

VA Palo Alto Health Care System

Livermore Division Realignment Analysis



VISN: Network 21, South Coast CARES Market

Facility Name: Livermore Division, Palo Alto Health Care System

Affected Facilities: Livermore Division (LVD)
Menlo Park Division (MPD)
Palo Alto Division (PAD)
Central Valley CBOC

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South Coast CARES Market – VA Palo Alto Health Care System

MARKET OVERVIEW: The South Coast CARES Market encompasses VA Palo Alto Health Care System's (VAPAHCS) Primary Service Area (PSA). VAPAHCS is a major tertiary care referral network with three divisions and six community based outpatient clinics (CBOCs).

Palo Alto Division [PAD] is home to one of VA's flagship tertiary care referral centers. This division provides tertiary care as well as a broad spectrum of medical, surgical, psychiatric, spinal cord, rehabilitation medicine, blind rehabilitation, traumatic brain injury, and hospice-palliative care services.

Menlo Park Division [MPD] provides comprehensive mental health and geriatric programs ranging from substance abuse, PTSD, homeless rehabilitation, geropsychiatric and extended care services. MPD is a regional referral facility for domiciliary and inpatient geropsychiatric services. MPD is also home to a National Center for PTSD and the only inpatient women's PTSD program in VA.

Livermore Division [LVD] provides both sub-acute and geriatric inpatient programs as well as primary, specialty, mental health and ancillary outpatient services.

Community Based Outpatient Clinics (CBOCs): VAPAHCS operates six CBOCs, located in Capitola, Modesto, Monterey, San Jose, Sonoma, and Stockton.

DEMOGRAPHIC STATISTICS: VAPAHCS provides primary, secondary and tertiary care within a large geographical region. This catchment area encompasses a 10-county, 13,500 square miles including San Jose, which is the 2nd largest Metropolitan Service Area (MSA) in the State of California. In FY02, approximately 327,000 veterans resided within VAPAHCS' PSA, of which 74,200 veterans were enrolled in VA healthcare.

Outpatient: In FY02, VAPAHCS provided 640,000 outpatient encounters.

Inpatient: In FY02, VAPAHCS provided 264,000 Bed Days of Care (BDOC) equating to an Average Daily Census (ADC) of 723 and an occupancy rate of 80%.

SPECIAL EMPHASIS PROGRAMS: VAPAHCS operates a number of specialized regional referral centers including spinal cord injury, blind rehabilitation, and traumatic brain injury. Other regional referral programs include cardio thoracic surgery, transplant surgery, Post Traumatic Stress Disorder (PTSD) and homeless veteran rehabilitation (domiciliary).

RESEARCH: With a \$44 million annual research budget, VAPAHCS operates one of the largest research programs in VHA with extensive research programs in geriatrics (GRECC), mental illness (MIRECC), Alzheimer's disease, and spinal cord regeneration. Research centers include: Rehabilitation Research & Development Center (RRDC), Health Economics Resource Center (HERC), Cooperative Studies Program Coordinating Center (CSPC), and a Program Evaluation & Resource Center (PERC).

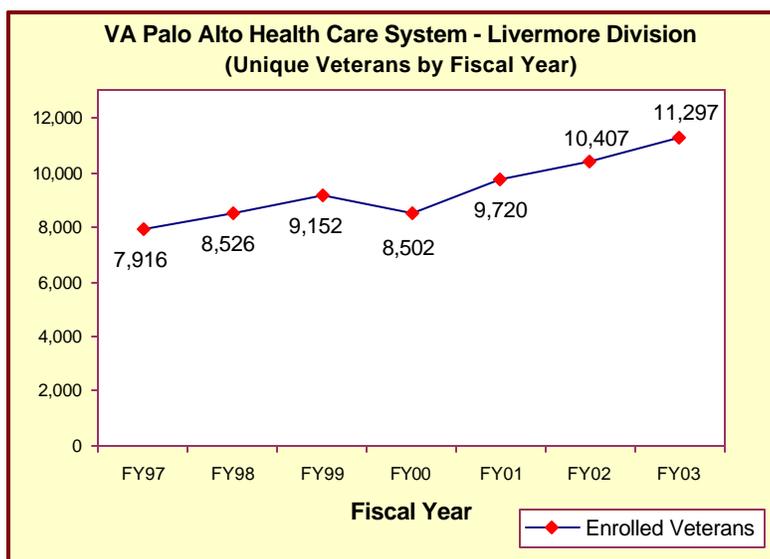
GRADUATE MEDICAL EDUCATION: VAPAHCS manages a broad range of Graduate Medical Education (GME) programs. In FY02, GME training was provided to 1,351 medical students, interns, residents and fellows from 102 academic institutions. The Stanford University School of Medicine remains VAPAHCS' primary academic affiliate.

Overview – VA Palo Alto Health Care System - Livermore Division

Livermore VA Medical Center (VAMC) began operations in 1929 at a tuberculosis hospital. Building 62, the main hospital building, was constructed in the late 1940s and was seismically retrofitted in the 1990s. A 120-bed nursing home unit (NHCU) was constructed at the Livermore VAMC in 1980 and is currently undergoing extensive renovations. The Livermore VAMC operated as an independent medical center until the mid-1990s. In 1995, the Livermore VAMC was integrated into VAPAHCS and was renamed Livermore Division (LVD). Today, LVD maintains 150 operating beds (120 NHCU beds and 30 intermediate care [sub-acute] beds). In FY02, LVD's ambulatory care clinics provided inpatient and outpatient care to 10,407 veterans. (see chart below)

VAPAHCS' revised CARES Market Plan recommended that LVD's primary and specialty care clinics be relocated to the Central Valley and East Bay to improve access to ambulatory care services. To that end, VAPAHCS proposed (based on VACO guidance) realigning LVD and out leasing the buildings and property through the Enhanced-Use Lease (E-UL) process.

As San Francisco Bay veterans migrate to the Central Valley, VAPAHCS anticipates continued growth within LVD's catchment area. Since FY97, LVD's veteran enrollment has increased by approximately 31 percent (7,916 unique users in FY97 vs. 11,297 unique users in FY03). Most veterans who utilize LVD today reside in outlying communities and commute to LVD for specialty care services. Veterans travel to LVD because San Joaquin County (Stockton CBOC), Stanislaus County (Modesto CBOC), and Tuolumne County (Sonora CBOC) only offer primary care and mental health services.



Source: KLF Menu - VAPAHCS' Enrollment Statistics

Of the 327,000 veterans who reside in VAPAHCS' 10-county catchment area, 130,000 are located in counties surrounding LVD. Most of the veterans who utilize LVD commute from communities in the East Bay or Central Valley. In fact, less than 10% of the total unique patients who utilized LVD in FY02 lived in the general vicinity of the campus. Veterans who live in the East bay or Central Valley must commute on heavily traveled interstates to obtain specialty care services currently located at LVD.

Collectively, VAPAHCS employs approximately 3,000 Full-time Equivalent (FTEs) multidisciplinary staff, of which 303 work at LVD. Under this proposed realignment proposal, the majority of LVD's employees would be relocated to other VAPAHCS' facilities. Savings from reducing LVD's operating costs would be redirected to support patient care activities. VAPAHCS obligates millions of dollars annually to maintain LVD's infrastructure and grounds that could be more efficiently employed to improve services for veterans.

1. Summary and Conclusions

a. Executive Summary

Following VISN 21's South Coast CARES Market plan submission, the Under Secretary for Health identified 20 VHA facilities nationwide to undergo a mission change study. Each impacted VISN was charged with completing a comprehensive analysis to determine whether realignment was a viable option. VAPAHCS' LVD had been identified as one of the sites to be studied. VISN 21 was tasked to "evaluate a strategy to convert from a 24 – hour a day operation to an 8 - hour operation."

LVD CARES' Realignment Proposal: After evaluation all possible options, VISN 21 completed a thorough analysis and submitted a response in June 2003 regarding LVD mission change. The study evaluated three (3) options: status quo, consolidation and closure. Subsequently, the Draft National Care Plan recommended that, "VA no longer operate health care services at this campus." The LVD realignment proposal recommended:

1. Relocating 80 of the 120-bed NHCU from LVD to a new nursing home at MPD
2. Contracting the remaining 40 beds to community nursing home facilities
3. Relocating LVD's 30-bed sub-acute unit from LVD to PAD
4. Establishing a large CBOC in the Central Valley to improve access and enhance existing services
5. Establishing a large CBOC in the East Bay to improve access and existing enhance services
6. Enhance-Use Lease (E-UL) LVD's 113-acre campus and utilize the revenues to enhance the delivery of healthcare to veterans

These aforementioned proposals were based on the following analyses:

First, VISN 21 concluded that the proposed realignment plan would improve access to outpatient services. Most veterans who utilize LVD today reside in outlying communities and commute to LVD for specialty care. Veterans travel to Livermore because San Joaquin County (Stockton CBOC), Stanislaus County (Modesto CBOC) and Tuolumne County (Sonora CBOC) offer only primary care and mental health services. In addition, most veterans in southern Alameda County live in the Fremont/Hayward area (approximately 20 miles from Livermore) where no VA CBOC currently exists. Therefore, the realignment of outpatient specialty services to an expanded Central Valley and a new East Bay CBOC would vastly improve access to care for the 130,000 veterans who reside in LVD's catchment area. In addition, the establishment of a new East Bay CBOC with primary, specialty and mental health services would improve access to these services for the majority of 55,000 veterans who reside in southern Alameda County.

Second, VISN 21 concluded that the proposed realignment plan would improve the quality of services provided within LVD's existing sub-acute and NHCU facilities. Veterans who currently utilize LVD's sub-acute facilities would benefit from a continuity of care standpoint by being realigned to a tertiary care setting at PAD. Veteran's who currently utilize LVD's NHCU facilities would benefit from being realigned to MPD, which already offers a broad array of inpatient geriatric services and has plans to become VISN 21's gerontology center.

Third, VISN 21 concluded that resources being obligated for maintaining LVD's aging infrastructure could be better utilized to enhance the delivery of healthcare services for veterans. LVD's main hospital building is 54 years old and is obsolete and deteriorating. The building requires significant renovations. The average age of all LVD buildings is 46 years old. While LVD's main hospital building was structurally reinforced in the 1990s, the building and other older buildings on the campus require significant resources to modernize and maintain. LVD's aging infrastructure continues to require excessive resources. For example, from FY00 to FY03, VAPAHCS obligated \$7,290,000 on non-recurring maintenance (NRM) and Minor projects to maintain LVD's infrastructure. In addition, there is another \$10,850,000 in required NRM and Minor maintenance projects that have been identified as necessary for LVD.

In conclusion, Network 21 concluded that the preferred alternative to realign and close LVD would vastly improve access to outpatient care and improve the quality of sub-acute and nursing home care. In addition, the preferred alternative would also reduce operational costs when reviewed in aggregate across the life cycle when compared to both the Market Plan Alternative and Alternative 2 (refer to operational costs summary section of this report). These savings, derived from the realignment and closure of LVD, would be redirected to enhance VAPAHCS' direct patient care activities.

b. Current Environment

(1) Facility Location and Condition of Buildings

LVD is situated on a hilly rural setting among vineyards, open land with low-density residential homes, and a natural park frontage in southeastern Alameda County. Access to the facility is via a two-lane country road located approximately six miles from the nearest interstate, Route 580.

LVD's buildings range in age from the early 1920's to 1982. Even though the primary buildings are structurally sound and present an appropriate architectural appearance, the aging utility infrastructure and both interior and exterior building maintenance issues continue to absorb considerable financial resources. For example, the main hospital building's plumbing waste lines are severely corroded and require replacement at an estimated cost of \$1,000,000. Installing new waste lines in an active clinical setting is a noteworthy obstacle that would need to be surmounted if VAPAHCS' decides to continue to operate the building. This building also requires a new roof at an estimated cost of \$700,000 and has significant asbestos issues that would have to be resolved.

LVD is comprised of 14 buildings including 2 temporary/modular buildings.

- LVD's Gross Square Feet (GSF): 229,143

- LVD's Vacant Space: 8,600 GSF

LVD has two (2) main clinical buildings:

Building 62, the main hospital building, is approximately 86,000 GSF. Building 62, initially designed for inpatient care, was seismically strengthened in the 1990s. Although Building 62 was retrofitted in the 1990s, the interior of the building has not been significantly modified.

Building 90 is a 120-bed nursing home including an Alzheimer unit. The first floor of the 2-story building was renovated in FY02 for \$1.3M.

(2) Workload Summary

LVD's baseline and projected workload can be found in the following table (Table 1). The VA's actuarial firm, Milliman USA, Inc, developed LVD's projected workload.

