

Draft Executive Briefing for Stakeholders

VA Health Care Business Plan Study for the VA Roseburg Healthcare System (VARHS)

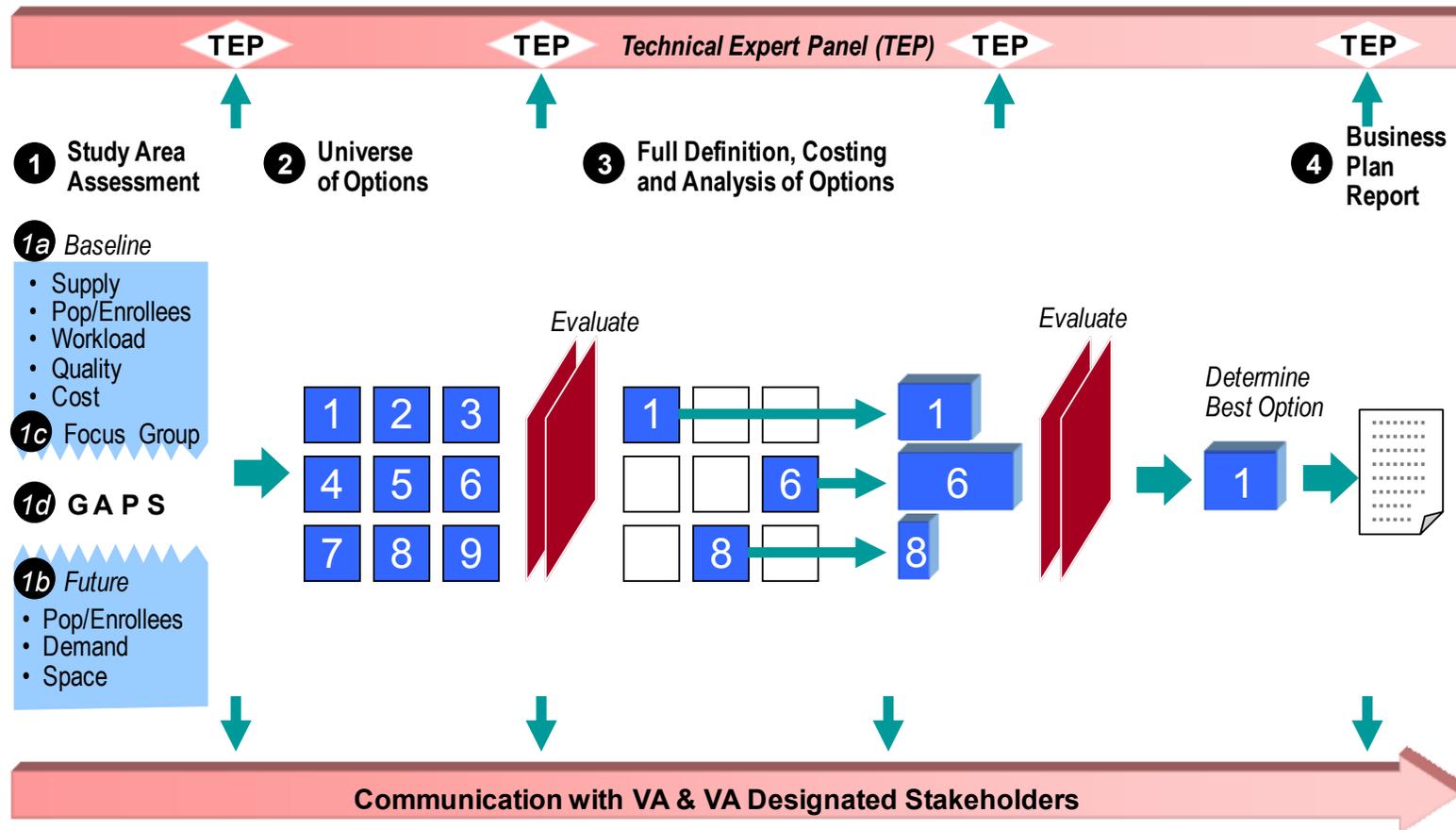
Roseburg, OR
December 14, 2010

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information of the client to whom it is addressed.*

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In order to optimize the care of veterans in the Roseburg area, the Booz Allen team used a market-driven approach to health care planning, which includes four major phases, to define the options



Throughout the course of the study, the team analyzed various sources of information to formulate options to improve service delivery for Veterans served by the VA Roseburg Health Care System (VARHS)

Data provided by VA

- ▶ Stakeholder input gathered during site visit
- ▶ Historical and current demographic data
 - Veteran Population and Enrollment
 - Inpatient (BDOC/Beds) and Outpatient (Encounters) Workload
 - Facility data
- ▶ Access data
 - Drive time Compliance
 - Utilization of Telemedicine
 - Patient Wait Times
- ▶ VA Enrollee Health Care Projection Model (EHCPM) demand data
 - Veteran Population and Enrollment Projections
 - Inpatient (BDOC/Beds) and Outpatient (Clinic Stops) Workload
- ▶ Cost data
- ▶ Human Resources data (FTEEs, Turnover rates, Sick Leave rates, Employee Satisfaction)
- ▶ Quality data
 - Performance Indicators
 - Patient Satisfaction

Other data analyzed by the study team

- ▶ Health care technology trends
- ▶ New models of care
- ▶ Interviews with VA and other health care experts
- ▶ Literature reviews
- ▶ Community specific information that may impact VA
- ▶ Community health care resources

The June 2010 site visit to the study area provided insight from employees and patients about how care is delivered and the VARHS relationship with community partners

- ▶ Although employees at the VARHS are highly dedicated to serving veterans of the Roseburg area, morale is low due to staffing and communication challenges
- ▶ Uncertainty about the future makes it challenging to determine a long-term vision among employees and patients at VARHS
- ▶ Staff, patients, and other community members feel there is a lack of clear communication and transparency about decisions that affect the VARHS
- ▶ Lack of local access to major specialty services and poorly executed referral systems are major concerns for patients and employees
- ▶ Despite some minor referral and administrative challenges, several private sector community hospitals are interested in cultivating a partnership with the VARHS

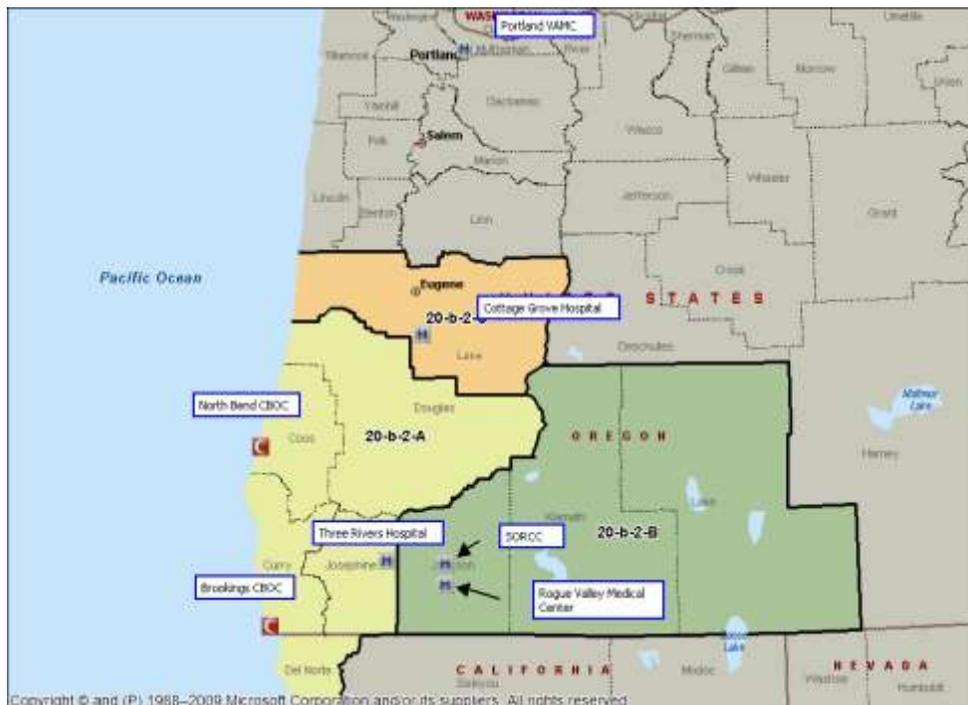
A second site visit in August 2010 provided additional stakeholder input

