

Department of Veterans Affairs

Capital Asset Realignment for Enhanced Services



VISN 22

Market Plans

Attention

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

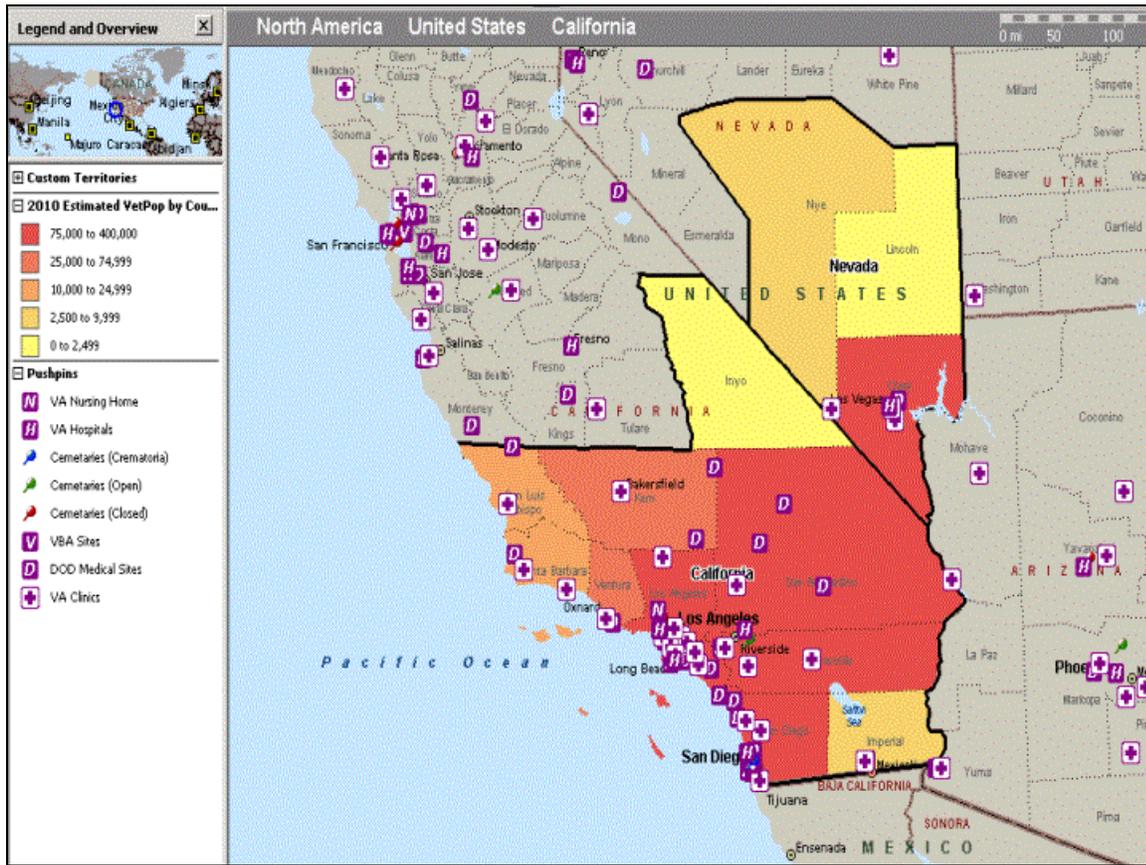
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I. VISN Level Information

A. Description of the Network/Market/Facilities

1. Map of VISN Markets



2. Market Definitions

Market Designation: The VA Desert Pacific Healthcare Network (VISN 22) encompasses a population of approximately 1.5 million veterans within an area of about 110,000 square miles. VISN 22 contains major population centers located at Las Vegas, San Diego, Los Angeles, and the Inland Empire (San Bernardino & Riverside). The significant geographical features include vast desert areas separating large population centers. Two of the largest counties in the continental U.S. are found in the Network (San Bernardino and Riverside). Additionally, Las Vegas in Clark County, NV is one of the fastest growing markets in the U.S. In order to identify Markets and possible submarkets, VISN 22 examined user and enrollee populations, referral patterns, distance and proximity to existing facilities, available roads and highways and any unique geographical or topographical situations. VISN 22 CARES is proposing 2 CARES markets & 3 submarkets, as follows:

Market	Includes	Rationale	Shared Counties
Nevada Market Code: 22B	Southern Nevada (3 counties): Clark, Lincoln, and Nye Counties.	The Nevada Market includes the southern counties of Clark, Lincoln, and Nye. The primary transportation corridor is Interstate 15 which runs north and south through the market area. Available health care services include primary care, mental health, and inpatient care. Clark County is home to the Southern Nevada Health Care System, and includes the Las Vegas Ambulatory Care Center, VA/DoD shared facility at Nellis AFB, and 3 CBOC's. For CARES analysis, demand projections will need to consider the phenomenal growth occurring in Clark County and the city of Las Vegas. NOTE: The vast majority of veterans in Esmeralda County obtain care at the Sierra Nevada Health Care System, and VISN 21 will take the lead for CARES planning.	Shared county with V21: Esmeralda County, NV NOTE: VISN 21 to take planning lead as 99% market share is in VISN 21.
California Market Code: 22A	11 counties 3 sub-markets	See below	
Code 22A-2 Southern	2 counties: San Diego, and Imperial	The Southern Submarket of the California Market area includes the southern counties of San Diego and Imperial. The primary transportation corridor is Interstate 8 which runs east and west through	

Market	Includes	Rationale	Shared Counties
Sub-market	Counties	the market area. The Southern submarket area is projected to have growth in the number of veteran enrollees through 2010. Health care services available to veterans include primary care, mental health, inpatient care, tertiary care and long term care. The Southern submarket area has a major tertiary referral center located in San Diego. There are also 5 CBOC's assigned to the parent facility.	
Code 22A-3 Inland sub-market	Inland Sub-market (3 counties): Riverside, San Bernardino, Inyo Counties	The Inland Submarket of the California Market area includes the inland counties of Riverside, San Bernardino, and Inyo. The primary transportation corridors are Interstates 10, 15, 40, and US 395. The submarket area is projected to have growth in the number of veteran enrollees through 2010. Health care services available to veterans include primary care, mental health, inpatient care, tertiary care and long term care. The Inland submarket area has a major tertiary referral center located in Loma Linda. There are also 5 CBOC's assigned to the parent facility. Inyo County in eastern California is a shared market with VISN 21. North Inyo County veterans obtain care at the Sierra Nevada Health Care System, and south Inyo County veterans obtain care at GLAHS, Loma Linda, and San Diego. Zipcode analysis needed to determine patient location/trends.	Shared county with V21: <i>Inyo County, CA</i> Zipcode analysis required to determine market share.
Code 22A-1 Coastal California Sub-market	Coastal Sub-market (6 counties): Kern, San Luis Obispo, Santa Barbara, Ventura, Los Angeles, Orange Counties	The Coastal Submarket of the California Market area includes the coastal and metropolitan counties of San Luis Obispo, Santa Barbara, Ventura, Kern, Los Angeles, and Orange. The primary transportation corridors are Interstates 5 (and all bypass freeway corridors), 10 (and all bypass freeway corridors), US 101, and CA 14. The submarket area is projected to have growth in the number of veteran enrollees through 2010. Health care services available to veterans include primary care, mental health, inpatient care, tertiary care and long term care. The Coastal submarket area has major tertiary referral centers located at Greater Los Angeles (West LA), and	Shared county with V21: <i>Inyo County, CA</i> Zipcode analysis required to determine market share.

Market	Includes	Rationale	Shared Counties
		Long Beach. There are 12 CBOC's assigned to the GLA parent, and 4 CBOC's assigned to the Long Beach parent	

3. Facility List

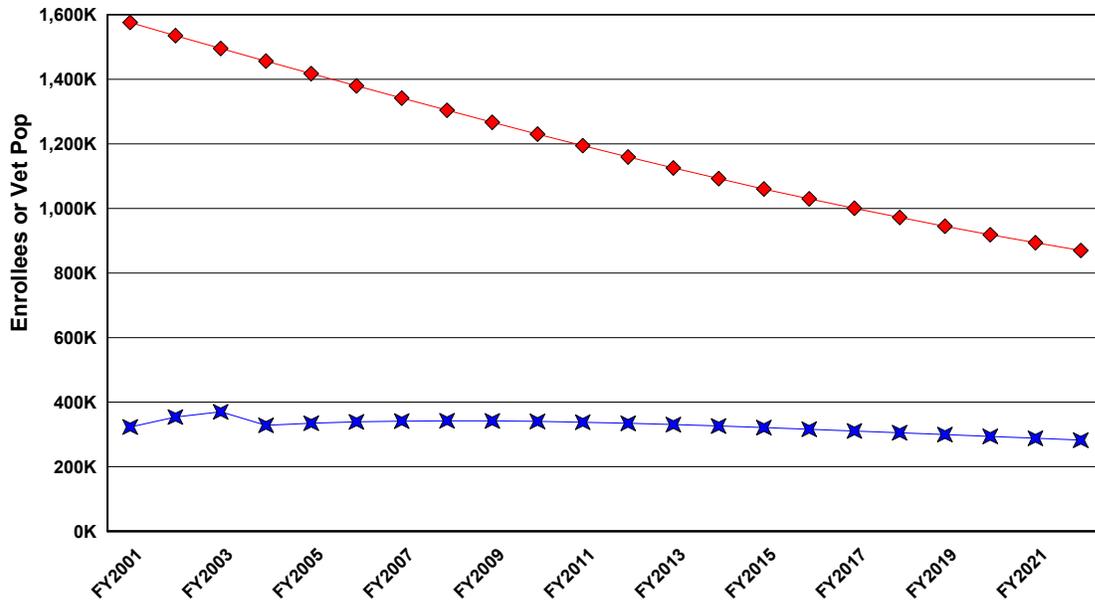
VISN : 22				
Facility	Primary	Hospital	Tertiary	Other
Las Vegas				
593 Southern Nevada HCS	✓	✓	-	-
593GA Las Vegas Homeless	✓	-	-	-
593GB Henderson	✓	-	-	-
593GC Pahrump	✓	-	-	-
Loma Linda				
605 Loma Linda VAMC	✓	✓	✓	-
605GA Victorville	✓	-	-	-
605GB Sun City	✓	-	-	-
605GC Palm Desert	✓	-	-	-
605GD Corona (Riverside County) CA	✓	-	-	-
605GE Upland	✓	-	-	-
Long Beach				
600 Long Beach HCS	✓	✓	✓	-
600GA Anaheim	✓	-	-	-
600GB Santa Ana	✓	-	-	-
600GC Cabrillo (Long Beach)	✓	-	-	-
600GD Sante Fe Springs/Whittier	✓	-	-	-
San Diego				
664 San Diego HCS	✓	✓	✓	-
664BY Mission Valley	✓	-	-	-
664GA El Centro	✓	-	-	-
664GB Vista	✓	-	-	-
664GC Chula Vista	✓	-	-	-
664GD Escondido	✓	-	-	-

West LA				
691 Greater Los Angeles HCS	✓	✓	✓	-
691A4 Sepulveda	✓	-	-	-
691GB Santa Barbara	✓	-	-	-
691GC Gardena	✓	-	-	-
691GD Bakersfield	✓	-	-	-
691GE Los Angeles	✓	-	-	-
691GF EAST LOS ANGELES CLINIC	✓	-	-	-
691GG Antelope Valley	✓	-	-	-
691GI Culver City	✓	-	-	-
691GK San Luis Obispo	✓	-	-	-
691GL Lompoc	✓	-	-	-
691GM Port Hueneme	✓	-	-	-
691GO San Gabriel	✓	-	-	-

