

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

Summary Report Of Initial Meeting

February 19-20, 2003
Jefferson Hotel, Washington, D.C.

Commissioners in Attendance:

Everett Alvarez, Jr., Chairman
Charles Battaglia
Joseph E. Binard, MD, FRCSC
Raymond Boland
Vernice Ferguson, RNB, M.A., F.A.A.N., F.R.C.N.
John Kendall, MD
Richard McCormick, PhD
Richard Pell, Jr.
Robert A. Ray
Sister Patricia Vandenberg, CSC
Raymond John Vogel, Vice Chairman
Jo Ann Webb, RN, MHA
Michael K. Wyrick, Major General, USAF (Ret.)
Al Zamberlan, F.A.C.H.E.

Commission Staff Present:

Richard E. Larson, Executive Director
Nicheole Amundsen
Ron Bednarz
Kathy Collier
Dick Fry
Bill Judy
Shirley Lai, Staff Assistant
Susan M. Webman, Counselor

February 19, 2003

**Opening Remarks -
Chairman Everett Alvarez**

Chairman Alvarez opened the meeting, welcomed the Commissioners and summarized the agenda for the next two days:

- Secretary of Veterans Affairs, Anthony Principi, leads off the agenda with a welcoming talk to the Commission.
- For the rest of today -- February 19 -- the Commission will receive presentations providing an overview and summary of the CARES program.
- Tomorrow -- February 20 -- the Commission will receive an ethics briefing and receive additional presentations in the morning. Most of the day will be spent in administrative session discussing the Commission's schedule, organization and administrative matters.

Most Commission sessions will be open; all matters of substance must be taken up in open session. Administrative and organizational matters are an exception to the requirement and may be discussed in closed session.

The Commission will have 15 members, including the Chairman. The Commission will be making field visits and holding public hearings to get its work done. A 15-member Commission provides the flexibility to divide the work up among panels if it wants -- perhaps three panels of five members each.

The Commission is working on a short time frame. CARES recommendations from VA's Under Secretary for Health are scheduled to be presented to the Secretary by the end of May. The Commission is being asked to deal with them by October.

The Chairman thanked the Commissioners for their willingness to participate. Recognizing that it will be impossible to satisfy everybody, he views the challenge as an opportunity to do something good and positive for those being served.

Chairman Alvarez next introduced VA Secretary Principi.

**Keynote Address
By
The Honorable Anthony J. Principi
Secretary of The Department of Veterans Affairs**

Secretary Principi welcomed the Commissioners with the following remarks:

The goal of VA's CARES project is clear ----- transformation of VA's legacy healthcare facilities, inherited from the last, or even the 19th, century, into the infrastructure we need to provide 21st century medical care to 21st Century veterans.

VA's CARES team, at both the local and national level, will do the research and evaluation needed to generate "planning initiatives" to make that transformation a reality. The Undersecretary for Health will evaluate those planning initiatives, synthesize them into a national perspective and present me with a national recommendation. I will make such amendments as I believe are appropriate and then present the national plan to you for your consideration.

The role of the CARES commission is not to define the breadth or depth of VA's healthcare mission. The extent to which VA provides healthcare is defined by the resources made available. The President and the Congress make that decision.

One segment of the resources available to us is comprised of our infrastructure.

Just as we do veterans a disservice if we utilize appropriated funds ineffectively or inefficiently, so do we do veterans a disservice if we continue to support facilities that are not longer efficient or effective because they were designed to provide care in ways now rendered obsolete, or because they are inappropriately located because of changes in veteran demographics, or because they are simply redundant.

These criteria will be incorporated into the plan that I will present to you. I am calling upon you to look at the plan presented to you with new and independent eyes, to give the plan a "reality check" to ensure that those of us who are inside the system haven't been so close to the plan and to our work that we overlook important facts or concerns.

I am not calling on you to conduct a "de novo" review of VA's medical system. Such a review would require resources, data, staff, expertise and time beyond that available to you.

A decade ago, the so-called “Mission Commission” evaluated the missions of VHA facilities and prepared an extensive report that I will summarize as “everything is fine, send more money”. That report has done little but gather dust. I want your commitment of time and effort to be rewarded with action, not dust. Veterans will be best served if our report, and your evaluation of the report, accept the reality of limited resources.

Nor will it be useful to base your analysis on speculation on the possible effects of future events overseas on the number of veterans, or that incidents in this country may create the need for domestic healthcare resources. In this war, I am informed that DoD is turning to TRICARE, that is, to the private sector healthcare system, for its primary backup. In the event of mass domestic casualties, no matter how caused, VA will support the National Disaster Medical System. But our primary mission is healthcare for veterans and the cost of sustaining infrastructure that is inappropriate, redundant or excess to that mission will be borne by veterans who would otherwise receive VA care.

However, the CARES process, and your analysis of the product of that process, is not simply an exercise in identifying hospitals for closure or downsizing. The goal of the report you will receive and evaluate is to identify ways VA can best utilize our necessarily limited resources of facilities and funding to provide quality 21st century medical care to the veteran population of the new century.

The CARES report will necessarily include initiatives for modernizing, expanding, or even constructing facilities. I believe our experience in the Chicago area from the network 12 CARES pilot is illustrative. In Chicago, the Lakeside inpatient facility will be replaced by an outpatient facility; the Westside hospital will have substantial new inpatient construction with updates at our other facilities.

We have to remember that VHA facilities today are the product of individual decisions made over a century of time. We have buildings built to provide healthcare in places, and means, that may no longer be appropriate, much less optimal.

For example: Many of our facilities were built as large TB hospitals or long term psychiatric hospitals when the standard of care was to simply warehouse patients in isolated rural areas

Many of our facilities are located in the districts of powerful members of Congress who are long dead without regard to current, much less projected, concentrations of veteran population.

Similarly, after WWI, VA built facilities on the grounds of army forts that were built on locations chosen to fight Indian wars in 19th Century ---- those locations may, or may not, be the best place to treat veterans in the 21st century.

The practice of medicine has changed since almost all of our facilities were built.

The move from inpatient hospitalization to outpatient care reduces need for acute inpatient beds and past VA construction to provide care now obsolete can today result in excess or redundant inpatient capacity in large cities or even rural areas. Similarly, Population migration: north to south, east to west, ---- can lead to imbalances in the location of our facilities, and hence our ability to treat veterans.

The bottom line is simple: Inappropriate (because designed for now outmoded care or because of location) infrastructure consumes resources that could be, and should be, put to better use in providing healthcare to veterans. VA will produce a report that will identify opportunities for improving our ability to provide quality healthcare for veterans by more effective deployment of physical resources. I want this commission to examine that report with a critical and independent eye and report back to me on the validity of those opportunities.

Discussion/Q&A:

In response to a Commissioner's request, the Secretary summarized his background and experience with veterans issues, highlighting his own military service experience as a Naval Academy graduate, a Vietnam War veteran and a Navy lawyer. He is married to a Navy nurse and has two sons on active duty. For almost ten years he worked for the

Senate Armed Services Committee and the Senate Veterans Affairs Committee. During the first Bush Administration, he served as the Deputy Secretary of VA.

The Secretary pointed out that because of his background he has both a personal and professional interest in the VA healthcare system. He wants it to be even greater than it already is. He said that the process now known as CARES really began several years ago when the VA moved from a hospital-focused system to a patient-focused system. VA now has more than 800 outpatient centers around the country, bringing health care closer to the veterans' homes. VA now needs to continue the work and make sure that the rest of the transition takes place. He established the Commission -- consisting of independent-minded experts and advocates -- to validate the data, hear from the stakeholders and present recommendations. He doesn't intend to politicize the Commission's report; he intends to act on it. Any help the Commission needs will be given.

Commissioner & Staff Introductions

Each of the commissioners present briefly reviewed his or her background and connection with the VA health care system.

Chairman Alvarez noted that the Commission staff has only been on the job for a few days. It totals seven now and will have fifteen eventually. Richard Larson, 27-year veteran of government service, will be the Executive Director. He has been a staff assistant to the Secretary and also was with the staff of Congressional Commission on Servicemembers and Veterans Transition Assistance that Secretary Principi chaired.

Presentation by Laura Miller Deputy Under Secretary for Health for Operations and Management

CARES Overview

The need for the CARES program stems from the transformation that VA has experienced over the last decade. Both VA and the health care profession have undergone profound change. Health care delivery systems are now emphasizing full continuous care rather than the episodic care of an earlier time that relied on "bricks and mortar" for delivery. The VA infrastructure was designed and built decades ago under a different concept. Today, VA's capital assets don't align with the current health care needs of veterans.

The purposes of CARES are to assess veterans' health care needs in each VA geographic area; to identify service delivery options for meeting those needs; and to recommend strategic realignment of capital assets linked to those needs.

CARES program goals are to improve access, quality and delivery of care in a cost-effective way. Over the past few years VA has established 611 community-based

outpatient clinics as a means of changing the way it delivers health care to veterans. Another CARES goal is to mitigate the impact of such changes on VA staffing and on communities.

Several key transforming principles have been adopted by VA in the past eight years. One of these is that the business of VA is health care, not hospitals. Health care is fundamentally a local activity. Mechanisms for monitoring health care should consider quality, satisfaction and access at an affordable cost.

The reasons why CARES is being implemented stem from a 1999 GAO Report, which looked at the infrastructure in one VISN (12-Chicago). GAO concluded that VA could save millions of dollars and enhance access to services by closing a Chicago area hospital. GAO said that one of every four dollars was being spent on capital assets, that inpatient capacity was sub-standard, and that there were building safety concerns. GAO recommended that VA implement a market-based plan to restructure its assets to improve veterans' health care service delivery.

At the time of the GAO report, the Department had over 4700 buildings and over 18,000 acres of land. A huge number of the buildings were designated as "historic." Many of these buildings were underused, vacant, aging and in need of repair. Historically, dollars allocated to infrastructure upgrade and replacements have not fully met the need. In recent years, Congress has withheld all allocations for facilities (including seismic upgrades and electrical system replacements) pending the outcome of the CARES planning process.

CARES was designed to enable the VA system to effectively utilize resources so that it can deliver more care to more veterans in the places where they need it most.

The GAO followed up its report suggesting closure of the Lakeside facility with a 1999 options study that suggested VA look at downsizing Hines and convert North Chicago to a community-based outpatient clinic (CBOC). Together, the two GAO studies created the controversy that led to CARES. The first CARES study was initiated in 2000. It produced different outcomes than the previous two studies.

In describing the CARES approach, Ms. Miller said that CARES was originally designed as 3-phase process. Phase I, the Pilot Study, would apply the CARES evaluation criteria to results of the delivery system option study. This was expected to take 90 days. Phase II would be to evaluate the effectiveness of both the CARES evaluation criteria and the CARES process. This phase was programmed for 375 days. Phase III was to make recommendations for future phases and would take another 375 days.

Phase I began in November 2000 in Veterans Integrated Service Network (VISN) 12 -- Chicago -- and encountered delays almost immediately. Ultimately, the process for Phase I took 11 months instead of the 90 days that had been estimated.

As a result of the Phase I experience, the CARES process was revised. The revised approach applies the CARES program to all of the remaining 20 VA VISNs. Also, Phase II will rely primarily on in-house staff to develop the VISNs' market plans using a nine-step process. Stakeholder communications will be strengthened throughout the process.

Ms. Miller touched briefly on the nine-step process to be used, but said other speakers would address the process in greater detail.

VA is now well into the re-designed process. Key timeline events include:

- Activities that have been completed are the program roll out, the establishment of markets, the development of demand data, and the identification of planning initiatives.
- April 15, 2003 -- Networks submit completed market plans; initiate central office review.
- June 1 -- VA publishes the draft National CARES plan and simultaneously submits it to the CARES Commission for review.
- September 30 -- The CARES Commission sends recommendations to the Secretary.
- October 30 -- Secretary's decision.

Discussion; Q&A

The question was asked as to what problems and criticisms were encountered in conducting the Chicago pilot. Ms. Miller said that from her perspective, one of the major problems was a lack of coordination and communication, both within the VISN and between the VISN and outside. It was a consultant-conducted study that lacked adequate validation before working up data into findings. More time should have been devoted to validating the data. Stakeholders concerns didn't get enough consideration. Additionally, cost estimates were inadequate and there were political concerns.

A Commissioner asked what is happening to the Lakeside facility in the implementation phase. Ms. Miller replied that VA is currently working on a plan to move Lakeside patients to the west-side facility by the end of the year. Some facilities (outpatient radiology and the clinics) will still be there pending location of a site for the multipurpose outpatient clinic.

Another Commissioner asked about the political climate that was created by the Phase I process. Ms. Miller replied that veterans showed a lot of concern.

**Presentation by Mark Catlett,
Principal Deputy Assistant Secretary for Management**

Why CARES?

Mr. Catlett briefly summarized his Office's responsibilities related to CARES, which center on facilities planning for VA in general and for the Veterans Health Administration (VHA) in particular.

Mr. Catlett cited a number of external influences that resulted in the current CARES program. Referring to the 1999 GAO Report mentioned by the previous speaker, he noted that all parties involved in VA funding – Office of Management and Budget (OMB), appropriations committees and authorizing committees --have supported the finding that one in every four VA dollars is spent on operating/maintaining medical infrastructure. Mr. Catlett pointed out, however, that the only way to reduce costs significantly in the closing of facilities are the staffing reductions which accompany the elimination of infrastructure. He believes that the GAO Report overlooks this fact.

A 1998 Price-Waterhouse-Coopers report said that VA was seriously under-investing in its infrastructure. They suggested that VA should be investing in the range of six to twelve percent of Plant Replacement Value (PRV) every year, including equipment and non-recurring maintenance. VA is probably now investing about a billion dollars on a \$27-\$28 billion investment, which is a little less than four percent. In 1985, VA investment was in the 10-12 percent range. This means that VA has shrunk in purchasing power by a factor of three since 1985.

There have been significant changes in the practice of medicine. VA needs to find appropriate mechanisms for addressing the changes. The VA infrastructure averages 50 years old and was built when medical treatment focused on inpatient care. There have been major changes in the market and in technology since then. Further, current policy calls for suppressing demand on priority seven and priority eight veterans, producing a significant change in the numbers. Under the new policies, VA will not be treating the same mix of patients it has treated in the past. Further, 80 percent of VA treatment is outpatient care and for many of the lower priority veterans; it supplements treatment veterans are getting elsewhere. The veteran population is also changing (age and where they live, for example).

A Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans is about to end (next month). It will report that VA should be investing five to eight percent of PRV and that it is currently investing at a two percent level. The fact is that VA is trying to get to a five to eight percent level just to restructure the system, not to maintain it. Moreover, some VA buildings aren't well suited to health care; others are not where veterans need them.