Workload or Space Category	2001 Workload (ADC for IP)	2001 Baseline Workload (beds, stops)	2012 Projected Workload (beds, stops)	2022 Projected Workload (beds, stops)
Inpatient Medicine				
Inpatient Surgery				
Inpatient Psych				
Inpatient Dom				
Inpatient NHCUC	121	162	162	162
Inpatient PRRT				
Inpatient SCI				
Inpatient BRC				
Outpatient Primary Care	17,073	17,073	26,456	20,150
Outpatient Specialty Care	25,072	25,072	34,106	28,014
Outpatient Mental Health	6,512	6,512	6,635	6,583
Ancillary & Diagnostics	7,844	7,844	11,863	9,823

Table 1 Livermore Division Baseline and Projected Workload

Source: VSSC

c. Proposed Realignment (Alternative #1, Preferred)

(1) Location and Description of Realigned Care

The Preferred alternative calls for all LVD's healthcare services to be realigned to other VAPAHCS facilities along with limited contract services with local community facilities. LVD's campus, property and structures, would then be available through E-UL. Proceeds from the E-UL would be utilized to enhance direct patient care activities. Elements of the preferred alternative include:

(a) Realignment of LVD's NHCUC Beds to VAPAHCS and Community

Today, VAPAHCS operates 393 NHCUC beds, of which, 120 beds are located at LVD. Relocating NHCUC beds to MPD is a critical factor in VAPAHCS' ability to realign and close LVD. VAPAHCS has submitted a Major construction project application for FY04 to replace MPD's seismically deficient Building 324, a 109-bed gero-psychiatric NHCUC, with a new 120-bed gero-psychiatric NHCUC. Building 324 is currently ranked number eight on the VA's Exceptionally High Risk (EHR) seismic list. The preferred option increases the size of the replacement facility for Building 324 at MPD by 80 beds, from 120 to 200 beds. This proposal would require 52,928 GSF of additional new construction at MPD. VISN 21 anticipated that LVD's more complex NHCUC patients would be transferred to MPD. VAPAHCS plans to establish a Gerontology Center at MPD, which should have a positive impact on quality for the care received by the realigned patients. VAPAHCS is also in the process of establishing a geriatrics fellowship program with the Stanford University School of Medicine, which would be located at MPD. This proposed realignment would strengthen VAPAHCS' academic affiliation specifically in the field of gerontology.

LVD's remaining 40 NHCU beds would be contracted out in the community. During FY01, there was an ADC of 12 NHCU beds within community nursing homes within LVD's catchment area (Alameda, San Joaquin, and Stanislaus Counties).

Community Resources: In Alameda, San Joaquin, Stanislaus, and Santa Clara Counties, there are over 80 nursing homes that the VA contracts with (See Appendix 1). Collectively, these facilities have a total of 7,318 NHCU beds. It is anticipated that there would be capacity in the community to accommodate the additional 40 beds, despite variable occupancy rates (Table 2).

Table 2 NHCU Facilities by County and Occupancy Rate

	Alameda	San Joaquin	Stanislaus	Tuolumne
Total #Facilities	69	25	17	1
#Sub-acute	1	0	0	0
#Mental	3	1	1	0
Occupancy	88%	92%	92%	82%

Source: Dr Jon Fuller, VAPAHCS

(b) Realignment of LVD's Sub-Acute Beds to PAD

(Note these beds are included in the inpatient NHCU Beds in Table 1 above) LVD's 30 sub-acute beds would be relocated to PAD. There is sufficient vacant inpatient space within PAD's new bed tower to accommodate LVD's 30 sub-acute beds, though there would be minor renovation costs associated with the impacted programs and facility modifications.

According to CARES space drivers, PAD has a total of 27,858 GSF of vacant space that would be converted to accommodate LVD's sub-acute relocation. Enhancing PAD's sub-acute bed capacity would decompress existing acute med/surg wards and would ultimately improve the continuity of care.

(c) Realignment of Low Volume Specialty Services to PAD

Under this proposed realignment plan, some LVD outpatient specialty care services would relocate to PAD. While it would be optimum to place many of these low volume specialty services within the new and/or expanded CBOC locations, some services simply do not have the demand volume (less than 1,000 stops) to justify leasing additional commercial space.

LVD's low volume specialty care clinics would likely relocate to PAD to garner additional operational efficiencies. A clinical review team would be tasked to evaluate existing LVD workload (by specialty) to determine whether the volume justifies maintaining specific low volume clinics in new CBOCs. If the existing and projected workload volume does not rise to meet predetermined thresholds, that clinical service would not be programmed into the proposed East Bay or Central Valley CBOCs.

There is sufficient vacant space at PAD to accommodate the realignment of these specialty services. A total of 3,647 GSF would be converted from vacant to accommodate the LVD's specialty care services.

(d) New East Bay CBOC

The preferred alternative recommends establishing a new East Bay CBOC to accommodate LVD's primary, specialty, mental health and ancillary workload. Based on this realignment proposal, 32,309 GSF of additional clinical space would be required. Of LVD total realigned outpatient services, 66% of primary care, 66% of mental health services, 50% of specialty care, and 50% ancillary services would be shifted to the new East Bay CBOC. It should be noted that of the 100,000 veterans that currently reside in Alameda County, over 55,000 live in southern Alameda County (55%). The only existing VA facility in Alameda County is located in the City of Oakland, which is in northern Alameda County. Therefore, the 55,000 veterans who reside in southern Alameda County must either commute to Palo Alto, Livermore or Oakland for medical care.

During the initial CARES plan, VAPAHCS redistributed existing and projected workload to support a new 45,000 GSF East Bay CBOC. The initial South Coast CARES plan did not realign LVD's workload. Subsequently, the realignment proposal was recommended and a percentage of LVD existing and projected ambulatory care workload was reallocated to proposed East Bay CBOC, accounting for an additional 32,309 GSF. Therefore, the combined East Bay allocated workload supports a CBOC sized at 77,309 GSF (45,000 GSF initial distribution; 32,309 GSF LVD distribution).

(e) Expanded Central Valley CBOC

The preferred alternative recommends expanded existing ambulatory care services in the Central Valley. Currently, 90,000 veterans reside in the VAPAHCS' Central Valley catchment area (San Joaquin County, Stanislaus County, Calaveras County and Tuolumne County). The expanded Central Valley CBOC would offer primary, specialty, mental health and ancillary services. The existing Modesto and Stockton CBOCs are both undersized and provide minimal clinical services (primary and mental health services). The expanded Central Valley CBOC would expand these primary care and mental health services and offer specialty care services in audiology, optometry, physical therapy and podiatry. Of the total LVD realigned outpatient services, 34% of primary care, 34% of mental health, 40% of specialty care, and 50% of ancillary & diagnostics would locate to the enhanced Central Valley CBOC.

To accommodate LVD's realigned primary, specialty, mental health and ancillary workload, VAPAHCS would lease 35,603 GSF of additional clinical space in the Central Valley. Therefore, the combined Central Valley allocated workload supports an enhanced Central Valley CBOC sized at 45,603 GSF (10,000 GSF existing CBOC; 35,603 GSF LVD distribution).

It should be noted that the proportion of LVD's primary care and mental health workload, transferred to the Central Valley CBOC, has been reduced to account for the fact that VAPAHCS already operates three existing Central Valley CBOCs, each of which already offers extensive primary care and mental health services.

2. Impacts on Preferred Alternative

(a) Travel Time

Ninety-five (95) percent of the 10,407 veterans who used LVD for care in FY02 were for outpatient services. Relocating ambulatory care services closer to where the majority of these veterans live would reduce travel time for most veterans seeking outpatient care. For example, the average travel time for veterans seeking primary care would be reduced from 46 minutes to 26 minutes under the preferred alternative. Similar reductions are noted for travel times in specialty care and mental health. These are significant reductions (See Travel Time section of this Report for additional detail).

Outpatient Summary: The new weighted average drive time calculations, from home of origin to new or enhanced CBOCs, would significantly improve access to primary, specialty and mental health services for veterans residing in East Bay and Central Valley communities. Relocating many high volume multi-specialty clinics from LVD to the Central Valley would undoubtedly improve ambulatory care access for the 90,000 veterans residing in San Joaquin, Stanislaus, and Tuolumne Counties. In addition, the 55,000 veterans residing in southern Alameda County would have improved access to a broad provision of clinical services unavailable to them today.

LVD's 626 admissions in FY02 represent only five (5) percent of the total users and they would typically be admitted only once a year. Shifting two thirds of LVD's NHCUs to MPD and the sub-acute beds to PAD would increase the travel time by ~10 minutes (based on VSSC analysis). Only the patients residing in Santa Clara County and a small percentage of those living in Alameda County would decrease travel time upon using MPD and PAD for inpatient services.

Inpatient Summary: Under this proposal, the weighed average drive time for inpatient care (sub-acute and NHCUs) would increase by approximately 10 minutes (home of origin to the PAD or the MPD). Many veterans located in outlying communities; however, would actually have shorter commutes for inpatient care because VAPAHCS would emphasize the use of community nursing home facilities for veterans residing in San Joaquin and Stanislaus Counties.

(b) Impact on Quality

There would be an anticipated positive impact on quality for the 80 NHCUs beds relocated from LVD to MPD due to the planned establishment of a gerontology center and enhanced academic affiliation with the Stanford University School of Medicine in the field of gerontology. In addition, a positive impact on quality is expected for the 30 sub-acute beds realigned to the PAD due to an improved continuity of care.

(c) Impact on Community

If LVD closes in the FY08 timeframe, there would be an anticipated negative short-term economic impact on the local community. Today, LVD is the eighth largest employer in the greater Livermore area¹. The LVD closure would be associated with less spending in the community as a result of the 300 LVD employees' positions being realigned to other sites. Approximately one-third of the LVD employees live in Livermore². However, as the new and expanded CBOCs are within a reasonable commuting distance, it is not expected that many of these employees would have to relocate their residences as a result of the realignment. It is anticipated that a successful E-UL development for a retirement community or the potential conversion of the property to a State Home would have positive economic impact as a result of construction and future employment.

(d) Impact on Staffing

VAPAHCS' intent is to offer LVD employees employment at other facilities. Most of these positions would be at the realignment sites (MPD, PAD, new East Bay CBOC, and expanded Central Valley CBOC). Existing employees that reside in the Central Valley and accept positions at MPD, PAD, or new East Bay CBOC would have increased commute times to and from work. LVD employees accepting positions at the expanded Central Valley CBOC would be in a lower locality pay area. VAPAHCS' leadership would make every effort to ensure an equitable system be in place for displaced employees (based on Office of Personnel Management [OPM] policy).

(e) Impact on Research and Academic Affiliations

Today, there are no significant research or major academic affiliations associated with LVD. Some trainees; however, do rotate to LVD in specific clinical services. These trainees would likely relocate with the realigned clinical service. The 80 NHCU beds realigned from LVD to MPD would have a positive impact on both research and academic affiliations because VAPAHCS is attempting to establish a Geriatrics Fellowship Program and a collaborative Aging Center at MPD with the Stanford University School of Medicine. With regard to LVD's sub-acute unit, the training and attending staff at PAD would follow these patients and would enhance the existing training programs.

¹ Source: Livermore City Manager

² Source: Livermore City Manager

3. Cost Effectiveness of Preferred Alternative

Table 3a below provides summary NPV financial data for all alternatives relative to the status quo (NPV = Status Quo Cost – Alternative Cost. All Status Quo NPVs are 0). The most positive NPV is for the 100% Contract Out Alternative with an advantage over the Status Quo over the life cycle of \$758 Million. However, as discussed elsewhere in this report, this is a non-viable option and, therefore, the projected financial advantages are unreliable compared to the cost estimates of other alternatives. Among the viable alternatives, Alternative 1 (Preferred) has an estimated NPV advantage of \$564 Million over the Status Quo and Alternative 2, a \$385 Million advantage over the Status Quo. Therefore, the relative cost effectiveness of the preferred Alternative 1 compared to Alternative 2 demonstrates a \$178 Million financial advantage over the life cycle when all costs and savings (capital and operating) are considered over all divisions. It is the best financial alternative among all viable options evaluated.

The Original Market Plan has an NPV of \$506 Million relative to the Status Quo and, like Alternative 1, is financially preferable to Alternative 2.