4. Veteran Population and Enrollment Trends

--- Projected Veteran Population

--- Projected Enrollees



5. Planning Initiatives and Collaborative Opportunities

a. Effective Use of Resources

Effective Use of Resources		
PI?	Issue	Rationale/Comments Re: PI
N	Small Facility Planning Initiative	
Y	Proximity 60 Mile Acute	The VISN is requested to consider mission changes and/or realignments in facilities within the California Market. Affected facility pairs include: • Long Beach HCS--Greater Los Angeles HCS(30)
Y	Proximity 120 Mile Tertiary	The VISN is requested to consider mission changes and/or realignments in facilities within the California Market. Affected facility pairs include: • Long Beach HCS--Greater Los Angeles HCS(30 miles) • Loma Linda VAMC--Greater Los Angeles HCS(74 miles) • Long Beach HCS--Loma Linda VAMC(76 miles) • Loma Linda VAMC--San Diego HCS(101 miles) • Long Beach HCS--San Diego HCS(105 miles)
Y	Vacant Space	All VISNs will need to explore options and develop plans to reduce vacant space by 10% in 2004 and 30% by 2005.

b. Special Disabilities

Special Disabilities Program		
PI?	Other Issues	Rationale/Comments
Y	Blind Rehabilitation	Proposed Blind Rehab Center to be coordinated with VACO
Y	Spinal Cord Injury and Disorders	Potential for realignment from acute to long term

c. Collaborative Opportunities

Collaborative Opportunities for use during development of Market Plans		
CO?	Collaborative Opportunities	Rationale/Comments
Y	DOD	The Navy has expressed an interest in partnering with VA in development of a new hospital on their base. They are planning on building a 68 bed hospital at Camp Pendleton, so there appears to be some sharing and partnering opportunities for future capacity issues. Inpatient, outpatient and/or ancillary Services should be explored by the VISN. There is already a VA presence at Nellis AFB in Vegas. Sharing and partnering opportunities may exist to meet the future demands in the Nevada market.

d. Other Issues

Other Gaps/Issues Not Addressed By CARES Data Analysis		
PI?	Other Issues	Rationale/Comments
Y	Condition of Research space within Visn 22 at Greater Los Angeles	
Y	Condition of NHCU space within Visn 22 at West LA and Sepulveda	
Y	Manage excess land. Overall reduction of vacant land for VISN 22	

e. Market Capacity Planning Initiatives

California Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	673,390		533,815	79%	297,110	44%
	Treating Facility Based **	701,060		499,289	71%	268,799	38%
Specialty Care	Population Based *	662,150		547,243	83%	375,537	57%
	Treating Facility Based **	674,483		534,251	79%	367,249	54%
Medicine	Population Based *	82,771		30,233	37%	4,939	6%
	Treating Facility Based **	84,270		27,935	33%	3,576	4%
Psychiatry	Population Based *	66662		-7966	-12%	-23239	-35%
	Treating Facility Based **	67212		-8220.09	-12%	-22888.4	-34%

Nevada Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	110,396		68,742	62%	54,931	50%
	Treating Facility Based **	123,193		59,918	49%	42,913	35%
Specialty Care	Population Based *	85,978		96,340	112%	92,867	108%
	Treating Facility Based **	87,501		104,804	120%	97,633	112%
Medicine	Population Based *	9,716		12,117	125%	10,038	103%
	Treating Facility Based **	8,262		7,524	91%	5,795	70%

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

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

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

6. Stakeholder Information

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

Stakeholder Narrative:

California Market:

The concerns/comments of the Stakeholders in the California Market were dependent on their home VA facility.

At Loma Linda and San Diego, stakeholders were concerned about wait times for care, parking problems and the lack of research space. All of these concerns were addressed in the CARES Market Plan. The construction of clinical additions at both sites was recommended to provide more space for the efficient provision of care and reduction in wait times. The construction of parking decks and additional research space was also included at both sites.

At both Long Beach and Greater Los Angeles stakeholders were concerned about how decisions will be made on excess land and space. This concern was most pronounced at Greater Los Angeles where community stakeholders expressed a desire to have a decision making role in the process, to have the plan be more long range rather than incremental reflecting a true master planning process and to have more time to develop the ideal process. Veterans groups want excess land to be used in accordance with its original intent, for veterans, and that commercial development should be very carefully studied to ensure appropriate benefit to VA and veterans. The wide variety of stakeholder concerns regarding excess land were considered in developing the Land Use Planning Committee Charter submitted with the CARES Market Plan.

The Planning Initiative to convert 30 acute SCI beds at Long Beach to long-term care beds is opposed by the PVA/CPVA Representatives in the Network. They believe an additional 30 long term care SCI beds should be added with no change to the number of acute beds. We have not addressed these comments as they conflict with the Planning Initiative.

The Planning Initiative to place a 24-bed Blind Rehabilitation Center in Network 22 has generated a number of comments from stakeholders. All stakeholders agree that the Network needs additional services for blind veterans. Most agree that adding more outpatient services at each facility would be ideal. Establishing an inpatient Blind Rehabilitation Center in the Network is not as universally accepted. Locating an inpatient center at either Long Beach or Greater Los Angeles has stakeholder support with the preferred location dependant on the home facility of the stakeholder. Travel time and travel reimbursement is also a

major concern for these veterans. This concern drives their desire to have more services provided in their local community by VA or contract. Long Beach was selected by the Network as the preferred site for an inpatient unit due to its central location, proximity to the large number of veterans in Los Angeles and Orange Counties and its current emphasis on addressing the needs of special populations such as SCI, Prosthetics and Rehabilitation. Additional time to weigh the options and consider the appropriate model of care is needed to address this Planning Initiative.

Nevada Market:

Stakeholders in the Nevada market have had very few comments on the CARES Market Plan. They have been focused on the closure of their Ambulatory Care Center, moving care to 10 locations throughout the Las Vegas community and the construction of an appropriately sized replacement facility. They have expressed concern that the CARES projections for the Las Vegas area underestimate what they believe to be the true growth. They also express the need for a VA hospital and nursing home. The CARES Market Plan does include a replacement Ambulatory CARE Center, increased inpatient beds and the need for a VA nursing home.

7. Collaboration with Other VISNs

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

Collaboration with Other VISNs Narrative:

Collaboration with other VISNs

The VA Desert Pacific Healthcare Network (VISN 22) collaborates with VISN 21 in two counties, one for each of its two markets. Since over 98% of Esmeralda County, Nevada veteran patients from the Southern Nevada Market utilize the VISN 21 Reno VAMC, VISN 22 coordinated with VISN 21 to assign Esmeralda County to VISN 21 for CARES planning purposes. Additionally, in the Inland Submarket of the Southern California Market, Inyo County veteran patients utilize both VISN 22 and VISN 21 facilities. However, since 56% utilize VISN 22, we maintained Inyo County within VISN 22 for CARES planning purposes. In 1999, the Network collaborated with VISN 18 in Arizona to establish a CBOC in Kingman, Arizona. This site treats a large number of both VISN 18 and VISN 22 “snowbird” patients/retirees who flock to the desert during the winter months. This collaboration was a non-competitive agreement to treat both Network’s

patients at that site without concern over which VISN received workload and resources.

Beyond the CARES market process, VISN 22 also sends a limited number of cardiac surgery patients to Palo Alto in VISN 21. Network organ transplantation patients are referred to VA national transplant centers. Liver transplants are sent to Portland in VISN 20, Kidney transplants to Nashville in VISN 9, heart transplants to Salt Lake City in VISN 19, and lung transplants to Madison in VISN 12.

B. Resolution of VISN Level Planning Initiatives

1. Proximity Planning Initiatives (if appropriate)

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

Proximity Narrative:

VISN 22 facilities are proposed to maintain the same missions and tertiary care status as currently identified within VHA. Additionally, the heavy traffic congestion between facilities in southern California and lack of public transportation prevent patients from traveling from site to site for health care services beyond limited collaboration between facilities. Consequently, VISN 22 is addressing the proximity initiative through extensive collaboration between facilities located within the CARES requirements (refer to full narrative/data tables on CARES portal). The Long Beach and Loma Linda facilities are 65 miles from each other. However, due to the heavy traffic congestion between the facilities and lack of public transportation, it is impossible to drive one-way between the two facilities within less than 1.5 hours or utilize the limited public transportation one-way in less than 3.75 hours (three trains and three busses minimal transfers). The two facilities will continue to collaborate on referrals and sharing for Pathology, Radiation Therapy, Radiology and Spinal Cord Injury. Long Beach has extra space but its vintage buildings were constructed between 1942-1989 and are in need of renovation were increased sharing occur, while Loma Linda was constructed 25 years ago but will need to construct additional clinic space to accommodate increased sharing and growth. The Greater Los Angeles and Loma Linda facilities are 76 miles from each other. However, due to the heavy traffic congestion between the facilities, it is impossible to drive one-way between the two facilities within less than 2 hours and less than 3 hours via public transportation (three train and 2 bus connections). The two facilities will continue to collaborate on referrals and sharing for Cardiac Surgery, Inpatient Psychiatry, Pathology, Radiation Therapy, and Radiology. Greater Los Angeles has extra space but its vintage buildings were constructed between 1900-1997 and are in need of renovation were increased sharing to occur. The Long Beach and Greater Los Angeles facilities are 30 miles from each other. However, travel time consistently averages one hour between these sites. Each also has a unique mission; Long Beach serving as the Network's and VHA's largest Spinal Cord Injury/Dysfunction clinical unit and Greater Los Angeles serving as the major interventional cardiology/ cardiac surgery and neurosurgery referral center. Long Beach serves primarily the veterans in Orange County while splitting the patients in Los Angeles County with Greater Los Angeles. Greater Los Angeles serves primarily the veterans in Ventura, Santa Barbara, San Luis Obispo, and Kern County while splitting the patients in Los Angeles County with Long Beach. The two facilities will continue to implement extensive collaboration and refer patients for interventional cardiology/cardiac

surgery, neurosurgery, Pathology/Laboratory, Radiation Therapy, and Radiology. The San Diego and Long Beach facilities are 105 miles from each other. Travel time during non-rush hour is a minimum of 1.5 hours and often longer during rush hour. Limited public transportation can take from 2-3 hours with multiple transfer points between busses and trains. The two facilities will continue to collaborate on referrals and sharing for neurosurgery, interventional Cardiology/Cardiac Surgery, Pathology/Laboratory, Radiation Therapy, and Radiology. The San Diego facility was constructed 31 years ago and does not have sufficient space to expand for growth or increases in referrals. Additional clinical space will be required at San Diego. The San Diego and Loma Linda facilities are 105 miles from each other. However, average travel time one-way to drive is 2 hours and 3-3.75 hours via limited bus/train connections. The two facilities will continue to collaborate on referrals and sharing for Cardiac Surgery, Inpatient Psychiatry, Pathology, Radiation Therapy, Spinal Cord Injury, and Radiology.