There is a difference between "users" and "enrollees." As this year began, VA split its "priority seven" group into two categories and it will now have a "priority eight" category. This policy change will reduce the number of enrollees in priorities seven and eight by two million veterans in 2012 and by another 200,000 by 2022 from the previous projections (not the current actual). Access to the health care system will be restricted for the new priority eight veterans. Additionally, co-pay and enrollment fees are expected to reduce demand for care by lower priority individuals.

In response to a question, Mr. Catlett explained that in 1998, Congress established a priority system for health care service delivery to veterans. The highest priority is for service-connected veterans. The largest group getting care from VA are the non-service connected disability individuals making less than \$24,000 a year (priority five). Category seven -- non-service-connected veterans making more than \$25,000 a year -- was subdivided using a complicated formula based on a HUD index. The Secretary made a decision a few weeks ago to restrict access to the system for new priority eight veterans. Of the two million individuals in the priority seven and eight categories, most are believed to be priority eights; income data needs to be collected to get an accurate distribution. Those who are already enrolled in the system are unaffected by the Secretary's decision and will continue to get care. The budget just submitted asks for higher co-pays and a \$250 annual premium for enrollees. This is expected to result in the decrease of two million enrollees by 2012 from the previous projection. The assumption is that those veterans who use VA for supplemental health care will not choose VA for health care under the new rules. Only about 50 percent of the two million priority seven veterans now enrolled in the system actually use the VA for health care. Many have signed up basically as a free insurance policy as backup. The point is that they use the system at a much lower rate than the higher priority veterans, even though they represent huge absolute numbers.

Mr. Catlett explained that the terms "enrollees" and "users" are often used interchangeably. But they are not the same. Twenty-four percent of VA *enrollees* are in priority categories seven and eight. But only about half are *users*. In 1996, before VA had enrollment, this group was less than three percent of the people using the system. Without the policy changes, this group would have risen to 42 percent of VA enrollees by 2012 and would have represented 30 percent of the users. The policy proposals, which have not yet been enacted into law, would reduce the number of priority seven and eight users to about 15 percent of the total number.

It has been difficult to build these policy decisions into the demand forecasting for CARES because the decisions didn't get made until late December. But the numbers have been run and the challenge now is to get the planning initiatives revised to reflect the new demand projections.

Both the Administration and the Congress have basically frozen VA capital asset spending pending completion of the CARES planning process. Over the past three years, VA has spent more of its major construction budget on the cemetery system than on the health care system. That's why CARES is critical to convincing people of the need to significantly increase its investment in health care facilities. Minor construction funding has also been held relatively constant and some important needs (such as safety improvements) are going unmet pending the CARES reports.

Not wanting to miss a year in the funding cycle, VA proposed a five-year CARES implementation program in the Fiscal Year (FY) 2004 budget. The initiative, which was based on the Network 12 study, proposed total funding of \$3.65 billion over five years,

\$730 million of which was for FY 2004. The initiative projected total savings of \$3.1 billion between 2006 and 2010 that could be channeled into direct health care funding. The proposed new funding was reduced to \$225 million in President's budget. About \$115 million appropriated funding has been provided to Network 12 as a result of the Pilot Phase CARES study. This has been supplemented by approximately \$90 million through Enhanced Use Lease with an additional amount anticipated from the leasing of the Lakeside facility in Chicago.

VA's Deputy Secretary has created a Senior Resources Group (SRG) to track and monitor progress. As the Networks are developing project plans and proposals, the SRG is working on a methodology for ranking and prioritizing the projects. There are seven draft criteria under consideration: (1) health care/healthcare service delivery priorities, (2) special disabilities, (3) safeguarding assets, (4) Presidential/Secretarial priorities, (5) capital asset priorities (portfolio goals), (6) financial priorities, and (7) research and education. The priority rankings that results from this process will help determine where VA puts its money for 2004 and beyond. In the next two to three months, the SRG will settle on the methodology to be used in applying these criteria.

Phase I -- the pilot CARES study conducted in Network 12 in 2001 -- will produce an investment of \$300 million in Network 12 facilities, resulting in more efficient infrastructure delivering modern care. Construction is already underway on about \$90 million worth of investments. VA also expects to realize about \$100 million from the sale of the Lakeside (Illinois) property. The intention is to reinvest that in VISN 12 -- West Side.

Phase I lessons learned focus on need for a more open and inclusive process and the importance of centrally driven initiatives.

Discussion/Q&A

A Commissioner asked how VA can rely on the \$6.5 billion figure before any decisions have been made. Mr. Catlett replied that the five-year proposal was submitted before final decisions were made because VA did not want to lose a year in the appropriations process. The \$6.5 billion figure was extrapolated from the VISN 12 experience. It will be revised after the Commission finishes its work.

The Commissioner also said that the timing of the review process will put the Commission behind the eight ball a little bit and asked if there was any way the April 15 date could be changed so that the Commission could get the market plans earlier. The response provided was that the National Cares Program Office (NCPO) is looking at mechanisms for getting the plans turned around faster. Other Commissioners also expressed a desire to have the market plans as soon as they are produced (preferably one at a time) to facilitate meeting the October deadline. VA staff indicated that the timeline is compressed and is very tight.

The question was asked whether the CARES assessments will be used on an ongoing basis to drive other strategic planning and resource decisions in VHA and whether there is a real understanding about this down into the ranks. The answer was that the CARES process will definitely be integrated into ongoing strategic planning. The NCPO staff weren't sure how far down in the VA organization this is understood.

The question was asked how community health care is being reviewed. The answer given was that VA is looking at community health care by evaluating what's needed and what's available by market area. There is the expectation that when the proposals come in they will explain what potential joint ventures, especially those with Department of Defense (DoD), were considered. Additionally, the Secretary has made it clear that VA is in the business of providing health care to veterans. It is not to be an insurance provider. Mr. Catlett indicated he believes that about 5 percent of VA's health care dollars go to contract services or pay for contract doctors in VA facilities. Every facility contracts for some services.

The President's Task Force apparently will recommend that DoD and VA engage in joint planning and budgeting for health care. Mr. Catlett commented that DoD has had significant involvement in the CARES program and that collaboration has been excellent. He also expects that the FY 2005 budget process will include more joint VA-DoD planning.

Mr. Catlett was asked why the budget request was reduced from \$730 million to \$225 million and if this is indicative of the Administration's views about CARES. He said he thinks OMB is just being skeptical until it sees the CARES product. Appropriators, too, have taken a strong position that the studies need to be completed in order to secure funding.

The question was asked as to the time frame in which the 611 CBOCs were brought on line. The answer was that most were brought on line since 1999 but there have been no new ones since the middle of last year. Most were small initially; some now have eight to ten staff. Many are comparable to a private healthcare practice office, except that they focus on the veterans' community and their needs. VA operates about three-fourths of the CBOCs, although generally not in space owned by VA.

A Commissioner stated that earlier studies have pinpointed who are the truly eligible users of the VA health care system. The number is specific and finite and VA knows who they are. DoD found that many eligible beneficiaries have alternative sources of care, making it easier to close the gap between projected demand and supply. Also VA, like DoD, may be sustaining traditional services that it doesn't really need to supply and it may also be providing some services in inappropriate facilities. VA might be able to improve services by outsourcing them or moving them to more appropriate facilities.

It was observed that long-term care is a "wild card" in the VA equation. VA doesn't have a policy now other than "do the best you can." Another Commissioner commented that VA really needs to articulate a policy on who is eligible for long-term care. Another

Commissioner noted that the President's Task Force seems to be relying heavily on what CARES does. It was further noted that CARES is a resource reallocation exercise, not a budget reduction exercise.

**Presentation by Jay Halpern
Acting Director
National CARES Program Office (NCPO)**

Overview of the CARES Program

Mr. Halpern said that his presentation would cover the basics of the CARES program: design decisions, policy decisions, strategies, the nine-step CARES cycle, the status of the program and its future, and stakeholder questions.

CARES is data driven, but incorporates value judgments. It looks at the demand for services in the future compared to current supply. The *mission* is to realign VA health care assets so as to improve veterans' access to health care. CARES is planning now for veterans' future needs. The CARES *vision* is a sustainable, flexible process that integrates clinical demand and facilities management.

The CARES program is using a nine-step planning and implementation process, each of which will be the subject of subsequent presentations:

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| Step One. Develop markets | Step Five. Review and evaluation
by the Under Secretary
for Health |
| Step Two. Analysis of needs | Step Six. CARES Commission
Review |
| Step Three. Identify planning
Initiatives | Step Seven. Secretary's decision |
| Step Four. Develop market plans | Step Eight. Implementation.
Step Nine. Integration into the
strategic planning cycle |

The rollout for CARES occurred last June. Markets were established in July. Planning initiatives were identified in October. NCPO is now waiting for the market plans to come in from the VISNs (there is a deadline of April 15 for their submission). VISN-level plans will be consolidated into a Draft National CARES plan, which will be published in June and simultaneously handed off to the Commission for its review.

After Commission review, the recommendations go to the Secretary for his decision. Approved plans will then be scheduled for implementation and integration into the regular VA strategic planning cycle.

The role of the headquarters-level NCPO is to develop, manage and coordinate CARES planning nationally. NCPO developed the data and analyses that underlie CARES and has provided them to the VISNs along with required planning initiatives for local development of plans.

NCPO reports to the Deputy Under Secretary for Health (Laura Miller) and also to the Deputy Secretary VA (Dr. Leo Mackay) through the special assistant (Smith Jenkins). Other key players include Jill Powers, Director of the VISN Service Support Center (VSSC) CARES Staff, which provides field and headquarters support to the NCPO and the VISNs.

Planning initiatives are the topics to be addressed in marketing plans. They are discrete, identifiable topics. The planning initiatives were identified centrally by headquarters based on the service gaps identified during the data analysis phase. Gaps are deficiencies between the status quo (the level of service delivered in FY 2001 as indicated by the data) and VA service targets for future years (2012 and 2022). In answer to a Commission question, Mr. Halpern explained that the gaps to be addressed in the plans focus on areas where the gaps are large or where there is high volume. A volume threshold was set when identifying planning initiatives.

The objective of market plans, which are developed locally, is the resolution of planning initiatives. "Resolving initiatives" means specifying how the VISNs will ensure that the gaps are bridged. VISN submissions will provide a plan to resolve each initiative on a market-by-market basis. These are the plans that NCPO will roll up into a draft National CARES plan after they have been reviewed and evaluated. Mr. Halpern promised to try to get the plans and supporting information to the Commission as quickly as possible to expedite their review.

Key CARES program strategies were also identified. These were:

- Standardized processes. VA wanted to standardize nationally how markets are delineated, how demand was forecasted and how costing was handled.
- Monitoring plan progress and providing assistance through the VSSC.
- Demonstrating stakeholder involvement. The pilot project in Chicago indicated the need and importance of providing for extensive stakeholder input.
- Deferring to local judgment in ranking and selecting proposed solutions. Headquarters identified planning initiatives based on projected gaps, but the VISNs will generate, evaluate, prioritize and select proposed solutions from among the many alternatives available.

The CARES program is national in scope. CARES was designed as a macro-level program. Headquarters developed the planning agenda and selected planning initiatives to ensure that CARES would be a unified national program, not 21 separate VISN-level programs. Headquarters supported this process by developing a national database.

Headquarters also developed and provided planning and analytical tools to facilitate the process. But solutions are being developed locally.

The VISNs never had more than six months to plan, which limited the scope of CARES. Included in the initial design were acute inpatient care, outpatient care, nursing homes, and domiciliary care. Proximity to acute care beds in small facilities and clusters of acute care facilities were also included, along with acute care access. Not included because of complexity were long-term psychiatric facilities and special disabilities. The initial plan was to hold these services constant. As the process progressed, special disabilities programs (spinal cord injury and blind rehabilitation) were added in. Programs that were held constant due to a lack of data or methodological difficulties were: domiciliary, long-term and residential rehabilitation psychiatric programs. The models initially used indicated there were negative outpatient mental health forecasts and programs for the seriously mentally ill. These data were believed to not accurately reflect the future state of mental health, so were not included in year's planning mode.

The CARES planning model calls for market-based plans to be developed at local level based on national projections of demand (enrollee utilization). The model looks at capacity in terms of current supply (2001) and future demand (2012 and 2022) for beds and visits. The years 2012 and 2022 were selected as forecasting targets -- 2022 because a 20-year investment period is a standard basis for assumptions. The year 2012 was selected as an intermediate forecasting point because it is the mid-point of the range. Mr. Halpern emphasized that data have been developed for every year.

VA used an actuarial firm to develop a model for enrollment forecasts -- the Enrollment Level Decision Analysis (ELDA) forecasting model. NCPO adapted the model for CARES. The model forecasts enrollment by priority groups and also forecasts utilization using a VA case mix matching process adjusted for morbidity, Medicare and other factors. The shortcoming of the model for CARES was that it doesn't do a very good job with special disability populations and some other programs (because of their small size).

For small facilities, NCPO looked at other models, including the DoD Base Reduction and Closing (BRAC) model. In the end, alternative futures were developed for acute care medicine, surgery and psychiatry. Initially, a facility had to have 50 beds or less in 2012 and 2022 to make the CARES list. This was later changed to 40 beds or less.

Proximity was another criterion. CARES looked at clusters of facilities that are close enough to consider service consolidations, integration and closures.

Access was an important and exciting criterion. CARES targets were set at 70 percent of enrollees within 30 minutes of primary care and 60 minutes of a hospital. VSSC and NCPO measured the driving time of enrollees to VA sites.

Stakeholder input is a critical part of the CARES program design. The expectation is that the process will be transparent at all levels. Headquarters expects VISNs to inform

stakeholders about what's going on, to seek their input, consider that input and use it if possible. Also, the process is to be documented.

One of the criticisms of the CARES process design was that it wasn't considering unmet demand because of funding constraints. Mr. Halpern said that there is no unconstrained demand anywhere in the whole health care system, including the private sector. CARES made adjustments in two parts. One was enrollment, which became a non-issue when enrollment forecasts showed significant growth. The other was utilization, where the assertion was that VA system use is being suppressed because of the waiting time to get an appointment. In response to this criticism, the CARES model uses the private sector data adjusted for key differences in the VA system (such as age, gender and morbidity). The CARES process also addressed a number of other data and model issues, including nursing home demand, domiciliary care forecasts and the seriously mentally ill.

Several planning tools were created to help VISNs, including the market definition guidebook, the IBM market planning template (which will be explained in a later presentation), a market planning handbook and market planning calculators. Easy access to the wealth of data developed for CARES is available on a VSSC web site.

