

New CARES Forecasting Data Run **Questions and Answers**

Why did VA rerun the enrollment forecasts for CARES?

In order for the CARES market plans to be the basis for credible funding requests to Congress, VA policy changes, including the recent enrollment decision and the administration's policies proposed in the FY 04 budget, must be incorporated into the CARES projections. Additionally, the VA only recently received the veteran-specific information from Census 2000 needed for CARES. Using Veteran Population numbers based on the 1990 Census has been an ongoing concern for veterans and stakeholders and rerunning the CARES data with Census 2000 information will improve the validity and credibility of the CARES projections.

In addition, the new enrollment policies, including enrollment fees, co-payment increases, and Priority 8 designation have been incorporated in new enrollment and utilization projections for CARES. The CARES office has also developed forecasting methods for Spinal Cord Injury and Blind Rehabilitation Programs and has identified several Planning Initiatives for each of these programs.

Did rerunning the numbers have a lot of impact on the old Planning Initiatives?

No. Across the Nation, there were only a few changes to CARES Planning Initiatives and most of those have limited impact upon the already selected Planning Initiatives. In all, there was a net decrease in the number of outpatient clinic stops by 1 million and a net increase in inpatient beds of 220 compared to previous projections across all market areas. In the final count, there were five fewer capacity planning initiatives and five changes to the small facility planning initiatives.

The small changes to the Planning Initiatives can be attributed to:

- CARES Planning Initiatives use a large (25%) threshold.
- Many gaps were so large that the increases or declines had no impact on the Planning Initiative threshold, for example some Planning Initiatives based on an 150 percent increase in projected demand. The new data run may have reduced that to 120 percent.
- Although there was a drop in the forecasted numbers of Priority 8s, the impact was not that great because Priority 8 veterans use VA health care at a lower rate, particularly for inpatient care.

VA will rerun the CARES demand projection model whenever there is a major change in policy to ensure applicability and accuracy of the projections. Veterans, employees, Congress, affiliates and other stakeholders have a right to expect CARES projections to be as accurate as possible and VA intends to meet those expectations.

What were the changes to the small facility planning list?

Five of VA's 162 hospitals were impacted by the rerun numbers and are either on or were taken off the small facility planning list. In summary, two hospitals were added and three were removed from the list. The VA medical centers in Dublin, Ga. and Walla Walla, Wash., VA are now projected to have fewer than 40 beds in 2012 and 2022, the standard set by the CARES program office. Three VA medical centers that were on the original list; Wilmington, Del.; Big Springs, Texas, and Sioux Falls, S.D., are now projected to need more than 40 beds in 2012 and/or 2022 and were removed from the list.

Currently there are 19 VA medical centers on the small facility list, these are: Castle Point, N.Y.; Altoona, Pa.; Butler, Pa.; Erie, Pa.; Ft. Wayne, Ind.; Saginaw, Mich.; Poplar Bluff, Mo.; Muskogee, Okla.; Kerrville, Texas; Prescott, Ariz.; Beckley, W.V.; Cheyenne, Wyo.; Grand Junction, Colo.; Walla Walla, Wash.; Des Moines, Iowa; Knoxville, Iowa; St. Cloud, Minn; Hot Springs, S.D. and Dublin, Ga.

What does that mean when a facility is on this list? Will all these hospitals close?

Not necessarily, there could be a change in the hospital mission or a determination to keep it open because it is the only care available to veterans. However, VA has concern for the quality of care and efficiency of operations that can be provided at facilities that have fewer than 40 beds.

Veterans' health care needs are changing, the way medical care is delivered is changing, and the veteran population is geographically shifting. The majority of VA medical care is provided in outpatient clinics and VA should not keep unneeded beds open at the expense of access and quality.

It is important to mention that hospital beds themselves do not equate with quality or quantity of medical care. All 19 facilities will be fully evaluated and alternatives developed that may provide for a more efficient use of resources while ensuring quality of care. Networks will review numerous quality issues, including clinical proficiency, safety, and ensuring that the mix of services provided at the facility are appropriate to demand projections. Other considerations include community health care options, access, condition of facility and patient satisfaction.

Chapter 5 of the CARES Guidebook-Phase II and the Market Plan Development Supplement provide specific guidance on quality measures and considerations to assist in assessing small facility planning. The Clinical CARES Advisory Group and the Under Secretary for Health will also evaluate the Market Plans from the standpoint of quality and patient safety. Some of issues to be evaluated include:

- How has the facility fared with accrediting bodies and other external reviews?
- How will specialty coverage be addressed?
- Are patient workload volumes sufficient to attract and fully utilize and maintain personnel and maintain skill levels appropriate to workload?
- Are surgical procedures performed often enough to meet known minimum standards for quality?
- What is the cost per bed day of care compared with VISN and VA national average?
- Are there opportunities to increase inpatient workload through sharing agreements (with DoD for example), enhanced use, etc.?

What happens to veterans if a facility does close?

Simply put: No veteran will lose his or her VA health care because of CARES. Though CARES may call for changes in the places where veterans health care is delivered, it will not reduce veterans health care services. If a draft Market Plan recommends closure of inpatient beds, it must illustrate an alternative way to provide that care.

In a recent VATV interview on CARES, Deputy Secretary Leo Mackay said, “I assure you in an iron-clad way, that CARES will not result – will not result– in the abandonment of an area of service or in veterans having no other options for VA care.”

How will CARES impact VA employees?