2. Special Disability Planning Initiative (if appropriate)

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

Your analysis should include the following:

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

Special Disability Narrative:

Blind Rehabilitation: The Planning Initiative to place a 24-bed Blind Rehabilitation Center in Network 22 has generated a number of comments from stakeholders. All stakeholders agree that the Network needs additional services for blind veterans. Most agree that adding more outpatient services at each facility would be ideal. Establishing an inpatient Blind Rehabilitation Center in the Network is not as universally accepted. Locating an inpatient center at either Long Beach (LB) or Greater Los Angeles has stakeholder support with the preferred location dependant on the home facility of the stakeholder. Travel time and travel reimbursement is also a major concern. This concern drives their desire to have more services provided in their local community by VA or contract. A new Blind Rehabilitation Center will require additional funds to be distributed to VISN 22 to provide and staff for this specialized service. LB was selected by the Network as the preferred site for an inpatient unit due to its central location, proximity to the large number of veterans in Los Angeles and Orange Counties and its current emphasis on addressing the needs of special populations such as SCI, Prosthetics and Rehabilitation. Additional time to weigh options and consider the appropriate model of care is needed to address this Planning Initiative. The LB campus is geared toward providing services to specialized populations. On campus is the largest Spinal Cord Injury facility (SCI) in the country with 120 authorized beds. The addition of a Blind Rehabilitation Center

will be a natural fit to the mission of treating special populations. LB grounds are adjacent to both commercial and residential neighborhoods that will be ideal for Orientation and Mobility training. The medical center is co-located with Cal State Long Beach, which enhances the campus for orientation and mobility training. LB shares the same advantage of easy transit to Cal State LA, for their Orientation and Mobility interns and students. Additionally Cal State Long Beach has a number of programs that will enhance a Blind Rehabilitation Program including: Kinesiology, Nursing, Recreation and Leisure Studies, Social Work, Rehabilitation Counseling, and Computer Science. LB has an Interdisciplinary Team in place, which includes Occupation Therapy, Psychology, Recreation Therapy, and Prosthetics. At LB, there are recreational facilities and activities for veterans, staff, and visitors to enjoy including a ball field and a beautiful patient garden. LB is centrally located between all three Southern California Veteran's Homes - Barstow, Chula Vista and GLA and would generate additional referrals from that site. LB receives referrals from the California Center for Partially Sighted and Braille Institute. There is an unmet need in the central part of VISN 22 for Blind Rehab outpatient service needs and if provided at LB, access will be increased throughout the VISN. Expanding the services at LB will provide an opportunity to expand the Blinded Veterans Association throughout the VISN. There is support from the local Long Beach VIST Coordinator all the way through the Medical Center Director. In addition, UC Irvine School of Medicine supports the Blind Rehabilitation Center proposal for the LB location.

Spinal Cord Injury & Disorders: The Spinal Cord Injury and Disorders special disability program population data supports the realignment of SCI/D beds from acute to long term. Conversion of SCI/D beds from acute to long term will require an increase in current funding levels to support full occupancy. The VALBHS campus is geared toward providing services to specialized populations. On campus is the largest Spinal Cord Injury facility (SCI) that has 120 authorized beds. Including long term care services for this special population will enhance the mission of VALBHS. The California Paralyzed Veterans of America (CPVA) support this planning initiative.

C. VISN Identified Planning Initiatives

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

Your analysis should include the following:

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

VISN Planning Initiatives Narrative:

Condition of research space: Research space at Greater Los Angeles (GLA) was identified as having functional deficiencies as well as not meeting seismic requirements. It is recommended that research space at GLA be replaced with new construction, which will be sized based on the amount of research funding (\$25 M.). During our analysis, we also discovered insufficient space exists at both San Diego and Loma Linda. New research additions are proposed for both facilities and will be sized based on the amount of research funding (San Diego \$50 M. and Loma Linda \$7 M.).

Condition of Nursing Home Care Units (NHCU): NHCU space at GLA was identified as having functional deficiencies. Although we do not have long term care projections, we expect the need for NHCU space will be required through 2022 and it is proposed to replace the existing structures with a new 180 bed NHCU.

Seismic: Seismic deficiencies have been identified at the campuses of GLA, Long Beach and San Diego. Major project proposals totaling approximately \$89 M. have been submitted to VACO but remain unfunded. The plan is to resubmit these proposals to correct these deficiencies in our major clinical buildings. Remaining seismic deficient buildings will also be addressed in our seismic correction plan.

Excess land use: All southern California campuses were identified as potential sites for Enhanced Use Lease Opportunities. The Network approach to this initiative is the development of a VISN 22 Excess Land Use Policy to be submitted in the CARES Market Plan. This policy will provide planning & zoning guidance developed with stakeholder input (including Homeowner Associations, and local government representatives) to ensure proposed developments are viable Enhanced Use projects.

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

1. Inpatient Summary

a. Workload

	BDOC Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
INPATIENT CARE	Baseline FY 2001 BDOC	FY 2012 BDOC	FY 2022 BDOC	In House BDOC	Other BDOC	In House BDOC	Other BDOC	Net Present Value
Medicine	92,532	127,991	101,903	118,924	9,069	98,713	3,193	\$ (40,780,403)
Surgery	54,500	53,702	42,880	52,110	1,595	41,500	1,383	\$ (5,171,961)
Psychiatry	71,937	64,698	48,651	61,659	3,040	46,405	2,248	\$ 1,206,003
PRRTP	24	24	24	24	-	24	-	\$ -
NHCU/Intermediate	530,443	530,443	530,443	178,993	351,450	178,993	351,450	\$ (47,443,733)
Domiciliary	104,741	104,741	104,741	104,741	-	104,741	-	\$ (12,710,996)
Spinal Cord Injury	29,586	29,586	29,586	29,586	-	29,586	-	\$ (2,207,464)
Blind Rehab	-	-	-	-	-	-	-	\$ (2,276,447)
Total	883,763	911,185	858,228	546,037	365,154	499,962	358,274	\$ (109,385,001)

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
INPATIENT CARE	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Medicine	151,313	268,534	213,088	256,165	212,939	\$ (40,780,403)
Surgery	83,511	92,807	74,098	92,877	74,156	\$ (5,171,961)
Psychiatry	109,364	119,992	89,867	119,453	89,483	\$ 1,206,003
PRRTP	33,330	33,330	33,330	-	-	\$ -
NHCU/Intermediate	285,904	285,904	285,904	380,901	380,901	\$ (47,443,733)
Domiciliary	155,913	155,913	155,913	155,913	155,913	\$ (12,710,996)
Spinal Cord Injury	129,603	118,603	118,603	129,603	129,603	\$ (2,207,464)
Blind Rehab	-	-	-	12,500	12,500	\$ (2,276,447)
Total	948,938	1,075,083	970,803	1,147,412	1,055,495	\$ (109,385,001)

2. Outpatient Summary

a. Workload

	Clinic Stop Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
Outpatient CARE	Baseline FY 2001 Stops	FY 2012 Stops	FY 2022 Stops	In House Stops	Other Stops	In House Stops	Other Stops	Net Present Value
Primary Care	824,252	1,383,459	1,135,964	1,076,411	307,051	916,425	219,541	\$ 153,745,650
Specialty Care	761,983	1,401,038	1,226,865	1,240,740	160,301	1,108,084	118,784	\$ (31,376,430)
Mental Health	557,324	587,370	572,334	565,077	22,295	550,672	21,665	\$ (26,623,268)
Ancillary& Diagnostic	884,346	1,701,152	1,562,066	1,440,236	260,918	1,345,018	217,051	\$ (103,155,416)
Total	3,027,906	5,073,019	4,497,230	4,322,464	750,565	3,920,199	577,041	\$ (7,409,464)

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
Outpatient CARE	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Primary Care	332,029	666,493	547,681	552,028	469,957	\$ 153,745,650
Specialty Care	613,168	1,474,641	1,290,468	1,369,310	1,222,640	\$ (31,376,430)
Mental Health	263,257	321,110	313,143	320,962	312,943	\$ (26,623,268)
Ancillary& Diagnostic	480,868	1,074,015	984,969	936,693	874,141	\$ (103,155,416)
Total	1,689,322	3,536,260	3,136,260	3,178,993	2,879,681	\$ (7,409,464)

3. Non-Clinical Summary

	Space Projections (from demand)			Post CARES (from solution)		
NON-CLINICAL	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Research	665,728	665,728	665,728	687,884	687,884	\$ (222,786,655)
Admin	1,382,506	2,298,198	2,083,976	1,775,803	1,691,714	\$ (57,144,818)
Outleased	219,007	219,007	219,007	219,007	241,075	N/A
Other	245,396	245,396	245,396	245,396	245,396	\$ (218,260,348)
Vacant Space	818,885	-	-	2,385,824	2,515,986	\$ 627,547,419
Total	3,331,522	3,428,329	3,214,107	5,313,914	5,382,055	\$ 129,355,598

II. Market Level Information

A. California Market

1. Description of Market

a. Market Definition

Market	Includes	Rationale	Shared Counties
Code 22A-2 Southern Sub-market	2 counties: San Diego, and Imperial Counties	The Southern Submarket of the California Market area includes the southern counties of San Diego and Imperial. The primary transportation corridor is Interstate 8 which runs east and west through the market area. The Southern submarket area is projected to have growth in the number of veteran enrollees through 2010. Health care services available to veterans include primary care, mental health, inpatient care, tertiary care and long term care. The Southern submarket area has a major tertiary referral center located in San Diego. There are also 5 CBOC's assigned to the parent facility.	
Code 22A-3 Inland sub-market	Inland Sub-market (3 counties): Riverside, San Bernardino, Inyo Counties	The Inland Submarket of the California Market area includes the inland counties of Riverside, San Bernardino, and Inyo. The primary transportation corridors are Interstates 10, 15, 40, and US 395. The submarket area is projected to have growth in the number of veteran enrollees through 2010. Health care services available to veterans include primary care, mental health, inpatient care, tertiary care and long term care. The Inland submarket area has a major tertiary referral center located in Loma Linda. There are also 5 CBOC's assigned to the parent facility. Inyo County in eastern California is a shared market with VISN 21. North Inyo County veterans obtain care at the Sierra Nevada Health Care System, and south Inyo County veterans obtain care at GLAHS, Loma Linda, and San Diego. Zipcode analysis needed to determine patient location/trends.	Shared county with V21: <i>Inyo County, CA</i> Zipcode analysis required to determine market share.

Market	Includes	Rationale	Shared Counties
Code 22A-1 Coastal California Sub-market	Coastal Sub-market (6 counties): Kern, San Luis Obispo, Santa Barbara, Ventura, Los Angeles, Orange Counties	The Coastal Submarket of the California Market area includes the coastal and metropolitan counties of San Luis Obispo, Santa Barbara, Ventura, Kern, Los Angeles, and Orange. The primary transportation corridors are Interstates 5 (and all bypass freeway corridors), 10 (and all bypass freeway corridors), US 101, and CA 14. The submarket area is projected to have growth in the number of veteran enrollees through 2010. Health care services available to veterans include primary care, mental health, inpatient care, tertiary care and long term care. The Coastal submarket area has major tertiary referral centers located at Greater Los Angeles (West LA), and Long Beach. There are 12 CBOC's assigned to the GLA parent, and 4 CBOC's assigned to the Long Beach parent	Shared county with V21: <i>Inyo County, CA</i> Zipcode analysis required to determine market share.

b. Facility List

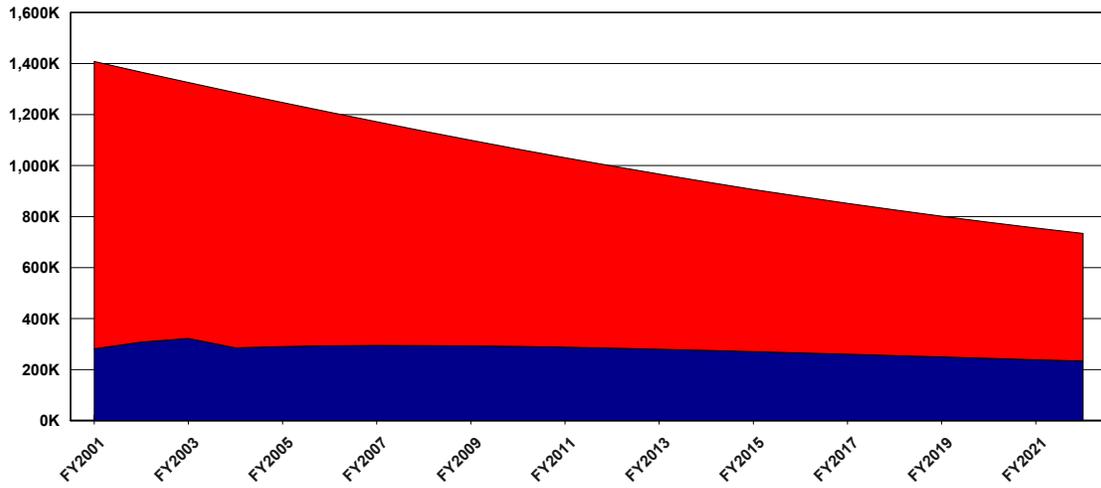
VISN : 22				
Facility	Primary	Hospital	Tertiary	Other
Loma Linda				
605 Loma Linda VAMC	✓	✓	✓	-
605GA Victorville	✓	-	-	-
605GB Sun City	✓	-	-	-
605GC Palm Desert	✓	-	-	-
605GD Corona (Riverside County) CA	✓	-	-	-
605GE Upland	✓	-	-	-
Long Beach				
600 Long Beach HCS	✓	✓	✓	-
600GA Anaheim	✓	-	-	-
600GB Santa Ana	✓	-	-	-
600GC Cabrillo (Long Beach)	✓	-	-	-
600GD Sante Fe Springs/Whittier	✓	-	-	-
San Diego				
664 San Diego HCS	✓	✓	✓	-
664BY Mission Valley	✓	-	-	-
664GA El Centro	✓	-	-	-
664GB Vista	✓	-	-	-
664GC Chula Vista	✓	-	-	-
664GD Escondido	✓	-	-	-
West LA				
691 Greater Los Angeles HCS	✓	✓	✓	-
691A4 Sepulveda	✓	-	-	-
691GB Santa Barbara	✓	-	-	-
691GC Gardena	✓	-	-	-
691GD Bakersfield	✓	-	-	-
691GE Los Angeles	✓	-	-	-
691GF EAST LOS ANGELES CLINIC	✓	-	-	-