Mr. Halpern said that the market plans submitted on April 15 will include acute inpatient medicine, surgery and psychiatry; outpatient primary care and specialty care; outpatient mental health growth components; a nursing home component; spinal cord injury and blind rehabilitation; small facilities and proximity; and vacant space.

Programs that were not included in CARES will be incorporated into the next strategic planning process (in March 2004). These include domiciliary programs, long-term psychiatry, psychiatric residential rehabilitation, sustained treatment and rehabilitation, compensated work therapy and PI's related to contraction of outpatient mental health. In answer to a question from the Commission, Mr. Halpern said that forecasts for these programs have been flat-lined for CARES planning.

Mr. Halpern stressed that there has been active collaboration between CARES and the DoD. DoD has participated in all of the CARES planning to date. As a result, 61 opportunities for joint collaboration have been identified and are being monitored by both VA and DoD. Moreover, a DoD physician serves on the CARES Clinical Advisory Group.

After the CARES Commission reviews the draft CARES National plan and conducts its hearings, its report will go directly to the Secretary. The NCPO understanding is that the Secretary will either approve or reject the recommendations or send the Plan back to the Commission to consider additional information.

Discussion/Q&A:

A Commissioner commented that the DoD's experience suggests that nailing down who the beneficiaries are goes a long way toward helping to reduce gaps. Congress is also

really interested in this. He suggested that the CARES program might want to look at the possibilities for doing this.

In response to another Commissioner, Mr. Halpern stated that the eventuality of a major ground war had not been factored into the data underlying CARES. The Commissioner observed that should such an event happen it could really alter the planning assumptions in terms of the number of veterans to be served in the future and the types of services they will require.

The subject of providing "surge capacity" for DoD was also discussed. Mr. Halpern said that the CARES model does not explicitly address the extent to which VA provides such "surge capacity" at least partly because they were unable to get good data. VA's emergency planning/preparedness and DoD backup missions have simply been "flat-lined" for planning purposes. This should be okay because VA isn't seeing massive reductions in capacity.

In response to another question, Mr. Halpern said that VA isn't seeing a reduction in the demand for beds. VA is also not seeing a change in the mix of demand for beds at the macro level.

A Commissioner asked whether the plans could be made available to the Commission as they come in from the VISNs. This would facilitate and expedite the review process. Mr. Halpern replied that the Department wants to turn VISN plans into a National CARES plan before turning them over to the Commission. However, NCPO will share lots of market information.

The question was asked whether the projected decline in enrollments has flattened somewhat based on the assumption that the \$250 enrollment fee will be a decisive factor in lower income brackets. The question was answered in the affirmative.

A Commissioner asked about the disposition of domiciliary services in the CARES planning process. Mr. Halpern replied that the data would have required the use of national averages for domiciliaries. This creates a problem of skewed data -- places that already have it are raised; places that don't already have it are lowered. Resolving this problem requires a policy decision.

**Presentation by Alan Berkowitz,
Senior Actuary
VA Office of the Actuary**

CARES Market Areas and Demand Projections

Mr. Berkowitz began by noting that under the Secretary's "One VA" concept, all parts of VA were required to participate in the CARES process -- VHA, VBA and NCA. All were charged with coming up with planning initiatives, and all are involved in seeking solutions together.

Most VA demand projections are done by an outside actuarial firm -- CACI/Milliman.

All of the demand forecasting revolves around four models:

- The "Veterans Population Projection Model (VetPop)" was developed by the Office of the Actuary. It projects new enrollees and was used to define market areas for CARES.
- The veteran enrollment projection model, developed by CACI/Milliman, was used to modify enrollment assumptions for CARES.
- The Enrollment Level Decision Analysis (ELDA) model, also developed by CACI/Milliman, is a demand model. It was used to identify projected gaps in demand for the CARES program.
- A model for Special Population Groups (e.g., blind rehabilitation and spinal cord injury).

How the models fit into CARES. Before the Office of the Actuary (OACT) existed, Milliman USA had been working on a veteran enrollee projection model, but it was used for budget forecasting purposes only. The current Vet Pop model was actually used to define CARES market areas by projecting new enrollees. The model has enrollment information by priority category, by zip code, etc. The second model, which uses the VetPop model, projects total enrollment in the VA program. It had to be modified by CARES assumptions to make it work at the market area level. Once the enrollee information is generated, the Milliman-developed demand model forecasts demand at the market area level. CARES uses this model to get at the gaps in the demand for VA care. This model is not sufficient to deal with special population groups (such as spinal cord injury). A later presentation by Dr. Chang will explain how the fourth model was developed.

The terms used in describing the CARES models include:

- "Veteran" -- Someone who has served their tour of duty and was released from military service with anything other than a dishonorable discharge.
- "Enrollee" -- Reflects a choice made by the veteran about whether to enroll in the VA program. Twenty-five million veterans right now are eligible for health care, but only six million have elected to enroll in the VA program.
- "Market share" -- How many of the VA target population (which is "all veterans") have made the choice to enroll.

Veteran Population Projection Model. The initial database used for the Vet Pop projection was the 1990 Census. The 2000 Census figures were released in January 2003 and have already been integrated into the CARES planning -- all of the figures have been updated. The impact of the Census 2000 updates on the numbers is modest.

The VetPop Projection Model adjusts the initial baseline projections:

- It adds "veteran births" -- actual service member separations from DoD through 2001 and projects from there based on future force strength.
- It subtracts veteran deaths, based on general mortality data;

- It factors in veteran movement -- migration at the state level.

The Gulf War produced only a modest increase in the number of veterans mainly because it was not a large-scale build up compared to prior wars, such as the Vietnam war to the Korean Conflict. Furthermore, many reservists are in fact veterans already because they served on active duty before reserve duty. Reservists who had no prior active duty (other than for training) but were activated to serve in the Gulf War did in fact become veterans by virtue of their Gulf War active duty.

For "veteran deaths" the model uses general population figures for non-retirees; VA doesn't have special projection rates for veteran versus non-veteran deaths. Beneficiary characteristics, such as gender and age, are also factored into the model. Overall, the model projects decreases in the number of veterans, with the South experiencing the least change and the Northeast and California experiencing the most. All age groups other than those over age 65 are in decline. Younger groups are declining more rapidly than older groups.

Special terminology used for this part of the program includes:

- "Health care priority groups." VA has defined 8 different priority groups. The specific characteristics that define each priority group are described on a separate handout (identified with the label "Tab 4a"). Group 1, the highest priority, consists of veterans with service-connected conditions rated 50 percent or more disabling. A recent policy decision created the lowest level, Group 8, by splitting the previous Group 7 into two parts using a complicated formula. Both Group 7 and Group 8 are made up of non service-connected and non-compensable service-connected veterans with income above a specified threshold level and who agree to make specified co-payments for health care.
- "Health service groups" -- forty-odd health care service categories defined by Milliman-USA, such as "medical," "nursing home," "blind rehabilitation," etc. The specific categories are also listed on the handout identified above ("Tab 4a").
- Space planning categories.

The **enrollment projection model** uses a formula that adjusts the VetPop model as follows:

- An enrollment rate was computed by county, by age group, and by priority group based on initial enrollment in September 2001.
- New enrollees were computed by subtracting the initial enrollment from the total veterans population and multiplying by the expected enrollment rate; projected deaths were subtracted from this number to determine the total projected enrollment in the VA health care program.

VA's national market share is 24 percent, computed by dividing the total veteran population by the end-of-year enrollment. However, market share is not evenly distributed. In many areas of the country, the VA market share is below 24 percent; in others it is above that figure.

The presentation next described how the **market areas** for CARES were defined. In defining VA markets, it is critical to know where the veterans using the services are located. This information is used to define health care market areas that have sufficient population and geographic size. Detailed maps were produced at county level using special software showing the size of the projected veterans and enrollee population by county, the location of VA facilities and the major road networks in the VISN. The maps were then adjusted for market share. Distance from VA facilities, expressed in travel time, was computed to produce spreadsheets that showed enrollees access to care by market area. A total of 77 market areas were identified. Each will have up to three capacity planning initiatives.

Different geographic regions present different challenges in planning access to care. Access gaps were defined in terms of *primary care* (less than 70 percent of enrollees were within 30 minutes and at least 11,000 enrollees are outside 30 minutes driving time) and *acute inpatient care* (less than 65 percent within 60 minutes driving time and at least 12,000 enrollees are outside 60 minutes driving time).

February 19, 2003 -- Afternoon Session

The afternoon discussion continued the *modeling* presentation with a discussion of the **demand model**, also known as the *Enrollment Level Decision Analysis (ELDA) model*. The model, which is described in detail in Chapter 4 of the CARES Phase II Guidebook, provides demand projections based on projected enrollment by (a) healthcare priority groups, (2) four age groups, and (c) geographic area -- county converted to market area. VA has used the model for five years and it works at National and VISN level. However, it had to be modified to provide market-level data for use in CARES demand forecasts.

A private sector firm (CACI/Milliman) developed the ELDA03 model, which produces enrollment projections by building on private sector benchmarks at the county level (which are different from the VA population) for 40 health care service categories. The benchmarks are adjusted to fit VA profiles for age and gender (for example, VA enrollees are 90 percent male and there are no children), morbidity, covered benefits, co-payments, degree of community management, reliance and area differences. The model also builds in a "trend factor" to reflect changes in medical practice during the projection period.

A special scenario review group discussion indicated that the initial projections showed a 33 percent growth in enrollment; this was unreasonable and had to be adjusted. The final scenario agreed to for CARES was limiting priority 7 enrollment rates so that no VISN exceeded a 50% market share and the national average would increase to no more than 40% in 2012 and 2022. No change in the enrollment rates would be made for priority groups 1-6. Also the Milliman demand model is not applicable for special disabilities groups, such as spinal cord injury and traumatic brain injury when applied below the national level. The presenter was also asked to comment on the fact that the OMB and the Congressional Budget Office (CBO) had used different numbers for their projections.

The response was that the issue had been discussed and resolved; the numbers should now be the same.

The *assumptions* used in the ELDA model for CARES were listed as enrollment rates, enrollee morbidity, geographic area, co-pay, benefits covered, age and gender, morbidity, reliance rates, trend rates, degree of community management and actual versus expected experience.

Developing the CARES demand model sometimes required adjustments to private sector demand factors to reflect the VA system. Initially, private sector *utilization rates* were used -- 316 visits per 1,000 enrollees. From there:

- The VA co-pay was lower so the projected demand was raised (multiply by a factor of +1.2).
- VA coverage is better, so the projected demand was raised again (multiply by a factor of +1.2).
- Gender differences were taken into account reducing projected demand (multiply by -.97).
- Morbidity factors (VA patients are sicker) raised demand (multiply by +1.9).
- There is less reliance on VA, reducing demand (multiply by -.8).
- Management improvements also reduce demand (multiply by -.055).
- Factor in the trend to outpatient care, raising demand (multiply by 1.1).

After adjustment, the projected demand came to 714 visits per 1000; priority 7 would have projected visits of 1408 per 1000 in 2022. In the final analysis, CARES is using 704 visits per 1000 as the projected demand because of its strategic horizon.

The modifications made to the ELDA03 model for CARES were:

- The National/VISN model was modified to project VISN/market area demand for CARES.
- The ELDA model uses 56 health care categories; the CARES model has 7 space categories and special population groups.
- The ELDA model forecasts in bed days and procedures; the CARES model forecasts in bed days and clinic stops.
- The ELDA model enrollment rates by priority and county are assumed to be constant; the CARES model caps priority 7 enrollment rates at 40 percent of national market share.
- The ELDA model is calibrated to FY 2001 actual experience for actual versus expected; the CARES model is calibrated upward if the FY 2001 actual-to-expected ratio is less than 1.

This results in a model in which workload projections for 2002-2022, based on projected veteran enrollees, is translated from private sector health care categories to CARES categories. Workload is mapped to CARES categories based on inpatient diagnostic related groups (DRGs) and outpatient private sector specialty allocations. CARES categories are:

Inpatient

- Medicine

Outpatient

- Primary care

- Surgery
 - Mental health
 - Psychiatric residential rehabilitation treatment program (PRRTP)
 - Domiciliary
 - Nursing Home (NH)/Intermediate
 - Spinal cord injury
 - Blind rehabilitation
 - Geriatrics
 - Specialty care
 - Mental health
 - Ancillary/diagnostic
- Non-Clinical and Space
- Administrative
 - Research
 - Vacant Space

The CARES demand model adjusts enrollment rates. Growth starts at 24 percent and is capped at 40 percent. No VISN may exceed 50 percent of market share.

The President's budget cuts enrollment in VA programs by changing the policies (creating a priority category 8, for example, and freezing enrollment in that category). As a result of the policy changes, one million clinic stops were cut from the projections. Even so there is a projected growth of 60 percent.

Commissioners were urged to review and carefully consider the material provided in their binders of maps and charts. These materials are critical to understanding the CARES program and its recommendations.

Discussion/Q&A:

In discussion, questions were raised about the numbers used in the demand model -- where they come from and how good they are. The replies indicated that the reference point for the numbers used is a private sector database. Adjustments are made based on known differences between the VA system and the private health care world and on VA actual experience. For budgeting purposes, actual VA experience is used. For CARES the 704 visits per 1,000 is being used because of its longer-term timeframe (2012 and 2022).

The key point made is that *enrollment* levels are driven by budget policies; *utilization* is not. The point was also made that a lot of veterans are only coming to the VA system for the pharmaceutical benefits; this doesn't happen in the private sector. Mental health is also an issue as VA provides a broader mental health benefit package and there are sharp differences between VA and the private sector in this area of health care/healthcare. The model has both positive and negative aspects, but overall is considered quite good.

**Presentation by Jill Powers, Director of the VISN Service Support Center (VSSC)
CARES Staff**

Identification of CARES Planning Initiatives (Step 3 in the CARES Process)

Key terms used for this presentation included:

- CARES Category -- The level at which CARES is conducted. Types of health care were grouped into 17 categories (such as Inpatient Medicine -- see table above). All data (supply, demand, costs and space) was summarized at the CARES category levels for analysis.
- *Gap* -- The difference between what was being supplied in 2001 and the amount projected to be demanded in future years out to 2022.
- Planning Initiative (PI) -- An identified future gap or overlap in health care services (VA only) for a market area that meets specific thresholds and needs to be resolved. Gaps are identified by county. VA knows the number of veterans and how much they use the system, so it can determine where they will go for service.
- Collaborative opportunity -- Identified opportunities for sharing, selling or collaboration to be considered in resolving planning initiatives. Opportunities include not only those within VA (with the cemetery system, for example) but also with DoD.

Ms. Powers next discussed the **criteria** that were used in selecting planning initiatives. There are five broad types of planning initiatives: (1) access, (2) proximity, (3) small facilities, (4) workload capacity, and (5) vacant space. Different criteria were used to identify PIs for each of these categories.

