



Department of Veterans Affairs  
Veterans Health Administration

Capital Asset Realignment for Enhanced Services

# CARES

## GUIDEBOOK - PHASE II

A circular logo featuring a stylized American flag with the word "CARES" written in blue capital letters across the bottom.

*Second Edition*  
*June 2002*

## CHAPTER 1: The CARES Process

### A. Background

The VA has undergone a profound transformation in the delivery of health care over the last decade. VA has moved from a hospital driven health care system to an integrated delivery system that emphasizes a full continuum of care. New technology and treatment modalities have changed how and where care is provided, with a significant shift from inpatient to outpatient services. VHA's infrastructure was designed and built decades ago, under a different concept of health care delivery, (i.e., hospital-centered inpatient care, long admissions for diagnosis and treatment, and changing geographic concentrations of eligible veterans). As a result, VHA's capital assets often do not align with current health care needs for optimal efficiency and access. The cost to maintain and operate VA health care facilities that may not provide efficient and accessible services in the future substantially diminishes resources that could otherwise be used to provide better care in more appropriate settings.

A March 1999 General Accounting Office (GAO) report concluded that VHA could significantly reduce the funds used to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets. In response to the GAO report and a subsequent Congressional hearing on July 22, 1999, VHA initiated development of the Capital Asset Realignment for Enhanced Services (CARES) Program.

The CARES Process is a data driven assessment of veterans' health care needs within each Network, and the strategic realignment of capital assets and related resources to better serve the needs of veterans. Through the CARES Process, VACO and Networks will develop plans for enhanced services based on objective criteria and analysis. These plans will take into account future directions in health care delivery, demographic projections, physical plant capacity, community health care capacity, and workforce requirements. A structured decision process will guide review and evaluation of Network capital asset realignment proposals. All savings generated through implementation of CARES will be reinvested to meet veterans' health care needs.

The CARES process was piloted in Network 12 using a contractor to develop both an objective assessment of veterans' health care needs and Service Delivery Options to meet those needs. After a detailed review process, the contractor recommended selected options to the Secretary, Department of Veteran Affairs; he in turn selected an option after consulting with stakeholders. The implementation process has begun in VISN 12.

CARES Phase 2 will extend the CARES Program to all 21 Networks within VHA. The design of CARES Phase 2 has benefited from valuable lessons learned in the CARES Pilot. CARES Phase 2 will rely primarily upon VACO and Network staff to develop the Network CARES Market Plans. VACO will identify Planning Initiatives for Networks that include specific areas where capital asset realignment opportunities appear to be significant. The national approach to CARES Phase 2 will incorporate standardized methodologies and processes including: forecasts of future enrollment and service needs, and methodologies for developing Network CARES Market Plans. Proposed realignments in the Network CARES Market Plans will consider sharing and collaboration with internal VA components such as VBA and external partners such as DoD. The Undersecretary for Health will review the Networks CARES Market Plans and prepare a draft National CARES Plan with recommendations to the Secretary.

A Commission of non-VA executives appointed by the Secretary will review the Undersecretary for Health's draft plan. The Commission will contribute an assurance of objectivity and external perspective to the recommendations contained within the draft plan. The Commission may make site visits and conduct hearings to gather stakeholder input. The Commission will review and analyze the data gathered from all sources and after consultation with the USH, make recommendations to the Secretary to consider in his review of the draft National CARES Plan.

CARES Phase 2 will strengthen stakeholder communication throughout the process by specifically involving them at key points in the process at both the Network and VACO levels to ensure consideration of their views in the development and review of Network and National Market Plans.

## **B. The CARES Process**

The CARES process involves nine steps, depicted graphically on page 5 and summarized below:

### **Step 1: Develop Market Areas and Sub Markets as the Planning Unit for Analysis of Veterans Needs.**

VACO will gather and review the following county data: projected veteran population, enrollment data, market share and transportation and other considerations such as natural barriers. This data will be used with the Networks to develop market areas and, as appropriate, sub markets. The market areas constitute the basic planning unit in the CARES process.

### **Step 2: Conduct Market Analysis of Veterans' Health Care Needs**

VACO will utilize the following data for market analyses:

- a. Standardized forecasts of future enrollees and their needs in each market throughout the system. An external actuarial consultant will provide this data to VACO.
- b. Information from program offices and Network Plans to complement the actuarial data.

- c. The current supply and location of services VA provides in each market.

### **Step 3: Identify Planning Initiatives for Each Market Area**

VACO will utilize the data in Step 2 to identify Planning Initiatives including:

- a. Apparent future gaps between supply and demand both geographically and in the number of resources required.
- b. Opportunities for DoD, VBA and NCA sharing.
- c. The need to find uses for excessive vacant space.
- d. Other specific strategic program issues, such as the future need and location of specialty referral services, enhanced use opportunities, emergency preparedness and Homeland Security and Contingency back up.

### **Step 4: Develop Market Plans to Address Planning Initiatives**

Networks will develop specific market plans that complete all the Planning Initiatives VACO identified within each market area. Networks will evaluate alternatives for addressing the Planning Initiatives and submit the most cost effective, feasible approach to meeting the future veteran health care needs program issues. Each Network will use a standardized set of planning criteria to develop its CARES Market Plan. Each Market Plan will also contain a Capital Asset Realignment (CAR) Plan.

### **Step 5: VACO Review and Evaluation**

The CARES Program Office staff and Under Secretary for Health's Clinical CARES Advisory Group (CCAG) will review each Network CARES Market Plan. The CCAG will be comprised of VACO clinical leaders and other consultants appointed by the Under Secretary for Health (USH). The CCAG will develop recommendations regarding the clinical impact of the Market Plans for the USH. To ensure that all VA assets are addressed in the market plans, the CARES One VA Committee (COVAC) will review each market plan and provide advice to the USH. The USH will consider these reviews and prepare a draft National CARES PLAN. The Draft National CARES Plan will be published and made available to stakeholders.

### **Step 6: Independent Commission Review**

The Secretary of Veterans Affairs will appoint a Commission comprised of non-VA executives to review the draft National CARES Plan. The Commission will contribute an assurance of objectivity and bring an external perspective to the recommendations contained within the draft plan. The Commission will focus on accessibility, cost effectiveness of care to be provided, while ensuring that the integrity of VA's health care and related missions is maintained, and any adverse impact on VA staff and affected communities is minimized. The Commission will take into consideration the views and concerns of stakeholders, including Veterans Service Organizations, medical school affiliates, local community groups, and

government entities. The Commission will evaluate comments received during the 60-day public comment period following the publications of the National CARES Plan by the USH and may conduct regional public hearings and site visits. The Commission will consult with the USH prior to making its recommendations to the Secretary to accept, modify, or reject with supporting comments the recommendations received in the draft National CARES Plan.

**Step 7: The Secretary Department of Veterans Affairs, Decides**

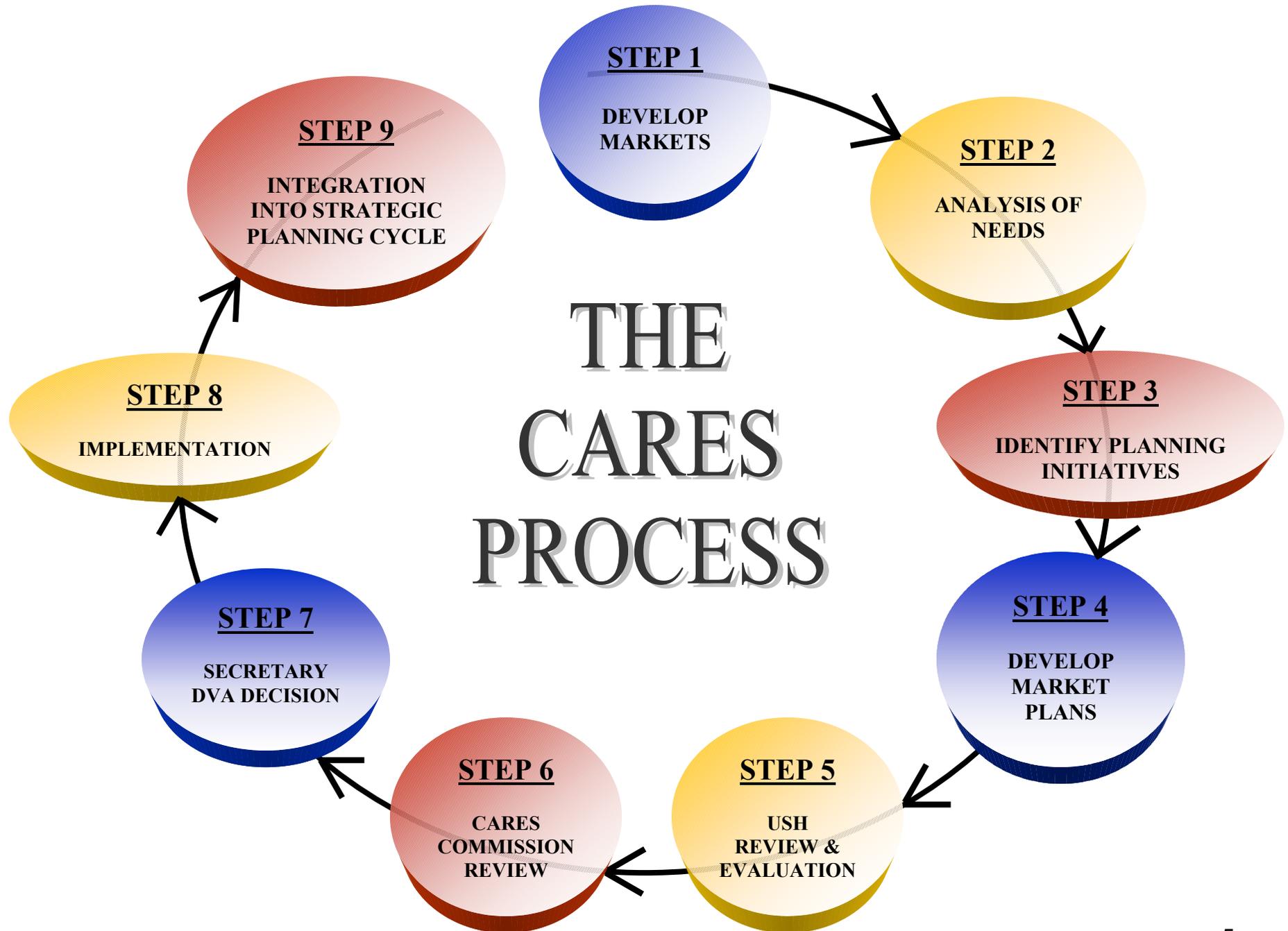
The Secretary will consider the Commission's recommendations regarding the draft National CARES plan and make a determination to accept, reject or modify with comments recommendations received in the draft National CARES Plan.

**Step 8: Implementation**

Depending upon the nature of the Secretary's decision, Networks may prepare detailed implementation plans for their CARES Market Plans that will be approved by VACO.

**Step 9: Integration into Strategic Planning Process**

As Networks proceed with the implementation of their Network CARES Market Plans, the Planning Initiatives will be refined and incorporated into the annual VHA strategic planning cycle. This will ensure that CARES program and capital implementation proposals are integrated into current VACO strategic planning, policy assumptions and objectives.



## CHAPTER 2: CARES DIRECTIVE

Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

VHA DIRECTIVE 2002-032

June 5, 2002

### CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) PROGRAM

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive describes the Capital Asset Realignment for Enhanced Services (CARES) Program. **NOTE:** *This directive rescinds VHA Directive 2000-040, dated October 24, 2000.*

#### **2. BACKGROUND:**

a. The National CARES Program will assess veteran health care needs in VHA Networks and identify Planning Initiatives (PI) to meet those needs in the future. The CARES Program will guide the realignment and allocation of capital assets to support the improved delivery of health care services. CARES will, thereby, improve quality as measured by access and improve the delivery of health care in a cost-effective manner, while maximizing positive opportunities and minimizing any adverse impacts on staffing, communities, and on other Department of Veterans Affairs (VA) missions.

b. VHA's current health care delivery model emphasizes a continuum of care provided within a regional or Network-based integrated delivery system. The existing capital infrastructure was designed primarily for inpatient care and, as a result, in many cases VHA's capital assets do not align with current health care needs for optimal efficiency. The cost to maintain and operate VA health care facilities that cannot provide efficient and accessible services diminishes resources that could otherwise be used to provide better care in more appropriate settings.

c. VHA's National Strategic Planning Guidance sets forth the requirements to clearly identify health care needs of the veteran population served by the Network, and articulates a framework to develop strategic plans to address those needs. Health care needs identified in the strategic plans will provide the context and the framework for capital asset management decisions. CARES will improve access and enhance VHA's delivery of health care by maintaining an environment that maximizes the quality of health care.

d. VA's vision for the National CARES Program is that veterans will benefit from:

- (1) Enhanced services for health care.
- (2) Improved future infrastructure in VA.

**VHA DIRECTIVE 2002-032**

**June 5, 2002**

- (3) VA's capital asset realignment.
- (4) Better managed information and systems.
- (5) Sharing of VA technology advantages with Department of Defense (DOD).
- (6) Strengthened support to National Defense, Emergency Response, and Homeland Security.

e. The CARES Program will:

- (1) Provide a clear vision for VHA health care to all stakeholders.
- (2) Address VHA's "Six for 2007 Strategic Objectives."
- (3) Maximize objectivity in future VHA health care planning.
- (4) Address the Secretary of Veterans Affairs' priorities of CARES.
- (5) Maximize inclusiveness and stakeholders' participation.
- (6) Address the strategic service delivery goals of Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA).

f. **The CARES Planning Process**

(1) The CARES planning process will:

(a) Incorporate Network-based data, strategic health care planning input, and the cooperative participation of all stakeholders toward achieving the stated vision and outcomes of the National CARES Program.

(b) Ensure that enhanced-use lease opportunities are addressed in a comprehensive manner. **NOTE:** *VA will improve the effective use of this important capital asset tool.*

(c) Identify opportunities for converting vacant space into alternative uses or disposing of excess assets in the most effective manner.

(d) Improve sharing facilities and services with DOD. **NOTE:** *Through the CARES planning process, all avenues for maximizing or pooling resources need to include the sharing of facilities and services with DOD.*

(2) **Definitions:**

(a) Capital Asset Realignment (CAR) Plan. A CAR plan summarizes changes to all identified capital assets associated with specific clinical or services planning initiatives. Changes may include increased investments, divestments, or realignments of capital assets.

(b) CARES Process. The CARES Process integrates health care planning and capital asset planning to maximize efficiency and provide the best quality health care services to veterans. An analysis of VHA's health care markets will be completed for each Network. This analysis begins in VA Central Office with a system wide determination of markets and realignment gaps. The gaps are determined in part by comparing the expected need and location of services by veterans in years 2012 through 2022 with the current location and capacity of VA health care services within each Network. The realignment gaps become PIs that are to be completed by the Networks. The Networks complete the PIs by developing solutions that will result in efficiently providing the required services and an optimal alignment of capital assets to best support those services. These solutions incorporate ongoing efforts to collaborate with DOD and also include assessment and utilization of community resources. The solutions are developed as Network Market Plans. The Market Plans are submitted to VA Central Office and incorporated into the draft VHA National CARES Plan. The CARES Commission will then review the draft National CARES Plan and their recommendations will be submitted to the Secretary, Department of Veterans Affairs.

(c) Evaluation Criteria. The Evaluation Criteria are the expected outcomes and performance results that serve as the basis for evaluating the CARES process. They are divided into threshold and impact criteria. **NOTE:** *The evaluation will be performed by the National CARES Program Office and the CARES Commission.*

(1) Impact Evaluation Criteria. Criteria that allow PIs to be evaluated for their impact upon key CARES goals and objectives. Impact criteria include:

- a. Health care quality as measured by access;
- b. Staffing and community impact;
- c. Support of other VA missions; and
- d. Optimizing use of resources.

(2) Threshold Evaluation Criteria. These are "pass or fail" criteria that must be met for any PI to be included in a market plan. The threshold criteria are defined as:

VHA DIRECTIVE 2002-032  
June 5, 2002

- a. Quality,
- b. Need,
- c. Access, and
- d. Safety of the health care environment.

(d) Market Plan. Market Plans will be produced at the Network level based upon health care markets within that Network. Each market plan is composed of the completed PI that solve each realignment gap identified for that market.

(e) National CARES Plan. The National CARES Plan is the compilation of the PIs approved by the Secretary of Veterans Affairs into an integrated and structured approach to providing health care services to veterans. The National CARES Plan is designed to optimize capital realignment to ensure that it supports the expected need by veterans for services from year 2012 through year 2022.

(f) Planning Initiatives (PIs). PIs are the issues identified by VA Central Office that must be resolved to ensure that the capital and programs required to meet the future health care needs of veterans will be available. They are the components of the individual Network Market Plans.

(g) National CARES Program Office (NCPO). The VHA NPCO was established to manage the National CARES program and is the main coordinating body that integrates the work of the other groups. This office consists of a multidisciplinary team of health care professionals, with varied technical skills, and has the primary responsibility to develop the National CARES Plan.

