Waco Veterans Affairs Medical Center
Waco, Texas
Dec. 18 and 19, 2003

No site description available

2003 CARES Draft Plan Assessment: Current Services will be transferred to other VAMCs and community contracts. Current inpatient psychiatry services will be met primarily at Temple. The VISN will also lease inpatient psychiatry beds in Austin. The balance of inpatient psychiatry, all of Blind Rehabilitation and a third of Waco’s nursing home care services will be transferred to the temple VAMCE. The balance of nursing home care needs will be contracted out in the community. Outpatient services will be transferred to a new location more strategically placed to improve access for patients from both Waco and Marlin. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in local services for veterans.

Funding: Central Texas Veterans Healthcare System increased its collections in FY 03 over the collections in FY 02, $14.8 million versus $11.7 million. Through efforts in hiring and training appropriate staff such as record coders, and obtaining the services of a billing company to train physicians to improve their coding, the entire CTVHCS has enjoyed a 20 percent increase in revenue. Management indicated increased enrollment, coupled with a flat line budget, presents their biggest budgetary challenge. The situation has made the expansion of services very difficult and presents the real possibility that the Health Care System will be unable to accommodate new enrollment. Since 1996, CTVHCS has experienced a 10 percent reduction in full time employees and FY 2004 budget shortfalls reflect a need to reduce another 125 FTE.

Enrollment and Access: The Waco VAMC reports having 17,000 enrolled veterans. Patient demographics at Waco are broken down as follows: 94 percent of the patients are outpatients, 6 percent are inpatients, and only 20 percent of inpatients are residents of the local community. Costs of operating the Waco VAMC range anywhere from $12 to $15 million dollars per year. At VA’s central office request to revise its first plan, the VA CARES planning committee recommended closing the facility by: treating more psychiatric patients as outpatients, in residential care, or with contract services in the local community; transferring about 30 nursing home patients to the Temple VAMC and contracting out the remaining patients to non-VA nursing homes within the local community; referring blind rehabilitation patients to other VA medical centers with blind rehabilitation treatment programs; treat an increasing number of PTSD veterans with Telemedicine; and operating a community based outpatient clinic in the Waco area.

Community Based Outpatient Clinics: There are currently four operational CBOCs in CTVHCS. Panel sizes for all primary care physicians are maintained at 1200 patients per provider. All eligible veterans who seek care at a CBOC are enrolled and are afforded an appointment.
Affiliations and Staffing: CTVHCS experiences considerable difficulty recruiting specialists such as neurologists, pulmonologists, dermatologists, orthopedic surgeons, vascular surgeons, and radiologists.

Physical Plant: VA believes closing the Waco VAMC will prove cost efficient by disposing of a number of old buildings requiring continued maintenance on a large area of land. Management believes WACO is cost prohibitive to maintain. The buildings cannot be demolished on this campus because they are on the national historic register. The Temple campus, over the past four years has demolished over 350,000 square feet of space in old unutilized buildings. The Austin clinic has grown beyond the present capacity available in the existing building. Enrollment continues to increase and has created an additional demand for increasing lease space.

Long Term Care, Mental Health and Homeless Services: The Waco VAMC is a multi-VISN referral facility for chronically mentally ill patients and a national referral facility for blind rehabilitation. It currently operates in-patient services for psychiatric, blind rehab, and nursing home patients. The Waco VAMC also has a 20-bed Post Traumatic Stress Disorder residential rehabilitation program. VA contends advancement in medicine no longer requires the institutionalization of as many psychiatric patients, and, therefore, the old Waco buildings and property are no longer needed.

Patient, Family and Employee Survey: None available.

El Paso Health Care System

El Paso, Texas
Feb. 11 and 12, 2004

The El Paso Health Care System provides primary and specialized ambulatory services to veterans in the El Paso area and surrounding counties and operates a CBOC in Las Cruces, N.M. There are also CBOCs in Alamogordo, N.M. (contractor operated and currently managed by Albuquerque VAMC), and in Silver City, N.M. (VA operated and currently managed by Albuquerque VAMC). The main, El Paso facility, opened in October 1995 and consists of 254,000 square feet in a four-story building. Inpatient care for acute medical and surgical emergencies is provided through an extensive VA/DoD sharing agreement with William Beaumont Army Medical Center. It has an eight-room ambulatory surgical suite located on the fourth floor. El Paso VAMC provides administrative support to a veterans outreach center and to the Fort Bliss and Fort Bayard National Cemeteries.

