Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES)

Secretary of Veterans Affairs

CARES DECISION

Office of the Secretary

May 2004

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CHAPTER 1

Secretary's Opening Statement and Acceptance of the CARES Commission Report

Introduction

President Abraham Lincoln's solemn promise — "to care for him who shall have borne the battle and for his widow and his orphan" — defines the heart of the mission of the Department of Veterans Affairs. As Secretary of Veterans Affairs, I am the steward of that promise and must ensure that all the Department's actions, programs, and policies reflect our collective commitment to that mission.

Medical care is a key component of the benefits and services enacted by Congress in recognition of the service, and sometimes the sacrifice, of the men and women whose military service preserved and protected America's freedoms. Neither medical science nor the veteran population is static and unchanging and VA must modernize its facilities to provide quality care. VA will fail in honoring our Nation's commitment to veterans if our medical system does not evolve with the times. Implementation of VA's health care promise must be a dynamic process if we are to provide veterans access to the quality health care necessary to keep faith with them, and with the American people.

Neither medical science nor the veteran population is static and unchanging and VA must modernize its facilities to provide quality care. VA will fail in honoring our Nation's commitment to veterans if our medical system does not evolve with the times.

While the practice of VA medicine has evolved, VA's medical infrastructure has not kept up. Our facilities are out of step with changes in the practice of medicine, the veterans we serve, and with statutory changes in the VA health care benefits package.

VA entered the 21st century with a legacy infrastructure, most of which was designed and built to provide medical care as it was practiced in the middle of the twentieth century or, in some cases, as it was practiced before World War I. Most of our facilities were designed and built in an era when medical care was synonymous with hospital care. It made sense then to define our Nation's health care commitment to most veterans as access to a hospital bed to the extent beds were available.

Over the last half century, American medicine has transformed itself from hospital centered to patient centered treatment. Most patients see their physicians on an outpatient basis and much treatment is provided by prescription drugs. Mentally ill patients are no longer consigned to remotely located, thousand-bed asylums for the remainder of their lives. Treatment for tuberculosis no longer involves lengthy institutionalization. VA medicine has kept up with, and sometimes led, these innovations. Additionally, in 1996, the Congress enacted legislation expanding eligibility for the complete continuum of VA care, including outpatient care and prescription drugs, to all 25 million veterans. As a result of these changes, the number of VA outpatient visits increased from 38 million to 50 million per year between 1999 and 2003 and the number of 30 day equivalent prescriptions per year increased from 142 million to over 200 million.

In addition, millions of veterans, following the population migration patterns of the Nation as a whole, moved to the South, the West and the Southwest. As a result, many VA facilities are now located where veterans used to live rather than where they live now.

While the practice of VA medicine has evolved, VA's medical infrastructure has not kept up. Our facilities are out of step with changes in the practice of medicine, the veterans we serve, and with statutory changes in the VA health care benefits package. VA's medical infrastructure has become old and outdated. VA's facilities average age exceeds 50 years while those of successful private sector health care providers average less than 10 years.

The Congress has been reluctant to appropriate the construction funding VA will need to bring itself into the 21st century until we have a coherent national plan for modernizing our facilities. The process now known as "CARES" (for Capital Asset Realignment for Enhanced Services) produced that plan. It was initiated in

1998 to provide VA, veterans, the Congress, and the American people with a 20-year plan to provide the infrastructure VA will need to provide 21st century veterans with 21st century medical care.

CARES is not a simple one-time solution, but the creation of a set of tools and a process for annual capital and strategic planning to enable VA to keep its eyes fixed on the future as it plans for the capital resources it will need to provide quality health care to veterans.

An Unprecedented and Comprehensive Effort

CARES is a comprehensive, system-wide approach to, and ongoing process for, identifying the demand for VA care and projecting into the future the appropriate function, size and location for VA facilities. CARES is not a simple one-time solution, but the creation of a set of tools and a process for annual capital and strategic planning to enable VA to keep its eyes fixed on the future as it plans for the capital resources it will need to provide quality health care to veterans.

Assessing the best way to adapt a health care system with more than 4,900 buildings on 15,000 plus acres of land to serve over 7 million enrolled veterans required a complex and carefully constructed deliberative process. The CARES process is unprecedented in the history of the Department of Veterans Affairs. From development to execution, staff in the National CARES Program Office, the Veterans Health Administration, VA staff offices and Administrations, and especially VA's stakeholders, devoted tireless effort in developing and applying the models and tools used to conduct CARES.

The CARES process is the most comprehensive assessment of VA capital infrastructure and the demand for VA health care ever achieved. Major steps in the CARES process included:

- Development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care;
- Calculation of the current supply and identification of current and future gaps in infrastructure capacity;
- Development of Veterans Integrated Service Network (VISN)-based local plans to meet those anticipated future gaps in care;

The CARES process is the most comprehensive assessment of VA capital infrastructure and the demand for VA health care ever achieved.

- Review of the proposed solutions by the Under Secretary for Health to develop a comprehensive national plan; and
- Assessment of the resulting Draft National CARES Plan (DNCP) by an independent commission.

THE CARES COMMISSION

In order to ensure objectivity and independence in the process, I transmitted the DNCP to an independent and objective 16-member CARES Commission for their evaluation and review.[1] I named Commissioners with a firm grounding in, and commitment to, veterans and veterans' health care. Chairman Everett Alvarez, Jr., the other 15-members of the CARES Commission, and the staff that supported them, proved that they were worthy of their appointment.

Their product, the CARES Commission Report, is a comprehensive review of the DNCP. Its findings are grounded not only on the collective analyses of the Commissioners, but on the personal experience gained from 81 site visits to VA and DoD medical facilities and State Veterans Homes, 38 formal public hearings at 20 VISNs, monthly public meetings since February 2003, and more than 212,000 public comments on the DNCP. Not only did this provide them with a comprehensive understanding of the issues included in CARES, it allowed them to meet with those veterans and stakeholders who would be directly affected by their recommendations. For their tireless service, I extend my most sincere gratitude and humbly convey the thanks of the Department and millions of veterans who were well served by their energy, insight, and thoughtfulness.

The CARES Commission Report is well reasoned and provides a roadmap for moving the Department forward in planning for, investment in, and location of, our capital facilities. This roadmap will not only help to realign VA's 1950's infrastructure to ensure VA continues to define the leading edge of medical care, it also will form a blueprint for evaluating VA's capital needs into the future.

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[1] The Draft National CARES Plan and CARES Commission Report can be accessed at *www.va.gov/cares.*

After careful review and consideration of the Commission's findings and recommendations, I am confident they present a carefully studied and strategically sound path forward for the Department. With that confidence, I formally accept the CARES Commission Report although I will use the flexibility it provides to minimize the effect of any campus or service realignment on continuity of care to veterans currently receiving services on those campuses. The following chapters describe my decision and how VA will begin implementation.

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The CARES Commission Report, and my decision document, comprise a blueprint for VA's future that will effectively guide us forward. It will be VA's reference for all future planning, and its recommendations and considerations will be updated and allowed to evolve in harmony with future events, implementation studies, further planning, and refinements.

What CARES Means Today

Implementation of CARES will not be instantaneous. If Congress approves VA's FY 2005 budget request, we will have approximately $1 billion available in 2004 and 2005 to begin renovating and modernizing VA's health care system. I anticipate the process will require additional investments of approximately $1billion per year for at least the next five years, with substantial infrastructure investments then continuing for the indefinite future. VA will establish priorities for individual projects through the normal capital asset planning process. That process will develop the detailed cost data on proposed projects needed to confirm each project's cost-effectiveness. It is important to remember that CARES is a plan to modernize VA's aging infrastructure. CARES will require substantial investment. However, not proceeding with CARES would require funding to maintain or renovate obsolete facilities and would leave VA with numerous redundant, outmoded, or poorly located facilities.

I will not be true to my mission of service to veterans if I allow paralysis by analysis to further delay VA's long overdue modernization.

It is also important to remember that implementation of CARES will enhance access to care, not reduce it. Today, approximately 24 percent of the veteran population is enrolled for VA care. The CARES plan assumes that in 2022, the end of the planning period, 33 percent of the veteran population will be enrolled for VA care.

The CARES Commission and interested stakeholders identified several ways to improve VA's capital asset planning. We already have implemented many of those improvements, e.g. incorporating enrollment data derived over longer periods of time, in our planning process. However, I will not be true to my mission of service to veterans if I allow paralysis by analysis to further delay VA's long overdue modernization.

I place a high priority on VA's obligation to care for veterans living with mental illness and am conscious of the fact that the decision will affect some facilities now providing mental health treatment. It is important to remember that health care, including long term inpatient health care, is defined, not by the buildings where care is provided, but rather by the skill and commitment of health care professionals. But while buildings do not define health care, buildings can constrain and limit care if they are poorly located, obsolete or no longer appropriate for the care patients need. Nowhere is this more apparent than in mental health, a discipline that long ago progressed beyond long-term warehousing of patients. Mentally ill veterans will be better served by modern and appropriately sized facilities located closer to their homes than they would be by continuing to force them to travel to remote areas for admission to facilities designed for pre-World War II treatment. While the CARES decision may change the site for providing care, VA will still provide the care. I established a benchmark for the CARES process mandating that VA's capacity to provide inpatient mental health care, including long-term inpatient care when necessary, would not be diminished. I have established the same benchmark for other forms of long-term care.

VA will soon complete and validate utilization models for long-term care and long-term mental health care, and the results of those models will be incorporated into the capital asset planning process. But I will not delay the start of VA's modernization process waiting for better data. That course leads only to indefinite delay because it is always possible to create a scenario for which better data might

become available. A key to successful leadership is not waiting for perfect data but in determining when the data are good enough to act today. The case is clear. Veterans will be best served by action to modernize VA now, not by delay.

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While CARES provides for numerous individual changes within individual VA networks that will lead to construction, renovation, and realignment of facilities, in aggregate CARES provides for system-wide improvements, including:

- *Improved Access:* The percentage of enrollees within VA's travel guidelines for acute care will increase from 72 percent to 82 percent. In 2001, VA met acute care access guidelines in only 49 of our 77 medical care market areas. When the CARES process is complete, we will meet that standard in all but four markets. We will also increase from 95 percent to 97 percent the percentage of enrollees within access guidelines for tertiary care. There also will be dramatic improvements in access to primary care, especially for veterans living in rural areas. Of the more than 250 community-based outpatient clinics (CBOCs) originally proposed, this decision document identifies 156 as highest priority. When all CBOCs are activated, the percentage of enrollees within primary care access guidelines will increase from 73 percent to 80 percent.
- *Modernization:* VA's infrastructure is old. Congress has been reluctant to fund modernization without a coherent national plan defining the infrastructure we will need in the decades to come. CARES is that plan and VA will now be able to move forward to modernize and renovate our facilities. The CARES plan identifies more than 100 major construction projects in 37 states, the District of Columbia, and Puerto Rico. In addition, adoption of the CARES plan will enable VA to plan minor construction projects to ensure continuing modernization of the facilities veterans will count upon in the decades to come.
- *Operating Costs:* While implementation of CARES will require billions of dollars in capital investment, operating costs are the dominant costs

Investment in modernized infrastructure, as well as costs avoided through vacating obsolete or redundant space, will pay off in funding made available to pay health care providers and purchase medical supplies and pharmaceuticals.

to provide health care. Investment in modernized infrastructure, as well as costs avoided through vacating obsolete or redundant space, will pay off in funding made available to pay health care providers and purchase medical supplies and pharmaceuticals.

- *Vacant Space:* Implementation of the CARES plan will decrease vacant space in the Veterans Health Administration from 8.57 million square feet to 4.93 million square feet, a reduction of 42.5 percent. The CARES plan will reduce the cost of maintaining vacant space over the period 2006 to 2022 from an estimated $3.4 billion to $750 million and allow VA to redirect those funds to patient care. In addition to improving health care quality through modernization and relocation, and improving access through additional access points, CARES will allow VA to treat more veterans by allowing VA to redirect funding from vacant buildings to patient care.

While all of these improvements represent a net benefit to veterans and a watershed investment in the future of the VA health care system, it is also important to acknowledge that some veterans, employees, stakeholders, and communities will see the scope and location of their local VA presence change. It will be understandably difficult for some to adapt to these changes, even though only the physical venue for care will change, not the commitment to quality health care. Recognizing that change can be a stressful process, I am committed to mitigating perceived adverse effects. Specific actions VA will take to ensure a minimal adverse impact on veterans and stakeholders include:

- No changes will be made to care patterns at existing sites of care until completion of arrangements for care at an alternative site providing comparable quality and appropriate access to care;
- VA will ensure continuity of care for those patients currently receiving care at sites scheduled for realignment with great sensitivity to their psychosocial needs;

Recognizing that change can be a stressful process, I am committed to mitigating perceived adverse effects.

- VA will take time to work with veterans, employees, local congressional delegations, communities, and other stakeholders to identify plans for alternate uses for facilities and locations where VA will no longer provide care;
- Where there is an anticipated change or reduction in employment at a specific site, VA will work closely with employees to manage changes by attrition, early retirements, transfers, retraining, and other benevolent mechanisms to ensure continuity of employment for our dedicated workforce; and
- Where further study is recommended, VA will continue to include stakeholders as part of the study process.

As a Department, VA will work closely and carefully with veterans, employees, veterans service organizations, unions, local congressional delegations, communities, and other stakeholders to manage changes and ensure minimal adverse impact as it moves forward in implementing CARES.

A Blueprint for the Future

Through the CARES process, VA developed and gathered more information about veterans than ever before. Sophisticated forecasting models provide new and more complete information about the demand for VA health care and a comprehensive assessment of our facilities has greatly improved the depth of understanding about the condition of VA's facilities. These factors, combined with the experience of conducting the CARES process, leave the Department well positioned to continue to expand the accuracy and scope of its planning efforts.

Restructuring of VA facilities is not unprecedented. In the past few years VA has, in locations as diverse as Ft. Lyons, Colorado; Martinez, California; Grand Island, Nebraska; Miles City, Montana; and Ft. Howard, Maryland, changed the scope of care at, or even closed, facilities while meeting the needs of veterans and minimizing the impact on employees and communities. The

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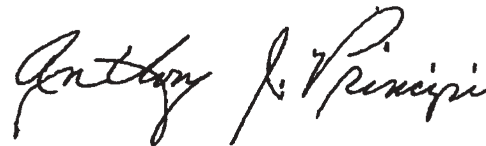
With the acceptance of the CARES Commission Report, I am confident that the Department of Veterans Affairs stands more ready than ever to continue to meet President Lincoln's solemn promise today and into the future.

only difference is that rather than facility-by-facility actions, CARES sets the stage for a systematic, data driven national plan to maximize veterans' access to quality care.

Today, CARES represents a baseline — a beginning from which VA will continue to evolve and improve its decision-making processes. Along with implementing specific CARES decisions, VA will now focus on integrating these tools into its annual capital and strategic planning efforts so that initiatives can be validated and updated. As the Department moves forward, it will always focus on ensuring use of the best information available for planning to meet the health care needs of our current and future heroes. With the acceptance of the CARES Commission Report, I am confident that the Department of Veterans Affairs stands more ready than ever to continue to meet President Lincoln's solemn promise today and into the future.



Anthony J. Principi
Secretary of Veterans Affairs

CHAPTER 2

Crosscutting Decisions and Implementation

Introduction

This chapter outlines the Secretary of Veterans Affairs' decisions on the crosscutting recommendations of the CARES Commission.

These are recommendations and decisions on policy issues that influence multiple individual decisions in the CARES process. After each Commission recommendation, the Secretary provides a response and guidance for implementation. Completion dates have been included where studies or plans are called for in implementation.

Commission recommendations were abbreviated to facilitate the readability of the document. Often, crosscutting recommendations are relevant to individual VISN recommendations. To help the reader make linkages between the crosscutting and VISN recommendations, many of these recommendations are later referenced in individual VISN sections.

The Secretary's decisions and guidance for each of the crosscutting recommendations made by the Commission follow.

THE CARES MODEL

CARES Commission Recommendation

The CARES Commission determined that the CARES Model provided a reasonable analytical approach for estimating VA enrollment, utilization, and expenditures. Recognizing the complexity of the CARES Model, the Commission sought expert advice from consultants who studied the Model, confirmed its validity and made recommendations to the Commission for further improvements.

Based on this analysis, the Commission recognized the CARES Model as a legitimate basis for planning. In accepting the Model, the Commission made several important recommendations, including: the need for a re-examination of the sustainable enrollment base to justify investments, completion of a lower-bound sensitivity analysis, and use of 30 months of data to arrive at an enrollment projection.

Secretary's Response and Implementation

The CARES Model was designed to produce the most accurate possible forecast of the current and future demand for veterans health care and the data used to develop the Draft National CARES Plan represented the best information available about the future demand for veterans' health care. To project future workload, CARES used a private sector utilization model to ensure that forecasts met private sector efficiency standards, but adjusted the Model to account for the unique characteristics of the veteran population and the VA benefits package. In addition, the National CARES Program Office, in consultation with stakeholders, developed separate projections of services that are unique to VA and generally not extensively available in the private sector. While the data and methodologies employed to project enrollment and workload are the most sophisticated that VA has ever used, they will continue to be improved as CARES is integrated into VA's annual strategic planning cycle.

As VA seeks to improve the Model, it will specifically address the recommendations of the CARES Commission.

While the data and methodologies employed to project enrollment and workload are the most sophisticated that VA has ever used, they will continue to be improved as CARES is integrated into VA's annual strategic planning cycle.

The following actions are ongoing and address all of the major recommendations specific to the CARES Model:

1. VA will increase the enrollment period used for CARES enrollment estimates to 29 months in the next full set of projections. The 17-month enrollment period used for CARES represented the most accurate data available at the time. Once the 29 months of data are available, VA will incorporate this larger information base into its forecasts. As experience is gained from additional months of actual enrollment, and data are verified as meeting quality standards, VA will further augment this component in successive Model forecasts of enrollment.
2. VA has completed development of a lower-bound sensitivity analysis for CARES projections. This analysis used more conservative assumptions to project enrollment and was intended to test the validity of the CARES data. VA is using the results of the analysis to further analyze CARES projections. The new set of forecasts explored the sensitivity of enrollment projections by using estimates of expected market shares by priority groups based upon the predominant pattern of current market shares.
3. The Commission acknowledged the work underway to improve the Model and to-date, VA has completed the following improvements, all of which will result in greater accuracy:
    - Projections of geographic state-to-state migration of the enrollee population;
    - Estimates of the probability of transitioning between priority levels;
    - Reliance on VA health care services versus the private sector is now calculated at the market area where previously it was calculated at the VISN level;
    - The Vietnam era cohort, with a relatively higher morbidity, has been adjusted for higher mental health utilization;
    - Estimates of the baseline Priority 5 eligible population have been significantly improved by incorporating new information on veterans' income from Census 2000;
    - Forecasting models for eleven VA mental health programs have been included and future utilization of services by the population of veterans

aged 65 and over has been adjusted to reflect expected changes in their need and utilization of health services; and

- Enrollment forecasts are improved by using 506 sectors as opposed to 3000 separate counties. Aggregating counties with very small numbers of veterans into broader sectors provides a more robust unit of analysis.

As recommended by the Commission, VA completed a rigorous re-examination of its forecasting Model by expanding the enrollment base period, completing a lower bound sensitivity analysis, and making Model improvements.

As recommended by the Commission, VA completed a rigorous re-examination of its forecasting Model by expanding the enrollment base period, completing a lower bound sensitivity analysis, and making Model improvements. VA has updated its forecasts with this information and is currently in the process of integrating these findings into its strategic and capital planning processes. The results of these forecasts have been used to validate the major construction proposals that will be incorporated into VA's capital planning process and will be reflected in VA's five-year capital plan. VA will submit its five-year capital plan to Congress in May 2004.

These actions are iterative enhancements to the CARES Model that will help VA ensure ongoing improvement in its ability to forecast demand for veterans health care. The Model will continue to be improved as VA integrates CARES into strategic and capital planning cycles. While these improvements will help further refine the CARES Model, they do not represent a compelling reason to delay the decision to move forward. There will always be improvements VA can make to more effectively forecast demand. For that reason, VA is always in pursuit of continuous improvement in its efforts to collect and analyze data relevant to improving health care delivery.

The Commission has endorsed the forecasting Model with the inclusion of the improvements described as an acceptable basis for planning. The data assembled to-date is by far the most comprehensive ever developed to support planning for future needs. VA must initiate the process of implementing CARES by acting today and committing to continuous ongoing improvement in planning for the future.

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CRITICAL ACCESS HOSPITALS

CARES Commission Recommendation

VA should establish a clear definition and clear policy on the Critical Access Hospital (CAH) designation prior to making decisions on the use of this designation.

Secretary's Response and Implementation

VA must ensure a standard of high quality of care at all of its medical facilities. Though VA's small and rural facilities are often among VA leaders in provision of quality health care, VA must carefully determine and monitor the scope of services to be performed at its small facilities — specifically those procedures that are complex in nature. Further, as medical care becomes more technologically advanced, small facilities may find it difficult to effectively maintain and use the tools necessary to practice health care at its most sophisticated levels. To establish parameters for how these facilities should prepare to meet future challenges, VA introduced the concept of a CAH, modeled after a Medicare designation for small hospitals.

The CAH was introduced to help ensure that veterans receive high quality care at VA's small facilities. Though the CARES Commission found the definition applied to these facilities in the DNCP to be lacking in specificity, VA needs a framework for ensuring the ongoing and future quality of care provided at its small and rural facilities. Recognizing that some small and rural facilities will be unable to maintain the workload necessary to perform certain surgical procedures or manage some complex illnesses effectively, VA must establish parameters to ensure high quality patient care.

To address this need, VA is developing a policy to define the appropriate scope of services that should be provided at small and rural facilities. The new policy, Veterans Rural Access Hospital (VRAH), will specifically define the clinical and operational characteristics of small and rural facilities within VA. The VRAH policy will be completed in June 2004.

In the interim, the missions of small facilities previously recommended for the CAH concept in the DNCP will not be altered. Once the new VRAH policy is approved, VA will study the scope of services performed at these facilities using the policy's criteria

Recognizing that some small and rural facilities will be unable to maintain the workload necessary to perform certain surgical procedures or manage some complex illnesses effectively, VA must establish parameters to ensure high quality patient care.

and the guidance provided. The VRAH policy will be shared with stakeholders and VA will seek further comments as facilities are studied.

VRAH studies will begin mid-summer, be completed by the end of the calendar year, and results will be included in VISN FY 2005 strategic planning submissions.

Community-Based Outpatient Clinics

Commission Recommendations

The CARES Commission made several recommendations for enhanced access to veterans health care through Community-Based Outpatient Clinics (CBOCs). Recognizing the need to apply uniform criteria and consistent national standards, the Commission reaffirmed that final decisions regarding the establishment of new CBOCs should remain under the purview of the Under Secretary for Health and the Secretary. Under that national framework, the Commission made several additional recommendations about how VA should prioritize CBOCs. The Commission found that the prioritization methodology in the DNCP disproportionately disadvantaged veterans living in rural areas that are underserved and lack appropriate access to care. They also sought flexibility for VISNs to relieve space deficits at parent facilities by adding new sites of care. Finally, the Commission recommended VA improve the efficiency of operations at existing sites and supply basic mental health services at all CBOCs.

Secretary's Response and Implementation

VA will continue its ongoing efforts to meet national standards for access to care for our Nation's veterans by establishing new sites of care through CBOCs. The Commission made several positive recommendations regarding CBOCs, and VA will act to ensure they are met. To that end, VA revised its national criteria for establishment of CBOCs to include emphasis on the importance of access to care for rural veterans, use of CARES travel guidelines to assess access to care, the availability of mental health services, and the flexibility for VISNs to relieve space deficits at crowded parent facilities by moving care to a nearby outpatient setting.

These actions complement existing CBOC criteria that include a focus on caring for Priority 1–6 veterans, ensuring that VISNs have necessary funds to operate new sites, developing well conceived business plans before implementing new sites, ensuring new CBOCs will increase access to care, and other factors. Further, VA will continue to explore opportunities to improve management of existing

CBOCs through more effective staffing, expanding hours of operation, and examining opportunities to augment services where appropriate.

These priorities reflect determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options.

VA will proceed with development of new CBOCs through CARES and will prioritize clinics that meet specific criteria. Priority criteria include CBOCs that:

1. Are in markets that have large numbers of enrollees outside of access guidelines and are below VA national standards for primary care access;
2. Are in markets that are classified as rural or highly rural and are below VA national standards for primary care access;
3. Take advantage of VA/DoD sharing opportunities;
4. Are associated with the realignment of a major facility; and
5. Are required to address the workload in existing overcrowded facilities.

These priorities reflect determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options. They also reflect the Department's ongoing commitment to strengthening sharing opportunities with the Department of Defense.

The 156 priority CBOCs listed at the end of this response will be implemented by 2012 pending availability of resources and validation with the most current data available. This list reflects VA's priorities for planning based upon the most current information. As VA proceeds in implementing CARES and as it engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural and highly rural areas. VA also will enable overcrowded facilities to better serve veterans and will continue to support sharing with DoD. These principles will remain priorities even if management strategies to meet them evolve as new data and information becomes available.

Recognizing that resources are not available to open all of these clinics immediately, VA will manage implementation of CBOCs by applying the revised CBOC criteria within the existing National CBOC Approval Process. This will

ensure a careful and considered implementation that mandates VISNs develop sound business plans, ensures national criteria are met, and that resources are available to provide the quality of care veterans expect from the Department. Resource requirements that must be in place to open new CBOCs include the capacity to manage specialty referrals and inpatient needs of new populations.

These priorities do not prohibit VISNs from pursuing other CBOC opportunities identified in the DNCP. VISNs will be able to propose any CBOC in the DNCP for activation; however, they must be able to demonstrate their ability to open priority clinics on schedule before they can open a clinic that is outside of the priority criteria.

VISNs will immediately begin preparation of proposals for development of CBOCs for this year. These proposals will be submitted for Central Office review in June.

CBOCs and New Sites of Care for Priority Implementation

VISN	Parent Facility	Planned New Facility Name	State
1	Togus VAMC	Houlton-PT – Contract	ME
1	Togus VAMC	Bangor Outreach – Dover Fox	ME
1	Togus VAMC	Bangor Outreach – Lincoln	ME
1	Togus VAMC	Rumford Outreach – Farmington	ME
1	Togus VAMC	Rumford Outreach – South Paris	ME
1	Togus VAMC	Cumberland County	ME
5	Martinsburg VAMC	Fort Detrick – DoD Joint Venture	MD
5	Baltimore VAMC	Fort Meade – DoD Joint Venture	MD
5	Baltimore VAMC	Owings Mill	MD
5	Baltimore VAMC	Baltimore City – Mental Health	MD
5	Washington DC VAMC	Fort Belvoir – DoD Joint Venture	VA
5	Washington DC VAMC	Southern Prince George	MD
6	Beckley VAMC	Lewisburg	WV
6	Beckley VAMC	Bluefield	WV
6	Salem VAMC	Staunton	VA
6	Salem VAMC	Radford	VA
6	Salem VAMC	Lynchburg	VA
6	Asheville VAMC	Franklin	NC
6	Asheville VAMC	Rutherfordton	NC
6	Asheville VAMC	Hendersonville	NC
6	Salisbury VAMC	Gastonia	NC
6	Salisbury VAMC	Hickory	NC
6	Salisbury VAMC	Greensboro	NC
6	Fayetteville VAMC	Hamlet	NC
6	Fayetteville VAMC	Lumberton	NC

VISN	Parent Facility	Planned New Facility Name	State
6	Fayetteville VAMC	Supply	NC
6	Hampton VAMC	Norfolk	VA
6	Richmond VAMC	Charlottesville	VA
6	Richmond VAMC	Emporia	VA
7	Dublin VAMC	Milledgeville	GA
7	Dublin VAMC	Brunswick	GA
7	Dublin VAMC	Perry	GA
7	Augusta VAMC	Athens	GA
7	Augusta VAMC	Aiken	SC
7	Atlanta VAMC	Stockbridge	GA
7	Atlanta VAMC	Noonan	GA
7	Charleston VAMC	Hinesville	GA
7	Charleston VAMC	Goose Creek	SC
7	Columbia VAMC	Spartanburg	SC
7	Central Alabama HCS	Enterprise	AL
7	Central Alabama HCS	Opelika	AL
7	Central Alabama HCS	Maxwell AFB	AL
7	Birmingham VAMC	Childersburg	AL
7	Birmingham VAMC	Guntersburg	AL
7	Birmingham VAMC	Bessemer	AL
8	Gainesville VAMC	Jackson County	FL
8	Gainesville VAMC	Putnam	FL
8	Gainesville VAMC	Camden	GA
8	Gainesville VAMC	Summerfield (South Marion)	FL
9	Mountain Home VAMC	Holston Medical Clinic	TN
9	Mountain Home VAMC	Pennington Gap Clinic	VA
9	Mountain Home VAMC	Thompson Clinic	VA
9	Mountain Home VAMC	Haysi Clinic	VA
9	Mountain Home VAMC	Davenport Clinic	VA
9	Mountain Home VAMC	Davis Clinic	VA
9	Mountain Home VAMC	West Lee County Clinic	VA
9	Mountain Home VAMC	Jellico	TN
9	Mountain Home VAMC	Pigeon Forge	TN
9	Memphis VAMC	Pontotoc County	MS
9	Memphis VAMC	Tunica	MS
9	Memphis VAMC	Greneda	MS
9	Memphis VAMC	Paris	TN
9	Memphis VAMC	Bolivar	TN
9	Memphis VAMC	Phillips County	AR
9	Memphis VAMC	Wynne County	AR
9	Memphis VAMC	Dyer County	TN
9	VATVHS – Murfreesboro	Maury County	TN
9	VATVHS – Murfreesboro	Athens	TN
9	VATVHS – Murfreesboro	Harriman	TN

VISN	Parent Facility	Planned New Facility Name	State
9	VATVHS – Murfreesboro	McMinn County	TN
9	VATVHS – Nashville	Glasgow	KY
9	VATVHS – Nashville	Giles County – Pulaski	TN
9	VATVHS – Nashville	Hopkins County	KY
9	Huntington VAMC	Gallipolis	OH
9	Huntington VAMC	Logan	WV
9	Louisville VAMC	Scott County	IN
9	Louisville VAMC	Grayson County	KY
9	Louisville VAMC	Carroll County	KY
9	Lexington VAMC	Berea	KY
9	Lexington VAMC	Perry County	KY
9	Lexington VAMC	London	KY
11	Illiana HCS	Charleston	IL
11	Marion VAMC	Peru	IN
11	Indianapolis VAMC	Martinsville	IN
15	Wichita VAMC	Hutchinson	KS
15	Marion (IL) VAMC	Hopkins County	KY
15	Marion (IL) VAMC	Graves County	KY
15	Marion (IL) VAMC	Knox County	IN
15	Marion (IL) VAMC	Davies County	KY
15	St. Louis VAMC	Sullivan	MO
15	Columbia VAMC	Jefferson City	MO
16	Little Rock VAMC	Mena	AR
16	Little Rock VAMC	Searcy	AR
16	Little Rock VAMC	Conway	AR
16	Little Rock VAMC	Pine Bluff	AR
16	Little Rock VAMC	Russellville	AR
16	Muskogee VAMC	Vinita	OK
16	Fayetteville (AR) VAMC	Jay	OK
16	Fayetteville (AR) VAMC	Branson	MO
16	Fayetteville (AR) VAMC	Ozark	AR
16	Oklahoma City VAMC	Enid	OK
16	Oklahoma City VAMC	Altus	OK
16	Oklahoma City VAMC	Stillwater	OK
16	Alexandria VAMC	Fort Polk	LA
16	Alexandria VAMC	Lake Charles	LA
16	Alexandria VAMC	Natchitoches	LA
16	Houston VAMC	Galveston (Site 1)	TX
16	Houston VAMC	Galveston (Site 2)	TX
16	Houston VAMC	Conroe	TX
16	Houston VAMC	Tomball	TX
16	Houston VAMC	Katy	TX
16	Houston VAMC	Richmond	TX

VISN	Parent Facility	Planned New Facility Name	State
16	Houston VAMC	Lake Jackson	TX
16	Jackson VAMC	Columbus	MS
16	Jackson VAMC	McComb	MS
16	New Orleans VAMC	Hammond	LA
16	New Orleans VAMC	Franklin	LA
16	New Orleans VAMC	Bogalusa	LA
16	New Orleans VAMC	LaPlace	LA
16	Eastern Southern	Eglin AFB	FL
17	San Antonio VAMC	Brooks AFB	TX
17	San Antonio VAMC	NE Bexar	TX
17	Dallas VAMC	Plano	TX
18	El Paso OPC	East El Paso	TX
18	Albuquerque VAMC	Albuquerque Urban	NM
18	Tucson VAMC	Urban 1	AZ
18	Tucson VAMC	Urban 2	AZ
19	Fort Harrison VAMC	Lewiston	MT
19	Fort Harrison VAMC	Cut Bank	MT
19	Salt Lake City VAMC	West Valley City	UT
20	Spokane VAMC	Central Washington	WA
21	Sierra Nevada HCS	Fallon	NV
21	San Francisco VAMC	North San Mateo	CA
21	Palo Alto HCS	East Bay	CA
21	Pacific Islands HCS	American Samoa	HI
23	Fargo VAMC	Bemidji	MN
23	Fargo VAMC	Dickinson	ND
23	Fargo VAMC	Jamestown	ND
23	Fargo VAMC	Devils Lake	ND
23	Fargo VAMC	Williston	ND
23	Fargo VAMC	Grand Forks	ND
23	Des Moines VAMC	Marshalltown	IA
23	Des Moines VAMC	Carroll	IA
23	Iowa City VAMC	Ottumwa	IA
23	Iowa City VAMC	Cedar Rapids	IA
23	Grand Island VAMC	O'Neil	NE
23	Grand Island VAMC	Holdredge	NE
23	Omaha VAMC	Bellevue	NE
23	Omaha VAMC	Shenandoah	IA
23	Sioux Falls VAMC	Wagner	SD
23	Sioux Falls VAMC	Watertown	SD
23	Sioux Falls VAMC	Spirit Lake	IA
23	Minneapolis VAMC	Redwood Falls	MN
23	Minneapolis VAMC	Rice Lake	MN
23	Minneapolis VAMC	Elk River	MN
23	St. Cloud VAMC	Alexandria	MN

MENTAL HEALTH SERVICES

Commission Recommendation

The Commission recognized the critical importance of mental health services to the veteran population. In reviewing the early projections for CARES, VA realized that it needed to make modifications to its projections for outpatient, acute inpatient, and long-term psychiatric mental health care programs. The Commission acknowledged VA is currently making adjustments to these models and recommended that, once complete, the forecasts be rerun, that gaps in service be identified, and that VA plan to address those gaps. The Commission also recommended that VA take action to ensure consistent availability of mental health services across the system, to provide mental health care at CBOCs, and to collocate acute mental health services with other acute inpatient services wherever feasible.

Secretary's Response and Implementation

VA is committed to meeting the mental health needs of our Nation's veterans and it is critical that VA's health care system provides comprehensive mental health care services at a high level of quality consistently across the country. Effective mental health treatment requires that veterans have appropriate access to a full continuum of mental health care services. While VA provides comprehensive and cutting edge mental health services in many locations across the country, it faces challenges in providing equitable access to those services to veterans in some areas. VA must provide quality and complete mental health service in all VISNs and will ensure this outcome by making improvements to its forecasting models and developing a comprehensive strategic plan for mental health care.

At the time of the release of the DNCP, projections for outpatient and acute psychiatric inpatient care contained inconsistencies and VA committed to improving its forecasting models to ensure that projections adequately reflect future need. In the interim, VA stipulated firm guidance that CARES plans would not include reductions in service for mental health until new models and reliable data are available.

VA has completed a new set of mental health demand forecasts that include the improvements cited by the Commission. These forecasts will be used in the development of a comprehensive VA Mental Health Strategic Plan and will be incorporated into VA's strategic planning process. This process will require every VISN to develop mental health market plans that incorporate the new forecasts as well as the policies established in the strategic plan to ensure that veterans across the VA system have appropriate access to quality and complete mental health care services.

It is not acceptable that the availability of mental health services be dependent on geographic location. VA's mental health strategic plan will do more than ensure that veterans will have appropriate access to quality and complete mental health services, it also will firmly set VA's sights on retaining its position as a leader and innovator in the field.

The VA Mental Health Strategic Plan will be completed in August 2004 and will provide clear direction on the inclusion of mental health services at CBOCs, the consistency of mental health services across the VISNs, the importance of collocating acute inpatient mental health services with other inpatient services, and guidelines for assuring appropriate access to a full continuum of mental health care services.

