

Chapter 5: Enhancing Outpatient Care

Modern Ambulatory Care Approach – A Vital Part of VA’s Integrated System of Health Care Delivery

Technological advances (prominently including minimally invasive procedures) and the increasing use of pharmaceutical therapy in lieu of hospitalization launched a dramatic, industry-wide increase in reliance on outpatient services in the 1980s. Fueled by cost economies realized through this more flexible approach, the trend grew rapidly into the 90s, but the VA health care system was not well positioned to benefit from this development.

VA must be prepared meet the total needs of veteran patients, including acute and tertiary care. Until 1996, archaic statutes required inpatient admissions for care that should have been delivered as outpatient services. Furthermore, changes in VHA’s operational culture – with its historic inpatient treatment orientation – were needed before the modern outpatient care model could be adapted to fit the VA system.¹

In reinventing its health care system in recent years, VA aggressively incorporated the positive features of ambulatory care into updated clinical practice patterns and performance measures (practice guidelines). The commitment to meet the total needs of veteran patients was accommodated through new referral patterns within the integrated VA system.

The success of VA’s commitment to provision of services across the full spectrum of care has been thoroughly documented in VA workload statistics: from FY 1996 to FY 2002, inpatient average daily census dropped 53 percent with a concurrent increase in outpatient visits of 54 percent². Moreover, at the end of the period, VA was treating over 1.5 million more veterans each year than it did at the beginning. Many patients also benefited by receiving care in a more convenient setting closer to their homes.

Recognizing the pivotal role which modern ambulatory care now plays in the VA system, the CARES process was designed to ensure (as detailed in this chapter) adequate future capacity in primary, specialty, and mental health care services to meet the projected future demand.

CARES Criteria for Outpatient Capacity Planning Initiatives

Planning initiatives were selected as the most significant gaps in care based upon national criteria applied in each market. Since they represent the most significant gaps, there is a higher degree of confidence that they will survive the inherent uncertainties of forecasts of the future. The new capital prioritization processes that will drive the selection of projects for capital funding include criteria directly related to the size of the gap. It is important to note, however, that VISN-level CARES Market Plans address workload and space solutions for all gaps in all CARES categories regardless of

¹ “Vision for Change: A Plan to Restructure the Veterans Health Administration,” Department of Veterans Affairs, Wash., D.C., 1995.

² VSSC “KLFMENU” <http://klfmenu.med.va.gov/> Financial Summary

whether or not a planning initiative was identified. Thus, all future workload is addressed in the planning process. Nevertheless, the primary approach was to identify where future “gaps” in service could be expected for each market within each VISN and then develop possible solutions (termed Outpatient Capacity Planning Initiatives) for managing the workload and capital needs in these markets. Capacity gap identification involved comparing current workload data (Base Year of FY 2002) with projections 10 and 20 years into the future (FY 2012 and FY 2022). Threshold Criteria for the three categories of care were established (as shown in Table 5.1) to determine where the “workload gaps” might be considered as Planning Initiatives.

Although data were available for a fourth outpatient CARES category, Ancillary/Diagnostics, the mixed nature of the workload comprising this category (tests and procedures) were too dissimilar for statistical inclusion with the other three, visit-oriented categories. For this reason, planning initiatives were not identified for Ancillary/Diagnostic services.

To illustrate application of the criteria, consider the first line of Table 5.1, which indicates that a gap would exist if two conditions in the primary care category were identified:

- The number of outpatient visits in FY 2012 or FY 2022 is projected to increase more than 25% over the volume in FY 2001; and
- In FY 2012 or FY 2022, projections show a gap of more than 26,000 “stops,” or clinic visits, over the number that took place in FY 2001.

Both the size of the workload gap (the margin by which it exceeds the threshold) and whether the gap was forecasted in both FY 2012 and FY 2022 were factors in deciding the priority and magnitude of response that went into the planning initiatives. One hundred forty-three (143) outpatient capacity planning initiatives were identified, all of them in response to gaps projected through increasing workload.

