VISN 1………………………………………………………………………………
Togus VA Medical Center (Augusta, ME)
Providence VA Medical Center
Connecticut VA Health Care System (West Haven VA Medical Center)
Manchester VA Medical Center
The Togus VA Medical Center is a primary and long-term care facility that provides inpatient and outpatient health care services. Outpatient care is also provided at five Community Based Outpatient Clinics (CBOCs) in Bangor, Calais, Caribou, Rumford and Sanford, and at a Mental Health Clinic in Portland, Maine’s largest city. With 67 operating beds, Togus provides general medical, surgical, intermediate and mental health beds, plus a 100-bed Nursing Home Care Unit (NHCU) consisting of 50 skilled and longer stay beds, and a 50-bed Dementia Unit. Encompassing over 500 acres with pond and natural woodlands, Togus is the oldest veterans facility in VA, dating back to 1866. The site includes a National Cemetery with 5,373 burial sites, the first burial being in 1867 and the last in 1961. Finally, the VA Regional Office for the State of Maine is collocated on the Togus campus, not far from the VAMC’s main administration building.

Fiscal Togus’s budget for FY2005 was $150 million. In FY 2006, it was $153 million, an increase of only 2%. Though management states in the questionnaire that it was able to actually increase the center’s FTEE slightly from FY2004 to FY2005 (following another hiring freeze), Togus FTEE has subsequently been trimmed by 3%. The problem is that, unlike much of New England, Togus has experienced significant patient growth over the years, but with only sporadic increases in resources.

The MCCF collection goal for FY 2005 was $11.2 million, which they exceeded by 15%, collecting $12.9 million. Of course, after that strong showing last year, the medical center found itself, this year, with an increase in its goal of almost one third, which they predict they can meet—but “with considerable effort.”

As detailed below, Togus has consistently been forced to utilize the capital investment fund to provide monies for daily operations of the VAMC.

Enrollment and Access The funding shortfall (above) clearly has had a tangible and malign result in waiting times:

In the case of urgent/emergent situations, veterans can be seen in a specialty clinic the same day of request or within a week. For non-emergent, routine care, SC [Service Connected] veterans can be scheduled in most clinics within 30-45 days; NSC veterans may be seen within the same time frame, but no more than 120 days. NSC veterans may not be able to be seen and are notified that they are being placed on a wait list and may wish to seek care in the community. These areas include: Ophthalmology; Orthopedics, and Urology. We have recently hired a new Urologist, which will eliminate the wait list in this specialty. We are in the process of obtaining locum tenens providers for
Ophthalmology, and Orthopedics to reduce our backlog...Until this additional staffing comes on board, we are referring care to the community. (From Mail Out Questionnaire, January 6, 2006).

The question of access remains a difficult one for any region with such a spread out and sparse population, particularly in Maine’s far north and eastern parts, making Telehealth a potential boon for Togus—with some 72 patients now enrolled in the program. The goal for FY 2006 is 148 (out of a total VISN goal of 220). Telehealth’s high-tech telephony consists of a phone set with video hook-up, along with ancillary equipment to record blood pressure etc. Provided by VA’s prosthetics service at about $3,000 per unit, these units may pay for themselves in increased convenience and service to the veterans and in reduced costs for VA. Hopefully, these units will decline in cost as they are produced in volume.

CBOCs There are five CBOCs in Maine: at Caribou, Bangor, Calais, Rumford, and Saco, plus a mental health center in Portland. All are VA-run and are at or near capacity, especially Bangor—which is also the largest CBOC in Maine. Plans are underway for a new “satellite” site, as well as a future CBOC (date unspecified) for the twin cities of Lewiston/Auburn on the Androscoggin River.

Affiliations and Staffing The Togus Medical Center is affiliated with the Henry Ford Hospital System in Detroit for rotations in urology. Students in psychiatry, clinical psychology, and dentistry also complete rotations at Togus. Additional affiliations include a variety of programs with the University of New England, the University of Rhode Island, University of North Carolina, University of Maine (Orono and Augusta), Southern and Central Maine Technical Colleges, and Northeastern University and others.

The straitened funding at Togus comes with a VISN mandate to reduce the Medical Center’s workforce, which has declined (in cumulative FTEE) 3% comparing FY 2005 to FY 2006 up to now. This loss particularly impacts maintenance, not surprising given Togus’s ravaged maintenance budget. Dietary personnel are also seriously impacted. Nursing staff has suffered, with double shifts becoming more common. The “impact on morale and the sense of support from the VISN” has been highly negative according to management, who also pointed out that Togus ranks third in the eight-facility VISN in terms of number of veterans served.