By improving its forecasting methodologies and refining its policies to present a national approach, VA will continue to improve the quality and accessibility of its mental health services. It is not acceptable that the availability of its mental health services be dependent on geographic location. VA's Mental Health Strategic Plan will do more than ensure that veterans will have appropriate access to quality and complete mental health services, it also will firmly set VA's sights on retaining its position as a leader and innovator in the field.

Long-Term Care

CARES Commission Recommendations

The Commission acknowledged the complexity of planning for the care of an aging veteran population and found that VA has not yet developed the forecasts and policies needed to project and plan to meet future demands for long-term care. Recognizing the need for additional work in this area, the Commission made several recommendations concerning how VA should address long-term care in implementing CARES.

The Commission's central recommendation was that VA develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliaries, residential treatment facilities, and nursing homes, and for seriously mentally ill veterans. Further, the Commission recommended that the plan include strategies for maximizing the use of State Veterans Homes, locating domiciliary units

as close to patient populations as feasible, and identifying freestanding nursing homes as an acceptable care model.

Pending completion of the long-term care strategic plan, the Commission recommended that VA only proceed with long-term care projects that make necessary life safety and maintenance improvements to existing facilities.

Secretary's Response and Implementation

VA is committed to caring for veterans who require long-term health care. To appropriately meet their needs, VA must offer a full continuum of care to veterans with a focus on keeping the patient in the least restrictive setting possible — allowing them to remain in their home and close to their family, but recognizing that some patients will need inpatient nursing home and inpatient mental health care. With a rapidly aging veteran population, planning to meet the long-term care needs of veterans is a complex undertaking that requires integration of forecasts and strategies for nursing home care, gero-psychiatric needs, domiciliary care, and long-term psychiatric care for the seriously mentally ill as well as strategies for expanding care coordination in the home, residential care, assisted living facilities and other less restrictive care settings.

All of these issues require management through a comprehensive long-term care plan. Completion of such a plan requires resolution of complex and sensitive policy issues about eligibility for the quantity and type of care VA should provide, especially for the nursing home population. Because VA had not developed reliable forecasts and policies for long-term care, strict guidance was issued to ensure that long-term care services would not be reduced in CARES.

VA must definitively plan to meet the needs of an aging veteran population, and will formulate an effective set of long-term care forecasts and policies. Today, VA is in the process of developing policy options for managing long-term care into the future, which will lead to a strategic plan for long-term care.

VA must definitely plan to meet the needs of an aging veteran population, and will formulate an effective set of long-term care forecasts and policies.

VA's long-term care strategic plan will address consistency of access to care across VA's health care system, include a clear policy on maximizing partnering opportunities with State Veterans Homes, allow VA to provide nursing home

care for aging veterans in freestanding nursing homes, and clarify the Department's commitments to gero-psychiatric care and to reducing the variation in mental health care services across the system.

Work on components of this plan is progressing and includes:

- An updated nursing home model that accounts for improvements in functional status, a gender adjustment, and estimates of reliance on VA sources of care;
- Incorporating long-term psychiatric bed needs as well as those for patients who are seriously mentally ill into the strategic planning model;
- A revised domiciliary care model weighted toward urban areas, closest to where patients typically reside; and
- Integration of residential rehabilitation bed needs, including substance abuse and PTSD, into the forecasting models.

In addition to improvements in these areas, VA is revising its current nursing home policy. While VA will continue to place short-term nursing home rehabilitation units on acute medical campuses whenever possible, it will now allow nursing homes that primarily provide long-term nursing home care to patients to be freestanding. For such freestanding nursing homes, it will be mandatory that acute inpatient hospital care arrangements are in place to ensure that VA facilities are prepared to effectively refer patients with emergent medical situations to facilities able to provide quality and timely health care services. VA will also ensure that these arrangements are in place for veterans receiving care in VA contract community nursing homes.

All of these analyses are important and all must be factored into VA's long-term care strategic plan. Until such a plan is completed, VA will limit planned reconfigurations, expansions, or replacements of long-term care facilities. Only projects that correct high risk seismic or safety deficiencies — where workload supports maintaining current bed levels and where the appropriateness of the site of the current facility is not in question — will be considered for major construction funding.

Excess VA Property

Commission Recommendation

The Commission recognized the importance of the enhanced use lease process and other mechanisms that will be needed to effectively manage the reuse of vacant and underutilized properties as VA implements CARES. The Commission Report includes several recommendations for improving VA's ability to manage capital assets. Most centrally, the Commission recommended that VA take steps to reform the enhanced use lease process to improve timeliness and efficiency. The Commission also recommended that VA should consider all options for alternate use of vacant and underutilized space, to include priority consideration of use for supportive services to homeless veterans. Finally, the Commission recommended that VA seek a separate appropriation of funds to maintain its historic properties.

Secretary's Response and Implementation

Successful implementation of CARES will rest in large part on VA's ability to effectively manage its vacant and underutilized space. Through CARES, VA expects to reduce its current vacant and underused space by 42 percent by 2022. VA will need to improve upon its ability to manage its capital assets in order to achieve this reduction.

The CARES Commission identified several key and interrelated areas where VA will need to improve management of capital assets. The ability to redirect savings to pay for direct care of veterans is a compelling incentive to improve. In view of the continuously rising cost of health care (providing care for a single veteran currently averages approximately $5,000/year), VA must take every opportunity for savings from reducing or eliminating maintenance of vacant or underused capital assets.

To maximize return on investment, VA will seek needed flexibilities by pursuing the following actions:

In view of the continuously rising cost of health care (providing care for a single veteran currently averages approximately $5,000/year), VA must take every opportunity for savings from reducing or eliminating maintenance of vacant or underused capital assets.

Enhanced Use Lease: VA has made numerous changes, both organizationally and functionally, to the enhanced use lease process since its inception over 10 years ago. This has been an evolutionary process as VA has gained experience and recognized increased applicability of this

important capital asset management tool. With this CARES decision, it is critical that VA continue to improve its capabilities. A cross-organizational team has made recommendations to further improve the timeliness and effectiveness of the enhanced use lease process. Process improvements will include carefully assigned delegations of authority, implementation of VA's Finance Office reorganization to include real property management expertise at the VISN level, and increased access to the real estate, financial, legal and marketing expertise needed to successfully implement, negotiate, and manage complex real estate projects. Increased delegation, within appropriate thresholds, to the newly created Chief Asset Manager (CAM) and Chief Logistic Officer (CLO) within each VISN will not only help to streamline the process, but also allows VA to retain maximum flexibility under current law, minimize duplicative review and approval processes, expand the number of trained and experienced staff who will possess an enhanced use lease-related skill set and increase responsibility and accountability for meeting program goals. These actions will improve both the timeliness and number of enhanced use lease projects for the Department.

Leveraging Assets: While the enhanced use leasing program is one vehicle for managing excess property, its full potential as a capital asset management tool is realized when the authority is used to leverage assets to acquire all, or a portion of, VA's needed commodities (services, facilities, etc.). VA needs to take full advantage of the power of the enhanced use leasing authority to accelerate the implementation of the CARES process. For example, consolidation from a multi to a single division health care system would most likely require a large capital investment in order to accommodate increases in workload at the receiving site, while the other site could be out-leased through enhanced use leasing. This out-lease would allow VA to leverage the investment value of unneeded assets to provide for a portion of the required new capital improvements to the remaining/new site as consideration "in-kind." Leveraging assets in this manner maximizes VA's ability to accelerate the implementation of approved CARES plans.

More Flexible Disposal Authority: VA is developing legislation for Independent Real Property Disposal Authority. This authority would allow VA to dispose of underused real property and retain proceeds for reinvestment in veterans' health care and capital improvements to medical facilities. Further, VA will propose changes to Appropriation and Authorization legislation to provide maximum flexibility for the placement and use of disposal receipts. If enacted, these legislative changes will significantly improve VA's ability to implement

CARES by providing VA with a mechanism to expeditiously shed unneeded and resource-draining assets and reinvest in its capital infrastructure.

Managing Historic Properties: VA will conduct a baseline study of its historic properties, identifying all applicable facilities, categorizing them by type and use, identifying existing maintenance costs, and developing strategies for most effectively managing them. Strategies for managing unneeded or underused historic properties could include partnerships with states, local historical societies, and other entities, disposal or donation if applicable, and appropriate upkeep and maintenance. Work on this effort is underway and VA will complete the study by the end of 2004.

Disposal or Reuse of VA Property: In all cases where it is recommended that VA dispose of or realign underused property, VA will consider all options for disposal, but will always give priority consideration to use that supports the needs of veterans, particularly homeless veterans.

Contracting for Care

CARES Commission Recommendations

The Commission recognized contracting for care as a legitimate tool for enhancing access to health care services for veterans. The Commission recommended that VA ensure alternatives are in place prior to any plans to alter existing services through contracting. Further, the Commission recommended that the Secretary ensure that quality criteria and procedures are in place for VA to use its contract authority effectively, monitor service delivery to ensure quality, and ensure that it has staff trained to negotiate cost effective contracts.

Secretary's Response and Implementation

As VA continues to use contracting to expand access to services for veterans, it must make sure that it takes advantage of all opportunities to purchase contract care more effectively. Today, contracts for health care are managed in a decentralized fashion, with individual facilities and VISNs purchasing care from local providers. While this provides local flexibility to manage care, it comes at a cost. By decentralizing its purchases, VA loses a valuable opportunity to use its substantial purchasing power to negotiate better prices.

To more effectively leverage its purchasing power as a national system, VA will develop a National Clinical Contracting Strategy that will articulate

> *This National Clinical Contracting Strategy will help VA to integrate consistent quality care measures among contract providers and improve pricing...*

options for aligning costs for services among contract providers throughout the country, taking into consideration regional economic factors and availability of services within communities. This National Clinical Contracting Strategy will help VA to integrate consistent quality care measures among contract providers and improve pricing by developing broad national agreements with community health care providers. Through development of a national strategy, VA will ensure high quality standards are in place while receiving a more competitive price for that care. The National Clinical Contracting Strategy will be presented for review and consideration by November 2004.

In the interim, proceeding in conformance with all current laws, VA will continue to use existing authorities and policies to enhance access to care for veterans through contracts. Contracting will not erode VA's core mission as a provider of health care. Further, services at an existing site will not be altered until viable alternatives in the community have been identified and agreements are in place to ensure the availability and quality of contract care.

To ensure the quality of contract care, VA is developing policy for establishing contracts for services that will include minimum standards for contracted inpatient services, quality of care indicators, review of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, a process for ongoing monitoring and evaluation, national review criteria and approval processes, and performance based contracting principles. In addition, to ensure future cost-effectiveness, VA will always seek multiple viable alternatives in the community before the decision is made to contract out a VA service. This will promote competition and ensure latitude for future contracting arrangements. To further ensure cost effectiveness, VA logistics personnel will continue to develop their negotiating skills in order to ensure that VA contracts are cost-effective.

Infrastructure and Safety

CARES Commission Recommendation

The Commission recommended that patient safety be the highest priority for VA CARES funding and that VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

Secretary's Response and Implementation

The importance of safety at VA facilities cannot be overstated and many of the projects in CARES are for seismic and life safety improvements that will promote patient and employee safety. While there is no question about the importance of safety in VA facilities, VA is mandated by law to categorize projects that "remedy life and safety code deficiencies" as its second highest criteria.

VA currently has a process in place that assigns priority weights to seven broad criteria used to evaluate capital projects. To ensure compliance with the law while implementing the intent of the CARES Commission's recommendation, VA will use its existing capital development process to revise the weights of its criteria so that patient and employee safety concerns are ranked as the second most important factor in consideration for construction funding. This process will be completed in time to be operative for submission of VA's five-year capital plan, scheduled for May 2004.

Education and Training

CARES Commission Recommendations

The Commission recognized two promising opportunities for VA to expand its partnerships with academic affiliates. The Commission recommended VA develop a plan to add a community-based outpatient component to existing and new education and training programs. The Commission also recommended VA establish national policy guidance for schools of nursing comparable to its medical school model and with other professional health educational institutions, as appropriate.

Secretary's Response and Implementation

The partnerships VA has with the Nation's academic community are an important component of VA's core mission of caring for our Nation's veterans. VA will continue to promote excellence and innovation in the education of future health care professionals and will work with the academic community to identify new opportunities to improve its education and training missions.

The Commission identified two new opportunities to pursue enhancements to VA's education and training missions that merit further study and consideration. Both recommendations represent new and innovative ideas for moving those missions forward.

The first recommendation calls for VA to explore opportunities to enhance and encourage use of CBOCs as training sites. VA will develop an initiative to

expand the use of CBOCs as a training site over the next two years. The initiative will begin with submission of competitive applications for up to fifty additional training positions at 25 to 30 sites. Further expansion of the program to other affiliated VA facilities would follow an evaluation of its success in achieving program objectives.

The second recommendation seeks expansion of VA's partnership with nursing schools and with other professional health education institutions as appropriate. This recommendation will be reviewed as VA revises its policy on affiliations. VA will also incorporate the recommendations from a pending report from the National Commission on VA Nursing as it considers this recommendation.

Special Disability Programs

CARES Commission Recommendations

The CARES Commission made several recommendations concerning VA's special disability programs. These recommendations included ensuring inter-VISN collaboration in developing placement options for special disability centers and an assessment of acute and long-term bed needs for Spinal Cord Injury Centers to ensure a proper balance. The Commission also recommended that VA optimize access to care for veterans by developing more outpatient-based blind rehabilitation opportunities. Finally, the Commission recommended VA strive to maintain excellence in all of its special disability programs.

Secretary's Response and Implementation

Caring for veterans with service-connected disabilities and those with special needs is VA's most important, and most recognizable, health care mission. VA is committed to its special emphasis programs and will make sure they are well positioned to effectively serve veterans into the future. CARES specifically addressed VA's spinal cord injury and disorders (SCI/D), and blind rehabilitation programs. VA will continue to pursue excellence in these areas and will expand the range of programs considered in future iterations of strategic planning to include treatment for traumatic brain injury and prosthetics. Other VA specialty programs are considered in the context of mental health and long-term care (PTSD, homeless, and substance abuse). The continuous pursuit of excellence in

VA is committed to its special emphasis programs and will make sure they are well positioned to effectively serve veterans into the future.

these areas will always be a priority for the Department. The Commission's recommendations for spinal cord injury and disorders and blind rehabilitation seek to ensure the quality of these programs into the future. VA will implement the following actions:

1. VA will open new Blind Rehabilitation Centers in Biloxi and Long Beach, and will continue its current strategic emphasis on placing blind rehabilitation services closer to populations in outpatient settings. This focus will be included in future planning guidance and will be incorporated into the FY 2005 strategic planning submission.
2. As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation will also consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for development of new SCI/D beds will be included in the FY 2005 VISN strategic planning submission. These plans will include the potential for new SCI/D Centers in Syracuse, Denver, Minneapolis, and VISN 16, and a certified SCI/D outpatient clinic in Philadelphia as well as expansions of existing SCI/D Centers in Memphis, Cleveland, Augusta and Long Beach. VA will also validate expansion of the existing or development of a new SCI/D Center in South Florida.

VA/DoD Sharing

CARES Commission Recommendation

The CARES Commission recommended that VA/DoD sharing should be one of the first considerations in addressing health care needs in a local area. The Commission also recommended that VA and DoD leadership provide the necessary authority, accountability, and incentives to local managers to encourage and facilitate sharing activities that improve health care delivery and control costs. The Commission recognized the difficulty that change in local leadership presents to sharing opportunities and recommended that VA and DoD take additional steps to more effectively manage that change.

Secretary's Response and Implementation

Sharing between the Department of Veterans Affairs and the Department of Defense is a priority of the President and for both Departments. As VA implements CARES it will continue to take all necessary steps to identify and act on available sharing opportunities.

This effort is important, but it comes with significant challenges. With complimentary, but different missions, VA and DoD have cultural differences as well as technical, mission-related, and operational issues that, at times, make sharing difficult. While these differing missions have historically limited sharing opportunities, VA and DoD have made significant progress to meet the President's goal for improving resource sharing.

Spurred by the President's challenge to improve partnering, VA has worked closely with DoD to improve sharing. This has been particularly true in the CARES process. Working together throughout the development of the DNCP, VA and DoD identified 74 potential sharing opportunities, many of which remain promising.[1] Moving forward, VA will work closely with the Department of Defense to make a reality of many of these opportunities.

This work will be managed through the VA/DoD Joint Executive Council (JEC), co-chaired by VA's Deputy Secretary and DoD's Under Secretary for Personnel and Readiness. The JEC recently established a Capital Asset Planning and Coordination (CAPC) Steering Committee, which will be responsible for identifying and implementing opportunities to improve services and maximize capital asset resource utilization. That body will oversee implementation of the VA/DoD recommendations that require capital planning and will seek to maximize productive collaboration between Departments in developing capital asset management sharing opportunities in the future. Recognizing the importance of maintaining local sharing efforts, the CAPC will also work to improve the stability of VA/DoD partnerships through transition of management at local facilities.

Though significant challenges remain for VA/DoD sharing, the Departments will continue to work together to share resources. Mutually committed to improving sharing, VA and DoD will enhance benefits and services to veterans, servicemembers, and their dependents, while improving use of taxpayer resources.

Mutually committed to improving sharing, VA and DoD will enhance benefits and services to veterans, servicemembers, and their dependents, while improving use of taxpayer resources.

[1] See Appendix A for a listing of promising sharing opportunities with the Department of Defense.

Research Space

CARES Commission Recommendations

The CARES Commission recommended VA move forward with the proposals in the DNCP to enhance research space and commented that the metrics used to determine research space needs should be re-examined.

Secretary's Response and Implementation

VA will continue to explore opportunities to enhance its research mission by improving the quality and size of research space — factors that contribute to the ability to innovate and remain at the forefront in development of treatments and technologies that will improve care to our Nation's veterans. As VA implements CARES, it will re-examine the measures used to determine research space needs. To ensure the accuracy of project proposals, VA will replace gross estimates for research space with actual measures of space. Moving forward, VA will continue to improve the process for forecasting research needs by integrating a more realistic estimate for research construction costs into the forecasting Model.

Care Delivery Innovations

CARES Commission Recommendation

The Commission recommends that VA use advanced practice nurses and telemedicine to enhance access to and quality of care, and urges wider application of these resources throughout the system.

Secretary's Response and Implementation

VA is continuously seeking opportunities to improve the access to and quality of care for our Nation's veterans. Telemedicine and the expanded use of advanced practice nurses and other health care professionals each represents a promising new approach to the way that VA provides care.

By leveraging technology, telemedicine can be an effective means of treating patients remotely. This is specifically important for veterans who live in remote and rural areas with significant commutes to sites of VA care and to specialists. Telemedicine allows VA to more regularly monitor the care of veterans in a way that is convenient for patients and enhances productivity of physicians.

For these reasons, VA will continue to implement and expand telemedicine and telehealth initiatives as a means to enhance access to specialist care for patients

and improve quality. Under VA's new Office of Care Coordination, activities will focus on the areas of telemental health, teledermatology, and teleretinal imaging. VA already has developed robust models to link VA medical centers and community-based outpatient clinics to improve access to these specialty consultations. These initiatives are currently being implemented and VA will seek to expand them in the future.

VA will continue to expand its national home telehealth network to directly link patients in their homes with clinicians in VA medical centers. Through telehealth, VA will enhance the management of chronic diseases such as diabetes, heart failure, and PTSD and improve access to these services for patients, especially those patients in rural areas. By managing care remotely, VA is preventing premature institutionalization of veterans and allowing community living for a clinically complex and frail population. VA will treat 7,500 patients in this manner by October 2004. These services will increase to 15,000 patients by May 2005 and 25,000 by October 2005.

Teleradiology services will also be expanded to enhance access to care. For more than a decade, VA has been using teleradiology to increase access to diagnostic imaging services in support of veterans' health. Teleradiology combines digital imaging and communications technologies to transfer clinical images and data between the site of the patient and the site providing consultation, interpretation or diagnosis. This allows VA medical facilities to link to highly skilled radiologist interpretation services at consolidated sites.

In areas with few radiologists, some VA teleradiology programs employ contracted radiologists to supplement care. In other areas, VA teleradiology programs provide VA diagnostic imaging services to DoD Medical Treatment Facilities that have few or in some instances no staff radiologists. The role of teleradiology is being actively explored as a means to provide radiology services in locations where radiologists are difficult to recruit, especially in rural areas. Teleradiology also has a potential role to play in improving the efficiency of delivering after-hours radiology reporting services. By expanding usage of teleradiology, VA will continue to enhance access to care.

VA also will expand its use of advanced practice nurses and other health care specialists. Among the most noted problems encountered in the VA system is in the area of waits and delays. While VA has made substantial progress in reducing the time veterans wait for appointments, the goal is ongoing and continuous improvement. The increased use of advanced practice nurses and other health care professionals will help VA to reduce waiting times at facilities while maintaining a high quality of care for veterans.

Telemedicine, telehealth, and the use of advanced practice nurses and other health care professionals are important new initiatives for VA. Moving forward, VA will continue to implement and expand these initiatives always with the goal of improving access to and the quality of veterans' health care.

ONEVA COLLABORATIONS

Secretary's Response and Implementation

Though the CARES Commission did not specifically discuss many of the proposed collaborations between the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA) in the DNCP, the Commission specified approval of all projects not specifically addressed in its report.[2] *OneVA* sharing opportunities are a priority for the Department. Throughout the CARES process, VA placed great emphasis on maximizing the use of VA assets to meet the service delivery goals of VBA and NCA. VA will continue to pursue these opportunities and, as a result, the benefits and burial program missions of the Department will be strengthened.

In many cases, VBA is spending significant resources on rental space for its Regional Offices. With rental costs at levels as high as $6 million per year, VA must take advantage of opportunities to collocate on VA property where such action enhances services and is economically favorable. Savings from effective consolidations can be better spent on the human and technology resources used to process compensation, pension, and education claims and provide loan guaranty and vocational rehabilitation and employment services. Wherever possible, VBA will identify opportunities to reduce its rent costs by seeking to collocate on VA property. By operating in this manner, VA will ensure it maximizes its resources to provide services to veterans and redirects significant savings from rental costs into claims processing and other benefits delivery missions.

Savings from effective consolidations can be better spent on the human and technology resources used to process compensation, pension, and education claims and provide loan guaranty and vocational rehabilitation and employment services.

Further, collocating also improves access to services, employee morale, and productivity by relocating facilities in new, modern, and efficient office spaces. In implementation of CARES and in future

[2] CARES Commission Report pg. 5-3

planning efforts, VBA will seek and implement opportunities to reduce or avoid costly rental obligations by collocating on VA property wherever it is feasible and cost-effective to do so.

For NCA, acquiring additional excess land is essential to prevent the premature closure of some national cemeteries. As NCA strives to effectively meet the burial needs of veterans, it will continue to seek opportunities to use existing VA land. This not only conserves scarce resources, it also better serves veterans by consolidating services and maintaining VA campuses as places that serve and honor our Nation's veterans. These initiatives are particularly critical in areas where NCA is running out of burial space and vacant land exists adjacent to a VA medical center. For example, without additional land for expansion, the Jefferson Barracks National Cemetery in St. Louis will close in 2010. Through the CARES process, VA identified land at the medical center that will allow VA to expand the cemetery and continue service to veterans.

As VA implements CARES, it will continue to monitor these collaborations and will vigorously pursue opportunities to maximize sharing of VA resources to make better use of taxpayer funds, while improving benefits and services to our Nation's veterans.[3]

CARES Independent Advisory Body

CARES Commission Recommendation

The Commission recommended that the Secretary establish an independent advisory body, with appropriate charter and authority, to monitor and advise the Secretary on the ongoing integration of CARES into VA's strategic planning process.

Secretary's Response and Implementation

The CARES process emphasized objectivity from its inception. Focusing on data to make decisions and using an independent Commission to review and make recommendations on its proposals, CARES steadfastly adhered to principles of objectivity throughout its development.

As CARES moves from development into implementation, it will continue to be an open process. Implementation plans, studies, and other CARES related initiatives identified in this decision document will be broadly shared with stakeholders whose input will be considered in decision-making processes.

[3] Priority opportunities for *OneVA* collaboration are listed in Appendix B.

Recognizing the complexity of CARES issues and the extreme importance and impact of many of its initiatives, it is critical that VA maintain a high-level national focus as it implements these decisions. VA will accomplish this by establishing a permanent, senior-level, CARES Implementation Board. The CARES Implementation Board will consist of senior leadership from across the Department, will work collaboratively with the VISNs to implement CARES, and will report directly to the Secretary. The Implementation Board will be responsible for assuring that CARES is integrated into strategic planning and that all of the decisions in this document are effectively planned, implemented, and managed. As VA progresses with implementation of these decisions, it will consider the use of an independent body to advise, monitor, and evaluate its progress as needed. If the need becomes clear, such an objective group will be appointed.

CHAPTER 3

VISN by VISN Decisions and Implementation

Introduction

This chapter provides the Secretary of Veterans Affairs' decisions on specific recommendations of the CARES Commission for the individual Veterans Integrated Service Networks (VISN).

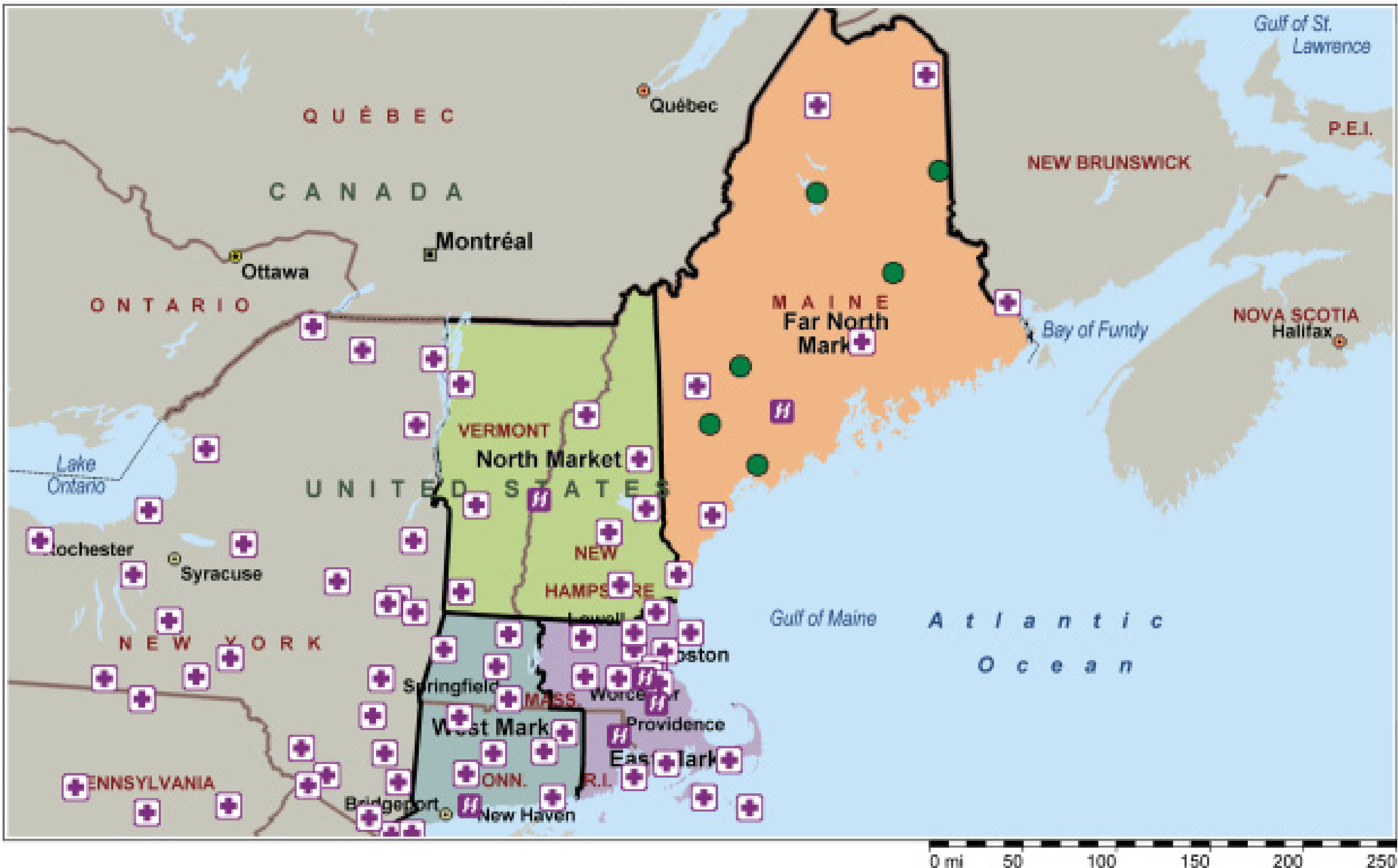
Arranged by VISN, each Commission recommendation is followed by the Secretary's decision and guidance. In many cases, completion dates have been included where studies or plans are called for in implementation.

To facilitate the readability of the document, many Commission recommendations were shortened, particularly in the case of those recommendations that recur throughout the document. These abbreviated decisions and those decisions that refer to crosscutting issues are cited as references in the Secretary's decisions. In these instances, the language in the crosscutting section applies to the recommendation noted.

Major crosscutting issues cited include:

- Critical Access Hospitals
- Community-Based Outpatient Clinics
- Mental Health Services
- Long-Term Care
- Excess VA Property
- Contracting for Care
- Infrastructure and Safety
- Special Disability Programs
- VA/DoD Sharing
- *OneVA* Collaborations

The Secretary's subject-by-subject decision to accept the CARES Commission recommendations for each VISN and his guidance on implementation of these decisions follow.



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CARES Decisions for VISN 1

CARES Commission Recommendation

Mission Change, Campus Realignment
Edith Nourse Rogers Memorial VA Medical Center in Bedford

1. The Commission does not concur with the DNCP proposal to change the mission of the Bedford VAMC.
2. The Commission recommends that VA conduct a thorough feasibility study of building a single, appropriately sized replacement medical center in the Boston area for acute and sub-acute inpatient services, residential rehabilitation services, and administrative and research support. This medical center would replace all such existing functions at the West Roxbury, Jamaica Plain, and Brockton campuses of the Boston HCS and the Bedford VAMC.
3. As part of the planning for a possible replacement medical center in the Boston area, the Commission recommends that the VISN develop a strategic plan to determine the appropriate size and location for coordinated long-term care services, including nursing home care and the Geriatric Research, Education and Clinical Center clinical and research services that are integrated with them, and ensure there is no loss of capacity and specialty programs.

Secretary's Decision

Mission Change, Campus Realignment
Edith Nourse Rogers Memorial VA Medical Center in Bedford

VA will undertake a comprehensive study of the feasibility of consolidating its existing four Boston area medical centers into one state-of-the-art tertiary care facility that will act as a hub for VA health care in the greater Boston area. The four existing VA Medical Centers in Boston range in age from 36 to 62 years. While these facilities have been improved since initial construction, all require ongoing renovation and upgrades and are in need of modernization.

In conducting its assessment of plans to consolidate services from the Bedford VAMC, the Commission noted the current fragmented nature of care across the four existing Boston area facilities, the need for substantial investment to modernize facilities that are already aging and will eventually need replacement, and VA's need to remain competitive in a medical

care environment where recruitment and retention of quality staff is difficult. Based on these findings, the Commission recommended that VA explore the feasibility of constructing a new, state-of-the-art tertiary VA medical center in the Boston area to replace its existing four facilities.

To assess the potential for consolidation, VA will undertake a comprehensive study of the feasibility, cost-effectiveness, and impact of developing a modern, efficient, health care system in the Boston area. The system to be studied would be anchored by a state-of-the-art tertiary care medical center and would include plans for development of strategically located multi-specialty outpatient clinics and CBOCs. The study also will analyze the demand for nursing home care services and plan to locate facilities in places that would preserve access for aging veterans and their families. The tertiary care medical center would deliver comprehensive inpatient care services, while allowing specialty care services such as cardiology, neurology, audiology, as well as primary and special VA mental health services to spread out into the community closer to where patients live. Further supported by CBOCs, the system of care would bring VA health care into communities throughout the Boston area, improving access to specialty care, primary care, mental health care, and nursing home services.

The study will focus on access to and quality of care, as well as the expected cost effectiveness of consolidation of the existing four facilities into a carefully planned and comprehensive health care system.

VA will begin development of a template that will define the scope and parameters of the study and act as a guide for the study process. Upon completion of the template, VA will assign a multi-disciplinary team with appropriate skills and experience to conduct the study. The team will use support from outside contractors and other subject matter experts as necessary to ensure it has access to all of the skills needed to complete the study effectively and efficiently. The study will include collaboration with stakeholders to ensure that their views are solicited and included in the process. The study is scheduled for completion in the beginning of 2005.

In the interim, VA will not pursue any mission changes at the Bedford campus, will proceed with only those maintenance and life safety projects at existing facilities that are necessary to ensure the quality and safety of patient care, and will pursue development of a long-term care strategic plan (*Reference – Long-Term Care, Excess VA Property: Crosscutting*).

CARES Commission Recommendation

Inpatient Care

1. The Commission concurs with the DNCP proposal to use contracting to improve access for hospital care in the North and Far North markets, and to pursue telemedicine opportunities.
2. The Commission concurs with the DNCP proposal to meet increasing inpatient demand in the East and West markets through in-house expansions at Providence and West Haven. Expansion at West Roxbury should be considered as part of the feasibility study for a replacement facility for Boston.

Secretary's Decision

Inpatient Care

VA will meet the increasing inpatient demand in the East and West markets through in-house expansions at the Providence and West Haven VAMCs. CARES plans for an inpatient expansion at West Roxbury will be placed on hold pending the outcome of the Boston study.

To meet the demand for care in the North and Far North markets, VA will use existing contracting authorities and policies to improve access for hospital care where necessary. VA also will continue to encourage a wider application of telemedicine to enhance access to and quality of care.

Veterans in the North and Far North markets are often referred for inpatient and diagnostic care at Boston area medical facilities, resulting in substantial commutes — sometimes for minor procedures. Veterans in these markets must travel up to three hours each way to receive basic inpatient care. With the range of services at existing VA hospitals and the availability of contract care in the community, these veterans should have better access to care. The current situation is not acceptable and VA will act to correct the problem. To ensure that VA improves access to care for veterans in the North and Far North markets, the VISN will develop a plan that identifies alternate referral patterns that are cost-effective and bring care closer to where veterans live. This plan will be completed and submitted for approval by August 2004 (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

III Outpatient Care

1. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
2. The Commission concurs with the DNCP proposal to use telemedicine programs at existing sites of care and at proposed new CBOCs to help address access issues.
3. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

Secretary's Decision

III Outpatient Care

VA will enhance access and meet new demand for primary, mental health, and specialty care through expansions at existing sites, use of existing authorities and policies to contract for care where necessary, and increased use of telemedicine.

