

Appendix F – Small Facility Planning Initiatives and Recommendations [Rationale, supporting data, and analysis]

General Recommendations and Policy Implications

- The following facility-specific recommendations refer **only** to **acute** inpatient beds. Unless otherwise noted, the recommendations do not pertain to the other missions of the small facilities with respect to primary care, other outpatient specialty care, inpatient LTC, and/or chronic psychiatry.
- A review or closure of Intensive Care Unit (ICU) beds in all small facilities appears warranted based upon the low volume of patients treated in the small facilities and a concern regarding staff proficiency.
- Quality of care as judged by currently available metrics indicate an acceptable (or better) quality of care in general in all of the small facilities reviewed, with the exception of several Length of Stay (LOS) issues for select DRGs. Further quality metrics, however, may not be sufficiently sensitive to detect subtleties of care delivery in low volume settings. The extant literature does indicate quality of care concerns for low volume procedures as well as examples indicating a putative quality of care gain realized through shifting service delivery to higher volume settings with more established processes of care. The newly established “floor concept” for performance measures is designed to better address this potential quality gap.
- Policy guidance or education may need to address the separation of “urgent care” vs. “emergency room” services. Specifically, closure of the latter does not preclude operation of the former.
- Coordination of 24/7 -access (to include travel) from impacted small facilities to alternative care sites (community and/or VAMC) must be effectively and reliably addressed to ensure delivery of requisite quality care. Coordination of transfers and referrals is seen as a prerequisite for implementation of the recommendations below.
- A “scope of services” or “scope of practice” should be established for each small facility. In particular, an evaluation of the surgical case mix (i.e., inpatient surgery vs. ambulatory surgery) should be included in the review process.
- In order to establish a category of “Critical Access Hospitals” or “CAH-like” facilities similar to the Medicare program designation, VHA policy guidance will need to be developed to define selection criteria and performance expectations.
- Creation of the CAH-like designation recognizes the vital role that many of VA’s small facilities fulfill in providing access to acute hospital care in rural or less densely populated areas. However, the linkage and relationships with referral hospitals need to be planned for, strengthened, and rationalized. Referral hospitals should be more involved in staff education and in streamlining referrals from small facilities.
- Apart from volume considerations (i.e., improved patient outcomes are seen in facilities performing greater numbers of certain procedures), VA’s strategy

to consolidate services in larger acute and/or tertiary care hospitals reflects the need to realize economies of scale in the provision of state-of-the-art imaging. Modern imaging infrastructure has a functional lifespan of 7 to 10 years (especially for the more sophisticated, high cost equipment). In addition, the advent of teleradiology permits specialists in medical imaging to be located in tertiary medical centers to provide basic radiology support to the smaller facilities. Ongoing investment in imaging infrastructure requires consolidation of more complex, sophisticated services in the larger acute and tertiary care medical centers.

Facility-specific Recommendations (Acute Beds only, unless specified otherwise)

VISN 3 VA Hudson Valley (Castle Point)

Summary Recommendation: Retain acute care beds at Castle Point. Consolidate the Castle Point and Montrose Campuses by retaining only outpatient services the Montrose Campus and transferring all inpatient services to Castle Point. Pursue enhance use leasing alternative to provide benefits to veterans such as assisted living facilities at Montrose. Proposal includes relocation of SCI/D (Spinal Cord Injury & Disorders) LTC (Long-term Care) beds to the Bronx.

Supplemental Recommendation:

- Convert acute Medicine beds at Castle Point to a CAH-like model of care delivery (CAH - 96 Hr. Inpatient Medicine)
- Review and pursue enhanced use (EU) projects at Montrose

Rationale:

- Although providing greater access in terms of driving time for patients, the Montrose campus is older and in greater need of repair/renovation than the Castle Point facility. In addition, Montrose is closer to the Bronx (30 miles) than Castle Point (60 miles).
- The potential for EU projects is greater at Montrose.
- Retention of some acute services at Castle Point is reasonable, based upon its greater distance from the Bronx and the congestion/traffic in the New York City area. Such retention is contingent upon conversion to a CAH-like model of acute care delivery.
- There is insufficient workload to support the operation of both campuses.
- The relocation of the SCI/D LTC beds is favored based upon the presence of a SCI/D Unit at the Bronx and the availability of tertiary care services there to better serve the needs of SCI/D veterans.