Physical Plant Though the oldest facility in VA, Togus wears its age gracefully, mainly because very few buildings date back before the 1930’s and VA has had a large modern addition built some years ago. But the considerable maintenance required for some of these older buildings has been monumentally neglected, with management citing $61 million in deferred maintenance. This shortfall, along with the rationing of medical care, is simply the most obvious and disturbing sign of the serious lack of funding Togus has suffered over the last several years.

Areas most urgently requiring work according to management are: “remediation of structural deficiencies, masonry restoration, roof repairs, reconstruction/repairs to roads
and parking lots.” Despite Togus’s enormous campus, parking is a real problem. This problem grows out of the surprisingly high cost of building new parking spaces and from the additional red tape mandated by VACO.

**Long Term Care, Mental Health and Homeless Services** Management states that long term care bed numbers are unchanged since the passage of the Millennium Act in 1999 with 100 NHCU beds still authorized. Unfortunately 25 of those are out of commission due to lack of staff; out of the remaining 75 beds, only 65 are actually filled, ostensibly due to a lack of demand.

The NHCU is divided into skilled and longer stay beds, and a separate Dementia Unit, including a locked unit on the third floor. Of the 50 authorized beds in the Dementia Unit, only 25 are filled; of the 50 beds authorized for the skilled and longer stay beds, 40 are presently filled. In Wing 73, Togus is looking to “specialize” end-of-life care. They have made a particular effort to provide a more “family-friendly” environment, with 15 overnight beds provided for family members.

The Mental Health clinic at Togus consists of a staff of four psychiatrists, and one mid-level physician’s assistant (PA), with one more PA in the process of being hired. The unit has 16 beds, both acute and hybrid, and an Average Daily Census of 14-16. About a third of admissions are for the detox program. There is also a small outpatient addiction services program with a Subaxone (Buprenorphine) function in the Portland Mental Health Clinic. The Mental Health clinic also features a PTSD program with a 30-day intensive six-hour per day program staffed with two PhD psychologists. Returning combat veterans number some 500, with 125 of those enrolled in mental health. All returning veterans are provided rapid access to all services with no significant wait for appointments.

A new program was recently instituted, called rather ominously “Dirigo” (“I direct,” which is the state motto). This is a new recreation center that provides a positive partnership of VA staff and volunteers, and provides a welcome outlet for Togus patients. It opened with a full course Christmas Dinner on December 15, followed a few days later with a Christmas Party, sponsored by The American Legion, Department of Maine.

**Providence VA Medical Center, Providence, RI**

*The American Legion visit to Providence VA Medical Center*  
March 6, 2006  
Task Force Member: Donald Lanthorn  
Field Service Representatives: Jacob Gadd

The Providence VA Medical Center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five Community-Based Outpatient Clinics (CBOCs) in Middletown (Rhode Island), and New Bedford, Hyannis, Nantucket and Martha’s Vineyard in Massachusetts. The medical
center serves a veteran population of about 140,000 in a primary service area that encompasses Rhode Island and southeastern Massachusetts.

The VAMC provides a broad range of medical services in primary care and 32 subspecialty clinics. The medical center’s Ambulatory Care Program is supported by a general medical and surgical inpatient facility with 60 to 73 operating beds.

**Fiscal**  Providence’s budget for FY 2005 was $120 million. For FY 2006, it was $122 million, or an increase of only 1.6%. Though management states in the questionnaire that no services or programs were eliminated as a result, this minuscule increase does not take into account the maintenance and replacement of the Medical Center’s infrastructure, which is aging and requires constant repair.

The MCCF collection goal for FY 2005 was $8,780,690, versus actual collections of $8,499,774, a shortfall of 3.2%. A Best Practices technique that has been emulated by the rest of VISN 1, but is not that common elsewhere, is having every patient register when they first arrive for an appointment in order to double check on their insurance status, their address etc. Though this slows down the process slightly, it does ensure that one source of error (and non-payment) with insurance claims is eliminated.

**Enrollment and Access**  Management states that there is a wait of less than 30 days for the average patient enrolling for the first time before his/her initial treatment (excluding, of course, the minority of new enrollees who are not requesting any health care). In the last year, management states that less than 50 veterans exceeded that wait time.