The study team visited the following VA and non-VA facilities:

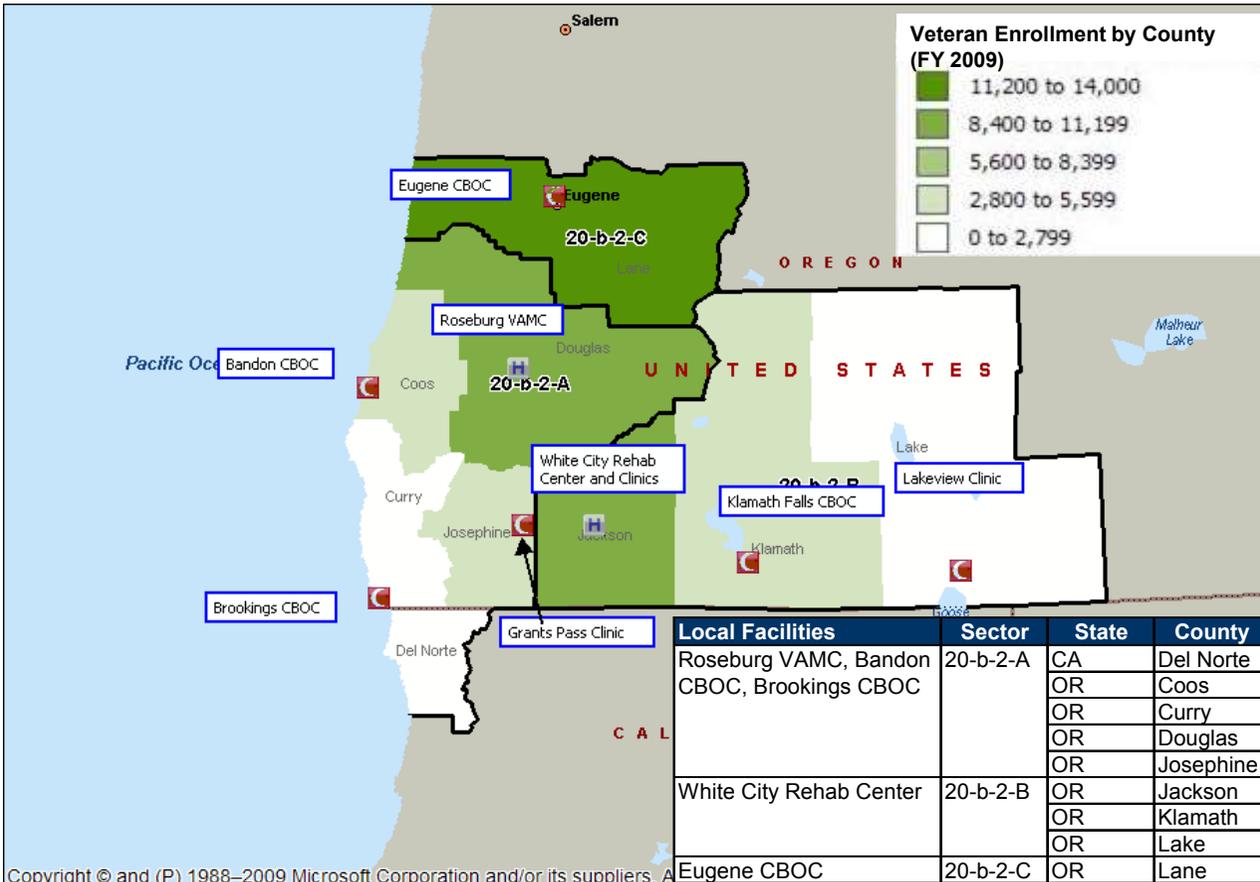
- ▶ Portland VAMC
- ▶ Southern Oregon Rehabilitation Center and Clinics (SORCC)
- ▶ Brookings CBOC
- ▶ North Bend CBOC
- ▶ Cottage Grove Hospital
- ▶ Rogue Valley Hospital
- ▶ Three Rivers Community Hospital

Major themes from second site visit included:

- ▶ Stakeholders reported a need for additional psychiatry support; community providers were reportedly fiscally driven and discharged patients too soon
- ▶ Relationships with community hospitals in the Medford area will need to be developed and strengthened if either facility is to provide services to VA
- ▶ Portland staff indicated that the high demand for its services makes it difficult to accept acute care referrals; strategic decisions about potentially serving as a highly technical tertiary referral center only are underway
- ▶ Community hospitals located near the coastal CBOCs are available to provide specialty services for VA patients
- ▶ Discussions with clinic staff also revealed that there were currently no telemedicine services at the clinics and there is varied understanding among the staff about what this technology can do
- ▶ Cottage Grove Hospital, a Critical Access Hospital (CAH) serving rural Lane county residents, demonstrates a unique model - very low tech with very high quality and efficient care even though the census is low; financially it is very viable and there is a conscience effort to limit what they do and do it well



The Southern Cascades study area is comprised of three sectors and nine counties, of which seven are rural or highly rural



Key Points

- ▶ Within the study area, the largest number of enrolled veterans reside in Lane County (Sector 20-b-2-C), followed by Jackson County (Sector 20-b-2-B) and Douglas County (Sector 20-b-2-A)
- ▶ Lake, Curry, and Del Norte Counties have the fewest enrolled veterans in the study area
- ▶ Lane County has the lowest proportion of enrollees to veteran population, accounting for only 36% of the enrollee market share, however, this share is likely to increase with the expansion of the Eugene CBOC
- ▶ Douglas County has the highest proportion of enrollees to veteran population, accounting for 65% of the enrollee market share

Note: those facilities listed on the chart above are the only ones examined in this study, however, within the map, one can see the additional local clinics/facilities listed: Grants Pass, Klamath Falls, Lakeview

VA enrollment data, used to analyze market share and rurality, shows a relatively high market share of enrollees to veteran population for the study area, at 42%, and a predominately rural environment