2003 CARES Draft Plan Assessment: The VISN 18 Executive Summary for El Paso Health Care System calls for expansion of the joint venture with William Beaumont Army Medical Center in El Paso and the expansion of the existing CBOC in Las Cruces, N.M.
**Funding:** The El Paso Health Care System’s FY 2002 budget was $49.7 million. In FY 2003 it was $57 million, with 21,242 unique patient visits that year – a 15 percent increase. MCCF collections in FY 2003 were $4,074,358, or 82 percent the $4,957,369 goal established by central office and the VISN. The FY 2004 goal is $4,984,560 – 5 percent over last year’s goal, and 22 percent above the actual amount garnered in 2003. It appears unlikely that El Paso will meet this new goal, though they have hired two new temporary employees for accounts receivable. A contractor on the VISN level assisted with collections, and has requested a clinical coordinator to assist with insurance denials. El Paso did not have to use capital investment dollars to supplement medical care. VAMC management sees its major fiscal challenge to be providing a spectrum of services when they are not an inpatient facility and must fee-out for services, most notably from WBAMC. Costs for sub-specialists tend to run higher than might be expected due to a lack of competition in the El Paso area. Finally, there are an unusually large number of non-service connected patients without insurance while the Millennium Bill has significantly increased expenditures.

**Enrollment and Access:** The El Paso VAMC market penetration was 31 percent in 2001. Management says there are no veterans waiting beyond 30 days for their first primary care appointment, and all follow-ups are based on patient need, with negligible waiting times. Of 21,553 enrollees, 19,052 or 88 percent are enrolled to receive primary care. The number of Priority Group 8 denials since the January 2003 cutoff is 925. According to Chief of Staff Dr. Steven Shapiro, a major challenge for El Paso in the near future will be the return of the Reserve and Guard units from Iraq and Afghanistan. These numbers are expected to be substantial because of the heavy military presence in the area and the Congressional mandate to provide medical care for these returning veterans for a period of two years after discharge.

**Community Based Outpatient Clinics:** El Paso operates one CBOC in Las Cruces, N.M., about an hour’s drive to the northwest. At present, the clinic is close to capacity but plans to expand into a new, adjoining building. This will allow the CBOC to add two new examining rooms with an RN and an LVN (plus an itinerant phlebotomist from El Paso). Mental health coverage has been increased at the CBOC. At present, a social worker spends 80 percent of his time there, and a psychiatrist comes in two days per week. At the time of the Task Force visit there was no physician on staff. A physician, Dr. Eaton, however, is slated to start shortly.

**Affiliations and Staffing:** The El Paso Health Care System is affiliated with Texas Tech University School of Medicine; New Mexico State University; Our Lady of the Lake in San Antonio (Social Work); El Paso Community College; and the University of Texas. Texas Tech, a two-year institution, is planning to become a four-year medical school by 2007-2009. Texas Tech presently has a residency program with WBAMC. The most critical affiliation, however, is between DoD and WBAMC, which provide inpatient and surgical support for El Paso VA. Since DoD and VA facilities abut each other and tend to flow together, it is difficult to see where one begins and the other leaves off. WBAMC can even access and input the VA’s CPRS system, though further IT expansion between VA and WBAMC is described as absolutely critical. In the area of
mental health, WBAMC is becoming increasingly important. VA manages an 18-bed ward – soon to be expanded to 22. The present commanding officer, Colonel Mitchell, leaves in August and VA is pushing to complete the move before a new CO arrives. The new CO may have a different agenda and the partnership works only when the regularly rotated CO’s want it to work. Dr. Cynthia Rivera, chief of behavioral health will manage her new unit with one military and one VA psychiatrist. We are headed toward a federal hospital paradigm, she says. The most difficult specialties to recruit are: cardiologist, radiologist and orthopedic surgeon. This is in large measure because of the disparity between VA’s wage scale for the top specialists and the market scale. In the non-specialty clinical areas there are also difficulties in recruiting and retaining medical instrument technologists (i.e. for diagnostic ultrasound), pharmacists, nurse practitioners, and according to Bonnie Baxter, chief of nursing and patient services, LVNs, where two positions remain vacant. The problem with recruiting and keeping nurses, according to Baxter, is the lack of appropriate pay at the higher levels. Presently there are no employees with J-1 Visas. Fee/contract physicians are used in the following specialties: cardiology, colonoscopy, OB/GYN, internal medicine (C&P), radiologists and sleep lab technicians.