For providing *access* to health care for enrolled veterans, the following criteria were used:

- Primary care is available to 70 percent of enrollees within the 30 minutes (60 minutes for highly rural) travel guidelines with fewer than 11,000 enrollees outside those limits *regardless of whether the enrollee chooses to go there*.
- Acute hospital care is available to 65 percent of the enrollees within the 60 minutes (90 minute for rural) travel guidelines and fewer than 12,000 enrollees are outside the limits.
- Tertiary hospital care is available to 65 percent of enrollees within the 3-4 hour guidelines with fewer than 12,000 enrollees outside the limits.

For *proximity* -- to improve cost-effectiveness and potentially improve quality -- the criteria were:

- Two or more acute hospitals within 60 miles of each other.
- Two or more tertiary hospitals within 120 miles of each other.

The *small facilities* criterion, designed to ensure appropriate quality of care in a cost-effective manner, was the existence of an acute hospital projected to have fewer than 40 acute medicine, surgery and psychiatry beds in FY 2012 and FY 2022.

The *workload capacity* criteria were aimed at ensuring adequate facilities to meet future demand for health care services. The criteria used were that markets were projected to

have a 25 percent increase or decrease in demand in FY 2012 or FY 2022 based on FY 2001 supply by CARES category exclusive of special disability programs.

Reducing *vacant space* was also a goal. The criterion used for PI selection was a reduction by 10 percent in FY 2004 and 30 percent in FY 2005.

The NCPO also looked at several different types of *collaborative opportunities* in choosing planning initiatives. Among these were possible co-location of Veterans Benefit Administration (VBA) offices in VHA space, possible use of VHA land and office space by the National Cemetery Administration (NCA), locations where VA and DoD might share services or operate joint ventures and areas with a high potential for enhanced use opportunities.

In discussion, it was noted that State veterans homes provide the majority of long-term care. These facilities are not included in the CARES planning figures.

The **gap analysis** process, which was used to determine the difference between the workload being supplied in FY 2001 and what is projected for fiscal years 2012 and 2022, was discussed next. This process was used to flag potential PIs.

The gap analysis process involved applying the criteria identified above to each market area. Enrollee *access* to health care was determined by calculating the percentage of enrollees in each market within the travel guidelines, calculating the number of enrollees in the market outside the travel guidelines and establishing a potential PI if both did not meet the established criteria threshold (identified above).

To determine *proximity*, the distance between inpatient facilities was measured. Those that fell within the 60 or 120-mile threshold were identified as potential planning initiatives.

To apply the *small facility* criteria, the projected number of acute beds was calculated for every facility. Those with less than 40 in 2012 and 2022 were identified as potential planning initiatives.

Workload capacity was measured by identifying CARES categories in each market with a 25 percent change (increase or decrease) in demand compared with the 2001 baseline. Those that met this criterion and also met a minimum absolute number were flagged as potential planning initiatives.

The actual **PI selection process** involved establishing a five-person team, including representatives of VISNs and clinical people, to identify and prioritize gaps. Using this team ensured a degree of standardization in the process. Based on the size of the gaps, the team recommended and prioritized the planning initiatives, considering VISN input in the process. Where potential initiatives met the access, proximity and small facility CARES criteria, those initiatives were selected. Vacant space initiatives were mandatory.

In making choices based on the *capacity* criteria, the team attempted to limit initiatives to three per market, basing the selection on the size of the gap and considering VISN input.

PI grids were developed for every VISN and market, showing all categories of initiatives and all criteria. The workload data for all CARES categories that were used in selecting and prioritizing initiatives are also displayed. Recently revised grids for every VISN and market are available on the CARES web site.

**Presentation by Jill Powers, Director of the VISN Service Support Center (VSSC)
CARES Staff**

Development of Market Plans
(Step 4 in the CARES Process)

The **market plan development** process provides for *resolution of PIs*, i.e., determining exactly how the gap between projected demand and existing (FY 2001) service levels should be bridged for each market area. This step is where VA currently is in the overall CARES process. The resolution process involves considering required alternatives, comparing alternatives using the CARES criteria (access, proximity, small facility, workload capacity and vacant space) and making recommendations on a final solution.

Each potential PI is being resolved multiple ways using the CARES criteria. Resolving a PI for *access* means improving access to health care for: primary care, acute hospital care and tertiary care. Choosing a location for the site of the care involves using demographic information and the access calculator tool that was especially developed for this purpose. VISNs were required to examine all of the following access alternatives and consider two for each initiative: community contracts, sharing (with DoD or with VA affiliates, for example), a new leased site, a new constructed site and expansion of services at the existing site.

Resolving a PI for *proximity* means searching for efficiencies and potential improvements in quality. Different sets of requirements were provided for acute facilities and tertiary facilities. For acute proximity, consideration of three alternatives was required: (1) no additional consolidations (maintaining the status quo), (2) maintaining only one of two facilities, and (3) consolidating services and integrating facilities. For tertiary proximity, two alternatives had to be considered: (1) consolidating services and integrating facilities, and (2) one other alternative of the VISN's choosing.

Resolving a PI for *small facility* criteria means assuring appropriate quality care in a cost-effective manner. VISNs were required to consider four alternatives: (1) retaining acute beds, (2) closing acute beds and referring enrollees to other VA Medical Centers, (3) closing acute beds and implementing a contracting, sharing or joint venture initiative, and (4) a combination of the preceding alternatives or some other alternative of the VISN's choosing.

Resolving a PI for *workload capacity* means ensuring the capacity to meet changing workload and utilization demand. This involves searching for efficiencies and potential improvements in quality. For increasing workload capacity, two of the following four alternatives must be considered: (1) manage the increasing workload in-house, (2) manage the workload by contracting out, (3) manage the workload through arrangements such as sharing, joint ventures, Enhanced use (EU), and (4) establish a new site of care. When demand projections call for decreasing workload capacity, VISNs were instructed to consider consolidating space, to prepare for re-direction of staff and resources and to take steps to lessen the impact on support services.

Resolving a PI for *vacant space* means improving the utilization of space. The intent is to reduce vacant space by 10 percent in 2004 and 30 percent in 2005. To achieve these reductions, VISNs must consider two of the following alternatives: (1) out-leasing, (2) divesting, (3) demolishing, (4) EU, and (5) donating.

In analyzing the alternatives, VISNs were instructed to use the CARES criteria. This will ensure appropriate consideration of (1) health care quality in terms of veterans' health care needs; (2) health care quality as measured by access to health care; (3) safety and environment; (4) the impact of the alternative on VA research and academic (affiliate) programs; (5) impact on VA staff and on the community as a whole; (6) support for other VA missions; and (7) optimizing the use of resources.

A **market planning template** was developed by IBM to facilitate VISN-level analysis and decision-making. The web-based template is standardized across all networks and generates analyses and recommended solutions by CARES category. The data, which were loaded into the template centrally, are finite and cannot be changed by the VISNs. The data include demand, supply, space availability and costs by type and by facility. In discussion, it was pointed out that the *supply* data (such as facility space availability) were generated locally in the first place and should be familiar to the VISNs. Most of the centrally supplied data consists of demand data from the projection models.

The template was explained using a flow-chart diagram. The template starts with *workload demand*. *Steps 1 and 2* -- deciding where to provide the care -- are done off line. The *facilities inventory* list is entered, and *access* is recalculated to make sure that the figures are at or near the seven percent or the 65 percent. From that point, a CARES category is selected (*step 3*). There are thirteen categories in all -- the six categories in which PIs were identified and other, special categories (such as nursing homes). Every category is reviewed for the entire VISN before moving on to the next category.

Step 4 involves looking at demand, by county and by market to *allocate the demand* from the veterans' homes to a treating facility. The template has default assumptions built in that provide limits on what the VISNs can do. Once the workload has been allocated, *step 5* involves deciding how the facility will *manage the workload* (e.g., increase capacity, transfer it to another VISN, share workload, etc.). Again, the template has default ranges for how much workload should be managed in house and how much is to be sent out either under contract or to another facility. After determining the in-house

workload, *step 6* is deciding how to *manage the space at the treating facility*. The template data includes how much space is available at each facility and its condition. VISN decisions can be within 25 percent of this number. From there, decisions will be made about how much to renovate, how much to add, how much construction will be required, and so on. After these decisions are entered into the template, *step 7* is to *calculate the cost*. Standardized costs for certain types of actions (such as upgrading a nursing facility) are pre-loaded into the model using the "space driver" tool. The template also does life-cycle costing to facilitate alternative evaluation. After the basic capital decisions are made, the operations costs are added in. The results are examined at this point (*step 8*) to test and *evaluate different alternatives* and *select the best alternative* (*step 9*).

A lot of work is required to get to the point where the template can be used, but there is a lot of data available to inform the decision-making. When the process is finished, VA will be able to display detailed information about how health care is being delivered now (the status quo) and what the changes will be.

Once the market planning template has been applied to all of the CARES categories and the vacant space has been assigned to the different categories, what's left over becomes the subject of separate decision-making (e.g., demolition, sharing, etc.).

This template is being used now to generate the reports that are due in mid-April.

Ms. Powers next explained the **market plan format** -- what the plans will look like when they are done. The format is still evolving and may be revised, but in general, the plan will start with VISN-level information and break that down into market-level information (each VISN can have several different markets). Market-level information will be further broken down by facility. *VISN-level data* will include (1) an overview (market information, facility information, enrollment trends, a list of PIs and collaborative opportunities, stakeholder information and collaboration information), and (2) the plan for resolution of any PIs at the VISN-level (acute and tertiary proximity, special disability program initiatives, long-term care and vacant space). Similarly, *market-level information* will provide (1) a market overview (providing the same information detailed at VISN-level above but specific to that market), and (2) resolution of PIs at market level (the only market-level PIs relate to access). *Facility-level information* goes into more detail about (1) resolution of PIs (acute proximity, tertiary proximity and small facility changes to be made), (2) how any collaborative opportunities that were identified (e.g., with DoD or other VA organizations) were incorporated into the solutions, and (3) resolution of workload capacity PIs.

Many other data sorts and information views can be obtained from the plans, including by CARES criteria, by CARES category, by state, VISN, market, facility and many others. The CARES plans provide a huge relational database.

Discussion/Q&A:

In response to a question about whether similar templates for planning are being used by other major health care systems in the country, Ms. Powers stated that VA is the first and only organization to use such a system.

The question was also asked as to where and how factors such as the VA's relationship with medical teaching facilities and VA research programs are tied in to the template. The answer provided was that they are embedded in the CARES criteria. They do have to be addressed in resolving the PIs. A Commissioner commented that it is also important to consider the continuing education of the staff. Sometimes people work in an isolated place, aren't close to the main hospital or have other environmental factors that should be considered. It was noted that this is being done.

A question was asked about whether the market share projections being provided to each VISN are capped at 40 percent. The response was that VA created a CARES scenario in order to have assumptions to use for planning before the budget policy decisions were made. That scenario capped each network at 50 percent with an overall national cap of 40 percent as a set of interim assumptions. The caps were removed completely as a result of the fiscal year 2004 President's budget policy decisions (enrollment priority categories and co-pay). With those changes, no market is over 50 percent. Everything that the Commission will get now is based on the President's budget for 2004.

A Commissioner indicated that he would like to know what the Commission can expect to see from the VISNs in terms of what they are using for a baseline and an end game for their plans. The answer was that the baseline is what they actually did in 2001. From there, changes are based on utilization projections. Plans will be aimed at resolving the gaps.

The comment was also made that there is a wide variance throughout the country as to what the level of users is as compared to enrollment. The Commission should expect to see some of this variance in the individual plans in terms of where the facilities are now compared to where they might be. The response was that typically VISNs aren't showing major growth in inpatient capacity; they are showing growth in outpatient capacity. The Commission should expect to see concentration of services, growth in sharing and in small facilities. There should be some real cutbacks in some areas.

**Presentation by Barbara Chang, M.D.
Consultant for Clinical and Academic Affairs**

Special Disability Programs

Dr. Chang introduced herself as a hematologist and oncologist by training with a master's degree in sociology. She joined the CARES staff in June of 2002, and is the only full-time physician that is involved in the CARES process. As such, she provides the principal liaison with the clinical staff.

One particular responsibility has been to bring the special disabilities programs (SDPs) into CARES. The process started with several assumptions. These were that: (1) CARES is committed to addressing the capital asset needs of the SDPs; (2) CARES planning will address the legislative mandates that exist for SDPs capacity; and (3) forecasts for more demand than is mandated will be used for planning. A special forecasting methodology was developed for SDPs based on input from the Veterans Service Organizations.

CARES focused on the VA **SDPs with Congressionally mandated capacities**. These are:

- Blind rehabilitation;
- Certain (not all) mental health services (seriously and chronically mentally ill, post-traumatic stress disorder, and substance abuse);
- Homeless;
- Spinal cord injury and disorders; and
- Traumatic brain injury.

Long-term care also has some Congressional mandates and was originally included in the planning. However, the CARES Office hasn't finished analyzing long-term care yet and it won't be ready to go to the VISNs for another couple of weeks.

Program officials and experts, along with VA central staff, were involved very early in the process.

Dr. Chang summarized the **basic CARES planning model**, stressing that

- (1) It is a health care services demand model.
- (2) It projects utilization and expenditures for the *enrolled* veteran population.
- (3) It uses private sector benchmarks, but adjusts those for VA enrollees and for the VA health care delivery system. This is important because the whole VA system is quite different from the private sector.
- (4) CARES used detailed 20-year projections for approximately 50 health care service categories and rolled those up into 17 CARES categories. Data for the special populations was teased out of this data.

Dr. Chang summarized some general **caveats** about the CARES planning model. One was that planning is *not* an exact science. Another is that the CARES model is not perfect; there are a lot of things that can happen. However, the staff is continuously trying to refine and improve it whenever possible. There are multiple unpredictable variables that may affect the application of the model. Some of those are internal to VA and some are external. They include changes in medical technology and societal changes. Dr. Chang also stressed that the CARES planning models are designed *not* for budget planning or for resource allocation to specific facilities. They are macro-level planning models. As such, they work best at the higher levels. Confidence levels are reduced when working with the models at smaller service levels (where the numbers are very small in terms of the overall planning, such as the facility level or for specific

services such as blind rehabilitation). Also there are no private sector benchmarks for VA SDPs. Further, current constraints on utilization may affect predicted future demand. For all the foregoing reasons, the main CARES model could not be used for SDPs.

