CHAPTER 2

Crosscutting Decisions and Implementation

INTRODUCTION

This chapter outlines the Secretary of Veterans Affairs' decisions on the crosscutting recommendations of the CARES Commission.

These are recommendations and decisions on policy issues that influence multiple individual decisions in the CARES process. After each Commission recommendation, the Secretary provides a response and guidance for implementation. Completion dates have been included where studies or plans are called for in implementation.

Commission recommendations were abbreviated to facilitate the readability of the document. Often, crosscutting recommendations are relevant to individual VISN recommendations. To help the reader make linkages between the crosscutting and VISN recommendations, many of these recommendations are later referenced in individual VISN sections.

The Secretary's decisions and guidance for each of the crosscutting recommendations made by the Commission follow.

THE CARES MODEL

CARES Commission Recommendation

The CARES Commission determined that the CARES Model provided a reasonable analytical approach for estimating VA enrollment, utilization, and expenditures. Recognizing the complexity of the CARES Model, the Commission sought expert advice from consultants who studied the Model, confirmed its validity and made recommendations to the Commission for further improvements.

Based on this analysis, the Commission recognized the CARES Model as a legitimate basis for planning. In accepting the Model, the Commission made several important recommendations, including: the need for a re-examination of the sustainable enrollment base to justify investments, completion of a lower-bound sensitivity analysis, and use of 30 months of data to arrive at an enrollment projection.

Secretary's Response and Implementation

The CARES Model was designed to produce the most accurate possible forecast of the current and future demand for veterans health care and the data used to develop the Draft National CARES Plan represented the best information available about the future demand for veterans' health care. To project future workload, CARES used a private sector utilization model to ensure that forecasts met private sector efficiency standards, but adjusted the Model to account for the unique characteristics of the veteran population and the VA benefits package. In addition, the National CARES Program Office, in consultation with stakeholders, developed separate projections of services that are unique to VA and generally not extensively available in the private sector. While the data and methodologies employed to project enrollment and workload are the most sophisticated that VA has ever used, they will continue to be improved as CARES is integrated into VA's annual strategic planning cycle.

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As VA seeks to improve the Model, it will specifically address the recommendations of the CARES Commission.

The following actions are ongoing and address all of the major recommendations specific to the CARES Model:

1. VA will increase the enrollment period used for CARES enrollment estimates to 29 months in the next full set of projections. The 17-month enrollment period used for CARES represented the most accurate data available at the time. Once the 29 months of data are available, VA will incorporate this larger information base into its forecasts. As experience is gained from additional months of actual enrollment, and data are verified as meeting quality standards, VA will further augment this component in successive Model forecasts of enrollment.
2. VA has completed development of a lower-bound sensitivity analysis for CARES projections. This analysis used more conservative assumptions to project enrollment and was intended to test the validity of the CARES data. VA is using the results of the analysis to further analyze CARES projections. The new set of forecasts explored the sensitivity of enrollment projections by using estimates of expected market shares by priority groups based upon the predominant pattern of current market shares.
3. The Commission acknowledged the work underway to improve the Model and to-date, VA has completed the following improvements, all of which will result in greater accuracy:
   - Projections of geographic state-to-state migration of the enrollee population;
   - Estimates of the probability of transitioning between priority levels;
   - Reliance on VA health care services versus the private sector is now calculated at the market area where previously it was calculated at the VISN level;
   - The Vietnam era cohort, with a relatively higher morbidity, has been adjusted for higher mental health utilization;
   - Estimates of the baseline Priority 5 eligible population have been significantly improved by incorporating new information on veterans' income from Census 2000;
   - Forecasting models for eleven VA mental health programs have been included and future utilization of services by the population of veterans

aged 65 and over has been adjusted to reflect expected changes in their need and utilization of health services; and

- Enrollment forecasts are improved by using 506 sectors as opposed to 3000 separate counties. Aggregating counties with very small numbers of veterans into broader sectors provides a more robust unit of analysis.

As recommended by the Commission, VA completed a rigorous re-examination of its forecasting Model by expanding the enrollment base period, completing a lower bound sensitivity analysis, and making Model improvements.

As recommended by the Commission, VA completed a rigorous re-examination of its forecasting Model by expanding the enrollment base period, completing a lower bound sensitivity analysis, and making Model improvements. VA has updated its forecasts with this information and is currently in the process of integrating these findings into its strategic and capital planning processes. The results of these forecasts have been used to validate the major construction proposals that will be incorporated into VA's capital planning process and will be reflected in VA's five-year capital plan. VA will submit its five-year capital plan to Congress in May 2004.

These actions are iterative enhancements to the CARES Model that will help VA ensure ongoing improvement in its ability to forecast demand for veterans health care. The Model will continue to be improved as VA integrates CARES into strategic and capital planning cycles. While these improvements will help further refine the CARES Model, they do not represent a compelling reason to delay the decision to move forward. There will always be improvements VA can make to more effectively forecast demand. For that reason, VA is always in pursuit of continuous improvement in its efforts to collect and analyze data relevant to improving health care delivery.

The Commission has endorsed the forecasting Model with the inclusion of the improvements described as an acceptable basis for planning. The data assembled to-date is by far the most comprehensive ever developed to support planning for future needs. VA must initiate the process of implementing CARES by acting today and committing to continuous ongoing improvement in planning for the future.

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CRITICAL ACCESS HOSPITALS

CARES Commission Recommendation

VA should establish a clear definition and clear policy on the Critical Access Hospital (CAH) designation prior to making decisions on the use of this designation.

Secretary's Response and Implementation

VA must ensure a standard of high quality of care at all of its medical facilities. Though VA's small and rural facilities are often among VA leaders in provision of quality health care, VA must carefully determine and monitor the scope of services to be performed at its small facilities — specifically those procedures that are complex in nature. Further, as medical care becomes more technologically advanced, small facilities may find it difficult to effectively maintain and use the tools necessary to practice health care at its most sophisticated levels. To establish parameters for how these facilities should prepare to meet future challenges, VA introduced the concept of a CAH, modeled after a Medicare designation for small hospitals.