691GG Antelope Valley	✓	-	-	-
691GI Culver City	✓	-	-	-
691GK San Luis Obispo	✓	-	-	-
691GL Lompoc	✓	-	-	-
691GM Port Hueneme	✓	-	-	-
691GO San Gabriel	✓	-	-	-

c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
California Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
N	Access to Primary Care					
N	Access to Hospital Care					
N	Access to Tertiary Care					
Y	Primary Care Outpatient Stops	Population Based	533,814	79%	297,108	44%
		Treating Facility Based	499,288	71%	268,797	38%
Y	Specialty Care Outpatient Stops	Population Based	547,241	83%	375,535	57%
		Treating Facility Based	534,252	79%	367,249	54%
N	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	4,439	1%	248	0%
Y	Medicine Inpatient Beds	Population Based	97	37%	16	6%
		Treating Facility Based	90	33%	12	4%
N	Surgery Inpatient Beds	Population Based	-4	-2%	-38	-24%
		Treating Facility Based	-6	-4%	-40	-24%
Y	Psychiatry Inpatient Beds	Population Based	-26	-12%	-75	-35%
		Treating Facility Based	-26	-12%	-74	-34%

e. Stakeholder Information

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

Stakeholder Narrative:

California Market: The concerns/comments of the Stakeholders in the California Market were dependent on their home VA facility. At Loma Linda and San Diego, stakeholders were concerned about wait times for care, parking problems and the lack of research space. All of these concerns were addressed in the CARES Market Plan. The construction of clinical additions at both sites was recommended to provide more space for the efficient provision of care and reduction in wait times. The construction of parking decks and additional research space was also included at both sites. At both Long Beach and Greater Los Angeles stakeholders were concerned about how decisions will be made on excess land and space. This concern was most pronounced at Greater Los Angeles where community stakeholders expressed a desire to have a decision making role in the process, to have the plan be more long range rather than incremental reflecting a true master planning process and to have more time to develop the ideal process. Veterans groups want excess land to be used in accordance with its original intent, for veterans, and that commercial development should be very carefully studied to ensure appropriate benefit to VA and veterans. The wide variety of stakeholder concerns regarding excess land were considered in developing the Land Use Planning Committee Charter submitted with the CARES Market Plan.

The Planning Initiative to convert 30 acute SCI beds at Long Beach to long-term care beds is opposed by the PVA/CPVA Representatives in the Network. They believe an additional 30 long term care SCI beds should be added with no change to the number of acute beds. We have not addressed these comments as they conflict with the Planning Initiative. The Planning Initiative to place a 24-bed Blind Rehabilitation Center in Network 22 has generated a number of comments from stakeholders. All stakeholders agree that the Network needs additional services for blind veterans. Most agree that adding more outpatient services at each facility would be ideal. Establishing an inpatient Blind Rehabilitation Center in the Network is not as universally accepted. Locating an inpatient center at either Long Beach or Greater Los Angeles has stakeholder support with the preferred location dependant on the home facility of the stakeholder. Travel time and travel reimbursement is also a major concern for these veterans. This concern drives their desire to have more services provided in their local community by VA or contract. Long Beach was selected by the Network as the preferred site for an inpatient unit due to its central location, proximity to the large number of veterans in Los Angeles and Orange Counties and its current emphasis on addressing the needs of special populations such as SCI, Prosthetics and Rehabilitation. Additional time to weigh the options and consider the appropriate model of care is needed to address this Planning Initiative.

f. Shared Market Discussion

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

Shared Market Narrative:

Inyo County in the California Market is shared by both VISN 22 and VISN 21. Since 56% of the patients are treated in VISN 22, Inyo County will remain in VISN 22 for CARES purposes but patients will continue to choose which facility they prefer for their care.

g. Overview of Market Plan

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

Executive Summary Narrative:

The California Market consists of San Diego, Imperial, San Bernardino, Riverside, Orange, Los Angeles, Inyo, Ventura, San Luis Obispo, and Kern counties. The market consists of three submarkets; the Coastal Submarket (includes the Greater Los Angeles HCS and the Long Beach HCS and their community clinics), the Inland Submarket (Loma Linda and its community clinics), and the Southern Submarket (San Diego and its community clinics). Inyo County is the smallest and only shared county with VISN

Greater Los Angeles will require Nursing Home Care Unit upgrades to meet Long Term Care (LTC) facility standards. Nursing Home needs can be met through contracting with the community, occupying a portion of the State Veterans Home, or by renovating currently existing space. The State of California has an approved project to construct a 500-bed LTC facility on the West Los Angeles campus. A replacement of the West Los Angeles nursing home buildings with a new one-story, state-of-the-art, 180-bed NHCU is proposed.

Market projections support a proposal for a 24-bed Blind Rehabilitation Unit within the Network. Currently, all demand for these services are referred outside of the Network.

Spinal Cord Injury (SCI) patients will continue to be referred to either Long Beach or San Diego SCI centers and 30 SCI beds at Long Beach will be converted from acute to LTC beds. Conversion of SCI/D beds from acute to long term will require an increase in current funding levels to support full occupancy. Acute SCI bed needs are projected to decline in VISN 22, but the decreases are offset by increases in LTC beds.

The following locations have seismic projects with authorization to proceed with Schematic Design. Facility, building, and estimated total project cost are listed in respective order for each project:

1. Long Beach, Bldg 128, \$13,700,000
2. Long Beach, Bldg 133, \$7,400,000
3. GLA, Bldg 300, \$5,400,000 (Verify variance with listed \$3,900,000 estimate)
4. GLA, Bldg 114, \$5,400,000 (Verify variance with listed \$4,100,000 estimate)
5. GLA Bldg 500/501 is authorized to proceed up to Design Development

At GLA, correction of seismic structural deficiencies is necessary for Building 500 and 501. Building 500 is the largest at-risk building in VHA. At San Diego, Building 1 is authorized to proceed up to Schematic Development. The project will retrofit existing seismic structures, add new structural elements to correct code deficiencies and mitigate life safety hazards and to allow for this essential facility to remain in operation in case of a seismic event. At Long Beach, the only project falling out is the '402' project involving Building 126OP and Building 7. This project presently does not have authorization to proceed with Schematics and the facility will need to pursue with VACO. The project will seismically upgrade/retrofit 36,000 GSF in existing Building 7 and provide additional 24,000 GSF of new space. Upon completion of Project 401 to consolidate clinical services and close Building 122, Building 7 will be essential to the Medical Center's mission. At Loma Linda, the proposed strategy is the construction of a 281,000 dgsf Clinical & Research Addition on campus. There are other clinical and administrative gaps at Loma Linda, which could be resolved by moving research functions from the main building into a separate building designated specifically for research. Research space in Bldg 1 is not contiguous and will be backfilled by adjacent administrative and/or clinical services. For San Diego, the proposed strategy is the construction of a 260,000 dgsf Research Addition on campus. San Diego currently CARES has identified Excess Land Use as a Planning Initiative at West LA and Long Beach. In regards to "One VA" collaboration, the National Cemetery Administration has approached GLA and is potentially interested in 20 acres on the West Los Angeles campus for a cemetery columbarium structure.

2. Resolution of Market Level Planning Initiatives: Access

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

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

Access Narrative:

Quality of care is not affected.

Guidelines:

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

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

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

3. Facility Level Information – Loma Linda

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

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

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

Proximity Narrative:

Loma Linda/Greater Los Angeles (GLA):

It is proposed that Loma Linda and Greater Los Angeles retain each facility (Option A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: Loma Linda and Network have already implemented administrative consolidations including the Network Business Center and Decision Support System (DSS). We have also initiated administrative consolidations with Human Resources, Fiscal, Information Technology, and OWCP. One clinical consolidation – prosthetics has been completed within the Network. Along with the Network administrative consolidations, Loma Linda will continue to consolidate clinical functions with GLA in Laboratory, Radiology, Cardiac Surgery, and Radiation Therapy. Although Loma Linda/GLA meet the access standards, the 76-mile drive takes a minimum of 1.5 hours one-way and a commute via public transportation takes 3.75 hours one way. The second (Alternative Option #C) but not preferred option is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either Loma Linda or GLA. Based on capacity, mission, and workload, consolidation of services does not make sense.

Loma Linda/Long Beach:

It is proposed that Loma Linda and Long Beach retain each facility (Option A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: Loma Linda and the Network have already implemented administrative consolidations as indicated above under Loma Linda/GLA. Along with the Network administrative consolidations, Loma Linda will continue to consolidate clinical functions with Long Beach in Laboratory, Radiology, Radiation Therapy, and Spinal Cord Injury. Although Loma Linda and Long Beach meet the access

standards, the 76-mile drive takes a minimum of 1.5 hours one-way and a commute via public transportation takes 3.75 hours one way. Alternative Option #C: The second but not preferred option is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either Loma Linda or Long Beach (refer to the workload analysis under Option #A). Based on capacity, mission, and workload, consolidation of services does not make sense.

Loma Linda/San Diego:

It is proposed that Loma Linda and San Diego retain each facility (Alternative Option #A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: Loma Linda and Network have already implemented administrative consolidations as indicated previously. Along with the Network administrative consolidations, Loma Linda will continue to consolidate clinical functions with San Diego in Laboratory, Radiology, Cardiac Surgery, Inpatient Psychiatry, and Radiation Therapy. Although Loma Linda and San Diego meet the access standards, the 105-mile drive takes a minimum of 2 hours one way and a commute via public transportation takes 2-3 hours one way. The second but not preferred option (Alternative Option C) is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either Loma Linda or San Diego. Based on capacity, mission, and workload, consolidation of services does not make sense.

Resolution Narrative of Small Facility PI

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

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

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

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

DOD Narrative:

The VISN VA/DoD Committee has identified a potential outpatient, primary care collaboration between the VA Loma Linda HCS and the Twenty Nine Palms Marine Base. Loma Linda is approaching a sufficient number of patients to meet the criteria to open a new Community Clinic in the Twenty Nine Palms/Yucca Valley area. Since Twenty Nine Palms already has an MTF, along with its Naval Hospital, this might be an opportunity to share a clinic with Twenty Nine Palms and have them treat our patients at that facility rather than open a new Community Clinic on our own. This was a recent issue and is not an alternative to fill a specific CARES gap.

