBOCs proposed in markets where there are demand gaps but not access gaps.

The highest priority group also includes CBOCs that are part of the realignment proposals and DoD collaborations. Proposed CBOCs identified through the CARES process in the draft National Plan will also go through a well-developed review process prior to any implementation.

Acute Inpatient Care

As a systematic planning process, CARES, with some campus and service realignments exceptions [7], validated that the current size and location of the acute inpatient care infrastructure will be to meet the future inpatient needs of veterans. The process forecasted that the future demand for acute beds would be largely in balance with current capabilities. Nevertheless, CARES also demonstrated that substantial investment of capital is required to maintain that acute infrastructure to meet the current and future specialized acute and tertiary needs of veterans.

Realignments/Efficient Utilization of Campuses for Veterans Services

The dramatic changes in health care delivery within the United States and the VA include improved methods of treating patients that have reduced lengths of stay and admissions as outpatient, community and home care replace inpatient care. As a result, many campuses have vacant space that is costly to maintain as described elsewhere in the plan. These changes, combined with an aged infrastructure (50.4 years average age of VA facilities) resulted in opportunities for reviewing the structure of our campuses to develop a more efficient footprint, possibly transfer services to other campuses and find opportunities to enhance use lease all or portions of campuses with services for veterans such as assisted living facilities. Revenues from these enhanced uses would be retained by the VISNs to invest in improved services for veterans.

Use of the National CARES Plan

Perhaps the most important use of the CARES Plan is a publicly available assessment of capital needs, based on assumptions, policies and methodologies that are open to discussion, systematic improvement, and change over time.

In a system as large as the VA, conducting a comprehensive assessment of current and future capital requirements poses an inherent risk of creating an unmanageable pool of funding requirements. However, a comprehensive assessment is necessary to determine the magnitude of the funding required to fully prepare for the future. While CARES included a comprehensive capital needs assessment of VA's acute infrastructure and existing outpatient sites, the plan recognizes that specific priorities and availability of funds will determine what is ultimately implemented. Of significance in the present context, the National CARES Plan should be viewed as not merely a set of stand-alone funding requirements, but rather as a strategic guide to the future investment of capital, intended to:

• Establish the need for capital requirements, similar to a Certificate of Need in state health care regulatory programs, which—in the case of CARES—reflect the priorities of the Under Secretary for Health and the Secretary of Veterans Affairs;

[7] Described in subsequent chapters (see especially Chapters 8 and 9).

• Identify realignments of services and campuses that will improve quality and efficiency;
• Provide a 5-year estimate of the capital required to meet all the needs identified; and
• Identify collaborations within VA and with DoD that will result in more efficient use of capital resources.

The Economics of CARES

CARES is a systematic process for determining the resources required to meet expected demand for VHA services over the next 20 years. The National CARES Plan reflects thousands of micro decisions made regarding how each VISN would address gaps in forecasted supply and demand for the CARES categories of health care services. Based upon the CARES forecasting planning model and using the computerized Market Planning Template [8], VISNs were able to develop planning scenarios and methodically determine costs of alternatives to manage workload changes or maintain current capacity as determined by the workload forecasts. Decisions whether to renovate, lease, build, or contract were facilitated for all CARES planning categories by using the Market Planning Template.

The CARES process required assessment of the quality of all existing space in use within the VHA—a monumental task in itself. The decisions (and costs) for acquiring additional space vs. renovating existing space were analyzed with the operating costs necessary to meet future patient services.

The use of standardized methods allowed many cost alternatives to be assessed in determining how to meet future demands. For example, the costs of contracts could be compared with using in-house resources. In addition, initial estimates of future revenues expected from enhanced use and other revenue generating solutions were identified.

Thus, CARES is multifaceted and no single dollar figure can be placed on all aspects of the process. Depending upon the specific financial aspect being considered, there are several ways of viewing the economics of CARES, as illustrated by the following observations:

Cost Minimization

A distinguishing characteristic of the proposals to address predicated gaps in clinical capacity and of any capital proposal valued at more than $2,000,000 dollars was that VISNs were required to consider alternative solutions. Comparative costs between ways to manage workload forecasts received strong consideration in selecting the preferred solution. However, other CARES criteria such as quality, and potential impact on DoD sharing and academic affiliations also were considered. In the Draft National CARES Plan, the lower cost alternative was selected in nearly 60% of all planning solutions. Improvements in the costing model may increase this percentage when the final National CARES Plan is completed.

Budget

A summary of budget implications of meeting capital costs for the expected workload demand projected in CARES is presented below. The estimates do not include any of the costs, savings, and revenue estimate from the realignment and consolidation of services discussed in Chapters 8 and 9 (Small Facilities and Realignment), except where they were part of the VISN proposed market plans and were included in the market plan template. In most cases, the estimated costs and savings were not included, but will be further developed prior to and during implementation.

Table 1.1 shows the current dollar cost estimates for the five-year budget cycle. These costs include all CARES categories except Research and Other Space. While all the costs represented in Table 1.1 must be refined through specific project applications and further costing to include capital costs and savings from realignments, they do provide an estimate of the magnitude of investment required to maintain and prepare the VHA capital infrastructure for the future.

TABLE 1.1.—ESTIMATED 5-YEAR CAPITAL BUDGET (IN CURRENT DOLLARS) FY 2004–FY 2008

Fiscal year	2004	2005	2006	2007	2008
Capital Estimates*	$921,356,849	$824,137,915	$743,161,421	$652,717,033	$455,889,005
Efficiency Savings Estimates**	157,137,865	202,516,767	233,910,786	241,083,813	287,966,010
Revenue Estimates***	27,955,741	31,930,287	65,059,026	68,245,255	70,579,766
Total Cost Estimates	736,263,243	589,690,862	444,191,609	343,387,966	97,343,228

* *Capital Investment Costs* include all proposed construction, demolition and build-out costs for new leases. The capital estimates do not include recurring lease costs. They do not yet include capital costs of savings associated with the realignment or consolidation of services that are in the Draft National CARES Plan but require further cost analysis before inclusion in the final Plan.

** *Efficiency Savings* include such things as savings in utility or maintenance costs from demolishing buildings or consolidation of services. These costs were estimated by VISNs. However, they did not have a standardized way to estimate these savings so this dollar figure is not a comprehensive estimate. These savings will be more fully developed during implementation.

*** *Revenues* were also estimated by the VISNs and are not comprehensive. Examples of revenues include estimates from Enhanced Use Lease initiatives or revenues from the sale of property. These estimates will also be more fully developed during implementation.

All Capital Investments

Capital investments for the 20-year planning period are estimated at $4,655,503,656 (in current dollars) plus $468,555,970 proposed for Research. Capital investment needs and estimates beyond the five-year period used in the budget estimates above are not as reliable as the 5-year budget period due the inherent difficulty of capital planning beyond a 5-year period. Capital Investment needs will be dictated by changing health care delivery practices and changes in technology. Although the amount of space required for future needs can be estimated using the workload projections, other capital needs cannot be identified beyond five years with the same degree of accuracy. The forecasting results will be reconsidered each year in the VHA planning cycle in order to ensure that the capital forecasts reflect changing policy, technology and other dynamics within the health care system.

Vacant/Underutilized Space

• The National CARES Plan would achieve a 42% reduction in vacant/underutilized space nationally, from 8,571,605 square feet in FY 2001 to 4,934,002 square feet in FY 2022.

[8] Described in Chapter 2.

• Savings from reducing vacant/underutilized space would total over $45 million per year. [Note that the GAO report which estimated a savings of $1 million a day was based on complete campus closures (about 19–20 campuses) and not individual building closures, so it is not comparable to this CARES study.]

• Total demolition costs would amount to $58,796,952.

Service Consolidations (Proximity) and Campus Realignments

Actual savings due to campus realignments, consolidations, downsizing and closures will be assessed in detail during the CARES implementation process. When the proposed realignments and consolidations are approved as strategic directions, final decisions regarding relative savings and costs of the changes will be fully analyzed before the implementation plan is finalized.

Implementation of the National CARES Plan

Implementation of the National CARES Plan will extend over many years. It will be multifaceted, depending upon whether implementation requires additional capital, recurring funding, primarily policy changes and/or realignments that are possible at minimal cost. For example, converting to a Critical Access Hospital [9] is driven more by policy than by resources, whereas meeting the requirements to upgrade the acute capital infrastructures are heavily dependent on budget. Priority mechanisms, either in place or recently revised (such as the Capital Asset Prioritization process), will advance funding proposals from the National CARES Plan on a project-by-project basis.

Extensive development of business plans, clinical service consolidation plans, contracting and other plans will require time to ensure that services are maintained to veterans during the transition period.

The National CARES Plan also proposed additional collaborations within VA—with VBA and NCA—to maximize the use of VA assets. These implementation plans will fall under the ''One VA'' Initiative managed by the VA. Numerous additional collaborations between VA and DoD sites will ensure the most effective use of federal health care assets and will be integrated within the VA/DoD collaborative mechanisms currently in place.

The community is an important partner in the implementation process. Partnerships with the community, in which community resources can be used to meet VA capital requirements, are proposed in the plan. Community contracts are an effective way to meet changes in demand that warrant investments in capital. They also often bring services closer to veterans, particularly in rural areas. They are particularly encouraged in the context of the demand peak in 2012 and 2013. Innovative approaches to community partnerships will be encouraged for further development during implementation.

Cycles of Improvement

CARES was the first step in VHA's revised strategic planning process. The planning horizon extends to 2022, and the plan is based upon enrollment and utilization forecasts. As in all strategic plans that look into the future based upon assumptions, policies, health care delivery and veteran choices, the planning system must be sufficiently flexible to adapt to a changing health care environment. The forecasts and forecasting methods will be continuously tested and improved by monitoring actual experience. In addition, alternative future scenarios may be created to ensure that investments that are planned remain viable as developments pose new challenges and opportunities. Until fully implemented, all approved CARES proposals will be updated based upon the latest forecasts of veteran enrollee workload.

Chapter 2: The CARES Planning Process

Phased Application Chosen To Facilitate Adjustments

Managing the capital assets of the nation's largest health care system is a complicated prospect by any measure. The CARES mission was to reform this undertaking into an objective process using unprecedented levels of data sophistication, systematic evaluation, and stakeholder involvement, integrated into a comprehensive 20-year look at VA's capital asset needs.

Anticipating that such an innovative methodology would benefit significantly from the ability to make adjustments after an initial trial, VA leaders chose a phased approach to designing and implementing CARES. Phase I was a pilot test of the process conducted by a contractor working with a single VA health care network (VISN 12); in Phase II, the refined CARES process was applied within the remaining 20 VISNs comprising the balance of the VA health care system.

The second, larger effort took place under the guidance of the National CARES Program Office (NCPO), but represented an intensely collaborative effort within the Veterans Health Administration, as well as with the other two VA Administrations, other VA support staff and many other organizations. The staff of the VISNs, in particular, played a key role in the process, and notable contributions were made by VA experts from special disability programs.

Pilot Experience Yields Local Action, Improvements to National Plan

In accordance with OMB guidelines,[10] the CARES process focuses on markets—or distinct veteran population areas. The Phase I pilot identified three market areas: the Chicago area, Wisconsin and the Upper Peninsula of Michigan.

In this initial effort, the contractor [11] developed a data driven, predictive methodology to assess veterans' health care needs in the test market, and then formulated various solutions that could meet those needs. Following a detailed review process, the contractor recommended options to the Secretary of Veterans Affairs. After consulting with stakeholders, the Secretary of Veterans Affairs made a decision to realign capital assets in the VISN 12 market areas.[12] The final results of CARES Phase I were announced in February 2002.

In preparing for CARES Phase II (extension of the refined methodology to all markets within VHA's remaining 20 VISNs), VA leadership decided that VA personnel, rather than contractor staff, would coordinate and carry out the planning process. The conversion from a contracted study in one VISN, to a VA-operated planning process extended to the entire system, went well beyond the scope of the pilot. The extensive revisions of the CARES process included not only substantive data validation issues, such as updating enrollment projections, but also refining utilization projections, creating a standardized costing and workload allocation tool, assessing all space in VHA facilities and developing new projection methods for special disability programs. In effect, CARES Phase II piloted a new process that would be

[9] See Chapter 8, Small Facilities.

[10] *OMB Capital Program Guide,* Version 1.0 (Washington, DC; July 1997).

[11] Booz, Allen Hamilton.

[12] Actions included: consolidation of inpatient activities at two Chicago VA facilities; conversion of Lakeside VA Medical Center to a long-term care facility; expansion of access to VA outpatient facilities in the market.

subsequently integrated into a redesigned strategic planning process.

The challenge of developing a national process while recognizing that health care is delivered through local systems required a new approach that included the following elements:

- Use of national databases and methodologies to determine current and future needs;
- The assessment of all space in VHA for its safety and functionality;
- National definition of the planning initiatives to be addressed by VISNs;
- VISN development of plans that address the planning initiatives;
- Standardized planning support systems and data for plan development and costing to ensure consistent results;
- Policy and tools that supported local and national stakeholder involvement;
- On-site technical support to the VISNs for plan development; and
- Detailed national review process to create a national plan from the VISN plans.

The CARES process was significantly strengthened by NCPO's refined forecasts of future veteran health care needs, based on projected demand data provided by a national actuarial firm, in conjunction with veteran population data from VA's Office of the Actuary. The VISNs used these data and an innovative planning application designed by the VA and developed by IBM [13] to develop solutions to meet those needs.

A notable enhancement in the Phase II planning model was increased commitment to the aggressive, systematic inclusion of stakeholders. The requirement for in-depth communications with vitally interested publics at national, regional and local levels was integral to the process. Multiple modalities and media were designed and used to inform stakeholders about CARES in general and to solicit their comments on potential changes in respective markets in particular.

Nine-Step Planning Model

The enhanced CARES model comprised a nine-step process designed to ensure consistency in the development of CARES Market Plans within each VISN.

Step 1: Identify Market Areas as the Planning Unit for Analysis of Veteran Needs

The VISNs identified market areas based on standardized data for veteran population, enrollment, and market share provided by NCPO. Each network also used local knowledge of their unique transportation networks, natural barriers, existing referral patterns and other considerations to help select their market areas (Appendix C).

Step 2: Conduct Market Analysis of Veteran Health Care Needs

A national actuarial firm—referred to hereinafter as CACI/Milliman [14]—that had developed enrollment, workload and budget projections for VA budget development, under VA direction modified the model to develop standardized forecasts of future enrollees and their utilization of resources from 2002 through 2022 for each market area in all VISNs. Translation of the data into the following VHA CARES Categories facilitated the identification of ''gaps'' between current VHA services and the level or location of services that will be needed in the future. These were ''high level'' macro categories that would enable planning to occur at a level of detail adequate for capital needs rather than detailed service-level planning (Appendix L):

Inpatient Medicine
Outpatient Primary Care
Inpatient Surgery
Outpatient Mental Health
Inpatient Psychiatry
Outpatient Specialty Care
Outpatient Ancillary and Diagnostic Care

The CACI/Milliman model also projected workload demand in the following categories, which were not used to identify gaps because private sector benchmark utilization rates were not available to validate results:

Residential Rehabilitation
Intermediate/Nursing Home Care
Spinal Cord Injury
Domiciliary
Blind Rehabilitation

Since the statistical model's data validation on these non-private sector services was not adequate for objective planning, these categories were either removed from the Phase II cycle (*i.e.*, held constant) or, as in the case of Blind Rehabilitation and Spinal Cord Injury, alternative forecasting models were developed outside of the CACI/Milliman model. Teams of VA planners and VHA experts from the concerned special disability programs collaborated to produce these unique projections. (Chapter 7 of this plan details CARES planning for special disability programs.) Data on the current supply and location of VHA health care services was collected for all facilities, markets and VISNs (Appendix O). In most instances, FY 2001 was used as the source year for baseline data. A profile was created for each VISN and made accessible to VHA staff on a web site established as the repository for all CARES data. Baseline data included:

- Space (condition, capacity and current vacant space)
- Workload (FY 2001 bed days of care and clinic stops)
- Unit Costs (facility specific in-house and contract unit costs)
- Special Disability Population Data
- Access Data
- Facility List
- Research Expenditures and Academic Affiliations
- Clinical Inventory
- Potential DoD, VBA and NCA Collaborations
- Enhanced Use Lease Valuations
- Summary of VISN FY 2003/FY 2007 Strategic Plans

Step 3: Identify Planning Initiatives for Each Market Area

Data collected in Step 2 made it possible to directly compare current access and capacity, with quantitative projections of future demand. ''Gaps'' in service were indicated in any market where actual utilization in FY 2001 was significantly less than utilization projected for FY 2012 and FY 2022.

Such gaps in various market areas formed the basis for the development of ''planning initiatives''—essentially a description of the potential future disparity between capacity and need. Since the time horizon was 10 to 20 years in the future, and the longer the future forecast, the greater the uncertainty, only the large capacity gaps, *i.e.*, 25 percent gaps meeting at least minimum volume thresholds, were generally selected.

Planning Initiative Selection Teams were formed, including members from the NCPO, the VISNs, representatives from VA's special disability programs, and the VISN Support Service Center (VSSC). The teams reviewed each overlap or gap in supply and demand data, selecting planning initiatives for each VISN and Market Area based on established criteria for planning

[13] *U.S. Department of Veterans Affairs: Cares Web-Enabled Template,* developed by PricewaterhouseCoopers (PwC), under contract to IBM Corp. Process is fully explained and documented in References Section.

[14] Primary contractor on the project evolved from Condor Technology Solutions, to CACI Inc., to Milliman USA, Inc.; for purposes of this plan, referred to as ''CACI/Milliman'

remedial action.[15] Planning Initiatives were identified in the following areas:

Access to Health Care Services
Outpatient Capacity (Primary Care, Specialty Care, Mental Health)
Inpatient Capacity (Medicine, Surgery, Psychiatry)
Special Disabilities (Blind Rehabilitation, Spinal Cord Injuries and Disorders)
Small Facilities
Consolidations and Realignments (Proximity)
Vacant Space
Collaborative Opportunities (DoD, VBA, NCA)

In addition to the Planning Initiatives, all workload changes that resulted in gaps between predicted demand and current supply were required to be managed in the market plans. Workload had to be managed (*i.e.*, accounted for in the plan with a determination of where and how services would be provided) at the market or VISN level. Options for managing workload included in-house provision of services or by contracting, sharing, or other arrangements. The requirement to manage all projected workload was a significant addition to the planning process, which was included in order to assure that all space needs were addressed in the National CARES Plan. Final planning initiatives are summarized in Appendices D through G.

Step 4: Develop Market Plans To Address Planning Initiatives and All Space Requirements

The selected planning initiatives formed the key elements of the VISN CARES Market Plans. All VISNs developed market plans, which included a description of the preferred solution selected by the VISN for all planning initiatives identified in every market as well as potential solutions considered to address each planning initiative.

VISN planning teams were expected to identify alternative solutions for their plan development process. In proposing these various alternative solutions, VISN planners were required to assemble specific supportive data, which were entered into the IBM-developed market-planning tool. The standardized algorithms in the market planning tool assured a consistent methodology for analyzing each solution's impact on workload, space and cost, as well as other CARES criteria such as quality, access, community impact, staffing and others. Since all space planning is relational and requires a comprehensive solution, all workload gaps were accounted for in the VISN plans. The allocation of expected workload demand and space needs were resolved in addition to the planning initiative gaps.

Thus, all VISNs used the same criteria and planning tool (using local operating and capital costs) to determine the relative merits of meeting future demand via contract, renovation of available space, new construction, sharing/joint ventures/enhanced use or acquiring new sites of care. VISNs briefed stakeholders on their planning initiatives, and presented their proposed solutions. Comments and other feedback from stakeholders were duly noted for incorporation into the planning process.

Step 5: VACO Review and Evaluation: Developing the Draft National CARES Plan

The VISN plans served as input to the development of the Draft National CARES Plan. The Draft National CARES Plan is not a compilation of individual VISN plans. It represents a comprehensive series of national decisions made after reviewing the individual VISN Market Plans. Each VISN CARES Market Plan was subjected to extensive review by three review groups before ultimately being considered by the Under Secretary for Health for inclusion in the Draft National CARES Plan. These review organizations were the NCPO-organized field and headquarters review teams, the Clinical CARES Advisory Group (CCAG) and the CARES Strategic Resource Group (also known as the ''One VA Committee.'') The clinical experts (CCAG) provided the most rigorous review and comments on issues with medical and other direct care (including mission-related) implications, while the Strategic Resource Group took a more generalized management approach, looking especially closely at matters concerning collaboration with other departments or administrations.

The NCPO performed a comprehensive and intensive review, assembling review groups to look at similar types of planning initiatives from all VISNs, assuring a structured assessment that was consistent across the VA system as well as an overall assessment of whether the individual solutions within a market added up to a sensible market plan. In many instances, VISNs accepted recommendations from these review groups to change initially proposed solutions to planning initiatives; in all instances, the feedback from the review groups became part of the record included with the VISN CARES Market Plans.

The next stop for each VISN CARES Market Plan was the Under Secretary for Health, who reviewed them and accompanying comments from the diverse review groups and stakeholders. As a result of the Under Secretary for Health's review of the adequacy of the market plans, VISNs were required to review the potential realignment of specific facilities/campuses and to consider the feasibility of conversion from a 24-hour/7day-per-week operations to an 8-hour/40-hour-per-week type of operation. The rationale for the requested review was to fully assess the potential to consolidate space and improve the cost effectiveness and quality of VA's health care delivery. The guidance included the continuation of all services to veterans as part of the realignment review. The results of this initiative were incorporated into the draft National CARES Plan.

The product of the Under Secretary's review process and policy decisions formed the draft National CARES Plan. Executive summaries of the VISN plans as amended by the National CARES Plan are included as Appendix A.

Step 6: Independent Commission Review

The Secretary of Veterans Affairs appointed an independent CARES Commission comprised of knowledgeable, well-respected executives from outside VA, to review and recommend action on the draft National CARES Plan.

The Under Secretary for Health delivered the draft National CARES Plan to the Secretary of Veteran Affairs, who then transmitted the draft National CARES Plan to the CARES Commission for review. The Under Secretary for Health published the plan in the **Federal Register**, and made a copy of the plan and all appendices available on the CARES website, making this information available to the general public. The Commission will conduct public hearings within each VISN to obtain direct stakeholder feedback on the National CARES Plan.

The publication date in the **Federal Register** for the Draft National CARES Plan officially begins a 60-day public comment period, during which interested parties may submit their views in writing to the Commission, addressed to: The CARES Commission, 810 Vermont Ave., NW, Wash., DC 20420.

The Commission is expected to carefully consider the views and concerns of all stakeholders, including veterans service organizations, medical

[15] Planning Selection Criteria can be found in the Reference Section.

school affiliates, local community groups and government entities.

At the conclusion of the public comment period, after considering these final contributions of views, and having thoroughly considered the draft plan and all relevant commentary and documentation, the CARES Commission will accept, reject or modify the draft National CARES Plan and make final recommendations to the Secretary.

Step 7: Secretary of Veterans Affairs Decision

The Secretary of Veterans Affairs will consider the Commission's recommendations and supporting comments regarding the Draft National CARES Plan, and make a determination to accept, reject or ask the Commission to consider additional information prior to his final decision.

Step 8: Implementation

VISNs will prepare detailed implementation plans for their CARES Market Plans, as directed by the Under Secretary for Health. The implementation plans will subsequently be submitted to the Under Secretary for approval. Approved market plans will be used by VISNs to develop capital proposals that will be selected for funding through a capital prioritization process that is linked to the CARES process and to subsequent strategic planning cycles.

Step 9: Integration Into Strategic Planning Process

As VISNs proceed with the implementation of their CARES Market Plans, the planning initiatives and proposed solutions will be refined and incorporated into the annual VHA strategic planning cycle. The integration of capital assets and strategic planning will ensure that programmatic and capital implementation proposals are integrated into current VHA strategic planning and resource allocation. The alignment of policy assumptions and strategic objectives will thus focus an integrated planning process.

Chapter 3: Stakeholder Involvement and Communications

Building Stakeholder Support

Veteran patients and the medical practitioners who care for them lie at the heart of the VA health care system, surrounded and supported by a ''body'' of other publics integrally affected by developments in the system.

As noted in the introduction of the CARES plan, these publics are termed ''stakeholders'' in the CARES process—a designation reflecting that they collectively hold a place of preeminent importance in the realm of veteran health care. Example stakeholders are veterans organizations, VA employees, academic affiliates, Department of Defense sharing partners, and the congressional delegations that represent all the other publics.

In a report to the Secretary of Veterans Affairs and in congressional testimony regarding capital assets planning, GAO concluded that stakeholders have not always had an appropriate role in dealing with VA capital assets. According to GAO, stakeholders should be involved in an active advisory role in developing procedures, criteria, etc., for CARES. Their inclusion and involvement not only facilitates receiving valuable perspectives from stakeholders, GAO stated, but also, in the process, enhances understanding of and builds support for the CARES process.[16]

Stakeholder Involvement Implicit in the Process

Recognizing the value of stakeholder advice, CARES designers made it implicit in the process to engage the widest possible range of stakeholders from beginning to end. When the program was first publicly announced, VA stated the firm commitment that it would include a coordinated communication effort to provide timely, accurate and consistent information about the purpose and process of CARES. This chapter of the plan documents the manner in which that commitment was honored.

As VA prepared to launch Phase II of the process, the Secretary of Veterans Affairs, Deputy Secretary, Under Secretary for Health and other key VA leaders thoroughly discussed CARES in congressional testimony and during speeches and briefings presented across the country. Additionally, VA leaders talked to the media extensively about the process during numerous print and broadcast interviews. The Associated Press and New York Times published stories about CARES that were rerun across the country, spurring localized stories in many smaller papers and media outlets. Both the Secretary and Deputy Secretary participated in videotaped presentations on CARES, which were shown at facility-level and regional town hall meetings and other stakeholder forums.

Unprecedented in Public Planning

The National CARES Program Office, the VHA Office of Communications and VA's Office of Congressional and Legislative Affairs collaborated in establishing a CARES communications environment of openness and cooperation. The goals were to:

- Inform primary stakeholders and other interested parties about CARES;
- Promote understanding of the planning data generated in the process; and
- Encourage maximum participation of all stakeholders in terms of not only learning about the process, but also providing advice during the development of methodology, and comments on specific planning initiatives being considered.

One innovative step taken in CARES communications took place over the Internet. Information web sites are routine elements in modern government, so establishment of the high quality, multifaceted CARES site was not unusual.

But the way this site was continuously updated to publish virtually every piece of CARES planning information as soon as it became available was unique. Allowing public access to information at the same instant it was received by national planners and senior officials was new to VA, and may well represent a level of openness unprecedented in public planning.

As the CARES process proceeded, anyone with access to the Internet could find up-to-the-minute information—listed by market and by VISN—on current VA capacity to provide care, projections on future needs, areas where planners identified service ''overlaps'' or ''gaps,'' and possible solutions to better meet future needs.

National Veterans Organization and Stakeholder Outreach

Veterans Service Organizations (VSOs)

At the beginning of Phase II of CARES, the National VSOs, including the American Legion, Veterans of Foreign Wars, Blinded Veterans Association, Paralyzed Veteran Association and Eastern PVA, Disabled American Veterans, Catholic War Veterans, Vietnam Veterans of America and numerous others, were thoroughly briefed on the process, and they were periodically updated on the program's progress in subsequent meetings.

These meetings, which were attended by CACI/Milliman staff and CARES program officials, involved comprehensive discussions of the primary statistical planning model, as well as other CARES methodologies. The VSOs played a role in numerous changes incorporated into the model and in other enhancements made in the process.

[16] *VA Health Care: VA is Struggling to Address Asset Realignment Challenges,* GAO/HEHS–00–88 (Washington, DC: April 5, 2000), p. 5.

Responding to queries and addressing concerns at the national level, the NCPO held monthly group meetings with VSOs, as well as dozens of individual CARES briefings for VSO leaders. Concerns related to local issues were relayed to CARES Communication Coordinators at the VISN level, who followed up with information or made other appropriate responses. While the NCPO endeavored to conduct vigorous outreach concerning CARES, many key aspects of the communication process were designed in response to discussions held at monthly VSO meetings. Examples included sharing monthly summaries of communications and outreach with VSOs; providing VSOs with real time planning initiative data selection information; and modifying the CARES forecasting contract to explore methodologies that could improve future forecasts of veteran demand for specific services.

The VSOs designated local points-of-contact to interact with VA counterparts (VHA's CARES points-of-contacts), helping to get information to key veteran constituents. Clearly, the National VSOs' assistance with CARES information distribution was critical to a successful communication effort at the local level.

As previously noted, National VSOs were provided with the data used to select the planning initiatives at the same time internal VA teams received the data. Subsequently, they received the planning initiative results to ensure that there was a clear understanding of the process and its results. As each VISN submitted its Market Plan, the NCPO provided copies to the VSOs, soliciting their views and comments.

U.S. Congress

CARES briefings were provided directly to the member, or to key staff, in the offices of 37 Senators and 80 Representatives. In some instances, these briefings were presented directly to the member by the Secretary of Veterans Affairs or the Deputy, or by the NCPO and VA's Office of Congressional and Legislative Affairs. Special emphasis was placed on briefings for the House and Senate Veterans' Affairs Committees. Representatives of national VSOs were present at many of these briefings. Congressional offices were encouraged to access the CARES web site for specific information about their local areas. A complete listing of congressional contacts in Washington, DC and the field is included in the Reference Section.

Affiliates

Following the announcement of the planning initiatives, VA's Office of Academic Affiliations, in conjunction with the NCPO, sent letters to VISN directors and the deans of VA's medical school affiliates encouraging discussion of CARES impact on academic issues. The letters emphasized the importance of timely participation in CARES, noting that some affiliation stakeholders in the Chicago area felt they had missed the opportunity to contribute advice in Phase I of CARES because they came late to the process.

Additionally, NCPO and the Office of Academic Affiliations kept the American Association of Medical Colleges (AAMC) informed and helped prepare an AAMC Presidential Memo for distribution to deans. The CARES process was the subject of briefings at two AAMC meetings.

Appendix M details affiliate outreach efforts conducted by individual VISNs.

Unions

A Memorandum of Understanding between VA and AFGE was developed to establish local union representation on all CARES planning committees. This commitment was honored, and VISN Market Plans were submitted to the union's Partnership Council members. See Appendix M for a description of individual VISN union outreach.

Employees

Extensive efforts were made at both VA Central Office and in the field to keep employees informed and up-to-date on CARES. At the time this Plan was published by the Under Secretary for Health, this was an on-going process.

When CARES was launched in 2002, a brief message announcing the program was printed on the biweekly Pay and Leave Slip delivered to each VA employee. Articles about CARES were published in the VA's national ''Vanguard'' employee newsletter, and the VA Satellite Telecast, ''Newscast to Employees,'' reported the launching of CARES. Several abbreviated update messages on CARES were transmitted over the intranet systems carrying VA's All Employee Daily Email.

VISN and facility level newsletters reported the birth of CARES and provided periodic updates. In addition, two, all employee Townhall meetings on CARES were held in VACO, and every VA hospital and VISN office held one or more Townhall CARES discussions with employees.

National Communication and Outreach Support

The VHA Office of Communications, in conjunction with the NCPO, worked with 20 VISN CARES Communications Coordinators across the country, disseminating information and answering queries about the process. Information and guidance was provided to the public affairs officers who were responsible for CARES communications at individual VA facilities. VHA Communications produced and distributed more than 40 national products, such as news releases, question and answer sets, fact sheets, videos, posters, brochures, and other products to help VA communicators in the field tell the CARES story in an accurate, thorough and consistent manner.

VHA and the VA's Office of Public Affairs jointly conducted three intensive training conferences on CARES communications, attended by VISN and facility directors and other key VHA field personnel charged with publicizing CARES, answering inquiries about it, etc. More than 300 people attended these two-and-a-half day sessions, learning techniques and sharing expertise to improve outreach and responsiveness to CARES stakeholders. In addition, NCPO sponsored three major conferences and seminars specifically designed to provide CARES information to Central Office employees, veterans service organizations and congressional staff.

Five shorter training sessions for facility-level public affairs officers were held in Dallas, New York, Durham, Boston and Los Angeles. More than 75 of these local VA communicators received a day of training and several products to help them publicize and explain CARES to stakeholders.

VA public affairs specialists discussed CARES outreach techniques in national conference calls, with 70–90 CARES Communications Coordinators participating every week. The VHA Office of Communications coordinated the calls, and regional staff of VA's Office of Public Affairs contributed ideas and expertise.

Millions of Communications Contacts

Many millions of stakeholders received some information about CARES through general reporting in print and broadcast media, but VA has no precise means of estimating these contacts. Some tangible indicators are, however, available.

VHA produces a monthly report that tracks actual contacts with stakeholders. A compilation of these monthly reports

indicates that more than 6.5 million contacts were directly sent information about CARES or received CARES information in face-to-face meetings.[17] This number of contacts represents the entire gamut of CARES stakeholders, including veterans, employees, union members among VA employees, congressional staff, affiliates, Department of Defense representatives, and members of the public.

Most of the VISNs relied heavily on communication modes, such as briefings, web sites, e-mails and mailings. Overall, of the 6,598,201 total stakeholder contacts, nearly 42 percent were in the form of mail-outs (e-mails, brochures, and newsletters).[18] More than 1.1 million or 16 percent were employee contacts, which accounted for the second largest category. The third largest category, at a little more than 1 million (or 2 percent), was VSO contacts.

Summary of Stakeholder Involvement

A thorough review was conducted of the Stakeholder Narratives that were a part of the VISN CARES Market Plans submitted April 15, 2003. Specifically, the review team looked at whether there was adequate outreach, whether input was solicited and received, and whether the input influenced the Market Plans. A thorough analysis of each market is available in Appendix M.

All VISNs reported extensive and intensive contacts with stakeholders, documenting a wide array of steps taken to apprise these groups of possible future changes in VA health care services. These contacts included both systematic and one-time efforts to solicit concerns and recommendations. Appendix M sets forth details by VISN and market.

A multiplicity of interactions disclosed recurrent concerns relating to such issues as access to care and facility closures from veterans, and job security from employees. See Appendix M for a listing of expressed concerns.

When evaluating all twenty-one (21) VISNs, no major ''red flags'' were discerned in the context of unanticipated stakeholder concerns. However, in some instances there were indications that VISNs and facilities did not fully address potential mission changes or realignments with stakeholders, preferring instead to wait until more formal decisions were made. These were relatively rare occurrences confined primarily to the Small Facilities and Proximity Planning Initiatives, since most planning initiatives dealt with expansions in outpatient care. In most cases, stakeholders were asked to respond to alternative solutions proposed for these Proximity and Small Facilities Planning Initiatives, and their concerns were described in solutions to those initiatives.

In summary, stakeholder narratives in the VISN CARES Market Plans showed that, across the board, VISNs made a concerted effort to inform their stakeholders of the CARES process, and to obtain and consider input from these stakeholders on controversial planning initiatives.

Chapter 4: Enhancing Access to Health Care Services

Clear and Compelling Purpose: Outpatient Access and Inpatient Capacity

The growth of Community-Based Outpatient Clinics (CBOCs) has improved access to services for veterans. CARES provided a mechanism to measure progress towards its stated goal of ''improving quality as measured by access.'' [19] Complementary to this stated goal was the intention to ensure that the current and future acute care infrastructure is capable of meeting the needs of veterans who access health care services. The CARES process enabled VA to develop a cost effective investment strategy to improve access in selected markets and ensure the availability of the acute care infrastructure.

Measuring Veteran Access to Care

The traditional way of measuring access in VHA was through determining where patients from a given county seek specific types of treatment, such as primary care, inpatient acute care, mental health care and specialized services. Episodes of treatment at all VA facilities in that county were tallied over a three-year period, and the proportional use of each VA facility was determined, *i.e.*, which percent used facility ''A'' vs. facility ''B,'' etc. Travel time to obtain services was not measured.

As previously noted, the planning focus of the CARES process was the ''market,'' or a distinct veteran population in a defined geographic area. The state-of-the-art methodology used in CARES not only was capable of greater precision in measuring access, but also provided more information to support planning decisions. The CARES approach involved determining the percentage of enrollees living within specific travel times to the nearest, appropriate VHA facility.

The new data allowed access within each market to be scored with regard to two ''thresholds:'' first, a minimum percentage of enrollees living within a specified travel time to obtain VA primary care; second, notwithstanding the percentage of enrollees living within these travel times, the total number living outside the guidelines could not exceed a specified number. In other words, to qualify as an ''access'' planning initiative according to the criteria developed for CARES, a market had to first meet a relative standard (percentage living within access guidelines) as well as an absolute standard (a specified number of enrollees living outside access guidelines). Table 4.1 presents the specific criteria.

