

Chapter 7: Enhancing Access to Special Disability Programs

Traditional Role, Substantial Responsibility in Special Disabilities

While the nation's commitment to provide medical care to eligible veterans extends across the full spectrum of injury and disease, the VA system has traditionally had a distinctive role in addressing the needs of veterans with special disabilities. In part because many of these special disabilities were incurred in wartime and in part because the intensive levels of care involved are often difficult for veterans to obtain elsewhere, VA has acquired substantial responsibility in this health care arena.

Cognizant of this history and the unique stature of Special Disability Programs (SDPs) within the VA health care system, CARES designers focused the initial application of the process on Special Disability Programs with congressionally-mandated capacity requirements, including:

- Blind Rehabilitation
- Mental Health - Seriously Mentally Ill (SMI), Post-Traumatic Stress Disorder (PTSD), and Substance Abuse
- Homelessness
- Spinal Cord Injury & Disorders (SCI/D)
- Traumatic Brain Injury (TBI)

Capacity Requirements

Under CARES, Spinal Cord Injury & Disorders (SCI/D) capacity requirements were to be maintained as measured by the monthly VA/PVA beds and staffing survey and VHA Directive 2002-022.¹ Similarly, the VISNs were advised that legislative capacity requirements for Blind Rehabilitation (BR) programs must be met.² However, since the CARES process set out to review the allocation and distribution of health care services throughout the VA system, an attempt was made to develop projections that would include an assessment of the SDPs. Program officials and clinical experts from the involved SDPs were consulted and participated actively throughout the process.

Workload Projections

Hitherto, VA has had no agreed-upon methods of projecting the needs of populations served by the SDPs. In general, the CARES planning model/process used an actuarial forecasting model (supplied by CACI/Milliman) with:

- VA and National Census databases to project enrollment and market share annually through 2022;
- Actuarial survival/mortality data and new active duty military separations;

¹ Survey by VA and the Paralyzed Veterans of America (PVA); Other references include: VHA Directive 99-013, Decision Making Authority for the SCI&D Program; VHA Directive 1176 and VA Handbook 1176.1, Spinal Cord Injury and Disorders System of CARE; and M-2, Part XXIV.

² See Reference Section: CARES Guidebook Phase II (June 2002, Chapter 5, Market Plans)

- Private sector databases to predict healthcare utilization, with adjustments for VA experience (lack of co-pay, male predominance, higher co-morbidity, use of Medicare and private sector health care and management efficiency);
- Criteria for access (travel time), safety, quality of care, impact on affiliations, research, and other missions (DoD contingency support and Homeland Security); and
- Survey of space, beds, and clinical services in all VA facilities and VISNs.

However, since VA programs to serve special disability populations are so unique, no comparable private sector utilization benchmarks were available for the SDPs; VA services continue to be the only benchmarks. Since projections for special disability programs therefore were based solely on VA utilization data, the SDP projections used in the CARES process in general were subject to several limitations:

- Some of the advantage of the Milliman forecasting model would be lost, since the VA workload data may be subject to supply constraints.³
- CARES models were not designed for service-level planning. They were configured for larger scale planning for capital asset needs. Smaller numbers tend to show wider variation and less reliability.
- In addition, internal variables, such as VA-specific factors like public policy decisions and the vision of the administration at any one time, may affect the planning assumptions used in the model.

Process and Procedures for Special Disability Program CARES Planning

The National CARES Program Office (NCPO) engaged the clinical leaders of the SDPs as active participants in the development of CARES planning models for SDPs. A Planning Initiative Selection Team made up of SDP representatives reviewed national data as projected using the CARES model from the existing Milliman categories.

In the areas of Mental Health and Traumatic Brain Injury, a number of consultations, discussions, and on-going investigation of the general CARES model did not lead to an alternative methodology to project needs for those specific SDPs. It was decided that specific recommendations from Mental Health would be further explored with representatives of the Mental Health Strategic Healthcare Group (SHG) and the Committee on the Care of Veterans with Serious Mental Illness (SMIC). Further progress in this area would be channeled into the strategic planning process that incorporates CARES.