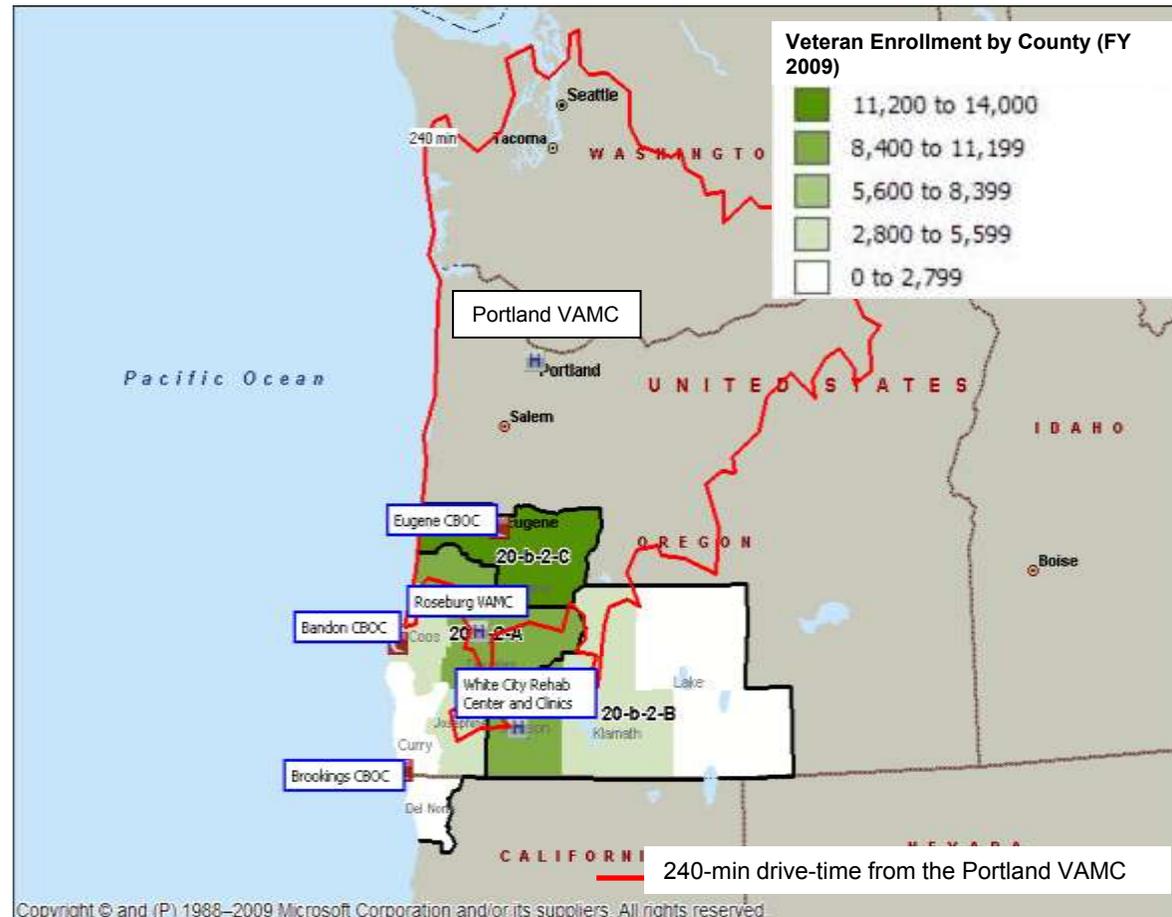
Sector	County, State	U/R/HR	Veteran Enrollment FY 2009	Veteran Population FY 2009	Enrollment Market Share (%)
	Coos, OR	R	3,616	8,909	41%
	Curry, OR	R	1,604	3,321	48%
	Douglas, OR	R	8,091	12,384	65%
	Josephine, OR	R	4,354	11,250	39%
	Del Norte, CA	R	1,274	3,385	38%
20-b-2-A	Subtotal		18,938	39,250	48%
	Jackson, OR	U	9,687	24,235	40%
	Klamath, OR	R	3,453	7,572	46%
	Lake, OR	HR	423	816	52%
20-b-2-B	Subtotal		13,563	32,623	42%
	Lane, OR	U	12,454	34,572	36%
20-b-2-C	Subtotal		12,454	34,572	36%
	Grand Total		44,955	106,446	42%

Source: Vet Pop and Enrollees BY09 data.xlsx

Based on a 240-minute drive-time from the Portland VAMC, approximately 53.5% of Southern Cascades study area veterans are within the access standard for tertiary care

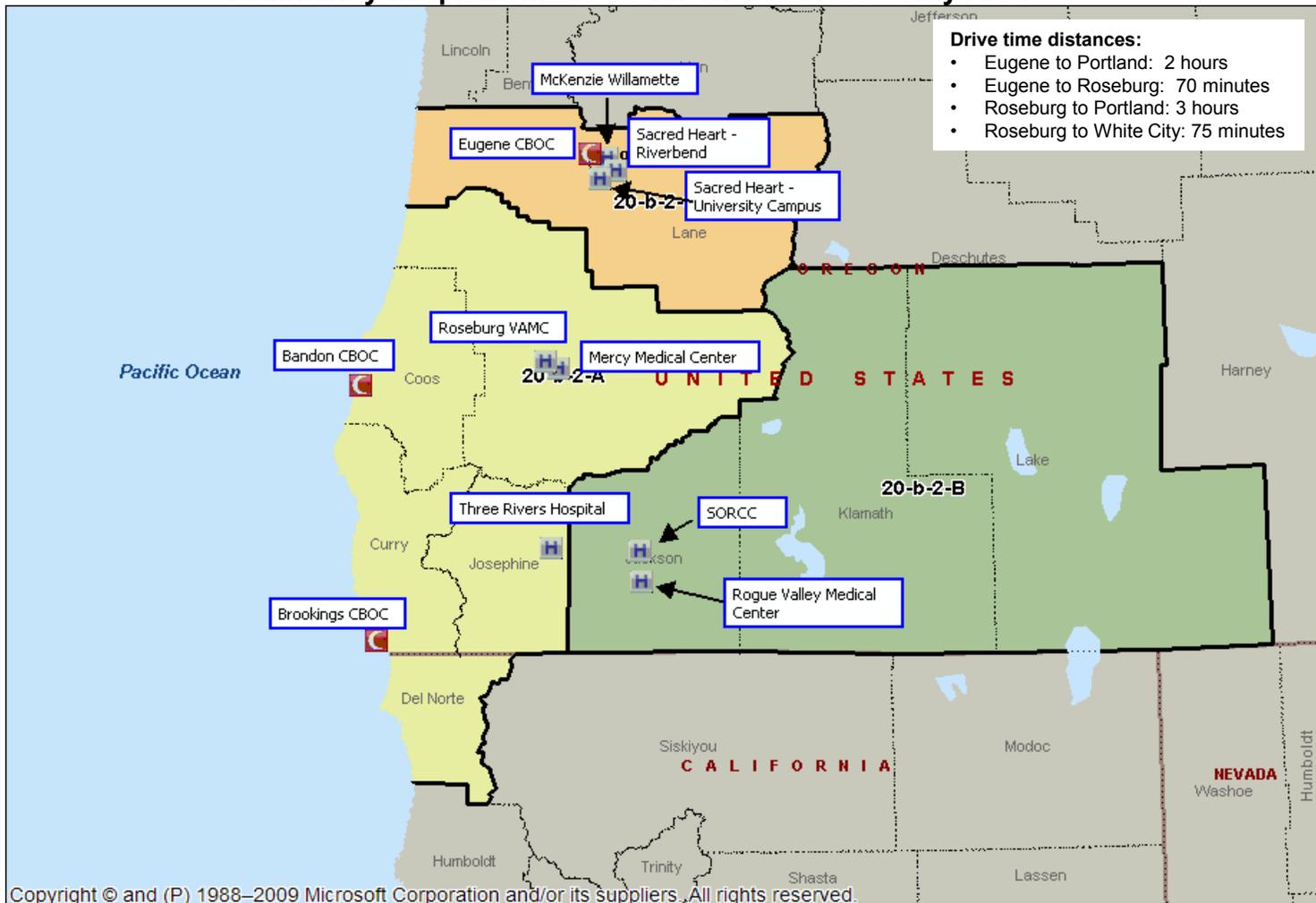
- ▶ Tertiary care is highly specialized; technologically advanced medical and surgical inpatient care is provided primarily by sub-specialists, including neurosurgeons, orthopedists, and cardiovascular surgeons
- ▶ The tertiary care access guideline for both urban and rural environments is 240 minutes
- ▶ Since the Roseburg VAMC does not provide tertiary care, this map displays a 240-minute drive-time radius with the Portland VAMC as the midpoint
- ▶ Veterans that are outside of the drive-time guidelines are frequently referred to community providers for tertiary care