Table 3a NPV Analysis for All Alternatives Relative to Status Quo (Update Submission)

Net Present Value	Status Quo (Plus capital)	Original Market Plan	100% Contract	Alt 1	Alt 2
Facility Being Reviewed: Livermore					
Recurring	-	\$ 54,635,941	\$ 605,894,013	\$ 605,894,013	\$ 234,325,484
Non Recurring	-	\$ 29,649,799	\$ 46,122,212	\$ 46,122,212	\$ 40,631,407
Total	-	\$ 84,285,740	\$ 652,016,225	\$ 652,016,225	\$ 274,956,891
Receiving Facility 1: Menlo Park					
Recurring	-	\$ 77,341,770	\$ 2,799,479	\$ -102,484,473	\$ 39,797,802
Non Recurring	-	\$ 93,875,392	\$ 93,875,392	\$ 100,179,771	\$ 112,788,528
Total	-	\$ 171,217,162	\$ 96,674,871	\$ -2,304,702	\$ 152,586,330
Receiving Facility 2: Palo Alto Clinics					
Recurring	-	\$ -263,122,168	\$ -380,705,737	\$ -475,772,081	\$ -433,817,610
Non Recurring	-	\$ -10,364,668	\$ -10,364,668	\$ -16,254,598	\$ -14,520,077
Total	-	\$ -273,486,836	\$ -391,070,405	\$ -492,026,679	\$ -448,337,687
Receiving Facility 3: Palo Alto					
Recurring	-	\$ -291,734,943	\$ -397,919,882	\$ -391,929,564	\$ -391,929,564
Non Recurring	-	\$ 815,259,958	\$ 798,358,140	\$ 798,358,140	\$ 798,358,140
Total	-	\$ 523,525,015	\$ 400,438,258	\$ 406,428,576	\$ 406,428,576
Grand Total		\$ 505,541,081	\$ 758,058,949	\$ 564,113,420	\$ 385,634,200

Table 3 b NPV Analysis for All Alternatives Relative to Status Quo (Initial Submission)

	Status Quo	Original Market Plan	100% Contract	Alternate 1	Alternate 2
Facility Being Reviewed: Livermore					
Recurring	\$0	\$ 63,192,976	\$663,852,935	\$663,852,935	\$285,219,445
Non Recurring	\$0	\$29,649,799	\$46,122,212	\$46,122,212	\$32,731,407
Total	\$0	\$ 92,842,775	\$709,975,147	\$709,975,147	\$317,950,852
Receiving Facility 1: Menlo Park					
Recurring	\$0	\$ 171,266,643	\$ 96,724,352	(\$32,475,710)	\$ 171,266,643
Non Recurring	\$0	\$ 93,875,392	\$ 93,875,392	\$81,075,392	\$ 93,875,392
Total	\$0	\$ 265,142,035	\$ 190,599,744	\$48,599,682	\$ 265,142,035
Receiving Facility 2: Palo Alto Clinics					
Recurring	\$0	(\$259,367,225)	(\$378,596,333)	(\$502,400,324)	(\$475,465,954)
Non Recurring	\$0	(\$10,364,668)	(\$10,364,668)	(\$16,586,196)	(\$16,415,587)
Total	\$0	(\$269,731,893)	(\$388,961,001)	(\$518,986,520)	(\$491,881,541)
Receiving Facility 3: Palo Alto					
Recurring	\$0	-\$268,182,774	(\$268,182,774)	(\$387,494,832)	(\$387,494,832)
Non Recurring	\$0	\$801,058,899	\$801,058,899	\$798,358,140	\$798,358,140
Total	\$0	\$ 532,876,125	\$532,876,125	\$410,863,308	\$410,863,308
GRAND TOTAL					
Recurring	\$0	(\$293,090,380)	\$113,798,180	(\$258,517,931)	(\$406,474,698)
Non Recurring	\$0	\$914,219,422	\$930,691,835	\$908,969,548	\$908,549,352
Total	\$0	\$621,129,042	\$1,044,490,015	\$650,451,617	\$502,074,654

Source: VCCS Financial Analysis

Alternative 1: Livermore’s Sub-acute, NHCU and Ambulatory Care Realignment Option

(Preferred Alternative) Alternative 1 recommends relocating LVD’s 30 sub-acute beds to PAD, transferring 80 NHCU beds from LVD to MPD, contacting 40 NHCU beds to the community and relocating ambulatory care functions to a new CBOC in the East Bay and an expanded CBOC in the Central Valley.

Today, VAPAHCS operates three divisions and CBOCs. According to the NPV Table above, consolidating inpatient services from three to two divisions would generate significant savings relative to the Status Quo alternative. Based on the VSSC financial analysis, VAPAHCS has developed a viable realignment plan to consolidate LVD’s inpatient and ambulatory care programs to maximize VHA operating dollars.

The LVD 113 acre campus is composed of 11 permanent buildings (210,000 GSF) and employs 303 staff. Consolidating sub-acute services to PAD and NHCU services to MPD creates economies of scale opportunities because overhead costs are reduced or eliminated altogether. Based on VAPAHCS’ own local financial analysis, ~\$7M can be garnered annually by eliminating LVD’s infrastructure and reducing overhead costs

attributed to operating this division. VAPAHCS would reinvest the savings achieved from LVD realignment to support direct patient care activities.

Realigning LVD would consolidate or eliminate much of the division's support and overhead functions such as boiler plant operations, food production, security, fire protection, maintenance and repair. The LVD realignment proposal was not based solely on the positive net present value (NPV) analysis. VAPAHCS' leadership believes that consolidating disjointed services and eliminating duplicative programs would ultimately improve access and achieve higher clinical outcomes. Therefore, Network 21 and VAPAHCS concluded that Alternative 1 is the most viable long-term alternative.

Alternative 2: Nursing Home and a Small Primary Care Clinic Remains at Livermore. Sub-acute and Ambulatory Care are Realigned

(Not Cost Effective) Alternative 2 recommends relocating LVD's 30 sub-acute beds to PAD and relocating ambulatory care functions to new CBOCs in the East Bay and Central Valley. This alternative proposes to leave LVD's 120-bed NHCU intact as a standalone nursing home.

Both alternatives (Alternative 1 and Alternative 2) advocate the relocation of sub-acute beds from LVD to PAD. LVD's sub-acute unit is located in the old hospital building's last remaining inpatient ward. In FY02, the 30-bed unit's occupancy rate was 52% based on an Average Daily Census (ADC) of 16 patients. These beds would be relocated to the PAD where the need for sub-acute beds would help decompress acute med/surg units.

Both alternatives (Alternative 1 and Alternative 2) advocate for the relocation of ambulatory care services to two (2) new CBOCs in the Central Valley and East Bay. LVD's main hospital building had been modified to support ambulatory care clinics; however, in reality, operating clinics out of an old hospital building on a remote parcel of land is not an appropriate and viable long-term solution. Therefore, both alternatives support the realignment of ambulatory care services and advocate for the relocation of services closer to where veterans live.

The difference between Alternative 1 and Alternative 2 deals with the plans for LVD's 120-bed NHCU. This second scenario, Alternative 2, would leave the 120-bed NHCU intact and the facility essential would become a freestanding building. In order to accomplish this alternative, VAPAHCS would add boilers to the existing NHCU and relocation food production, storage, and receiving would require ~\$8M to modify the plant. Upon completion, the remaining buildings at LVD would be leased or razed based on E-UL opportunities.

Leaving LVD's NHCU intact as a standalone facility is neither cost effective nor efficient option because of the remoteness of the division. LVD is located in a remote location and NHCU patients who experience medical emergencies would rely on 911 for emergency medical coverage.

Therefore, Alternative 2 was determined to be more expensive than the other options and would not generate the efficiencies or improved clinical outcomes required to accept this alternative.

100% Contract Alternative

(Not Viable) Alternative 3 proposes contracting-out all care to the community. This option is not viable because community nursing homes do not have the capacity or the skills to accommodate the VA's more complex patients.

The third alternative would contract all VA health care to community facilities. This option is non-viable because community facilities, especially community nursing homes do not have the capacity to handle the volume of service required to service LVD's nursing home and sub-acute demand. This would require a monumental undertaking because nearly 12,000 veterans obtained health care service at LVD in FY03. LVD's most recent statistics include:

- Nearly 12,000 veterans treated in FY03
- Approximately 70,000 outpatient encounters in FY03
- Over 700 admissions in FY03
- More than 46,000 bed days of care (BDOC) in FY03

Within VAPAHCS' catchment area, there are only 5 facilities that serve patients with serious mental health care needs and none that serve patients with difficult medical and psychiatric issues. Approximately 50% of VAPAHCS' nursing home population has concomitant medical disorders including psychoses. Even if there was community capacity, the cost estimates that are being provided do not take into consideration special care needs that we have to contract in addition to the basic rate. Re-hospitalization rates are not addressed, as most community facilities do not have the same capacity to manage complex patients as our VA NHCU programs do. In summary, California's nursing homes are in crisis in which there is a real question whether they would survive let alone serve our veteran population. Even if they do, the capacity of them to serve our present and/or future veteran population is a question that currently has not been addressed.

Nursing home care in the state of California is at a critical juncture. Patient demographics are aging with the fastest growing segment of the population being the age group over the age of 85. This is magnified in the veteran population with 50% of its population greater than the age of 65 as compared to 15% of the general population. Accommodating the needs of the aging population in institutional settings is a daunting challenge, particularly in California where little construction in the nursing home industry has occurred over the past decade. It is also an expensive proposition which the California Health Care Foundation, in its report of July 2003.

The IBM/VSSC financial model assumes that contracting LVD's NHCU and sub-acute beds to the community costs \$210 per BDOC compared to the \$410 in-house. This argument is flawed in that the marginal costs associated with operating that VA staffed bed should be analyzed and compared to the \$210. The fixed costs should be backed out from the base cost because if the beds were contracted out, these fixed costs would be reallocated to the remaining VA staffed beds at PAD and MPD. The true marginal costs to operate LVD NHCU and sub-acute beds are not known. Comparing the \$210 for community NHCU beds to VA's \$410 NHCU cost is a flawed analysis.

Original Market Plan Alternative

(Not Cost Effective) The Original Market Plan alternative is not cost effective in light of the VSSC financial analyses.

In completing the initial market plans for the VISN 21 CARES study, LVD was left generally intact with very little workload transferred to other VAPAHCS facilities. Subsequently, VAPAHCS determined that maintaining three divisions was not cost effective in the long run because of the tremendous overhead costs associated with maintaining three separate divisions.

The NVP financial analysis indicates that the original market plan would be more costly than the preferred alternative. In addition, VAPAHCS' leadership believes that consolidating disjointed services and eliminating duplicative services would ultimately improve access and achieve higher clinical outcomes.

In conclusion, Network 21 and VAPAHCS support the NVP analysis and recommend that the preferred alternative to realign LVD's inpatient and ambulatory care service be approved.

4. Other Alternatives Considered

(a) Status Quo

Under this particular alternative, all services at LVD remain, as they exist today. The major disadvantage associated with the status quo is that access to the majority of the 10,500 veterans using LVD for outpatient services would be far worse than in the preferred alternative. The second major disadvantage is that the VAPAHCS would continue to maintain LVD's aging infrastructure. If services at LVD were realigned, those resources could be used to enhance health care services to veterans.

(b) Market Plan Alternative Identified in the CARES Model

The original South Coast Market Plan alternative would leave all services at LVD, as they exist today. However, under this alternative, the South Coast Market would also build a new East Bay CBOC and develop an expanded Central Valley CBOC. The disadvantages associated with this alternative include the continued infrastructure maintenance costs related to LVD campus and the fact that the new East Bay CBOC and the expanded Central Valley CBOC are not sized for the additional outpatient workload from LVD. These inappropriately sized facilities would lead to long waiting times to get an appointment. There is no LVD E-UL potential in this alternative.

(c) Contract 100% Livermore Workload

This scenario would contract all health care services to the community. Providing care to veterans is VA's core mission. The following justification had deemed this contract scenario non-preferred.

The mental health private sector is not familiar with the unique needs of the veteran and cannot offer the comprehensive mental health benefits offered in the VA system. It is not likely that non-VA providers whose practice is comprised of only a minority of veterans would be able to understand the special requirements of veterans. Veterans and Veteran Service Organizations have repeatedly voiced this objection to contracting.

Contracting would cause disruption in the continuity and coordination of care. Logistical barriers such as not sharing the same informatics system, security requirements, and geographical barriers would hamper communication between VA and non-VA providers. These communication barriers would generate excessive referrals and possible delays in appropriate care or other diminishment in the quality and coordination of care. Also, the VA system has unique documentation requirements for the providers that are not compensable in the private sector. The provider time required for entering requests for lab, diagnostics and consults, entering encounter data and many of the documentation requirements for the clinical practice guidelines would be considered outside the realm of a normal private clinical practice. This would make it difficult, if not impossible, to contract at Medicare rates.

California's nursing homes are in crisis in which there is a real question whether they will survive let alone completely serve 100% of our veteran population. For example, there is only one sub-acute facility that serves Alameda County and the valley area and it is currently running at a 90% occupancy rate, as are the other nursing home community facilities. Furthermore only 5 facilities serve patients with serious mental health care needs and none that serve patients with difficult medical and psychiatric issues, which make up approximately 50% of our veteran nursing home population. While VAPAHCS should be able to place approximately 40 NHCU patients in the community at the assumed Medicare rate of \$210, it is highly improbable that VA would get this rate for the more complex patients. Therefore, in the 100% Contract Alternative where the VA would be forced to place all 120 NHCU patients in the community, the more complex patients requiring intensive care would drive the \$210 average Medical rate up. This makes the 100% Contracted NPV cost totals suspect. The Network does not believe it can achieve the contracted rates for the VA population.

Cost comparisons of VA and civilian care have been a source of considerable discussion for many, many years. The in-house costs for VA include pharmaceuticals and physician services. In the contracted community services, physician services are billed separately through Medicare. In addition, a significant portion of VA workload includes specialty care such as dementia care, PTSD, and other mental health services. These services are rarely found in the community and when they are found, special contracts must be established at higher rates. In addition, the VA system has a closed medical service whereas virtually all community facilities have an 'open' medical staff. This is important in determining additional costs that are not included in the contract

price such as acute re-hospitalization. There is evidence that VA nursing homes have a lower re-hospitalization rate and ER utilization than community nursing homes, which would decrease the total cost of care for the veteran and not necessarily the VA nursing home costs.

(d) Retain Nursing Home at Livermore (Alternative # 2)

In this alternative the nursing home and a small outpatient clinic would remain at LVD. This alternative also includes the realignment of the majority of the outpatient workload to the new East Bay and Expanded Valley CBOCs as well as the realignment of all sub-acute beds from LVD to PAD. Conceptually, Building 90, the nursing home, would remain and Building 88, an administrative building near the nursing home, would be converted to a low volume outpatient clinic sized to provide primary care to the local Livermore veterans. The current energy plant would require a more efficient plant with lower output for the reduced demand. Though this use of low-pressure steam equipment would negate the need for 24-hour boiler operators, a Minor construction project submission would be required. Because of LVD's rural location, it would take a considerable amount of time for a civilian ambulance to respond. Physician staff on site would still be required, 7 days a week, 24 hours a day. This alternative still allows for the remainder of the VA campus to be partitioned off from the nursing home and clinic building. This smaller parcel of land could still be available for an E-UL.