VISN 4	Altoona
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Summary Recommendation: Transition to implementation in FY2012 of a combination of contracting acute care and referring to another VAMC (mainly Pittsburgh).

Supplemental Recommendation:

- Convert beds to a CAH-like model of care delivery (CAH - 96 Hr. Inpatient Medicine) in short term. Transfer acute bed services to VAMC Pittsburgh or contract with local communities by 2012. Continue other services on site (outpatient and nursing home care).

Rationale:

- Declining workload and the availability of community-based referral options were the key considerations in recommending closure of acute services at Altoona.
- Deferral of the transition to contracting and referral is recommended until 2012, after which further declines are anticipated.
- In the interim, transition to a CAH-like functioning is recommended.

VISN 4	Butler
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Summary Recommendation: Contract or refer acute inpatient services to another VAMC; acute bed services will be accommodated at the Pittsburgh VAMC, with emergency services via local community contracts. Nursing beds and outpatient clinics will remain open.

Rationale:

- The extremely small size of the inpatient service (Average Daily Census of less than 4 patients in FY01 and FY02) and the proximity to Pittsburgh (36 miles) were the key factors influencing the recommendation for closure of acute beds.

VISN 4	Erie
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Summary Recommendation: Retain acute medicine beds, with limited 'scope of practice'.

Supplemental Recommendation:

- Convert inpatient surgical beds to surgical observation beds and continue ambulatory surgery, with referral of complex surgery to Pittsburgh, other VAMCs, or the local community (as appropriate).
- External evaluation to determine if ICU beds are appropriate.

Rationale:

- Erie has a number of referral options, including local hospitals of high quality and to Pittsburgh (133 miles), Cleveland, and Buffalo. However, Erie’s proposal demonstrated that it was already taking advantage of these referral options to the extent currently feasible. A compelling case was made for maintenance of an acute care capability for less complex cases and stabilization/referral of more complex cases as warranted.
- Participation in graduate medical education (osteopathic residents) and other ancillary health care professionals was a factor favoring keeping Erie’s acute beds open.
- Surgical and ICU bed volumes are too low to justify keeping these bed services open.

VISN 6	Beckley
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Summary Recommendation: Retain Acute Beds, modified by limiting ‘scope of practice’

Supplemental Recommendations:

- Convert medicine beds to a CAH-like model of care delivery (CAH - 96 Hr.) Inpatient Medicine
- Convert inpatient surgery beds to surgery observation beds. Refer complex or major surgery to other VAMCs and emergent surgery to local facilities.
- Close ICU beds.
- Construct a new nursing home care facility to address current functional space deficiencies.

Rationale:

- Beckley’s relative isolation, low cost per BDOC¹ (\$729), and lack of quality referral options in the local community were key determinants of the recommendation to retain acute beds.
- Nevertheless, closure of inpatient surgery and ICU beds coupled with an effort to decrease average lengths of stay (ALOS) are needed to improve quality and efficiency of operations.

VISN 7	Dublin
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Summary Recommendation: Retain acute beds, modified by limiting ‘scope of practice’

Supplemental Recommendations:

- External evaluation to determine if ICU beds are appropriate .

¹ Bed day of care

- Transition Surgery beds to observation beds. Refer complex, non-urgent or emergent surgery to other VAMCs. Contract with local community hospitals for emergent surgery.
- Retain existing nursing home care beds, domiciliary programs, and outpatient clinics.

Rationale:

- As one of the larger small facilities reviewed, Dublin serves a considerable area of rural central Georgia, with the nearest facility being Augusta (105 miles on secondary roads) – hence, the recommendation to retain acute beds.
- There are no appropriate community referral options and the VA hospital is an important part of the local community.
- Despite good quality indicators and despite the number of beds being too high (mid-30s) to qualify as a “CAH-like” facility, there is concern about the low surgery volume for certain major cases. Thus, closure of inpatient surgery with retention of ambulatory surgery, and referral of complex cases to tertiary VAMCs is recommended.