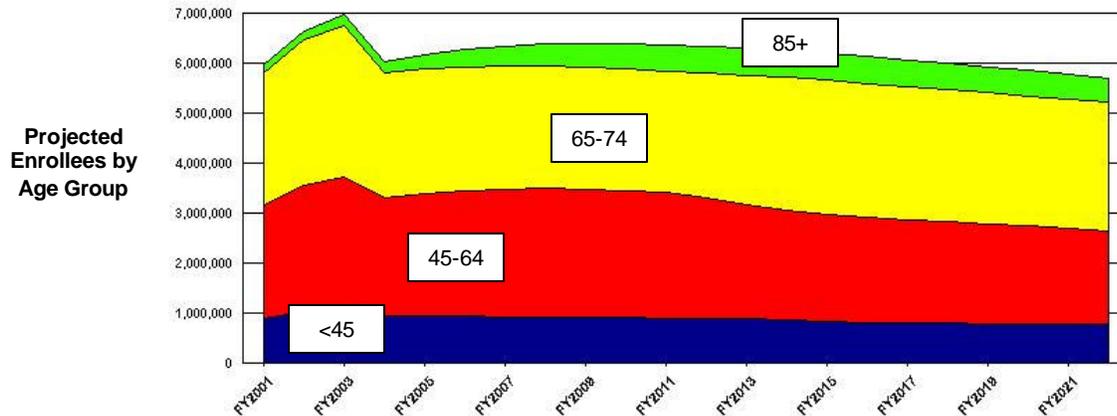
Table 5.1 Number of PIs Identified Using Outpatient Gap Threshold Criteria

CARES Category	Threshold Criteria % Change from FY2001	Workload Criteria (Stops)	# PIs Identified
Primary Care	25%	26,000	53
Specialty Care	25%	30,000	71
Mental Health	25%	16,000	19

Outpatient Workload Trends

Workload projections for both the outpatient and the inpatient categories discussed in the next chapter are impacted by projected enrollment trends, by anticipated changes in health care practices, and by new technologies that permit more treatment on an outpatient rather than an inpatient basis. Changes in veteran enrollment are impacted by the aging of current enrollees, influx of new enrollees from active duty status, and reliance on Medicare and other private sector health providers, as shown in Figure 5.1.³

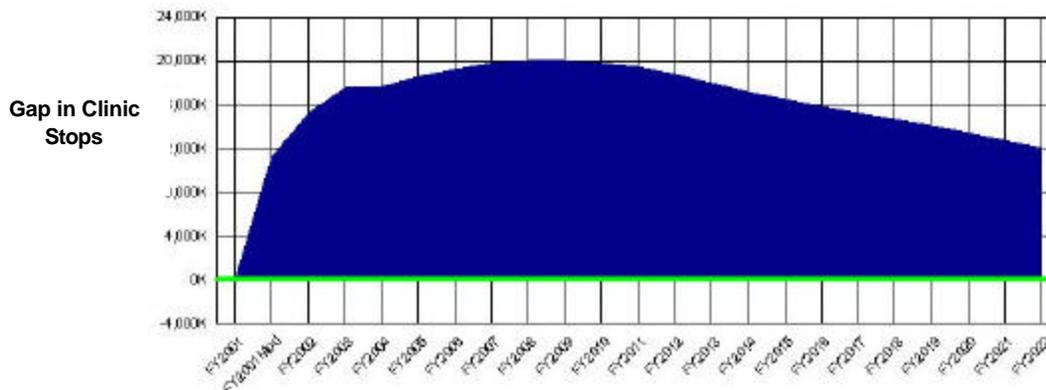
**Figure 5.1 National CARES Enrollment Projections by Age Group
Projected Enrollees 2001 to 2022**



Gaps in Clinic Stops

Figures 5.2 through 5.5 show the variance in outpatient workload (clinic stops) projected for each year through FY 2022 compared with baseline workload (actual FY 2001). This variance between projected workload and baseline workload is referred to as a 'gap'. The CARES forecasting model projects that outpatient clinic stops will increase significantly from the baseline year through FY 2009 and then will gradually decline as illustrated in Figure 5.2 below. The projected workload in FY 2022, although lower than the peak in FY 2009, will still represent a net increase in workload from FY 2001.