Tertiary Care Access: 240-Minute Drive-Time from the Portland VAMC



Community partners provide acute medical and surgical services to VA patients in the Southern Cascades study area; Eugene and Medford areas have multiple community hospitals

Community hospitals in the Southern Cascades Study Area



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The study team examined performance and patient satisfaction data to enhance our understanding of how the VARHS performs compared to other VA facilities

Performance Indicators

- ▶ Overall, VARHS exceeded benchmark standards in over half of its performance measures for the first and second quarters of FY 2010
- ▶ Metrics indicated a need to improve performance in a number of areas for mental health and substance abuse
 - Like other health systems, VARHS and VISN 20 are not meeting VA standards for mental health services for homeless veterans
- ▶ The study team recognizes the inherent challenges associated with developing conclusions based on performance measure data alone, understanding that performance metrics may be imprecise measurements of clinical quality and are subject to data collection errors

Patient Satisfaction

- ▶ In general, results of the SHEP data indicated that patients were satisfied with their access to care and the quality of communication with their providers at VARHS
- ▶ These findings were consistent in both the inpatient and outpatient setting
- ▶ Contrary to what the stakeholders reported during the study team's site visit, the SHEP data revealed lower satisfaction scores with the overall hospital environment and veteran willingness to recommend the hospital to other veterans
- ▶ Similar to the clinical performance metrics, the SHEP data has inherent limitations and must be cautiously interpreted



The study team also reviewed employee satisfaction at the VARHS

- ▶ The results of an employee satisfaction survey conducted earlier this year indicated an overall favorable level of satisfaction, with a few notable exceptions:
 - **Job satisfaction: supervision and senior management** received the lowest average ratings with 2.76 and 2.72, respectively, out of a possible 5 points
 - **Organizational assessment: job control** was given the lowest average rating of 3.02.
 - **Culture: the entrepreneurial and group** categories received the lowest overall average ratings of 2.53 and 2.70, respectively

- ▶ These data are consistent with stakeholder comments voicing a low level of satisfaction in these areas

- ▶ Comparing employee satisfaction from 2007 to 2010, the study team found that job satisfaction ratings **increased** for:
 - Work amount
 - Pay satisfaction
 - Supervision
 - Promotion opportunity
 - Praise

- ▶ However, the following areas **decreased** during the same period:
 - Work type
 - Senior management
 - Customer satisfaction

- ▶ The most remarkable difference was seen in the **culture** component of the assessment: between 2007 and 2010, employees indicated a negative change for **group and entrepreneurial** issues



Furthermore, the study team also evaluated human resource data sources, including staff retention

- ▶ Employee retention rates vary across VISN 20
 - In particular, for the VARHS, the number of employees has increased by approximately 188 since FY 2005 but, the overall facility total loss rate has increased by approximately 2.41%
 - The total facility loss rate for the PVAMC has decreased steadily since FY 2005 while VARHCS has increased. However, VAHRS rates are below its urban counterpart

Facility	Employee Turnover	2005	2006	2007	2008	2009
Portland VAMC	FYTD Distinct Employees	2,967	3,061	3,254	3,620	3,901
	Facility Total Loss Rate	16.57%	17.57%	15.66%	14.58%	13.90%
Roseburg HCS	FYTD Distinct Employees	799	815	884	920	987
	Facility Total Loss Rate	11.27%	12.07%	12.01%	12.60%	13.68%

Roseburg HCS includes Roseburg VAMC, Eugene CBOC, North Bend (Bandon) CBOC, Brookings CBOC

Total Loss includes retirements, terminations, quitting, and on-boarding

Source: V20 Employee Data_HR Data Roseburg.xlsx

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The study team uses the VA Enrollee Health Care Projection Model (EHCPM) to determine future workload for the study area

Notable factors of the EHCPM:

1 Veteran Enrollment

- ▶ Generates an estimate of total veteran enrollment by member month and annualizes these projections to estimate annual enrollment projections; in addition, adjustments are made specific to the veteran population to project future utilization, so that as the composition of the enrolled population changes over time, so will utilization patterns

3 Reliance on VA services

- ▶ Accounts for estimates of reliance on VA services, namely that those with heavy reliance will use VA resources more intensely and those with lower reliance will use VA resources less intensely (but private sector resources more heavily)

2 Priority Level & Morbidity

- ▶ Eligibility is determined by priority level, which is assigned based on the type and severity of the Veteran's medical condition, the relationship of the condition to military service ("service connected"), the Veteran's income level, and other factors
- ▶ Veterans in priority groups 1-6 have the highest average utilization of health care services within the VA, while priority groups 7 and 8 tend to use fewer services; because the Veteran population has a substantially higher disease burden than an age- and gender-matched private sector population, the model further adjusts for veteran morbidity

4 Degree of Care Management

- ▶ Adjusts projections to reflect the degree of care management, with the assumption that increased management of patient conditions will reduce the need for hospitalizations and will reduce the length of stay in acute care settings for those who are hospitalized



Model projections show a 60% decrease in demand for inpatient services in the Roseburg sector by 2029; the current average daily census of 16 is about half of the modeled FY2009 med-surg bed projection

Sector 20-b-2-A
(Roseburg), inpatient bed demand is expected to fall by 60% over the next 20 years

Strategic Planning Category	FY 2009 Baseline	FY 2019 Modeled	FY 2029 Modeled	% Change from 2009–2029
Medical	24	13	10	-58%
Surgical	11	7	4	-64%
Medical/Surgical Subtotal	35	20	14	-60%
Mental Health	8	5	3	-63%
Total	43	25	17	-60%

Sector 20-b-2-B
(White City) will experience a 16% decrease in bed demand over the next 20 years

Strategic Planning Category	FY 2009 Baseline	FY 2019 Modeled	FY 2029 Modeled	% Change from 2009–2029
Medical	8	11	9	13%
Surgical	4	5	4	0%
Medical/Surgical Subtotal	12	16	13	8%
Mental Health	7	4	3	-57%
Total	19	20	16	-16%

Sector 20-b-2-C
(Eugene) is expected to decrease by 7% in inpatient bed demand by 2029, the least of all three sectors

Strategic Planning Category	FY 2009 Baseline	FY 2019 Modeled	FY 2029 Modeled	% Change from 2009–2029
Medical	8	9	8	0%
Surgical	4	4	3	-25%
Medical/Surgical Subtotal	12	13	11	-8%
Mental Health	3	4	3	0%
Total	15	17	14	-7%

Outpatient demand projections for the Southern Cascades study area show significant increases in all areas, particularly primary and specialty care through FY 2029

Outpatient Demand (Clinic Stops) for the Southern Cascades Study Area, FY 2009–FY 2029

Strategic Planning Category	FY 2009 Baseline	FY 2019 Modeled	FY 2029 Modeled	% Change from 2009–2029
Amb: Primary Care-Geriatrics-Urgent Care	134,574	156,623	166,150	23%
Amb: Medical & Other Non-Surg Specialties	67,975	77,031	84,168	24%
Amb: Surgical Specialties	46,505	53,945	56,526	22%
Amb: Mental Health Programs	100,748	105,488	111,424	11%
Blind Rehab	141	169	184	30%
Spinal Cord Injury	629	625	579	-8%
Amb: Dental Clinic	38,071	38,807	38,169	0%
Amb: Laboratory and Pathology	108,223	126,440	129,680	20%
Amb: Radiology and Nuclear Medicine	35,009	41,447	44,282	26%
Total	531,875	600,575	631,162	19%

Source: So Cascades Workload projections BY MARKET BY09.xlsx.