2. Analysis

a. Description of Current Programs and Services Environment

(1) Current Mission (See Executive Summary)

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. MPD provides a broad range of mental health programs ranging from substance abuse, PTSD, homeless rehabilitation, geropsychiatric and extended care services. MPD is a regional referral facility for domiciliary and inpatient geropsychiatric services. MPD is also home to a National Center for PTSD. LVD provides both sub-acute and geriatric inpatient as well as primary, specialty, mental health and ancillary outpatient services. Today, VAPAHCS operates six CBOCs, which are located in Capitola, Modesto, Monterey, San Jose, Sonora, and Stockton.

LVD began operations in 1929 as a tuberculosis hospital. Building 62, the main hospital building, was constructed in the late 1940s and was seismically retrofitted in the 1990s. A 120-bed nursing home unit (NHCU) was opened on LVD grounds in 1980 and is in the process of being extensively renovated. Today LVD operates 120 long-term care beds and 20 intermediate care beds. Ambulatory care clinics at LVD provide primary care and specialty care to 10,407 unique patients.

The Draft National CARES Plan recommended realigning LVD. If the CARES Commission and the Secretary approve the National CARES Plan, the following components would occur:

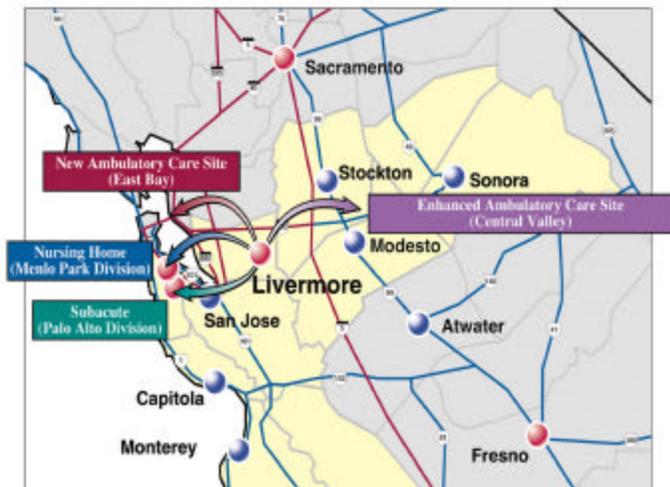
Relocate 80 NHCU beds from LVD to MPD

Relocate the 30 sub-acute beds from LVD to PAD

Contract 40 NHCU beds in community

New expanded San Joaquin Valley CBOC

New East Bay CBOC



(2) Proposed Realignment Plan

(a) Long Term Care Beds

Today, 120 beds of VAPAHCS' 393 long-term care beds are operated in Building 90 at LVD. Relocating nursing home beds to MPD is a critical factor in VAPAHCS' ability to realign and close LVD. The remaining 40 LVD long-term care beds would be contracted out to the community. Appendix 1 provides a listing of facilities by name within each county. It is anticipated that these nursing homes are able to accommodate designated workload.

(b) Inpatient Programs

On the inpatient side, 30 sub-acute beds would realign to PAD and 120 nursing home beds would shift to MPD, where an enlarged and remodeled Building 324 would house these extended care patients and the remaining 40 beds contracted out as described above.

(c) Outpatient Programs

LVD's outpatient redistribution plan is more complex and involves relocating workload to a new East Bay CBOC and an enlarged Central Valley CBOC at Modesto. Based on examination of patient origin demographics and the clinical capabilities at the two receiving CBOCs, split percentages were arrived at that redistribute workload in a balanced manner. Primary care, for example, would shift 66% of LVD's workload to the new East Bay facility and 34% to the Central Valley. The same split also holds true for mental health ambulatory care workload. Specialty care splits somewhat differently as a 10% portion would be referred to PAD with 50% to the East Bay CBOC and 40% to the Central Valley CBOC. Finally, ancillary/diagnostic outpatient workload shifts in an estimated 50/50 split to the new East Bay CBOC and the enhanced Central Valley CBOC.

(2) Alternative 2

Alternative 2 of the LVD Realignment Plan downsizes the Livermore campus while retaining all NHCU beds and a smaller primary care presence. As in Alternate 1, 30 sub-acute care beds would transfer to PAD's main hospital. In terms of outpatient care, the redistribution is very similar to Alternate 1 with the exception that LVD retains 21% of its current primary care and mental health workload. The new East Bay and expanded Central Valley CBOCs would receive the largest percentages of all types of ambulatory care workload. As before, PAD would receive 10% of the current specialty care workload.

b. Enrollee Travel Time

Table 4 Enrollee Travel Time

Alternate # 1 VAPAHCS' Livermore Division										
CARES Category (Dom, Specialty Care or NHCU)	County Name (With 50% or more of the workload)	FY 2012 Workload (BDOC)	Travel time from County to Facility being studied	Workload to be transferred to Menlo Park	Travel Time from County to Facility A	Workload to be transferred to Palo Alto	Travel Time from County to Facility B	Workload to be transferred to Facility C	Travel Time from County to Facility C	New weighted Travel Time (calculated)
NHCU				132						
Sub-acute						30				

Alternate # 2 VAPAHCS' Livermore Division										
CARES Category (Dom, Specialty Care or NHCU)	County Name (With 50% or more of the workload)	FY 2012 Workload (BDOC)	Travel time from County to Facility being studied	Workload to be transferred to Menlo Park	Travel Time from County to Facility A	Workload to be transferred to Palo Alto	Travel Time from County to Facility B	Workload to be transferred to Facility C	Travel Time from County to Facility C	New weighted Travel Time (calculated)
Sub-acute						30				

(1) Alternative 1 Realignment of LVD's Inpatient (Sub-Acute & NHCU) and Ambulatory Care Services

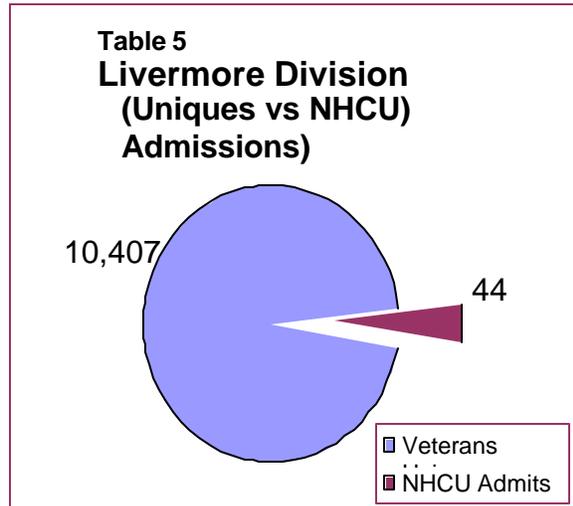
(a) Inpatient

Alternative 1 recommends relocating 110 inpatient beds (sub-acute and NHCU) from LVD to PAD and MPD and contracting the remaining demand to local community facilities. Based on CARES' actuarial projections, LVD would require 162 sub-acute and NHCU beds by 2012, which equates to ~60,000 BDOC. The remaining demand for sub-acute and NHCU beds would be obtained through partnerships with community resources.

Under this proposal, the weighted average drive time for inpatient care (sub-acute and NHCU) would increase by approximately 10 minutes (home of origin to PAD or MPD). Many veterans located in outlying communities, however, would actually have shorter commutes for inpatient care because VAPAHCS would emphasize the use of community nursing home facilities for veterans residing in San Joaquin and Stanislaus Counties.

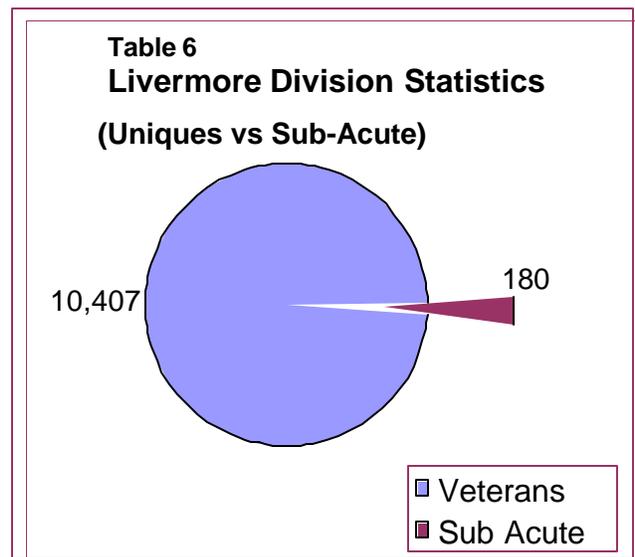
1 Long Term Care

LVD's long-term care beds would relocate to MPD. Of the 10,407 veterans seen at LVD in FY01, 44 or 4% were admitted to a nursing home bed (Table 5). Approximately 100 veterans (23 Hayward, 16 San Jose, 11 Fremont, 10 Oakland, 6 Alameda, 6 Newark, 6 Santa Clara, 5 Palo Alto, etc.) would have benefited from this proposed Menlo Park option, had this option been available in FY01. Approximately 100 veterans (47 Stockton, 42 Modesto, etc.) would benefit from the proposed option of establishing community nursing home contracts in their local community.



2 Sub-Acute Beds

LVD's sub-acute beds would relocate to PAD. Of the 10,407 veterans seen at LVD in FY01, 180 or 2 % were admitted to a sub-acute bed (Table 6). Approximately 35 veterans (8 Fremont, 8 Hayward, 5 San Leandro, 3 Palo Alto, 2 Mountain View, 2 Oakland, and 2 Union City, etc.) would have benefited from this proposed Palo Alto option, had this option been available in FY01. Palo Alto Division's lack of sub-acute bed availability inhibits the decompression of ICU, step down, and acute med/surg beds. The ability to transfer patients from a higher acuity to a lower acuity greatly enhances throughput, reduces bottlenecks, divert rates, and ER/OR closure. In addition, inter-ward transfers with the same treatment team, improves the continuity of care.



3 Travel Time– Inpatient Services

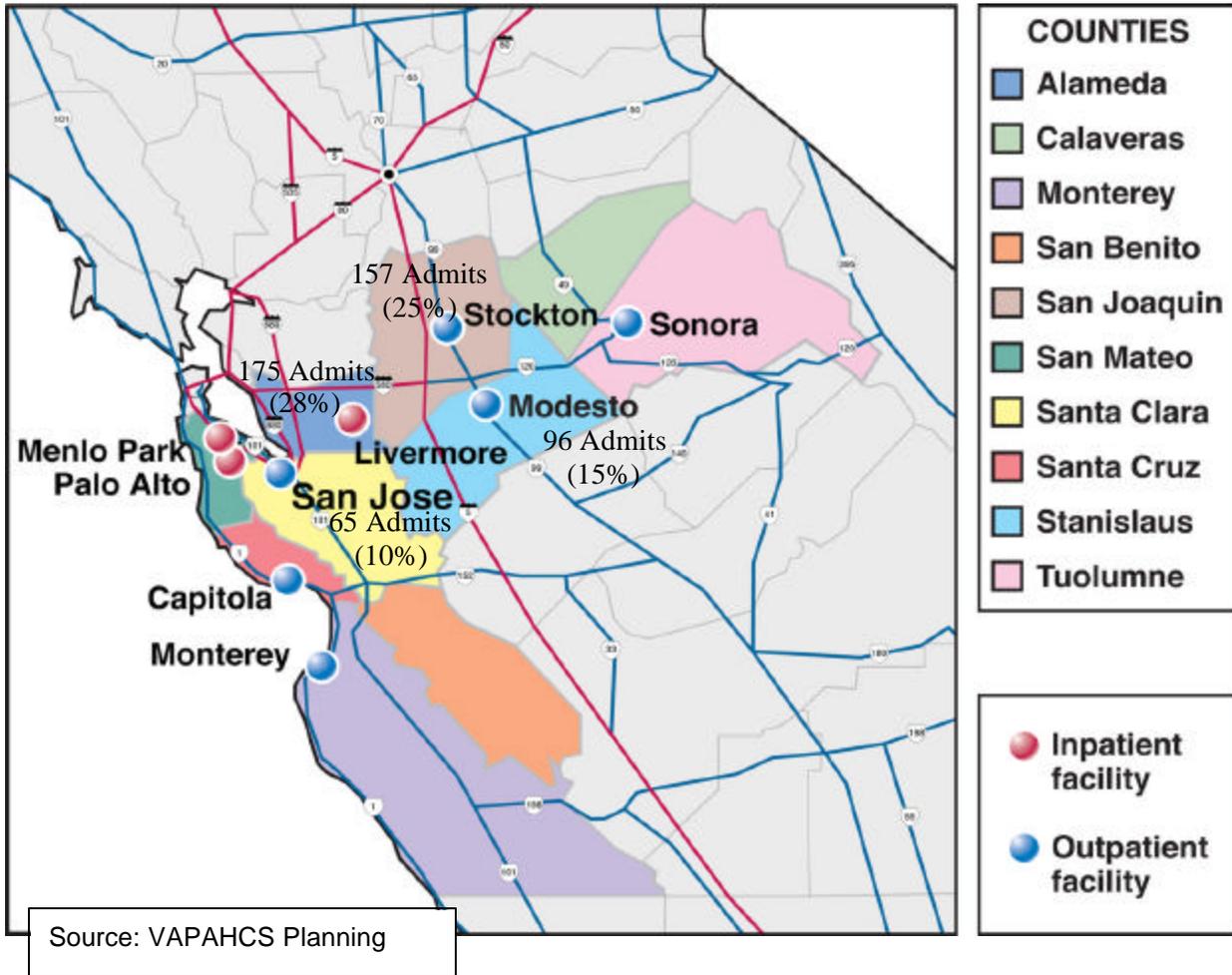
Table 7

County of Origin	Sub-Acute		Long-Term Care		Combined Admissions		Workload will shift to:		
	Admissions	Percent of Total	Admissions	Percent of Total	Admissions	Percent of Total	Palo Alto	Menlo Park	Contract Hospital
San Joaquin	49	27.2%	108	24.3%	157	25.1%	31.2%	34.4%	34.4%
Alameda	47	26.1%	128	28.8%	175	28.0%	26.9%	54.9%	18.3%
Stanislaus	33	18.3%	63	14.2%	96	15.4%	34.4%	33.3%	32.3%
Santa Clara	11	6.1%	54	12.1%	65	10.4%	16.9%	61.5%	21.5%
Other	40	22.2%	92	20.7%	132	21.1%	30.3%	56.1%	13.6%
Total	180	100.0%	445	100.0%	625	100.0%	28.8%	47.4%	23.8%