A Commissioner asked about the reasons for discussing the caveats, noting that they send the wrong message to some people and tend to cast doubt on the CARES process. Dr. Chang responded that the material is designed to answer the questions that get asked by different groups who are involved in CARES. Some people are looking for a level of accuracy and certainty that doesn't exist in the CARES model. A Commissioner suggested that future presentations should indicate that the CARES model is a work in progress that is constantly being re-examined and improved.

Dr. Chang stated that there are both advantages and disadvantages to not having private sector benchmarks. One of the disadvantages of not having them is that using VA data alone runs the risk of carrying forward any supply constraints that may exist currently. Consequently, alternative forecasting methodologies had to be sought or developed for these programs.

From the beginning, the SDP CARES process involved clinical leaders and matched them with data management and actuarial experts. A separate team consisting wholly of SDP representatives was put together to select PIs. A key difference was that the SDP team focused on *programmatic initiatives* not VISN-level initiatives. The SDP planning initiative PIs selection process took place between November 2002 and the end of January 2003. The SDP team used the CACI/Milliman contractor to explain how their model would work with the SDPs programs.

Program leaders were used to develop refinements of the data analysis and planning methodology. The time for the SDP planning process was extended past the closing date for the rest of the market plans in order to develop appropriate models. The team was able to develop models for at least two of the programs (blind rehabilitation and spinal cord injury) and recommendations have now gone out to the VISNs.

In discussing this aspect of CARES, it is important to separate "special disability patient populations" from "special disability services and programs." The same patient may use services that cross from one program to another (for example, a blinded spinal cord injury patient that also gets treated for post-traumatic stress disorder). The SDP team wanted to make sure that its projections adequately assessed the need for *service*. To do this, it was decided that the needs assessment and the enrollment projections would take into account the actuarial shifts over time.

The needs assessment for these population shifts was complicated to some extent by the lack of external benchmarks and in some cases by the lack of good outcome data. Once again the small size of the SDP compared to the overall program complicated the planning. In the end, many SDP services are *policy-driven* rather than *data driven*. There is no external counterpart for these services -- the VA provides them and does a wonderful job, but VA has nothing to compare itself against.

Dr. Chang next updated the Commission on the *status* of the PIs in each of the SDP areas. The *mental health group* has had numerous meetings. It is looking at services for the seriously and chronically mentally ill, substance abuse, post-traumatic stress disorder and the homeless. The group is continuing to study that model. Some recommendations are expected. In a sense, this area is a long-term research project. In the interim, since time is short, the team has taken a number of steps and will include the following in the current cycle: (1) no negative outpatient PIs, (2) the number of domiciliary beds will be held constant at the 2001 level, and (3) beds for non-benchmarked mental health programs (such as substance abuse, residential rehabilitation, and compensated work therapy programs) will also be held constant at the 2001 level. VA will continue to study this area and include it in the next version.

Discussion/Q&A:

A Commissioner noted that there are serious concerns that the homeless veterans' population is not being adequately addressed. He expects the Commission to hear advocates in different locations argue that localities with vacant space should give top priority to homeless veterans and that the space should be donated. Dr. Chang responded that the VISNs have been specifically instructed that if they have vacant space and want to use it for homeless veterans they should recommend that action. A recent report from the VHA's Office of the Medical Inspector addressed this issue and a group has been formed to look at it. The term "domiciliary" really denotes a whole collection of programs and sometimes there are people in those beds that shouldn't be in them (such as acute psychiatric patients). The whole program needs to be reviewed in terms of what the appropriate levels of care are. Once that has been done, VA will be able to do the forecasting. The Commissioner said that the reality is that vacant space utilization planning among the VISNs is revenue driven. Even if they are told they can use vacant space for the homeless if they want to, they won't do it because their top priority will be to lease that space to derive revenue. Dr. Chang further replied that it might also happen because of reimbursement under programs other than CARES; how revenue goals are met depends on your perspective.

Another Commissioner asked how many domiciliary beds there are in the system now. Accurate information on that wasn't immediately available. Dr. Chang did say that about 80 percent of them are being used for mentally ill veterans, 15 percent for frail and elderly veterans and the other five percent for miscellaneous.

For *traumatic brain injury* the team involved researchers in the process, the area is also under study and some excellent work is expected to yield results in the future. In the meantime, there are no changes.

The SDP team was able to develop alternative forecasting models for *blind rehabilitation* and *spinal cord injury*. The blind rehabilitation was used as the prototype. An outside researcher had been mapping the distribution of blinded veterans within the veterans' population and had maps of the entire country. The team applied that information to the

enrollee population and used that as a prevalence model. The team then used the current utilization rate based on actual experience and applied that forward to future years. For blindness, there is a direct relationship to the age of the population. This made it easy to project. The prevalence model for spinal cord injury was developed a number of years ago by the Paralyzed Veterans of America. This model was adapted for CARES, with projections being based on the actual utilization rates.

The SDP team had an extensive debate about defining gaps and the criteria to use for selecting PIs. They opted to aim for a defensible data-driven planning process that is similar to the rest of CARES in general. This meant using grounded workload and population data, which is essential to meeting Departmental needs and for convincing Congress, GAO and others. Also, CARES is ultimately about space, so it will be necessary to translate workload back into space considerations. The team also considered shifts in program emphasis (e.g., shifting to more outpatients).

For the *blind rehabilitation* PIs, the projections went up almost across the country because of the aging of the veteran population. There was enough change to justify recommending two new Blind Rehabilitation Inpatient Centers (they met the 20-bed criteria for VISNs 16 and 22). The team also recommended outpatient rehabilitation centers for the VISNs without Blind Rehabilitation Centers (there are currently ten throughout the country). Finally, the team recommended restoring bed capacity to VISNs, which didn't have centers. Not all of the beds have been open in the past few years due to staffing and budget constraints. There is currently a one-year waiting time for veterans to get into a Blind Rehabilitation Center for treatment.

For *spinal cord injury*, the SDP team is recommending four new spinal cord injury units that met the 20-bed threshold in VISNs 2, 16, 19 and 22. There are currently six VISNs that do not have spinal cord injury units. If these recommendations are accepted, there will still be three (the team is recommending a second unit for one of the VISNs -- VISN 16, which is both large and a high-growth area). The team also recommended expanding the beds for SCI in VISN 7 in Augusta. VISN 3 is a small facility with spinal cord injury beds that might have to be relocated; the team wants any issues there to be handled as sensitively as possible. Long-term care facilities for spinal cord injury were recommended for development in VISN 8, VISN 9 and VISN 22.

The "bottom line" for SDPs is that models and recommended PIs were developed for two of the Congressionally mandated programs (Blind Rehabilitation and Spinal Cord Injury) while maintaining a constant level of service for the other SDPs. All of the others will be ready for inclusion in ongoing strategic planning and into the next cycle of CARES.

Discussion/Q&A:

A Commissioner asked what the effect would be on the one-year waiting time for Blind Rehabilitation services if the teams' recommendations are implemented. Dr. Chang said that she couldn't give a definitive answer. The program officials are focused on the continuum of care and providing all the services. Expanding the beds to full capacity

would reduce the wait to some extent, but it wouldn't have a major effect on the waiting time. The throughput currently is about 2000 patients per year and they stay for about 6-8 weeks, but the population is growing. The Commissioner suggested that the VA might want to re-think how it approaches the problem. There will be an expectation of improvement if the funding is increased. Dr. Chang agreed, but noted that CARES isn't about who gets taken care of tomorrow; it's about who gets taken care of five, ten and twenty years from now. Waiting time is an operational issue.

**Presentation by Barbara Chang, M.D.
Consultant for Clinical and Academic Affairs**

**CARES Review Processes
(Steps Five, Six and Seven in the CARES Process)**

The rest of the process concerns what happens after all of the plans are submitted. There will be three levels of review:

- By the Under Secretary for Health,
- By the CARES Commission, and
- By the Secretary.

The first level of review, by the Under Secretary for Health, will consist of the following major players: (1) the NCPO, (2) the Clinical CARES Advisory Group, and (3) the CARES One-VA Review, which will be conducted by the SRG.

A Commissioner questioned the purpose of the review by the SRG. He understood that the SRG was to monitor the overall CARES process and address all policy issues. If they are also to be involved in reviewing the market plans and recommendations, how will this affect the June 1 hand-off of the plans to the Commission? The answer provided was the One-VA Review was always a part of the planned review process; the SRG is the group that has been designated to conduct this review. The review will be done in the planned time frame.

The NCPO consists of all of the staff assigned to the CARES process -- VA staff, the multi-disciplinary CARES Planning Group and VSSC staff.

The Clinical CARES Advisory Group (CCAG) is made up of clinicians from all the major clinical programs (including the special populations and nursing), the National Center for Patient Safety, academic affiliations, research, quality and performance, field representatives, and the DoD. The *role* of the CCAG is to review the market plans in detail, review the draft National CARES Plan and request clarification or changes if necessary and make recommendations to the Under Secretary for Health. At this stage, the CCAG could send recommendations back to the VISNs if they had questions or didn't think the plan was adequate, asking for clarification or to have something reconsidered. The group is not to be a "rubber stamp;" it is to do a thorough and complete review. The CCAG has been constituted, has been through training on CARES and have been participating in the process in various ways. The basic criteria for CCAG review are (1)

clinical need (over the entire continuum of care), (2) patient safety and (3) quality of care. In response to a question from the Commission, Dr. Chang indicated that the Commission could be informed of what the CCAG recommendations are. Ultimately, though, the Under Secretary for Health has to sign off on the draft National CARES Plan before it goes to the Commission.

Dr. Chang emphasized that VISNs will have to provide for making the required care available in their plans. They must show how they intend to do this. The impact criteria include access (both ways-- not only distance but also time), the impact on the community, efficiency and mission-related considerations (such as the effect on academic mission, research mission and DoD contingency missions). She is often asked whether CARES is only about "the bottom line" -- costs. Only one of the criteria -- efficiency -- deals directly with costs. While important, it is not the only criterion.

The DoD has been involved in the CARES process in an effort to maximize the opportunities for joint ventures and sharing. Plans will be reviewed to make sure that those opportunities have been taken into account. Other DoD interests include TriCare contracts, contingency planning and coordination of medical strategic planning.

The *second level of review* is by the CARES Commission. After the Under Secretary for Health reviews the recommendations, he will approve a draft National CARES Plan and forward it to the Commission. *Note for the record: The Secretary will forward the draft plan to the Commission.* The draft plan will be distributed publicly and on the web. It will be open for comments for 60 days. The Commission will review the plan and stakeholder input by conducting site visits and holding hearings. The Commission will also be responsible for collecting public comments. The goal is to make the process as transparent as possible. A later presentation will provide more detailed information about stakeholder input. If the Commission has issues with the plan, the process requires consultations with the Under Secretary for Health about possible modifications before it goes to the Secretary.

The *third level of review* will be by the Secretary, who will consider not only the plan but also the Commission's recommendations. The NCPO has been told that the Secretary will either accept or reject the Commissions' recommendations as a whole or send the plan back for reconsideration. The objective is to avoid making piecemeal decisions.

Bullet three on slide 14, Summary (1) stated, "Primary recommendations to the Secretary are from the CARES Commission (after USH sign-off)" [sic]. It was clarified that the CARES Commission recommendations would not be signed off by the USH prior to the Commissions submission to the Secretary.

A Commissioner asked whether there would be an opportunity for the Commission to suggest changes to the Under Secretary for Health *before* recommendations are sent to the Secretary. The answer, provided by the Chairman, was that the Secretary wants the Commission to report directly to him on these matters. It was also noted that the draft plan will be transmitted to the Commission by the Secretary, not by the Under Secretary.

A question was also asked about exactly who will be responsible for preparing the draft National plan as part of the first level of review. The answer provided was that the responsibility will fall mainly on the NCPO. The Commissioner expressed his hope and expectation that the draft National plan will reflect cross-level proposals among VISN plans and not just making the individual plans into an aggregate National plan. There are stakeholders who have significant concerns that go across VISN boundaries. He hopes that the Under Secretary will be able to look across boundaries in putting together a National plan. Dr. Chang agreed that one of the benefits of CARES is addressing the uneven distribution of health care in the system.

Chairman Alvarez closed the proceedings for the day by summarizing the agenda for the second day of the meeting.

February 20, 2003

Chairman Alvarez opened the meeting by introducing two additional Commissioners, Ms. Jo Ann Webb and Dr. John Kendall, who briefly summarized their backgrounds and experience. The Chairman summarized the agenda for the day's meeting. He also emphasized that yesterday's presentations were intended as an introductory overview; the Commission will be getting into each of the subjects covered in more depth in future meetings. He asked the Commissioners to identify any needs for more information and also to indicate when they are getting too much.

In that connection, Richard Larson, the Commission's Executive Director, and Dr. Chang briefly explained the background and briefing binder books -- a total of four volumes -- that have been assembled for each of the Commissioners. These books contain very detailed information and are intended to serve as reference books. They will be shipped to the Commissioners' homes.

In relation to yesterday's discussions, a Commissioner asked if the books contained a definition describing the difference between "acute care" and "tertiary care." The response was that the definitions should be somewhere in the books, but that an acute care facility provides basic inpatient medical services and basic surgery and not much more. A tertiary care facility provides the full spectrum of care. VA also has "quaternary facilities" that provide organ transplants and other kinds of highly specialized services.

Overview of VISNs Communications Liaisons

Presentation by Barbara Chang, M.D. Consultant for Clinical and Academic Affairs

One of the weaknesses of CARES Phase I (the VISN 12 pilot program) was insufficient stakeholder involvement and communications. For Phase II, a three-pronged approach was adopted to avoid this problem:

- Communicating information -- VA policy now mandates that the VISNs undertake outreach and communication with stakeholders regarding CARES.
- Seeking and tracking input -- there is a formal system for tracking the input that is received and there are VISN-level monthly reports.
- Documenting and considering the input -- the CARES process requires the use of documented stakeholder input.

The CARES program objective is to ensure continuous stakeholder involvement, but especially at the key stages of the process: developing proposed market areas, identifying PIs, developing market plans and reviewing the draft National plan. The CARES program is currently at the "market plan development" stage. When the market plans come in from the VISNs (April 15), the NCPO will share them with the veterans service organizations (VSOs) as part of the NCPO review. In response to a question from a Commissioner, Dr. Chang indicated that NCPO will use the national-level veterans organizations to distribute the materials down to their state and local units for input.

