

# Department of Veterans Affairs

## Capital Asset Realignment for Enhanced Services



**VISN 21**

**Market Plans**

## **Attention**

The VISNs developed the initial CARES Market plans under direction from the National CARES Program Office (NCPO). After these were submitted by the VISN, they were utilized as the basis for the National CARES Plan. However, the CARES National Plan includes policy decisions and plans made at the National Level which differ from the detailed Network Market Plans. Therefore, some National policy decisions that are in the National Plan are not reflected in the Network Market Plans. These initial VISN Market Plans have detailed narratives and data at the VISN, Market and Facility level and are available on the National CARES Internet Site : <<<http://www.va.gov/CARES/>>>.

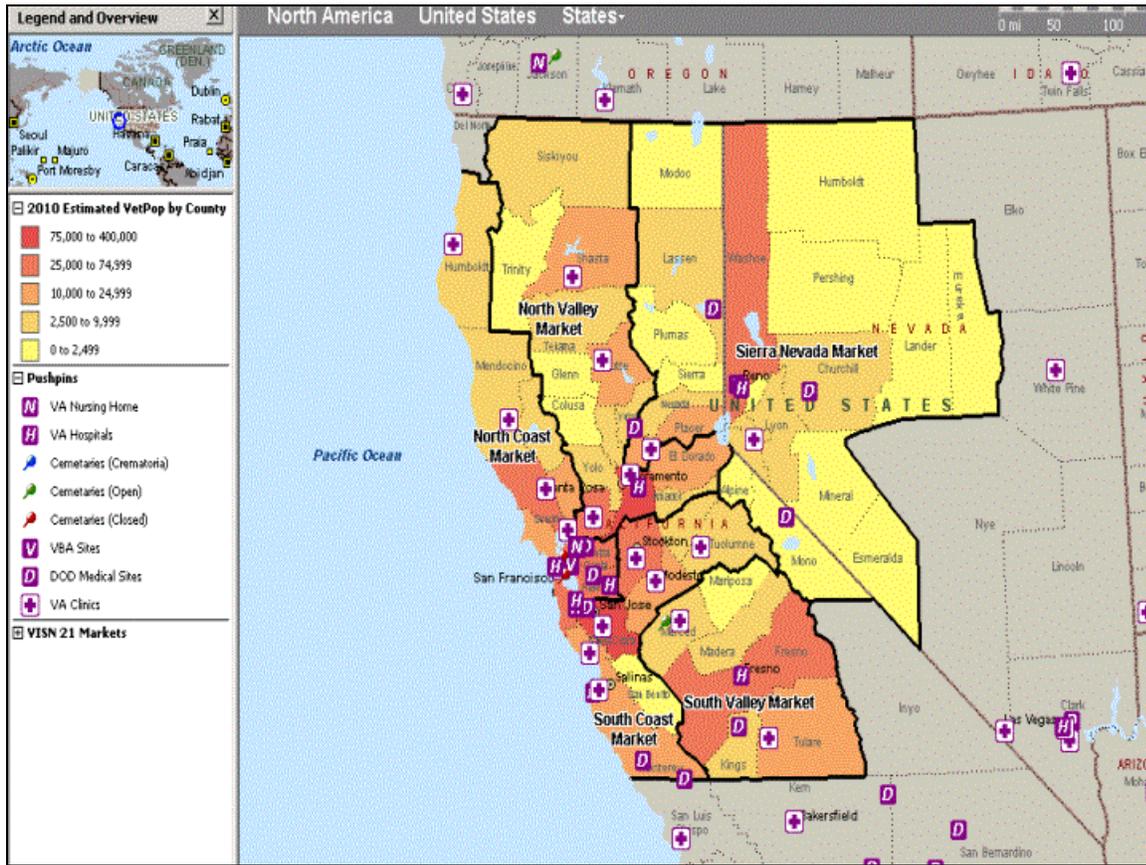
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# I. VISN Level Information

## A. Description of the Network/Market/Facilities

### 1. Map of VISN Markets



## 2. Market Definitions

**Market Designation:** The VA Sierra Pacific Network (VISN 21) proposes six markets and no sub-markets as follows, including the rationales for each. Rationales for grouping counties into markets include locations of population centers in each county, travel times and access to services from population centers, geographic barriers and travel patterns, historical utilization and referral patterns, planned future expansion of services.

Market	Includes	Rationale	Shared Counties
North Coast Code: 21A	10 California counties (two , Alameda and San Mateo, shared with South Coast market)	The market extends from the northwest coast of California below the Oregon border (excluding VISN 20's Del Norte county) through San Francisco/Oakland and into the East Bay. Highway 101 (north-south) runs the length of this market. The Bay Area presents significant transportation/access challenges due to traffic, bridges, and other urban characteristics. Veterans in this market utilize VAMC San Francisco, one of two Network tertiary care medical centers for acute and tertiary care services and tend to rely on a large array of primary care clinics for outpatient care. The North Coast market offers a full continuum of services with two VA Nursing Homes, a Specialty Ambulatory Care Center, and four CBOCs.	

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
North Valley  Code: 21B	14 California counties	<p>The North Valley market extends through the northern interior of the state from the central Oregon border, through rural northern California and the Sacramento Valley to the Carquinez Straits. Highway 5 (north-south) joins Highway 80 (east-west) in the Sacramento Valley. At the north end of this market, a VISN 20 CBOC exists within the 50-mile buffer, with very little crossover workload. The California state capitol of Sacramento serves as the metropolitan center that anchors the North Valley market. The VA Northern California Health Care System (NCHCS) operates several facilities throughout this market, including the secondary care facility, VA Sacramento Medical Center. NCHCS has active sharing agreements in place with Travis AFB and the system serves a large TRICARE population. There are five CBOCs that further support this market. The North Valley market tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco as appropriate.</p>	
South Coast  Code: 21D	10 California counties (two, Alameda and San Mateo, shared with North Coast market)	<p>The South Coast market stretches from the San Francisco Bay area (mid-San Mateo County) through the Silicon Valley, Livermore Valley, and along the coastal counties through Monterey County. The northern portion of this market area (Palo Alto and San Jose) poses significant transportation/access challenges due to traffic and congestion (Highway 101). This market area is largely urban and is the location of the VA Palo Alto Health Care System (PAHCS), one of two VA tertiary care referral centers supporting the Network. The PAHCS has three divisions including Palo Alto, Menlo Park, and Livermore, and supports a very large TRICARE population. The market offers a full continuum of veteran health care services, which is further supported by two</p>	

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
		NHCUs, a Specialty Ambulatory Care Center, and five CBOCs.	
South Valley  Code: 21F	6 California counties	The South Valley market extends through the central valley of the state. Highways 5 and 99 run parallel (north-south) linking Merced County, through the San Joaquin valley south to Kings and Tulare counties. The south end of the Sierra Nevada mountain range borders the eastern portion of this market. Other than Fresno County, this market area consists of rural counties. The southern portion of this Network borders VISN 22, where CCHCS draws some patients from the 50-mile “buffer zone”, the location of the Bakersfield CBOC. The city of Fresno serves as the metropolitan area that anchors the South Valley market and is the location of the secondary care facility, VA Central California Health Care System (CCHCS). A NHCU and two CBOCs also support this market area. The South Valley tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco as appropriate.	
Sierra Nevada  Code: 21E	8 California counties and 12 Nevada counties	The Sierra Nevada market extends from the northeast Oregon border south, following the Sierra Nevada mountain range, including the Lake Tahoe region, and often making travel more difficult in the winter. Interstate 80 (east-west) is the major highway that links this market, from central Nevada through Reno into the California Sierra foothills. In the central and eastern portion of this market there are several large highly rural (frontier) counties. The southern portion of this market borders VISN 22, where Esmeralda County (Nevada) will now be included with this market/VISN 21 due to workload shifting (DPPB). The city of Reno serves as the metropolitan center that anchors the Sierra Nevada market and is the location of the secondary facility, VA Sierra Nevada	

Market	Includes	Rationale	Shared Counties
		Health Care System (SNHCS). A NHCU and two CBOCs further support this Network. The Sierra Nevada tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco as appropriate.	
Pacific Islands  Code: 21C	4 Hawaiian counties, Philippines, Guam, and American Samoa	The unique Pacific Islands market presents many geographic, transportation, and challenging health care access issues. The market includes the State of Hawaii, which is comprised of six islands (Oahu, Hawaii, Maui, Kauai, Molokai, and Lanai) and four counties. Also included in this market is the island of Guam, the Philippines, American Samoa, and several smaller Pacific islands. The city of Honolulu is located on the island of Oahu, and is the site of the VA Medical & Regional Office Center (VAMROC) that provides both medical care services and veterans benefits and is collocated at Tripler Army Medical Center (TAMC) where the VA has established both a large Ambulatory Care Center and a VA Center for Aging (NHCU/Rehab). Four CBOCs are located on each of the larger Hawaiian Islands. Inpatient care is primarily delivered through a VA/DOD Joint Venture agreement with TAMC. This market also includes the VA Regional Office & Outpatient Clinic in Manila, the location of a VA Ambulatory Care Center. Fee basis programs further support outpatient and inpatient care in remote locations. As appropriate, complex tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco.	

### 3. Facility List

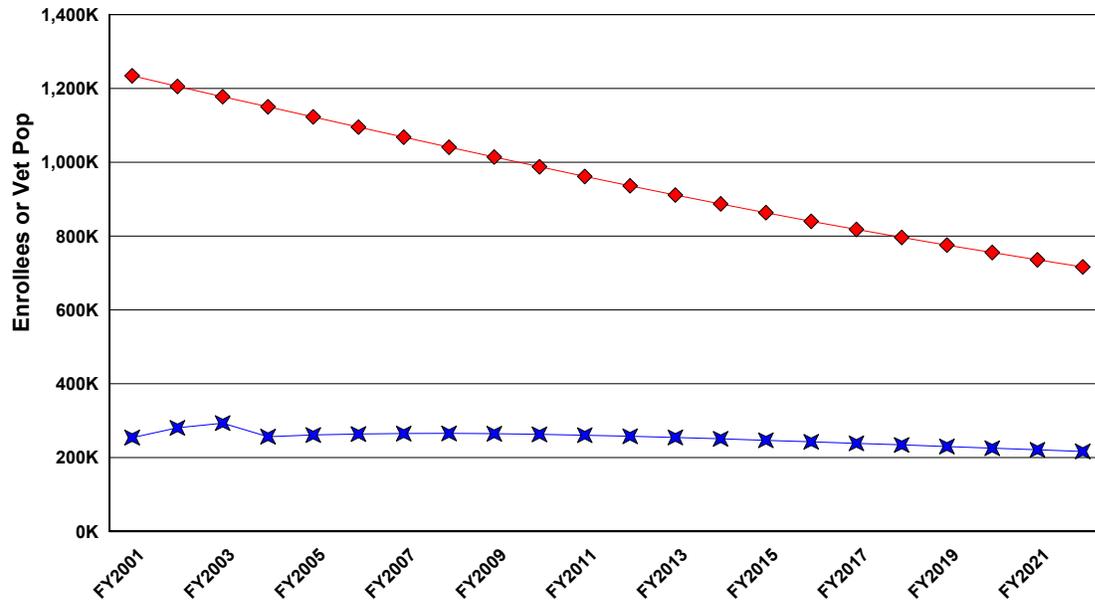
VISN : 21				
Facility	Primary	Hospital	Tertiary	Other
<b>Fresno</b>				
570 Fresno	✓	✓	-	-
570GA Merced	✓	-	-	-
570GB Tulare	✓	-	-	-
<b>Honolulu</b>				
459 Honolulu	✓	✓	-	-
459GA Maui	✓	-	-	-
459GB Hilo	✓	-	-	-
459GC Kailua-Kona	✓	-	-	-
459GD Lihue	✓	-	-	-
459GE Guam	✓	-	-	-
New VAMROC CBOCs	✓	-	-	-
<b>Livermore</b>				
640A4 Livermore	✓	-	-	-
<b>Manila</b>				
358 Manila	✓	-	-	✓
<b>Menlo Park</b>				
640A0 Palo Alto-Menlo Pk	✓	✓	-	-
<b>No Cal System of Clinics</b>				
612BY Oakland	✓	-	-	-
612GD Fairfield	✓	✓	-	-
612GE Vallejo/Mare Island	✓	-	-	-
612GF Martinez	✓	-	-	-
612GH McClellan	✓	-	-	-
<b>Palo Alto</b>				

640 Palo Alto-Palo Alto	✓	✓	✓	-
640BY San Jose	✓	-	-	-
640GA Palo Alto HCS- Capitola	✓	-	-	-
640GB Sonora (Tuolumne County)	✓	-	-	-
640HA Stockton	✓	-	-	-
640HB Modesto	✓	-	-	-
640HC Monterey	✓	-	-	-
New Palo Alto Clinics	✓	-	-	✓
<b>Reno</b>				
654 Sierra Nevada HCS	✓	✓	-	-
654GA Sierra Foothills	✓	-	-	-
654GB Carson Valley	✓	-	-	-
<b>Sacramento</b>				
612A4 N. California HCS-Sacramento	✓	✓	-	-
612B4 Redding	✓	-	-	-
612GG Chico	✓	-	-	-
New Marysville City	✓	-	-	-
<b>San Francisco</b>				
662 San Francisco	✓	✓	✓	-
662BU 13th & Mission VA Clinic	✓	-	-	-
662GA Santa Rosa	✓	-	-	-
662GC Eureka	✓	-	-	-
662GD Ukiah	✓	-	-	-
New New North Coast Clinics	✓	-	-	-

#### 4. Veteran Population and Enrollment Trends

--- Projected Veteran Population

---- Projected Enrollees



## 5. Planning Initiatives and Collaborative Opportunities

### a. Effective Use of Resources

Effective Use of Resources		
PI?	Issue	Rationale/Comments Re: PI
N	Small Facility Planning Initiative	
Y	Proximity 120 Mile Tertiary	The following pairs of medical centers providing tertiary hospital care are within a 120 mile radius: San Francisco and Palo Alto. Review potential redundancies in services and develop plan as appropriate.
N	Proximity 60 Mile Acute	No facility fell within the proximity gap
Y	Vacant Space	All VISNs will need to explore options and develop plans to reduce vacant space by 10% in 2004 and 30% by 2005.

### b. Special Disabilities

Special Populations Planning Initiatives		
PI?	Issue	Rationale/Comments Re: PI
N	Blind Rehab	VISN 21 has received a recommendation to consider restoring its BRC program to full bed capacity
N	SCI	

**c. Collaborative Opportunities**

<b>Collaborative Opportunities for use during development of Market Plans</b>		
<b>CO?</b>	<b>Collaborative Opportunities</b>	<b>Rationale/Comments</b>
Y	<b>Enhanced Use</b>	San Francisco and Sacramento were designated as potential sites for Enhanced Use Lease Opportunities.
N	<b>VBA</b>	There are no potential <b>VBA</b> opportunities with the VA that were found in this VISN for review .
N	<b>NCA</b>	There were no potential <b>NCA</b> opportunities.
Y	<b>DOD</b>	There are potential <b>DoD</b> opportunities with the VA that were found in the Pacific Island Market to build on existing relationships in Hawaii and Guam to enhance access to tertiary and acute care and to meet primary and specialty care outpatient needs. There may be opportunities of enhanced collaboration around medical research with DoD in Hawaii, particularly given DoD's anticipation of a new research facility on Oahu. In addition, there are opportunities with DoD in the North Valley Market at Travis AFB to enhance current relationships in order to provide enhanced access to inpatient care, primary care, and specialty care.

**d. Other Issues**

<b>Other Gaps/Issues Not Addressed By CARES Data Analysis</b>		
<b>PI?</b>	<b>Other Issues</b>	<b>Rationale/Comments</b>
Y	58% of Domiciliary demand in VISN 21 is being met outside of VISN 21. This should be coordinated with other VISNs, primarily VISN 20.	Coordinate domiciliary planning with other VISNs, primarily VISN 20.
Y	Siesmic Issues exist at San Francisco, Fresno and Palo Alto.	The safety of the buildings must be considered in the Market Plan.
Y	Enhanced Use Lease Opportunities	The VISN identified the following Enhanced Use Lease Opportunities: 100 bed LT Care Unit in Sacramento; OPC & LTC Joint Venture with Alameda County; New Research Complex at San Francisco VAMC; Assisted Living Facility at Menlo Park Div. Of Palo Alto; and Eye Institute at Palo Alto.

**e. Market Capacity Planning Initiatives**

**North Coast Market**

<b>Category</b>	<b>Type of Gap</b>	<b>FY2001 Baseline</b>	<b>Fy 2001 Modeled ***</b>	<b>FY 2012 Gap</b>	<b>FY 2012 % Gap</b>	<b>FY 2022 Gap</b>	<b>FY 2022 % Gap</b>
Primary Care	Population Based *	155,892		66,263	<b>43%</b>	7,671	<b>5%</b>
	Treating Facility Based **	175,553		110,856	<b>63%</b>	42,186	<b>24%</b>
Specialty Care	Population Based *	151,695		42,801	<b>28%</b>	3,850	<b>3%</b>
	Treating Facility Based **	199,191		64,400	<b>32%</b>	18,431	<b>9%</b>
Surgery	Population Based *	12,368		(4,527)	<b>-37%</b>	(6,856)	<b>-55%</b>
	Treating Facility Based **	16,040		(5,747)	<b>-36%</b>	(8,633)	<b>-54%</b>

**North Valley Market**

<b>Category</b>	<b>Type of Gap</b>	<b>FY2001 Baseline</b>	<b>Fy 2001 Modeled ***</b>	<b>FY 2012 Gap</b>	<b>FY 2012 % Gap</b>	<b>FY 2022 Gap</b>	<b>FY 2022 % Gap</b>
Primary Care	Population Based *	132,275		64,610	<b>49%</b>	18,491	<b>14%</b>
	Treating Facility Based **	118,006		19,259	<b>16%</b>	(13,131)	<b>-11%</b>
Specialty Care	Population Based *	105,206		61,032	<b>58%</b>	32,077	<b>30%</b>
	Treating Facility Based **	90,199		39,812	<b>44%</b>	17,260	<b>19%</b>

### Pacific Islands Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	60,128		44,925	75%	30,598	51%
	Treating Facility Based **	66,332		44,587	67%	30,809	46%
Specialty Care	Population Based *	35,269		74,238	210%	66,326	188%
	Treating Facility Based **	36,656		77,745	212%	70,524	192%

### Sierra Nevada Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	73,463		25,609	35%	5,258	7%
	Treating Facility Based **	73,568		19,230	26%	225	0%
Specialty Care	Population Based *	67,623		30,348	45%	16,832	25%
	Treating Facility Based **	64,900		26,969	42%	13,929	21%

## South Coast Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	126,110		50,204	40%	8,486	7%
	Treating Facility Based **	128,379		53,622	42%	11,958	9%
Specialty Care	Population Based *	125,780		59,362	47%	25,209	20%
	Treating Facility Based **	131,368		60,836	46%	27,183	21%
Surgery	Population Based *	10,242		(4,081)	-40%	(5,785)	-56%
	Treating Facility Based **	15,534		(5,546)	-36%	(8,168)	-53%
Psychiatry	Population Based *	24493		-7631	-31%	-11037	-45%
	Treating Facility Based **	37475		-3939.94	-11%	-12614.56	-34%

## South Valley Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	79,240		943	1%	(21,728)	-27%
	Treating Facility Based **	80,874		897	1%	(20,993)	-26%

\* – Population Based: Sum of the workload demand based on where the enrollee lives. Sum of the workload projections for the enrollees living in the counties geographically located in the Market. This is not necessarily where they go for care.

\*\* – Treating Facility Based: Sum of the workload demand based on where the enrollee goes for care. Sum of the facility data for the facilities geographically located in the Market. (Due to the traffic or ever referral patterns, the population based and treating facility projections will not match at the market level, although nationally they will be equal)

\*\*\* – Modeled data is the Consultants projection based on what the workload **would have been if adjusted for community standards.**

## 6. Stakeholder Information

Summary narrative on key stakeholder issues by Market, and how the comments/concerns were incorporated in the Market Plan.

### Stakeholder Narrative:

#### STAKEHOLDER ISSUES

VISN NAME: 21 Sierra Pacific Network

Summary narrative on key stakeholder issues by Market, and how the comments/concerns were incorporated in the Market Plan.

VA Sierra Pacific Network incorporated key stakeholder issues through its six Market's feedback forums. The VISN Public Affairs Specialist (PAS) was responsible for feedback and responding to a total of ten letters that were submitted to the Network.

These included congressional and veterans service organization letters. Nine of the ten letters concerned the VA Northern California Health Care System/North Valley Market.

Network Director, with Market Committee collaboration, provided written responses to stakeholder's requests. VISN PAS communicated weekly with Market Committee

Communication Liaisons. Market SummaryNorth CoastFeedback: Proximity Planning Initiative San Francisco VA Medical Center's staff and affiliate (University of California San Francisco) are concerned that recruitment and retention are affected due to the

possibility of consolidation of services with VA Palo Alto Health Care System. Feedback

Process: CARES feedback is a shared responsibility between the Public Affairs Officer (PAO) and the CARES Committee Chair. The PAO provides feedback to the Market

Committee and they adjust proposed solutions to appropriately meet future veteran needs. The PAO and Chair are responsible for responding to stakeholders as to the status of their

recommendations.North ValleyFeedback: Redding/Chico OPC ExpansionStakeholders

want contracted inpatient beds and expanded services at Redding and Chico

OPCs.Feedback Process: Stakeholder's issues are presented at stakeholder's meetings.

CARES Chair addresses concerns immediately or assures a response at the next meeting or in writing. CARES Chair meets and discusses issues with planning and program staff.

Updated planning initiatives' handouts are provided at briefings. South CoastFeedback:

Consolidated services between Modesto and Stockton OPCs.Congressional staff and veterans indicate they do not want either of these facilities to close or

consolidate.Feedback Process: CARES feedback is the responsibility of the PAO. The PAO provides feedback to the Executive Committee and Market Committee for review

and discussion. The Market Committee member's adjust proposed solutions to

appropriately meet future veteran needs. The Market Committee invited stakeholder(s) to present their concerns and to discuss complex issues. The PAO is responsible for

responding to stakeholders as to the status of their recommendations.South

ValleyFeedback: Positive support for Planning Initiatives ~ Expand Specialty Care;

Increase DoD collaboration; and Replace seismically deficient buildings.

