

2012 and 2022 had to be less than 40 beds.

Each market with one or more of the 19 identified “small facilities” received the Handbook for Market Plan Development (available in References) to provide instructions for the small facility evaluation process. The guidance required development of a minimum of three scenarios (with an optional fourth or ‘combination’ scenario):

- Retain acute hospital beds;
- Close acute hospital beds and reallocate workload to another VHA facility;
- Close acute hospital beds and implement contracting, sharing or joint venturing for workload in the community;
- Optional: Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

It should be noted that the CARES planning process only addressed the acute care missions of small facilities and did not address the long-term care or chronic psychiatry missions of VA facilities. Therefore, any recommendations refer only to the acute care beds.

Table 8.1. lists the 19 facilities with Small Facility Planning Initiatives that met the selection criteria, which used FY2001 as the base year.⁵²

TABLE 8.1.—SMALL FACILITY PLANNING INITIATIVES

VISN & facility	Baseline beds	Projected 2012	Projected 2022
V03 Hudson Valley	10	13	9
V04 Altoona	19	19	13
V04 Butler	9	10	8
V04 Erie	18	14	10
V06 Beckley	32	15	10
V07 Dublin	33	36	30
V11 Fort Wayne	26	17	14
V11 Saginaw	13	25	20
V15 Poplar Bluff	18	15	11
V16 Muskogee	25	37	29
V17 Kerrville	22	15	12
V18 Prescott	29	28	22
V19 Cheyenne	14	17	14
V19 Grand Junction	23	24	18
V20 Walla Walla*	34	40	36
V23 Des Moines	39	34	24
V23 Hot Springs	31	23	20
V23 Knoxville	27	26	20
V23 St. Cloud	21	26	18

*22 bed Psychiatry Residential Rehab. Program included in 34 beds, actual acute beds are 14.

Review and Recommendations For Small Facility Planning Initiatives

Evaluations of each small facility were incorporated into a criteria-driven checklist for detailed review of each VISN-level proposal submitted. Supplemental data that were considered consisted of the following:

- Cost data and scenario inputs on the VSSC CARES Portal (web-site);
- Patient Satisfaction Survey data from FY2002 (courtesy of the SHEP/PACE Office);
- Lists of surgical procedures performed at each of the small facilities (by volume and code) for FY2001 and FY2002;
- Average bed day of care (BDOC) costs compared to Medicare unit costs for each of the small facilities for Medicine, Surgery, and Psychiatry beds;
- Top diagnosis related group (DRGs) with average length of stay (ALOS) for each small facility;
- Distance to the nearest VA Facility as determined independently (using MapPoint software);

• Literature reviews as appropriate, including Medicare Critical Access Hospital (CAH) Guidance (Appendix N).

A summary of the recommendations from the small facility review follows. Table 8.2 shows the final recommendations on small facilities as recommended for implementation by the Under Secretary of Health. Appendix F includes detailed recommendations for small facilities.

Retain Acute Hospital Beds

Eleven medical centers would retain their acute hospital beds, but would have a restricted “scope of practice” that would limit surgical inpatient beds and intensive care unit beds. Surgery beds would be converted to ‘observation’ beds.

Convert Acute Beds to Critical Access Hospital Model

Seven of the eleven facilities would convert their acute beds to CAH-like model. Several medical centers already met the CAH criteria: low acuity levels; short ALOS (less than four days); a

decreasing number of acute care beds; and few, if any, ICU beds. Nevertheless, of the remaining small facilities reviewed, most showed a longer ALOS (than Medicare), although there was a mixed picture with respect to cost per BDOC (which was lower than contract costs in some, and higher than contract cost for others). Though costs for conversion to a CAH-like operation could not be estimated at the time of the review, such conversions were expected to reduce in-house operating costs. Nonetheless, one of the key drivers in recommending a transition to a CAH-like model of acute care delivery was the expectation that the quality of care and patient outcomes could be improved by:

- Greater coordination of care (at the VISN and Market levels);
- Earlier transfer and/or referral of complex cases; and
- Consolidation of volume-dependent cases in tertiary care facilities.

Other overriding factors supporting the “retain acute bed” option included a facility’s role as a local health care

⁵² Based upon BDOC projections after updating for Census 2000 in January 2003.