(h) CARES Planning Group (CPG). In addition to staff from the major VHA program offices, CPG consists of staff from: VBA, NCA, Office of Management, Office of Policy and Planning, and Office of Acquisition and Materiel Management. They have an advisory role as well as provide support to NCPO.

(i) CARES Commission. To ensure objectivity in the National CARES process, the Secretary of Veterans Affairs will appoint a CARES Commission, consisting of nine external non-VA members. The Commission becomes involved in the process after:

(1) The Network CARES Market Plans are reviewed by NCPO, the Clinical CARES Advisory Group, the CARES One VA Committee, and the Under Secretary for Health, and

(2) The draft National CARES Plan has been prepared.

(3) The National CARES Plan includes Veterans Integrated Service Networks (VISN) PIs identified by VA Central Office. PIs are market-based proposals within the VISN for the delivery of health care services. For utilization forecasting, the use of enrollment projection data provided by the actuarial firm for years 2012 through 2022 is mandated. **NOTE:** *Networks will receive a CARES Guidebook containing detailed instructions and an explanation of the CARES planning process.*

**3. POLICY:** It is VHA policy that capital assets must be realigned through the CARES program to meet veterans' current and projected health care needs.

**4. ACTION:**

a. **VISN Director.** The VISN Director is responsible for:

(1) Providing input and implementing a CARES Market Plan that:

(a) Supports quality health care delivery,

(b) Improves access to veterans' health care services,

(c) Guides future capital investments, and

(d) Addresses the impact on the delivery of benefits and services provided to veterans by VBA and NCA.

(2) Completing the data requirements for the identification of gaps in markets that require PIs, based on the standardized methodology provided from NCPO.

(3) Attending official meetings with the NCPO regarding these PIs.

(4) Submitting completed CARES market plans with PIs to VHA Central Office by November 30, 2002. The executive summary of the Network report must include an assessment of the relative strengths and weaknesses of each CARES Market Plan within the VISN; and how the PIs compare, support and align with the Network's strategic goals and objectives as well as the Uniform Benefits Package, the Millennium Health Care and Benefits Act of 1999, and Section 203 of Public Law 107-135, on Maintenance Capacity for Specialized Treatment and Rehabilitative Needs of Disabled Veterans. The CARES Market Plan will also address the impact on the strategic service delivery goals of VBA and NCA.

(5) Identifying capital investment requirements for the implementation of the approved PIs, and incorporating them into its CAR Plan. CAR must support veterans' health care needs and reflect linkage and alignment of capital proposals to specific strategic goals and objectives in the National strategic plans.

**VHA DIRECTIVE 2002-032**  
**June 5, 2002**

(6) Designating an executive group or utilizing the Strategic Planning Council (SPC), CARES Task Force (CTF), Executive Leadership Council (ELC), or equivalent group to serve as a Network Steering Committee (NSC) for CARES. The NSC, or equivalent, must include representatives of VHA field management, representation from the VHA missions of clinical care, education (Academic Affiliations), and research, as well as from VBA regional offices, NCA, and DOD.

(7) Ensuring (in consultation with the NCPO) ) that VA's stakeholders are kept fully informed throughout the CARES process and that appropriate input is obtained and communicated for consideration. **NOTE:** *Communication is a critical element in CARES planning.*

(8) Reviewing Network health care shared markets (geographic areas where Networks meet), collaborating with neighboring Networks, and making recommendations concerning the planning initiatives for those shared markets.

**NOTE:** *Deviations from these procedures and requirements in the CARES Guidebook need to be requested with justification from the CARES office.*

b. **Communications Coordinator.** A key member of the VISN CARES team, the Communications Coordinator's role is to keep the stakeholder constituency informed throughout the process. This includes meetings, as well as written communications, at all key milestones of the process. The CARES Guidebook contains requirements for a Network and National Communications Plan that gives a framework to be followed and implemented. Networks must maintain records of all deliberative processes, stakeholders' communications, as well as all documentation supporting or relating to the CARES planning process. Any questions or concerns need to be directed to the VHA Office of Communications (202) 273-8591. **NOTE:** *See subparagraph 4c(5) on CARES Commission for their role in stakeholder communication.*

c. **VHA Central Office Review and Approval of CARES Planning Initiatives**

(1) **National CARES Program Office (NCPO).** The major duties of NCPO are to:

(a) Coordinate the administration of the CARES process within VA Central Office.

(b) Direct and assist the VISNs in providing data and data analysis for the CARES PIs.

(c) Identify the Network market gaps that determine the CARES PIs.

(d) Collaborate with the Office of Public Affairs and VHA Office of Communications to ensure the stakeholder participation occurs throughout the process.

(e) Develop and maintain a CARES Guidebook to provide instructions and guidance for developing CARES PIs.

(f) Review CARES PIs for consistency with veterans' health care needs, evaluation criteria, and the performance goals and objectives of the National VA Strategic Plan.

(g) Coordinate the CARES Program with VBA and NCA.

(h) Coordinate with DOD on the development of the National CARES Plan to maximize sharing and collaboration of capital assets.

(i) Ensure that each PI provides specific quantifiable documentation that addresses the criteria identified in the CARES Evaluation Criteria.

(j) Prepare a National CARES Plan for VHA senior management and the CARES Commission that includes ranking criteria, a summary of all PIs, and the evaluation of each market plan.

(k) Collaborate with the CARES Planning Group activities.

(l) Maintain records of all deliberative processes, stakeholders' communications, as well as all documentation supporting or relating to the CARES planning process.

(m) Prepare the final report and recommendations from the National CARES Commission, including stakeholders' comments, and provide all necessary staff support until the completion of the CARES project.

(n) Perform evaluation of the CARES process through continuous review and adjustment.

***NOTE:*** Upon approval of the National CARES Plan, the NCPO will eventually be phased out. Implementation plans are the responsibility of the Office of the Deputy Under Secretary for Health for Operations and Management.

(2) **CARES Planning Group (CPG).** The duties of CPG are to:

(a) Identify and recommend policy issues and criteria related to the CARES planning process.

**VHA DIRECTIVE 2002-032**

**June 5, 2002**

(b) Assist in the coordination of all elements within the National CARES Plan.

(c) Consider input from all sources and incorporates adjustments into the CARES planning process accordingly.

(d) Address all CARES policy issues referred from program offices, Networks, and elsewhere.

(e) In unison with NCPO, evaluate the CARES process on an ongoing basis and provide guidance to NCPO.

(f) Participate in the evaluation of the CARES planning process at its conclusion.

(g) Publish minutes of its meetings and share them with pertinent offices.

(h) Assist in the development and maintenance of CARES planning guidance.

(3) **Under Secretary for Health's Clinical CARES Advisory Group (CCAG).** The duties of CCAG, comprised of VA Central Office clinical leaders and other consultants appointed by the Under Secretary for Health, are to:

(a) Advise the Under Secretary for Health on the National CARES Plan.

(b) Develop recommendations regarding all clinical, research and educational issues within the National CARES Plan.

(4) **CARES One VA Committee (COVAC).** *NOTE: VHA will convene a CARES One VA Committee comprised of VHA senior managers, senior clinical program managers, and VA department senior managers, including: VBA, NCA, Office of Management, and the Office of Policy and Planning.* COVAC reviews and evaluates the draft National CARES Plan, and coordinates it with VA's strategic plan. Following this evaluation, COVAC, in an advisory role to the Under Secretary for Health, formulates a decision memo for acceptance by the Under Secretary for Health. These duties include:

(a) Advising the Under Secretary for Health prior to final endorsement of the National CARES Plan.

(b) Making recommendations concerning any elements of the draft National CARES Plan that transcends VHA.

(5) **CARES Commission.** The duties of the CARES Commission are to:

(a) Accept, modify or reject with supporting comments the recommendations received from the Under Secretary for Health (draft National CARES Plan).

(b) Apply CARES evaluation criteria in its recommendations.

(c) Fulfill the requirements of the Federal Advisory Committee Act.

(d) Operate an “open and fair” process, while ensuring that all VA assets and health care requirements have been considered and addressed.

(e) Interact with stakeholders, including Veterans Service Organizations, medical school affiliates, government entities, or local community groups, as necessary.

(f) Evaluate comments received during the public comment period and address those and other stakeholder concerns in its recommendations to the Secretary of Veterans Affairs.

(g) Respond as “Stewards of America’s Resources” to any final stakeholders criticism, concern, or Congressional inquiry.

(h) Consult with the Under Secretary for Health prior to making its recommendations.

(i) Conduct regional public hearings and site visits, as appropriate, to evaluate the draft National CARES Plan in developing its recommendations.

**NOTE: *Implementation of the National CARES Plan.*** *Implementation of the National CARES Plan is not addressed in this directive; however, Chapter 8, CARES Guidebook Phase II, explains the process.*

## **5. REFERENCES:**

a. Office of Management and Budget (OMB) Capital Programming Guide, July 1997.

b. VA Capital Investment Methodology Guide, May 2000.

c. VHA National Strategic Planning Guidance, January 2002.

**VHA DIRECTIVE 2002-032**

**June 5, 2002**

d. VHA Directive 1660.1, Enhanced Health Care Resource Sharing Authority – Sharing.

**6. FOLLOW-UP RESPONSIBILITY:** The CARES Office (10AC) is responsible for the contents of this VHA Directive. Questions may be addressed to 202-565-5272.

**7. RESCISSIONS:** VHA Directive 2000-040, dated October 24, 2000, is rescinded. This VHA Directive expires May 31, 2007.

S/ Nevin M. Weaver for  
Robert H. Roswell, M.D.  
Under Secretary for Health

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## CHAPTER 3: COMMUNICATION

### A. Background

The purpose of the Communications Chapter is to describe the requirements and components of the VACO and Network Communications Plans as well as the roles and responsibilities of the National CARES Program Office (NCPO), the VHA Office of Communications, the Office of Public and Intergovernmental Affairs (OPA), and network and facility communications staff.

The importance of timely and accurate communications during the CARES process cannot be overstated. Because of the potential major impact of the CARES planning initiatives, internal and external stakeholders will be watching the process closely. The Secretary will approve a National CARES Market Plan that will meet future veteran health care needs and provide enhanced health care services, while assuring highest quality care and optimal access for a defined veteran population in the most cost-effective manner. Changes that may occur through the implementation of these planning initiatives could affect many VA employees, organizations, communities, and individuals associated with the provision of health care to veterans.

Communication must be an integral part of the process from the beginning; and a coordinated communication effort with the broad range of internal and external stakeholders is critical. Stakeholders need to know about the CARES process and the planning initiatives being developed, to have the opportunity to provide their views during the development of the planning initiatives, and to be assured that their comments and concerns have been considered. They must also be able to comment on the final recommendations from the Under Secretary during the 60-day comment period and the CARES Commission process. To assure a consistent message throughout the process, VACO must make sure that the release of information is accurate, coordinated, and timely.

CARES is a planning process to ensure that the health care needs of veterans align with VHA's capital assets, both now and into the future. Communication strategies should always emphasize the expected outcome of the CARES process - more accessible quality health care for more veterans. Communications strategies will be developed around the principle that the CARES process should result in more cost effective, accessible quality health care for more veterans by realigning the capital infrastructure.

### B. The CARES Communication Plan

The CARES Communication Plan is a critical contributor to the success of CARES; as such, its development and implementation must be a highly collaborative effort

between the National CARES Program Office (NCPO), the VHA Office of Communications, the Office of Public and Intergovernmental Affairs (OPA) and network and facility communication staff.

Due to the volume and nature of information that may be generated as a result of CARES, it is imperative that all communication elements work closely together to address the important issues that may be raised by all stakeholders and respond in a coordinated and timely manner. This will be ensured by the development of a detailed communication plan and continuous monitoring of its implementation.

### **1. CARES Communication Plan Goals:**

- Inform the maximum number of stakeholders and ensure that they have an opportunity to provide their views at key stages in the CARES process.
- Ensure that all communications about the CARES project are accurate, timely and focused
- Acknowledge and respond to stakeholder communications at all levels of VA; ensure that discussions are open and comprehensive.

### **2. Scheduled Communication Milestones:**

It is expected that communications to target audiences will be scheduled to correspond with the following CARES milestones to ensure a consistent level of communication and input from stakeholders:

- a. CARES Phase 2 National Rollout Announcement
- b. Definition of Market Areas to be Used for CARES Planning
- c. Identification of Planning Initiatives to be completed by Networks
- d. Submission of Market Area Plans to VACO
- e. Publication of the draft National CARES Plan by the Undersecretary of Health
- f. Site Visits by the CARES Commission
- g. Secretary of Department of Veterans Affairs Decision

### **3. Cares Communication Plan Structure:**

The VHA Office of Communications (VHAOC) will take the lead in designing and implementing the CARES Communications Plan. Working in conjunction with the National Cares Project Office and OPA, communication strategy and project messages will be developed and appropriate materials, websites and other electronic materials prepared. Using the established communications systems and pathways, these materials and messages will be provided to the networks.

A communications liaison will be designated as part of the National CARES Program Office and will work with VHA Office of Communications and OPA to develop and disseminate formal communications materials for the CARES Project. The VHA Office of Communications will work with network and facility staff to include their input and to assure that communications materials are disseminated fully and promptly.

Although VACO will administer the formal communications process, it is evident from past experiences that informal communications can also establish a long lasting perception and must be closely coordinated. These communications need to be supported and must be handled effectively.

#### **4. CARES Communication Roles and Responsibilities:**

##### **a. VACO**

Nationally, the NCPO, the VHA Office of Communications and OPA will coordinate CARES communications, develop brochures, slides, and other tools and prepare the National Communications Plan. Communications for local stakeholders regarding CARES issues should be consistent with and drawn upon the same information, and be disseminated according to an approved timetable.

##### **1) The National CARES Program Office will:**

- Track national stakeholder comments via letters and e-mail and will draft written responses for national VSOs, congressional inquiries and other national stakeholders as appropriate in collaboration with the VHA Office of Communications.
- Work closely with the VHA Office of Communications and OPA in the development of briefing materials, white papers, testimony, etc. for meetings and conferences;
- Provide guidance and assistance to network staff through regularly scheduled conference calls and as requested by OPA, networks and facility PAOs.

##### **2) The VHA Office of Communications and OPA will:**

- Update and maintain the CARES web site;
- Work with the NCPO to develop the national communication strategy, goals and objectives;
- Work with NCPO to develop standardized Power Point slides for use in briefing network stakeholders
- Develop national media products and communication goals and objectives;

- Assist in the development of briefing materials
- Handle national media queries and set up interviews with CARES Program officials, the Secretary and Deputy Secretary;
- Provide advice and guidance to the Network Communication Coordinators and Regional OPAs;
- Develop announcement timelines and coordinate national timelines with local timelines developed by the Network Communications Coordinator and Regional OPAs, (a sample timeline is included at the end of this chapter);
- Work closely with network communications officials to assure network communications efforts are in accordance with the National CARES Communications Plan.

### 3) Regional Offices of Public Affairs will:

- Assist in development of Network CARES communication strategy;
- Assist in identifying audiences and frequency of messages;
- Recommend and help to develop appropriate tools for reaching identified audiences;
- Work with the VHA Office of Communication, OPA and Network Communications Coordinators to develop key messages, communication tools and information for distribution to stakeholders; (See Attachment C)
- Provide media training for VISN and facility media spokesperson, when necessary;
- Respond to media queries when appropriate and alert the VHA Office of Communications and OPA when inquiries are from national media or sensitivities are evident;
- Assist the Network CARES Communications Coordinator in the organization and coordination of public forums, i.e. town hall meetings, press briefings, CARES Commission meetings with stakeholders, etc.
- Work closely with network communications officials to assure network communications efforts are in accordance with the National CARES Communications Plan.

#### b. Networks:

Each Network will appoint a **CARES Communications Coordinator** and an **Assistant CARES Communications Coordinator** to work closely with the NCPO, the VHA Office of Communications, and OPA to coordinate CARES messaging, release of information and announcements, response to stakeholder comments and queries, and media inquiries.

The role of the Network CARES Communication Coordinator will be to establish and maintain clearly defined and open lines of communication that

will facilitate input and comments from VA's stakeholders. The Communications Coordinator ensures that VA's stakeholder constituency is kept fully informed throughout the process and that appropriate stakeholder feedback is obtained. Communication with stakeholders includes, but is not limited to, media coverage, town hall meetings, focus groups, interviews, presentations position paper, and Internet/Intranet information. These communications will occur at all key milestones of the process and at other points in the process as requested or designated.

The Network Communications Coordinator will also ensure that all stakeholder comments and concerns are communicated to both the Network Steering Committee for CARES and the NCPO for consideration and will document stakeholder comments and concerns, along with action taken by the Network, or the NCPO in response to stakeholder feedback.