Feedback Process: The only stakeholder feedback received is that it would be desirable to have an outpatient clinic in the proposed State Veterans Home in Fresno County.

Proposal has been submitted to California state planners. Sierra Nevada Feedback: Positive support for Planning Initiatives ~ Expand Specialty Care, Primary Care and Tertiary Hospital Access. Feedback Process: CARES feedback is communicated to the PAO who conveys the feedback to the CARES Steering Committee. Feedback was solicited through various mechanisms from stakeholders. In particular, feedback was sought from VSOs regarding specific planning initiatives. The feedback is considered by the CARES Steering Committee and incorporated into the planning initiatives. The PAO is responsible for responding to stakeholders regarding the status of their recommendations. Pacific Islands Feedback: Positive support for Planning Initiatives ~ Expand Specialty Care, Primary Care and Tertiary Hospital Access. Feedback Process: CARES feedback is acquired at stakeholder meetings. Feedback is positive and minimal, and responded to at meetings.

## **7. Collaboration with Other VISNs**

Summary narrative of collaborations with neighboring VISNs, and result of collaborations. Include overview of Proximity issues across VISNs.

### **Collaboration with Other VISNs Narrative:**

Collaborations With Neighboring Networks: County Shift Between VISNs: Esmeralda County was shifted from VISN 22 to VISN 21 because most of the Veteran Care received by enrolled veterans in that County is provided by VISN 21 Sierra Nevada Market Facilities. This shift was coordinated with VISN 22. Domiciliary Care: 58% of the Domiciliary care for VISN 21 patients is provided in other VISNs (primarily White City in VISN 20). VISN 21 has a 100 Bed Domiciliary currently and does not plan on providing additional Domiciliary beds within the VISN. The VISN has looked at reuse of vacant space and potential realignments, but has decided to make no changes in this phase of CARES. This has been coordinated with VISN 20. Domiciliary care is not a Planning initiative category for this phase of CARES. Special Population: Collaborations with other networks is covered in the VISN Special Population narrative. Proximity: There are no VISN 21 Proximity issues with other VISNs

## B. Resolution of VISN Level Planning Initiatives

### 1. Proximity Planning Initiatives (if appropriate)

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

#### **Proximity Narrative:**

PROXIMITY PLANNING INITIATIVE VISN NUMBER: 21 MARKET NAME North Coast/South Coast. FACILITIES: San Francisco VA Medical Center (SFVAMC)VA Palo Alto Health Care System (VAPAHCS) Provide a summ outlining the process, and how PI was resolved. VAPAHCS & SFVAMC are approx. 39.5 mi. apart. With an exhaustive objective analysis of existing/proj. workload, referral patterns, academic aff., teaching & research programs, VAPAHCS & SFVAMC Tertiary Care Steering Committee [Cmte] found that facility has the bed capacity, infrastructure, nor clinical staff to accommodate the full workload of the other. During the process, the Cmte viewed DRG, CPT, fee workload, CARES portal data, high cost/low volume wrkld, and consulted with all service chiefs. Many activities &/or services were identified for consolidation (cons)over the next 20 yrs. The Cmte further recognizes the need to monitor future data trends to identify more cons as they impact CARES criteria. 3 options evaluated: Status Quo (Alt.A)-Not Utilized. Closure of One Facility (Alt B)-Not Feasible. Lmtd Integration & Cons. Alt C-1; Admin. Cons. Other Feasible- Alt C-2; Admin and Clinical Cons.-Preferred. Discuss any changes in the Network ops. plan. Clinical Services to VAPAHCS:Long-term inpt dementia care and neuro-behav problems (incl. sub. abuse), New capacity in NHCUC beyond N.Coast demand, ECT, LTC for Chronic Mentally Ill, Certain lab contract Testing. Clinical Services to SVAMC: Parkinson's Dis.& Epilepsy Surgery & Brain Mapping, Portions of Neurosurgery, Brain Stem Auditory Evoked Responses, Somato Sensory Evoked Potentials, All surgery requiring intra-op. spinal cord & root monitoring, spec. neuro testing, Electronystagmograph, Brachytherapy, Endovascular embolism, Mohs Surgery, Portions of Radiology including Neuroradiology through better use of PACS, All Dental Surgery incl Dental Implants, Portions of Laboratory Services (Flow cytometry/CD4 and TB). Admin Svcs to PAVAHCS:(unless otherwise noted) Warehousing Ops, Disposal of Govt Prop,Recycle Program, Repro(SFVAMC),Mgmt of Grounds & Trans, Prosthetics and Sensory Aids Purchasing Agent Services,IRM Help Desk, Classification Position--HR Mgmt Svc (SFVAMC),Police Tng, Network Cons. Finance Ops,Asset Mgmt Ops,Acquisition Ops. List alts considered and why alt. was selected. A - Status Quo: Though Alt A could not be selected in CARES, note that cons has occurred prior to CARES and will be documented in Portal. Cons include: VAPAHCS: Blind Rehab., Spinal Cord,Traumatic Brain Inj Rehab,PET Scanner, Lithotripsy, Dom Care,HIV/HCV viral load & genotyping, Geriatric Research & Clin Ed Cntr. SFVAMC: Pacemaker and AICD, Hepatitis testing to SFVAMC from Sierra Nevada

Market. B - Closure of One Fac: Not viable because of Network size, access constraints, and pop. served in baseline and out years. C- Lim. Cons(Two Alt):Admin Cons(C-1) maintains both facilities and cons selected admin svcs. The Network's Pref. Alt, C-2, not only includes those cons in C-1, but selected clin cons which retained the high quality of care at both sites and max efficiencies. CARES Criteria: Quality-Both facilities maintain excellence in quality-no neg impact. Safety & Env-Both will address seismic def. as needed. Access-Maintained. No addit. PI generated. Res/Affil.Exc. qual of clin prgms from the affil. with UCSF & Stanford maint & 2 of the lrgst research programs in VA. Staff/Comm. Min impact to staff. Allows workload to shift. Support Other Missions. DoD/VA sharing grows Optimizing Resources. 8.5 FTEE; \$2.37M saved annually

## **2. Special Disability Planning Initiative (if appropriate)**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

### **Your analysis should include the following:**

1. Describe the impact that the planning initiative will have on the mandated funding levels for special disability programs:
  - SCI
  - Blind Rehab
  - SMI
  - TBI
  - Substance Abuse
  - Homeless
  - PTSD
2. Discuss how the planning initiative may affect, complement or enhance special disability services.
3. Describe any potential stakeholder issues revolving around special disabilities related to the planning initiative.

### **Special Disability Narrative:**

PROXIMITY PLANNING INITIATIVE VISN NUMBER: 21 MARKET NAME North Coast/South Coast. FACILITIES: San Francisco VA Medical Center (SFVAMC)VA Palo Alto Health Care System (VAPAHCS) Provide a summ outlining the process, and how PI was resolved. VAPAHCS & SFVAMC are approx. 39.5 mi. apart. With an exhaustive objective analysis of existing/proj. workload, referral patterns, academic aff., teaching & research programs, VAPAHCS &

SFVAMC Tertiary Care Steering Committee [Cmte] found that facility has the bed capacity, infrastructure, nor clinical staff to accommodate the full workload of the other. During the process, the Cmte viewed DRG, CPT, fee workload, CARES portal data, high cost/low volume wrkld, and consulted with all service chiefs. Many activities &/or services were identified for consolidation (cons)over the next 20 yrs. The Cmte further recognizes the need to monitor future data trends to identify more cons as they impact CARES criteria. 3 options evaluated: Status Quo (Alt.A)-Not Utilized. Closure of One Facility (Alt B)-Not Feasible. Lmtd Integration & Cons. Alt C-1; Admin. Cons. Other Feasible- Alt C-2; Admin and Clinical Cons.-Preferred. Discuss any changes in the Network ops. plan. Clinical Services to VAPAHCS:Long-term inpt dementia care and neuro-behav problems (incl. sub. abuse), New capacity in NHCU beyond N.Coast demand, ECT, LTC for Chronic Mentally Ill, Certain lab contract Testing. Clinical Services to SVAMC: Parkinson's Dis.& Epilepsy Surgery & Brain Mapping, Portions of Neurosurgery, Brain Stem Auditory Evoked Responses, Somato Sensory Evoked Potentials, All surgery requiring intra-op. spinal cord & root monitoring, spec. neuro testing, Electronystagmograph, Brachytherapy, Endovascular embolism, Mohs Surgery, Portions of Radiology including Neuroradiology through better use of PACS, All Dental Surgery incl Dental Implants, Portions of Laboratory Services (Flow cytometry/CD4 and TB). Admin Svcs to PAVAHCS:(unless otherwise noted) Warehousing Ops, Disposal of Govt Prop,Recycle Program, Repro(SFVAMC),Mgmt of Grounds & Trans, Prosthetics and Sensory Aids Purchasing Agent Services,IRM Help Desk, Classification Position--HR Mgmt Svc (SFVAMC),Police Tng, Network Cons. Finance Ops,Asset Mgmt Ops,Acquisition Ops. List alts considered and why alt. was selected. A - Status Quo: Though Alt A could not be selected in CARES, note that cons has occurred prior to CARES and will be documented in Portal. Cons include: VAPAHCS: Blind Rehab., Spinal Cord,Traumatic Brain Inj Rehab,PET Scanner, Lithotripsy, Dom Care,HIV/HCV viral load & genotyping, Geriatric Research & Clin Ed Cntr. SFVAMC: Pacemaker and AICD, Hepatitis testing to SFVAMC from Sierra Nevada Market. B - Closure of One Fac: Not viable because of Network size, access constraints, and pop. served in baseline and out years. C- Lim. Cons(Two Alt):Admin Cons(C-1) maintains both facilities and cons selected admin svcs. The Network's Pref. Alt, C-2, not only includes those cons in C-1, but selected clin cons which retained the high quality of care at both sites and max efficiencies. CARES Criteria: Quality-Both facilities maintain excellence in quality-no neg impact. Safety & Env-Both will address seismic def. as needed. Access-Maintained. No addit. PI generated. Res/Affil.Exc. qual of clin prgms from the affil. with UCSF & Stanford maint & 2 of the lrgst research programs in VA. Staff/Comm. Min impact to staff. Allows workload to shift. Support Other Missions. DoD/VA sharing grows Optimizing Resources. 8.5 FTEE; \$2.37M saved annually

### C. VISN Identified Planning Initiatives

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria. (See Chapter 5 Attachment 3 guidebook and Market Plan handbook.)

#### Your analysis should include the following:

1. List all of the VISN PIs and provide a short summary. Post the entire summary documentation on the portal.

#### VISN Planning Initiatives Narrative:

VISN Identified PIs: (1) Seismic Issues and (2) Dom Care I. Seismic Issues exist in the North Coast Mkt (SFVAMC), the South Coast Mkt (PAD & MPD), and the South Valley Mkt (Fresno VAMC). The PI Sol is to correct these def thru \$162.5M in Maj ConstDef (Status Quo) and Network Plan to correct by MktNorth Coast Mkt: SFVAMC has signif seis defic in 5 bldgs. Each of these bldgs is listed as an "EHR Bldg" in VA contracted Natl Seismic Study accomplished by Degenkolb Engrs. The VISN has submitted 2 seis maj const proj for inclusion in VA's Const Budget. The 1st maj proj is a seis upgrade of Bldg 203, a 5 story, 335,000 SF structure. This bldg houses all of the Medl Cent's acute inpt bed units, diag & trmt svcs, surg, rec, med ctr support svcs and limited res activities. Bldg 203 is considered the number 1 seismic risk fac on VA's EHR List. Portions of this bldgs are in danger of collapse in a maj earthquake. The seis correction maj proj is currently in design. The current cost estimate for this maj proj is \$31M. The 2nd seismic maj const proj at SFVAMC corrects seismic deficiencies in Bldgs 1, 6, 8 and 12. These 4 bldgs total 154,000GSF and house MH and med clinics, res and admin functions. The current const cost est for the Maj proj to correct the seis deficiencies in these bldgs is \$51.5M. The total Maj Const cost for Seis Proj in the North Coast Mkt is \$82.5M. South Coast Market: PAD has 2 Seis Maj Const Proj to correct seis deficiencies in Bldgs 2 and 4. Both these bldgs are considered as "EHR Buildings" in VA's Contracted Natl Seismic Study. These 2 bldgs rank as the 2nd and 3rd highest risk on VA's EHR Bldgs List in the entire VA. Bldg 2 is a 75,000GSF fac that houses locked inpt psych units. The cost est for this seismic maj const proj is \$14M. Bldg 4 is a 90,000GSF fac that houses res functions. The cost est for the seis maj to correct the deficiencies in Bldg 4 is \$22M. Both of these projects are in design. Menlo Park Division has 1 seis maj const proj to correct deficiencies in Bldg 324. Bldg 324 is a 79,000SF fac that houses geriatric inpt psych units. This proj is designed and the current major proj const estimate is \$32M. The total Maj Const cost for Seis Proj in the South Coast Mkt is \$68M. South Valley Market: The Fresno VAMC campus has 5 bldgs are considered seis deficient. These fac (Bldgs 10, 11, 12, 13 & 14) house outpt clinics and admin functions. The cost estimate for a maj proj to repl these bldgs is \$12M.

Seis Deficiencies & Impact on CARES Criteria Threshold Criteria: Failure to correct the seis deficiencies at SFVAMC, PAD & MPD of PAHCS and Fresno VAMC will neg impact 1 of the most important CARES threshold Criteria-Providing Health Care in a

Safe Environ. Maj earthquakes have the real potntl of rendering all or any of these bldgs unusable. Which in turn, could certainly have a neg impact the del of the High Qual Health Care normally provided at all of these med ctrs (i.e., inability to del care in structurally damaged bldgs). In addition several of these pt care bldgs have the potntl of collapse in a maj seis event, which would also have a significant neg impact on the criteria of prov health care in a safe envir.II. Dom Care: 58% of Dom demand for VISN21 Enrollees is being met outside VISN21. This should be coordinated with other VISNs, primarily VISN20.

Dom Care is not being addressed as a PI in this Phase of CARES. However, VISN21 has an FY01 demand of 81,605 BDOC in Dom. 58% of this Network's demand is being met in other VISNs (primarily VISN20 at White City). This equates to 116 beds of Dom care being met outside the VISN. VISN21 has evaluated vacant spc and considered consols to prov addtl Dom spc. To date no cost efficient solution has been developed. VISN21 recommends the status quo. This has been coordinated with VISN20.

**D. VISN Level Data Summary of Post Market Plan (Workload, Space, & Costs)**

**1. Inpatient Summary**

**a. Workload**

	BDOC Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
<b>INPATIENT CARE</b>	Baseline FY 2001 BDOC	FY 2012 BDOC	FY 2022 BDOC	In House BDOC	Other BDOC	In House BDOC	Other BDOC	<b>Net Present Value</b>
Medicine	76,822	85,045	66,145	69,506	19,924	56,288	14,082	\$ (135,347,617)
Surgery	48,332	33,505	25,142	29,112	6,270	22,467	4,540	\$ 145,203,578
Psychiatry	57,662	59,820	43,780	57,430	4,495	42,447	2,336	\$ (25,710,031)
PRRTP	22,717	22,717	22,717	22,717	-	22,717	-	\$ (7,242,435)
NHCU/Intermediate	497,402	497,402	497,402	251,962	245,440	251,962	245,440	\$ (89,788,521)
Domiciliary	34,169	34,169	34,169	34,169	-	34,169	-	\$ -
Spinal Cord Injury	12,279	12,279	12,279	12,279	-	12,279	-	\$ -
Blind Rehab	7,601	7,601	7,601	7,601	-	7,601	-	\$ -
<b>Total</b>	<b>756,984</b>	<b>752,538</b>	<b>709,236</b>	<b>484,776</b>	<b>276,129</b>	<b>449,930</b>	<b>266,398</b>	<b>\$ (112,885,026)</b>

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
<b>INPATIENT CARE</b>	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	<b>Net Present Value</b>
Medicine	158,645	169,246	128,553	174,748	142,140	\$ (135,347,617)
Surgery	59,912	47,915	35,074	50,349	38,853	\$ 145,203,578
Psychiatry	103,756	96,416	70,412	100,363	74,838	\$ (25,710,031)
PRRTP	47,899	68,091	68,091	60,212	60,212	\$ (7,242,435)
NHCU/Intermediate	386,982	386,982	386,982	377,026	377,026	\$ (89,788,521)
Domiciliary	123,888	59,358	59,358	59,358	59,358	\$ -
Spinal Cord Injury	54,378	54,378	54,378	54,378	54,378	\$ -
Blind Rehab	33,352	33,352	33,352	33,352	33,352	\$ -
<b>Total</b>	<b>968,812</b>	<b>915,738</b>	<b>836,200</b>	<b>909,786</b>	<b>840,157</b>	<b>\$ (112,885,026)</b>

## 2. Outpatient Summary

### a. Workload

	Clinic Stop Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
<b>Outpatient CARE</b>	Baseline FY 2001 Stops	FY 2012 Stops	FY 2022 Stops	In House Stops	Other Stops	In House Stops	Other Stops	Net Present Value
Primary Care	642,708	891,160	693,761	856,933	64,231	679,785	43,980	\$ (233,647,751)
Specialty Care	585,522	891,008	746,480	739,903	205,110	625,828	179,656	\$ (309,214,429)
Mental Health	449,919	450,684	448,566	427,481	71,209	432,048	58,522	\$ (84,271,634)
Ancillary& Diagnostic	654,592	968,139	835,713	773,391	209,752	654,268	196,450	\$ (57,231,650)
<b>Total</b>	<b>2,332,741</b>	<b>3,200,992</b>	<b>2,724,521</b>	<b>2,797,708</b>	<b>550,302</b>	<b>2,391,929</b>	<b>478,608</b>	<b>\$ (684,365,464)</b>

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
<b>Outpatient CARE</b>	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	<b>Net Present Value</b>
Primary Care	312,166	517,638	401,080	540,967	428,858	\$ (233,647,751)
Specialty Care	439,536	1,000,122	833,318	925,582	789,679	\$ (309,214,429)
Mental Health	232,371	255,435	254,247	256,998	261,085	\$ (84,271,634)
Ancillary& Diagnostic	370,488	640,367	546,603	606,923	512,685	\$ (57,231,650)
<b>Total</b>	<b>1,354,561</b>	<b>2,413,561</b>	<b>2,035,248</b>	<b>2,330,470</b>	<b>1,992,307</b>	<b>\$ (684,365,464)</b>

### 3. Non-Clinical Summary

	Space Projections (from demand)			Post CARES (from solution)		
<b>NON-CLINICAL</b>	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	<b>Net Present Value</b>
Research	434,453	434,453	434,453	1,239,315	1,711,412	\$ (366,695,163)
Admin	1,137,362	1,173,690	1,024,570	1,338,368	1,305,691	\$ (26,525,985)
Outleased	231,937	231,937	231,937	156,500	156,500	N/A
Other	228,808	228,808	228,808	228,808	228,808	\$ (4,224,041)
Vacant Space	120,230	-	-	140,621	249,116	\$ 161,445,673
<b>Total</b>	<b>2,152,790</b>	<b>2,068,888</b>	<b>1,919,768</b>	<b>3,103,612</b>	<b>3,651,527</b>	<b>\$ (235,999,516)</b>

## II. Market Level Information

### A. North Coast Market

#### 1. Description of Market

##### a. Market Definition

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
North Coast Code: 21A	10 California counties (two , Alameda and San Mateo, shared with South Coast market)	The market extends from the northwest coast of California below the Oregon border (excluding VISN 20's Del Norte county) through San Francisco/Oakland and into the East Bay. Highway 101 (north-south) runs the length of this market. The Bay Area presents significant transportation/access challenges due to traffic, bridges, and other urban characteristics. Veterans in this market utilize VAMC San Francisco, one of two Network tertiary care medical centers for acute and tertiary care services and tend to rely on a large array of primary care clinics for outpatient care. The North Coast market offers a full continuum of services with two VA Nursing Homes, a Specialty Ambulatory Care Center, and four CBOCs.	

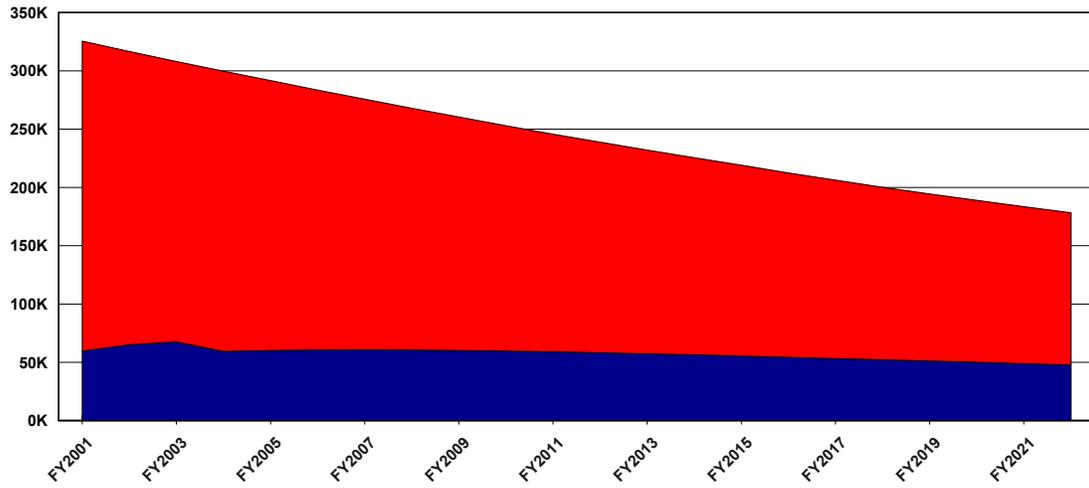
**b. Facility List**

<b>VISN : 21</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>No Cal System of Clinics</b>				
612BY Oakland	✓	-	-	-
612GD Fairfield	✓	✓	-	-
612GE Vallejo/Mare Island	✓	-	-	-
612GF Martinez	✓	-	-	-
612GH McClellan	✓	-	-	-
<b>San Francisco</b>				
662 San Francisco	✓	✓	✓	-
662BU 13th & Mission VA Clinic	✓	-	-	-
662GA Santa Rosa	✓	-	-	-
662GC Eureka	✓	-	-	-
662GD Ukiah	✓	-	-	-
New New North Coast Clinics	✓	-	-	-

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
North Coast Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care	Access				
	Access to Hospital Care	Access				
	Access to Tertiary Care	Access				
Y	Primary Care Outpatient Stops	Population Based	66,266	43%	7,674	5%
		Treating Facility Based	110,859	63%	42,190	24%
Y	Specialty Care Outpatient Stops	Population Based	42,801	28%	3,850	3%
		Treating Facility Based	64,402	32%	18,432	9%
N	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	-355	0%	-1,152	-1%
N	Medicine Inpatient Beds	Population Based	8	13%	-10	-17%
		Treating Facility Based	-8	-13%	-23	-38%
Y	Surgery Inpatient Beds	Population Based	-15	-37%	-22	-55%
		Treating Facility Based	-19	-36%	-28	-54%
N	Psychiatry Inpatient Beds	Population Based	3	6%	-12	-22%
		Treating Facility Based	-5	-22%	-9	-37%

**e. Stakeholder Information**

Discussion of stakeholder input and how concerns/issues were addressed.