The CAH was introduced to help ensure that veterans receive high quality care at VA's small facilities. Though the CARES Commission found the definition applied to these facilities in the DNCP to be lacking in specificity, VA needs a framework for ensuring the ongoing and future quality of care provided at its small and rural facilities. Recognizing that some small and rural facilities will be unable to maintain the workload necessary to perform certain surgical procedures or manage some complex illnesses effectively, VA must establish parameters to ensure high quality patient care.

To address this need, VA is developing a policy to define the appropriate scope of services that should be provided at small and rural facilities. The new policy, Veterans Rural Access Hospital (VRAH), will specifically define the clinical and operational characteristics of small and rural facilities within VA. The VRAH policy will be completed in June 2004.

In the interim, the missions of small facilities previously recommended for the CAH concept in the DNCP will not be altered. Once the new VRAH policy is approved, VA will study the scope of services performed at these facilities using the policy's criteria

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and the guidance provided. The VRAH policy will be shared with stakeholders and VA will seek further comments as facilities are studied.

VRAH studies will begin mid-summer, be completed by the end of the calendar year, and results will be included in VISN FY 2005 strategic planning submissions.

COMMUNITY-BASED OUTPATIENT CLINICS

Commission Recommendations

The CARES Commission made several recommendations for enhanced access to veterans health care through Community-Based Outpatient Clinics (CBOCs). Recognizing the need to apply uniform criteria and consistent national standards, the Commission reaffirmed that final decisions regarding the establishment of new CBOCs should remain under the purview of the Under Secretary for Health and the Secretary. Under that national framework, the Commission made several additional recommendations about how VA should prioritize CBOCs. The Commission found that the prioritization methodology in the DNCP disproportionately disadvantaged veterans living in rural areas that are underserved and lack appropriate access to care. They also sought flexibility for VISNs to relieve space deficits at parent facilities by adding new sites of care. Finally, the Commission recommended VA improve the efficiency of operations at existing sites and supply basic mental health services at all CBOCs.

Secretary's Response and Implementation

VA will continue its ongoing efforts to meet national standards for access to care for our Nation's veterans by establishing new sites of care through CBOCs. The Commission made several positive recommendations regarding CBOCs, and VA will act to ensure they are met. To that end, VA revised its national criteria for establishment of CBOCs to include emphasis on the importance of access to care for rural veterans, use of CARES travel guidelines to assess access to care, the availability of mental health services, and the flexibility for VISNs to relieve space deficits at crowded parent facilities by moving care to a nearby outpatient setting.

These actions complement existing CBOC criteria that include a focus on caring for Priority 1–6 veterans, ensuring that VISNs have necessary funds to operate new sites, developing well conceived business plans before implementing new sites, ensuring new CBOCs will increase access to care, and other factors. Further, VA will continue to explore opportunities to improve management of existing

CBOCs through more effective staffing, expanding hours of operation, and examining opportunities to augment services where appropriate.

These priorities reflect determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options.

VA will proceed with development of new CBOCs through CARES and will prioritize clinics that meet specific criteria. Priority criteria include CBOCs that:

1. Are in markets that have large numbers of enrollees outside of access guidelines and are below VA national standards for primary care access;
2. Are in markets that are classified as rural or highly rural and are below VA national standards for primary care access;
3. Take advantage of VA/DoD sharing opportunities;
4. Are associated with the realignment of a major facility; and
5. Are required to address the workload in existing overcrowded facilities.

These priorities reflect determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options. They also reflect the Department's ongoing commitment to strengthening sharing opportunities with the Department of Defense.

The 156 priority CBOCs listed at the end of this response will be implemented by 2012 pending availability of resources and validation with the most current data available. This list reflects VA's priorities for planning based upon the most current information. As VA proceeds in implementing CARES and as it engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural and highly rural areas. VA also will enable overcrowded facilities to better serve veterans and will continue to support sharing with DoD. These principles will remain priorities even if management strategies to meet them evolve as new data and information becomes available.

Recognizing that resources are not available to open all of these clinics immediately, VA will manage implementation of CBOCs by applying the revised CBOC criteria within the existing National CBOC Approval Process. This will

ensure a careful and considered implementation that mandates VISNs develop sound business plans, ensures national criteria are met, and that resources are available to provide the quality of care veterans expect from the Department. Resource requirements that must be in place to open new CBOCs include the capacity to manage specialty referrals and inpatient needs of new populations.

These priorities do not prohibit VISNs from pursuing other CBOC opportunities identified in the DNCP. VISNs will be able to propose any CBOC in the DNCP for activation; however, they must be able to demonstrate their ability to open priority clinics on schedule before they can open a clinic that is outside of the priority criteria.

VISNs will immediately begin preparation of proposals for development of CBOCs for this year. These proposals will be submitted for Central Office review in June.

CBOCs and New Sites of Care for Priority Implementation

VISN	Parent Facility	Planned New Facility Name	State
1	Togus VAMC	Houlton-PT – Contract	ME
1	Togus VAMC	Bangor Outreach – Dover Fox	ME
1	Togus VAMC	Bangor Outreach – Lincoln	ME
1	Togus VAMC	Rumford Outreach – Farmington	ME
1	Togus VAMC	Rumford Outreach – South Paris	ME
1	Togus VAMC	Cumberland County	ME
5	Martinsburg VAMC	Fort Detrick – DoD Joint Venture	MD
5	Baltimore VAMC	Fort Meade – DoD Joint Venture	MD
5	Baltimore VAMC	Owings Mill	MD
5	Baltimore VAMC	Baltimore City – Mental Health	MD
5	Washington DC VAMC	Fort Belvoir – DoD Joint Venture	VA
5	Washington DC VAMC	Southern Prince George	MD
6	Beckley VAMC	Lewisburg	WV
6	Beckley VAMC	Bluefield	WV
6	Salem VAMC	Staunton	VA
6	Salem VAMC	Radford	VA
6	Salem VAMC	Lynchburg	VA
6	Asheville VAMC	Franklin	NC
6	Asheville VAMC	Rutherfordton	NC
6	Asheville VAMC	Hendersonville	NC
6	Salisbury VAMC	Gastonia	NC
6	Salisbury VAMC	Hickory	NC
6	Salisbury VAMC	Greensboro	NC
6	Fayetteville VAMC	Hamlet	NC
6	Fayetteville VAMC	Lumberton	NC

