

CARES Planning Initiative Selection Criteria for Non-Special Disability Programs



**National CARES Project Office (NCPO)/
VISN Support Service Center (VSSC)**

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CARES Planning Initiative Selection Criteria (Excluding Special Disability Programs)

A. Purpose

The purpose of this document is to define the data-driven criteria and thresholds used by VA Central Office in selecting and prioritizing Planning Initiatives from the CARES gap data for VISN Market Plan development for all CARES categories except Special Disability Programs. A separate supplement will provide guidance for identifying Planning Initiatives for the Special Disability Programs.

B. Background

The process by which CARES gap data will be presented and analyzed using Planning Initiative Selection Teams is outlined in a previously published document titled, "Selecting Planning Initiatives: A Description of the Process for Participants and Stakeholders." Gaps will be analyzed for access to care, redundancy of services, workload demand. Planning Initiatives will be identified for significant gaps between current supply of services and future workload demand. This document defines the actual criteria and thresholds used to identify a gap as "significant", and the prioritization process that will ultimately identify a VISN's set of Planning Initiatives for development in their Market Plan.

C. Methodology

Step 1: Gaps between current supply (FY2001) and future demand (FY2012 and FY2022) will be summarized in an Excel spreadsheet for all CARES categories.

VISN Gaps

- Proximity Gaps (Distance Between Acute Care and Tertiary Care Facilities)

Market Level Gaps (Demand Data by Market and Facility Data)

- 50-Bed Acute Care Hospitals (Projected BDOC/Beds)
- Inpatient Medicine (BDOC/Beds)
- Inpatient Surgery (BDOC/Beds)
- Inpatient Psychiatry (BDOC/Beds)
- Inpatient Residential Rehab (PPRTP/PTSD RRTP) (BDOC/Beds)
- Inpatient Nursing Home/Intermediate Medicine (BDOC/Beds)
- Inpatient Domiciliary (BDOC/Beds) at each facility in the market
- Outpatient Primary Care (Clinic Stops)
- Outpatient Specialty Care (Clinic Stops)
- Outpatient Mental Health (Clinic Stops)
- Primary Care Access (FY2001 % Enrollees Within Travel Guidelines)
- Hospital Care Access (FY2001 % Enrollees Within Travel Guidelines)
- Tertiary Care Access (FY2001 % Enrollees Within Travel Guidelines)
- Vacant Space (Square Footage)

Step 2: Workload variance and the percent increase/decrease from FY2001 in beds, clinic stops and number of enrollees will be calculated for both FY2012 and FY2022.

Step 3: The FY2012 gaps and the FY2022 gaps will both be sorted in descending order by the absolute value of the percent increase/decrease from FY2001.

Step 4: For each of the two years (FY2012 and FY2022), the thresholds listed in Section D of this document will be applied to each of the CARES categories to determine what is considered a "significant gap." For the CARES category workload gaps, criteria will be applied to the facility gaps that make up that market. If any of the market's facilities meet the threshold in FY2012 for a CARES category, then a Planning Initiative will be identified for that market.

NOTE: Gaps that meet thresholds in FY2012 but not in FY2022 will be considered Planning Initiatives. Gaps that do not meet thresholds in FY2012 but do meet thresholds in FY2022 will not be considered Planning Initiatives. Because the FY2022 projections are less precise, there is less confidence in relying on FY2022 bed projections. However, looking at the FY2022 gaps gives a perspective on planning the appropriate solution to a FY2012 gap.

Step 5: Gaps that have met the criteria and threshold levels to be considered "significant" will then be prioritized from the largest absolute value percent change from FY2001 to the lowest absolute value percent change. This step will be done for the FY2012 gaps and for the FY2022 gaps.

Step 6: The prioritized gaps for FY2012 and FY2022 will be placed side by side and the Planning Initiative Selection Team will determine the final combined prioritization.

Step 7: Discussion will be held with the Planning Initiative Selection Team on the outcome of the above selection and prioritization process to see if there are any areas of concern with what Planning Initiatives reached top priority, and the number of Planning Initiatives that resulted for each market and for the VISN as a whole.