**Stakeholder Narrative:**

Feedback from stakeholders included a comment that SFVAMC should improve access and travel times for outpatient specialty care. This was submitted via the quarterly input from veterans service officers meeting. The CARES plan for the North Coast Market includes expanded specialty care at Santa Rosa as well as improved transportation to Santa Rosa from the outlying areas which will decrease the need to travel to SFVAMC.

The University affiliate voiced written concern over the potential decrease in surgical beds in 2022. NCPO reviewed and withdrew the planning initiative.

**f. Shared Market Discussion**

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

**Shared Market Narrative:**

North Coast Market Plan sees patients from outside VISN 21 for Pacemaker and Auto Implantable Cardiac Surveillance. In addition, veterans are referred for gastric surgery for obesity, Cardiac & Neurosurgical procedures including movement disorders. Due to the significant demand for homeless domiciliary care, VISN 21 will continue to rely on other VISNs to meet the needs of VISN 21 veterans.

SWOO analysis:

Strengths: The med center draws high caliber clinicians, has an excellent relationship with its affiliate, which drives high clinical performance and quality results; laudable research (2nd largest research in VA), and provides training and education opportunities.

Weaknesses: The market has not met the specialty care needs of its veterans as well as availing transportation to them to get to the medical center. The Bay area is congested and difficult for the aged. Seismic deficiencies are a weakness for all hospitals in the Bay area.

Opportunities: Strat and CARES market planning has identified ways to meet specialty care at existing and new CBOCS. Transportation is being addressed. New DoD, E-U and affiliate opportunities are abundant.

Obstacles: Funding!! Lack of parity in salaries and health care professions--even clerks makes it difficult to draw some positions to SFVAMC and maintain operational efficiency.

**g. Overview of Market Plan**

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

**Executive Summary Narrative:**

1. Workload gaps exist in both planning years with the most sig increase in 2012 of 110,859 Primary Care Clinic stops (63%) using treating facility projection. Pref. Alt Short Term: Expand primary care at San Fran VA Med Ctr (SFVAMC) thru Minor via existing space; Expand CBOCs in Santa Rosa and Ukiah; Expand HBPC at all CBOCS; New CBOC in North San Mateo; Relocate 13th & Mission for new Primary Care. Mid Term: Move Mental Health from Oakland Army Base to Highland Hsp; Expand Eureka CBOC (contract); Establish new CBOC in Lake Co. Long Term: Replacement lease facility for Oakland OPC; New CBOCs in Richmond and Pittsburgh/Antioch. Other Feasible Alt: Build Ambulatory Care Center in Santa Rosa to replace and expand current leased facility; Build Amb Care Cntr in Oakland

2. Outpatient Specialty Care: Wrkld gaps exist in both planning years with the most sig increase in 2012 of 64,402 Specialty Clinic stops (32%) using treating facility projection. CARES Market Plan for Specialty Care will include a Pref Option that distributes wrkld among parent and satellite facilities. Pref Alt. Short Term: Expand specialty outpatient programs and telemedicine in Oakland/Alameda and Santa Rosa, Ukiah and Eureka; Transpor-tation access for veterans to improving network of shuttle vans thru market; Expand Amb. Care Specialties (Eye & ENT) at SFVAMC w/ previously approved Minor; Exp outpt med and surg procedures at Martinez; Building 203 Seismic Retrofit (app. awaiting \$). Mid Term: Expand outpt surg and med procedure capacity and specialty clinics (Add'l cardiac cath lab in SFVAMC, Minor Submission for outpt neuro-rehab program at Martinez; pain, pre-op, cardiology, neurology, C&P geriatrics, and other specialty clinics at SFVAMC), and E&A/ER expansion at SFVAMC. Long Term: Utilize space used and vacated by Research for expansion of new specialty; programs at SFVAMC Other Feasible Alternatives: Build Amb Care Cntr in Oakland to replace & expand current leases at MLK and Oakland Army Base, Build 60,000 gsf Amb Care Cntr in Santa Rosa to replace and expand current leased facility

3. Tertiary Care Proximity: VA Palo Alto Health Care System (VAPAHCS) and SFVAMC are located approximately 39.5 miles apart. Based on the relative proximity, NCPO established a PI regarding tertiary care and tasked VAPAHCS and SFVAMC to review their clinical and admin programs and identify potential

opportunities for cost efficiencies using CARES criteria. The Network's Pref Alt called for selected clinical and admin consolidations and is listed in the portal

4. Other Workload or Space Planning Gaps: VA/DoD

Collab SFVAMC and the 60th Medical Group (60MDG) at Travis AFB are initiating a new sharing agreement for a Brachytherapy Program that would allow for treatment of DoD beneficiaries at SFVAMC & training of DoD staff by SFVAMC staff. Hyperbaric medicine will also be initiated at 60MDG. DoD funded \$2 M grant recently approved for MRI/MRSI research in neurodegenerative disease at SF. Other Sharing in Oakland Outpt Clinic with US Army for shared space, training, and military sick call needs.

5. Research Space Deficiency Current- 131,466 sf Needed- 359,621 sf Pref Alt: Research Facility on site through for Enhanced Use. Other Feasible Alt: Research Fac off site

6. Facility Condition/Seismic Safety Issues: Bldg 203 Seismic Retrofit; Seismic upgrade of Buildings 1, 6, and 8, & Bldg. 12 replacement/seismic upgrade and Parking Lot 1 new parking structure.

7. Other-Parking Shortage: Significant parking deficit at SFVAMC. Build new parking structure (600-700 spaces) adjacent to existing structure as part of Enhanced Use; new visitors parking lot (200-300 spaces)

8. North Coast Market sees patients from outside VISN 21 for Pacemaker Surveillance and Auto Implantable Cardiac Surveillance Care, surgery to reverse morbid obesity, and neurosurgery for movement disorders.

## 2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

### Access Narrative:

No Impact

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
<b>Primary Care</b>	<b>85%</b>	9,543	<b>88%</b>	6,991	<b>89%</b>	5,257
<b>Hospital Care</b>	<b>77%</b>	14,632	<b>78%</b>	12,817	<b>78%</b>	10,513
<b>Tertiary Care</b>	<b>92%</b>	5,089	<b>94%</b>	3,496	<b>95%</b>	2,389

### Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time  
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time  
Rural Counties – 90 minutes drive time  
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours  
Highly Rural Counties – within VISN

### 3. Facility Level Information – New North Coast Clinics

#### a. Resolution of VISN Level Planning Initiatives

##### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

##### **Proximity Narrative:**

No Impact

##### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

##### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

No Impact

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

***Proposed Management of Workload – FY 2012***

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections)											
	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>												
Medicine	-	-	-	-	-	-	-	-	-	-	-	\$ -
Surgery	-	-	-	-	-	-	-	-	-	-	-	\$ -
Intermediate/NHCU	-	-	-	-	-	-	-	-	-	-	-	\$ -
Psychiatry	-	-	-	-	-	-	-	-	-	-	-	\$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	-	-	-	-	-	-	-	-	-	-	-	\$ -
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections)											
	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>												
Primary Care	-	-	20,000	20,000	-	-	-	-	-	-	20,000	\$ (75,641,117)
Specialty Care	-	-	-	-	-	-	-	-	-	-	-	\$ -
Mental Health	-	-	-	-	-	-	-	6,000	-	-	6,000	\$ (14,257,498)
Ancillary & Diagnostics	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	-	-	20,000	20,000	-	-	-	6,000	-	-	26,000	\$ (89,898,615)

**Proposed Management of Space – FY 2012**

		Space (GSF) proposed by Market Plans in VISN									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>INPATIENT CARE</b>											
Medicine	-	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	-	-	-	-	-	-	-	-	-	-	-
Psychiatry	-	-	-	-	-	-	-	-	-	-	-
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		Space (GSF) proposed by Market Plan									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>OUTPATIENT CARE</b>											
Primary Care	-	13,400	13,400	-	-	-	-	16,600	-	16,600	3,200
Specialty Care	-	-	-	-	-	-	-	-	-	-	-
Mental Health	-	3,300	3,300	-	-	-	-	3,000	-	3,000	(300)
Ancillary and Diagnostics	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		16,700	16,700	-	-	-	-	19,600	-	19,600	2,900
<b>NON-CLINICAL</b>											
Research	-	-	-	-	-	-	-	-	-	-	-
Administrative	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		-	-	-	-	-	-	-	-	-	-

#### **4. Facility Level Information – No California System of Clinics**

##### **a. Resolution of VISN Level Planning Initiatives**

###### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

###### **Proximity Narrative:**

No Impact

###### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

###### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

Under the PSA realignment of Oakland OPC to North Coast is an agreement with the Army's 63rd Regional Command. This agreement is essentially barter for shared space at the former Oakland Army Base in exchange for VA to take on sick call, and provide training opportunities.

Impact CARES Criteria: Meets Other Missions of VA, and Optimizes Resources, and Enhances Access

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

#### **VISN Identified Planning Initiatives Narrative:**

No Impact



**Proposed Management of Space – FY 2012**

		Space (GSF) proposed by Market Plans in VISN									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>INPATIENT CARE</b>											
Medicine	-	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	39,730	39,729	(1)	39,730	-	-	-	-	-	39,730	1
Psychiatry	-	-	-	-	-	-	-	-	-	-	-
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>39,730</b>	<b>39,729</b>	<b>(1)</b>	<b>39,730</b>	-	-	-	-	-	<b>39,730</b>	<b>1</b>
		Space (GSF) proposed by Market Plan									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>OUTPATIENT CARE</b>											
Primary Care	66,718	61,718	32,158	29,560	-	-	-	20,000	-	49,560	(12,158)
Specialty Care	125,533	125,533	86,831	38,702	-	20,000	-	40,000	-	98,702	(26,831)
Mental Health	53,615	47,015	22,583	24,432	-	-	-	12,000	-	36,432	(10,583)
Ancillary and Diagnostics	104,936	104,936	74,930	30,006	-	30,000	-	20,000	-	80,006	(24,930)
<b>Total</b>	<b>350,801</b>	<b>339,202</b>	<b>216,502</b>	<b>122,700</b>	-	<b>50,000</b>	-	<b>92,000</b>	-	<b>264,700</b>	<b>(74,502)</b>
<b>NON-CLINICAL</b>											
Research	-	41,724	21,101	20,623	1,200	7,500	-	10,750	-	40,073	(1,651)
Administrative	259,027	115,817	-	115,817	-	-	-	-	-	115,817	-
Other	25,130	25,130	-	25,130	-	-	-	-	-	25,130	-
<b>Total</b>	<b>284,157</b>	<b>182,671</b>	<b>21,101</b>	<b>161,570</b>	<b>1,200</b>	<b>7,500</b>	-	<b>10,750</b>	-	<b>181,020</b>	<b>(1,651)</b>

## 5. Facility Level Information – San Francisco

### a. Resolution of VISN Level Planning Initiatives

#### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

#### **Proximity Narrative:**

During the Proximity PI devel. process, the Cmte analyzed DRG, CPT, fee workload, CARES portal data, high cost/low volume wrkld, & consulted with service chiefs from every service. Several activities &/or services were ID'd for Cons over the next 20 yrs. The Cmte further recognizes the need to monitor future data trends to identify further consolidations as they impact CARES criteria.

3 options evaluated: Status Quo--Not Utilized; Closure of One Facility--Not Feasible; Limited Integration & Consolidation (Cons), Admin Cons--Other Feasible; and Alt

C-2, Admin & Clin Cons--Preferred Alternative

Status Quo: Though Alt A could not be selected in CARES, it is imp.t. to note that facility & Network cons has occurred prior to CARES. They include:(VAPAHCS) Blind Rehab, Spinal Cord Inj., Traumatic Brain Injury Rehab, PET Scanner, Lithotripsy, Dom Care, HIV/HCV viral load & genotyping, and Geriatric Research & Clin Ed Cr; (SFBVAMC) Pacemaker & Auto Implantable Cardiac Defibrillator Surveillance, Hepatitis testing to SFBVAMC from Sierra Nevada Market. Admin Cons. in contracting, third party, planning, and police services.

The Network's Preferred Alt, C-2, selected Clin and Admin Consolidations which retained the high quality of care at both sites & maxed efficiencies.

Clin Services to VAPAHCS: Long-term inpatient dementia care & neurobehav. prob. (incl. sub. abuse), New capacity in NHCU beyond North Coast demand, ECT, LTC for Chronically Mentally Ill, certain lab specialized & sendout testing  
Clin Services to SFBVAMC: Parkinson's Disease & Epilepsy Surgery & Brain Mapping, portions of neurosurgery, Brain Stem Auditory Evoked Responses, Somato Sensory Evoked Potentials, all surgery requiring intra-operative spinal cord & root monitoring, specialized neuro testing, restorative eye, Electronystagmographs, Brachytherapy, Endovascular Embolism, Mohs Surgery,

portions of radiology incl. neuroradiology via PACS, all dental surgery , portions of lab svcs, (Flow Cytometry/CD4, TB testing) Admin Services to PAVAHCS (unless otherwise noted) Warehousing Ops, Disposal of Govt Prop., Recycle Program, Repro (SFVAMC), Mgmt of Grounds & Transportation, Prosthetics & Sensory Aids Purchasing Agent Services, IRM Help Desk, Classification Position--HRMS (SFVAMC), and Police Tng.

Network Cons: Finance, Asset Management, & Acquisition Operations

Impact on CARES Criteria:

Healthcare Quality--Both facilities maintain excellence in quality with no neg impact;

Safety & Environment--Both will address seismic deficiencies;

Access--Maintained, without additional PI generated; Research/Affiliations--The outstanding quality of the clin programs resulting from the affiliations with UCSF & Stanford is maintained, with very highly rated teaching programs & 2 of the largest research programs in the VA; Staffing/Community--Minimal impact to staffs at both sites. Allows workload to shift betwn sites during periods of staff shortages, bed availability

Support Other Missions--DoD/VA sharing grows for both orgs; Opt Resources--8.5 FTEE savings & over \$2.37M estimated through clinical and administrative consolidation & space optimization annually.

### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

North Coast & the 60th Medical Group at Travis AFB are working an agreement for Brachytherapy services at SFVAMC. Estimated cases to average 22 per year. This agreement also allows training of DoD clinicians by SFVAMC staff and affiliate. SFVAMC has excess capacity available in this specialty. Hyperbaric Medicine is also being discussed for a possible sharing agreement between the 60th and SFVAMC. Veterans referred by SFVAMC can be treated at Travis AFB. Estimated cases per year are approximately 12, though one case has multiple dives (visits). Patients requiring hyperbarics are currently referred down to VISN 22 in Long Beach.

Impact to CARES Criteria: Supports research and other missions of VA, as well as optimizing resources.

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

**Enhanced Use Narrative:**

Enhanced Use Enhanced-Use project for a new Research Center on the San Francisco VAMC campus. CARES projects a significant space deficiency in Research space at the San Francisco VAMC (2nd largest Research program in VA) campus. An Enhanced Use (EU) lease with Northern California Institute for Research & Education (NCIRE) & San Francisco VA Medical Center (SFVAMC) is planned to develop a new research facility on the SFVAMC Campus that will allow for the continued growth of research programs & activities, & address the research space deficiency. Research activities at SFVAMC are currently constrained by the lack of adequate facilities. Research laboratories are inadequate in terms of design, size & location. Research activities occupy 118,000 NSF, including a 15,000 NSF Animal Care Facility, & are located in 14 different buildings on the Medical Center Campus. The location of many of these research functions in Clin & Admin settings is far from ideal. Many of the research laboratories & support spaces are undersized & located in dispersed & disjointed facilities, which in turn, seriously impact efficient research operations. Consequently these facility constraints significantly hamper growth in VA funded research programs & activities as well as a near term anticipated growth factor of between 50 to 75 percent in non-VA-funded research at SFVAMC. Parking facilities on the SFVAMC Campus are included in the plan for all parking displaced by the EU facility & for providing additional parking for the projected additional staff that will work in the new research facility. E-U Business Plan approved, Public Hearing held, awaiting Secretary's decision on Designation. CARES Criteria Impact: Improves Healthcare Quality & Need, provides a safe environment in a seismically safe facility, supports research, benefits community at large and optimizes use of resources (need for add'l parking)

## **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

### **VISN Identified Planning Initiatives Narrative:**

#### **VISN 21 IDENTIFIED PLANNING INITIATIVE: SEISMIC SAFETY PROJECTS SFVAMC**

Status Quo: Currently, SFVAMC has five buildings, which have been independently evaluated by Degenkolb & Assoc for structural soundness and determined to pose a high degree of risk to either life safety of building occupants or to the continued operation of the essential functions contained therein. VA has generated a national Exceptionally High Risk (EHR) listing of its most critical buildings requiring seismic retrofitting. Bl. 203, the main hospital building for SFVAMC, is ranked second nationally. Buildings 1, 6, 8 and 12 at SFVAMC also rank highly on the list and have driven the development of major construction project applications. If none of these buildings are retrofitted, VA would be exposing patients, staff and visitors to life safety risks should a major quake occur. In addition, the risk of loss of operations of this tertiary care medical center to 1.2 Million veterans within the VISN would be increased. Preferred Alternative: The alternative preferred for CARES submission calls for seismically retrofitting Bl. 203 first through a major construction project. This project was included with the President's FY03 budget, but not funded by the Congress. Because it is the main hospital structure, it is critical to fund and complete retrofitting as early as possible. The other four buildings were submitted for FY04 funding approval in a consolidated major retrofitting project. This project was not approved and will now be split into two separate majors for ease of phasing and implementation. These buildings contain a combination of patient care, research and some administrative functions.

#### **Impacts on CARES Criteria:**

-Quality and Need: Seismically retrofitting essential facilities containing inpatient care, diagnostic care, specialty outpatient programs and much of the research at the nation's second largest funded research facility will enable the continuation of top quality care to veterans at the SFVAMC. Loss of these

structures due to a major quake would likely eliminate much of the excellence in clinical and research programs that now exist on site.

-Safety and Environment: Seismic retrofitting by definition is aimed at improving the safety of a facility and the persons who use it.

- Research and Affiliations: As noted above, the nation's second largest VA research facilities houses many of its ongoing investigations in these five SFVAMC buildings. Loss of programs through major quake would be devastating in terms of the direct research benefits lost and investments that could not be easily recaptured.

-Staffing and Community: Seismic retrofitting makes a facility safer for all: the staff, the patients and community who might need to use SFVAMC in event of an emergency or local disaster. Loss of a facility due to earthquake would remove a vital resource from western SF and eliminate up to \$250 Million from the Bay Area economy.

-Optimizing Resources: Seismically retrofitting facilities in order to keep them safe and functional is a means of avoiding a new and costlier replacement facility. In terms of capital costs, it is frequently more cost effective than a total replacement.

-Support of Other VA Missions: SFVAMC supports the local VA Cemetery and conducts C&P evaluations in support of VBA. Keeping Bl. 203 in operation is important to both.

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>												
Medicine	15,787	150	15,788	151	316	-	-	-	-	-	15,472	\$ (6,424,064)
Surgery	10,132	(5,060)	10,132	(5,060)	-	-	-	-	-	-	10,132	\$ (2,490,167)
Intermediate/NHCU	45,835	-	45,835	-	11,918	-	-	-	-	-	33,917	\$ -
Psychiatry	5,895	(231)	5,895	(230)	118	-	2,100	-	-	-	3,677	\$ 25,239,526
PRRTP	854	-	854	-	-	-	-	-	-	-	854	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>78,503</b>	<b>(5,141)</b>	<b>78,504</b>	<b>(5,139)</b>	<b>12,352</b>	<b>-</b>	<b>2,100</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>64,052</b>	<b>\$ 16,325,295</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>												
Primary Care	152,974	54,977	142,974	44,978	11,438	-	-	-	-	-	131,536	\$ 18,875,603
Specialty Care	149,471	12,231	149,471	12,231	7,474	-	-	-	-	-	141,997	\$ (103,108,997)
Mental Health	118,819	(815)	118,819	(814)	7,130	-	-	-	-	-	111,689	\$ -
Ancillary & Diagnostics	138,785	53,423	138,785	53,424	15,267	-	-	-	-	-	123,518	\$ (6,124,949)
<b>Total</b>	<b>560,048</b>	<b>119,817</b>	<b>550,049</b>	<b>109,818</b>	<b>41,309</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>508,740</b>	<b>\$ (90,358,343)</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved to Vacant
<b>INPATIENT CARE</b>	<b>FY 2012</b>	48,273	9,482	48,273	9,482	-	3,000	-	-	41,791	(6,482)
Medicine		16,819	1,599	16,819	1,599	-	-	-	-	15,220	(1,599)
Surgery		49,713	-	49,713	(1)	-	-	-	-	49,713	1
Intermediate Care/NHCU		9,359	3,214	5,957	(188)	-	-	-	-	6,145	188
Psychiatry		4,065	-	-	-	-	-	-	-	-	-
PRRTP		-	-	-	-	-	-	-	-	-	-
Domiciliary program		-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury		-	-	-	-	-	-	-	-	-	-
Blind Rehab		-	-	-	-	-	-	-	-	-	-
<b>Total</b>		<b>128,229</b>	<b>18,360</b>	<b>120,761</b>	<b>10,892</b>	-	<b>3,000</b>	-	-	<b>112,869</b>	<b>(7,892)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved to Vacant
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	94,293	47,171	88,129	41,007	10,000	-	18,000	-	75,122	(13,007)
Primary Care		156,197	68,198	156,197	68,198	28,900	-	10,000	-	126,899	(29,298)
Specialty Care		61,429	11,730	61,429	11,730	-	-	-	-	49,699	(11,730)
Mental Health		118,578	49,789	118,577	49,788	25,000	-	-	-	93,789	(24,788)
Ancillary and Diagnostics		430,498	176,889	424,332	170,723	63,900	-	28,000	-	345,509	(78,823)
<b>Total</b>											
<b>NON-CLINICAL</b>	<b>FY 2012</b>	-	(131,466)	588,714	457,248	33,000	-	119,500	200,000	486,339	(102,375)
Research		-	(155,573)	186,700	31,127	-	-	-	-	155,573	(31,127)
Administrative		21,524	-	21,524	-	-	-	-	-	21,524	-
Other		-	-	-	-	-	-	-	-	-	-
<b>Total</b>		<b>21,524</b>	<b>(287,039)</b>	<b>796,938</b>	<b>488,375</b>	<b>33,000</b>	-	<b>119,500</b>	<b>200,000</b>	<b>663,436</b>	<b>(133,502)</b>

**B. North Valley Market**

**1. Description of Market**

**a. Market Definition**

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
North Valley  Code: 21B	14 California counties	The North Valley market extends through the northern interior of the state from the central Oregon border, through rural northern California and the Sacramento Valley to the Carquinez Straits. Highway 5 (north-south) joins Highway 80 (east-west) in the Sacramento Valley. At the north end of this market, a VISN 20 CBOC exists within the 50-mile buffer, with very little crossover workload. The California state capitol of Sacramento serves as the metropolitan center that anchors the North Valley market. The VA Northern California Health Care System (NCHCS) operates several facilities throughout this market, including the secondary care facility, VA Sacramento Medical Center. NCHCS has active sharing agreements in place with Travis AFB and the system serves a large TRICARE population. There are five CBOCs that further support this market. The North Valley market tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco as appropriate.	