It is too early in the process to speculate on how health care realignments and enhancements will impact VA employees and veterans. Employees are important stakeholders and are encouraged to provide input throughout the CARES process. The CARES planning process requires that Market Plans contain strategies to minimize any adverse impact on employees. The National CARES Plan will be presented to the Secretary for decision in October 2003. Upon receiving approval for the National Market Plan, each Network will develop a comprehensive implementation plan. A key part of the implementation plan is identifying how stakeholders will be kept informed and involved in the implementation process. Every effort will be made to minimize the impact on employees and patients. If warranted, staff reductions will be accomplished gradually through attrition, early retirements, reassignments to programs where services are being enhanced and reassignments to other locations.

How did VA project data on veteran enrollment for VA health care?

VA estimated how many veterans there will be in the years to come and how many of them will enroll in VA health care. To estimate how many veterans there will be, VA counted how many veterans there are and then for each future month, added the number of new veterans expected to be discharged from the Armed Forces and subtracted the number of estimated deaths.

Predicting how many veterans would enroll adds additional complexity and VA had to make some assumptions based on veterans’ choices during the relatively short time since enrollment started. To lessen the chance of error, VA estimated specific enrollment rates for veterans in four age groups and in each of the enrollment priorities. All of these different rates were estimated for every county in the United States.

Then VA multiplied the predicted number of veterans with the predicted enrollment rate to get the predicted number of newly enrolled veterans for each projection year.

What are the data sources VA is using in CARES?

1. Projections from the 2000 Census data;
2. Historical military separations and projected separations (using the Defense Department’s actuarial model);
3. VA’s Compensation and Pension file. This file identifies veterans with disabilities and can help determine migration patterns (studies show that veterans are twice as mobile compared with the general population as a whole); and

4. Enrollee projections (prepared by an outside contractor). Current and projected enrollee data are analyzed by county (or zip code for urban areas), age group and enrollment categories. Additionally, the data includes the Secretary's recent decision to stop enrolling Priority 8 veterans, and other proposed policy changes such as an enrollment fee and increased copayments for outpatient visits and pharmaceuticals.

What are the criteria to be used in evaluating Planning Initiatives?

1. Health care quality and need (whether the initiatives impact on the quality of care and whether the initiatives meet the identified gaps in services);
2. Safety and environment of care;
3. Appropriate access to care (travel time);
4. Impact on research and education programs;
5. Impact on employees and communities;
6. Impact on community health care providers;
7. Support of other VA missions (VA-DoD collaboration, collocation with other VA administrations, VA's contingency role as medical backup to DoD, VA's role in Homeland Security and emergency preparedness); and
8. Optimizing the use of VA resources (cost-effectiveness, "right sizing" and realigning facilities based on future demand and needs).

Will CARES be including long term care planning initiatives with the new set of numbers?

Yes, the nursing home/long term care forecasting model is being revised to enable the identification of Planning Initiatives for this CARES cycle. Revised projections were updated for policy changes, with Census 2000 incorporated. The following policies should be noted:

1. Nursing home planning initiatives will be resolved as other Planning Initiatives when the data becomes available.
2. The main source for allocation of the increased demand for long term care should be state and community nursing home beds. While policy guidance does not preclude renovations of existing beds or building new beds, VA's emphasis is on increasing the proportion of beds provided by the state and the community.
3. The projected demand assumes the development of home health care, Adult Day Care, Home-based Primary Care, and Reduced Physical Functioning (RPF – a.k.a. 'assisted living') resources for the strategic development of the long term care continuum. Market plans will address the strategic development of these programs in this and future strategic planning cycles.
4. VA will be looking for innovative alternatives to institutional long term care whenever possible.

Are there any areas that VA will not be looking at during this cycle of CARES?

Yes. There will be no Planning Initiatives for domiciliary, reductions in outpatient mental health and long term psychiatric (residential rehabilitation) care. Work is underway to improve the forecasting models and to address policy issues for these programs. Meanwhile, current bed levels and outpatient programs will be held constant for this cycle of CARES.

What’s the next step in the CARES process? What can I do to participate?

Networks have until April 15 to develop Draft Market Plans (solutions) to the Planning Initiatives (gaps). At that time, all the Draft Market Plans will be reviewed by the Under Secretary for Health and various clinical teams. This plan will then be given to the independent CARES Commission for review (see timeline below).

Now is the most critical time for stakeholder involvement and stakeholders are encouraged to contact their local VA facilities. Nevertheless, veterans and stakeholders are not limited to providing input during this time. In fact, veterans and stakeholders are encouraged to be actively involved throughout the entire CARES process.

To assure that veterans’ and stakeholders’ concerns are properly addressed, an independent CARES Commission will be appointed by the Secretary of Veterans Affairs. The Commission will consider views and concerns presented in writing during the 60-day public comment period following submission of the initial recommendations by the Under Secretary for Health and in public hearings held by the Commission.

CARES TIMELINE

Roll out	<i>June 2002</i>
Markets established	<i>July 2002</i>
Demand data (Actuary & VSSC)	<i>Oct 2002</i>
Planning Initiatives identified	<i>Nov 2002</i>
Submit completed market plans	April 15, 2003
Initiate VHA/Under Secretary review	April 15, 2003
Publish Draft Nat’l CARES Plan	June 1, 2003
CARES Commission review	June 1, 2003
Recommendations to Secretary	Sept. 30, 2003
Secretary’s Decision	Oct. 30, 2003