TABLE H.1.—ACCESS CRITERIA

Type of care	Time criteria (minutes)	Threshold criteria (%)	Number of enrollees outside of guidelines	#PIs
Primary Care	30 Min.—Urban 30 Min.—Rural 60 Min.—Highly Rural	70	Less Than 11,000	27
Acute Hospital	60 Min.—Urban 90 Min.—Rural	65	Less Than 12,000	24

[17] Note: the large numbers are in part due to potential briefing and/or mail-outs to the individuals on multiple occasions. In addition, some media releases were counted as part of the ''contacts'' submitted by the VISNs and VA facilities. Due to the complex nature of the CARES process and the projection models, multiple briefings and educational sessions were not only desirable and necessary to convey the scope of the enterprise, but also to create ''educated publics'' who could be more actively involved as stakeholders.

[18] Again, as noted above, some of the contacts were via local media in the form of news coverage. The volume is indicative of the extensive local efforts (see Appendix M) to engage various stakeholder groups in a dialogue on the CARES process and to receive their input into the planning.

[19] VHA Directive 2002–032, June 5, 2002; ''Capital Asset Realignment for Enhanced Services (CARES) Program''.

TABLE H.1.—ACCESS CRITERIA—Continued

Type of care	Time criteria (minutes)	Threshold criteria (%)	Number of enrollees outside of guidelines	#PIs
Tertiary Care	120 Min.—Highly Rural 240 Min.—Urban 240 Min.—Rural Community Standard—Highly Rural	65	Less Than 12,000	6

(Specific methodology for calculating travel time to VA care can be found in Appendix P; a technical explanation of specific access calculations is contained in the References Section.)

To illustrate the application of these criteria as shown in Table 4.1 above, the first line in the table (dealing with primary care) should be understood to connote the following:

- Column 1: States type of care as Primary, Acute Hospital or Tertiary.
- Column 2 (time criteria) and Column 3 (threshold): taken together, stipulate that at least 70 percent of enrolled veterans living in urban or rural areas of the market should live within the following travel times to a VA primary care facility: for urban and rural areas, 30 minutes; for highly rural areas, 60 minutes.
- Column 4 (number of enrollees): states that there can be no more than specified number of enrollees living outside the time guidelines.
- Column 5 (number of PI's): reports that 27 planning initiatives were proposed to correct ''access issues'' nationwide for primary care.

An ''access issue'' was defined in markets that failed to meet both thresholds, *i.e.*, less than the stated percentage of enrollees met the travel time requirement and more than the specified number of enrollees lived outside the travel time guidelines. Following the data analysis and identification of access issues, VA planners developed solutions within each market, for each Access Planning Initiative.

Of the 57 total Access Planning Initiatives, 27 (or 47%) were for primary care, 24 (or 42%) for acute hospital care, and six (or 11%) for tertiary hospital care. (Appendix D contains a listing of access initiatives for each VISN.)

Summary of Access Planning Initiative Solutions

Approaches to resolving access issues fell into the following categories:

Primary Care

- New community-based outpatient sites, either VA-staffed (*i.e.*, ''in-house'') or via contract
- New Joint VA/DoD ambulatory care clinics

Acute Hospital Care

- Renovation of existing infrastructure to reactivate acute care services
- Referral to other VA facilities that may have augmented capacity
- Contracting with, or leasing space within, community-based non-VA facilities
- Joint ventures or sharing agreements with DoD or affiliated hospitals

Tertiary Care Services

- Contracting with community tertiary care facilities and DoD facilities
- Referrals to VA tertiary facilities that may have augmented capacity

Outpatient Access Investment Strategy

The backlog of acute inpatient capital needs identified in the CARES process has made the improvement of access a complex problem from many perspectives. Increases in new access points historically have generated new users to the VHA health care system beyond forecasted utilization. This new demand for care, if not cautiously approached in the National CARES Plan, could increase acute inpatient needs before a systematic infrastructure improvement process is in place to ensure that the expected new demand can be met in a quality inpatient environment. In addition, the financial requirements for construction or leases of new access sites, as well as for additional operating funds, would compete with the funding requirements for delivering health care services to current and projected veteran enrollees.

An important initial step for CARES was to produce a system-wide assessment of the magnitude of capital and operating needs. The magnitude of the capital backlog, the growth in projected outpatient demand, and the number of access gaps had not been systematically measured prior to the CARES process. In the CARES effort, VISNs proposed to meet these projected increases in outpatient demand through renovation and expansion of existing outpatient delivery sites, and through establishing 161 new CBOCs in markets where there were Access Planning Initiatives. In addition, 73 new CBOCs were proposed in markets where there was not an Access Planning Initiative, but where there were gaps between future projected demand and current capacity.

When the results of the market plans were compiled, it was clear that difficult policy decisions had to be made in order to achieve a balanced growth of outpatient capacity and access, while ensuring the safety and availability of the acute inpatient infrastructure. As a result, the National CARES Plan includes CBOC priority groups that focused the initial growth of CBOCs in markets with large future outpatient gaps (Capacity Planning Initiatives), large access gaps (Access Planning Initiatives) and where the largest number of projected enrollees per new CBOC reflects an efficient allocation of resources.

The following are the priority groups that comprise the CBOC investment strategy in the National CARES Plan:

- Highest priority group (1): Markets that have large future capacity gaps in addition to large access gaps and where the number of enrollees who do not meet access guidelines per CBOC proposed is greater than 7,000 enrollees per CBOC (48 CBOCs). This group includes additional CBOCs that are linked to realignment and five key DoD outpatient collaborations.
- Second priority group (2): Markets that met the same criteria as in highest priority group, but where the numbers of enrollees that do not meet access guidelines are less than 7,000 enrollees per CBOC proposed.
- Third priority group (3): Markets with large demand gaps but where 70% or more enrollees were within access driving time guidelines. Since these markets did not have access planning initiatives a planning target for them is to meet their growth in outpatient demand by expansion at existing sites.

Inpatient Access Investment Strategy

Improvements in inpatient access were considered more critical than improvements in outpatient access, since an acute inpatient episode of care presents a daily burden to a veteran's support system. Many studies have

described the importance of that support system in reducing lengths of stay and improving clinical outcomes. VISN Market Plans often proposed the use of contract care to improve hospital access, a solution that can be more flexible in covering the geography of a market, meeting fluctuations in demand and as a result may be more cost effective than the establishment of VA-owned sites of care. Improving inpatient access while meeting future capacity requirements can be accomplished without creating the kind of competing resource demands noted in the outpatient care situation.

Projected Improvements In Access

Tables 4.2 and Table 4.3 show the improvement in the enrollee population access to care. Table 4.2 contains information on the projected improvements in access percentages and the number of enrollees remaining outside the access guidelines by type at the national level. The primary care access data only includes the impact of the 48 CBOCs in the high priority group. It is important to compare these numbers with the baseline acceptable level, or threshold, which was 70% of enrollees within travel time guidelines for primary care, 65% for hospital and tertiary care.

TABLE 4.2.—PERCENT ENROLLEES WITHIN GUIDELINES AND NUMBER OF ENROLLEES OUTSIDE GUIDELINES BY TYPE: FY 2001–FY 2022

Type	FY 2001		FY 2012		FY 2022	
	Percent enrollees within guideline	Number enrollees outside guidelines	Percent enrollees within guideline	Number enrollees outside guidelines	Percent enrollees within guideline	Number enrollees outside guidelines
Primary Care	74	1,474,354	74	1,554,720	74	1,410,224
Hospital Care	72	1,573,205	82	1,079,649	82	970,448
Tertiary Care	94	318,960	97	179,941	97	161,741

(Compare with baseline thresholds of 70% for primary care, 65% for hospital and tertiary care.)

As indicated in Table 4.2, from a national system perspective, most VA medical facilities are currently within national guidelines for access, since most facilities are located near veteran population centers and because of the growth in the VA of over 600 CBOCs. Current high levels of access are consistent with an investment strategy that ensures the availability of the acute care infrastructure to veterans.

With the implementation of the National CARES Plan, dramatic improvement is projected in acute hospital care access (approximately 600,000 more enrollees within guidelines) and significant improvement is projected in tertiary care access (approximately 150,000 more enrollees within guidelines). While the number of enrollees outside primary care access guidelines increases in FY 2012, it drops slightly below the FY 2001 baseline in FY 2022. The increase in the number of enrollees outside access guidelines in FY 2012 is due to the peak in total enrollment during that time period, although the percentage of total enrollees within access guidelines remains steady at 74 percent.

If the 48 new high priority group CBOCs (in eight additional market areas) were implemented, then, by FY 2012, 79% of all markets (see Table 4.3) would be projected to have achieved the threshold for primary care access. Substantial improvements in hospital access occur as well. Projecting forward to FY 2022, the forecast was that these access improvements would be sustained for primary and tertiary care, and there would be a slight additional improvement for hospital care.

TABLE 4.3.—PERCENTAGE OF MARKET AREAS WITHIN ACCESS GUIDELINES BY TYPE: FY 2001–FY 2022

[73 Market Areas—excludes Puerto Rico]

Type	FY01	FY12	FY22
Primary Care	67	79	79
Hospital Care	66	89	90
Tertiary Care	100	100	100

New Primary Care Access Sites

Table 4.4 lists the specific CBOCs included in the highest priority CBOC investment group. These 48 CBOCs are located in markets that have large future capacity gaps in addition to large access gaps and where the number of enrollees who do not meet access guidelines per CBOC proposed is greater than 7,000 enrollees per CBOC. In addition to this list of 48 CBOCs, new primary care access sites that are linked to realignment or key DoD collaborations are also considered in the highest priority CBOC investment group.

TABLE 4.4.—NEW ACCESS SITES IN NATIONAL CARES PLAN

VISN	Market area	Facility parent	Facility name	Planned to open
6	Northeast	Richmond	Charlottesville	2006
6	Northeast	Richmond	Emporia	2005
6	Northeast	Hampton	Norfolk	2005
6	Southwest	Asheville	Franklin	2004
6	Southwest	Salisbury	Greensboro	2007
6	Southwest	Asheville	Hendersonville	2004
6	Southwest	Salisbury	Hickory	2004
6	Southwest	Salisbury	Gastonia	2010
6	Southwest	Asheville	Rutherfordton	2009
7	Alabama	Birmingham	Opelika	2009

TABLE 4.4.—NEW ACCESS SITES IN NATIONAL CARES PLAN—Continued

VISN	Market area	Facility parent	Facility name	Planned to open
7	Alabama	Birmingham	Childersburg	2006
7	Alabama	Birmingham	Guntersville	2008
7	Alabama	Birmingham	Bessemer	2004
7	Alabama	CAVHCS—West Campus	Enterprise	2010
7	Georgia	Augusta	Aiken	2006
7	Georgia	Augusta	Athens	2004
7	Georgia	Dublin	Milledgeville	2009
7	Georgia	Dublin	Brunswick	2008
7	Georgia	Atlanta	Stockbridge	2007
7	Georgia	Atlanta	Newnan	2008
7	Georgia	Dublin	Perry	2005
7	South Carolina	Charleston	Hinesville	2006
7	South Carolina	Columbia (SC)	Spartanburg	2005
8	South Carolina	South Charleston	Summerville	2006
8	North	Gainesville	Camden	2006
8	North	Gainesville	Jackson County	2005
8	North	Gainesville	Putnam	2005
8	North	Gainesville	Summerfield	2006
16	Central Lower	Houston	Conroe	2005
16	Central Lower	Alexandria	Fort Polk	2005
16	Central Lower	Houston	Galveston (Dual Site—Site 1)	2004
16	Central Lower	Houston	Galveston (Dual Site—Site 2)	2004
16	Central Lower	Houston	Katy	2007
16	Central Lower	Alexandria	Lake Charles	2006
16	Central Lower	Houston	Lake Jackson	2009
16	Central Lower	Alexandria	Natchitoches	2006
16	Central Lower	Houston	Richmond	2008
16	Central Lower	Houston	Tomball	2006
16	Eastern Southern	Eastern Southern	Eglin AFB	2004
20	Inland North	Spokane	Central Washington	2006
23	Iowa	Des Moines	Carroll	2006
23	Iowa	Des Moines	Marshalltown	2004
23	Iowa	Iowa City	New Cedar Rapids	2004
23	Iowa	Iowa City	Ottumwa	2006
23	Minnesota	St. Cloud	Alexandria	2005
23	Minnesota	Minneapolis	Elk River	2005
23	Minnesota	Minneapolis	Redwood Falls	2006
23	Minnesota	Minneapolis	Rice Lake	2007

Chapter 5: Enhancing Outpatient Care

Modern Ambulatory Care Approach—A Vital Part of VA's Integrated System of Health Care Delivery

Technological advances (prominently including minimally invasive procedures) and the increasing use of pharmaceutical therapy in lieu of hospitalization launched a dramatic, industry-wide increase in reliance on outpatient services in the 1980s. Fueled by cost economies realized through this more flexible approach, the trend grew rapidly into the 90s, but the VA health care system was not well positioned to benefit from this development.

VA must be prepared to meet the total needs of veteran patients, including acute and tertiary care. Until 1996, archaic statutes required inpatient admissions for care that should have been delivered as outpatient services. Furthermore, changes in VHA's operational culture—with its historic inpatient treatment orientation—were needed before the modern outpatient care model could be adapted to fit the VA system.[20]

In reinventing its health care system in recent years, VA aggressively incorporated the positive features of ambulatory care into updated clinical practice patterns and performance measures (practice guidelines). The commitment to meet the total needs of veteran patients was accommodated through new referral patterns within the integrated VA system.

The success of VA's commitment to provision of services across the full spectrum of care has been thoroughly documented in VA workload statistics: from FY 1996 to FY 2002, inpatient average daily census dropped 53 percent with a concurrent increase in outpatient visits of 54 percent[21]. Moreover, at the end of the period, VA was treating over 1.5 million more veterans each year than it did at the beginning. Many patients also benefited by receiving care in a more convenient setting closer to their homes.

Recognizing the pivotal role which modern ambulatory care now plays in the VA system, the CARES process was designed to ensure (as detailed in this chapter) adequate future capacity in primary, specialty, and mental health care services to meet the projected future demand.

CARES Criteria for Outpatient Capacity Planning Initiatives

Planning initiatives were selected as the most significant gaps in care based upon national criteria applied in each market. Since they represent the most significant gaps, there is a higher degree of confidence that they will survive the inherent uncertainties of forecasts of the future. The new capital prioritization processes that will drive the selection of projects for capital funding include criteria directly related to the size of the gap. It is important to note, however,

[20] "Vision for Change: A Plan to Restructure the Veterans Health Administration," Department of Veterans Affairs, Wash., DC, 1995.

[21] VSSC "KLFMENU" *http://klfmenu.med.va.gov/* Financial Summary.

that VISN-level CARES Market Plans address workload and space solutions for all gaps in all CARES categories regardless of whether or not a planning initiative was identified. Thus, all future workload is addressed in the planning process. Nevertheless, the primary approach was to identify where future ''gaps'' in service could be expected for each market within each VISN and then develop possible solutions (termed Outpatient Capacity Planning Initiatives) for managing the workload and capital needs in these markets. Capacity gap identification involved comparing current workload data (Base Year of FY 2002) with projections 10 and 20 years into the future (FY 2012 and FY 2022). Threshold Criteria for the three categories of care were established (as shown in Table 5.1) to determine where the ''workload gaps'' might be considered as Planning Initiatives.

Although data were available for a fourth outpatient CARES category, Ancillary/Diagnostics, the mixed nature of the workload comprising this category (tests and procedures) were too dissimilar for statistical inclusion with the other three, visit-oriented categories. For this reason, planning initiatives were not identified for Ancillary/Diagnostic services.

To illustrate application of the criteria, consider the first line of Table 5.1, which indicates that a gap would exist if two conditions in the primary care category were identified:

- The number of outpatient visits in FY 2012 or FY 2022 is projected to increase more than 25% over the volume in FY 2001; and
- In FY 2012 or FY 2022, projections show a gap of more than 26,000 ''stops,'' or clinic visits, over the number that took place in FY 2001.

Both the size of the workload gap (the margin by which it exceeds the threshold) and whether the gap was forecasted in both FY 2012 and FY 2022 were factors in deciding the priority and magnitude of response that went into the planning initiatives. One hundred forty-three (143) outpatient capacity planning initiatives were identified, all of them in response to gaps projected through increasing workload.

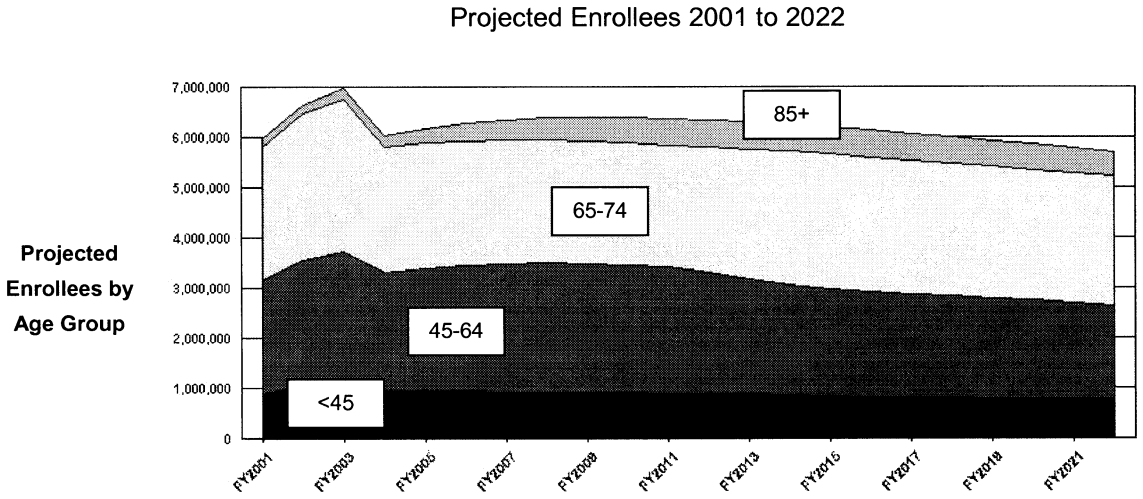
TABLE 5.1.—NUMBER OF PIS IDENTIFIED USING OUTPATIENT GAP THRESHOLD CRITERIA

CARES category	Threshold criteria %change from FY2001	Workload criteria (stops)	# PIs identified
Primary Care	25	26,000	53
Specialty Care	25	30,000	71
Mental Health	25	16,000	19

Outpatient Workload Trends

Workload projections for both the outpatient and the inpatient categories discussed in the next chapter are impacted by projected enrollment trends, by anticipated changes in health care practices, and by new technologies that permit more treatment on an outpatient rather than an inpatient basis. Changes in veteran enrollment are impacted by the aging of current enrollees, influx of new enrollees from active duty status, and reliance on Medicare and other private sector health providers, as shown in Figure 5.1.[22]

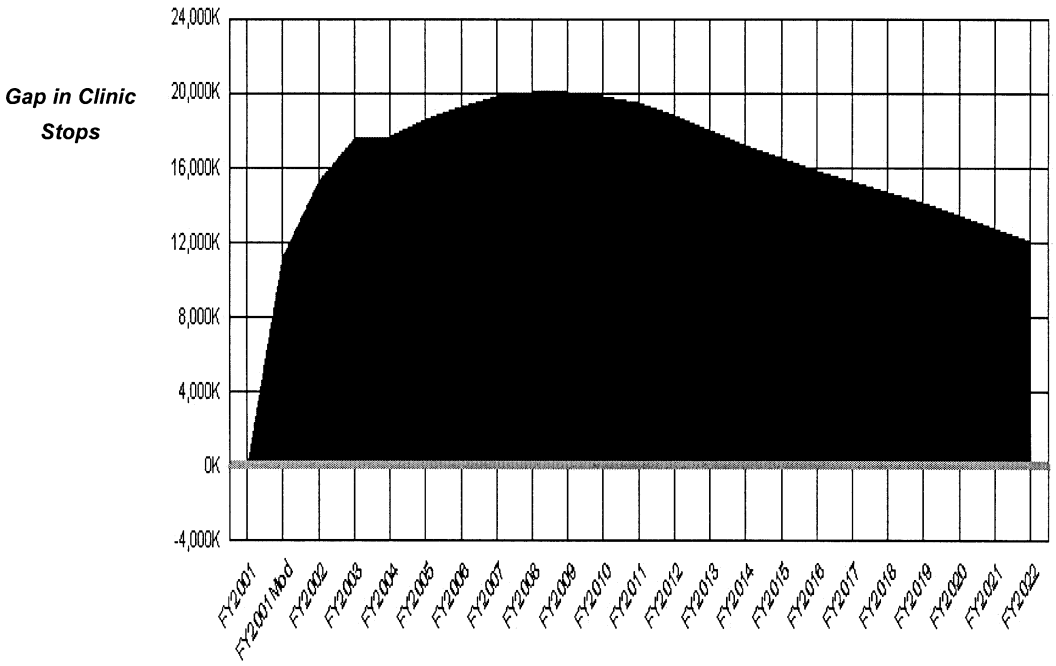
Figure 5.1 National CARES Enrollment Projections by Age Group



[22] CACI/Milliman Enrollment/Demand Model can be found under References

Figure 5.2 CARES National Outpatient Workload Gaps

Primary Care, Specialty Care and Mental Health



Gaps in Clinic Stops

Figures 5.2 through 5.5 show the variance in outpatient workload (clinic stops) projected for each year through FY 2022 compared with baseline workload (actual FY 2001). This variance between projected workload and baseline workload is referred to as a ''gap''. The CARES forecasting model projects that outpatient clinic stops will increase significantly from the baseline year through FY 2009 and then will gradually decline as illustrated in Figure 5.2 below. The projected workload in FY 2022, although lower than the peak in FY 2009, will still represent a net increase in workload from FY 2001.

Breaking up this single trend line for a closer look at the three CARES outpatient categories reflects significant differences in projected gaps in each respective area.

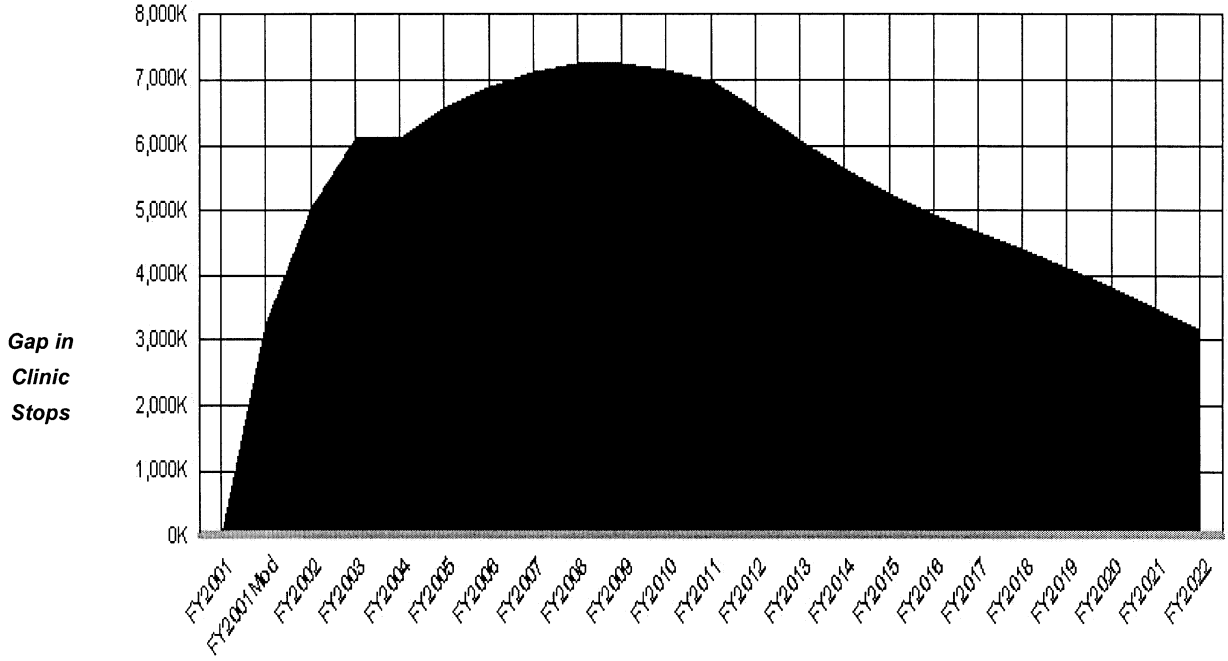
Primary Care

Projected national workload gaps, measured in outpatient primary care clinic stops,[23] are shown in the graph below. The most significant gap in workload is projected between the baseline year (FY 2001) and the first year of forecast demand (FY 2002). This initial gap in what VHA actually provided in FY 2001 and what the model forecasts for FY 2002 was due to the CACI/Milliman Demand Model assumptions that supply would be available for all projected veteran demand. The model implied that FY 2001 workload was artificially suppressed due to budgetary, capital or staffing constraints.

The primary care workload gap is projected to grow in future years until an anticipated decrease in enrollment levels (due to declining veteran population) becomes a significant factor around FY 2009 (as shown in Figure 5.3 below).

[23] Appendix L lists the clinic stop codes (subspecialties) associated with each of the Outpatient CARES Categories.

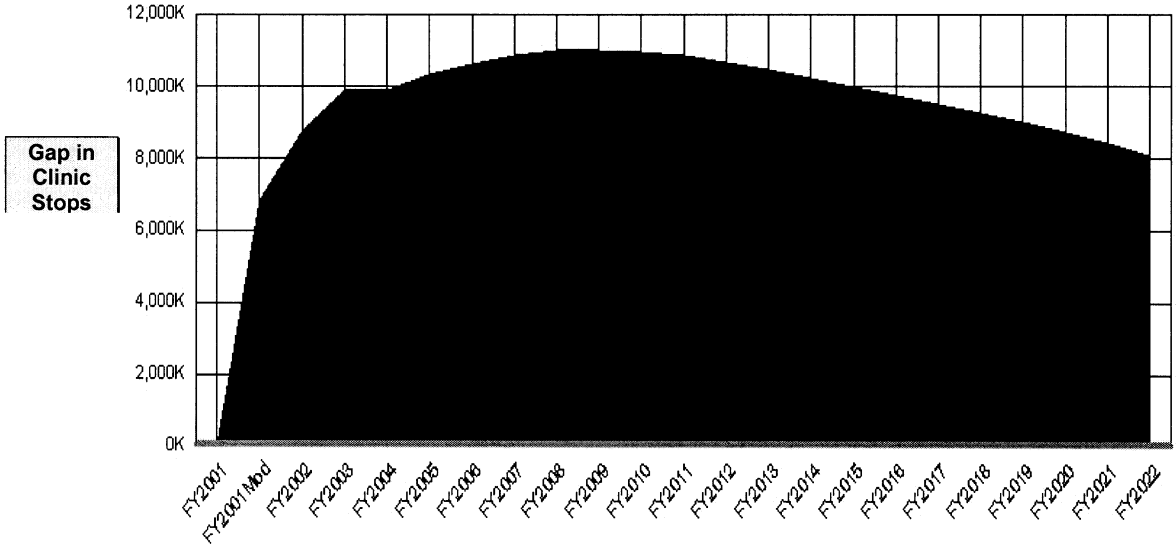
Figure 5.3 Projected Gaps in Primary Care Clinic Stops by Fiscal Year



Specialty Care

Projected national workload gaps, measured in outpatient specialty care clinic stops, are shown in the graph below (Figure 5.4). Again, the most significant gap is projected between FY 2001 and the first year of forecasted demand. This forecasted, initial gap is even more pronounced for specialty care (an indication which validates VHA's current focus on reducing waiting times for such sub-specialty services as cardiology, ophthalmology, orthopedics and urology). The projected gap in specialty care workload continues to grow in future years until the anticipated decline in enrollment levels becomes a significant factor in FY 2010.

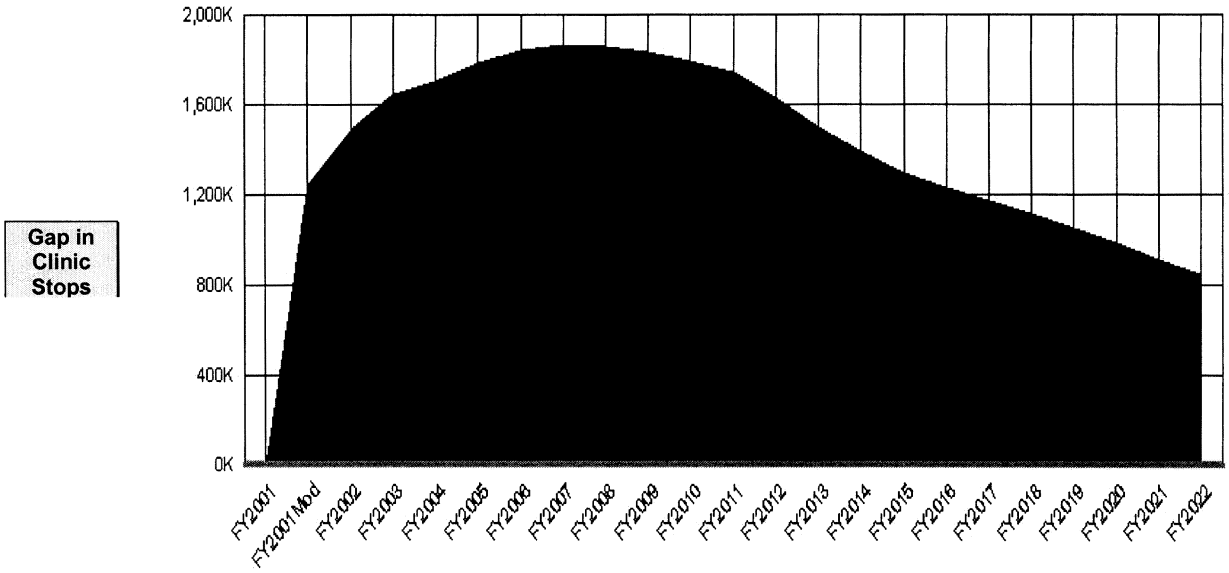
Figure 5.4 Projected Gaps in Specialty Care Clinic Stops by Fiscal Year



Mental Health

Projected national workload gaps, measured in outpatient mental health clinic stops, are shown in Figure 5.5. Declining enrollment levels and utilization rates of veterans age 65 and older become significant factors in FY 2008.[24]

Figure 5.5 Projected Gaps in Mental Health Care Clinic Stops by Fiscal Year



Summary of Outpatient Capacity Solutions

VISN CARES Market Plans identified a variety of options to resolve all projected outpatient workload gaps, including those associated with Outpatient Capacity Planning Initiatives, and manage space requirements at each facility.

Tables 5.2 and 5.3 show how VHA will handle outpatient workload for two snapshots in time, FY 2012 and FY 2022. Outpatient workload units in these tables represent the total number of clinic stops projected for each facility in each VISN, rolled up to the national level. The total number of projected clinic stops in each CARES category was used to estimate the amount of space needed at each facility for each of the planning years. VISNs were required to solve each of their facilities' total space needs in each of the CARES categories. Tables 5.2 and 5.3 focus on outpatient Primary Care, Specialty Care and Mental Health Care solutions for two of the planning years—FY 2012 and FY 2022.

By FY 2022, VHA will handle approximately 85 percent of all outpatient workload in-house. Contracting for outpatient workload is used as a short-term solution to a greater extent in earlier years when workload is at its peak.

TABLE 5.2.—WORKLOAD SOLUTIONS FOR OUTPATIENT CATEGORIES—FY 2012

Workload alternative	Primary care		Specialty care		Mental health	
	Number of clinic stops	Percent of total	Number of clinic stops	Percent of total	Number of clinic stops	Percent of total
Contract	2,959,588	14.3	3,835,207	17.2	1,214,262	12.0
Joint Venture	44,450	0.2	203,608	0.9	22,200	0.2
In-Sharing	88,860	0.4	66,518	0.3	442	0.0
Sell	0	0.0	640	0.0	530	0.0
In-house	17,547,286	85.1	18,135,140	81.6	8,851,592	87.8
Total Demand	20,640,184	.....	22,241,113	.....	10,089,026	.....

[24] **Note:** The Mental Health outpatient projection methodology is being reviewed and is under revision. The projections shown in Figure 5.5 are probably underestimates of the demand for services. The forecasts will be updated for the next Fiscal Year strategic planning cycle.

TABLE 5.3.—WORKLOAD SOLUTIONS FOR OUTPATIENT CATEGORIES—FY 2022

Workload alternative	Primary care		Specialty care		Mental health	
	Number of clinic stops	Percent of total	Number of clinic stops	Percent of total	Number of clinic stops	Percent of total
Contract	2,175,508	12.5	3,056,393	15.4	957,536	10.3
Joint Venture	41,450	0.2	200,950	1.0	24,200	0.3
In-Sharing	88,860	0.5	66,518	0.3	442	0.0
Sell	0	0.0	640	0.0	530	0.0
In-house	15,089,305	86.8	16,470,253	83.3	8,336,124	89.4
Total Demand	17,395,123		19,794,754		9,318,832	

Table 5.4 presents outpatient space solutions for all planning years combined—through FY 2022. A combination of solutions are planned to resolve space requirements in order to meet future outpatient workload demand. Primary care solutions rely more heavily on the use of leased space as part of providing appropriate access and space within markets.

TABLE 5.4.—SPACE SOLUTIONS FOR OUTPATIENT CATEGORIES—CUMULATIVE THROUGH 2022

Space alternative	Primary care		Specialty care		Mental health	
	Square feet	% total	Square feet	% total	Square feet	% total
Existing-Non Renovated	4,867,243	48.1	8,583,918	42.7	3,260,328	56.8
Renovate Existing	984,836	9.7	1,299,938	6.5	540,547	9.4
Convert Vacant	363,183	3.6	1,324,502	6.6	284,919	5.0
New Construction	1,064,626	10.5	4,776,324	23.7	658,975	11.5
Donate	56,785	0.6	128,554	0.6	22,520	0.3
Lease	2,745,428	27.1	3,768,876	18.7	973,200	17.0
Enhanced Use	45,500	0.4	240,000	1.2	0	0.0
Total Space Proposed	10,127,601		20,122,112		5,740,489	

A salient feature of this multifaceted approach to acquiring needed space is flexibility. Varied approaches of this nature can be helpful in working around unexpected delays, further assuring that the VA health care system will have adequate capacity in critically important ambulatory services.

National CARES Plan

The National CARES Plan, developed from the VISN CARES Market Plans, focuses on improvements to existing outpatient delivery sites. The focus is part of the overall National CARES Plan strategic direction for maintaining VHA's current infrastructure. Existing VHA sites and their capital requirements are included in the National CARES Plan without any priority groupings. Priority setting will occur during project-specific decisions. Reflecting a perceived need to structure new CBOCs into priority groups prior to implementation, VHA decided to group the proposed new outpatient access sites (CBOCs) into 3 priority levels, as described in detail in Chapter 4.[25] Priority groupings will enable VHA to carefully phase-in new CBOC growth so that a balanced expansion of outpatient capacity at existing and new sites can be achieved.

Chapter 6: Ensuring Inpatient Capacity

Inpatient Services Redefined: Reduced Capacity, Refined Expectations

With the increased reliance on ambulatory services noted in the preceding chapter, the role of VA inpatient facilities has not diminished, but rather has become more precisely defined. In the VA system, that role is to serve as the vital referral junction for acute and tertiary care, as well as a point of convergence for other health care services not available in ambulatory care facilities.

Background on Changing Inpatient Environment

The dramatic shift from inpatient to outpatient care in the VA system over the past few years was briefly described in the previous chapter of this plan. Several salient features of the concomitant changes VA has experienced in inpatient hospital care are discussed below.

The transition was begun in a gradual fashion when, between 1969 and 1994, there was a 56 percent decline in average daily census (ADC) from 91,878 to 39,953, respectively.[26] Overall, VA beds declined by about 50,000 over this 25-year period. Between 1995 and 2002, there was a further drop and even more striking shift to outpatient health care delivery. During this seven-year period, there was a drop in the ADC of about 60 percent to 14,925.[27] Acute operating beds fell by 63 percent (from about 52,000 in 1994 to about 19,000 in 2002). The period of most rapid decline in bed utilization and numbers of beds was 1997 to 1998. After 1998, the average occupancy rate started to rise to a high of 80 percent in 1999 (in 2002, about 75 percent compared to 71 percent in 1994). In addition, strengthening of primary care services, such as home care, case management, telemedicine, and patient self-help instruction has reduced the number of medicine bed days of care.

The changes from inpatient to outpatient care have also been coupled with and, to a large extent made possible by, rapid advances in medical technology, which require on-going

[25] Table 4.4, Chapter 4, lists the new access sites included in the draft National CARES Plan.