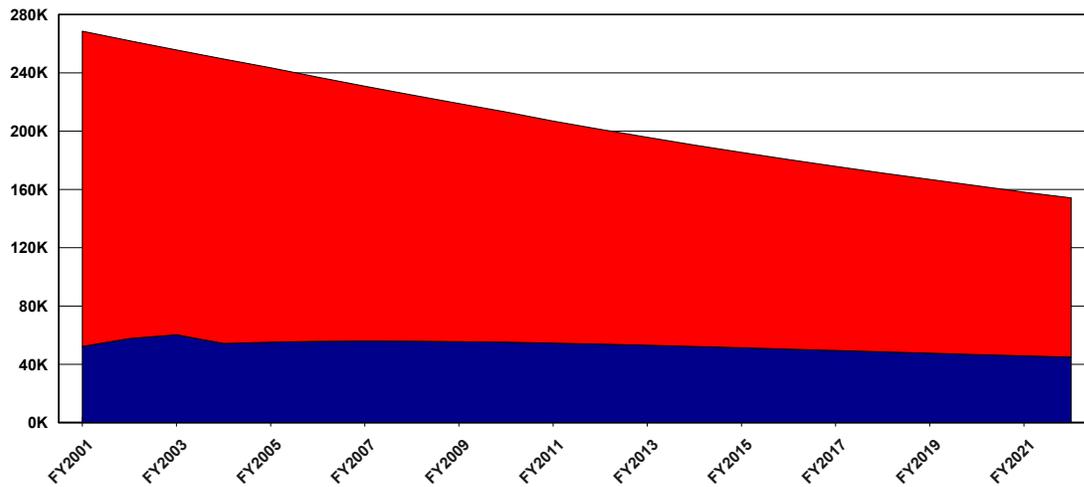
**b. Facility List**

<b>VISN : 21</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Sacramento</b>				
612A4 N. California HCS-Sacramento	✓	✓	-	-
612B4 Redding	✓	-	-	-
612GG Chico	✓	-	-	-
New Marysville City	✓	-	-	-

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
North Valley Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care	Access				
	Access to Hospital Care	Access				
	Access to Tertiary Care	Access				
Y	Primary Care Outpatient Stops	Population Based	64,611	49%	18,492	14%
		Treating Facility Based	19,258	16%	-13,132	-11%
Y	Specialty Care Outpatient Stops	Population Based	61,035	58%	32,078	30%
		Treating Facility Based	39,813	44%	17,260	19%
N	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	235	1%	69	0%
N	Medicine Inpatient Beds	Population Based	13	36%	1	2%
		Treating Facility Based	22	84%	10	39%
N	Surgery Inpatient Beds	Population Based	-1	-5%	-6	-30%
		Treating Facility Based	-1	-5%	-4	-30%
N	Psychiatry Inpatient Beds	Population Based	10	36%	-1	-4%
		Treating Facility Based	6	317%	3	178%

**e. Stakeholder Information**

Discussion of stakeholder input and how concerns/issues were addressed.

**Stakeholder Narrative:**

The VISN 21 - North Valley Market has incorporated all concerns addressed by stakeholders into our market plans. Certainly, the demand for primary care and specialty care at our sites have been addressed by the development of planning initiatives within our overall market plan. Since, June 2002, the VISN 21 North Valley Market held seven (7) congressional briefings, twelve (12) Veteran Service Officer (VSO) briefings, eleven (11) town-hall meetings for veterans, stakeholders, and employees and one (1) affiliate briefing. Significant concerns and resolution is addressed below: 1. FEEDBACK: Veterans in the far northern areas of California are underserved due to a lack of available inpatient VA beds. Patients requiring inpatient treatment must travel far distances to obtain medical care rather than having an opportunity to be treated within their own community. VA should contract with a local hospital for 10 inpatient beds so veterans have access to care 24/7. SOURCE: Congressman Wally Herger and the Shasta-Butte Veterans Advisory Council. INCORPORATED INTO MARKET PLAN: CARES projections indicate that the inpatient workload needs in the Shasta-Butte Primary Service Area may be as high as ten beds. VISN 21 - North Valley Market Committee has incorporated the use of up to ten contract beds in the market plan. 2. FEEDBACK: VISN 21 - North Valley Market should implement building expansions and additions at the Redding and Chico OPCs to accommodate growing workload and to help reduce waiting times. SOURCE: Congressman Wally Herger and the Shasta-Butte Veterans Advisory Council. INCORPORATED INTO MARKET PLAN: VISN 21 - North Valley Market Committee incorporated a building expansion at the Chico Outpatient Clinic into our CARES Market Plan. This expansion will help to decompress congested conditions at the Redding OPC and reduce waiting times for patients at both medical facilities. VISN 21- North Valley Market Committee has also proposed establishing a CBOC in Marysville-Yuba City to also help alleviate some of the congestion at the Chico OPC and Sacramento medical facilities. An addition and/or expansion of the Redding OPC was also proposed in the Market Plan. This addition/expansion will be implemented only after management staff has had an opportunity to assess the impact of the Chico building expansion on the Redding OPC workload and wait times. 3. FEEDBACK: VA should carefully review data to ensure veteran population are correct and that projected growth in Redding-Chico area accurately reflect local economic conditions to include the departure of HMO's in the area. SOURCE: Congressman Wally Herger. INCORPORATED INTO MARKET PLAN: VISN 21 - North Valley Market Committee has reviewed data carefully to verify veteran projects for Shasta-Butte Primary Service Area. VISN 21 - North Valley Market Committee has requested that the CARES Program Office provide additional information to substantiate projected growth and if necessary, we will adjust the market plan to reflect any

changes. 4. FEEDBACK: VISN 21 - North Valley Market Committee need to address potential shortfalls with the limited information being used in the CARES evaluation process. Shortfalls should include long waiting times, inadequate staffing, and lack of specialized services at the Fairfield VA Outpatient Clinic. SOURCE: Mr. Carl Young, Commander, DAV Post 84, Vacaville, CA. INCORPORATED INTO MARKET PLAN: VISN 21- North Valley Market Committee incorporated into its market plan an initiative to expand specialty care capability at the Fairfield VA outpatient Clinic using existing space and equipment.

**f. Shared Market Discussion**

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

**Shared Market Narrative:**

Inpatient Psych Beds – from Palo Alto to VAMC Sacramento: VA Northern California Health Care System (VANCHCS) reallocating enough psychiatric workload each year to fill ten beds at VAMC Sacramento. This will amount to 33% of our total acute psychiatric workload. The remainder of our acute psychiatric workload will be distributed to VA Palo Alto Health Care System. This CARES planning initiative has been coordinated with VA Palo Alto Health Care System and they concur with this initiative. Also, as addressed under collaborative opportunities, both the Northern California Health Care System and the 60th Medical Group are exploring the possibility of a VA/DOD collaboration for a VA inpatient Mental Health Unit at the David Grant Medical Center. A joint VA/Air Force working group is working out details on potentially opening up this unit as early as 2004. Stakeholders have been briefed and participate in the planning process.

**g. Overview of Market Plan**

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

**Executive Summary Narrative:**

Background: The North Valley Market extends through the northern interior of the state through rural northern California and the Sacramento Valley. The North Valley Market includes 14 large and diverse counties, operating several facilities throughout the market, including VAMC Sacramento. A new expanded 55-bed inpatient tower has recently completed construction with occupancy planned for the summer 2003. VAMC Sacramento maintains a strong affiliation with the University of California Davis, School of Medicine (UCD). The North Valley Market has nurtured and developed a strong alliance with the 60th Medical Group, at Travis Air Force Base, California. North Valley Market has evaluated the health care services it provides, identifying the best way to meet veteran health care needs, and realigning our medical facilities and services to meet those needs effectively and more efficiently. PI: Outpatient Primary Care, Sacramento (Increase): Active Planning Scenario: 1. Expand Redding OPC NSF in FY05 via new construction for administrative space; convert former administrative space to clinical space to meet the modest increased demand for primary care in the Redding PSA. 2. Expansion of Chico OPC, currently underway, will provide additional primary care capability 3. Expand primary care services at Mare Island and Fairfield OPCs, by utilizing existing VA clinical space/capacity, to meet the increased demand for primary care in the Mare Island & Fairfield PSAs. 4. Expand primary care services in Sacramento by leasing from FY04 to FY15 to cover temporary spike in primary care demand in the Sacramento area Other Feasible Alternative: 1. Expand Redding OPC from FY05 to FY15 by leasing space to accommodate administrative functions; convert former administrative space to clinical space to meet modest increase in primary care demand in the Redding PSA. 2. Expansion of Chico OPC, currently underway, will provide additional primary care capability 3. Expand primary care services at Mare Island and Fairfield OPCs, by utilizing existing VA clinical space/capacity, to meet the increased demand for primary care in the Mare Island & Fairfield PSAs. 4. Expand primary care services in Sacramento by leasing 10,000 NSF from FY04 to FY15 to cover temporary spike in primary care demand in the Sacramento area PI: Outpatient Specialty Care (Increase): Active Planning Scenario: 1. Construct building at Sacramento VAMC in FY05 to accommodate specialty care providers in support of both inpatient and outpatient specialty care services (this minor construction project is necessary due to insufficient funding in major construction program, New Inpatient Bed Tower) 2. Expand Redding OPC in FY05 via new construction for administrative space; convert former

administrative space to clinical space to meet the increased demand for specialty care in the Redding PSA3. Utilize existing clinical space and capacity at the Fairfield and Mare Island OPCs supplemented by clinical space/capacity at the Martinez OPC and our VA/DOD partner DGMC, to accommodate increased demand for specialty services in Fairfield and Mare Island PSAs 4. Expand Chico OPC lease by from FY03 to FY22

Other Feasible Alternative:

1. Due to severely limited clinical space at Sacramento VAMC contract out the vast majority of outpatient specialty care services in Sacramento in fiscal years 2005 through 2022
2. Expand Redding OPC by leasing from FY05 through FY22 to accommodate administrative functions; convert former administrative space to clinical space to meet modest increase in specialty care demand in the Redding PSA3. Utilize existing clinical space and capacity at the Fairfield and Mare Island OPCs supplemented by clinical space/capacity at the Martinez OPC and our VA/DOD partner DGMC to accommodate increased demand for specialty services in Fairfield and Mare Island PSAs
4. Expand Chico OPC lease from FY03 to FY22

## 2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

### Access Narrative:

The quality of care will be improved by the addition of a CBOC in Marysville offering primary care services. This effects over 1,500 current enrollees. Inpatient acute psychiatric care will also be added to the services offered in the N. Valley Market so patients wouldn't have to travel to Palo Alto for this care. The increase in inpatient capacity with the activation of the new Sacrameto VA bed tower in the Spring'03 will help the N. Valley will help alleviate a deficiency in current capacity again the baseline demand.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	72%	15,648	79%	11,311	75%	11,229
Hospital Care	67%	18,442	67%	17,774	73%	12,127
Tertiary Care	88%	6,706	88%	6,463	98%	898

### Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time  
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time  
Rural Counties – 90 minutes drive time  
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours  
Highly Rural Counties – within VISN

### **3. Facility Level Information – Marysville City**

#### **a. Resolution of VISN Level Planning Initiatives**

##### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

##### **Proximity Narrative:**

No Impact

##### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

##### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

No Impact

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

**VISN Identified Planning Initiatives Narrative:**

No Impact



**Proposed Management of Space – FY 2012**

		Space (GSF) proposed by Market Plans in VSN									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/Moved to Vacant
	FY 2012										
<b>INPATIENT CARE</b>											
Medicine	-	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	-	-	-	-	-	-	-	-	-	-	-
Psychiatry	-	-	-	-	-	-	-	-	-	-	-
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		Space (GSF) proposed by Market Plan									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/Moved to Vacant
	FY 2012										
<b>OUTPATIENT CARE</b>											
Primary Care	-	-	-	-	-	-	-	-	-	-	-
Specialty Care	-	-	-	-	-	-	-	-	-	-	-
Mental Health	-	-	-	-	-	-	-	-	-	-	-
Ancillary and Diagnostics	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
<b>NON-CLINICAL</b>											
Research	-	-	-	-	-	-	-	-	-	-	-
Administrative	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											

#### **4. Facility Level Information – Sacramento**

##### **a. Resolution of VISN Level Planning Initiatives**

###### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

###### **Proximity Narrative:**

No Impact

###### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

###### **Small Facility Narrative:**

No Impact

## **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

### **DOD Narrative:**

DOD: Our collaborative efforts with DOD, (the 60th Medical Group) is a mainstay in our ability to provide access and quality care to our patients. Our relationship with the 60th Medical Group is excellent and we consider them a “high priority” and real “partner” in our ability to provide care to our patient population. The foundation of our health care delivery system is VAMC Sacramento and the other facilities within VANCHCS, along with the 60th Medical Group (DOD), and the remaining care is provided by contract services. VA/DOD Support Agreement between the 60th Medical Group, David Grant Medical Center, Travis Air Force Base, California and the Northern California Health Care System (VANCHCS) is one of the most active collaborative VA/DOD efforts in sharing health care delivery within the Veterans Health Affairs. David Grant Medical Center (DGMC) is the second largest medical center within the United States Air Force. DGMC offers a full array of medical/surgical capability and tremendous opportunities for sharing activities with VANCHCS. An active collaborative sharing agreement has been in effect since 1994 and continues to mature. Active participation has led to numerous sharing opportunities with the 60th Medical Group. They include: The 60th Medical Group provides VANCHCS approximately \$2.0 million for inpatient medical/surgical care annually. Average Daily Patient Load (ADPL), is approximately 2.0 patients. The close-proximity to the 60th Medical Group allows VANCHCS inpatient capability for our Solano County veterans. The current inpatient reimbursement methodology is based on 75% of the CHAMPUS Maximum Allowable Charge (CMAC), which is very competitive in the health care market. Estimated cost avoidance is \$500,000.00 for inpatient care for VANCHCS annually. VANCHCS provides laboratory, radiology, physical therapy, and women’s health support, for the 60th Medical Group TRICARE Beneficiary population. This sharing workload amounts to approximately \$800,000 revenue generation annually for VANCHCS. Currently, both the Northern California Health Care System and the 60th Medical Group are exploring the possibility of a VA/DOD collaboration for a VA inpatient Mental Health Unit at the David Grant Medical Center. A joint VA/Air Force working group is working out details on potentially opening up this unit as early as 2004. Stakeholders have been briefed and participate in the planning process. Also, through the Joint Integrated Working Group (JIWG), a monthly meeting between the 60th Medical Group and VANCHCS, and the bi-monthly VISN21/Office of Lead Agent, Region 10 meeting we continue to explore expanding outpatient specialty care through our sharing agreement with the Air Force. Another recent

planning initiative is the joint VA/DOD use of a VA Pharmacy at the McClellan VAOPC.

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

ENHANCED USE: There is an initiative to provide Long Term Care on VAMC Sacramento via Enhance-use Opportunity. The VA Business Plan and Public Hearing have been completed. This initiative is currently on hold due to VA Moratorium on EU-LTC projects. The stakeholders have been briefed and feedback received on this planning initiative. On March 17, 2003 a meeting with perspective partner was conducted and concept development discussed. Meetings were also held with representatives from Sacramento County to discuss possibility of acquiring additional land at no cost to the VA.

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

**VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

***Proposed Management of Workload – FY 2012***

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections		(from projections)									
INPATIENT CARE	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Medicine	14,848	6,799	14,848	6,799	2,055	1,717	-	-	-	-	11,076	\$ 55,963,038
Surgery	3,854	(201)	3,855	(200)	662	310	-	-	-	-	2,883	\$ 8,073,168
Intermediate/NHCU	35,972	-	35,972	-	35,972	-	-	-	-	-	-	\$ -
Psychiatry	2,482	1,886	3,284	2,688	-	-	-	-	-	-	3,284	\$ (16,224,055)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>57,155</b>	<b>8,483</b>	<b>57,959</b>	<b>9,287</b>	<b>38,689</b>	<b>2,027</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>17,243</b>	<b>\$ 47,812,151</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections		(from projections)									
OUTPATIENT CARE	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Primary Care	137,265	19,259	131,265	13,260	22,316	-	-	-	-	-	108,949	\$ 2,337,702
Specialty Care	130,010	39,812	130,010	39,812	67,000	-	-	-	-	-	63,010	\$ 21,995,640
Mental Health	33,757	235	33,758	236	11,141	-	6,000	-	-	-	16,617	\$ 5,159,792
Ancillary & Diagnostics	143,715	32,182	143,715	32,183	27,306	-	-	-	-	-	116,409	\$ (28,539,855)
<b>Total</b>	<b>444,746</b>	<b>91,488</b>	<b>438,748</b>	<b>85,490</b>	<b>127,763</b>	<b>-</b>	<b>6,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>304,985</b>	<b>\$ 953,279</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/Moved/Vacant
<b>INPATIENT CARE</b>	<b>FY 2012</b>										
Medicine	32,428	34,557	8,361	26,196	-	-	-	-	-	26,196	(8,361)
Surgery	5,375	4,786	1,950	2,836	1,950	-	-	-	-	4,786	-
Intermediate Care/NHCU	-	-	-	-	-	-	-	-	-	-	-
Psychiatry	1,211	8,013	(4,480)	12,493	-	-	-	-	-	12,493	4,480
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>39,015</b>	<b>47,356</b>	<b>5,831</b>	<b>41,525</b>	<b>1,950</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>43,475</b>	<b>(3,881)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/Moved/Vacant
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>										
Primary Care	85,447	81,712	25,739	55,973	4,000	5,000	-	10,000	-	74,973	(6,739)
Specialty Care	175,904	103,966	46,095	57,871	-	21,200	-	4,000	-	83,071	(20,895)
Mental Health	18,773	13,792	3,352	10,440	-	-	-	4,200	-	14,640	848
Ancillary and Diagnostics	111,753	111,753	70,880	40,873	-	-	-	50,000	-	90,873	(20,880)
<b>Total</b>	<b>391,877</b>	<b>311,223</b>	<b>146,066</b>	<b>165,157</b>	<b>4,000</b>	<b>26,200</b>	<b>-</b>	<b>68,200</b>	<b>-</b>	<b>263,557</b>	<b>(47,666)</b>
<b>NON-CLINICAL</b>	<b>FY 2012</b>										
Research	-	81,439	48,200	33,239	-	8,000	-	25,000	-	66,239	(15,200)
Administrative	245,989	153,000	25,974	127,026	-	-	-	-	-	127,026	(25,974)
Other	23,347	23,347	-	23,347	-	-	-	-	-	23,347	-
<b>Total</b>	<b>269,336</b>	<b>257,786</b>	<b>74,174</b>	<b>183,612</b>	<b>-</b>	<b>8,000</b>	<b>-</b>	<b>25,000</b>	<b>-</b>	<b>216,612</b>	<b>(41,174)</b>

**C. Pacific Islands Market**

**1. Description of Market**

**a. Market Definition**

Market	Includes	Rationale	Shared Counties
Pacific Islands  Code: 21C	4 Hawaiian counties, Philippines, Guam, and American Samoa	The unique Pacific Islands market presents many geographic, transportation, and challenging health care access issues. The market includes the State of Hawaii, which is comprised of six islands (Oahu, Hawaii, Maui, Kauai, Molokai, and Lanai) and four counties. Also included in this market is the island of Guam, the Philippines, American Samoa, and several smaller Pacific islands. The city of Honolulu is located on the island of Oahu, and is the site of the VA Medical & Regional Office Center (VAMROC) that provides both medical care services and veterans benefits and is collocated at Tripler Army Medical Center (TAMC) where the VA has established both a large Ambulatory Care Center and a VA Center for Aging (NHCU/Rehab). Four CBOCs are located on each of the larger Hawaiian Islands. Inpatient care is primarily delivered through a VA/DOD Joint Venture agreement with TAMC. This market also includes the VA Regional Office & Outpatient Clinic in Manila, the location of a VA Ambulatory Care Center. Fee basis programs further support outpatient and inpatient care in remote locations. As appropriate, complex tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco.	