VISN 11	Fort Wayne
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Summary Recommendation: Combination of contracting in the local community plus referral to other VAMCs as appropriate – predominantly Indianapolis and Marion, but also Ann Arbor and Detroit.

Supplemental Recommendation:

- Transfer inpatient services to Indianapolis, Ann Arbor, or Detroit Medical Centers or arrange for community contracts.
- Retain outpatient care at current site or another suitable location.
- Explore enhanced use lease possibilities for the Ft. Wayne campus.

Rationale:

- The VISN recommendation was supported – i.e., a combination of referral to other VAMCs and contracting with the community.
- Low and declining workload, coupled with other options for provision of high quality services, were the major considerations in the recommendation.

VISN 11	Saginaw
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Summary Recommendation: Contract with community providers and/or refer acute inpatient services to another VAMC

Supplemental Recommendation:

- Transfer/consolidate acute medicine beds to/with Detroit and/or Ann Arbor VAMCs or manage services through community contracts.
- Retain nursing home care and outpatient services.

Rationale:

- The VISN recommendation was supported – i.e., a combination of referral to other VAMCs and contracting with the community, with closure of acute beds.
- Saginaw did not make a case for retaining its acute bed capacity. The low volume current workload (ADC of less than 8 acute medicine patients in FY01 and FY02) and the availability of other options for provision of care were major considerations.

VISN 15	Poplar Bluff
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Summary Recommendation: Retain acute beds.

Supplemental Recommendation:

- Convert medicine beds to a CAH-like model of care delivery (CAH-96 Hr. Inpatient Medicine). [Note: already functioning as a CAH.]

Rationale:

- Poplar Bluff appears to be functioning effectively and efficiently in a CAH-like capacity at present. It is relatively isolated from other VAMCs (almost equidistant between Memphis and St. Louis – about 150 miles to either facility, although the major referral pattern is within Missouri and VISN 15). The ALOS² is about 3.5 days and the cost per BDOC is extremely low (\$471).
- There are no alternative providers in the vicinity that can match Poplar Bluff in measures of quality or cost.
- It has no inpatient surgery or ICU beds (i.e., an appropriate level of complexity is treated).
- Poplar Bluff appears to be fulfilling its role within the VA health care system admirably.

VISN 16	Muskogee
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Summary Recommendation: Retain acute beds, modified by limiting 'scope of practice', with additional 15-bed in-patient psych unit.

Supplemental Recommendations:

- Convert inpatient surgical beds to surgical observation beds. Inpatient, major surgery would be transferred to other VAMCs or contracted through community providers.
- Strengthen the Utilization Review program to decrease lengths of stay to comply with Medicare standards.
- Implement efficiencies to reduce costs per BDOC.
- Evaluate and justify psychiatry bed expansion.

² Average length of stay

Rationale:

- Muskogee is relatively close to a major population center in Tulsa, OK, which has no VAMC.
- A new bed tower was recently opened at Muskogee, with capacity exceeding demand for services.
- Thus, Muskogee has proposed to expand inpatient psychiatry, on behalf of VISN 16, which has projected increased demand for psychiatry beds and limited capacity.
- Closure of acute beds at Muskogee at this point in time would leave the Tulsa area without inpatient access to VA care.
- The surgery and ICU beds are recommended for closure due to low volume of selected major procedures. Ambulatory surgery would continue.
- Relatively high cost per BDOC (\$1589) and longer than comparable Medicare ALOS for selected diagnoses were concerns raised during the review process.

VISN 17	Kerrville
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Summary Recommendation: *Short-term:* retain acute beds, modified by limiting 'scope of practice.' *Longer-term:* transition to closure of acute beds when San Antonio VAMC is able to accept referrals, then implement (Contract and/or refer acute inpatient care).

Supplemental Recommendations:

- Convert medicine beds to a Critical Access Hospital (CAH - 96 Hr. Inpatient Medicine) in short term.
- Coordinate transition to contract plus referrals with the San Antonio VAMC.
- Retain nursing home and outpatient clinics.