Physical Plant: According to management, physical plant issues are minimal since VA opened its present building in October 1995. Management has put aside $1.7 million for non-recurring maintenance funding for FY ‘04, which is considered adequate for their needs. A 2,800-square-foot addition is contemplated for mental health expansion. However, expansion out of the present building is the long-term goal. According to Director Byron Jaqua, VA will “have to expand out of this building.” Though the partnership with DoD has served VA well in the past, the consensus in El Paso is that with present growth trends VA will eventually need an expanded, perhaps tertiary facility. “We need to have a hospital here” according to Dr. Rivera. At present, WBAMC has lost one third of its staff to overseas deployments (160 to Iraq), forcing VA to send many patients who would normally receive surgery at Beaumont to the community instead. Further, restricted access to WBAMC because it is on a military installation could potentially create a problem for emergency cases transported by ambulance particularly during military alerts.

Long Term Care, Mental Health and Homeless Services: All inpatient mental health patients are slated for the new 18-22 patient ward being completed this summer at WBAMC. Mental health at El Paso has changed significantly in the past five years with the number of uniques and encounters growing at about 8 percent annually in that period. Many changes are the result of a drastic reorganization of the service and the loss of seasoned staff due to retirements and illness. Despite reduction in senior staff, mental services have been expanded through: increased mental health services at Las Cruces CBOC, serving veterans closer to their homes; addition of three telemedicine clinics staffed by two psychologists and one psychiatrist; utilizing video teleconferencing (V-Tel) equipment for long distance inpatient admissions; developing several different therapy groups including a depression group, bereavement group and a stress and sugar group (Diabetes patients with mental health issues); increased military sexual trauma (MST) services with both male and female MST coordinators; increased substance abuse
services with weekly joint patient staffing and a contracted residential drug and alcohol facility (Alivane, Inc.) to provide better support of treatment efforts; and an increase of monitoring and continuity of care, and improvements in internal/external referrals.

Patient, Family and Employee Surveys: None available.

Grand Junction Veterans Affairs Medical Center
Grand Junction, Colo.
Feb. 13, 2004

The Grand Junction Medical Center is a 58-bed (authorized), primary and secondary care facility serving a veteran population of 37,000 in the Western Slope of the Colorado Rockies, including southeastern Utah. It provides acute medical, surgical and psychiatric inpatient services as well as a full range of outpatient services. Specialized programs include a mental health care center, same day surgery, observation beds, mobile MRI imaging and mobile lithotrypsy. Care is also provided, when needed on a fee-for-service and contract basis, including radiation therapy and other specialized procedures. In 1999 the VAMC was the recipient of the Robert W. Carey Quality Award. The VAMC has also been host to the National Disabled Veterans Winter Sports Clinic since 1986. The week-long annual clinic offers disabled veterans opportunities to experience and learn downhill and cross-country skiing, rock climbing, scuba diving and various other sports and educational activities.

2003 CARES Draft Plan Assessment: The VISN 19 Executive Summary for Grand Junction, CO calls for conversion to a critical access hospital which means a mission change might cause the medical center to close down the intensive care unit. It might also limit the amount of inpatient care to less than four days, as well as a possible limitation on the medical center’s already limited emergent care.

Funding: VAMC Grand Junction’s FY 2002 budget was $33.0 million. In FY 2003 it was $35.8 million, an 8 percent increase. The Medical Center has been able to maintain FY 2002 levels of service, open enrollment and staffing levels with the FY 03 budget. MCCF collections in FY 2003 were $3,558,583 of a $3,275,764 goal (8.6 percent better than goal). FY 2004 goal is $3,777,223. Management feels that it can meet that goal. They have not had to use capital investment dollars to supplement their medical care budget. VAMC management sees its major fiscal challenge as maintaining appropriate staffing levels within budget “while continuing to provide excellent patient care second to none.” Of course, as elsewhere, the perennial lateness of the VA Budget creates uncertainty and operational problems.

Enrollment and Access: Management states that there are presently 604 veterans who are waiting beyond 30 days for their first primary care appointment. All follow-up appointments are made per provider request. At present 57 percent of hospital admissions are made through the emergency room. Of the 9,198 veterans seen in FY 03, 7,689 (84 percent) are assigned to a primary care provider. At present there is no wait for
appointments and no waiting list. Since the January 2003 cutoff of new Priority Group 8 veteran enrollees, 314 veterans have applied. Management has not calculated the lost income this represents.