Referrals to specialists are also generally within 30 days, though for some specialties this time frame is exceeded. The Renal Clinic, covered by contract physicians, averages about a 54-day wait.

Problems of access are not a major concern for a VAMC operating in a state the size of Rhode Island.

**CBOCs**  The Medical Center’s five CBOCs cover not only Rhode Island, but cross the eastern border into Massachusetts, with four of the facility’s five CBOCs located in the southeastern part of that state. Despite the in-depth coverage, one physician suggested that an additional CBOC or two would be justified for the northern part of Rhode Island. The five CBOCs follow the coastline from Providence east to Cape Cod. Two of the clinics, on Nantucket and Martha’s Vineyard islands are contract and serve a small (in the case of Nantucket, a minuscule) population. The rest, including the Hyannis location, are VA-staffed. Certainly, no one would want to suggest that Providence does not take the issue of access seriously.

The **Middletown CBOC** is right outside Gate 10 of the Newport Naval Air Station and has two MD’s and a manager as well as two patient care assistants. The CBOC boasts 2,149 uniques with 2,625 patients enrolled. According to Dr.Terri Tamase, one of the two MD’s on staff, they are “most proud of being a real family clinic.” The CBOC opened in
November 2000 and has a waiting list of under 30 days. No-shows vary from around 6% to 13%. Many patients come from as far as 39 miles—something of a distance in Rhode Island where the many inlets and bridges make a relatively short commute seem longer. Special programs and services include psychiatry, nutritionist and social workers, as well as access to ACA (Advanced Clinic Access), allowing the scheduling of specialist appointments the same day.

**Affiliations and Staffing** Providence VAMC has active affiliations with both Brown University and Boston University Schools of Medicine. Over 300 residents, interns, and students are trained at the VAMC annually. There are also nursing student affiliations with the University of Rhode Island, Rhode Island College and Salve Regina University, as well as affiliations with other university programs such as pharmacy, social work, optometry and psychology. Through sharing agreements, services are available in the areas of Radiation Therapy, Professional Radiology Services, Sleep Lab, Electron Microscopy, and Cardiac Catheter Laboratory.

FTEE levels have fluctuated, like many VA facilities, according to the vagaries of the funding process. The FTEE for clinicians hit 803.9 in FY 2005 (up slightly from 798.3 the year before), and is now around 787. However, the number of outpatients and inpatients treated has increased somewhat in the same period: 274,741 outpatient visits last year versus 272,752 for the year before. Comparable figures for inpatients would be 3,321 versus 3,244.

The biggest problem in recruiting at present is with the Intensive Care Unit, particularly nurses, though the recent hiring of a nurse recruiter has apparently made a big improvement there. Along with the expected problems with major specialties such as anesthesiology, radiology and part time positions in general, the biggest challenge at Providence has been hiring qualified security people, even though the starting salary is at the GS-5 level (in Providence in the $30,000’s annually). The problem, in fact, is less in the hiring than in the retention, since security has now become a growth business.

**Physical Plant** has clearly become the number one problem, not only at Providence, but at almost all the other medical centers in VISN 1 (New England). Most of the VAMC dates to the 1940’s and inpatient rooms are designed for four or even eight patients: few with full baths. Though clever renovation and upgrading gives the facility a more up-to-date appearance, the layout for ICU, patient areas etc. is outmoded. Also maintaining the creaking structure of the building has become a major financial and management burden. Even the parking situation has become difficult due to the Medical Center’s limited space and the shortage of construction funds. The Medical Center has no vacant space or unused facilities, according to management.

Management is looking toward spending a minimum of $60 million for structural additions, it is hoped, as part of the CARES process. Per management:

*Supplemental funding provided in last year’s budget improved an otherwise bleak outlook for maintenance and repairs; however resources are not keeping up with needed*
replacements as facilities age. Our clinical addition (a CARES project in Concept Stage) has been delayed to FY 2009 at the earliest. We are slated to receive funding FY2007 for two minor construction projects, rehabilitation of the psychiatric ward and construction of a research center. Several requirements for renovation and repair remain unfunded [including]... improve[d] heating, ventilation and air conditioning, security improvements and roof replacements.