Final Recommendations:

- Refer to Chapter 9 Campus Realignment Section

Rationale:

- Despite strong local community support, Kerrville workload is projected to decline over the next 20 years.
- It is relatively close (70 miles on an Interstate) to the San Antonio VAMC, its closest referral center.
- Greater consolidation of services and coordination with San Antonio appears to be warranted. The timing of the transition will depend upon the ability of San Antonio to accommodate Kerrville referrals.

VISN 18	Prescott
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Summary Recommendation: Retain acute beds/Increase Beds

Supplemental Recommendation:

- Strengthen the Utilization Review program to decrease lengths of stay to comply with Medicare standards.
- Explore increasing inpatient and specialty care to decrease pressure on the Phoenix VAMC services (for patients who live in northern Arizona only)

Rationale:

- Prescott is located 95 miles from Phoenix, which accepts some of its tertiary referrals. Other referrals go to Tucson for more complex care.
- Integration into the local community (a popular and growing retirement area) is good.
- VISN 18 would like to expand some of Prescott's inpatient services in order to relieve Phoenix of some of its inpatient workload pressure.
- Costs and LOS appear appropriate.

VISN 18	Big Spring
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Summary Recommendation: Study the feasibility of consolidating acute inpatient, outpatient specialty, nursing home, and mental health care services in the Odessa/Midland area.

Supplemental Recommendation:

- Inpatient Surgery was recently converted to ambulatory surgery only and needs will be met through a combination of local contracts and referrals to other VAMCs.
- Expand current outpatient clinic in Odessa/Midland to a multi-specialty clinic.

Rationale:

- Big Spring is a relatively old facility in a location that was formerly a regional population center. However, Big Spring failed to develop over the past 50 years. West TX population centers in Odessa, Midland, and Lubbock are currently served by CBOCs.
- Projected workload credited to Big Spring was felt to be inflated due to the proximity to other population centers and to the use of VISN-level reliance in projections.
- Psychiatry is already being contracted out and surgery beds have been closed at the direction of the VISN.
- Exploring relocation of services elsewhere in West TX appears to be more consistent with improving access to care for veterans in this area.

VISN 19	Cheyenne
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Summary Recommendation: Retain acute beds, modified by limiting 'scope of practice'

Supplemental Recommendations:

- Develop appropriate parameters (more restrictive) for types of in-house surgery procedures.
- Close ICU beds.
- Convert Med/Surg to a CAH-like model of care delivery (CAH -96 Hr. Inpatient Medicine). [Note: coordinate transition to CAH with Denver VAMC to assure capacity to absorb additional transfers and referrals.]

Rationale:

- Despite a very small bed service size, Cheyenne is relatively isolated and serves a sparsely, but widely dispersed population. Denver is 106 miles distant – using roads upon which travel is difficult during winter months.
- Access to acute care would be compromised were Cheyenne to close its acute beds.
- Cheyenne's cost per BDOC (\$983) is lower than contract costs.
- Its location and size make it ideal for transition to CAH-like facility.

VISN 19	Grand Junction
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Summary Recommendation: Retain acute medicine beds, modified 'scope of practice'

Supplemental Recommendations:

- Develop appropriate parameters (more restrictive) for types of in-house surgery procedures.
- Close ICU beds.
- Convert med/surg to a CAH-like model of care delivery (96 Hr. Inpatient Medicine). [Note: coordinate transition to CAH with Denver VAMC to assure capacity to absorb additional transfers and referrals.]
- Pursue other opportunities to enhance workload (e.g., IHS)

Rationale:

- Grand Junction is even more isolated than Cheyenne, with the nearest facility being in Denver (253 miles).
- Access to acute care would be compromised were Grand Junction to close its acute beds.
- Its cost per BDOC (\$1120) is lower than contract costs would be.
- Its location and size make it ideal for transition to CAH-like facility.
- For both Cheyenne and Grand Junction, transition to CAH-like operations will depend upon the capacity at the Denver VAMC and its ability to accommodate increased referrals.

VISN 20	Walla Walla
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Summary Recommendation: Campus would no longer provide VA health care service, apart from outpatient clinics, and contract for services with community providers

Supplemental Recommendation:

- Contract for inpatient services in local and surrounding communities
- Proposed consideration of relocation of nursing home services to a more populous area and/or contracting.
- Retention of outpatient services.
- Explore enhanced use possibilities, such as assisted living and/or other compatible uses.