**Community Based Outpatient Clinics:** Grand Junction has one CBOC located at Montrose, Colo., located 65 miles to the southeast. It is nearing capacity. Present enrollment is approximately 800. The waiting times are well within the 30-day period prescribed.

**Affiliations and Staffing:** No major medical school affiliation, though the VAMC has affiliation agreements with a number of institutions in Colorado and neighboring states and North Carolina. On occasion they have a Colorado University Medical student. They keep in touch with the State Veterans Home in Rifle, Colo., (“We try to keep the communication open”). They also have Mesa State nursing students as interns. There are no J-1 Visa physicians at the present time. The VAMC is presently seeking to recruit an internal medicine physician. They are in the process of recruiting a surgeon and psychiatrist. In years past they had the greatest difficulty in recruiting for an oncology/chemotherapy nurse, requiring the VAMC to discontinue chemotherapy. Also difficult to recruit are LPNs, HR specialists, administrative service chiefs, coders and pharmacists. The VAMC uses a number of hiring incentives to aid recruitment including a relocation/recruitment bonus, relocation expense, and an employee debt reduction program.

**Physical Plant:** To expand existing space they hope to add a third floor to their outpatient building by 2007. Management is also contemplating a new Operating Room and Surgery Center. The physical plant is aging and suffers from a number of deficiencies. The boilers are “close to replacement.” The facility is at present converting to chill water-cooling, which is being done in stages due to cost. The computer room will need to expand as will its inadequate cooling system. Windows should be replaced in quantity and the façade of the main building needs to be refinished. On buildings 20, 7, and 34 the roofs must be replaced. Living quarters need to be demolished “to meet current codes.”

**Long Term Care, Mental Health and Homeless Services:** Grand Junction VAMC has a 30-bed transitional care unit and an additional three contract nursing homes that presently accommodate 10 VA patients. The VAMC level of long-term/extended care has remained the same since the passage of the Millennium Health Care and Benefits Act of 1999. The mental health program has experienced little change in inpatient workload, though the outpatient program has grown significantly. Intensive case management program has been “extremely successful” according to management and has improved its continuum of care. An increase in the PTSD clinical team program was mandated to require a charge nurse for the psychiatric unit (3P), upgrading of instruction for nursing staff and new computer software: all of which have been helpful in improving VAMC efficiency according to management. In the future, Grand Junction is considering an Alzheimer’s unit for its hospital. The question is presently under review for feasibility. Grand Junction VAMC has a Homeless veterans project with two other local agencies to
provide permanent supported housing for eight veterans. Homeward Bound of the Grand Valley will provide case management. VA will coordinate and provide medical and psychiatric care for the veterans. The program will accept the first veterans the second half of 2004 for the first four units. The second four units will be ready for occupancy early next year.

**Patient, Family and Employee Surveys:** None available.

**San Francisco Veterans Affairs Medical Center**

**San Francisco, Calif.**

**Dec. 4, 2003**

The San Francisco VA Medical Center is a major tertiary care referral center with 124 acute care beds. It is known for state-of-the-art acute medical, neurological, surgical, and psychiatric care. It has 400 employees in its research programs, which use VA and outside grants. The facility has the only VA system 4 Tesla MRI machine (under installation). The new MRI will be used to detect potential strokes in the brain and to possibly detect the onset of Alzheimer’s and delay its onset. The San Francisco VA saw 40,337 uniques in FY 2003, an increase of 1,771, or 4 percent, over FY 2002. Patient satisfaction is 87 percent for new primary care and 86 percent for established primary care.

**2003 CARES Draft Plan Assessment:** The VISN 21 Market Plan Summary for San Francisco VAMC calls for services to be consolidated at San Francisco including clinical, administrative and reproduction services. Clinical services to be transferred include: Parkinson’s Disease and epilepsy surgery and Brain Mapping, part of neurosurgery including stereotactic radiosurgery (including Gamma Knife), brainstem auditory evoked responses; somato-sensory evoked potentials, all surgery requiring intra-operative spinal cord and root monitoring, electronystagmographs, brachytherapy for prostate cancer, endovascular, embolism of AVM, Mohs surgery, portions of radiology including neuroradiology through increased use of PACS, and all dental surgery including dental implantology, and portions of laboratory services. Expansion of existing CBOCs is planned including a multi-specialty expanded CBOC in the Central Valley and a new CBOC (supposedly near Fremont).