The VISN also will develop new sites of care and CBOCs through the National CBOC Approval Process. VISN 1 has six new sites of care targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Togus VAMC	Houlton-PT – Contract	ME
Togus VAMC	Bangor Outreach – Dover Fox	ME
Togus VAMC	Bangor Outreach – Lincoln	ME
Togus VAMC	Rumford Outreach – Farmington	ME
Togus VAMC	Rumford Outreach – South Paris	ME
Togus VAMC	Cumberland County	ME

The new CBOC in Cumberland County and the five part-time telemedicine clinics will support the Togus VAMC by enhancing care for veterans living in remote locations in the Far North market. These new sites will help bring the market to national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

IV Extended Care

The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing LTC facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

IV Extended Care

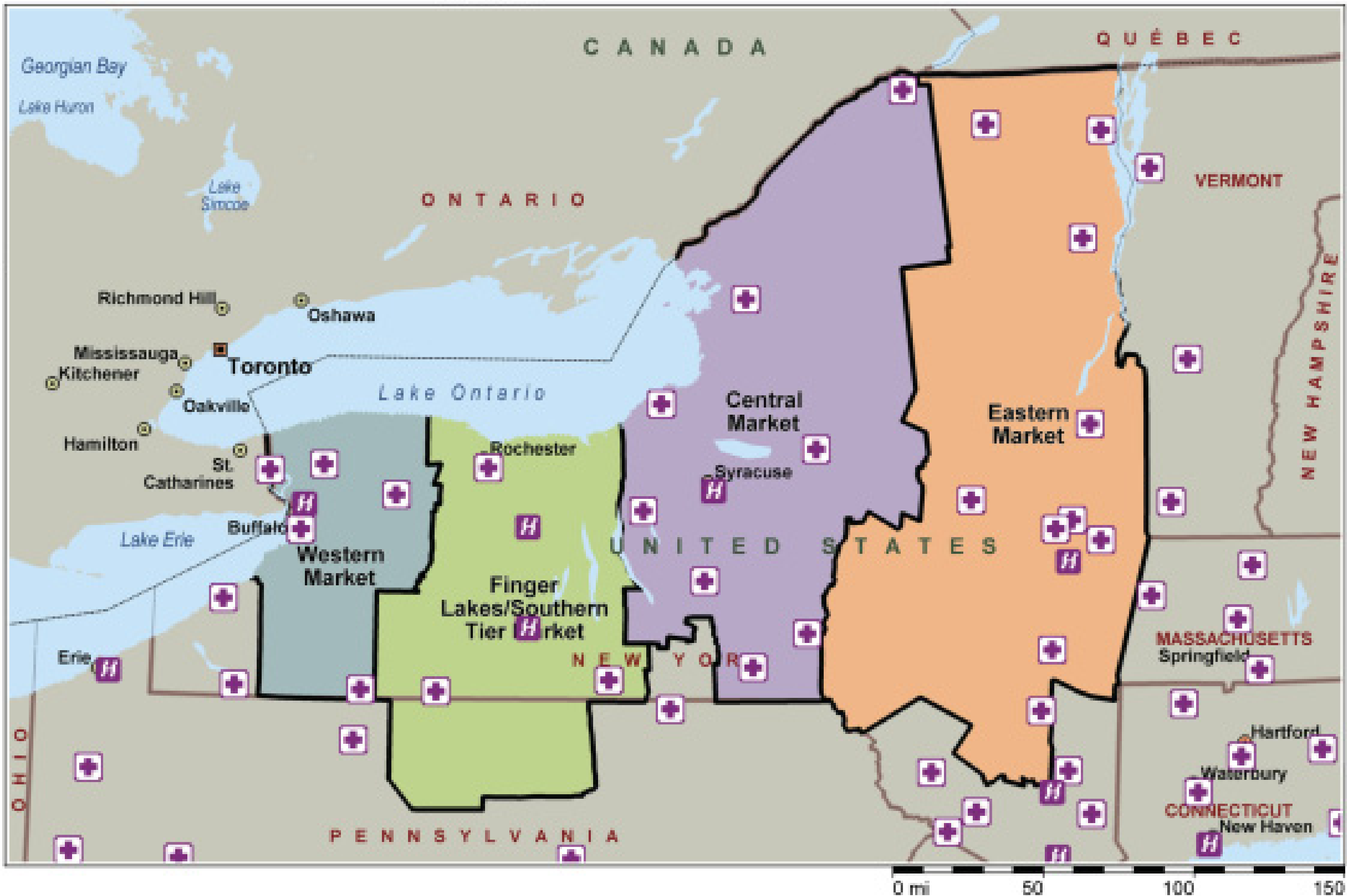
VA will develop a long-term care strategic plan based on well-articulated policies. Until VA completes a long-term care strategic plan, it will only proceed with maintenance and life safety projects at existing long-term care facilities that are necessary to ensure the quality and safety of patient care (*Reference – Long-Term Care: Crosscutting*).

Secretary's Decision

V *OneVA* Collaborations

VA is developing space at the Newington VAMC for use as a collocated benefits administration office for the Hartford VA Regional Office. VBA will move into this space in the fall of 2004 (*Reference –* OneVA *Collaborations: Crosscutting*).

VISN 2



Pushpins

- VA Clinic
- VA Hospital
- Planned New CBOC

Markets

- Central Market
- Eastern Market
- Finger Lakes/Southern Tier Market
- Western Market

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CARES Decisions for VISN 2

CARES Commission Recommendation

Mission Change, Campus Realignment
Canandaigua and Finger Lakes Market

1. The Commission does not concur with the DNCP proposal on transferring services from Canandaigua to other VA Medical Centers (VAMCs) within the VISN.
2. The Commission recommends that Canandaigua retain long-term care, including the nursing home, psychiatric nursing home care, and the domiciliary.
3. The Commission concurs with the DNCP proposal to transfer acute inpatient psychiatric beds.
4. The Commission also concurs with the DNCP proposal that Canandaigua retain its ambulatory care.
5. The Commission recommends that the VISN develop another strategic plan for the challenges it faces in Canandaigua with high overhead costs, unused or underutilized buildings, and the impact on the community and on employees.
6. In line with Recommendation 5 above, the Commission recommends that the VISN involve stakeholders and the community to help resolve these challenges.

Secretary's Decision

Mission Change, Campus Realignment
Canandaigua and Finger Lakes Market

Built in 1932 and sized to care for a capacity of 1,700 patients, the Canandaigua VAMC was built in a different era for a different type of patient care. Today, the Canandaigua VAMC operates 276 inpatient beds at an average daily census of 166. Built for more than 6 times as many beds, the campus now has significant vacant and underused space. The campus sits on 171 acres of land and includes 23 buildings, most of which were built between 1932 and 1937. Approximately 26 percent of the campus is vacant or underused and forecasts for the Finger Lakes market show decreasing enrollment through 2022. If VA makes no changes to the Canandaigua campus, it will continue to operate with substantial vacant and underused space that is costly to maintain and diverts patient care resources to building and grounds maintenance.

VA can no longer afford to let dollars appropriated for medical care be ineffectively allocated to maintain idle property. Avoidable expenditures must be captured and reinvested in veterans health care services in the Finger Lakes market. To ensure that VA moves toward more efficient operations in Canandaigua, the VISN will work in collaboration with stakeholders to develop a Master Plan for the Canandaigua campus that will promote improved services to veterans in the most effective infrastructure.

The Master Plan will include construction of a new multi-specialty outpatient clinic and nursing home complex to replace the patient care facilities currently located on the Canandaigua campus. The plan also will include the transfer of acute inpatient psychiatric patients from Canandaigua to Buffalo and Syracuse, a transfer that will improve care coordination by collocating acute inpatient psychiatry with other acute medicine services. The new nursing home complex will accommodate nursing home, domiciliary, and residential rehabilitation patients and will provide gero-psychiatric services and hospice care. These new facilities will ensure that Canandaigua area veterans are treated in modern, state-of-the-art facilities designed for provision of quality health care and built to more effectively

meet their needs. The new facilities will remain in Canandaigua and be incorporated into the Master Plan.

The Master Plan also will include strategies for managing the transition of acute inpatient psychiatric care from Canandaigua to Syracuse and Buffalo, assuring that the transition is sensitive to the clinical and psychosocial needs of the gero-psychiatric population and minimizes any medical impact such a transfer may induce. All other patient care services currently in place at the Canandaigua VAMC will be accommodated in the new facilities with the potential for enhanced services to include new clinics as needed.

The Master Plan will include careful study of the appropriate size and location of the new facilities as well as a detailed cost-effectiveness analysis to ensure maximum effective use of VA resources. The Plan also will ensure that the decision to dispose of or reuse excess VA property serves to enhance the Department's mission. VA will work closely with stakeholders to identify alternate uses for excess property.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. This will include assuring continuity of patient care to the greatest extent possible, and managing any reductions in employment through natural attrition, transfer, early retirement, retraining or other benevolent mechanisms. Reductions in force will be used only when absolutely necessary. VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

While VA expects this transition to occur over several years, VA will complete the Master Plan by the end of 2004 (*Reference – Excess VA Property, Long-Term Care: Crosscutting*).

CARES Commission Recommendation

II Inpatient Care

The Commission concurs with the DNCP proposal to contract for the projected increase for inpatient medicine care with community providers in markets with increased need, given the relatively small increase in beds and the benefit of providing such care nearer to patient residences.

Secretary's Decision

II Inpatient Care

VA will meet the increased demand for inpatient care by utilizing existing authorities and policies to contract for care in the community where necessary (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

III Outpatient Care

Given projected increases in workload in primary and specialty care, the Commission recommends that the need for either expanded and/or additional CBOCs be part of the strategic plan for VISN 2.

Secretary's Decision

III Outpatient Care

VISN 2 has been a leader in establishing CBOCs and currently meets access standards for 80–90 percent of veterans across its four markets. VA will meet new demand for outpatient care by expanding existing outpatient services and utilizing existing authorities and policies to contract for care where necessary. The VISN also will consider new CBOCs in future strategic planning processes (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

IV Special Disability Programs – Spinal Cord Injury and Disorders (SCI/D) Center

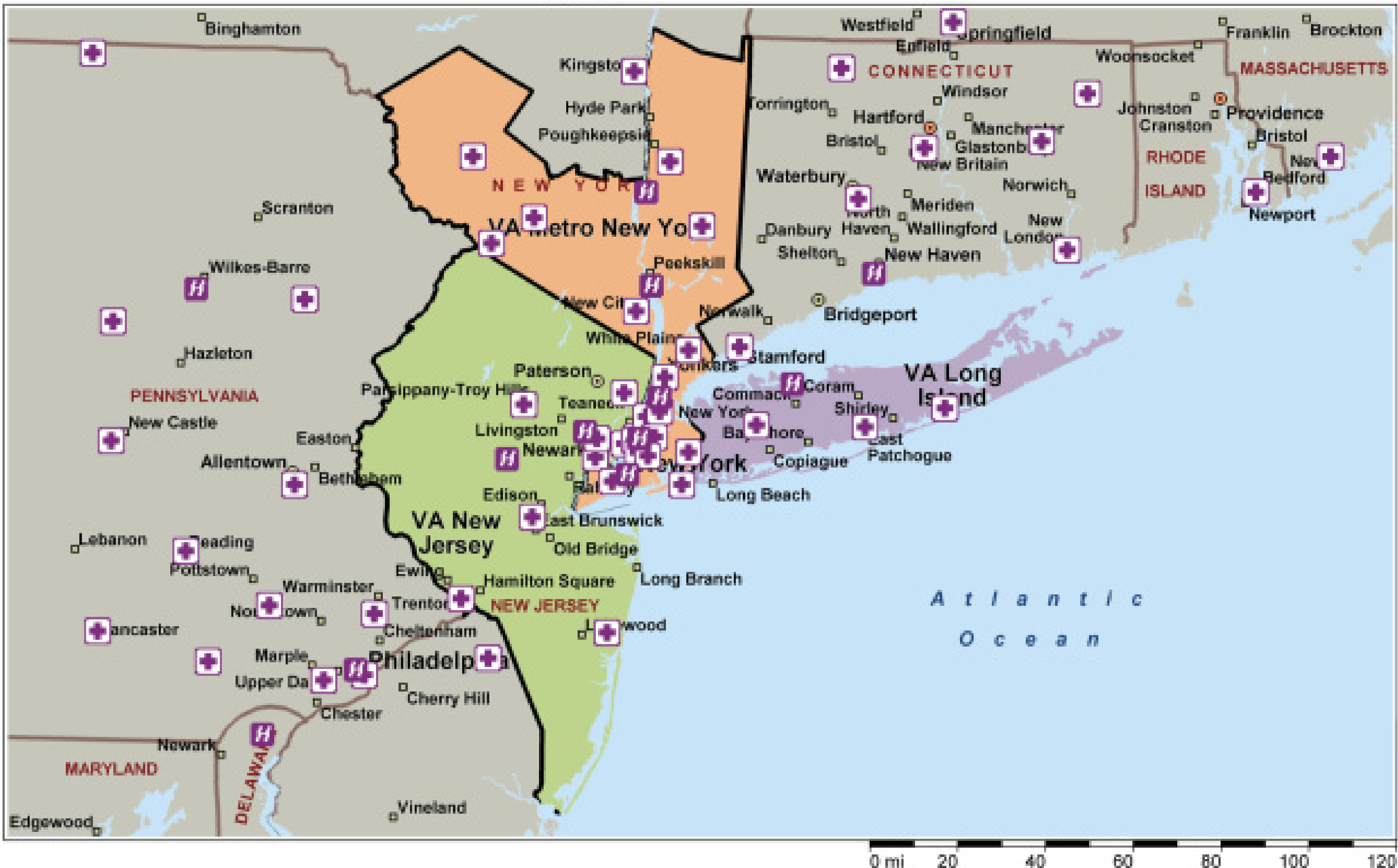
The Commission concurs with the DNCP proposal to build a new SCI/D Center in Syracuse.

VA should conduct an assessment of acute and long-term bed needs for SCI/D Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

Secretary's Decision

IV Special Disability Programs – Spinal Cord Injury and Disorders (SCI/D) Center

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for development of an SCI/D Center in Syracuse will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).



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CARES Decisions for VISN 3

CARES Commission Recommendation

- **Study Feasibility of Consolidating the Manhattan and Brooklyn VAMCs**

The Commission concurs with the DNCP proposal that a feasibility study should be carried out before any proposal to consolidate the Manhattan campus of the NY Harbor Health Care System (HCS) with the Brooklyn campus is put forward.

Secretary's Decision

- **Study Feasibility of Consolidating the Manhattan and Brooklyn VAMCs**

VA will undertake a thorough feasibility study of the potential to consolidate the Manhattan and Brooklyn campuses of the New York Harbor HCS in the VISN's New York market. The facilities are in close proximity to one another and both have significant vacant and underused space. Through consolidation, VA has the potential to improve use of sophisticated major medical equipment, reduce costly vacant and underused space, and enhance services through development of a comprehensive tertiary medical center that can act as a hub and provide the full continuum of care for Manhattan and Brooklyn area veterans.

To assess the potential for consolidation, VA will develop a comprehensive study of the feasibility, cost-effectiveness, and impact of developing a modern, efficient, health care system in the New York area. The system to be studied would be anchored by a comprehensive tertiary care medical center located in either Manhattan or Brooklyn and will include plans for development of strategically located multi-specialty outpatient clinics and CBOCs targeted to support the tertiary hub, maximize access, and bring primary, mental health, and specialty care services closer to where veterans live. The study also will analyze the demand for nursing home care services. The tertiary care medical center will deliver comprehensive inpatient care services, while allowing specialty care services such as cardiology, neurology, audiology, as well as primary and special VA mental health resources to spread out into the community closer to patients. Further supported by CBOCs, the system of care would bring VA health care into neighborhoods throughout the New York area, improving access to specialty, primary care, mental health, and nursing home services.

The study will focus on access to and quality of care, as well as the expected cost effectiveness of consolidation of the existing Manhattan and Brooklyn inpatient care missions into a comprehensive tertiary care medical center supported

by a carefully planned system of multi-specialty outpatient clinics, CBOCs, and nursing home care services.

VA will begin development of a template that will define the scope and parameters of the study and act as a guide for the study process. Upon completion of the template, VA will assign a multi-disciplinary team with appropriate skills and experience to conduct the study. The team will use support from outside contractors and other subject matter experts as necessary to ensure it has access to all of the skills needed to complete the study effectively and efficiently. The study will include collaboration with stakeholders and ensure that their views are solicited and included in the process. The study will be completed by the beginning of 2005.

In the interim, VA will proceed with only those maintenance and life safety projects at existing facilities that are necessary to ensure the quality and safety of patient care, and will pursue development of a long-term care strategic plan (*Reference – Long-Term Care, Excess VA Property: Crosscutting*).

CARES Commission Recommendation

II Mission Change
Montrose and Castle Point Campuses of the Hudson Valley HCS

1. The Commission does not concur with the DNCP proposal to move all inpatient beds from Montrose to Castle Point.
2. The Commission recommends that the inpatient psychiatry beds be moved from the Montrose campus to the Castle Point campus.
3. The Commission recommends that the nursing home care beds be moved from the Montrose campus to the Castle Point campus.
4. The Commission recommends that the domiciliary-based residential rehabilitation programs and ambulatory care services remain at the Montrose campus.
5. The Commission recommends that the enhanced use leasing proposals for the Montrose campus that have been held in abeyance pending the completion of the CARES process now go forward as soon as is feasible.

Secretary's Decision

Mission Change
Montrose and Castle Point Campuses of the Hudson Valley HCS

The Montrose and Castle Point campuses of the Hudson Valley Health Care System are both underutilized. Both facilities were designed to serve an inpatient-based system of health care that is not compatible with modern medicine. The Montrose campus was built in 1950 for a capacity of 1,984 hospital beds and now operates 291 beds. The Castle Point campus was transferred to VA in 1924. It was originally built for 600 tuberculosis beds and now operates 122 inpatient beds. Maintenance of campuses with such large amounts of vacant and underused space requires VA to spend dollars appropriated for veterans health care on buildings and grounds maintenance. VA can no longer afford to misuse scarce resources in this manner.

VA will implement a consolidation of services between the Montrose and Castle Point campuses that will enhance patient care and make more effective use of VA health care resources. The consolidation will transfer acute psychiatric, long-term psychiatric, and nursing home beds from the Montrose to the Castle Point campus. To accomplish this consolidation, VA will augment the mission at the Castle Point campus with new construction and reduce the footprint on the Montrose campus through an enhanced use lease for assisted living and other compatible uses or divestiture of property.

Transfer of acute and long-term psychiatry beds to Castle Point will improve care coordination by collocating psychiatry beds with other inpatient care. VA will also improve access to care for veterans in the northern portion of the VISN by enhancing VA's presence between the Albany and Bronx VAMCs. Consolidation of nursing home services at Castle Point also will improve patient care. Today, both campuses operate aging nursing homes that require modernization. By consolidating these services at Castle Point, VA can build one new state-of-the-art and appropriately sized nursing home designed to provide high quality nursing home care services. VA will develop plans for the size of the new nursing home using its long-term care and mental health strategic plans.

VA will continue to provide outpatient, domiciliary, and residential rehabilitation services at the Montrose campus. By retaining these services, VA will ensure continued access to care for domiciliary and residential rehabilitation services for a patient population that comes primarily from the New York metropolitan area. Montrose area veterans will still receive outpatient services at the Montrose campus. With the transfer of psychiatric and nursing home care beds, VA can plan to make

more effective use of the Montrose campus by pursuing enhanced use lease opportunities for the vacant and underused space.

To accomplish this transition, VA will develop a Master Plan for both the Montrose and Castle Point campuses ensuring an effective transition of services. The Plan will include strategies for ensuring continuity of care for, and sensitivity to the clinical and psychosocial needs of, patients transferred in the realignment. The Plan also will make sure that the realignment decision for the excess VA property at the Montrose campus will consider, but will not be limited to, an existing enhanced use lease proposal for an assisted living complex. The potential for collaboration with the National Cemetery Administration also will be considered in the Master Plan. Any reuse or disposal of property on the Montrose Campus will serve to enhance the Department's mission.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. This will include ensuring continuity of patient care to the greatest extent possible, and managing any reductions in employment through natural attrition, transfer, early retirement, retraining or other benevolent mechanisms. VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

While this transition is expected to take place over several years, VA will complete a Master Plan by the end of 2004 (*Reference – Excess VA Property, Long-Term Care: Crosscutting*).

CARES Commission Recommendation

Campus Realignment
St. Albans Campus of the New York Harbor HCS

The Commission concurs with the DNCP proposal for changing the St. Albans campus.

Secretary's Decision

Campus Realignment
St. Albans Campus of the New York Harbor HCS

The St. Albans campus was not designed for modern health care delivery, is aging, and is in need of replacement. To ensure veterans are cared for in safe and operationally efficient settings, VA will implement plans to replace the infrastructure at the St. Albans campus.

To manage the replacement of the St. Albans campus, VA will develop a Master Plan that will propose an efficient and cost-effective design for the replacement buildings at St. Albans and ensure an effective transition of services. VA will develop plans for the size of the nursing home and domiciliary buildings using its mental health and long-term care strategic plans. The Master Plan also will describe the most effective footprint for the campus and ensure that any plans for alternate use or disposal of VA property serve to enhance the Department's mission.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition and will work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

While this transition is expected to take place over several years, VA will complete a Master Plan by the end of 2004 (*Reference – Excess VA Property, Long-Term Care: Crosscutting*).

CARES Commission Recommendation

IV **Inpatient Care**

The Commission concurs with the DNCP proposal to address the increased demand by FY 2012 in the Metro New York market for inpatient services through absorption at the Brooklyn and New York campuses along with some contracting in the community.

The Commission also concurs with the DNCP proposal to meet the increased demand in the New Jersey market for inpatient services through expansion of in-house space via new construction and conversion of vacant space.

Secretary's Decision

IV **Inpatient Care**

VA will meet the demand for inpatient care in the New York market by providing care at existing facilities and through use of existing authorities and policies to contract for care where necessary. Results of the feasibility study for the Manhattan and Brooklyn consolidation will be incorporated into plans to manage the forecasted increase in demand for inpatient care. The New Jersey market will meet increased demand for inpatient services through new construction to expand in-house capacity, and by converting vacant space (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

V Primary and Specialty Outpatient Care

The Commission concurs with the DNCP proposal to meet the increase in demand for outpatient care through new construction to expand in-house capacity, conversion of vacant space, and using contracting in the community.

Secretary's Decision

V Primary and Specialty Outpatient Care

The VISN will meet increases in demand for care through expansion, renovation of existing space, or new construction at existing locations. The VISN also will use existing authorities and policies to contract for care where necessary. Development of new CBOCs will be considered through the National CBOC Approval Process (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VI Special Disability Programs
Relocation of SCI/D Centers from East Orange, NJ, and Castle Point, NY, to the Bronx

The Commission concurs with the DNCP proposal to relocate the spinal cord injury and disorders (SCI/D) beds from Castle Point to the Bronx and with the DNCP proposal not to relocate the SCI/D beds from East Orange to the Bronx at this time.

The Commission recommends that VA direct inter-VISN coordination and action in order that the VISN 3's proposed consolidation at the Bronx facility of all the VISN's SCI/D beds can take place as soon as is feasible.

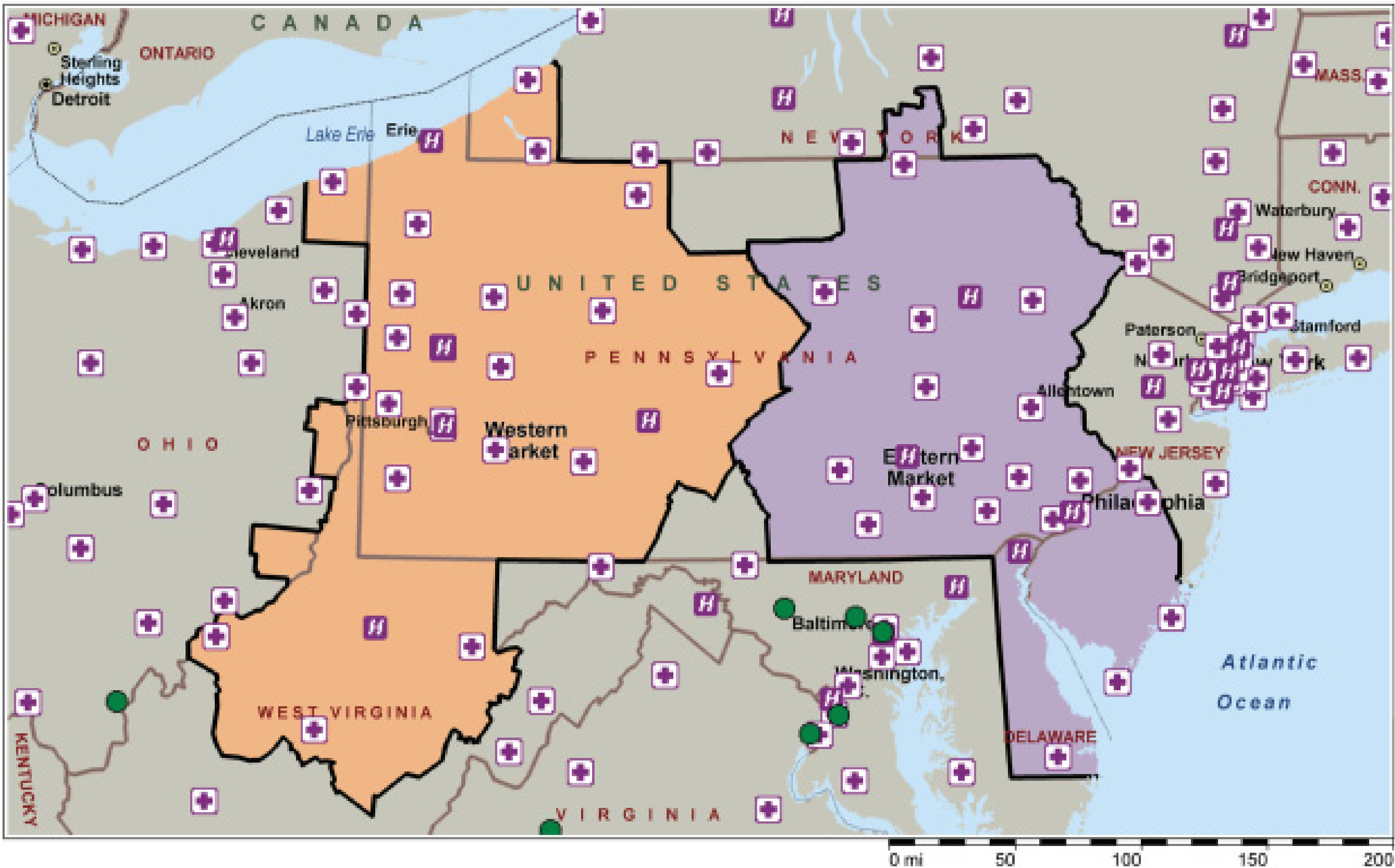
VA should conduct an assessment of acute and long-term bed needs for SCI/D Centers to provide the proper balance of beds to better serve veterans and reduce waiting times.

Secretary's Decision

VI Special Disability Programs
Relocation of SCI/D Centers from East Orange, NJ, and Castle Point, NY, to the Bronx

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for transferring SCI/D beds from the Castle Point VAMC to the Bronx VAMC as well as study and decision for managing referral patterns from East Orange and the Eastern part of VISN 4 will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

VISN 4



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CARES Decisions for VISN 4

CARES Commission Recommendation

Mission Change, Campus Realignment
Pittsburgh's Highland Drive Division

1. The Commission concurs with the DNCP proposal to consolidate services at the Highland Drive Division of the Pittsburgh HCS with the University Drive Division and the Heinz Progressive Care Center. The Commission, however, recommends that VA conduct an improved life cycle cost analysis.
2. The Commission recommends that VA consider the appropriateness of the current renovation of inpatient units at the Highland Drive Division in light of the DNCP proposal for consolidation.
3. The Commission recommends that VA consider enhanced use leasing (EUL) or divesture of the Highland Drive Division property.

Secretary's Decision

Mission Change, Campus Realignment
Pittsburgh's Highland Drive Division

VA will consolidate the Highland Drive Division to the University Drive and Heinz campuses of the Pittsburgh HCS. This consolidation will be accomplished through major construction that will modernize patient care facilities at the University Drive and Heinz campuses and improve the environment of care for area veterans.

This transition also will improve care coordination and access to care. By collocating inpatient psychiatry services at University Drive and domiciliary and residential rehabilitation services at the Heinz campus, VA will improve quality of care for veterans in Western Pennsylvania by consolidating services to more effectively coordinate care. Plans for a new parking garage will improve patient access to care by relieving longstanding shortages of parking at the University Drive campus. VA also expects to achieve resource efficiencies from this plan.

The VISN has submitted a construction project application for this consolidation for the FY 2005 budget that includes an improved, project-based life cycle cost analysis. VA will develop a Master Plan to ensure that the consolidation is effectively implemented.

The Master Plan will ensure that there is no interruption of existing services until construction of the new facilities is completed and transfer of patients from the Highland Drive to the University Drive and Heinz campuses can be managed effectively, with sensitivity to the patients' psychosocial and clinical needs.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this consolidation. The transition will include ensuring continuity of patient care and managing any changes in employment through natural attrition, transfer, early retirement, retraining or other benevolent mechanisms. VA will continue to work closely with its stakeholders to ensure that this consolidation is managed effectively.

Upon completion of construction and patient transfer, VA will seek alternate uses for, or disposal of, the Highland Drive campus. These uses may include, but will not be limited to, an enhanced use lease of the campus. VA will ensure that disposal or reuse of the campus will serve to enhance the Department's mission.

While this consolidation is expected to occur over several years, the VISN will produce a Master Plan to guide the transition by September 2004.

CARES Commission Recommendations

Mission Change, Small Facilities
Butler, Erie, and Altoona VAMCs

Butler

The Commission concurs with the DNCP proposal to close acute care services at Butler. The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Butler area veterans and that the VISN pursue available resources in the Butler community, particularly with regard to Butler Memorial Hospital. The Commission further recommends that Butler VAMC maintain its outpatient and long-term care programs.

Altoona

1. The Commission concurs with the DNCP proposal that Altoona maintain its outpatient services as well as its long-term care programs.
2. The Commission does not concur with the DNCP proposal for Altoona to close its acute care services by FY 2012 and recommends that acute care beds be closed at Altoona as soon as reasonable.

3 The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Altoona area veterans and that the VISN pursue available resources in the Altoona community.

Erie

1 The Commission concurs with the DNCP proposal that Erie close its inpatient surgical services and retain outpatient (including outpatient surgery) and its long-term care programs.

2 The Commission does not concur with the DNCP proposal that Erie maintain the remainder of its current inpatient services and recommends that all acute care beds be closed as soon as reasonable.

3 The Commission recommends that VISN 4 continue its referral practices to the Pittsburgh HCS for Erie area veterans and that the VISN pursue available resources in the Erie community.

Secretary's Decision

II Mission Change, Small Facilities
Butler, Erie, and Altoona VAMCs

Butler

The Butler VAMC, located approximately 40 miles from the Pittsburgh HCS, operates eight acute inpatient beds with an average daily census of four. The census at the Butler VAMC is among the lowest for an inpatient population in VA's health care system. Management of such a small workload raises both clinical and operational challenges. With such a low volume of care, the facility is limited in the scope of services it can perform with the staff and medical resources at its disposal. Recognizing the challenges associated with operating such a small inpatient capacity, VA will cease operation of inpatient care services at the Butler VAMC. Before any action is taken, VA will ensure that it has a solution in place to provide high quality and accessible inpatient care to Butler area veterans.

One promising solution is an enhanced use lease proposal to provide inpatient care for veterans through construction of a new Butler Memorial Hospital on the grounds of the Butler VAMC. This arrangement would allow VA to close its acute inpatient beds and continue care for area veterans on the Butler campus. It also would provide local veterans with access to a more robust inpatient care system

and would keep inpatient services collocated with VA-operated outpatient and nursing home services on the Butler campus.

VA will aggressively pursue negotiations with Butler Memorial Hospital and will seek resolution of this agreement by the end of 2004. In the interim, Butler will retain its acute inpatient beds. In the event that this agreement cannot be formalized, VA will seek alternate solutions for providing inpatient care to Butler area veterans using the Pittsburgh VAMC and existing policies and authorities to contract for care. In no case will VA transfer existing outpatient or long-term care from the Butler Campus.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this transition. To minimize the impact on patients, VA will ensure continuity of patient care to the greatest extent possible. For employees, VA will seek to minimize any impact by reassigning staff to other work areas and providing appropriate retraining, if necessary. Should any negative impact in employment occur, VA will manage any changes in employment through natural attrition, transfer, early retirement, retraining or other benevolent means. VA also will work closely with its stakeholders to ensure that this transfer of services is managed effectively (*Reference – Contracting for Care, Excess VA Property: Crosscutting*).

Altoona

VA is committed to providing continuity of care throughout Western Pennsylvania and recognizes the potential impact that closure of inpatient medicine services would have for area veterans. The realignment of the Pittsburgh HCS will have implications for referral patterns for the region and the Commission recognized that the simultaneous reduction of services at both the Erie and Altoona VAMCs may have a combined negative effect on the delivery of VA care in the region. Further, the Commission suggested that beds in Altoona should be closed as soon as reasonable. After due consideration, the Secretary does not find it reasonable to consider the closure of the inpatient medicine beds at the Altoona VAMC for the foreseeable future.

The Altoona VAMC was recommended in the DNCP for mission change to a Critical Access Hospital, a concept intended to ensure the ongoing and future quality of care at small facilities by defining the appropriate scope of practice. In its report, the Commission found that VA needed a more complete definition for the CAH concept. VA is now in the process of developing a "Veterans Rural Access Hospital" (VRAH) policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural

facilities. This policy will be completed in June 2004 and will be used to ensure that VA continues to provide quality and appropriate care to veterans at small and rural facilities like the Altoona VAMC.

Once the VRAH policy is approved, VA will study the Altoona VAMC, as well as other similar facilities, to determine whether they meet the criteria for designation as a VRAH and to define the appropriate scope of practice and ensure that it meets quality standards. In the interim, the Altoona VAMC will continue to operate in accordance with its current mission.

The VRAH study will be completed by the end of the calendar year and results will be included in the VISN's FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

Erie

The Erie VAMC is a remotely located medical center that provides inpatient medicine, surgery, and long-term care services. VA is committed to providing continuity of care in Western Pennsylvania and recognizes the potential impact that closure of inpatient medicine services would have for area veterans. The realignment of the Pittsburgh HCS will have implications for referral patterns for the region and the Commission recognized that the simultaneous reduction of services at both the Erie and Altoona VAMCs may have a combined negative effect on the delivery of VA care in the region. The Commission recognized this impact in recommending that beds at Erie be closed as soon as reasonable. After due consideration, the Secretary does not find it reasonable to consider the closure of the inpatient beds at the Erie VAMC for the foreseeable future.

Due to its similarity to other facilities designated as Critical Access Hospitals (CAH), VA will evaluate the Erie VAMC under the VRAH policy. The size of the inpatient census and the distance of the Erie VAMC from a major urban center justify its inclusion for analysis under this policy.

VA is now in the process of developing a VRAH policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities. This policy will be completed in June 2004 and will be used to ensure that VA continues to provide quality and appropriate care to veterans at small and rural VA facilities like the Erie VAMC.

Once approved, VA will study the Erie VAMC, as well as other similar facilities, to determine whether they meet the criteria for designation as a VRAH and to define the appropriate scope of practice, particularly surgical practice,

and ensure that it meets quality standards. In the interim, the Erie VAMC will continue to operate in accordance with its current mission.

The VRAH study will be completed by the end of the calendar year and results will be included in the VISN's FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

CARES Commission Recommendation

III Enhanced Use
Butler VAMC

1. The Commission concurs with the DNCP proposals regarding enhanced use lease (EUL) opportunities at the Butler VAMC. The Commission also recommends that the EUL proposal with Butler Memorial Hospital be made a high priority for VA and that the evaluation of this EUL opportunity be completed within six to nine months.
2. The Commission concurs with the EUL proposal with Butler County for a new 16-bed intermediate mental health facility on VA grounds.

Secretary's Decision

III Enhanced Use
Butler VAMC

VA will expedite negotiations to develop an enhanced use lease with Butler Memorial Hospital for new construction of a community hospital on the Butler campus that will provide inpatient services to veterans. VA also will pursue the opportunity to partner with Butler County to develop an intermediate mental health facility on the Butler campus. When these lease agreements are reached, VA will attempt to expedite implementation.

In both cases, VA will ensure that these partnerships serve to enhance the Department's mission. As VA proceeds with new development opportunities, it will ensure that the Butler campus retains its presence as a veterans facility, remaining a place in the community that area veterans recognize as their own (*Reference – Excess VA Property: Crosscutting*).

CARES Commission Recommendation

IV Inpatient Care

1. The Commission concurs with the DNCP proposals to improve inpatient care through in-house expansions and community contracts, where appropriate.
2. The Commission recommends that the Philadelphia and Wilmington VAMCs proceed with further consolidation of services.

Secretary's Decision

IV Inpatient Care

VA will meet the anticipated demand for inpatient care across the VISN through expansion of in-house services and by using existing authorities and policies to contract for care where necessary. Further, VA will continue to consolidate services between the Philadelphia and Wilmington VAMCs as appropriate (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendations

V Outpatient Care

The Commission concurs with the DNCP proposal to meet increased demand through in-house expansion, contracting out, enhanced use arrangements, and increased use of CBOCs.

Secretary's Decision

V Outpatient Care

VISN 4 anticipates increasing demand for primary care through 2022, particularly in the Eastern market. VA will meet this increase through expansion, renovation, new construction, and use of existing authorities and policies to contract for care where necessary. New CBOCs in selected locations will be considered through the National CBOC Approval Process (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VI Special Disability Programs
Spinal Cord Injury Outpatient Clinic at the Philadelphia VAMC

1. The Commission concurs with the DNCP proposal to establish a certified spinal cord injury and disorders (SCI/D) outpatient clinic in Philadelphia.
2. The Commission recommends that inter-VISN coordination and planning for SCI/D patients be improved, especially between VISN 3 and VISN 4. Once this inter-VISN coordination has been improved, the Commission recommends that VA reevaluate the current and projected SCI/D bed needs for VISN 4 in order to determine whether a 30-bed SCI Center should be established in the eastern part of VISN 4.