**Long Term Care, Mental Health and Homeless Services** Since the enactment of the Millennium Health Care and Benefits Act of 1999, the number of operating beds has remained stable at 73. Some 61 are now presently in use for long term care. As part of the Mental Health Strategic Plan, management has stated that it would like to emphasize MHICMs to provide for their more serious and chronic mental health patients: about 30 to 40 patients. Another priority is providing mental health to all CBOCs, while at the same time emphasizing Tele-mental health. Unfortunately, an impediment to expanding the mental health program is the fact that the physical plant for the mental health area is now inadequate to providing up-to-date mental health services.

Providence has also been active in clinical research, including a study of the use of virtual reality systems for veterans with mental health problems like PTSD, though the last is “not ready for Prime Time” per Mental Health’s Dr. Johnston.

A major part of the VAMC’s homeless program (Veterans Transitional Support Program) is run out of the Rhode Island Veterans Home in Bristol. The homeless program, which is entirely separate from the state-run facility, is staffed by two VA employees, a coordinator and a nurse. This is presently a 15-bed program that is slated to expand to 30 beds by spring. The program grew out of a 1993 grant for homeless veterans that would charge the residents only a small portion of their incomes. At present, there is a waiting period of from three to six months for admission.

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**Connecticut VA Health Care System (West Haven VA Medical Center)**

*The American Legion visit to the West Haven VA Medical Center*

*March 7, 2006*

*Task Force Member: Donald Lanthorn*

*Field Service Representatives: Jacob Gadd*

VA Connecticut Health Care System is comprised of an inpatient facility and Ambulatory Care Center in West Haven, an Ambulatory Care Center in Newington as well as a system of Community Based Outpatient Clinics (CBOCs). The CBOCs are represented in Danbury, New London, Stamford, Waterbury, Windham and Winsted. The mission is “to fulfill a grateful nation’s commitment to its veterans by providing high quality
healthcare, promoting health through prevention and maintaining excellence in teaching and research.” The West Haven medical center maintains 191 beds and provides primary, secondary and tertiary care in medicine, geriatrics, neurology, and psychiatry and surgery services. The hospital includes a Northeast Blind Rehabilitation Center and a $38 Million Research Program.

**Fiscal** West Haven’s budget for FY 2005 was $269 million. In FY 2006 it was $274 million, representing an increase in funding of about 2%. The MCCF collection goal for FY 2005 was $22,806,436; $23,336,989 was collected. The collection goal for FY 2006 is $25,679,580, a 12.6% increase over last year’s goal and a 10% increase over last year’s collections. VA Connecticut received approximately 1.5% less than needed to cover inflation in FY 2006 over FY 2005. Every effort is being made to minimize the impact of this shortfall. West Haven is currently off target for MCCF goals, due to a slow start. The facility is confident in its MCCF program, but stated the projected figures will be a stretch. The increase in prescription co-pay and an increased awareness of the clinical staff to the importance in correctly identifying service-connected and non-connected conditions will help improve collection rates.

**Enrollment and Access** West Haven was one of the original pilot sites for Advanced Clinical Access and has been using the simplified process for patients to set up their own appointments, at their convenience, for four years. Currently, 79,452 veterans are enrolled. Annually, there are 523,633 outpatient visits and approximately 54,000 veterans treated. The time from veterans’ submission of an enrollment application (1010 EZ) and their receipt of initial healthcare is on average 30 days. There were approximately 140 new patient appointments that exceeded the standard of 30 days. The time for veterans referred by their primary care practitioners to specialty care clinics depended on whether the veteran was service-connected. If the veteran is service connected, the wait time has been less than 30 days; if the veteran is non-service connected, the wait time is 120 days. In FY 2005, 85% of new patients were seen within 30 days, 98% of established Primary Care patients were seen in less than 30 days, and there was a less than 10% no show/cancellation rate. In FY 2005, VA Connecticut saw approximately 3,800 veterans for Compensation and Pension Examinations. The facility covered the costs of providing these exams and currently provides Gulf War Registry exams.

VA Connecticut has an active outreach effort for returning OIF/OEF troops. As a result of these efforts, from October 1, 2005 through January 31, 2006, 1,352 new patients have enrolled in the VA and approximately 1,000 have been treated. This represents .025% of the current patient care load. The largest impact on workload for returning veterans has been in the dental service. There is a designated OIF/OEF point of contact, which helps connect the returning veteran through outreach at military reserve and National Guard debriefing sessions.