**Funding:** VAMC San Francisco’s FY 2002 budget was $183 million. In FY 2003 it was $202 million, an increase of 10 percent. According to management, these budget levels allowed the VAMC to maintain previous levels of service as well as staffing levels. MCCF collections were $4,822,000 in FY 2002 and $6,779,000 in FY 2003 an increase of 41 percent. The FY 2003 collections slightly exceeded the year’s goal of $6,751,333. The FY 2004 goal is $7,909,501. Management feels it is “on track to reach this goal.” To improve its collections, the VAMC has: upgraded its insurance identification using a contract with Siemens which matches patient names to current insurance policies; added agencies to assist in unpaid outstanding insurance claims when there has been no response from insurers for 60 days; brought in additional patient accounts staff; and developed an active VISN-wide effort to identify best techniques for billing and
collections. Major budgetary challenges include raising the necessary funding for the
critical seismic corrections for the old, outdated main hospital building, and the
inordinate expense required to recruit and retain staff in this very high-cost area (and the
VAMC is still not keeping up with community salaries for physicians, nurses and
technologists).

**Enrollment and Access:** Management states that it has no patients waiting beyond thirty
days for a primary care appointment, or for follow-up appointments (as of November
2003). This includes patients not only at the San Francisco VAMC, but also at two
CBOCs – Eureka and Santa Rosa. The third CBOC at Ukiah has space problems that are
being addressed.

**Community Based Outpatient Clinics:** The VA has four CBOCs, three staffed by VA,
and one contract. The Ukiah CBOC is maxed out for patients and efforts are underway to
expand the facility. A new CBOC is planned for South San Francisco, in San Mateo
County just south of the City and County of San Francisco. It is planned to open in
December and will relieve pressure on primary care at San Francisco VAMC (it is also a
little more convenient for people in southeastern San Francisco to get to). Mental health
staffs are on duty at all four CBOCs. San Francisco’s CBOCs are far-flung. Though Santa
Rosa is in the far northern suburbs, Eureka is about a six-hour, tortuous drive north from
San Francisco with Ukiah about halfway. There is a VA-run free bus service, but during
the site visit, management was encountering problems with the small vans that serve as
buses and which VA’s Central Office now considers potentially hazardous. More
critically, the San Francisco VAMC and the large Menlo Park and Palo Alto facilities to
the south are all on the west side of San Francisco Bay while, the greater part of the San
Francisco Bay Area’s veteran population is east of the Bay. The East Bay must survive
with just a couple of clinics, which paradoxically are under the jurisdiction of the
Sacramento VAMC, even though the two large clinics in Oakland are only a fifteen-
minute trip by rapid transit from downtown San Francisco. There is not a single clinic on
the eastern littoral of San Francisco Bay between Oakland and San Jose, a good two-hour
or more car trip. This region is almost entirely part of Alameda County with 100,410
veterans (per 2000 Census) versus the 96,419 veterans (per 2000 Census) in the two
counties between San Francisco and the San Mateo/Palo Alto medical centers in the West
Bay. And the East Bay’s vets are more likely to need VAMC services than the West Bay
veterans. Clearly the more populous – and poorer – East Bay is underserved, especially
when one considers the difficulty of transiting the three long, packed toll bridges that link
the two shores. Though the CARES plan calls for a CBOC in Freemont (just north of San
Jose) to replace Livermore, the proposal’s language seems tentative. If Livermore does
close as planned, an even greater amount of medical services will have moved to the
West Bay with or without Fremont. Interestingly the one new CBOC planned, for South
San Francisco, will also be in the West Bay corridor.

**Affiliations and Staffing:** The San Francisco Medical Center has been affiliated for
over 30 years with the University of California, San Francisco School of Medicine, one
of the top medical schools in the country. The affiliation with the UCSF School of
Medicine is integral to the success of the VAMC. VAMC and the UCSF School of
Medicine jointly recruit physicians. The VAMC has 128 residency positions covering all specialties, except obstetrics, pediatrics, and family practice. San Francisco VAMC is a major teaching hospital, providing about one third of all medical student clinical training. The VAMC has the second largest funded research program in the VHA with a $54 million annual research budget. The VAMC has three (the maximum) Medical Science Research Enhancement Award Programs – neurology, prostate cancer and bone research, and one HSR&D REAP in aging research. The research program includes seven core facilities: clinical research center, animal care facility including transgenic mouse facility, cell imaging core, molecular core, proteomics core, brain imaging center, and echocardiography core. Recruitment and retention are major issues with the VAMC primarily due to the high cost of living in the San Francisco area and VA salary scales versus those offered locally, especially by the University of San Francisco Medical School. Additionally a serious nursing shortage is being experienced nationwide. However, capital asset funding has not been used for personnel purposes. The annualized cost of bonuses for FY 2003 was $1,199,983 with $960,953 used for retention and $239,030 for recruitment/relocation. Professional staff desires to be on a par financially with the senior medical staff at the university, not at assistant professor levels. RN shortages have caused staffing difficulties in inpatient units, in ICU, TCU and OR.