**1. The Network Communications Coordinator will:**

- Work with the NCPO, VHA Office of Communications and OPA to develop key messages, communication tools and information for all stakeholders in their respective Network;
- Continually assess communications process and recommend strategy, action, or changes in communications based on this evaluation;
- Work with Regional OPAs to keep facility PAOs informed and ready to respond to local constituents and media;
- Designate a VISN spokesperson to respond to the media and work with facilities to ensure there is a facility spokesperson;
- Ensure that all stakeholder input is communicated to the VHA Office of Communications, the NCPO or the CARES Commission for consideration as appropriate; and
- Coordinate public forums for key announcements, town hall meetings, press briefings, CARES Commission meetings with stakeholders, etc;
- Document stakeholder comments and concerns along with the action taken by the Network, the facilities and the CARES Commission in response to stakeholder input.
- Develop scheduled meetings with target stakeholder audiences

**2. Network Media Spokesperson will:**

- Coordinate with key facilities in their networks to ensure that a spokesperson from the facility has also been designated and is aware of sensitivities and CARES talking points. Regional OPAs in collaboration with the VHA Office of Communications and the NCPO will conduct media training where necessary.

- Develop template news release concerning CARES Commission meetings
- Develop key messages, talking points and other tools for network and facility communications;
- Update the CARES Hot Issues section on the Shared Knowledge Mall;
- Work closely with the CARES Commission to prepare for public forums;
- Develop a Network and OPA Regional Office mail group to provide updates and discuss general CARES communications issues.

### **5. National CARES Communication Plan:**

The VACO Communications Plan will be approved by the Undersecretary for Health and the Secretary. The VACO Communications Plan includes tools that will be used by Networks to ensure that there are standardized messages that are communicated by all Networks.

- Development of CARES Key Messages and Talking Points: In coordination with the VHA Office of Communications, OPA, and the Network Communications Coordinator, the NCPO will develop the “key messages” and communication timelines for Steps 1,2,3,4,5,6 and 7 of the CARES process described in Chapter 1.
- Development and Production of Communication Products: The VHA Office of Communications, OPA and the NCPO will develop national communication vehicles including brochures, newsletters, information letters, handouts, white papers, oral presentations, slides, PowerPoint presentations, videos, web pages, etc. The Network Communications Coordinator will work closely with the VHA Office of Communications, OPA and the NCPO in the development of communication products specifically targeted for stakeholders of a particular network.
- Standardized Introductory Response Letters: describing the CARES process when responding to stakeholder comments and inputs.
- Technical Assistance and Advice: The VHA Office of Communications and OPA will provide assistance, guidance and advice to the Network in all matters having to do with the communication of CARES.
- Target audiences and schedule: In coordination with the NCPO, OPA, and the Network Communications Coordinator, the VHA Office of Communications will develop the target audiences and schedules for the communications process. (See Attachment A in this chapter)

- Respond to National and Local Stakeholders: The process used to respond and systematically consider stakeholder input to VACO regarding the completion of planning initiatives and other CARES issues.
- Monitoring of Network Communications: A reporting process from Networks that will monitor the following:
  - a. Issues raised by stakeholders that require national attention.
  - b. The process used to systematically consider stakeholder input in the completion of planning initiatives.
  - c. Meetings and other communications to stakeholders.
  - d. Establishment and completion of scheduled communications including regularly scheduled meetings.
- Periodic Briefings of stakeholders and external partners such as VSO's and DoD to keep them informed about CARES Process progress and to discuss issues as they arise.
- Periodic briefings of key VACO groups and officials such as COVAC, NLB, USH and the Secretary

#### **6. Maintenance of the Communication Plans:**

The CARES Communication Plan will need to remain flexible as unanticipated events occur. The plan will also need to be updated when the Network moves into implementation phase. For example, the key points or target audiences for communication for a Network that is in the Market Plan Development step may be different than the key points or target audience when the Network is in the Implementation phase.

#### **7. Communication Tools:**

The national CARES Internet web site ([www.va.gov/cares](http://www.va.gov/cares)) will provide consistent information to interested stakeholders around the country, and will be adapted to local issues. Frequent working video conferencing sessions should be conducted with the VISN communications representatives to develop ongoing messages to be reflected in all CARES communications. Examples of potential communication vehicles include, but are not limited to the following:

- Internet sites
- E-mail messages
- Presentations
- Newsletters (national and local)
- Briefing packages
- Notice boards
- Individual employee letters

- Management and Team meetings/briefings
- Workshops
- Videos/video broadcasts
- Press releases
- Directives
- Information Bulletins

### **8. Summary:**

Ongoing accurate communications are essential, both within the various organization elements responsible for coordinating the CARES studies and with stakeholders. Stakeholders want to be involved from the beginning, and must be assured that their views are being considered. They also want to know that the information they are receiving is accurate and timely.

The National CARES Program Office will take the lead in crafting the program message and working with VHA and OPA to coordinate communications efforts at the national, network and local levels. The VHA Office of Communications, the Office of Public and Intergovernmental Affairs and the Network Communications Coordinators will be full partners in design, production and dissemination of communication tools. Communicating information concerning the Planning Initiatives submitted must be carefully coordinated with all organizational elements.

Stakeholders should be made aware that Planning Initiatives being evaluated will not be accepted until they have been thoroughly reviewed by the National CARES Program Office, considered by the CARES Commission, vetted through consideration of stakeholder comments and suggestions, and receive a final evaluation by the Secretary. In addition, the CARES Commission may conduct regional public hearings and site visits to evaluate comments received during the 60-day public comment period. Finally, every effort will be made at the conclusion of the process to explain, and provide data supporting the decisions made.

### Target Audiences

The Networks must clearly identify the target audiences and the communications methods for those target audiences. (See Attachment B for format) It also is recognized that communications need to address internal and external audiences. The impact that our internal stakeholders (i.e., employees, volunteers, medical affiliates, etc.) will have on the communication process at the outset requires that they be brought into the communications loop and provided the training and tools to assist in the external communications efforts. Early in the process, each Network and facility will need to identify all stakeholders and maintain a current list for communications.

**The following are examples of some of the stakeholder groups and organizations, which must be included in the communications process:**

#### **External Stakeholders:**

- House and Senate Veterans Affairs Committees
- House and Senate Appropriations Committees
- Members of Congress who represent communities being studied, as well as state, county and local politicians
- Veterans Service Organizations (national and state)
- State Directors of Veterans Affairs
- State Veterans Homes
- Medical schools with affiliations with affected medical centers (Dean's Committees)
- Local hospitals or providers with which affected medical centers have relationships
- Office of Management and Budget
- General Accounting Office
- Department of Defense Health Care Centers
- Local and national media (print, television, and radio)

#### **Internal Stakeholders (VA-wide):**

- VHA, VBA and NCA Leadership
- Other VA top management
- National and Local Union Representatives
- Partnership and Management Assistance Councils

#### **Internal Stakeholders (VISN and facility level):**

- Network and Facility Director
- Chief of Staff and Key Medical Personnel
- Employees

**Target Audience Communication Format**

The sample format may be used by the Network to schedule communications to specific target audiences around defined stages in the CARES process as described in Section 2 Scheduled Communications Milestones.

<b>Target Audience A:</b>			
Planned Communication Dates	Actual Date	Purpose	Outcomes

<b>Target Audience B:</b>			
Planned Communication Dates	Actual Date	Purpose	Outcomes

<b>Target Audience C:</b>			
Planned Communication Dates	Actual Date	Purpose	Outcomes

Communication Tools

CARES Communication  
Key Message:

More Accessible, Quality Care for More Veterans.

DESCRIPTIONS & PROCEDURES:

	Description	Procedures
Information brochure	Small brochure for mass mailing with general information and contacts	Prepared by VHA Office of Communications and distributed through the networks.
VHA Information Letter		Prepared and distributed by VHA
Town meetings	and handouts.	Approved by NCPO, VHA Communications, held locally as needed.
Oral Presentations	Informational presentations to groups - may include slides	Approved by NCPO and VHA Communications, held locally as needed.
Web Pages	Informational web site with downloadable documents, Intranet and Internet.	Approved by VHA Communications, maintained by NCPO
Slides, view graphs (training)	Media presentations	Prepared by NCPO, reviewed by VHA Office of Communications and OPA
Status Reports / Newsletters	Written media, on a scheduled basis	Prepared by NCPO and Network Communications Coordinator, If local, Network shall prepare response, and send through NCPO. If national/central - response prepared by NCPO.
RFI's (written/phone)	Requests from anywhere - e-mail, phone, letters, sent to VHA or locally	
Video satellite (training/status)	Networks	Format and agenda approved by VHA PAO, logistics by EES
Conferences	Face-to-face learning sessions for VA employees	Format and agenda approved by NCPO and VHA Communications Office, logistics by EES
Guidebook	VA only	Prepared by NCPO and CPG.
White Papers		
Pre-briefing		
Briefings		
Pre-hearing		
Hearings		

AUDIENCE AND FREQUENCY

	Field communication							Centralized Communication										
	Veterans	Employees	Unions	VISN staff	MC Mgmt	Congress (Local)	VSOs (local)	VHA HQ key staff offices	Secretary / Deputy Secretary	VA Top Mgmt	Congress (DC)	VSO (natl)	AAMC	Special Disability Group Reps	IOG	OMB	GAO	
Information brochure																		Contractor
VHA Information Letter																		
Town meetings																		
Oral Presentations																		
Web Pages																		Contractor
Slides, view graphs (training)																		
Status Reports / Newsletters																		
RFI's (written/phone)																		
Video satellite (training/status)																		
Conferences				HQ	HQ													
Guidebook																		
White Papers																		
Pre-briefing																		
Briefings																		
Pre-hearing																		
Hearings																		

Legend:  
 Weekly  
 Monthly  
 Quarterly  
 On-going / As needed

Communication Tools cont.

CARES Communication



**Key Message: More Accessible, Quality Care for More Veterans.**

**COMMUNICATION TOOLS:**

	Description	Procedures
Information brochure	Small brochure for mass mailing with general information and contacts	Prepared by the VHA Office of Communications and NCPO.
VHA Information Letter		Prepared and distributed by NCPO.
Town meetings	Oral presentations to groups with question and answer. May include slide shows and handouts.	Approved by NCPO & Network Communications Coordinator, held locally as needed.
Oral Presentations	Informational presentations to groups - may include slides	Developed by NCPO, VHA Office of Communications and OPA, used nationally and locally as needed.
Web Pages	Informational web site with downloadable documents. Intranet and Internet.	Maintained by NCPO and the VHA Office of Communications.
Slides, view graphs (training)	Media presentations	Developed by NCPO, VHA Office of Communications and OPA, used nationally and locally as needed.
Status Reports / Newsletters	Written media, on a scheduled basis	Prepared by NCPO, VHA Office of Communications and the Network Communications Coordinators
RFI's (written/phone)	Requests For Information from anywhere - e-mail, phone, letters, sent to VHA or locally	If local, local Network shall prepare response. If national/central - response prepared by NCPO.
Video satellite (training/status)	Live broadcasts to reach a large nationwide audience at the Medical Centers or Networks	Format and agenda approved by VHA Communications Office, logistics by EES
Conferences	Face-to-face learning sessions for VA employees	Format and agenda approved by NCPO and VHA Communications Office, logistics by EES.
Guidebook	Written guidebook for the process. Also available on the web site for download - VA only	Prepared by NCPO, format and final review by DepSec and Secretary of VA.
White Papers	Summary document of the issue	Prepared by NCPO and Network staff as appropriate.
Briefings	Formal presentations for external stakeholders	Prepared by NCPO
Hearings	Formal testimonies for Congress	Prepared by NCPO
News Releases & Fact Sheets	Information tools prepared for National and local media	Prepared by VHA Office of Communications and OPA

Communication Tools cont.

CARES Centralized Communication



Key Message: More Accessible, Quality Care for More Veterans.

AUDIENCE AND FREQUENCY

Centralized Communication											
	VHA HQ key staff offices	Secretary/ Deputy Secretary	VA Top Mgmt	Congress (DC)	VSO (natl)	AAMC	Special Disability Group Reps	OIG	OMB	GAO	Nat'l Media
Information brochure	10C	10C	10C	10C	10C	10C	10C	10C	10C	10C	
VHA Information Letter	NCPO		NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	
Oral Presentations	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	
Web Pages	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C
Slides, view graphs (training)	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	
Status Reports / Newsletters	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N
RFI's (written/phone)	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N
Guidebook	NCPO/CPG	NCPO/CPG	NCPO/CPG								
White Papers	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NCPO/10N	NTCO/10N	NCPO/10N	
Briefings	NCPO	NCPO		NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO
Hearings	NCPO			NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	NCPO	
New releases & Fact Sheets											10/C&OPA

Communication Tools cont.

CARES Field Communication



Key Message: More Accessible, Quality Care for More Veterans.

AUDIENCE AND FREQUENCY

	Field communication							
	Veterans	Employees	Unions	VISN staff	MC Mgmt	Congress (Local)	VSOs (local)	Local media
Information brochure	10C	10C	10C	10C	10C	10C	10C	
VHA Information Letter		NCPO		NCPT	NCPT			
Town meetings	Network	Network	Network	Network	Network	Network	Network	Network
Oral Presentations	TBD	TBD	TBD	TBD	TBD	TBD	TBD	
Web Pages	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	NCPO/10C	
Slides, view graphs (training)	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	
Status Reports / Newsletters	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	
RFI's (written/phone)	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	NCPO/Network	
Video satellite (training/status)		EES	EES	EES	EES	EES	EES	
Conferences		TBD	TBD	TBD	TBD	TBD	TBD	
Guidebook		NCPO/CPG	NCPO/CPG	NCPO/CPG	NCPO/CPG			
White Papers						Network	Network	
Briefings						Network	Network	
New releases & Fact Sheets							Network/10COPA	Network/10C/OPA

## Chapter 4: CARES PLANNING MODEL

### A. Introduction:

This chapter establishes a national methodology for the development of key components of Network CARES Market Plans (NCMPs) that will be used to create a National CARES Plan. This chapter describes standardized data sources, projections, analytical methods and templates to be used in the identification of Planning Initiatives to address gaps in healthcare services and infrastructure. Because CARES is in the initial stages of development, some of the specific methods and templates may be revised, but the basic planning approach will remain constant. As improvements are made to the CARES planning process, updated information will be disseminated.

### B. Planning Horizon:

The planning horizon for CARES is 2012. However, solutions to Planning Initiatives to be completed up to and including 2022, that have long-standing capital assets, must be appropriate for the demographics and projected needs of the veteran population from 2012 - 2022. The longer planning horizon of the CARES process reflects the time required to implement capital initiatives, their relative fixed status once activated, and the significant changes expected in veteran population.

The underlying premise in CARES is that the cost to maintain and operate VA health care facilities that cannot provide efficient and accessible services diminishes resources that could otherwise be used to provide better care in more appropriate settings.

The overarching planning assumptions that frame the CARES process are contained in the VHA Strategic Planning Guidance 2003-2007; these include strategic, financial, human resource, capital and emergency management priorities and directions for a 5-year period.

### C. Overview of the Process:

CARES planning is a systematic process. The National CARES Program Office will work with Networks to identify the market areas within the Networks. Markets are the basic CARES planning units. The NCPO will evaluate future demand and current supply and identify gaps in facilities, services and/or infrastructure for the geographic markets within each Network. These gaps will be designated as Planning Initiatives. The NCPO, working with VBA, NCA, DoD and VHA program offices and Network Strategic Plans, will also identify other strategic issues such as Enhanced Use opportunities, Homeland Security, Contingency Backup and Emergency Preparedness that may be designated as Planning Initiatives. Networks will

subsequently complete the Planning Initiatives with cost effective, viable solutions that ensure services and infrastructure are aligned to meet patient demand and health care needs. Networks will develop CARES Market Plans comprised of completed Planning Initiatives. These Market Plans will be submitted to VACO for approval and incorporation into a National CARES Plan.

Networks are not to contract for consultant services while undergoing this process without receiving prior approval from the CARES Office. Chapter 7 of this guide describes the contracting process to be followed.

#### **D. Planning Model:**

The CARES planning model consists of 5 steps that provide the information necessary to develop CARES Planning Initiatives:

**Step One:** Defining the **Veteran Population Base** for CARES. In this initial planning step, the NCPO will produce Condor/Milliman USA enrollment projection data and estimated veteran population data (VetPOP2001) by county for Networks to review and validate. The primary goal of this planning step is to establish viable baseline data for the CARES planning process.

**Step Two:** Define Markets and Sub-Markets. After defining the total enrollee population, the NCPO, in collaboration with the Network, will define markets and, as necessary, sub-markets to establish units for the planning process. The main goals of this planning step are to specify the counties or zip codes comprising a market or sub market, classify each county as urbanized, rural or highly rural and determine the percentage of enrollees within travel standards for specified services categories

**Step Three:** Determine Demand for HealthCare Services. This planning step is key to the development of Planning Initiatives and entails an understanding of current and projected future utilization of health care services associated within markets and sub markets. NCPO will provide Condor/Milliman with US projection data of future utilization based on enrollee population. NCPO will also project space requirements using the VA Space Driver. The goal of this critical planning step is to quantify future demand for services and space for each market through 2022.

**Step Four:** Determine Supply for HealthCare Services. This planning step involves a comprehensive inventory of current services and evaluation of existing infrastructure conducted by Networks or VA facilities. The goal of this is to develop a comprehensive bank of information on current infrastructure, services, programs employment and costs in each Network.

**Step Five:** Identify Planning Initiatives. This final planning step uses the analyses and information from Steps 1-4 to analyze gaps between supply and demand for 2012 through 2022. The NCPO will conduct the gap analyses, review Network Strategic Plans, and use input from VACO programs to identify Planning Initiatives. The Planning Initiatives will be reviewed with the Networks and a compilation of CARES Planning Initiatives to be completed by the Networks will be established.