The VISN VA/DoD Committee has identified a potential outpatient, primary care collaboration between both the Greater Los Angeles HCS and the VA Loma Linda HCS and the DoD MTF in China Lake near Ridgecrest. Veteran patients in the Ridgecrest zip code travel a long distance to either the GLA facility or the Loma Linda facility for their outpatient care. Since China Lake MTF is in Ridgecrest, perhaps GLA and Loma Linda patients could go to the China Lake MTF via a sharing opportunity with DoD. Additionally, patients from Lake Isabella, who currently are treated by a local provider or who travel to the Bakersfield Community Clinic, may also be willing to travel to Ridgecrest for their care. Multiple opportunities could be explored between the facilities involved. This was a recent issue and is not an alternative to fill a specific CARES gap

VBA Collaborative Opportunities

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

VBA Narrative:

No Impact

NCA Collaborative Opportunities

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

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

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

Enhanced Use Narrative:

All southern California campuses were identified as potential sites for Enhanced Use Lease Opportunities. The Network approach to this initiative is the development of a VISN 22 Excess Land Use Policy to be submitted in the CARES Market Plan. This policy will provide planning & zoning guidance developed with stakeholder input (including Homeowner Associations, and local government representatives) to ensure proposed developments are viable Enhanced Use projects.

Resolution of VISN Identified PIs

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

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

VISN Identified Planning Initiatives Narrative:

Condition of research space: For the VA Loma Linda Healthcare System, the proposed strategy for resolving clinical capacity, research, and administrative gaps in the Inland Submarket of the California Market is the construction of a 281,000 sqsf Clinical & Research Addition on campus. Research can occupy 45,000 sf. The existing Research space in Bldg 1 is not contiguous and will be backfilled by adjacent administrative and/or clinical services.

The only alternate considered was status quo, e.g., Research remains in Bldg 1, and admin space is built in the new addition. This resulted in dysfunctional arrangement, and therefore not considered.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections	(from projections)	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
INPATIENT CARE	FY 2012	from 2001										
Medicine	22,604	3,635	22,604	3,635	1,200	-	-	-	-	-	21,404	\$ (3,305,161)
Surgery	8,722	(1,575)	8,723	(1,574)	410	-	-	-	-	-	8,313	\$ 430,727
Intermediate/NHCU	100,235	-	100,235	-	61,144	-	-	-	-	-	39,091	\$ -
Psychiatry	6,233	1,752	6,233	1,752	554	-	-	-	-	-	5,679	\$ 660,251
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
Total	137,794	3,812	137,795	3,813	63,308	-	-	-	-	-	74,487	\$ (2,214,183)
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections	(from projections)	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
OUTPATIENT CARE	FY 2012	from 2001										
Primary Care	218,783	62,207	218,783	62,207	82,677	-	-	-	-	-	136,106	\$ 34,067,113
Specialty Care	229,933	104,482	229,933	104,482	11,345	-	-	-	-	-	218,588	\$ (25,479,504)
Mental Health	76,886	1,822	76,887	1,822	2,490	-	-	-	-	-	74,397	\$ (5,125,768)
Ancillary & Diagnostics	275,231	142,783	275,232	142,784	6,746	-	-	-	-	-	268,486	\$ (19,792,540)
Total	800,833	311,293	800,835	311,295	103,258	-	-	-	-	-	697,577	\$ (16,330,699)

Proposed Management of Space – FY 2012

		Space (GSF) proposed by Market Plans in VISN										
Space (GSF) (from demand projections)		Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012											
INPATIENT CARE												
Medicine	45,136	16,246	44,520	15,630	28,890	4,737	-	-	-	-	33,627	(10,893)
Surgery	13,756	(2,159)	13,800	(2,115)	15,915	-	-	-	-	-	15,915	2,115
Intermediate Care/NHCU	43,780	-	43,779	(1)	43,780	-	-	-	-	-	43,780	1
Psychiatry	13,992	1,342	13,857	1,207	12,650	-	-	-	-	-	12,650	(1,207)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	116,664	15,429	115,956	14,721	101,235	4,737	-	-	-	-	105,972	(9,984)
		Space (GSF) proposed by Market Plan										
Space (GSF) (from demand projections)		Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012											
OUTPATIENT CARE												
Primary Care	103,922	59,168	68,053	23,299	44,754	-	10,000	-	-	-	54,754	(13,299)
Specialty Care	240,280	150,790	240,447	150,957	89,490	-	115,000	-	-	-	204,490	(35,957)
Mental Health	41,019	16,974	40,918	16,873	24,045	-	16,000	-	-	-	40,045	(873)
Ancillary and Diagnostics	183,415	124,340	182,570	123,495	59,075	-	95,000	-	-	-	154,075	(28,495)
Total	568,636	351,272	531,988	314,624	217,364	-	236,000	-	-	-	453,364	(78,624)
NON-CLINICAL												
Research	-	(53,187)	43,939	(9,248)	53,187	-	45,000	-	-	-	98,187	54,248
Administrative	258,470	127,389	200,000	68,919	131,081	40,000	-	-	-	-	171,081	(28,919)
Other	13,826	-	13,826	-	13,826	-	-	-	-	100,000	113,826	100,000
Total	272,296	74,202	257,765	59,671	198,094	40,000	45,000	-	-	100,000	383,094	125,329

4. Facility Level Information – Long Beach

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

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

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

Proximity Narrative:

Long Beach/Loma Linda:

It is proposed that Long Beach and Loma Linda retain each facility (Option A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: Long Beach and the Network have already implemented administrative consolidations including the Network Business Center and Decision Support System (DSS). We have also initiated administrative consolidations with Human Resources, Fiscal, Information Technology, and OWCP. One clinical consolidation – prosthetics has been completed within the Network. Along with the Network administrative consolidations, Long Beach will continue to provide care to referrals from Loma Linda in Laboratory, Radiology, Radiation Therapy, and Spinal Cord Injury. Although Long Beach/Loma Linda meet the access standards, the 56-mile drive takes a minimum of 1.5 hours one-way and a commute via public transportation takes 3.75 hours one way. The second (Alternative Option #C) but not preferred option is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either Loma Linda or GLA. Based on capacity, mission, and workload, consolidation of services does not make sense.

Long Beach/GLA:

It is proposed that Long Beach and GLA retain each facility (Option C) w/ additional consolidations of services. GLA will become the referral center for more complex care while Long Beach will serve more as the rehabilitation facility. Option #B, closure of one facility, is unacceptable for the following reasons: Long Beach and the Network have already implemented administrative consolidations as indicated above under Loma Linda/GLA. Along with the Network administrative consolidations, Long Beach will continue to consolidate clinical functions with GLA in neurosurgery and interventional

cardiology/cardiac surgery. Although Long Beach and GLA meet the access standards, the 30-mile drive takes a minimum of 1 hour one-way and a commute via public transportation takes 1-1.5 hours one way. Alternative Option #B: The second but not preferred option is to maintain both facilities with no additional consolidation.

Long Beach/San Diego:

It is proposed that Long Beach and San Diego retain each facility (Alternative Option #A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: Long Beach and the Network have already implemented administrative consolidations as indicated previously. Along with the Network administrative consolidations, Long Beach will continue to consolidate clinical functions with San Diego in Neurology and Cardiac Surgery. Although Long Beach and San Diego meet the access standards, the 93-mile drive takes a minimum of 1.5 hours one way and a commute via public transportation takes 2-3 hours one way. The second but not preferred option (Alternative Option C) is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either Loma Linda or San Diego. Based on capacity, mission, and workload, consolidation of services does not make sense.

Resolution Narrative of Small Facility PI

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

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

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

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

DOD Narrative:

No Impact

VBA Collaborative Opportunities

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

VBA Narrative:

No Impact

NCA Collaborative Opportunities

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

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

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

Enhanced Use Narrative:

All southern California campuses were identified as potential sites for Enhanced Use Lease Opportunities. The Network approach to this initiative is the development of a VISN 22 Excess Land Use Policy to be submitted in the CARES Market Plan. This policy will provide planning & zoning guidance developed with stakeholder input (including Homeowner Associations, and local government representatives) to ensure proposed developments are viable Enhanced Use projects.

Resolution of VISN Identified PIs

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

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

VISN Identified Planning Initiatives Narrative:

Seismic: The only project falling out is Long Beach's '402' project involving Building 126OP and Building 7. This project presently does not have authorization to proceed with Schematics. LB will need to pursue with VACO. Project 600-402 Seismic Correction and Clinical Consolidation, Correct Fire/Safety Deficiencies Building 7. The project will seismically upgrade/retrofit 36,000 GSF in existing Building 7 and provide additional 24,000 GSF of new space. The additional space will compensate for overall GSF losses due to required placement of seismic shearwalls and reconfiguration as necessary. This new configuration and space will allow for the relocation of all the surgical specialty clinics from Bldg. 122, which is slated to be demolished under a current project 600-401, and further relocation of ENT, audiology and the inpatient pharmacy from other seismically unsafe buildings. This project centralizes all medical/surgical outpatient functions within this tertiary care Medical Center. This

project consolidates the clinics and services into a seismically safe building located in close proximity to other patient care services. The project cost is estimated at \$24.6 million + asbestos abatement (\$300,000). Total project cost include construction, pre-design development, contingencies, design fees, impact costs, activation costs, construction management costs, and inflation.

Probability of significant seismic event – US Geological Survey shown that fault lines run directly through the site of the VA Long Beach, which could caused sever damage if a significant earthquake occurs.

Excess land use: The Network has established a Land Use Planning committee and process that will address all land use issues in Network 22. The Land Use Planning Committee is charged with addressing land use issues and developing a criteria based process for re-use of excess land located within the VA Desert Pacific Healthcare Network. The Committee will evaluate excess land available for re-use, provided developments are in compliance with established guidelines. The Committee will establish a formal process whereby stakeholder input will be obtained on each project under consideration. Any excess land use would have to comply with this policy.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections		(from projections)									
INPATIENT CARE	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Medicine	24,199	6,452	24,200	6,453	5,000	-	-	-	-	-	19,200	\$ (7,697,092)
Surgery	9,669	(1,296)	9,670	(1,295)	39	-	-	-	-	-	9,631	\$ (567,652)
Intermediate/NHCU	68,208	-	68,208	-	34,787	-	-	-	-	-	33,421	\$ (2,903,642)
Psychiatry	6,628	(1,752)	6,628	(1,752)	-	-	-	-	-	-	6,628	\$ (235,465)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	23,839	-	23,839	-	-	-	-	-	-	-	23,839	\$ (2,207,464)
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ (2,276,447)
Total	132,543	3,404	132,545	3,406	39,826	-	-	-	-	-	92,719	\$ (15,887,762)
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections		(from projections)									
OUTPATIENT CARE	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Primary Care	252,075	101,963	252,075	101,963	155,000	-	-	-	-	-	97,075	\$ 104,820,137
Specialty Care	255,009	107,442	255,010	107,443	110,000	-	-	-	-	-	145,010	\$ 98,214,423
Mental Health	62,269	1,399	62,269	1,400	2,453	-	-	-	-	-	59,816	\$ (11,514)
Ancillary & Diagnostics	417,061	221,261	417,061	221,261	220,000	-	-	-	-	-	197,061	\$ (4,829,412)
Total	986,414	432,066	986,415	432,067	487,453	-	-	-	-	-	498,962	\$ 198,193,634