One limitation of the VA's EHCPM is that inpatient bed projections do not account for varying levels of acuity

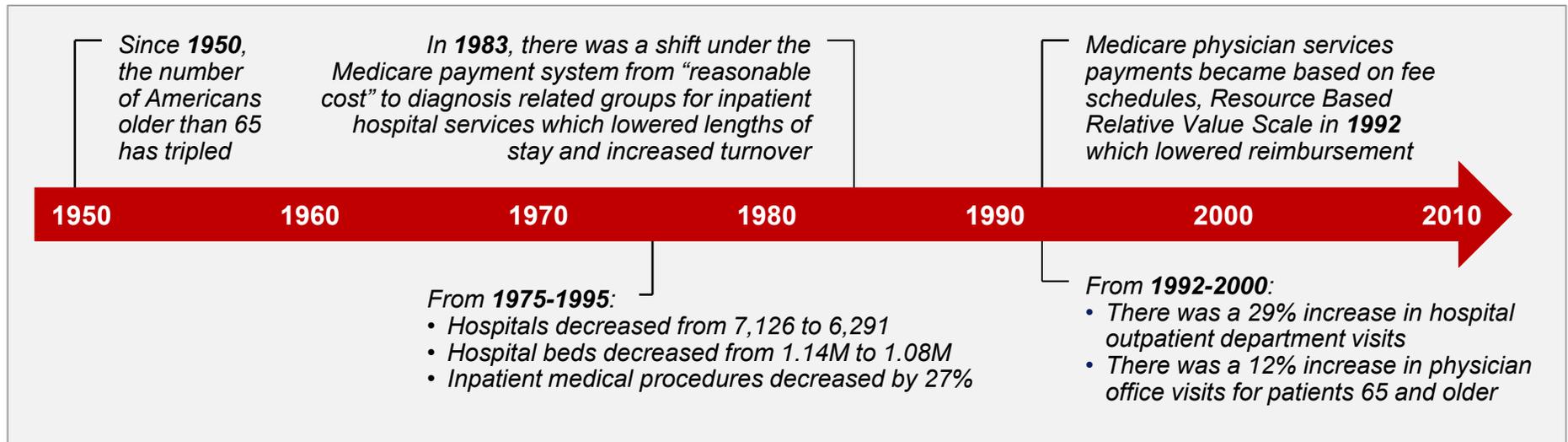
- ▶ One important factor to note when reviewing bed demand numbers for the Southern Cascades study area is that the VA's EHCPM does not identify the specific levels of acuity that may be required to meet the demand for acute medicine, surgery, and psychiatry services
- ▶ In fact, the projections include a wide array of acuity levels; many of the complicated medical and surgical cases may require robust and multiple subspecialty care and different combinations of staff, equipment, infrastructure, and other resources
- ▶ As a result, those beds are aggregated in the overall bed demand for study area even though Roseburg does not have the ability to care for those types of patients and would ultimately refer them to Portland or the community
- ▶ Therefore the model does not specifically predict patient demand locally versus tertiary referrals to other facilities

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Advances in technology and pharmaceuticals, an aging population, and Federal changes in how care is reimbursed have transformed how care is delivered

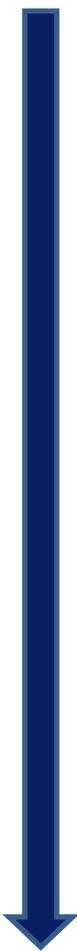
- ▶ Improvements in medical technology and better pharmaceuticals resulted in non invasive or minimally invasive procedures and improved management of chronic conditions, which expanded outpatient service utilization
- ▶ Hospitals are decreasing in number and in size and yet are treating patients with greater acuity
- ▶ The population is aging which impacts service delivery models and resource allocation
- ▶ The government's cost containment strategies under Medicare and Medicaid have provided incentives for shifts in sites of services



Sources: Jarvis, William R., (2001). Infection Control and Changing Health-Care Delivery Systems. *Emerging Infectious Diseases, Volume 7, Number 2*.
Bernstein AB, Hing E, Moss AJ, Allen KF, Siller AB, Tiggle RB. Health care in America: Trends in utilization. Hyattsville, Maryland: National Center for Health Statistics. 2003.

Similar to the health care industry, other industries like the automotive, telecommunications, and banking have undergone dramatic changes in the past twenty years

1990



2010

<p>The delivery of healthcare has evolved in an effort to serve the uninsured and rural patients where clinician recruitment is difficult</p>	<p>The auto industry has undergone sweeping changes in safety, design and fuel economy over the past 20 years</p>	<p>Technology, style and increasing consumer demand has dramatically changed the telecommunications industry since 1990</p>	<p>Over the past two decades, the way in which bank services are conducted have become more automated</p>
			
			
			

Delivery of health care in the New Orleans area post Katrina is a prime example of how one community embraced change and improved access by placing care closer to the patient

- ▶ “It’s not about getting to the hospital, it’s about getting to a doctor.” – Dr. Nancy Synderman, NBC Medical News Correspondent, August 2010
(<http://www.msnbc.msn.com/id/34276015/vp/38887729#38887729>)
- ▶ Following the storm, the number of hospitals in the New Orleans area shrunk from 39 to 24; this included the facility that provided the most care to the uninsured
- ▶ With a significant reduction in beds, 87 neighborhood-based primary care units were created to ensure services were available for those that remained in the region
- ▶ The changes to health care delivery in New Orleans represents an important paradigm shift for providing access to patients; community primary care systems with good referral networks improve access

Telehealth is a major priority within VHA, since it is an innovative way to bring specialty care to rural veterans residing in isolated areas, without degrading the quality of care

- ▶ Within VA, patient aligned care teams (PACT) combine technologies to improve access and enhance service by bringing care to the patient
- ▶ In addition, VA recently announced a partnership between VA and Indian Health Services (IHS) focusing on the development of health information technology by developing new models of care to increase access for veterans living in extremely rural areas; specifically this partnership will use:
 - Tele-health services such as tele-psychiatry and tele-pharmacy
 - Mobile communication technologies
 - Enhanced telecommunications infrastructure to support collaboration in remote areas
 - Sharing of training programs and materials supporting these models of care
 - Sharing of knowledge gained from testing of new models of care
- ▶ In the community, patient-centered medical homes, a team-based model of care, is lead by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes



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In addition to the factors analyzed in the market assessment, the study team recognizes there are complexities involved in planning services for small rural communities such as VARHS