**Affiliations and Staffing** VA Connecticut is affiliated with Yale University and University of Connecticut Schools of Medicine and Dentistry, allowing VA Connecticut to participate in the education and training of more than 675 physicians and dentists annually. Having these affiliations helps VA Connecticut attract high quality clinicians.
Students gain experience in disciplines such as nursing, occupational therapy, x-ray, laboratory and nuclear medicine.

Staffing remains a concern, due to budget cutbacks. There is a shortage of nurses, doctors, pharmacists and coders. Providence VAMC is helping with a temporary coder. Two staff coders are on contract currently, with two more positions being filled. Fee/Contact physicians are used for anesthesiology, interventional cardiology, cardiac surgery, dental, general surgery, orthopedic surgery, plastic surgery, radiology and urology. The Physician’s Pay Bill is estimated to increase payroll by $850,000 the first year; this will be partially offset by decreases in scarce medical contracts. West Haven utilizes a full range of options available in recruiting the best candidates, special salary rates, above minimum entry rates, recruitment bonuses and relocation bonuses.

**Physical Plant**  The physical plant for VA Connecticut West Haven Campus is aging and has been identified through the Capital Facilities Study as being rated “D”. Primary systems with problems are infrastructures such as steam systems, heating and cooling as well as electrical systems. Through a competitive internal process within VISN 1, VA Connecticut is prioritizing Non-recurring Maintenance Projects (NRM) for consideration. Unfortunately, the needs greatly exceed the availability of funding. The physical space for inpatient care is suffering as well where the existing medical wards do not meet current criteria for space and functionality. These issues have been identified through CARES and this facility has submitted a major construction project for approval. The subject project is now being re-submitted for the FY 2008. Additionally, a process is underway to develop minor applications for the 2007 submission cycle to address issues with specialty care, outpatient treatment programs, as well as ICU Step Down bed renovation projects.

**Long Term Care, Mental Health and Homeless Services**  The Nursing Care unit has 32 functional beds with an average daily census of 22 patients. In the long term care facility, it does not have designated hospice rooms, and collectively, the rooms were very institutional. VA would serve its patients better if it could dedicate three or four as “hospice” when a need exists and make them less institutional in décor and privacy. There are not separate beds for Alzheimer’s or dementia patients. There is a four-bed hospice program and a ten-bed hoptel for families. West Haven has a best practice in pressure ulcer management. There are two nurses for the hospital who only specialize in the prevention and treatment of bed ulcers exclusively. VA Connecticut has a PTSD Residential Rehabilitation Program (PRRP) located at Newington Ambulatory Care Center. The homeless veterans program has 4-5 staff members who help with outreach and liaison with community shelters. Currently, there are 100 transitional beds.

Mental health care services are comprehensive and nationally known. Services offered include: vocational rehabilitation, a Community Care Center, substance abuse, PTSD services and military sexual trauma. There are three new staff who specialize in PTSD for OEF/OIF veterans and six staff members who are part of a vet-to-vet peer program. Primary Care expressed an interest in having an imbedded Mental Health professional
located in its area, indicating space was not the concern, but just “management commitment.”

Errera Community Care Center  Located off the West Haven grounds in a converted warehouse, Errera Community Care Center provides an invaluable service to veterans transitioning back into everyday life. The Center, ran by a dynamic and enthusiastic social worker, Dr. Lorrie Harkness, emphasized that the center helps veterans see how to live life beyond substance abuse through diverse interventions to skills, strengths and abilities. The facility is run by veterans; they relate to one another through help with checking in, cooking meals, and sharing experiences, daily classes in writing, recovery, disability awareness and a wellness group. Historically, mental health patients were treated on locked wards and not given much independence. The mentality was patients had to take medications and go to classes but this center has made fundamental changes in the approach. By letting the veteran reach out to get support and offer the classes they are interested in, the commitment is strengthened and the treatment enhanced. There are 60 full-time employees, with 81,000 visits in 2005.

Patient Surveys This meeting consisted of nine veteran inpatients. All the patients felt that the quality of care was “good.” The veterans all lived within 10 miles, except one who was transported from Northampton, Massachusetts, and their family members were in the immediate area also. Some veterans had complaints about getting into to see the podiatry clinic. One veteran said it took over four months for him to get an appointment when he needed to have his toenails cut. Another veteran commented that the Blind Center was excellent. The group overall was pleased with the care and attention staff provide here at VA Connecticut.