VISN	Parent Facility	Planned New Facility Name	State
6	Fayetteville VAMC	Supply	NC
6	Hampton VAMC	Norfolk	VA
6	Richmond VAMC	Charlottesville	VA
6	Richmond VAMC	Emporia	VA
7	Dublin VAMC	Milledgeville	GA
7	Dublin VAMC	Brunswick	GA
7	Dublin VAMC	Perry	GA
7	Augusta VAMC	Athens	GA
7	Augusta VAMC	Aiken	SC
7	Atlanta VAMC	Stockbridge	GA
7	Atlanta VAMC	Noonan	GA
7	Charleston VAMC	Hinesville	GA
7	Charleston VAMC	Goose Creek	SC
7	Columbia VAMC	Spartanburg	SC
7	Central Alabama HCS	Enterprise	AL
7	Central Alabama HCS	Opelika	AL
7	Central Alabama HCS	Maxwell AFB	AL
7	Birmingham VAMC	Childersburg	AL
7	Birmingham VAMC	Guntersburg	AL
7	Birmingham VAMC	Bessemer	AL
8	Gainesville VAMC	Jackson County	FL
8	Gainesville VAMC	Putnam	FL
8	Gainesville VAMC	Camden	GA
8	Gainesville VAMC	Summerfield (South Marion)	FL
9	Mountain Home VAMC	Holston Medical Clinic	TN
9	Mountain Home VAMC	Pennington Gap Clinic	VA
9	Mountain Home VAMC	Thompson Clinic	VA
9	Mountain Home VAMC	Haysi Clinic	VA
9	Mountain Home VAMC	Davenport Clinic	VA
9	Mountain Home VAMC	Davis Clinic	VA
9	Mountain Home VAMC	West Lee County Clinic	VA
9	Mountain Home VAMC	Jellico	TN
9	Mountain Home VAMC	Pigeon Forge	TN
9	Memphis VAMC	Pontotoc County	MS
9	Memphis VAMC	Tunica	MS
9	Memphis VAMC	Greneda	MS
9	Memphis VAMC	Paris	TN
9	Memphis VAMC	Bolivar	TN
9	Memphis VAMC	Phillips County	AR
9	Memphis VAMC	Wynne County	AR
9	Memphis VAMC	Dyer County	TN
9	VATVHS – Murfreesboro	Maury County	TN
9	VATVHS – Murfreesboro	Athens	TN
9	VATVHS – Murfreesboro	Harriman	TN

VISN	Parent Facility	Planned New Facility Name	State
9	VATVHS – Murfreesboro	McMinn County	TN
9	VATVHS – Nashville	Glasgow	KY
9	VATVHS – Nashville	Giles County – Pulaski	TN
9	VATVHS – Nashville	Hopkins County	KY
9	Huntington VAMC	Gallipolis	OH
9	Huntington VAMC	Logan	WV
9	Louisville VAMC	Scott County	IN
9	Louisville VAMC	Grayson County	KY
9	Louisville VAMC	Carroll County	KY
9	Lexington VAMC	Berea	KY
9	Lexington VAMC	Perry County	KY
9	Lexington VAMC	London	KY
11	Illiana HCS	Charleston	IL
11	Marion VAMC	Peru	IN
11	Indianapolis VAMC	Martinsville	IN
15	Wichita VAMC	Hutchinson	KS
15	Marion (IL) VAMC	Hopkins County	KY
15	Marion (IL) VAMC	Graves County	KY
15	Marion (IL) VAMC	Knox County	IN
15	Marion (IL) VAMC	Davies County	KY
15	St. Louis VAMC	Sullivan	MO
15	Columbia VAMC	Jefferson City	MO
16	Little Rock VAMC	Mena	AR
16	Little Rock VAMC	Searcy	AR
16	Little Rock VAMC	Conway	AR
16	Little Rock VAMC	Pine Bluff	AR
16	Little Rock VAMC	Russellville	AR
16	Muskogee VAMC	Vinita	OK
16	Fayetteville (AR) VAMC	Jay	OK
16	Fayetteville (AR) VAMC	Branson	MO
16	Fayetteville (AR) VAMC	Ozark	AR
16	Oklahoma City VAMC	Enid	OK
16	Oklahoma City VAMC	Altus	OK
16	Oklahoma City VAMC	Stillwater	OK
16	Alexandria VAMC	Fort Polk	LA
16	Alexandria VAMC	Lake Charles	LA
16	Alexandria VAMC	Natchitoches	LA
16	Houston VAMC	Galveston (Site 1)	TX
16	Houston VAMC	Galveston (Site 2)	TX
16	Houston VAMC	Conroe	TX
16	Houston VAMC	Tomball	TX
16	Houston VAMC	Katy	TX
16	Houston VAMC	Richmond	TX