Secretary's Decision

VI Special Disability Programs
Spinal Cord Injury Outpatient Clinic at the Philadelphia VAMC

As part of the implementation process, VA will validate the demand for SCI/D beds in the region as well as the referral patterns between VISNs to ensure that veterans with spinal cord injury and disorders have appropriate access to care in the region. Implementation plans for development of a certified SCI/D outpatient clinic in Philadelphia will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

CARES Commission Recommendation

VII Extended Care

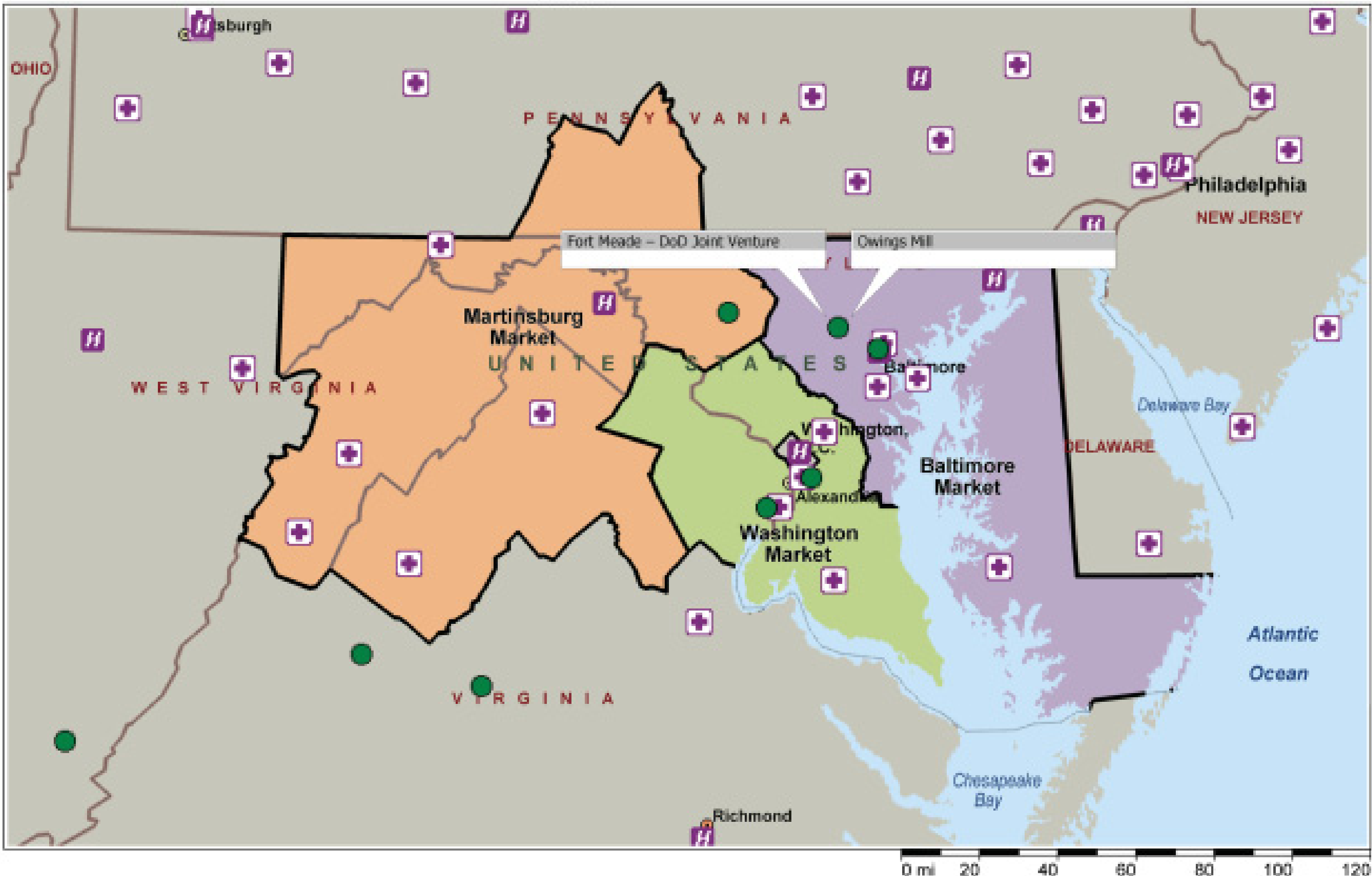
The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

VII **Extended Care**

VA will develop a long-term care strategic plan based on well-articulated policies. Until VA completes a long-term care strategic plan, it will only proceed with maintenance and life safety projects at existing long-term care facilities that are necessary to ensure the quality and safety of patient care (*Reference – Long-Term Care: Crosscutting*).

VISN 5



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CARES Decisions for VISN 5

CARES Commission Recommendation

Campus Realignment, Extended Care
Perry Point VAMC

1. The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.
2. The Commission concurs with the DNCP proposal to redesign the Perry Point campus, including enhanced use leasing, subject to the preparation and approval of a strategic plan.

Secretary's Decision

Campus Realignment, Extended Care
Perry Point VAMC

The Perry Point campus is located at the banks of the Susquehanna River and Chesapeake Bay and is situated on 364 acres of land, much of which is underused or vacant. While some buildings on the campus have been recently renovated, others are in dire need of repair, including the nursing home, which is almost 80 years old. To ensure that VA makes necessary improvements to patient care buildings and most effective use of existing buildings and land, VA will develop a Master Plan for the realignment of the Perry Point campus.

While the mission of the Perry Point VAMC will remain unchanged, the Master Plan will propose an efficient, cost-effective, and appropriately sized design that will reduce vacant and underused space on the campus and include modernization of patient care buildings to meet current and anticipated needs. The plan will include construction of a replacement

nursing home. Plans for the size of the nursing home will be developed using the long-term care and mental health strategic plans. The Master Plan will ensure that plans for alternate use or disposal of VA property serve to enhance the Department's mission.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

While this transition is expected to take place over several years, VA will complete a Master Plan by the end of 2004 (*Reference – Excess VA Property, Long-Term Care: Crosscutting*).

CARES Commission Recommendation

Inpatient Acute Psychiatry and Residential Rehabilitation Care

1. The Commission concurs with the DNCP proposal to move 77 domiciliary beds from Martinsburg VA Medical Center to Washington, DC.
2. In view of the fact that there are a large number of homeless veterans in the Washington, DC, area, the Commission recommends that consideration be given to transferring more residential rehabilitation beds to the Washington, DC, area.
3. The Commission concurs with the DNCP proposal to move 22 acute psychiatry beds from Perry Point to the Washington, DC VAMC.

Secretary's Decision

II Inpatient Acute Psychiatry and Residential Rehabilitation Care

While the Washington DC market has the largest population of homeless veterans in the region, it currently has no domiciliary beds. As a result, homeless veterans are primarily referred to Martinsburg for domiciliary care. The transfer of 77 domiciliary beds from Martinsburg to the Washington, DC area will improve access to care for many homeless veterans. As VA proceeds with implementation planning and future strategic planning, it will continue to explore the possibility of transferring more domiciliary care services to the Washington, DC area.

VA will improve access to acute inpatient psychiatry services in the VISN by shifting 22 beds from the Perry Point VAMC to the Washington DC VAMC. This bed transfer will help VA to meet forecasted increases in demand in the Washington, DC area.

The VISN will develop a plan to manage the transfer of beds in its FY 2005 strategic planning submission. VA is committed to minimizing any impact on patients, employees, and the community and will continue to work closely with its stakeholders to ensure that development and implementation is managed effectively.

CARES Commission Recommendation

III Outpatient Care

The Commission concurs with the DNCP proposal to address the need for increased space for outpatient primary, mental health, and specialty care through in-house expansion, new construction, and leases.

Secretary's Decision

III Outpatient Care

The VISN will meet increases in demand for care through expansion, renovation, new construction of existing space, or leases. Existing authorities and policies will be used to contract for care where necessary.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 5 has five new CBOCs and a mental health clinic targeted for priority implementation by 2012:

Parent Facility	New Facility Name	State
Martinsburg VAMC	Fort Detrick – DoD Joint Venture	MD
Baltimore VAMC	Fort Meade – DoD Joint Venture	MD
Baltimore VAMC	Owings Mill	MD
Baltimore VAMC	Baltimore City – Mental Health	MD
Washington DC VAMC	Fort Belvoir – DoD Joint Venture	VA
Washington DC VAMC	Southern Prince George	MD

These CBOCs will enhance VA/DoD sharing, improve access to care for area veterans, and relieve space deficits at the crowded Baltimore and Washington DC VAMCs. The Baltimore City site will enhance mental health services for Baltimore area veterans (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendations

IV VA/DoD Sharing

1. The Commission concurs with the DNCP proposal on developing joint ventures with DoD at Fort Meade, Fort Detrick, and Fort Belvoir.
2. The Commission recommends that the DNCP proposal for the VISN 5 VA/DoD collaborative opportunities include clear, written evidence of a joint commitment.

Secretary's Decision

IV VA/DoD Sharing

VA will work with DoD to implement sharing opportunities at Fort Meade, Fort Detrick, and Fort Belvoir (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

V Enhanced Use

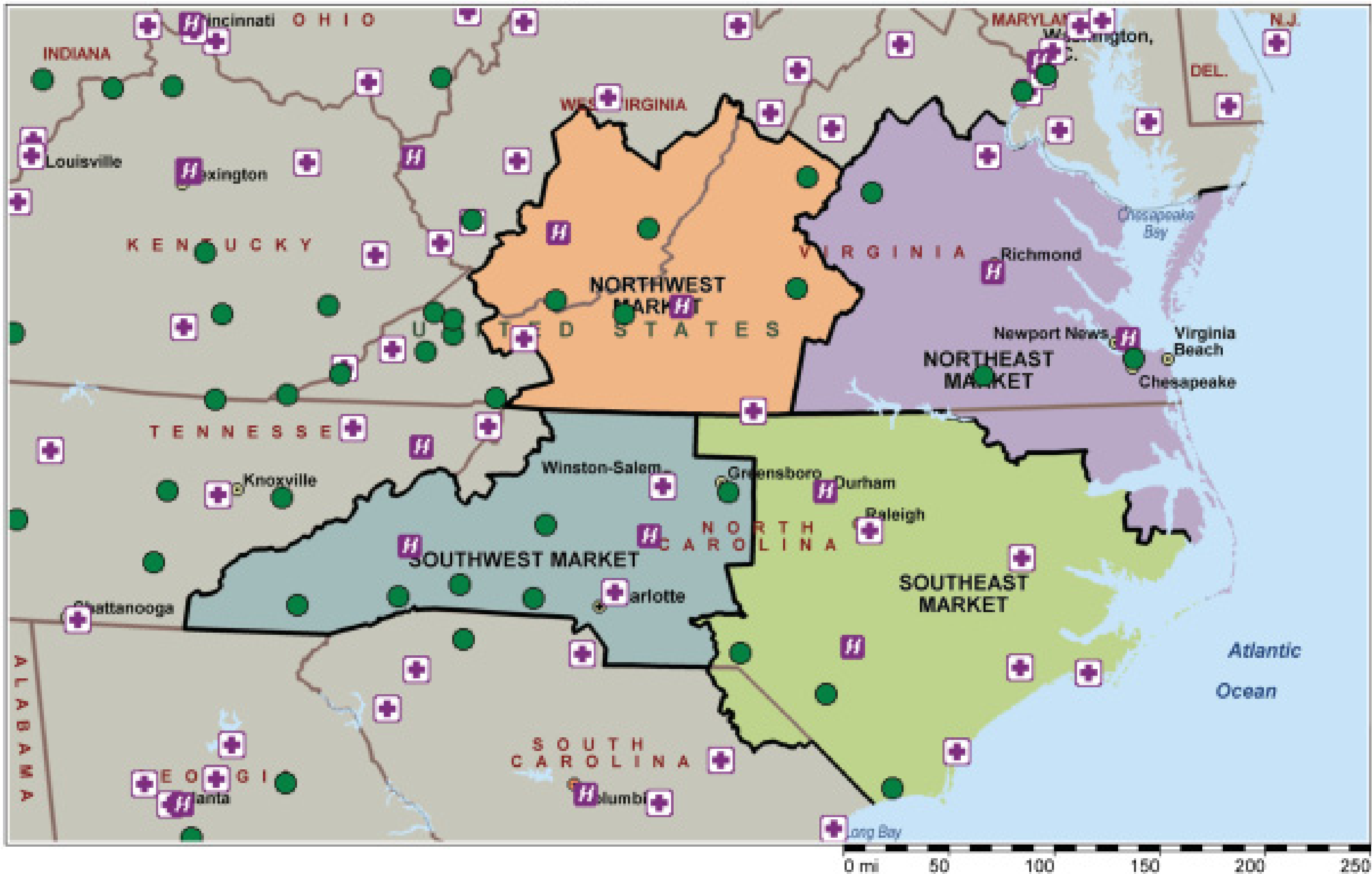
The Commission concurs with the DNCP proposal for an enhanced use lease project at Fort Howard.

Secretary's Decision

V Enhanced Use

The VISN will pursue its plan to realign the Fort Howard campus using enhanced use lease authorities (*Reference – Excess VA Property: Crosscutting*).

VISN 6



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CARES DECISIONS FOR VISN 6

CARES Commission Recommendation

- **Small Facility**
  Beckley VAMC

1. The Commission recommends that VA establish a clear definition and clear policy on the critical access hospital (CAH) designation prior to making a decision on the use of this designation.
2. The Commission does not concur with the DNCP proposal to convert Beckley into a CAH and recommends closing the acute inpatient hospital beds and contracting for acute care in the community as soon as reasonable.
3. The Commission recommends that Beckley retain its multi-specialty outpatient services and nursing home.

Secretary's Decision

- **Small Facility**
  Beckley VAMC

VA is committed to providing continuity of care to Beckley area veterans and recognizes the potential impact that closure of inpatient medicine services would have. While the Commission noted the availability of care options in the community, it also recognized stakeholder concerns about the quality of care available and the distance to other VA medical centers. The Commission recommended that beds at the Beckley VAMC should be closed as soon as reasonable. After due consideration, the Secretary does not find it reasonable to consider the closure of the inpatient medicine beds at the Beckley VAMC for the foreseeable future.

The Beckley VAMC was recommended in the DNCP for mission change to a Critical Access Hospital, a concept intended to ensure the ongoing and future quality of care at small facilities by defining the appropriate scope of practice. In its report, the Commission found that VA needed a more complete definition for the CAH concept. VA is now in the process of developing a "Veterans Rural Access Hospital" (VRAH) policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities. This policy will be completed in June 2004 and will be used to ensure that VA continues to provide quality and appropriate care to veterans at small and rural facilities like the Beckley VAMC.

Once the VRAH policy is approved, VA will study the Beckley VAMC, as well as other similar facilities, to determine whether it meets the criteria for designation as a VRAH and to define the appropriate scope of practice to ensure that it meets quality standards. In the interim, the Beckley VAMC will continue to operate in accordance with its current mission.

The VRAH study will be completed by the end of the calendar year and results will be included in the VISN's FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

CARES Commission Recommendation

Extended Care
Beckley VAMC

1. The Commission concurs with the DNCP proposal to improve nursing home space at Beckley.
2. The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities, VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

Extended Care
Beckley VAMC

VA will develop a long-term care strategic plan based on well-articulated policies. Until VA completes a long-term care strategic plan, it will only proceed with maintenance and life safety projects at existing long-term care facilities that are necessary to ensure the quality and safety of patient care (*Reference – Long-Term Care: Crosscutting*).

CARES Commission Recommendation

III Inpatient Care

1. The Commission concurs with the DNCP proposal to increase the access for hospital care in the Southeast market by providing limited inpatient care at the Camp Lejeune Naval Hospital.
2. The Commission concurs with the DNCP proposal for new construction and renovation of inpatient space throughout this VISN but notes that converting current outpatient space into inpatient wards will increase current deficits in outpatient space.

Secretary's Decision

III Inpatient Care

VA will pursue the opportunity to improve access to inpatient care in VISN 6 by developing a sharing agreement with the Camp Lejeune Naval Hospital (*Reference – VA/DoD Sharing: Crosscutting*).

VA will increase inpatient capacity throughout the VISN through new construction, renovation, or conversion of vacant space. VA will ensure that enhancements to inpatient care will assess the impact on, and not diminish the availability of, outpatient care.

CARES Commission Recommendation

IV Outpatient Care

The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space gaps in Hampton, Richmond, Durham, Fayetteville, Asheville and Salisbury.

The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

IV Outpatient Care

VA will address current and projected space deficiencies in Hampton, Richmond, Durham, Fayetteville, Asheville, and Salisbury through new construction, conversion of vacant space, and by using existing authorities and policies to contract for care where necessary.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 6 has 17 new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Beckley VAMC	Lewisburg	WV
Beckley VAMC	Bluefield	WV
Salem VAMC	Staunton	VA
Salem VAMC	Radford	VA
Salem VAMC	Lynchburg	VA
Asheville VAMC	Franklin	NC
Asheville VAMC	Rutherfordton	NC
Asheville VAMC	Hendersonville	NC
Salisbury VAMC	Gastonia	NC
Salisbury VAMC	Hickory	NC
Salisbury VAMC	Greensboro	NC
Fayetteville VAMC	Hamlet	NC
Fayetteville VAMC	Lumberton	NC
Fayetteville VAMC	Supply	NC
Hampton VAMC	Norfolk	VA
Richmond VAMC	Charlottesville	VA
Richmond VAMC	Emporia	VA

These new sites of care will help the VISN, which currently is below access standards in all four of its markets, to meet national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

∨ Enhanced Use

The Commission concurs with the DNCP proposal for Durham's enhanced use leasing (EUL) project and further recommends that specific target dates for implementation be set and final actions defined.

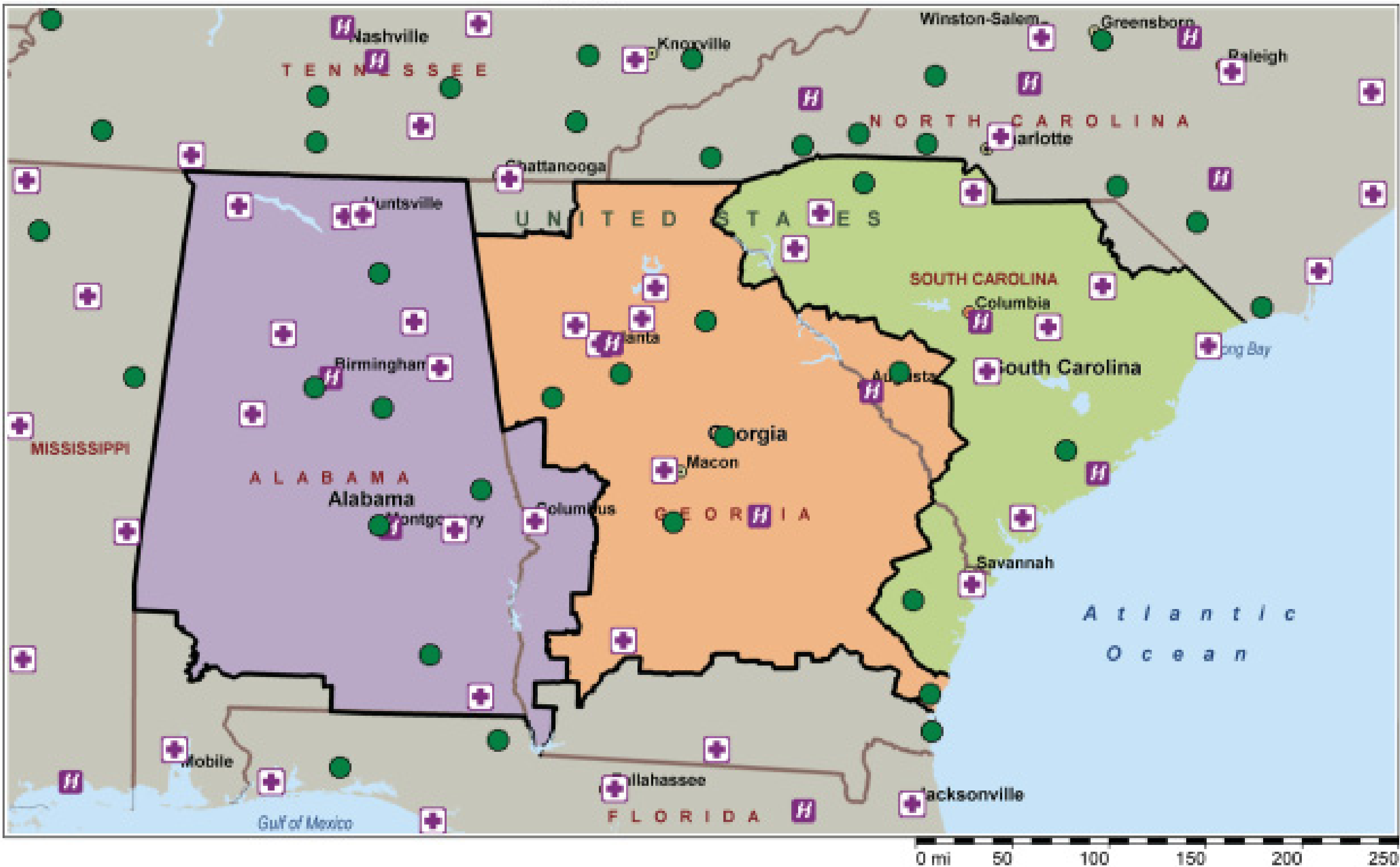
If the EUL plan does not materialize, the Commission recommends that the VISN quickly develop an alternative approach to meet shortfalls in its outpatient primary and specialty care, research, and parking space needs.

Secretary's Decision

∨ Enhanced Use

VA will meet anticipated patient care, parking, and research space needs in Durham through an existing proposal for an enhanced use lease project or through new construction, conversion of vacant space, leases, or use of existing policies and authorities to contract for care where necessary (*Reference – Excess VA Property, Contracting for Care: Crosscutting*).

VISN 7



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CARES Decisions for VISN 7

CARES Commission Recommendation

I **Mission Change**
Augusta VAMC

1 The Commission does not concur with the DNCP proposal to study the feasibility of consolidating selected current services at the Uptown Division to the Downtown Division because the proposed realignment is not practical.

2 The Commission concurs with the DNCP proposal to realign the footprint at the Uptown Division campus and to evaluate that campus for alternative uses under the enhanced use leasing (EUL) program.

Secretary's Decision

I **Mission Change**
Augusta VAMC

VA will not pursue consolidation of Augusta's two divisions at this time, but will plan to make more efficient use of vacant and underused space at the Uptown Division of the Augusta VAMC. To ensure that VA makes most effective use of existing buildings and land, VA will develop a Master Plan for the Uptown Division of the Augusta VAMC.

The Master Plan will propose an efficient, cost-effective, and appropriately sized footprint that will reduce vacant and underused space on the campus. The Master Plan also will ensure that any plan for alternate use or disposal of VA property serves to enhance the Department's mission.

VA will complete the Master Plan by the end of 2004 (*Reference – Excess VA Property*).

CARES Commission Recommendation

II **Mission Change**
Dublin VAMC

The Commission concurs with the DNCP proposals that the Dublin VAMC should retain its inpatient programs, with intensive care unit (ICU) beds subject to a VHA-directed external evaluation; that transition surgery beds be changed

to observation beds; and that Dublin refer complex or non-emergent surgery to other VAMCs, and contract with local community hospitals for emergent surgery.

Secretary's Decision

II Mission Change
Dublin VAMC

The Dublin VAMC is approximately 90 miles from Augusta and 140 miles from Atlanta. With a need for approximately 36 beds in FY 2012 and 30 beds in FY 2022 and with limited options for community care in close proximity, VA will maintain inpatient care services at this facility.

VA will develop an implementation plan for the Dublin VAMC that will include transition of surgery beds to observation beds for outpatient surgery. The implementation plan also will incorporate the recommendations of an ongoing, system-wide, study of ICU beds scheduled to be completed in June 2004. As VA manages this transition, it will ensure veterans have access to quality care.

The implementation plan will be included in the VISN's FY 2005 strategic planning submission (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

III Mission Change
Montgomery, AL
(Central Alabama Veterans Health Care System [CAVHCS], West Campus)

The Commission concurs with the DNCP that the proposal to convert Montgomery to an outpatient-only facility and to contract out inpatient care requires further study.

Secretary's Decision

III Mission Change
Montgomery, AL
(Central Alabama Veterans Health Care System [CAVHCS], West Campus)

During preparation of the Draft National CARES Plan, VA found it did not have sufficient information to make a decision to convert the CAVHS to an outpatient-only facility. Recognizing that sufficient analysis had yet to be completed, the CARES Commission agreed VA should further study the potential for conversion of the facility to an outpatient-only mission.

VA will proceed with a study of the feasibility of converting the Montgomery CAVHS to an outpatient-only facility as part of the CARES implementation process.

The study will examine the impact of mission change on access to and quality of care as well as the cost-effectiveness of potential realignment. VA will consider comments from stakeholders as it conducts the study. The study will be completed by the end of 2004.

CARES Commission Recommendation

IV Inpatient Care

The Commission concurs with the DNCP proposals on the use of contract hospital sites, conversion of vacant space, new construction, renovation, and leasing as required in the Alabama and South Carolina markets to meet access and capacity issues in these markets.

Secretary's Decision

IV Inpatient Care

The veteran population is growing in both the Alabama and South Carolina markets. VA will meet the anticipated increase in demand and resolve existing access gaps by converting existing vacant space, new construction, renovation, leasing as required, and use of existing authorities and policies to contract for care where necessary (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

V Outpatient Care

1. The Commission concurs with the DNCP proposals to add CBOCs; to expand existing CBOCs via contracting, leasing and new construction; and to realign the use of space at the VAMCs via renovation, conversion of vacant space, new construction and leasing.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

V Outpatient Care

The veteran population is shifting to the Southeastern and Southwestern United States and all three markets in the VISN are seeing the workload growth associated with that shift. The VISN will use new construction and leasing to expand existing CBOCs and other existing space to more effectively manage the demand for outpatient care.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 7 has 16 new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Dublin VAMC	Milledgeville	GA
Dublin VAMC	Brunswick	GA
Dublin VAMC	Perry	GA
Augusta VAMC	Athens	GA
Augusta VAMC	Aiken	SC
Atlanta VAMC	Stockbridge	GA
Atlanta VAMC	Noonan	GA
Charleston VAMC	Hinesville	GA
Charleston VAMC	Goose Creek	SC
Columbia VAMC	Spartanburg	SC
Central Alabama HCS	Enterprise	AL
Central Alabama HCS	Opelika	AL
Central Alabama HCS	Maxwell AFB	AL
Birmingham VAMC	Childersburg	AL
Birmingham VAMC	Guntersburg	AL
Birmingham VAMC	Bessemer	AL

These new sites of care will help the VISN, which currently is below access standards in all three of its markets, to meet national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VI Enhanced Use, Collocation with the Veterans Benefits Administration and Collaboration with Academic Affiliates

1. The Commission concurs with the DNCP proposal on the VBA collocation and enhanced use lease proposal at Columbia.
2. The Commission supports the concept of cooperative partnering and recommends promptly evaluating the Medical University of South Carolina (MUSC) and VA joint venture proposal.

Secretary's Decision

VI Enhanced Use, Collocation with the Veterans Benefits Administration and Collaboration with Academic Affiliates

VA will continue to consider options for sharing opportunities with the Medical University of South Carolina.

VA will explore the feasibility of collocating the Columbia VBA Regional Office at the Columbia VAMC through enhanced use lease. VBA will develop a collocation feasibility study by September 2004 (*Reference* – OneVA *Collaborations: Crosscutting*).

CARES Commission Recommendation

VII Special Disability Programs – Spinal Cord Injury/Disorder (SCI/D)

1. The Commission concurs with the DNCP proposal to add 11 beds immediately at the Augusta VAMC and increase to the projected 20 SCI/D beds needed by FY 2012.
2. VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce waiting times.

Secretary's Decision

VII Special Disability Programs – Spinal Cord Injury/Disorder (SCI/D)

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location

and inter-VISN collaboration as appropriate. Implementation plans for development of an SCI/D expansion at the Augusta VAMC will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

CARES Commission Recommendation

VIII VA/DoD Sharing Opportunities

The Commission concurs with maximizing space utilization and services among the VA and DoD health care operations to provide enhanced services for veterans.

Secretary's Decision

VIII VA/DoD Sharing Opportunities

VA will continue to pursue opportunities to share resources with Maxwell AFB, and Charleston and Beaufort Naval Hospitals as well as other DoD entities in VISN 7 (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

IX Extended Care

1. The Commission concurs with the DNCP proposal on the need for renovations to the nursing home care units at Charleston and Columbia.
2. The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

IX Extended Care

VA will develop a long-term care strategic plan based on well-articulated policies. Until VA completes a long-term care strategic plan, it will only proceed with maintenance and life safety projects at existing long-term care facilities that are necessary to ensure the quality and safety of patient care (*Reference – Long-Term Care: Crosscutting*).

CARES Commission Recommendation

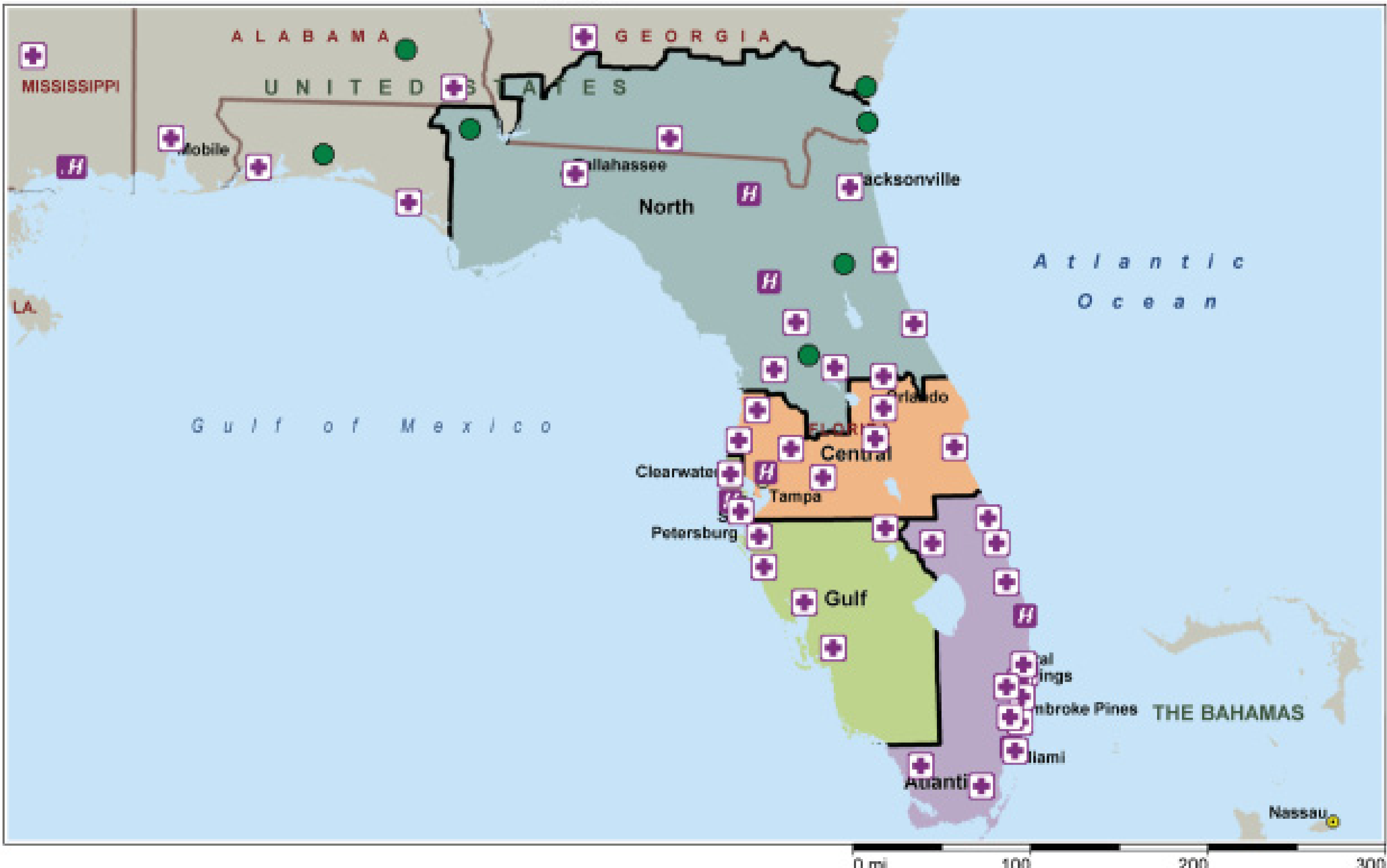
X Facility Condition

The Commission concurs with the DNCP proposal to renovate inpatient wards at the Atlanta, Columbia, and Charleston VAMCs.

Secretary's Decision

X Facility Condition

VA will make necessary renovations at the Atlanta, Columbia, and Charleston VAMCs to ensure that local veterans are cared for in safe and efficient facilities designed to provide high quality health care.



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CARES Decisions for VISN 8

CARES Commission Recommendation

I **New Hospital (Access)**
Orlando

The Commission concurs with the DNCP proposal on the construction of a new inpatient facility in Orlando and recommends the number of beds in the proposal be validated in relation to the proposed new Tampa VAMC bed tower.

Secretary's Decision

I **New Hospital (Access)**
Orlando

VA will construct a new medical center in Orlando to meet the growing needs of a Central Florida market that is currently underserved. With only 45 percent of area veterans within access standards for hospital care, the Orlando area needs a new medical center.

VA will develop a plan for the design and construction of this project by September 2004.

CARES Commission Recommendation

II **Realignment (Mission Change)**
Lake City VAMC

1. The Commission does not concur with the DNCP proposal to move Lake City's inpatient surgery services to Gainesville at the present time.
2. In light of the projected growth of enrollees and the access gap in the North market, the Commission further recommends that any consideration of a transfer of inpatient services from Lake City to Gainesville be delayed until FY 2012.
3. The Commission concurs with the DNCP proposal to maintain nursing home care and outpatient services at Lake City.

Secretary's Decision

II **Realignment (Mission Change)**
Lake City VAMC

The Secretary will not consider transfer of surgical services from the Lake City VAMC to the Gainesville VAMC at this time. The proposal to transfer surgical and other inpatient services will be reconsidered after construction of a new bed tower in Gainesville is complete. In the interim, there will be no change to the mission of the Lake City VAMC.

CARES Commission Recommendation

III **Inpatient Care**
Tampa VAMC

1. The Commission concurs with the DNCP proposal for construction of an inpatient bed tower at the Tampa VAMC primarily on the basis of infrastructure and safety issues.
2. The Commission recommends that as the planning for the bed tower at Tampa proceeds, the number of beds in the proposal be validated in relation to the proposed new Orlando inpatient facility.

Secretary's Decision

III **Inpatient Care**
Tampa VAMC

VA will proceed with plans to build an inpatient bed tower at the Tampa VAMC. The Tampa VAMC is an active medical center that is aging and in need of significant upgrades to ensure that patients receive care in a safe and efficient health care environment designed to provide high quality health care. The addition of a new bed tower at the facility will resolve pressing infrastructure and safety issues.

VA will develop a plan for the design and construction of this project by September 2004.

CARES Commission Recommendation

IV Other Inpatient Care
Gulf South Market, North Market

1. The Commission concurs with the DNCP proposal to address the access gap for inpatient services in the Gulf South market (Bay Pines VAMC) by contracting for care. The Commission also concurs with the VISN proposal to realign the number of operating beds in the Gulf South market.
2. The Commission concurs with the DNCP proposal for a DoD/VA joint venture with the Naval Air Station Hospital at Jacksonville and a contractual arrangement with University of Florida/Shands and new construction at Gainesville to meet inpatient demand in the North market.
3. The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care in the Panhandle of Florida.

Secretary's Decision

IV Other Inpatient Care
Gulf South Market, North Market

VA will increase access to and availability of services to veterans in the Gulf South and North markets of VISN 8 and to the Florida Panhandle area, currently shared by VISNs 8 and 16, through sharing opportunities with DoD, new construction, shifting of resources, and use of existing authorities and policies to contract for care where necessary.

VA will evaluate establishment of contractual relationships with the University of Florida/Shands and the Naval Air Station Hospital at Jacksonville to provide inpatient services for the North market.

VA also will plan for new construction to increase inpatient capacity at the Gainesville VAMC.