Rationale:

- Although Walla Walla is relatively isolated from other VAMCs (the nearest VA is Spokane, 152 miles), there are hospital providers available in the communities that it currently serves.
- Since these communities are somewhat widely spaced, access to acute care would actually be improved by contracting with local providers of hospital care.
- The physical plant at Walla Walla is old and in poor condition. Extensive renovations would be needed to keep acute services open.
- Thus, the VISN's recommendation to close acute beds at Walla Walla was accepted.

VISN 23	Des Moines/Knoxville
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Summary Recommendation: Close acute beds and LTC (NHCU) beds at Knoxville & move to Des Moines – consolidation of these facilities.

Supplemental Recommendations:

- Complete an external evaluation to determine if ICU beds are appropriate for Des Moines.
- Review and consider conversion to ambulatory only or reduced scope of practice for Surgical services at Des Moines.
- Knoxville will retain its outpatient clinics and will transfer all other workload to Des Moines (including inpatient, long-term, and domiciliary care).

Rationale:

- The VISN recommendation to consolidate Knoxville and Des Moines by closing inpatient services at Knoxville was deemed acceptable and appropriate based upon:
 - The proximity of the two facilities (44 miles)
 - Declining inpatient acute for both facilities, but more markedly for Knoxville.
 - The predominantly LTC mission of Knoxville
 - Greater population density in the Des Moines area

- Relocation of LTC/NHCU beds from Knoxville is proposed based upon greater convenience for patients in the Des Moines area.

VISN 23	Hot Springs
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Summary Recommendation: Combination of retaining critical access beds, contracting for services and referral to another VAMC

Supplemental Recommendation:

- Retain acute beds (downsized) and convert to CAH model as part of its consolidation with Ft. Meade.
- More complex patient will be appropriately transferred to Ft. Meade or for contracted care in Rapid City, SD.

Rationale:

- Hot Springs is one of VA's most isolated small facilities – 93 miles from Fort Meade, the nearest VAMC.
- There is **no** local JCAHO-accredited hospital in the area. Therefore, Hot Springs meets the distance criteria as a CAH.
- Workload, census, and acuity of care indicators suggest that it is already beginning to function as a CAH-like hospital, fulfilling and important role in providing medical services to a medically underserved community.
- In addition to downsizing its acute beds, Hot Springs would also contract out and refer whenever necessary and appropriate.
- Reviewers concurred with this proposal as representing the best way to meet the health care needs of veterans living in this area.

VISN 23	Knoxville
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See Des Moines/Knoxville above.

VISN 23	St. Cloud
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Summary Recommendation: Contract and/or refer acute inpatient services

Supplemental Recommendation:

- Retain acute psychiatry, other mental health, domiciliary, and outpatient care. [Note: as of 2002, St. Cloud, no longer provides acute medicine services, but does have intermediate medicine beds. CARES recommendations will not constitute a change in its current operations.]
- Evaluate the number of patients referred to Minneapolis and assure accessibility and coordination of referrals.

Rationale:

- By the time of the small facility review, St. Cloud had already closed its acute medicine beds.
- Nevertheless, reviewers examined the proposal and found an acceptable rationale for the transition, which relies upon referral to other VAMCs and contracting in the local community whenever necessary and desirable to meet patient care needs.
- St. Cloud and VISN 23 were felt to have taken appropriate action (ahead of the CARES schedule).

Chart 1. Small Facilities Identified (baseline & projected beds)