Stakeholders. The main stakeholders were identified as (1) veterans and their families, (2) VSOs, (3) Congressional representatives, (4) affiliates, (5) employees and employee unions, and (6) other organizations such as state and local governments, future veterans, historic preservation groups. About 40 percent of VA's 4,800 buildings are listed in the National Register of Historic Places, so they have an interest. Academic affiliates include the 107 medical schools that are affiliated with the VA. Their interests and concerns are extensive. VA is a major training site for graduate medical education. About eight percent of all graduate medical students are in the VA at any one time and about 28,000 rotate through VA facilities in the course of a year. VA has also pioneered in special post-graduate fellowships, geriatrics in particular. A detailed list of academic affiliates is included in the handout material. The interactive web site has more information about major affiliates. VA is also required to participate in training for health care/healthcare professional in allied health fields -- nurses, pharmacists, social workers and others. VA helps train 45,000 students a year in these fields, about 3,000 of those with direct funding. This training is very important to VA because the people often come back and work for the agency. The training is also important because there are a lot of health care workforce shortages, both now and in the future.

VISN-Level Communication Reporting Requirements. The NCPO has asked the VISNs to report monthly on (1) what they have done in terms of outreach to stakeholders, and (2) what input they have received from stakeholders. In Phase I, the Pilot Phase, over 12,000 pieces of correspondence of various types had to be processed for just one VISN. The current Phase involves 20 VISNs. A *web-based reporting system* has been established to deal with the expected volume of communications. One characteristic of the system is that it is secure. The site is a password-protected Intranet site that only a limited number of employees may access. Another characteristic is that the site is designed in a hierarchical fashion, meaning that not everybody that has access to the system has access to everything that's on it. At the facilities level, authorized users can see what they have entered for their facility, and selected VISN employees can see what is in the system for all the facilities in that VISN, etc. The third characteristic is that

reports can be compiled and sorted for various time intervals. The system was designed knowing that the Commission will want to see this information. Issues are tracked by type, by number and by stakeholder group. "Hot spots" and major concerns also can be identified. The system is very easy to use and includes extensive stakeholder reference lists.

A Commissioner asked whether the tracking system also includes what decision was made with regard to the input received and why it was accepted or rejected. Dr. Chang replied that the information in the system includes the facility's response, action and impact on the plan. The handout material includes a copy of the actual web-based forms that are used for this purpose. The process systematically documents how the input is being used for VISN planning.

At national level, the CARES program is making a special effort to conduct outreach to VSOs, particularly in regard to special disability populations and unmet demand, to incorporate concerns about these matters into the planning process. Additionally, American Federation of Government Employees (AFGE) and other unions expressed concerns about the impact of CARES early in the process. Unions have been assured that CARES is a long-term process and that any downsizing resulting from implementation would take place over several years. Unions have been included on VISN-level planning committees, along with academic affiliates.

The overall communications effort has been very broad and has involved a lot of education, training, publications and web site development. The effort has been conducted as a team.

Discussion/Q&A:

A Commissioner indicated that it would be helpful to get an assessment of how effective VISN-level communications have been before the Commission begins to make site visits. The Commission will need to know what it's getting in to in the different locations. Dr. Chang agreed.

Another Commission asked whether an attempt had been made to communicate with VA employees other than through unions, which represent only a portion of the total. The response was that there have been many efforts, including town hall meetings, newsletters, e-mail communications to all employees and other communications. NCPO has recently finished a roll-up of all the reports received during the past five months. NCPO will provide those reports to the Commission.

A Commissioner noted that Medical Centers hold regularly scheduled monthly meetings with VSOs and that it would be helpful if the Commission could arrange to visit while one of those meetings is happening.

Another question asked was how far down in the VSO organizations will CARES go when they share the draft report: National office only or down to department- and

division-level? The answer given was "both." Mr. Carswell will explain how NCPO disseminates information.

A Commissioner asked how long it takes to get the new Census population data (for 2000) back out to the VISNs so they can run it through their plans and produce updates. The response was that it has been done and took about four weeks. VISNs are looking at the impact on their planning now. So far the impact has been modest, or even minimal, producing only a 2.4 percent net change in PIs, all in initiatives that were on the borderline (just above or just below).

A Commissioner expressed concern that the level of information that exists among senior managers in the VA system may be inadequate. There is a lot of information available and it is very difficult to digest, but it could be very helpful in keeping people informed. Dr. Chang indicated that NCPO has done a lot of briefings, both regular and special, and outreach already, including a four-day session for people involved in planning at the VISN and service levels.

**Presentation by Ms. Kerri Childress
Director of Field Communications
VHA Office of Communications**

CARES Media Products

Ms. Childress said that her job is to produce CARES media products, which involves taking the detailed information and putting it into a format and language that local VA public affairs officers can use to provide briefings to veterans who know nothing about CARES. The goals of her operation are:

- To provide products to local public affairs offices that represent a consistent and accurate voice across the country and
- To give the field organizations products they can use and make their job as easy as possible.

CARES is only one of the responsibilities that Public Affairs Offices have at field level, although it will certainly be a priority while the Commission is there. She tries to give them information that they can turn around quickly, add in anything local and have it ready to go. Products are sent out to the field in a "Power Point" format so that they are immediately usable. She distributed a packet containing samples of fact sheets and media products that have been sent to the field from headquarters.

Ms. Childress said her office in VHA works closely with the CARES Program Office and also with the VA Office of Public Affairs, which issues the releases. Everything that has gone out to the field -- PIs, market maps, etc. -- is available on the CARES web site at <http://www.va.gov/CARES/> and anyone can access it. When the market plans come in from the VISNs, they will also be made available on the web site. When the National plan is done, it, too, will be on the web site. The web site is an important tool. It isn't

possible to deliver all of the materials everyone might want directly to them, but the web site makes the information available and accessible.

There is a VISNs of CARES Communication Coordinators in the field. They are very active; about half have regular stakeholder meetings and have constant contact with them. Another one-quarter of the field coordinators are doing "pretty well." The final quarter she works with constantly to encourage more active outreach to stakeholders. Ms. Childress also noted that the distribution of effort is somewhat uneven. The VISNs doing the least amount of outreach are those with the fewest amount of changes or where the changes are all positive (Florida, for example). Where extensive changes are being considered (such as Pennsylvania) more outreach is going on and it will be needed.

Ms. Childress offered to put together a package of media clippings for the Commission so they can see how the media are reporting CARES. The reactions to CARES have generally been pretty balanced and positive, even innocuous in some cases.

The CARES Communications Coordinators in the field will be critically important to the Commission. They will help the Commission set up hearings. They know where the "hot spots" are and what issues are important locally because they have held stakeholder meetings. They can also suggest hearing sites and specific locations. They will be the "on ground troops" who will work with the Commission staff to put together the publicity related to the Commission's visits. Ms. Childress highly recommended that the Commission give serious consideration to their recommendations because they know their localities and their stakeholders. They have been waiting for the Commission and are excited about working with it. She has asked the Executive Director to provide information about the Commission's planned schedule to the field as early as possible, even if the schedule is just tentative.

An e-mail group related to CARES outreach and media activity has been established, and Ms. Childress offered to add the Commissioners to it if they want that. She would also welcome their participation in the regular Thursday conference call, which involves between 60 and 90 people.

A Commissioner asked about the experience in the field with regard to basics, such as data reliability. Have there been a lot of local disagreements with the numbers and the forecasts sent out from headquarters? The answer given was that re-running the numbers and sending out the 2000 Census data helped a lot. She also said that it's understandable why the forecasts might be different -- different people use different assumptions. Even so, there were very few changes to the PIs. As a follow-up, the question was asked whether the assumptions have been delineated in a single document. The response was that the description of the ELDA model has that information and a one-page summary was provided.

Another Commissioner asked who gets the media products that are distributed to the field. He said that he is in the field and he doesn't get them. Who do they go to? The response given was that the field coordinators are supposed to get them to the local VSO

representatives and others. The Commissioner noted that the VSOs don't really have the capability to make extensive distribution out to their organizations. Just getting materials to the state department of an organization doesn't get the job done; the materials don't go out. Ms. Childress said she is open to any suggestions about how to get the information out.

Another Commissioner asked what is being done about the 25 percent of field coordinators that were characterized as "not up to snuff"? Ms. Childress said that headquarters is working hard on that issue.

A Commissioner noted that State Directors of Veterans Affairs are key communicators. They can be a big help to the program.

**Presentation by Mr. John Carswell
VSO Coordinator
National CARES Program Office**

Communications With Veterans Service Organizations

Mr. Carswell's job is to coordinate communications with the Nation's veterans' organizations, of which there are hundreds. About 40 of these are more than just fraternal and actually provide services to veterans -- veterans' service organizations (VSOs). Of these, about a dozen have sufficient resources and national staff to be very influential. They are a critical component of the CARES outreach program. Six of the VSOs have been actively engaged with CARES from the beginning: the American Legion, Blinded Veterans Association, Disabled American Veterans, Paralyzed Veterans of America, the Veterans of Foreign Wars and the Vietnam Veterans of America. They are considered a core group.

The organizations have extended conditional support for the CARES process. The VSOs have long recognized the problems that CARES is addressing. Insofar as they have confidence that CARES will result in enhanced services, they can support it. The VSOs believe that they were instrumental in the inception of CARES. But there are two absolute conditions for their support. The first condition is that the process must be entirely open and the VSOs must have the opportunity for substantive input before the decisions are made. The second is that CARES must put planning for veterans at the center of the CARES planning process.

The objective of the CARES communications strategy is to facilitate the substantive input. It is unacceptable to the VSOs for VA to go through the whole CARES process, develop plans and recommendations and then allow them to comment. They will not be patronized. The VSOs do not consider themselves merely stakeholders. They believe that the veterans health care system belongs to them and exists because of their political influence and their service to their country. In their view, VA is an expression of deeply rooted moral values that have to do with patriotism, honor and service. It's not about economics. They view planning and policy-making for the system as their rightful

province. Mr. Carswell said he thinks the CARES program understands these principles well and appreciates them. The CARES communications strategy was crafted to reflect the program's commitment to these principles.

The VSOs are not monoliths. In that, they are typical of all national organizations, including VHA. They have the same issues with span of control and with barriers and communications problems. The CARES communications strategy is designed to facilitate substantive input in this environment. NCPO knows that they can't just disseminate information and expect the VSOs to act on it. The national organizations can't independently analyze it and form their positions, coordinating them with their national and local entities and move at the pace that is required. So the CARES strategy is to drive the information into the VSOs from both ends -- the top and the bottom -- and help them to use and understand it. The VISN communications coordinators are the key to the success of the strategy from the "bottom up" perspective. They are pouring a flood of information out to the veterans that they have traditionally worked with and also to the VISN representatives of the big national organizations. At the same time, Mr. Carswell's job is to work with the top levels, making sure that the national organizations get every scrap of relevant information that comes out. VSOs are now receiving an enormous amount of information and are struggling to keep up. But the key is to use the VSOs to distribute information within their organization. As the doors are opened, the VSOs can be expected to take some responsibility and accountability for the decisions that are being made.

At the national level, there is a VSO CARES working group consisting of the core group of six organizations already mentioned. NCPO works with that group to develop vehicles of communication within the organization. At the local level, the CARES communicators have contacted and are working with the local VISNs that have existed for a long time. When the national organizations designated points of contact, NCPO helped these people to forge links with the contacts at local levels. Points of contact were designated in each VISN. Not all organizations have the resources to designate points of contact in every VISN, but there is sharing at the top through the VSO CARES working group. The local contacts have a responsibility to keep their national offices informed of what's happening at local level.

Mr. Carswell believes that the CARES communication process is working excellently in some respects. There is a strong commitment within the National CARES Program Office and the cadre of local CARES coordinators to conduct a completely open process. One hundred percent of the data being used for CARES has been provided to the VSOs. There is also active, ongoing outreach at the local level. The national VSO offices have devoted significant staff and resources to monitoring CARES, both in Washington and locally. However, they don't have unlimited staff and resources. The same people working on CARES also work on other veterans' issues, such as claims. They are spread thin.

Discussion/Q&A: A Commissioner asked if he had any figures about how many veterans who access the VA system don't belong to VSOs. The response from the individuals

present was that they didn't really know that. Discussion suggested that a figure of "about half" (maybe three to four million) would be generous, but there was a high degree of uncertainty associated with that estimate. It would also be interesting to know how many of the three or four million VSO members are VA enrollees. The thinking was that it should be a pretty large number because there was a drive over the past few years to get people to enroll. It was suggested that this question might be asked of the VSOs.

Before proceeding, the Chairman made a general announcement about the need to maintain a "firewall." The Commission is independent. It reports to the Secretary. To maintain its independence, it must build a firewall that will preserve a degree of separation. It has to be clear that the Commission is separate from VHA and the National CARES Program Office. The Commission needs to have access to information and engage in information sharing without breaching this firewall. One Commissioner asked how can the Commission be independent and stay loyal. He said he is seriously loyal to the VA. Several Commissioners commented. One said he took the job because he values the system and the services provided to veterans. He is loyal to the principles of the system -- what's good for veteran and what's good for the VA in the long run. Another pointed out that the Commission would be totally ineffective if it were to be seen as a part of the VA staff. It would be viewed as a "rubber stamp." A third said her loyalty is to the veteran. The Commission's job is to determine what's best for the veteran, not the VA as an institution.

The Chairman announced that he has asked John Vogel to be the Vice Chairman of the Commission.

**Presentation by Colonel Thom Kurmel, USA
U.S. Department of Defense
Office of the Assistant Secretary of Defense for Health Affairs**

CARES-DoD Integration

Colonel Kurmel introduced himself as the Director of Facilities Life Cycle Management in the Office of the Assistant Secretary of Defense for Health Affairs. In that capacity, he is responsible for facilities planning. He serves as the CARES liaison with DoD. His presentation will discuss how DoD sees itself fitting into the CARES process. DoD has come at the issue from both sides: at the VISN level and at DoD level.

The DoD and VA have very different health care systems, but there are overlaps in significant areas and there are also opportunities to take advantage of existing sharing agreements that have come to light as part of the CARES process. DoD sees itself as a resource to VA for CARES.

DoD really likes the CARES process and has had discussions about how it might use it for its own health care planning. The DoD's population projections are different from VA's -- the populations are stable and growing less dynamically than VA's and they aren't

shifting around to migrate to different areas of the country. So the DoD approach to health care planning is different. But, like CARES, it considers the population to be served, does detailed projections and looks at the assets available. DoD planning is very local and very personalized.

One difficulty is that DoD is organized very differently from VA. There are three services that provide health care to DoD beneficiaries. They are organized differently across the country. Also DoD uses a "lead agency" concept and has TriCare contracts. This makes it tricky to coordinate the two systems in planning. His job is to help the CARES program sort that out. The goal of his DoD program mirrors CARES: putting the right facility in the right place.