Following these planning steps, Networks will develop Planning Initiatives and Market Plans. This component of the Planning Process is discussed more completely in Chapter 5.

#### **Planning Process Responsibilities:**

The National CARES Program Office (NCPO) will complete the following required steps in the CARES planning process:

- Define the current and future veteran population base for each Network
- Define healthcare markets in collaboration with Networks
- Determine current and future demand based upon enrollment projections
- Evaluate current and future supply of capital assets to meet future demand
- Identify major gaps between supply and demand at the Network and Market levels to be addressed by Network Planning Initiatives
- Coordinate the identification of key planning issues by VA programs, DoD offices, and from Network Strategic Plans to be addressed by Network Planning Initiatives
- Identify planning initiatives that Networks must utilize in developing CARES market plans
- Identify major vacant space issues that should be addressed.
- Review and evaluate Network CARES Market Plans.

Networks will complete the following steps:

- Review data produced by the NCPO (enrollee projections, demand forecasts within market areas) and provide feedback or requests for approval of deviations;
- Conduct inventory of current healthcare supply and infrastructure and develop key data inputs for the NCPO (i.e. Strategic Plans, Capital Plans, Clinical Inventories, Space and Functional surveys – Highest and Best-Use surveys)
- Complete Planning initiatives by conducting Network, Market and as appropriate Sub-market detailed planning
- Develop and submit Network CARES Market Plans composed of Planning Initiatives that complete the NCPO identified Planning Initiatives (see Chapter 5)
- Complete cost analyses and cost template for each Planning Initiative, as well as at least one alternative solution considered; this includes estimated cost savings for each CARES Planning initiative (see Chapter 5)
- Address CARES planning criteria for each Planning Initiative (see Chapter 5) and at least one alternative solution considered.
- Develop implementation/realignment plans to implement the CARES Market Plan upon approval by the Secretary.

The CARES planning process is a continuous improvement process. It involves extensive interaction between the CARES Program Office and Networks; and the output from each of these planning steps may need to be reviewed, refined and revised based on information and insight gained from other steps in the process. To

the extent feasible, the NCPO will use National data sources to produce Network CARES planning data and to the extent feasible will provide an opportunity for review, validation and response by the Network.

#### **E. Resources:**

Although the process for Phase 2 is somewhat different than the Phase 1 Pilot, it may be helpful to review the Phase 1 process.

<http://www.va.gov/cares/page.cfm?pg=12>.

In addition, the Phase 2 CARES process mirrors aspects of the DOD's planning process in its more centralized approach to identifying Planning Initiatives and the use of an external CARES Commission.

<http://www.defenselink.mil/pubs/brac040298.pdf>.

#### **F. CARES Planning Process:**

##### **Step One - Define The Veteran Population Base For CARES:**

CARES planning is based on the enrolled veteran population. Current and projected enrollee data will be analyzed by county (and for selected urban areas by zip code), as well as by age group and priority level. The NCPO and Networks will identify significant trends in veteran population and enrolled veterans from demand projections provided by actuarial analysis.

The consulting firm Condor/Milliman USA projected the future enrolled population by county (this data will be updated by July 2002 to include Vet Pop 2001 and the 2001 enrollment base). These projections are based on the following assumptions:

- For a given geographic area, the rate at which non-enrolled veterans enroll will change by projection year, age group and priority, based on historical trends.
- Changes in the number of enrollees is dependent upon projected changes in the underlying veteran population (e.g. mortality, migration, etc.)
- Facility preferences and associated facility markets will remain stable.
- No new influx of enrollees will occur due to war, creation of new markets, or because of suppressed demand.

Adjustments to the enrollee projections may be needed if any of the Condor/Milliman USA assumptions are not valid for a local market area. Factors might include: recently activated VA facilities, new healthcare facilities proposed in CARES Market Plans, or major shifts in Medicare delivery system availability that would change the degree of reliance on VA. Networks must base proposed adjustments on solid evidence, using verifiable data sources and sound methodology that an independent review can substantiate. Data must provide evidence of a trend in a given direction; single and/or short-term variances will not be sufficient to require a rework of the projections. Networks must utilize commonly accepted planning, forecasting and finance methods, processes and formulas in proposing variances. Any adjustments

made to the baseline projections must be approved by the NCPO and integrated into forecasts by the consultant.

### **Steps:**

1. NCPO will produce for Network review and use:
  - Current and projected enrollees by county, age group, and priority level from data provided by Condor/Milliman USA. This data will initially come from the Enrollment Level Decision Analysis (ELDA) 02 and provide projections to 2010. The data will be updated in July 2002 for ELDA 03 to include zip code specific data for selected urban areas and to provide updated projections for 2012 to 2022.
  - Estimated veteran population by county (and zip code for urban areas) from the VetPop2001 data.
  
2. Networks will:
  - Review the data and validate that it provides a viable baseline for CARES planning OR will provide a request for modified data using verifiable data sources that can be substantiated by NCPO and external review (as described previously).

### **Expected Outcome:**

- Establish that the enrollee numbers used for the CARES planning process are the most accurate available.
- Establish that no known changes in the foreseeable future will invalidate the assumptions used in making enrollment projections.
- Establish that the enrollee numbers are representative of the veteran population likely to need VA services in the area

CARES data is available on the VSSC Web site at: <http://vssc.med.va.gov> under Reports – CARES. Baseline FY01 actual enrollment is available on the VHA OPP website. A link on the web site allows CARES data to be sent FTP to local workstations. In addition, upon request, the VSSC will mail CDs with CARES data.

### **Step Two - Define Markets and Sub-Markets To Be Served:**

The next step in the process, after defining the total enrollee population, is to define the Network markets in order to establish units for a gap analyses between supply and projected demand. The NCPO will utilize these markets as the basic planning unit in CARES. Networks will develop their CARES Market Plans from Planning Initiatives at the market level and, as appropriate, at the sub-market level. Each County (or zip code for selected urban areas) in the Network will be assigned to a Market and, if indicated, a sub-market.

A health care market is an aggregated geographic area having a sufficient population and geographic size to benefit from both the coordination and planning of health care services and to support a full healthcare delivery system through either V.A. facilities, DoD, or private sector community facilities (i.e. primary care, mental health care, inpatient care, tertiary care, if available, and long term care). Market boundaries might also be influenced by:

- State and county boundaries
- Geographic barriers (i.e. mountains, oceans, distance, etc)
- Distance/travel time to existing VA facilities

A market may contain distinct sub-markets useful for Network planning purposes. Sub-markets may reflect a clustering of the enrollee population within travel times for accessing care so that their needs can be provided for within the access guidelines. In addition, in large urban areas sub-markets are useful in identifying distinct access patterns within the area. Standard (acceptable) travel times for accessing care may vary based on community or regional standards (see Figure 2A).

The NCPO, after working with field staff and piloting a process has modified the classification of market areas and created a category of highly rural areas to accommodate primarily western states with large, low-population density areas where travel times, based upon community expectations may be longer. For these areas, the NCPO will accept some modifications based upon community standards primarily for highly rural areas. As a National guideline, the NCPO will utilize the access times defined during the CARES Phase 1 Pilot. The guidelines and areas as of this printing are not final.

**Figure 2A: Miles and Travel Time Guidelines  
By Population Density and Type of Care**

Type of Care	Urban	Rural	Highly Rural
Primary Care	30 minutes 6 miles	30 minutes 20 miles	60 minutes 60 miles
Specialty Ambulatory Care	60 minutes 12 miles	90 minutes 60 miles	120 minutes 120 miles
Extended Care	60 minutes 12 miles	90 minutes 60 miles	120 minutes 120 miles
Inpatient hospital care	60 minutes 12 miles	90 minutes 60 miles	120 minutes 120 miles
Tertiary hospital Care	3-4 hours if available	3-4 hours if available	Community Standard

In addition to specific travel times, sub-markets may also be based on considerations such as:

- Proximity to VAMC or other foci of inpatient care
- Historical veteran user preference
- Transportation systems and traffic patterns

- Natural features (i.e. lakes, mountains or large geographical areas)

**Steps:**

1. Based on current data availability, NCPO will produce population/enrollee density maps and supporting data for projection year 2010 for each Network, and depict market areas to be utilized for the analysis of demand and development of CARES market plans. (The list of maps provided is in Figure 2B)
2. NCPO will review and finalize its preliminary recommendations about markets in collaboration with Networks. This step will result in a detailed listing of counties and, as appropriate, zip codes that comprise separate markets within each Network.
3. NCPO will produce data on where enrollees by county currently access different levels of services, which will enable analysis of travel distances and access. (Figure 2D) This will also be provided in Step 4, Supply.
4. Networks will review the markets and maps and identify sub-markets as necessary.
5. Networks will classify counties within markets and sub-markets as Urban, Rural or Suburban and provide that information to the NCPO (see Figure 2C).
6. Networks will identify markets/sub-markets shared with other Networks. For these markets, Networks must collaborate and coordinate in the development of standard travel times, planning initiatives and capital asset plans.
7. Networks will produce a summary chart on Markets, in collaboration with NCPO (see Figure 2C and 2D)
8. Networks will review the standard travel distances/times for urban, suburban and rural areas within markets and sub markets and in cases where the national guidelines do not apply, will recommend modifications with sound justifications. The Center for Health Services Research and Policy at George Washington University web site provides information on travel standards for many states: <[http://www.gwu.edu/~chsrp/MANGA/Table3.8/Table3\\_8.htm](http://www.gwu.edu/~chsrp/MANGA/Table3.8/Table3_8.htm)>

*For each Market Area in which the NCPO identifies Planning Gaps, Networks must develop a comprehensive CARES Market Plan.*

**Expected Outcome:**

- Definition of each market and sub-market by specifying the counties or zip codes comprising the market and sub-market.
- Classification of each county/zip as urban, suburban or rural.

- Identification of each market/sub-market shared by more than one Network
- Calculation of % of enrollees within travel guidelines for primary care, secondary hospital care for the baseline and projection years.

**FIGURE 2B: List of NCPO Produced Maps**

- Map 1 Change in Veteran Population projections 2001-2010 by Network.
- Map 2 Market share projected by state 2001.
- Map 3 Network population projections by county for 2010.
- Map 4 Network projected enrollees by county for 2010.
- Map 5 Estimated market share by counties for 2001.
- Map 6 Network enrollee projections by county for 2010, with interstate highways.
- Map 7 Network projected population by county for 2010 (w/o VA facilities shown).
- Map 8 Access time boundaries for 2010 around VA enrollee projections using National inpatient care travel guidelines.
- Map 9. Access time boundaries around enrolled forecasted population using National primary care travel time guidelines.

Note: In July 2002, Condor Milliman USA will update all data with projections at the county and zip code levels for urbanized areas for 2012. The NCPO will revise maps with the updated data as appropriate.

**FIGURE 2C:** Projected Network Enrollees and Percentage Within Travel Time Guidelines By Counties and Markets

The NCPO will develop a chart similar to that provided below that depicts the % of projected enrollees that have access to VA healthcare facilities within Standard Travel Times/Distances. Networks will assist the NCPO in defining Counties as Urban, Rural or Suburban.

VISN	Markets	Counties or Zip Codes that comprise each market	Urban Rural, Highly Rural	Projected Enrollees	% Enrollees Within Travel Guidelines Primary Care	% Enrollees Within Travel Guidelines Specialty, Hospital and Extended Care	% Enrollees Within Travel Guidelines Inpatient Tertiary Care	If market or sub-market shared, indicate VISN #

*\*Note: VHA definitions for Urbanized Areas, Rural and Highly Rural are as follows:*

- (1) **Urbanized Areas:** The counties that are within the Census Bureau defined of Urbanized Areas or are outside an urbanized area and have a population density greater than 166 per square mile.
- (2) **Rural:** Counties that have a population density of less than 166 per square mile and are outside an urban area.
- (3) **Highly Rural:** A subset of the rural (low-density) population classification that is highly rural and is primarily in western states.

**FIGURE 2D: Current Facility Usage and Average Travel Distances  
By Market Areas**

The NCPO will develop a chart similar to that provided below that shows current VA facility usage by Market for specific service delivery categories; this will include the % of care that each facility provides to veterans from individual counties and the average distance traveled.

<b>COUNTY NAME</b>				
<b>INPATIENT CARE (FY 2001)</b>	<b>Facility Name</b>	<b>BDOC</b>	<b>% of total BDOC in Market provided by Facility</b>	<b>Average Distance from County to Facility</b>
Medicine	Facility A	12069	54%	22
	Contracted			
	Sum of All other not listed above	10409	46%	58
	<b>TOTAL</b>	<b>22,478</b>		
Surgery	Facility A	5528	57%	23
	Contracted			
	Sum of all other not listed above	4205	43%	60
	<b>TOTAL</b>	<b>9,733</b>		
Intermediate Care Beds	Facility B	1141	28%	151
	Facility C	577	14%	192
	Contracted			
	Sum of all other not listed above	2400	58%	200
<b>TOTAL</b>	<b>2,977</b>			
Psychiatry	Facility A	8950	50%	18
	Facility B	1362	8%	128
	Contracted			
	Sum of all other not listed above	7670	43%	110
<b>TOTAL</b>	<b>17,982</b>			
PRRTP	Facility A			
	Facility B			
	Contracted			
	Sum of all other not listed above			
	<b>TOTAL</b>			

**Step Three - Determine Demand For Healthcare Services:**

Understanding the demand for services is critical for conducting a gap analysis and creating Market Plans. Demand analysis requires an understanding of current and projected future utilization of healthcare services; it will be arrayed and analyzed by market/sub-market and treating facility.

Condor/Milliman USA based its projections of future utilization and demand for health care services on the enrolled population forecasts (adjusting for non enrollee users) rather than current users. The demand projections for services by the enrollees match veteran case mix and age with private sector use rates within each Network, and adjust demand for VA patient morbidity in comparison with the private sector patients, and VA patient use of the private sector health care services.

A Network-specific community management rating based upon local data adjusts the forecasted need for resources based upon an efficiency rating scale of 1) loosely managed, 2) moderately managed or 3) well managed, and assumptions regarding the VA's progress within these categories. The projections also include assumptions of increased utilization of outpatient services, and changes in the future enrollment mix, (i.e. increased category 7 enrollees with lower utilization of services).

If any assumption included in the projections is not valid for specific Network/Market/Sub-market, and may have a significant impact on the forecasted demand, Networks can request adjustments. Networks must base any adjustment requests on solid evidence and on a sound methodology that an outside review can substantiate. The National CARES Program Office must approve such requests in advance of Planning Initiative development (refer to Step 1: Define the Veteran Population Base for CARES).

Projected future utilization by priority and age group will be available by county or zip code (for urban areas) AND by treating facility. Condor/Milliman USA projections use categories of care that are similar to those in the private sector, with the exception of the non-medical benefits category, which was specifically created for VA. The VSSC converts their demand projections into bed days, beds and DSS clinic stops and aggregates them by combining the age and priority groups (Figures 3A and 3B).