- ▶ Stakeholders have varying degrees of understanding of new health care models and technologies
 - The shift to patient aligned care teams (PACT) focusing on providing the appropriate levels of care in a variety of settings
 - The shift from the inpatient setting to outpatient care, and the reduction in beds throughout US hospitals; modern health care is about keeping patients out of the hospital by providing more primary and outpatient care, including outpatient surgery, and home care
 - New technologies that allow providers to care for patients remotely which improves access to specialty care for inpatient and outpatients

- ▶ Planning for small rural hospitals such as Roseburg VAMC is challenging due to several factors
 - Shifting demographics make recruitment and retention of specialists difficult and results in difficulty accessing services, both in terms of the array of services available, and location of the services away from population centers
 - Health care experts recognize that low volume inpatient programs may not meet quality standards

Recent decisions related to services at the VA Roseburg Healthcare System are notable and also were factored into the options

- ▶ A 15-bed neuropsychiatry unit will be renovated to meet patient privacy and to improve design constraints. This is the only locked unit in the Southern Cascades area
- ▶ VARHS recently established a contract with a local community group to staff the Roseburg VAMC Emergency Department with board certified ED physicians; additional funding provided by VISN 20 also supports staff for specialty services in ophthalmology and colonoscopy
- ▶ Plans are underway to relocate and expand the Eugene CBOC in 2013 to enhance specialty services, including ambulatory surgery
- ▶ In 2009, the VA implemented a new Surgical Complexity designation process and Roseburg was assigned as a Standard level facility (this new nation-wide VA program was designed to enhance the quality of surgical programs by requiring specific hospital infrastructures for multiple subspecialties and services)
- ▶ VISN 20 leadership is working with medical centers throughout the VISN, who were also impacted by this new policy, to create innovative solutions to ensure that intermediate surgical services can still be provided locally for veterans within VISN 20
- ▶ Due to concerns about patient safety and low volumes, additional service changes were made in October 2009 when the VARHS closed the 4-bed intensive care unit (ICU)
 - Surgical patients with co-morbidities and patients with increasing acuities that may require ICU care are now transferred or referred to other VAMCs or community providers



The study team analyzed a variety of other factors that will impact the delivery of health services and the options considered for VARHS

- ▶ The study team attempts to provide evidence-based solutions, however there are also “difficult to quantify” factors that must be considered when developing comprehensive health service solutions for veterans in the Roseburg area

How will each of these factors affect how care is delivered to study area veterans in the future?

- ▶ Rural location of the Roseburg market sector, while most patients live in urban areas to north and south sectors
- ▶ Expanded Eugene CBOC in 2013 (potential impact of increasing inpatient demand in the Roseburg catchment area, including Medford and Eugene)
- ▶ Addition of 6 inpatient beds at the Portland VAMC in 2011
- ▶ Portland VAMC future role as only a tertiary care referral center
- ▶ Health care reform and its new payment models on the capacity of private hospitals and their willingness to partner with VA
- ▶ Near term future of telemedicine in the VA
- ▶ Recruitment and retention of health care providers in the Roseburg area
- ▶ New homeless facility on the Roseburg campus (planned but unfunded)
- ▶ Potential for a new State Veterans Home on the Roseburg campus (this has not yet been confirmed or funded)

- ▶ The health service delivery options must be flexible in order to accommodate these factors

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The market analysis and other factors suggest that gaps and concerns exist in six closely related areas

- ▶ Each of the gaps discussed below affect the viability of service delivery strategies that will be assessed to enhance veteran access to a full range of services, close the gap between current supply and future demand, create a future vision, and improve the coordination of care with non-VA providers:

1 Located in a predominately rural area:

VARHS supports a significant veteran population, but the medical center is located in the most rural and least populated market sector - most patients live in the larger metropolitan areas

2 Limited spectrum of inpatient and outpatient services:

Challenges in the recruitment and retention of physician specialists and other caregivers in the Roseburg market sector (e.g., technicians and licensed practical nurses)

3 Lack of formal referral network:

As the number of veterans requiring VA specialty care increases, it will be more difficult to coordinate care with non-VA providers; this jeopardizes continuity and quality of care

4 Limited capacity in Portland:

A growing workload at the Portland VAMC may limit its capacity to accept referrals from the VARHS

5 Future demand for outpatient care:

A gap between current and projected future demand and the VARHS' capacity for providing outpatient specialty services

6 Lack of shared vision:

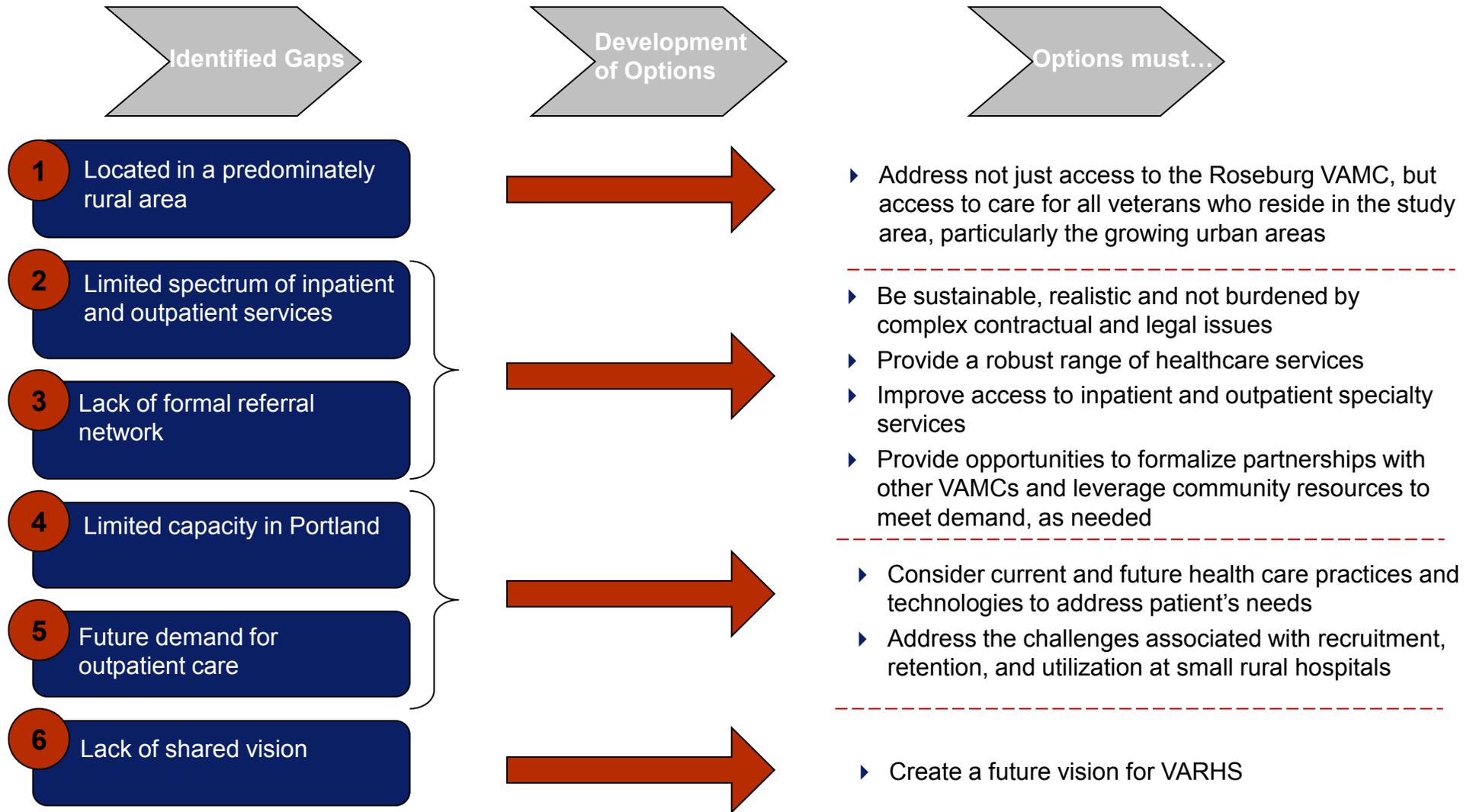
The lack of a clear shared vision for the VARHS undermines efforts to plan for current and future services – stakeholders consistently made this argument during the team's site visit



