

TABLE 8.2.—SMALL FACILITY RECOMMENDATIONS—Continued

Facility	VISN	Retain acute beds*	Convert to 'CAH-like' model	Contract and/or refer	Decrease and/or re-view surgery	Close or re-view ICU beds	Comments
Converting to contract/referral or consolidation.	8	
Total facilities reviewed.	19	

* Except ICU & surgery beds.

** Acute Psychiatry beds will remain open.

Conclusions

The transition from an emphasis on inpatient care to outpatient care has been based upon advances in medical technology and therapy. In addition, for the VA, declining inpatient care has been coupled with an expansion of primary care, outpatient specialty care (especially ambulatory or 'same day' surgery), and better case management. The trend towards more sophisticated imaging and advances in invasive techniques, which shorten hospital stays but require the investment in expensive major equipment, has led to a further consolidation of care in tertiary care facilities of more complex cases. Optimal and efficient functioning of the VA's health care delivery system depends upon early referral and transfer of patients with complicated conditions and those requiring major surgery, where outcomes may be volume-dependent.

These trends have led to declines in bed days of care in smaller facilities to the point at which staff proficiency and outcomes may be compromised in low-volume sites. Moreover, economies of scale in provision of the latest medical and imaging technology cannot be realized. Nevertheless, many small VA medical centers (VAMCs) are important providers of health care in their communities. Several have already managed to achieve an appropriate level of functioning by decreasing their ALOS and early referral of patients with conditions beyond their scope of services. Others (by choice or through recommendation) would close their acute beds and manage acute patients through a combination of referral to other VAMCs and to community hospitals. The specific solutions to the issues of access to acute care depend upon the location of the facility and the availability and quality of alternative health care providers.

In response to the impact of the changes described above, many private sector rural hospitals closed or became

no longer viable. In an effort to support access to acute care in rural areas, CMS began funding "Critical Access Hospitals" through Medicare in 1999. Reimbursement under Medicare was linked to meeting certain criteria and operational standards, as well as JCAHO accreditation (from 2002 onwards).⁵³

The CARES review of small facilities in the VA has proposed a CAH-like process of designating small facilities, requiring that they meet certain operational standards and restricting their "scope of practice." The intent of this process would be to improve the efficiency, effectiveness, and to enhance the level of functioning of, small facilities within the context of VA's national system of health care delivery. Over the course of the next year, the VA will develop and implement policies to govern the operation of acute beds in small VA facilities, which may fit into a CAH-like model of health care delivery.

Chapter 9: Proximity and Campus Realignments

Facility Placement

In recent years, site selection for VA health care facilities has been supported by careful planning, from needs assessment and demographic analyses, to evaluation of area transportation networks and, of course, careful consideration of the proximity of other VA medical service capacity.

But the placement of medical facilities for veterans has not always been so discriminating. In fact, many VA facilities owe their location less to prudent study than to historic happenstance. For example, the veterans health system had no choice whatsoever in the location of an entire chain of hospitals it acquired en masse from the Public Health Service via

⁵³ Note: According to a GAO study, while Medicare reimbursement is "at cost", pilots in Montana (called "Medical Assistance Facilities") showed that Medicare costs were less expensive than treatment would have been in full service rural hospitals. [GAO/HEHS-96-12R, Oct. 1995.]

Presidential Executive Order. The several U.S. military hospitals turned over to the VA through intergovernmental transfers were located on sites convenient for defense bases. And the location of some VA-built hospitals was influenced by events not entirely under VA control, e.g., land donation, legislative "ear marking" of funds for a particular site, etc.⁵⁴

The resultant arrangement of VA facilities, while not exactly haphazard, was far from the balanced array of services modern strategic planners would design from scratch in order to maximize efficiency in future service to veterans.

In addition, the dramatic changes in health care delivery within the United States and the VA include improved methods of treating patients that have reduced lengths of stay and admissions as outpatient, community and home care replace inpatient care. As a result many campuses have vacant space that is costly to maintain as described elsewhere in the plan. These changes, combined with an aged infrastructure (50.4 years average age of VA facilities) resulted in the need to review the structure of our campuses to develop a more efficient footprint, to transfer services to other campuses, and to find opportunities to enhance use lease all or portions of campuses with services for veterans such as assisted living facilities. Revenues from these enhanced uses would be retained by the VISNs to invest in improved services for veterans.

There were two components in the planning process for reviewing the potential for realigning services and campuses to improve the cost effectiveness and quality of care. The first component, labeled "Proximity," identified tertiary and acute hospitals located within CARES-prescribed distance criteria, and focused on acute

⁵⁴ Adkins, Robinson E., *Medical Care of Veterans*, Wash., DC, 90th Congress, 1st Session, House Committee Print No. 4., p. 119.