Physical Plant: As an older structure and one in a severe earthquake zone, San Francisco VAMC has a host of physical plant issues, some of them critical. There are serious seismic deficiencies in the main hospital building and four other, smaller buildings nearby. Ancillary concerns include elevator upgrades, two new emergency generators, improved street lighting and a more modern fire alarm system. There is also inadequate space to accommodate all clinicians on duty (i.e. a dearth of exam rooms). Finally parking capacity is extremely limited. A $41.1 million seismic upgrade is in the design stage. The design development contract has been awarded and “the work is proceeding smoothly” according to management. It is obvious that these upgrades and repairs must have top priority in VA; the funding for the construction and completion of the upgrades was dropped from the FY 03 budget. On a list of Seismically High Risk buildings throughout VA, Building 203 (San Francisco VAMC’s main building) was ranked number one.

Long Term Care, Mental Health and Homeless Services: The average daily count for the VAMC’s VA-staffed nursing home is 104 with a target of 108. At the beginning of FY 2004 there were 43 veterans in contract nursing home beds. The VAMC has 25 psychiatrists on duty and the Chief of Mental Health Service, Dr. Charles Marmar suggested that mental health was “better off” not being included in the CARES process because it would have been shortchanged in some manner. They have expanded access to veterans in the community and assured continuity of care by developing mental health services in all three CBOCs: in Santa Rosa, Ukiah and Eureka, including specialized PTSD and substance abuse services. The VAMC established comprehensive mental health services for homeless veterans at 13th and Mission streets (the run-down “Mission District”), including alcohol and drug abuse clinics, clinics for homeless and other inner city veterans with chronic serious mental illness, and PTSD clinics. They set up a Mental Health Intensive Case Management program for chronic and severe mental illness to
reduce incidence and prolongation of hospital stays. The VAMC has established a 12-bed short stay locked unit for SMI cases, a 16-bed general psychiatry Partial Hospitalization Program and a 24-bed substance abuse day hospital. There is also a transitional community care team to insure continuity of care as patients move from inpatient to outpatient care. They have created a new geropsychiatry program to provide assessment and treatment for veterans with memory disorder, late life depression and late life addiction, and to provide comprehensive mental health service to nursing home residents. Expanded consultation services by creating outpatient mental health clinics inside primary care, merging medical and mental health care. The VAMC trained over 300 psychiatry residents and 300 medical students in the recognition and treatment of veteran specific mental health problems. Conducted original research on the causes and treatment of combat related PTSD, addiction, dementia, schizophrenia and bipolar disorder. Twice awarded a VA Center of Excellence in PTSD, one of only two such programs in the nation.

Patient, Family and Employee Surveys: None available.

VA Palo Alto Health Care System
Palo Alto, Calif.
Dec. 5, 2003

The VA Palo Alto Health Care System (VAPAHCS) is a major tertiary referral center with three hospital-based divisions serving the VA Sierra Pacific Network (VISN 21). The Palo Alto Division is home to one of the most sophisticated tertiary care centers in the Veterans Health Administration All acute care, acute inpatient psychiatry, spinal cord injured, rehabilitation medicine, blind rehabilitation and hospice services are located at PAD. The Menlo Park Division, located seven miles to the North, provides both inpatient and outpatient comprehensive domiciliary care, mental health, Post Traumatic Stress Disorder and long-term geriatric care. The Livermore Division, located forty miles East of Palo Alto, provides sub-acute and geriatric inpatient services as well as primary, subspecialty and ancillary outpatient services. In recent years, VAPAHCS has made significant efforts to provide ambulatory care services within each of its 10 county catchment areas. Currently, VAPAHCS operates six CBOCs. These outpatient clinics are located in San Jose, Monterey, Capitola, Modesto, Stockton and Sonora. VAPAHCS operates a total of 903 beds including a 100-bed domiciliary, a 112-bed acute psychiatric facility, a 125-bed geropsychiatric nursing home, a 43-bed spinal cord injury center, a 32-bed Western Region blind rehabilitation center and a total of 245 skilled nursing home care beds at the Menlo Park and Livermore divisions. VAPAHCS operates a number of special regional referral and treatment centers including a spinal cord injury center and a Western Region blind rehabilitation center. Other major referral programs offered include cardio thoracic surgery, PTSD and homeless veterans rehabilitation. VAPAHCS operates one of the largest TRICARE programs in VA. VAPAHCS manages one of six mental illness research & education clinic centers in VA. VAPAHCS is also home to one of four patient safety centers of inquiry and the Center operates two state-of-the-art simulation centers. In 2002, VA awarded VAPAHCS six "Centers of Excellence" Awards
recognizing the autopsy program, domiciliary care for homeless veterans program, AIDS program, spinal cord injury and disorders program, comprehensive medical rehabilitation program and cardiac surgery program. VAPAHCS maintains one of the largest research programs in VA with extensive research centers in geriatrics, mental health, Alzheimer's disease, spinal cord regeneration, schizophrenia, rehabilitation research and development center, HIV research and a health economics resource center. VAPAHCS has one of four cooperative studies program coordinating centers and a program evaluation & resource center.