**Figure 5.2 CARES National Outpatient Workload Gaps
Primary Care, Specialty Care and Mental Health**



³ CACI/Milliman Enrollment/Demand Model can be found under References

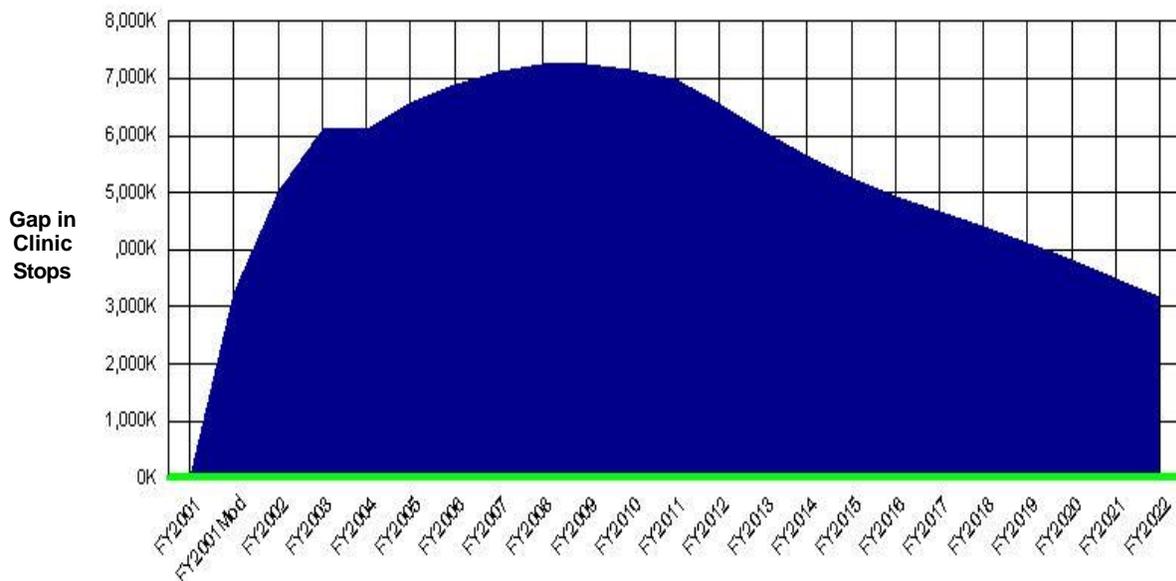
Breaking up this single trend line for a closer look at the three CARES outpatient categories reflects significant differences in projected gaps in each respective area.

Primary Care

Projected national workload gaps, measured in outpatient primary care clinic stops⁴, are shown in the graph below. The most significant gap in workload is projected between the baseline year (FY 2001) and the first year of forecast demand (FY 2002). This initial gap in what VHA actually provided in FY 2001 and what the model forecasts for FY 2002 was due to the CACI/Milliman Demand Model assumptions that supply would be available for all projected veteran demand. The model implied that FY 2001 workload was artificially suppressed due to budgetary, capital or staffing constraints.

The primary care workload gap is projected to grow in future years until an anticipated decrease in enrollment levels (due to declining veteran population) becomes a significant factor around FY 2009 (as shown in Figure 5.3 below).

Figure 5.3 Projected Gaps in Primary Care Clinic Stops by Fiscal Year

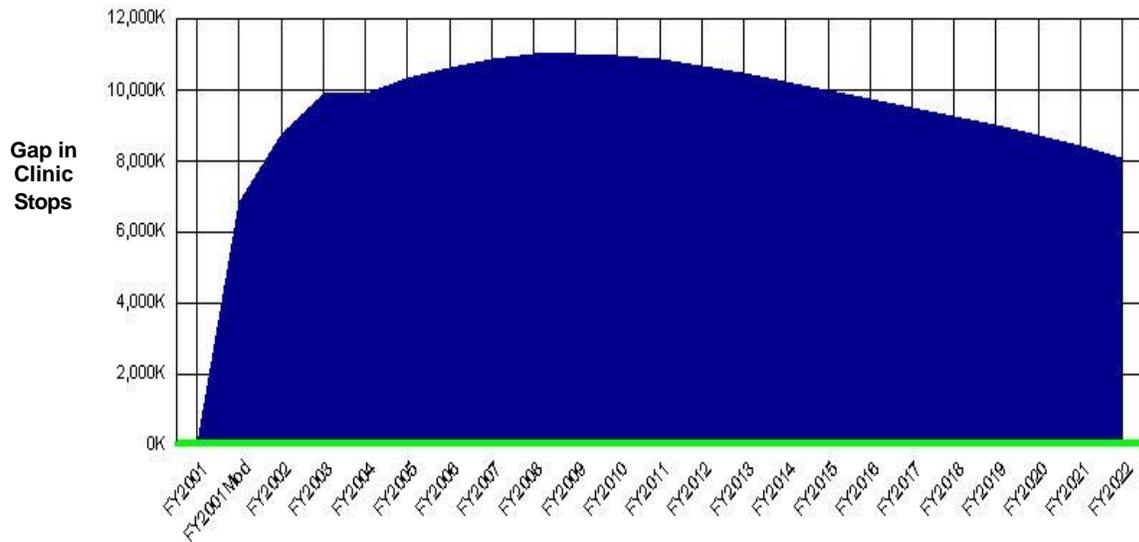


⁴ Appendix L lists the clinic stop codes (subspecialties) associated with each of the Outpatient CARES Categories