**Figure 3A:** Demand Projections by Service and Unit of Measure

Milliman Service Category	Milliman Units of Measure	VA Translation	NCPO Grouping for Demand/Supply and GAP Analysis
Inpatient Acute <ul style="list-style-type: none"> <li>• Medicine</li> <li>• Surgery</li> <li>• Psychiatry</li> <li>• Substance Abuse</li> <li>• Maternity Deliverables</li> <li>• Maternity Non-Deliverables</li> </ul>	Admission Days	Beds	Inpatient Services <ul style="list-style-type: none"> <li>• Medicine</li> <li>• Surgery</li> <li>• Psychiatry</li> <li>• PR RTP</li> </ul>
Long Term Care <ul style="list-style-type: none"> <li>• Nursing Home</li> <li>• Long Term Psych</li> </ul>	Days	Beds	Long Term Care <ul style="list-style-type: none"> <li>• NHCU</li> <li>• Domiciliary</li> </ul>
Non-Medical Benefits <ul style="list-style-type: none"> <li>• Blind Rehab</li> <li>• Spinal Cord Injury</li> <li>• Psych &amp; PTSD Residential</li> <li>• Rehab</li> <li>• Substance Abuse</li> <li>• CWT/TR</li> <li>• Respite Care</li> <li>• Domiciliary</li> <li>• STAR I II III</li> </ul>	Bed Days of Care		Special Emphasis Programs (beds) <ul style="list-style-type: none"> <li>• Blind Rehab</li> <li>• SCI</li> </ul> Uniques (this data will reflect VA capacity requirements) <ul style="list-style-type: none"> <li>• Blind Rehab</li> <li>• SCI</li> <li>• PTSD</li> <li>• PTSD-SMI</li> <li>• Homeless</li> <li>• SMI</li> <li>• Sub Abuse</li> <li>• TBI</li> </ul>
Ambulatory Care <ul style="list-style-type: none"> <li>• Allergy Immune</li> <li>• Allergy Testing</li> <li>• Anesthesia</li> <li>• Cardiovascular</li> <li>• Consults</li> <li>• ER Visits</li> <li>• Glasses/Hearing Aids</li> <li>• Hearing/Speech</li> <li>• Immunizations</li> <li>• Inpatient Visits</li> <li>• Maternity Deliverables</li> <li>• Maternity Non-Deliverables</li> <li>• Misc. Medical</li> <li>• Office/Home Visits</li> <li>• Outpatient Psych</li> <li>• Outpatient Sub Abuse</li> <li>• Pathology</li> <li>• Physical Exams</li> <li>• Physical Medicine</li> <li>• Radiology</li> <li>• Surgery</li> <li>• Sterilizations</li> <li>• Therapeutic Injections</li> <li>• Urgent Care</li> <li>• Vision Exams</li> </ul>	CPT Procedures, Exams or Visits	DSS Clinic Stops	Ambulatory Care <ul style="list-style-type: none"> <li>• Primary Care</li> <li>• Specialty Care</li> <li>• Mental Health</li> <li>• Geriatrics</li> <li>• Ancillary</li> <li>• Diagnostics</li> <li>• Other</li> </ul>
Other <ul style="list-style-type: none"> <li>• Prescription Drugs</li> <li>• PDN/Home Health</li> <li>• Ambulance</li> <li>• Durable Medical Equipment</li> <li>• Prosthetics</li> </ul>	Scripts/Units/Services		

Figure 3B: Costing Map

Milliman Service Category	Milliman Work Units	VA Units	VA Demand/Costing Units	VA Space Driver Units
<b>INPATIENT ACUTE HOSPITAL</b>				
Medical	Admits/Days	Beds	Medicine Beds	Medicine Beds
Surgical	Admits/Days	Beds	Surgery Beds	Surgery Beds
Psychiatric	Admits/Days	Beds	Psychiatry Beds	Psychiatry Beds
Substance Abuse	Admits/Days	Beds	Psychiatry Beds	Psychiatry Beds
Maternity Deliveries	Admits/Days			
Maternity Non-Deliveries	Admits/Days			
<b>LONG-TERM CARE</b>				
HI SNF/ECF	Days	Beds	Intermediate Med Beds	Intermediate Med Beds
Nursing Home	Days	Beds	Nur Home Beds	Nur Home Beds
Non-Acute Psychiatric	Days	Beds	Psychiatry Beds	Psychiatry Beds
<b>NON-MEDICAL BENEFITS (Inpatient)</b>				
Blind Rehab	Days	Beds	Blind Rehab Beds	Blind Rehab Beds
Spinal Cord Injury	Days	Beds	SCI Beds	SCI Beds
Psych & PTSD Res Rehab Pgm	Days	Beds	PRRTP Beds	PRRTP Beds
Substance Abuse Res Rehab	Days	Beds	PRRTP Beds	PRRTP Beds
CWT/TR	Days	Beds		
Respite Care	Days	Beds		
Domiciliary STAR I II III (sustained treatment and rehab for psych & subabu)	Days	Beds	Dom Beds	Dom Beds
			Psychiatry Beds	Psychiatry Beds
<b>AMBULATORY</b>				
Allergy Immunotherapy	proced	DSS Clinic		Adult Day Care
Allergy Testing	proced	Stops		Audiology
Anesthesia	proced	DSS Clinic		Primary Care
Cardiovascular	proced	Stops		Specialty Care
Consults	consults	DSS Clinic		Urgent Care
Emergency Room Visits	visits	Stops		Cardiology
Glasses/Hearing Aids	visits	DSS Clinic		Chaplain Service
Hearing/Speech Exams	exams	Stops		Day Treatment Cnt
Immunizations	proced	DSS Clinic		Dental
Inpatient Visits		Stops		Dialysis
Maternity Deliveries	visits	DSS Clinic		Digestive/GI/Endoscopy
Maternity Non-Deliveries	visits	Stops	Primary Care	Eye Clinic
Misc. Medical	proced	DSS Clinic	Specialty Care	EEG/Neurology

		Stops		
Office/Home Visits	visits	DSS Clinic	Mental Health	Geriatrics
		Stops		
Outpatient Psychiatric	visits	DSS Clinic	Geriatrics	Home Based Prim Care
		Stops		
Outpatient Alcohol & Drug	visits	DSS Clinic	Ancillary/Dx	Mental Health
		Stops		
Pathology	proced	DSS Clinic	Other	Nuclear Medicine
		Stops		
Physical Exams	exams	DSS Clinic		Pathology
		Stops		
Physical Medicine	visits	DSS Clinic		Pharmacy
		Stops		
Radiology	proced	DSS Clinic		Psychology
		Stops		
Surgery	proced	DSS Clinic		Pulmonary/Resp
		Stops		
Sterilizations	proced	DSS Clinic		Radiation Therapy
		Stops		
Therapeutic Injections	proced	DSS Clinic		Radiology
		Stops		
Urgent Care Visits	visits	DSS Clinic		Recreational Therapy
		Stops		
Vision Exams	exams	DSS Clinic		Rehab Medicint
		Stops		Social Work
				Substance Abuse

**OTHER**

Prescription Drugs	scripts	unchanged
PDN/Home Health	units	unchanged
Ambulance	units	unchanged
Durable Medical Equipment	units	unchanged
Prosthetics	units	unchanged

Milliman did not model special disability programs. The health care services provided by special disability programs are currently included in the Milliman demand projections and are not separated out. A portion of the bed related services for some of the programs are included in the non-medical demand projections, but many of the other services demanded by these special disability groups cannot be isolated out from the Milliman demand data. For the two Special Disability programs that have specific bed types associated with them, specifically Spinal Cord Injury and Blind Rehab, it is possible for the CARES process to track these bed levels.

The utilization projections are the starting point for analyzing demand. For Special Disability programs, where VA is mandated to maintain specific capacity (defined differently by program), the mandated levels will be substituted as needed for the projections, to ensure that Networks are in compliance with the laws (i.e. 1996 BDOC or bed levels). Forecasted results will be available as well for some special disability services, but mandated capacity will be the minimum level required.

NCPO will analyze demand in outpatient, inpatient, long-term care and special disability programs, noting trends over time and identifying years when changes in demand occur (Figure 3C). As appropriate, Network evaluation of demand by sub-

market and/or specific service/service line will facilitate viable Planning Initiative completion and Capital Realignment Plans.

In addition to analyzing demand for services, demand for space will be forecasted utilizing the VA space driver. Networks/facilities will develop the initial Space Driver data, with support from the VISN Support Service Center. The Condor/Milliman treating facility projections data will be utilized as a starting point for future space projections.

**Steps:**

1. The NCPO will analyze demand by market, utilizing projected enrollees by County (zip code for urban areas) translated into VA workload units and summarized by standardized planning workload categories. (See Figure 3C below)

**Figure 3C: NCPO Analysis of Future Demand for Service**

COUNTY NAME:						
INPATIENT CARE (FY 2001)	Facility Name	BDOC in FY 2001	BDOC in FY 2002	BDOC in FY 2005	BDOC in FY 2006	Future Years.....
Medicine	Facility A					
	Contracted					
	Sum of all facilities not listed above					
	<b>TOTAL</b>					
Surgery	Facility A					
	Contracted					
	Sum of all facilities not listed above					
	<b>TOTAL</b>					
Intermediate Care Beds	Facility B					
	Facility C					
	Contracted					
	Sum of all facilities not listed above					
<b>TOTAL</b>						
Psychiatry	Facility A					
	Facility B					
	Contracted					
	Sum of all facilities not listed above					
	<b>TOTAL</b>					

- The NCPO will analyze demand by Facility, utilizing projections from Milliman. (Figure 3D)

**Figure 3D: NCPO Analyses by Milliman Projections**

INPATIENT CARE (FY 2012)	Operating		Target	
	Bed	ADC	Occupancy Rate	BDOC
Medicin			85%	
Surger			85%	
Intermediate Care			95%	
Psychiatr			85%	
PRRT			85%	
Long Term			95%	
Domiciliary			95%	
Spinal Cord			85%	
Blind			85%	

OUTPATIENT CARE (FY 2012)	Total		%	
	Clinic Stops	Stops	to be fee- based	Fee Visits
Primary				
Specialty				
Mental				
Geriatric				
Ancillary and				
All				
Tota				

- The NCPO will analyze demand by Network for Special Disability Programs at the Network level. (Figure 3E)

**Figure 3E: Demand for Special Disability Programs**

SPECIAL DISABILITY PROGRAMS	Uniques				
	in 2001	in 2002	in 2004	in 2005	Future Years....
Blind Rehabilitation					
Spinal Cord Injury					
Substance Abuse					
Traumatic Brain Injury					
Homeless					
Seriously Mentally Ill					
Post Traumatic Stress Disorder					

- Networks/facilities will develop future space requirements utilizing Condor/Milliman treating facility data. (Figure 3F-on the following page)

**Figure 3F: Demand for Space in Gross Square Feet (DGSF)**

<b>INPATIENT CARE (FY 2012)</b>	<b>DGSF in 2012</b>	<b>DGSF in 2022</b>
Medicine		
Surgery		
Intermediate Care Beds		
Psychiatry		
PRRTP		
Nursing Home Care		
Domiciliary program		
Spinal Cord Injury		
Blind Rehab		
<b>OUTPATIENT CARE (FY 2012)</b>	<b>DGSF in 2012</b>	<b>DGSF in 2022</b>
Primary Care		
Specialty Care		
Mental Health		
Geriatrics		
Ancillary and Diagnostics		
All Other		
Total		
<b>NON-CLINICAL</b>	<b>DGSF in 2012</b>	<b>DGSF in 2022</b>
Research		
Other Administrative		
Vacant Space		

5. Networks will analyze demand by market and sub-market as appropriate, and will provide the NCPO with input regarding unique considerations that need to be factored into the demand analysis.

**Expected Outcomes:**

- Quantification of future demand for services for each market and sub-market using the standardized planning workload categories described above.
- Quantification of future demand for space for each facility using the VA Space Driver.

**Resources:**

Detailed information on the Milliman USA projections is available on the Office of Policy and Planning web site at: <http://vaww.va.gov/vhaopp/default.htm>.

Information on the VA Space Driver is available as an attachment to Step 4 of this Chapter of the CARES Guidebook.

**FIGURE 3G: VA Translations of Milliman Projections**

1. Bed Days of Care will be translated into operating Beds by utilizing the following formula:

BDOC Formula	
Total BDOC/365=ADC	
ADC/Occupancy Rate = Beds	
Occupancy Rates: NHCU = 95%	
Domiciliary = 95%	
Acute Inpatient = 85%	
RRPT = 95%	

2. Milliman Outpatient Workload will be converted to DSS Stops utilizing the following methodology:

Breakout categories are 4 age groups (under 45, 45-64, 65-85, and 85+) and 2 priority groups (1-6; 7).

- a. Using FY 01 ambulatory care patient data, map every CPT code to the Milliman Ambulatory Care Category.
- b. For every Milliman Category,
  - 1) compute the number of CPT codes that occurred at every DSS clinic stop for each of the breakout categories.
  - 2) compute the number of clinic stops that occurred at every DSS clinic stop for each of the breakout categories.
  - 3) compute the ratio of clinic stops to CPT codes that occurred for every DSS clinic stop for each breakout category.

	Ratio of CPT codes to DSS Stops	Milliman Category					
	Age Grp 1	Age Grp 1	Age Grp 2	Age Grp 2	Age Grp 3	Age Grp 3	
DSS Clinic Stop	Prior 1-6	Prior 7	Prior 1-6	Prior 7	Prior 1-6	Prior 7	Office Visits
ALLERGY IMMUNOLOGY	4.00%	3.00%	30.00%	59.00%	30.00%	17.00%	
CARDIOLOGY	2.00%	30.00%	1.00%	3.00%	30.00%	30.00%	
DERMATOLOGY	2.00%	3.00%	40.00%	30.00%	34.00%	23.00%	
ENDO METAB (EXCEPT DIABETES)	34.00%	5.00%	23.00%	23.00%	34.00%	7.00%	
DIABETES	23.00%	34.00%	10.00%	15.00%	20.00%	2.00%	
GASTROENTEROLOGY	23.00%	23.00%	34.00%	7.00%	33.00%	8.00%	

- c. Convert the Number of CPT\* codes in step 2a above to a percentage of the total CPT codes in the Milliman category for each breakout category, for each DSS clinic stop.

**FIGURE 3G cont'd**

- d. Apply the percentage in step 3 to the future Milliman projected procedures/visits/exams to compute the future expected number of CPT codes for each DSS clinic stop.
- e. Apply the ratio of CPT codes to clinic stop to each cell in order to compute the expected future number of clinic stops.

	% CPT Codes	Milliman Category					
	Age Grp 1	Age Grp 1	Age Grp 2	Age Grp 2	Age Grp 3	Age Grp 3	
DSS Clinic Stop	Prior 1-6	Prior 7	Prior 1-6	Prior 7	Prior 1-6	Prior 7	Office Visits
ALLERGY IMMUNOLOGY	3.00%	15.00%	20.00%	40.00%	30.00%	17.00%	2,000
CARDIOLOGY	2.00%	30.00%	1.00%	3.00%	30.00%	30.00%	30,000
DERMATOLOGY	2.00%	3.00%	40.00%	30.00%	34.00%	23.00%	5,000
ENDO METAB (EXCEPT DIABETES)	23.00%	5.00%	23.00%	23.00%	26.00%	7.00%	10,000
DIABETES	23.00%	34.00%	10.00%	30.00%	20.00%	2.00%	30,000
GASTROENTEROLOGY	23.00%	23.00%	5.00%	7.00%	33.00%	8.00%	20,000
							50,000

\* Note: assumption made that 1 CPT code is equivalent to 1 Milliman procedure/exam/visit. See figure 3H on following pages.

**FIGURE 3H: NCPO Mapping Of DSS Stop Codes For Demand Analysis**

Category	Stop	Stop Name
Ancillary/Diagnostic	105	X-RAY
	108	LABORATORY
	109	NUCLEAR MEDICINE
	110	CARD/VAS NUC MED
	111	ONCOLOGY NUC MED
	112	INF DIS NUC MED
	113	RADIONUCLIDE TMT
	114	SING PH EM TOMOG
	115	ULTRASOUND
	125	SOCIAL WORK SVC
	127	TOPO BRAIN MAP
	132	MAMMOGRAM
	134	PAP TEST
	144	RADIONUC THERAPY
	146	PET
	149	RAD THERAPY TRMT
	150	COMPUT TOMOGRA (CT)
	151	MAG RES IMAG (MRI)
	152	ANGIOGR CATHETERIZ
	153	INTERVEN RADIOGRAPH
	154	MEG-MAGNETOENCEPHALOGRAPHY
	160	CLINICAL PHARM
	161	SPECIAL DSS PHARMACY USE
	163	CHAPLAIN-CLIN SVC IND
	164	CHAPLAIN-CLIN SVC GRP
	165	BEREAVE. COUNSEL
	166	CHAPLAIN-IND
	167	CHAPLAIN-GROUP
	168	CHAPLAIN COLLATERAL
	201	PM & RS
	202	REC THERAPY SERVICES
	205	PHYSICAL THERAPY
	206	OCCUPATION THPY
	207	PM & RS INCENTIVE
	208	PM & RS COMP WORK
	209	VISIT COORD.
	211	POST-AMPUTATION
	212	EMG
	213	PM & RS VOC ASSIST
	214	KINESIOTHERAPY
	703	MAMMOGRAM
	704	PAP TEST
	902	CAT SCAN

	903	RADIATION THPY
	907	NUCLEAR MRI
Geriatrics	121	RESID CARE-NON MH
	170	HBPC PHYSICIAN
	171	HBPC-RN/RNP/PA
	172	HBPC-NURSE EXTEND
	173	HBPC-SOCIAL WORK
	174	HBPC-THERAPIST
	175	HBPC DIETICIAN
	176	HBPC-CLIN PHARMACY
	177	HBPC-OTHER
	190	ADULT DAY HEALTH
	318	GERIATRIC CLINIC
	319	GERIAT EVAL/MGT (GEM)
	320	ALZH/DEMEN/CLIN
Mental Health	502	MENTAL HEALTH-IND
	505	DAY TRMT-IND
	506	DAY HOSPITAL-IND
	507	DRUG DEPEND-IND
	508	ALCOHOL TRMT-IND
	509	PSYCHIATRY-IND
	510	PSYCHOLOGY-IND
	511	NEUROBEHAV-IND
	512	PSYCHIATRY CONS
	513	SUBST ABUSE-IND
	514	SUBST ABUSE-HOME
	515	CWT/TR-HCMI
	516	PTSD GROUP
	517	CWT/SUB ABUSE
	518	CWT/TR SUB ABUSE
	519	SUBST/PTSD TEAMS
	520	LT ENHANCE INDIV
	521	LT ENHANCE GROUP
	523	OPIOID SUBSTITUTION
	524	ACT DUTY SEX TRAUMA
	525	WOM STRESS TREAT
	529	HCHV/HMI
	531	MH PRIM CARE TEAM-IND
	532	PSYC/SOC REHAB-IND
	533	MH INV BIOMED CARE-IND
	535	MH VOCAT ASSIST
	538	PSYCHOLOGICAL TESTING
	540	PTSD CL TEAM-PCT
	541	PTSD CLINIC
	547	INTEN SUBS ABUSE TRT
	548	SUB ABUSE DAY HOSP