[26] GAO/HEHS–95–121, VA Health Care: Opportunities for Service Delivery Efficiencies [* * *]

[27] From the VA's KLF Menu Database.

investment in imaging equipment.[28] Applications include cardiac catheterization, invasive radiology (including angiography), sophisticated scanning (CT, MRI, and PET), and micro-vascular and minimally invasive surgical techniques that are highly dependent upon the use of expensive imaging equipment. Atypical anti-psychotics, second-generation anti-depressants, and better case management have decreased the need for hospitalization of mentally ill veterans. The focus on patient safety and outcomes in acute care settings and the volume-quality relationship are discussed further in Chapter 8, Small Facilities. Furthermore, a recent study conducted by the VA emphasized the need for early referral and intervention in patients with acute cardiovascular events.[29] Conclusions of recent medical literature underscore the need to consolidate volume-dependent procedures in tertiary care hospitals and to refer patients with complex medical conditions (*e.g.*, requiring ICU care) as early as possible. The appropriate functioning of VA hospitals as a part of a health care delivery network (rather than stand-alone, full-service hospitals) is critical to the provision of the highest quality of care for our veteran patients.

Referral Patterns More Important Than Ever

In view of the dramatic increase of patients who have gained access to VA health care through the greatly expanded number of community based clinics, it is clearly more important than ever to have dependable referral patterns to robust inpatient services. In this context, the CARES process examined the size, placement and configuration of existing inpatient services. Inpatient capacity was compared to future projections to identify markets that could expect significant future increases and/or decreases in inpatient medicine, surgery, and psychiatry services. The process then proceeded to develop possible solutions for managing the inpatient workload and capital needs in markets with capacity gaps.

CARES Criteria for Inpatient Capacity Planning Initiatives

Planning initiatives represent the most significant gaps in care on a national basis and will be a priority focus during the implementation phase of CARES. It is important to note, however, that CARES Market Plans address workload and space solutions for all gaps in all CARES categories regardless of whether a planning initiative was identified.

Inpatient Capacity Planning Initiatives were identified for each market of each VISN for workload gaps that met threshold criteria listed in Table 6.1. Both the size of the workload gap and whether the gap remained in both FY 2012 and FY 2022 were factors in identifying a planning initiative. The gap had to involve at least +/-20 projected inpatient beds or represent a 25 percent change from FY 2001 to be considered for identification as a PI. Gaps that met these criteria in both FY 2012 and FY 2022 were considered more significant than those meeting the criteria in one year only. Of the 60 Inpatient Planning Initiatives identified, 37 represented gaps due to increasing workload and 23 represented gaps due to decreasing workload.

TABLE 6.1.—INPATIENT GAP THRESHOLD CRITERIA

CARES category	Threshold criteria % change from FY 2001	Workload criteria (beds)	# PIs with increasing demand	# PIs with decreasing demand
Medicine	25	±20	23	11
Surgery	25	±20	3	5
Psychiatry	25	±20	11	7

Inpatient Workload Trends

Gaps in Inpatient Beds

Figures 6.1 through 6.4 show the variance in inpatient workload (beds) projected for each year through FY 2022 compared with baseline workload (actual FY 2001). This variance between projected workload and baseline workload is referred to as a ''gap''. Beds were estimated by using projected ''bed days of care'' from the CACI/Milliman demand model.[29a]

As with outpatient care, the trend line for each category is impacted by the enrollment projections that decline over time (Chapter 5, Figure 5.1), and by continued changes in technology and health care practices that allow more treatment on an outpatient rather than an inpatient basis. Declining enrollees and inpatient stays contribute to the downward trends in later years.

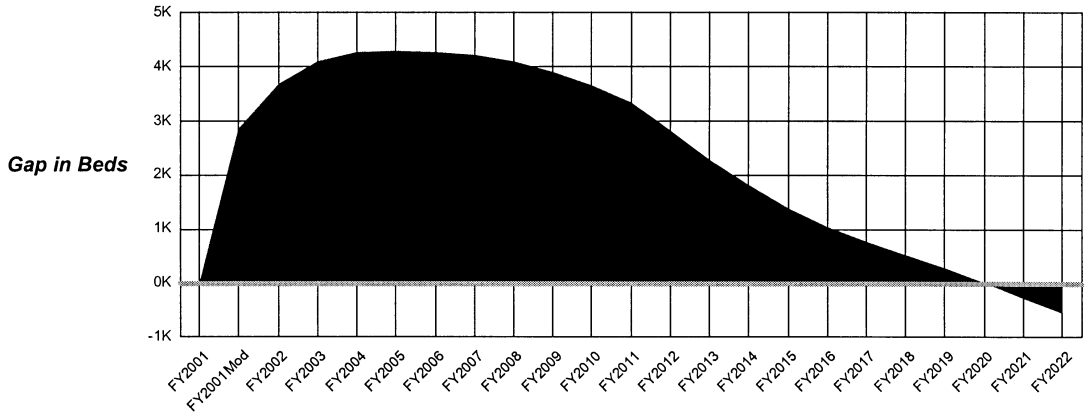
The CARES forecasting model projects a modest national gap in bed days of care beginning in the base year FY 2001 that grows to FY 2004 and then declines gradually over the forecast period to projected a net decrease in bed days and related beds in FY 2022 as shown in the graph below.

[28] Ludmerer, KM, Time to Heal [Oxford University Press: Oxford, New York, 1999], pp.176–177, 319.

[29] The VA Report may be found at: *http://www.va.gov/opp/eval/1_Table%20of%20Contents.pdf]* See also: American College of Cardiology/American Heart Association Practice Guidelines, 2002 *http://www.circulationaha.org/*—which emphasize an ''early invasive'' approach to cardiovascular care.

[29a] Projected Beds are calculated as (projected bed days of care)/365 days a year/.85 percent occupancy).

Figure 6.1 CARES National Inpatient Workload Gaps
Inpatient Medicine, Surgery, and Psychiatry Beds (Includes Contract Care)



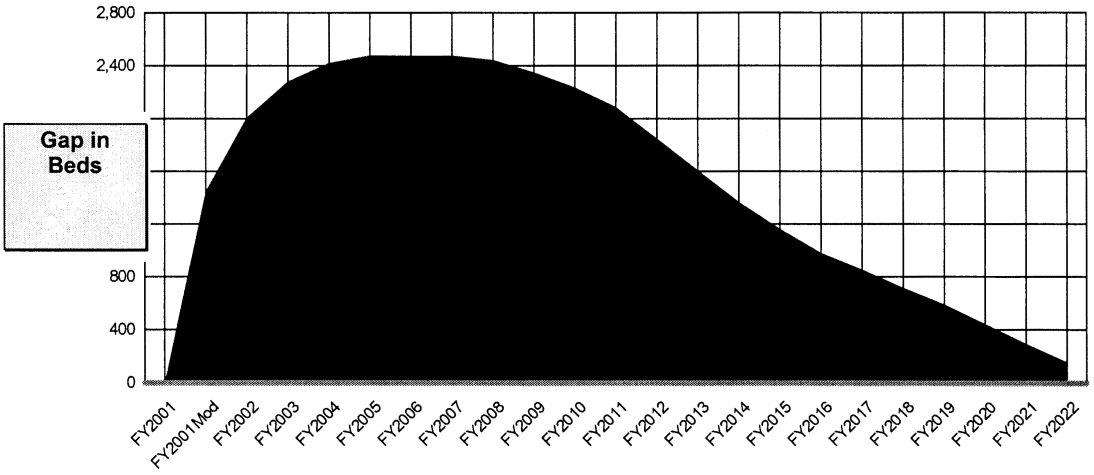
Estimated Beds = Bed Days of Care/365 days/.85 Percent Occupancy

Because this trend line masks significant differences in projected gaps for the three inpatient CARES categories, each category and its trend line will be discussed separately.

Inpatient Medicine

National projected workload gaps, measured in projected beds, for inpatient medicine are shown in Figure 6.2. As seen with the outpatient trends in Chapter 5, a significant gap in workload occurs between the baseline year (FY 2001) and the first year of forecasted demand (FY 2002), a reflection of the demand model's implication that budget, capital and staffing constraints existed in FY 2001 and are removed from future workload projections. The positive inpatient medicine gaps peak in FY 2008 when the impact of enrollment levels and trends in inpatient medicine begin reducing demand. By FY 2022, inpatient medicine beds are only slightly higher than in FY 2001.

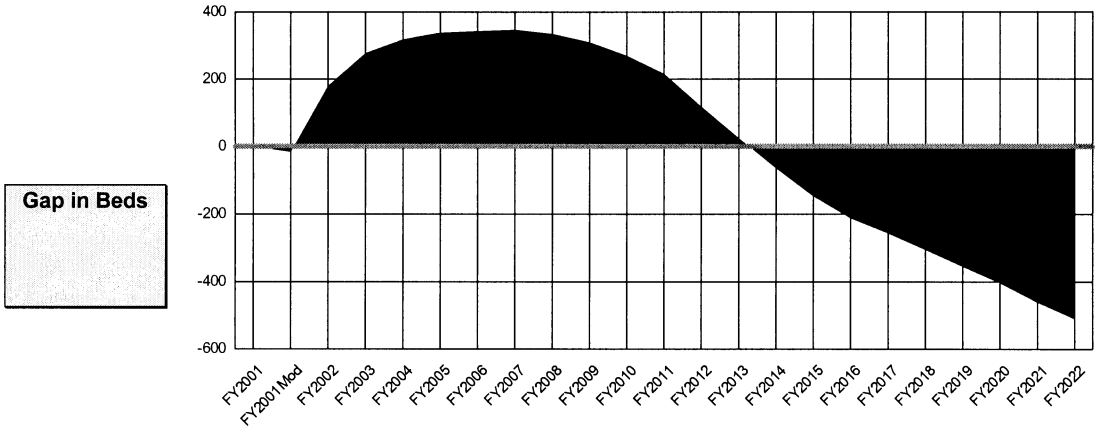
Figure 6.2 Projected Gaps in Inpatient Medicine Beds by Fiscal Year (Includes Contract Care)



Inpatient Surgery

Projected workload gaps for inpatient surgery show an opposite trend than for inpatient medicine (as shown in Figure 6.3 below). Actual FY 2001 baseline beds days of care for inpatient surgery are greater than the first year of forecasted demand (FY 2002) indicating a slight overcapacity of 4,907 bed days of care, or 16 beds for inpatient surgery on a national basis. However, the gap grows in a positive direction until FY 2007 when enrollment levels and trends in inpatient surgery, such as declines in lengths of stay and more treatments being provided on an outpatient basis, become significant factors. By FY 2022 inpatient surgical demand is significantly lower than in FY 2001.

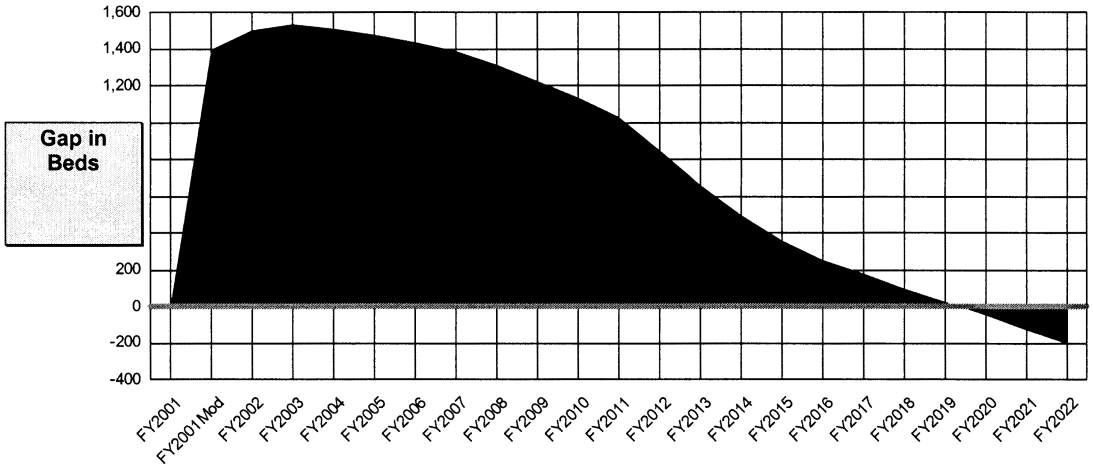
Figure 6.3 Projected Gaps in Inpatient Surgery Beds by Fiscal Year (Includes Contracts)



Inpatient Psychiatry

Inpatient psychiatry gaps indicate a current shortage of beds, but a rapid decline in demand beginning as early as FY 2004 that continues steadily until FY 2022 when demand drops below FY 2001 levels, as shown in Figure 6.4 below.[30]

Figure 6.4 Projected Gaps in Inpatient Psychiatry Beds by Fiscal Year (Includes Contracts)



Summary of Inpatient Capacity Solutions

VISN CARES Market Plans identified a variety of solutions to resolve all projected inpatient workload demand, including workload demand associated with Inpatient Capacity Planning Initiatives, and manage space requirements at each facility.

Tables 6.2 and 6.3 focus on inpatient Medicine, Surgery and Psychiatry solutions for two of the planning years—FY 2012 and FY 2022. Inpatient workload units in these tables represent the total number of bed days of care (not beds) projected for each facility in each VISN, rolled up to the national level. The total number of projected bed days of care in each CARES category was used to estimate the amount of space needed at each facility for each of the planning years. VISNs were required to solve each of their facilities' total space needs in each of the CARES categories.

By FY 2022, VHA will handle approximately 90 percent of all inpatient workload in-house. Contracting is used as a short-term solution to a greater extent in earlier years during workload peaks. Approximately 169 inpatient beds (52,522 bed days of care) are planned as joint ventures with the Department of Defense or other entities.

[30] Note: Inpatient Psychiatry projections are presently undergoing revision. Revised projections should be available for next year's strategic planning cycle.

TABLE 6.2.—WORKLOAD SOLUTIONS FOR INPATIENT CATEGORIES—FY 2012

Workload alternative	Medical care		Surgical care		Psychiatry care	
	Bed days of care	Percent of total	Bed days of care	Percent of total	Bed days of care	Percent of total
Contract	340,929	13.4	83,021	8.6	183,047	8.6
Joint Venture	30,475	1.2	5,112	0.5	28,525	1.3
In-Sharing	5,575	0.2	6,506	0.7	365	0.0
Sell	0	0.0	0	0.0	0	0.0
In-house	2,162,899	85.2	867,449	90.2	1,916,714	90.1
Total Demand	2,539,878		962,088		2,128,651	

TABLE 6.3.—WORKLOAD SOLUTIONS FOR INPATIENT CATEGORIES—FY 2022

Workload alternative	Medical care		Surgical care		Psychiatry care	
	Bed days of care	Percent of total	Bed days of care	Percent of total	Bed days of care	Percent of total
Contract	206,850	10.1	51,185	6.6	102,266	5.6
Joint Venture	24,769	1.2	4,284	0.6	23,469	1.3
In-Sharing	5,575	0.3	6,394	0.8	365	0.0
Sell	0	0.0	0	0.0	0	0.0
In-house	1,803,287	88.4	714,929	92.0	1,691,730	93.1
Total Demand	2,040,481		776,792		1,817,830	

Table 6.4 presents inpatient space solutions for all planning years combined—through FY 2022. Overall, the capital investments needed for inpatient care are more reflective of the total volume of workload (bed days of care), and not in response to an increasing or decreasing workload gap. The proposed investments are indicative of the condition of the current space for inpatient wards across VHA and the need to upgrade or modernize existing clinical space.

TABLE 6.4.—SPACE SOLUTIONS FOR INPATIENT CATEGORIES—CUMULATIVE THROUGH FY 2022

Space alternative	Medical care		Surgical care		Psychiatry care	
	Square feet	% total	Square feet	% total	Square feet	% total
Existing-Non Renovated	2,722,180	57.4	1,029,718	61.4	1,709,795	46.5
Renovate Existing	839,754	17.7	336,844	20.1	677,858	18.4
Convert Vacant	391,957	8.3	109,430	6.5	552,604	15.0
New Construction	475,281	10.0	158,302	9.4	590,808	16.0
Donate	110,558	2.3	16,700	1.0	49,000	1.3
Lease	199,878	4.2	26,900	1.6	104,990	2.8
Enhanced Use	7,000	0.1	0	0.0	0	0.0
Total Space Proposed	4,746,608		1,677,894		3,685,055	

National CARES Plan

The CARES investment strategy is to ensure that the acute care infrastructure will be available to meet the current and future acute care requirements. As a result of this strategy, all markets with proposed capital requirements related to acute inpatient care are included in the National CARES Plan.

Chapter 7: Enhancing Access to Special Disability Programs

Traditional Role, Substantial Responsibility in Special Disabilities

While the nation's commitment to provide medical care to eligible veterans extends across the full spectrum of injury and disease, the VA system has traditionally had a distinctive role in addressing the needs of veterans with special disabilities. In part because many of these special disabilities were incurred in wartime and in part because the intensive levels of care involved are often difficult for veterans to obtain elsewhere, VA has acquired substantial responsibility in this health care arena.

Cognizant of this history and the unique stature of Special Disability Programs (SDPs) within the VA health care system, CARES designers focused the initial application of the process on Special Disability Programs with congressionally-mandated capacity requirements, including:

- Blind Rehabilitation
- Mental Health—Seriously Mentally Ill (SMI), Post-Traumatic Stress Disorder (PTSD), and Substance Abuse
- Homelessness
- Spinal Cord Injury & Disorders (SCI/D)
- Traumatic Brain Injury (TBI)

Capacity Requirements

Under CARES, Spinal Cord Injury & Disorders (SCI/D) capacity requirements were to be maintained as measured by the monthly VA/PVA beds and staffing survey and VHA Directive 2002–022.[31]

[31] Survey by VA and the Paralyzed Veterans of America (PVA); Other references include: VHA

Continued

Similarly, the VISNs were advised that legislative capacity requirements for Blind Rehabilitation (BR) programs must be met.[32] However, since the CARES process set out to review the allocation and distribution of health care services throughout the VA system, an attempt was made to develop projections that would include an assessment of the SDPs. Program officials and clinical experts from the involved SDPs were consulted and participated actively throughout the process.

Workload Projections

Hitherto, VA has had no agreed-upon methods of projecting the needs of populations served by the SDPs. In general, the CARES planning model/process used an actuarial forecasting model (supplied by CACI/Milliman) with:

- VA and National Census databases to project enrollment and market share annually through 2022;
- Actuarial survival/mortality data and new active duty military separations;
- Private sector databases to predict healthcare utilization, with adjustments for VA experience (lack of co-pay, male predominance, higher co-morbidity, use of Medicare and private sector health care and management efficiency);
- Criteria for access (travel time), safety, quality of care, impact on affiliations, research, and other missions (DoD contingency support and Homeland Security); and
- Survey of space, beds, and clinical services in all VA facilities and VISNs.

However, since VA programs to serve special disability populations are so unique, no comparable private sector utilization benchmarks were available for the SDPs; VA services continue to be the only benchmarks. Since projections for special disability programs therefore were based solely on VA utilization data, the SDP projections used in the CARES process in general were subject to several limitations:

- Some of the advantage of the Milliman forecasting model would be lost, since the VA workload data may be subject to supply constraints.[33]
- CARES models were not designed for service-level planning. They were configured for larger scale planning for capital asset needs. Smaller numbers tend to show wider variation and less reliability.
- In addition, internal variables, such as VA-specific factors like public policy decisions and the vision of the administration at any one time, may affect the planning assumptions used in the model.

Process and Procedures for Special Disability Program CARES Planning

The National CARES Program Office (NCPO) engaged the clinical leaders of the SDPs as active participants in the development of CARES planning models for SDPs. A Planning Initiative Selection Team made up of SDP representatives reviewed national data as projected using the CARES model from the existing Milliman categories.

In the areas of Mental Health and Traumatic Brain Injury, a number of consultations, discussions, and on-going investigation of the general CARES model did not lead to an alternative methodology to project needs for those specific SDPs. It was decided that specific recommendations from Mental Health would be further explored with representatives of the Mental Health Strategic Healthcare Group (SHG) and the Committee on the Care of Veterans with Serious Mental Illness (SMIC). Further progress in this area would be channeled into the strategic planning process that incorporates CARES.

However, in the areas of Blind Rehabilitation and Spinal Cord Injury & Disorders, the NCPO and SDP leaders were able to develop acceptable alternative data analyses and forecasting methodologies to enable inclusion of these SDPs in CARES. Subject matter experts working with actuarial and data management support personnel produced these pioneering approaches:[34] Which were generally based on:

- The prevalence of the Special Disability Group (SDG) in the veteran population as derived from external studies.
- Enrollment projections by health care priority group used in the overall CARES demand model as applied to the target group to obtain estimates of the enrolled SDG by VISN.
- Utilization rates based on actual FY2001 experience by VISN. Appropriate utilization rates were then applied to each projection year through 2022.

Planning Initiative selections for the Special Disability Programs were based upon the revised projections and were incorporated into the VISN-level Market Plans by February 2003. SCI/D and BR program representatives worked with the VISN-level CARES Steering Committees or Task Forces to resolve the proposed planning initiatives and met with VISN-level staff and involved veterans service organizations (VSOs).

Blind Rehabilitation (BR) Forecasts and Planning Initiatives

The BR projections, Planning Initiatives, planning recommendations, and final recommendations for CARES are summarized in Appendix Q. Briefly, two new Blind Rehabilitation Centers (BRCs) were proposed and will be forwarded for approval as follows:

- 36-bed BRC in Biloxi (VISN 16)
- 24-bed BRC in Long Beach (VISN 22)

Nevertheless, over the past several years, the BR program has increasingly emphasized the establishment of outpatient rehabilitation services in the continuum of care for visually impaired veterans. The BR program is designed to improve the quality of life for blinded and severely visually impaired veterans through the development of skills and capabilities needed for personal independence, emotional stability, and successful integration into the community and family environment.

Prior to the CARES process, the BR program was comprised of 10 Inpatient BRCs (in 8 VISNs), 92 full-time Visual Impairment Services Team (VIST) Coordinators, 20 Blind Rehabilitation Outpatient Specialists (BROS), 5 National Program Consultants, and Inpatient Computer Access Training programs at medical centers throughout the country and Puerto Rico. Services are provided using a multi-disciplinary team approach. In addition, there are currently one Visual Impairment Services Outpatient Rehabilitation Program (VISOR) and three Visual Impairment Centers to Optimize Remaining Sight (VICTORS) programs.

Spinal Cord Injury Forecasts and Planning Initiatives

The SCI/D program is a network of services provided in a ''hub-and-spokes'' format; the hubs are the SCI Centers and the spokes are non-center facilities. Interdisciplinary and coordinated services utilize referral guidelines to determine the appropriate site of care.

Prior to the CARES process, there were 23 SCI Centers in 15 VISNs. Due to the sizable increase in users of specialty services over the last 6 years, the CARES recommendations call for additional future capacity. The SCI/D projections, planning initiatives,

Directive 99–013, Decision Making Authority for the SCI&D Program; VHA Directive 1176 and VA Handbook 1176.1, Spinal Cord Injury and Disorders System of CARE; and M–2, Part XXIV.

[32] See Reference Section: CARES Guidebook Phase II (June 2002, Chapter 5, Market Plans).

[33] **Note:** private sector utilization is also constrained by the benefits packages that third-party payers are willing to fund.

[34] A detailed description of the methods and projections used can be found in Appendix Q.

planning recommendations, and final recommendations for CARES are summarized in Appendix Q. Briefly, 4 new SCI/D Units were proposed and will be forwarded for implementation as follows:

- 30-bed SCI/D Unit in Syracuse (alternatively, Albany) (VISN 2)
- 30-bed SCI/D Unit in VISN 16 (exact location still under study ''proposed, North Little Rock)
- 30-bed SCI/D Unit in Denver (VISN 19)
- 30 to 40-bed unit in Minneapolis (VISN 23)

Expansion of 20 additional SCI/D beds in Augusta (VISN 7) was planned. Other initiatives included expansion of LTC (long-term care) SCI/D beds in conjunction with SCI/D Units as follows:

- 30 beds in Tampa (VISN 8)
- 20 beds in Memphis (VISN 9)
- 30 beds in Long Beach (VISN 22)
- 20 beds in Cleveland (VISN 10) [35]

Other planning issues addressed included the proposed consolidation of all VISN 3 SCI/D beds from Castle Point to the Bronx VAMC with an outpatient SCI/D program remaining at Castle Point. In addition, and outpatient SCI/D clinic will be developed at the Philadelphia VAMC.

Future Directions

Mental Health, Domiciliary/Homelessness

The NCPO, CACI/Milliman, and representatives of the Mental Health SHG and the SMI (Seriously Mentally Ill) Committee have conducted a series of reviews of the mental health inpatient and outpatient projections. The intent of the reviews was to attempt to understand the drivers of the CARES projections for psychiatry and for programs related to mental health, such as the domiciliary programs. There was a general consensus that mental health projections needed to be further studied and refined.

For the CARES planning process, the following workload projections were held constant:

- Outpatient mental health, whenever a decrease in projected visits projected was observed;
- All non-benchmarked residential rehab programs: Substance Abuse Residential Rehabilitation, Compensated Work Therapy, Residential Rehabilitation, Post-Traumatic Stress Disorder Residential Rehabilitation Treatment, Sustained Treatment and Rehabilitation (STAR) and Domiciliary Programs.

Domiciliary beds and other non-benchmarked services were originally projected based upon a national average utilization rate, which, in effect, would have resulted in a redistribution of beds from those VISNs or markets with larger numbers of beds to those with fewer beds. Such redistribution was felt to be inappropriate and raised a number of policy and programmatic questions, which are being explored further and will be revised as CARES is incorporated into the next strategic planning cycle.

The goals of the review will be to modify and improve the projection methodology for Mental Health services in general and residential rehabilitation programs in particular. Decisions regarding the utilization rates and distribution of the various Mental Health rehabilitation programs should be focused on the mission and programmatic content of these programs, and quantified by the available data. Recommendations should be ''evidenced-based'' to the extent possible. Any alternative projections methodology should be linked to VA's official Veteran Population demographic database.

Traumatic Brain Injury

The VA has established four primary Traumatic Brain Injury (TBI) Centers, located at the VAMCs in Richmond, VA; Minneapolis, MN; Palo Alto, CA; and Tampa, FL. These four TBI Centers provide leadership for the additional 19 VAMCs and three military hospitals participating in the TBI Network for provision of specialized TBI services.[36]

TBI services were included in the current cycle of CARES, but workload data for this area were not separately listed. Applicable workload was included in various categories, including outpatient specialty care, inpatient rehabilitation, and outpatient primary care, as appropriate. The NCPO discussed the application of the CARES process in this specialty area with program officials within the Rehabilitation Strategic Healthcare Group for TBI programs. Research in the forecasting and geographic distribution of need for TBI services is on going and will be incorporated into VA's strategic planning efforts as it becomes available.

National CARES Plan

Based upon projections for increased demand for services, several new Blind Rehabilitation Centers (VISNs 16 and 22) and SCI/D units (VISNs 2, 16, 19, and 23) have been included in the National CARES Plan. In addition, expansion of SCI/D long-term care beds in VISNs 8, 9, 10, and 22 have been recommended for implementation as well as additional acute/sustaining SCI/D beds in VISN 7. An outpatient SCI/D clinic at Philadelphia VAMC will be developed to meet the needs of veterans in the Eastern Market of VISN 4, including South Jersey, Eastern Pennsylvania and Delaware.

Table 7.1 below summarizes the cost of capital investments required to accomplish the proposed enhancements to Special Disability Programs outlined in this chapter.

TABLE 7.1.—CAPITAL INVESTMENTS FOR SPECIAL DISABILITY PROGRAMS FY 2022–FY 2022

Special disability program	Renovation of existing space (square feet)	New construction (square feet)	Lease (square feet)	Total costs in current $
Blind Rehabilitation	31,106	35,500	0	$9,587,628
Spinal Cord Injury	41,799	382,172	0	94,263,411
Residential Rehab	65,594	63,705	26,874	15,458,463
Domiciliary	328,419	111,153	0	52,330,817

Note: These cost estimates do not include the proposed Philadelphia outpatient SCI/D clinic.

[35] **Note:** although not originally an SDP-proposed planning initiative, the additional SCI/D LTC beds in Cleveland have been proposed by VISN 10 and are supported by the CARES planning model projections for SCI/D LTC.

[36] Refer to IL 10–97–010, Traumatic Brain Injury Network of Care.

Chapter 8: Strategic Directions of Small Facilities

Small Facilities To Play Appropriate Role

The skill and dedication of the men and women who provide health care to the nation's veterans should not be judged by the size of the facility at which they work. Surveys of patient satisfaction indicate that, from the consumers' viewpoint, there is no correlation between facility size and the perceived quality of service.[37] Furthermore, some of the highest honors achieved in VA health care for overall quality and efficiency have been won by smaller facilities.[38]

However, the inherently lower volume of care provided at smaller facilities has undeniable implications for specific types of procedures (the clear relationship between volume and outcomes for certain medical and surgical procedures is discussed below).

The CARES process therefore included an in-depth review of small facilities, to assure that they will play an appropriate role in providing high quality, cost-effective care throughout the VA system. A Small Facility Planning Initiative process was instituted to determine if and how resources, facilities, and services should be realigned to provide acute care in the future. The specific objectives were:

- To assure provision of cost-effective, appropriate, high quality patient care. ''Quality'' includes clinical proficiency across the spectrum of care, safe environment, and appropriate facilities.
- To evaluate the functioning of small facilities within each market and VISN as part of VA's health care delivery system.
- To consider each small facility's role in meeting projected acute inpatient care demand.

Overview

As described in detail in the Overview section of Chapter 6 of this Plan (''Ensuring Inpatient Capacity''), there have been striking changes in American medicine in recent years, prominently including a fundamental shift to ambulatory care. The changes from inpatient to outpatient care have been coupled with and, to a large extent, made possible by rapid advances in medical technology, which require ongoing investment in imaging equipment.[39]

Recent emphasis on patient safety and outcomes in acute care settings, especially from surgical procedures, point to a need to rethink how the VA delivers health care across its system of hospitals and clinics.

Many of the technological advances and the patient safety/quality emphases favor a reduction and consolidation of beds in centers that can provide state-of-the-art and ''cutting edge'' medicine to our nations'' veterans.[40] VA medical centers can no longer provide care that only meets local standards of quality, but increasingly must aim to be part of a ''world class'' system of health care delivery. VA's own recent study of outcomes in patients with acute cardiovascular events pointed out that veterans were being referred for interventional treatment at less than the rate of Medicare patients and were being referred later.[41] Networking and early referral has been shown to improve outcomes for rural health care providers.[42] Likewise, the medical literature and consumer groups, like the Leapfrog group, have emphasized the relationship between volume and outcomes for certain kinds of procedures and for intensive care unit (ICU) treatment.[43 44 45 46 47]

The VA has felt the impact of these changes, particularly in its small medical centers. Responses have ranged from closing surgery or medicine acute beds to consolidation of two or more acute care facilities. Many of the medical centers with low workload and small acute bed sections chose to close, due to one or more of the following factors: Staff proficiency, quality of care, small ICU bed numbers, staff retention, cost of capital improvements, and availability of other health care options in their communities.[48]

At the same time, other small VA facilities have recognized and attempted to meet the health care needs of veterans in areas where access to care and the availability of other alternative providers is limited. Rural health care initiatives developed and used by the Centers for Medicare and Medicaid Services (CMS) to support access to acute care in remote areas have resulted in the adoption of a ''Critical Access Hospital'' (CAH) model for Medicare reimbursement.[49]

In order to qualify for CAH reimbursement from Medicare, facilities must meet the following criteria.[50]

- Must be located more than 35 miles from the nearest hospital (waivers and flexible interpretation have been allowed);
- Must be deemed by the state to be a ''necessary provider;''
- Must have no more than15 acute beds [with up to 25 beds total, including ''swing'' beds for respite/hospice and/or SNF (skilled nursing facility) services]; [ICU beds are discouraged];
- Cannot have length of stays (LOS) greater than 96 hours (except respite/hospice);
- Must be part of a network of hospitals;
- May use physician extenders (Nurse Practitioners or Physician's Assistants or registered Nurse Midwives) with physicians available on call.

In practice, CAH providers have filled an important need for health care services, as many are located in areas designated as shortage areas.[51] The most common diagnoses treated in CAHs are acute respiratory and acute gastrointestinal disorders.

CARES Criteria

In order to be selected as a ''small facility'' for the purposes of CARES, a facility had to meet of the following three criteria:

- Had to provide acute hospital bed services;
- Had to have acute medicine beds;
- The total of projected acute beds for medicine, surgery and psychiatry in

[37] American Customer Satisfaction Index, 2002.

[38] Examples: Grand Junction, CO, won the 2001 Presidential Award for Quality; Erie, PA and Walla Walla, WA, VAMCs received VA's top-ranked Carey Award for Quality in 2001.

[39] Ludmerer, KM, Time to Heal [Oxford University Press: Oxford, New York, 1999], pp.176–177, 319.

[40] *E.g.*, an abdominal aortic aneurysm can be stented, using minimally invasive surgery with a LOS of 24 to 48 hours as compared to many days to a few weeks for an open surgical repair.

[41] Note current approaches to cardiovascular care favor an ''early invasive'' approach. [For the VA Report: *http://www.va.gov/opp/eval/1_Table%20of%20Contents.pdf*] See also: American College of Cardiology/American Heart Association Practice Guidelines, 2002 [*http://www.circulationaha.org/*].

[42] Johnson, DE, Network Improves Rural Care, Health Care Strategic Management, 9(12): 8, 1991.

[43] Birkmeyer, JD *et al.*, Hospital Volume and Surgical Mortality in the United States. NEJM [New England Journal of Medicine] 346: 1128–37, 2002. [Editorial same issue: Volume and Outcome—It is Time to Move Ahead, pp. 1161–164.]

[44] Bach, PB, *et al.*, The Influence of Hospital Volume on Survival after Resection for Lung Cancer. NEJM 345: 181–188, 2001.

[45] Canto, JG, *et al.*, The Volume of Primary Angioplasty Procedures and Survival after Acute Myocardial Infarction. NEJM 342: 1573–1580, 2000.

[46] Begg, DB, *et al.*, Variations in Morbidity after Radical Prostatectomy. NEJM 346: 1138–1144, 2002.

[47] *http://www.leapfroggroup.org*

[48] Examples include: Manchester, NH; Bath, Batavia, & Canandaigua, NY; Bonham, TX; White City, OR; Livermore, CA; Lincoln and Grand Island, NB.

[49] Created by the Balanced Budget Act of 1997 (BBA) as part of the Medicare Rural Hospital Flexibility Program.

[50] *http://www.hospitalconnect.com/aha/member_relations/cah/faq.html* [AHA website-FAQs].

[51] For references, see Appendix N.

2012 and 2022 had to be less than 40 beds.

Each market with one or more of the 19 identified ''small facilities'' received the Handbook for Market Plan Development (available in References) to provide instructions for the small facility evaluation process. The guidance required development of a minimum of three scenarios (with an optional fourth or 'combination' scenario):

- Retain acute hospital beds;
- Close acute hospital beds and reallocate workload to another VHA facility;
- Close acute hospital beds and implement contracting, sharing or joint venturing for workload in the community;
- Optional: Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

It should be noted that the CARES planning process only addressed the acute care missions of small facilities and did not address the long-term care or chronic psychiatry missions of VA facilities. Therefore, any recommendations refer only to the acute care beds.

Table 8.1. lists the 19 facilities with Small Facility Planning Initiatives that met the selection criteria, which used FY2001 as the base year.[52]

TABLE 8.1.—SMALL FACILITY PLANNING INITIATIVES

VISN & facility		Baseline beds	Projected 2012	Projected 2022
V03	Hudson Valley	10	13	9
V04	Altoona	19	19	13
V04	Butler	9	10	8
V04	Erie	18	14	10
V06	Beckley	32	15	10
V07	Dublin	33	36	30
V11	Fort Wayne	26	17	14
V11	Saginaw	13	25	20
V15	Poplar Bluff	18	15	11
V16	Muskogee	25	37	29
V17	Kerrville	22	15	12
V18	Prescott	29	28	22
V19	Cheyenne	14	17	14
V19	Grand Junction	23	24	18
V20	Walla Walla*	34	40	36
V23	Des Moines	39	34	24
V23	Hot Springs	31	23	20
V23	Knoxville	27	26	20
V23	St. Cloud	21	26	18

*22 bed Psychiatry Residential Rehab. Program included in 34 beds, actual acute beds are 14.