Assumptions:

1. All Sub-Acute will go to Palo Alto
2. Two thirds of the LTC workload will go to Menlo Park and one third out on contract
3. Three fourths of Alameda and Santa Clara workload will shift to Menlo Park
4. Fifty percent of San Joaquin and Stanislaus workload will shift to Menlo Park

Illustration 2 Admissions by Location and Percentage



(b) Outpatient

Alternative 1 recommends relocating outpatient services (primary, specialty, mental health and ancillary services) to a new multi-specialty CBOC in the East Bay and a greatly enhanced multi-specialty CBOC in the Central Valley.

The aforementioned CBOCs, would significantly improve access to primary, specialty and mental health services for veterans residing in East Bay and Central Valley communities (Table 8). Overall travel time for primary care improved by 20 minutes and specialty care by 24 minutes. Relocating many high volume multi-specialty clinics from LVD to the Central Valley would undoubtedly improve ambulatory care access for the ~86,000 veterans residing in San Joaquin, Stanislaus, and Tuolumne Counties. In addition, the 55,000 veterans residing in Southern Alameda County would have improved access to a broad provision of clinical services unavailable to them today.

Table 8 Alternative1, Realigned Travel Time

Alternate # 1											
Name of Facility Being Studied: Livermore											
CARES Category (Dom, Specialty Care or NHCU)	Counties (With Bulk of the workload)	FY 2012 Workload (BDOC/ Stops)	Travel time from County to Livermore	Current weighted Travel Time (calculated)	Workload to be transferred to Menlo Park	Travel Time from County to Menlo Park	Workload to be transferred to Pal Alto	Travel Time from County to Palo Alto	Workload to be transferred to Contract	Travel Time from County to Contract Facilities	New weighted Travel Time (calculated)
NHCU	Alameda	15,729	30		10,635	45	4,231	40	878	30	43
	San Joaquin	14,100	50		3,850	100	4,399	95	5,850	30	69
	Santa Clara	5,842	50		4,593	35	987	30	256	30	34
	Stanislaus	8,651	55		881	115	2,976	110	4,794	30	66
			44,321		44						
CARES Category (Dom, Specialty Care or NHCU)	Counties (With Bulk of the workload)	FY 2012 Workload (BDOC/ Stops)	Travel time from County to Livermore	Current weighted Travel Time (calculated)	Workload to be transferred to Pal Alto	Travel Time from County to Pal alto	Workload to be transferred to New E-Bay CBOC	Travel Time from County to New E-Bay CBOC	Workload to be transferred to New C Valley CBOC	Travel Time from County to New C-Valley CBOC	New weighted Travel Time (calculated)
Primary Care	Alameda	5,818	30				5,818	30			
	San Joaquin	7,958	50						7,958	20	
	Stanislaus	6,133	55						6,133	30	
			19,909		46						
Specialty Care	Alameda	5,743	30		574	40	5,169	30			
	San Joaquin	10,786	50		1,079	95			9,707	20	
	Stanislaus	8,772	55		877	110			7,895	30	
			25,301		47						
Mental Health	Alameda	1,711	30				1,711	30			
	San Joaquin	1,676	50						1,676	20	
	Stanislaus	1,636	55						1,636	30	
			5,023		45						

Source: Shaded data provided by VSSC; White areas provided by VAPAHCS

(2) Alternative 2 Realignment of LVD's Sub-Acute and Ambulatory Care Services

(a) Inpatient

Alternative 2 recommends relocating sub-acute inpatient services to a vacant ward at PAD. In FY01, LVD's sub-acute ADC was 16, which equates to an occupancy rate of 52 percent. Increasing the number of lower acuity (sub-acute) beds at PAD would further decompress acute med/surg and ICU wards. This initiative would increase hospital bed capacity, reduce divert rates and improve patient throughput. While this alternative proposes relocating LVD's 30 sub-acute beds to PAD, the NHCU would remain at LVD.

While the weighted average travel time to PAD would increase for some veterans, the quality of care provided at PAD would greatly improve the delivery of patient care. For example, the sub-acute unit at LVD is not capable of handling life-threatening complications such as Myocardial Infarctions (MI). LVD codes are handled by calling 911. Improving the delivery of high quality care requires consolidating fractured services to garner better outcomes and efficiencies. This is not the case at PAD where sub-acute patients would be treated within a tertiary care medical center.

(b) Outpatient

Alternative 2 recommends relocating outpatient services (primary, specialty, mental health and ancillary services) to a new multi-specialty CBOC in the East Bay and a greatly enhanced multi-specialty CBOC in the Central Valley. Alternative 2 establishes a new primary care clinic at LVD. Portions of LVD's administrative building (Building 88) would be converted to outpatient primary care and mental health clinics. In FY01, approximately 1,000 veterans, who lived in the local communities of Livermore, Dublin, and Pleasanton, utilized LVD for ambulatory care. This alternative ensures that these veterans are afforded ambulatory care in their local community.

The new weighted travel time calculations, from home of origin to the CBOCs, would be significantly reduced for veterans residing in the East Bay and Central Valley. Overall travel time for primary care improved by 20 minutes and specialty care by 24 minutes. The 90,000 veterans who live in the Central Valley would have access to many specialty care services currently unavailable at VAPAHCS' existing CBOCs. In addition, veterans residing in the East Bay would be afforded a broad provision of clinical services at a new state-of-the-art CBOC.

Table 9 Alternative 2, Realigned Travel Time

Alternate # 2 Name of Facility Being Studied: Livermore											
CARES Category (Dom, Specialty Care or NHCU)	Counties (With Bulk of the workload)	FY 2012 Workload (BDOC/ Stops)	Travel time from County to Livermore	Current weighted Travel Time (calculated)	Workload to be transferred to Menlo Park	Travel Time from County to Menlo Park	Workload to be transferred to Pal Alto	Travel Time from County to Palo Alto	Workload to be transferred to Contract	Travel Time from County to Contract Facilities	New weighted Travel Time (calculated)
NHCU	Alameda	15,729	30								
	San Joaquin	14,100	50								
	Santa Clara	5,842	50								
	Stanislaus	8,651	55								
			44,321		44						
CARES Category	Counties (With Bulk of the workload)	FY 2012 Workload (BDOC/ Stops)	Travel time from County to Livermore	Current weighted Travel Time (calculated)	Workload to be transferred to Pal Alto	Travel Time from County to Pal Alto	Workload to be transferred to New E-Bay CBOC	Travel Time from County to New E-Bay CBOC	Workload to be transferred to New C-Valley CBOC	Travel Time from County to New C-Valley CBOC	New weighted Travel Time (calculated)
Primary Care	Alameda	5,818	30				2,233	30			
	San Joaquin	7,958	50						7,958	20	
	Stanislaus	6,133	55						6,133	30	
			19,909		46						
Specialty Care	Alameda	5,743	30		574	40	5,169	30			
	San Joaquin	10,786	50		1,079	95			9,707	20	
	Stanislaus	8,772	55		877	110			7,895	30	
			25,301		47						
Mental Health	Alameda	1,711	30				343	30			
	San Joaquin	1,676	50						1,676	20	
	Stanislaus	1,636	55						1,636	30	
			5,023		45						

Source: Shaded data provided by VSSC; White areas provided by VAPAHCS

(c) Current Physical Condition of the Realignment Site and Patient Safety

LVD is situated on 112 acres located in a rural setting just south of the city of Livermore, California. The campus has 14 buildings that range in age from the oldest at 79 years to the newest, which is only 13 years old. Table 10 shows the size and age of the different buildings on the campus. It also indicates that the average age of the structures is 53 years or 46 years using a weighted average based on the square footage in a building as a percent of the entire campus square footage multiplied by the age.

LVD's main clinical facility, Bldg 62, was originally built in 1949 with approximately 190-beds (Table 11). Today its only inpatient service is a single 30-bed sub-acute unit. The other inpatient facility at LVD is the NHCU, Building 90, which was opened as a 120-bed facility in 1982. There are no significant patient safety issues. Currently, LVD has approximately 8,600 GSF in vacant space. This vacant space is comprised of the former quarters unit, B-16, and garages, B-58.

Table 10 LVD Building Demographics

Count	Function	Bldg No.	Building Data				Weighted Age*	Comments
			Bldg Sq Ft (GSF)	% of Total SF	Year Built	Avg Age		
1	Boiler Plant	6	6,300	2.4%	1924	79	1.9	
2	Engineering	16	4,000	1.5%	1924	79	1.2	Vacant
3	Resident Housing	30	1,035	0.4%	1930	73	0.3	
4	Engineering	58	4,600	1.8%	1938	65	1.2	Vacant
5	Hospital Bldg	62	116,700	45.0%	1949	54	24.3	
6	Administration	64	27,400	10.6%	1951	52	5.5	
7	Administration	65	19,200	7.4%	1953	50	3.7	
8	Engineering	69	900	0.3%	1952	51	0.2	
9	Engineering	74	617	0.2%	1953	50	0.1	
10	Administration	88	19,900	7.7%	1978	25	1.9	
11	Nursing Home	90	48,700	18.8%	1982	21	3.9	
12	Engineering	T10	1,200	0.5%	1930	73	0.3	
13	Engineering	T16	5,100	2.0%	1946	57	1.1	
14	Modular	T34	3,600	1.4%	1990	13	0.2	
			<u>259,252</u>			<u>53</u>	<u>46</u>	

*Each Bldg's age is weighted by its % of SF to the entire campus

Source: CARES Portal

Table 11 LVD 2001 Baseline Facility Data

2001 Baseline Data	Name of Facility Being Studied: Livermore								
	Facility Name	Campus Acreage	Original Bed Capacity (Beds)	Number of Vacant Bldgs	Number of Occupied Bldgs	Vacant Space (SF)	Average Facility Condition Score	Annual Capital Costs	Valuation of Campus (AEW)
Livermore	112	310	2	14	8,600	4.7	\$604,771	\$82,000,000	

Source: VSSC

Because of the average age of LVD facilities the maintenance expenses are substantial. For example, over the past three years a total of \$7,291,000 has been spent on required NRM and infrastructure Minor projects. In addition another \$10,856,000 is estimated for identified future NRM and Minor project needs (Table 12). In addition, due to the existing structural layout of the older buildings on the campus, it is difficult to reconfigure existing space to meet modern health care standards.