VISN	Parent Facility	Planned New Facility Name	State
16	Houston VAMC	Lake Jackson	TX
16	Jackson VAMC	Columbus	MS
16	Jackson VAMC	McComb	MS
16	New Orleans VAMC	Hammond	LA
16	New Orleans VAMC	Franklin	LA
16	New Orleans VAMC	Bogalusa	LA
16	New Orleans VAMC	LaPlace	LA
16	Eastern Southern	Eglin AFB	FL
17	San Antonio VAMC	Brooks AFB	TX
17	San Antonio VAMC	NE Bexar	TX
17	Dallas VAMC	Plano	TX
18	El Paso OPC	East El Paso	TX
18	Albuquerque VAMC	Albuquerque Urban	NM
18	Tucson VAMC	Urban 1	AZ
18	Tucson VAMC	Urban 2	AZ
19	Fort Harrison VAMC	Lewiston	MT
19	Fort Harrison VAMC	Cut Bank	MT
19	Salt Lake City VAMC	West Valley City	UT
20	Spokane VAMC	Central Washington	WA
21	Sierra Nevada HCS	Fallon	NV
21	San Francisco VAMC	North San Mateo	CA
21	Palo Alto HCS	East Bay	CA
21	Pacific Islands HCS	American Samoa	HI
23	Fargo VAMC	Bemidji	MN
23	Fargo VAMC	Dickinson	ND
23	Fargo VAMC	Jamestown	ND
23	Fargo VAMC	Devils Lake	ND
23	Fargo VAMC	Williston	ND
23	Fargo VAMC	Grand Forks	ND
23	Des Moines VAMC	Marshalltown	IA
23	Des Moines VAMC	Carroll	IA
23	Iowa City VAMC	Ottumwa	IA
23	Iowa City VAMC	Cedar Rapids	IA
23	Grand Island VAMC	O'Neil	NE
23	Grand Island VAMC	Holdredge	NE
23	Omaha VAMC	Bellevue	NE
23	Omaha VAMC	Shenandoah	IA
23	Sioux Falls VAMC	Wagner	SD
23	Sioux Falls VAMC	Watertown	SD
23	Sioux Falls VAMC	Spirit Lake	IA
23	Minneapolis VAMC	Redwood Falls	MN
23	Minneapolis VAMC	Rice Lake	MN
23	Minneapolis VAMC	Elk River	MN
23	St. Cloud VAMC	Alexandria	MN

MENTAL HEALTH SERVICES

Commission Recommendation

The Commission recognized the critical importance of mental health services to the veteran population. In reviewing the early projections for CARES, VA realized that it needed to make modifications to its projections for outpatient, acute inpatient, and long-term psychiatric mental health care programs. The Commission acknowledged VA is currently making adjustments to these models and recommended that, once complete, the forecasts be rerun, that gaps in service be identified, and that VA plan to address those gaps. The Commission also recommended that VA take action to ensure consistent availability of mental health services across the system, to provide mental health care at CBOCs, and to collocate acute mental health services with other acute inpatient services wherever feasible.

Secretary's Response and Implementation

VA is committed to meeting the mental health needs of our Nation's veterans and it is critical that VA's health care system provides comprehensive mental health care services at a high level of quality consistently across the country. Effective mental health treatment requires that veterans have appropriate access to a full continuum of mental health care services. While VA provides comprehensive and cutting edge mental health services in many locations across the country, it faces challenges in providing equitable access to those services to veterans in some areas. VA must provide quality and complete mental health service in all VISNs and will ensure this outcome by making improvements to its forecasting models and developing a comprehensive strategic plan for mental health care.

At the time of the release of the DNCP, projections for outpatient and acute psychiatric inpatient care contained inconsistencies and VA committed to improving its forecasting models to ensure that projections adequately reflect future need. In the interim, VA stipulated firm guidance that CARES plans would not include reductions in service for mental health until new models and reliable data are available.

VA has completed a new set of mental health demand forecasts that include the improvements cited by the Commission. These forecasts will be used in the development of a comprehensive VA Mental Health Strategic Plan and will be incorporated into VA's strategic planning process. This process will require every VISN to develop mental health market plans that incorporate the new forecasts as well as the policies established in the strategic plan to ensure that veterans across the VA system have appropriate access to quality and complete mental health care services.

It is not acceptable that the availability of mental health services be dependent on geographic location. VA's mental health strategic plan will do more than ensure that veterans will have appropriate access to quality and complete mental health services, it also will firmly set VA's sights on retaining its position as a leader and innovator in the field.

The VA Mental Health Strategic Plan will be completed in August 2004 and will provide clear direction on the inclusion of mental health services at CBOCs, the consistency of mental health services across the VISNs, the importance of collocating acute inpatient mental health services with other inpatient services, and guidelines for assuring appropriate access to a full continuum of mental health care services.

By improving its forecasting methodologies and refining its policies to present a national approach, VA will continue to improve the quality and accessibility of its mental health services. It is not acceptable that the availability of its mental health services be dependent on geographic location. VA's Mental Health Strategic Plan will do more than ensure that veterans will have appropriate access to quality and complete mental health services, it also will firmly set VA's sights on retaining its position as a leader and innovator in the field.

LONG-TERM CARE

CARES Commission Recommendations

The Commission acknowledged the complexity of planning for the care of an aging veteran population and found that VA has not yet developed the forecasts and policies needed to project and plan to meet future demands for long-term care. Recognizing the need for additional work in this area, the Commission made several recommendations concerning how VA should address long-term care in implementing CARES.

The Commission's central recommendation was that VA develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliaries, residential treatment facilities, and nursing homes, and for seriously mentally ill veterans. Further, the Commission recommended that the plan include strategies for maximizing the use of State Veterans Homes, locating domiciliary units

as close to patient populations as feasible, and identifying freestanding nursing homes as an acceptable care model.

Pending completion of the long-term care strategic plan, the Commission recommended that VA only proceed with long-term care projects that make necessary life safety and maintenance improvements to existing facilities.

Secretary's Response and Implementation

VA is committed to caring for veterans who require long-term health care. To appropriately meet their needs, VA must offer a full continuum of care to veterans with a focus on keeping the patient in the least restrictive setting possible — allowing them to remain in their home and close to their family, but recognizing that some patients will need inpatient nursing home and inpatient mental health care. With a rapidly aging veteran population, planning to meet the long-term care needs of veterans is a complex undertaking that requires integration of forecasts and strategies for nursing home care, gero-psychiatric needs, domiciliary care, and long-term psychiatric care for the seriously mentally ill as well as strategies for expanding care coordination in the home, residential care, assisted living facilities and other less restrictive care settings.