Review and Recommendations For Small Facility Planning Initiatives

Evaluations of each small facility were incorporated into a criteria-driven checklist for detailed review of each VISN-level proposal submitted. Supplemental data that were considered consisted of the following:

- Cost data and scenario inputs on the VSSC CARES Portal (web-site);
- Patient Satisfaction Survey data from FY2002 (courtesy of the SHEP/PACE Office);
- Lists of surgical procedures performed at each of the small facilities (by volume and code) for FY2001 and FY2002;
- Average bed day of care (BDOC) costs compared to Medicare unit costs for each of the small facilities for Medicine, Surgery, and Psychiatry beds;
- Top diagnosis related group (DRGs) with average length of stay (ALOS) for each small facility;
- Distance to the nearest VA Facility as determined independently (using MapPoint software);
- Literature reviews as appropriate, including Medicare Critical Access Hospital (CAH) Guidance (Appendix N).

A summary of the recommendations from the small facility review follows. Table 8.2 shows the final recommendations on small facilities as recommended for implementation by the Under Secretary of Health. Appendix F includes detailed recommendations for small facilities.

Retain Acute Hospital Beds

Eleven medical centers would retain their acute hospital beds, but would have a restricted ''scope of practice'' that would limit surgical inpatient beds and intensive care unit beds. Surgery beds would be converted to 'observation' beds.

Convert Acute Beds to Critical Access Hospital Model

Seven of the eleven facilities would convert their acute beds to CAH-like model. Several medical centers already met the CAH criteria: low acuity levels; short ALOS (less than four days); a decreasing number of acute care beds; and few, if any, ICU beds. Nevertheless, of the remaining small facilities reviewed, most showed a longer ALOS (than Medicare), although there was a mixed picture with respect to cost per BDOC (which was lower than contract costs in some, and higher than contract cost for others). Though costs for conversion to a CAH-like operation could not be estimated at the time of the review, such conversions were expected to reduce in-house operating costs. Nonetheless, one of the key drivers in recommending a transition to a CAH-like model of acute care delivery was the expectation that the quality of care and patient outcomes could be improved by:

- Greater coordination of care (at the VISN and Market levels);
- Earlier transfer and/or referral of complex cases; and
- Consolidation of volume-dependent cases in tertiary care facilities.

Other overriding factors supporting the ''retain acute bed'' option included a facility's role as a local health care

[52] Based upon BDOC projections after updating for Census 2000 in January 2003.

provider in the community, the distance to another VHA facility, and innovative consolidations.

Closure of Acute Hospital Beds

Eight medical centers were recommended for closure of acute hospital beds over the next several years. One facility's acute bed closure would occur as a transition. In Altoona, the transition would occur after 2012, when beds are expected to decline much further. Knoxville's acute and long-term beds would be closed through a consolidation of Knoxville with Des Moines, which is a distance of 44 miles. The majority of these facilities are proposing to provide inpatient care through a combination of referrals to another VA medical center and community hospital(s). The intention of the acute bed closures is to keep access local, maintain customer satisfaction through better access, and improve cost efficiencies and patient outcomes.

Other

In addition, Big Spring, Texas (VISN 18) will close inpatient surgery. Big Spring will be reviewed as a realignment issue and studied for the possibility of no longer providing health care services on the Big Spring campus. Development of a Critical Access Hospital, that would include a plan for a nursing home and expansion of an existing clinic to a multi-specialty outpatient clinic, will be explored for the Odessa-Midland area.

TABLE 8.2.—SMALL FACILITY RECOMMENDATIONS

Facility	VISN	Retain acute beds *	Convert to 'CAH-like' model	Contract and/or refer	Decrease and/or review surgery	Close or review ICU beds	Comments
Hudson Valley Castle Point.	3	Y	Y	.....	N/A	N/A	Enhanced Use at Montrose. Castle Point retains beds. Convert to CAH.
Erie	4	Y	N	.....	Y	Y	Convert inpt to outpt. surgery w/ (with) surgery observation (obs.) beds. Eval. ICU.
Beckley	6	Y	Y	.....	Y	Y	Convert inpt to outpt surgery w/ obs. beds; convert to CAH. Close ICU beds.
Dublin	7	Y	N	.....	Y	Y	Transition inpt surg. to outpt w/ obs. beds. Eval. ICU beds.
Poplar Bluff	15	Y	Y	.....	N/A	N/A	Functioning as CAH at present.
Muskogee	16	Y	N	.....	Y	Y	Convert inpt to ambulatory surgery w/surg. observation (obs.) beds. Eval. ICU. Eval. Psych. bed expansion.
Prescott	18	Y	N	.....	N/A	N/A	Bed expansion to lessen demand pressure on Phoenix.
Cheyenne	19	Y	Y	.....	Y	Y	Convert to CAH, close ICU and continue surgery but w/limited scope of practice.
Grand Junction	19	Y	Y	.....	Y	Y	Convert to CAH, close ICU and continue surgery but w/limited scope of practice.
Des Moines	23	Y	N	.....	Y	Y	Move acute beds from Knoxville to Moines Des Moines. Eval. ICU & for reduced scope of surgical practice.
Hot Springs	23	Y	Y	Y	N/A	N/A	Convert to CAH; decreased beds w/increased contract/referral.
Altoona	4	Transition	Y	Y	N/A	Y	Implement closure of acute beds by 2012; interim, convert to CAH.
Butler	4	N	N/A	Y	N/A	N/A	Transfer medicine services to Pittsb. & contract emergency care.
Fort Wayne	11	N	N/A	Y	N/A	N/A	Acute medicine would close by contracting and transferring to other VAMCs.
Saginaw	11	N	N/A	Y	N/A	N/A	Acute medicine would close by contracting and transferring to other VAMCs.
Kerrville	17	N	N	Y	N/A	N/A	Implement in coordination with San Antonio capacity; in interim, convert to CAH.
Walla Walla	20	N	N/A	Y	N/A	N/A	Contracted beds only.
Knoxville	23	N	N/A	N	N/A	N/A	Consolidate with Des Moines.
St. Cloud	23	N**	N/A	Y	N/A	.....	Transfer medicine services to Minneapolis & contract.
Total "Yes"	.....	11	7	8	7	8	

TABLE 8.2.—SMALL FACILITY RECOMMENDATIONS—Continued

Facility	VISN	Retain acute beds *	Convert to 'CAH-like' model	Contract and/or refer	Decrease and/or review surgery	Close or review ICU beds	Comments
Converting to contract/referral or consolidation.	.....	8	.....	.....	.....	.....	
Total facilities reviewed.	.....	19	.....	.....	.....	.....	

* Except ICU & surgery beds.
** Acute Psychiatry beds will remain open.

Conclusions

The transition from an emphasis on inpatient care to outpatient care has been based upon advances in medical technology and therapy. In addition, for the VA, declining inpatient care has been coupled with an expansion of primary care, outpatient specialty care (especially ambulatory or 'same day' surgery), and better case management. The trend towards more sophisticated imaging and advances in invasive techniques, which shorten hospital stays but require the investment in expensive major equipment, has led to a further consolidation of care in tertiary care facilities of more complex cases. Optimal and efficient functioning of the VA's health care delivery system depends upon early referral and transfer of patients with complicated conditions and those requiring major surgery, where outcomes may be volume-dependent.

These trends have led to declines in bed days of care in smaller facilities to the point at which staff proficiency and outcomes may be compromised in low-volume sites. Moreover, economies of scale in provision of the latest medical and imaging technology cannot be realized. Nevertheless, many small VA medical centers (VAMCs) are important providers of health care in their communities. Several have already managed to achieve an appropriate level of functioning by decreasing their ALOS and early referral of patients with conditions beyond their scope of services. Others (by choice or through recommendation) would close their acute beds and manage acute patients through a combination of referral to other VAMCs and to community hospitals. The specific solutions to the issues of access to acute care depend upon the location of the facility and the availability and quality of alternative health care providers.

In response to the impact of the changes described above, many private sector rural hospitals closed or became no longer viable. In an effort to support access to acute care in rural areas, CMS began funding ''Critical Access Hospitals'' through Medicare in 1999. Reimbursement under Medicare was linked to meeting certain criteria and operational standards, as well as JCAHO accreditation (from 2002 onwards).[53]

The CARES review of small facilities in the VA has proposed a CAH-like process of designating small facilities, requiring that they meet certain operational standards and restricting their ''scope of practice.'' The intent of this process would be to improve the efficiency, effectiveness, and to enhance the level of functioning of, small facilities within the context of VA's national system of health care delivery. Over the course of the next year, the VA will develop and implement policies to govern the operation of acute beds in small VA facilities, which may fit into a CAH-like model of health care delivery.

Chapter 9: Proximity and Campus Realignments

Facility Placement

In recent years, site selection for VA health care facilities has been supported by careful planning, from needs assessment and demographic analyses, to evaluation of area transportation networks and, of course, careful consideration of the proximity of other VA medical service capacity.

But the placement of medical facilities for veterans has not always been so discriminating. In fact, many VA facilities owe their location less to prudent study than to historic happenstance. For example, the veterans health system had no choice whatsoever in the location of an entire chain of hospitals it acquired en masse from the Public Health Service via Presidential Executive Order. The several U.S. military hospitals turned over to the VA through intergovernmental transfers were located on sites convenient for defense bases. And the location of some VA-built hospitals was influenced by events not entirely under VA control, *e.g.*, land donation, legislative ''ear marking'' of funds for a particular site, etc.[54]

The resultant arrangement of VA facilities, while not exactly haphazard, was far from the balanced array of services modern strategic planners would design from scratch in order to maximize efficiency in future service to veterans.

In addition, the dramatic changes in health care delivery within the United States and the VA include improved methods of treating patients that have reduced lengths of stay and admissions as outpatient, community and home care replace inpatient care. As a result many campuses have vacant space that is costly to maintain as described elsewhere in the plan. These changes, combined with an aged infrastructure (50.4 years average age of VA facilities) resulted in the need to review the structure of our campuses to develop a more efficient footprint, to transfer services to other campuses, and to find opportunities to enhance use lease all or portions of campuses with services for veterans such as assisted living facilities. Revenues from these enhanced uses would be retained by the VISNs to invest in improved services for veterans.

There were two components in the planning process for reviewing the potential for realigning services and campuses to improve the cost effectiveness and quality of care. The first component, labeled ''Proximity,'' identified tertiary and acute hospitals located within CARES-prescribed distance criteria, and focused on acute

[53] **Note:** According to a GAO study, while Medicare reimbursement is ''at cost'', pilots in Montana (called ''Medical Assistance Facilities'') showed that Medicare costs were less expensive than treatment would have been in full service rural hospitals. [GAO/HEHS–96–12R, Oct. 1995.]

[54] Adkins, Robinson E., *Medical Care of Veterans,* Wash., DC, 90th Congress, 1st Session, House Committee Print No. 4., p. 119.

inpatient as well as highly specialized services. After a review of the results of the Proximity initiatives and recommendations by the Under Secretary for Health, a second component was added to this process, entitled Campus Realignment.

The second component focused on the so-called ''Division II'' facility (a division of another VA hospital, but located on its own, separate campus). Division II facilities are usually smaller or less active facilities integrated to varying degrees with their larger, parent facilities. The Division II facilities may have acute beds, but more typically have non-acute inpatient programs as well as a variety of ambulatory services. In considering the results of the CARES Proximity review, the USH noted that many Division II facilities had been overlooked, particularly those without acute inpatient beds.

Previous Consolidations

As noted elsewhere in this Plan, the delivery of, demand for, and economics of health care have changed dramatically over the past decade. The VHA has continually strived to meet and stay ahead of the challenges in this changing environment. Several total facility integrations and a multitude of consolidations of acute inpatient programs, subspecialty programs, diagnostic and therapeutic services and administrative services have occurred in recent years. Some of the facilities reviewed have achieved consolidations, integrations and mission changes that support CARES goals.

Proximity

The Proximity component involved identifying opportunities for consolidations and infrastructure realignments due to close geographic proximity of VHA facilities with similar missions. Planners were cognizant that consolidating or eliminating duplicative clinical and administrative services would increase efficiencies, allowing reinvestment of the savings in enhancing services to veterans.

For tertiary care facilities in close proximity, the focus was on the cost effectiveness of offering highly specialized services and optimizing the use of scarce medical specialties. The standard for proximity (60 miles for acute facilities and 120 miles for ''tertiary'' facilities) was determined as a practical range for which cooperative arrangements and referrals within a network of facilities might take place.

The Planning Initiative Selection Team identified 32 Proximity Planning Initiatives involving 19 tertiary and 13 acute care facilities. A complete listing and the results of the review are contained in Appendix G.

Campus Realignments

After reviewing the results of the Proximity process, the Under Secretary for Health (USH) review team determined that the opportunity for consolidations and more effective utilization of space had not been fully explored with respect to Division II facilities. A review of utilization data and team analyses led to the identification of the Division II facilities with potential for further consolidation, including changes such as converting from 24-hour, 7-days/week to 8-hours, 5-days/week operations.

Evaluation Process for Campus Realignment

The identified sites were reviewed for initial concept feasibility for inclusion in the Draft National CARES plan. A more comprehensive evaluation will occur prior to approval of the draft National CARES Plan and prior to implementation. The concept criteria used were:

1. Can the proposal be implemented in the next 5 years?
2. What and how much workload will be absorbed at other VA facilities?
3. What and how much workload will be contracted in the community?
4. How much in capital investments will be required? How much will be saved?
5. What will become of the campus or excess space?
6. How much in recurring dollars will be saved to reprogram elsewhere?
7. Can the FTEE be absorbed in the 8-hour operation, or at other VA sites?

The results by facility are summarized in Table 9.1 below.

TABLE 9.1—CAMPUS REALIGNMENT PROPOSALS

VISN	Facility	Description
1	Bedford, MA	Maintain current outpatient services at Bedford campus or another site accessible to veterans. Current services for inpatient psychiatry, domiciliary, nursing home and other workload will be transferred from Bedford campus to Brockton, West-Roxbury and other appropriate campuses (Manchester VAMC). The remainder of the Bedford campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
1	Jamaica Plains, Boston, MA	Study the feasibility of redesigning the Jamaica Plains campus to consolidate services into fewer buildings for operational savings and to maximize the enhanced use lease potential of the campus for assisted living or other compatible types of use. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
2	Canandaigua, NY	Current services of acute inpatient psychiatry, nursing home, domiciliary and residential rehabilitation services at Canandaigua will be transferred to other VAMCs within the VISN. Outpatient services will be provided in Canandaigua's market. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
3	Lyons, NJ	Campus remains open with current mission.
3	St. Albans, NYC	St Albans maintains existing services. Build new facilities for outpatient, nursing home, and domiciliary care. Demolish old facilities. Design new construction to include facility placement on site to maximize the area for an enhanced use lease project for alternative uses to benefit veterans such as an assisted living facility or other compatible use. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.

TABLE 9.1—CAMPUS REALIGNMENT PROPOSALS—Continued

VISN	Facility	Description
3	Montrose, NY	Maintain outpatient services on the Montrose campus at a location that maximizes the enhanced use lease potential of the site. Current domiciliary, psychiatry, medicine, nursing home and other inpatient units will be transferred to Castle Point. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
3	Manhattan/Brooklyn, NYC	Develop a plan to consider the feasibility of consolidating inpatient care at Brooklyn. Incorporate the proposed outpatient improvements for Brooklyn in the current proposed plan. Maintain a significant outpatient primary and specialty care presence at the current site or another location in Manhattan. Evaluate the site for enhanced use leasing. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
4	Pittsburgh-Highland Drive (HD), PA	Current services at Highland Drive will be transferred to University Drive and Aspinwall campuses, with new facilities for psychiatry, mental health, and related research and administrative services. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
5	Perry Point, MD	While maintaining the current mission, redesign the campus to maximize the enhanced use lease of the campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans. The redesign of the campus should include the current proposed new nursing home, other required new buildings to consolidate services; and preservation of the historic sites: the Mansion, Grist Mill, and 5 acres of Indian burial grounds.
7	Augusta-Uptown Division (UD), GA	Augusta Uptown Division will remain open. Study the feasibility of realigning the campus footprint including the feasibility of consolidating selected current services at the Uptown Division to the Downtown Division or other VAMCs and contracting with the community. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans. Explore with DoD the feasibility of greater coordination of VA/DoD services at either VA division.
7	Central Alabama (CAVHCS)-West (Montgomery), AL.	Montgomery campus would remain open. The proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study.
8	Lake City, FL	Transfer of current inpatient surgery services to Gainesville. Inpatient medicine will be re-evaluated when Gainesville has expanded inpatient capacity (due to construction of a proposed new bed tower). Nursing home care and outpatient services will remain at Lake City.
9	Lexington-Leestown (L), KY	Current services of outpatient care and nursing home care will be transferred to the Cooper Drive campus, as space is available. Due to possible space limitations at Cooper Drive it may be necessary to relocate some outpatient primary and outpatient mental health services to alternative locations other than Cooper Drive. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans. Enhanced use opportunities for the majority of the Leestown campus appear to exist with Eastern State Hospital.
10	Brecksville, OH	Current services at the Brecksville Division will be transferred to the Wade Park Division. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
15	Leavenworth, KS	The Secretary's Advisory Board developed a realignment plan for Topeka and Leavenworth that was accepted by the USH. Further realignments would not be cost effective. Realignments include nursing home, psychiatry, and domiciliary care.
16	Gulfport, MS	Gulfport's current patient care services will be transferred to the Biloxi division and possibly Keesler AFB. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
17	Marlin, TX	Remaining current outpatient services will be transferred to a new and more accessible location in the Marlin and Waco area. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
17	Kerrville, TX	Kerrville will continue to provide nursing home and outpatient services. Acute care services will be transferred to San Antonio VAMC as space becomes available from the proposed inpatient construction at San Antonio. In the interim, Kerrville would convert to a Critical Access Hospital (CAH). An enhanced use lease for assisted living for veterans is under development. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.

TABLE 9.1—CAMPUS REALIGNMENT PROPOSALS—Continued

VISN	Facility	Description
18	Big Spring, TX	Close surgery and contract for care in communities nearest to patients. Study the possibility of no longer providing health care services at Big Spring by development of a Critical Access or acute care hospital for the Odessa Midland area. That study would include a nursing home and expansion of an existing clinic to a multi specialty outpatient clinic.
20	Vancouver, WA	Study/develop plan to enhance use lease the campus by contracting for nursing home care and relocating outpatient services. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
20	White City, OR	White City will maintain outpatient services. The Domiciliary care and CWT programs will be transferred to other VAMCs in VISN 20. The balance of the campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
20	Walla Walla, WA	Walla Walla will maintain outpatient services and contract for acute inpatient medicine and psychiatry (will improve hospital access in the Inland North Market) and nursing home care. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
21	Livermore, CA	Current nursing home bed services will be transferred to Menlo Park campus and community contracts. Outpatient services are to be transferred to an expanded San Joaquin Valley CBOC and a new East Bay CBOC closer to where the patients live. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.
23	Hot Springs, SD	Hot Springs will remain open as Critical Access Hospital (CAH)
23	Knoxville, TN	Knoxville will remain open. All VA Central Iowa HCS inpatient care, including acute care, long-term care and domiciliary care at Knoxville will be transferred to the Des Moines campus. A new 120-bed nursing home is proposed at Des Moines to replace the 226 nursing home beds at Knoxville. VA Central Iowa HCS will operate a CBOC at Knoxville for outpatient care once inpatient care is shifted to Des Moines.

Future Actions on Campus Realignment

While the campus realignment initiative was complementary to the CARES plans submitted by the VISNs, it was developed after those plans. Therefore, the capital requirements and cost savings of proposed campus realignment proposals were not developed and analyzed using the IBM template and are not included in the summary cost tables in the draft National CARES Plan.

Further analysis will be undertaken during the CARES Commission review to prepare for their recommendations to the Secretary. In addition, should the CARES Commission recommend and the Secretary concur in these recommendations there would be a detailed assessment of all costs and service relocations as part of the initial phase of implementation of the National CARES Plan.

Chapter 10: Health Care Quality and Need

Refined Quality Measures

Continuing refinements in measurement methodologies, combined with the growing availability of more detailed administrative databases, have brought a new dimension of precision to the issue of quality in health care. No longer a subjective, ''physician-only, peer review'' matter, quality has become a legitimate planning consideration.[5]

CARES Market Plans were required to address the impact that a proposed planning initiative solution would have on the quality of health care services provided to veterans. CARES focused on the impact of the following six aspects of quality that might result from a decision to realign services, close a facility, consolidate programs, change missions or add new sites of care.

Quality performance indicators
Continuity and coordination of care
Volume as it relates to proficiencies
Access to health care services
Mix of services
Capacity needs

Although quality is generally thought of as being measured at the clinical service-delivery level, changes in capital assets to meet changing workload demands can also impact the quality of care provided. Small Facilities Planning Initiatives examined quality from a clinically oriented perspective evaluating whether small facilities should operate under a more limited scope of practice referring more complex cases to other VA medical centers or to the community. Proximity Planning Initiatives identified clinical consolidations that could improve the volume of services or expertise available within a particular VISN or market.

Impact of CARES Market Plans on Health Care Quality and Need

Markets sometimes selected solutions that were not the most cost effective alternative for well-founded reasons, but in no cases did they select an alternative that had a less than desirable impact on quality without including a plan for elimination of that impact. One consistent theme found in these narratives was the demonstration that quality is higher in VHA facilities than in community facilities as demonstrated by JCAHO accreditation, National Committee on Quality Assurance (NCQA) scores and VHA performance measure results. This drove decisions to provide services in-house rather than to contract out. When contracting out was selected, strengthening contract oversight or enhancing case management programs was generally always proposed to minimize any impact on quality.

[5] NEJM, Quality of Care—What is it? Volume 335:891–894, Sept. 19, 1996.

Performance indicators, however, were only one of the CARES quality criteria. CARES also looked at quality across five other different aspects: Coordination, volume, access, mix of services, and capacity needs of health care services. The general impact of each type of planning initiative on the six aspects of quality is summarized in the table below.

TABLE 10.1.—HEALTH CARE QUALITY AND NEED IMPROVEMENTS FROM MARKET PLAN SOLUTIONS

Planning initiatives	Improve performance indicators	Improve continuity/coordination	Increase workload volume	Improve veteran access	Expand service mix	Meet capacity needs
Access		X		X		
Capacity	X	X	X	X	X	X
Small Facility	X		X			
Consolidations/Realignments			X	X		
Special Disabilities			X	X		X
Collaborations			X	X		
Vacant Space				X	X	X

Quality and Access to Primary Care, Acute Hospital and Tertiary Care Services

Markets with access planning initiatives for primary, acute hospital or tertiary care services were required to propose new access sites to improve the number of enrollees within driving time guidelines. Improvements in access resulting from the National CARES Plan strategy are discussed in Chapter 4, ''Enhancing Access to Health Care Services.'' New access sites were proposed using various combinations of leases, contracts, joint ventures, and VA staffed and non-VA staffed alternatives. While cost was a factor used by markets to determine their preferred alternative, quality issues such as the ability to provide sufficient volume, mix of services or availability of health care professionals weighed heavily in their decisions.

Quality and Workload Capacity Solutions

Quality Performance Indicators

The main quality factor discussed in inpatient and outpatient capacity planning initiative narratives was the strong desire to maintain a high level of quality care as measured by patient satisfaction, clinical performance and preventive care measures and waiting times. Facilities felt strongly about achieving compliance with these VHA priority performance goals and chose an option that maintained quality or minimized the negative impact on their outcomes, whether that solution was provided at the parent facility, off-site or through non-VA providers.

Continuity and Coordination of Care

Many inpatient and outpatient capacity planning initiative solutions, particularly outpatient primary care and mental health, involved off-site care through either new access sites or expansion of existing sites. The decision to use VA versus non-VA providers was often based on data that VA providers have more control over quality outcomes through the administration of clinical guidelines and prevention measures. Many markets chose solutions that maintained the current character of their primary care group practice models to ensure a consistently high level of quality care for all enrolled veterans. Those who chose non-VA provider solutions for positive financial or access impact also felt strongly about compliance with these measures and proposed to minimize the potential negative impact on quality by strengthening contractual oversight of quality outcomes or by enhancing case management programs to ensure coordination and continuity of care.

Volume of Service Provided

Solutions to outpatient specialty and acute inpatient capacity planning initiatives showed a greater concern for quality based on volume of care. In the case of outpatient specialty care, markets often proposed moving more primary care off-site to allow expansion of specialty care at the parent facility. The reasons most often stated for this strategy were the availability of sub-specialist providers, minimizing negative impact on affiliations due to volume of care, and proximity to diagnostic and therapeutic services. Solutions for off-site specialty care usually involved moving only selected subspecialties to Community Based Outpatient Clinics or using non-VA providers. In the case of inpatient medicine and surgery, non-VA providers were often chosen as the preferred solution because the impact on quality due to low volume of care was perceived to be more important than the impact on quality due to fragmentation of care among multiple providers. Consolidation of acute programs within a market, and other realignments for reasons of quality, cost and staffing efficiencies, were often seen in acute inpatient psychiatry.

Access to Care

Both VA and non-VA solutions seek to have a positive impact on quality by improving access and reducing waiting times. This was stressed most often in outpatient specialty and mental health planning initiatives. Specialty care waiting times have been a focus of VHA over the past few years. For outpatient mental health, integration into a patient's community was viewed as having a significant impact on quality due to increased compliance with treatment plans and decreased potential for hospitalization.

Mix of Services

Many markets chose to establish new or to expand existing Community Based Outpatient Clinics or Satellite Outpatient Clinics (SOPs) to include primary, mental health, specialty and ancillary/diagnostic care. These markets provide models using this expanded mix of services to improve quality by decreasing waiting times, reducing duplicated tests and repeat visits, and increasing patient satisfaction. Markets that did not have the population base to support these larger CBOCs or SOPs generally felt that quality of care, based on these same factors, would be greatest if provided at the parent facility where patients would have access to specialized and support services.

Capacity Needs

Market Plans were required to resolve capacity needs in workload and space. Controls were in place to ensure that the plans did resolve these gaps in the IBM Market Planning Template.

Quality and Small Facilities

The majority of medical centers that proposed closing acute hospital beds planned to refer workload to other VHA facilities and to community hospitals in order to keep access local, maintain customer satisfaction and improve cost efficiencies. The impact on all aspects of quality was considered positive. The medical centers that proposed to retain less than 40 acute hospital beds indicated that the potential impact on quality from low volume would be offset by such factors as being a key provider in the community or vast distances to other VHA facilities. A proposed solution for minimizing the impact of low volume on quality involves a conversion of acute beds to a Critical Access Hospital (CAH). Medicare's CAH criteria includes such provisions as being part of a referral hospital network, length of stays no more than 96 hours, full-time emergency coverage, and designation by the state as a ''necessary provider.[56]

Quality and Proximity/Campus Realignments

No consolidation or realignment proposals resulting from proximity planning initiatives are anticipated to have a negative impact on quality. Quality issues resulting from proposed realignments were discussed in the narratives in terms of the impact on medical school affiliations, DoD sharing agreements and veteran access. Consolidation of services, particularly small volume and high cost procedures and subspecialties, was viewed as having a positive impact on quality of services provided.

Quality and Special Disability Programs

Spinal Cord Injury and Disorders and Blind Rehabilitation planning initiative solutions focused on quality in terms of expanding capacity and improving access to meet veteran needs through 2022. Some facilities propose space enhancements to improve the quality of the environment in which these services are provided.

Quality and Collaborative Opportunities

Quality was often stated as a positive impact of DoD collaborative initiatives, generally based on volume and mix of services. DoD physicians that are given clinical privileges at a VHA facility enhance care to veterans and maintain their proficiency for small volume procedures. DoD has more extensive experience with the treatment of women and children and offers patient care and resident training expertise in these specialties.

Quality and Vacant Space

CARES Market Plan vacant space solutions largely impacted cost efficiency and environmental safety, with a lesser impact on health care services and need. Vacant space was converted or reserved for future health care services when demand data supported the need. Buildings determined to be unsafe or unusable buildings too costly to maintain were proposed for demolition. Usable buildings not needed for future health care services were proposed for enhanced use lease, out-leasing, collaborative efforts or other alternatives that would avoid cost or produce revenue. Some of the enhanced use lease solutions would improve access and service mix by providing veterans with additional services, such as independent living and assisted living.

Chapter 11: Capital Investments (Safety and Environment)

Relationship of Capital Assets to Safety and the Environment

The CARES process recognizes that the management of VHA's capital assets must be coordinated with respect to the functionality of the space, occupational safety and health, fire safety, seismic considerations, and other building and equipment design criteria which affect safety codes and standards. This chapter of the CARES Plan addresses these issues as well as the general area of capital investment.

Process of Developing Market Plans

The VISN market planning process was largely determined by the web-based computer application developed by IBM called the IBM Market Planning Template.[57] Appendix K outlines the assumptions and limitations of the IBM Market Planning Template used to develop capital investment plans. The template required the following steps:

1. Allocate the projected workload demand at the market level to VISN facilities for each CARES Category.
2. Manage projected workload demand by determining how much workload would be managed in-house or through community contracts, joint ventures, sharing, or a combination of any of these choices. The amount of workload managed in-house determined how much space was needed at a treating facility for a particular CARES Category.
3. Manage projected space needs at each treating facility for each CARES Category through new construction, converting vacant space, leasing space in the community, or through an enhanced use initiative or donated space. The projected space required at a treating facility to meet the in-house workload demand was determined using a square foot/workload unit (space driver) unique to each facility and based on optimum space (Appendix O). The projected space was compared to current space available at a facility in that CARES Category, and a ''space needed'' or ''space overage'' amount was calculated. The IBM Market Planning Template allowed a VISN to find a space solution within 25% of the projected space need, allowing some flexibility in addressing local efficiencies, such as the use of longer hours or more staff. In some cases, this 25% was not sufficient, but the template would not allow less than 75% of the space need to be met.

Capital Plans

A Capital Plan will be developed during the implementation phase of CARES. The Capital Plans will cover a five to ten year time period rather than the 20-year planning horizon used for VISN Market Plans. A shorter time frame for capital planning is necessary in order to keep current with changing technology and health care delivery systems. The 20-year workload projections will be used to validate the need for the projects over the expected 20-year life of the investment.

Improving Safety and Functionality of Existing Space

Maintain Appropriate Tertiary Care Environment

As VHA increases access to both outpatient and inpatient health care services, one of the primary missions of the CARES planning process is to ensure that a safe and appropriate infrastructure is sustained at VA's tertiary care facilities. The National CARES Plan proposes capital investments in the seven core CARES categories (inpatient medicine, surgery, psychiatry and outpatient primary care, mental health, specialty, ancillary/diagnostic) of $1.7 billion dollars to support VHA tertiary care facilities. This is a sub-set of the $2.6 billion dollars proposed for capital investments in those seven clinical CARES categories for all facilities combined.

[56] Chapter 8 ''Strategic Direction of Small Facilities'' and Appendix N ''Critical Access Hospital Designation''

[57] IBM Market Planning Template Technical Summary is included under References.

Safety and Functionality of Existing Space

By projecting veteran workload needs for the next twenty years, CARES was able to determine what existing infrastructure will be needed through the year 2022, assess the condition of that infrastructure, and plan to bring it to acceptable industry standards. The current condition of VHA's physical environment was measured through a facility survey process that resulted in an overall Condition Score for all existing space (Appendix O). Elements that were scored and weighted to make up the Condition Score for space in each CARES Category at each VHA facility included layout, code compliance, handicap accessibility and patient privacy. Space in each CARES Category at each facility was scored on a range of 1 to 5 with 5 being the best. Space with a Condition Score of less than 3 was considered for renovation to a score of 5. The following table shows the impact of these planned improvements.

TABLE 11.1.—RENOVATION AND IMPROVEMENTS TO EXISTING SPACE FY 2002–FY 2022

Type of investment	Total space	Prior weighted condition score of space	Total cost (current $'s)	Revised condition score of space
Convert Vacant	3,779,421	2.40	$402,859,514	5.00
Renovate Existing	7,981,188	3.41	603,040,996	5.00
National Totals	11,760,609	3.09	1,005,900,510	5.00

Data and Report Last Updated: 6/26/03.

Note: Table 11.1 includes all CARES categories except Research and Other Space. It includes the seven, core inpatient and outpatient clinical categories as well as Nursing Home/Intermediate, Domiciliary, Spinal Cord Injury, Blind Rehabilitation, Residential Rehabilitation, and Administration.

As seen in Table 11.1 above, the overall Condition Score for existing VHA space planned for renovation in CARES is 3.09, reflecting current compliance with recommended guidelines for space condition. Figures 11.3 and 11.4, later in this chapter, show the distribution by year of the necessary renovations to existing infrastructure. The majority of renovation costs appear in years 2004 through 2006, indicating the immediate need to improve the quality and functionality of VHA's infrastructure.

Vacant space was also given a Condition Score at each VHA facility. Vacant space that was converted to usable space to address workload gaps in VISN Market Plans had an even lower average Condition Score of 2.40 (Table 11.1). The conversion of this vacant space to meet workload demand will also result in the improvement of this space to acceptable levels.

Seismic Strengthening

The VA Secretary has made seismic strengthening a priority to assure the safety of our infrastructure in high-risk areas of the country. VHA has currently placed 63 sites on its priority list. VISN responses in meeting this priority through the CARES process are shown in the table below.

TABLE 11.2.—PROPOSED SEISMIC CORRECTIONS (VISN COST ESTIMATES IN CURRENT DOLLARS)

VISN	Facility name	Market name	Cost
8	San Juan	Puerto Rico	$85,000,000
20	American Lake	Western Washington	21,840,000
20	Portland	South Cascades	49,680,000
20	Roseburg	South Cascades	17,000,000
20	White City *	South Cascades	(**)
20	Seattle	Western Washington	16,960,000
20	Walla Walla *	Inland North	5,700,000
21	Fresno	South Valley	12,000,000
21	Palo Alto	South Coast	28,972,872
21	San Francisco	North Coast	51,000,000
22	Long Beach	California	39,000,000
22	San Diego	California	49,100,000
22	West LA	California	64,400,000
Total			440,652,872

* Being considered for realignment
** Included in Building Replacement Costs.

Parking Improvements

Although parking improvements were not directly included in the IBM Market Planning Template, many VISNs did submit initiatives under the Vacant Space category. Adequate parking is considered a necessary part of ensuring full access to health care services. VISN Market Plans have identified eight parking initiatives; five initiatives are planned for accomplishment through the enhanced use program and three through new construction.

Meeting Capacity Demand for the Future

In addition to ensuring that VHA maintains an appropriate tertiary care environment and improves the safety and functionality of its existing infrastructure, CARES addresses infrastructure needs to meet projected future demand.

Outpatient Capital Investments

The CARES planning model projected an overall increase in the demand for

outpatient services (primary care, specialty care and mental health care), which resulted in a demand for additional space. The peak in this workload demand was usually managed through contracting for care or leasing space, both of which reduce the demand for in house space. Therefore, outpatient demand resulted in less renovation of existing space and conversion of vacant space as compared to inpatient demand. Figures 11.1 and 11.2 show the relationship between workload demand gaps and space demand gaps for outpatient care. By comparing the trends in both charts below, it can be seen that space gaps over a 20-year period followed workload projection trends.