However, in the areas of Blind Rehabilitation and Spinal Cord Injury & Disorders, the NCPO and SDP leaders were able to develop acceptable alternative data analyses and forecasting methodologies to enable inclusion of these SDPs in CARES. Subject matter experts working with actuarial and data management support personnel produced these pioneering approaches,⁴ which were generally based on:

³ Note: private sector utilization is also constrained by the benefits packages that third-party payers are willing to fund.

⁴ A detailed description of the methods and projections used can be found in Appendix Q.

- The prevalence of the Special Disability Group (SDG) in the veteran population as derived from external studies.
- Enrollment projections by health care priority group used in the overall CARES demand model as applied to the target group to obtain estimates of the enrolled SDG by VISN.
- Utilization rates based on actual FY2001 experience by VISN. Appropriate utilization rates were then applied to each projection year through 2022.

Planning Initiative selections for the Special Disability Programs were based upon the revised projections and were incorporated into the VISN-level Market Plans by February 2003. SCI/D and BR program representatives worked with the VISN-level CARES Steering Committees or Task Forces to resolve the proposed planning initiatives and met with VISN-level staff and involved veterans service organizations (VSOs).

Blind Rehabilitation (BR) Forecasts and Planning Initiatives

The BR projections, Planning Initiatives, planning recommendations, and final recommendations for CARES are summarized in Appendix Q. Briefly, two new Blind Rehabilitation Centers (BRCs) were proposed and will be forwarded for approval as follows:

- 36-bed BRC in Biloxi (VISN 16)
- 24-bed BRC in Long Beach (VISN 22)

Nevertheless, over the past several years, the BR program has increasingly emphasized the establishment of outpatient rehabilitation services in the continuum of care for visually impaired veterans. The BR program is designed to improve the quality of life for blinded and severely visually impaired veterans through the development of skills and capabilities needed for personal independence, emotional stability, and successful integration into the community and family environment.

Prior to the CARES process, the BR program was comprised of 10 Inpatient BRCs (in 8 VISNs), 92 full-time Visual Impairment Services Team (VIST) Coordinators, 20 Blind Rehabilitation Outpatient Specialists (BROS), 5 National Program Consultants, and Inpatient Computer Access Training programs at medical centers throughout the country and Puerto Rico. Services are provided using a multi-disciplinary team approach. In addition, there are currently one Visual Impairment Services Outpatient Rehabilitation Program (VISOR) and three Visual Impairment Centers to Optimize Remaining Sight (VICTORS) programs.

Spinal Cord Injury Forecasts and Planning Initiatives

The SCI/D program is a network of services provided in a “hub-and-spokes” format; the hubs are the SCI Centers and the spokes are non-center facilities. Interdisciplinary and coordinated services utilize referral guidelines to determine the appropriate site of care.

Prior to the CARES process, there were 23 SCI Centers in 15 VISNs. Due to the sizable increase in users of specialty services over the last 6 years, the CARES recommendations call for additional future capacity. The SCI/D projections, planning initiatives, planning recommendations, and final recommendations for CARES are summarized in Appendix Q. Briefly, 4 new SCI/D Units were proposed and will be forwarded for implementation as follows:

- 30-bed SCI/D Unit in Syracuse (alternatively, Albany) (VISN 2)
- 30-bed SCI/D Unit in VISN 16 (exact location still under study – proposed, North Little Rock)
- 30-bed SCI/D Unit in Denver (VISN 19)
- 30 to 40-bed unit in Minneapolis (VISN 23)

Expansion of 20 additional SCI/D beds in Augusta (VISN 7) was planned. Other initiatives included expansion of LTC (long-term care) SCI/D beds in conjunction with SCI/D Units as follows:

- 30 beds in Tampa (VISN 8)
- 20 beds in Memphis (VISN 9)
- 30 beds in Long Beach (VISN 22)
- 20 beds in Cleveland (VISN 10)⁵

Other planning issues addressed included the proposed consolidation of all VISN 3 SCI/D beds from Castle Point to the Bronx VAMC with an outpatient SCI/D program remaining at Castle Point. In addition, an outpatient SCI/D clinic will be developed at the Philadelphia VAMC.