DoD has been part of the CARES process from the beginning. Their staff participates in conference calls. Every service has met with every VISN and made connections with the planning that's going on now. An extensive spreadsheet showing overlap (which is on the web site) has been developed that shows connections at the local level. The hard work begins when DoD (and the Commission) tries to make sense out of the great ideas that are coming from the planning initiatives. DoD knows there will be some things that it needs to link up with its program. The DoD planning time frame right now is set for 2009. DoD may have to back up and make a CARES connection at a place that isn't currently included in the DoD facilities program. This will require some "comptroller gymnastics" at DoD. DoD has a program for investing in its facilities already that will need to be checked against the CARES process. There will be things that need to be smoothed out.

In response to a Commissioner's question, Colonel Kurmel said that DoD collaboration with CARES process started last summer. Service representatives were formally brought on board in November 2002.

A Commissioner commented that the DoD timeline is very different from VA's and that with the next set of TriCare contracts the 11 TriCare areas are being compressed into three. He asked if the DoD regions and VA's VISNs will ever match and whether DoD and VA do joint planning. Colonel Kurmel replied that the idea is a good one. There has been some discussion about doing joint capital planning but it probably won't happen rapidly. For now, DoD will continue to collaborate with VA on an informal basis when it conducts its planning. As an example, he cited DoD plans to integrate an existing VA CBOC into the planning for new medical facilities at Fort Belvoir, Virginia.

The service contacts are very important links. At Health Affairs level they can't reach down into the health care systems that the services provide. The three services get the money and they do the work. They own their individual facilities planning processes. The service contacts provide liaison with this system at local level.

DoD-wide, 66 potential areas of collaboration were identified. Not all of these will be PIs that made it through the CARES process. Many are already ongoing. The Army, with the biggest footprint, has the most. Other areas of potential interest include very

large markets with overlapping Federal health care capability (such as Washington, DC, San Antonio, San Diego, the Pacific Northwest, Tidewater, Virginia and the Florida Gulf Coast area). These are outside of CARES, but represent the potential for additional collaboration.

Sixteen localities with the potential or need for early collaboration were identified, including two in Virginia, two in South Carolina, four in Florida and two in Colorado. These sites may or may not be included as CARES initiatives.

Next steps involve DoD helping the VA to develop its PIs and market plans. Outside of CARES, DoD is doing its own capital facilities planning, which will have to be linked with CARES eventually. DoD will also have to realign its capital plan. Several things are going on that might affect how the capital plan looks in the future, both short range and long range. DoD isn't sure what locations they will have to work with after the Base Realignment and Closing (BRAC) process. They expect to find out shortly what the BRAC outlook is.

Discussion/Q&A: One Commissioner asked how much of a problem the VA shift from hospital-based care to patient-based care has been for DoD. If the Commission is going to recommend closure, it needs to know which direction the planning is headed. Colonel Kurmel said that the shift changes the equation for the contingency bed mission, which is updated annually. DoD isn't sure how or how much because the equation is based on casualty efforts that DoD is currently revising. The effect isn't an easy thing to understand. The policy that is used to specify what the bed requirements are at the current time is public information (not classified). The information is very specific and exists by VISN and by hospital. Other than that, he's not really sure what the answer to the question is.

Another Commissioner noted that the Air Force has also changed emphasis over the last few years, reducing the number of beds and spending more of its time on outpatients. If there a war or a terrorist attack overwhelms the DoD or civilian hospitals, beds would be needed. Where do the people go? VA is looked on by both the military and the civilian sector as the source of surge capacity to provide such beds in connection with a national or international event. The question in his mind is how much of that fact VA is putting forward in defense of its infrastructure? And how much is Congress willing to pay for this asset? The answer appears to be "Not much, if any" since Congress is not now funding VA facilities.

Another Commissioner said that VA has always been the backup to DoD. At one time there was a requirement for 90,000 beds just because VA was fulfilling this backup mission. DoD and others are assuming that VA has surge capacity. If it doesn't, he is concerned about where we will get the capability to absorb the casualties from an event like an anthrax attack.

VA has built some assumptions about surge capacity into its planning. It has identified key sites. Dr. Chang expressed the view that where the staffing would come from for a catastrophic event is more of a problem than finding beds.

The Commissioner observed that DoD concluded several years ago that there are some things that can't be justified based on peacetime demands. VA surge capacity is one of those things.

NCPO Staff commented that VA is not only responsible for providing backup and surge capacity for the military, the current Federal Response Plan and certain National Security Decision Directives make it responsible for providing capacity for local areas in the event of terrorist attack or weapons of mass destruction. There is the potential for a massive overload.

**Presentation to the CARES Commission
Dr. Robert Roswell
Under Secretary for Health
February 20, 2003**

Before I start, let me respond to a comment made earlier about VA's ability to support DoD at this critical time. Five years ago we had 205,000 employees taking care of 2.7 million veterans. Today we have 183,000 employees taking care of 4.7 million veterans. Our staffing has gone down while at the same time our workload has almost doubled. Additionally, we have a DoD contingency mission and 8.8 percent of our workforce is subject to mobilization at a time when we need them most. I support, respect and honor that contingency mission, but the critical thing is not surge capacity with regard to beds, it's staffing.

We have asked all of our VISN directors to begin to identify mechanisms to bring back retired annuitants, to bring back part-time nurses, to bring back former nurses who are in non-nursing roles. We have worked with OPM. But I'll tell you, holding on to facilities with the idea that they create surge bed capacity to me is not the answer. My concern is getting the nurses and the clinical staff spaces. But let me assure you, this is something I take very seriously.

It is a pleasure to be here and it's great to see a lot of people I haven't seen in a long time. Let me just take a moment and share with you my personal feeling about the importance of CARES. We've got 54-year old hospitals that are totally inappropriate to take care of today and tomorrow's health care needs for veterans. We've just got way too much infrastructure.

I believe we got to where we are because we used capital construction -- capital assets -- as our budget tool for many years. We began a major building process at the end of World War II. In fact, the number of FTE's in the construction office significantly outnumbered the rest of the headquarters. For years and years, we used construction as

our primary budget allocation tool. "Build a new hospital, get more money, build a clinic and get more money."

Budgets for the most part were augmented by what we used to call the "blood and guts line." It followed whatever the general inflationary rate was, whatever the appropriation increase was. But the way you built a budget was to build a hospital. We operated 172 hospitals -- that's the number I'm generally familiar with -- and we had our best, most talented leadership running those hospitals and they were very competitive for budget. The way you worked your budget was to build bigger, better hospitals with cardiac surgery and anything else you could find. If you couldn't fill the beds one way you figured out a way to fill them another way, whether you called that long-term neuropsychiatry care or whatever, that's how we got to where we are. Senior managers competed for dollars and the dollars followed the capital assets.

We've moved away from all that and moved on to a utilization-based model. But it's not a whole lot better because the utilization model looks at, in fact, how people consume health care services and that actually encourages the utilization of health care services.. One morning we woke up and said, "My goodness. We've got way too many hospitals. How did this happen?" Well, we let it happen by itself.

I think that the challenge before us now with the CARES process is to not focus so much on capital assets as to focus on patients. I feel very strongly that the CARES process is about looking at the veteran population and trying to determine as best we can what their needs will be 10 years, 20 years down the road. And then from that, figure out how we'll meet those needs with our capital infrastructure.

We've learned a lot in the CARES process so far. We've got some of the best actuaries in the business and we've looked at enrollment projections, but frankly there is no best planning model for some of the services we provide. We've also learned that some of the services we provide -- such as domiciliaries -- aren't really services. They're capital assets that house a variety of different programs and its an eclectic mix of different kinds of services.

So what we've tried to structure in the CARES process is what we know best and what we can learn best from the health care industry. I think it's an ambitious process and it's one in which we have a huge investment.

Specifically, let me point out that I believe the industry standard for capital assets maintenance is somewhere between two to four percent of capital assets cost. Our construction budget hasn't been anywhere close to two to four percent of our \$40 billion-plus capital asset inventory. Never. And recently, it's become even less. And that two to four percent is a conservative figure based on typical capital assets, not 54- year- old hospitals, which have a much higher maintenance cost.

What little minor construction budget money we had to maintain our capital assets has virtually dried up over the last several years waiting the outcome of CARES. The reality

is, "Why spend more money until you know what you need?" Consequently in the 2003 budget, four major life safety projects to provide for accessible medical centers in places like San Francisco, where a reasonable person would say we're going to have a continuing need to provide care and services, was not funded. It was pulled out of our budget. And that causes me a lot of concern, because a bad situation has gotten worse pending the outcome of the process that you're involved with.

So you have my absolute, total complete support. I'll do anything I can to make your job easier. You have a difficult job and I certainly appreciate your willingness to help us. We're really committed to bringing this process to closure on time to make sure that the Secretary will have time to make a decision after publishing the plan and that the implementation plan can be finalized. I certainly stand ready to do anything I can to help facilitate that.

I wanted to take just a minute and talk about some of the directions we see health care going in because it's relevant to capital assets. The Secretary made the enrollment decision recently to discontinue enrollment of Priority 8 veterans. That has been amplified in the 2004 budget request, in which we said we would further charge a \$250 enrollment fee for Priority 7s and 8s. The idea is to discourage people who are casual users who don't really rely on VA for their health care needs.

One of the phenomena that have occurred in recent years because of the open enrollment is not only that there has been a huge growth in users, but there has also been a lower reliance on VA for health care needs. Many veterans are using VA primarily for prescription drug benefits and primary care services. But these veterans have changed the fundamental nature of our health care system. They have pulled us away from a comprehensive system of tertiary care and rehabilitation care. And it would be a travesty, in my mind, if we engage in another conflict in Southwest Asia and there are thousands of men and women returning to a system that has only outpatient clinics and prescription drug care and not comprehensive rehabilitation care.

So I'm very opposed to the idea that we can continue to let the system move in that direction. I believe that we've got to re-focus the system on meeting the comprehensive tertiary needs of our patients. And that's reflected in the enrollment decisions and in the enrollment fee for the '04 budget. It's also reflected in VA +Choice, which is a Medicare packaging plan that would allow Priority 8 veterans, who are not currently enrolled and who are Medicare beneficiaries to seek health care from VA.

Another major policy proposal in the '04 budget concerns geriatric care and a shift away from institutional long-term care provided by the VA. It's a very controversial decision and we'll have to wait for Congressional action on it. But let me quickly point out that we are not shirking our long-term care responsibilities. We are looking at a shift away from VA staffed long-term care beds. VA spends an average of \$350 per patient a day staffing institutional beds. That compares with an average contract community nursing home cost of approximately \$175 a day and a State home per diem cost of less than \$60 a day. VA's is the least efficient.

In fact, we're providing the highest level of skilled care. But the truth is that VA staff nursing home beds, for the most part, aren't providing institutional long-term care. They're providing post-acute rehabilitation care. That's why the per diem costs are so high. And it's critical that we have that post-acute rehabilitation care. Otherwise the efficiency we have been able to generate with our acute care program and the outcomes of our rehabilitation program would be different.

In VA, almost 80 percent of the patients who leave a VA nursing home are discharged to home. That's not long-term care, but it's the level of care we need. We need to preserve it for that function. So the '04 budget policy says we will honor our statutory requirements to provide lifelong care for veterans. That means we'll provide post-acute rehabilitation care, drastic care and geriatric evaluations and management. However, we'll begin to shift institutional care to State homes when it's needed, while still continuing to have a significant number of nursing home beds.

And we have a third level of care -- the contract community nursing home beds. The reality is that's a consolation prize. When a veteran can use long-term custodial care, historically we have placed him on a contract for up to six months in a community nursing home to allow him time to apply for and receive Medicaid entitlement to cover the cost of his care. It's a consolation prize. "Who's going to provide your care? We'll give you a contract to get your affairs in order so you can self-pay with Medicaid." But that, unfortunately, makes what we have to offer self-funded. We can do that much more efficiently. We don't need to offer a consolation prize. Our best practice is that we can engage Medicaid application and entitlement without even the need for any bridging contract.

So we're seeing a reduction in contract community nursing homes this year. We're seeing a reduction in the VA staff nursing home care and are continuing to put money into the State home grant program.

But the exciting part about the long-term care is home health care. To me, that's where the fundamental change in health care is. We're shifting to care coordination and we're shifting to become a long-term care outpatient system that provides medical care in the home using health aids, using interactive technology and using techniques where we can actually monitor patients on a daily basis. That allows a veteran's 50-year marriage to be maintained intact; it's much higher quality of life; there's much lower incidence of falls and accidents than occur in nursing homes. It just provides a much higher quality of life.

People say, "Yeah, but what happens when the primary care giver becomes ill or unable to perform?" That's a problem. In that situation, we try to preserve the marital relationship, which is not possible in a VA staff nursing home. So we're working on a model that keeps the partner in an assisted living facility with an adult health care provider who will provide housing. VA would come in with care management techniques -- completely interactive technology, but in the ALF to provide health care treatment. We're very intrigued with this model and we've actually started a new

program office in our VA headquarters to do that. I really believe it's the kind of care we need.

In fact, the CARES process can help us with this. The enhanced use leasing authority is much too slow, much too cumbersome with Congressional notification and public hearings, just a lengthy process. But if we can get the enhanced use leasing authority fixed, we could take VA property and facilities and make them available to private assisted living facility providers. They could come in and renovate the space, make it available for veterans and their spouses. VA would provide the health care for the veterans.

Care coordination is not just for the elderly though; essentially, it's a process we're applying to disease management, – particularly chronic disease. Health care in this Nation is, and has always been, a provider-centered delivery of services. What does that mean? It means we focus on us as the providers and our needs, not the patients' needs. When I went to medical school in the early '70s, VA was touted as the safety net for America's veterans. No veteran would ever fall through the cracks of health care in America because the VA hospital system was there. If a veteran suffered a disabling stroke, if a veteran developed diabetes, or end-stage renal disease, VA was there. And we were genuinely proud of that. But did you ever stop and think "What a horrible way to provide health care to our most deserving people in America?" They would have to suffer a catastrophic disability before they could get the care they needed? That's ridiculous. It's absolutely the opposite of what the model should be.

Health care has got to be focused on prevention and on health maintenance. Not on being a safety net. No one should have to suffer a stroke before they get to care. So we shifted from a hospital system to an integrated health care system. We have outpatient care, primary care.

We have the best performance of any large health care provider in the Nation. Using 18 indicators of quality, VA has moved to the benchmark in 16 of those 18 indicators for intervention and preventive services. We're doing a much better job today focusing on the needs of the patient. But unfortunately, even today, as good as we are -- world-class leaders in-patient care quality, patient delivery and access -- we're still a provider-centered organization. When a veteran comes in to the primary care center, what does the physician say? "Well, you've got diabetes or you've got arthritis and congestive heart failure, I need to see you back in two months."