VA will improve collaboration between VISNs 8 and 16 to ensure veterans living in the Florida Panhandle receive quality care in locations accessible to them (*Reference – VISN 16, Inpatient Care*).

CARES Commission Recommendation

Outpatient Care

1. The Commission concurs with the DNCP proposal for adding four new points of primary care in the North market and by expansion of existing CBOCs in all five markets.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOC's outlined in the DNCP.

Secretary's Decision

Outpatient Care

VA has seen enormous growth in veterans relocating to VISN 8 over the past several years and forecasts indicate that growth will continue into the future. VA will increase capacity for outpatient care by expanding existing CBOCs throughout the VISN.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 8 has four new CBOCs targeted for priority implementation by 2012.

Parent Facility	Planned New Facility Name	State
Gainesville VAMC	Jackson County	FL
Gainesville VAMC	Putnam	FL
Gainesville VAMC	Camden	GA
Gainesville VAMC	Summerfield (South Marion)	FL

These new sites of care will help the VISN, which currently is below access standards in its North market, to meet national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VI VA/DoD Sharing

The Commission recommends that the VISN plans for the DoD collaborative opportunities in VISN 8 include clear, written evidence of a joint commitment.

Secretary's Decision

VI VA/DoD Sharing

VA will continue to work with DoD to develop sharing opportunities in VISN 8 (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

VII Special Disability Programs
Spinal Cord Injury/Disorder (SCI/D) Beds at Tampa

1. The Commission does not concur with the DNCP on the addition of 30 SCI/D beds in Tampa. The Commission recommends that, prior to a final decision to increase the number of SCI/D beds at Tampa, VA's Chief Consultant for SCI/D consider alternative locations in or near VISN 8 for an additional SCI Center.
2. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

Secretary's Decision

VII Special Disability Programs
Spinal Cord Injury/Disorder (SCI/D) Beds at Tampa

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns, the location, and inter-VISN collaboration. Implementation plans for development of a new or expanded SCI presence in South Florida will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

CARES Commission Recommendation

VIII Excess VA Property

The Commission concurs with the DNCP proposal for further exploration of enhanced use lease project opportunities at Bay Pines and Miami.

Secretary's Decision

VIII Excess VA Property

VA will explore enhanced use lease project opportunities at the Bay Pines and Miami VAMCs (*Reference – Excess VA Property: Crosscutting*).

CARES Commission Recommendation

IX Infrastructure and Safety

The Commission recommends the expeditious construction of a new seismically safe bed tower in San Juan. The Commission recommends the VISN validate the bed, space, and cost requirements given the projected decreasing demand for inpatient care in that market.

Secretary's Decision

IX Infrastructure and Safety

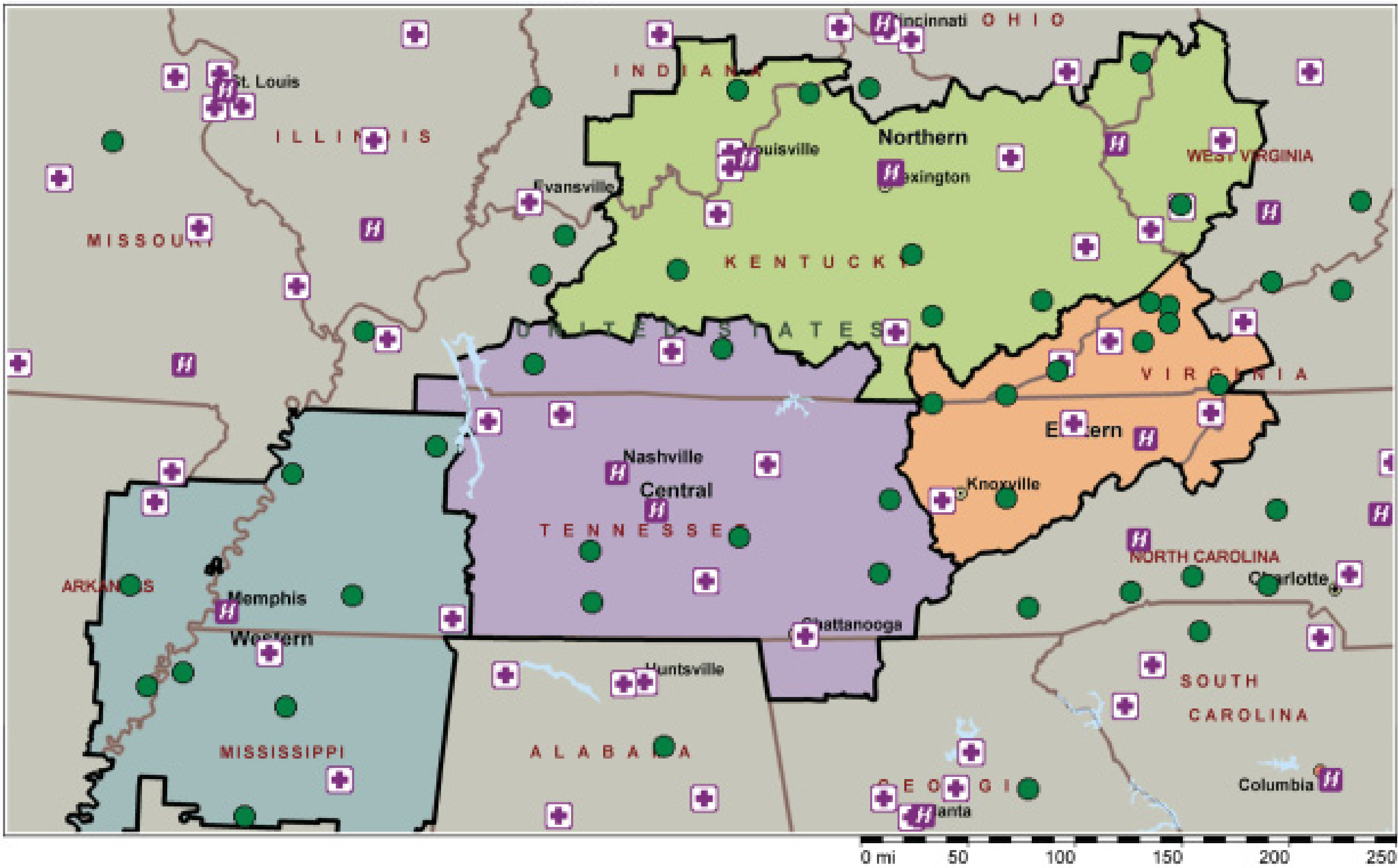
VA will build an appropriately sized, seismically safe, and operationally efficient inpatient bed tower at the San Juan VAMC. The San Juan VAMC is an active medical center that is aging and in need of significant upgrades to ensure that patients receive care in a safe and efficient health care environment that is designed to provide high quality health care. The addition of a new bed tower at the facility will resolve pressing infrastructure and safety issues.

VA will develop a plan for the design and construction of this project, to include validation of bed needs by September 2004.

Secretary's Decision

X ***OneVA* Collaborations**

VA is in the process of identifying a site for establishing a new national cemetery in the Sarasota area and will evaluate the feasibility of potential collocation opportunities within the site selection process (*Reference* – OneVA *Collaboration: Crosscutting*).



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CARES Decisions for VISN 9

CARES Commission Recommendation

Evaluate Building a Replacement Hospital
Louisville VAMC

1. The Commission concurs with the DNCP proposal that VA study the feasibility of building a replacement medical center for the Louisville VAMC in proximity to the University of Louisville, including the possibility of shared infrastructure with the medical school and the VBA office.
2. Due to the poor environment of care and overcrowding at the current medical center, the Commission recommends the study commence immediately, focus on building a replacement hospital near the University of Louisville, and be completed within a short time so that corrective actions can begin in the very near future.

Secretary's Decision

Evaluate Building a Replacement Hospital
Louisville VAMC

VA will study the need for a replacement hospital for the Louisville VAMC. The Commission recognized that the Louisville VAMC is in need of renovation, that there is an opportunity to partner with the University of Louisville, and that there is additional potential for collocation of a VBA presence at a new Louisville facility.

VA will undertake a comprehensive study of the feasibility, cost-effectiveness, and impact of replacing the current Louisville VAMC with a new state-of-the-art medical center. The study will focus on access to and quality of care as well as referral patterns with other regional medical centers, the potential for collaboration with the University of Louisville, and collocation with the Veterans Benefits Administration.

VA will begin development of a template that will define the considerations and parameters of the study and act as a guide for the study process. Upon completion of the template, VA will assign a multidisciplinary team with appropriate skills and experience to conduct the study. The team will use support from outside contractors and other subject matter experts as needed to ensure it has access to all of the skills necessary to complete the study effectively and efficiently. The study will include collaboration with stakeholders to ensure that their comments are solicited and included in the process.

VA will complete this study by the end of 2004.

CARES Commission Recommendation

Campus Realignment
Lexington VAMC

1. The Commission does not concur with the DNCP proposal on transferring current outpatient care and nursing home care services from Leestown to Cooper Drive. The Commission recommends that the Lexington-Leestown campus remain open and continue to provide nursing home, outpatient care, and administrative services.
2. The Commission recommends that the VA move swiftly to secure an enhanced use lease with Eastern State Hospital and/or the Kentucky Department of Veterans Affairs, as VA would not have to move from the Leestown campus in order for Eastern State Hospital to begin using this space. The Commission recommends that plans be developed to make the footprint of the Leestown campus smaller, making most of the campus available for disposition and/or enhanced use leasing.

Secretary's Decision

Campus Realignment
Lexington VAMC

The Secretary will not consider consolidation of the Leestown campus at Cooper Drive, but VA will pursue opportunities to reduce the footprint of the Leestown campus.

To ensure that VA makes most effective use of existing buildings and land, VA will develop a Master Plan for the Leestown campus. While the mission of the Leestown campus will remain unchanged, the Master Plan will propose an efficient, cost-effective, and appropriately sized footprint that will reduce vacant and underused space on the campus. The Master Plan will consider enhanced use lease opportunities and will ensure that any plan for alternate use or disposal of VA property serves to enhance the Department's mission.

VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

VA will complete the Master Plan by the end of 2004 (*Reference – Excess VA Property: Crosscutting*).

CARES Commission Recommendation

III **Campus Realignments**
Nashville and Murfreesboro VAMCs

The Commission concurs with the DNCP proposal to consolidate services at Murfreesboro and Nashville, and recommends that the VISN proceed with its plan for providing outpatient surgical services at both campuses.

Secretary's Decision

III **Campus Realignments**
Nashville and Murfreesboro VAMCs

VA will continue to consolidate services between Nashville and Murfreesboro. Nashville will provide inpatient acute medicine and surgery programs, while Murfreesboro will provide acute and long-term care psychiatry services as well as nursing home services. Both facilities will retain primary care and outpatient surgery. This consolidation will improve quality of care through more effective care coordination and will enhance efficiency by reducing duplicative services between the two sites.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this transition and will continue to work closely with its stakeholders to ensure that development and implementation of this transfer is managed effectively.

The VISN will include a plan for managing the transition in its FY 2005 strategic planning submission.

CARES Commission Recommendation

IV **Inpatient Medicine and Surgery**

1. The Commission concurs with the DNCP proposals to increase inpatient medicine services in the Central and Western markets 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).
2. The Commission concurs with the DNCP proposal on contracting for excess demand, particularly in the Charleston, WV area.

Secretary's Decision

IV Inpatient Medicine and Surgery

VA will meet increases in demand for inpatient medicine and surgery in VISN 9 through use of existing authorities and policies to contract for care in Chattanooga, Charleston, WV, and other areas in the VISN where necessary. VA also will increase capacity through in-house expansions in Nashville and Memphis (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

V Outpatient Primary and Specialty Care

1. The Commission concurs with the DNCP proposal to expand services at current sites of care, to expand the use of telemedicine, and to use community contracts, but notes that this is not an adequate solution to the substantial access and capacity deficiencies in this VISN, which cannot be met without additional sites of care.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

V Outpatient Primary and Specialty Care

VISN 9 has significant access gaps for primary care. VA will meet current and forecasted access and capacity gaps in the VISN by expanding existing sites of care, increasing use of telemedicine, and using existing authorities and policies to contract for care where necessary.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 9 has 32 new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Mountain Home VAMC	Holston Medical Clinic	TN
Mountain Home VAMC	Pennington Gap Clinic	VA
Mountain Home VAMC	Thompson Clinic	VA
Mountain Home VAMC	Haysi Clinic	VA
Mountain Home VAMC	Davenport Clinic	VA
Mountain Home VAMC	Davis Clinic	VA
Mountain Home VAMC	West Lee County Clinic	VA
Mountain Home VAMC	Jellico	TN
Mountain Home VAMC	Pigeon Forge	TN
Memphis VAMC	Pontotoc County	MS
Memphis VAMC	Tunica	MS
Memphis VAMC	Greneda	MS
Memphis VAMC	Paris	TN
Memphis VAMC	Bolivar	TN
Memphis VAMC	Phillips County	AR
Memphis VAMC	Wynne County	AR
Memphis VAMC	Dyer County	TN
VATVHS – Murfreesboro	Maury County	TN
VATVHS – Murfreesboro	Athens	TN
VATVHS – Murfreesboro	Harriman	TN
VATVHS – Murfreesboro	McMinn County	TN
VATVHS – Nashville	Glasgow	KY
VATVHS – Nashville	Giles County – Pulaski	TN
VATVHS – Nashville	Hopkins County	KY
Huntington VAMC	Gallipolis	OH
Huntington VAMC	Logan	WV
Louisville VAMC	Scott County	IN
Louisville VAMC	Grayson County	KY
Louisville VAMC	Carroll County	KY
Lexington VAMC	Berea	KY
Lexington VAMC	London	KY
Lexington VAMC	Perry County	KY

These new sites of care will help the VISN, which currently is below access standards in all four of its markets, to meet national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VI Mental Health Care

1. The Commission does not concur with the DNCP proposal and recommends maintaining inpatient psychiatric and outpatient mental health services in at least all current locations until mental health services VISN-wide have been reevaluated.
2. The Commission recommends that VISN 9 leadership complete a thorough review of mental health services in the VISN, including in CBOCs, and develop and implement a plan to provide an appropriate level of services.
3. The Commission recommends that acute inpatient mental health services be provided with other acute inpatient services whenever feasible.
4. The Commission recommends that additional enhanced use lease opportunities with the Commonwealth of Kentucky be explored.

Secretary's Decision

VI Mental Health Care

The CARES process identified significant access and capacity gaps for mental health services throughout VISN 9. The Secretary recognizes the importance of availability of and access to mental health services for veterans and is committed to ensuring that all VISNs provide comprehensive and accessible mental health services. This commitment will be reflected in the mental health strategic plan scheduled for completion in August 2004.

In the interim, VISN 9 has developed and is in the process of implementing a plan to improve mental health services. That plan will be coordinated with the VA Mental Health Strategic Plan and incorporated into the FY 2005 VISN strategic planning submission.

The VISN also will maintain inpatient psychiatric and outpatient mental health services in all current locations until mental health services VISN-wide have been reevaluated (*Reference – Mental Health: Crosscutting*).

VA will explore enhanced use lease opportunities with the Commonwealth of Kentucky.

CARES Commission Recommendation

VII VA/DoD Sharing

The Commission concurs with expansion of space for primary care and outpatient mental health services at the Fort Knox CBOC.

Secretary's Decision

VII VA/DoD Sharing

VA will work with DoD to expand space for primary and outpatient mental health services at the Fort Knox CBOC (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

VIII Special Disability Programs
Spinal Cord Injury/Disorder (SCI/D)

The Commission concurs with the DNCP proposal on the expansion of SCI/D beds at Memphis. VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

Secretary's Decision

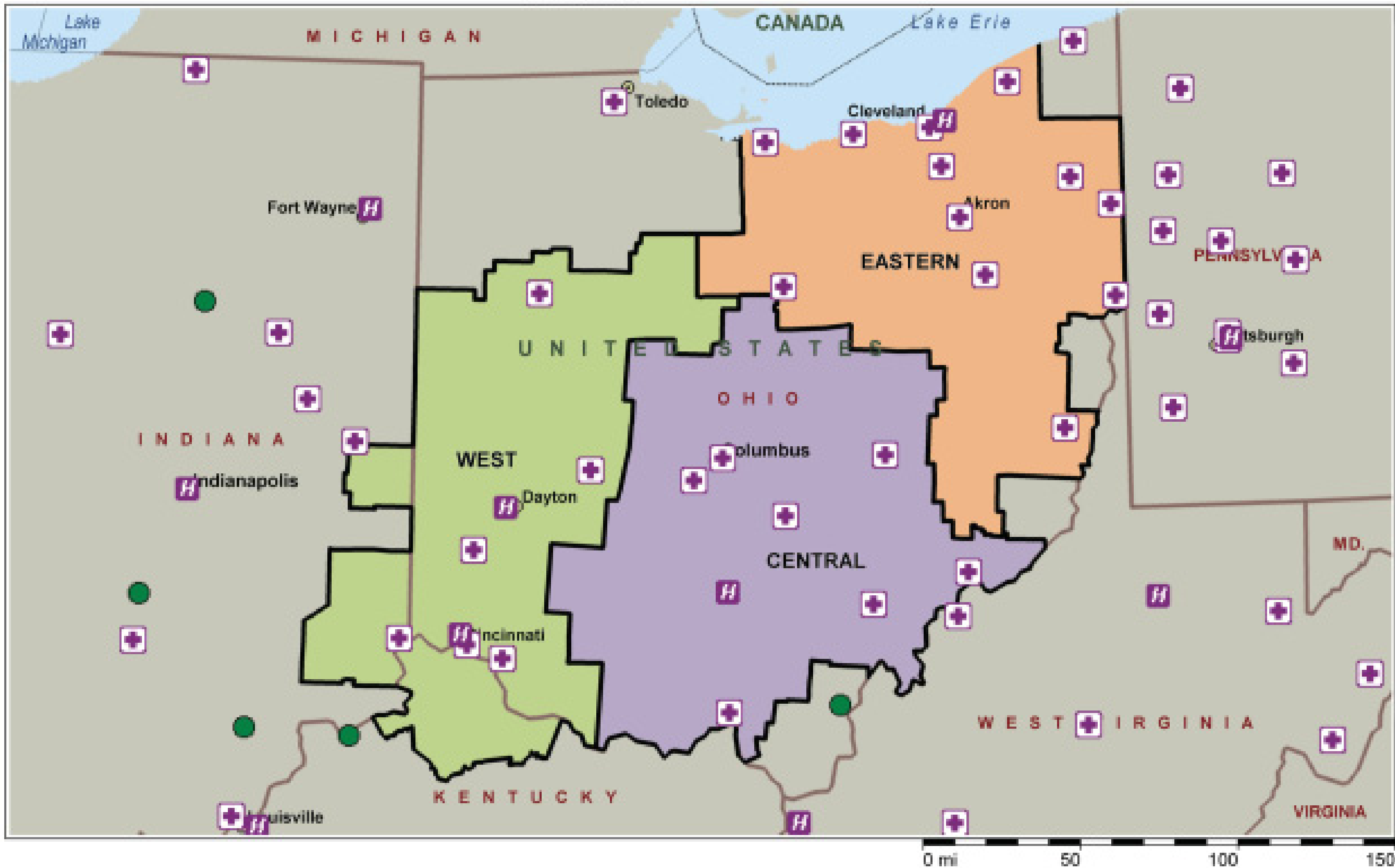
VIII Special Disability Programs
Spinal Cord Injury/Disorder (SCI/D)

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for expansion of SCI/D beds in Memphis will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

Secretary's Decision

IX *OneVA* Collaborations

VA will transfer approximately 50 acres of land from the Mountain Home VAMC to the National Cemetery Administration for cemetery expansion.
VA will develop a plan for this transfer by September 2004 (*Reference* – OneVA *Collaboration: Crosscutting*).



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CARES Decisions for VISN 10

CARES Commission Recommendation

Mission Change and Campus Realignment
Brecksville and Wade Park
Divisions of the Cleveland VA Medical Center (VAMC)

1. The Commission concurs with the DNCP proposal to relocate current psychiatric, nursing home, domiciliary, and residential services from Brecksville to Wade Park, provided the existing level of services can be maintained.
2. The Commission concurs with the DNCP proposal to pursue enhanced use leasing opportunities at Brecksville in exchange for property adjacent to Wade Park.

Secretary's Decision

Mission Change and Campus Realignment
Brecksville and Wade Park
Divisions of the Cleveland VA Medical Center (VAMC)

VA will consolidate the Brecksville Division to the Wade Park Division of the Cleveland VAMC. This consolidation will be accomplished through an enhanced use lease and major construction project that will modernize and expand the patient care facilities at the Wade Park campus. Once completed, this will allow VA to provide Cleveland area veterans with health care at one newly renovated and comprehensive tertiary medical center.

This consolidation will improve services for Cleveland veterans. New construction and renovation will improve the environment of care by replacing aging patient care buildings at Brecksville with new and renovated facilities at the Wade Park VAMC. It will improve coordination of care by collocating all patient treatment and administrative services at one medical center that can comprehensively handle all of the inpatient care needs of Cleveland area veterans. The consolidation also will improve resource use, redirecting patient care resources from maintenance of aging facilities at Brecksville to patient care at the expanded Wade Park VAMC.

The VISN has submitted a construction project application for this consolidation that includes an improved and project-based life cycle cost analysis. This plan estimates significant resource savings with an anticipated payback period of four years. To ensure effective implementation of this consolidation, VA will develop

a Master Plan for the Brecksville and Wade Park campuses. The Master Plan will ensure that there is no interruption of existing services until construction of the new facility is completed and transfer of patients from the Brecksville campus to the Wade Park campus can be managed effectively.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this transition. To minimize impact on patients, VA will ensure continuity of patient care to the greatest extent possible. For employees, VA will seek to minimize any impact by reassigning staff to other work areas and providing appropriate retraining if necessary. Should any negative impact in employment occur, VA will manage any changes in employment through natural attrition, transfer, early retirement, retraining or other mechanisms. VA will continue to work closely with its stakeholders to ensure that this consolidation is managed effectively.

The consolidation proposal plans for an enhanced use lease agreement for the Brecksville campus. VA will ensure that the terms of the lease will serve to enhance the Department's mission.

While this consolidation is expected to occur over several years, the VISN will complete a Master Plan to guide the transition by September 2004.

CARES Commission Recommendation

II Access to Hospital Care and Inpatient Medicine Services

1. The Commission concurs with the DNCP proposal to contract for inpatient care with local hospitals in Columbus and Canton.
2. The Commission recommends analysis of the impact on other facilities of adding services in Columbus, particularly on Chillicothe.

Secretary's Decision

II Access to Hospital Care and Inpatient Medicine Services

The Columbus area is among the fastest growing in the Nation and VA currently forecasts the need for enhanced capacity and access to inpatient care. To meet these needs, VA will use existing authorities and policies to contract for care in Columbus and Canton. As VA plans to contract for inpatient care, it will analyze the impact of contracting on the mission of the Chillicothe VAMC (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

III Replacement Outpatient Specialty Care Clinic

1. The Commission concurs with building an expanded 260,000 square foot replacement outpatient specialty care center in Columbus, OH, on Federal land donated by the DoD Defense Supply Center.
2. The Commission recommends that the new Columbus outpatient specialty care center be a high priority.

Secretary's Decision

III Replacement Outpatient Specialty Care Clinic

VA will expand care for Columbus area veterans through construction of a comprehensive multi-specialty outpatient clinic on Federal land donated by the DoD Defense Supply Center. This new multi-specialty clinic will meet a clear need to expand multi-specialty outpatient services in Columbus. The VA clinic that currently serves Columbus veterans was designed to support 135,000 annual outpatient visits. This year it will accommodate more than 205,000. Further, due to space constraints and the limited scope of care currently provided, many veterans are forced to travel significant distances to neighboring VA medical facilities to receive basic care. Development of a new multi-specialty outpatient clinic will largely alleviate that burden by enhancing services and improving access for Columbus area veterans.

The VISN will submit a plan for the development of the multi-specialty clinic by September 2004.

CARES Commission Recommendation

IV Outpatient Primary and Mental Health Care

The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

IV Outpatient Primary and Mental Health Care

All of the markets in VISN 10 anticipate growth in primary care workload. To meet those anticipated gaps, VA will expand capacity at existing sites through new construction and use of existing authorities and policies to provide contract care where necessary. The VISN also will develop new CBOCs through the National CBOC Approval Process (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

V Special Disability Program – Spinal Cord Injury and Disorders (SCI/D) Center

1. The Commission concurs with the DNCP proposal to add 20 long-term care beds to the Cleveland SCI/D Center.
2. The Commission recommends that VA should conduct an assessment of acute and long-term bed needs for SCI/D Centers to provide the proper balance of beds to better serve veterans and reduce wait times.

Secretary's Decision

V Special Disability Program – Spinal Cord Injury and Disorders (SCI/D) Center

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for development of an expanded SCI/D presence in Cleveland will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

CARES Commission Recommendation

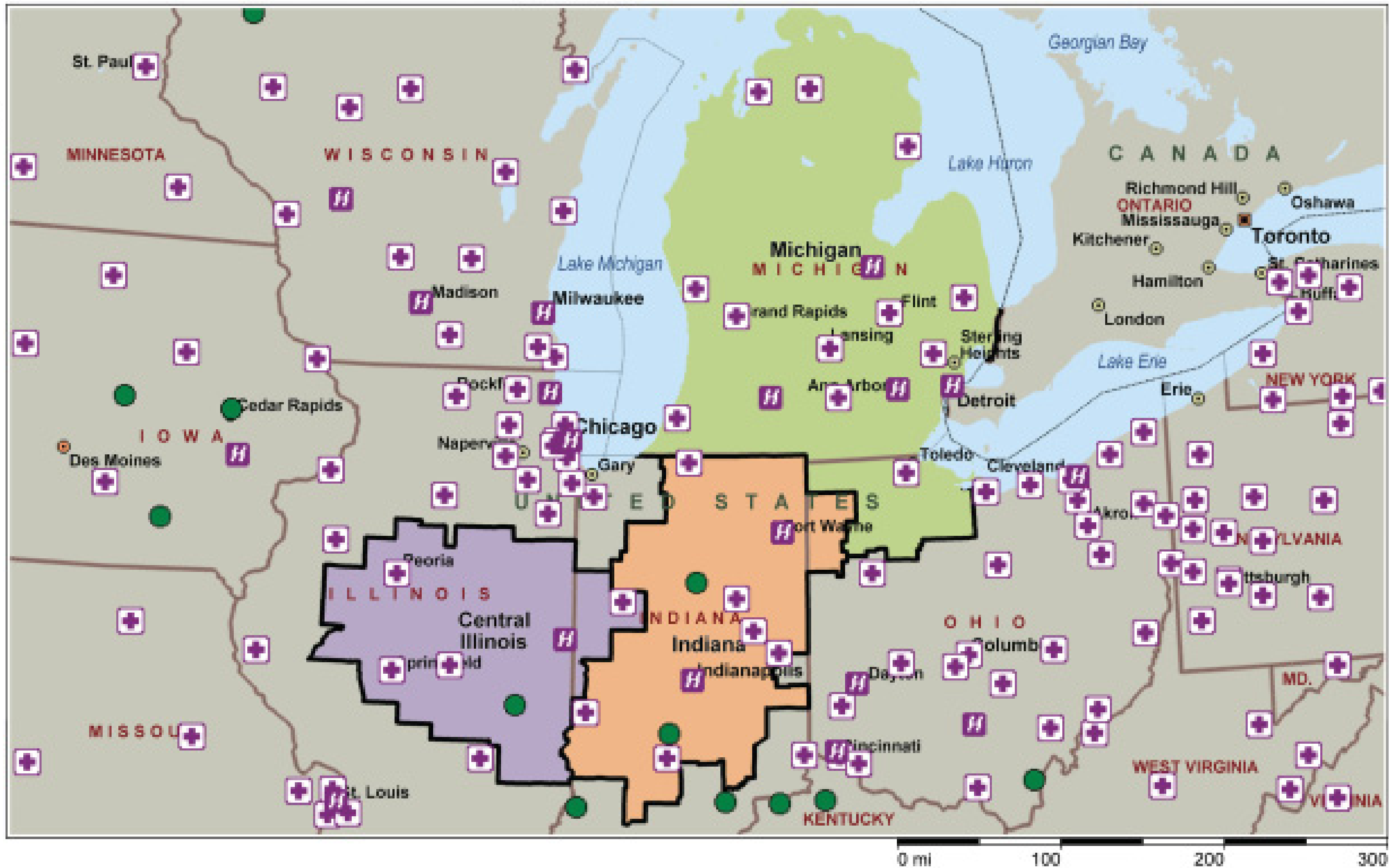
VI **Enhanced Use**

1. The Commission concurs with the DNCP proposal relating to enhanced use lease projects at Cincinnati to lease quarters and use the proceeds for additional parking.
2. The Commission concurs with the DNCP proposal relating to enhanced use lease of Dayton's empty buildings.

Secretary's Decision

VI **Enhanced Use**

VA will pursue existing proposals for enhanced use projects at the Cincinnati and Dayton VAMCs (*Reference – Excess VA Property: Crosscutting*).



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CARES Decisions for VISN 11

CARES Commission Recommendation

- **Small Facility**
  Fort Wayne Campus – Northern Indiana Health Care System

  1. The Commission concurs with the DNCP proposal to close acute care at Fort Wayne and transfer these services to other VA facilities or contract in the local community.
  2. The Commission concurs with the DNCP proposal to maintain outpatient care at Fort Wayne.

Secretary's Decision

- **Small Facility**
  Fort Wayne Campus – Northern Indiana Health Care System

The Fort Wayne VAMC operates 26 inpatient medicine beds. The average daily census is currently 22. Forecasts indicate that the need for beds will decrease to 17 by 2012 and 14 by 2022. Citing the anticipated decrease in demand for care, quality alternatives for contract care available in the community, and the potential for resource savings through closure of acute beds, the Commission recommended closure of acute care services at the Fort Wayne VAMC and replacement of those services through contracts for care in the community and by transferring care to the Indianapolis VAMC.

VA will plan to close acute care services at the Fort Wayne VAMC, but will retain existing outpatient care services at the Fort Wayne campus and consider expanding the hours of operation. While this recommendation will result in change for Fort Wayne area veterans and employees, VA is committed to working with stakeholders to effectively manage the transition of services and to maintaining access to care.

To manage the change, the VISN will develop a transition plan for the closure of acute care services and transfer of care to the Indianapolis VAMC and to contract care in the community. The plan will ensure that alternatives to quality and accessible care will be in place before any reduction in beds occurs.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. This will include ensuring continuity of patient care to the greatest extent possible, and managing any changes in employment through natural attrition, transfer, early retirement, retraining or other mechanisms. VA will continue to work closely with its stakeholders to ensure that development and implementation of this transition is managed effectively.

VA will complete the transition plan by the end of 2004 (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

Small Facility
Saginaw VAMC

1. The Commission concurs with the DNCP proposal to discontinue acute medical services at Saginaw, but does not concur with adding beds at the Ann Arbor VAMC to accommodate additional workload from Saginaw (see Inpatient Care).
2. The Commission concurs with the DNCP proposal to maintain nursing home and outpatient care at Saginaw.

Secretary's Decision

Small Facility
Saginaw VAMC

The Saginaw VAMC operates 27 inpatient medicine beds, 6 intermediate beds and 81 nursing home care beds. The average daily census for acute medicine beds at Saginaw is currently 11. Forecasts indicate that the need for beds will decrease to 25 by 2012 and 20 by 2022. Citing the low bed levels and the availability of quality alternatives for contract care in the community, the Commission recommended that VA close acute care services at the Saginaw VAMC and replace those services through contracts for care in the community and by transferring care to the Ann Arbor and Detroit VAMCs.

VA will plan to close acute care services at the Saginaw VAMC. The Saginaw VAMC will retain its outpatient care services, nursing home services, and its intermediate medicine beds. While VA recognizes that this recommendation will mean change for Saginaw area veterans and employees, VA is committed to managing the transition effectively. VA anticipates that this change will improve access to care for local veterans by contracting for care in the community, particularly in the northern part of lower Michigan where veterans often have long drives to the Saginaw VAMC.

To effectively manage this change, the VISN will develop a transition plan for the closure of acute care services and transfer of care to the Ann Arbor and Detroit VAMCs and to contract care in the community. The plan will ensure that alternatives to quality and accessible care will be in place before any reduction in beds occurs.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. The transition will include ensuring continuity of patient care to the greatest extent possible, and managing any changes in employment through natural attrition, transfer, early retirement, retraining or other mechanisms. VA will continue to work closely with its stakeholders to ensure that development and implementation of this transition is managed effectively.

VA will complete the transition plan by the end of 2004 (*Reference – Contracting for Care, Long-Term Care: Crosscutting*).

CARES Commission Recommendation

Inpatient Care

1. The Commission does not concur with the DNCP proposal to add additional beds at Ann Arbor to accommodate additional workload from Saginaw.

2. The Commission recommends that the inpatient workload projections be validated. If validated, the Commission supports the DNCP proposal for construction of beds at Ann Arbor and opening the unused unit at Detroit.

Secretary's Decision

III Inpatient Care

VA will revalidate the inpatient workload projections to determine if the construction of new beds at Ann Arbor and the activation of currently vacant space at Detroit are required to meet projected demand. The results and impact of the revalidation of inpatient workload projections will be included in the VISN FY 2005 strategic planning submission.

CARES Commission Recommendation

IV Improve Access to Hospital Care in Central Illinois

The Commission concurs with the DNCP proposal to contract with hospitals in Central Illinois for inpatient care.

Secretary's Decision

IV Improve Access to Hospital Care in Central Illinois

VA will improve access to inpatient care in the Central Illinois market using existing authorities and policies to contract for inpatient care where necessary (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

V Outpatient Care

1. The Commission concurs with the DNCP proposal for outpatient care.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

V Outpatient Care

VA will expand existing sites of care through conversion or renovation of existing space, leasing additional space, increasing use of telemedicine, and using existing authorities and policies to contract for care where necessary.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 11 has three new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Illiana HCS	Charleston	IL
Marion VAMC	Peru	IN
Indianapolis VAMC	Martinsville	IN

These new sites of care will help the VISN, which currently is below access standards in its Central Illinois and Indiana markets, to meet national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VI Proximity of Ann Arbor and Detroit VAMC Services

1. The Commission concurs with the DNCP proposal to maintain tertiary facilities in Michigan at both the Ann Arbor and Detroit, with continued consolidation of services.
2. The Commission recommends shifting appropriate Post-Traumatic Stress Disorder (PTSD) and substance abuse services from Battle Creek to Detroit.

Secretary's Decision

VI **Proximity of Ann Arbor and Detroit VAMC Services**

VA will maintain tertiary facilities at both the Ann Arbor and Detroit VAMCs, with continued consolidation of services as recommended in the DNCP.

VA will study referral patterns for patients treated in the PTSD and substance abuse treatment unit in Battle Creek and determine whether, and what proportion of, beds should be transferred to Detroit to improve access. The VISN will include the results of the study in its FY 2005 strategic planning submission.

CARES Commission Recommendation

VII **Pursue Enhanced Use Leasing**
Danville and Battle Creek Excess Space

With respect to the proposed enhanced use lease at the Illiana VAMC for a replacement nursing home, the Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

The Commission concurs with pursuing enhanced use leasing opportunities at the Battle Creek VAMC.