Manchester (NH) VA Medical Center

The American Legion visit to the Manchester VA Medical Center
January 10, 2006
Task Force Member:  VA&R Chairman K. Robert Lewis
Field Service Representatives:  Michael M. Smith

Providing primary and secondary care, the Manchester VAMC supports programs in Medicine, Surgery, Extended Care and Ambulatory Care. Services include a Nursing Home Care Unit (NHCU), Hospital-Based Home Care, Adult Day Care, Respite and Hospice Services, and the Women Veterans Health Program.

Primary Care provides an array of outpatient services including Mental Health, Ambulatory Surgery and several specialized clinics. Manchester’s active research program focuses on PTSD, as well as other behavioral disorders.

Fiscal Manchester’s budget for FY 2005 was $85,212,000. In FY 2006, it was $84,459,000, representing a decline in funding of about 1%. This decline in funding stands in stark contrast to the annual inflation rate for healthcare, which approaches
double digits. The MCCF collection goal for FY 2005 was $5,958,000; $6,703,000 was collected--12.5% above goal. The collection goal for FY 2006 is set at $6,942,000; management declares that it is “optimistic” about meeting this goal. It pointed to the establishment of ACA Collaborative Teams, which are designed “to capture all potential billable episodes of care, including potential fee basis cases, EKGs and oncology. We continue to capture veterans’ billable insurances via interviews, correspondence, contract identification, and promoting the benefits for veterans.” On the down side, Manchester will have to contend with EMRA limitations on collection amounts from insurers, based on limits already set for Medicare.

Despite this, Manchester did not have to use capital investment dollars to supplement its medical care budget, and actually added services to include an Orthopedic Clinic and Surgery, expansion of the Outpatient Surgery and the Women’s Clinic, new ENT, OPT, EMG, EEG and Renal Care clinics, and an updating of VAMC’s Medical Library. It is the opinion of management that VERA’s capitated model favors smaller, outpatient facilities like Manchester, which also is advantaged by an increased workload that brings in more VERA dollars. But an increased workload would also consume more of those dollars.

**Enrollment and Access** For first time appointments, “98% of veterans seeking healthcare…during FY 05 received their initial healthcare in 30 days or less from time of application.” For referrals from Primary Care, 94% of veterans received their specialty care in 90 days or less. A potential problem in the future is whether the VAMC will be able to save its 24-hour Emergency Room from proposed cutbacks that would make it available to veterans only during normal business hours. This change would impact not only emergency services on the weekends and nights, but would limit the ER’s effectiveness during weekday hours as well. Fortunately, though not far from the Maine border, Manchester does not face the major challenges of access that Togus does, since New Hampshire, a relatively small state, has veterans living in the north of the state who have the option of seeking treatment at the VAMC across the river in White River Junction, VT. Manchester’s Primary Care chief feels that last year they had the “best access in the US.”

**CBOCs** There are four outpatient clinics: at Portsmouth, Tilton, Conway and Somersworth. All of these are at or near capacity. Except for dermatology and dental, there has so far been no excessive waiting time. According to management, both Portsmouth and Somersworth are considered by the head of Primary Care to be “underserved”, in part due to losing a topnotch MD applicant for the Somersworth CBOC because of a budget cutback.

**Affiliations and Staffing** Manchester VAMC is affiliated with the Dartmouth Medical School. There are nursing student affiliations with Northeastern University, and the University of Massachusetts—Lowell. Other affiliations include the General Hospital Institute of Health Professions, Rivier, and the New Hampshire Community Technical College, as well as affiliations with Harvard University involving dentistry and with the Massachusetts School of Pharmacy.
Staffing remains a concern, due to budget cutbacks (see CBOCs above), but this has not prevented the VAMC from expanding services (see Fiscal above). Though in some respects Manchester has benefited from the VERA model, the VAMC Director, the Head of Nursing and other managers complain that “there’s no depth” in staffing. If an individual retires, or is sick, or simply takes a vacation, it becomes a real scramble to back up that employee’s duties.

**Physical Plant**  Like many VAMC’s in the East, Manchester has an aging physical plant, which needs constant work most particularly on the external façade (brick cladding leaks). Maintaining the heating/air conditioning plant is always a challenge (steam radiator heating). Interestingly there is a shortage of space--not a surplus--with all space being either in use or leased out. There is clearly a funding shortfall in maintenance of the aging physical plant, though up to now the VAMC has not needed to use any equipment dollars to support non-recurring maintenance expenditures, or to fund capital improvements.