All of these issues require management through a comprehensive long-term care plan. Completion of such a plan requires resolution of complex and sensitive policy issues about eligibility for the quantity and type of care VA should provide, especially for the nursing home population. Because VA had not developed reliable forecasts and policies for long-term care, strict guidance was issued to ensure that long-term care services would not be reduced in CARES.

VA must definitively plan to meet the needs of an aging veteran population, and will formulate an effective set of long-term care forecasts and policies. Today, VA is in the process of developing policy options for managing long-term care into the future, which will lead to a strategic plan for long-term care.

VA must definitely plan to meet the needs of an aging veteran population, and will formulate an effective set of long-term care forecasts and policies.

VA's long-term care strategic plan will address consistency of access to care across VA's health care system, include a clear policy on maximizing partnering opportunities with State Veterans Homes, allow VA to provide nursing home

care for aging veterans in freestanding nursing homes, and clarify the Department's commitments to gero-psychiatric care and to reducing the variation in mental health care services across the system.

Work on components of this plan is progressing and includes:

- An updated nursing home model that accounts for improvements in functional status, a gender adjustment, and estimates of reliance on VA sources of care;
- Incorporating long-term psychiatric bed needs as well as those for patients who are seriously mentally ill into the strategic planning model;
- A revised domiciliary care model weighted toward urban areas, closest to where patients typically reside; and
- Integration of residential rehabilitation bed needs, including substance abuse and PTSD, into the forecasting models.

In addition to improvements in these areas, VA is revising its current nursing home policy. While VA will continue to place short-term nursing home rehabilitation units on acute medical campuses whenever possible, it will now allow nursing homes that primarily provide long-term nursing home care to patients to be freestanding. For such freestanding nursing homes, it will be mandatory that acute inpatient hospital care arrangements are in place to ensure that VA facilities are prepared to effectively refer patients with emergent medical situations to facilities able to provide quality and timely health care services. VA will also ensure that these arrangements are in place for veterans receiving care in VA contract community nursing homes.

All of these analyses are important and all must be factored into VA's long-term care strategic plan. Until such a plan is completed, VA will limit planned reconfigurations, expansions, or replacements of long-term care facilities. Only projects that correct high risk seismic or safety deficiencies — where workload supports maintaining current bed levels and where the appropriateness of the site of the current facility is not in question — will be considered for major construction funding.

EXCESS VA PROPERTY

Commission Recommendation

The Commission recognized the importance of the enhanced use lease process and other mechanisms that will be needed to effectively manage the reuse of vacant and underutilized properties as VA implements CARES. The Commission Report includes several recommendations for improving VA's ability to manage capital assets. Most centrally, the Commission recommended that VA take steps to reform the enhanced use lease process to improve timeliness and efficiency. The Commission also recommended that VA should consider all options for alternate use of vacant and underutilized space, to include priority consideration of use for supportive services to homeless veterans. Finally, the Commission recommended that VA seek a separate appropriation of funds to maintain its historic properties.

Secretary's Response and Implementation

Successful implementation of CARES will rest in large part on VA's ability to effectively manage its vacant and underutilized space. Through CARES, VA expects to reduce its current vacant and underused space by 42 percent by 2022. VA will need to improve upon its ability to manage its capital assets in order to achieve this reduction.

The CARES Commission identified several key and interrelated areas where VA will need to improve management of capital assets. The ability to redirect savings to pay for direct care of veterans is a compelling incentive to improve. In view of the continuously rising cost of health care (providing care for a single veteran currently averages approximately $5,000/year), VA must take every opportunity for savings from reducing or eliminating maintenance of vacant or underused capital assets.

To maximize return on investment, VA will seek needed flexibilities by pursuing the following actions:

In view of the continuously rising cost of health care (providing care for a single veteran currently averages approximately $5,000/year), VA must take every opportunity for savings from reducing or eliminating maintenance of vacant or underused capital assets.

Enhanced Use Lease: VA has made numerous changes, both organizationally and functionally, to the enhanced use lease process since its inception over 10 years ago. This has been an evolutionary process as VA has gained experience and recognized increased applicability of this

important capital asset management tool. With this CARES decision, it is critical that VA continue to improve its capabilities. A cross-organizational team has made recommendations to further improve the timeliness and effectiveness of the enhanced use lease process. Process improvements will include carefully assigned delegations of authority, implementation of VA's Finance Office reorganization to include real property management expertise at the VISN level, and increased access to the real estate, financial, legal and marketing expertise needed to successfully implement, negotiate, and manage complex real estate projects. Increased delegation, within appropriate thresholds, to the newly created Chief Asset Manager (CAM) and Chief Logistic Officer (CLO) within each VISN will not only help to streamline the process, but also allows VA to retain maximum flexibility under current law, minimize duplicative review and approval processes, expand the number of trained and experienced staff who will possess an enhanced use lease-related skill set and increase responsibility and accountability for meeting program goals. These actions will improve both the timeliness and number of enhanced use lease projects for the Department.

Leveraging Assets: While the enhanced use leasing program is one vehicle for managing excess property, its full potential as a capital asset management tool is realized when the authority is used to leverage assets to acquire all, or a portion of, VA's needed commodities (services, facilities, etc.). VA needs to take full advantage of the power of the enhanced use leasing authority to accelerate the implementation of the CARES process. For example, consolidation from a multi to a single division health care system would most likely require a large capital investment in order to accommodate increases in workload at the receiving site, while the other site could be out-leased through enhanced use leasing. This out-lease would allow VA to leverage the investment value of unneeded assets to provide for a portion of the required new capital improvements to the remaining/new site as consideration "in-kind." Leveraging assets in this manner maximizes VA's ability to accelerate the implementation of approved CARES plans.

More Flexible Disposal Authority: VA is developing legislation for Independent Real Property Disposal Authority. This authority would allow VA to dispose of underused real property and retain proceeds for reinvestment in veterans' health care and capital improvements to medical facilities. Further, VA will propose changes to Appropriation and Authorization legislation to provide maximum flexibility for the placement and use of disposal receipts. If enacted, these legislative changes will significantly improve VA's ability to implement

CARES by providing VA with a mechanism to expeditiously shed unneeded and resource-draining assets and reinvest in its capital infrastructure.