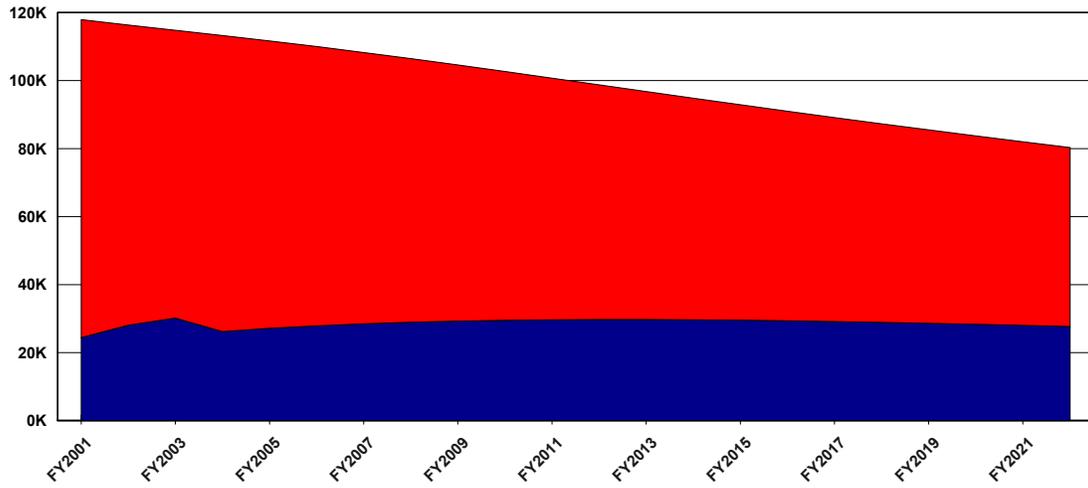
**b. Facility List**

<b>VISN : 21</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Honolulu</b>				
459 Honolulu	✓	✓	-	-
459GA Maui	✓	-	-	-
459GB Hilo	✓	-	-	-
459GC Kailua-Kona	✓	-	-	-
459GD Lihue	✓	-	-	-
459GE Guam	✓	-	-	-
New VAMROC CBOCs	✓	-	-	-
<b>Manila</b>				
358 Manila	✓	-	-	✓

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Pacific Islands Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care	Access				
	Access to Hospital Care	Access				
<b>N</b>	Access to Tertiary Care	Access				
<b>Y</b>	Primary Care Outpatient Stops	Population Based	44,927	75%	30,599	51%
		Treating Facility Based	44,588	67%	30,809	46%
<b>Y</b>	Specialty Care Outpatient Stops	Population Based	74,241	210%	66,327	188%
		Treating Facility Based	77,746	212%	70,523	192%
<b>N</b>	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	56	0%	-325	-1%
<b>N</b>	Medicine Inpatient Beds	Population Based	6	28%	0	2%
		Treating Facility Based	9	36%	3	12%
<b>N</b>	Surgery Inpatient Beds	Population Based	-5	-29%	-8	-46%
		Treating Facility Based	-2	-12%	-5	-28%
<b>N</b>	Psychiatry Inpatient Beds	Population Based	8	50%	1	8%
		Treating Facility Based	8	55%	2	12%

**e. Stakeholder Information**

Discussion of stakeholder input and how concerns/issues were addressed.

**Stakeholder Narrative:**

The CARES process has been consistently presented and updated at various key stakeholder meetings including both the VA Advisory Board and State Office of Veterans Affairs Advisory Board meetings. CARES has also been repeatedly discussed with local veteran groups including the VA Advisory Council, the Oahu Veterans Council, neighbor island councils and many veteran organizational meetings. At each of these meetings questions were answered to the satisfaction of the attendees. This facility has not received to date any form of written or electronic feedback from our veteran stakeholders.

CARES updates have been incorporated in station newsletters, again with no feedback. The CARES process has been explained to employees and key staff members at various meetings. Feedback was minimal and responded to on the spot. CARES has also been discussed with the leadership of Tripler Army Medical Center.

Letters and packets were sent out to our Congressional delegation with positive responses. Representative Ed Case did respond asking for more information. The response to the representative is in the process of being drafted.

**f. Shared Market Discussion**

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

**Shared Market Narrative:**

Located 2500 miles from the US mainland, shared markets with other VISN's are impractical and, indeed are limited even within VISN 21. The strong island culture of Ohana, or family makes referrals for all but the most complex and costly care counter-productive. Honolulu does refer veterans to mainland facilities for specialized care provided by special emphasis programs such as Blind Rehabilitation and Spinal Cord Injury however.

**g. Overview of Market Plan**

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

**Executive Summary Narrative:**

The Pacific Island Market plan builds on and compliments the strategic plan formed with the construction of the Honolulu VAMC Ambulatory Care Center, Center for Aging, and collaborative partnership with the Tripler Army Medical Center. This partnership, or VA/DoD Joint Venture relies on Tripler for hospital and tertiary care for the veterans of Hawaii, with joint or shared facilities for ambulatory surgery and specialty care. Veterans receive primary care from the state-of-the-art Ambulatory Care Center or through one of five Community Based Outpatient Clinics on neighbor Hawaiian islands and in Guam. The Market Plan and preferred solution to the projected capacity gap in primary care builds on this foundation with three additional Community Based Outpatient Clinics scheduled for American Samoa and two new locations on Oahu, as well as the construction of a new joint ambulatory surgery center and specialty clinics within the Ambulatory Care Center. Finally, the Community Based Outpatient Clinic in Guam will be replaced by a new facility as part of the VA/DoD joint venture construction of a replacement US Navy hospital in Guam. Critical to the provision of care across vast distances is the installation of telemedicine capabilities in each of the locations. Finally, the planned construction of a joint Research facility will address all of VA's research needs into the future. This plan will assure access to high quality care for pacific island veterans seeking primary, specialty, tertiary hospital care, and long term care. Honolulu has always relied on its ability to remain flexible in providing care to Hawaii veterans by supplementing VA care with community fee-based and contract care. The lack of a hospital and its related infrastructure has been viewed as a strength rather than a weakness. The alternative to the preferred plan or solution to capacity gaps in primary and specialty care continues to be making the appropriate choice on the continuum of VA staff care to fee or contract care. If staffing leased Community based Outpatient Clinics is not cost-effective in the years planned, fee and contract care will fill the gaps until the demand justifies such clinics. Likewise, the planned construction of a joint surgery center and specialty clinics, while ideal and most desirable, can be deferred by contract care until the demand justifies an alternative. The selection of Honolulu as one of three VA/DoD Joint Venture prototypes will free the partners from many of the institutional obstacles encountered in the past. The ability to manage resources to treat a combined beneficiary population will result in high quality, cost-effective care to the beneficiaries of both Departments.

## 2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

### Access Narrative:

Access to primary care and hospital care are within the Access Standard. Access to tertiary care is provided by Tripler Army Medical Center through a VA DOD Sharing Agreement. Therefore, the tertiary access % will equal those for hospital care for Hawaii veterans.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	88%	3,147	91%	2,676	91%	2,489
Hospital Care	73%	7,080	73%	8,029	71%	8,021
Tertiary Care	73%	7,080	73%	8,029	71%	8,021

### Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time  
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time  
Rural Counties – 90 minutes drive time  
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours  
Highly Rural Counties – within VISN

### 3. Facility Level Information – Honolulu

#### a. Resolution of VISN Level Planning Initiatives

##### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

##### **Proximity Narrative:**

No Impact

##### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

##### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

A decade long VA/DoD sharing agreement with Tripler Army Medical Center provides hospital, specialty, and tertiary care for Hawaii veterans. Plans to renovate VA Ambulatory Care Center space as a collaborative measure to improve access to outpatient surgery and specialty care for both VA and DoD beneficiaries, along with contracted services where indicated, will ensure access for all Hawaii veterans. Selection as one of three VA/DoD Joint Venture Prototypes will remove the barriers to successful sharing that have plagued both Departments for years.

A second collaborative initiative is being developed with the Navy in Guam, where plans are underway for the FY 08 construction of a new replacement Navy hospital there. The joint venture construction of this facility will ensure accessible, high quality primary, specialty, and hospital care for veterans in Guam and the Northern Mariana islands. As these veterans are able to receive more of their care in Guam, the pressure they exerted on Honolulu resources will diminish.

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

**Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

**Enhanced Use Narrative:**

No Impact

**Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

**VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

***Proposed Management of Workload – FY 2012***

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>												
Medicine	11,084	3,129	11,084	3,129	11,084	-	-	-	-	-	-	\$ -
Surgery	4,893	(682)	4,894	(681)	1,223	3,671	-	-	-	-	-	\$ 173,240,207
Intermediate/NHCU	44,757	-	44,757	-	28,197	-	-	-	-	-	16,560	\$ -
Psychiatry	7,534	2,897	7,535	2,898	1,357	-	-	-	-	-	6,178	\$ (5,625,722)
PRRTP	3,388	-	3,388	-	-	-	-	-	-	-	3,388	\$ (5,860,131)
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>71,656</b>	<b>5,344</b>	<b>71,658</b>	<b>5,346</b>	<b>41,861</b>	<b>3,671</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>26,126</b>	<b>\$ 161,754,354</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>												
Primary Care	110,918	44,587	97,319	30,988	10,706	-	-	-	-	-	86,613	\$ 16,064,862
Specialty Care	114,401	77,745	110,401	73,746	36,433	70,000	-	-	-	-	3,968	\$ 192,298,274
Mental Health	47,330	56	47,331	56	3,314	-	10,000	-	-	-	34,017	\$ 21,971,363
Ancillary & Diagnostics	107,893	62,267	107,893	62,267	59,342	42,000	-	-	-	-	6,551	\$ 48,514,856
<b>Total</b>	<b>380,542</b>	<b>184,655</b>	<b>362,944</b>	<b>167,057</b>	<b>109,795</b>	<b>112,000</b>	<b>10,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>131,149</b>	<b>\$ 278,849,355</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved to Vacant
<b>INPATIENT CARE</b>											
Medicine	-	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	27,820	27,820	-	27,820	-	-	-	-	-	27,820	-
Psychiatry	10,009	10,008	10,008	-	-	-	-	12,000	-	12,000	1,992
PRRTP	16,127	16,127	16,127	-	-	-	-	12,500	-	12,500	(3,627)
Domiciliary program	-	-	(64,530)	64,530	-	-	-	-	-	64,530	64,530
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>53,956</b>	<b>53,955</b>	<b>(38,394)</b>	<b>92,350</b>	-	-	-	<b>24,500</b>	-	<b>116,850</b>	<b>62,895</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved to Vacant
<b>OUTPATIENT CARE</b>											
Primary Care	49,359	43,306	29,708	13,598	-	-	-	20,000	-	33,598	(9,708)
Specialty Care	84,314	4,365	(1,324)	5,689	-	-	-	-	-	5,689	1,324
Mental Health	25,530	19,730	(13,056)	32,786	-	-	-	-	-	32,786	13,056
Ancillary and Diagnostics	31,073	4,193	(1,262)	5,455	-	-	-	-	-	5,455	1,262
<b>Total</b>	<b>190,276</b>	<b>71,594</b>	<b>14,066</b>	<b>57,528</b>	-	-	-	<b>20,000</b>	-	<b>77,528</b>	<b>5,934</b>
<b>NON-CLINICAL</b>											
Research	-	21,070	19,475	1,595	10,727	7,000	-	-	-	19,322	(1,748)
Administrative	108,164	80,300	13,382	66,918	13,000	-	-	-	-	79,918	(382)
Other	10,648	10,648	-	10,648	-	-	-	-	-	10,648	-
<b>Total</b>	<b>118,812</b>	<b>112,018</b>	<b>32,857</b>	<b>79,161</b>	<b>23,727</b>	<b>7,000</b>	-	-	-	<b>109,888</b>	<b>(2,130)</b>

#### **4. Facility Level Information – VAMROC CBOCs**

##### **a. Resolution of VISN Level Planning Initiatives**

###### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

###### **Proximity Narrative:**

No Impact

###### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

###### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

Plans to develop two new CBOC's on Oahu will open opportunities for collaboration with DoD who has active duty military as well as retirees and their dependents across the island.

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

***Proposed Management of Workload – FY 2012***

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections											
INPATIENT CARE	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Medicine	-	-	-	-	-	-	-	-	-	-	-	\$ -
Surgery	-	-	-	-	-	-	-	-	-	-	-	\$ -
Intermediate/NHCU	-	-	-	-	-	-	-	-	-	-	-	\$ -
Psychiatry	-	-	-	-	-	-	-	-	-	-	-	\$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	-	-	-	-	-	-	-	-	-	-	-	\$ -
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections											
OUTPATIENT CARE	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Primary Care	-	-	13,600	13,600	-	-	-	-	-	-	13,600	\$ (32,975,559)
Specialty Care	-	-	4,000	4,000	4,000	-	-	-	-	-	-	\$ (7,973,689)
Mental Health	-	-	-	-	-	-	-	10,000	-	-	10,000	\$ (24,537,174)
Ancillary & Diagnostics	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	-	-	17,600	17,600	4,000	-	-	10,000	-	-	23,600	\$ (65,486,422)

**Proposed Management of Space – FY 2012**

		Space (GSF) proposed by Market Plans in VISN									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>INPATIENT CARE</b>											
Medicine	-	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	-	-	-	-	-	-	-	-	-	-	-
Psychiatry	-	-	-	-	-	-	-	-	-	-	-
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		Space (GSF) proposed by Market Plan									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>OUTPATIENT CARE</b>											
Primary Care	-	6,800	6,800	-	-	-	-	6,800	-	6,800	-
Specialty Care	-	-	-	-	-	-	-	-	-	-	-
Mental Health	-	5,800	5,800	-	-	-	-	5,000	-	5,000	(800)
Ancillary and Diagnostics	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		12,600	12,600	-	-	-	-	11,800	-	11,800	(800)
<b>NON-CLINICAL</b>											
Research	-	-	-	-	-	-	-	-	-	-	-
Administrative	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		-	-	-	-	-	-	-	-	-	-

**D. Sierra Nevada Market**

**1. Description of Market**

**a. Market Definition**

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
Sierra Nevada  Code: 21E	8 California counties and 12 Nevada counties	The Sierra Nevada market extends from the northeast Oregon border south, following the Sierra Nevada mountain range, including the Lake Tahoe region, and often making travel more difficult in the winter. Interstate 80 (east-west) is the major highway that links this market, from central Nevada through Reno into the California Sierra foothills. In the central and eastern portion of this market there are several large highly rural (frontier) counties. The southern portion of this market borders VISN 22, where Esmeralda County (Nevada) will now be included with this market/VISN 21 due to workload shifting (DPPB). The city of Reno serves as the metropolitan center that anchors the Sierra Nevada market and is the location of the secondary facility, VA Sierra Nevada Health Care System (SNHCS). A NHCU and two CBOCs further support this Network. The Sierra Nevada tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco as appropriate.	

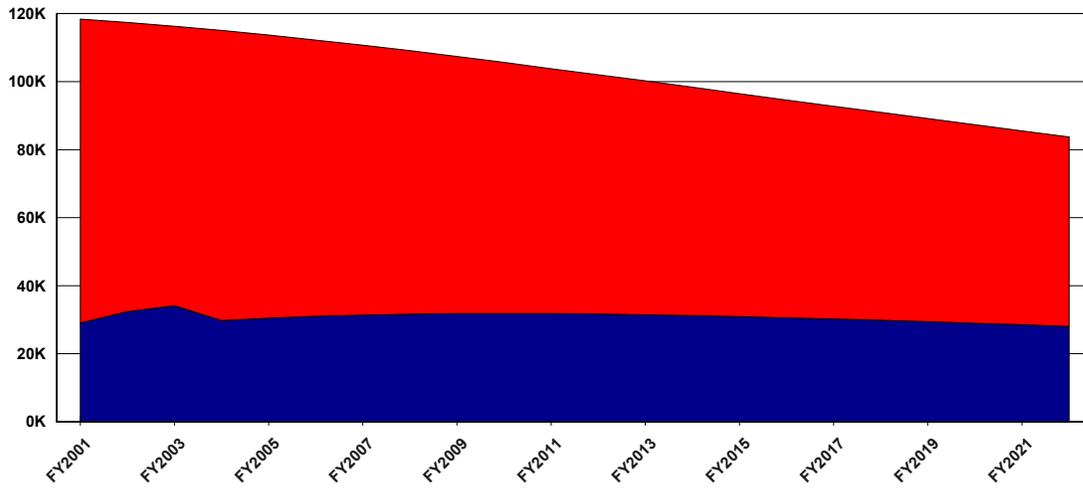
**b. Facility List**

<b>VISN : 21</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Reno</b>				
654 Sierra Nevada HCS	✓	✓	-	-
654GA Sierra Foothills	✓	-	-	-
654GB Carson Valley	✓	-	-	-

### c. Veteran Population and Enrollment Trends

--- Projected Veteran Population

--- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Sierra Nevada Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care	Access				
	Access to Hospital Care	Access				
Y	Access to Tertiary Care	Access				
Y	Primary Care Outpatient Stops	Population Based	25,608	35%	5,260	7%
		Treating Facility Based	19,231	26%	228	0%
Y	Specialty Care Outpatient Stops	Population Based	30,351	45%	16,833	25%
		Treating Facility Based	26,969	42%	13,929	21%
N	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	7	0%	-201	-1%
N	Medicine Inpatient Beds	Population Based	4	16%	-2	-9%
		Treating Facility Based	5	22%	-1	-4%
N	Surgery Inpatient Beds	Population Based	-6	-31%	-8	-47%
		Treating Facility Based	-3	-27%	-5	-44%
N	Psychiatry Inpatient Beds	Population Based	3	18%	-3	-17%
		Treating Facility Based	5	35%	-1	-5%

**e. Stakeholder Information**

Discussion of stakeholder input and how concerns/issues were addressed.

**Stakeholder Narrative:**

Within the Sierra Nevada Market regular communication has been initiated with major stakeholder groups through a variety of means including written bulletins, e-mails, newsletter articles, and in-person briefs. Major stakeholder groups include employees, volunteers, Veteran Service Organizations, the Nevada Office of Veterans Affairs, California Veteran Service Officers, and Congressional offices (Nevada and California). Formal feedback has been solicited from these individuals and groups utilizing specially designed comment forms, discussions, and through e-mail. Written and verbal responses have been overwhelmingly positive with most noting they favor the CARES process. Several responses indicated they were undecided and asked questions about the process. Feedback after providing the requested information indicates they are supportive of the process. The Planning Initiatives for this market all reflect growth and the need for additional services. As such, planning efforts have been well received by stakeholders. Comments are compiled and reported to the Sierra Nevada Market Cares Steering Committee for their consideration. However, it is noteworthy that there have been no specific recommendations presented as all comments received were either very generic or simply supportive in nature. The planning initiatives proposed during this process were very much in keeping with previous and ongoing discussions in the VA Sierra Nevada Health Care System, Reno Strategic Planning Council and VSO committees. The comments do strongly indicate that the process is supported and veterans are pleased with the care they are receiving at VA Sierra Nevada Health Care System sites.

**f. Shared Market Discussion**

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

**Shared Market Narrative:**

The VA Sierra Pacific Network (VISN 21) closely reviewed bordering data for counties assigned to VISNs 19, 20, and 22. Of the data reviewed the only counties, which were at issue, were allocated to VISN 22. These included the counties of Esmeralda, NV and Inyo, CA where a large percent of historical workload was attributed to VISN 21. These counties are both highly rural and have very few enrollees per square mile. The VISN 22 Network Executive Leadership Board agreed to approve reassignment of Esmeralda to VISN 21 for CARES purposes. As such, Esmeralda County is included in the Sierra Nevada

Market, VISN 21 where the workload has historically migrated. VISN 22 also considered the reassignment of Inyo County to VISN 21, however did not support this change as the workload was more evenly split between the two Networks. The addition of Esmeralda County to VISN 21 had little impact as the veteran population is less than 200.

**g. Overview of Market Plan**

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

**Executive Summary Narrative:**

Market Overview: The Sierra Nevada Market includes 12 counties in northern Nevada and eight counties in northeastern California, and encompasses the Lake Tahoe region. VA Sierra Nevada Health Care System (VASNHCS) is the only VHA facility in this market. VISN 22 agreed to reassign Esmeralda County, NV to this market/VISN based on veteran utilization. While other markets project a large decline in enrollees in 2022, the Sierra Nevada Market reflects minimal changes. After 2003 the projected enrollees slowly decline and remain flat from 2007 to 2014. In 2022, the projected enrollees (28,014) are slightly less than the 2001 enrollees (29,033). The market penetration rate (FY01=25.53%) peaks at 33.46% in 2022.

There were three Planning Initiatives (PI) that emerged for the Sierra Nevada Market.

1.) Tertiary Care Access

ISSUE: Within the Sierra Nevada Market, only 30% of the veterans reside within the tertiary care access standard. The remaining 70% of the enrollees must drive greater than four hours to access VA tertiary care services. RESOLUTION: The first objective is to reduce the frequency of enrollee travel to the Bay Area VA tertiary care facilities. Approximately 59% of all transfers to Bay Area VA tertiary care facilities were for specialty care, rather than “tertiary care”. Often these patients were admitted awaiting their outpatient procedure. By expanding the array of specialized clinical services provided in Reno; the burden and frequency of patient travel would be reduced and quality of care enhanced. To meet the second objective of improving access to tertiary care services, VASNHCS will pursue options for increased contract tertiary care services within the Reno area, and request the infusion of additional operating dollars to support

this care. By implementing these and other measures, the tertiary care access increases to 100%.

## 2.) Specialty Care Capacity

ISSUE: A significant positive gap in specialty care exists (FY12) in both the treating facility (42%) and population-based (45%) data. In FY22, the treating facility and population-based gap are both reduced to 24%.

RESOLUTION: The selected approach for addressing this PI is to utilize and expand existing capital assets at the VAMC Reno campus in order to increase capacity, while also improving access to care. This will more than double existing Specialty Care space. Increased capacity will be realized through the conversion of vacant space, offering a net increase of 27,000 sf by FY04, and an additional 21,000 by FY06.

## 3.) Primary Care Capacity

ISSUE: A significant positive gap in Primary Care outpatient stops is projected in both the treating facility (26%) and population based (35%) data for FY12. In FY22 the gap in Primary care services for both treating facility and population-based no longer exists.

RESOLUTION: The selected approach includes expansion of Primary Care capacity at Reno VAMC, as well as Auburn and Minden CBOCs. Two new (contract) CBOCs in Susanville and Fallon are planned to provide the necessary flexibility for addressing workload demands. Due to facility and site limitations at the Reno campus, increased Primary Care workload will be primarily supported by expanding CBOC capacity. The impact of workload growth will also be realized in the Triage unit where urgent care walk-ins and emergency services are expected to increase. Capital projects will include a small construction project in Triage, renovation of vacated space for Reno Primary Care, and expanded leased space at Auburn.