VISN	Market Name	Station Name	Planning Category	Baseline Beds FY2001	Projected Beds FY2012	Projected Beds FY2022
3	VA Metro New York	VA Hudson Valley HCS	Medicine	9	13	9
3	VA Metro New York	VA Hudson Valley HCS	Surgery	0	0	0
3	VA Metro New York	VA Hudson Valley HCS	Psychiatry	1	1	0
VA Hudson Valley HCS Total				10	13	9
4	Western	Altoona	Medicine	17	13	9
4	Western	Altoona	Surgery	0	0	0
4	Western	Altoona	Psychiatry	1	5	4
Altoona Total				19	19	13
4	Western	Butler	Medicine	9	9	7
4	Western	Butler	Surgery	0	0	0
4	Western	Butler	Psychiatry	0	1	1
Butler Total				9	10	8
4	Western	Erie	Medicine	13	12	9
4	Western	Erie	Surgery	5	1	1
4	Western	Erie	Psychiatry	0	0	0
Erie Total				18	14	10
6	Northwest	Beckley	Medicine	28	12	8
6	Northwest	Beckley	Surgery	2	0	0
6	Northwest	Beckley	Psychiatry	2	2	2
Beckley Total				32	15	10
7	Georgia	Dublin	Medicine	27	31	26
7	Georgia	Dublin	Surgery	4	3	2
7	Georgia	Dublin	Psychiatry	2	2	2
Dublin Total				33	36	30
11	Indiana	Fort Wayne	Medicine	20	12	10
11	Indiana	Fort Wayne	Surgery	2	1	0
11	Indiana	Fort Wayne	Psychiatry	4	4	4
Fort Wayne Total				26	17	14
11	Michigan	Saginaw	Medicine	10	21	17
11	Michigan	Saginaw	Surgery	1	0	0
11	Michigan	Saginaw	Psychiatry	2	4	3
Saginaw Total				13	25	20
15	East	Poplar Bluff	Medicine	17	14	10
15	East	Poplar Bluff	Surgery	1	0	0
15	East	Poplar Bluff	Psychiatry	1	1	1
Poplar Bluff Total				18	15	11
16	Upper Western	Muskogee	Medicine	20	33	26
16	Upper Western	Muskogee	Surgery	4	3	2
16	Upper Western	Muskogee	Psychiatry	1	1	1
Muskogee Total				25	37	29
17	Southern	Kerrville	Medicine	20	14	12
17	Southern	Kerrville	Surgery	1	0	0
17	Southern	Kerrville	Psychiatry	1	0	0
Kerrville Total				22	15	12

VISN	Market Name	Station Name	Planning Category	Baseline Beds FY2001	Projected Beds FY2012	Projected Beds FY2022
18	Arizona	Prescott	Medicine	27	26	21
18	Arizona	Prescott	Surgery	1	0	0
18	Arizona	Prescott	Psychiatry	2	2	1
Prescott Total				29	28	22
19	Eastern Rockies	Cheyenne	Medicine	11	14	11
19	Eastern Rockies	Cheyenne	Surgery	2	2	2
19	Eastern Rockies	Cheyenne	Psychiatry	1	2	2
Cheyenne Total				14	17	14
19	Grand Junction	Grand Junction	Medicine	11	13	10
19	Grand Junction	Grand Junction	Surgery	5	4	3
19	Grand Junction	Grand Junction	Psychiatry	7	6	5
Grand Junction Total				23	24	18
20	Inland North	*Walla Walla	Medicine	8	12.8	10
20	Inland North	Walla Walla	Surgery	0	0	0
20	Inland North	Walla Walla	Psychiatry	25	27	25
Walla Walla Total				34	40	36
23	Iowa	Des Moines	Medicine	25	24	17
23	Iowa	Des Moines	Surgery	12	8	6
23	Iowa	Des Moines	Psychiatry	2	2	2
Des Moines Total				39	34	24
23	South Dakota	Hot Springs	Medicine	14	7	4
23	South Dakota	Hot Springs	Surgery	1	0	0
23	South Dakota	Hot Springs	Psychiatry	15	16	15
Hot Springs Total				31	23	20
23	Iowa	Knoxville	Medicine	13	10	7
23	Iowa	Knoxville	Surgery	2	1	0
23	Iowa	Knoxville	Psychiatry	12	16	12
Knoxville Total				27	26	20
23	Minnesota	St. Cloud	Medicine	8	6	5
23	Minnesota	St. Cloud	Surgery	1	0	0
23	Minnesota	St. Cloud	Psychiatry	13	20	14
St. Cloud Total				21	26	18

* Total include psychiatric residential rehabilitation beds. Actual acute care total is less than 40 beds in 2012.