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The study team used the following guiding principals when developing the options to enhance service delivery to the study area



There were six inpatient strategies included in the Universe of Options to improve the delivery of acute care for Roseburg veterans

Option 1: Status Quo	Option 2: Shared Services	Option 3: Veterans Community-Based Acute Care Center (VCBACC)	Option 4: Rural Enhanced Access Community Hospital (REACH)	Option 5: Contract All Inpatient Care	Option 6: Roseburg as a Full Service Level II Medical Center
<ul style="list-style-type: none"> ▶ This option is used as the baseline comparison for evaluating all other potential service delivery options ▶ In this scenario, the VARHS would continue to provide services as it does today ▶ As a level III designated hospital, the Roseburg VAMC would provide low acuity inpatient medicine, surgery, and mental healthcare, long-term care and rehabilitation services as well as its current Emergency Department and ambulatory care program ▶ All high acuity care (i.e., tertiary care) would be referred to other VAMCs or to the community 	<ul style="list-style-type: none"> ▶ In this option, specialty physicians would work part time for the Roseburg VAMC and for community providers, such as Mercy Medical Center, Sacred Heart Medical Center, and/or McKinsey Willamette Medical Center ▶ Having dual appointments between VA and community hospitals will help address the recruitment challenges and patient volumes that rural communities like Roseburg struggle to manage ▶ This option would require a high degree of care coordination and contractual partnerships with willing private sector partners 	<ul style="list-style-type: none"> ▶ In this option, Roseburg VAMC would supplement the Status Quo by leasing beds at a community hospital and providing low-acuity care and surgery services by VA physicians ▶ Veterans would continue to receive VA quality healthcare from VA physicians and VA care coordinators but in a community hospital setting that is aimed to reduce travel burden ▶ This option would require a high degree of care coordination and contractual partnerships with willing private sector partners ▶ Additional specialty care would be purchased at the community hospital 	<ul style="list-style-type: none"> ▶ In this option, Roseburg VAMC would enhance medical and surgical services with selected specialty care through innovative application of combined technologies that have been successfully used in other healthcare settings ▶ This option focuses on expanding services through the enhanced use of telemedicine services, such as home-based monitoring/patient self-testing, remote imaging and delayed consultations, and real-time consultations ▶ Specialty consultations would be performed by VA-employed physicians located elsewhere and assisted by Roseburg VAMC staff, allowing VARHS to expand its array of inpatient services 	<ul style="list-style-type: none"> ▶ In this option, Roseburg VAMC would maintain inpatient acute mental health, long-term care, rehabilitation, and the required ancillary services to support the remaining inpatient services ▶ All acute inpatient care would be purchased in the community and the Roseburg VAMC would no longer provide acute inpatient medicine and surgery services ▶ The existing Emergency Department would be replaced with an Urgent Care clinic that will be supported by community Emergency Departments in the evenings 	<ul style="list-style-type: none"> ▶ In this option, the Roseburg VAMC would expand its scope of inpatient services and become a level II medical center ▶ Under this higher complexity model, the Roseburg VAMC would have a medium number of Veterans Equitable Resource Allocation (VERA) pro-rated personnel, a medium level of teaching/research activities, and a medium level of patient risk ▶ The number of inpatient surgery beds would increase and the hospital would reopen its Intensive Care Unit (ICU) to provide level 3 and 4 ICU care

The internal project team conducted an initial screening session prior to the formal TEP session to determine which options from the universe of options would proceed for full analysis

- ▶ During this initial screening session, team members conducted an extensive discussion to evaluate each of the options based on the major criteria by designating a pass, indeterminate, or fail result
- ▶ Two or more “fail” grades would result in an overall fail score
- ▶ Although status quo was not evaluated during this screening phase, it will be included in the full analysis of options as the baseline; all other options will be compared to status quo and evaluated against it
- ▶ The study team recognizes that all service delivery options will have advantages and disadvantages; a perfect solution does not exist

#	Option Description	Access	Quality	Impact on Neighboring Facilities	Impact on Employees	Risk	Overall Score and Explanation
1	Status Quo						Used as a baseline to compare all other options
✓ 2	Shared Services	Pass	Pass	Pass	Pass	Indeterminate	PASS – will proceed to full evaluation because it potentially facilitate the recruitment of specialty physicians, improving access and quality to study area veterans
✓ 3	Veterans Community Based Acute Care Center (VCBACC)	Pass	Pass	Pass	Pass	Indeterminate	PASS – will be considered for full analysis because it maintains VA providers of care while addressing the challenges associated with rural health
✓ 4	Rural Enhanced Access Community Hospital (REACH)	Pass	Pass	Pass	Pass	Indeterminate	PASS – will further be evaluated because of its strength as an innovative model of care that could solve access issues in Roseburg and similar rural VA hospitals across the nation
✓ 5	Contract All Services	Pass	Pass	Pass	Indeterminate	Indeterminate	INDETERMINATE – based on quality factors and the potential impact on neighbors and employees, ultimately evaluated for full analysis
6	Roseburg as a Full Service Level II Medical Center	Fail	Indeterminate	Indeterminate	Indeterminate	Fail	FAIL – will not proceed for full analysis because of problems with recruitment, volume and shifting demographics and access to specialty services

Four viable options were considered from an initial field of six options, that included the status quo

Shared Services

- ▶ Specialty physicians would be shared between the Roseburg VAMC and community hospitals
- ▶ Will help address the specialty physician recruitment challenges
- ▶ Requires a high degree of care coordination, contractual partnerships and shared call schedules

Veterans Community-Based Acute Care Center (VCBACC)

- ▶ Admit VA patients to community hospitals where VA physicians would be the “attending of record”; would be supplemented by VA Care Coordinator that would also round on VA patients each day
- ▶ Veterans would have access to broader spectrum of services in higher volume hospital
- ▶ This option would require a high degree of care coordination, contractual partnerships and shared call schedules

Contract All Inpatient Care

- ▶ All acute inpatient care would be purchased in the community and the Roseburg VAMC would no longer provide acute inpatient medicine and surgery services
- ▶ The existing Emergency Department would be replaced with an Urgent Care clinic that will be supported by community Emergency Department in the evenings
- ▶ Roseburg VAMC would maintain inpatient acute mental health, long-term care, rehabilitation, and the required ancillary services to support those services

Rural Enhanced Access Care Hospital (REACH)

- ▶ Roseburg VAMC would enhance medical and surgical services with selected specialty care by integrating information and communication technologies with traditional health care delivery methods
- ▶ Expands services through the enhanced use of telemedicine services, such as home-based monitoring/patient self-testing, remote imaging and delayed consultations, and real-time consultations
- ▶ Specialty consultations would be performed or augmented by VA physicians located elsewhere and assisted by Roseburg VAMC staff, allowing VARHS to expand its array of inpatient and outpatient services
- ▶ Serves as demonstration project to address common set of access needs across the enterprise; will require strong innovative leadership and support at local, VISN and national level;