	550	MENTAL HYG-GRP
	551	IPCC COMM CL/DAY
	552	MENT HLT INT (MHICM)
	553	DAY TRMT-GRP
	554	DAY HOSPITAL-GRP
	555	DRUG DEPEND-GRP
	556	ALCOHOL TRMT-GRP
	557	PSYCHIATRY-MD GROUP
	558	PSYCHOLOGY-GROUP
	559	PSY/SOC REHAB-GRP
	560	SUBST ABUSE-GRP
	561	PCT PTSD-GRP
	562	PTSD-INDIVIDUAL
	563	MH PRIM CARE TEAM-GRP
	564	MH TEAM CASE MGT
	565	MH MED CARE ONLY-GRP
	566	MH RISK FAC RED EDU GRP
	571	READJ COUNSEL-IND
	572	READJ COUNSEL-GRP
	573	MH INCEN THER-GRP
	574	MH COMP WK THER-GRP
	575	MH VOCAT ASSIST-GRP
	576	PSYCHOGERIA CLIN/INDV
	577	PSYCHOGERIA CLIN/GRP
	578	PSYCHOGERIA DAY PGM
	580	PTSD DAY HOSP
	581	PTSD DAY TREAT
	589	N.A. DUTY SEX TRAUMA
	713	GAMBLING ADDICTION (2ND ONLY)
	730	DOM GENERAL CARE
	731	PRRTP GENERAL CARE
Other	103	TELEPHONE TRIAGE
	118	HOME TRTMT SVCS
	119	CNH FOLLOW-UP
	145	PHARMAC PHYSIOL
	147	PHONE/ANCILLARY
	148	PHONE/DIAGNOSTIC
	155	INFO ASSISTS TECHNOLOGY
	169	TELEPHONE/CHAPLAIN
	178	TELEPHONE/HBHC
	179	TELE HOME CARE
	181	TELEPHONE/DENTAL
	215	SCI HOME PROGRAM
	216	PHONE REHAB SUPP
	290	OBSERVATION MEDICINE
	291	OBSERVATION SURGERY
	292	OBSERV PSYCHIATRY

	293	OBSERVATION NEUROLOGY
	294	OBSERV BLIND REHAB
	295	OBSERV SPINAL CORD
	296	OBSERV REHABILITATION
	324	PHONE MEDICINE
	325	PHONE NEUROLOGY
	326	PHONE GERIATRICS
	331	PRE-BED M.D.- MED
	332	PRE-BED R.N.- MED
	351	ADV ILL COORD (AICC)
	370	LTC SCREENING (2ND ONLY)
	424	PHONE SURGERY
	425	TELE/PROSTH/ORTH
	428	TELEPHONE OPTOMETRY
	451	451-LOCAL CREDIT PAIR
	452	452-LOCAL CREDIT PAIR
	453	453-LOCAL CREDIT PAIR
	454	SPECIAL REGISTRY 5
	455	455-LOCAL CREDIT PAIR
	456	SPECIAL REGISTRY 6
	458	SPECIAL REGISTRY 7
	459	SPECIAL REGISTRY 8
	460	460-LOCAL CREDIT PAIR
	461	SPECIAL REGISTRY 1
	462	462-LOCAL CREDIT PAIR
	463	463-LOCAL CREDIT PAIR
	464	464-LOCAL CREDIT PAIR
	465	465-LOCAL CREDIT PAIR
	466	466-LOCAL CREDIT PAIR
	467	467-LOCAL CREDIT PAIR
	468	468-LOCAL CREDIT PAIR
	469	SPECIAL REGISTRY 2
	470	SPECIAL REGISTRY 3
	471	471-LOCAL CREDIT PAIR
	472	472-LOCAL CREDIT PAIR
	473	473-LOCAL CREDIT PAIR
	474	RESEARCH
	475	475-LOCAL CREDIT PAIR
	476	476-LOCAL CREDIT PAIR
	477	477-LOCAL CREDIT PAIR
	478	478-LOCAL CREDIT PAIR
	479	SPECIAL REGISTRY 4
	480	480-LOCAL CREDIT PAIR
	481	481-LOCAL CREDIT PAIR
	482	482-LOCAL CREDIT PAIR
	483	483-LOCAL CREDIT PAIR
	484	484-LOCAL CREDIT PAIR
	485	485-LOCAL CREDIT PAIR

	501	HMI OUTRCH.
	503	MEN HLTH RESID CARE
	504	PCC MED CENTER VISIT
	522	HUD-VASH
	526	TELE SPEC PSYCH
	527	PHONE GENERAL PSYCH
	528	PHONE/HMLESS MENT ILL
	530	TELEPHONE/HUD-VASH
	536	TELE/MH VOC ASSIST
	537	TELE PSYC/SOC REHAB
	542	TELEPHONE PTSD
	543	TELE ALCOHOL DEPEND
	544	TELE DRUG DEPENDENCE
	545	TELE SUBSTANCE ABUSE
	546	TELEPHONE/MHICM
	579	TEL/PSYCHOGERIATRICS
	590	COMM OUTR HMLS-STAFF
	604	HOME H-DIAL TRNG
	608	HOME P-DIAL TRNG
	609	HOME H-DIAL TRMT
	610	CONTRACT DIALYSIS
	611	TELEPHONE DIALYSIS
	650	CONTRACT NH DAYS
	651	STATE NH DAYS
	652	STATE DOM DAYS
	653	STATE HOSP CARE
	654	RESIDENTIAL NON-VA CARE
	655	COMMUNITY NON-VA CARE
	656	DOD NON-VA CARE
	657	ASSIST LIVING VENDOR WORK
	670	ASSIST LIVING VHA-PAID STAFF
	680	HOME/COMM ASSESS
	681	VA-PD HOME/COMM HC
	682	VA-REF HOME/COMM CARE
	725	DOM OUTREACH SERVICE
	726	DOM AFTERCARE COMMUN
	727	DOM AFTERCARE-VA
	728	DOM ADMIT/SCREEN SVC
	729	TELEPHONE/DOMICILIARY
	801	IN-VISN OTHER VAMC 2-103
	802	OUT OF VISN VA 2-103
	803	COMMERCIAL 2-103 PHNE TRIAGE
	905	AMB SURGERY SVCS
	906	BLOOD/B.P. TRANS
Primary Care	101	EMERGENCY UNIT
	102	ADMIT/SCREENING
	117	NURSING

	120	HEALTH SCREENING
	122	PUB HEALTH NURS
	123	NUTR/DIET - IND
	124	NUTR/DIET - GRP
	129	HYPERTENSION SCR
	130	CHOLESTEROL SCR
	131	BREAST CANCR SCR
	133	CERV CANCER SCR
	135	COLORECTAL SCR
	136	FOBT-GUAIAC SCR
	137	ALCOHOL COUNSEL
	138	SMOKING CESS.
	139	WEIGHT CONTROL
	140	PHYS.FIT/EXER.
	141	VET IMMUNIZATION
	142	COLORECTAL EXAM
	143	PER.GULF COUNSEL
	301	GENERAL INT MED
	309	HYPERTENSION
	322	WOMENS CLINIC
	323	PRIM CARE/MED
	350	GERIATRIC PRIM CARE
	450	C & P EXAMS
	690	TELEMEDICINE
	701	HYPERTEN SCREEN
	702	CHOLESTER SCREEN
	705	FOBT-GUAIAC SCR
	706	ALCOHOL SCREEN
	707	SMOKING CESSATION
	708	NUTRITION
	709	PHYS FIT/EXER CS
	710	INFLUENZA IMMUNIZ
	711	INJ CS/SEAT BELT
	712	HEP C REGISTRY PAT
	999	EMPLOYEE HEALTH
Specialty Care	104	PULMONARY FUNCT
	106	EEG
	107	EKG
	116	RESPIRATORY THERAPY
	126	EVOKE POTENTIAL
	128	PROL VIDEO - EEG
	180	DENTAL
	203	AUDIOLOGY
	204	SPEECH PATHOLOGY
	210	SCI
	217	BROS-BLIND REHAB SPEC
	218	CAT BLIND REHAB

	302	ALLERGY IMMUNOL
	303	CARDIOLOGY
	304	DERMATOLOGY
	305	ENDOCR/METAB
	306	DIABETES
	307	GASTROENTEROLOGY
	308	HEMATOLOGY
	310	INFECTIOUS DIS
	311	PACEMAKER
	312	PULMONARY/CHEST
	313	RENAL/NEPHROL
	314	RHEUM/ARTHRITIS
	315	NEUROLOGY
	316	ONCOLOGY/TUMOR
	317	COUMADIN CLINIC
	321	GI ENDOSCOPY
	327	INVASIVE O.R. PROC
	328	MED/SURG DAY MSDU
	329	MEDICAL PROC UNIT
	330	CHEMO UNIT-MED
	333	CARDIAC CATH
	334	CARDIAC STRESS TEST
	401	GENERAL SURGERY
	402	CARDIAC SURGERY
	403	ENT
	404	GYNECOLOGY
	405	HAND SURGERY
	406	NEUROSURGERY
	407	OPHTHALMOLOGY
	408	OPTOMETRY
	409	ORTHOPEDICS
	410	PLASTIC SURGERY
	411	PODIATRY
	412	PROCTOLOGY
	413	THORACIC SURGERY
	414	UROLOGY
	415	VASCULAR SURGERY
	416	AMB SURG EVAL(NON-MD)
	417	PROSTH/ORTHOTICS
	418	AMPUTATION CLIN
	419	ANES PRE/POST-OP CONS
	420	PAIN CLINIC
	421	VASCULAR LAB
	422	CAST CLINIC
	423	PROSTHETICS SVCS
	426	WOMEN SURGERY
	427	PRIM CARE/SURG
	429	OUTPAT CARE IN O.R.

	430	CYSTO ROOM UNIT
	431	CHEMO UNIT-SURG
	432	PRE-BED MD-SURG
	433	PRE-BED RN-SURG
	435	SURGICAL PROC UNIT
	457	TRANSPLANT
	601	ACUTE H-DIAL TMT
	602	CHRON AST H-DIAL
	603	LIM SELF H-DIAL
	605	ACUTE P-DIAL TMT
	606	CHRON AST P-DIAL
	607	LIM SELF P-DIAL
	904	CHEMOTHERAPY

**FIGURES 3I:** Analysis of Future Demand for Service

Following are examples of the type of data that will be produced utilizing demand data.

The tables below will show the enrollee projections and unique patients for **each** year from FY 2001 (actual) through 2022 for

Enrollee Projections and Variations By Year From 2012 Projection											
State	Market	Baseline 2001	Variance from 2012 (+/-)	Projected 2002	Variance from 2012 (+/-)	Projected 2003	Variance from 2012 (+/-)	Projected 2004...	Variance from 2012 (+/-)	Projected ...2012	Variance from 2012 (+/-)
	Market A										
	Market B										
	Etc										

each Market. The projections and the variances from FY 2001 are shown for the year 2012, although projections will be shown out to 2022.

The table below shows projected demand by Service Categories by Market/County and projected change by year.

Unique Patient Projections and Variations By Year From 2012 Projection											
State	Market	Baseline 2001	Variance from 2012 (+/-)	Projected 2002	Variance from 2012 (+/-)	Projected 2003	Variance from 2012 (+/-)	Projected 2004...	Variance from 2012 (+/-)	Projected ...2012	Variance from 2012 (+/-)
	Market A										
	Market B										
	Etc										

**Step Four - Determine Supply For Healthcare Services:**

To effectively evaluate the ability of existing capital assets to meet future demand, VHA must first conduct a comprehensive inventory of current services and an evaluation of existing infrastructure. Each VA facility will develop its clinical inventory and infrastructure assessment, including care provided through contract and sharing arrangements, as appropriate.

The NCPO will evaluate the following major components of supply for health care services:

- Inventory of Current VA Services & Summary of Operations
- Assessment of Physical Infrastructure
- Other data as specified

**A. Inventory of Current VA Services & Summary of Operations**

Workload data used to inventory supply will be based on the last completed fiscal year and will include measures similar to those used when evaluating demand (i.e. beds; bed days of care, DSS clinic stops) to facilitate the Gap Analysis. The source of this data may be the VISN, although most workload data is in National Databases (Bed Control, DSS, etc).

1. Inventory of current services will include the following:
  - a. A listing of all VA facilities and unique patients served
  - b. Acute inpatient services by bed type (e.g. medicine, surgery, psychiatry) including operating beds, Average Daily Census (ADC), occupancy rate, Bed Days of Care (BDOC), and current costs per BDOC. This will be provided by Facility (in-house and Fee Care), and by Market (county level) (See Figure 4A)
  - c. Ambulatory Care Services and costs by site and DSS stop codes summarized by Primary Care, Specialty Care, Mental Health, Geriatrics, Ancillary Services and Other. This will be provided by Facility, (In-house and Fee Care) and by Market (County level)
  - d. Long Term Care Services by site, including Nursing Home and Domiciliary, as well as current gaps in meeting Millennium Bill capacity requirements by Network
  - e. Special Disability Programs by site including unique patients treated and beds, as well as gaps in meeting Millennium Bill capacity requirements by Network
  - f. Facility Clinical Inventory of clinical programs and how services are provided. (See figure 4E for Clinical Inventory Template)

2. Summary of Operations. This will provide descriptive statistics that will assist in understanding the scope of operations at current facilities.
  - a. Affiliations, including summary of VA Approved and Funded resident FTE
  - b. Research, including summary of VA and non-VA research funds
  - c. Employment profile, including staffing by facility
  - d. Current cost per unit of care

(See figure 4A for details of data to support the inventory of VA services and operations)

## **B. Assessment of Physical Infrastructure**

This will include analysis of existing infrastructure, both owned and leased, and key impact areas that will need consideration in development of Capital Asset Plans.

1. Facility Condition Assessment (FCA)
2. Space and functional (S&F) survey including VA owned and leased property, non-VA tenants, sq ft, and vacant space. (See figure 4C for FCA and S&F requirements)
3. Capital Investment Plan CIP: Approved Major construction projects and Minor projects from the latest Operating Plan, as well as CIP projects from the Network Strategic Plan.
4. Highest and best alternative use report, for those markets identified for high potential for Enhanced Use (when available). Valuation of facilities report (when available).

Note for users: VA Headquarters has embarked on an initiative to perform site valuations in support of the CARES program. This initiative also includes identification of sites that have high potential for Enhanced-Use Lease (EUL) success and for providing significant economic and mission benefits to the Department. A consultant has been engaged to identify high potential EUL opportunities, to develop a CARES valuation methodology and to apply to this methodology to VA's portfolio of approximately top 50 sites. It will likely be expanded to all 180 sites if required by VHA.

The CARES valuation initiative is to be accomplished in two phases. The first phase includes developing an acceptable valuation methodology and testing this methodology on two VA sites. The test sites selected by VHA are the two and three division medical centers located in Cleveland, OH (Brecksville and Wade Park) and Pittsburgh, PA (Highland Drive, University Drive and Aspinwall).

(See figure 4B for data to support the inventory of VA physical infrastructure)

### C. Other

An analysis of supply will also include other data that will help assess the current environment. This will include Network Strategic Plans, DoD services, major sharing activities and other significant data identified by Networks

#### Steps:

1. NCPO will analyze supply by facility utilizing the following data from National and Network data sources as a baseline.
  - a. National Data Sources: This data is available from National databases or the NCPO. CARES baseline workload and cost data will be available to Networks via the VSSC web site at <http://vssc.med.va.gov>:
    - Inpatient, Outpatient, Long Term Care and Special Disability workload by facility
    - Network % of goal in meeting Special Disabilities capacity requirements
    - Employee and Resident FTE by facility
    - Research funds by facility
    - Cost per unit of care using DSS costs
    - Minor and NRM operating plans
    - List of DoD healthcare facilities in each Market
    - Contract Hospital and NHC workload and fee outpatient workload
    - List of VA tertiary care hospitals
  - b. Network Data Sources: Networks have developed or will develop this data as part of the CARES planning process.
    - Space and Functional Survey results
    - Facility Condition Assessment results
    - Facility Clinical Inventories
    - Network Strategic Plans and Capital Investment Plans
    - Other information that the Network considers important for an understanding of current healthcare supply. (In Figure 4D are templates that may be useful for gathering other information needed for development of Market Plans, such as phone survey templates, etc)
    - Networks are encouraged to contact their State Health Department or State Health Planning Agency or local planning agencies to get data on the expected future market availability of acute inpatient care services, long term care services and alternatives to institutional care. This will complement the current availability determined from surveys and contacts.
    - Specific DoD services available in market areas.

2. Networks will submit Supply Data to the NCPO (i.e. Space and Functional Survey results, facility clinical inventories). Networks will also inform the NCPO about unique considerations that need to be factored into the NCPO supply analysis. In addition, as Networks develop their CARES Market Plans, they will develop additional supportive information on supply including (as appropriate): Enhanced Use initiatives, Best use alternatives, VA/DoD sharing, DoD capacity, community capacity. Attachment to 4D of this guide contains sample templates for collecting and displaying community data.