Proposed Management of Space – FY 2012

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
INPATIENT CARE	FY 2012										
Medicine	55,418	21,837	43,968	10,387	33,581	-	-	-	-	33,581	(10,387)
Surgery	17,503	(390)	17,432	(461)	17,893	-	-	-	-	17,893	461
Intermediate Care/NHCU	64,153	-	64,151	(2)	64,153	-	-	-	-	64,153	2
Psychiatry	10,737	2,628	10,737	2,628	1,900	-	-	-	-	10,009	(728)
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	(96,631)	96,631	-	96,631	-	-	-	-	96,631	-
Blind Rehab	96,631	96,631	12,500	12,500	-	12,500	-	-	-	12,500	-
Total	244,442	24,075	245,419	25,052	1,900	12,500	-	-	-	234,767	(10,652)
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
OUTPATIENT CARE	FY 2012										
Primary Care	113,434	76,791	48,538	11,895	-	-	-	-	-	36,643	(11,895)
Specialty Care	263,680	143,387	159,511	39,218	-	-	-	-	-	120,293	(39,218)
Mental Health	43,040	(11,376)	43,068	(11,348)	-	-	-	-	-	54,416	11,348
Ancillary and Diagnostics	264,250	169,290	126,119	31,159	-	-	-	-	-	94,960	(31,159)
Total	684,404	378,092	377,236	70,924	-	-	-	-	-	306,312	(70,924)
NON-CLINICAL	FY 2012										
Research	-	(57,880)	57,966	86	-	-	-	-	-	57,880	(86)
Administrative	552,567	223,723	381,148	52,304	-	120,000	-	-	-	448,844	67,696
Other	79,594	-	79,594	-	-	15,000	-	-	-	94,594	15,000
Total	632,161	165,843	518,708	52,390	-	135,000	-	-	-	601,318	82,610

5. Facility Level Information – San Diego

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

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

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

Proximity Narrative:

San Diego/Loma Linda:

It is proposed that Long Beach and Loma Linda retain each facility (Option A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: San Diego and the Network have already implemented administrative consolidations including the Network Business Center and Decision Support System (DSS). We have also initiated administrative consolidations with Human Resources, Fiscal, Information Technology, and OWCP. One clinical consolidation – prosthetics has been completed within the Network. Along with the Network administrative consolidations, San Diego will continue to provide care to referrals from Loma Linda in Laboratory, Radiology, Radiation Therapy, and Cardiac Surgery. Although San Diego and Loma Linda meet the access standards, the 122-mile drive takes a minimum of 2 hours one-way and a commute via the minimal public transportation takes 2-3 hours one way. The second (Alternative Option #C) but not preferred option is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either Loma Linda or GLA. Based on capacity, mission, and workload, consolidation of services does not make sense.

San Diego/Long Beach:

It is proposed that San Diego and Long Beach retain each facility (Alternative Option #A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: San Diego and the Network have already implemented administrative consolidations as indicated previously. Along with the Network administrative consolidations, San Diego will continue to provide care for patients referred for Interventional Cardiology/Cardiac Surgery and Neurosurgery.

Although San Diego and Long Beach meet the access standards, the 110-mile drive takes a minimum of 2 hours one-way and a commute via the minimal public transportation takes 2-3 hours one way. The second (Alternative Option #C) but not preferred option is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either San Diego or Long Beach. Based on capacity, mission, and workload, consolidation of services does not make sense.

Resolution Narrative of Small Facility PI

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

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

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

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

DOD Narrative:

The VA San Diego HCS has an overarching sharing agreement for services with the Balboa Naval Medical Center in San Diego. The Naval Medical Center was one of the CARES alternatives considered to resolve the inpatient medical gap for San Diego. However, this remains an alternate because of Balboa's staff availability due to military operations' support. Ongoing discussions with VA and DOD continue via VISN 22 VA-DOD committee which includes DOD TRICARE Region 9 and senior VA officials.

VBA Collaborative Opportunities

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

VBA Narrative:

No Impact

NCA Collaborative Opportunities

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

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

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

Enhanced Use Narrative:

All southern California campuses were identified as potential sites for Enhanced Use Lease Opportunities. The Network approach to this initiative is the development of a VISN 22 Excess Land Use Policy to be submitted in the CARES Market Plan. This policy will provide planning & zoning guidance developed with stakeholder input (including Homeowner Associations, and local government representatives) to ensure proposed developments are viable Enhanced Use projects.

Resolution of VISN Identified PIs

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

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

VISN Identified Planning Initiatives Narrative:

Condition of research space: For the VA San Diego Healthcare System, the proposed strategy for resolving research, and administrative gaps in the Southern Submarket of the California Market is the construction of a 260,000 dgsf Research Addition on campus. Research can occupy the entire building as well as the existing space in Bldg.1. The 30,000 sf moved to vacant as part will be backfilled to close the gap in the Administrative category, as well as future termination of existing leased researched space. The only alternate considered was status quo, e.g., Research remains in Bldg 1, and several existing leased sites throughout the community. This resulted in dysfunctional arrangement, and therefore not considered.

Seismic: The project will retrofit existing seismic structures and add new structural elements to correct code deficiencies. The intent of the upgrade is to mitigate life safety hazards and to allow for this essential facility to remain in operation after a seismic event. Code deficiencies include an inability of many structural members to withstand forces now used for design calculations in our risk zone. The project is 100% related to seismic upgrades. Alterations would only occur in areas impacted by the structural changes. Building 1 is classified as an exceptionally high-risk building. Non-structural deficiencies were corrected by a previous project and are not within the scope of this project.

The projected cost for this project is \$47.1 million + asbestos abatement (\$2 million). Magnitude estimate provided by VACO estimating division on 5/29/01. Major cost driver is the size of facility (854,900 gross square feet involved in the project). Base construction costs estimated at \$31.1 million. Total project costs include construction, pre-design development, contingencies, design fees, impact costs, construction management costs, and inflation. Alternatives considered include build a new medical center, lease a new medical center, lease space from other medical centers or contract out, and send patients to other VA facilities (not viable). Technical design alternatives include: Reinforced concrete shear walls (Scheme 1), Steel braced frames (Scheme 2), and unbonded braces (Scheme 3).

The A/E (GLHN) recommends either the steel braced frame or the unbonded brace scheme. Construction costs are similar, but scheme 3 has less impact on facility. The key risk factors is the probability of significant seismic event – fewer earthquakes in San Diego area, however, high risk due to local faults (e.g. Rose Canyon fault). Operational impact severity depends on the scheme selected. Many areas must be vacated to perform the work. Legal & Contractual issues include the use of patented unbonded brace technology which is owned by a foreign company. A previous study dated June 1, 1996 includes site-specific geotechnical study determined earthquake response spectra including maximum ground acceleration factor.

In a report dated February 18, 1997, Degenkolb confirmed design deficiencies and developed a concrete shear wall scheme. On April 7, 2000, GLHN presented an in-depth study to evaluate other structural schemes. Scheme 3 was favored, but sole source concerns were raised.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

# BDOCs proposed by Market Plans in VISN														
	# BDOCs demand projections		(from projections)											
INPATIENT CARE	FY 2012	2013	Variance from 2001	from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Medicine	20,241	5,807	398	10,788	20,241	5,807	199	-	-	-	-	-	20,042	\$ 1,446,511
Surgery	10,788	398	-	96,886	10,788	398	71	-	-	-	-	-	10,717	\$ (1,700,398)
Intermediate/NHCU	96,886	-	-	15,037	96,886	-	85,260	-	-	-	-	-	11,626	\$ (2,025,588)
Psychiatry	15,037	(3,540)	-	-	15,037	(3,540)	672	-	-	-	-	-	14,365	\$ 2,984,011
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	5,747	-	-	5,747	5,747	-	-	-	-	-	-	-	5,747	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -
Total	148,699	2,665	2,665	148,699	148,699	2,665	86,202	-	-	-	-	-	62,497	\$ 704,536
Clinic Stops proposed by Market Plans in VISN														
	Clinic Stops demand projections		(from projections)											
OUTPATIENT CARE	FY 2012	2013	Variance from 2001	from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
Primary Care	249,320	128,361	91,559	258,692	249,321	128,361	18,944	-	-	-	-	-	230,377	\$ 5,765,292
Specialty Care	258,692	91,559	-	79,596	258,692	91,559	10,348	-	-	-	-	-	248,344	\$ (21,369,472)
Mental Health	79,595	1,261	-	335,398	79,596	1,262	8,036	-	-	-	-	-	71,560	\$ 66,446
Ancillary & Diagnostics	335,398	175,956	-	923,007	335,398	175,956	12,395	-	-	-	-	-	323,003	\$ (25,312,188)
Total	923,005	397,136	397,136	923,007	923,007	397,139	49,723	-	-	-	-	-	873,284	\$ (40,849,922)

Proposed Management of Space – FY 2012

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
INPATIENT CARE	FY 2012										
Medicine	18,294	41,687	18,301	23,386	8,841	-	-	-	-	32,227	(9,460)
Surgery	6,322	22,720	6,400	16,320	1,273	-	-	-	-	17,593	(5,127)
Intermediate Care/NHCU	-	15,633	-	15,633	-	-	-	-	-	15,633	-
Psychiatry	9,517	35,051	9,345	25,706	2,835	-	-	-	-	28,541	(6,510)
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	(21,972)	21,972	-	21,972	-	-	-	-	-	21,972	-
Blind Rehab	21,972	-	-	-	-	-	-	-	-	-	-
Total	34,133	137,063	34,046	103,017	12,949	-	-	-	-	115,966	(21,097)
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
OUTPATIENT CARE	FY 2012										
Primary Care	75,474	129,011	74,639	54,372	-	-	-	46,000	-	100,372	(28,639)
Specialty Care	152,196	273,178	152,195	120,983	-	-	25,000	85,000	-	230,983	(42,195)
Mental Health	(13,225)	39,358	(13,267)	52,625	-	-	-	-	-	52,625	13,267
Ancillary and Diagnostics	126,175	206,722	126,828	79,894	-	-	-	76,000	-	155,894	(50,828)
Total	340,620	648,269	340,395	307,874	-	-	25,000	207,000	-	539,874	(108,395)
NON-CLINICAL	FY 2012										
Research	(113,698)	341,580	227,882	113,698	-	260,000	-	-	-	373,698	32,118
Administrative	157,445	327,000	106,722	220,278	30,000	-	-	-	-	250,278	(76,722)
Other	-	29,555	-	29,555	-	-	-	-	800,975	830,530	800,975
Total	43,747	698,135	334,604	363,531	30,000	260,000	-	-	800,975	1,454,506	756,371

6. Facility Level Information – West LA

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

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

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

Proximity Narrative:

Greater Los Angeles/Loma Linda:

It is proposed that Greater Los Angeles (GLA) and Loma Linda retain each facility (Option A) w/ no additional consolidations of services beyond those services currently consolidated. Option #B, closure of one facility, is unacceptable for the following reasons: GLA and the Network have already implemented administrative consolidations including the Network Business Center and Decision Support System (DSS). We have also initiated administrative consolidations with Human Resources, Fiscal, Information Technology, and OWCP. One clinical consolidation – prosthetics has been completed within the Network. Along with the Network administrative consolidations, Loma Linda will continue to refer patients to GLA for the clinical functions of Laboratory, Radiology, Cardiac Surgery, and Radiation Therapy. Although Loma Linda/GLA meet the access standards, the 76-mile drive takes a minimum of 1.5 hours one-way and a commute via public transportation takes 3.75 hours one way. The second (Alternative Option #C) but not preferred option is to maintain both facilities but consolidate services/integrate facilities. Under Option #C, there would be no impact on the missions of either GLA or Loma Linda. Based on capacity, mission, and workload, consolidation of services does not make sense.

GLA/Long Beach:

It is proposed that GLA and Long Beach retain each facility (Option C) w/ additional consolidations of services. GLA will become the referral center for more complex care while Long Beach will serve more as the rehabilitation facility. Option #B, closure of one facility, is unacceptable for the following reasons: GLA and the Network have already implemented administrative consolidations as indicated above under GLA/Loma Linda. Along with the Network administrative consolidations, GLA will continue to consolidate clinical

functions with Long Beach in Neurosurgery and Interventional Cardiology/Cardiac Surgery. Although GLA and Long Beach meet the access standards, the 30-mile drive takes a minimum of 1 hour one-way and a commute via public transportation takes 1-1.5 hours one way. Alternative Option #B: The second but not preferred option is to maintain both facilities with no additional consolidation.

Resolution Narrative of Small Facility PI

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

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

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

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

DOD Narrative:

The VISN VA/DoD Committee has identified a potential outpatient, primary care collaboration between the the VA Greater Los Angeles HCS' Lompoc Community Clinic and the DoD Medical Treatment Facility (MTF) at Vandenburg Air Force Base. This was a recent issue and is not an alternative to fill a specific CARES gap.