Table 12 LVD Minor and NRM Projects, FY00-FY03

FY	PROJECT NO.	PROJECT TITLE	TOTAL
NRM Program			
EY00	640 .00 .113L	RENOVATE INTERIOR FINISH, BLDG 90	82,707
EY00	640 .99 .109L	REPLACE EXTERIOR, B. 90	193,007
EY00	Various	SUM OF STATION LEVEL PROJECTS UNDER \$150K (EST)	200,000
Subtotal			475,714
EY01	640 .01 .114	CENTRAL CHILLER PLANT STUDY	49,867
EY01	640 .00 .116L	REPLACE LIGHTING (T12 W/ T8 LVD)	61,776
EY01	640 .00 .132L	REPLACE ELEVATOR, BLDG. 63 LIVERMORE	278,776
EY01	640 .01 .111L	RENOVATE C/L LAB 4TH FL, B62	170,636
EY01	640 .98 .112L	REPLACE FIRE ALARM SYSTEM	120,796
EY01	640A4 .01 .125L	INSTALL HVAC, ELEV EQPT, RM.	12,064
EY01	640A4 .02 .101L	REFINISH WINDOWS, B88	67,282
Subtotal			877,100
EY02	640 .00 .113L	RENOVATE INTERIOR FINISH, BLDG 90	1,281,281
EY02	640 .98 .113L	REPLACE FIRE ALARM SYSTEM	1,577,668
EY02	640 .01 .111L	RENOVATE C/L LAB 4TH FL, B62	170,636
EY02	640 .98 .126L	RENOVATE LOBBY, B62	297,601
EY02	640A4 .02 .131L	INSTL ADV FOOD DEL SYS, B00	28,066
EY02	640A4 .01 .135L	INSTALL HVAC, ELEV EQPT, RM.	52,103
EY02	640A4 .02 .134L	FITNESS CENTER, B64	108,047
EY02	640A4 .02 .142L	REPLACE HOT WATER HEATER, BLDG 64	114,000
EY02	640A4 .02 .148L	SITE PREP, X - RAY EQPT, B62	49,232
EY02	640A4 .02 .165L	UNDERGROUND COMMUNICATION LINES	54,270
Subtotal			2,733,000
EY03		BUILDING 64, REPLACE SEWER	100,000
EY03		BUILDING 90, REPL SPRINKLER HEADS W/ QUICK RESPONSE	60,000
EY03		REKEY FACILITIES	26,000
EY03		LVD, INSTALL ADV FOOD DELIVERY SYS	220,492
EY03		BUILDING 90, REFINISH INTERIOR, PH 2, A&B WINGS	90,000
EY03		BUILDING 65, INSTALL VALLEY CUTTER	35,000
EY03		BUILDING 67, RE - BUILD EXISTING COOLING TOWERS	5,000
EY03		LVD, REBUILD LOWER END HVAC COMPRESSORS	74,000
EY03		BUILDING 88, REPLACE STORM DRAIN	18,000
EY03		BUILDING 90 & CHILLER BUILDING, SEA - L EXT WALL	19,000
EY03		BUILDING 88, REPL HEAT EXCHNG & DOM HOT WTR	20,000
Subtotal			604,492
Total NRM Projects Obligated FY00 to FY03			5,672,400
EJIT		RE - STRIPE PARKING LOTS, ROADWAYS	19,000
EJIT		REPLACE WASTE LINES, B62	900,000
EJIT		REPLACE ROOF, B62	700,000
EJIT		INVEST/REPL HOT WATER LOOP SYS, B00	421,000
EJIT		PAINT RESERVOIR LVD	200,000
EJIT		INS - TL GROUNDING SYS B62, 64, T16, 65	616,000
EJIT		HVAC SYS EVALUATION, B88	20,000
EJIT		REPL COOLING TOWER, B00	237,000
EJIT		REPAIR ROAD, SIDEWALKS, LVD	400,000
EJIT		INSTL OXYGEN SYS, B00	455,000
EJIT		REFINISH EXTERIOR, BLDG 65, 6, 74	820,000
EJIT		INSTL AIRLOCK, AMB ENTRANCE, B62	205,000
EJIT		REPL STORM DRAIN LINE, LVD	742,000
EJIT		RENOV 6TH FL, B62	600,000
EJIT		DEMO 16, 16A, 58, 62 LVD	125,000
EJIT		REPLACE ROOF, BLDG 65	156,000
EJIT		UPGRADE CHILLERS, B62	200,000
EJIT		LOW PRESSURE STEAM - CONV, LVD	800,000
EJIT		REPLACE CHILLER, BLDG 90	100,000
EJIT		INSTL CO - GEN SYSTEM	650,000
EJIT		REPLACE IRRIG SYS, AG WATER, LVD	903,000
EJIT		REPLACE PERIMETER FENCE, LVD	182,000
Future Proposed NRM Projects			9,591,000
Minor Construction			
EY00	NONE		
EY01	NONE		
EY02	640 .336	REPLACE HVAC, BLDG. 64	1,619,092
EY02	NONE		
Total Minor Projects Obligated FY00 to FY03			1,619,092
EJIT	640 .247	STORE/TREAT RECY GROUND WATER	1,275,000
Future Proposed Minor Projects			1,275,000

Source: VAPAHCS Engineering

(d) Impact Considerations

(1) Capital Costs Summary

Alternate 1, the preferred option, totals \$110.2 Million in life cycle capital costs across all divisions (See Table 13a & b below; identical tables). This is due to the 200-bed NHCU at Menlo Park division, which adds over \$12.8 Million to the 120 bed base NHCU costs shown in all other alternatives (\$18.9 Million). Also, an additional \$2.6 Million in renovation costs at PAD to modify space for the transferred sub-acute unit creates slightly higher capital costs for Alternative 2 than in the other options. Alternate 2 totals \$105.4 Million in life cycle capital costs across all divisions, about \$5 Million less than the preferred alternative. While retention of the NHCU creates cost avoidance around \$12.8 Million, the need for \$7.9 Million new construction and renovation work at LVD for facility modifications (boiler plant, warehouse, kitchen and new OPT clinic space) reduces the capital investment difference between Alt 1 and Alt 2.

Table 13a Capital Cost Summary Analysis for Alternatives (Updated Submission)

New Data Run 10/30/03

Capital Cost Summary	Status Quo (Plus capital)	Original Market Plan	100% Contract	Alt 1	Alt 2
Facility Being Reviewed: Livermore					
New Construction	-	-	\$ 0	\$ 0	\$4,900,000
Renovation	-	-	\$ 0	\$ 0	\$3,000,000
Total	-	-	\$ 0	\$ 0	\$7,900,000
Receiving Facility 1: Menlo Park					
New Construction	-	\$ 18,913,136	\$ 18,913,136	\$ 31,522,514	\$ 18,913,136
Renovation	-	-	\$ 0	\$ 0	\$ 0
Total	-	\$ 18,913,136	\$ 18,913,136	\$ 31,522,514	\$ 18,913,136
Receiving Facility 2: Palo Alto					
New Construction	-	\$ 55,757,900	\$ 55,757,900	\$ 55,757,900	\$ 55,757,900
Renovation	-	\$ 20,255,680	\$ 22,870,571	\$ 22,870,571	\$ 22,870,571
Total	-	\$ 76,013,580	\$ 78,628,471	\$ 78,628,471	\$ 78,628,471
Receiving Facility 3: Palo Alto Clinics					
New Construction	-	-	\$ 0	\$ 0	\$ 0
Renovation	-	-	\$ 0	\$ 0	\$ 0
Total	-	-	\$ 0	\$ 0	\$ 0

Source: VSSC

Table 13b Capital Cost Summary Analysis for Alternatives (Initial Submission)

Capital Costs Summary					
	Status Quo	Original Market Plan	100% Contract	Alternate 1	Alternate 2
Facility Being Reviewed: Livermore					
New Construction	\$0	\$0	\$0	\$0	\$4,900,000
Renovation	\$0	\$0	\$0	\$0	\$3,000,000
Total	\$0	\$0	\$0	\$0	\$7,900,000
Receiving Facility 1: Palo Alto					
New Construction	\$0	\$55,757,900	\$55,757,900	\$55,757,900	\$55,757,900
Renovation	\$0	\$20,255,680	\$20,255,680	\$22,870,571	\$22,870,571
Total	\$0	\$76,013,580	\$76,013,580	\$78,628,471	\$78,628,471
Receiving Facility 2: Menlo Park					
New Construction	\$0	\$18,913,136	\$18,913,136	\$31,713,136	\$18,913,136
Renovation	\$0	\$0	\$0	\$0	\$0
Total	\$0	\$18,913,136	\$18,913,136	\$31,713,136	\$18,913,136
Receiving Facility 3: Palo Alto Clinics					
New Construction	\$0	\$0	\$0	\$0	\$0
Renovation	\$0	\$0	\$0	\$0	\$0
Total	\$0	\$0	\$0	\$0	\$0
GRAND TOTAL					
New Construction	\$0	\$74,671,036	\$74,671,036	\$87,471,036	\$79,571,036
Renovation	\$0	\$20,255,680	\$20,255,680	\$22,870,571	\$25,870,571
Total	\$0	\$94,926,716	\$94,926,716	\$110,341,607	\$105,441,607

Source: VSSC

(b) Operating Cost Summary

(b) Operating Cost Summary

Table 14a below shows the Operating Cost Summary for the alternatives across all sites. When viewed in aggregate across the life cycle, the Status Quo has the lowest total costs across all sites at \$6.1 B, to be expected since it presumes no change. The non-viable, 100% Contract Alternative is next at \$6.7 B, largely because the analysis employed Medicare rates for contract NHCU and Outpatient Care, which we strongly contend, are unrealistically low, and do not include a VA overhead allowance. Among the viable alternatives, Alternative 1 is next in terms of lowest life cycle operational costs at \$6.94 B, which is not significantly different from the Original Market Plan also at \$6.88 B. Finally, Alternate 2 at \$7.05 is the highest of all for life cycle operating costs, some \$111.8 Million more costly than the preferred Alternative 1 over the life cycle. Alternative 1 achieves its superiority by vastly reducing the operating budget at LVD relative to all others, with most costs for the interim years FY04-FY06 when full operations are still in place. These savings are great enough that they mitigate all of the increased costs associated with the new East Bay and Central Valley clinics as well as the transferred workload to both PAD and Menlo Park.

Table 14a Operating Cost Summary Analysis for Alternatives (Updated Submission)

New Data Run 10/30/03

Operating Cost Summary	Status Quo (Plus capital)	Original Market Plan	100% Contract	Alt 1	Alt 2
Facility Being Reviewed: Livermore					
Operating Costs	\$ 689,261,130	\$ 634,625,189	\$ 159,400,244	\$ 159,400,244	\$ 454,935,646
Receiving Facility 1: Menlo Park					
Operating Costs	\$ 1,467,806,778	\$ 1,390,465,008	\$ 1,465,007,299	\$ 1,570,291,251	\$ 1,428,008,976
Receiving Facility 2: Palo Alto Clinics					
Operating Costs	-	\$ 263,122,168	\$ 380,705,737	\$ 503,182,179	\$ 458,686,342
Receiving Facility 3: Palo Alto					
Operating Costs	\$ 3,904,481,203	\$ 4,590,927,903	\$ 4,703,306,471	\$ 4,704,849,534	\$ 4,704,849,534
Grand Total	\$ 6,061,549,111	\$ 6,879,140,268	\$ 6,708,419,784	\$ 6,937,723,208	\$ 7,049,480,498

Source: VSSC

Table 14b Operating Cost Summary Analysis for Alternatives (Initial Submission)
Old Data (Numbers shaded in gray)

Operational Costs Summary					
	Status Quo	Original Market Plan	100% Contract	Alternate 1	Alternate 2
Facility Being Reviewed: Livermore					
Operating Costs	\$718,989,414	\$634,625,189	(\$89,981,091)	(\$89,981,091)	\$436,395,023
Receiving Facility 1: Menlo Park					
Operating Costs	\$1,568,850,568	\$1,390,465,008	\$1,465,007,299	\$1,583,335,720	\$1,390,465,008
Receiving Facility 2: Palo Alto Clinics					
Operating Costs	\$0	\$263,122,168	\$380,705,737	\$503,104,319	\$478,207,482
Receiving Facility 3: Palo Alto					
Operating Costs	\$4,067,195,816	\$4,590,927,903	\$4,703,306,471	\$4,705,493,746	\$4,705,493,746
TOTAL COST	\$6,355,035,798	\$6,879,140,268	\$6,459,038,416	\$6,701,952,694	\$7,010,561,259

Source: VSSC

(c) Human Resources

From FY 1993-2002, VAPAHCS overall turnover rate averaged out to 11.25% for all occupations. During that same time frame, turnover for Registered Nurses averaged 10.5% and Nursing Other (LVNs and Nursing Assistants) was equal to 9.23%. The overall Labor Market in the Bay Area is a highly competitive one particularly for clinical occupations.

LVD's mission would be maintained until the final date of closure or conversion. However, the longer the timeframe is before a final decision regarding the fate of LVD's more difficult it will be to maintain workforce stability due to uncertainty. At present, potential hires are choosing not to be employed at LVD and unanticipated turnover is occurring. This situation would dramatically worsen if the decision is made to contract 100% of LVD services.

Currently, there is a critical nationwide shortage of qualified staff in multiple healthcare occupations. It is not likely that this situation will improve within the next several years. This situation is exacerbated not only by the high cost-of-living, but also by the intense competition from the private sector. Despite these significant and continuing challenges, management will undertake a variety of options to maintain staffing levels sufficient to carry out the patient care mission.

One option would be to fill positions on a temporary basis. Other options would be to use temporary agencies, contracts, registry employees, fee basis staff, consultants and attendings. The costs of these latter options would be much higher than hiring staff under the tradition Title 5 and Title 38 United States Code authorities. Additionally, staffing essential positions by means of these latter options would result in a less reliable workforce, and will thus have a negative impact on the overall stability of the organization. The situation will be profoundly adversely affected by a decision to contract out 100% of services at the LVD. This will be primarily due to increased turnover rate of staff.

The proposed plan includes alternatives that support the development of clinics in the East Bay and the Central Valley. The exact location of the "new sites of care" has yet to be determined. If the proposed new sites of care are adopted, there is a high probability that the majority of employees, approximately 75%-85%, would be able to commute to one of these clinics. This projection was based upon a review of home addresses of employees. The distance between MPD and PAD to LVD is approximately 33 and 40 miles, respectively. If employees had to commute to MPD or PAD, fewer employees, approximately 30%-40%, may be willing to travel the distance. This is due to the fact that there are more employees living east of Livermore than west (which is closer to the Menlo Park and Palo Alto Divisions).