**Expected Outcomes:**

- Profile of each facility, including workload, special disabilities programs, affiliations, scope of research programs, employment, and costs per unit of care.
- Facility specific clinical inventories
- Detailed information on facility infrastructure
- Descriptive summary of functionality of existing space, including estimates of vacant or underutilized space, seismic issues, proximity and efficiency issues.
- Identification of Enhanced Use leasing activities.

**FIGURE 4A: Supply Data Charts**

The following are examples of data that will be produced from national data sources for each site of care/facility

INPATIENT CARE (FY 2001)	Operating Beds	ADC	Occupancy Rate	BDOC	Cost / BDOC	Contract BDOC	Contract Cost / BDOC
Medicine							
Surgery							
Inermediate Care Beds							
Psychiatry							
PRRTP							
Nursing Home Care							
Domiciliary Program							
Spinal Cord Injury							
Blind Rehab							

OUTPATIENT CARE (FY 2001)	Clinic Stop	DSS Cost / Clinin Stop	Fee Units	DSS Cost / Fee Unit
Primary Care				
Specialty Care				
Mental Health				
Geriatrics				
Ancillary and Diagnostics				
All Other				
Total				

SPECIAL DISABILITY PROGRAMS (FY 2001)	Uniques	Cost / Uniques
Blind Rehabilitation		
Spinal Cord Injury		
Substance Abuse		
Traumatic Brain Injury		
Homeless		
Seriously mentally Ill		
Post Traumatic Stress Disorder		

**FIGURE 4A: Supply Data Charts**

Research Funding	VA Funded \$	Non-VA Funded \$	Total \$
Facility A			
Facility B			
Facility C			

Staffing	Total
Facility A	
Facility B	
Facility C	

Affiliates	University Name	Funded & Approved GME postions*
Facility A		
Facility B		
Facility C		

FIGURE 4A: Supply Data Charts

<b>COUNTY NAME:</b>			
<b>INPATIENT CARE (FY2001)</b>	<b>Facility Name</b>	<b>BDOC</b>	<b>% of total BDOC in Market provided by Facility</b>
Medicine	Facility A	12069	53.69%
	Contracted		
	Sum of all facilities not listed above	10409	46.31%
	<b>TOTAL</b>	<b>22,478</b>	<b>100%</b>
Surgery	Facility A	5528	56.80%
	Contracted		
	Sum of all facilities not listed above	4205	43.20%
	<b>TOTAL</b>	<b>9,733</b>	<b>100%</b>
Intermediate Care Beds	Facility B	1141	27.71%
	Facility C	577	14.01%
	Contracted		
	Sum of all facilities not listed above	2400	58.28%
	<b>TOTAL</b>	<b>2,977</b>	<b>100%</b>
Psychiatry	Facility A	8950	49.77%
	Facility B	1362	7.57%
	Contracted		
	Sum of all facilities not listed above	7670	42.65%
	<b>TOTAL</b>	<b>17,982</b>	<b>100%</b>

**FIGURE 4B:** Infrastructure Data Charts

The following are examples of data that will be produced from Space and Functional Surveys:

<b>INPATIENT CARE (FY 2001)</b>	<b>DGSF</b>	<b>Quality of Space (1-5)</b>
Medicine		
Surgery		
Intermediate Care Beds		
Psychiatry		
PRRTP		
Nursing Home Care		
Domiciliary program		
Spinal Cord Injury		
Blind Rehab		
<b>OUTPATIENT CARE (FY 2001)</b>	<b>DGSF</b>	<b>Quality of Space (1-5)</b>
Primary Care		
Specialty Care		
Mental Health		
Geriatrics		
Ancillary and Diagnostics		
All Other		
Total		
<b>NON-CLINICAL</b>	<b>DGSF</b>	<b>Quality of Space (1-5)</b>
Research		
Other Administrative		
Vacant Space		

**FIGURE 4C: Evaluation of VA's Existing Capital Assets**

One of the key components in the CARES process is the assessment of whether the existing capital assets meet current and future demands for healthcare. This assessment consists of two surveys – the **Space and Functional Survey** (S&F) and the **Facility Condition Assessment** (FCA).

The Space and Functional (S & F) surveys evaluate both the quantity and quality of physical infrastructure that VA owns or leases. The Facility Condition Assessment (FCA) provides an overview of the existing infrastructure by major building system. Together, these tools will give a snapshot of functions/departments that exist at each facility (summary of programs), how much capital infrastructure is committed to those functions (existing DGSF), how that compares to a “projected” capital commitment determined by a program (Space Driver) that was developed to give a gross approximation of capital needed for various departments or functions at a facility, the general condition of the space as well as the functionality of the capital (layout, adjacencies, etc.).

The information obtained from the S&F surveys will be used to develop a capital implementation plan (or plans) to correspond to each CARES Planning Initiative that the network develops. Capital options will also be costed out for each initiative. Building information gathered in the S&F survey and the FCA, such as age, general condition, floor-to-floor heights or other architectural limitations, geographic location and the degree of dysfunction noted in the physical walkthrough of space will contribute favorably to determining the cost of various capital realignment options. Networks will follow consistent cost estimating guidelines for determining capital costs associated with each initiative and will also need to arrive at a value for excess real property that VA might sell or lease. Sources of these valuations should be either real estate broker opinions or application of real property appraisal methodologies.

**Space and Functional Surveys**

The Space and Functional (S & F) surveys evaluate both the quantity and quality of physical infrastructure that the VA owns or leases. They also identify ‘excess capital’ (vacant or out leased) that might help the network meet the demand for services identified during CARES. Networks could develop excess land or space as a source of revenue (through sale or lease) to facilitate cost effective VHA health care.

The S&F consists of 7 components:

1. A set of marked up VAMC Drawings indicating the current use of the space
2. Building Information including: building names and numbers, current departmental occupants, amount of square feet per department, and functional and re-use scores for each department/floor or building.

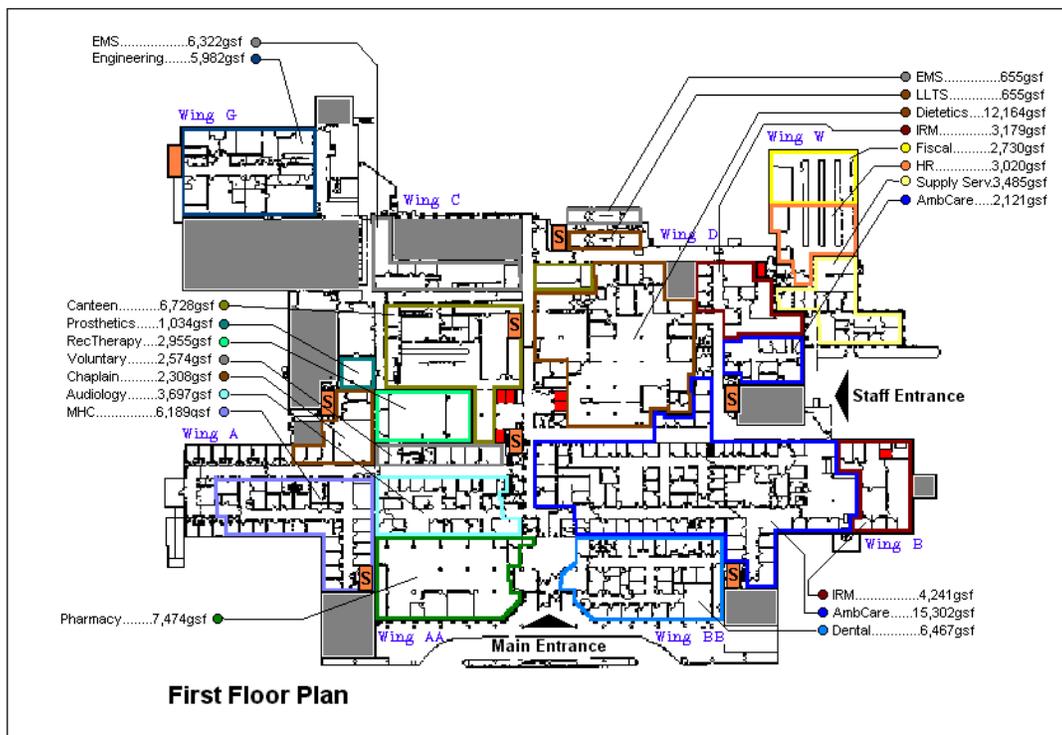
3. List of Leased Property and the function, square footage, cost and contract information.
4. List of Real Property owned by each site, utilization of space, existing parking capacity, and functional score of the land.
5. A list of Off-site Assets utilized by the site including CMOP, State Veterans Home beds, Homeless Grant/Per Diem program beds, and contracted NHC beds.
6. A list of all owned equipment with an acquisition cost over \$1 Million, including the condition, age, replacement cost, useful life, etc, of the equipment.
7. Projected Space per department (Space Driver), and the gap between existing and projected space.

**Component #1: VAMC Drawings**

Each VAMC shall provide an up-to-date set of scaled plans including (1) a site plan showing all buildings, roads, parking and site boundaries; (2) a floor plan for each floor of each habitable building showing boundaries, size and function of each major block of space. All space will be labeled using the departments (programs) as listed on the attached Space Indicator Sheet, and measured in Departmental Gross Square Feet.

The floor plan should identify vacant space and indicate its previous use, including the number and type of beds if previously used as a ward. All existing bed units should be named (i.e. 2 west) and labeled with the number and type of beds currently active. If space is out-leased, label the space with the tenant's name.

An example of a drawing is below:



## Component #2: Building Information

Once the drawings are complete, a Network Survey Team led by a Network representative and comprised of Medical Center and Network clinical and facility staff will then participate in each physical survey at each facility in the network to ensure consistent and uniform interpretation of space and function within that network. This Survey Team will visit each Medical Center within the VISN and, if feasible, each Leased Outpatient Clinic or CBOC larger than 5000 square feet. (The team members from the Medical Center will change at each site, but the Team Leader and Network staff will remain consistent.)

During the site visits, the Team will validate the departmental boundaries to capture the proper square footage by department and to verify vacant and out-leased space. The main purpose of the visit is to score the departments and/or buildings for Functional and Re-use potential as outlined below. (A sample Building Information Sheet is in Attachment 1 to this Chapter.) All scoring is on a 1-5 basis, with 5 being the optimum score:

### - Functional Scores -

Layout: Score each department as to the viability of its current physical layout. Score for issues of patient or materiel flow and overall efficiency.

Adjacencies: Score each department as to its location with respect to the other departments to which it is functionally related.

Code: Score each department as to its compliance with auditing/review bodies such as Joint Commission on Accreditation of Healthcare Organizations, NFPA Life Safety Code, or the College of American Pathologists.

Accessibility: Score each department (where applicable) as to its compliance with handicap accessibility standards (Americans with Disabilities Act, Uniform Federal Accessibility Standards).

Privacy: Score each department (where applicable) as to its compliance with patient privacy standards.

Ceiling Height: Score each floor as to the ceiling height, with a score of 5 for any slab-to-slab height of 16 feet or having interstitial space above, and a score of 1 for heights of less than 11 feet. This is used for determining renovation potential.

### - Re-use Potential Scores -

Score each floor, vacant space and/or building as to the potential to reuse the space for Hospital Beds, Nursing Home Beds, Clinical Space, Administrative space and Logistics (warehouse, dietetics, etc). All scoring is similar to the scores above, on a 1-5 basis, with 5 being the optimum score, with practically no renovation needed to

re-use the space for one of those functions, with a score of 3 requiring NRM level funding, and a 1 score meaning not useable.

In addition, score space for its potential as an Enhanced Use Lease to a non-VA entity. It is understood that this is a very limited estimation of EU value, done without benefit of market analysis.

Then score each building as to its potential for demolition. A score of 5 would indicate that a building is no longer functional and is a prime candidate for demolition. Scores would then proceed downward as the need for the building increases. A score of 1 indicates a solid need for the structure and a minimal potential for demolition.

### **Component #3: Leases**

The database includes a list of all leases (including parking). Leased buildings greater than 5000 s.f. shall be treated the same as VA owned space for survey purposes. Drawings and departmental block diagrams for leased buildings greater than 5000 s.f. shall be provided and recorded in the database "building info" just as any other VA owned space would be. If a CBOC is contracted, instead of in Leased space, that is also entered under this tab in the S&F database. Information provided on leases includes: Address, type of facility (clinical, research, etc), lease type, annual rent, terms of lease, expiration dates, square footage and type of square footage.

### **Component #4: Real Property**

The S&F database includes a list of all owned real property. Information includes: State, County, description of land (urban, suburban, rural), the type of neighboring land (commercial, residential, etc), the total number of VHA acres, NCA acreage, out leased acreage, and number of acres available. Note in this section if VBA or NVA are on the VHA site. Include the total number of parking spaces including surface, structure and leased parking spaces.

The Real Property is then scored on site access, access to public transportation, availability of parking, topography, site utilities, easements and subterranean limitations. All scoring is similar to the scores above, on a 1-5 basis, with 5 being the optimum score.

### **Component #5: Off-Site Assets**

The S&F database captures a list of off-site assets that the site uses. Information includes: whether the site utilizes a CMOP and the distance to that CMOP; off-site beds including the number of State Veterans Home beds and Homeless Grant/Per Diem program beds available for Medical Center use; and the ADC for contracted NHC beds.

## Component #6: Equipment

A list of all medical equipment with an acquisition cost over \$1 Million is provided here. Information includes: a short description of the equipment, the location, the condition, the year installed, the year due for replacement, costs for acquisition, replacement, and upgrade, and the remaining value.

## Component #7: Space Driver

### - Projecting Space -

This final component of the Space & Functional Survey data is the projected space each department needs. It uses the Space Driver; a VHA space-planning model intended to provide a strategic view of space program needs. While the Space Driver began five years ago as a direct distillation of the last approved version of the H-08-9/7610 official Space Planning criteria, many portions have benefited from more recent input from the field. Operation of the Space Driver model requires four basic inputs as listed below:

1. The prime input, the **TOTAL UNIQUE PATIENTS**, is available in a STA3N level report from the KLF menu; using the STA3N data assures that there is no redundancy in the numbers. This input is used to select from the 48 different Space Driver worksheets. There is one worksheet for each 1,000 increment of uniques and the one closest to the total uniques is to be used.
2. An **OPERATING BED TOTAL** for each inpatient type is required. These numbers are locally derived with concurrence from the network. The Space Driver lists 18 possible bed types.
3. To provide maximum flexibility, each formula in the spreadsheet has been structured with options to the extent allowed by the EXCEL format. The bulk of the effort to complete the worksheet is in providing **SPECIFIC PROGRAMMATIC INPUT FOR EACH FUNCTION** at the site. It is essential that someone with extensive local knowledge complete the left-hand portion of the spreadsheet. Each functional line item requires a response. If that function does not exist at the facility, the correct response is ZERO. If that function does exist, the correct response can be ONE, or depending on the function, there may be as many as five more options from which to choose. Select the option that best describes that function. The purpose of this tweaking is to allow the outcome to be more responsive to local needs and circumstances. At the bottom right of the worksheet is a space for input of Space Out-leased to Non-VHA users. This input is based either on an estimate or on a CARES Space & Functional Survey.
4. In order to complete the worksheet, provide **TOTAL FTEE**. This is required to drive the few functions that are not workload driven. Count all types of FTEE, including part time and volunteer.

After all inputs have been entered, Space Driver will total all inputs and automatically include 2% of the total for swing space (cell G95) and 15% for building common (gross) space (cell G96). The building common percentage was derived from the 1997 Capital Asset Review Process, which showed that 15% of the total GSF is an average and reasonable amount of building common space.

#### **- Determining the gap between existing and projected space -**

Once the projected space from the Space Driver is entered in the database, the projections are compared to actual space entered under the Building Information stage. The space projections are then distributed among all the spaces for a department, depending on whether that space was cramped or was underutilized. This will then generate a Need or Excess of Space for each Department.

This exercise will also be conducted for the projected FY 2012 uniques.

#### **- Deviations from Projected Space -**

Facilities that request a deviation from the square footage projected on the Space Drivers will submit a request for deviation to the CARES Space & Functional Survey Committee through their VISN Office. The CARES Space & Functional Committee will make an objective evaluation of each request & validate the need for deviation on a case-by-case basis. The committee will make determinations for acceptance or disapproval of the deviation based on the justification submitted. The Deviation Request will consist of a completed facility space driver without deviations and a second space driver with the requested deviation(s) highlighted. A written narrative justification for the deviation will also accompany the request. Once approved, the deviations must be documented in the comments section of the database. NCPO will appoint members of the CARES Space & Functional Survey Committee, including VACO 18, VSSC and field staff.

#### **- Facility Condition Assessments -**

The Facility Condition Assessment (FCA) will provide an independent and documented overview of infrastructure conditions in a simple, concise, easy to understand report.

The Facility Condition is a result of a site visit to the VAMC by an interdisciplinary team from the Office of Facilities Management (OFM), or a contractor under the supervision of OFM. Members of the team will include professionally experienced staff with extensive knowledge in the particular discipline. Required disciplines will include architecture, mechanical engineering, electrical engineering, estimating, structural engineering, steam generation/plumbing, automatic transport, and site. The data collected for this report will be from the contractor's personal inspection with

the appropriate VAMC staff and analysis of their knowledge and familiarity of facility systems. As-built drawings will provide information for structural and site utilities.