Though the VAMC has no major construction projects in the works, or planned, it does have a number of minor construction projects on the drawing board. Drawing on “strong VISN support,” the VAMC currently has one project in the works for the IPCU and the NHCU, and another for a Specialty Care addition. The NHCU expansion will be completed in “early March” and will provide another 45-50 exam rooms.

**Long Term Care, Mental Health and Homeless Services**  Manchester’s operating bed level at the time of the passage of the Millennium Act was 112. Today it is still 112, though 60 of these are currently out of service due to construction of the NHCU’s new quarters. Management also pointed to the 250 beds in the State Veterans Home in Tilton, including 100 that were recently added. While the VA’s NHCU provides palliative care, it does not provide hospice care. Manchester also has a Homeless Veterans Coordinator that has logged some 100 veterans so far, out of an estimated 300 in the catchment area (the program is in conjunction with White River Junction, Vermont Medical Center). Many of the homeless are referred to the Bedford Medical Center outside of Boston for therapy and transitional housing, though Manchester does provide a housing allotment.

**Roundtable**  This meeting consisted of six veterans, including five inpatients and one outpatient. The one outpatient lived only one mile away, while the inpatients generally came some distance (as did their family and friends to visit them), usually about 45 to 60 miles. One inpatient lived only four miles distant. The overall opinion was positive, with several veterans using terms like “very good,” “good,” or even “excellent” to describe the character of the care they were receiving. The only negatives were the food, which ranged from “excellent,” to “fair” to “Hospital Food—What were you eating?” (the meeting was held over lunch). The sense you got from most of the veterans encountered on the site visit was that they considered Manchester VAMC as “their” medical center, a place that they felt a certain sense of ownership for, a not atypical response, particularly for the more rural and smaller facilities.
Stratton VA Medical Center, Albany, NY

The American Legion visit to Stratton VA Medical Center
May 15, 2006
Task Force Member: John Hickey
Field Service Representatives: Michael M. Smith

The Stratton VA Medical Center is located in the heart of Albany, NY. Opened in 1951, the medical center serves veterans in 22 counties of upstate New York, western Massachusetts and Vermont. It has 156 authorized beds.

The Medical Center (VAMC) is a tertiary care facility classified as a Clinical Referral Level 2 Facility. It is an integrated, university-affiliated medical center providing a full range of patient care services including primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care.

The Stratton VA operates 11 Community Based Outpatient Clinics (CBOCs) located in Catskill, Clifton Park, Elizabethtown, Fonda, Glens Falls, Kingston, Malone, Plattsburgh, Schenectady, Sidney, and Troy. There is also a Vet Center located on Central Avenue in Albany.

Fiscal Albany’s budget for FY 2005 was $147 million. In FY 2006, it was $152 million, or an increase of only a little over three percent. Management reports, however, that the budget did allow them to maintain services, though they started the year with a “deficit” of $1.4 million (meaning they used money from the capital and other accounts, such as for the CMOP, which turned out fortunately to have excess funds). The Supplemental helped Albany add FTEE and at present the VAMC is “doing fairly well”, according to Director Mary Ellen Piché. Some questions remain, however, as to the long-term effect of present funding on the maintenance of physical plant (see Physical Plant below). During FY 2005 “a portion of capital investment dollars were temporarily used to support operating functions.”

The MCCF collection goal for FY 2005 was $7,976,709. Collections amounted to $8,251,160, which is an increase of 3.4 percent over goal. The collection goal for FY 2006 is $8,783,725, slightly more than last year’s collection. Management feels that it will meet this goal, due to increased efficiencies in their billing efforts. Albany has increased its “identified episodes to bill,” and says it has been aggressive with insurance identification: patients are asked about insurance information at each clinical encounter, providers educated on proper documentation, and high cost/high volume clinical processes analyzed using the “Six Sigma” methodology.

Enrollment and Access Management states that there is a wait of less than 30 days for first time appointments. Concerning wait times for specialty care, management states that the “Goal is open access or [a] next clinic date. Varies clinic to clinic.”
Albany relies on one of VA’s most extensive CBOC systems, with 11 CBOCs spread around the tri-city area (Albany, Schenectady, and Troy) north almost up to the Canadian border (Plattsburgh). This, reportedly, is the largest number of CBOCs per VAMC in the country, and is due to the far-flung nature of the Albany catchment area.