Managing Historic Properties: VA will conduct a baseline study of its historic properties, identifying all applicable facilities, categorizing them by type and use, identifying existing maintenance costs, and developing strategies for most effectively managing them. Strategies for managing unneeded or underused historic properties could include partnerships with states, local historical societies, and other entities, disposal or donation if applicable, and appropriate upkeep and maintenance. Work on this effort is underway and VA will complete the study by the end of 2004.

Disposal or Reuse of VA Property: In all cases where it is recommended that VA dispose of or realign underused property, VA will consider all options for disposal, but will always give priority consideration to use that supports the needs of veterans, particularly homeless veterans.

CONTRACTING FOR CARE

CARES Commission Recommendations

The Commission recognized contracting for care as a legitimate tool for enhancing access to health care services for veterans. The Commission recommended that VA ensure alternatives are in place prior to any plans to alter existing services through contracting. Further, the Commission recommended that the Secretary ensure that quality criteria and procedures are in place for VA to use its contract authority effectively, monitor service delivery to ensure quality, and ensure that it has staff trained to negotiate cost effective contracts.

Secretary's Response and Implementation

As VA continues to use contracting to expand access to services for veterans, it must make sure that it takes advantage of all opportunities to purchase contract care more effectively. Today, contracts for health care are managed in a decentralized fashion, with individual facilities and VISNs purchasing care from local providers. While this provides local flexibility to manage care, it comes at a cost. By decentralizing its purchases, VA loses a valuable opportunity to use its substantial purchasing power to negotiate better prices.

To more effectively leverage its purchasing power as a national system, VA will develop a National Clinical Contracting Strategy that will articulate

options for aligning costs for services among contract providers throughout the country, taking into consideration regional economic factors and availability of services within communities. This National Clinical Contracting Strategy will help VA to integrate consistent quality care measures among contract providers and improve pricing by developing broad national agreements with community health care providers. Through development of a national strategy, VA will ensure high quality standards are in place while receiving a more competitive price for that care. The National Clinical Contracting Strategy will be presented for review and consideration by November 2004.

This National Clinical Contracting Strategy will help VA to integrate consistent quality care measures among contract providers and improve pricing...

In the interim, proceeding in conformance with all current laws, VA will continue to use existing authorities and policies to enhance access to care for veterans through contracts. Contracting will not erode VA's core mission as a provider of health care. Further, services at an existing site will not be altered until viable alternatives in the community have been identified and agreements are in place to ensure the availability and quality of contract care.

To ensure the quality of contract care, VA is developing policy for establishing contracts for services that will include minimum standards for contracted inpatient services, quality of care indicators, review of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, a process for ongoing monitoring and evaluation, national review criteria and approval processes, and performance based contracting principles. In addition, to ensure future cost-effectiveness, VA will always seek multiple viable alternatives in the community before the decision is made to contract out a VA service. This will promote competition and ensure latitude for future contracting arrangements. To further ensure cost effectiveness, VA logistics personnel will continue to develop their negotiating skills in order to ensure that VA contracts are cost-effective.

INFRASTRUCTURE AND SAFETY

CARES Commission Recommendation

The Commission recommended that patient safety be the highest priority for VA CARES funding and that VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

Secretary's Response and Implementation

The importance of safety at VA facilities cannot be overstated and many of the projects in CARES are for seismic and life safety improvements that will promote patient and employee safety. While there is no question about the importance of safety in VA facilities, VA is mandated by law to categorize projects that "remedy life and safety code deficiencies" as its second highest criteria.

VA currently has a process in place that assigns priority weights to seven broad criteria used to evaluate capital projects. To ensure compliance with the law while implementing the intent of the CARES Commission's recommendation, VA will use its existing capital development process to revise the weights of its criteria so that patient and employee safety concerns are ranked as the second most important factor in consideration for construction funding. This process will be completed in time to be operative for submission of VA's five-year capital plan, scheduled for May 2004.

EDUCATION AND TRAINING

CARES Commission Recommendations

The Commission recognized two promising opportunities for VA to expand its partnerships with academic affiliates. The Commission recommended VA develop a plan to add a community-based outpatient component to existing and new education and training programs. The Commission also recommended VA establish national policy guidance for schools of nursing comparable to its medical school model and with other professional health educational institutions, as appropriate.

Secretary's Response and Implementation

The partnerships VA has with the Nation's academic community are an important component of VA's core mission of caring for our Nation's veterans. VA will continue to promote excellence and innovation in the education of future health care professionals and will work with the academic community to identify new opportunities to improve its education and training missions.

The Commission identified two new opportunities to pursue enhancements to VA's education and training missions that merit further study and consideration. Both recommendations represent new and innovative ideas for moving those missions forward.

The first recommendation calls for VA to explore opportunities to enhance and encourage use of CBOCs as training sites. VA will develop an initiative to

expand the use of CBOCs as a training site over the next two years. The initiative will begin with submission of competitive applications for up to fifty additional training positions at 25 to 30 sites. Further expansion of the program to other affiliated VA facilities would follow an evaluation of its success in achieving program objectives.

The second recommendation seeks expansion of VA's partnership with nursing schools and with other professional health education institutions as appropriate. This recommendation will be reviewed as VA revises its policy on affiliations. VA will also incorporate the recommendations from a pending report from the National Commission on VA Nursing as it considers this recommendation.

SPECIAL DISABILITY PROGRAMS

CARES Commission Recommendations

The CARES Commission made several recommendations concerning VA's special disability programs. These recommendations included ensuring inter-VISN collaboration in developing placement options for special disability centers and an assessment of acute and long-term bed needs for Spinal Cord Injury Centers to ensure a proper balance. The Commission also recommended that VA optimize access to care for veterans by developing more outpatient-based blind rehabilitation opportunities. Finally, the Commission recommended VA strive to maintain excellence in all of its special disability programs.