Figure 11.1 National Outpatient Workload Gaps in Clinic Stops (Includes Contract Care)
FY 2002 – FY2022

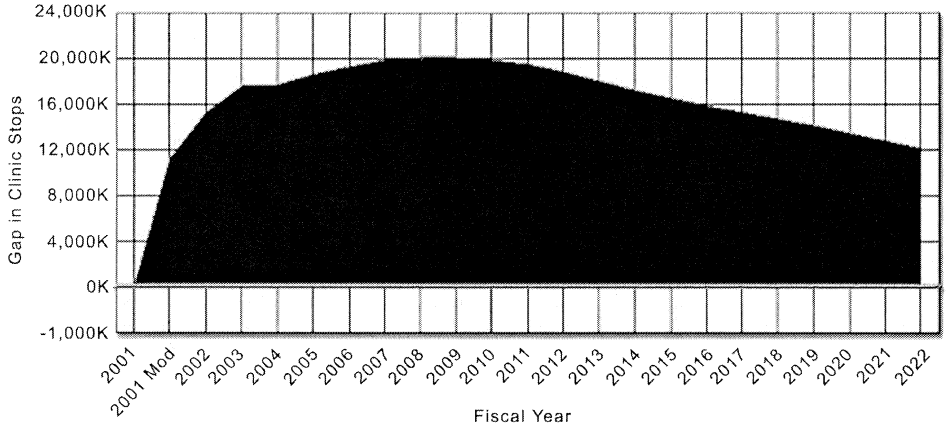


Figure 11.2 National Outpatient Space Gaps in Square Feet
FY 2022 – FY 2022
Includes Outpatient Primary Care, Specialty Care and Mental Health

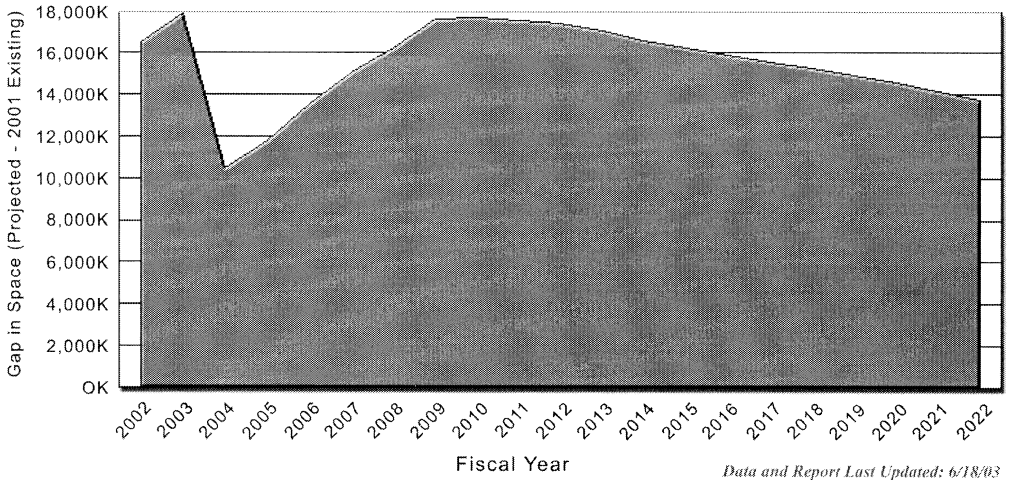
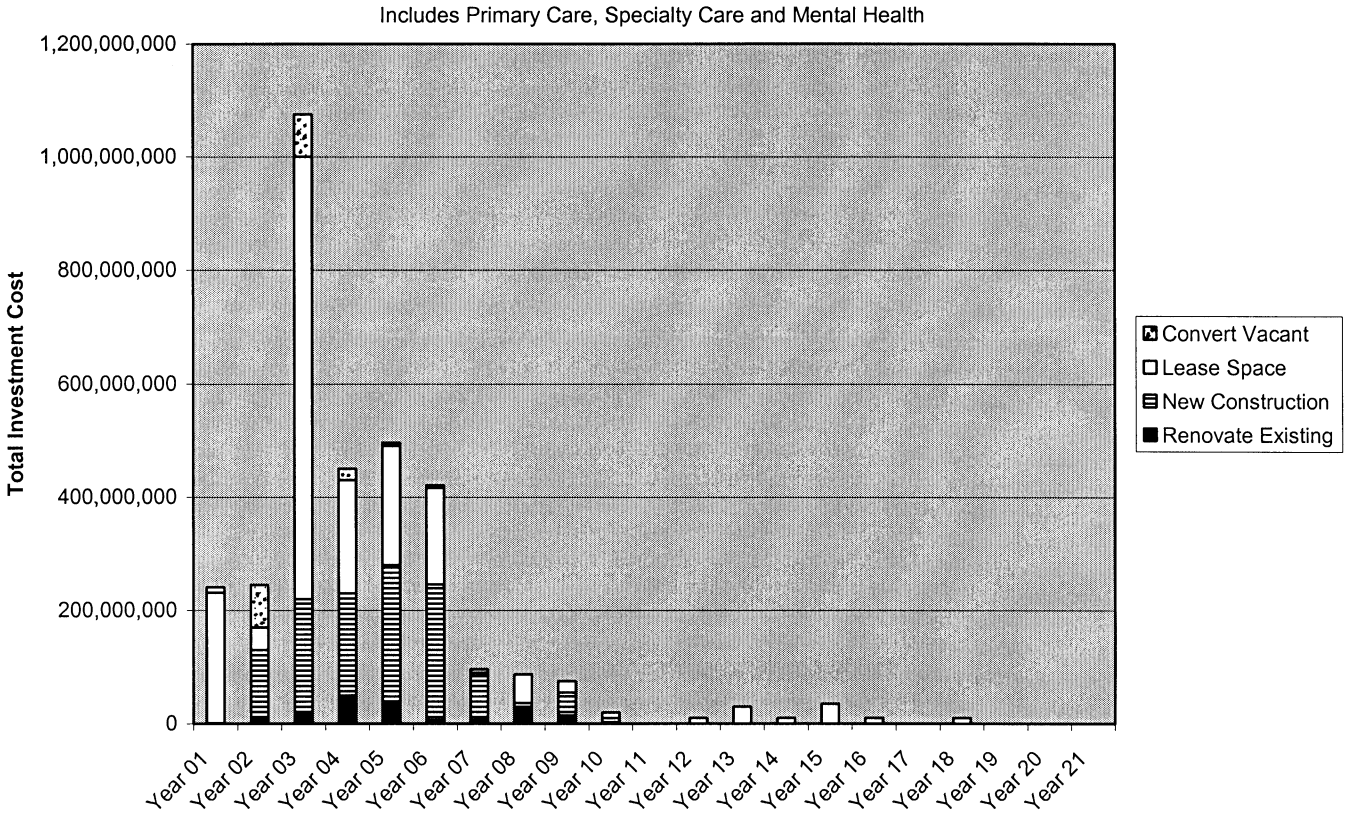


Figure 11.3 National Inpatient Capital Investments in Current Dollars

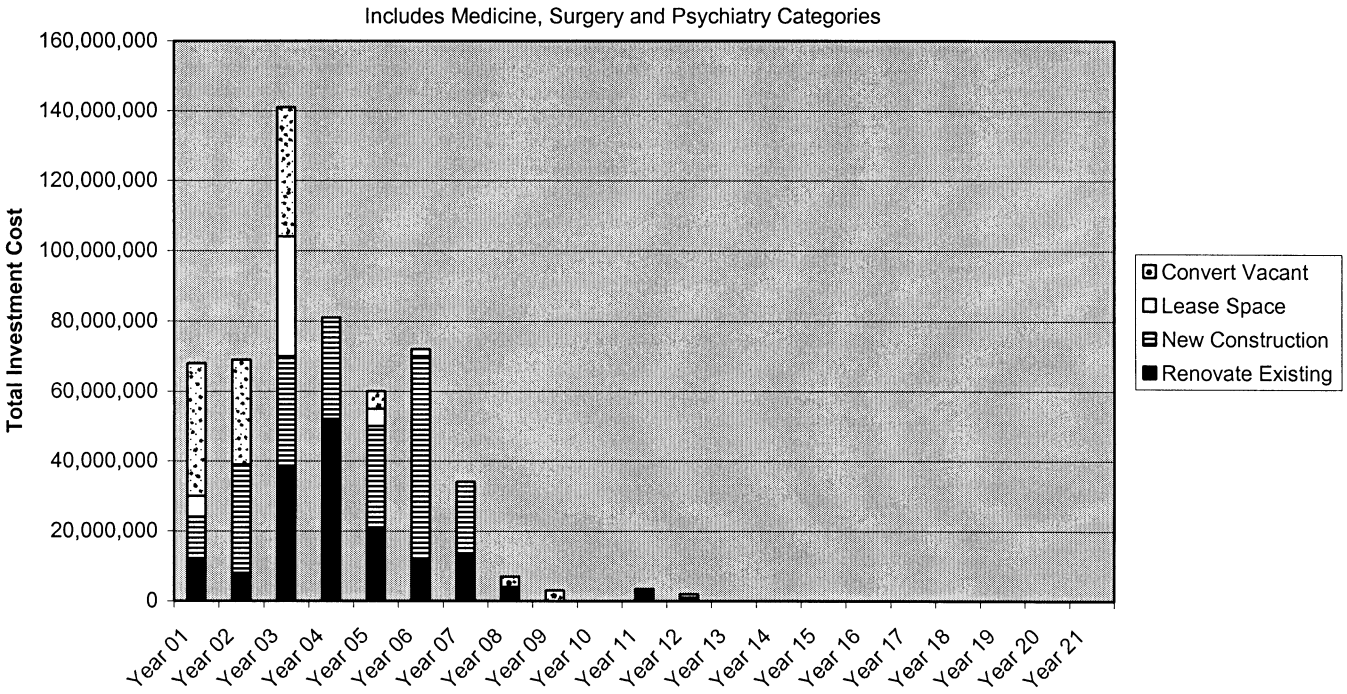


Inpatient Capital Investments

Current inpatient infrastructure is not adequately sized to meet the current demand for space. Additionally, the existing space did not meet patient privacy or other standards for environment of care. However, with the majority of the outpatient increases managed through contracts or in leased space, space within existing facilities can be renovated to accommodate the needs.

Figure 11.4 shows the capital investments proposed for inpatient care. New construction and conversion of vacant space make up a significantly larger portion of inpatient capital investments than it did for outpatient care. Outpatient care is more readily provided through Community Based Outpatient Clinics or other off-site leased facilities.

Figure 11.4 National Inpatient Capital Investments in Current Dollars



Types of Capital Investments

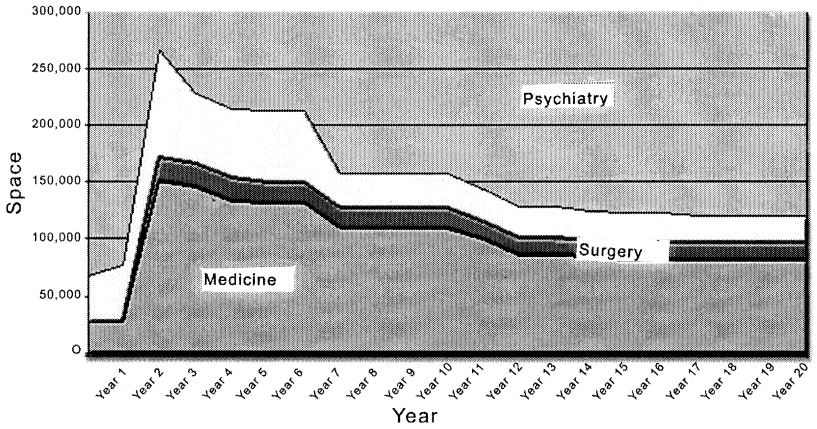
VA-Owned versus Leased Space

VA-owned space expansion was achieved through new construction or conversion of vacant space. 16,201,969 square feet of new construction and 4,121,335 square feet of vacant space conversion have been identified to address increasing workload capacity. While some of this expansion is needed to meet future workload demand, some space shortages were identified as currently existing.

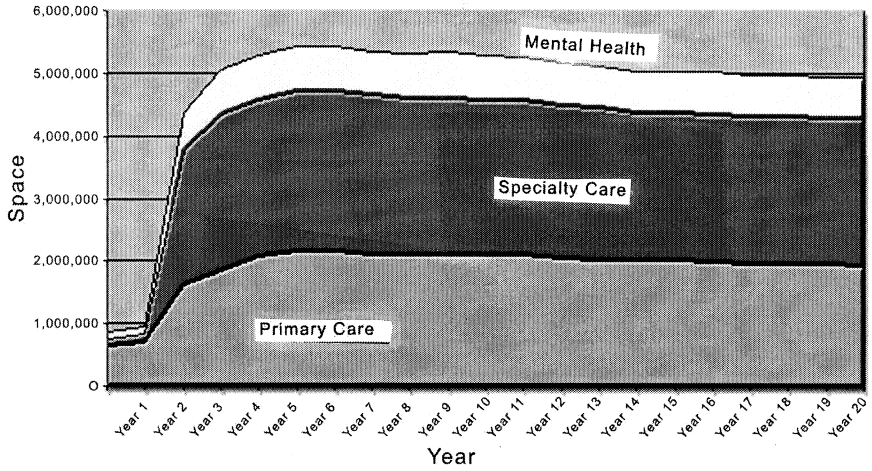
Leased space was utilized for peak demands in in-house workload. Leasing was a good temporary solution that eliminated the need for permanent VA owned space. The chart below shows the total proposed leased space by year. The second chart graphically depicts the square footage leased by year compared to the workload demand.

Figure 11.5 Total Leased Space

Amount of Inpatient Leased Space in Square Feet



Amount of Outpatient Leased Space in Square Feet



Enhanced Use Lease To Expand VHA Capacity

Enhanced use lease initiatives have been identified as an option for expanding capacity at a facility to meet future workload demand. A total of 792,200 square feet of enhanced use lease space is proposed nationally. Of this square footage, 54 percent represents expansion of clinical programs; 46 percent is identified for additional administration and research space.

The CARES Planning Process has encouraged the VA to manage excess land through collaborations with NCA, VBA, and enhanced use lease initiatives. Eleven VISNs identified sites in their CARES Market Plans for future cemeteries. Five thousand acres will be or have been allocated for NCA. More details on collaborative opportunities are available in Chapter 13.

Donated Space

Donated space was used only on a limited basis as a solution to expand space capacity. Donated space was also used for unusual space situations, such as extended clinic hours or renovation of existing space to improve capacity (Appendix K).

Chapter 12: Reducing Vacant Space

Background

The GAO Report (GAO/HEHS–99–145) titled ''VHA Health Care Improvements Needed in Capital Asset Planning and Budgeting'' from August 1999 states:

VA's large, aged infrastructure could be the biggest obstacle confronting its efforts to transform itself from a hospital-based operator to a health care provider that relies on integrated networks of VA and non-VA providers to meet veterans' health care needs. Over the next few years, VA could spend one of every four of its health care dollars operating, maintaining, and improving capital assets at its 181 major delivery locations that encompass over 4,700 buildings on 18,000 acres of land nationwide.

The cost savings cited by GAO are based upon total closure of facilities and not the reduction of vacant space that is dispersed throughout numerous campuses within individual buildings, which is our current condition. However recognizing the importance of reducing vacant space, the CARES Plan included a discrete component—described in this chapter of the plan—designed to reduce excess space and conserve resources by lowering maintenance and operational costs of infrastructure not needed by VHA to meet its various missions.

The description and data on the reduction in vacant space does not include the results of the realignment

reviews that are described in Chapter 9. This data will be fully developed during implementation planning.

Baseline CARES Data

To evaluate the ability of existing capital assets to meet future demand, VHA first conducted a comprehensive survey of current infrastructure, (Appendix O). This Space and Functional Survey evaluated both the quantity and the quality of the physical infrastructure that was owned or leased by VHA. This was used to develop the inventory of existing VHA-owned space that included approximately 8.5 million square feet of vacant space.

Projecting Vacant Space

The existing VHA-owned space inventory and the workload projections were used to develop a projected demand for space. Using the projected demand for space, VISNs developed a 20-year plan of actions (renovation, new construction, converting vacant space, leasing) that adjusted the existing inventory to meet projected need. Space that was not utilized for patient care, support of patient care or other VA missions, was identified as vacant. The resulting vacant space was then proposed for demolition, divestiture, out leasing or enhanced use.

Summary of Vacant Space Planning Initiatives

The CARES planning process resulted in a projected 42% reduction of vacant space from 8,571,605 square feet in FY2001 (excludes space that is currently out leased) to 4,934,002 square feet in FY2022 for a net reduction of 3,637,603 square feet. See Table 12.1.

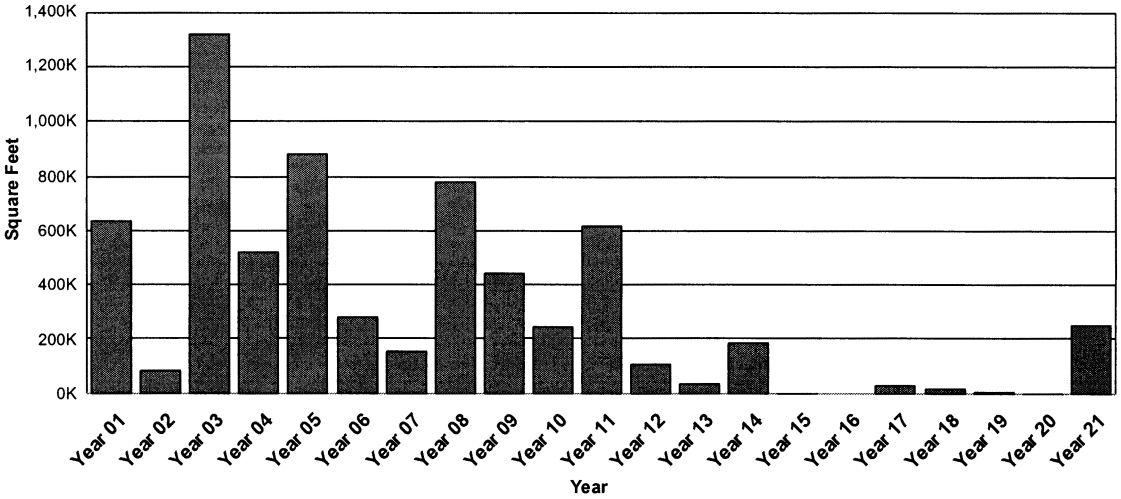
TABLE 12.1.—REDUCTIONS IN VACANT SPACE IN SQUARE FEET (FY 2001 TO FY 2022)

	FY 2001	FY 2022
Total Space	93,949,947	118,156,557
Vacant Space ...	8,571,605	4,934,002
% Vacant	9	4

The following charts and tables depict VHA's plans to manage its vacant space over the 20 year planning horizon.

Figure 12.1 graphically depicts reduction in vacant space over the 20 year planning cycle.

Figure 12.1 Reduction in Vacant Space



Most of the reduction in vacant space is accomplished in the first few years of the planning horizon since much of this space is currently vacant and not dependent upon realigning space. In addition, from Year 1 to Year 11, demolition remains fairly high as new vacant space is created by consolidations of existing services/buildings and modern building replacements. Decreases in vacant space in the later years occur because complete units (buildings or wings) have been demolished and the vacant space remaining is scattered in pockets throughout facilities. The increase in the reduction of vacant space in Year 21 is due to two facilities planning to undergo mission changes. The fact that domino moves are needed to phase in these mission changes, and the fact that historic buildings are involved, caused the final demolition of their space to occur in Year 21 rather than earlier.

Figure 12.2 depicts the vacant space that has been planned for out leasing. Out leasing includes space leased to Service Organizations, Community Service Organizations, National and Community Homeless programs, and State, Local and other Federal agencies.

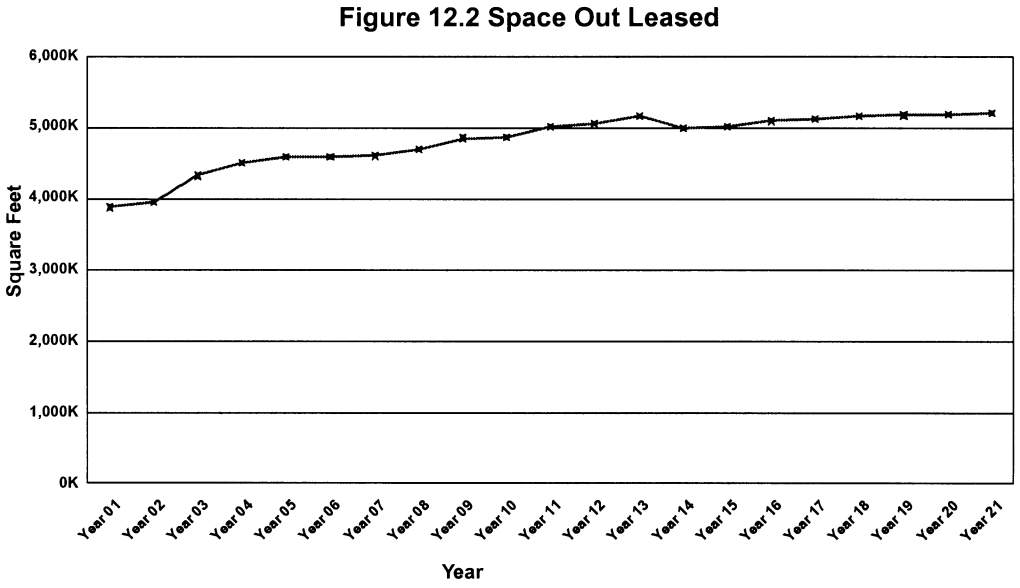


Figure 12.3 below indicates the space that has been planned for enhanced use lease opportunities that could generate revenue for VHA.

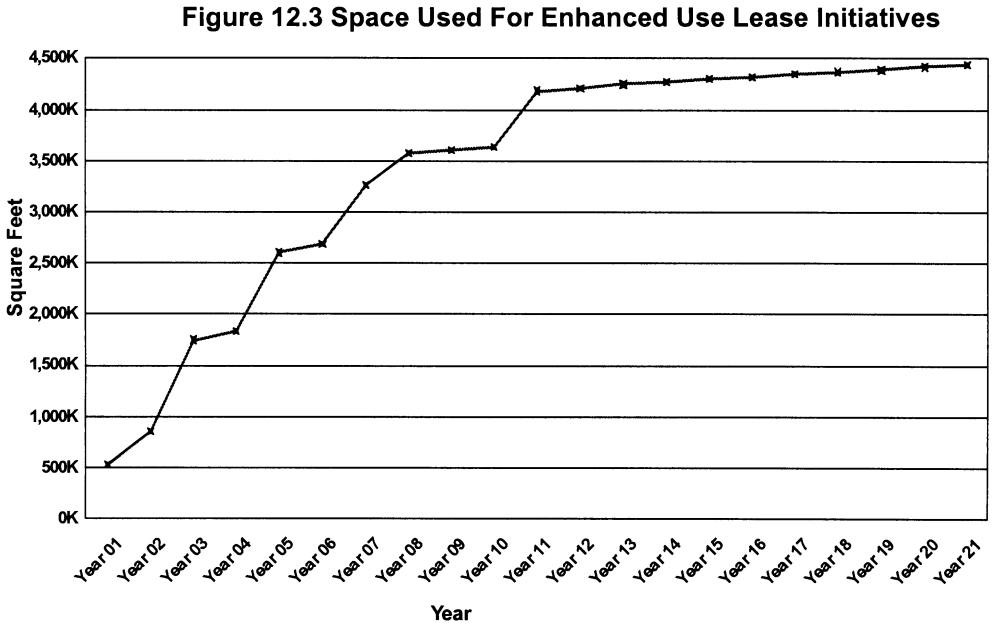
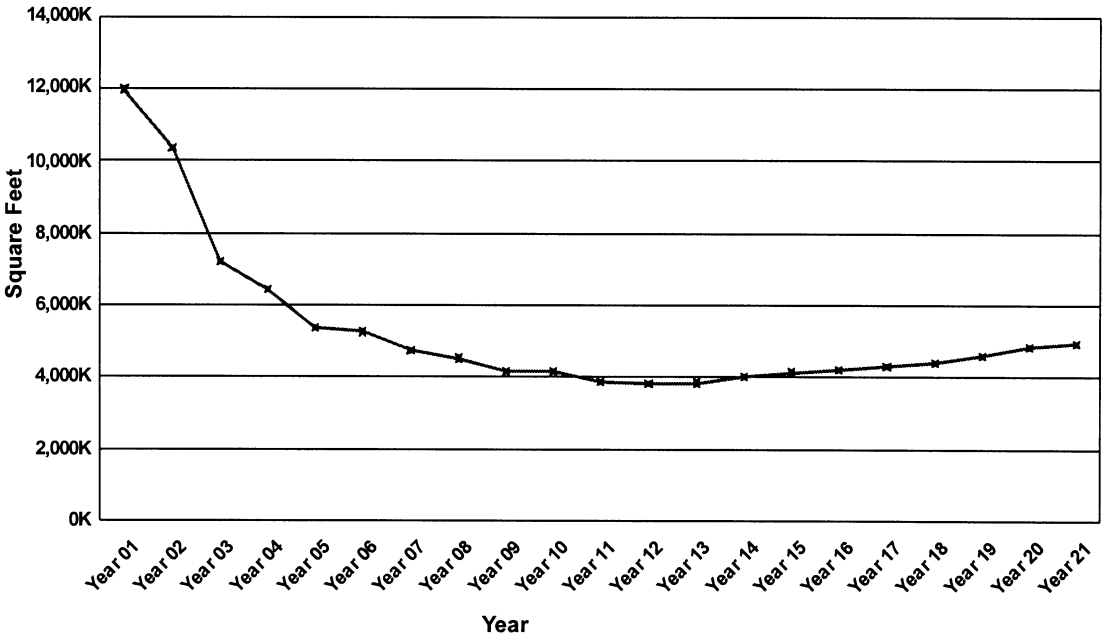


Figure 12.4 Space Remaining Vacant



As mentioned in other areas of this plan, proposed capital investments cannot be accurately predicted beyond five years. This also applies in predicting alternative uses of vacant space. The demand for possible vacant space at VA facilities could change in the future based on a number of factors such as the economy or changes in health care delivery practices. In most instances, the vacant space is not contiguous but consists of pockets of vacant space scattered throughout the campuses, rendering it useless for alternative uses.

Savings associated with the reduction in vacant space are shown below. The reduction in vacant space described in Table 12.2 represents a minimum reduction since it does not include reductions in vacant space that will occur due to realignments of campuses and reuse of the campus through enhanced use leasing.[58]

TABLE 12.2.—RECURRING COST OF VACANT/UNDERUTILIZED SPACE THROUGH 2022

[Costs are in current dollars]

	FY 2001	FY 2022	Difference
Vacant/underutilized space in square feet (SF)	8,571,605 SF	4,934,002 SF	3,637,603 SF
Average cost/sf to maintain in current $[58]	$12.39 per SF	$12.39 per SF	.....
Annual cost ($ per year)	$106,245,044	$61,156,955	$45,088,089
Other savings/profits/costs ($ per year)*	.....	$15,493,381	.....
Revised annual costs ($ per year)*	$106,245,044	$45,663,574	$60,581,470
Cost per day ($ per day)	$291,082	$125,105	$165,977

Note: *Other Savings/Profits/Costs related to the management of vacant space include such things as revenues from enhanced use lease initiatives, operational savings from building demolition, or revenues from sale of property. VISNs did not have a standardized way to enter these cost estimates so this dollar figure is not all inclusive of the potential savings from the management of vacant space.

Campus Closures

The CARES planning process has identified several potential campus closures for which the total savings has not yet been fully evaluated. Chapter 9 on Proximity and Campus Realignments and Appendix G, Proximity Planning Initiatives, contain additional information regarding facility mission changes and the potential uses for the resulting vacant space.

Chapter 13: VBA and NCA Collaborative Initiatives

Serving Veterans: ''The Family Business''

In addition to the Veterans Health Administration, which provides the medical services at the heart of this CARES Plan, two other primary VA branches manage programs and services for veterans. The Veterans Benefits Administration (VBA) oversees the Department's programs for compensation and pension, education, loan guaranty and life insurance. The National Cemetery Administration (NCA) is responsible for burial benefits, national cemeteries and the State Cemetery Grants Program.

In planning future changes in VHA's infrastructure, the CARES process not only considered strategies to address projected health care demand, but also sought opportunities for efficiencies in rent and property management through

[58] Cost provided by Professional Estimator in VHA Office of Facilities Management.

collaboration with these other two VA administrations.

Summary of Proposed VBA Initiatives

A number of very positive, long-standing examples of collaborations resulting in such efficiencies can be found around the nation. These involve either the placement of VBA benefits offices on VA medical center grounds, or leased space shared by VBA offices and VA outpatient clinics. With the benefits of such actions well known, incorporating such arrangements in future strategic plans was a given.

Therefore, intense teamwork between VBA planners and various VISNs was needed to identify 17 CARES planning initiatives involving interdepartmental collaboration. At the time the CARES Plan was prepared for publication, these initiatives remained in early stages of development. As a result, only a preliminary assessment of the feasibility of these potential collaborations is presented here.

While both VHA and VBA approached any proposed collaborative venture with the objective of finding cost efficiencies, the consensus was that service to veterans would remain the priority consideration. In this context, review of these initiatives focused on the extent to which they would support and enhance VBA's productivity, accuracy, and timeliness in delivering benefits.

Specifically, VBA evaluated and prioritized proposals to co-locate benefits offices onto VA medical center grounds at 17 locations, based on the potential to improve claims processing and accessibility to veterans. The initiatives were categorized in three priority levels and accordingly assigned general time periods for further development and implementation. The following listings include comments about the criteria considered in this process:

High Priority Initiatives: Co-location of VBA offices at 6 VA Medical Center sites during years 2004–2010. Evaluation indicates that claims processing and accessibility requirements would be met, while achieving a high return on the transition investment (*i.e.*, areas involved are subject to expensive rents, and significant costs can be avoided or reduced).

Medium Priority Initiatives: Co-location of VBA offices at 11 VA Medical Center sites during years 2011–2016. Evaluation indicates that claims processing and accessibility requirements would be met, but the transition investment would bring lower return because rents are less expensive at these designated sites.

Low Priority Initiatives: Co-location of a VBA office at one VA Medical Center site during 2017–2022. Evaluation indicates that claims processing and accessibility requirements would not be met, notwithstanding rent circumstances.

The high priority VBA co-location initiatives developed in the CARES process—on which further development and implementation are recommended during the period 2004–2010—are listed below. A more comprehensive listing and explanation of all high, medium and low priority sites can be found in Appendix H.

- VISN 1 (Newington CT)
- VISN 7 (Columbia) SC
- VISN 18 (Albuquerque, NM)
- VISN 22 (Los Angeles, CA)
- VISN 22 (Reno, NV)
- VISN 23 (Minneapolis, MN)

Summary of Proposed NCA Initiatives

The National Cemetery Administration (NCA) collaborated with VHA in the CARES process to identify potential excess land at VA Medical Centers that could be used to provide burial options for veterans and eligible family members.

After an analysis of VA properties and projected future needs in each VISN, NCA identified 58 locations within 18 VISNs, where acquiring available land would be of interest. As a result of discussions at the Planning Initiative Selection Conference, 23 initiatives involving 14 VISNs were identified. Further review and analysis by VHA and NCA narrowed this list to a total of 16 collaborative opportunities within 11 VISNs.

Major reasons for inability to collaborate on some of the initiatives included insufficient acreage available at the medical facility, and unsuitability of the site for cemetery development (for example, due to inappropriate topography or aesthetics).

At the time this CARES Plan was prepared for publication, these NCA collaboration initiatives remained in early stages of development. Therefore, only a preliminary assessment of their feasibility is presented here.

Similar to the circumstance noted above for collaboration between VHA and VBA, both VHA and NCA approached these potential collaborations with the objective of finding cost efficiencies. And again, the consensus was that service to veterans would remain the priority consideration.

In this instance, review of the initiatives focused on NCA's goals and strategies, and the initiatives were scored on their potential to improve the efficiency, timeliness of services, and overall accessibility of burial benefits and national cemeteries.

The planning horizon for high priority NCA CARES initiatives was designed as 2004–2010. The following sites were selected for these high priority initiatives, based on the potential to continue to provide access to burial services to veterans, or to provide access to veterans not currently served by existing NCA or state veteran cemeteries:

- VISN 3 (VA Hudson Valley HCS and Montrose)
- VISN 6 (Salem)
- VISN 8 (Future co-location at Sabana Seca Naval Facility at San Juan)
- VISN 10 (Chillicothe)
- VISN 15 (Leavenworth and St. Louis)
- VISN 20 (Walla Walla)
- VISN 22 (West LA)

A complete listing of sites for medium priority initiatives (for potential action during the years 2011–2016), and low priority initiatives (potential action in the years 2017–2022), and further explanation of the high priority sites, is presented in Appendix H.

Chapter 14: Partnering with the Department of Defense

Federal Medicine: DoD and VA Opportunities

There is a tremendous potential for savings through sharing of medical services and other resources among federal medical providers. Because of sheer size and wide dispersion around the country, the VA and DoD health care systems in particular have available numerous collaborative opportunities.

VA operates 162 hospitals and more than 850 community and outpatient clinics, nationwide, at a cost of more than $28 billion. DoD spends a similar amount on health care, split between approximately 75 military hospitals and 600 clinics and through networks run by managed care support contractors.

Resource sharing between the VA and DoD facilities has been increasing since the early 1980's. Some of the specific activities involved are major medical and surgical services, laundry, blood supply and other laboratory services, specialty care, training activities, joint venture construction and the operation of facilities.

In the summer of 2001, the President's Management Agenda was announced. The agenda is an aggressive strategy for improving the management of the federal government. Contained in the agenda is a specific section entitled

''Improved Coordination of VA and DoD Programs and Systems.'' In this section, the President directed VA and DoD to improve the coordination of benefits, services, information and infrastructure to ensure the highest quality of health care and efficient use of resources.

In response to the President, VA and DoD established a Joint Executive Council (JEC) in February 2002 to facilitate and monitor health care, benefits, and other sharing activities. During the past year, the two Departments have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through the JEC.

Reflecting a new sense of order after establishment of the JEC, VA and DoD sharing efforts can now be categorized as follows:

- Local sharing agreements allow VA Medical Centers and Military Treatment Facilities (MTFs) to exchange inpatient care, outpatient care, and ancillary services as well as support services.
- Joint venture sharing agreements pool resources to build new facilities or to capitalize on existing facilities.
- National sharing initiatives, coordinated by the JEC, are interagency initiatives, such as joint disability discharge physicals.

CARES Designers Foresaw Additional Sharing Progress

Since the CARES process was initiated just as these intensified sharing actions were being implemented, it might seem that expecting significant further improvements or savings from this area would be somewhat optimistic.

Nevertheless, the enhanced CARES design exhibited a strong conviction that the process would deliver further progress—as reflected in one of the stated goals for CARES planning: ''to improve sharing facilities and services with DoD.''

In fact, the CARES process identified dozens of additional sharing opportunities. In many instances, the potential new opportunities were immediately helpful in developing solutions to planning initiatives that VISNs already had identified through other CARES components (*e.g.*, enhancing access, ensuring inpatient capacity, etc.)

The draft VISN Market Plans therefore were submitted with numerous planning initiatives for additional sharing with local DoD facilities. These initiatives were reviewed by an interagency team, which included representatives from the National CARES Program Office and the VISNs, as well as representatives from Tricare, Army, Navy and the Air Force. The review analyzed these collaborative opportunities in the context of projected workload for both departments.

The reviewers conducted a detailed evaluation, in some cases directly contacting the VISNs to clarify their submissions. After the review, the team divided the collaborative opportunities into the following five categories.

1. High Priority

a. There exists an acute demand for access to services or facilities on the part of DoD or VA

b. There appears to be substantial mutual advantages to collaboration

c. DoD has proposed a major construction facilities project at the collaboration site. The proposed project is currently in planning or design and immediate coordination is required to determine the scope, cost, and operational implications of collaboration.

d. The project has high visibility to Congress and senior leadership of DoD and/or VA.

2. Near Term

a. The potential for mutually advantageous collaboration appears high.

b. DoD or VA may be contemplating a facilities project, the scope and cost of which could be affected by collaboration.

c. Formal planning and design have not yet been initiated.

d. Preliminary discussions and coordination activities should start in the current fiscal year.

3. Future

a. Potential for mutually advantageous collaboration appears possible, but there exists no compelling reason to pursue detailed planning at this time.

b. No new facilities or projects are currently contemplated by either DoD or VA.

c. Should continue to be considered but likely will not be seriously evaluated until after completion of the 2005 Base Realignment and Closure process (BRAC 2005).

4. Good Ideas

a. Refers to potential collaborative opportunities that have little or no impact on capital investment programs.

b. Relates more to operational functions that would likely produce better business practices.

c. Would not normally be considered within the purview of CARES but instead would be better suited to examination in other DoD/VA sharing venues.

5. Local Development

a. Potential for mutually advantageous collaboration is not readily apparent.

b. VISN CARES analysts have indicated proximity to DoD facilities could lead to further investigation.

c. No new facilities or projects are currently contemplated by DoD or VA.

Collaboration Results

Collaborations and Sharing Opportunities are detailed in Appendix I.

TABLE 14.1.—NUMBER OF DOD COLLABORATIONS BY PRIORITY

High Priority	21
Near Term Development	13
Future Development	9
Good Ideas	5
Local Development	26

High Priority DoD Collaborations

Selected Highlights (A complete list of initiatives can be found in Appendix I)

VISN 3: VA New Jersey HCS and Ft Monmouth (USA). Army is providing space for a CBOC to address primary care. The clinic would treat both veterans and military personnel.

VISN 5: VAMC Washington and Fort Belvoir (USA). Fort Belvoir providing space in new facility for VA primary and specialty care.

VISN 20: VAM&ROC Anchorage and Fort Wainwright (USA). VA will relocate to new clinic space in the new hospital at Fort Wainwright and expand primary and specialty care and mental health services.