The Sierra Nevada Market has effectively addressed the targeted capacity and access issues, while employing solutions that maximize the use of capital assets and offer flexibility for the future.

## 2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

### Access Narrative:

A significant gap was found in veteran access to tertiary care for the Sierra Nevada Market where only 30% can access tertiary care within the threshold. Currently, enrollees travel to Bay Area VA facilities. The first objective met is to reduce the frequency of enrollee travel to the Bay Area VA tertiary care facilities. Approximately 59% of all FY02 transfers to Bay Area VA tertiary care facilities were cardiac cases, primarily outpatient. By expanding the array of complex clinical services provided at VAMC Reno; the burden and frequency of patient travel would be greatly reduced. Opportunities are also identified for the provision of (limited) tertiary care services through existing VA/DOD sharing arrangements. Such arrangements would serve to lessen the burden of travel by approximately one hour (175 miles vs. 225/250 miles). Effectively the only patients transferred to VA tertiary care facilities in San Francisco or Palo Alto, would be the most complex surgical cases.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	68%	10,149	74%	8,228	74%	7,284
Hospital Care	79%	6,660	79%	6,645	79%	5,883
Tertiary Care	30%	22,201	100%	-	100%	-

### Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time  
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time  
Rural Counties – 90 minutes drive time  
Highly Rural Counties – 120 minutes drive time

Tertiary Care:

Urban & Rural Counties – 4 hours  
Highly Rural Counties – within VISN

### 3. Facility Level Information – Reno

#### a. Resolution of VISN Level Planning Initiatives

##### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

##### **Proximity Narrative:**

No Impact

##### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

##### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

No Impact

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

**VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN														
	# BDOCs (from demand projections)		Variance from 2001		Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
	FY 2012	(from 2001)	FY 2012	(from 2001)										
<b>INPATIENT CARE</b>														
Medicine	8,724	1,581	8,724	1,581	175	-	-	-	-	-	-	-	8,549	\$ (511,206)
Surgery	2,483	(917)	2,483	(917)	75	-	-	-	-	-	-	-	2,408	\$ -
Intermediate/NHCU	49,201	-	49,201	-	31,489	-	-	-	-	-	-	-	17,712	\$ -
Psychiatry	5,928	1,538	5,928	1,538	178	-	-	-	-	-	-	-	5,750	\$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>66,335</b>	<b>2,201</b>	<b>66,336</b>	<b>2,202</b>	<b>31,917</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>34,419</b>	<b>\$ (511,206)</b>
Clinic Stops proposed by Market Plans in VISN														
	Clinic Stops (from demand projections)		Variance from 2001		Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
	FY 2012	(from 2001)	FY 2012	(from 2001)										
<b>OUTPATIENT CARE</b>														
Primary Care	92,798	19,230	92,798	19,231	10,500	-	-	-	-	-	-	-	82,298	\$ (942,009)
Specialty Care	91,869	26,969	91,869	26,969	5,513	-	-	-	-	-	-	-	86,356	\$ (8,004,067)
Mental Health	29,234	7	29,234	8	2,000	-	-	-	-	-	-	-	27,234	\$ (2,457,497)
Ancillary & Diagnostics	103,558	33,929	103,558	33,929	36,000	-	-	-	-	-	-	-	67,558	\$ (4,174,041)
<b>Total</b>	<b>317,458</b>	<b>80,136</b>	<b>317,459</b>	<b>80,137</b>	<b>54,013</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>263,446</b>	<b>\$ (15,577,614)</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
<b>INPATIENT CARE</b>	<b>FY 2012</b>	20,348	5,060	20,347	5,059	-	-	-	-	19,038	(1,309)
Medicine		6,021	(2,752)	6,020	(2,753)	-	-	-	-	8,773	2,753
Surgery		25,726	-	25,725	(1)	-	-	-	-	25,726	1
Intermediate Care/NHCU		10,810	(7,535)	10,810	(7,535)	-	-	-	-	18,345	7,535
Psychiatry		-	-	-	-	-	-	-	-	-	-
PRRTP		-	-	-	-	-	-	-	-	-	-
Domiciliary program		-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury		-	-	-	-	-	-	-	-	-	-
Blind Rehab		-	-	-	-	-	-	-	-	-	-
<b>Total</b>		<b>62,905</b>	<b>(5,227)</b>	<b>62,902</b>	<b>(5,230)</b>	-	-	-	-	<b>71,882</b>	<b>8,980</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	50,593	15,111	47,733	12,251	-	-	10,730	-	49,279	1,546
Primary Care		94,993	60,470	94,992	60,469	4,000	-	4,356	-	90,687	(4,305)
Specialty Care		15,275	9,258	14,979	8,962	-	-	6,000	-	12,017	(2,962)
Mental Health		63,274	32,549	43,913	13,188	-	-	-	-	35,725	(8,188)
Ancillary and Diagnostics		<b>224,135</b>	<b>117,388</b>	<b>201,617</b>	<b>94,870</b>	<b>4,000</b>	<b>-</b>	<b>21,086</b>	<b>-</b>	<b>187,708</b>	<b>(13,909)</b>
<b>Total</b>											
<b>NON-CLINICAL</b>	<b>FY 2012</b>	-	(9,648)	19,015	9,367	-	-	-	-	16,426	(2,589)
Research		180,980	69,153	134,200	22,373	-	-	-	-	111,827	(22,373)
Administrative		12,061	-	12,061	-	1,000	-	-	-	13,061	1,000
Other		<b>193,041</b>	<b>59,505</b>	<b>165,276</b>	<b>31,740</b>	<b>1,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>141,314</b>	<b>(23,962)</b>
<b>Total</b>											

## E. South Coast Market

### 1. Description of Market

#### a. Market Definition

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
South Coast  Code: 21D	10 California counties (two, Alameda and San Mateo, shared with North Coast market)	The South Coast market stretches from the San Francisco Bay area (mid-San Mateo County) through the Silicon Valley, Livermore Valley, and along the coastal counties through Monterey County. The northern portion of this market area (Palo Alto and San Jose) poses significant transportation/access challenges due to traffic and congestion (Highway 101). This market area is largely urban and is the location of the VA Palo Alto Health Care System (PAHCS), one of two VA tertiary care referral centers supporting the Network. The PAHCS has three divisions including Palo Alto, Menlo Park, and Livermore, and supports a very large TRICARE population. The market offers a full continuum of veteran health care services, which is further supported by two NHCUs, a Specialty Ambulatory Care Center, and five CBOCs.	

**b. Facility List**

<b>VISN : 21</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Livermore</b>				
640A4 Livermore	✓	-	-	-
<b>Menlo Park</b>				
640A0 Palo Alto-Menlo Pk	✓	✓	-	-
<b>Palo Alto</b>				
640 Palo Alto-Palo Alto	✓	✓	✓	-
640BY San Jose	✓	-	-	-
640GA Palo Alto HCS- Capitola	✓	-	-	-
640GB Sonora (Tuolumne County)	✓	-	-	-
640HA Stockton	✓	-	-	-
640HB Modesto	✓	-	-	-
640HC Monterey	✓	-	-	-
New Palo Alto Clinics	✓	-	-	✓

<b>VISN : 21</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Fresno</b>				
570 Fresno	✓	✓	-	-
570GA Merced	✓	-	-	-
570GB Tulare	✓	-	-	-
<b>Honolulu</b>				
459 Honolulu	✓	✓	-	-
459GA Maui	✓	-	-	-
459GB Hilo	✓	-	-	-
459GC Kailua-Kona	✓	-	-	-

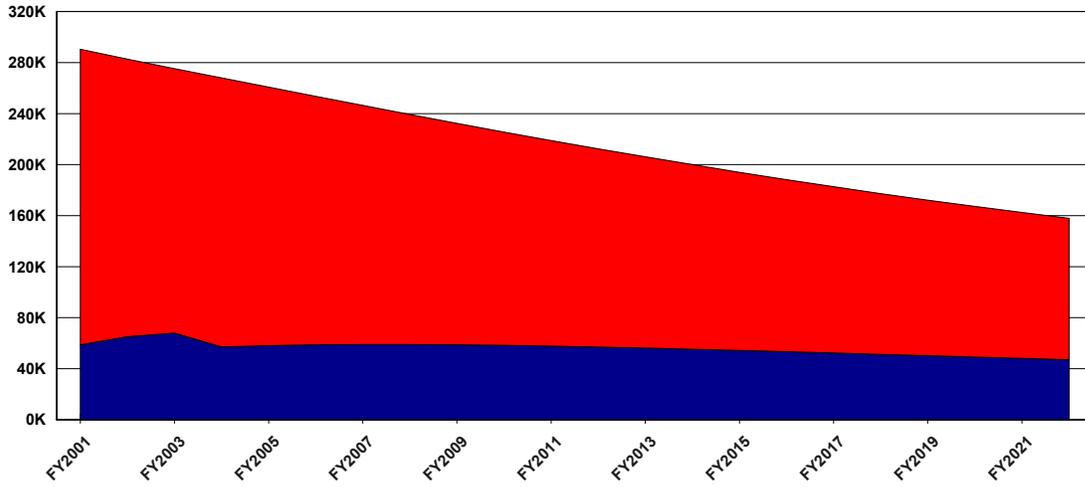
459GD Lihue	✓	-	-	-
459GE Guam	✓	-	-	-
New VAMROC CBOCs	✓	-	-	-
<b>Livermore</b>				
640A4 Livermore	✓	-	-	-
<b>Manila</b>				
358 Manila	✓	-	-	✓
<b>Menlo Park</b>				
640A0 Palo Alto-Menlo Pk	✓	✓	-	-
<b>No Cal System of Clinics</b>				
612BY Oakland	✓	-	-	-
612GD Fairfield	✓	✓	-	-
612GE Vallejo/Mare Island	✓	-	-	-
612GF Martinez	✓	-	-	-
612GH McClellan	✓	-	-	-
<b>Palo Alto</b>				
640 Palo Alto-Palo Alto	✓	✓	✓	-
640BY San Jose	✓	-	-	-
640GA Palo Alto HCS- Capitola	✓	-	-	-
640GB Sonora (Tuolumne County)	✓	-	-	-
640HA Stockton	✓	-	-	-
640HB Modesto	✓	-	-	-
640HC Monterey	✓	-	-	-
New Palo Alto Clinics	✓	-	-	✓
<b>Reno</b>				
654 Sierra Nevada HCS	✓	✓	-	-
654GA Sierra Foothills	✓	-	-	-
654GB Carson Valley	✓	-	-	-
<b>Sacramento</b>				

612A4 N. California HCS-Sacramento	✓	✓	-	-
612B4 Redding	✓	-	-	-
612GG Chico	✓	-	-	-
New Marysville City	✓	-	-	-
<b>San Francisco</b>				
662 San Francisco	✓	✓	✓	-
662BU 13th & Mission VA Clinic	✓	-	-	-
662GA Santa Rosa	✓	-	-	-
662GC Eureka	✓	-	-	-
662GD Ukiah	✓	-	-	-
New New North Coast Clinics	✓	-	-	-

### c. Veteran Population and Enrollment Trends

--- Projected Veteran Population

--- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
South Coast Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care	Access				
Y	Access to Hospital Care	Access				
	Access to Hospital Care	Access				
Y	Primary Care Outpatient Stops	Population Based	50,204	40%	8,489	7%
		Treating Facility Based	53,625	42%	11,962	9%
Y	Specialty Care Outpatient Stops	Population Based	59,362	47%	25,210	20%
		Treating Facility Based	60,843	46%	27,190	21%
N	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	724	1%	344	0%
N	Medicine Inpatient Beds	Population Based	-2	-3%	-15	-23%
		Treating Facility Based	2	2%	-14	-17%
Y	Surgery Inpatient Beds	Population Based	-13	-40%	-19	-56%
		Treating Facility Based	-18	-36%	-26	-53%
Y	Psychiatry Inpatient Beds	Population Based	-25	-31%	-36	-45%
		Treating Facility Based	-13	-10%	-41	-34%

**e. Stakeholder Information**

Discussion of stakeholder input and how concerns/issues were addressed.

**Stakeholder Narrative:**

VISN 21's South Coast Market has completed extensive communication activities with regard to Capital Asset Realignment for Enhanced Service (CARES) planning. The South Coast Market leadership has explained the CARES process to its stakeholders through numerous forums. Prior to the beginning of CARES Phase I, VAPAHCS provided regular updates on the status of CARES in VISN 12 and the impact it would have at employee, VAVS Committee and monthly Veterans Service Officer meetings.

Since the beginning of CARES Phase II, the South Coast Market has performed the following communications activities: Held six Open Forums on CARES; Published monthly articles on CARES and the South Coast Market's planning initiatives (PIs) in the VAPAHCS newsletter, which is widely read by employees and veterans; Held five Congressional liaison meetings extending invitations to all districts within the South Coast Market; Discussed the status of CARES and the Planning Initiatives at every monthly Veteran and County Service Officers meeting since June 2002. CARES overviews were also on the agendas for the September, November and February VAPAHCS VAVS Committee Meetings. The South Coast Market has two separate VAVS Committee's that comprise forty service and civic organizations. One hundred and forty-two individuals represent these organizations. The South Coast Market also participated in a Veterans Round Table in Stockton, California on March 6, 2003. The round table meeting was organized by the State of California 5th District Supervisor. The round table meeting provided the opportunity for the South Coast Market's Committee Chairperson to address Planning Initiatives (PIs) that had a direct impact on San Joaquin County. The South Coast Market Committee Chairperson was able to discuss the relocation of the Stockton Clinic to a more accessible site in the Stockton community and the potential consolidation of the Stockton and Modesto community-based clinics in the San Joaquin valley that would address gaps in health care services for the years 2012 and beyond. This possible consolidation would result in the increase of some specialty service not currently offered. At VAPAHCS weekly Executive Council and VAPAHCS monthly Director Staff meetings, the status of the CARES processed and the Planning Initiatives are reviewed and discussed. Union representatives are included in these forums.

All CARES feedback from stakeholders is communicated to the South Coast Market's CARES Committee, Executive Council, veteran meetings and several other forums to disseminate comments and concerns. Avenues for the collection of feedback from stakeholders include, web page comment form, 1-800 number, comment form provided in the health care system newsletter, and twenty-six public forums. The South Coast Market Committee has reviewed constituent's

comments and concerns. Their issues have been incorporated into the South Coast Market's CARES Plan.

**f. Shared Market Discussion**

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

**Shared Market Narrative:**

**OVERVIEW:** VA Palo Alto Health Care System (VAPAHCS) has developed its CARES Planning Initiatives (PIs) to ensure that special emphasis and referral programs are not adversely impacted. To that end, VAPAHCS has taken proactive steps to ensure that these programs have the resources necessary to meet current and future demand. Capacity issues, however, remain an ongoing concern due to facility constraints and staffing shortages.

**SPINAL CORD INJURY:** Today, VAPAHCS maintains a 43-bed Spinal Cord Injury (SCI) center located at the Palo Alto Division. VAPAHCS' SCI center is one of 23 VHA facilities nationwide. According to CARES' actuarial projections, demand for VAPAHCS' SCI beds is projected to increase from 43 beds in FY01 to 46 beds in FY22. According to CARES' data, the demand for long-term care (LTC) SCI beds is expected to increase from 10 beds in FY01 to 76 beds in FY22. If these projections are realized, VAPAHCS may lack the resources required to treat LTC SCI patients. VAPAHCS' SCI facility serves as both a local and regional referral center for both inpatient and outpatient care.

**BLIND REHABILITATION:** VAPAHCS maintains a 32-bed blind rehabilitation facility located at the Palo Alto Division. VAPAHCS' blind rehabilitation center is one of eight VHA facilities nationwide. In 2001, approximately 7,500 bed days of care (BDOC) were provided at VAPAHCS' Western Blind Rehabilitation Center (WBRC). Due to increasing demand for blind rehabilitation, the backlog of patients waiting to be referred to VAPAHCS, from other VISNs, continues to grow. A number of program changes have enabled VAPAHCS' WBRC to reduce the length of stay (LOS). These initiatives have enabled the Center to increase the number of veterans served annually. VAPAHCS' WBRC serves as both a local and regional referral center for inpatient and outpatient care.

**HOMELESS DOMICILIARY:** VAPAHCS maintains a 100-bed homeless domiciliary located at the Menlo Park Division. In FY01, the domiciliary maintained a 95 percent average daily census (ADC). Demand for homeless domiciliary services is significantly larger than VISN 21's existing capacity. Today, 58 percent of VISN 21's domiciliary care is purchased from VISN 20 – White City. Due to the significant demand for homeless domiciliary care, VISN

21 will continue to utilize other networks to meet VISN 21's unmet domiciliary demand. In addition, VAPAHCS has developed a number of collaborative agreements with local and County organizations to mitigate veteran homelessness. VAPAHCS' homeless domiciliary serves as a local and regional referral center.

**TRAUMATIC BRAIN INJURY (TBI):** VAPAHCS maintains a 24-bed rehabilitation medicine unit, which includes 8 TBI beds. VAPAHCS' TBI program is one of four comprehensive TBI centers in the VHA. The facility supports West Coast VA facilities and is a referral center for the Department of Defense (DoD).

**POST TRAUMATIC STRESS DISORDER (PTSD):** The National Center for PTSD is located at VAPAHCS' Menlo Park Division. This Center maintains 50 PTSD beds (40-male & 10-female) The women's PTSD program is the only inpatient residential rehabilitation facility in the VHA. The Center serves as a local, regional and national resource for patient evaluation and treatment, professional education and training, consultation, and research related to PTSD.

**CARDIO THORACIS SURGERY:** VAPAHCS provides comprehensive cardiac surgery including open-heart surgery to VISN 21 and 22 veterans. VAPAHCS' cardiac surgery program is a local and regional referral center.

**TRANSPLANT SURGERY:** Most organ transplant surgery is performed with our primary affiliate, Stanford University Medical Center. After surgery, veterans are transferred back to PAD to recover. VAPAHCS receives organ transplant referrals from VA facilities nationwide. VAPAHCS' transplant program is a local, regional, and national referral center.

**g. Overview of Market Plan**

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

**Executive Summary Narrative:**

**MARKET OVERVIEW:** The South Coast Market encompasses VA Palo Alto Health Care System's (VAPAHCS) Primary Service Area (PSA). VAPAHCS is a major tertiary referral center with three hospital-based divisions and a network of six community based outpatient clinics (CBOCs). The Palo Alto Division (PAD) is home to one of VA's flagship tertiary care referral centers. This division provides acute inpatient medicine, surgery, psychiatry, spinal cord, rehabilitation medicine, blind rehabilitation, traumatic brain injury, and hospice-palliative care services. The Menlo Park Division (MPD) provides specialized mental health, substance abuse, PTSD, homeless rehabilitation, gero-psychiatric and extended care services. MPD is a regional referral facility for domiciliary and inpatient gero-psychiatric services. MPD is home to a National Center for PTSD. The Livermore Division (LVD) provides both sub-acute and geriatric inpatient as well as primary, subspecialty, mental health and ancillary outpatient services.

**OUTPATIENT CARE PI:** According to CARES' actuarial projections, the South Coast Market should anticipate a 64% increase in primary care and 87% increase in specialty care outpatient growth between 2001 and 2012. In order to satisfy veterans' primary and specialty care requirements, the South Coast Market Committee recommends establishing two new CBOCs (Fremont & San Mateo), expanding existing CBOCs (Stockton, Modesto, & Monterey), constructing a state-of-the-art ambulatory care facility (PAD), and approving a VA/DoD joint clinic in Monterey.

**SURGERY PI:** The South Coast Market's affiliation with the Stanford University School of Medicine enables veterans to obtain world-class, cutting edge medical and surgical treatment. Annually, thousands of surgical patients, from throughout the nation, are referred to PAD. The South Coast's referral system provides critical surgical services to veterans who reside throughout the United States.

**ACUTE PSYCHIATRY PI:** The South Coast Market has developed a number of comprehensive acute inpatient psychiatric referral programs, which are located at two different divisions (PAD & MPD). The consolidation of South Coast's acute inpatient psychiatric units into Building 2 (PAD), would generate efficiencies both in terms of delivery of care and fixed and variable cost reduction.

**SPECIAL EMPHASIS PROGRAMS:** The South Coast Market operates a number of specialized regional and national referral centers including blind rehabilitation, homeless domiciliary, spinal cord injury, traumatic brain injury, PTSD, cardio thoracic and transplant surgery.

**RESEARCH:** With a \$44 million annual research budget, the South Coast Market manages the 3rd largest research program in the VA. The South Coast Market Committee recommends consolidating all research activities to PAD; however, PAD is constrained in terms of research facilities and parking capacity.

**GRADUATE MEDICAL EDUCATION:** VAPAHCS manages a broad range of Graduate Medical Education (GME) programs. In 2002, GME training was provided to 1,351 medical students, interns, residents and fellows from 102 academic institutions. VAPAHCS' major academic affiliation is with the Stanford University School of Medicine.

**SEISMIC MITIGATION PLAN:** A total of sixty-nine buildings in the VA inventory have been identified as exceptionally high risk (EHR). Today, 4 of the top 5 buildings on the EHR list are located in the South Coast Market. These buildings represent the greatest hazard of all buildings in the VA inventory. They are typically large buildings, often bed buildings, in high seismic zones that have not yet been strengthened. The South Coast's Building 2 (Inpatient Psych), Building 4 (Research), Building 324 (Gero-Psych NHCU), and Building 6 (Administration) remain at the top of the VA's EHR seismic inventory list. Buildings 137, 205, & 301 should be razed once the clinical, research, and administrative programs are relocated.

## 2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

### Access Narrative:

Acute Hospital Access PI:

Based on the initial CARES projections, the South Coast market's access to acute hospitalization was originally expected to be 53 percent. Subsequently, the South Coast market has taken a number of steps to improve access to acute hospitalization. After incorporating the following fee basis acute care services with local hospitals into the database, the South Coast market's access standards with regard to acute hospitalization has increased from 53 percent to 79 percent. As a result of these contracts, the acute access planning initiative has been resolved and the Market now meets all access standards (primary, acute hospital, and tertiary care).