**CBOCs** Albany uses the CBOC system not only to help cover northeastern New York State, but also to provide better primary care coverage for the greater Albany area, including Schenectady and Troy which each have their own CBOC. The most distant CBOC, in Plattsburgh, is of major importance given the isolation of the area. Substance abuse has been an important mental health initiative for some years, given the high rates of addiction among the veteran population. Unfortunately, Plattsburgh is also a potential “bank breaker” according to the VAMC’s Director, due to the costs of contracting out nursing home care and other health services.

**Affiliations and Staffing** Affiliated residency programs are fully integrated with Albany Medical College. Residents and medical students from Albany Medical College and other medical schools rotate through the medical center on a continuous basis. Albany also provides internships/fellowships for most health care disciplines, including social work, nursing public relations, and health care administration.

Concerning hiring of clinicians, management states that “We are having difficulty finding well-qualified candidates who want to work at this location—mostly due to salary.” The greatest challenge is recruiting a gastroenterologist, radiologist, and neurologist. Other clinicians in short supply are LPN’s, a health physicist, and a nuclear medicine technologist. Despite the difficulty in attracting specialists, the center still reports that the Physicians’ Pay Bill has resulted in an extra $1.7 million in wage expenses. To attract more specialists and other scarce personnel, mechanisms such as special recruitment, retention and relocation bonuses, and special salary rates are utilized.

**Physical Plant** Management stated, “not having a major construction project awarded since 1987.” It has, however, had a slew of minor construction projects approved and funded, each of the past six years, with the exception of FY 2005, including a new Intensive Care Unit, Veterans Service Center and Pharmacy. Nonetheless, management states that: “the rising costs of infrastructure maintenance tend to outpace the annual increases in capital investment allocations,” thereby creating a problem found throughout the nation’s northern tier: high cost, sometimes obsolete structures, and some of which representing a catastrophe waiting to happen (for example: Albany’s ancient water main might fail altogether, probably forcing the evacuation of at least part of the hospital). Maintenance is also being cut back, as it is throughout VA. In the case of Albany, the maintenance crew has been cut from 90 to 40. “Preventive maintenance is not being done,” according to Facility Management; they estimate a backlog in infrastructure upkeep at $51 million for the cost of new projects, including maintenance and minor Non-Recurring Maintenance. Though management worked on two minor project submissions for FY 2007, only one was submitted (per CO) and this was muscled out of the picture by other projects considered more worthy elsewhere (only a small number of submissions can be approved, because of funding). Clearly, this is a problem, which
resolutely fails to go away, and is not really being addressed by VACO, particularly now that the CARES Plan has gone into hiding.

**Long Term Care, Mental Health and Homeless Services** When the Millennium Act was passed in 1999, Albany had three long-term care beds (all for POW’s) and today has 21 beds. At present there are 50 operating beds in the Nursing Home Care Unit (NHCU) out of a total of 87 operating beds. Of those only 37 are presently filled. Though it does not have a Dementia Unit, it does admit veterans with a dementia diagnosis. It also has several long-term care contract nursing homes in the community, some of them in areas very distant from the Medical Center, such as Plattsburgh.

Management states that: “The Behavioral Health Clinic has made several clinic additions to accommodate the treatment needs of [combat] veterans. We have identified a full time clinician for availability to do outreach, provide clinic visits, and [handle] case management follow up to all veterans coming to Behavioral Health for services. We have added a [combat vet] clinic to schedule veterans who call or walk in for appointments in addition to making staff immediately available. We have also initiated a PTSD treatment group for [combat] veterans as well as a family information seminar for family members. Training has been completed for 40 mental health clinicians, sensitizing them to the specific needs of [combat] veterans who may request assessment or treatment for PTSD.”

Following a nationwide trend, Albany currently staffs all 11 of its CBOCs with mental health staff, including counseling services and psychiatric medication.

Also encouraging was the fact that Albany was able to obtain a grant from VACO for new mental health positions at the CBOCs, Seriously Mentally Ill Program, and PTSD treatment. This is good for three years and will help Albany make up for past cuts.

Since there is no Domiciliary at Albany (the network Domiciliary is at Canandaigua), its homeless program primarily consists of outreach efforts. In the Albany catchment area, VA oversees six grants from VA to local providers to provide housing and case management services to homeless veterans. The VAMC manages 96 beds in four facilities.