Secretary's Decision

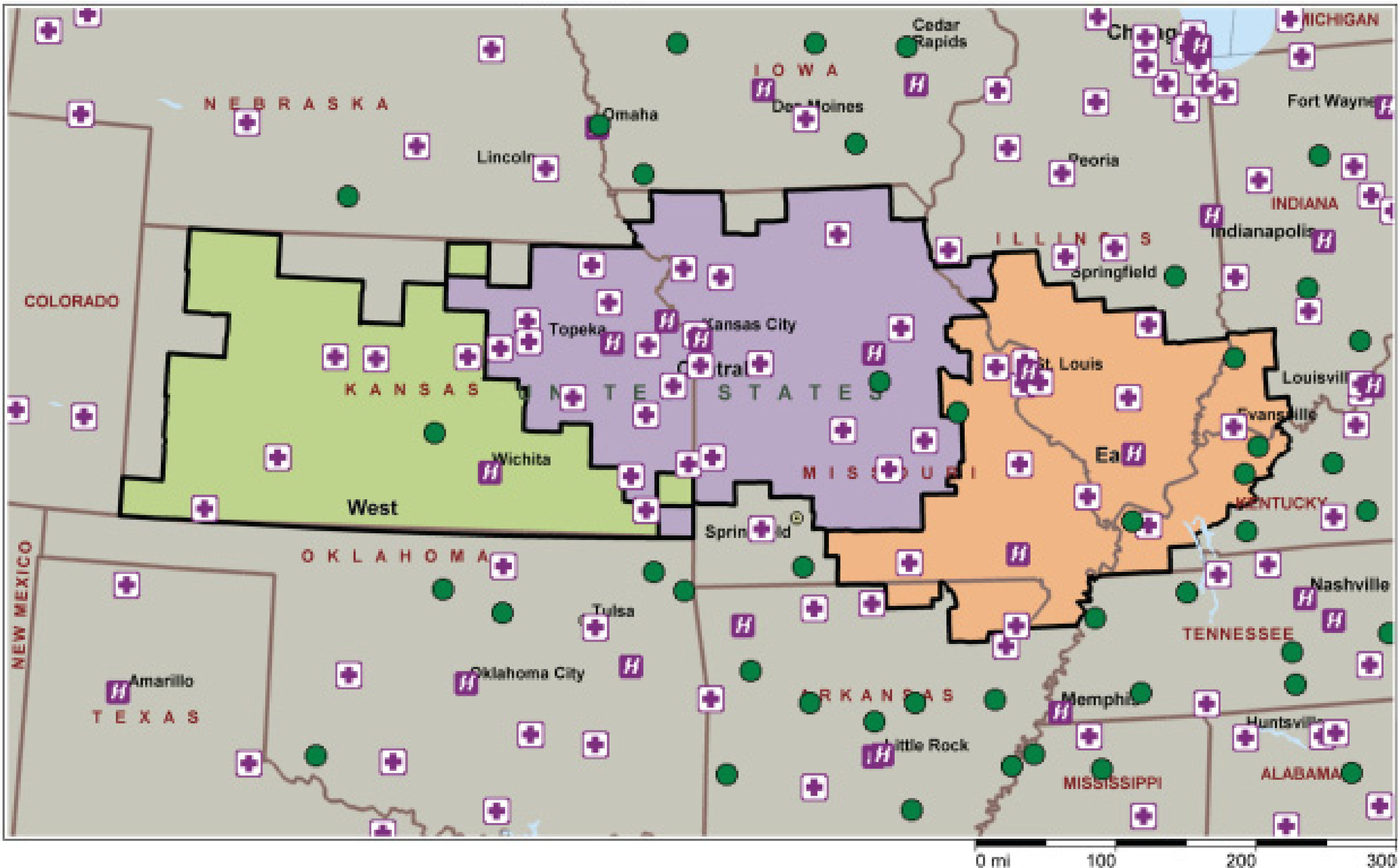
VII **Pursue Enhanced Use Leasing**
Danville and Battle Creek Excess Space

VA will pursue potential enhanced use lease projects at the Illiana HCS, Battle Creek, and Fort Wayne VAMCs. VA will ensure that any disposal, reuse, or enhanced use lease of its properties serves to enhance the Department's mission (*Reference – Long-Term Care, Excess VA Property: Crosscutting*).

Secretary's Decision

VIII *OneVA* Collaborations

VA will explore the feasibility of providing additional land at the Marion VAMC to NCA for expansion of the existing cemetery. VA will further assess this opportunity and develop a recommendation for moving forward by September 2004 (*Reference* – OneVA *Collaborations: Crosscutting*).



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CARES Decisions for VISN 15

CARES Commission Recommendation

I **Consolidation of Services/Proximity**
Kansas City and Leavenworth VAMCs

The Commission concurs with the DNCP proposal to implement the recommendations of the Secretary's Advisory Board.

Secretary's Decision

I **Consolidation of Services/Proximity**
Kansas City and Leavenworth VAMCs

VA will implement the recommendations of the Secretary's Advisory Board for realignment and consolidation of services between Kansas City, Topeka, and Leavenworth. Major recommendations include, but are not limited to, realignment of psychiatry and nursing home beds between the Leavenworth and Topeka campuses, realignment of intensive substance abuse treatment programs, and referral of complex surgical procedures to Kansas City. All of these recommendations will serve to improve coordination and effectiveness of health care provision across the region.

CARES Commission Recommendation

II **Small Facility**
Poplar Bluff VAMC

1. The Commission does not concur with the DNCP that Poplar Bluff currently operates as a critical access hospital (CAH).
2. The Commission recommends that VA establish a clear definition and clear policy on CAH designation prior to making a decision regarding the Poplar Bluff VAMC.
3. The Commission recommends that a target date be set for making a full cost-benefit analysis of sustaining inpatient services versus contracting for such services. The Commission further recommends that, based on the results of that assessment, a decision be made regarding whether or not to close inpatient services at Poplar Bluff.

4 The Commission recommends that, regardless of the decision on inpatient services, outpatient services and long-term care remain at Poplar Bluff.

Secretary's Decision

Small Facility
Poplar Bluff VAMC

The Poplar Bluff VAMC serves veterans in a rural area. This 16-bed acute facility currently operates at full capacity and forecasts project only marginal decline in inpatient care - 15 and 11 beds in 2012 and 2022. While there are limited options for contracting in the community, it is important that VA examine the potential for savings through contracting by conducting a detailed cost-effectiveness analysis. The analysis will assess the cost of retaining care versus contracting in the community and will also include an assessment of the impact on access. This cost-effectiveness analysis will examine the efficiency of providing care at the Poplar Bluff VAMC.

VA also must ensure that veterans treated at Poplar Bluff receive high quality and clinically appropriate health care. In the DNCP, the Poplar Bluff VAMC was recommended for mission change to a CAH, a concept intended to ensure VA continues to provide quality and appropriate care at small facilities by defining the appropriate scope of practice. In its report, the Commission found that VA needed a more complete definition for the CAH concept. VA is now in the process of developing a "Veterans Rural Access Hospital" (VRAH) policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities. This policy will be complete in June 2004 and will be used to ensure that VA is providing quality and appropriate care to veterans at small and rural facilities like the Poplar Bluff VAMC.

Once the VRAH policy is approved, VA will study the Poplar Bluff VAMC, as well as other similar facilities, to determine whether it meets the criteria for designation as a VRAH and to define the appropriate scope of practice to ensure that it meets quality standards. The results of the VRAH study will provide the framework for the cost-effectiveness analysis. In the interim, the Poplar Bluff VAMC will continue to operate in accordance with its current mission.

The VRAH study will be completed by the end of the calendar year and results will be included in the VISN FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

CARES Commission Recommendation

III Inpatient Services – Psychiatry

The Commission concurs with the DNCP proposal on shifting workload between the Central and Western markets to meet inpatient psychiatry workload.

Secretary's Decision

III Inpatient Services – Psychiatry

VA will meet inpatient psychiatry demand by shifting workload between markets, expanding in-house capacity where needed, and by using existing authorities and policies to contract for care where necessary (*Reference – Mental Health Services, Contracting for Care: Crosscutting*).

CARES Commission Recommendation

IV Outpatient Care

1. The Commission concurs with the DNCP proposal on expansion of in-house services, new construction, space conversion, and utilization of community contracts to address capacity gaps for outpatient care. However, it notes that substantial access gaps and many of the capacity gaps are unlikely to be resolved without additional sites of care.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

IV Outpatient Care

VA will meet current and forecasted demand and access gaps for outpatient care by expanding existing sites through new construction, conversion, and renovation. The VISN also will expand its use of telemedicine and use existing policies and authorities to contract for care where necessary.

The VISN will develop new CBOCs through the National CBOC Approval Process. VISN 15 has seven new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Wichita VAMC	Hutchinson	KS
Marion (IL) VAMC	Hopkins County	KY
Marion (IL) VAMC	Graves County	KY
Marion (IL) VAMC	Knox County	IN
Marion (IL) VAMC	Davies County	KY
St. Louis VAMC	Sullivan	MO
Columbia VAMC	Jefferson City	MO

These new sites of care will help the VISN, which currently is below access standards in its West and East markets, to meet national access standards. The Jefferson City clinic will relieve a space deficit at a crowded Columbia VAMC (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

V **Excess VA Property/Enhanced Use Lease**
Historic Buildings at Leavenworth

1. The Commission concurs with the DNCP proposal to pursue an enhanced use lease, including the assisted living project, at the Leavenworth campus.
2. The Commission recommends that VA develop a viable plan for funding this proposal.
3. The Commission further recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed enhanced use lease process. VA should also consider using vacant space to provide supportive services to homeless veterans.

Secretary's Decision

V Excess VA Property/Enhanced Use Lease
Historic Buildings at Leavenworth

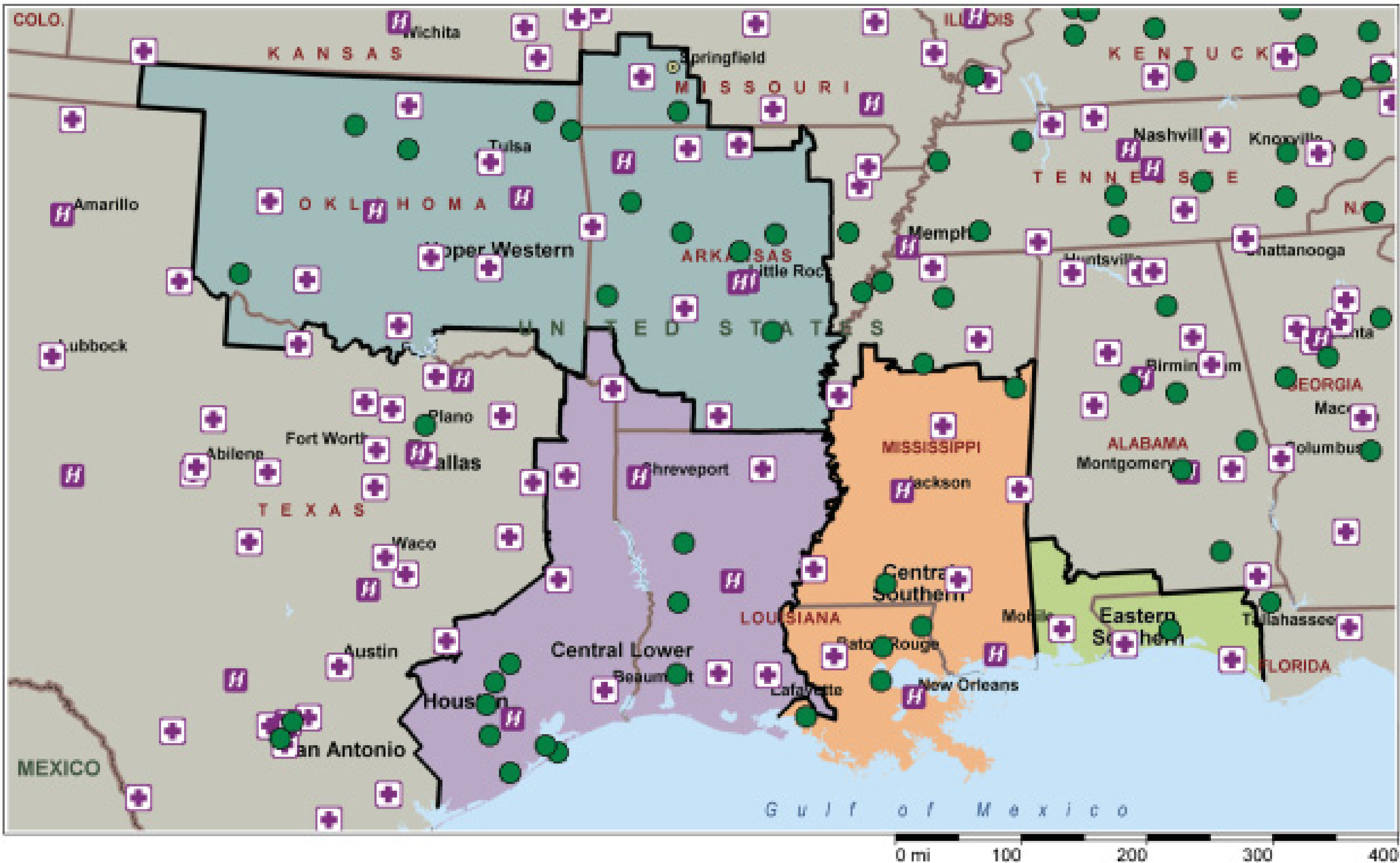
VA will pursue an enhanced use lease opportunity to renovate vacant buildings and develop an assisted living facility for local veterans. In developing the enhanced use lease agreement, VA will ensure that plans for funding the project are viable and the agreement will serve to enhance the Department's mission (*Reference – Excess VA Property: Crosscutting*).

Secretary's Decision

VI *OneVA* Collaborations

VHA will pursue an enhanced use lease project which will provide NCA with additional acreage to expand the Leavenworth National Cemetery.

NCA will develop a major construction project in collaboration with VHA to transfer land and mitigate the depletion of gravesites and closure of the Jefferson Barracks National Cemetery. VA will develop plans for these projects by September 2004 (*Reference –* OneVA *Collaborations: Crosscutting*).



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CARES Decisions for VISN 16

CARES Commission Recommendation

Consolidation/Realignment
Gulfport and Biloxi VAMCs

1. The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life cycle cost analysis for the Gulfport campus.
2. The Commission recommends that there be a clear commitment from DoD for the utilization of Keesler Air Force Base (AFB) as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing DoD and VA health services.
3. The Commission concurs with the DNCP proposal to develop enhanced use lease opportunities at Gulfport.
4. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed enhanced use lease process. VA should also consider using vacant space to provide supportive services to homeless veterans.

Secretary's Decision

Consolidation/Realignment
Gulfport and Biloxi VAMCs

VA will consolidate the services provided at the Gulfport VAMC to the Biloxi VAMC and will develop plans to reuse or divest the Gulfport campus. This consolidation will be accomplished through major construction that will modernize patient care facilities at the Biloxi campus and provide area veterans with health care in newly renovated facilities.

By consolidating services at Biloxi, VA plans to enhance services for area veterans by improving the environment of care and care coordination. New and renovated facilities at Biloxi will improve the environment of care. Consolidation will improve care coordination by combining all existing services at both facilities onto one site designed to provide comprehensive, and consistent quality of, patient

care services. The plan also is expected to save money that can be reinvested in health care. To ensure that the plan is economically favorable, a detailed cost effectiveness analysis of the proposal will be included upon submission of a major construction project proposal. VA also will continue to seek sharing opportunities with Keesler AFB in support of the consolidation.

To ensure effective implementation, VA will develop a Master Plan for transfer of services from the Gulfport VAMC to the Biloxi VAMC, and for enhanced use or disposal of the Gulfport campus. The Master Plan will ensure that there is no interruption of existing services until construction of the new facilities is completed and transfer of patients from the Gulfport to the Biloxi campus can be managed effectively. Upon completion of construction and patient transfer, VA will seek alternate uses for, or disposal of, the Gulfport campus. Options will include, but not be limited to, an enhanced use lease of the campus. VA will ensure that disposal or reuse of the campus serves to enhance the Department's mission.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this consolidation and will continue to work closely with its stakeholders to ensure that it is managed effectively.

While this consolidation is expected to occur over several years, the VISN will complete a Master Plan to guide the transition by September 2004.

CARES Commission Recommendation

Small Facility
Muskogee VAMC

1. The Commission concurs with the DNCP proposal to maintain the inpatient medicine program at Muskogee. The Commission recommends that a more thorough study be conducted of meeting health care needs of the population through the Muskogee VAMC versus using community resources in the Muskogee/Tulsa area. A target date should be set for completion of this study. In the short term, inpatient medical services should be sustained. A decision to expand inpatient psychiatry should consider results of the study.

2. The Commission concurs with the DNCP proposal to close inpatient surgery and ICU beds at Muskogee and that ambulatory surgery should continue with surgery observation beds available.

Secretary's Decision

II **Small Facility**
Muskogee VAMC

VA is committed to veterans in the Tulsa/Muskogee area and will study how to best meet their health care needs. The Muskogee VAMC currently has excess capacity, while the region's patient population growth is focused in the Tulsa area. VA will study the needs in the region, including the potential for expansion of inpatient psychiatry at the Muskogee VAMC, and develop a strategy to more effectively manage the vacant space at the Muskogee VAMC and enhance services in the region.

The study will assess the demand for health care in the Muskogee/Tulsa region and recommend a plan to best meet the health care needs of veterans, while maximizing use of resources. VA will develop a template that will define the scope and parameters of the study and act as a guide for the study process. Upon completion of the template, VA will assign a multi-disciplinary team with appropriate skills and experience to conduct the study. The study will solicit views of stakeholders to ensure that their comments are included in the process. The study will be completed by the beginning of 2005.

While the study is underway, VA will plan for the closure of the Muskogee VAMC's five-bed inpatient surgery program. The Muskogee VAMC will retain ambulatory surgery and have observation beds available. To manage the transition of these surgery beds, VA will develop an implementation plan that will ensure minimal impact to patients and employees. The implementation plan will be included in the VISN FY 2005 strategic planning submission.

CARES Commission Recommendation

III **Inpatient Care and VA/DoD Sharing**

1. The Commission concurs with the DNCP proposal regarding VA/DoD sharing in the Eastern Southern market with Pensacola Naval Hospital and Eglin AFB to provide inpatient services.
2. The Commission recommends contracting in the community to ensure essential inpatient care in the underserved Eastern Southern market.
3. The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care from veterans in the Florida Panhandle.

Secretary's Decision

III Inpatient Care and VA/DoD Sharing

The Commission recognized the need for expanded services in the Florida Panhandle area. The Eastern Southern market is the only market in the VISN without a medical center and it, along with the western part of the North market in VISN 8, is underserved for inpatient care. To provide enhanced access to services for the Florida Panhandle area, VA will pursue ongoing negotiations to develop an outpatient presence adjacent to the Pensacola Naval Hospital. By collocating outpatient services next to an inpatient DoD facility, VA will position itself to develop a sharing arrangement with the Navy to provide inpatient care services. The combination of inpatient and outpatient care would create hospital services for veterans living in the Panhandle of Florida. VA will work to finalize arrangements so that it can enhance services in this underserved region. The VISN also will continue to pursue opportunities to expand its current sharing with Eglin AFB to enhance inpatient care services.

VA will pursue continued collaboration between VISNs 8 and 16 to improve services to Florida Panhandle area veterans and will use existing authorities and policies to contract for inpatient care services where necessary (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

IV Outpatient Care

1. The Commission concurs with the DNCP proposals to add CBOCs in VISN 16 to resolve access to primary care gaps as well as gaps in capacity to meet demand for outpatient services.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

IV Outpatient Care

VA will improve access and meet the increased demand for outpatient care services by expanding capacity through construction, conversion of existing space, renovation, and by using existing authorities and policies to contract for care where necessary.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 16 has 29 new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Little Rock VAMC	Mena	AR
Little Rock VAMC	Searcy	AR
Little Rock VAMC	Conway	AR
Little Rock VAMC	Pine Bluff	AR
Little Rock VAMC	Russellville	AR
Muskogee VAMC	Vinita	OK
Fayetteville (AR) VAMC	Jay	OK
Fayetteville (AR) VAMC	Branson	MO
Fayetteville (AR) VAMC	Ozark	AR
Oklahoma City VAMC	Enid	OK
Oklahoma City VAMC	Altus	OK
Oklahoma City VAMC	Stillwater	OK
Alexandria VAMC	Fort Polk	LA
Alexandria VAMC	Lake Charles	LA
Alexandria VAMC	Natchitoches	LA
Houston VAMC	Galveston (Site 1)	TX
Houston VAMC	Galveston (Site 2)	TX
Houston VAMC	Conroe	TX
Houston VAMC	Tomball	TX
Houston VAMC	Katy	TX
Houston VAMC	Richmond	TX
Houston VAMC	Lake Jackson	TX
Jackson VAMC	Columbus	MS
Jackson VAMC	McComb	MS
New Orleans VAMC	Hammond	LA
New Orleans VAMC	Franklin	LA
New Orleans VAMC	Bogalusa	LA
New Orleans VAMC	LaPlace	LA
Eastern Southern	Eglin AFB	FL

These new sites of care will help the VISN, which currently is below access standards in all four of its markets, to meet national access standards. The Eastern Southern clinic will enhance access to veterans in the underserved Pensacola area (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

V Special Disability Programs – Blind Rehabilitation Center

The Commission concurs with the DNCP proposal to establish a blind rehabilitation center in Biloxi. The Commission recommends further analysis to determine the size of the center.

Secretary's Decision

V Special Disability Programs – Blind Rehabilitation Center

VA will analyze regional demand and then establish an appropriately sized blind rehabilitation center in Biloxi. VA will complete the analysis by the end of 2004 and the results will be included in the VISN FY 2005 strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

CARES Commission Recommendation

VI Special Disability Programs – Spinal Cord Injury and Disorders (SCI/D) Center

1. The Commission concurs with the DNCP proposal to establish a 30-bed SCI/D Center in VISN 16, but does not concur with locating it at North Little Rock.
2. The Commission recommends that VA further study where an SCI/D Center should be located, taking into consideration referral patterns and excess capacity at the closest SCI/D Centers.

Secretary's Decision

VI Special Disability Programs – Spinal Cord Injury and Disorders (SCI/D) Center

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration. Implementation plans for development of a new SCI/D Center in VISN 16 will be included in the FY 2005 VISN strategic planning submission.

CARES Commission Recommendation

VII Excess VA Property

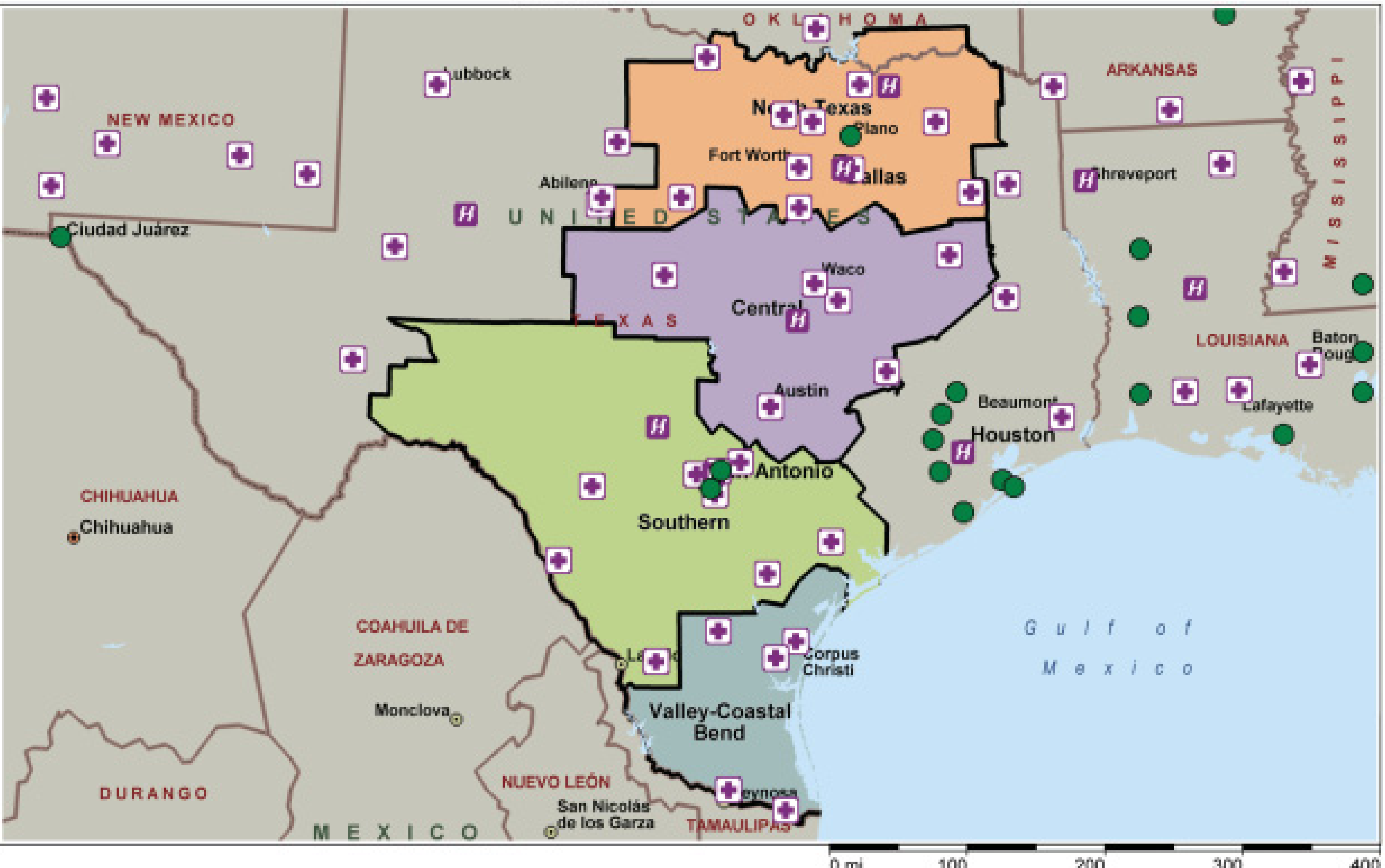
1. The Commission concurs with the DNCP proposal for an enhanced use lease cooperative arrangement to construct a high-rise medical arts building at the Houston VAMC.
2. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed enhanced use lease process. VA should also consider using vacant space to provide supportive services to homeless veterans.

Secretary's Decision

VII Excess VA Property

VA will continue to explore enhanced use lease opportunities at the Houston VAMC (*Reference – Excess VA Property: Crosscutting*).

VISN 17



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CARES Decisions for VISN 17

CARES Commission Recommendation

I Mission Change
Waco VAMC

1. The Commission concurs with the DNCP proposal to transfer services from the Waco campus to appropriate locations within the VISN as follows:
   a. A portion of acute care inpatient psychiatry to Austin;
   b. The balance of acute care and all the long-term inpatient psychiatry to the Temple VAMC; and
   c. PTSD residential rehabilitation services to the Temple VAMC, with no decrease in capacity.
2. The Commission does not concur with the DNCP proposal to transfer Waco nursing home services to the community.
3. The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.
4. The Commission concurs with the DNCP proposal to transfer the blind rehabilitation center (BRC) from Waco, but recommends that the VISN determine an appropriate location taking into account access and the BRC's role as a regional rehabilitation referral center.
5. The Commission concurs that a new multi-specialty outpatient clinic be established in the Waco area.
6. The Commission recommends that time be provided for the transition to allow an orderly transfer with minimal disruption to patients and families and for the VISN to involve veterans, stakeholders, and the community in a plan for the Waco campus that is most beneficial to veterans.

Secretary's Decision

I Mission Change
Waco VAMC

The Waco campus includes 123 acres of land and 36 main hospital buildings, many of which are vacant or underutilized. At its peak, the campus operated more

than 2,000 beds. Today it operates 346 acute inpatient beds, with a current average daily census of 206. As a result, VA is maintaining significant excess infrastructure at enormous cost. These resources are diverted from veterans' medical care.

The Commission made several observations concerning the proposed Waco campus realignment, including the potential benefits of collocating inpatient psychiatric care with other acute inpatient care in Temple, expansion of access to care for the growing Austin area, and a clear need to more effectively manage the substantial vacant space on the Waco campus. The Commission expressed concerns about continuity of care for Waco's nursing home patients and the need for a more detailed cost-effectiveness analysis for any plans to realign the campus.

The Secretary is also concerned by the lack of adequate financial data on the cost of construction necessary to relocate patients to the Temple campus as well as the possible savings achievable through the proposed realignment. Therefore, the Secretary directs a further comprehensive study of the cost and continuity of care issues of such a realignment. The study will evaluate the most appropriate means and site for providing care to veterans now treated at the Waco campus and will include an analysis of moving the VBA Regional Office onto the Waco VAMC campus. Irrespective of any realignment, it will also identify options for divesting or leasing a significant portion of the underutilized property in order to generate savings and revenues that could be applied to VA's health care mission.

The mission of the Waco campus will not be altered while VA proceeds with the study. As VA considers options for realignment to enhance services while more effectively using resources, it will work in collaboration with stakeholders to ensure that their comments are solicited and considered. VA is committed to minimizing any impact on patients, employees, and the community as it manages the study process.

The study will be submitted to the Secretary no later than January 1, 2005 (*Reference – Excess VA Property: Long-Term Care-Crosscutting*).

CARES Commission Recommendation

Mission Change
Kerrville VAMC

1. The Commission does not concur with the DNCP proposal to convert the Kerrville VAMC to a critical access hospital (CAH). VA should establish a clear definition and clear policy on the CAH designation prior to making decisions on the use of this description.
2. The Commission concurs with the DNCP proposal to transfer the Kerrville VAMC's acute inpatient services and recommends

that the VISN contract with community health care providers for these acute inpatient services, including urgent care services, in lieu of or until space is available at the San Antonio facility.

3 The Commission recommends clarification of proposed construction and renovation costs at San Antonio.

4 The Commission concurs with the DNCP proposal that the nursing home and outpatient services remain at Kerrville.

Secretary's Decision

Mission Change
Kerrville VAMC

The Kerrville VAMC operates 25 inpatient medicine beds, including five ICU beds. The average daily census at Kerrville is currently 12. Forecasts indicate that the need for beds will decrease to 15 by 2012 and 12 by 2022. Citing the need for significant infrastructure upgrades to buildings, the availability of quality contract care in the community, and the potential for resource savings through closure of acute beds, the Commission agreed with the DNCP recommendation to close acute care services at the Kerrville VAMC and transfer care to the San Antonio VAMC as part of a major renovation of that facility. Upon renovation of the San Antonio facility, Kerrville veterans would receive inpatient care at an upgraded inpatient facility modernized to provide high quality health care services. The Commission sought clarification of construction costs at San Antonio and recommended that VA replace existing inpatient services with contracts for care in the community while waiting for necessary renovations to be completed in San Antonio.

VA will close acute care services at the Kerrville VAMC upon agreement on a cost effective contracting option in the community that meets quality of care requirements or upon the availability of space in San Antonio for transfer of services. Until one of these transfers is possible, the Kerrville VAMC will continue to operate its inpatient care mission. The Kerrville VAMC will retain its nursing home care services and will be able to expand its outpatient care services upon realignment.

To effectively manage this change, the VISN will develop a transition plan for the closure of acute care services at the Kerrville campus. This plan will include development of an effective contracting option and a plan for eventual transfer of inpatient beds to San Antonio.

The plan also will include a detailed cost-effectiveness analysis that will include consideration of any additional construction costs in San Antonio. The plan will ensure that alternatives to care will be in place before any reduction in beds occurs.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. This will include assuring continuity of patient care to the greatest extent possible, and managing any changes in employment through natural attrition, transfer, early retirement, retraining or other mechanisms. VA will continue to work closely with its stakeholders to ensure that development and implementation of this transition is managed effectively.

VA will complete the transition plan by the end of 2004 (*Reference – Long-Term Care: Crosscutting*).

CARES Commission Recommendation

III Inpatient Care

1. The Commission concurs with the DNCP proposal to correct inpatient access gaps in the Central and Valley-Coastal Bend markets through contracting or leasing of beds in the local community.
2. The Commission concurs with the proposal to expand in-house services at the Dallas VAMC through construction and renovation.

Secretary's Decision

III Inpatient Care

VA will meet the increased demand for care in Dallas through in-house expansion.

VA will improve access to inpatient care for veterans in the Central and Valley-Coastal Bend markets by using existing authorities and policies to contract for care in Harlingen and Corpus Christi. These contracts will help VA to improve access to inpatient care in the Valley-Coastal Bend market.

VA also will improve access to inpatient care for Austin area veterans by leasing, using existing authorities and policies to contract for care where necessary, and by seeking development of an affiliation relationship with the University of Texas Health Science Center for inpatient services in the Austin area (*Reference – Contracting Care: Crosscutting*).

CARES Commission Recommendation

IV Outpatient Care

1. The Commission concurs with the DNCP proposal to expand services at current sites of care as proposed by the DNCP, but notes that this is not an adequate solution to the access and capacity gaps in the VISN.

2 In the Valley-Coastal Bend market, the Commission concurs with moving the Brownsville CBOC to Harlingen in affiliation with the University of Texas.

3 The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

IV **Outpatient Care**

VA will meet the increased demand for outpatient care in the VISN through expansion, renovation, new construction, and use of existing authorities and policies to contract for care where necessary.

VA also will move the Brownsville CBOC to Harlingen where an affiliation with the University of Texas Health Science Center – San Antonio will enhance access to some specialty care services.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 17 has three new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
San Antonio VAMC	Brooks AFB	TX
San Antonio VAMC	NE Bexar	TX
Dallas VAMC	Plano	TX

The San Antonio sites will enhance access to services for veterans in San Antonio and support VA/DoD sharing opportunities. The Plano CBOC will help to relieve space at a crowded Dallas facility (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

V **VA/DoD Sharing**

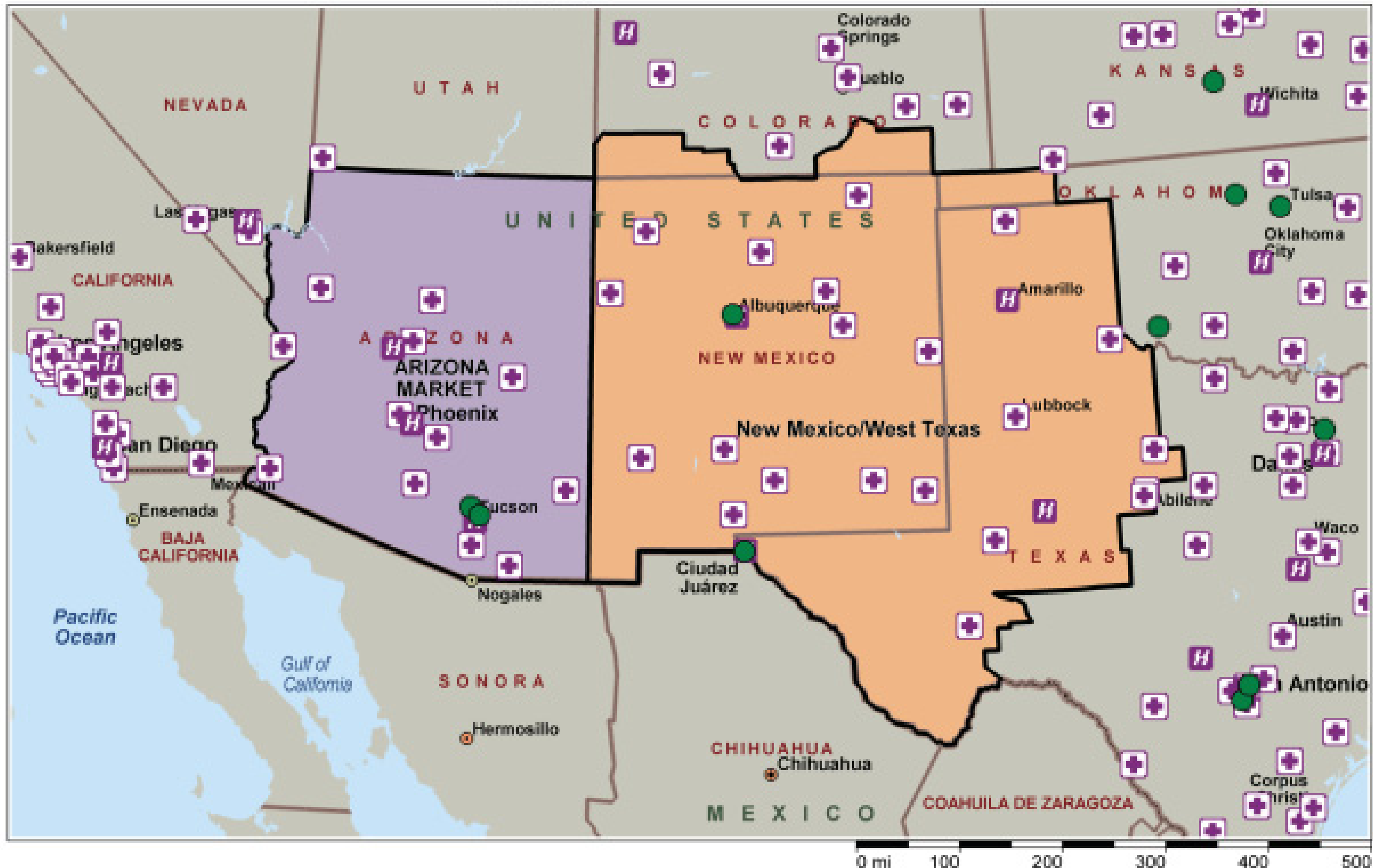
The Commission concurs with the DNCP proposal that VISN 17 pursue collaborative and sharing opportunities with DoD.

Secretary's Decision

V **VA/DoD Sharing**

VA will continue to pursue sharing opportunities with DoD across VISN 17 (*Reference – DoD/VA Sharing: Crosscutting*).