The VISN VA/DoD Committee has identified a potential outpatient, primary care collaboration between both the Greater Los Angeles HCS and the VA Loma Linda HCS and the DoD MTF in China Lake near Ridgecrest. Veteran patients in the Ridgecrest zip code travel a long distance to either the GLA facility or the Loma Linda facility for their outpatient care. Since China Lake MTF is in Ridgecrest, perhaps GLA and Loma Linda patients could go to the China Lake

MTF via a sharing opportunity with DoD. Additionally, patients from Lake Isabella, who currently are treated by a local provider or who travel to the Bakersfield Community Clinic, may also be willing to travel to Ridgecrest for their care. Multiple opportunities could be explored between the facilities involved. This was a recent issue and is not an alternative to fill a specific CARES gap

VBA Collaborative Opportunities

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

VBA Narrative:

Greater Los Angeles has been approved for new construction. Per discussion with VBA, a new building on the campus at West LA will be accomplished through an enhanced-use project. Discussions are on-going with VBA for including approximately 36,000 gross square feet for VAMC use

NCA Collaborative Opportunities

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

NCA Narrative:

NCA to utilize 20 acres of GLA land for a columbarium.

Top Enhanced Use Market Opportunity

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

Enhanced Use Narrative:

All southern California campuses were identified as potential sites for Enhanced Use Lease Opportunities. The Network approach to this initiative is the development of a VISN 22 Excess Land Use Policy to be submitted in the CARES Market Plan. This policy will provide planning & zoning guidance developed with stakeholder input (including Homeowner Associations, and local government representatives) to ensure proposed developments are viable Enhanced Use projects.

Resolution of VISN Identified PIs

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

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

VISN Identified Planning Initiatives Narrative:

Condition of research space is identified as a VISN planning initiative due to the lack of capacity to accommodate additional investigators as well as age and condition of the buildings. The research complex at West LA consists of Buildings 113, 114, and 115 which were all built in 1930. In order to make wet lab space usable requires renovations to accommodate equipment required by modern research techniques. Such renovations require major investments which are not economical given the age of the buildings and the original design.

The GLA research program currently has funding in the amount of approximately \$36 million and has a strong history of accomplishment with numerous nationally and internationally recognized investigators credited with major advances in healthcare. Seismic renovation of an existing 60,000 s.f. research Building 115 and creation of new 50,000 s.f. research building located at the West Los Angeles

Healthcare Center will serve to resolve all non-compliance issues by providing a renovated existing research building in conjunction with a new multi-story, state-of-the-art research addition, using VA space criteria as a minimum, that will total approximately 110,000 s.f. Presently, our medical research buildings are over 70 years old.

Condition of Nursing Home Care Units (NHCU): Existing Nursing Home Care Unit space at GLA is substandard due to the age and design of the buildings. These buildings were not originally built as long term care facilities and are currently inadequate to meet long term care facility standards. Nursing Home needs can be met through contracting with the community, occupying a portion of the State Veterans Home, and by renovating currently existing space. The State of California has an approved project to construct a 500-bed long term care facility on the West Los Angeles campus. A replacement of the West Los Angeles nursing home buildings with a new one-story, state-of-the-art, 180-bed nursing home building is proposed. Both existing nursing home buildings date back to 1938. Although through the years they have been remodeled for nursing home use, it is evident that these buildings have physical limitations, are narrow and multilevel, and are non-conducive for our nursing home function and mission.

Seismic: At GLA, correction of seismic structural deficiencies is necessary for Building 500, the only inpatient building, which also houses outpatient and ancillary services. Correction of seismic deficiencies is also needed for Building 501, the West LA Chiller Plant. Seismic corrections will upgrade both buildings to “essential facility” seismic standards to enable them to resume direct patient care operations immediately after a significant seismic event. This project is 100% related to seismic upgrades and will provide conformance to California Senate Bill SB 1953 which requires that hospital buildings, posing a significant threat to life safety, be removed from service or retrofitted by the year 2008. Building 500 is approximately 937,000 gross square feet and is ranked number 7 in the category of Exceptionally High Risk (EHR) buildings developed by Degenkolb’s EHR Isit only adds up to 750,000 square feet. This makes Building 500 the largest at-risk building in VHA.

Excess land use: The Network has established a Land Use Planning committee and process that will address all land use issues in Network 22. The Land Use Planning Committee is charged with addressing land use issues and developing a criteria based process for re-use of excess land located within the VA Desert Pacific Healthcare Network. The Committee will evaluate excess land available for re-use, provided developments are in compliance with established guidelines. The Committee will establish a formal process whereby stakeholder input will be obtained on each project under consideration.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections		(from projections)									
	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
INPATIENT CARE												
Medicine	45,161	12,041	45,162	12,042	84	-	-	-	-	-	45,078	\$ (23,798,883)
Surgery	19,093	475	19,093	475	12	-	-	-	-	-	19,081	\$ (3,903,163)
Intermediate/NHCU	225,846	-	225,846	-	130,991	-	-	-	-	-	94,855	\$ (23,553,309)
Psychiatry	31,094	(4,680)	31,095	(4,679)	19	-	-	-	-	-	31,076	\$ (3,787,903)
PRRTP	24	-	24	-	-	-	-	-	-	-	24	\$ -
Domiciliary	104,741	-	104,741	-	-	-	-	-	-	-	104,741	\$ (12,710,996)
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
Total	425,959	7,836	425,961	7,838	131,106	-	-	-	-	-	294,855	\$ (67,754,254)
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops demand projections		(from projections)									
	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
OUTPATIENT CARE												
Primary Care	480,170	206,758	480,171	206,759	44,531	-	-	-	-	-	435,640	\$ 24,838,153
Specialty Care	465,101	230,768	465,101	230,769	15,467	-	-	-	-	-	449,634	\$ (17,143,059)
Mental Health	305,869	(44)	305,869	(44)	6,455	-	-	-	-	-	299,414	\$ (11,190,023)
Ancillary & Diagnostics	427,293	131,906	427,294	131,907	6,996	-	-	-	-	-	420,298	\$ (23,110,842)
Total	1,678,433	569,388	1,678,435	569,390	73,449	-	-	-	-	-	1,604,986	\$ (26,605,771)

Proposed Management of Space – FY 2012

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
INPATIENT CARE	FY 2012										
Medicine	98,453	98,270	43,478	54,792	20,000	-	-	-	-	74,792	(23,478)
Surgery	31,694	31,674	4,661	27,013	-	-	-	-	-	27,013	(4,661)
Intermediate Care/NHCU	162,338	162,338	-	162,338	-	130,000	-	-	-	292,338	130,000
Psychiatry	50,374	50,343	(1,156)	51,499	-	-	-	-	-	51,499	1,156
PRRTP	33,330	-	(33,330)	33,330	-	-	-	-	-	33,330	33,330
Domiciliary program	155,913	155,913	-	155,913	-	-	-	-	-	155,913	-
Spinal Cord Injury	(11,000)	11,000	-	11,000	-	-	-	-	-	11,000	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
Total	532,102	509,538	13,653	495,885	20,000	130,000	-	-	-	645,885	136,347
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	Variance from 2001	Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
OUTPATIENT CARE	FY 2012										
Primary Care	230,482	217,820	44,864	172,956	-	53,700	-	16,000	26,000	268,656	50,836
Specialty Care	500,774	499,094	246,870	252,224	-	200,000	-	-	-	452,224	(46,870)
Mental Health	164,863	164,678	36,375	128,303	-	60,000	-	-	-	188,303	23,625
Ancillary and Diagnostics	272,186	273,194	48,959	224,235	-	115,000	-	-	-	339,235	66,041
Total	1,168,306	1,154,786	377,068	777,718	-	428,700	-	16,000	26,000	1,248,418	93,632
NON-CLINICAL	FY 2012										
Research	-	243,336	(196,745)	440,081	-	245,000	-	-	-	685,081	441,745
Administrative	791,981	722,655	88,171	634,484	-	-	-	-	-	634,484	(88,171)
Other	106,928	106,928	-	106,928	-	-	-	-	-	106,928	-
Total	898,909	1,072,919	(108,574)	1,181,493	-	245,000	-	-	-	1,426,493	353,574

B. Nevada Market

1. Description of Market

a. Market Definition

Market	Includes	Rationale	Shared Counties
Nevada Market Code: 22B	Southern Nevada (3 counties): Clark, Lincoln, and Nye Counties.	<p>The Nevada Market includes the southern counties of Clark, Lincoln, and Nye. The primary transportation corridor is Interstate 15 which runs north and south through the market area. Available health care services include primary care, mental health, and inpatient care. Clark County is home to the Southern Nevada Health Care System, and includes the Las Vegas Ambulatory Care Center, VA/DoD shared facility at Nellis AFB, and 3 CBOC's. For CARES analysis, demand projections will need to consider the phenomenal growth occurring in Clark County and the city of Las Vegas.</p> <p>NOTE: The vast majority of veterans in Esmeralda County obtain care at the Sierra Nevada Health Care System, and VISN 21 will take the lead for CARES planning.</p>	Shared county with V21: Esmeralda County, NV NOTE: VISN 21 to take planning lead as 99% market share is in VISN 21.

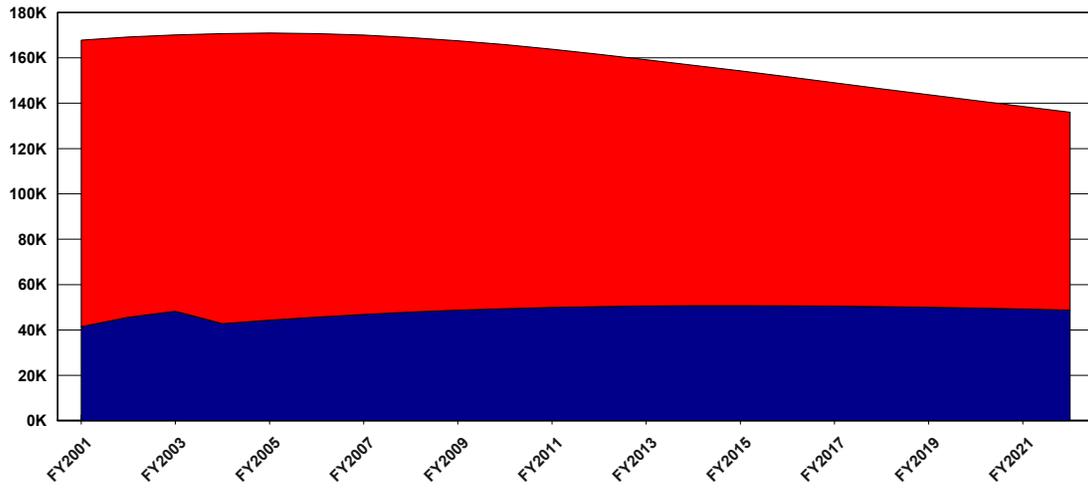
b. Facility List

VISN : 22				
Facility	Primary	Hospital	Tertiary	Other
Las Vegas				
593 Southern Nevada HCS	✓	✓	-	-
593GA Las Vegas Homeless	✓	-	-	-
593GB Henderson	✓	-	-	-
593GC Pahrump	✓	-	-	-

c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Nevada Market			February 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
N	Access to Primary Care					
N	Access to Hospital Care					
N	Access to Tertiary Care					
Y	Primary Care Outpatient Stops	Population Based	68,742	62%	54,931	50%
		Treating Facility Based	59,919	49%	42,913	35%
Y	Specialty Care Outpatient Stops	Population Based	96,341	112%	92,869	108%
		Treating Facility Based	104,804	120%	97,633	112%
N	Mental Health Outpatient Stops	Population Based	25,106	60%	12,567	30%
		Treating Facility Based	25,609	69%	14,762	40%
Y	Medicine Inpatient Beds	Population Based	39	125%	32	103%
		Treating Facility Based	24	91%	19	70%
N	Surgery Inpatient Beds	Population Based	10	48%	7	34%
		Treating Facility Based	4	28%	2	15%
N	Psychiatry Inpatient Beds	Population Based	14	68%	6	31%
		Treating Facility Based	3	21%	-1	-8%

e. Stakeholder Information

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

Stakeholder Narrative:

Nevada Market: Stakeholders in the Nevada market have had very few comments on the CARES Market Plan. They have been focused on the closure of their Ambulatory Care Center, moving care to 10 locations throughout the Las Vegas community and the construction of an appropriately sized replacement facility. They have expressed concern that the CARES projections for the Las Vegas area underestimate what they believe to be the true growth. They also express the need for a VA hospital and nursing home. The CARES Market Plan does include a replacement Ambulatory CARE Center, increased inpatient beds and the need for a VA nursing home.

f. Shared Market Discussion

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

Shared Market Narrative:

Esmeralda County of the Nevada Market patients prefer to obtain treatment at the Reno VAMC, which is in VISN 21. Since over 98% of the patients in the county are treated at Reno and only 2% in Las Vegas, for CARES purposes, we have assigned Esmeralda County to VISN 21 and they will pick this up on their CARES Market Plan.

g. Overview of Market Plan

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

Executive Summary Narrative:

The Nevada Market consists of Clark, Nye and Lincoln Counties. For CARES, demand projections must consider the phenomenal growth occurring in Clark County. Las Vegas in Clark County, NV, is one of the fastest growing markets in the U.S. Clark County is home to the VA Southern Nevada Health Care System, and includes the Las Vegas Ambulatory Care Center, VA/DoD shared acute Federal Hospital at Nellis AFB, and 3 CBOC's. Available health care services include primary care, mental health, and inpatient care. Southern Nevada does not have any small facility, tertiary care or acute care initiatives. Long Term Care is a major gap because no VA Nursing Home Care Unit (NHCU) beds are available within the market, the average age of veterans treated is 61 years, and 42% are age 65 and over, and only community nursing homes (CNH) are available. Contracting with community nursing homes (CNH) in Southern Nevada is limited because of quality of care deficiencies, high CNH occupancy rates, lack of specialized services, and a low number of skilled beds. Although the new Nevada State Veterans Home is being completed in FY03, this will not eliminate the need for a NHCU. The NHCU will be constructed at either the Mike O'Callaghan Federal Hospital or in the surrounding community. Market projections support a proposal for a 24-bed Blind Rehabilitation Unit within the Network. The Nevada market demonstrates a demand for Blind Rehabilitative services and a new center would improve access and better meet patient's needs. Currently, all demand for these services are referred outside of the Network. Southern Nevada Market's patients will be referred to a proposed new inpatient blind rehabilitation unit for their inpatient blind rehabilitation care. As the data supports, VISN 22 shows a 99% increase in demand for these services in 2012 and a 95% increase through 2022. Spinal Cord Injury patients from the Nevada Market will continue to be referred to either the Long Beach or San Diego SCI centers and 30 SCI beds at Long Beach will be converted from acute to long-term care beds. Acute care will require expanded beds within the O'Callahan Federal Hospital as part of the ongoing relationship with DoD at Nellis Air Force Base. Primary Care enrollees will increase from a baseline of 45,375 to 50,333 in FY2012 and then decreases back to 48,749 in FY2022. Growth will be handled through the construction of a new ambulatory care building. Additionally, there are potential opportunities for collaboration with DoD. Stakeholders in the Nevada market have had very few comments on the CARES Market Plan. They have expressed concern that the CARES projections for the Las Vegas area underestimate what they believe to be the true growth. They also express the need for a VA hospital and nursing home.

The CARES Market Plan does include a replacement Ambulatory CARE Center, increased inpatient beds and the need for a VA nursing home. For the VA Southern Nevada Healthcare System, the proposed strategy for resolving CARES gaps includes construction of a new 120-bed unit for the Long Term Care gap, construction of a new Stand Alone Out Patient Clinic (SOPC) for the outpatient gap and expansion of the number of inpatient beds at the Michael O’Callaghan Federal Hospital (MOFH) for the acute care medicine gap. The approved ER Tower Minor Construction project will also add an additional 6 beds to the inpatient allocation of beds. The Nevada Market will have minimal vacant space in FY2022, and MOFH space will be reserved-adjacent. No Historical Structures are involved. In regards to initiatives to support “One VA” partnerships, contingency support arrangements are in place with the Air Force. The proposed Stand Alone Center will provide 14,065 square feet for VBA. Finally, NCA has no known need at this time for collaboration with the facility.

2. Resolution of Market Level Planning Initiatives: Access

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

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

Access Narrative:

No Impact

Guidelines:

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

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

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

3. Facility Level Information – Las Vegas

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

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

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

Proximity Narrative:

No Proximity issue identified in the Nevada Market.

Resolution Narrative of Small Facility PI

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

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

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

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

DOD Narrative:

The Southern Nevada HCS in the Nevada market has an extensive collaboration between the VA and the DOD through the Michael O'Callaghan Federal Hospital. This inpatient facility is divided between the VA-DOD staffed beds with Las Vegas responsible for 52 beds. Additionally, surgical specialty and subspecialty clinics and space are contained in the federal hospital which provides the inpatient acute care for the Nevada market. This extensive collaboration dates back ten years and continues to be a model for the entire VA system.

VBA Collaborative Opportunities

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

VBA Narrative:

At Las Vegas, a VBA/VAH colloaction will occur at the proposed new clinic site in the Las Vegas primary service area.

NCA Collaborative Opportunities

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

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

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

Enhanced Use Narrative:

All southern California campuses were identified as potential sites for Enhanced Use Lease Opportunities. The Network approach to this initiative is the development of a VISN 22 Excess Land Use Policy to be submitted in the CARES Market Plan. This policy will provide planning & zoning guidance developed with stakeholder input (including Homeowner Associations, and local government representatives) to ensure proposed developments are viable Enhanced Use projects.

Resolution of VISN Identified PIs

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

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

VISN Identified Planning Initiatives Narrative:

Condition of Nursing Home Care Units (NHCU): For the VA Southern Nevada Healthcare System (VASNHS), the proposed strategy for resolving a shortage of Nursing Home Care Unit (NHCU) beds in the Nevada Market is to construct a new 120-bed unit. The need for a VA Nursing Home Care Unit (NHCU) in Southern Nevada is based on three significant factors: Rapid veteran population growth in Southern Nevada; Lack of community and VA nursing home capabilities in Southern Nevada; and The average age of veterans treated at VASNHS is 61 years, and 42% are age 65 and over.

Currently, veterans in Southern Nevada can only access nursing home care via contract community nursing homes. Contracting with community nursing homes (CNH) in Southern Nevada is limited due to: Quality of care deficiencies; High CNH occupancy rates ranging from 80% to 96%; Lack of specialized services including ventilator care, sub-acute care, Alzheimer's/Dementia care, and Gero-

psychiatric care; and Low number of skilled beds. In the U.S., the state of Nevada is ranked last with the lowest number of skilled beds per 1,000 persons age 65 and older. Nevada has 22 beds per 1,000, age 65+ with the National average at 54 beds per 1,000, age 65+.

Another point of access that will soon be available to veterans is the new 180-bed Nevada State Veterans Home. A final VA certification inspection will be conducted in April 2003. The State Home certification, combined with the contract nursing home program, will help but will not eliminate the need for a VA Nursing Home Care Unit (NHCU). Utilizing linear regression analysis VASNHS estimates that 153 veterans will be utilizing CNH beds by 2012, and in 2022, the CNH census is estimated to be approximately 268 patients. This estimate is based on the growth of the veteran population in Southern Nevada and the continued demand for nursing home care, which far exceeds community capacity. A 120-bed VA Nursing Home Care Unit would fill the gap for nursing home beds.

A VA NHCU in Southern Nevada would address the current and future demand for nursing home specialized care and services. This includes sub-acute care, Alzheimer's/Dementia care, a locked gero-psychiatric unit, rehabilitative care, and sub-acute care. The addition of a VA NHCU either at the site of the Mike O'Callaghan Federal Hospital (our VA/DoD joint venture site) or in the surrounding community would not only increase our scope of clinical services, but would vastly improve the care and treatment currently available to Southern Nevada veterans.

The alternative is to continue to expand the community nursing home program, however the demand for nursing home beds in the Las Vegas Community is greater than available capacity. The CNH program does not provide for the more complex needs of the VASNHS geriatric population, specifically, geropsych, Alzheimer's and sub-acute patients. This alternative is therefore not feasible.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
	FY 2012	Variance from 2001	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
INPATIENT CARE												
Medicine	15,786	7,524	15,786	7,524	2,586	-	-	-	-	-	13,200	\$ (7,425,778)
Surgery	5,430	1,200	5,431	1,201	1,063	-	-	-	-	-	4,368	\$ 568,525
Intermediate/NHCU	39,268	-	39,268	-	39,268	-	-	-	-	-	-	\$ (18,961,194)
Psychiatry	5,706	981	5,706	981	1,795	-	-	-	-	-	3,911	\$ 1,585,109
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
Total	66,190	9,705	66,191	9,706	44,712	-	-	-	-	-	21,479	\$ (24,233,338)
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
	FY 2012	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
OUTPATIENT CARE												
Primary Care	183,111	59,918	183,112	59,919	5,899	-	-	-	-	-	177,213	\$ (15,745,045)
Specialty Care	192,304	104,804	192,305	104,805	13,141	-	-	-	-	-	179,164	\$ (65,598,818)
Mental Health	62,751	25,608	62,751	25,608	2,861	-	-	-	-	-	59,890	\$ (10,362,409)
Ancillary & Diagnostics	246,169	144,901	246,169	144,901	14,781	-	-	-	-	-	231,388	\$ (30,110,434)
Total	684,335	335,231	684,337	335,233	36,682	-	-	-	-	-	647,655	\$ (121,816,706)

Proposed Management of Space – FY 2012

		Space (GSF) (from demand projections)		Space Driver Projection		Variance fr 2001		Space Needed/ Moved to Vacant	
	FY 2012	Variance from 2001		Space Driver Projection	Variance fr 2001				Space Needed/ Moved to Vacant
INPATIENT CARE									
Medicine	27,847	17,183		27,720	17,056	10,664	14,000	24,664	(3,056)
Surgery	7,212	842		7,251	881	6,370	-	6,370	(881)
Intermediate Care/NHCU	-	-		95,000	95,000	-	-	95,000	-
Psychiatry	9,666	(1,734)		9,465	(1,935)	11,400	-	11,400	1,935
PRRTP	-	-		-	-	-	-	-	-
Domiciliary program	-	-		-	-	-	-	-	-
Spinal Cord Injury	-	-		-	-	-	-	-	-
Blind Rehab	-	-		-	-	-	-	-	-
Total	44,725	16,291		139,436	111,002	28,434	14,000	137,434	(2,002)
		Space (GSF) (from demand projections)		Space Driver Projection		Variance fr 2001		Space Needed/ Moved to Vacant	
OUTPATIENT CARE									
Primary Care	88,809	65,505		88,606	65,302	23,304	-	37,500	2,198
Specialty Care	196,728	166,550		197,080	166,902	30,178	-	148,000	(18,902)
Mental Health	32,787	28,919		32,940	29,072	3,868	-	21,750	(7,322)
Ancillary and Diagnostics	148,095	125,391		148,088	125,384	22,704	-	130,000	4,616
Total	466,420	386,366		466,714	386,660	80,054	30,000	447,304	(19,410)
NON-CLINICAL									
Research	-	(882)		1,063	181	882	-	882	(181)
Administrative	317,457	249,638		145,000	77,181	67,819	-	108,000	30,819
Other	15,493	-		15,493	-	15,493	-	12,000	12,000
Total	332,950	248,756		161,556	77,362	84,194	-	204,194	42,638