2003 CARES Draft Plan Assessment: The VISN 21 Executive Summary for The VA Palo Alto Health Care System calls for current nursing home services at Livermore to be transferred to Menlo Park campus and contracts in the community. Outpatient services are proposed to transfer to an expanded Central Valley CBOC and a new East Bay CBOC closer to where the patients live. Both CBOCs will offer primary care, specialty services and mental health services. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans. Services to be consolidated at Palo Alto included the following: administrative services: warehousing operations, disposal of government property program, recycling program, management of grounds and transportation services, prosthetics & sensory aids purchasing agents, IRM help desk and police training. Increasing primary care demand in all six markets, to include The Palo Alto Health Care System, is being met primarily through expansion of existing CBOCs, as well as increasing services at parent facilities. In some cases expanded hours are planned to increase capacity. Increasing specialty care demand in all six markets, including Palo Alto, is being met by using in-housing expansion (new construction, renovation and leases), utilizing telehealth options for select clinics and offering selected high volume specialty care services on-site at larger CBOCs. Decreasing demands in surgery in the South Coast Market is being managed by reducing in-house services at Palo Alto. The VISN is pursuing the following enhanced use lease opportunities: Joint venture for ambulatory and long-term care with Alameda County and assisted living facility at the Menlo Park Division of Palo Alto Health Care System. The VISN has also proposed seismic construction projects at facilities in Palo Alto and Menlo Park among other facilities within the VISP.

Funding: FY 2002 budget was $351,427,000. The FY 2003 budget was $379,162,000, an increase of about 8 percent. FY 2004 incorporates projections but is expected to be $407,502,000, an increase from FY 2003 of 7 percent. MCCF goal for FY 2003 was $12,899,182. Total collections for FY 2003 were $13,551,363. MCCF collections goal for FY 2004 is $15.4 million and they expect to reach that goal. Capital funds were used to support furniture purchases, which in previous years was funded from operating dollars. VAPAHCS has an active medical care cost fund steering committee that continually analyzes and corrects deficiencies in our documentation, billing, and collection methods. However, the major barrier to VAPAHS collecting more of the amounts billed pertains to the inability to collect from certain HMOs who refuse to acknowledge VAPAHCS as an approved provider in their plan. Many of the veterans
billed are over age 65; this automatically reduces the amount VAPAHCS can collect from those veterans’ insurance carriers. Some major budgetary challenges Palo Alto faces are having adequate budget increases to support competitive salaries in such a high cost of living area. When salaries are not competitive we often need to hire the staff on contract, which often is twice the salary costs if we were unable to hire the staff such as radiologists, specialists in surgery, technicians for radiologists and nuclear medicine. Another budgetary concern is having adequate increases to satisfy annual pay raises, retention, allowances, and recruitment bonuses to continue to retain and attract highly qualified staff.

**Enrollment and Access:** There are approximately 900 patients waiting more than one month for a new patient appointment. This number is likely an over-estimation as it includes patients who have chosen to switch providers or sites of care. These patients are given 40-minute appointments with their new provider and in this respect appear as new patients. No patients wait greater than 30 days for a follow up appointment. The major portion of the veteran population in the Bay Area using Livermore or even facilities west of San Francisco come from the East Bay and Central Valley population centers. Only an estimated 4,000 to 5,000 veterans out of 12,000 unique patients, total (FY 2003) come from the Livermore area. VAPAHCS has 74,257 veterans enrolled with a market penetration of about 24 percent. FY2002 outpatient visits totaled 508,861 in primary care, specialty care and mental health. All CBOCs have VA mental health staff.