Preferred Option:

Continue to develop and maintain fee basis contracts with community hospitals in Monterey, San Joaquin, Stanislaus, and Tuolumne to meet the acute hospital needs of veterans residing in communities where the acute hospital access standards are not met.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	92%	4,983	93%	3,989	93%	3,292
Hospital Care	53%	29,273	79%	11,967	79%	9,877
Tertiary Care	100%	-	100%	-	100%	-

**Guidelines:**

Primary Care: Urban & Rural Counties – 30 minutes drive time  
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time  
Rural Counties – 90 minutes drive time  
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours  
Highly Rural Counties – within VISN

### 3. Facility Level Information – Livermore

#### a. Resolution of VISN Level Planning Initiatives

##### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

##### **Proximity Narrative:**

No Impact

##### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

##### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

No Impact

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

**VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>												
Medicine	2,519	54	1,283	(1,182)	-	-	1,283	-	-	-	-	\$ 23,837,838
Surgery	256	(225)	47	(434)	-	-	47	-	-	-	-	\$ 10,640,331
Intermediate/NHCU	56,329	-	56,329	-	12,393	-	-	-	-	-	43,936	\$ -
Psychiatry	122	(222)	122	(222)	-	-	122	-	-	-	-	\$ 1,473,160
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>59,226</b>	<b>(393)</b>	<b>57,781</b>	<b>(1,838)</b>	<b>12,393</b>	<b>-</b>	<b>1,452</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>43,936</b>	<b>\$ 35,951,329</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>												
Primary Care	26,455	9,382	26,455	9,382	-	-	-	-	-	-	26,455	\$ -
Specialty Care	34,102	9,030	24,103	(969)	-	-	4,000	-	-	-	20,103	\$ 43,311,362
Mental Health	6,646	125	6,647	126	-	-	2,000	-	-	-	4,647	\$ 6,849,932
Ancillary & Diagnostics	11,859	4,015	11,860	4,016	-	-	-	-	-	-	11,860	\$ -
<b>Total</b>	<b>79,062</b>	<b>22,552</b>	<b>69,065</b>	<b>12,555</b>	<b>-</b>	<b>-</b>	<b>6,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>63,065</b>	<b>\$ 50,161,294</b>

**Proposed Management of Space – FY 2012**

		Space (GSF) proposed by Market Plans in VISN									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>INPATIENT CARE</b>											
Medicine	5,240	19,841	5,240	-	-	-	-	-	-	-	-
Surgery	427	18,662	427	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	52,090	22,113	(1)	52,090	-	-	-	-	-	52,090	1
Psychiatry	198	3,857	198	-	-	-	-	-	-	-	-
PRRTP	-	11,386	-	-	-	-	-	-	-	-	-
Domiciliary program	-	57,197	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>57,954</b>	<b>52,089</b>	<b>5,864</b>	<b>(1)</b>	<b>52,090</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>52,090</b>	<b>1</b>
		Space (GSF) proposed by Market Plan									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>OUTPATIENT CARE</b>											
Primary Care	19,841	19,841	(12,874)	32,715	-	-	-	-	-	32,715	12,874
Specialty Care	37,513	18,662	3,262	18,851	-	-	-	-	-	18,851	(3,262)
Mental Health	5,517	801	(859)	4,716	-	-	-	-	-	4,716	859
Ancillary and Diagnostics	11,386	11,386	(3,497)	14,883	-	-	-	-	-	14,883	3,497
<b>Total</b>	<b>74,257</b>	<b>57,197</b>	<b>3,092</b>	<b>71,165</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>71,165</b>	<b>13,968</b>
<b>NON-CLINICAL</b>											
Research	-	-	-	-	-	-	-	-	-	-	-
Administrative	72,716	91,000	4,403	68,313	22,687	-	-	-	-	91,000	-
Other	12,258	12,258	-	12,258	-	-	-	-	-	12,258	-
<b>Total</b>	<b>84,974</b>	<b>103,258</b>	<b>4,403</b>	<b>80,571</b>	<b>22,687</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>103,258</b>	<b>-</b>

#### **4. Facility Level Information – Menlo Park**

##### **a. Resolution of VISN Level Planning Initiatives**

###### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

###### **Proximity Narrative:**

No Impact

###### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

###### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

No Impact

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

## **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

### **Enhanced Use Narrative:**

**OVERVIEW:** For the past seven years, VA Palo Alto Health Care System (VAPAHCS) and Sunrise Development Corporation have discussed leasing Menlo Park Division (MPD) property to construct an assisted living facility.

**CONCEPT PROPOSAL:** The Sunrise Development Corporation intends to develop a high-end assisted living senior housing facility. The transaction contemplates a 45-year enhanced-use lease (E-UL) proposal with two ten-year options, for seven acres, formerly a nine-hole golf course, at the Menlo Park Division. The Sunrise Development Corporation would develop, operate and maintain a 64,000 GSF facility with 85 assisted living units (not to exceed 102 residents) for non-VA use. Sunrise Development Corporation would assume all financial and legal obligations to develop, own and operate this development. At the end of the 45-year agreement, the VA would have the option to occupy or elect to demolish the buildings.

The Sunrise Development Corporation would compensate the VA for the lease in the amount of three hundred ninety-five thousand two hundred fifty dollars (\$395,250.00) in cash and/or equivalent in-kind services per year. Over the life of the lease, the VA would generate \$30,652,000.00. The proposal would provide VAPAHCS financial resources to improve and modernize its infrastructure.

The E-UL objective is to:

1. Receive “in-kind” services
2. Manage vacant and/or underutilized buildings & property

Compensation to the VA for this lease would be “in-kind” and could consist of the following:

- Seismic upgrade, minor renovation
- The Sunrise assisted living facility would enable VAPAHCS to expand its Alzheimer patient care activities to an onsite facility in partial consideration of ground lease payments

This project would have limited impact on VA operations. The developer would assume all risk. Access to Sunrise Assisted Living Facility would be from a new access point separate from existing VA traffic. The impacted parcel of land was formerly a VA nine (9) hole golf course at the Menlo Park Division.

The VA currently pays a ground maintenance contractor to maintain the golf course and the VA expends resources to water and maintain this large seven (7) acre parcel of land that does not meet the Health Care System's strategic vision. This E-UL proposal would reduce current support service costs for ground maintenance by \$36,400 annually (\$1,638,180 over the 45-year lease period) and personnel costs for police by \$43,665 annually (\$1,964,925 over the 45-year lease period) as compared to the Status Quo.

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

### **VISN Identified Planning Initiatives Narrative:**

VA SEISMIC STUDY: A total of sixty-nine buildings in the VA inventory have been identified as exceptionally high risk (EHR). Today, 4 of the top 5 buildings on the EHR list are located in the South Coast Market (VA Palo Alto Health Care System). These buildings represent the greatest hazard of all buildings in the VA inventory. They are typically large buildings, often bed buildings, in high seismic zones that have not yet been strengthened.

The VA's "Top 5" EHR seismic ranking:

1. VAPAHCS - Palo Alto Division: Building 2
2. VAPAHCS - Menlo Park Division: Building 137
3. VAPAHCS - Palo Alto Division: Building 4
4. American Lake: Building 81
5. VAPAHCS - Menlo Park Division: Building 324

MENLO PARK DIVISION (MPD) - SEISMIC DEFICIENCIES: VA Palo Alto Health Care System – Menlo Park Division’s Building 137 (National Center for PTSD & Outpatient Mental Health), Building 205 (Research), Building 301 (Research), and Building 324 (Gero-psychiatric Extended Care) remain at the top of the VA’s EHR seismic inventory list.

BUILDING 324 – INPATIENT GERO-PSYCHIATRY: Building 324 is VISN 21’s primary site for comprehensive gero-psychiatric extended care. These veterans require inpatient gero-psychiatric facilities specially designed to conform to their psychiatric disorders. They suffer from serious mental illnesses such as chronic schizophrenia, bipolar disorder, PTSD, major depression, and other forms of psychosis.

MITIGATION PLAN: Building 324 is 5th on the VA’s EHR list. This major construction project would construct a 120-bed gero-psychiatric extended care replacement facility in support of VISN 21’s gero-psychiatric veteran population. This project will replace the existing functionally and seismically deficient gero-psychiatric facility.

BUILDING 137 – OUPATIENT MENTAL HEALTH & PTSD: Building 137 houses a National Center for PTSD and a multitude of outpatient mental health programs. Relocating these clinical programs is the most cost effective and expedient approach to resolving the existing seismic deficiencies.

MITIGATION PLAN: Building 137 is 2nd on the VA’s EHR list. The existing clinical programs have been relocated to vacant or underutilized MPD facilities. Program relocation is nearly complete. Asbestos abatement and facility demolition will commence in June 2003. Site restoration will follow.

BUILDING 205 – RESEARCH: VAPAHCS’ existing research facilities have serious seismic deficiencies. VAPAHCS’ continued research achievements necessitate suitable research accommodations.

MITIGATION PLAN: Building 205 is 12th on the VA’s EHR list. Following the seismic retrofit of Building 4, Building 205’s research programs will relocate to PAD, the building will then be razed.

BUILDING 301 - RESEARCH: Building 301 houses the VA’s bone density program. Relocating these clinical research programs to seismically safe clinical space is the most cost effective and expedient approach to resolving the existing seismic deficiencies.

MITIGATION PLAN: This minor construction project would relocate Building 301’s clinical research program to PAD and then the building will be razed.

**BUILDING 323 – OUPATIENT PSYCHIATRY & PTSD:** Building 323 is an out leased building, which houses several veteran homeless programs including shelters.

**MITIGATION PLAN:** Building 323 is 6th on the VA's EHR list. This major construction project will include column reinforcement, and will add additional interior and exterior shear walls.

**SUMMARY:** The aforementioned seismic projects are critical to the health care system's future operations. Correcting seismic deficiencies, in advance of a potential catastrophic disaster is advantageous. Demolishing ~160,000 GSF would reduce operating and maintenance expenses.

Menlo Park Division's seismic correction cost estimate is \$36,100,000

**b. Resolution of Capacity Planning Initiatives**

***Proposed Management of Workload – FY 2012***

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections		(from projections)									
INPATIENT CARE	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Medicine	5,111	(113)	1,274	(3,950)	-	-	1,274	-	-	-	-	\$ 38,804,237
Surgery	10	(17)	10	(17)	-	-	-	-	-	-	10	\$ -
Intermediate/NHCU	88,150	-	88,150	-	18,512	-	-	-	-	-	69,638	\$ (3,615,076)
Psychiatry	12,098	(2,222)	5,862	(8,458)	-	-	-	-	-	-	5,862	\$ 62,209,237
PRRTP	18,178	-	16,178	(2,000)	-	-	-	-	-	-	16,178	\$ 17,444,698
Domiciliary	34,169	-	34,169	-	-	-	-	-	-	-	34,169	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>157,716</b>	<b>(2,352)</b>	<b>145,643</b>	<b>(14,425)</b>	<b>18,512</b>	<b>-</b>	<b>1,274</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>125,857</b>	<b>\$ 114,843,096</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections		(from projections)									
OUTPATIENT CARE	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Primary Care	14,182	8,518	4,131	(1,533)	-	-	-	-	-	-	4,131	\$ 39,181,005
Specialty Care	8,534	5,872	6,535	3,873	-	-	-	-	-	-	6,535	\$ 6,240,521
Mental Health	37,611	3	37,612	4	-	-	-	-	-	-	37,612	\$ -
Ancillary & Diagnostics	7,919	6,500	7,920	6,501	-	-	-	-	-	-	7,920	\$ -
<b>Total</b>	<b>68,246</b>	<b>20,893</b>	<b>56,198</b>	<b>8,845</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>56,198</b>	<b>\$ 45,421,526</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
<b>INPATIENT CARE</b>											
Medicine	10,631	-	-	-	-	-	-	-	-	-	-
Surgery	17	17	17	-	-	-	-	-	-	-	(17)
Intermediate Care/NHCU	127,935	127,934	(1)	127,935	-	-	-	-	-	127,935	1
Psychiatry	19,600	9,496	(14,013)	23,509	-	-	-	-	-	23,509	14,013
PRRTP	34,665	30,851	(3,814)	34,665	-	-	-	-	-	34,665	3,814
Domiciliary program	59,358	59,358	-	59,358	-	-	-	-	-	59,358	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>252,206</b>	<b>227,656</b>	<b>(17,811)</b>	<b>245,467</b>	-	-	-	-	-	<b>245,467</b>	<b>17,811</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
<b>OUTPATIENT CARE</b>											
Primary Care	10,553	3,016	(1,576)	4,592	-	-	-	-	-	4,592	1,576
Specialty Care	14,083	10,783	2,078	8,705	-	-	-	-	-	8,705	(2,078)
Mental Health	31,218	31,218	(26,836)	58,054	-	-	-	-	-	58,054	26,836
Ancillary and Diagnostics	7,603	7,603	(43,174)	50,777	-	-	-	-	-	50,777	43,174
<b>Total</b>	<b>63,257</b>	<b>52,620</b>	<b>(69,508)</b>	<b>122,128</b>	-	-	-	-	-	<b>122,128</b>	<b>69,508</b>
<b>NON-CLINICAL</b>											
Research	-	-	(73,759)	73,759	-	-	-	-	-	73,759	73,759
Administrative	108,982	100,451	(20,936)	121,387	-	-	-	-	-	121,387	20,936
Other	42,972	42,972	-	42,972	-	-	-	-	-	42,972	-
<b>Total</b>	<b>151,954</b>	<b>143,423</b>	<b>(94,695)</b>	<b>238,118</b>	-	-	-	-	-	<b>238,118</b>	<b>94,695</b>

## 5. Facility Level Information – Palo Alto

### a. Resolution of VISN Level Planning Initiatives

#### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

#### **Proximity Narrative:**

OVERVIEW: VA Palo Alto Health Care System (VAPAHCS) and San Francisco VA Medical Center (SFVAMC) are the only two tertiary care facilities in VISN 21, which serves a population of 1.14 million veterans. The current arrangement with two tertiary care centers has served the Sierra Pacific Network (VISN 21) well and led to national prominence in clinical care, research and education.

Initially, the North and South Coast Market Committees developed a joint white paper explaining that each facility, VAPAHCS and SFVAMC, remains a leader with respect to their tertiary care programs. Subsequently, the VAPAHCS & SFVAMC Tertiary Care Steering Committee was established to identify and evaluate collaborative opportunities. After a thorough assessment of both facilities, the Steering Committee recommended consolidating a number of clinical and administrative programs. In April 2003, the final report, entitled “VAPAHCS & SFVAMC Proximity Study,” was submitted to the National CARES Program Office (NCPO).

MEDICAL SCHOOL ACADEMIC AFFILIATIONS: SFVAMC is affiliated with the University of California - San Francisco (UCSF) School of Medicine and VAPAHCS is affiliated with the Stanford University School of Medicine. These relationships, with two of the most prestigious medical schools in the nation, have developed and flourished over the last 30 to 40 years.

RESEARCH PROGRAMS: Also linked to the high quality of care is the large research enterprise in VISN 21. VAPAHCS and SFVAMC maintain two (2) of the three (3) largest research programs in the VA. In FY01, the SFVAMC research budget totaled \$51 million while VAPAHCS research budget totaled \$44 million.

EXECUTIVE SUMMARY (TERTIARY CARE STUDY): With an exhaustive objective analysis of existing/projected workload, referral patterns, academic affiliations, teaching & research programs, the VAPAHCS & SFVAMC Tertiary Care Steering Committee found that neither health care system has the infrastructure, bed capacity, nor clinical staff to accommodate the full workload of the other. During the Proximity PI evaluation process, the Committee analyzed DRG, CPT, fee workload, CARES portal data, high cost/low volume workload & consulted with service chiefs from every service. Several activities and/or services were identified for consolidation over the next 20 years. The Committee further recognizes the need to monitor future data trends to identify further consolidation opportunities.

The VAPAHCS & SFVAMC Tertiary Care Steering Committee evaluated three (3) options. The options included the following:

- Alternative A: Status Quo (Not Utilized)
- Alternative B: Closure of One Facility (Not Feasible)
- Alternative C: Limited Integration & Consolidation (Recommended)

Alternative A (STATUS QUO): Although this alternative could not be selected in CARES, it is important to note that numerous facility and Network consolidations have already occurred prior to CARES. (See Proximity Study)

Alternative B (CLOSURE): This option was not viable because of Network size, access constraints, space and facility constraints, and staff/community limitations. (See Proximity Study)

Alternative C (LIMITED CONSOLIDATION): Administrative consolidations (C-1) option maintains both facilities and consolidates selected administrative services. C-1 was not the preferred option. The Network recommended alternative, C-2, because it not only includes those consolidations found in C-1, but also included selected clinical consolidations. This preferred alternative would retain the high quality of care at both sites while achieving maximum efficiencies. (See Proximity Study)

### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

#### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

OVERVIEW: Currently, the VA and DoD maintain two separate outpatient clinics in Monterey. Approximately 76,000 VA/DoD beneficiaries (45,000 VA & 31,000 DoD) reside within 30 minutes of Monterey. In FY01, 8,000 veterans were enrolled in the VA Clinic; 6,500 were enrolled in the US Army Clinic; the remainder utilized the TRICARE Managed Care Support Contract (MCSC). In FY01, VA, DoD, and TRICARE providers generated approximately 250,000 outpatient encounters. Over the past 5 years, the VA Clinic's outpatient workload increased by 43%. The DoD requirements for additional linguistic personnel have inundated the existing US Army Clinic, which is currently located at the Defense Language Institute (DLI). Collectively, over 100 staff members are employed at the VA and US Army Clinics. Combining operations would undoubtedly generate some economies of scale both in terms of improved delivery of care and fixed-variable cost reductions.

ACCESS TO HEALTHCARE: In conjunction with the 1993 Fort Ord Base Realignment and Closure (BRAC), the Silas B. Hayes Army Community Hospital and the US Army Troop Medical Clinic (TMC) were both deactivated. In February 1995, the DoD relinquished control of the TMC and transferred the property and clinic to VAPAHCS. In 1993, the Army Community Hospital was mothballed and has since been converted to other non-healthcare functions. Since

Fort Ord was deactivated, the Presidio of Monterey has had insufficient medical facilities and staffing resources required to support the active duty, dependent and retiree population.

OFFICE OF THE [ARMY] SURGEON GENERAL (OTSG): In January 2003, Carolyn Bulliner, Health Facility Planner for the US Army Health Facility Planning Agency in Falls Church, VA (OTSG), notified the National CARES Program Office (NCPO), through an email, expressing the DoD's interest in developing a collaborative venture with the VA on the Monterey Peninsula. The US Army Medical Department expressed interest in developing a VA/DoD sharing arrangement in Monterey, CA. Ms. Bulliner reported that, "The existing DoD clinic at the Presidio of Monterey is not big enough nor resourced to provide care for active duty dependents. The beneficiaries have experienced difficulty accessing providers thru the TRICARE managed care support contract."

VA CLINIC OPERATIONS (EXISTING): Over the past seven years, the VA has successfully developed and expanded its Community Based Outpatient Clinic (CBOC) into a multi-specialty clinic with a comprehensive provision of clinical services ranging from primary care and mental health to cardiology and orthopedics. Existing facility constraints do not permit further expansion. The clinic is landlocked and has nowhere else to expand.

ARMY CLINIC OPERATIONS (EXISTING): The DoD maintains a significant active duty presence on the Monterey Peninsula. Today, the Peninsula's active duty population remains the 2nd largest concentration in Northern California. The active duty population is ~6,500; dependant and retiree population ~25,000. In fact, the Monterey Peninsula force structure, at the Defense Language Institute, the Navy Post Graduate School, and Fort Ord, is nearly the size as that of Travis Air Force Base, which has a large USAF Medical Center.

BUSINESS PLAN: Currently, the DoD's Monterey outpatient facilities are inadequate. In the foreseeable future, the VA Clinic will lack adequate capacity to meet the needs of its beneficiaries. To that end, both organizations expressed interest in exploring innovative approaches to delivering healthcare services to the combined 76,000 eligible VA/DoD beneficiaries. The conceptual VA/DoD Monterey joint venture clinic would be a VA owned and managed facility built on existing Fort Ord property. Conceptually, the VA/DoD clinic would be 100,000 GSF and would provide primary, specialty and mental health services. In addition, laboratory, radiology and pharmacy services will be available

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

**OVERVIEW:** VA Palo Alto Health Care System (VAPAHCS) and Stanford University School of Medicine (SUSOM) have discussed leasing Palo Alto Division (PAD) property to construct a world-class vision center.

**CONCEPT PROPOSAL:** SUSOM would construct a vision center that would combine research, education, and patient care activities. VAPAHCS would enter into a 35-year Enhanced-Use Lease (E-UL) sharing agreement with its primary academic affiliate, SUSOM. This proposal would lease approximately 3.7 acres of undeveloped PAD property to SUSOM. The proposal has three main objectives:

1. Achieve world-class innovations in eye care and make these advances available to VAPAHCS' veterans through extensive collaboration and potential sharing of services
2. Advance VA ophthalmologic clinical research programs
3. Manage vacant and/or underutilized buildings and property

**PORPOSED E-UL SCOPE:** SUSOM's \$65,000,000 proposal would establish a world-class vision facility for advancements in ophthalmologic research and treatment. The property development includes the construction of a 75,000 GSF clinical/research building and parking structure. The vision center would support the advancement of ophthalmological therapies and techniques through clinical trials, cutting-edge research, and education of clinicians in the treatment of patients with eye diseases. The EU-L proposal would establish a collaborative partnership between VAPAHCS and SUSOM.

**RESEARCH AND COLLABORATION:** The E-UL project would advance VA ophthalmologic research programs by addressing the needs of vision-impaired veterans. The SUSOM investment allows VAPAHCS to improve eye care services to veterans while enriching collaboration in research and clinical practice between VAPAHCS and SUSOM. Today, VAPAHCS maintains a comprehensive ophthalmologic surgical program. VA/SUSOM collaborative efforts will further develop and complement existing services. The investment allows a private sector organization to collaborate with VA, while assuming full development and financial management, toward meeting the eye care needs of our veteran population. The E-UL proposal will enhance services to VA's special populations including spinal cord injured veterans, veterans with low vision and blind veterans. Most importantly, this initiative would decrease basic eye care wait times.

**EYE CARE STATISTICS:** As World War II, Korean, Vietnam and Gulf War era veterans grow older, demand for degenerative eye care will marketably increase. The goal of this initiative is to help meet veterans' eye care needs. It is estimated that 1.4 million VISN 21 veterans could benefit from this proposed vision center. Today, 36,000 veterans receive eye care through VISN 21. Approximately 8,750 VAPAHCS' veterans are vision impaired.