The outpatient strategy leverages the existing CBOCs in Eugene, North Bend (Bandon) and Brookings, and the robust ambulatory care program at Roseburg VAMC

- ▶ The study team assumes that the expansion plans for the Eugene CBOC will proceed as planned
 - Services include: primary care, mental health, laboratory and pathology, and radiology
 - The Eugene CBOC will expand outpatient specialty services and ambulatory surgery
 - Demand is expected to increase and the impact on inpatient referrals to Roseburg and Portland should be further evaluated upon activation
- ▶ Supporting the Roseburg VAMC and Eugene CBOC will be the North Bend (Bandon) and Brookings CBOCs
 - Services include: primary care, mental health, laboratory and pathology, and radiology
- ▶ The need for additional outpatient mental health services in the North Bend, Brookings and White City/Medford areas should be further evaluated
- ▶ The Emergency Department contract at Roseburg continues in all options that maintain inpatient med/surg beds at Roseburg

All options assume that selected inpatient services will remain on campus to support veterans

- ▶ In all options, the study team suggests that the following inpatient services remain at the Roseburg VAMC because the facility is a critical resource for Veterans within and surrounding the Southern Cascades study area
 - Inpatient mental health
 - Long term care
 - Rehabilitative services
 - Ancillary services such as pharmacy, laboratory, and radiology to support the remaining inpatient services
- ▶ In the following slides, the options examine only one component of acute inpatient services: medicine and surgery, while assuming that the other significant components of inpatient care will remain at the Roseburg campus

Option 2, Shared Services will potentially facilitate the recruitment of specialty physicians, improving access and quality to study area veterans

► Description:

- Inpatient and outpatient care would continue to be provided at Roseburg VAMC
- Specialty physicians would work part-time for VA and community partners
- All high acuity care would be referred to other VAMCs (e.g., Portland) or to the community

► Strengths:

- Sharing resources with community partners would alleviate problems with limited workload volumes and difficulty recruiting specialty physicians
- Maintains VA bricks and mortar presence that is preferred by veterans
- Retains all current inpatient services at the Roseburg VAMC and improves access to some specialized services previously unavailable at the Roseburg VAMC
- Improves clinical quality by providing highly trained specialists to veterans
- Provides additional opportunities for clinicians to maintain their clinical skills
- Decreases patient wait times by increasing the availability of providers
- Provides employees with opportunities to work with and learn from higher-complexity trained specialists at community hospitals

► Weaknesses:

- Risks associated with physician contracts and implementation (e.g. call schedules and salary)
- Access for Lane and Jackson county enrollees and veterans in outlying counties is not improved
- Does not address the fundamental issue of recruiting physicians in the community
- Diminished ability for VA to control future services due to shared decision-making
- Significant risks related to administrative issues, such as licensure, scheduling, and payroll; the change management aspect of this option is critical to its success

Option 3, VCBACC will maintain VA providers of care while addressing the challenges associated with rural health

▶ Description:

- Low acuity inpatient services would be provided by VA clinicians in contracted beds at private-sector community partner hospitals
- VA physicians would be the “attending of record” and would be supplemented by VA Care Coordinator that would also round on VA patients each day
- Specialty services would be purchased, ideally onsite at the partner hospitals, with tertiary care referred to other VAMCs (Portland) or the community, if VA were unable to accept referrals
- VCBACCs are established in all three sectors

▶ Strengths:

- Increases the number of facilities where veterans can receive inpatient care and decreases their travel burden
- Veterans would have access to broader spectrum of services in higher volume hospital
- Expands access to specialty services
- Maintains clinical and service quality standards with care provided by VA-employed physicians and care coordinators
- Reduces the referral burden to other VA facilities (e.g., Portland VAMC, Seattle VAMCs, and others)
- Offers greater flexibility in meeting demand
- Increases exposure to emerging technology and newer facilities
- Increases job opportunities for care coordinators
- Maintains VA identity and culture

▶ Weaknesses:

- Unknown future capacity and availability, as well as unknown future demand at the private-sector community hospitals
- Risk of recruitment by private-sector partners
- Contracts would need to be developed efficiently and in a manner that is agreeable to all partners
- Untested; VA has no experience with implementing VCBACC nor does is there legal authority to implement this model



Option 4, Rural Enhanced Access Care Hospital (REACH) is an innovative model of care that could solve access issues in VARHS and similar rural VA hospitals across the nation

► Description:

- Enhance medical and surgical services with selected specialty care by integrating information and communication technologies with traditional health care delivery methods
- Expands services through the enhanced use of telemedicine services, such as home-based monitoring/patient self-testing, remote imaging and delayed consultations, and real-time consultations
- Consultations would be done remotely by VA-employed physicians in varying locations
- High acuity medicine and surgery services would be contracted to the community, if other VAMCs were unable to accept referrals

► Strengths:

- Increases the array of services and decreases drive time for patients in the VARHS catchment area
- Addresses recruitment and retention challenges inherent for small and rural hospitals
- Provides an opportunity to serve as a model for care delivery in rural settings across VA's healthcare system
- Reduces reliance on neighboring facilities (VA and non-VA) for specialty care and is likely to be sustainable
- Retains current employees and increases their capabilities with marketable telemedicine skills
- Strengthens relationships between VARHS and other VAMC physicians
- Offers the potential for innovation and leadership in emerging field
- Presents minimal legal or contractual challenges with purchased care from non-VA providers
- Maintains VA identity and culture

► Weaknesses:

- Requires considerable process improvement, change management, and integration to garner meaningful use from technology, and re-training of staff
- Some risk involved with identifying leadership to “champion” this model through planning, implementation and evaluation phases



Option 5, Contract Inpatient Care will close medical/surgical services and contract care in the community

▶ Description:

- All acute medical/surgical inpatient services at VARHS would be contracted out
- Inpatient mental health and long term care, and robust outpatient care services would remain on the Roseburg campus
- Tertiary medicine and surgery services would continue to be contracted to the community, if other VAMCs were unable to accept referrals
- The existing Emergency Department would be replaced with an Urgent Care clinic that will be supported by community Emergency Department in the evenings

▶ Strengths:

- Improves access to care in terms of drive time and can provide complete range of services
- Improves access to physicians with significant training and experience in specialty health care services
- Helps alleviate the capacity constraints seen at the Portland VAMC and other VAMCs

▶ Weaknesses:

- Less VA control over care coordination and cost
- Mental health patients that continue to reside at the Roseburg campus will not have access to acute medical or surgical services onsite
- Potential patients from the new State Veterans Nursing Home and homeless shelter, who will reside on the Roseburg campus, will not have access to acute medical and surgical services onsite
- Loss of VA culture of care
- Limitations on service utilization and quality control on clinical and service quality
- Unknown future capacity and availability at community hospitals
- Loss of jobs and lower employee morale
- VA's cumbersome and long contractual and reimbursement process is a major obstacle
- Veterans fear they would be subjected to financial risk for uncovered services



Next steps and timeline

- ▶ Feedback will continue to be collected through early January , 2011 and can be sent to the study email inbox: varhs-study@bah.com
- ▶ Feedback can also be hand-written and mailed to:
 - Colleen Sheppard**
 - Booz Allen Hamilton**
 - 1 Preserve Parkway**
 - Suite 200**
 - Rockville, MD 20852**
- ▶ Incorporate stakeholder feedback and deliver final report in late January 2011