VISN 16: Gulf Coast Veterans Health Care System (Biloxi and Gulf Port Divisions) and Keesler AFB hospital are pursuing an opportunity to relocate selected services of the Gulf Port and Biloxi Divisions through sharing with Keesler AFB. This would result in the vacancy of the Gulf Port Division and the opportunity to enhance-use lease the property.

Near Term Development DoD Collaborations

Selected Highlights (A complete list of initiatives can be found in Appendix I)

VISN 5: Baltimore VAMC and Fort Meade (USA). Army would provide space for a VA CBOC.

VISN 20: Seattle VAMC and Bremerton Naval Hospital. Sharing agreement for medical (acute inpatient medicine and emergency services) and ancillary (pharmacy first-fills and laboratory) and support of veterans enrolled at the CBOC Bremerton.

Chapter 15: Research and Academic Affiliations

Contributions to American Health Care

The primary VHA mission is serving the health care needs of the nation's veterans. But VHA has three other statutory missions—medical education, research, and serving in a contingency backup role to the Department of Defense (DoD), coupled with supporting Homeland Security.

The VA was authorized in the post-World War II era to implement involvement in research and medical education in order to attract talented, young medical professionals into the VA system. The arrangement has paid tremendous dividends. Not only has the VA had the benefit of highly skilled medical staff, but also the ''side benefit'' contributions to the nation at large in research and education have been tremendous.

VA research has produced an array of remarkable medical advances over the years, from the pioneer kidney and liver transplants, and the scientific basis for CT scanning, to more recent, groundbreaking therapies for many types of mental illness. Seventy percent of physicians now practicing in the nation have had some portion of their training in the VA system. The VA health care system also plays a substantial training role throughout the allied health professions.

VA's contingency roles are also of vital importance, both in support of DoD and the Public Health Service during times of disaster or national emergency. Moreover, the VA is one of the nation's principal assets for responding with medical assistance in large-scale national emergencies as part of the Homeland Security network.

This Chapter highlights the following:

- VA Research
- VA's Academic Affiliations
- Relationship of these missions to CARES

Research

VA's research program is one of the largest and most productive in the nation. The Office of Research and Development oversees VA's research in biomedicine, rehabilitation, health services and cooperative studies. With an annual budget of nearly $400 million and total research dollars of more than $1 billion, VA research funds more than 5,200 investigators at 113 VA facilities across the country. VA-based investigators are currently conducting more than 17,000 active research projects designed to enhance the health care VHA provides to veterans. Each of the divisions has particular areas of expertise, but the divisions also increasingly work across disciplinary boundaries to maintain focus on improving patient care. In addition, VA's research program seeks to translate knowledge gained through research into practice by ensuring that new information is quickly made available to those who deliver care. Moreover, VHA clinician-investigators provide high quality care to veterans, who, as a result, have access to experimental drugs and protocols before these ''cutting-edge'' treatments are available in private or community hospitals.

CARES and Research

Research is considered a CARES non-clinical service in that it does not generate patient workload directly. As such, workload criteria are not appropriate measures of need. To determine the space needed at each facility to support its research program, CARES developed a measure that assigns a dollar value to each square foot of research space, equaling $150 research dollars per square foot. This ratio was derived from dividing the total VHA research dollars in FY2001 by the total square footage of research space in the same year. This ratio is applied to the projected research funding at each facility to determine space needs in the future.

The National CARES Plan contains more than 20 research leases, new construction, and enhanced use (EU) lease proposals that address one or more of the following situations:

- Space available at VA facilities does not meet VA criteria and is far enough under criteria to warrant replacement rather than renovation;
- Future projections indicate a need for a significant amount of additional research space—exceeding the amount locally available;
- Community and/or affiliate partnering is proposed to provide and/or share research space.

When research space is slated to decrease in the future, the space is vacated and either made available for other uses or held in reserve. A number of market plans expect a positive impact on research from planning initiatives that expand in-house inpatient and outpatient services; in several situations, research space will be increased through reallocating existing facility space.

Capital costs for research are not included in other cost estimates in the National CARES Plan because research does not generate patient workload directly. Research is a critical part of the VA mission, however, and a summary of capital improvement costs from the VISN Market Plans is presented in Table 15.1.

TABLE 15.1.—SUMMARY OF CAPITAL INVESTMENTS FOR RESEARCH THROUGH FY 2022

Capital investment	Square feet	Total cost in current $
Renovate Existing Space	828,993	$87,077,891
New Construction	1,509,417	326,267,915
Lease (Build Out Costs)	986,464	55,210,164
Enhanced Use	350,400	0
Total		468,555,970

Academic Affiliations

VA is the largest single provider of health professional training in the world. Currently, 130 VHA facilities have affiliations with 107 of the nation's 126 medical schools and over 1,200 other educational institutions.[59] In FY2002, over 76,000 students received clinical training in VHA facilities. Through these partnerships, almost 28,000 medical residents and 16,000 medical students receive some of their training at VHA medical centers every year. Accounting for approximately nine percent of the Graduate Medical Education (GME) in the United States, VHA supports 8,800 physician resident positions in almost 2,000 residency programs accredited in the name of our

[59] Reference: VHA Directive 1400, July 31, 2002. Enabling legislation and basic authority for VHA's conduct of education and training programs are contained in Title 38 U.S. Code Chapters 73 and 81.

university partners[60]. VHA physician faculty members have joint appointments at the university and at VHA, participating in patient care at VHA facilities, supervising students and residents, and conducting research. VHA would have difficulty delivering high quality patient care without the physician staff and residents that are available through these affiliations. Moreover, residents provide much of the direct medical care, including ''24/7'' coverage of inpatient services, in those VA medical centers with housestaff. From an historical perspective, VHA's affiliations with the nation's medical schools dates from the drafting of Memorandum No. 2, initiated by General Omar Bradley in 1946.

CARES and Academic Affiliations

In general, the CARES Market Plan narratives indicate a preference for maintaining facility-based research programs and academic affiliations, citing the loss of affiliations as one potentially negative impact of contracting and/or inpatient and outpatient service reductions. Only one VISN cited the potential for new affiliations and research through contracting with community facilities.

In the past few years, a number of consolidations of affiliated VA medical centers have occurred with somewhat mixed results. In 2002, the follow-up report of a study of three integrations was published.[61] The ''lessons learned'' from the study of three VA systems with strong academic affiliations—*i.e.*, VA Chicago Health Care System, VA New York Harbor Healthcare System, and VA Boston Healthcare System—may be summarized as follows (from Section 5.2, ''Looking Forward,'' of the reference cited):

- Staff should to be prepared for a lengthy change and adjustment period that will result from the major organizational change involved in consolidations or integrations.
- Major reorganizations need to be carefully staged and synchronized in order to assure that infrastructure and physical space needs are prepared for the restructuring of clinical services.
- Although medical center integration is generally undertaken with an expectation of saving money, an initial need for capital investment is required. Buildings must be adapted to new (consolidated) uses, often having increased capacity from their prior status. The savings are to be realized from long-term operational efficiencies.
- Moreover, while the division of inpatient and outpatient care may make conceptual sense, a number of logistic problems are created and encountered—especially when the same staff must work at two divisions of a facility. Studies of patient flow patterns, of staff working relationships, and of transportation issues need to be dealt with in advance as part of the planning efforts.
- Shared leadership of education programs is difficult in practice. Recruitment of faculty (attending physicians) and especially of service line and/or section chiefs often becomes problematic.
- Early and on-going involvement of all affiliates is key in assuring a coordinated planning process. Similar academic standing of the involved affiliates may facilitate collaboration, and unequal standing tends to hinder productive interaction.
- VA's critical missions in research and education should be acknowledged and support of those missions seen as an explicit goal of any integration.

The above-cited study by Dr. Van Deusen Lukas *et al.* also pointed out that, with respect to the integration process.[62]

- All three systems studied reported some success in passing JCAHO review and in achieving operating efficiencies.
- Different approaches to clinical integration were noted in each of the examples. [The authors characterized these as ''wait and see'' (Chicago), ''targeted opportunities'' (New York Harbor), and ''full consolidation'' (Boston).
- Not surprisingly, Boston achieved the most progress, but also faced the greatest challenges in terms of transition issues, timing of moves and restructuring space needs, organizational issues, and external impacts (especially budgetary challenges and lack of initial funding for renovation construction projects).

The authors also noted that, from the standpoint of the academic missions involved, education was more affected than research during facility integrations. The impact on education was largely because of the service-based organization of clinical teaching, which, in the integrated facilities, required some division and/or sharing not only of teaching responsibilities but also of administration (*e.g.*, which affiliate recruits and hires the service chief, how residents are supervised and evaluated in a dual affiliation situation, and how faculty are appointed).

Summary and Conclusions

VA's missions in health professions' education and medical research continue to be strongly supported by the CARES process. Opportunities for enhancement of research space have been identified. With respect to education, research done by the HSR&D Management Decision and Research Center points out that tertiary facility consolidations and integrations may be successfully accomplished. However, the process is a complicated and difficult undertaking. Integration is subject to a number of key factors that require the on-going participation of the academic affiliates in the transition to an integrated facility management. Facility consolidations require an initial, up front capital investment to reconfigure space in order to achieve long-term operational efficiencies. The most successful examples are those in which the involved academic affiliates are active participants in the planning for the new organizational structures.

Please refer to Chapter 9, Proximity and Campus Realignments, for information on the proposed resolution of Proximity Planning Initiatives that may involve consolidation of services. As VA moves forward with the implementation process, recognition and continued attention to its academic mission (research and education) and partners (academic affiliates) will ensure a smoother transition in the proposed consolidations and the maintenance of high quality care to veterans.

Chapter 16: Staffing and Community Impact

Anticipating Impact Was Integral to Process

A salient feature of CARES was the ability to recognize and manage interrelated consequences of various planning solutions.

Consider, as an example, the dynamics for an Access Planning Initiative. When an access ''gap'' was discerned, other issues immediately came into play, including ''Partnering with DoD'' (to examine potential sharing of military ambulatory care services), ''Ensuring Inpatient Capacity'' (to evaluate referral patterns for any outpatient service solution), and ''Quality'' (which ultimately reviewed any arrangement to provide care.)

This capability is prominently applied in anticipating the impact of

[60] Office of Academic Affairs Web Site, Veterans Health Administration, Department of Veterans Affairs [*http://www.va.gov/oaa/default.asp*]

[61] Lukas C VD, Camberg L, Taneja LC, Integration of Affiliated VA Medical Centers: Second Report (June 2002; HSR&D Management Decision and Research Center, Boston). [*http://www.va.gov/resdev/prt/affiliated-integration-2.doc*]

[62] Lukas, *et al.*, Op. cit. ''Highlights.''

proposed changes in VHA's physical infrastructure and mix of services. In the development of solutions to planning initiatives, VISNs were asked to consider what effect, if any, the proposed solutions would have on staffing and the community. Information regarding the impact is contained in the narrative portion of proposed solutions within each Market Plan. This chapter summarizes those findings.

Staffing Adjustments

VISNs identified the potential impact of the planning initiative solutions on current and projected number of staff and defined the effects as significant increases, decreases, or minimal adjustments. The market plans described the VISN's strategies to mitigate the potential impact of staffing changes on current staff and to minimize downsizing and relocation problems. Plan explained how the network communicated the potential impact of the staffing changes to current employees.

Outpatient

Between the base year (2002) and 2022, projected demand for care increases significantly for two of the CARES categories—specialty care and primary care. Market plans describe how VISNs will need to plan for the recruitment and hiring of additional staff to care for the projected increased workload.

More VISNs identified planning initiatives for increased projected demand in specialty care than in any other capacity workload category. In response, 69 percent of the specialty care planning initiative solutions called for new staff. In seven percent of the solutions, staff would be reassigned and in two percent, markets recommend temporary staff. It was anticipated that recruiting will be a problem for markets with shortages of specialty care providers, especially in rural areas, or where salary caps limit VA's ability to compete with the community for specialists.

A large number of planning initiatives were also identified for primary care gaps due to projected increased demand. Of the 174 planning solutions, 64 percent contained statements supporting the need for additional staff to care for the projected increase in primary care workload. In nine percent of the solutions, markets would reassign staff, two percent would use temporary staff, and eight percent reported minimal or no impact on staffing. Recruiting primary care staff was cited as less of a problem than described for specialty care staff.

While fewer markets submitted planning initiative solutions for mental health, 68 percent of solutions reported the need for additional staff. Staffing needs may increase system-wide after mental health is studied in the next strategic planning cycle.

Inpatient

Network solutions to a projected decline in Inpatient workload for medicine and surgery were more likely to reassign staff to other programs. Reducing staff as a strategy was proposed in very few instances.

Community Impact

VISNs identified the potential impact of the planning initiative solutions on community, community health care delivery systems and employees. VISNs described their strategies to minimize any potential negative impact on the community health care delivery systems and economy. The plans also describe VISN strategies to communicate the potential impact on the community.

The majority of solutions proposed for the planning initiatives will have a positive impact on the community, especially the solutions for expanded and more accessible primary, specialty and mental health care. The solutions will improve veteran satisfaction, offer opportunities for more employment and employee relocation, revitalize community financial environments, improve continuity of services, and enhance community relations. Overall, in most cases, the planning solutions offer positive, beneficial changes to the community and community health care systems.

Fewer than ten of the solutions evoked potential negative community reaction. Negative comments were found in narratives for medicine, psychiatry, research, vacant space and ancillary diagnostics. Potential community concerns were more likely to be mentioned if jobs would be lost due to a facility closure or if the buildings targeted for demolition were on the National Historical Register. Projected loss of space and downsizing of inpatient programs may have a negative impact on the ability of VHA's research program to recruit and retain funded investigators and associated staff. Other concerns were the limited capacity to contract for specialists and mental health professionals in the community.

VISNs will continue to use many strategies to communicate and explain the planning initiative solutions and their impact on veterans, employees, stakeholders, and the community at large. Examples of communication methods are described in Chapter 3. The ultimate objective in this CARES area is to support the primary goal of enhancing health care services to veterans, within an environment that is comfortable with change.

Chapter 17: VA's Role in Support of the Department of Defense and in a Federal Response to Domestic Incidents

Less Visible, Extremely Important 4th Mission

In addition to caring for veterans, engaging in research and medical education, and operating the Veterans National Cemetery System, there is a fourth mission assigned to the Department of Veterans Affairs. That mission is to serve in a primary back up role to the Department of Defense Military Healthcare System (MHS) during war or national emergency, and also to assist other Federal agencies in providing medical and other services during natural disaster or terrorist attack.

While the CARES planning model cannot predict future conflicts or national emergencies, CARES planning guidance does require VHA to consider these responsibilities as decisions are made about the placement, size and scope of hospitals and clinics, and to ensure that decisions do not compromise emergency management and support functions.

Even before describing VHA's specific role in supporting DoD, this reassuring statement can be made: Planning initiatives developed in the Draft National CARES Plan did not pose significant downsizing of acute care beds in any VA facility designated to play a key (receiving center) role in the contingency support mission. This means, essentially, that no VA in-house space that might be required by DoD in this context is at risk because of CARES process decisions.

Preparing to meet VHA's fourth mission is an ongoing challenge. The principle risk for VHA is the ability to secure staff to meet emergency surge requirements to care for patients. VHA annually assesses the number of beds that could be available in 24, 48, and 72 hours. VHA also retains the authority to contract for care in times of emergency and has flexibility in using that authority. CARES addresses support to DoD in a couple of ways. First, CARES plans for an 85 percent occupancy rate when planning for space needs in its hospitals. This creates a 15 percent margin for surge space in the event of an emergency. In addition there is no significant downsizing of future beds in Primary Receiving Centers that would

place any in house space requirements at risk in the future. Second, VHA is constantly improving and testing the process by which facilities would make this surge space available in time of war or national emergency.

CARES Market Plans Impact on National Defense and Homeland Security

VISNs were required to discuss in their CARES Market Plans the impact of planning initiative solutions on the VA's fourth mission. They were asked to describe the strategy the VISN would use to meet a realistic estimate for DoD contingency needs and those contingency needs provided by VA's Emergency Management Strategic Health Care Groups. As indicated previously, the overwhelming majority of planning initiative solutions, and other bed gap solutions, had either no impact or a positive impact on support to DoD contingency needs. The potential positive impact is a result of the expected improvement in the acute inpatient infrastructure that will ensure that VA's facilities are available to meet any contingency needs and the overall expansion in space proposed in the plan.

Potential negative impact from planning initiative solutions are anticipated in the following areas:

Contracting Services in the Community

VISNs that proposed planning initiative solutions involving significant community contracts had different views on the impact on DoD contingency planning. Most did view contracting as eliminating the medical center's contingency support capacity, and proposed working with DoD to find ways of ensuring preparedness in the future or including national emergency provisions in contracts. However, a few facilities saw expansion of contract services as a chance to develop a closer relationship with community hospitals that could support disaster preparedness in the future. A few facilities felt the delivery of mental health services dealing with PTSD and potential outcomes in the event of a conflict, would be better delivered by VA than through community providers due to expertise in these areas.

Small Facilities

Facilities with fewer than 40 acute beds, which the Draft National CARES Plan recommended should eliminate acute beds or change to a Critical Access Hospital (CAH) designation, will no longer be a resource for hospital beds in the event of military action or national emergency. A list of these facilities can be found in Chapter 8, ''Strategic Direction of Small Facilities.'' The extent that these small facilities would be used in the event of a conflict would determine the extent of the impact on DoD contingency planning. However, none of these small facilities is currently designated as a Primary Receiving Center.[63]

Consolidations and Realignments (Proximity)

Facilities proposed for closure as part of the solution of a Proximity Planning Initiative can be found in Chapter 9, ''Proximity and Campus Realignments.'' Closures will not have an impact on DoD contingency planning in those markets.

Out Leasing

VISNs which lease space to the National Guard or other agencies involved with national defense were reluctant to terminate the leases to gain space back for patient care services. In many cases, the leases were retained and other alternatives for space expansion at the facility were proposed.

Staffing

Although VISN CARES Market Plans include infrastructure or service expansions at many facilities that support VHA's emergency response role, the ability to acquire emergency staffing to provide the additional care is an issue not addressed in this cycle of CARES.

Chapter 18: Optimizing Use of Resources

Optimize Resources To Meet Needs

A brief review of the titles of preceding chapters in this CARES Plan brings into focus the complexity of realigning the capital assets of a health care system, and the inter-related nature of CARES components.

For example, there are multiple, overlapping considerations in planning to improve access, enhance ambulatory care, ensure the availability of inpatient services, and protect special disability programs. These elements of the CARES process are interwoven, influencing each other as well as the central issue of quality in caring for veterans. The inherent linkage of CARES elements further extends to avoiding duplicative facilities, supporting research and medical education, reducing vacant space, and virtually every other component discussed in the plan.

With all of these items simultaneously in play during the CARES process, with dynamic adjustments being made to maximize beneficial effects and minimize negative impact on other components, it was prudent to apply a unifying filter at the end of the process. This took the form of a review to ensure that CARES-driven actions would optimize the use of limited resources, while meeting future changes in workload demand. This chapter describes the ''resource optimization'' review and provides a summary assessment of how resources were optimized in the CARES process.

Managing Workload Economically

One criteria used in the development of CARES Market Plans was a consideration of the most economical method for managing workload through in-house, contract, joint ventures or sharing and the most economical way to manage the space for in-house workload through renovation, new construction, conversion of vacant space or enhanced use. Operating costs of underutilized and vacant space were to be reduced. One of the driving forces behind CARES was a General Accounting Office report indicating that VHA expends as much as $1 million a day on underused or inefficient capital infrastructure.[64]

Workload Demand

Table 18.1 shows the national projected changes in workload demand by CARES Category. Except for inpatient surgery, workload is increasing over the 20 years of the CARES planning horizon. The draft National CARES Plan describes how the increase in workload will be managed, focusing on the space and capital requirements through FY 2022.

[63] A List of DoD Primary Receiving Centers can be found under References or at *www.va.gov/emshg*.

[64] GAO Report available under References.

TABLE 18.1.—CHANGE IN NATIONAL WORKLOAD DEMAND 2001 THROUGH 2022 IN BED DAYS OF CARE AND VISITS

Planning category	FY 2001 workload	FY 2012		FY 2022	
		Total demand	% change	Total demand	% change
Primary Care (Visits)	12,972,821	20,451,216	58	17,211,299	33
Specialty Care (Visits)	10,950,477	22,112,050	102	19,657,531	80
Mental Health (Visits)	7,621,946	10,091,975	32	9,310,644	22
Ancillary/Diagnostic (Visits)	14,756,388	25,952,483	76	24,260,090	64
Medicine (BDOC)	1,794,836	2,533,902	41	2,036,878	13
Surgery (BDOC)	821,656	949,937	16	764,596	–7
Psychiatry (BDOC)	1,599,750	2,130,950	33	1,819,064	14

Costs To Implement CARES Market Plans

Cost Minimization in Managing Workload

Planning guidance encouraged the VISNs to select the most viable options for meeting projected care demands. For managing workload, this was accomplished by selecting one of the following options: in-house, contracting, sharing and joint ventures, or a combination of these options. VISNs were provided through the IBM Market Template with a systematic tool to evaluate the costs of the options.

Initially, for CARES planning purposes, in-house workload costs were assumed to be equal to unit costs obtained from VHA's Decision Support System (DSS) database for each facility. During the review process, the methodology for measuring in-house costs was improved to allow for marginal costs to be used for marginal gaps in workload. Contracting costs were set equal to Medicare (provider and facility) costs in each county and were provided by CACI/Milliman (Appendix O).

A basic assumption of the CARES planning model was that the cost of additional workload performed in-house would be equal to the associated DSS unit, variable, and indirect fixed costs, as appropriate, multiplied by the additional workload units. If workload was moved between facilities, savings at the transferring facility were calculated on the basis of these costs. Additional costs at the receiving facility were calculated using the same costing rules with the receiving facility's unit costs. There were no economies of scale assumed in the model. Any efficiencies resulting from reallocation of workload had to be estimated and entered into the model by the VISNs.

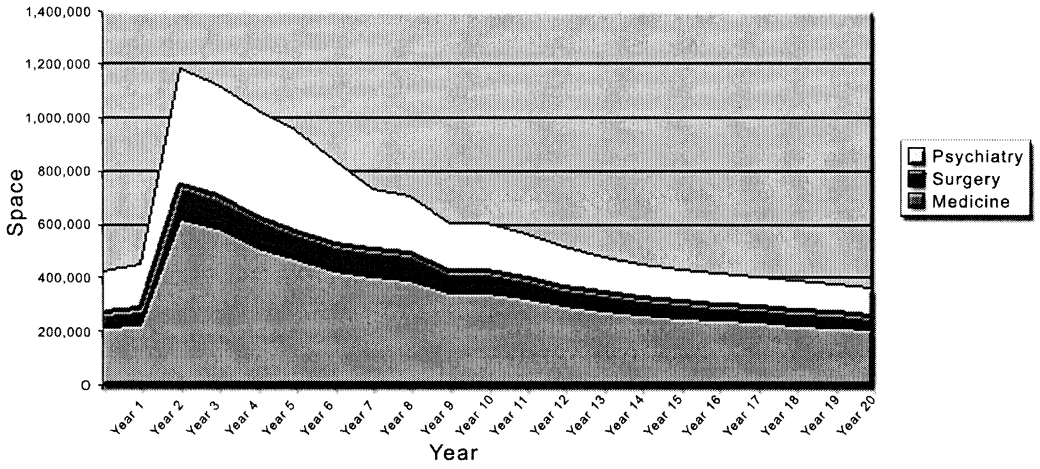
Analysis of the cost of alternative options for the Planning Initiatives indicates that 60 percent of the options selected were the lower cost option. However, the cost of alternative options was based upon unit costing this will change when VISNs have the opportunity to re-evaluate their selections prior to final approval of the plan.

Flexibility

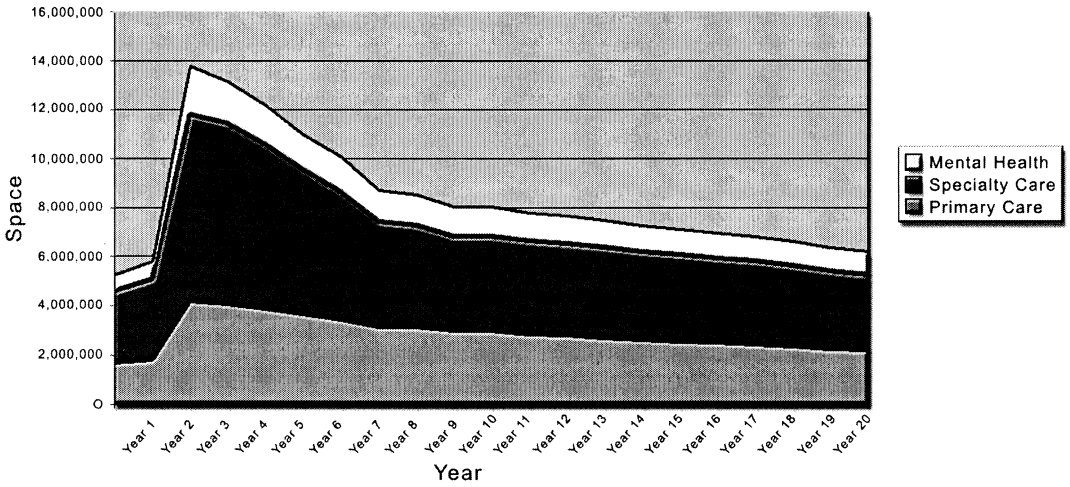
Utilization of resources is optimized when flexibility is maintained in the face of peak workload and variable workload. VISNs smoothed out variation in in-house workloads to avoid unnecessary fixed construction costs by the use of contracts. In general, VISN CARES Market Plans reflect increased utilization of contract care during periods of peak demand. The amount of care that would be contracted would then decline as workload fell to the point at which the VISNs were able to accommodate demand within their existing infrastructure. This is reflected in the two graphs below.

Figure 18.1 Forecasted Contract Workload FY 2002

Amount of Inpatient Care Contracted



Amount of Outpatient Care Contracted



Managing Space

Planning guidance encouraged the VISNs to select the most viable options for meeting space needs as projected by in-house workload demands. For managing space, this was accomplished by selecting one of the following options: new construction, leased space, conversion of vacant space, enhanced use and donated space or a combination of options. Existing space could be renovated to improve quality or functionality, but renovation alone could not expand the space.

Cost estimates for construction, renovation, demolition and lease were provided by VHA's Office of Facilities Management Professional Estimators. These regionally adjusted construction and lease costs were based on the condition and type of space to be renovated, the type of space to be constructed, the type of new construction or the type of space to be leased.

VISNS considered how they would meet the space needs associated with their planning initiatives, increasing workload and environment of care concerns. Market Plan solutions included acquisition of additional space, and improvement of existing space, through new construction, leasing, renovation, and enhanced use development.

Chapter 11 describes in detail the cost-effective solutions VISN developed to manage projected space needs.

Non-Recurring Costs to Manage Space

Based on the preferred space solutions selected by the VISNs for meeting in-house workload demand, Table 18.2 reflects a potential capital cost for the non-flatlined, clinical CARES Categories. These costs include new construction, renovation and build out costs for leases. This does not include recurring costs for leases.

TABLE 18.2.—TOTAL CAPITAL COSTS BY CLINICAL CARES CATEGORIES THROUGH 2012 IN CURRENT DOLLARS

CARES category	Capital costs in current $
Medicine	222,693,711
Ancillary/Diagnostic	678,354,996
Mental Health	264,906,059
Specialty Care	1,253,538,192
Primary Care	460,512,706
Psychiatry	221,496,568
Surgery	75,776,725
Total	3,177,278,957

Note: Costs in Table 18.2 include only the seven core clinical CARES categories, and therefore are a sub-set of the total capital estimates in Table 1.1.

VISN's tended to use lease space to accommodate in-house workload during periods of peak demand and new construction and conversion of space for sustained increases as shown in the chart below.

TABLE 18.3.—LEASED SPACE THROUGH 2012

CARES category	Leased space in square feet
Medicine	177,381
Ancillary/Diagnostic	1,437,653
Mental Health	855,596
Specialty Care	3,606,576
Primary Care	2,536,801
Psychiatry	97,740
Surgery	25,300
National totals	8,737,047

Vacant/Underutilized Space Savings

Implementation of the VISN CARES Market Plans would reduce the amount of vacant/underutilized space by 42 percent, from 8,571,605 square feet in FY 2001 to 4,934,002 square feet in FY 2022. Vacant space totals do not include space that is out-leased to third parties.

TABLE 18.4.—REDUCTIONS IN VACANT/UNDERUTILIZED SPACE IN SQUARE FEET

	FY 2001	FY 2022
Total Space	93,949,947	118,156,557
Vacant Space	8,571,605	4,934,002
% Vacant	9	4

Recurring cost associated with remaining vacant/underutilized space is estimated at $167,553 daily.[65]

Savings associated with the reduction in vacant space are shown below. The reduction in vacant space described in Table 18.5 represents a minimum reduction since it does not include reductions in vacant space that will occur due to realignments of campuses and reuse of the campus through enhanced use leasing.

TABLE 18.5.—RECURRING COST OF VACANT/UNDERUTILIZED SPACE THROUGH 2022

[Costs are in current dollars]

	FY 2001	FY 2022	Difference
Vacant/Underutilized Space in Square Feet (SF)	8,571,605 SF	4,934,002 SF	3,637,603 SF
Average Cost/SF to Maintain Current $[66]	$12.39 per SF.	$12.39 per SF.	
Annual Cost ($ per year)	$106,245,044	$61,156,955	$45,088,089
Other Savings/Profits/Costs ($ per year)*	.....	$15,493,381	
Revised Annual Costs ($ per year)	$106,245,044	$45,663,574	$60,581,470
Cost per Day ($ per day)	$291,082	$125,105	$165,977

[66] Cost provided by Professional Estimator in VHA Office of Facilities Management.

Note: *Other Savings/Profits/Costs related to the management of vacant space include such things as revenues from enhanced use lease initiatives, non-unit costs savings from building demolition, or revenues from sale of property. VISNs did not have a standardized way to enter these cost estimates so this dollar figure is not all inclusive of the potential savings from the management of vacant space.

Other Economic/Financial Considerations

A number of economic and financial considerations influenced a VISN's selection of how they would manage their future needs. Some of these considerations included:

- Feasibility of contracting in the community for services at Medicare rates;
- Projected availability of services in the community;
- Savings and efficiencies as a result of shifting services among sites;
- Efficiencies resulting from enhanced productivity by providing additional facilities, such as additional exam rooms for medical providers;
- Efficiencies resulting from joint ventures with affiliates and DoD through shared capital; and
- Revenues from enhanced use and shared services with affiliates, DoD and other entities.

Although 60 percent of the solutions selected by VISNs were the lower cost alternatives, in 40 percent of the solutions a VISN appeared to choose the more expensive alternative for solving a planning initiative or closing a capacity gap. Many times the least expensive alternative was not feasible or preferred for the reasons described above. In other cases, access and quality considerations prevented the VISN from choosing what appeared to be the least expensive alternative. In each case where VISNs did not choose the least expensive alternative, they provided rationales in their narratives on cost savings and optimizing resources.

While in many cases VISNs were able to develop cost estimates of the factors described above that would make one alternative more costly than another and incorporate them into their decision-making, many times these factors were difficult to estimate. Factors such as the availability of contract services in a community were difficult to quantify in the IBM planning software, and decisions to choose a more costly alternative were explained in the narrative portion of their market plans. More extensive analyses will take place as the CARES plans are implemented and these estimates will be improved.

Chapter 19: Extended Care Improvements

Thanks to ''Greatest Generation,'' Destiny of Leadership & Innovation

Demographics, prominently including what has been called America's ''Greatest Generation,'' made VA's destiny as a world leader in geriatrics and extended care inescapable; the high cost and limited quality of life inherent in institutional nursing home care made an innovative approach to this responsibility inevitable.

The projected peak in the number of elderly veterans (most of whom served during World War II) will occur during the first decade of this century, approximately 20 years in advance of that occurrence (peak number of older citizens) in the general U.S. population. VA health care therefore has been at the forefront of caring for older patients, identifying and developing treatments for age-related conditions, and studying the aging process itself. The number of Veterans over 85 years of age triples from 380,000 today to 1.2 million by 2010.

Just over two decades ago, forecasts concerning the growing number of older veterans first caused political leaders and medical planners alike to look ahead to the year 2000 with trepidation.[67] With the number of veterans age 75 and older expected to exceed three million by the Millennium, there was growing anxiety about VA's ability to increase nursing home capacity sufficiently to accommodate eligible veterans. In response to these concerns, VA began developing innovative approaches to providing extended care. The Millennium has come and gone, and at the time this CARES Plan was published, the number of veterans age 75 and older had just exceeded 4 million. VA extended care workload data indicate that the nursing home care program has been strained, but it has not collapsed; veterans' needs have been met in traditional settings—in VA's three nursing home programs (VA, contract community, and State Home), and in increasingly innovative, non-institutional settings.

National CARES Forecasts for Nursing Home Care

Today, eligibility for nursing home care is prescribed by statute and is increasingly reserved by policy for the highest priority veterans. The Millennium Health Care and Benefits Act for Veterans, passed into law in 1999, defines eligibility for long-term care and provides for a continuum of non-institutional extended care as part of the basic benefits package for VA enrollees.

One of VHA's strategic objectives in extended care is to provide treatment in the least restrictive setting. Further, VA is exploring ways to avoid institutionalization, by supporting successful aging in Veterans own homes and communities. VHA nursing home programs provide post-acute rehabilitation enabling veterans to return to the community and home. Rehabilitation programs are more costly than community based nursing homes but increase the efficiency of acute care programs by permitting timely and safe discharge after acute care. Rehabilitation programs provide a critical step in the continuum of care that can ultimately result in a veteran being able to return to their home environment. In addition, there is long-term nursing home care that is maintenance-oriented, typically

[67] *The Aging Veteran: Present and Future Medical Needs;* VA Response to PL 94–581, Section 117(a), March, 1980., p. II.

prescribed when the veteran can no longer remain in the community or home. However, nursing home care is not only costly, it can impair family relationships and reduce the overall quality of life. As a result, the population requiring nursing home care must be carefully selected after other alternative delivery settings are ruled out. Technology and skills exist in today's health care delivery system to meet a substantial portion of extended care needs in non-institutional settings.

VHA encourages the use of non-institutional extended care services such as Adult Day Health Care, Assisted Living and other home care alternatives in all circumstances other than those in which institutionalization is unavoidable.

Forecasting Model Requires Revision, But Space Conditions Addressed

The current nursing home model does not adequately address the following important considerations:

1. How will improvements in the health status of the elderly impact long-term care?

2. How will trends in the use of alternatives to Nursing Home care impact-projected demand for Nursing Home care?

3. How can the use of home health care be substituted for institutional care?

The model is being revised to provide improved projections for the next strategic planning cycle that will remove the bias towards the use of nursing home care over non-institutional alternatives. Since the model could not adequately reflect current and emerging practices in extended care, no planning initiatives were developed based on future workload gaps identified in this program area.

Although planning initiatives were not identified for Nursing Homes, VISNs were encouraged to submit capital investment proposals in their CARES Market Plans to address poor space conditions. While this chapter only discusses VA capital improvements, the overall supply of nursing home beds will be addressed during the next strategic planning cycle, so State Veterans Nursing Home beds and community nursing home beds will be included.

Nursing Home Capital Improvements

Capital improvements submitted by VISNs in their CARES Market Plans to remedy space deficiencies are summarized in Table 19.1. While investments will not be submitted for implementation until bed need forecasts are available, the following table provides information regarding the current assessment of space needs and their resolution.

CARES planning guidance recommended that space with a Condition Score less than 3.0 be considered for renovation. Condition Scores were derived from the Space and Functional Surveys conducted at each VHA facility during the baseline data collection phase of CARES (Appendix O). The surveys quantify the general condition and functionality of the space, resulting in a combined weighted average Condition Score for layout, code compliance, handicap accessibility, and patient privacy. Scores range from a high quality score of 5.0 to a low quality score of 1.0. The majority of Intermediate/Nursing Home Care capital investments in the CARES Market Plans are proposed based on low Condition Scores.

TABLE 19.1—SUMMARY NURSING HOME CARE INVESTMENTS FY 2002–FY 2022

Type of investment	Number of facilities	Activation years	Square footage	Total cost in current $
New Construction	12	2004–2012	854,267	191,595,461
Convert Vacant Space	1	2003	15,100	1,933,361
Renovations	24	2005–2016	747,548	57,391,534
Enhanced Use Lease	1	2004	95,000	(*)
Total	38	2003–2016	1,711,915	250,920,356

* Not Available.