D. Criteria and Thresholds for Identifying Planning Initiatives

Measurable criteria used to select Planning Initiatives (significant gaps) from the gap data listed in the previous section will include:

Special Disabilities (VISN): Planning Initiatives will be identified by a separate process. This will be defined as a separate supplement to the Planning Initiative process.

Proximity (VISN): Identify acute care hospitals with similar missions that are within 60 miles of each other, or two tertiary care hospitals with similar missions within 120 miles of each other. These facilities may need to look at opportunities for consolidation and infrastructure realignment due to close geographic

proximity (Redundancy of Services). Once the Planning Initiative Selection Team has validated with the VISN Representative that the identified facilities meet these criteria, a Planning Initiative will be developed.

Data Source: MapPoint 2000 distances between facilities identified by each VISN as having acute care or tertiary care missions.

Additional Data Provided: Number of Enrollees, Veteran Population, Clinical Inventory, and FY2001 Users for identified facilities.

40-Bed Facilities (Market): Identify acute care facilities (acute medicine, surgery, and/or psychiatry) that are projected to be at 40-beds or less in FY2012 and FY2022 for further review. Once the Planning Initiative Selection Team has validated with the VISN Representative that the identified facilities meet these criteria, a Planning Initiative will be developed. One of the areas of validation will include the removal of long term psychiatry beds from the acute psychiatry bed counts. Long-term psychiatry beds should not be included in the 40-bed level. These data are not readily available.

NOTE: Facilities that meet thresholds in FY2012 but not in FY2022 will be considered Planning Initiatives. Facilities that do not meet thresholds in FY2012 but do in FY2022 will not be considered Planning Initiatives. Because the FY2022 projections are less precise, there is less confidence in relying on FY2022 bed projections. However, looking at the FY2022 gaps gives a perspective on planning the appropriate solution to a FY2012 gap.

Data Source: List of VA facilities to see nearest VA facilities, and Clinical Inventories. VSSC calculations based on projected bed days of care for FY2012 and FY2022 for acute medicine, surgery and psychiatry, translated to projected beds using the following formula:

Acute Care Beds (85% Occupancy Rate) = BDOC/365 days/.85

Inpatient Workload (Market): Planning Initiatives are identified for a market if one or more facilities have a variance that increases or decreases by at least **6,204 BDOC (20+ beds)**.

Data Source: Thresholds were set based on an estimated amount of facility workload that would result in the need for an increase or decrease of 12,000 square feet or more to accommodate. 20 beds were selected as a size for which a facility may have to reconfigure wards. This also equates to about 12,000 square feet using the national average of two square feet per bed day of care (National Space and Functional Survey Data).

Outpatient Workload (Market): Planning Initiatives are identified for a market if one or more facilities have a variance that increases or decreases by the following thresholds:

- Primary Care and Geriatrics = 26,000 stops
- Specialty Care = 30,000 stops
- Mental Health = 16,000 stops

NOTE: Planning Initiatives will not be identified for the Ancillary/Diagnostic CARES category. This category consists of many different types of workload with varying space demands. The resulting data is difficult to use as a planning tool.

Data Source: Thresholds were set based on an estimated amount of facility workload that would result in the need for an increase or decrease of 7,000 square feet or more to accommodate. This calculation was different for each type of care, utilizing VA Handbook 7610 Space Planning Criteria (Formerly H-08-9).

Primary Care: 7,000 square feet translates into the following estimated clinic stops.

7,000 square feet = 16 exam rooms plus support space (pharmacist, dietician, social worker, waiting, toilets, reception, storage, etc.)

8 Providers x 3,200 Clinic Stops/Provider/Year (see below) = 25,600 Clinic Stops per Year

Assumptions:

Clinic Hours = 8 hours/day

7,000 Square Feet = 16 exam rooms

Exam Rooms per Provider = 2

Estimated Providers = 8

Clinic Stop Length per Provider = 30 minutes

Clinic Stops/Provider/Day = 16 clinic stops per provider day

Work Days per Year = 250 work days

Clinic Stops/Provider/Year Unadjusted = 4,000 stops

Exam Room Efficiency = 80%

Clinic Stops/Provider/Year Adjusted = 3,200 stops

Specialty Care: 7,000 square feet translates into the following estimated clinic stops.

7,000 square feet = 10 exam rooms plus support space (procedure rooms, waiting, toilets, reception, storage, etc.)