Specialty Care

Projected national workload gaps, measured in outpatient specialty care clinic stops, are shown in the graph below (Figure 5.4). Again, the most significant gap is projected between FY 2001 and the first year of forecasted demand. This forecasted, initial gap is even more pronounced for specialty care (an indication which validates VHA's current focus on reducing waiting times for such sub-specialty services as cardiology, ophthalmology, orthopedics and urology). The projected gap in specialty care workload continues to grow in future years until the anticipated decline in enrollment levels becomes a significant factor in FY 2010.

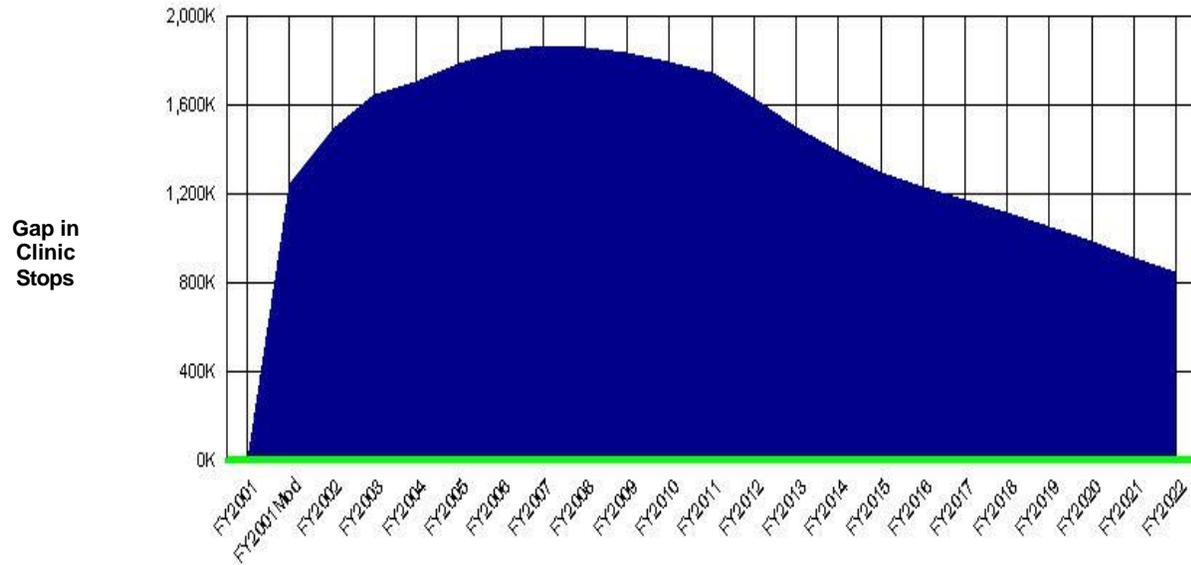
Figure 5.4 Projected Gaps in Specialty Care Clinic Stops by Fiscal Year



Mental Health

Projected national workload gaps, measured in outpatient mental health clinic stops, are shown in Figure 5.5. Declining enrollment levels and utilization rates of veterans age 65 and older become significant factors in FY 2008.⁵

Figure 5.5 Projected Gaps in Mental Health Care Clinic Stops by Fiscal Year



⁵ **Note:** The Mental Health outpatient projection methodology is being reviewed and is under revision. The projections shown in Figure 5.5 are probably underestimates of the demand for services. The forecasts will be updated for the next Fiscal Year strategic planning cycle.

Summary of Outpatient Capacity Solutions

VISN CARES Market Plans identified a variety of options to resolve all projected outpatient workload gaps, including those associated with Outpatient Capacity Planning Initiatives, and manage space requirements at each facility.