New Construction

New construction nursing home investments are proposed at the following facilities:

VISN 03—St. Albans
VISN 03—Castle Point
VISN 05—Perry Point
VISN 06—Beckley
VISN 10—Cleveland-Wade Park
VISN 19—Denver
VISN 20—American Lake
VISN 20—Walla Walla [68]
VISN 21—Menlo Park
VISN 22—Las Vegas
VISN 22—West Los Angeles
VISN 23—Des Moines

The majority of the new construction proposed replaces existing nursing home beds at facilities with low Condition Scores where complete replacement was less costly than renovation.

Renovation of Current Space

Of the 24 facilities with nursing home renovation improvements submitted in the VISN CARES Market Plans, nine currently have Condition Scores below 3.0 (renovation recommended), six facilities have Condition Scores between 3.0 and 4.0 and nine have Condition Scores greater than 4.0. Renovations of space with scores greater than 3.0 include seismic corrections and changes in functionality of existing space for a new or growing program. Programs for specialized geriatric psychiatric care, such as Alzheimer's Units, often require adaptation to the normal nursing home care setting.

Enhanced Use Lease

One enhanced use lease proposal is included in VISN 11 for replacement nursing home beds at Illiana HCS (Danville), due to poor quality space.

Convert Vacant Space

VAMC Clarksburg in VISN 4 has recently converted most of its vacant space for additional nursing home capacity.

Chapter 20: The Future

Conversion to Systematic Pursuit of Improvement

Continuous improvement is basic to the philosophy of virtually every quality management program, a regular tenet of best business practices, and—in fact—the final step in the CARES process. From the outset, it was envisioned that CARES planning procedures would be

[68] Under review for realignment.

incorporated into the systematic program of ongoing strategic planning activities, conducted in regular cycles to continuously improve the placement and configuration of capital assets in the VA health care system.

This chapter of the plan explains how CARES will be integrated into the new VHA strategic planning process, and how the CARES capital agenda ultimately will be completed. Implementation of the capital requirements of CARES into the VA capital planning process is also described.

Completing The Agenda

While the projections for the majority of clinical programs and associated capital needs were studied in Phase II, some categories assumed a current workload due to required improvements in the projection methodologies. Their capital needs and services will be studied between the publication date of this plan, and April 2004 (VHA strategic plan due date) for mental health, domiciliary, long term psychiatry, and nursing home care.

In September 2003, the CACI/Milliman enrollment projection FY 2004 model will be run to provide the framework to complete the postponed topics. The September model results will be closely integrated with the Secretary's Enrollment Level Decision model run in July as part of the preparation of the FY 2005 budget that will be sent to Congress in February 2004.

Integration of the CARES Process Into VHA Strategic Planning

The CARES planning process and VHA's strategic planning process under the Office of Policy and Planning (OPP) currently function programmatically as two separate planning processes.

CARES was established as a separate activity outside the Office of Policy and Planning's strategic planning process when it was a contracted study for the VISN 12 pilot. The National CARES Program Office was formed to begin Phase 2 in December 2001 under the direction of the Deputy Secretary for the Department of Veteran Affairs, although organizationally staff resided in VHA. While the CARES program utilized the Enrollment Level Decision Analysis (ELDA) model, the model had not been used for strategic planning. The adaptation to CARES required different planning assumptions based upon a 20-year time horizon as contrasted with the shorter run budget planning time horizon. The assumptions differed in part because the short-term market share growth projected under the enrollment model was not sustainable for the long-range projections under CARES. Many other forecasting issues were identified as a result of the forecasts utilized at a local market area instead of a national level. A separate CARES contract was developed that was jointly developed by NCPO and OPP. The next contract with Milliman for enrollment projections will incorporate budget and strategic planning assumptions and requirements into a single contract, unifying the long term CARES modeling with short term planning activities.

The National CARES Program Office collaborated with the Office of Policy and Planning for other planning functions. OPP's Planning System's Support Group (PSSG) piloted the CARES travel time access methodology and assisted in the development of the Market Area maps. In addition, the VA Long Term Care Model resides in OPP and is managed by the PSSG. The OPP, CARES, and Geriatrics and Extended Care Strategic Healthcare Group formed a team to revise the long-term care model to respond to the Secretary's revisions to the long-term care policy. Teamed with VA's Office of the Actuary, VA and non-VA researchers are revising the Nursing home bed and alternatives forecasting model as described in the Nursing Home Chapter.

The Under Secretary for Health asked the National Leadership Board's Strategic Planning Committee to determine how CARES planning should be integrated into the VA/VHA strategic planning process, including which data sets and assumptions will be used as a basis for planning, and how timelines for the process will be incorporated into the VHA strategic planning cycle. Representatives from key offices associated with CARES and strategic planning participated in discussions to develop recommendations to integrate the planning processes.

The National Leadership Board recommended strategic planning and CARES should become an integrated process under OPP and use the same projected enrollment database by July 2004. The term, CARES, will no longer be used after this current plan is completed. The first step will be the integration of the future planning activities into the strategic planning guidance.

Integrating the strategic planning process under one office provide more consistent and coordinated guidance to VHA program and field office planning efforts. The CARES planning data, assumptions, processes, and timelines will reconcile with other existing strategic planning activities of the Administration and activities required by Congress and OMB.

Capital Prioritization Process

The plan approved by the Secretary will be the source of capital projects that are incorporated into VA's 5-year capital plan. Specific projects submitted by VISNs will be prioritized annually using criteria integrated with the CARES planning criteria and other Departmental and Presidential priorities.

Implementation

There are aspects of the plan that can be implemented without capital investments after the Secretary's approval. They are primarily the result of service consolidations, campus realignments and the changes in the acute mission of small facilities. After the national Cares Plan is approved, detailed planning to determine the final feasibility of these realignments will be incorporated into the VHA strategic planning process.

Appendix A—VISN Market Plan Executive Summaries

VISN 1 Executive Summary

Access

Primary Care—The draft National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time.

Hospital Care—Access in the North and Far North markets is being met through community contracts. In addition, telemedicine and telecare programs will be used across the network to improve quality and access for primary care and specialty care. The Maine Telemedicine program for the private sector will be used to provide cost effective care to the Maine veterans in collaboration with the VA.

Campus Realignment/Consolidation of Services

Bedford—Outpatient services will be maintained at the Bedford campus. Current services of inpatient psychiatry, domiciliary, nursing home and other workload) from the Bedford campus will be transferred to Brockton, West-Roxbury and other appropriate campuses (Manchester). The remainder of the Bedford campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

Jamaica Plains—Study the feasibility of redesigning the Jamaica Plains campus to consolidate services into buildings for operational savings and to maximize the enhanced use lease potential of the campus for assisted living or other compatible types

of use. Retain multi-disciplinary outpatient clinic.

Outpatient Services

Primary Care—Increasing primary care demand in the Far North, East and West markets is being met primarily through community contracts, telemedicine, and expansion of existing CBOCs. Some in-house expansion is planned for Brockton, Togus and Newington. Excess outpatient demand from West Roxbury and from the Causeway Clinic will be moved to Jamaica Plains.

Mental Health—Increasing demand for mental health in the Far North and North markets is being met through community contracts, telemedicine, and expansion of existing CBOCs that will include mental health services.

Specialty Care—Increasing specialty care demand in all four markets is being met using community contracts to the extent feasible, telemedicine, shifting selected services to CBOCs and in-house expansion through significant new construction and conversion of vacant space. Northampton will lease 50,000 sq.ft. in the Springfield area. West Roxbury and Providence have replacement operating room projects in their specialty care expansions.

Inpatient Services

Medicine—Increasing inpatient medicine demand and access gaps in the Far North and North markets is being met through community contracts, also needed to resolve access gaps. Increasing inpatient medicine demand in the East and West markets is being met through in-house expansion at West Roxbury, Providence and West Haven.

Psychiatry—Decreasing inpatient psychiatry demand in the East market is being met through the consolidation of acute psychiatry at Bedford, Brockton and Providence.

Vacant Space

VISN 1 will have total of 255,829 sq. ft. of vacant space in 2022. This represents a reduction of 51.4% from 2001 (526,674 sq. ft.).

Extended Care

Proposed capital investments to remedy space deficiencies in nursing homes include renovation of 51,289 existing sq. ft in the West market (Northampton & West Haven) and the renovation of 43,017 sq. ft in the Far North market (Togus).

Collaboration

VBA—Relocate the VARO from Hartford to Newington.

Facility Condition—Low facility condition scores (scores below 3.0) at many VISN 1 facilities have been addressed through renovation projects that are phased early in the plan due to immediate infrastructure needs, many of which have been on hold pending CARES. No space is being renovated that will not be needed through the year 2022.

VISN 2 Executive Summary

Campus Realignment/Consolidation of Services

Canandaigua—Current services of acute inpatient psychiatry, nursing home, domiciliary and residential rehabilitation services at Canandaigua will be transferred to other VAMCs within the VISN. Outpatient services will be provided in Canandaigua's market. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

Outpatient Services

Primary Care—Increased primary care outpatient services has been identified in the Finger Lakes/Southern Tier market. There is a significant increase in primary care workload, especially in Monroe County. The VISN proposes to utilize contractual services in close proximity to the patients' homes to address increased outpatient primary care demand.

Specialty Care—Increasing specialty care outpatient services has been identified in three markets (all but the Western market). The VISN is proposing a combination of approaches tailored to the individual needs of each market. These approaches include utilizing fee basis; contracting for services in the counties where the patient lives; maintaining existing current workload at the existing medical center and existing CBOCs and renovating CBOC space.

Inpatient Services

Medicine—Increased inpatient medicine services are projected for both the Central and the Finger Lakes/Southern Tier markets. The VISN proposes to move workload from the Western or Central market to the Finger Lakes & Southern Tier market and utilize contracting for services in the counties where the patient resides. This includes utilizing fee basis and contracts for inpatient medicine services. Additional contract services will need to be established for the increased projected workload especially in the Monroe County area. Projected increase at Bath can be handled in the current space.

Vacant Space

VISN 2 will have total of 182,950 sq. ft. of vacant space in 2022. This represents a reduction of 15.9% from 2001 total vacant space (217,546 sq. ft.).

Special Populations

Build a new 30 bed SCI/D Unit at the Syracuse VAMC.

Inpatient Services

Medicine—Increased inpatient medicine services has been identified for both the Central and the Finger Lakes/Southern Tier markets. The VISN proposes to move workload from the Western or Central market to the Finger Lakes & Southern Tier market to utilize contracting for services in the counties where the patient resides. This includes utilizing fee basis and contracts for inpatient medicine services. Additional contract services will need to be established for the increased projected workload, especially in the Monroe County area. Projected increase at Bath can be handled in the current space.

Enhanced Use

The VISN has identified the Buffalo VAMC and the Canandaigua VAMC as having potential Enhanced Use opportunities.

VISN 3 Executive Summary

Campus Realignment/Consolidation of Services/Small Facilities

St. Albans—Build new facilities for outpatient, nursing home and domiciliary care. Demolish old facilities and design new construction on site to maximize the area for an enhanced use lease project such as assisted living facility, or other compatible uses to benefit veterans. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

Lyons—Lyons maintains its current services because of lack of nursing home space and psychiatric space at East Orange and legislative requirements to maintain in-house nursing home units preclude any changes.

Montrose—Current services of domiciliary beds and all other inpatient units including psychiatry, medicine and nursing home will be transferred to Castle Point. Maintain outpatient services on the Montrose campus at a location that maximizes the enhanced use lease potential of the site. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

Castle Point—Current inpatient services will be transferred from Montrose to Castle Point. The Spinal Cord Injury (SCI) Unit would be relocated to the Bronx. Castle Point Campus will maintain an SCI outpatient unit. Castle Point will convert to a Critical Access Hospital based.

New York (Manhattan) and Brooklyn—Develop a plan to consider the feasibility of consolidating acute inpatient care at the Brooklyn and incorporate the proposed outpatient care improvements for Brooklyn in the current plan. Maintain a significant outpatient primary and specialty care presence in Manhattan at the current site or another appropriate location in Manhattan.

Outpatient Services

Primary Care—Increased primary care outpatient demand has been identified in all three of the Network's markets. The VISN proposes to meet the majority of this need through expansion of in-house space via new construction (138,000 sq. ft.), conversion of vacant space (70,000 sq. ft.) and utilization of community contracts. A new joint VA/DoD CBOC is proposed for Ft. Monmouth, NJ. A new CBOC for Passaic County, NJ is included in the plan but is not in the high implementation priority group.

Specialty Care—All three of the Network's markets are projected to experience increased outpatient specialty care demand. The VISN proposes to meet the majority of this need through the expansion of in-house services with new construction (457,000 sq. ft.),

vacant space conversion (114,000 sq. ft.) and some utilization of community contracts.

Inpatient Services

Medicine—Decreasing demand identified in the Metro New York market will be absorbed at the Brooklyn and New York campuses with some contracting in the community. Increasing demand projected for the New Jersey market will be accommodated in-house through new construction (50,000 sq. ft.) and conversion of vacant space (77,200 sq. ft.).

Psychiatry—Decreasing demand identified in the Metro New York market will be absorbed at the Brooklyn and New York campuses. Increasing demand projected for the New Jersey market will be met through the expansion of in-house services with new construction (107,000 sq. ft.) and the conversion of vacant space (129,000 sq. ft.).

Extended Care

Proposed capital investments for nursing home care to remedy space deficiencies include renovation of 19,533 existing sq. ft. in the VA New Jersey market (VA New Jersey HCS) and new construction of 150,000 sq. ft. in the VA Metro New York market (St. Albans & VA Hudson Valley HCS).

Vacant Space

VISN 3 will have a total of 469,844 sq.ft. of vacant space in 2022. This represents a reduction of 53.1% from 2001 total vacant space (1,001,997 sq.ft.).

Enhanced Use

The VISN proposes development of long-term leases of existing golf courses and associated buildings and pursuing public/private development of VA buildings and/or land for uses including senior housing, assisted living, and other similar life care. Any revenues will remain in the VISN to invest in services for veterans.

Collaboration

VBA—Collocate the Newark Regional Office into currently available VHA space at the Lyons Campus of the VA New Jersey Health Care System.

NCA—A feasibility study must be completed to evaluate any potential land impediments at the Castle Point and Montrose campuses of the VA Hudson Valley HCS for use by NCA. Both campuses have excess land that can be made available to NCA.

DoD—Opportunities currently under review include collocation of the Ainsworth Clinic with Brooklyn, establishment of a new CBOC at Ft. Monmouth, and development of shared services between West Point and Montrose.

Special Populations

The LTC Spinal Cord Injury (SCI) unit will be consolidated from Castle Point to the Bronx. SCI Unit at the East Orange Campus will remain. Outpatient SCI services will be maintained at Castle Point.

VISN 4 Executive Summary

Campus Realignment/Consolidation of Services

Highland Drive—Current services at Highland Drive will be transferred to University Drive and Aspinwall campuses, with new facilities for psychiatry, mental health, and related research and administrative services. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans. A major construction project to accommodate services at the University Drive and Aspinwall campuses is required.

Small Facility

Butler will maintain nursing home and outpatient services and close its hospital acute care services. Altoona will maintain outpatient services and close its hospital acute care services by 2012 as the need for acute care beds declines. Erie will maintain its current services except it will close its inpatient surgical services and retain outpatient surgery and observation beds. The inpatient demand from these programs will be referred to Pittsburgh or contracted out to the community.

Outpatient Services

Specialty care is increasing in demand for both markets and primary care in the eastern market. In-house expansion, contracting out, and enhanced use arrangements will handle the specialty care workload. Space for additional in-house specialty clinics will be achieved through increased use of CBOCs for primary care to free up specialty care space at VAMCs. These CBOCs are proposed but are not in the national high priority category.

Inpatient Services

Inpatient medicine demand is increasing in the Eastern market while inpatient surgery demand is decreasing in the Western market. The Eastern market increase will be managed by in-house expansion, contracting out, and enhanced use at all five hospital sites. The Pittsburgh HCS in the Western market will convert the decreasing surgery beds to medicine beds to absorb part of workload from Butler, Altoona and Erie.

Extended Care

Proposed capital investments for nursing home care to remedy space deficiencies are included for Altoona, Butler, Coatesville, Lebanon and Clarksburg.

Vacant Space

VISN 4 will have a total of 446,001 sq.ft. of vacant space in 2022. This represents an increase of 15% over 2001 total vacant space (387,373 sq.ft.). Further analysis is required in order to determine how this can be avoided through improved space planning.

Enhanced Use

Butler is exploring a number of potential enhanced use proposals. The proposals include: adult residential living program, 16-bed intermediate psychiatry facility, administrative space for DOD, and community diagnostic services center. In addition, the local community hospital (Butler Memorial) and Butler have explored enhanced use opportunities on the VA campus to expand specialty care. This innovative proposal would enhance services to veterans in the Butler area and could result in replacing older buildings with more state-of-the-art, energy efficient space.

Collaborations

Collaborative opportunities are being explored with the VBA in Pittsburgh and Wilkes-Barre.

VISN 5 Executive Summary

Consolidation of Services

Washington and Baltimore have consolidated a significant number of services and will continue to investigate clinical and administrative program efficiencies, *e.g.* radiation therapy, brachytherapy, warehouse functions.

Outpatient Services

Primary Care and Mental Health—Increasing primary care and mental health demand is being met in all three markets through a combination of in-house expansion, expansion of existing Community Based Outpatient Clinics (CBOCs) and the establishment of DoD joint ventures. Outpatient mental health is being integrated with primary care at all sites.

Specialty Care—Increasing specialty care demand at Martinsburg, Baltimore and Washington is being met using a combination of in-house expansion (new construction and leases), offering selected high volume specialty care services at larger CBOCs, and community contracts. Perry Point will use primarily community contracts for specialty care expansion.

Inpatient Services

Psychiatry—Decreasing inpatient psychiatry demand in the Baltimore market has been met through the downsizing of beds at Baltimore in FY2002. Increasing inpatient psychiatry demand in the Washington market is being met through a shift of beds from Perry Point to Washington with in-house space expansion.

Extended Care

Proposed capital investments for nursing home care units to remedy space deficiencies include the renovation of 18,000 existing sq. ft in the Martinsburg market (Martinsburg), the renovation of 22,208 existing sq. ft. in the Washington market (Washington) and new construction of 67,000 sq. ft. in the Baltimore market (Perry Point).

Mental Health—Some domiciliary beds are being shifted from Martinsburg to Washington to establish a domiciliary presence in DC area and to obviate the need for replacement of poor quality space at Martinsburg.

Vacant Space

VISN 5 will have a total of 127,310 sq.ft. of vacant space in 2022. This represents a reduction of 66.3% from 2001 total vacant space (377,381 sq.ft.).

Enhanced Use

Ft. Howard—An enhanced use lease has been approved for Ft. Howard that targets 297,613 sq. ft. to develop a retirement community for veterans and non-veterans. Revenues will remain in the VISN to invest in services for veterans.

Perry Point—While maintaining the current mission, redesign the campus to maximize the enhanced use lease potential of the campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans. The redesign of the campus should include the current proposed new nursing home, other required new buildings to consolidate services; and preservation of the historic sites: the Mansion, Grist Mill, and 5 acres of Indian burial grounds.

Collaboration

VBA—All three Compensated Work Therapy Programs (CWT) in VISN 5 are developing a contract (MOU) with their Regional Vocational Office to provide a service by which veterans enrolled in VR&E programming would be evaluated by the CWT program for Chapter 31 feasibility purposes.

DoD—DoD opportunities developed include: outpatient joint ventures in all three markets with Ft. Detrick, Ft. Meade and Ft. Belvoir; joint resident education program between Walter Reed AMC and VAMC Washington, targeted to expand VISN-wide and; the Armed Forces Retirement Home as a possible location for a new domiciliary presence in the DC area.

VISN 6 Executive Summary

Access

Primary Care—Increase primary care access points in two markets by adding nine (9) new CBOCs: six (6) in the Southwest market and three (3) in the Northeast market. The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, new access points in the Southeast and Northwest markets are not included in the National Plan, but they are not in the high priority implementation category.

Hospital Care—Increase the access for hospital care in the Southeast market by providing limited inpatient care at a DoD site located in the eastern part of the market that will enable this market to meet the hospital access guidelines.

Small Facility

Beckley, WV—Retain acute medicine beds. Convert their bed designation to Critical Access Hospital Beds. Close inpatient surgery beds and utilize observation beds, local contracting, or transfer to other VAMCs to meet surgical needs.

Outpatient Services

Primary Care—Increase primary care services in all of the four markets to meet increased demand and access guidelines. VISN 6 will use a combination of approaches tailored to the individual needs of each market. Approaches include establishing new CBOCs using a mix of VA-staffed clinics in leased space and contract-model clinics in the Southwest and Northeast markets; expanding existing CBOCs; establishing new Satellite Outpatient Clinics (SOPC) in certain former CBOC sites; and renovating and/or constructing new outpatient space.

Specialty Care—Increase specialty care services at six care sites and in three markets with the exception of Northwest market. VISN 6 will use a combination of approaches tailored to individual needs of each market. Approaches include providing specialty care services at multiple SOPCs/CBOCs; as a major component of outpatient additions; and using community contracts for the early years before lease/construction and for peak years.

Mental Health—Increase the mental health outpatient services in three markets with the exception of the Northwest market due to increased demand and primary care in all four markets. The VISN will use a combination of approaches tailored to the individual needs of each market. These approaches include incorporating Mental Health into CBOCs; renovating and constructing new outpatient space at the parent facilities; and providing some limited workload by contract.

Inpatient Services

Medicine—Increased inpatient medicine services have been identified for both the Southeast and the Southwest markets. This will require constructing new space, renovating existing space and using telemedicine links with out-station locations to augment coordination, timeliness and quality of care. Community contracts for projected peak year usage will also be employed as appropriate.

Surgery—Increased inpatient surgery services have been identified for both the Southeast and the Southwest markets. This will require a combination of ward renovation projects and new construction. To create enough space for these projects, outpatient functions currently located in inpatient areas will be relocated to the proposed outpatient additions. The projects will be supplemented by sharing agreements for acute hospital care, as appropriate. There is a slight decrease in demand at Salisbury. Therefore, no significant changes are planned at this time beyond an increased reliance on in-house versus contract services and a focus on increased productivity.

Psychiatry—Increased inpatient psychiatry services have been identified for the Southeast market. This will require ward renovation projects that will provide space and address patient privacy and efficiency issues at each facility. To create sufficient space for these projects, outpatient functions currently located in inpatient areas will be relocated to the proposed outpatient additions. Decreased inpatient psychiatry services will be addressed through the elimination of 47 beds by FY 2022.

Extended Care

Proposed capital investments in nursing homes to remedy space deficiencies include the renovation of 5,000 existing sq.ft. in the Northeast market (Hampton) and new construction of 40,000 sq.ft. in the Northwest market (Beckley) for a replacement facility.

Vacant Space

VISN 6 will have a total of 104,518 sq.ft. of vacant space in 2022. This represents a reduction of 72.0% from 2001 total vacant space (373,034 sq.ft.).

Enhanced Use

Durham has an approved enhanced use project in which a real estate development company will finance, build, operate and maintain, on the VAMC grounds a mixed-use development (approximately 650,000 sq. ft.) consisting of a hotel, retail space, office buildings, and parking garage addition for non-VA use.

Collaboration

NCA—Provide additional acreage to the NCA at Salisbury and for a possible new site at Salem.

VISN 7 Executive Summary

Access

VISN 7 has a primary care access gap in all three markets and an acute hospital gap in the Alabama and South Carolina markets. The plan includes 15 new CBOCs in the Alabama (AL), the Georgia (GA), and South Carolina (SC) markets to address the primary care access gap. The acute hospital gap will be met in AL by contracts in Huntsville and Dothan and in the SC market by contracts in Greenville, SC and Savannah, GA.

Campus Realignment/Consolidation of Services

Central Alabama Health Care System—Montgomery—The proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study.

Augusta, GA—Study the feasibility of realigning the campus footprint including the feasibility of consolidating selected current services at the Uptown Division to the Downtown Division. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility or other compatible uses. Any revenues or in kind services will remain in the VISN to invest in services for veterans. Explore with DoD the feasibility of greater coordination with DoD services at either VA division.

Small Facility

Dublin VAMC to retain its inpatient program, but will evaluate ICU bed needs and review surgical program for appropriate scope of practice.

Outpatient Services

Increasing demand for primary care and specialty care in all 3 markets and mental health in the SC market will be met by addition of 15 new CBOCs, expansion of existing CBOCs via contract, lease and new construction. Demand will also be met by reconfiguration of space at the VAMCs via renovation, conversion of vacant, new construction and leasing.

Inpatient Services

Increasing demand for medicine in both AL & SC markets, surgery in AL and psychiatry in the SC market will be met by contract hospital sites, conversion of vacant space, new construction, renovation, and leasing as required by each site of care.

Extended Care

Proposed capital investments for Nursing Home Care Units (NHCU) to remedy space deficiencies include the renovation of 67,247 existing sq.ft. in the South Carolina market (Charleston & Columbia).

Vacant Space

VISN 7 will have a total of 284,005 sq.ft. of vacant space in 2022. This represents a reduction of 57.2% from 2001 total vacant space (664,146 sq.ft.).

Enhanced Use

Columbia has an enhanced use project utilizing 26 acres.

Collaborations

VBA—The VBA will co-locate on Columbia VAMC property as part of the enhanced use project.

DoD—Following are the new DOD/VA opportunities VISN 7 is planning or exploring: (1) Atlanta is exploring the possibility of locating their new South Fulton County CBOC at Joel Army Medical Clinic (Ft. McPherson), (2) Charleston plans to construct a new Savannah CBOC at Hunter Army Airfield when the current Savannah CBOC lease expires in 2005, (3) New Hinesville, GA CBOC will either be on the Ft. Stewart Army Base or in the Hinesville community, (4) Plan to contract for hospital care in the Savannah community may be met by purchasing DoD care from nearby Ft. Stewart, (5) Montgomery realignment will examine opportunities to purchase inpatient care from Maxwell AFB as part of studying the realignment of inpatient services, and (6) Central Alabama Veterans Health Care System is pursuing options with Ft. Rucker (Enterprise AL area) and Ft. Benning (Columbus, GA). VISN 7/DoD has a Tiger Team in place to evaluate additional sharing opportunities including possible application for demonstration site for the VA/DoD Health Care Resources Sharing Project (NDAA).

Special Populations

Increase the number of SCI beds at the Augusta VAMC by adding 11 beds now and increase to the projected need by 2012.

Facility Condition

Inpatient wards—The inpatient ward conditions at the Atlanta, Columbia and Charleston VAMC's were identified as a VISN Planning Initiative.

Lease Expirations

The Greenville CBOC will be relocated to larger leased space and the Savannah CBOC will be relocated to new construction at Hunter AFB.

VISN 8 Executive Summary

Access

VISN 8 has a primary care access gap in the North market and an acute hospital gap in Central, Gulf, and North markets. Primary care access in the North market will be met by adding 4 new points of primary care. Acute hospital access in Central market will be increased by adding a new VA owned and operated site for hospital care in Orlando (Gulf market), by adding new contract sites for hospital care in the Gulf South market area (Ft Meyers) and for North market, by adding 2 new points of acute medical care at Jacksonville Shands (contract) and Jacksonville DoD (Joint Venture)

Campus Realignment/Consolidation of Services

Lake City—Transfer of current inpatient surgery services now to Gainesville. Inpatient medicine service transfer to Gainesville will be reevaluated when Gainesville has expanded inpatient capacity (due to construction of a proposed new bed tower). Nursing home care and outpatient services will remain at Lake City.

Outpatient Services

Increasing demand for primary care and specialty care in all 5 markets and mental health in 2 markets will be met by addition of 4 new CBOC's (North market only), expansion of existing CBOC's via contract, lease and new construction. Demand will also be met by reconfiguring of space at the VAMCs via renovation, conversion of vacant, and new construction.

Inpatient Services

Tampa (West Central Florida sub-market) will build a new inpatient bed tower above the new Spinal Cord Injury (SCI) Center to meet medical, surgical, and psychiatry inpatient workload. Decreasing medicine demand for Gulf market, and medicine and surgery for Puerto Rico markets is addressed through the downsizing of beds at Bay Pines between FY2012 and 2022 and San Juan between 2006 and 2022. San Juan space will be realigned through an approved and funded major project in 2006. Increasing psychiatry demand in the North market will be met through new construction at Gainesville.

Vacant Space

VISN 8 will have a total of 250,390 sq.ft. of vacant space in 2022. This represents an increase of 405.6% over 2001 total vacant space (49,525 sq.ft.). This will require further analysis to determine how this can be avoided through improved space planning.

Enhanced Use

Potential enhanced use projects are being explored for Bay Pines. None have been developed for inclusion in this cycle of CARES. University of Miami enhanced use lease project proposal is in development. University of Miami will pay for construction cost of adding three additional floors to existing research building at estimated cost of $8 million. Miami will address interior needs at est. cost of $10 million. Project identified for design in 2005 and construction in 2006–2007.

Collaborations

DoD—Outpatient joint ventures in the Puerto Rico market with Fort Buchanan and in the Gulf market with McDill AFB, Inpatient joint venture in the North market with Jacksonville Navy Hospital.

NCA—NCA is interested in acreage for a cemetery along with any proposed construction in the Sarasota or Fort Myers area.

VBA—VBA and Jacksonville OPC are exploring mini VARO sites. New site for Jacksonville clinic has space planned for small VBA office. A mini-VARO in West Palm Beach is also being explored. An expanded VBA presence is being explored as part of the plan to establish inpatient services at Orlando in the Central market.

Special Populations

Increase the number of Long Term SCI beds at Tampa by adding a 30-bed wing to the current SCI building.

VISN 9 Executive Summary

Access

Primary Care—The draft National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time.

Campus Realignment/Consolidation of Services

Lexington—Current services of outpatient care and nursing home care will be transferred to Cooper Drive. Due to possible space limitations at Cooper Drive it may be necessary to relocate some outpatient primary care and outpatient mental health psychiatric services to alternative locations other than Cooper Drive. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Enhanced use opportunities for the majority of the Leestown campus with the state of Kentucky appears to exist with Eastern State Hospital. Any revenues or in kind services will remain in the VISN to invest in services for veterans. Plans also include the pursuit of collaborative opportunities between the Louisville and Lexington VAMCs.

Nashville and Murfreesboro—Maintain both facilities and develop complimentary missions through the consolidation of services. Nashville will provide inpatient acute medicine and surgery programs while retaining a minimum number of medicine beds at Murfreesboro to support demand generated from the long-term programs. Murfreesboro will provide acute and long-term inpatient psychiatry and nursing home care services.

Outpatient Services

Primary Care and Mental Health—Outpatient demand is increasing in three of the four markets for primary care and in two of the four markets for mental health care. Increased capacity for these services is being addressed through a combination of in-house expansion (renovations and leases) and expansion of existing contracts (CBOCs). In addition, outpatient mental health is being integrated with primary care at all sites.

Specialty Care—Increase the capacity for outpatient specialty care in all four markets. The plan is to use a mix of in-house expansion, telemedicine, inclusion of selected high volume specialty services at larger CBOCs and through the use of community contracts.

Inpatient Services

Medicine—Increase inpatient medicine services in the Central and Western markets to meet demand through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central market and in outlying areas as available in the Western market).

Surgery—Consolidate inpatient surgery at Murfreesboro to Nashville, along with contracting for some surgical beds within the Chattanooga community. Maintain existing services to provide selected high volume surgical services at the Huntington facility with recurring reevaluation of quality and cost-effectiveness. Contract for excess demand, particularly in the Charleston, WV area.

Psychiatry—To meet inpatient psychiatry demand in the Northern market, acute inpatient psychiatry services will be centralized to one site within the Northern market or refer patients to the Murfreesboro, Tennessee program. Options to centralize services within the North market include provision of these services as part of the enhanced use agreement with the State of Kentucky on the Leestown campus or consolidating services to the Louisville VAMC.

Louisville—Construction of a new or fully renovated facility sized to meet service delivery requirements and projected demand will be studied. Options include construction of a new medical center, full renovation of the current facility and the potential for a collaborative hospital within a hospital arrangement with University of Louisville Medical School affiliate. Opportunities exist for VBA co-location as well as enhanced DOD sharing should a new facility option be selected.

Vacant Space

VISN 9 will have a total of 121,348 sq.ft. of vacant space in 2022. This represents a reduction of 74.8% from 2001 total vacant space (481,551 sq.ft.).

Enhanced Use

Enhance use leasing is proposed for parts of the Lexington-Leestown property with the State of Kentucky for an acute and long-term care psychiatry facility (Eastern State Hospital, 238 beds). There is the potential for Eastern State to provide acute and long-term psychiatric services for veterans as part of the enhanced use lease. There is additional opportunity for enhanced use leases with the State of Kentucky Department of Veterans Affairs for a 60–80 bed domiciliary and a 40-bed transition/homeless shelter.

Collaboration

VBA—Co-locate the Louisville VA Medical Center and Louisville Regional Office operation on the same campus or same physical structure. This will be considered in conjunction with the overall facility plan for Louisville. This opportunity is predicated on the identification of cost benefits outcomes of three options, including construction of a new facility, total renovation of the existing facility or development of a collaborative project with the affiliate medical school. A parking garage will be necessary regardless of the option selected.

NCA—Expansion of existing national cemetery at Mountain Home. Initial agreement has been reached on two 50-acre sites.

DoD—Expansion of space for primary care and outpatient mental health services at Fort Knox CBOC.

Special Populations

Add 20 LTC SCI beds within the current Spinal Cord Injury unit at Memphis.

VISN 10 Executive Summary

Access

Hospital Care—Improve access to acute hospital care in the Central and Eastern markets to ensure that at least 65% of veteran enrollees are within the driving time guidelines. This would be achieved by contracting for acute hospital care in the local community of Columbus, Ohio, which would increase the percentage of veterans within the standard access guideline from 39% to 83% in 2012 and to 84% in 2022. Currently, the Eastern market is within the guidelines for access to hospital care. The Eastern market would provide hospital care utilizing contracts in the Canton, Ohio area, allowing the market to stay within the hospital access guidelines.

Campus Realignment/Consolidation of Services

Cleveland—Current services at the Brecksville division will be transferred to the Wade Park division. This project will require new construction of 500,730 sq. ft. and renovation of existing space at the Wade Park of 140,400 sq. ft. This project includes the enhanced use lease of 102 acres at Brecksville in exchange for property adjacent to Wade Park. This consolidation will result in a reduction of 548,363 sq. ft. of the Brecksville Division. The Western market is also expanding the sharing/consolidation of services between the Cincinnati and Dayton VA Medical Centers.

Outpatient Services

Primary Care and Mental Health—Increasing primary care outpatient services is being addressed in all three markets through a combination of in-house expansion (leases and new construction), use of telemedicine, and expansion of existing Community Based Outpatient Clinics (CBOCs), in addition to new CBOCs. Outpatient mental health services have been an integral part of the existing CBOCs and the Network will continue to support the expansion of mental health services in all network CBOCs.

Specialty Care—Columbus, OH: A new expanded 260,000 sq. ft. outpatient specialty care center would be built on the DoD/Defense Supply Center site located in Columbus, Ohio. DoD has up to 200 acres available at this location at no cost to the Department of Veterans Affairs. At the completion of this project, 150,000 sq. ft. of leased space will be terminated. Overall, VISN 10 is increasing specialty care outpatient services in all three markets and at all six care sites. The need is being met by utilizing a combination of in-house expansion (new construction and leases), offering selected high volume specialty care services at larger CBOCs, and through community contracts.

Inpatient Services

Medicine—Increasing inpatient medicine services in the Eastern market is being met through the consolidation of the Brecksville division to Wade Park. This will require new construction and renovation of existing space for Medicine at the Wade Park division. The Central market will utilize community hospital contracts and other arrangements within the Columbus metropolitan area to provide local inpatient services.

Extended Care

Capital Investment for a new nursing home to remedy space deficiencies of the current nursing home at Brecksville is planned. The nursing home is part of the consolidation plans.

Vacant Space

VISN 10 will have a total of 115,989 sq.ft. of vacant space in 2022. This represents a reduction of 65.1% from 2001 total vacant space (332,125 sq.ft.).

Enhanced Use

Enhanced use is proposed for 690,669 sq. ft. of space. The vast majority (548,363 sq. ft. or 79%) is associated with the consolidation of activities of the Brecksville Division to Cleveland-Wade Park. The remaining space (142,306 sq. ft.) is associated with proposed enhanced use lease projects at Cincinnati (leasing of Quarters and use proceeds for additional adjacent parking) and Dayton (leasing of empty building).

Collaboration

NCA—NCA is considering the use of up to 50 acres on the Chillicothe campus for a cemetery site, but not before 2009.

VISN 11 Executive Summary

Access

Primary Care—The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time.