10 Providers x 3,000 Clinic Stops/Provider/Year (see below) = 30,000 Clinic Stops per Year

Assumptions:

Clinic Hours = 8 hours/day

7,000 Square Feet = 10 exam rooms

Exam Rooms per Provider = 1

Estimated Providers = 10

Clinic Stop Length per Provider = 30 minutes

Clinic Stops/Provider/Day = 16 clinic stops per provider day

Work Days per Year = 250 work days

Clinic Stops/Provider/Year Unadjusted = 4,000 stops

Exam Room Efficiency = 75%

Clinic Stops/Provider/Year Adjusted = 3,000 stops

Mental Health: 7,000 square feet translates into the following estimated clinic stops.

7,000 square feet = 10 exam rooms plus support space (group rooms, waiting, toilets, reception, storage, etc.)

10 Providers x 1,600 Clinic Stops/Provider/Year (see below) = 16,000 Clinic Stops per Year

Assumptions:

Clinic Hours = 8 hours/day

7,000 Square Feet = 10 exam rooms

Exam Rooms per Provider = 1

Estimated Providers = 10

Clinic Stop Length per Provider = 60 minutes

Clinic Stops/Provider/Day = 8 clinic stops per provider day

Work Days per Year = 250 work days

Clinic Stops/Provider/Year Unadjusted = 2,000 stops

Exam Room Efficiency = 80%

Clinic Stops/Provider/Year Adjusted = 1,600 stops

Access (Market): Identify markets in which less than 70% of projected 2012 or 2022 enrollees are within Primary Care access guidelines, 65% within Acute Hospital and Tertiary Care access guidelines. These targets were set based on the national trim mean percent of enrollees meeting driving time guidelines and the mean number of enrollees impacted, within each of the three categories across all markets. Planning Initiatives are identified as follows:

- Primary Care Access: Below target of 70%; 11,000 enrollees impacted.
- Hospital Care Access: Below target of 65%; 12,000 enrollees impacted.
- Tertiary Care Access: Below target of 65%; 12,000 enrollees impacted.

Number of Enrollees Impacted Calculation

- Primary Care: (Guideline 70%) - Market Access %) * FY2001 Enrollees
- Hospital/Tertiary Care: (Guideline 65%)- Market Access %) * FY2001 Enrollees

Data Source:

Driving Time Guidelines:

| GUIDELINES | Urban | Rural | Highly Rural |
|--|------------|------------|--------------|
| Primary Care | 30 minutes | 30 minutes | 60 minutes |
| Inpatient Hospital Care (Med/Surg/Psych) | 60 minutes | 90 minutes | 120 minutes |
| Tertiary Hospital Care | 3-4 hours | 3-4 hours | Within VISN |

Calculation of Thresholds:

The numbers of enrollees who did not meet the driving time standards for Primary Care, Hospital Care and Tertiary Care were calculated for each market. Thresholds for the number of enrollees impacted by not meeting the driving time guidelines were set at 50% of the 5% trimmed mean of these non-compliant enrollees. The Tertiary Care threshold was set at the same level as Hospital Care since nationally the number of non-compliant enrollees was very small.

Vacant Space (Market): Vacant space will be totaled by market. Vacant space is the difference between owned space and space required by the workload-driven CARES categories for the years 2012 to 2022. There are no threshold criteria for vacant space. All facilities will automatically have a required Planning Initiative for Vacant Space that will address any excess space after all other Planning Initiatives have been developed. Vacant Space will fluctuate during the Market Plan process depending upon space used or eliminated in developing solutions to Planning Initiatives. It is expected that vacant/excess space will be reduced by at least 10% in the first year of Market Plans, and 30% in the second year.

Data Source: Space and Functional Surveys

Space Capacity Gaps: Space capacity gaps will not be identified as Planning Initiatives. Space is directly proportional to workload demand. Therefore, no Planning Initiatives will be identified for space only, except for Vacant Space.

Data Source: Space and Functional Surveys

Space Condition Gaps: Space condition gaps will not be identified as Planning Initiatives, but will be addressed during the Market Plan process. The Planning Initiative software will have the space condition codes identified with each CARES category. .

Data Source: Space and Functional Surveys