Chart 2 – Selected Findings/Data Reviewed											
Small Facility	VISN	2001 Beds	2012 Beds	2022 Beds	Surgery (Yes/No)	ICU (Yes/No)	JCAHO HAP Score	Community Hosp. (Yes/No)	Nearest VAMC	Cost/BDOC	Contract Cost
VA Hudson Valley (Castle Point)	3	10	13	9	No	No	94	Yes	Bronx (76 miles)	\$1,035	\$1,370
Altoona	4	19	19	13	No	Yes	96	Yes	Pittsburgh (95 miles)	\$1,120	\$1,088
Butler	4	9	10	8	No	Yes	95	Yes	Pittsburgh (36 miles)	\$1,179	\$1,088
Erie	4	18	14	10	Yes	Yes	94	Yes	Pittsburgh (133 miles)	\$1,471	\$1,088
Beckley	6	32	15	10	Observation	Yes	92	Yes	Salem (114 miles)	\$729	\$1,118
Dublin	7	33	36	30	Yes	Yes	94	Yes	Augusta (105 miles)	\$1,113	\$1,282
Fort Wayne	11	26	17	14	No	Yes	86	Yes	Indianapolis (130 miles)	\$1,002	\$1,322
Saginaw	11	13	25	20	No	Yes	93	Yes	Ann Arbor (87 miles)	\$1,571	\$1,350
Poplar Bluff	15	18	15	11	No	No	97	Yes	Memphis (152 miles)	\$471	\$1,264
Muskogee	16	25	37	29	Yes	Yes	94	Yes	Fayetteville (101 miles)	\$1,589	\$1,132
Kerrville	17	22	15	12	No	Yes	93	Yes	San Antonio (70 miles)	\$870	\$1,180
Prescott	18	29	28	22	No	Yes	89	Yes	Phoenix (95 miles)	\$769	\$1,521
Cheyenne	19	14	17	14	Yes	Yes	94	Yes	Denver (106 miles)	\$983	\$1,499
Grand Junction	19	23	24	18	Yes	Yes	97	Yes	Denver (253 miles)	\$1,120	\$1,523
Walla Walla	20	34	39.8	36	No	Yes	97	Yes	Spokane (152 miles)	\$1,457	\$1,573
Des Moines & Knoxville	23	66	60	44	Yes	Yes	92	Yes	Iowa City (113 miles) Iowa City (111 miles)	\$1,394	\$1,249
Hot Spring	23	31	23	20	No	Observation	90	No ³	Fort Meade (93 miles)	\$1,086	\$1,231
St. Cloud	23	21	26	18	No	No	92	Yes	Minneapolis (90 miles)	\$1,079	\$1,409

³ There is no JCAHO-accredited hospital. There is a 10-bed hospital that closed in 1998 and reopened in 2001 as a CAH.

Chart 3. Findings/Data Reviewed (continued)				
Small Facility	VISN	Surgery Contract Cost (per BDOC)	In-House Surgery Cost (per BDOC)	Overall Inpatient Medicine Perceived Quality [Nat'l Avg. 0.72; 2002 SHEP* data]
VA Hudson Valley	3	N/A	N/A	N/A
Altoona	4	N/A	N/A	0.7
Butler	4	N/A	N/A	0.69
Erie	4	\$1,868	\$1,904	0.7
Beckley	6	N/A	N/A	0.67
Dublin	7	\$2,322	\$1,069	0.64
Fort Wayne	11	N/A	N/A	N/A
Saginaw	11	N/A	N/A	0.69
Poplar Bluff	15	N/A	N/A	0.67
Muskogee	16	\$1,926	\$1,531	0.67
Kerrville	17	N/A	N/A	0.68
Prescott	18	N/A	N/A	0.69
Cheyenne	19	\$2,816	\$1,632	0.7
Grand Junction	19	\$2838	\$1,258	0.7
Walla Walla	20	N/A	N/A	0.67
Des Moines & Knoxville	23	\$2,278	\$1,619	0.68
Hot Spring	23	N/A	N/A	0.71
St. Cloud	23	N/A	N/A	N/A

*SHEP = Survey of Healthcare Experiences (patient satisfaction survey)