**WESTERN BLIND REHABILITATION CENTER:** VAPAHCS' Western Blind Rehabilitation Center (WBRC) is one of eight such facilities in the VA. Due to increasing demand for blind rehabilitation, the backlog of patients waiting to be referred to VAPAHCS, from other VISNs, continues to grow. The proposed E-UL site will abut VAPAHCS' WBRC. Stanford University's Vision Center will provide much needed optometry and ophthalmology services to vision impaired veterans.

IMPROVED ACCESS: Centrally located between VISNs 18 through 22, Palo Alto is an equitable travel destination for veterans of the Western States seeking specialized eye care. The initiative will demonstrate true cooperation between VA and a private organization in meeting the specialty eye care needs of veterans.

VA CONCEPT PROPOSAL APPROVAL: In December 2002, Secretary Principi approved this aforementioned E-UL vision center proposal.

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

### **VISN Identified Planning Initiatives Narrative:**

VA SEISMIC STUDY: A total of sixty-nine buildings in the VA inventory have been identified as exceptionally high risk (EHR). Today, four of the top five buildings on the EHR list are located in the South Coast Market (VA Palo Alto Health Care System). These buildings represent the greatest hazard of all buildings in the VA inventory. They are typically large buildings, often bed buildings, in high seismic zones that have not yet been strengthened.

The VA's "Top 5" EHR seismic ranking:

1. VAPAHCS - Palo Alto Division: Building 2
2. VAPAHCS - Menlo Park Division: Building 137
3. VAPAHCS - Palo Alto Division: Building 4
4. American Lake: Building 81
5. VAPAHCS - Menlo Park Division: Building 324

PALO ALTO DIVISION (PAD) - SEISMIC DEFICIENCIES: VAPAHCS – Palo Alto Division's Building 2 (Inpatient Psychiatry), Building 4 (Research) and Building 6 (Administration) remain at the top of the VA's EHR seismic inventory list.

BUILDING 2 – ACUTE INPATIENT PSYCHIATRY: Building 2, originally designed to house 104 acute psychiatric patients, is VISN 21's primary site for

acute inpatient psychiatric treatment. Veterans who are seriously and chronically mentally ill, require specially designed inpatient facilities for the safe and efficient treatment of their psychiatric disorders. These veterans suffer from serious mental illnesses such as chronic schizophrenia, bipolar disorder, Post Traumatic Stress Disorder (PTSD), major depression, and other forms of psychosis. Non-VA services are generally not available to provide the level or degree of treatment that these veterans require.

MITIGATION PLAN: Building 2 remains the 1st priority on the VA's EHR list. This major construction project would seismically reinforce and renovate Building 2. Advanced Planning Funds (APF), for design, have been obligated. Construction dollars; however, have yet to be appropriated. Seismic mitigation plans include column reinforcement, adding additional interior and exterior shear walls, and renovating patient wards to satisfy JCAHO patient privacy requirements. Construction funding is required.

BUILDING 4 – CONSOLIDATED RESEARCH: VAPAHCS' \$44 Million annual research budget represents the 3rd largest [research] program in the VA. The academic affiliation with the Stanford University School of Medicine has played a pivotal role in Palo Alto's research achievements. The existing research facilities have serious seismic deficiencies. The health care system's continued research success centers on its ability to obtain suitable research accommodations.

MITIGATION PLAN: Building 4 is 3rd on the VA's EHR list. This major construction project would seismically reinforce and renovate Building 4. Advanced Planning Funds have been obligated. Construction dollars; however, have yet to be appropriated. Seismic mitigation plans include column reinforcement, constructing additional interior and exterior shear walls, HVAC installation and lab expansion. Construction funding is required.

BUILDING 6 - ADMINISTRATION: VAPAHCS is a major tertiary referral center with nine separate locations: three hospital-based divisions and a network of clinics. Most administrative services have already been consolidated into Building 6. These services include: A&MMS, Business Office, DSS, EMS, Engineering, Fiscal, HR, and IRMS.

MITIGATION PLAN: This major construction project would seismically reinforce and renovate Building 6. The seismic mitigation plan includes column reinforcement, adding additional interior and exterior shear walls, HVAC installation and miscellaneous renovation.

SUMMARY: The aforementioned seismic projects are critical to the health care system's future operations. Correcting seismic deficiencies, in advance of a potential catastrophic disaster is advantageous.

Palo Alto Division's seismic correction cost estimate is \$43,250,000



**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections		# BDOCs proposed by Market Plans in VISN									
	FY 2012	(from 2001 projections)	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>												
Medicine	18,552	584	23,625	5,657	945	-	-	2,557	1,825	-	27,062	\$ (247,017,460)
Surgery	9,721	(5,305)	9,932	(5,094)	100	-	-	47	1,825	-	11,704	\$ (44,259,961)
Intermediate/NHCU	34,964	-	34,964	-	19,972	-	-	-	-	-	14,992	\$ (86,173,445)
Psychiatry	21,315	(1,496)	26,751	3,940	-	-	2,100	-	-	-	28,851	\$ (97,584,189)
PRRTP	297	-	2,297	2,000	-	-	-	-	-	-	2,297	\$ (18,827,002)
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	12,279	-	12,279	-	-	-	-	-	-	-	12,279	\$ -
Blind Rehab	7,601	-	7,601	-	-	-	-	-	-	-	7,601	\$ -
<b>Total</b>	<b>104,729</b>	<b>(6,217)</b>	<b>117,449</b>	<b>6,503</b>	<b>21,017</b>	<b>-</b>	<b>-</b>	<b>4,704</b>	<b>3,650</b>	<b>-</b>	<b>104,786</b>	<b>\$ (493,862,057)</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections		Clinic Stops proposed by Market Plans in VISN									
	FY 2012	(from 2001 projections)	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>												
Primary Care	141,364	35,723	126,416	20,775	-	-	-	-	30,000	-	156,416	\$ (112,161,624)
Specialty Care	149,567	45,934	143,568	39,934	5,743	-	-	4,000	50,000	-	191,825	\$ (304,739,322)
Mental Health	45,072	595	45,072	596	1,803	-	6,000	18,000	-	-	55,269	\$ (35,499,761)
Ancillary & Diagnostics	194,996	52,843	184,996	42,843	22,200	-	-	-	15,000	-	177,796	\$ (17,106,574)
<b>Total</b>	<b>530,999</b>	<b>135,094</b>	<b>500,052</b>	<b>104,148</b>	<b>29,746</b>	<b>-</b>	<b>6,000</b>	<b>22,000</b>	<b>95,000</b>	<b>-</b>	<b>581,306</b>	<b>\$ (469,507,281)</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
<b>INPATIENT CARE</b>	<b>FY 2012</b>										
Medicine	37,045	56,289	(5,331)	61,620	-	-	-	-	-	61,620	5,331
Surgery	15,977	19,429	(7,860)	27,289	-	-	-	-	-	27,289	7,860
Intermediate Care/NHCU	34,778	24,827	(9,951)	34,778	-	-	-	-	-	34,778	9,951
Psychiatry	34,532	46,739	13,525	33,214	25,000	-	-	-	-	58,214	11,475
PRRTP	13,234	13,234	-	13,234	-	-	-	-	-	13,234	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	33,352	54,378	(21,026)	54,378	-	-	-	-	-	54,378	-
Blind Rehab	54,378	33,352	-	33,352	-	-	-	-	-	33,352	-
<b>Total</b>	<b>223,296</b>	<b>248,248</b>	<b>(9,617)</b>	<b>257,865</b>	<b>25,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>282,865</b>	<b>34,617</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>										
Primary Care	101,783	117,312	49,933	67,379	-	60,000	-	30,000	-	157,379	40,067
Specialty Care	208,199	278,146	126,319	151,827	18,000	94,000	-	10,000	-	273,827	(4,319)
Mental Health	25,529	32,609	7,116	25,493	-	-	-	-	-	25,493	(7,116)
Ancillary and Diagnostics	135,561	140,459	36,828	103,631	-	15,000	-	6,000	-	124,631	(15,828)
<b>Total</b>	<b>471,071</b>	<b>568,526</b>	<b>220,196</b>	<b>348,330</b>	<b>18,000</b>	<b>169,000</b>	<b>-</b>	<b>46,000</b>	<b>-</b>	<b>581,330</b>	<b>12,804</b>
<b>NON-CLINICAL</b>	<b>FY 2012</b>										
Research	-	484,203	322,880	161,323	42,969	200,000	-	-	75,000	479,292	(4,911)
Administrative	-	330,000	81,900	248,100	67,292	-	-	-	-	315,392	(14,608)
Other	68,483	68,483	-	68,483	-	-	-	-	-	68,483	-
<b>Total</b>	<b>68,483</b>	<b>882,686</b>	<b>404,780</b>	<b>477,906</b>	<b>110,261</b>	<b>200,000</b>	<b>-</b>	<b>-</b>	<b>75,000</b>	<b>863,167</b>	<b>(19,519)</b>

## 6. Facility Level Information – Palo Alto Clinics

### a. Resolution of VISN Level Planning Initiatives

#### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

#### **Proximity Narrative:**

No Impact

#### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

#### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

No Impact

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

**VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections	(from projections)	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
	FY 2012	Variance from 2001										
<b>INPATIENT CARE</b>												
Medicine	-	-	-	-	-	-	-	-	-	-	-	\$ -
Surgery	-	-	-	-	-	-	-	-	-	-	-	\$ -
Intermediate/NHCU	-	-	-	-	-	-	-	-	-	-	-	\$ -
Psychiatry	-	-	-	-	-	-	-	-	-	-	-	\$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	-	-	-	-	-	-	-	-	-	-	-	\$ -
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections	(from projections)	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
	FY 2012	Variance from 2001										
<b>OUTPATIENT CARE</b>												
Primary Care	-	-	25,000	25,000	-	-	-	-	-	-	25,000	\$ (99,904,626)
Specialty Care	-	-	18,000	18,000	-	-	-	-	-	-	18,000	\$ (90,831,069)
Mental Health	-	-	-	-	-	-	-	8,000	-	-	8,000	\$ (28,316,346)
Ancillary & Diagnostics	-	-	10,000	10,000	-	-	-	-	-	-	10,000	\$ (27,411,363)
<b>Total</b>	-	-	<b>53,000</b>	<b>53,000</b>	-	-	-	<b>8,000</b>	-	-	<b>61,000</b>	<b>\$ (246,463,404)</b>

**Proposed Management of Space – FY 2012**

		Space (GSF) proposed by Market Plans in VISN									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>INPATIENT CARE</b>											
Medicine	-	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	-	-	-	-	-	-	-	-	-	-	-
Psychiatry	-	-	-	-	-	-	-	-	-	-	-
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											
		Space (GSF) proposed by Market Plan									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>OUTPATIENT CARE</b>											
Primary Care	-	18,750	18,750	-	-	-	-	22,000	-	22,000	3,250
Specialty Care	-	26,100	26,100	-	-	-	-	25,000	-	25,000	(1,100)
Mental Health	-	4,720	4,720	-	-	-	-	4,700	-	4,700	(20)
Ancillary and Diagnostics	-	7,900	7,900	-	-	-	-	8,000	-	8,000	100
<b>Total</b>		<b>57,470</b>	<b>57,470</b>					<b>59,700</b>		<b>59,700</b>	<b>2,230</b>
<b>NON-CLINICAL</b>											
Research	-	-	-	-	-	-	-	-	-	-	-
Administrative	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>											

## F. South Valley Market

### 1. Description of Market

#### a. Market Definition

Market	Includes	Rationale	Shared Counties
South Valley  Code: 21F	6 California counties	<p>The South Valley market extends through the central valley of the state. Highways 5 and 99 run parallel (north-south) linking Merced County, through the San Joaquin valley south to Kings and Tulare counties. The south end of the Sierra Nevada mountain range borders the eastern portion of this market. Other than Fresno County, this market area consists of rural counties. The southern portion of this Network borders VISN 22, where CCHCS draws some patients from the 50-mile “buffer zone”, the location of the Bakersfield CBOC. The city of Fresno serves as the metropolitan area that anchors the South Valley market and is the location of the secondary care facility, VA Central California Health Care System (CCHCS). A NHCU and two CBOCs also support this market area. The South Valley tertiary care referrals go to VA Palo Alto Health Care System and VAMC San Francisco as appropriate.</p>	

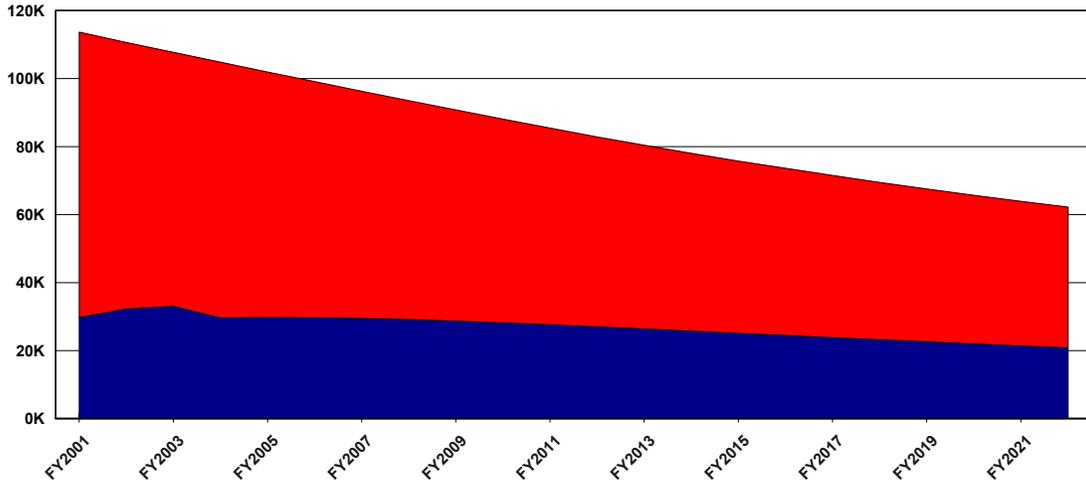
**b. Facility List**

<b>VISN : 21</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Fresno</b>				
570 Fresno	✓	✓	-	-
570GA Merced	✓	-	-	-
570GB Tulare	✓	-	-	-

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
South Valley Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care	Access				
	Access to Hospital Care	Access				
	Access to Hospital Care	Access				
N	Primary Care Outpatient Stops	Population Based	944	1%	-21,727	-27%
		Treating Facility Based	898	1%	-20,992	-26%
Y	Specialty Care Outpatient Stops	Population Based	33,620	51%	10,054	15%
		Treating Facility Based	35,724	57%	13,631	22%
N	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	99	0%		0%
N	Medicine Inpatient Beds	Population Based	-5	-17%	-5	-17%
		Treating Facility Based	-4	-14%	-4	-14%
N	Surgery Inpatient Beds	Population Based	-10	-49%	-10	-49%
		Treating Facility Based	-6	-46%	-6	-46%
N	Psychiatry Inpatient Beds	Population Based	5	47%	5	47%
		Treating Facility Based	5	48%	5	48%

**e. Stakeholder Information**

Discussion of stakeholder input and how concerns/issues were addressed.

**Stakeholder Narrative:**

VA Central California Health Care System has maintained continuous communications and on-going relationships with stakeholders within the South Valley Market. Several methods have been used to communicate CARES including town halls, forums and large and small meetings have been conducted during the CARES process to inform stakeholders on Planning Initiatives affecting the South Valley Market and to update them on the potential alternatives that were are exploring. During this process, the South Valley Market received minimal, albeit positive, stakeholder feedback and as a result no changes have been incorporated into the market plan.

**f. Shared Market Discussion**

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

**Shared Market Narrative:**

VA Central California Health Care System has maintained continuous communications and on-going relationships with stakeholders within the South Valley Market. Several methods have been used to communicate CARES including town halls, forums and large and small meetings have been conducted during the CARES process to inform stakeholders on Planning Initiatives affecting the South Valley Market and to update them on the potential alternatives that were are exploring. During this process, the South Valley Market received minimal, albeit positive, stakeholder feedback and as a result no changes have been incorporated into the market plan.

**g. Overview of Market Plan**

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

**Executive Summary Narrative:**

VA Central California Health Care System (CCHCS), located in the South Valley Market, is an affiliated health care system comprised of a medical center and Geriatric Extended Care Unit (GECU) in Fresno. In addition CCHCS supports outpatient clinics in Merced and Tulare. Comprehensive health care is provided through primary care, specialty care and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. CCHCS serves an area consisting of 150,000 veterans distributed over five counties. The medical center is a 65-bed acute care general medical and surgical center with state of the art primary, secondary and specialty care in major diagnostic and treatment categories. CCHCS maintains a strong affiliation with the University of California at San Francisco (UCSF), and serves as the center for the resident program in Fresno. In addition, the medical center maintains an active affiliation with 30 educational facilities to train health care professionals in a variety of disciplines including: medicine, dentistry, optometry, and pharmacy. The facility also manages an active research program with 18 active research projects and 9 active principal investigators with a total research funding of \$300,000. Central California HCS is projecting an increase in specialty care outpatient growth of 57% in 2012 and 52% in 2022 (CARES Planning years). This increase, combined with existing inefficiencies in space due to the configuration of the original building (activated in 1950), generates a need for additional space. CCHCS recommends a combination of renovating existing space and building additional space. There were a variety of alternatives considered including renovation of existing space, construction of additional space, leasing additional space and contracting for specialty services in the community. The market plan includes all of these options. Our Preferred Planning Scenario includes remodeling of the 7th floor in Building One for outpatient Mental Health in 2004. In FY 2005 and 2006 the 4th floor of Building 1 will be remodeled to accommodate the existing base line Specialty Clinic needs as well as a new Endoscopy Suite. The space will be remodeled in two phases that will result in a total remodel approximately 22,000 remodeled square feet. This will allow 13 of the existing specialty clinic rooms on the 2nd floor to be relocated to the 4th floor, thereby opening up the 2nd floor of the Outpatient Clinic Building to be refurbished for additional Primary Care. In 2007, a major construction project will create new space of approximately 60,000 gsf. It will address the seismically deficient administrative and mental health buildings as well as provide an Imaging Suite and Specialty Clinics. The

relocation of the current Imaging Suite to the new building will allow 2 East (10,000 gsf) and 3 East (4,000 gsf) in Building One to be remodeled to meet our needs for additional specialty care clinical space. An alternative to the scenario above is to contract for specialty care in the community. This scenario was rejected because the community does not have the capacity to provide these at the level we would need them.

## 2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

### Access Narrative:

South Valley Market meets the required Access Standards.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	68%	10,205	66%	9,174	65%	7,286
Hospital Care	79%	6,697	81%	5,126	82%	3,747
Tertiary Care	100%	-	100%	-	100%	-

### Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time  
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time  
Rural Counties – 90 minutes drive time  
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours  
Highly Rural Counties – within VISN

### **3. Facility Level Information – Fresno**

#### **a. Resolution of VISN Level Planning Initiatives**

##### **Resolution Narrative of Proximity PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

##### **Proximity Narrative:**

No Impact

##### **Resolution Narrative of Small Facility PI**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

##### **Small Facility Narrative:**

No Impact

### **DOD Collaborative Opportunities**

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **DOD Narrative:**

VA Central California Health Care System (Fresno) has identified several opportunities to collaborate with DoD specifically, Lemoore Naval Air Station (NAS) to provide additional specialty services for our patients. The close proximity of Lemoore NAS provides convenient access for our South Valley catchment. An active collaborative sharing agreement currently exists between VA Central California and Lemoore NAS to provide pathology services and the relationship has been highly successful for both locations. In addition, VA Central California provides MRI examinations to active duty personnel. The identified need for increased specialty care services in the South Valley Market has initiated VA Central California's exploration of a more in-depth relationship with Lemoore NAS. Our most recent sharing agreement between both facilities is for Lithotripsy and will prove to be beneficial for both VA Central California and Lemoore NAS. With the success of these agreements VA Central California and Lemoore NAS are exploring additional collaborations to provide for the projected needs of the veterans in our market.

### **VBA Collaborative Opportunities**

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **VBA Narrative:**

No Impact

### **NCA Collaborative Opportunities**

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **NCA Narrative:**

No Impact

### **Top Enhanced Use Market Opportunity**

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

#### **Enhanced Use Narrative:**

No Impact

### **Resolution of VISN Identified PIs**

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections	(from projections)	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001</b>	<b>Total BDOCs</b>	<b>Variance from 2001</b>	<b>Contract</b>	<b>Joint Ventures</b>	<b>Transfer Out</b>	<b>Transfer In</b>	<b>In Sharing</b>	<b>Sell</b>	<b>In House</b>	<b>Net Present Value</b>
Medicine	7,496	(1,252)	7,497	(1,251)	150	-	-	-	-	-	7,347	\$ -
Surgery	1,994	(1,734)	1,995	(1,733)	20	-	-	-	-	-	1,975	\$ -
Intermediate/NHCU	50,149	-	50,149	-	33,600	-	-	-	-	-	16,549	\$ -
Psychiatry	4,427	1,426	4,428	1,427	600	-	-	-	-	-	3,828	\$ 4,802,012
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>64,067</b>	<b>(1,559)</b>	<b>64,069</b>	<b>(1,557)</b>	<b>34,370</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>29,699</b>	<b>\$ 4,802,012</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections	(from projections)	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001</b>	<b>Total Stops</b>	<b>Variance from 2001</b>	<b>Contract</b>	<b>Joint Ventures</b>	<b>Transfer Out</b>	<b>Transfer In</b>	<b>In Sharing</b>	<b>Sell</b>	<b>In House</b>	<b>Net Present Value</b>
Primary Care	81,771	897	81,771	898	3,271	-	-	-	-	-	78,500	\$ (1,882,121)
Specialty Care	98,935	35,725	98,935	35,725	4,947	-	-	-	-	-	93,988	\$ (25,960,663)
Mental Health	34,735	99	34,736	100	3,821	-	-	-	-	-	30,915	\$ (844,407)
Ancillary & Diagnostics	95,454	23,271	95,454	23,271	7,637	-	-	-	-	-	87,817	\$ (3,918,810)
<b>Total</b>	<b>310,895</b>	<b>59,992</b>	<b>310,896</b>	<b>59,993</b>	<b>19,676</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>291,220</b>	<b>\$ (32,606,001)</b>