Secretary's Response and Implementation

Caring for veterans with service-connected disabilities and those with special needs is VA's most important, and most recognizable, health care mission. VA is committed to its special emphasis programs and will make sure they are well positioned to effectively serve veterans into the future. CARES specifically addressed VA's spinal cord injury and disorders (SCI/D), and blind rehabilitation programs. VA will continue to pursue excellence in these areas and will expand the range of programs considered in future iterations of strategic planning to include treatment for traumatic brain injury and prosthetics. Other VA specialty programs are considered in the context of mental health and long-term care (PTSD, homeless, and substance abuse). The continuous pursuit of excellence in

VA is committed to its special emphasis programs and will make sure they are well positioned to effectively serve veterans into the future.

these areas will always be a priority for the Department. The Commission's recommendations for spinal cord injury and disorders and blind rehabilitation seek to ensure the quality of these programs into the future. VA will implement the following actions:

1. VA will open new Blind Rehabilitation Centers in Biloxi and Long Beach, and will continue its current strategic emphasis on placing blind rehabilitation services closer to populations in outpatient settings. This focus will be included in future planning guidance and will be incorporated into the FY 2005 strategic planning submission.
2. As part of the implementation process, VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds. Validation will also consider referral patterns as well as location and inter-VISN collaboration as appropriate. Implementation plans for development of new SCI/D beds will be included in the FY 2005 VISN strategic planning submission. These plans will include the potential for new SCI/D Centers in Syracuse, Denver, Minneapolis, and VISN 16, and a certified SCI/D outpatient clinic in Philadelphia as well as expansions of existing SCI/D Centers in Memphis, Cleveland, Augusta and Long Beach. VA will also validate expansion of the existing or development of a new SCI/D Center in South Florida.

VA/DoD SHARING

CARES Commission Recommendation

The CARES Commission recommended that VA/DoD sharing should be one of the first considerations in addressing health care needs in a local area. The Commission also recommended that VA and DoD leadership provide the necessary authority, accountability, and incentives to local managers to encourage and facilitate sharing activities that improve health care delivery and control costs. The Commission recognized the difficulty that change in local leadership presents to sharing opportunities and recommended that VA and DoD take additional steps to more effectively manage that change.

Secretary's Response and Implementation

Sharing between the Department of Veterans Affairs and the Department of Defense is a priority of the President and for both Departments. As VA implements CARES it will continue to take all necessary steps to identify and act on available sharing opportunities.

This effort is important, but it comes with significant challenges. With complimentary, but different missions, VA and DoD have cultural differences as well as technical, mission-related, and operational issues that, at times, make sharing difficult. While these differing missions have historically limited sharing opportunities, VA and DoD have made significant progress to meet the President's goal for improving resource sharing.

Spurred by the President's challenge to improve partnering, VA has worked closely with DoD to improve sharing. This has been particularly true in the CARES process. Working together throughout the development of the DNCP, VA and DoD identified 74 potential sharing opportunities, many of which remain promising.[1] Moving forward, VA will work closely with the Department of Defense to make a reality of many of these opportunities.

This work will be managed through the VA/DoD Joint Executive Council (JEC), co-chaired by VA's Deputy Secretary and DoD's Under Secretary for Personnel and Readiness. The JEC recently established a Capital Asset Planning and Coordination (CAPC) Steering Committee, which will be responsible for identifying and implementing opportunities to improve services and maximize capital asset resource utilization. That body will oversee implementation of the VA/DoD recommendations that require capital planning and will seek to maximize productive collaboration between Departments in developing capital asset management sharing opportunities in the future. Recognizing the importance of maintaining local sharing efforts, the CAPC will also work to improve the stability of VA/DoD partnerships through transition of management at local facilities.

Though significant challenges remain for VA/DoD sharing, the Departments will continue to work together to share resources. Mutually committed to improving sharing, VA and DoD will enhance benefits and services to veterans, servicemembers, and their dependents, while improving use of taxpayer resources.

Mutually committed to improving sharing, VA and DoD will enhance benefits and services to veterans, servicemembers, and their dependents, while improving use of taxpayer resources.

[1] See Appendix A for a listing of promising sharing opportunities with the Department of Defense.

RESEARCH SPACE

CARES Commission Recommendations

The CARES Commission recommended VA move forward with the proposals in the DNCP to enhance research space and commented that the metrics used to determine research space needs should be re-examined.

Secretary's Response and Implementation

VA will continue to explore opportunities to enhance its research mission by improving the quality and size of research space — factors that contribute to the ability to innovate and remain at the forefront in development of treatments and technologies that will improve care to our Nation's veterans. As VA implements CARES, it will re-examine the measures used to determine research space needs. To ensure the accuracy of project proposals, VA will replace gross estimates for research space with actual measures of space. Moving forward, VA will continue to improve the process for forecasting research needs by integrating a more realistic estimate for research construction costs into the forecasting Model.

CARE DELIVERY INNOVATIONS

CARES Commission Recommendation

The Commission recommends that VA use advanced practice nurses and telemedicine to enhance access to and quality of care, and urges wider application of these resources throughout the system.

Secretary's Response and Implementation

VA is continuously seeking opportunities to improve the access to and quality of care for our Nation's veterans. Telemedicine and the expanded use of advanced practice nurses and other health care professionals each represents a promising new approach to the way that VA provides care.

By leveraging technology, telemedicine can be an effective means of treating patients remotely. This is specifically important for veterans who live in remote and rural areas with significant commutes to sites of VA care and to specialists. Telemedicine allows VA to more regularly monitor the care of veterans in a way that is convenient for patients and enhances productivity of physicians.

For these reasons, VA will continue to implement and expand telemedicine and telehealth initiatives as a means to enhance access to specialist care for patients

and improve quality. Under VA's new Office of Care Coordination, activities will focus on the areas of telemental health, teledermatology, and teleretinal imaging. VA already has developed robust models to link VA medical centers and community-based outpatient clinics to improve access to these specialty consultations. These initiatives are currently being implemented and VA will seek to expand them in the future.