Future Directions

Mental Health, Domiciliary/Homelessness

The NCPO, CACI/Milliman, and representatives of the Mental Health SHG and the SMI (Seriously Mentally Ill) Committee have conducted a series of reviews of the mental health inpatient and outpatient projections. The intent of the reviews was to attempt to understand the drivers of the CARES projections for psychiatry and for programs related to mental health, such as the domiciliary programs. There was a general consensus that mental health projections needed to be further studied and refined.

⁵ Note: although not originally an SDP-proposed planning initiative, the additional SCI/D LTC beds in Cleveland have been proposed by VISN 10 and are supported by the CARES planning model projections for SCI/D LTC.

For the CARES planning process, the following workload projections were held constant:

- Outpatient mental health, whenever a decrease in projected visits projected was observed;
- All non-benchmarked residential rehab programs: Substance Abuse Residential Rehabilitation, Compensated Work Therapy, Residential Rehabilitation, Post-Traumatic Stress Disorder Residential Rehabilitation Treatment, Sustained Treatment and Rehabilitation (STAR) and Domiciliary Programs.

Domiciliary beds and other non-benchmarked services were originally projected based upon a national average utilization rate, which, in effect, would have resulted in a redistribution of beds from those VISNs or markets with larger numbers of beds to those with fewer beds. Such redistribution was felt to be inappropriate and raised a number of policy and programmatic questions, which are being explored further and will be revised as CARES is incorporated into the next strategic planning cycle.

The goals of the review will be to modify and improve the projection methodology for Mental Health services in general and residential rehabilitation programs in particular. Decisions regarding the utilization rates and distribution of the various Mental Health rehabilitation programs should be focused on the mission and programmatic content of these programs, and quantified by the available data. Recommendations should be “evidenced-based” to the extent possible. Any alternative projections methodology should be linked to VA’s official Veteran Population demographic database.

Traumatic Brain Injury

The VA has established four primary Traumatic Brain Injury (TBI) Centers, located at the VAMCs in Richmond, VA; Minneapolis, MN; Palo Alto, CA; and Tampa, FL. These four TBI Centers provide leadership for the additional 19 VAMCs and three military hospitals participating in the TBI Network for provision of specialized TBI services.⁶

TBI services were included in the current cycle of CARES, but workload data for this area were not separately listed. Applicable workload was included in various categories, including outpatient specialty care, inpatient rehabilitation, and outpatient primary care, as appropriate. The NCPO discussed the application of the CARES process in this specialty area with program officials within the Rehabilitation Strategic Healthcare Group for TBI programs. Research in the forecasting and geographic distribution of need for TBI services is on going and will be incorporated into VA’s strategic planning efforts as it becomes available.

⁶Refer to IL 10-97-010, Traumatic Brain Injury Network of Care.

National CARES Plan

Based upon projections for increased demand for services, several new Blind Rehabilitation Centers (VISNs 16 and 22) and SCI/D units (VISNs 2, 16, 19, and 23) have been included in the National CARES Plan. In addition, expansion of SCI/D long-term care beds in VISNs 8, 9, 10, and 22 have been recommended for implementation as well as additional acute/sustaining SCI/D beds in VISN 7. An outpatient SCI/D clinic at Philadelphia VAMC will be developed to meet the needs of veterans in the Eastern Market of VISN 4, including South Jersey, Eastern Pennsylvania and Delaware.

Table 7.1 below summarizes the cost of capital investments required to accomplish the proposed enhancements to Special Disability Programs outlined in this chapter.

**Table 7.1 Capital Investments for Special Disability Programs
FY 2022 – FY 2022**

Special Disability Program	Renovation of Existing Space (Square Feet)	New Construction (Square Feet)	Lease (Square Feet)	Total Costs in Current \$
Blind Rehabilitation	31,106	35,500	0	\$9,587,628
Spinal Cord Injury	41,799	382,172	0	\$94,263,411
Residential Rehab	65,594	63,705	26,874	\$15,458,463
Domiciliary	328,419	111,153	0	\$52,330,817

NOTE: These cost estimates do not include the proposed Philadelphia outpatient SCI/D clinic.