VISN 18



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CARES Decisions for VISN 18

CARES Commission Recommendation

I **Small Facility**
Phoenix and Prescott VAMCs

The Commission concurs with the DNCP proposal to retain patients at Prescott who would have been referred to Phoenix.

Secretary's Decision

I **Small Facility**
Phoenix and Prescott VAMCs

Both the Phoenix and the Prescott VAMCs have experienced workload increases in the past five years and project further increases through 2012. While the Prescott VAMC has a small inpatient capacity of 25, the Phoenix VAMC is rapidly running out of space. With room to expand at Prescott, VA will proceed with plans to more effectively manage care in the region by retaining patients at Prescott who would have been referred to Phoenix. This will enhance services and access for veterans living in the Prescott area and make space available at the Phoenix VAMC to absorb increasing demand. The Prescott VAMC also will increase its out-patient specialty care capability, reducing the need to refer patients to Phoenix.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this transition. In planning for this change, VA will continue to work closely with its stakeholders to ensure that development and implementation of this change is managed effectively.

The VISN will submit a plan for this transition in its FY 2005 strategic planning submission.

CARES Commission Recommendation

II **Mission Change – Study Feasibility of Closing**
Big Spring VAMC

1. The Commission concurs with the DNCP proposal insofar as it relates to studying the possibility of no longer providing health care services at Big Spring. The study should take into account the input of stakeholders regarding access to care.
2. The Commission recommends that VA establish a clear definition and clear policy on the critical access hospital (CAH) designation prior to making a decision on the use of this designation.

Secretary's Decision

II **Mission Change – Study Feasibility of Closing *Big Spring VAMC***

During preparation of the Draft National CARES Plan, VA found it did not have sufficient information to make a decision about a proposal to close the Big Spring VAMC and develop a Critical Access Hospital (CAH) in the Odessa–Midland area. Recognizing that a satisfactory analysis had yet to be completed, the CARES Commission agreed VA needed to continue to study the potential of closing inpatient beds at the Big Spring VAMC and transferring them to a CAH facility in the Odessa–Midland area.

VA will proceed with a study of the feasibility of closing inpatient care and transferring inpatient services from the Big Spring VAMC to the Odessa–Midland area. Part of that study will include analysis of what type of facility should be developed in the Odessa–Midland area. While the DNCP recommended a CAH, in its report the Commission found that VA needed a more complete definition for the CAH concept. VA is now in the process of developing a "Veterans Rural Access Hospital" (VRAH) policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities. This policy will be completed in June 2004. The VRAH policy will be used to determine if the Odessa–Midland area would be an appropriate location for such a facility and what the appropriate scope of practice should be based on projected demand for care. The VISN will consider comments from stakeholders as part of the feasibility study.

The study, including the incorporation of the VRAH policy, will be completed by the end of 2004 and the results will be included in the VISN FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

CARES Commission Recommendation

III **Inpatient Care**

1. The Commission concurs with the DNCP proposal to address inpatient medicine access and capacity issues through renovation, reopening closed units, and contracting for care.

2. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3. The Commission concurs with the DNCP proposal to meet increasing demand for inpatient psychiatry by expanding services at Phoenix, Tucson, and Albuquerque.

Secretary's Decision

III Inpatient Care

VA will meet the need to enhance access to and expand capacity for inpatient care through renovation, reopening of closed units, and using existing authorities and policies to contract for care where necessary. VA will meet increasing demand for inpatient psychiatry by expanding services at Phoenix, Tucson, and Albuquerque (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

IV Outpatient Care

1. The Commission concurs with expanding services at existing sites of care, but notes that this is only a partial solution to capacity and access issues in VISN 18.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

IV Outpatient Care

The VISN will meet increases in demand for outpatient care through expansion, renovation, new construction, and use of existing authorities and policies to contract for care where necessary.

VA will develop new CBOCs in coordination with the National CBOC Approval Process. VISN 18 has four CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Albuquerque VAMC	Albuquerque	NM
Tucson VAMC	Urban 1	AZ
Tucson VAMC	Urban 2	AZ
El Paso OPC	East El Paso	TX

These four CBOCs will enhance services to veterans in VISN 18 by relieving space deficits at crowded VA facilities (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

V VA/DoD Sharing

1 The Commission recommends that there be a clear commitment from DoD to expand the existing VA/DoD joint venture with William Beaumont Army Medical Center. Predicated upon VA having this commitment, the Commission concurs with expanding the VA/DoD joint venture, including inpatient beds staffed and operated by VA and additional outpatient services.

2 The Commission concurs with the DNCP proposal to collaborate with DoD in providing primary care services for DoD personnel at the Mesa CBOC.

Secretary's Decision

V VA/DoD Sharing

VA will pursue expansion of the existing joint venture with the William Beaumont Army Medical Center.

VA will pursue a DoD collaboration to provide primary care services for DoD personnel at the Mesa CBOC (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

VI Extended Care

1 The Commission concurs with the DNCP proposal on the need for renovation of nursing homes in VISN 18.

2 The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

VI **Extended Care**

VA will develop a long-term care strategic plan based on well-articulated policies. Until VA completes a long-term care strategic plan, it will only proceed with maintenance and life safety projects at existing long-term care facilities that are necessary to ensure the quality and safety of patient care (*Reference – Long-Term Care: Crosscutting*).

CARES Commission Recommendation

VII **Enhanced Use**

The Commission concurs with the DNCP proposal for the Phoenix and Albuquerque enhanced use leasing projects.

Secretary's Decision

VII **Enhanced Use**

VA will pursue existing enhanced use lease opportunities at the Phoenix and Albuquerque VAMCs. Decisions made to reuse or dispose of VA property will serve to enhance the Department's mission (*Reference – Excess VA Property: Crosscutting*).

CARES Commission Recommendation

VIII **Research**

The Commission concurs with the DNCP proposal on the need to improve research capabilities to enhance patient care and physician recruitment.

Secretary's Decision

VIII **Research**

VA will continue to explore opportunities to enhance research capabilities in VISN 18.

Secretary's Decision

IX ***OneVA*** **Collaboration**

VA will evaluate transfer of land from the Prescott VAMC to NCA for expansion of the columbarium. An assessment of the potential for this collaboration will be completed by September 2004 (*Reference –* OneVA *Collaborations: Crosscutting*).

VISN 19

Pushpins
- VA Clinic
- VA Hospital
- Planned New CBOC

Markets
- Eastern Rockies
- Grand Junction
- Montana
- Sheridan, Wyoming
- Western Rockies

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CARES Decisions for VISN 19

CARES Commission Recommendation

Replacement VAMC at Denver

1. The Commission concurs with the DNCP proposal for building a replacement medical center with DoD on the Fitzsimmons campus and recommends that it be made a high priority.
2. The Commission concurs in principle with the DNCP proposal to build a replacement nursing home unit.
3. The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

Replacement VAMC at Denver

VA will build a replacement VA medical center through a sharing agreement with DoD on the Fitzsimmons campus with some shared facilities with the University of Colorado. The Denver VAMC is old, has deficiencies in patient privacy, and has space deficits of 41,000 square feet in inpatient space and 201,000 square feet in outpatient space. Recognizing the need for increased space and for enhanced facilities, VA will proceed with advanced planning to develop a replacement facility.

To ensure effective implementation of this project, VA will develop a Master Plan for transition from the existing Denver VAMC to the new facility on the Fitzsimmons campus. The Master Plan will include strategies for managing patient transfer, new construction, and development of an enhanced use lease or disposal of the existing Denver campus upon transfer of all patient care services. It will also include a cost-effectiveness analysis to ensure that the plan and sharing opportunities are fiscally sound. VA will develop plans for the size of the replacement nursing home using its long-term care and mental health strategic plans. VA will ensure that the decision on disposal or reuse of excess VA property serves to enhance the Department's mission.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

While VA expects this transition to occur over several years, VA will complete the Master Plan by September 2004 (*Reference – VA/DoD Sharing, Long-Term Care, Excess VA Property: Crosscutting*).

CARES Commission Recommendation

II Special Disability Programs – Spinal Cord Injury and Disorders (SCI/D) Center

The Commission concurs with the DNCP proposal to add a 30-bed SCI/D Center at Denver.

Secretary's Decision

II Special Disability Programs – Spinal Cord Injury and Disorders (SCI/D) Center

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for development of an SCI/D Center in Denver will be included in the FY 2005 VISN strategic planning submission and as part of the Master Plan for the Denver replacement facility (*Reference – Special Disability Programs: Crosscutting*).

CARES Commission Recommendation

III Small Facility
Cheyenne VAMC

The Commission does not concur with the DNCP proposal that Cheyenne's mission should be changed. The Commission recommends Cheyenne retain its current mission due to its significant distance from other VAMCs; the high quality of care, including surgical care; the excellent condition of its buildings; the cost-effectiveness of operations; and the negative impact a mission change would have on the affiliation with the University of Wyoming and the DoD collaboration.

Secretary's Decision

Small Facility
Cheyenne VAMC

Facilities like the Cheyenne VAMC play an important role in the health care of veterans who reside in rural areas. The Cheyenne VAMC is more than 100 miles from Denver, the nearest VAMC. In addition, many patients from Sheridan, WY use the Cheyenne VAMC for inpatient care. The Wyoming market already has a travel access gap and there is only one local Joint Commission on Accreditation of Healthcare Organizations (JCAHO)-accredited hospital within 60 minutes of the Cheyenne VAMC. To maintain access to inpatient care in the rural Cheyenne area, the Cheyenne VAMC will retain its inpatient care mission.

While the Cheyenne VAMC will retain its inpatient care mission, it is important that VA ensure the quality of care it provides at its small facilities — specifically the scope of surgical procedures performed. The Cheyenne VAMC was designated in the DNCP for mission change to a Critical Access Hospital (CAH), a concept intended to ensure ongoing and future quality of care at small facilities by defining the appropriate scope of practice. In its report, the Commission found that VA needed a more complete definition for the CAH concept. VA is now in the process of developing a "Veterans Rural Access Hospital" (VRAH) policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities. This policy will be completed in June 2004 and will be used to ensure that VA continues to provide quality and appropriate care to veterans at small and rural facilities like the Cheyenne VAMC.

Once the VRAH policy is approved, VA will review the scope of Cheyenne VAMC surgical services to determine whether it meets the criteria for surgical practice as will be defined in the VRAH policy. In the interim, the Cheyenne VAMC will continue to operate in accordance with its current mission.

The VRAH study will be completed by the end of the calendar year and results will be included in the VISN FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

CARES Commission Recommendation

IV **Small Facility**
Grand Junction VAMC

The Commission does not concur with the DNCP proposal that Grand Junction's mission should be changed. The Commission recommends that Grand Junction retain its current mission due to its significant distance from other VAMCs and the high quality of care.

Secretary's Decision

IV **Small Facility**
Grand Junction VAMC

Facilities like the Grand Junction VAMC play an important role in the health care of veterans residing in rural areas. The Grand Junction VAMC is approximately 250 miles from either Denver or Salt Lake City, with mountain ranges on either side of the facility. There are only two local JCAHO-accredited hospitals within 60 minutes of the Grand Junction VAMC. Data for inpatient medicine and surgical services indicate that the costs of care at Grand Junction are lower than Medicare unit costs. Grand Junction also was honored with the President's Quality Award in 2001 in recognition of its focus on organizational improvement and results. These factors all support the need for Grand Junction VAMC to retain its inpatient care mission.

While the Grand Junction VAMC will retain its inpatient care services, it is important that VA ensure the ongoing and future quality of care it provides at its small facilities — specifically the scope of surgical procedures performed. The Grand Junction VAMC was designated in the DNCP for mission change to a CAH, a concept intended to ensure quality of care at small facilities by defining the appropriate scope of practice. In its report, the Commission found that VA needed a more complete definition for the CAH concept. VA is now in the process of developing a "Veterans Rural Access Hospital" (VRAH) policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities. This policy will be completed in June 2004 and will be used to ensure that VA continues to provide quality and appropriate care to veterans at small and rural facilities like the Grand Junction VAMC.

Once the VRAH policy is approved, VA will review the scope of the Grand Junction VAMC's surgical services to determine whether it meets the criteria for surgical practice as will be defined in the VRAH policy. In the interim, the Grand Junction VAMC will continue to operate in accordance with its current mission.

The VRAH study will be completed by the end of the calendar year and results will be included in the VISN FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

CARES Commission Recommendation

V **Small Facility and Seismic**
Fort Harrison VAMC

1. The Commission concurs with the DNCP proposal to maintain the current mission of the Fort Harrison VAMC.
2. The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

Secretary's Decision

V **Small Facility and Seismic**
Fort Harrison VAMC

VA will maintain the current mission of the Fort Harrison VAMC and will ensure patient and employee safety by correcting existing seismic deficiencies (*Reference – Patient and Life Safety: Crosscutting*).

CARES Commission Recommendation

VI **Inpatient Care**

The Commission concurs with the DNCP proposal to improve acute hospital access by contracting for inpatient care in the Eastern Rockies, Montana, and Wyoming markets and for tertiary care in the Montana and Wyoming markets.

Secretary's Decision

VI Inpatient Care

VA will improve access to hospital and tertiary care by using existing authorities and policies to contract for care in the Eastern Rockies, Montana, Wyoming, and Grand Junction markets (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

VII Outpatient Care

1. The Commission concurs with the DNCP proposal to meet part of the future demand for more primary care, mental health, and specialty outpatient care through construction and conversion of space at current sites of care, and to increase specialty care at selected current sites of care, as well as contracting in high peak periods of growth. The Commission notes, however, that merely increasing services at existing sites of care will not resolve access gaps in some markets.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

VII Outpatient Care

VA will meet the demand for primary, mental health, and specialty outpatient care through construction and conversion of space at existing sites and by using existing authorities and policies to contract for care where necessary.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 19 has three new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Fort Harrison VAMC	Lewiston	MT
Fort Harrison VAMC	Cut Bank	MT
Salt Lake City VAMC	Salt Lake City	UT

These new sites of care will help the VISN, which currently is below access standard in its Montana market, to meet national access standards and will relieve a space deficit at a crowded Salt Lake City VAMC (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

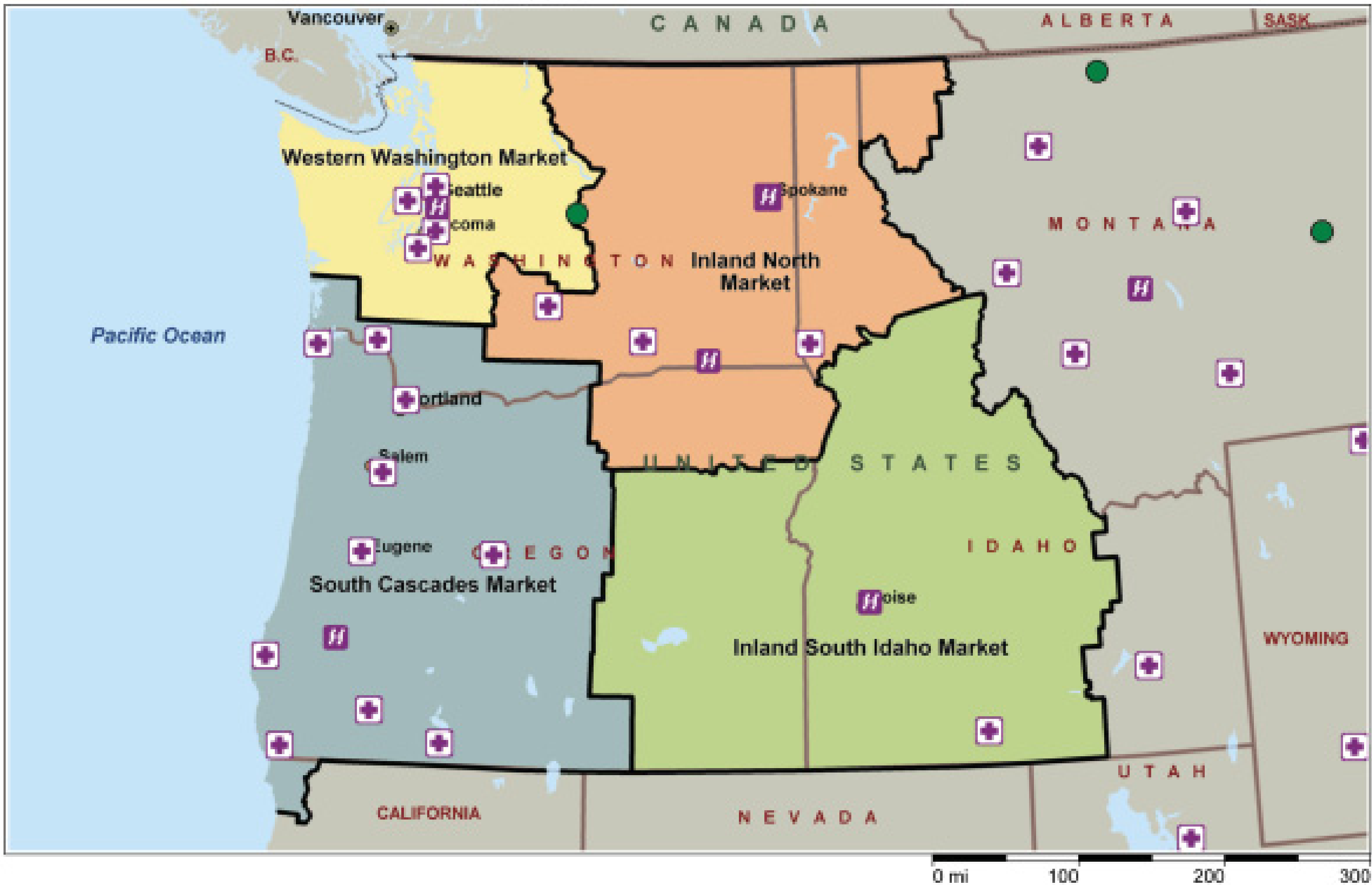
VIII **Enhanced Use**
Salt Lake City VAMC

The Commission concurs with the DNCP proposal for the Phase II enhanced use project at Salt Lake City.

Secretary's Decision

VIII **Enhanced Use**
Salt Lake City VAMC

VA will proceed with Phase II of the enhanced use lease project at the Salt Lake City VAMC (*Reference – Enhanced Use Lease: Crosscutting*).



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CARES DECISIONS FOR VISN 20

CARES Commission Recommendation

- **Realignment**
  Vancouver VAMC

1. The Commission does not concur with the DNCP proposal to vacate the Vancouver campus. The Commission recommends maintaining the current mission at the Vancouver facility, while reducing the campus footprint.
2. The Commission recommends that VA explore options to expand Vancouver's function, particularly with regard to relocating services from the Portland VA Medical Center (VAMC).

Secretary's Decision

- **Realignment**
  Vancouver VAMC

Together, the Portland VAMC and its Vancouver campus provide the full continuum of care to veterans in the Portland/Vancouver metropolitan area. In its review of the DNCP, the Commission found that the missions of the two facilities were complimentary and that realignment from Vancouver to Portland would not be possible given the current space deficits at the Portland VAMC. Based upon these findings, both the Portland and Vancouver VAMCs will retain their missions.

While the Secretary will not consider consolidation of the Vancouver campus at this time, VA will pursue opportunities to reduce the footprint of the Vancouver campus. To make sure that VA makes most effective use of existing buildings and land, VA will develop a Master Plan for the Vancouver campus. The Master Plan will include options to expand Vancouver's function by relocating services from the Portland VAMC, which is landlocked and congested.

The Master Plan will propose an efficient, cost-effective, and appropriately sized infrastructure design that will reduce vacant and underused space on the campus. It also will consider enhanced use lease opportunities for almost 20 acres of land. VA will ensure that any plans for alternate use or disposal of VA property serve to enhance the Department's mission.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

VA will complete the Master Plan by the end of 2004 (*Reference – Excess VA Property: Crosscutting*).

CARES Commission Recommendation

Small Facility and Campus Realignment
White City Southern
Oregon Rehabilitation Center Clinic (SORCC)

1. The Commission does not concur with the DNCP proposal to transfer the domiciliary and Compensated Work Therapy (CWT) programs from White City to other VAMCs. The Commission agrees with the VISN-recommended alternative that the White City SORCC maintain its current mission.
2. The Commission concurs with the DNCP proposal that White City should retain its outpatient services.

Secretary's Decision

Small Facility and Campus Realignment
White City Southern
Oregon Rehabilitation Center Clinic (SORCC)

The CARES Commission found that the White City SORCC is a unique regional substance abuse treatment resource, serving veterans who have not been successfully rehabilitated in other domiciliary programs in a clinical

setting that is innovative and difficult to duplicate. Based upon these findings, VA will maintain all current services at the White City SORCC.

While the Secretary will not consider transfer of services at White City at this time, VA will pursue opportunities to reduce the footprint of the campus. To ensure that VA makes the most effective use of existing buildings and land, VA will develop a Master Plan for the White City campus. The plan will propose an efficient, cost-effective, and appropriately sized infrastructure design that will reduce vacant and underused space on the campus. It also will consider enhanced use lease opportunities. VA will also ensure that any plan for alternate use or disposal of VA property serves to enhance the Department's mission.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan is managed effectively.

VA will complete the Master Plan by the end of 2004 (*Reference – Excess VA Property: Crosscuttin*g).

CARES Commission Recommendation

III Small Facility and Campus Realignment
Walla Walla VAMC

1. The Commission concurs with the DNCP proposal to close the Walla Walla VAMC and, where appropriate, contract for acute inpatient medicine and psychiatry care and nursing home care in the Walla Walla geographic area.
2. The Commission concurs with the DNCP proposal to maintain outpatient services and recommends that outpatient care be moved off the Walla Walla VAMC campus after inpatient services have been relocated.

Secretary's Decision

III Small Facility and Campus Realignment
Walla Walla VAMC

The Walla Walla campus includes 88 acres of land and 28 buildings from the Fort Walla Walla period of 1858 to 1947. Fifteen of the buildings are listed on the historic register and six remain in use for patient care and support. The Walla Walla VAMC currently provides inpatient medicine, psychiatric, and nursing home care services as well as outpatient care. The buildings on the campus are aging, unsuitable for patient care, and require significant renovations to correct deficiencies, including the need for seismic upgrades and lead-based paint removal.

After considering the Commission's recommendations, the Secretary determined that further study is required. Accordingly, the Secretary will commission a comprehensive study to determine how to improve the environment of care in Walla Walla, while maximizing use of VA resources. The study will evaluate the demand for health care against the availability of care in the community and patient safety concerns as well as consider the limitations and substantial costs of maintaining an aging and expensive medical center campus for a current total inpatient and nursing home average daily census of 53. The study will examine multiple options and will include the potential for partnership with community and private sector organizations to provide nursing home and psychiatric inpatient care to veterans in the community. VA will consider options for moving into a more modern and efficient infrastructure designed to provide quality patient care.

The study will take into account the fact that the existing campus is much larger than needed to provide VA medical care and consumes scarce resources that could be better applied to meeting veterans' needs. The study will identify the appropriate physical resources needed for VA's mission and identify options to divest or lease excess property to generate revenues that could be applied to VA's health care mission.

VA will ensure veterans have continued access to quality care as it conducts the study and implements the study's recommendations. Particular sensitivity will be devoted to the clinical and psychosocial needs of nursing home and psychiatric inpatients. While VA conducts the study, the mission of the Walla Walla campus will remain unchanged.

In considering alternative uses for the Walla Walla campus, VA will ensure that any decision on disposal or reuse of excess VA property serves to enhance the Department's mission. As VA moves forward with this study, it is committed to minimizing any impact on patients, employees, and the community and will work closely with its stakeholders to ensure that this study, and its ensuing implementation, are managed effectively.

The study will be submitted to the Secretary no later than January 1, 2005 (*Reference – Contracting for Care, Excess VA Property: Crosscutting*).

CARES Commission Recommendation

IV **Small Facility**
Roseburg VAMC

The Commission concurs with the DNCP proposal on converting surgical beds to 24-hour surgical observation beds at Roseburg.

Secretary's Decision

IV **Small Facility**
Roseburg VAMC

VA will convert surgical beds to 24-hour surgical observation beds at the Roseburg VAMC.

CARES Commission Recommendation

V **Inpatient Care**

The Commission concurs with the DNCP proposal to move 15 inpatient beds from American Lake to Madigan Army Medical Center.

Secretary's Decision

V **Inpatient Care**

VA will transfer 15 inpatient beds from the American Lake VAMC to the Madigan Army Medical Center, freeing up 8,500 square feet of space at American Lake to meet primary care demand (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

VI Outpatient Care

1. The Commission concurs with the DNCP proposal to add a new CBOC in the Inland North market; to increase primary care services in three other markets through VA/DoD joint ventures, new construction, and converting in-house space; to meet increased demand for mental health services in the Inland North market in-house and through contracting; and to increase outpatient specialty care services in all five markets through two new CBOCs, new construction, in-house expansion, and contracting.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

VI Outpatient Care

VA will meet increased demand for outpatient services through VA/DoD joint ventures, expansion, renovation, new construction, and use of existing authorities and policies to contract for care where necessary.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 20 has one new CBOC targeted for priority implementation:

Parent Facility	Planned New Facility Name	State
Spokane VAMC	Central Washington	WA

This new CBOC will help the VISN, which currently is below access standard in its Inland North market, meet national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VII VA/DoD Collaboration

The Commission concurs with the DNCP proposal on DoD initiatives and recommends the Elmendorf Air Force Base proposal be expedited due to the expiration of the lease space currently occupied by the Alaska VA Health Care System (HCS) in FY 2007.

Secretary's Decision

VII VA/DoD Collaboration

VA will expedite the joint venture opportunity with Elmendorf Air Force Base to ensure that an agreement is in place before the current lease for the Alaska VA HCS expires in 2007. VA will continue to pursue additional VA/DoD sharing opportunities across the VISN to include ongoing collaborations with Bassett ACH as well as Everett and Bremerton Naval Hospitals (*Reference – VA/DoD Sharing: Crosscutting*).

CARES Commission Recommendation

VIII Infrastructure and Safety

The Commission concurs with the DNCP proposal for the seismic/life safety projects in VISN 20. The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

Secretary's Decision

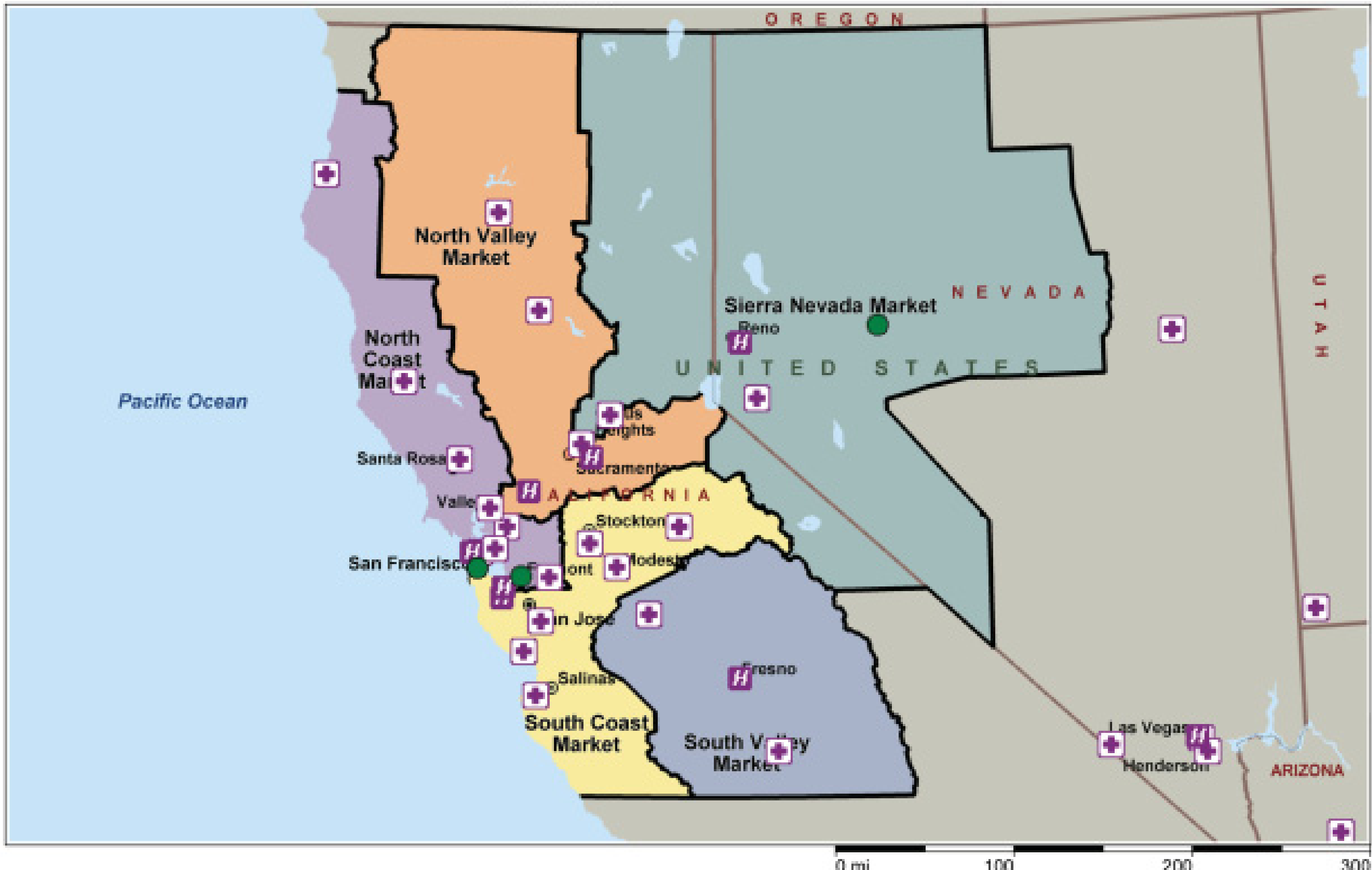
VIII **Infrastructure and Safety**

VA will improve patient and employee safety by correcting existing seismic and life safety deficiencies in Roseburg, White City, American Lake, Seattle and Portland (*Reference – Infrastructure and Safety: Crosscutting*).

Secretary's Decision

IX ***OneVA*** **Collaborations**

VA will pursue a land transfer from VHA to NCA to expand the Roseburg National Cemetery. VA will develop a plan for this transfer by September 2004 (*Reference –* OneVA *Collaborations: Crosscutting*).



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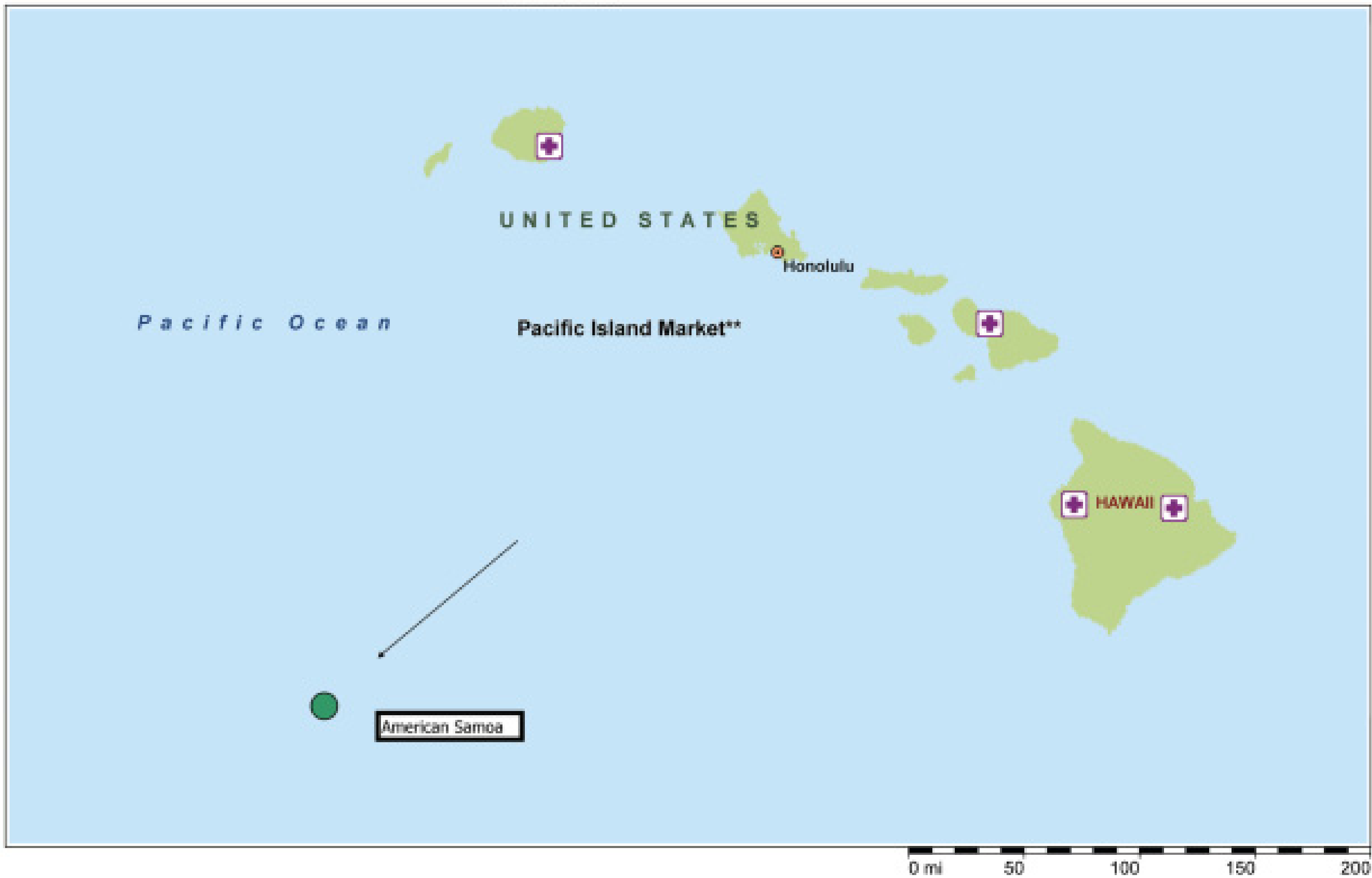

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CARES Decisions for VISN 21

CARES Commission Recommendation

- **Campus Realignment**
  Livermore VAMC

  1. The Commission does not concur with the DNCP proposal that nursing home care at Livermore be transferred to Menlo Park and the community.
  2. The Commission recommends that the long-term care services (nursing home beds) at Livermore be retained as a freestanding nursing home care unit.
  3. The Commission concurs with the DNCP proposal to transfer sub-acute beds to Palo Alto.
  4. The Commission concurs with the DNCP proposal to shift outpatient care to CBOCs.

Secretary's Decision

- **Campus Realignment**
  Livermore VAMC

VA will realign the Livermore campus to improve access to and quality of patient care by moving services closer to where patients live and by collocating care. The realignment will include transfer of outpatient care to an expanded Central Valley clinic and to a new East Bay clinic. The realignment also will move sub-acute and low-volume specialty services currently provided at Livermore to the Palo Alto VAMC where they will be collocated at a tertiary care facility.

VA is committed to the care of its nursing home patients and will maintain access to services locally by retaining a nursing home presence in Livermore through construction of a new facility. Because this new facility will not be collocated with other VA care, VA will develop a referral agreement to ensure it is able to effectively respond to emergent situations.

The Livermore campus currently requires significant ongoing maintenance and scarce patient care resources are used for maintenance of buildings and grounds. This realignment will redirect funds spent on maintaining Livermore's deteriorating physical plant to patient care services. Through realignment, VA will enhance care to veterans and make better use of its resources.

To ensure that this transition is managed effectively, VA will develop a Master Plan for the Livermore campus. The Master Plan will include strategies for managing the transition of patient care services associated with realignment. It also will include a careful study of the appropriate size and location of the new nursing home to include a cost-effectiveness analysis to ensure maximum effective use of VA resources. Plans for the nursing home will be developed using the long-term care and mental health strategic plans. The Master Plan also will ensure that the decision on disposal or reuse of excess VA property serves to enhance the Department's mission.

VA recognizes that this realignment will change the location and nature of some services provided in the Livermore area. VA is committed to managing these transfers effectively and to minimizing any impact on patients, employees, and the community. This will include assuring continuity of patient care to the greatest extent possible, and managing any changes in employment through natural attrition, transfer, early retirement, retraining or other benevolent mechanisms. VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan are managed effectively.

While VA expects this transition to occur over several years, VA will complete the Master Plan by the end of 2004 (*Reference – Long-Term Care, Excess VA Property: Crosscutting*).