**Community Based Outpatient Clinic:** Currently, VAPAHCS operates six CBOCs. These outpatient clinics are located in San Jose, Monterey, Capitola, Modesto, Stockton and Sonora. Two new CBOCs are planned, one in East Bay between Oakland and San Jose and the other in the Great Central Valley south of Sacramento and east of the San Francisco Bay Coastal Range. Capitola is at capacity. This site is limited in size as it is collocated within the Capitola Vet Center. There are no plans to expand this site. This site was established to be a joint venture with the CVC. To expand the site would require ending the relationship with CVC and would require a large influx of resources. The Capitola Clinic is located between the large CBOCs in San Jose and Monterey. The clinical space in the Monterey Clinic was recently expanded by 30 percent. Principles of Advanced Clinic Access have been employed at all the CBOCs in dealing with delays in appointments. Additionally, new providers have been added at Monterey, Modesto, Stockton, and San Jose within the past year and are currently building up their panels. This will help correct any deficiencies between supply and demand. All CBOCs are moving toward a patient driven scheduling system. In this system the physician identifies the time frame for appointments but the patient chooses the date and time.

**Affiliations and Staffing:** VAPAHCS has active affiliations with Stanford University School of Medicine. Over 1,300 University residents, interns, and students are trained each year. VAPAHCS has 80 affiliation agreements to train health care professionals in disciplines to include: anesthesia, audiology and speech pathology, chaplain, dental, HSR&D, medicine, nursing, nutrition and food, optometry, pathology and laboratory, pharmacy, physical medicine and rehabilitation, podiatry, psychology, social work and blind rehabilitation. Staffing levels in FY 2003 were essentially the same as levels in FY
2002. Due to a lack of competitive salaries in some areas VAPAHCS has needed to resort to substantially more expensive staff contracts for anesthesiology, general and interventionist radiologists, cardiothoracic, vascular, and neurosurgeons, and technologists for radiology and nuclear medicine. VAPAHCS has also experienced difficulty in recruitment for highly qualified candidates for middle management positions in many of the administrative areas.

**Physical Plant:** VAPAHCS has several buildings with serious seismic deficiencies. They include (in order of severity of seismic deficiencies): Building No. 2 within the Palo Alto Division, which houses acute psychiatric inpatients; Building No. 324 at the Menlo Park Division, which houses geropsychiatric long term care inpatients; Building No. 4 at the Palo Alto Division, which houses clinical research; Building No. 205 at the Menlo Park division, which houses the Cooperative Studies Research Program; and Building No. 6 at the Palo Alto Division, which houses administrative services. VAPAHCS has repeatedly submitted major construction project applications to correct the seismic deficiencies in Buildings No. 2, 4, 324, and 205.

**Long Term Care, Mental Health and Homeless Services:** Prior to the Millennium Health Care and Benefits Act of 1999 the number of long-term/extended care beds within the VAPAHCS was 393; today there are 454 such beds within VAPAHCS and 43 veterans in contract nursing home beds. The Menlo Park division has a 50-bed homeless veterans rehabilitation domiciliary, which has been designated as a national program of excellence. It is a comprehensive long-term residential program designed to end the cycle of homelessness by working intensely with homeless veterans to try and help them learn how to live their lives in a more positive way. This includes learning communication and coping skills, vocational training, cognitive behavioral therapy, as well as learning how to take personal responsibility. The program has been in existence since 1988 and has been extremely successful. There is also a health care for homeless veterans contract and per diem program. The primary function of this program is to oversee four different grant and per diem transitional housing facilities located through out their catchment area. The sites are: Clara Mateo Alliance, Homeless Vets Housing (both located on the grounds of the Menlo Park Division), Veterans Transition Center (located on the grounds of Fort Ord, which is where the Monterey Clinic is located), and Native Directions (located in the San Joaquin Valley). Between these four GPD facilities there are 134 beds funded. The primary services that the HCVH program provides are: clinical assessment and referral to needed medical, psychiatric, and substance abuse services; long-term sheltered transitional assistance, case management, and rehabilitation; employment assistance in conjunction with VA and non-VA programs, and information and referral. The HCHV also has strong ties with the local county homeless coalitions and is involved with their continuum of care efforts in securing funding from other federal and local agencies.

**Patient, Family and Employee Surveys:** Information not available.