The proposed plan include alternatives that support the development of clinics in the East Bay and the Central Valley as well as the relocation of NHCU and/or sub acute beds to other divisions within VAPAHCS, all of which constitute a need for staff and their continued employment. Due to this need, it is anticipated that there will be a

minimal impact due to the fact that the majority of staff employees will be internally placed within VAPAHCS. For the few remaining employees that may not be placed internally, HR will work to place those employees at nearby VA facilities/sites.

If the decision is made to contract out 100% of services at LVD, it is certain to impact all staff (LVD has approximately 300 staff employees). This is due to the fact that services supporting the need for staff will be removed by the contract.

Although it is difficult to make an accurate projection on relocation expenses due to multiple unknown factors, the 100% contracting out alternative could substantially increase the overall costs due to the high number of staff employees impacted.

VAPAHCS' management is confident that all staff within VAPAHCS can be placed, except in the event that the contracting out of 100% services at LVD is selected. If this occurs, the amount could be substantial considering the number of staff that would be impacted.

At present, there is no LVD staff possessing skills and/or performing duties unique to LVD. Therefore, we do not anticipate major issues/concerns in staff mix except in the event that it is decided to contract out 100% of services at LVD.

While precise estimates of the impact and timing of workforce issues on the cost of major CARES-generated mission changes will likely be impossible to determine, it is recommended that, as a minimum, the following be considered in responding to this request for additional information:

All human resources considerations will be reviewed to minimize disruptions to the quality of employee lives and maximize the opportunities for continued employment within VAPAHCS.

Every effort will be made to insure that the CARES process does not adversely affect employees.

(d) Patient Care Issues and Specialized Programs

There are no VA special emphasis programs such as Blind Rehabilitation, PTSD, Traumatic Brain Injury, PTSD, GRECC, Homeless, or Spinal Cord Injury programs located at LVD.

The Preferred Alternative calls for all health care services at the LVD to be realigned to other sites within VAPAHCS and into the community. Relocating nursing home beds to MPD requires bed expansion. The preferred option increases the size of the nursing home bed facility at MPD by 80 beds from 120 to 200 beds. This will require 52,928 GSF of additional new construction at MPD. It is anticipated that the more complex LVD' NHCU patients (Alzheimer care) will also be transferred to MPD.

VAPAHCS plans to establish a Specialized Gerontology Center at MPD, which should have a positive impact on quality for the care received by the realigned patients. VAPAHCS is also in the process of establishing a Geriatrics Fellowship Program with Stanford University at MPD. The realignment will strengthen the academic affiliation. As mentioned previously, the remaining 40 NHCU beds at LVD would be contracted in the community.

Under this proposed realignment plan, some LVD outpatient specialty care services would relocate to PAD. While it would be optimum to place many of these low volume specialty services within the new and/or expanded CBOC locations, some services simply do not have the demand volume (less than 1,000 stops) to justify leasing additional commercial space.

LVD's low volume specialty care clinics would likely relocate to PAD to garner additional operational efficiencies. A clinical review team would be tasked to evaluate existing LVD workload (by specialty) to determine whether the volume justifies maintaining specific low volume clinics in new CBOCs. If the existing and projected workload volume does not rise to meet predetermined thresholds, that clinical service would not be programmed into the proposed East Bay or Central Valley CBOCs.

There is sufficient vacant space at PAD to accommodate the realignment of low volume specialty care services. A total of 3,647 GSF will be converted from vacant space to accommodate these specialty services.

Remaining specialty, mental health and ancillary workload will be provided in two CBOCs, a new East Bay CBOC, which will require a lease of 35,603 GSF of additional space and an expanded multi-specialty clinic in the Central Valley requiring 32,309 GSF of additional space.

(e) Impact on Research and Academic Affairs

There are no ongoing research activities at LVD. The long distance from VAPAHCS' academic affiliate, Stanford University School of Medicine, and LVD is not conducive to research or academic partnerships. The realignment of programs to MPD and PAD has a strong potential for both Research and Academic Affiliations. The realignment of 80 NHCU beds to MPD would coincide with the establishment of a Geriatrics Fellowship Program with Stanford University. This will result in more education and training programs, as the proximity is convenient and applicable. Additionally, if activities were moved to PAD and MPD, patients may be more willing to participate as subjects for research endeavors.

(1) Research Programs at Realigned Sites (MPD, PAD)

MPD: Research Activities

Health Services Research and Development (HSR&D) - Center for Health Care Evaluation - Center of Excellence
Cooperative Studies Program Coordinating Center (CSPCC)
Program Evaluation and Resource Center (PERC)
Health Economics Resource Center (HERC)
Queri Coordinating Center
Family Research Center
Older Adult and Family Research Center
Clinical Trials

PAD: Research Activities

Stanford/VA Alzheimer's Research Center
Mental Illness Research & Education Coordinating Center (MIRECC)
Geriatric Research & Education Coordinating Center (GRECC)
Rehabilitation Research & Development (RR&D) - Center of Excellence
HIV Center of Excellence
Patient Safety Center of Inquiry
Clinical Studies Unit
Laboratory Research
Clinical Trials

(2) Training Programs at the Realigned Sites

Training programs are ongoing in several subspecialties throughout PAD and MPD. Additionally programs and fellowships in specialty programs including the GRECC, MIRECC, Psychosocial Rehabilitation, and Palliative Care for over 100 professional each year.

Please see matrix table on next page for advantages/disadvantages with each alternative.

(f) Reuse of the Realigned Campus

LVD has potential as a California State Veterans Home. Because California has recently decided on the locations for several new state homes and given the financial challenges facing the State today, it is unlikely that LVD would be added to the list of future state homes.

The LVD property also has significant E-UL potential as a retirement community, or even as a resort. In consultation with the VA Office of Asset and Enterprise Management (OAEM), a very conservative estimate on the expected revenues for the property would be 10% of the property's value. The VA accomplished a recent land valuation as part of the CARES process through a national consultant (AEW).

The land value as determined by AEW has been estimated at \$6.4M after demolition of existing buildings. Therefore based on the national consultants valuation, the VA could expect to generate \$640,000 a year in E-UL revenue. An additional 1.5% to 2.5% per year over the term of the lease is a reasonable expectation to protect the VA against inflation.

It should be noted that VAPAHCS has also contracted for an estimate on the land valuation at LVD from a local property consultant. This land appraisal is considerably higher than the CARES AEW estimate. Based on the local property appraiser's estimate, LVD has a market value of \$27.8M (\$26.1M after demolition of structures). Using the same 10% formula as above, VA could expect to receive as much as \$ \$2.6M a year in revenues from a lease of the property. For purposes of this study Network 21 and VAPAHCS have decided to estimate the annual revenue from the E-U at \$1.5M in current (FY04) dollars. While this is higher than the amount that would be generated using the AEW estimate, it is also considerably lower than the revenue that would be generated if the local property appraisal were used. It is believed to be a fair estimate at this point, and has been coordinated with OAEM.

Table 15 Alternatives Matrix

(j) Summarize Alternative Analysis

LIVERMORE DIVISION, VA PALO ALTO HEALTH CARE SYSTEM

Preferred alternative description and rationale:	Consolidate all Livermore programs to other sites (NHCU 80 to MP, 30 Sub-Acute to PA, 52 to Contract), New East Bay Clinic; Expand Central Valley Clinic, Realign some specialty clinic services to Palo Alto, and reuse Livermore for EU Project consistent with veterans health needs or to develop long term revenue stream to benefit VAPAHCS. Main rationale for realignment is to relocate expanded services to communities closer to where Livermore users reside (Central Valley and south East Bay Area). In addition, this plan creates opportunities for capital investment avoidance and substitutes either private sector reuse of campus for extended care or for commercial enterprise, which will bring new revenues into the system.				
Short Description	Status Quo Livermore maintains all current inpatient and outpatient services and operates on a 24/7 basis.	Original CARES Market Plan LVD largely status quo. Some Primary and Specialty Care shifted to new East Bay, Central Valley and Palo Alto Division. All NHCU and sub-acute care remains at Livermore.	100% Contract Provide all current programs and services through community contractors.	Alternate # 1 (Preferred) Consolidate all Livermore programs to other sites (NHCU 80 to MP, 30 Sub-Acute to PA, 52 to Contract) New East Bay Clinic; Expand Central Valley Clinic, Realign some Spec Care to PA. Reuse Livermore for EU Project consistent with veteran's health needs.	Alternate # 2 Livermore retains NHCU & small Primary Care & Mental Health only; New East Bay Clinic and Expanded Central Valley Clinic; Palo Alto absorbs Specialty OPT and 30 Sub-Acute Medicine beds
Total Construction Costs	\$0	\$94,926,716	\$94,926,716	\$110,341,607	\$105,441,607

	Status Quo	Original CARES Market Plan	100% Contract	Alternate # 1 (Preferred)	Alternate # 2
Impact on Access--	Status Quo	Status Quo	Limited specialists, sub acute care and nursing home availability.	NHCU - Travel times will increase on average due to shift to Menlo Park of 80 beds. OPT travel times will substantially improve (down 20 minutes on average) as new East Bay and expanded Central Valley CBOCs provide most OPT care in local communities of Livermore users.	NHCU - Travel times will remain equal as NHCU stays at Livermore (sub-acute patients and families will have longer distances to Palo Alto). OPT travel times will substantially improve as new East Bay and expanded Central Valley CBOCs provide most OPT care in local communities of Livermore users.
Impact on Quality	Status Quo	No quality changes expected as Livermore continues its NHCU and new or expanded clinics siphon off some of Livermore OPT workload.	Unknown. Depends upon availability of providers in specific counties and communities where Livermore users reside. Greatest concern is for complex NHCU pts where community homes unlikely to provide same quality of care as VA.	NHCU - 80 ADC shifted to MPD will benefit by association with new Gerontology Ctr. Improved Sub-Acute Care by virtue of location within hospital setting. OPT Specialty may improve with care shifted to Palo Alto or new East Bay as outreach by PAD MDs more likely.	No quality changes expected as Livermore continues its NHCU and new or expanded clinics take place of Livermore OPT programs.
Impact on Staffing & Community	Status Quo	Status Quo	Most adverse option for VA staff that would be subject to reassignment. Likelihood that staff would leave VA if they could not be accommodated at sites closer to their homes.	Significant impact to VA staff that will be offered priority for transferring to NHCU at Menlo Park or at new/expanded clinics. Community will oppose loss of Livermore Division until it is known what will replace it (i.e., Under EU lease, could have larger	Minor dislocation to staff that would transfer from downsized programs at Livermore to new or growing clinics in the East Bay or Central Valley.

	Status Quo	Original CARES Market Plan	100% Contract	Alternate # 1 (Preferred)	Alternate # 2
Impact on Staffing & Community, Continued				private sector extended care facility; state home; or a private hotel/commercial entity). Adverse economic impact for local community in the short term.	
Impact on Research and Education	Status Quo- No Research or Major Academic Affiliations with LVD	Status Quo- No Research or Major Academic Affiliations with LVD	Status Quo- No Research or Major Academic Affiliations with LVD	Growth of NHCU program at Menlo Park will promote the new Gerontology Center and related training programs.	Status Quo- No Research or Major Academic Affiliations with LVD
Optimizing Use of Resources	Will require extensive and continuing investment in 70-year-old Livermore infrastructure.	Will require extensive and continuing investment in 70-year-old Livermore infrastructure.	Maximizes capital investment savings in exchange for big increase to operating budget for contract costs. Such costs may be unpredictable from year to year as market supply fluctuates.	Capital savings at Livermore offset by need for new construction at Menlo Park and build outs/leases for New East Bay and Central Valley CBOCs. Operating Costs likely to be a wash.	Downsizing of Livermore campus will enable capital cost avoidance. Shifting of operating costs from one CBOC to another should be neutral.
Support other VA Missions	No Impact	No Impact	No Impact	Does not impact other missions; Space available for VBA or NCA after realignment Implemented	Does not impact other missions; Space available for VBA or NCA after realignment implemented

	Status Quo	Original CARES Market Plan	100% Contract	Alternate # 1 (Preferred)	Alternate # 2
Other Significant Considerations	VAPAHCS cannot continue to invest capital into Livermore Division without compromising overall system needs	VAPAHCS cannot continue to invest capital into Livermore Division without compromising overall system needs	<p>Current market data suggests occupancy rates at 90% for CNH beds, especially for long-term mental health care.</p> <p>In fee for service environment, providers focus on increasing profits by generating more RVUs per encounter or increasing the frequency of contacts. Contracting oversight for quality of care becomes more important/more expensive.</p> <p>VA system has unique documentation requirements for providers that are not compensable in the private sector. The provider time required for entering requests for lab, diagnostics and consults, entering encounter data and clinical practice guidelines are considered outside the realm of a normal private clinical practice. This would make it difficult to contract at Medicare rates.</p>	Livermore Reuse Plan / EU is critical key for success. If campus converts to extended care programs available to veterans (assisted living, domiciliary, etc) then entire Network benefits from the campus conversion. If lucrative commercial lease is negotiated, then major new revenue stream available to support system needs.	Hybrid approach is a compromise that keeps all parties happy, but can we afford to expand OPT clinics without greater resource shift from Livermore?