CARES Commission Recommendation

II Inpatient Care and Access

The Commission concurs with the DNCP proposal for expansion of services at the Reno VA Medical Center (VAMC) and contracting for services in South Coast and Sierra Nevada markets as needed to meet inpatient access demands.

Secretary's Decision

II Inpatient Care and Access

VA will expand services at the Reno VAMC and enhance telemedicine services between the Reno, Palo Alto and San Francisco VAMC's. VA will use existing authorities and policies to contract for care in the Sierra Nevada and South Coast markets where necessary (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

III Outpatient Care

1. The Commission recommends that VA open a new CBOC closer to the residences of patients who now receive outpatient care at Livermore.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

III Outpatient Care

VA will meet the increase in demand for outpatient care in all four markets through expansion, renovation, new construction, and use of existing authorities and policies to contract for care where necessary.

VA will develop new CBOCs through the National CBOC Approval Process. VISN 21 has four new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Sierra Nevada HCS	Fallon	NV
San Francisco VAMC	North San Mateo	CA
VA Palo Alto HCS	East Bay	CA
Pacific Islands HCS	American Samoa	HI

The Fallon CBOC will help the VISN, which currently is below access standard in its Sierra Nevada market, meet national access standards. The American Samoa CBOC will support VA/DoD sharing, the North San Mateo clinic will relieve space at a crowded San Francisco VAMC, and the East Bay clinic will be opened in conjunction with the realignment of the Livermore VAMC *(Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

IV **VA/DoD Sharing**

The Commission concurs with the DNCP proposals on DoD collaborations.

Secretary's Decision

IV **VA/DoD Sharing**

VA will continue to pursue collaborative opportunities with DoD across the VISN. VA will work to expand its sharing arrangement with Travis Air Force Base, continue its collaborative work with Tripler Army Medical Center, and seek new VA/DoD sharing opportunities in American Samoa and Guam (*Reference – DOD/VA Sharing: Crosscutting*).

CARES Commission Report

V Infrastructure and Life Safety

1. The Commission concurs with the DNCP proposals for seismic construction projects at facilities in the North Coast, South Coast, and South Valley markets.
2. The Commission recommends that patient and employee safety should be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/ life safety deficiencies as soon as possible.

Secretary's Decision

V Infrastructure and Life Safety

VA will improve patient and employee safety by correcting existing seismic and life safety deficiencies in Palo Alto, San Francisco, Menlo Park, and Fresno (*Reference – Infrastructure and Safety: Crosscutting*).

CARES Commission Recommendation

VI Consolidation of Services
San Francisco and Palo Alto VAMCs

The Commission concurs with the DNCP proposal to maintain both San Francisco and Palo Alto as separate facilities and to realign and consolidate services as the VISN is able to do so.

Secretary's Decision

VI Consolidation of Services
San Francisco and Palo Alto VAMCs

VA will maintain San Francisco and Palo Alto as separate tertiary facilities, but will continue to consolidate administrative and clinical services between both facilities as recommended in the DNCP.

CARES Commission Recommendation

VII **Enhanced Use**

The Commission concurs with the DNCP proposal to provide a research facility at San Francisco.

Secretary's Decision

VII **Enhanced Use**

The Secretary will continue to consider proposals to improve research and long-term care missions through enhanced use lease opportunities that recognize limitations of existing space at the medical center and enhance VA's primary mission of patient care (*Reference – Enhanced Use Lease: Crosscutting*).

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CARES Decisions for VISN 22

CARES Commission Recommendation

New Hospital – VA/DoD Sharing
Las Vegas

1. The Commission recommends that VA continue the joint venture with the Michael O'Callaghan Federal Hospital at Nellis AFB in Las Vegas for inpatient beds and that the partnership be expanded to meet VA's increased need for acute care services. This partnership allows for shared services that support inpatient beds and will reduce redundancies and be more cost-efficient than operating two separate hospital facilities.
2. The Commission recommends that VA provide a collocated multi-specialty outpatient clinic and nursing home care unit in the Las Vegas area.
3. The Commission recommends that, given the uniqueness of the Las Vegas situation and the increased need for VA inpatient care in southern Nevada, if DoD cannot continue the partnership by fulfilling the medical needs of veterans, the VA should exercise the option of constructing a new VA hospital in Las Vegas, as recommended in the DNCP.

Secretary's Decision

New Hospital – VA/DoD Sharing
Las Vegas

The Nevada market is experiencing rapid growth in demand for VA health care and the need for additional services for Las Vegas area veterans is urgent. Currently, VA is treating Las Vegas veterans in community-based clinics located throughout the city, fragmenting care across ten sites. Compounding the problem are referral patterns that require many Las Vegas area veterans to travel long distances to Los Angeles and San Diego for a range of inpatient procedures and at added expense to the Department. VA will move forward to develop a VA medical center campus that will include multi-specialty outpatient, nursing home, and inpatient services to care for the rapidly growing Las Vegas veteran population.

VA will begin planning for the new Las Vegas facility by developing a Master Plan for a new medical center campus. The Master Plan will include careful consideration of the size and location of the campus as well as a cost-effectiveness analysis to ensure VA maximizes use of its resources. VA will develop plans for the size of the nursing home using its long-term care and mental health strategic plans, and will explore the opportunity to collaborate with the University of Nevada as it plans for the new facility.

VA will continue to pursue sharing opportunities with DoD at the Michael O'Callaghan Federal Hospital at Nellis AFB. This has been a successful collaboration and VA will work closely with DoD to ensure continued sharing.

This significant expansion of services to Las Vegas veterans will greatly improve the quality and coordination of care in an area that is experiencing rapid growth. As VA plans for development of the new facility in Las Vegas, it will consider what other ancillary facilities are necessary to support the new medical center campus allowing potential for additional DoD sharing.

VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan are managed effectively. While this transition is expected to take place over several years, VA will complete the Master Plan by the end of 2004 (*Reference – VADoD Sharing, Long-Term Care: Crosscutting*).

CARES Commission Recommendation

Realignment/Consolidation of Services Due to Proximity
West LA and Long Beach VAMCs

The Commission concurs with the DNCP proposal to maintain existing facilities at the Long Beach and West LA campuses, and to integrate services where appropriate.

Secretary's Decision

Realignment/Consolidation of Services Due to Proximity
West LA and Long Beach VAMCs

VA will maintain the Long Beach and West LA campuses as separate tertiary care facilities, but will continue to consolidate administrative and clinical services between both facilities as recommended in the DNCP.

CARES Commission Recommendation

III Inpatient Care

The Commission concurs with the DNCP proposal to address the need for additional inpatient medicine beds in the California market through the conversion and renovation of existing space and to use contracted services to meet demand during peak periods.

Secretary's Decision

III Inpatient Care

VA will meet increased demand for inpatient care through new construction, by converting and renovating existing space, and by using existing authorities and policies to contract for care where necessary (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

IV Outpatient Care

1. The Commission concurs with the DNCP proposal to address capacity gaps through new construction, shifting workload, and expansion of services.
2. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

Secretary's Decision

IV Outpatient Care

VA will meet anticipated gaps in outpatient care through new construction for additional space, shifting workload between facilities, expansion of services, and use of existing authorities and policies to provide contract care where necessary. VA will consider addition of new CBOCs through the National CBOC Approval Process (*Reference – Contracting for Care: Crosscutting*).

CARES Commission Recommendation

V Special Disability Programs

1. The Commission concurs with the DNCP proposal to establish a new blind rehabilitation center on the Long Beach campus.
2. The Commission concurs with the DNCP proposals for Long Beach to realign 30 beds from acute spinal cord injury and disorders (SCI/D) to long-term SCI/D. The Commission recommends that VA conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to better serve veterans and reduce waiting times.

Secretary's Decision

V Special Disability Programs

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for SCI services at the Long Beach VAMC will be included in the FY 2005 VISN strategic planning submission.

VA will include plans to develop a new 24-bed blind rehabilitation center on the Long Beach campus in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

CARES Commission Recommendation

VI Infrastructure and Life Safety

The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

Secretary's Decision

VI Infrastructure and Life Safety

VA will improve patient and employee safety by correcting seismic and life safety deficiencies at the West LA, Long Beach, and San Diego facilities (*Reference – Patient and Life Safety: Crosscutting*).

CARES Commission Recommendation

VII **Excess Land Use**
West LA Campus

1. The Commission concurs with the DNCP proposal for the Network Land Use Planning Committee to address the use of VA land, especially the property on the West LA campus, with stakeholder input. The Commission recommends, however, that the committee be augmented with the addition of stakeholder representation on the committee in an advisory capacity.
2. The Commission concurs with the DNCP proposal for construction of a new clinical addition to consolidate clinical services.
3. The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed enhanced use leasing process. VA should also consider using vacant space to provide supportive services to homeless veterans.

Secretary's Decision

VII **Excess Land Use**
West LA Campus

Spread across 387 acres in an urban neighborhood, the West LA campus is a unique resource and it is important that VA preserve the integrity of the land originally granted for use as an Old Soldiers home. VA is committed to maintaining the property for uses that serve to enhance the Department's mission.

To ensure that VA has a clear framework for managing the vacant and underused property at the West LA campus, VA will develop a Master Plan for the campus in collaboration with stakeholders who will have input into the plan's development.

The Master Plan will be completed by the end of 2004 (*Reference – Excess VA Property: Crosscutting*).

CARES Commission Recommendation

VIII **Long-Term Care/Facility Condition**

1. The Commission concurs with the DNCP proposal for upgrading existing long-term care and chronic psychiatric care units recognizing that some renovations are needed to improve the safety and maintenance of the facilities' infrastructure and to modernize patient areas.
2. The Commission recommends that VA provide for nursing home care, collocated with a multi-specialty outpatient clinic, in the Las Vegas area.
3. The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities, VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

VIII **Long-Term Care/Facility Condition**

VA will develop a long-term care strategic plan based on well-articulated policies. Until VA completes a long-term care strategic plan, it will only proceed with maintenance and life safety projects at existing long-term care facilities that are necessary to ensure the quality and safety of patient care (*Reference – Long-Term Care: Crosscutting*).

CARES Commission Recommendation

IX **Research**

The Commission concurs with the DNCP proposal for new research facilities at Loma Linda, San Diego, and West LA locations.

Secretary's Decision

IX Research

VA will explore opportunities to develop new research facilities at the Loma Linda, San Diego, and West LA campuses that are consistent with its patient care mission.

CARES Commission Recommendation

X VA/DoD Sharing and Other Collaborations

1. The Commission recommends that VA/DoD collaboration should be a major consideration in addressing health care needs in a local area.
2. The Commission concurs with collocating the VBA office to West LA campus and providing VBA space in the proposed outpatient clinic in Las Vegas, NV.
3. The Commission concurs with collocating an NCA columbarium on 20 acres of the West LA campus.

Secretary's Decision

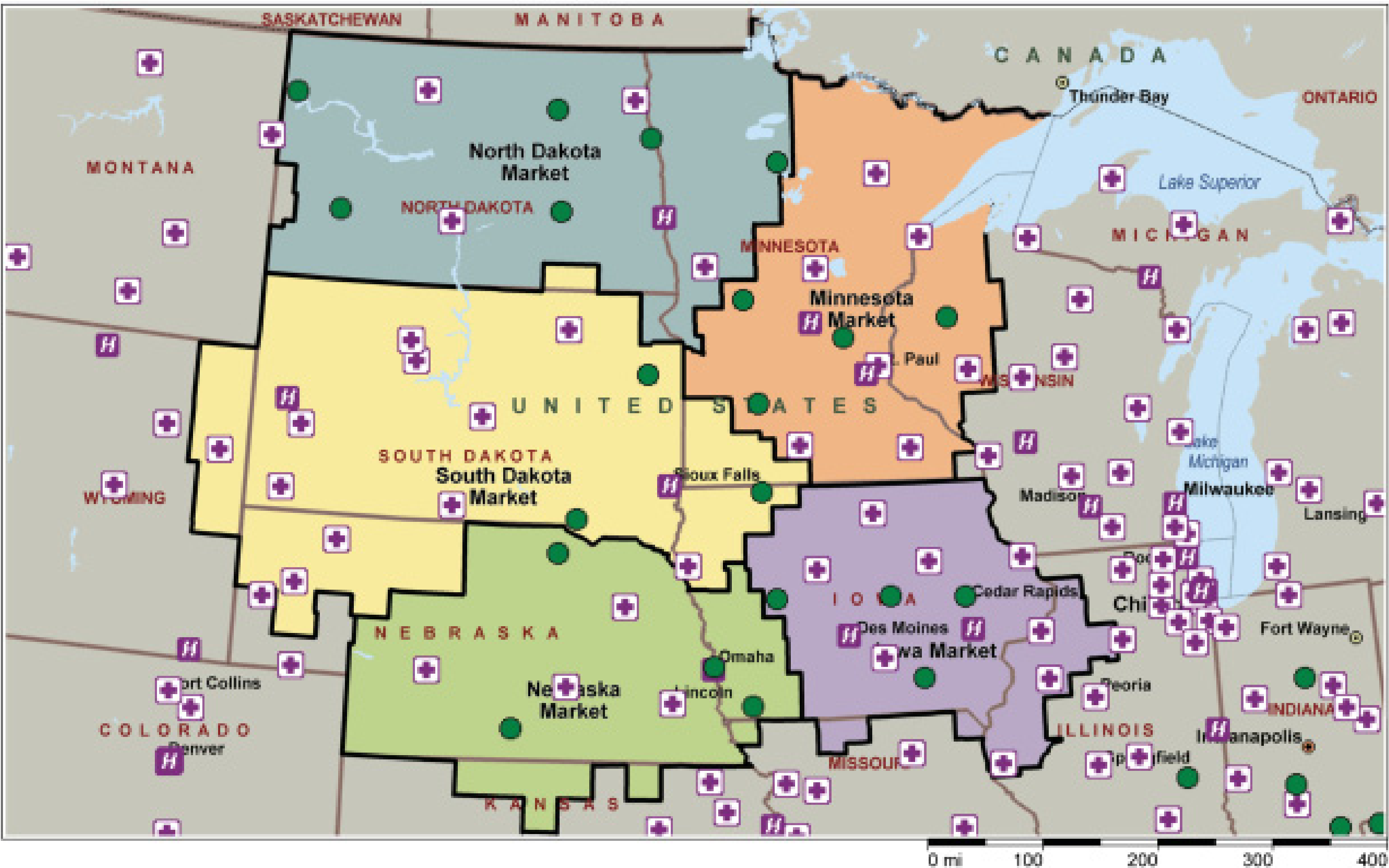
X VA/DoD Sharing and Other Collaborations

VA will continue to pursue sharing with the Air Force at Nellis Air Force Base as stated in discussion of the proposal for a new medical center campus in Las Vegas. VA also will pursue other sharing opportunities with DoD in VISN 22 (*Reference – VA/DoD Sharing*).

VA will explore the feasibility of collocating the VBA Regional Office at the West LA VAMC. VA will also plan to collocate VBA space in the new medical center campus planned for Las Vegas, NV. These collaborations will not only improve access to services, but will redirect savings from rental costs into claims processing, vocational rehabilitation and employment, education, loan guaranty, and other VBA priorities. VBA will develop collocation feasibility studies for these collaborations by September 2004.

VA will collocate an NCA columbarium on 20 acres of available land at the West LA campus and pursue additional opportunities for expanding the NCA presence on the West LA campus. VA will develop a plan for this collocation by September 2004 (R*eference* – OneVA *Collaborations: Crosscutting*).

VISN 23



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CARES Decisions for VISN 23

CARES Commission Recommendation

- **Small Facility and Campus Realignment**
  Knoxville and Des Moines VAMCs

1. The Commission concurs with the DNCP proposal to move all inpatient services to Des Moines and to retain outpatient services at Knoxville, provided there are safeguards in place to ensure that no VA-operated long-term care beds in the VISN are lost nor the capacity to care for the patients now being treated at Knoxville.
2. The Commission recommends that acute inpatient mental health services should be provided with other acute inpatient services whenever feasible.
3. The Commission recommends that prior to taking any action to reconfigure or expand long-term care capacity or replace existing long-term care facilities VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.

Secretary's Decision

- **Small Facility and Campus Realignment**
  Knoxville and Des Moines VAMCs

VA will transfer inpatient care from the Knoxville VAMC to the Des Moines VAMC. The Knoxville VAMC has several buildings that are in need of renovation to correct life safety and environment of care issues, including nursing home units that do not meet community standards. By transferring the acute psychiatry, intermediate medicine, domiciliary, and nursing home care services currently operating at the Knoxville VAMC to the Des Moines VAMC, VA will not only avoid costly renovations to existing buildings, but also will improve care coordination, enhance the environment of care, and move care closer to the population center in Des Moines. By enhancing care and using resources more efficiently, VA can better serve Iowa veterans.

Moving inpatient care from Knoxville to Des Moines will improve care coordination by enhancing interdisciplinary collaboration through collocation. Acute and long-term psychiatry will be collocated with other acute care services, and nursing home services will be moved closer to the population center. Nursing home services also will be improved through construction of a new state-of-the-art nursing home in Des Moines that will improve the environment of care. Plans for the new nursing home will be developed using the long-term care and mental health strategic plans. The Knoxville campus will retain outpatient care services.

To ensure effective management of this transition, VA will develop a Master Plan for the realignment of the Des Moines and Knoxville campuses. The Master Plan will propose an efficient, cost-effective, and appropriately sized footprint that will reduce vacant and underused space on both campuses. The Master Plan also will ensure that any plan for alternate use or disposal of VA property serves to enhance the Department's mission and that the transition will not result in a reduction of long-term nursing home care capacity in VISN 23.

VA is committed to minimizing any impact on patients, employees, and the community as it manages this planning process and transition. This will include assuring continuity of patient care to the greatest extent possible, and managing any changes in employment through natural attrition, transfer, early retirement, retraining or other mechanisms. VA will continue to work closely with its stakeholders to ensure that development and implementation of the Master Plan are managed effectively.

While this realignment is expected to take place over several years, VA will complete the Master Plan by the end of 2004 (*Reference – Excess VA Property, Long-Term Care: Crosscutting*).

CARES Commission Recommendation

II **Small Facility and Campus Realignment**
Hot Springs VAMC

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

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

Secretary's Decision

II Small Facility and Campus Realignment
Hot Springs VAMC

Facilities like the Hot Springs VAMC play an important role in the provision of care for veterans residing in rural areas. While the average daily census at Hot Springs was less than ten inpatients in 2003, there is no VAMC within 60 miles and no Joint Commission on Accreditation of Healthcare Organizations (JCAHO)-accredited hospitals in the Hot Springs area. Serving a rural location with few viable options for community care, the Hot Springs VAMC will continue to serve as a valuable health care resource for South Dakota veterans.

While the Hot Springs VAMC will remain open, the DNCP recommended that its mission be changed to a CAH, a concept intended to ensure ongoing and future quality of care at small facilities by defining the appropriate scope of practice. In its report, the Commission found that VA needed a more complete definition for the CAH concept. VA is now in the process of developing a "Veterans Rural Access Hospital" (VRAH) policy that will provide a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities. This policy will be completed in June 2004 and will be used to ensure that VA will continue to provide quality and appropriate care to veterans at small and rural facilities like the Hot Springs VAMC.

VA is committed to providing quality care to rural veterans. Once the VRAH policy is approved, VA will study the Hot Springs VAMC, as well as other similar facilities, to determine whether it meets the criteria for designation as a VRAH, and to define the appropriate scope of practice to ensure it continues to meet quality standards. In the interim, the Hot Springs VAMC will continue to operate in accordance with its current mission.

The VRAH study will be completed by the end of the calendar year and results will be included in the VISN FY 2005 strategic planning submission (*Reference – Critical Access Hospital: Crosscutting*).

CARES Commission Recommendation

III **Small Facility**
St. Cloud VAMC

The Commission concurs with the DNCP proposal to maintain inpatient acute psychiatry, domiciliary, nursing home, and outpatient services at St. Cloud. The Commission concurs with transferring medicine beds from St. Cloud to Minneapolis and with contracting in the community.

Secretary's Decision

III **Small Facility**
St. Cloud VAMC

Over the past 2 years, as part of a pilot program, VA closed all inpatient medicine beds at the St. Cloud VAMC and transferred care to the Minneapolis VAMC and to the community by using existing authorities and policies to contract for care. VA will maintain inpatient acute psychiatry, domiciliary, nursing home, and outpatient services at the St. Cloud VAMC and continue to manage inpatient medicine demand through referral to the Minneapolis VAMC and to the community through contracts.

CARES Commission Recommendation

IV **Inpatient Care**

1. The Commission concurs with the DNCP proposal to contract for acute hospital and tertiary hospital care in the community to improve access to hospital and tertiary care for veterans in this VISN.
2. The Commission concurs with the DNCP proposal that construction and renovation for the purpose of modernization proceed at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities.
3. The Commission concurs with the DNCP proposal regarding the need to upgrade the existing long-term care unit at Grand Island.

Secretary's Decision

IV Inpatient Care

Access to inpatient care is below the VA standard in four of the five markets in VISN 23. VA will use existing contracting authorities and policies to improve access to hospital and tertiary care across the VISN by contracting for care where necessary (*Reference – Contracting for Care: Crosscutting*).

VA also will modernize existing facilities through new construction and renovation at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, and St. Cloud facilities.

Plans for renovation of the Grand Island long-term care unit will be developed using the long-term care and mental health strategic plans (*Reference – Long-Term Care: Crosscutting*).

CARES Commission Recommendation

V Outpatient Care

1. The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
2. The Commission concurs with the DNCP proposal for outpatient construction and conversion of space to address current and projected space needs at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities.

Secretary's Decision

V Outpatient Care

The VISN will meet the increases in demand for outpatient care through expansion, renovation, new construction, and use of existing authorities and policies to contract for care where necessary.

Further, VA will enhance capacity for outpatient care in VISN 23 through construction and conversion of existing space to address current and projected space needs at the Minneapolis, Fargo, Iowa City, Omaha, Des Moines, Knoxville, Sioux Falls, Fort Meade, and St. Cloud facilities.

The VISN also will develop new CBOCs through the National CBOC Approval Process. VISN 23 has 21 new CBOCs targeted for priority implementation by 2012:

Parent Facility	Planned New Facility Name	State
Fargo VAMC	Bemidji	MN
Fargo VAMC	Dickinson	ND
Fargo VAMC	Jamestown	ND
Fargo VAMC	Devils Lake	ND
Fargo VAMC	Williston	ND
Fargo VAMC	Grand Forks	ND
Des Moines VAMC	Marshalltown	IA
Des Moines VAMC	Carroll	IA
Iowa City VAMC	Ottumwa	IA
Iowa City VAMC	Cedar Rapids	IA
Grand Island VAMC	O'Neil	NE
Grand Island VAMC	Holdredge	NE
Omaha VAMC	Bellevue	NE
Omaha VAMC	Shenandoah	IA
Sioux Falls VAMC	Wagner	SD
Sioux Falls VAMC	Watertown	SD
Sioux Falls VAMC	Spirit Lake	IA
Minneapolis VAMC	Redwood Falls	MN
Minneapolis VAMC	Rice Lake	MN
Minneapolis VAMC	Elk River	MN
St. Cloud VAMC	Alexandria	MN

These new sites of care will help the VISN, which currently is below access standards in all five of its markets, to meet national access standards (*Reference – Contracting for Care, Community-Based Outpatient Clinics: Crosscutting*).

CARES Commission Recommendation

VI Enhanced Use and Collaboration with VBA

1 The Commission concurs with the DNCP proposal for enhanced use leasing projects for VISN 23.

Secretary's Decision

VI Enhanced Use and Collaboration with VBA

VA will pursue existing enhanced use leasing opportunities in VISN 23 (*Reference – Excess VA Property: Crosscutting*).

VA will explore the feasibility of collocating the St. Paul VBA Regional Office at the Minneapolis VAMC. VBA will develop a collocation feasibility study by September 2004 (*Reference* – OneVA *Collaborations: Crosscutting*).

CARES Commission Recommendation

VII Special Disability Programs
SCI/D Unit at the Minneapolis VAMC

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

Secretary's Decision

VII Special Disability Programs
SCI/D Unit at the Minneapolis VAMC

As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation also will consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for development of a new SCI Center in Minneapolis will be included in the FY 2005 VISN strategic planning submission (*Reference – Special Disability Programs: Crosscutting*).

APPENDIX A

Promising VA/DoD Collaborations

VISN	Location	Sharing Opportunity
3	Fort Monmouth, NJ	VA is sharing space with the Army for a CBOC at Patterson ACH.
5	Fort Belvoir, VA	The Army is providing VA 60,000 sq. ft. for primary and specialty care for the DC VAMC. Construction to begin in FY 05.
5	Fort Meade and Fort Detrick, MD	VA will pursue sharing opportunities to provide outpatient services through shared CBOCs.
6	Langley AFB, VA	VA and DoD have a sharing agreement for pathology services with possible expansion to include inpatient, ICU and surgical services.
6	Camp Lejeune, NC	VA and DoD have a sharing agreement to provide inpatient care services.
7	Charleston Naval Hospital, SC	A minor construction application has been submitted to join the Navy's construction project for a joint VA-Navy clinic at the Naval Weapons Station at Goose Creek.
7	Maxwell AFB, AL	An MOU is under development for a VA podiatry clinic at Maxwell AFB that will treat active duty and VA patients.
7	Beaufort Naval Hospital, SC	VA will continue to pursue negotiations for sharing at the Beaufort Naval Hospital.
8	Naval Air Station Hospital at Jacksonville, FL	VA will evaluate establishment of contractual relationships with the University of Florida/Shands and the Naval Air Station Hospital at Jacksonville to provide inpatient services for the North market.

VISN	Location	Sharing Opportunity
8	Army Hospital Ft. Buchanan, PR	VA will continue discussions with US Army South for potential land use at Fort Buchanan.
8	NH Roosevelt Roads Ceiba, PR	VA will continue to discuss opportunities to use land at Roosevelt Roads.
8	MacDill AFB, FL	VA will explore the feasibility of a joint VA/DoD clinic at the Bay Pines VAMC.
9	Fort Knox, KY	VA will proceed with an expansion of space for primary care and outpatient mental health services at the Fort Knox CBOC.
10	Columbus, OH	VA will expand care through construction of a 260,000 square foot multi-specialty outpatient clinic on Federal land donated by the DoD Defense Supply Center.
16	Fort Sill, OK	The Army is providing 3 dental operatories which began servicing veterans in December of 2003.
16	Eglin AFB, FL	VA is collaborating in the Eastern Southern market with the Eglin AFB, FL. A 10-acre CBOC site has been agreed upon and discussions for inpatient care will begin in earnest as the shared CBOC is completed.
16	Pensacola Naval Hospital, FL	VA is exploring the possibility of collaborating in the Eastern Southern market with the Pensacola Naval Hospital. The land use agreement that will make the building site available for construction is in final stages. There is a sharing agreement for inpatient and some specialty care currently in place with the Pensacola Naval Hospital.
16	Keesler AFB, MS	VA is seeking a clear commitment from DoD for expanded sharing as VA plans to realign the Gulfport campus to Biloxi. Inpatient mental health beds are currently being provided by VA to DoD personnel.
17	NE Bexar, TX	The North Central Bexar County Clinic was submitted as a DoD/VA Incentive Funding initiative. This initiative will allow the San Antonio HCS to share resources with the USAF to operate a VA/DoD staffed primary care clinic providing services to both VA and DoD beneficiaries. This clinic is expected in FY05.
17	Fort Hood, TX	The Temple VAMC is operating a joint VA/DoD sleep clinic with the Darnall ACH.
18	Fort Bliss, TX	VA and DoD seek to expand sharing agreements at the William Beaumont Hospital.
18	Mesa, AZ	VA will pursue a DoD collaboration to provide primary care services for DoD personnel at the Mesa CBOC.

VISN	Location	Sharing Opportunity
19	Denver, CO	VA will build a replacement VA medical center through a sharing agreement with the DoD on the Fitzsimmons campus with some shared facilities with the University of Colorado.
20	Elmendorf AFB, AL	The Alaska VAMC and Elmendorf Air Force Base seek to expand sharing to replace existing services provided by VA through lease at its existing facility. A project to replace the VA clinic has been submitted.
20	Madigan, WA	VA will transfer 15 inpatient beds from the American Lake VAMC to Madigan Army Medical Center.
20	Fairbanks, AL	The Anchorage VAMC currently has a clinic collocated at Ft. Wainwright. The clinic will expand when the new Army Hospital is completed in 2006.
20	Bremerton, WA	The Navy will provide acute inpatient medicine, emergency room and ancillary services in support of the VA CBOC in Bremerton. VA will pursue the potential for provision of urology services from the Navy.
21	Naval Hospital, Guam	The Navy will provide land near a planned new Navy Hospital for construction of a VA CBOC. This new Hospital in the Marianas Islands in Guam will provide specialty care and inpatient care for veterans.
21	American Samoa	VA will continue to evaluate opportunities to partner with DoD to enhance services to veterans in American Samoa.
21	Travis AFB, CA	VA is proceeding with plans to expand inpatient psychiatry beds for veterans and a joint dialysis unit at Travis AFB.
21	Honolulu, HI	Tripler Army Base will continue a joint venture with VA to provide veterans access to tertiary/acute & specialty services.
21	Monterey, CA	The Palo Alto VAMC will continue development of a joint VA/DoD outpatient clinic at Monterey to provide primary and specialty care services to veterans and specialty care to DoD active duty and Tricare beneficiaries.
22	Nellis AFB, NV	VA will build a new hospital in Las Vegas, but will continue to seek opportunities to pursue collaborations at the MOFH.
23	Offutt AFB, NE	There is a proposal for a contract CBOC on Offutt AFB.
23	Grand Forks AFB, ND	There is a proposal for a CBOC at the Grand Forks AFB as a collaborative sharing agreement with DoD.

APPENDIX B

Priority *OneVA* Collaborations

VISN	Location	*OneVA* Collaboration
1	Newington, CT	VA is developing space at the Newington VAMC for use as a collocated benefits administration office for the Hartford VA Regional Office.
3	Castle Point and Montrose, NY	VA will continue to explore collaborative opportunities for development of land for use as a national cemetery at the Castle Point and Montrose campuses.
7	Columbia, SC	VA will explore the feasibility of collocating the Columbia VBA Regional Office at the Columbia VAMC through enhanced use lease.
8	Sarasota, FL	VA is in the process of identifying a site for establishing a new national cemetery in the Sarasota area and will evaluate the feasibility of potential collocation opportunities within the site selection process.
9	Louisville, KY	VA will study the feasibility of collocating the VBA Regional Office at the potential replacement hospital to be studied for the Louisville VAMC.
9	Mountain Home, TN	VA will plan for the transfer of approximately 50 acres of land from the Mountain Home VAMC to NCA for cemetery expansion.
11	Marion, IN	VA will explore the feasibility of providing additional land at the Marion VAMC to NCA for expansion of the existing cemetery.
15	Leavenworth, KS	VHA will pursue an enhanced use lease project which will provide NCA with additional acreage to expand the Leavenworth National Cemetery.

VISN	Location	*OneVA* Collaboration
15	Jefferson Barracks, MO	NCA will develop a major construction project in collaboration with VHA to transfer land to mitigate the depletion of grave-sites and closure of the Jefferson Barracks National Cemetery.
17	Waco, TX	VA will explore the feasibility of collocating the VA Regional Office in Waco to the grounds of the Waco VAMC.
18	Prescott, AZ	VA will evaluate transfer of land at the Prescott VAMC to NCA for expansion of the columbarium.
20	Roseburg, OR	VA will pursue a land transfer from VHA to NCA to expand the existing Roseburg National Cemetery.
22	Los Angeles, CA	VA will explore the feasibility of collocating the VBA Regional Office at the West LA VAMC.
22	Los Angeles, CA	VA will collocate an NCA columbarium on 20 acres of available land at the West LA campus and pursue additional opportunities for expanding the NCA presence on the West LA campus.
22	Las Vegas, NV	VA will plan to collocate VBA space in the new hospital planned for Las Vegas, NV.
23	Minneapolis, MN	VA will explore the feasibility of collocating the St. Paul VBA Regional Office at the Minneapolis VAMC.

APPENDIX C

Acronyms and Glossary

Acronym	Reference
ADC	Average Daily Census
ACH	Army Community Hospital
AFB	Air Force Base
BRC	Blind Rehabilitation Center
CAH	Critical Access Hospital
CARES	Capital Asset Realignment for Enhanced Services
CBOC	Community-Based Outpatient Clinic
DNCP	Draft National CARES Plan
DoD	Department of Defense
EUL	Enhanced Use Lease
FY	Fiscal Year
GAO	General Accounting Office
GRECC	Geriatric Research, Education and Clinical Center
HCS	Health Care System
ICU	Intensive Care Unit
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LTC	Long-Term Care

Acronym	Reference
MH	Mental Health
MOFH	Michael O'Callaghan Federal Hospital
MOU	Memorandum of Understanding
NCA	National Cemetery Administration
NCPO	National CARES Program Office
NH	Naval Hospital
NH	Nursing Home
NHCU	Nursing Home Care Unit
PL	Public Law
PRRTP	Psychiatric Residential Rehabilitation Treatment Program
PTSD	Post-Traumatic Stress Disorder
RO	VBA Regional Office
SCI	Spinal Cord Injury
SCI/D	Spinal Cord Injury & Disorder
SMI	Serious Mental Illness
SORCC	Southern Oregon Rehabilitation Center Clinic
USH	Under Secretary for Health
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
VRAH	Veterans Rural Access Hospital
VSO	Veterans Service Organization
VSSC	VISN Support Service Center

Definitions

Access Guidelines — Minimum percentage of enrollees living within a specific travel time to obtain VA care. For the CARES process, guidelines were defined as follows:

> *Access to Primary Care:* 70 percent of veterans in urban and rural communities must be within 30 minutes of primary care; for highly rural areas, this requirement is within 60 minutes.
>
> *Access to Hospital Care:* 65 percent of veterans in urban communities must be within 60 minutes of hospital care; for rural areas, this requirement is within 90 minutes; and for highly rural areas, this requirement is within 120 minutes.
>
> *Access to Tertiary Care:* 65 percent of veterans in urban and rural communities must be within 4 hours of tertiary care; for highly rural areas, this requirement is within the VISN.

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.

CARES Commission — A Commission chartered by the Secretary of Veterans Affairs to provide independent and objective review of the DNCP and to ensure that stakeholder views were fully incorporated in the Secretary's CARES decision. The Commission was independent of VA and composed of 16 members, all of whom are veterans advocates and have a thorough knowledge of VA. The Commission's review included site visits, public hearings and meetings, and analysis of comments from veterans and stakeholders.

CBOC (Community-Based Outpatient Clinic) — VA operated, contracted, or leased, health care facility geographically distinct or separate from the parent medical facility.

The Draft National CARES Plan — A plan developed by the VA Under Secretary of Health that aggregated individual VISN market plans into a comprehensive National plan. The draft plan evaluated future demand for veterans' health care services against current supply and realigned VA capital assets in a way that would result in more accessible, high quality health care for veterans.

Enhance Use Lease Authority — Authority that allows VA to enter into agreements with non-government entities for the use of VA space or land for private development, resulting in some form of benefit to the Department of Veterans Affairs and to veterans. This benefit could be in the form of an annual reimbursement, discounted services, or the use of the building the non-government entity would construct.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) — The Joint Commission evaluates and accredits more than 16,000 health care organizations and programs in the United States. An independent, not-for-profit organization, JCAHO is the nation's predominant standards-setting and accrediting body in health care.

Master Plan — A comprehensively prepared vision of improvements to be accomplished on the site. It is commonly developed with a multi-disciplinary team of professionals including architects, engineers, planners, logisticians, cost estimators, schedulers and health care professionals. It can also include strategies for optimizing and managing the transfer of clinical, social, and other services to ensure minimal disruption and maximum utilization of resources. The time horizon and components of a typical Master Plan is dependent upon the scope and complexity of the contemplated work.

Observation Beds — Hospital beds used for short-term inpatient care (less than 24 hours) without counting as a hospital admission.

Planning Initiative (PI) — A VACO-identified future gap, potential overlap in services, large change in demand, or required access improvement for a market area that met specific thresholds and that needed to be resolved.

Proximity — Two or more acute or tertiary hospital facilities with similar missions within close proximity of each other.

Realignments — The DNCP identified facilities that should move services from one facility to another, contract for care to ensure inpatient access as appropriate and in all cases maintain outpatient services in the community.

Small Facilities — Medical centers that have fewer than 40 acute beds projected 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.

Veterans Rural Access Hospital Policy — A new VA policy that will define the appropriate scope of services to be provided at small and rural VA facilities. This policy is expected to be approved in June 2004.

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