Tables 5.2 and 5.3 show how VHA will handle outpatient workload for two snapshots in time, FY 2012 and FY 2022. Outpatient workload units in these tables represent the total number of clinic stops projected for each facility in each VISN, rolled up to the national level. The total number of projected clinic stops in each CARES category was used to estimate the amount of space needed at each facility for each of the planning years. VISNs were required to solve each of their facilities' total space needs in each of the CARES categories. Tables 5.2 and 5.3 focus on outpatient Primary Care, Specialty Care and Mental Health Care solutions for two of the planning years – FY 2012 and FY 2022.

By FY 2022, VHA will handle approximately 85 percent of all outpatient workload in-house. Contracting for outpatient workload is used as a short-term solution to a greater extent in earlier years when workload is at its peak.

Table 5.2 Workload Solutions for Outpatient Categories – FY 2012

Workload Alternative	Primary Care		Specialty Care		Mental Health	
	Number of Clinic stops	Percent of Total	Number of Clinic stops	Percent of Total	Number of Clinic stops	Percent of Total
Contract	2,959,588	14.3%	3,835,207	17.2%	1,214,262	12.0%
Joint Venture	44,450	0.2%	203,608	0.9%	22,200	0.2%
In-Sharing	88,860	0.4%	66,518	0.3%	442	0.0%
Sell	0	0.0%	640	0.0%	530	0.0%
In-house	17,547,286	85.1%	18,135,140	81.6%	8,851,592	87.8%
Total Demand	20,640,184		22,241,113		10,089,026	

Table 5.3 Workload Solutions for Outpatient Categories – FY 2022

Workload Alternative	Primary Care		Specialty Care		Mental Health	
	Number of Clinic stops	Percent of Total	Number of Clinic stops	Percent of Total	Number of Clinic stops	Percent of Total
Contract	2,175,508	12.5%	3,056,393	15.4%	957,536	10.3%
Joint Venture	41,450	0.2%	200,950	1.0%	24,200	0.3%
In-Sharing	88,860	0.5%	66,518	0.3%	442	0.0%
Sell	0	0.0%	640	0.0%	530	0.0%
In-house	15,089,305	86.8%	16,470,253	83.3%	8,336,124	89.4%
Total Demand	17,395,123		19,794,754		9,318,832	

Table 5.4 presents outpatient space solutions for all planning years combined – through FY 2022. A combination of solutions are planned to resolve space requirements in order to meet future outpatient workload demand. Primary care solutions rely more heavily on the use of leased space as part of providing appropriate access and space within markets.

Table 5.4 Space Solutions for Outpatient Categories – Cumulative through 2022

Space Alternative	Primary Care		Specialty Care		Mental Health	
	Square Feet	% Total	Square Feet	% Total	Square Feet	% Total
Existing-Non Renovated	4,867,243	48.1%	8,583,918	42.7%	3,260,328	56.8%
Renovate Existing	984,836	9.7%	1,299,938	6.5%	540,547	9.4%
Convert Vacant	363,183	3.6%	1,324,502	6.6%	284,919	5.0%
New Construction	1,064,626	10.5%	4,776,324	23.7%	658,975	11.5%
Donate	56,785	0.6%	128,554	0.6%	22,520	0.3%
Lease	2,745,428	27.1%	3,768,876	18.7%	973,200	17.0%
Enhanced Use	45,500	0.4%	240,000	1.2%	0	0.0%
Total Space Proposed	10,127,601		20,122,112		5,740,489	

A salient feature of this multifaceted approach to acquiring needed space is flexibility. Varied approaches of this nature can be helpful in working around unexpected delays, further assuring that the VA health care system will have adequate capacity in critically important ambulatory services.

National CARES Plan

The National CARES Plan, developed from the VISN CARES Market Plans, focuses on improvements to existing outpatient delivery sites. The focus is part of the overall National CARES Plan strategic direction for maintaining VHA’s current infrastructure. Existing VHA sites and their capital requirements are included in the National CARES Plan without any priority groupings. Priority setting will occur during project-specific decisions. Reflecting a perceived need to structure new CBOCs into priority groups prior to implementation, VHA decided to group the proposed new outpatient access sites (CBOCs) into 3 priority levels, as described in detail in Chapter 4.⁶ Priority groupings will enable VHA to carefully phase-in new CBOC growth so that a balanced expansion of outpatient capacity at existing and new sites can be achieved.

⁶ Table 4.4, Chapter 4, lists the new access sites included in the draft National CARES Plan.