Hospital Care—Increase access for hospital care in the Central Illinois market by contracting with community providers at two new sites on the western side of the market.

Consolidation of Services

The Ann Arbor and Detroit facilities currently have several services that they have consolidated and they include: cardiac surgery, neurosurgery, interventional cardiology, cochlear implant, gynecologic cytopathology, nuclear medicine, sleep laboratory, GRECC, HSR&D, contract

administration, prosthetic management. Future consolidations to be considered are: home oxygen management, and radiology interpretation.

Small Facility

Saginaw and Ft. Wayne divisions of NIHCS will maintain outpatient and nursing home services. Acute medicine services will be transferred to Indianapolis, Ann Arbor and Detroit. There will be partial contracting out for inpatient/emergent care services and to improve the access for patients in the northern sectors of Lower Michigan. Patient transfer protocols will be upgraded to address these significant changes, and the Ann Arbor HCS must be upgraded prior to any bed consolidation to address the transfer of projected medicine patients to this facility. VAMCs Detroit and Indianapolis do not require renovation prior to either consolidation.

Outpatient Services

Specialty Care—Increase the specialty outpatient care services in all three markets and at all eight care sites to include selected CBOCs. Three innovative telemedicine networking systems located at the tertiary level facilities are also proposed. These new systems can provide care and consultation services to the veteran in either another VHA facility or at his/her home. These systems will particularly assist the older veteran with ambulation issues, dementia, Alzheimer's, Parkinson's, and the SCI patient. These systems have shown that they can increase patient satisfaction, and significantly reduce the number of emergency room, and other visits, and future hospitalizations.

Primary Care—Increase the primary outpatient care services in two markets and at all care sites except the Illiana HCS at Danville, Illinois.

Inpatient Services

Medicine—Increase inpatient medicine beds in the Michigan market to meet the projected demand. The Ann Arbor HCS and the Detroit VAMC will need to increase their compliment of medicine beds to meet that projected demand and to add additional beds to meet the change in acute beds from Saginaw (small facility) and the consolidation of five beds from the Battle Creek VAMC.

Extended Care

A new nursing home is proposed using the enhanced-use leasing process to remedy several space and functional deficiencies in the Central Illinois market (Illiana HCS).

Vacant Space

VISN 11 will have a total of 252,761 sq.ft. of vacant space in 2022. This represents a reduction of 71.4% from 2001 total vacant space (884,615 sq.ft.).

Enhanced Use

There are several enhanced use lease projects planned by the network to address significant space issues to meet the projected primary and specialty outpatient care workload. There are significant enhanced use projects planned at the Battle Creek (new Mental Health Building & Vet Center), the Illiana HCS for the new nursing home care unit, and at NIHCS—Ft. Wayne Division to relocate their outpatient services and dispose of their inpatient building to a community provider.

Collaboration

VBA—Co-locate the VARO to the Indianapolis VAMC.

NCA—The Network is planning to demolish several buildings at the NIHCS-Marion Division to rid itself of unwanted, historic, vacated space and to appropriately backfill with providing additional acreage (9 acres) to the existing and co-located NCA cemetery.

Special Populations

The Network is proposing to establish a Blind Rehabilitation Outpatient Service (BROS) presence at each of the seven care sites.

VISN 15 Executive Summary

Campus Realignment/Consolidation of Services Proximity

Leavenworth—Continuation of the Secretary's Advisory Board recommendations. The Secretary's Advisory Board was created prior to CARES to consider realignments within VISN 15. The Advisory Board developed a comprehensive plan for realignment and consolidation of services between Topeka and Leavenworth that was approved by the USH and incorporated into the VISN's CARES plan. It included realignments of nursing home care unit, psychiatry and outpatient surgery. Under this plan Leavenworth would maintain acute beds. In addition, Leavenworth will provide additional primary care capacity for Kansas City, and both Leavenworth and Topeka would retain 24/7 emergency services at both campuses.

Small Facility

Poplar Bluff—Poplar Bluff will maintain acute care beds. This facility currently operates as a Critical Access Hospital and will continue as such when VHA develops its CAH criteria.

Outpatient Services

Primary Care—Increased primary care outpatient demand has been identified in all three of the Network's markets. The majority of this need will be met through expansion of in-house space via new construction (18,000 sq. ft.) conversion of vacant space (44,500 sq. ft.), lease space (182,900 sq. ft.) and utilization of community contracts. The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. While new access points in the Central and the East markets are included in the National Plan, they are not in the high implementation priority category at this time.

Specialty Care—All three of the Network's markets are projected to experience increased outpatient specialty care demand. The VISN proposes to meet the majority of this need through the expansion of in-house services with new construction (405,400 sq. ft.), vacant space conversion (63,400 sq. ft.), lease space (20,000 sq. ft.) and utilization of community contracts. In addition, some shifting of care between facilities is proposed.

Inpatient Services

Psychiatry—Decreasing demand in the Central market will be offset by the increased workload from the Western market (Western market has no in-patient psychiatry beds). Inpatient workload will be met through a combination of in-house and community contracts. New construction (66,800 sq. ft.) is proposed to meet projected space needs.

Vacant Space

VISN 15 will have a total of 241,618 sq.ft. of vacant space in 2022. This represents a reduction of 70.5% from 2001 total vacant space (819,050 sq.ft.).

Enhanced Use

The Network is developing a project at the Leavenworth campus that would rehabilitate 39 historic buildings for mixed use, including an assisted living facility. In addition, there would be an expansion of the Leavenworth National Cemetery. The second project is the out-leasing of approximately 2.5 acres of land to a commercial developer in exchange for the construction of a parking garage adjacent to the St. Louis-John Cochran facility.

Collaboration

NCA—Collaborative opportunities under development include the expansion of the Leavenworth National Cemetery described above and potential expansion of the Jefferson Barracks National Cemetery by 2008.

DoD—Opportunities include sharing CBOC space at the current CBOC at the Warrensburg State Veterans Home with Whiteman AFB. In addition, Kansas City may provide laboratory testing for Whiteman Air Force Base. The VISN and Scott AFB are currently discussing concepts for a joint planning of a replacement hospital at Scott AFB.

Facility Conditions

Infrastructure issues associated with the chilled water, steam, and electrical distribution systems in buildings housing inpatient care have been identified due to the high risk of disrupting health care delivery operations. Estimated correction costs exceed $20 million.

VISN 16 Executive Summary

Access

Primary Care—VISN 16 has a primary care access gap in all four markets and an acute hospital gap as well in the Eastern Southern market. The plan includes as a high implementation priority category, 11 CBOCs for the Eastern Southern and Central Lower markets. The National CARES Plan attempts to balance meeting national access guidelines while ensuring the current and future viability of its acute care infrastructure. Consequently, while new access points in the Upper Western and the Central Southern markets in this VISN are included in the National Plan, they are not in the high implementation priority category at this time.

Hospital—The acute hospital gap will be met in Eastern Southern market through a sharing agreement with Eglin AFB, adding a point of care by contracting in Panama City, continued contracting with University of South Alabama in Mobile and expanding services currently provided by Pensacola Naval Hospital via a joint venture.

Consolidation/Realignment

Gulfport's current patient care services will be transferred to the Biloxi campus and possibly Keesler AFB. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility or other compatible uses to benefit veterans. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

Small Facility

Muskogee maintains its inpatient program, but will evaluate ICU bed needs and review surgical program for appropriate scope of practice.

Outpatient Services

Increasing demand for primary care and specialty care in all 4 markets will be met by the addition of 11 new CBOC's in the Eastern Southern and the Central Lower markets, expansion of existing CBOC's via contract, lease and new construction. In addition, it will be met by reconfiguration of space at the VAMCs via renovation, conversion of vacant, and new construction.

Inpatient Services

Increasing demand for medicine in Central Southern (CS), Eastern Southern (ES), and Upper Western (UW) markets, and Psychiatry in CS and UW will be met by renovation in UW and CS and new construction in Biloxi to accommodate the consolidation of Gulfport services to Biloxi. Increasing demand in ES will be met through joint venture, sharing and contract.

Extended Care

Proposed capital investments for nursing homes to remedy space deficiencies include the renovation of 23,735 existing sq. ft. in the Central Lower market (Alexandria & Shreveport) and include the renovation of 61,231 existing sq. ft. in the Central Southern market (Biloxi).

Vacant Space

VISN 16 will have a total of 122,921 sq.ft. of vacant space in 2022. This represents a reduction of 46.3% from 2001 (228,743 sq.ft.).

Enhanced Use

Houston has the potential for an enhanced use lease cooperative arrangement with the private sector to construct a high-rise medical arts building.

Collaborations

DoD—Eastern Southern market—Joint venture with Pensacola Naval Hospital, sharing with Eglin AFB and Tyndall AFB involving a broad range of services; Central Lower—Sharing with Ft. Polk involving Primary Care, Mental Health, and Psychiatric services; Upper Western—Sharing with Ft. Sill and Tinker AFB dental, primary care and possibly other services; Central Southern—Sharing or possible joint venture with Keesler AFB for services yet to be determined.

NCA—The consolidation of Gulfport division to Biloxi will impact acreage available for possible NCA expansion.

VBA—There is the possibility of replacing the existing VBA office located on the Central Arkansas Healthcare System-North Little Rock campus with new construction on the campus.

Special Populations

Build a new 20-bed Blind Rehabilitation Center at Biloxi. Construct a new 25-bed SCI Center at the Central Arkansas Healthcare System-North Little Rock division.

VISN 17 Executive Summary

Access

Primary Care—The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time.

Hospital—Deficiencies in hospital access in Austin, Lower Rio Grande Valley, are being met through contracting or leasing beds in local communities.

Campus Realignment/Consolidation of Services/Small Facility

Kerrville—Kerrville will continue providing nursing home and outpatient services. Acute inpatient services will be transferred to San Antonio as space becomes available from the proposed inpatient construction at San Antonio. In the interim, Kerrville would convert to a Critical Access Hospital (CAH). In addition, inpatient services will be contracted for in Harlingen and Corpus Christi.

Waco—Current services will be transferred to Temple and community contracts and leases used to provide these services. Current inpatient psychiatry services will be met primarily at Temple. The VISN will also lease 27-inpatient psychiatry beds in Austin. Blind Rehabilitation and a third of Waco's nursing home care services will be transferred to the Temple VAMC. The balance of nursing home care needs will be contracted out in the Waco Central Texas market area. Outpatient services will be moved to a new location more strategically placed to improve access for patients from both Waco and Marlin.

Outpatient Services

Primary Care and Mental Health—Increasing demand for primary care and mental health outpatient services is being met across the network primarily through expansion of Community Based Outpatient Clinics (CBOCs). Outpatient mental health is being integrated with primary care at all sites as well as being expanded in-house at parent facilities.

Specialty Care—Increasing specialty care services in all four markets is being met using a combination of in-house expansion (new construction, renovation and leases), which offer selected high volume specialty care services at larger CBOCs, and community contracts.

Inpatient Services

Medicine and Psychiatry—Increasing demand in the North market will be met by expanding in-house services at the Dallas through construction and renovation projects. In addition, contracts for hospital care in Austin, Harlingen and Corpus Christi will increase services in the remaining three markets.

Vacant Space

VISN 17 will have a total of 365,954 sq.ft. of vacant space in 2022. This represents a reduction of 1.6% from 2001 total vacant space (372,025 sq.ft.).

Enhanced Use

A major enhanced use project for assisted living in Kerrville has been submitted for approval.

Collaboration

DoD—North market—Sharing opportunity with Joint Reserve Base in North Fort Worth for a possible CBOC. Central market—Sharing opportunities between Fort Hood and the Temple Medical Center (telemedicine, orthopedics, psychiatry, sleep lab, training). South market ''Inpatient/outpatient sharing and enhanced use among San Antonio, Brooks Army Medical Center and Wilford Hall Air Force Medical Center including CBOCs, consolidating reference labs, domiciliary, Consolidated Mail Out Pharmacy (CMOP), discharge physicals, sleep lab, and consolidation of bone marrow transplant programs at VA.

VISN 18 Executive Summary

Access

The gap in hospital and tertiary care access in the New Mexico/West Texas market is being met through expanding the joint venture with DoD in El Paso and contracting in Midland/Odessa, Lubbock, and Roswell.

Campus Realignment/Consolidation of Services/Small Facility

Prescott—Medicine workload at Prescott will increase by taking patients who would have been referred to Phoenix. This will also enhance the ability to recruit specialists at Prescott to meet the need for outpatient specialty care. Utilization review will ensure that lengths of stay are comparable to Medicare guidelines.

Big Spring—Close surgery and contract for care in communities nearest to patients. Study the possibility of no longer providing health care services at Big Spring by development of a Critical Access Hospital for the Odessa-Midland area that would include a nursing home and expansion of an existing clinic to a multi-specialty outpatient clinic. Also as part of the study, consider the possible need for acute hospital care in the area.

Outpatient Services

Primary Care and Mental Health—Increasing primary care and mental health

outpatient service is being addressed in both markets primarily through expansion of existing Community Based Outpatient Clinics (CBOCs) as well as increasing services at parent facilities. Outpatient mental health is being integrated with primary care at all sites.

Specialty Care—Increasing specialty care services in both markets will be met using a combination of in-house expansion (new construction, renovation and leases), and by offering selected high volume specialty care services at larger CBOCs, and through community contracts.

Inpatient Services

Medicine—Increasing demand in the Arizona market will be met by expanding in-house services at all three facilities using renovation projects. In the New Mexico/West Texas market, demand will be met by expanding the joint venture at the William Beaumont Army Medical Center adjacent to the El Paso OPC as well as contracting for care in Lubbock, Roswell, and local communities in West Texas and New Mexico for emergency care.

Psychiatry—The increasing demand for inpatient psychiatry will be met by expanding services at Phoenix, Tucson, and Albuquerque in addition to expanding the VA/DoD joint venture at William Beaumont Army Medical Center in El Paso. Contracting for emergency care will also be implemented in Mexico and West Texas.

Vacant Space

VISN 18 will have a total of 8,054 sq.ft. of vacant space in 2022. This represents a reduction of 80.0% from 2001 total vacant space (40,368 sq.ft.).

Extended Care

Proposed capital investments for nursing homes include the renovation of 58,314 sq. ft. in the New Mexico/West Texas market (Albuquerque & Amarillo) and the renovation of 124,209 sq. ft. in the Arizona market (Phoenix, Prescott & Tucson).

Enhanced Use

A major enhanced use leasing project at Phoenix is being pursued which will make office space available on its campus in downtown Phoenix to affiliates, as well as DoD and the private sector. Albuquerque is pursuing a multi-use project that includes collocation of the VARO, a hoptel, and an assisted living facility.

Collaboration

DoD—The VISN is pursuing expansion of the joint venture with William Beaumont Army Medical Center in El Paso as well as a primary care clinic with Luke AFB at the Mesa CBOC.

Research

The VISN will join with Arizona State University (ASU) to establish an Arizona Biomedical Institute. In addition, the VISN is working with both ASU and University of Arizona to establish a Molecular Diagnostics and Research Laboratory. Albuquerque also has a very active research program that has numerous space and functional deficiencies. All of these initiatives will require construction and/or enhanced use projects.

VISN 19 Executive Summary

Access

Primary Care—The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time.

Hospital Care—Increased access for hospital care in the Eastern Rockies, Montana, Wyoming, Grand Junction and Western Rockies markets by contracting at seven sites in VISN 19.

Tertiary Care—Increased access for hospital care in the Eastern Rockies and Montana markets by contracting for care at three sites.

Small Facility

Grand Junction and Cheyenne—Maintain acute bed sections at both facilities and develop appropriate parameters (more restrictive) for types of in-house surgery procedures. Complete an evaluation to determine if ICU beds could be closed (VA external review survey).

Fort Harrison—Fort Harrison maintains current services

Outpatient Services

Primary Care—Increasing the primary care outpatient services in one market, and highly rural care in all markets requires new construction and conversion of space. The replacement hospital at Denver will include a large outpatient care project and a VA/DoD joint venture.

Specialty Care—Increase specialty care outpatient services in all five markets and at all care sites. Contracting is utilized in high peak periods of growth. New construction of 359,600 sq. ft. is planned in to meet environment of care concerns and the increasing workload demand. Other solutions include renovation, conversion of existing space and leasing alternatives.

Inpatient Services

Medicine—Increase inpatient medicine services in the Eastern Rockies market. The majority of the increasing demand will be absorbed at VAMC Denver. This is part of the replacement facility (new construction) proposal at Denver. Excess space will be demolished.

Extended Care

Capital investments for nursing home care (NHCU) to remedy space deficiencies include the new construction of 32,271 sq. ft. in the Eastern Rockies market (Denver).

Vacant Space

VISN 19 will have a total of 198,534 sq.ft. of vacant space in 2022. This represents an increase of 66.3% over 2001 total vacant space (119,357 sq.ft.). This will require further analysis to determine how this can be avoided through improved space planning.

Enhanced Use

Enhanced use leasing is being explored at Salt Lake (Phase 2). Proposal was submitted to demolish old VA buildings and replace buildings with a new building. VA will occupy some of the space.

Collaboration

DoD—Activities include (1) F.E. Warren AFB & Cheyenne: VAMC continuing to allow the use of facilities for minor number of services, (2) U.S. Air Force Academy & Denver ongoing discussions related to available VA services, (3) Buckley AFB & Denver: discussions continue regarding Buckley AFB patients using new facility at Fitzsimmons, (4) Ft. Carson Army & CBOC: discussions continue regarding VA use of space and facilities at Ft. Carson Army base in Colorado Springs, and (5) Hill AFB & Salt Lake: no potential agreements identified.

Special Populations

Build a new SCI Center located with the replacement facility at Denver.

Facility Condition

Low Condition Scores—Renovation was the main solution for the majority of buildings that had condition scores that were lower than 3.0. Lead paint problems will be improved in all facilities.

Seismic

The seismic condition will be improved by the construction projects at Fort Harrison.

Replacement Facility Study at Denver

The Denver replacement hospital is included in the plan.

VISN 20 Executive Summary

Access

Primary Care—VISN 20 will increase primary care access points in the Inland North markets by adding a new CBOC site in Central Washington State and enhancing the Spokane mobile clinic. This will help achieve access for more than 70% of veterans who will be within a 30-minute drive time of primary care.

Hospital Care—Inland North and South Cascades markets plan to meet the need for increased hospital access by contracting at 6 sites.

Tertiary Care—Alaska, Inland North and Inland South markets plan to increase access to tertiary care by contracting in Anchorage, AK; and Spokane, Tri-Cities, and Yakima, WA.

Campus Realignment/Consolidation of Services

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

White City Domiciliary—The domiciliary and CWT programs will be transferred to other VAMCs. Maintain outpatient services. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility or other compatible uses. Any revenues or in kind

services will remain in the VISN to invest in services for veterans.

Walla Walla—Maintain outpatient services and contract for acute inpatient medicine and psychiatry care (will improve hospital access in the Inland North market) and nursing home care. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

Small Facility

Roseburg—Converting surgical beds to 24-hour surgical observation beds is underway at Roseburg.

Spokane—Develop appropriate parameters (more restrictive) for types of in-house surgery procedures.

Outpatient Services

Primary Care—Increase the primary care outpatient services in three markets and at all care sites through planned CBOC and DoD joint ventures, and new construction and converting in-house space.

Mental Health—Increased demand for mental health in the Inland North market will be managed in-house and through increased contracting. Mental Health and primary care services are integrated into all new CBOCs.

Specialty Care—All five markets and all care sites will need to increase outpatient specialty care services. In all cases, approaches include expanding specialty care in-house services and contracting in high peak periods of growth. Additionally, two CBOCs will offer selected high volume specialty care services. New construction of 228,467 sq. ft. is planned to meet access, environment of care concerns, and the increasing workload demand. Other solutions include a combination of renovation, conversion of existing space, and leasing.

Inpatient Services

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

Vacant Space

VISN 20 a total of 273,862 sq.ft. of vacant space in 2022. This represents an increase of 10.5% over 2001 total vacant space (247,887 sq.ft.). This will require further analysis to determine how this can be avoided through improved space planning.

Enhanced Use

White City, Portland, Roseburg, and Seattle are exploring enhanced use leasing projects.

Collaboration

DoD—The proposed collaborations between VA and DoD include: (1) a pilot VA/DoD demonstration site with American Lake Division, VA PSHCS, and Madigan Army Medical Center; (2) ongoing collaboration efforts with Everett, Bremerton, and Oak Harbor Naval Hospital; and (3) VA Alaska HCS is planning for expanded sharing/integration with both Bassett Army Community Hospital and Elmendorf Air Force Base in order to meet demand projections in both Fairbanks and Anchorage.

VBA—The proposed collaborations at Boise, Portland and Seattle are still in development. Potential collocation is available on the Boise campus. Alaska VAHSRO, VHA, and VBA activities will continue to be collocated after new clinic construction.

NCA—Roseburg as a high priority for NCA collaboration.

Facility Condition

Low Condition Scores—Renovation was the main solution for the majority of buildings with condition scores lower than 3.0. Lead paint problems will be improved in all facilities.

Seismic

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

VISN 21 Executive Summary

Access

Tertiary Care—Sierra Nevada market will expand services at Reno VAMC and contract locally.

Hospital Care—South Coast market will contract locally to meet demand and improve access.

Campus Realignment/Consolidation of Services

Livermore—Current nursing home services will be transferred to Menlo Park campus and contracts in the community. Outpatient services are proposed to transfer to an expanded San Joaquin Valley CBOC and a new East Bay CBOC closer to where the patients live. Both CBOCs will offer primary care, specialty services and mental health services. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

San Francisco/Palo Alto—Services to be consolidated at San Francisco include the following: Administrative Services: Reproduction Services (*i.e.*, copies), an HR Classification. Clinical Services: Parkinson's Disease and Epilepsy Surgery and Brain Mapping, portions of Neurosurgery including Stereotactic Radiosurgery (including Gamma Knife), Brainstem auditory evoked responses, Somato sensory evoked potentials, All surgery requiring intra-operative spinal cord and root monitoring, Electronystagmographs, Brachytherapy for Prostate Cancer, Endovascular, embolism of AVM, Mohs Surgery, Portions of Radiology including Neuroradiology through increased use of PACS, All Dental Surgery including Dental Implantology, and portions of Laboratory Services.

Services to be consolidated at Palo Alto include the following: Administrative Services: Warehousing operations, Disposal of government property program, Recycling program, Management of grounds and transportation services, Prosthetics & Sensory Aids purchasing agents, IRM help desk and police training. Clinical Services: Long-term inpatient care for dementia, neurobehavioral problems and substance abuse, Electroconvulsive therapy (ECT), Long-term care for chronically mentally ill and Selected laboratory contract testing.

Outpatient Services

Primary Care—Increasing primary care demand in all six markets is being met primarily through expansion of existing CBOCs, as well as increasing services at parent facilities. In some cases, expanded hours are planned to increase capacity. A multi-specialty expanded CBOC in the San Joaquin Valley and a new CBOC are in the plan as high priorities to meet the outpatient requirements associated with the closure of Livermore. However, since the National CARES Plan attempts to balance meeting national access guidelines, while other access points are included in the National Plan, they are not in the high implementation priority category at this time.

Specialty Care—Increasing specialty care demand in all six markets is being met by using in-house expansion (new construction, renovation and leases), utilizing telehealth options for select clinics and offering selected high volume specialty care services on-site at larger CBOCs.

Inpatient Services

Surgery—Decreasing demand in South Coast market is being managed by reducing in-house services at Palo Alto.

Psychiatry—Decreasing demand in South Coast market is being managed by reducing in-house services.

Vacant Space

VISN 21 will have a total of 207,745 sq.ft. of vacant space in 2022. This represents a reduction of 1.0% from 2001 total vacant space (208,899 sq.ft.).

Enhanced Use

Proposals are being developed involving research at San Francisco and long-term care in Sacramento. These proposals involve construction as well as leasing. In addition the VISN is pursuing the following enhanced use lease opportunities: Joint venture for ambulatory and long-term care with Alameda County and assisted living facility at the Menlo Park Division of Palo Alto Health Care System.

Collaboration

DoD—The VISN is developing the following collaborative opportunities with DoD: In Pacific Island market enhancing access to tertiary and acute care and to meet primary and specialty care outpatient needs through expanded agreements with Tripler AFB. There may be opportunities of collaboration in medical research with DoD in Hawaii, particularly given DoD's anticipation of a new research facility on Oahu. In addition, there are opportunities

with DoD in the North Valley market at Travis AFB to provide enhanced access to inpatient care, primary care, and specialty care. Also working with DoD on joint ventures for both inpatient and outpatient care in Monterrey.

Seismic

The VISN has proposed seismic construction projects at facilities in the North Coast, South Coast and South Valley markets, including VA facilities in Palo Alto, San Francisco Menlo Park and Fresno.

VISN 22 Executive Summary

Campus Realignment/Consolidation of Services

Long Beach-Greater LA: The two facilities will continue to refer patients for interventional cardiology/cardiac surgery and neurosurgery as well as implementing extensive collaboration in the areas of laboratory, radiation therapy, and radiology. Other opportunities for consolidation, integration and cooperation are anticipated in Geriatrics and Extended Care and Mental Health.

Outpatient Services

Increasing demand for primary care and specialty care services in both the California and Nevada markets will be met by expansion of existing CBOC's via clinical services contracts, replacement leases, and new construction and reconfiguration of space at the VAMC's via enhanced use leases, renovations, conversion of vacant space and new construction.

Inpatient Services

Increasing demand for inpatient medicine beds in the California and Nevada markets will be met by VA/DoD sharing, conversion of vacant space and renovation of existing space. The peak demand, which occurs between 2004 and 2012, will be addressed through contracting. The majority of decreasing demand for inpatient psychiatry will be addressed through the downsizing of beds at all California market facilities between FY2012 and 2022.

Las Vegas—Develop a plan for a new hospital in Las Vegas that would include the current plans for a multi-specialty outpatient clinic.

Extended Care

Proposed capital investments for nursing home care to remedy space deficiencies identified include the new construction of 95,000 sq. ft. in the Nevada market (Las Vegas) and the renovation of 79,786 sq. ft. (Long Beach & San Diego) and the replacement of 130,000 sq. ft. in the California market (Greater LA).

Vacant Space

VISN 22 had total vacant space of 818,885 sq. ft. in 2001. This total will be reduced by 208,812 sq. ft. through enhanced use leasing and by 241,075 sq. ft. through out-lease leaving a total of 574,687 sq. ft. of vacant space. This represents a reduction of 29%.

The Network CARES Market Plan proposes that a majority of the vacant space be reduced through demolition of vacated buildings on the north side of the West Los Angeles campus and at the Sepulveda campus. The Plan includes a strategy to consolidate all care, with the exception of long-term care, on the south side of the West Los Angeles campus as part of building a new clinical addition on the south side. This project would be in addition to a co-location project with VBA. A wide variety of outpatient mental health programs and support staff would also be located within this new clinical addition to accommodate the rising workload. The proposed clinical addition would also consolidate other clinical services currently in buildings on the north campus and free up a majority of the north campus for demolition of old buildings and construction of a State Nursing Home, expansion of the Los Angeles National Cemetery or other veteran-focused projects. This consolidation would also improve the efficiency of care delivery and improve patient access to services on the West Los Angeles campus.

Enhanced Use

The Network approach to this initiative is the development of a VISN 22 Excess Land Use Policy included in the CARES Market Plan. This policy will provide planning and guidance developed with stakeholder input (including community representatives and local government representatives) to ensure proposed developments are viable enhanced use lease projects.

Collaborations

DoD—DoD collaboration opportunities included in the plan are through the Michael O'Callaghan Federal Hospital in Las Vegas, Balboa Naval Hospital in San Diego and with Medical Treatment Facilities throughout southern California.

VBA—VBA collaborations include construction of a new VARO building at the West LA campus. Space in this building will be included for VHA administrative functions. This will be accomplished through an enhanced-use lease project. In the Nevada market, the plan includes collocation of VBA space at the new site of the Las Vegas OPC.

NCA—Utilize 20 acres of West LA campus land for a columbarium.

Special Populations

Long Beach—A new 24-bed Blind Rehabilitation Center and conversion of 30 acute SCI beds to long-term care SCI beds are planned.

Facility Condition

Nursing Home—Improvement and expansion of nursing home space is achieved mainly through renovation and new construction. Capital investments consist of renovation of 64,000 sq. ft. at Long Beach and 16,000 sq. ft. at San Diego, new construction of 95,000 sq. ft. at Las Vegas and construction of a 130,000 sq. ft. replacement facility at the West LA campus.

Research

Improvement and expansion of research space is achieved mainly through new construction. Capital investments consist of construction of 45,000 sq. ft. at Loma Linda, 260,000 sq. ft. at San Diego, and 245,000 sq. ft. at the West LA campus. Existing space will be demolished at West LA, and backfilled in San Diego and Loma Linda.

Seismic

The plan addresses seismic issues through new construction and demolition of old buildings at the West LA campus and Long Beach, and through renovation at San Diego, Long Beach, and West LA. Costs for seismic improvements are $39 million for Long Beach, $49.1 million for San Diego, and $64.4 million for West LA.

Land

VISN 22 has developed an Excess Land Use Policy that provides a process to address excess land. Upon review by the CARES Commission and approval by the Secretary of Veterans Affairs, the Land Use Planning process will guide local VA leadership when recommending re-use initiatives to the Secretary.

VISN 23 Executive Summary

Access

Primary Care—Primary care access will be improved in two markets with seven new Community Based Outpatient Clinics (CBOCs) for the Iowa and the Minnesota markets included in the plan. The National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, new access points in the Nebraska, North Dakota and South Dakota markets are in the National Plan; however, they are not in the high implementation priority category at this time.

Hospital Care—Access to VA hospital care will improve in the Iowa, Minnesota, North Dakota and South Dakota markets through community contracts at eleven sites.

Tertiary Care—Tertiary Care access will improve for veterans in the North Dakota market by contracting for care in Bismarck and Minot.

Campus Realignment/Consolidation of Services/Small Facility

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

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

St. Cloud—Maintain acute psychiatry, domiciliary, other mental health and outpatient services. Acute medicine is transferred to Minneapolis and contracts in the local community.

Des Moines—Must be upgraded to accommodate the transfer of projected workload from Knoxville.

Outpatient Services

Specialty Care—Specialty care outpatient services will increase in four markets and at all care sites. Contracting is utilized in high peak periods of growth. New construction of 171,000 sq. ft. is planned in VISN 23 to meet access initiatives, environment of care concerns and the increasing workload demand. Other solutions include renovation, conversion of existing space and leasing alternatives.

Primary Care—Primary care outpatient services will increase in five markets. Planned CBOCs in the Iowa and Minnesota markets, new construction and internal conversion will help improve access. The new CBOCs planned will be leased sites or contract care. In-house expansions will occur through capital investments in renovation, conversion and new construction.

Inpatient Services

Medicine—Inpatient medicine services will decrease in the Iowa, Minnesota, Nebraska and South Dakota markets. As a result, St. Cloud will shift all medicine beds to Minneapolis. VA Central Iowa Health Care System will transfer all medicine beds located at Knoxville to Des Moines. The VISN will also transfer some medicine from in-house care to contract care to improve hospital access for veterans. The VISN proposes significant capital investments for tertiary care ICUs, monitored beds and overall facility conditions.

Surgery—Inpatient surgery services will decrease in the Minnesota market resulting in a tremendous shift from inpatient to outpatient care. As a result, space will be realigned from inpatient to outpatient specialty care at VAMC Minneapolis.

Extended Care

Capital investments for a nursing home care unit to remedy space deficiencies include the new construction of 50,000 sq. ft. in the Iowa market (Des Moines), and the renovation of 26,806 sq. ft. in Nebraska market (Grand Island) are planned.

Vacant Space

VISN 23 will have a total of 329,682 sq.ft. of vacant space in 2022. This represents a reduction of 21.6% from 2001 total vacant space (420,424 sq.ft.).

Enhanced Use

Three enhanced use lease projects are proposed: (1) Single Room Occupancy Initiative Concept plan (approval pending), (2) Federal Credit Union Concept plan (approved), public hearing completed requires approximately an acre of property on medical center campus, and (3) A St. Paul VARO enhanced use initiative with a private developer to co-locate onto the Minneapolis campus.

Collaboration

VBA—Three collaborations are proposed: (1) The VARO St. Paul would relocate to new construction on land at the VAMC Minneapolis campus through an enhanced use lease proposal (high priority), (2) Central Iowa Health Care System collaboration is an enhanced use lease development project to relocate the Iowa VARO from the Federal Building in downtown Des Moines to the Des Moines medical center (medium priority), and (3) VA Nebraska-Western Iowa Health Care System is exploring a co-location with VBA on the Lincoln campus (medium priority).

NCA—VA Central Iowa Health Care System and the State of Iowa Department of Veterans Affairs propose a State sponsored Veterans Cemetery on VA land at the Knoxville campus. The current status of the proposal is dependent upon state legislative action.

DoD—Collaborations are planned for community based outpatient clinic at the Offutt AFB and Grand Forks AFB.

Special Populations

Build a new Spinal Cord Injury (SCI) center at Minneapolis.

Facility Condition

Low Condition Scores—VISN 23 proposed renovation as the main solution for the majority of buildings with condition scores lower than 3.0 except for the domiciliary program. Lead paint problems will be corrected in all facilities.

Appendix B—Glossary of Acronyms and Definitions

Acronyms

ADC—Average Daily Census
AL—Assisted Living
BRC—Blind Rehabilitation Center
CAH—Critical Access Hospital
CARES—Capital Asset Realignment for Enhanced Services
CBOC—Community Based Outpatient Clinic
CMS—Centers for Medicare and Medicaid Services
CWT—Compensated Work Therapy Program
DoD—Department of Defense
EU—Enhanced Use
EUL—Enhanced Use Lease
FTEE—Full Time Equivalent Employee
FY—Fiscal Year
GAO—General Accounting Office
GRECC—Geriatric Research, Education and Clinical Center
HSR&D—Health Services Research & Development
ICU—Intensive Care Unit
LTC—Long Term Care
MOA—Memorandum of Agreement
MOU—Memorandum of Understanding
NCPO—National CARES Program Office
NDAA—National Defense Authorization Act
NHCU—Nursing Home Care Unit
OPC—Outpatient Clinic
PTSD—Post-Traumatic Stress Disorder
RO—VBA Regional Office
SCI—Spinal Cord Injury
SCI&D—Spinal Cord Injury & Disorder
SOPC—Satellite Outpatient Clinic
SMI—Seriously Mentally Ill
Sq. Ft.—Square Foot
VA—Department of Veterans Affairs —
VACO—VA Central Office
VAMC—VA Medical Center
VBA—Veterans Benefits Administration
VHA—Veterans Health Administration
VISN—Veterans Integrated Service Network
VR&E—Vocational Rehabilitation & Employment
VSO—Veteran Service Organization
VSSC—VISN Support Service Center

Definitions

Acute Care Hospital—Offers primary care, general internal medicine, and limited surgical and diagnostic capabilities.

Access guidelines—Minimum percentage of enrollees living within a specific travel time to obtain a VA primary care, plus an absolute standard *i.e.*, a specific number of enrollees living outside the access guidelines.

Capacity Planning Initiative—A plan to meet large increases or decreases in inpatient or outpatient resources with the appropriate resources.

CARES (Capital Asset Realignment for Enhanced Services)—A planning process that evaluates future demand for veterans' health care services against current supply and realigns VHA capital assets in a way that results in more accessible, high quality health care for veterans.

CBOC (Community—Based Outpatient Clinic)—VA operated, or contracted or leased healthcare facility geographically distinct or separate from parent medical facility.

Critical Access Hospital (CAH)—Center for Medicare and Medicaid designation of hospitals that are located more than 35 miles from the nearest hospital; must have no more than 15 acute beds; ICU beds discouraged: cannot have length of stays (LOS) greater than 96 hours (except respite/hospice); and must be part of a network of hospitals.

Market Plan—A description of proposed actions to meet the outpatient and inpatient needs for veterans for the next 20 years. It focuses on access, capital requirements, and potential realignments and consolidations.

Market share—The percentage of veteran population enrolled for healthcare services.

Planning Initiative (PI)—A VACO identified future gap, potential overlap in services, large change in demand, or required access improvements for a market area that met specific thresholds and that need to be resolved.

Proximity—Two or more acute or tertiary hospital facilities with similar missions within close proximity of each other.

Small Facilities—Medical Centers that have a projected acute bed levels fewer than 40 beds in 2012 and 2022.

Tertiary Care Hospital—Provides a full range of basic and sophisticated diagnostic and treatment services across the continuum of care, including some of the most highly specialized services. Tertiary medical centers are generally affiliated with schools of medicine, participate in undergraduate and graduate medical education, conduct clinical and basic medical research, and serve as regional referral centers.

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