I'm sorry, that's wrong. That's provider-centric care. That's not the way to provide care. Care is about focusing on the patient. Care is not 20 minutes in a doctor's office twice a year. That's not what good health care is about. Good health care is about working with the patient, 24-hours a day, seven days a week, and involving the patient in their health care. Providing health care is really a continuous process; it's a partnership between the veteran and the provider. And you can't do that in 20 minutes in an outpatient clinic. And we have packed everything you can possibly imagine into that 20-minute outpatient appointment. That's why outcomes are so good.

With our computerized patient record system and clinical reminders we're able to administer all of those preventive indexes and chronic disease indications in the outpatient clinic. But we've got to fundamentally shift health care to the idea that we're not providing care just in case of complications, but just in time when the complications begin to develop. And the same care coordination concept that I spoke about for the long-term care needs to be applied to our most complex cases with chronic diseases. We need to put interactive technology in the home, monitor veterans' care and well being in the home. When a red flag pops up, we know it and that's when we get the patient in to the provider.

Using these kinds of techniques you can expect to be able to reduce the demand on the primary care services and specialty care. An initial pilot program shows that we can reduce the cost of comprehensive care by over 65 percent and can reduce acute admissions, emergency visits, bed days of care -- almost any measure of health care utilization can be reduced by the application of these techniques. We can even reduce the number of prescription drugs the patient takes. There is a significant reduction in the overall cost of care.

My point is there are some exciting things happening in health care. We're better situated than any provider in the world to do this because of the advanced stage of our computerized records system. That's what it takes. You have to use broad technology to allow the patient to interface with the web-based medical records system that's integrated with the computerized patient records system. There are a lot of confidentiality concerns, but our IT architecture plan is to move to a web-based medical records system that is owned by the veteran. It's called "My Health e-Vet." The idea is that the veteran actually has access to their medical records, takes ownership and is involved in maintaining them using interactive technology for reporting.

So tomorrow's VA health care system has got to be a system -- it's got to be a system -- that meets the full, comprehensive needs of veterans, including those who may suffer disabilities we haven't yet seen. The lessons we learned after the Gulf War can't be repeated. Men and women came back from that conflict with unexplained, undiagnosed illnesses. We needed a vast infrastructure to be able to provide the spectrum of care to help understand that. We needed a research infrastructure to be able to deploy a research agenda. We needed an educational component to be able to work with our partners. We needed a comprehensive health care system.

Our rehabilitation system, whether its post-traumatic stress or blind rehabilitation or spinal cord injury -- all of the things we are world renown for -- is based on the ability to support those with full and tertiary services. You can't run a stand-alone spinal cord injury center. You have to have urologists, you have to have plastic surgery, neurosurgery, you have to have full imaging capability to be able to do that. And it takes that tertiary core to be able to provide the special injury items.

So first and foremost we've got to preserve the tertiary core of the VA health care system. And as we do that, we then have to move the focus of health care from provider to patient. We have to change the idea from "the patient comes to us" to "we provide services to the patient." That requires a lot of affirmative changes in the way we think about health care. But that's the journey VA has started on.

And as we pursue that journey by capital asset inventory as reflected in some of the CARES planning initiatives, it is my sincere hope that if we identify opportunities through the CARES process we can use any properties, resources, capital assets that may become available to further that agenda.

That's the way I see the health care system. I'll close by saying that if there's anything you need, my office and all of our staff in VHA are fully committed to the process. You have a very difficult job. You have my admiration and respect for accepting that job. I'll certainly do anything I can to make that job a little bit easier. If we have time, I'd be happy to answer any questions you have.

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

February 19-20, 2003
Jefferson Hotel, Washington, D.C.

Summary Report Of Initial Meeting
Administrative and Organizational Discussions
(Administrative Session)

February 19, 2003

In a brief end of the day session on February 19, Ms. Webman, Commission Counselor, discussed the requirements for meeting in open session versus executive or administrative session. The basic rule is that if the issues being discussed concern the substance of the Commission's work, then the meeting must be open. If the issues being discussed involve administrative and organizational matters (such as how the Commission will make decisions, where hearings will be held, hearing formats, etc.), they can be decided in administrative session.

The Chairman indicated that he wants an executive session on the second day of the Commission's initial meeting so the members can have an open discussion of the process and schedule, workload, organization and Commissioner availability. He is looking for Commissioner contributions to the process because nobody yet has a clear picture of the magnitude of the job to be done. He believes the Commission will have a difficult task and he would like to develop a practical approach for how to get a handle on it. The Chairman also asked the Executive Director to review how the Commissioners will get paid and other administrative matters as outlined in the "read ahead" packet.

Additionally, he intends to appoint a Vice Chairman, probably tomorrow. Notes will be taken of the meetings by an official reporter and by two staff members. Any materials that are attributable to individual Commission members will be checked with the member before being put up on the web site. Commissioners were alerted to the fact that e-mail communications within the Commission, while secure, may be subject to disclosure.

February 20, 2003

Ethics Briefing

Presented By

Roberto DiBella, Office of the General Counsel, DVA

The Commission received an ethics briefing from Roberto DiBella, VA Office of the General Counsel. He noted that everyone on the Commission had already completed their disclosure forms. He noted the Commission's work is very important to VA so it's important to certify that there are no conflicts of interest. He asked the Commissioners to certify that they have reviewed the ethics packet that he distributed.

Mr. DiBella stressed that there are sanctions for violating the ethics rules, including fines or imprisonment. He reminded the Commission that its proceedings are public; Commissioners should be aware that what they say might be published or distributed. Commissioners are special government employees when they are doing the Commission's business. When they are on Commission business, Commissioners are not allowed to participate in any official dealings that will affect their direct outside financial interests or those imputed to them (e.g., the interests of spouses, children or any organization with which they are employed or for which they are a trustee or director). But the limits apply to special employees only to matters that Commissioners work on as part of the Commission. The rules are spelled out in the materials provided.

Mr. DiBella also outlined the gift rule. Commissioners may accept any gifts they want to as long as they are not associated with their position on the Commission. The bottom line is that employees can accept a gift on a one-time basis as long as the market value is \$20 or less or \$50 from one source in the same year. In some cases, it might also be possible for Commissioners to resolve potential conflict issues by recusing themselves from deliberations and decisions about certain matters. The key to avoiding violations is to ask *first* if there is any question -- ask before acting. The General Counsel's Office will be happy to advise Commissioners if there is a potential issue. Asking first is desirable because the ethics laws do have teeth. Special employees have been prosecuted for violations in the past.

A question was asked about gifts involving travel, accommodations, etc. when the Commission is paying a set amount. The answer provided was that a Commissioner would be entitled to reimbursement only for out of pocket expenses.

In executive session, the Commission discussed and decided **administrative, organizational and scheduling matters**. Executive Director Richard Larson led the discussion.

Administrative Arrangements

Commission staff offices are located at 1575 "I" Street on the 6th floor (202-501-2000). Commissioners will have space there to use when they are in town. Commissioners should call before coming to the office to obtain security clearance and parking space.

For Commission travel & accommodations, Shirley Lai will be the primary point of contact.

Regarding the location of future Commission meetings, Commissioners were asked to comment on the facility used for the initial meeting (the Jefferson Hotel) as a possible site. There is conference space in the building where the office is, but it is heavily booked well in advance. If the Commission wants to use it, the staff will need to reserve it early.

With regard to read-ahead materials, Mr. Larson said the staff would provide more lead time for future meetings. He asked the Commissioners to indicate by e-mail the format in which they wish to receive materials (hard copy, CD-ROM or DVD). The Commission staff were requested to provide indexes for the materials if possible and to ask speakers to provide executive summaries with their materials. Advance material sent out to Commissioners by express mail should specify "no receipt required."

A website will be established for the Commission. It will be used to make meeting schedules and summaries available to the public and the Commissioners. The plan is also to use the web site to receive public comments on the draft National CARES plan after publication. When issued, the draft plan will stipulate that comments should be sent directly to the Commission as the primary collection point. Commissioners were asked to give serious consideration to what communications process they will use. Intra-Commission communications on the web site would be internal but available, if requested, under the Freedom of Information Act (FOIA).

Staff support: The Secretary has approved 15 staff to support the Commission. Mr. Larson envisions that eight or nine of these will be –policy and program analysts with analytical and strategic thinking skills. One person will serve as both the legal counselor for the Commission and its report writer. Three people will be devoted to logistical support (travel, hearing coordination, etc.). The Director will also ask each facility to be visited to assign a logistical support person. The Commission will also be able to use VA's national VISNs of public affairs people.

Staff needs: The Director is looking for two high-level systems policy and planning experts with health care delivery knowledge to provide the Commission with expert advice. First priority is to look inside VA, then outside. Another need is for a "senior data expert" who can dig into and manipulate the huge amount of data associated with

CARES. Commissioners should send recommendations to fill these positions to the Executive Director by e-mail

Separation: The Secretary has ordered the Commission to maintain a "firewall" between it and the NCPO staff to ensure independence. The Executive Director gave several examples of recent decisions that have emphasized the need to keep the Commission separate from the VA process. The Secretary wants the Commission to maintain its independence. Commission staff will have access to NCPO information and expertise, but separation is to be maintained. The Executive Director will resolve any questions.

Commissioners' Pay/Reimbursement: Commissioners are entitled to \$500 per day compensation for each day spent working on Commission business. After discussing the matter, it was agreed that each Commissioner should decide what to claim rather than use a standard formula. The Director will provide the memorandum-type forms to be used for claiming compensation. He requested that Commissioners submit monthly bills electronically for their time at the beginning of each month. Commissioners were also asked to provide the information necessary for direct deposit of pay (social security numbers and bank information). Reimbursement for travel expenses will be provided using a separate form ("accounts payable"). When traveling, Commissioners will be advised of per diem rates for relevant cities; lodging will be reimbursed on the basis of actual expenses. Commissioners are required to use the Government's system for airline ticketing.

Organization and Scheduling

The Commission next discussed how it would go about accomplishing its assigned task. The Executive Director suggested that the Commission has the opportunity to make some early foundation decisions. These include:

- (1) Whether the CARES model is a reasonable model.
- (2) Whether the demand data used to identify the gaps that defines the PIs are valid
- (3) Whether the PIs are consistent with the policy guidance.

Making these decisions involves building up the knowledge of the Commission -- digging more deeply into the model and data that were outlined at the initial meeting, with staff support.

The plan is to meet once a month until the draft National CARES Plan is submitted to the Commission on June 2. At that point, the Commission will need to begin making site visits and holding formal hearings to further inform its decision-making process. After comparing individual schedules and availability, agreement was reached for the following schedule:

- March 11-13 -- Three-day meeting. Commission to receive in-depth briefings on (1) the demand model (one day); (2) market areas, gaps and special populations (one day); and (3) PIs (one day).

- April 2-4. Three-day meeting. In depth briefings on finalize market template (one day); decision making as to (a.) Whether the Demand Model, including special populations, is a reasonable model for the purpose for which it was used (one day); and (b.) Whether the NCPO reasonably adhered to uniform application of policy guidance and made consistent applications of the data when establishing the PIs (one day).
- May 14. One-day meeting. Review sample market plan; develop Commission strategy for hearings.
- June 2 -- Commission receives the draft National CARES plan (Dr. Roswell's report) from the Secretary.
- June 10-11 -- Two-day meeting. Commission to receive a briefing from Dr. Roswell's Office, the NCPO Staff and the Commission Staff to summarize the plan and any changes to VISN plans that were made by the Under Secretary's Office (1-1/2 days). Commission will also make final decisions on hearing strategy, sites and schedule (1/2 day).

Commission members expressed a strong desire to be provided with materials as far in advance as possible to allow adequate time for review. VISN Market Plans should be delivered to the Commission *seriatim*, not in a single block. There will be over 200 plans (77 market areas times two to three PIs per area). The length of each VISN's plans will vary in size for each market area. However, an Executive Summary of 10-pages for each market area may be provided. A standard format will be followed. It was emphasized that the task of the Commission is to review and validate what was done by VA, not to develop its own plan. Staff is to brief the Commission on the most glaring things that it should be aware of before each field hearing.

Phase two for the Commission involves holding *public hearings* and making *site visits*. The following decisions were made for planning purposes:

- The Commission will organize into three teams of five Commissioners each. Each hearing will be chaired by a Commissioner. Members may want to rotate among teams. A quorum of three members will be required to conduct a hearing (this means that at least four of the five panelists should be available for the scheduled dates and places to avoid problems stemming from emergencies).
- Hearings will begin June 16 at the earliest and will end no later than August 9. Staff will develop a tentative schedule based on these dates.
- A "mid process" full Commission meeting will be held in Washington on July 1st.
- There will be a minimum of one hearing per VISN; many or most will have two hearings. This will result in about 40 hearings, or 14 hearings per panel. "Hearings" are formal proceedings.
- A hearing will be held in Washington, D.C. in the later part of July. It is expected that the full Commission will participate in this hearing.
- A tentative decision was made to hold three- to four-hour hearings. Hearings will be held at various times, including nights and weekends, in order to accommodate the work schedules of those invited to speak.
- Where feasible, hearings will be held on campus at VA facilities.

- In many locations, site visits will be held in conjunction with hearings, preferably in advance. Staff will recommend sites to visit.
- Only invited speakers will present testimony at the hearings. Invited speakers will be top-tier stakeholders, such as statewide VSOs, State Veterans Affairs Directors, employees, military organizations, affiliates, state and local officials and veterans' directors and business leaders. In areas where specific or unusual issues exist, other stakeholder groups may be invited to speak. Others who wish to testify may do so through the public comment process.
- Each presentation should last 20 minutes. Speakers will be timed. They will be given the hearing parameters in advance and will be asked to provide written testimony for the record along with a summary. This process will allow the hearings to focus on questions and answers.
- The hearings will be documented by: (1) the written presentations; (2) audio-taping (but not transcribing) the full proceeding; and (3) having a note-taker develop a detailed summary. Staff will also be in attendance to help document.
- Teams will receive materials pertinent to each hearing about a week in advance of the hearing and will be briefed by the staff 2 days before the hearing by telephone conference call. Summaries will be produced 2-3 days after the hearing.
- Each panel will include one female, one nurse, one doctor and one VSO. It is noted that all three women Commissioners are also nurses. An effort will be made to avoid assigning former VA employees and current VA employees on the Commission's staff to their former home territory. Commissioners should inform the Executive Director soon as to which geographic areas represent potential "conflict of interest" appearances for them.
- Commission decision-making will be by a show of hands. The Chairman would like to operate by consensus as much as possible.

Once hearings are concluded, the staff will summarize, analyze and make usable the information developed from the hearings and earlier deliberations. This will require a minimum of two weeks. At that point, presumably around Labor Day, the Commission will need to meet and make preliminary decisions. A draft report can then be produced, after which the Commission will need to review the report and make final decisions. The timing of the process is very tight, but that is unavoidable.