//////////////////////////////////End//////////////////////////////////

APPENDICES (included for web release)

Appendix 1 Contracted Nursing Home VAPAHCS

Northern Alameda County (35)					Beds
1	Alameda Care Center	430 Willow Street	Alameda	94501	166
2	Bay View Nursing & Rehab	516 Willow Street	Alameda	94501	180
3	Emmanuel Conv. Hospital	508 Westline Drive	Alameda	94501	151
4	Marina Senior Care	3201 Fernside Blvd.	Alameda	94501	32
5	South Shore Conv. Hosp	625 Willow Street	Alameda	94501	26
6	Waters Edge, The	2401 Blanding Avenue	Alameda	94501	120
7	Ashby Care Center	2270 Ashby Avenue	Berkeley	94705	31
8	Berkeley Pines Care Center	2223 Ashby Avenue	Berkeley	94705	36
9	Elmwood Nursing Rehab	2829 Shattuck Avenue	Berkeley	94705	74
10	Kyskameena Sanitarium	2131 Carleton Street	Berkeley	94704	60
11	Bellaken Skilled Nursing	2760 26 th Avenue	Oakland	94601	61
12	Clinton Village Conv. Hosp.	1833 10 th Avenue	Oakland	94606	99
13	Excell Health Care Center	3025 High Street	Oakland	94619	99
14	Fruitvale Healthcare Center	3020 E 15 th Street	Oakland	94601	140
15	Garfield MHC	1451 28 th Avenue	Oakland	94601	96
16	High Street Care Center	3145 High Street	Oakland	94619	44
17	Lake Park Retirement Res	1850 Alice Street	Oakland	94612	26
18	Lakeshore Conv. Hospital	1901 third Avenue	Oakland	94606	38
19	MacArthur Care Center	309 MacArthur Blvd.	Oakland	94610	53
20	McClure Conv Hosp& Rehab	2910 McClure Street	Oakland	94609	60
21	Medical Hill Rehab. Center	475 29 th Street	Oakland	94609	124
22	Mercy Retire & Care Center	3431 Foothill Blvd.	Oakland	94601	59
23	Oakland Care Center	3030 Webster Street	Oakland	94609	98
24	Oakridge Conv. Center	2919 Fruitvale Avenue	Oakland	94603	99

25 Piedmont Gardens Health	110 Forty First Street	Oakland	94611	94
26 Rounseville Rehab Center	210 40 th Street Way	Oakland	94611	70
27 Salem Care Center	2361 E. 29 th Street	Oakland	94606	48
28 St. Pauls Towers	100 Bay Place	Oakland	94610	43
29 Willow Tree Nursing Center	2124 57 th Avenue	Oakland	94621	82
30 Bancroft Conv. Hospital	1475 Bancroft Avenue	San Leandro	94577	39
31 Jones, Conv. Hospital	524 Callan Avenue	San Leandro	94577	25
32 San Leandro Healthcare Ctr	368 Juana Avenue	San Leandro	94577	60
33 St. Luke's Subacute Care	1652 Mono Avenue	San Leandro	94578	72
34 Sunbridge Care & Rehab	14766 Washington Avenue	San Leandro	94578	99
35 Villa Fairmont MHC	15200 Foothill Blvd.	San Leandro	94578	96

2,700

Southern Alameda Countyn (29)

1 Evergreen Castro Valley	20259 Lake Chabot Road	Castro Valley	94546	91
2 Redwood Conv. Hospital	22103 Redwood Road	Castro Valley	94546	70
3 St. John Kronstadt Conv. Ctr	4432 James Avenue	Castro Valley	94546	49
4 Valley Pointe Nursing Rehab	20090 Stanton Avenue	Castro Valley	94546	50
5 Wisteria Care Center	20524 Wisteria Street	Castro Valley	94546	25
6 Bassard Conv. Hospital	3269 D Street	Hayward	94541	71
7 Bay Point Healthcare Center	442 Sunset Blvd	Hayward	94541	99
8 Bethesda Home	22427 Montgomery Street	Hayward	94541	40
9 Courtyard Care Center	1625 Denton Avenue	Hayward	94545	74
10 Driftwood Healthcare Center	19700 Hesperian Blvd.	Hayward	94541	88
11 Eden West Conv. Hospital	1805 West Street	Hayward	94545	99
12 Gateway Nursing Center	26660 Patrick Avenue	Hayward	94544	99
13 Hayward Conv. Hospital	1832 B Street	Hayward	94541	99
14 Hayward Hills Healthcare	1768 B Street	Hayward	94541	74

15 Majestic Pines Care Center	1628 b Street	Hayward	94541	75
16 Parkview Healthcare Center	27350 Tampa Avenue	Hayward	94544	121
17 St. Anthony Care Center Inc	553 Smalley Avenue	Hayward	94541	30
18 St. Christopher Conv. Hosp	22822 Myrtle Street	Hayward	94541	36
St. Francis Extended Care				
19 Inc	718 Bartett Avenue	Hayward	94541	62
20 St. Therese Conv. Hosp	21863 Vallejo Street	Hayward	94541	36
21 Sunbridge Care & Rehab	26660 Patrick Avenue	Hayward	94544	99
22 Vintage Estates Of Hayward	25919 Gading Road	Hayward	94544	99
23 Hacienda Care Center	76 Fenton Street	Livermore	94550	83
24 Silver Oak Manor	788 Holmes Street	Livermore	94550	37
Pleasanton Heathcare				
25 Center	300 Neal Street	Pleasanton	94566	139
26 Fremont Healthcare Center	39022 Presidio Way	Fremont	94538	115
27 Crestwood Geri Treatment	2171 Cowry Avenue	Fremont	94538	126
28 Sun crest Rehab	2500 Country Drive	Fremont	94536	126
29 Park Central Nursing Cntr	2100 Parkside Drive	Fremont	94536	99

2,311

Santa Clara County (9)

1 Pleasant View Conv. Hosp.	22590 Voss Avenue	Cupertino	95014	170
2 Almaden Care & Rehab	2065 Los Gatos-Almaden Rd	San Jose	95128	77
3 Courtyard Care Center	240 Northlake Drive	San Jose	95117	76
4 Crestwood Manor	1425 Fruitvale Avenue	San Jose	95128	173
5 Herman Sanitarium	2295 Plummer Avenue	San Jose	95125	99
6 Skyline Healthcare Center	2065 Forest Avenue	San Jose	95128	253
7 Vista Manor Nursing Center	120 Jose Figueres Avenue	San Jose	95116	99
8 Valley House Care Center	991 Clyde Avenue	Santa Clara	95054	205
9 Julia Conv Hospital	276 Sierra Vista Avenue	Mountain View	94042	97

1,249

San Mateo County (2)

1 Menlo Park Place	1275 Crane Street	Menlo Park	94025	160
2 Cordilleras Mental Health	200 Edmonds Road	Redwood City	94062	96
				256

Santa Cruz County (4)

1 7 th Avenue Center	1171 Seventh Avenue	Santa Cruz	95062	99
2 Driftwood Manor	675-24 Avenue	Santa Cruz	95060	92
3 Watsonville Nursing (East)	535 Auto Center Drive	Watsonville	95076	87
4 Watsonville Nursing (West)	525 Auto Center Drive	Watsonville	95076	95
				373

Monterey County (4)

1 Monterey Care Center	1575 Skyline Drive	Monterey	93940	77
2 Monterey Pines	1501 Skyline Drive	Monterey	93940	99
3 Skyline Nursing Center	348 Iris Drive	Salinas	93906	80
4 The Ridge Care & Rehab	350 Iris Drive	Salinas	93906	103
				359

San Benito County (1)

1 Hollister Nursing Center	900 Sunset Drive	Hollister	95023	70
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San Joaquin County (5)

1 Manteca Nursing & Rehab	410 Eastwood Avenue	Manteca	95336	176
2 Crestwood Manor	1130 Monaco Court	Stockton	95207	190
3 SunBridge Elmhaven Care	6940 Pacific Avenue	Stockton	95207	128
4 SunBridge Hampton Care	442 Hampton Street	Stockton	95207	120
5 SunBridge Heritage Care	9107 N. Davis Road	Stockton	95209	75
				689

Stanislaus County (2)

1 Crestwood Manor Evergreen Rehab Care	1400 Celeste Drive	Modesto	95355	194
2 Centro	2030 Evergreen Avenue	Modesto	95350	175
<hr/>				369

Appendix 2 Alternative # 1			
Workload or Space Category	2001 Wkld (ADC for IP)	2001 Baseline Wkld (beds, stops)	2012 Projected Wkld (beds, stops)
Inpatient Medicine			
Inpatient Surgery			
Inpatient Psych			
Inpatient Dom			
Inpatient NHCU	121	162	162
Inpatient PR RTP			
Inpatient SCI			
Inpatient BRC			
Outpatient Primary Care	17,073	17,073	26,456
Outpatient Specialty Care	25,072	25,072	34,106
Outpatient Mental Health	6,512	6,512	6,635
Ancillary & Diagnostics	7,844	7,844	11,863
Research SPACE	N/A	N/A	N/A
Admin SPACE	N/A	N/A	N/A
Other SPACE	N/A	N/A	N/A

Short description: (Preferred Alternative) - New East Bay Clinic est at 45,000 GSF - Expanded Central Valley Clinic est				
2022 Projected Wkld (beds, stops)	% transferred	Year to begin transfer	Receiving Facility Name	Receiving Facility % contracted out
162	81%	2007	Menlo Park	32%
	19%	2007	Palo Alto	0
				Total beds
20,150	66%	2007	East Bay	none
	34%	2007	Central Valley	none
28,014	50%	2007	East Bay	none
	40%	2007	Central Valley	none
	10%	2007	Palo Alto	none
6,583	66%	2007	East Bay	none
	34%	2007	Central Valley	none
9,823	50%	2007	East Bay	none
	50%	2007	Central Valley	none
				Total Stops
N/A				
N/A				
N/A				

Central Valley County	Vet Pop	Enrollees	Penetration Rate
San Joaquin	42,446	7,141	17%
Stanislaus	31,339	6,334	20%
Tuolumne	8,027	2,240	28%
Central Valley Catchment	81,812	15,715	19%
Alameda (South)*	55,161	10,334	19%
East Bay Catchment Total	55,161	10,334	19%
Alameda (North)*	45,416	6,262	14%

East Bay CBOC	FY01
Primary Care	11,268 stops
Specialty Care	12,536 stops
Mental Health	4,298 stops
Ancillary/Diagnostic	3,920 stops
Total	32,022 stops

Expanded Central Valley CB	FY01	Modesto FY01	Combined Clinics
Primary Care	5,800 stops	12,033 stops	17,833 stops
Specialty Care	10,028 stops		10,028 stops
Mental Health	2,214 stops	3,008 stops	5,222 stops
Ancillary/Diagnostic	3,920 stops		3,920 stops
Total	21,962 stops	15,042 stops	37,004 stops

*Total Alameda County 2001 est at 100,577 based on Actuarial analysis from *Livermore Realignment Analysis*

Appendix 3 Alternative # 2			
Workload or Space Category	Baseline Wkld	2001 Baseline Wkld (beds, stops)	2012 projected Wkld
Inpatient Medicine			
Inpatient Surgery			
Inpatient Psych			
Inpatient Dom			
Inpatient NHCU	121	162	162
Inpatient PR RTP			
Inpatient SCI			
Inpatient BRC			
Outpatient Primary Care	17,073	17,073	26,456
Outpatient Specialty Care	25,072	25,072	34,106
Outpatient Mental Health	6,512	6,512	6,635
Ancillary & Diagnostics	7,844	7,844	11,863
Research SPACE	N/A		N/A
Admin SPACE	N/A		N/A
Other SPACE	N/A		N/A

Short description: (Maintain LVD NHCU and Bldg 88 [Primary Care/Admin Building]) - New East Bay Clinic est at 45,000 GSF				
2022 Projected Wkld	% to be transferred	Year to begin transfer	Receiving Facility Name	Receiving Facility % contracted out
162	81%		Livermore	7%
	19%		Palo Alto	0
				Total beds
20,150	45%	2007	East Bay	none
	34%	2007	Central Valley	none
	21%	2007	Livermore Clin	none
28,014	50%	2007	East Bay	none
	40%	2007	Central Valley	none
	10%	2007	Palo Alto	none
6,583	45%	2007	East Bay	none
	34%	2007	Central Valley	none
	21%	2007	Livermore	none
9,823	50%	2007	East Bay	none
	50%	2007	Central Valley	none
				Total Stops
N/A				
N/A				
N/A				

Appendix 3, Continued

Central Valley County	Vet Pop	Enrollees	Penetration Rate
San Joaquin	42,446	7,141	17%
Stanislaus	31,339	6,334	20%
Tuolumne	8,027	2,240	28%
Central Valley Catchment	81,812	15,715	19%
Alameda (South)*	55,161	10,334	19%
East Bay Catchment Total	55,161	10,334	19%
Alameda (North)*	45,416	6,262	14%

*Total Alameda County 2001 est at 100,577 based on Actuarial

Proposed East Bay CBOC	FY01
Primary Care	7,670 stops
Specialty Care	12,536 stops
Mental Health	2,930 stops
Ancillary/Diagnostic	3,920 stops
Total	27,056 stops

LVD CBOC (Bldg 88)	FY01
Primary Care	3,600 stops
Mental Health	1,368 stops
Total	4,968 stops

Expanded Central Valley CB	FY01	Modesto FY01
Primary Care	5,800 stops	12,033 stops
Specialty Care	10,028 stops	
Mental Health	2,214 stops	3,008 stops
Ancillary/Diagnostic	3,920 stops	
Total	21,962 stops	15,042 stops