VA will continue to expand its national home telehealth network to directly link patients in their homes with clinicians in VA medical centers. Through telehealth, VA will enhance the management of chronic diseases such as diabetes, heart failure, and PTSD and improve access to these services for patients, especially those patients in rural areas. By managing care remotely, VA is preventing premature institutionalization of veterans and allowing community living for a clinically complex and frail population. VA will treat 7,500 patients in this manner by October 2004. These services will increase to 15,000 patients by May 2005 and 25,000 by October 2005.

Teleradiology services will also be expanded to enhance access to care. For more than a decade, VA has been using teleradiology to increase access to diagnostic imaging services in support of veterans' health. Teleradiology combines digital imaging and communications technologies to transfer clinical images and data between the site of the patient and the site providing consultation, interpretation or diagnosis. This allows VA medical facilities to link to highly skilled radiologist interpretation services at consolidated sites.

In areas with few radiologists, some VA teleradiology programs employ contracted radiologists to supplement care. In other areas, VA teleradiology programs provide VA diagnostic imaging services to DoD Medical Treatment Facilities that have few or in some instances no staff radiologists. The role of teleradiology is being actively explored as a means to provide radiology services in locations where radiologists are difficult to recruit, especially in rural areas. Teleradiology also has a potential role to play in improving the efficiency of delivering after-hours radiology reporting services. By expanding usage of teleradiology, VA will continue to enhance access to care.

VA also will expand its use of advanced practice nurses and other health care specialists. Among the most noted problems encountered in the VA system is in the area of waits and delays. While VA has made substantial progress in reducing the time veterans wait for appointments, the goal is ongoing and continuous improvement. The increased use of advanced practice nurses and other health care professionals will help VA to reduce waiting times at facilities while maintaining a high quality of care for veterans.

Telemedicine, telehealth, and the use of advanced practice nurses and other health care professionals are important new initiatives for VA. Moving forward, VA will continue to implement and expand these initiatives always with the goal of improving access to and the quality of veterans' health care.

ONEVA COLLABORATIONS

Secretary's Response and Implementation

Though the CARES Commission did not specifically discuss many of the proposed collaborations between the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA) in the DNCP, the Commission specified approval of all projects not specifically addressed in its report.[2] *OneVA* sharing opportunities are a priority for the Department. Throughout the CARES process, VA placed great emphasis on maximizing the use of VA assets to meet the service delivery goals of VBA and NCA. VA will continue to pursue these opportunities and, as a result, the benefits and burial program missions of the Department will be strengthened.

In many cases, VBA is spending significant resources on rental space for its Regional Offices. With rental costs at levels as high as $6 million per year, VA must take advantage of opportunities to collocate on VA property where such action enhances services and is economically favorable. Savings from effective consolidations can be better spent on the human and technology resources used to process compensation, pension, and education claims and provide loan guaranty and vocational rehabilitation and employment services. Wherever possible, VBA will identify opportunities to reduce its rent costs by seeking to collocate on VA property. By operating in this manner, VA will ensure it maximizes its resources to provide services to veterans and redirects significant savings from rental costs into claims processing and other benefits delivery missions.

Savings from effective consolidations can be better spent on the human and technology resources used to process compensation, pension, and education claims and provide loan guaranty and vocational rehabilitation and employment services.

Further, collocating also improves access to services, employee morale, and productivity by relocating facilities in new, modern, and efficient office spaces. In implementation of CARES and in future

[2] CARES Commission Report pg. 5-3

planning efforts, VBA will seek and implement opportunities to reduce or avoid costly rental obligations by collocating on VA property wherever it is feasible and cost-effective to do so.

For NCA, acquiring additional excess land is essential to prevent the premature closure of some national cemeteries. As NCA strives to effectively meet the burial needs of veterans, it will continue to seek opportunities to use existing VA land. This not only conserves scarce resources, it also better serves veterans by consolidating services and maintaining VA campuses as places that serve and honor our Nation's veterans. These initiatives are particularly critical in areas where NCA is running out of burial space and vacant land exists adjacent to a VA medical center. For example, without additional land for expansion, the Jefferson Barracks National Cemetery in St. Louis will close in 2010. Through the CARES process, VA identified land at the medical center that will allow VA to expand the cemetery and continue service to veterans.

As VA implements CARES, it will continue to monitor these collaborations and will vigorously pursue opportunities to maximize sharing of VA resources to make better use of taxpayer funds, while improving benefits and services to our Nation's veterans.[3]

CARES Independent Advisory Body

CARES Commission Recommendation

The Commission recommended that the Secretary establish an independent advisory body, with appropriate charter and authority, to monitor and advise the Secretary on the ongoing integration of CARES into VA's strategic planning process.

Secretary's Response and Implementation

The CARES process emphasized objectivity from its inception. Focusing on data to make decisions and using an independent Commission to review and make recommendations on its proposals, CARES steadfastly adhered to principles of objectivity throughout its development.

As CARES moves from development into implementation, it will continue to be an open process. Implementation plans, studies, and other CARES related initiatives identified in this decision document will be broadly shared with stakeholders whose input will be considered in decision-making processes.

[3] Priority opportunities for *OneVA* collaboration are listed in Appendix B.

Recognizing the complexity of CARES issues and the extreme importance and impact of many of its initiatives, it is critical that VA maintain a high-level national focus as it implements these decisions. VA will accomplish this by establishing a permanent, senior-level, CARES Implementation Board. The CARES Implementation Board will consist of senior leadership from across the Department, will work collaboratively with the VISNs to implement CARES, and will report directly to the Secretary. The Implementation Board will be responsible for assuring that CARES is integrated into strategic planning and that all of the decisions in this document are effectively planned, implemented, and managed. As VA progresses with implementation of these decisions, it will consider the use of an independent body to advise, monitor, and evaluate its progress as needed. If the need becomes clear, such an objective group will be appointed.