Each element within each building system will be graded A, B, C, D, or F. A brief narrative description will describe the element and justify the grade. The FCA will also provide an estimate of remaining useful life span for each element and cost estimates to correct the deficiencies graded "D" and "F", or that portion of a combination grade. The FCA will also provide estimated costs for total building replacement, including the relative percentage of that cost identified for each major system. (A sample Building Evaluation Report and a Facility Summary Report are attached as Attachments 3 & 4)

### **- Specific Scope for each Discipline -**

The major portion of the data listed below will be collected with the assistance of the appropriate VAMC staff.

Architectural System: FCA will include a physical inspection of all architectural components, including roofs, flashing, coping, exterior wall assemblies, windows, interior finishes/doors, ceiling systems, life safety requirements, handicapped accessibility features, major fixed equipment, counters and signage/way finding. A cursory review of the JCAHO Statement of Conditions will identify any outstanding Life Safety issues beyond the physical inspection.

Heating Ventilating and Air Conditioning (HVAC) Systems: FCA will include a physical inspection of all HVAC systems including air handlers, package equipment, room terminal units, refrigeration equipment, piping, valves, ductwork, room air distribution, controls, indoor air quality issues and other equipment and system components essential for the operation of the HVAC systems.

Chiller Plant and Distribution System: FCA will include a physical inspection of the chiller plant and related systems including refrigeration equipment, cooling towers and condenser water pumping systems, primary and secondary chilled water pumping systems, condenser water system, valves, other equipment and system components essential for the operation of the Chiller system.

Automatic Transport Systems: FCA will include a physical inspection of all vertical transport systems such as elevators, dumbwaiters, etc.

Plumbing, Medical Gas, and Fire Sprinkler Systems: FCA will include a physical inspection of all storm water, domestic cold water, domestic hot water and domestic hot water re circulation systems, domestic hot water heaters, medical air, O2 and vacuum systems and sprinkler systems.

Electrical, Lighting, Communications and Signaling Systems: FCA will include a physical inspection of all electrical, lighting, communications and signaling systems including incoming electrical service and switchgear, incoming telephone service and switch, main facility fire alarm system, site lighting and security systems, secondary

distribution system (transformer, secondary service equipment, risers, panel boards and branch circuit wiring), essential electrical system (all related equipment including fuel oil tanks), interior lighting and power, interior fire alarm system, interior telephone, data and communications systems (nurse call, TV, intercom, radio), lightning protection system and electrical, signal and telephone closets.

Structural Systems: FCA will include a visual inspection of the buildings to detect any settlement or cracks in the masonry etc. The type of foundation, structural floor system (including vertical members) shall be documented from as-built drawings. Building compliance with seismic/wind load requirements shall be determined. Any deficiencies in the structural system that can cause life-threatening situations shall be identified.

Site Access: FCA will include a physical inspection of all site features including roads, parking, curb and gutters, walks, exterior accessibility (including exterior steps and ramps), wayfinding (exterior signage), fencing, and landscaping. Also make note of off site directional signage. All underground site utilities such as water, storm water, sanitary, and natural gas systems shall be evaluated. The source(s) of the utilities, the age and condition of the pipe mains, inlets, and fire hydrants, outflow of storm and sanitary lines and remaining life expectancy shall be documented from as-built drawings and VAMC input. Site electrical and steam distribution (including heating oil system) shall be included under their specific headings. Processes involving hazardous materials including asbestos, incineration, waste material, nuclear waste, medical waste, and hazardous waste shall be evaluated and documented from a meeting with the VAMC industrial hygienist.

Steam Generation Systems: FCA will include a physical inspection of all boiler plant equipment including boilers, burners, energy recovery devices, burner controls, combustion controls, instruments, condensate storage tank, deaerating feed water heater, water and oil pumps, chemical treatment systems, water softeners, water dealkalyzers, make-up water system, blowoff tank, stacks or chimney and breeching, piping system, fuel oil tanks. Boiler inspector's reports on the boilers and deaerator shall be reviewed.

Outside Steam Distribution Systems: FCA will include an evaluation of these systems by means of interviews with the VAMC personnel who maintain the systems and with the aid of system plot plans furnished by the VAMC.

FIGURE 4C1: Model Summary of Building Space Analysis

# 111 VAMC, Anywhere

Page 1 of 1

## Building 28

Floor	Department	Beds	Projected Space	Existing Space	Vacant Space	Excess	Needed	-----Functionality-----						-----ReUse-----						
								Lay	Adj	Cod	Acc	Priv	Hgt	Hosp	NHC	Clin	Adm	Log	EU	Dem
B	Beds NHC	45	20,918	15,452			5,466	5.0	5.0	5.0	5.0	5.0	1.0	4.0	5.0	3.0	3.0	1.0	5.0	1.0
B	Beds HOPTEL	8	3,060	2,841			219	4.0	4.0	5.0	5.0	3.0	1.0							
B	Engineering		2,030	2,140		110		5.0	5.0	5.0	5.0	5.0	1.0							
<b>Floor B</b>		<b>53</b>	<b>26,008</b>	<b>20,433</b>		<b>110</b>	<b>5,685</b>													
1	Beds Med-Neur-Rehab	22	9,801	11,054		1,253		4.0	3.0	5.0	4.5	5.0	1.0							
1	Beds NHC PT & OT		5,099	3,767			1,332	4.5	5.0	5.0	4.0	5.0	1.0	4.0	5.0	3.0	3.0	1.0	5.0	1.0
1	Geriatrics		575	850		275		5.0	4.0	5.0	5.0	5.0	1.0							
1	Unassigned VACANT			4,646		4,646														
<b>Floor 1</b>		<b>22</b>	<b>15,475</b>	<b>20,317</b>		<b>6,174</b>	<b>1,332</b>													
2	Geriatrics		6,029	8,901		2,872		5.0	5.0	5.0	4.5	5.0	1.0	1.0	1.0	2.0	4.0	1.0	3.5	1.0
2	Education		321	400		79		4.5	5.0	5.0	5.0	5.0	1.0							
<b>Floor 2</b>			<b>6,350</b>	<b>9,301</b>		<b>2,951</b>														
<b>Building 28</b>		<b>75</b>	<b>47,833</b>	<b>50,051</b>		<b>9,235</b>	<b>7,017</b>							<b>Avg Re-Use</b>	<b>3.7</b>	<b>2.7</b>	<b>3.3</b>	<b>1.0</b>	<b>4.5</b>	<b>1.0</b>

**FIGURE 4C2: Model Summary of Building Space Analysis cont.**

04/09/02

**111 VAMC Anywhere**

Page 1 of 2

Input Dept	Space Driver Projection	Existing DGSF	Projected DGSF	Excess	Needed	Vacant Space
42 Beds Med-Neur-Rehab	18,711	12,219	18,711	1,253	7,745	
20 Beds Surgical	8,910	1,165	8,910		7,745	
0 Beds SCI	0					
0 Beds Intermediate	0					
0 Beds Blind Rehab	0					
7 Beds MICU	3,987	4,357	3,987	370		
0 Beds CCU	0					
14 Beds SICU	7,973	9,129	7,973	1,156		
18 Beds MH/Behavioral Med	10,039	7,469	10,039		2,570	
45 Beds NHC	26,017	19,219	26,017	0	6,798	
0 Beds 23Hr Observation	0					
0 Beds Psych Res Rehab	0					
0 Beds Domiciliary	0					
0 Beds Homeless Dom	0					
8 Beds HOPTEL	3,060	2,841	3,060		219	
0 Beds Hospice	0					
0 Adult Day Care	0					
2 ACS-Primary Care	34,832	57,415	34,832	22,583		
2 ACS-Specialty Care	18,982	20,622	18,982	1,640	0	
2 ACS-Urgent Care	9,185	10,052	9,185	867	0	
2 Audiology	4,055	6,696	4,055	2,641	0	
2 Cardiology	6,953	13,163	6,953	6,210	0	
2 Dental	8,324	3,411	8,324	0	4,913	
1 Dialysis	8,175	7,236	8,175	0	939	
1 EEG/Neurology	1,818	1,888	1,818	70	0	
2 Digestive/Endoscopy	5,200	5,926	5,200	726		
2 Eye Clinic	4,544	4,766	4,544	222	0	
3 Geriatrics	10,618	15,677	10,618	5,059	0	
0 Hosp Based Home Care	0					
4 Nuclear Medicine	9,261	9,547	9,261	286	0	
1 Mental Health Clinic	4,652	5,368	4,652	716	0	
2 Substance Abuse Clinic	1,099	2,817	1,099	1,718	0	
2 Day Hospital	1,573	1,721	1,573	148	0	
4 Day Treatment Center	7,578	1,050	7,578	0	6,528	
4 Pathology	22,812	21,222	22,812	0	1,590	
2 Pharmacy	11,214	12,550	11,214	1,336	0	
1 Prosthetics	2,052	3,872	2,052	1,820	0	
4 Psychology	3,434	3,549	3,434	115	0	
1 Psychiatry	3,806	3,255	3,806	0	551	
1 Pulmonary/Resp Care	5,328 ****	2,728	2,664	64	0	
1 Radiation Therapy	7,722	10,074	7,722	2,352	0	
4 Radiology	24,068	19,530	24,068	0	4,538	
1 Recreational Therapy	8,457	4,488	8,457		3,969	
1 Rehab Medicine	12,940	10,240	12,940	0	2,700	
1 Social Work	1,962	1,480	1,962	0	482	
4 Surgical	34,266	30,997	34,266		3,269	
1 Canteen Service	13,193	7,244	13,193	0	5,949	
2 Nutrition/Food	6,625	10,731	6,625	4,106	0	
3 Education	6,977	8,690	6,977	1,713	0	
1 Environmental Mgmt	4,764	4,750	4,764	0	14	

\*\*\*\* indicates the total Space Driver Projection differs from the sum of the individual entries ... utilization is determined based on the sum of the individual entries.

**FIGURE 4C2: Model Summary of Building Space Analysis cont.**

04/09/02

# 111 VAMC Anywhere

Page 2 of 2

Input Dept	Space Driver Projection	Existing DGSF	Projected DGSF	Excess	Needed	Vacant Space
4 Linen Service	8,170	2,652	8,170	0	5,518	
1 Centralized Staff Fac	2,819	2,960	2,819	141	0	
1 Engineering	10,994	11,591	10,994	597	0	
3 Library	1,083	4,121	1,083	3,038	0	
4 Medical Media	3,078	1,570	3,078		1,508	
1 Chaplain	3,482	1,232	3,482	0	2,250	
4 Medical Research/Dev	66,601	80,016	66,601	13,415		
2 SPD Service	9,176	10,266	9,176	1,090	0	
1 Voluntary Service	2,114	932	2,114	0	1,182	
4 A&MM Warehouse	15,984	13,660	15,984		2,324	
1 A&MM Admin	2,126	1,402	2,126		724	
2 Clinical Svc Admin	2,388	14,311	2,388	11,923	0	
4 Director's Suite	7,672	10,469	7,672	2,797	0	
1 Fiscal	2,419	6,487	2,419	4,068	0	
4 Human Resources	2,740	2,555	2,740	0	185	
3 IRM	7,753	7,945	7,753	192	0	
2 Medical Admin	16,272	10,007	16,272	0	6,265	
1 Nursing Svc Admin	3,806	2,567	3,806	0	1,239	
2 On-Call Pgm	4,590	1,816	4,590	148	2,922	
2 Lobby Space	1,385	1,962	1,385	577	0	
2 Police/Security	1,374	1,103	1,374	0	271	
1 VSO/Vet Assistance	1,269	1,178	1,269	0	91	
1 Child Care Center	10,773	3,956	10,773		6,817	
0 Credit Union	0					
1 Employee Fitness	0					
0 Residential Qtrs	0					
Common Space	83,139	****				
Swing Space	11,085	29,712	11,085	18,627		
Outleased						
Unassigned VACANT		65,699	0	65,699		65,699
<b>Total (TGSF) for 111 Any</b>	<b>667,458</b>	<b>669,323</b>	<b>581,655</b>	<b>179,483</b>	<b>91,815</b>	<b>65,699</b>

\*\*\*NOTE\*\*\* includes space breakdown for some leased spaceText32:

Space Driver Tier	6	OP Visits	147,908	FY 2000 Unique Patients	27,238
Medical Care Group #	6	Leased OP Visits	59,815	FY 99 Utilization Factor	1.035
Assessment Date	02/07/2001	Cntrcted OP Visits	1,089	FY 2000 Avg. Miles	

Assessment Team                      Adjustments to Space Driver  
 People from the Network and MC

\*\*\*\* indicates the total Space Driver Projection differs from the sum of the individual entries ... utilization is determined based on the sum of the individual entries.

**VAMC Anywhere**

**(FCA Building Evaluation Form)**

**VISN 24**

**Building 1**

<b>Condition</b>	<b>Year Built</b>	<b>Last Renov</b>	<b>Floors</b>	<b>GSF</b>	<b>Current Function</b>	Administrative
	1929	1936	2	29,600	<b>Proposed Function</b>	Administrative

Condition

	Useful	Remain Life	Correction \$ Life	Description				
<b>Architectural</b>								
Accessibility	C	*	*	\$0 Bldg access via new lift. Half of bathrooms are accessible.				
Exterior Walls	B	75	*	\$0 Stucco, wood trim & ironwork all in very good condition.				
Fixed Equipment	n/a	15		\$0				
Interior Finish/Door	B/D	10	varies	\$118,000 Mostly newer finishes. Needs 1/2 new carpet & 1/4 new wall covering.				
Life Safety	C	*	*	\$0 Not sprinklered. No smoke detectors. But has fire alarm system.				
Roof	B	20	20	\$0 Flat clay tile roof in very good condition.				
Signage/Wayfindg	C	10	4	\$0 Newer signage, but too stylized.				
Windows	C	20	6	\$0 Older single glazed alum windows in fair condition.				
<b>System Total Correction</b>				\$118,000	<b>Replacement Cost</b>	\$1,360,000	<b>Ratio</b>	0.09
<b>Electrical</b>								
Elec/Tele Closets	n/a	*		\$0 Small elec closet on each floor plus comb elec/tele closet.				
Emerg Elec Sys.	C	20	5	\$0 200A MDP in bsmt and small panel on each floor. Old but adequate.				
Fire Alarm	A	15	15	\$0 New Honeywell multiplex, addressable system being installed.				
Lighting & Power	D	25	12	\$68,000 Upgrade lighting with T8 lamps and elec ballasts and LED exits.				
Lightning Protect	n/a	20		\$0 Determine need by Risk Assessment Guide, NFPA 780.				
Nurse Call/Int/TV	C	15	7	\$0 CCTV only.				
Secondary Dist.	C	30	9	\$0 300A MDP & distribution in fair condition.				
Telephone/Data	B	15	11	\$0 Systems upgraded in '95, includes PA system.				
Transformer	n/a	30		\$0 Underground secondary feeder from Bldg 2 Swbd.				
<b>System Total Correction</b>				\$68,000	<b>Replacement Cost</b>	\$484,000	<b>Ratio</b>	0.14
<b>Mechanical</b>								
Air Handling Equip	C/F	25		\$30,000 AHU is in good condition, however, outdated induction units & radiators are old & fight each other resulting in waste of energy. No A/C in corridor.				
<b>System Total Correction</b>				\$30,000	<b>Replacement Cost</b>	\$541,000	<b>Ratio</b>	0.06
<b>Plumbing</b>								
Fixtures/Piping	C			\$0 VAMC input suggests most plumbing systems are in good condition.				
<b>System Total Correction</b>				\$0	<b>Replacement Cost</b>	\$217,000	<b>Ratio</b>	0.00
<b>Structural</b>								
Floor Systems	B	100	30	\$0 Concrete oneway joists supported over concrete beams.				
Foundations	B		30	\$0 Spread footings.				
Seismic/Wind Load	n/a			\$0 No seismic requirements.				
Vertical Members	B	100	30	\$0 Concrete columns.				
<b>System Total Correction</b>				\$0	<b>Replacement Cost</b>	\$815,000	<b>Ratio</b>	0.00

## VAMC Anywhere - (FCA Facility Summary Report)

VISN 24

Condition	Correction \$	Description			
<b>Building</b>	<b>1</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Main Hospital - AB&amp;C</b>	<b>\$2,886,000</b>	<b>\$31,040,000</b>	<b>0.09</b>	<b>180,923</b>	
Windows	C-/D	\$276,000	Older single glazed alum windows should be replaced. Open ext wall at Women's clinic to expose windows.		
Signage/Wayfindg	B/D	\$37,000	Replace poor signage on 3/4/5. Circulation thru Surgery & Dental is problematic.		
Roof	B/D	\$56,000	Built up roofs at A & B in very good condition. Repair gutter lining at A. Replace approx 9,500 sq ft of roof at C.		
Life Safety	C-/D	\$55,000	Bldg meets codes, but is only 1/4 sprinklered. Complete sprinklering of remaing 3/4. Make various repairs cited in JACHO SOC. Install new stair treads at 6 stairways.		
Interior Finish/Door	B/D	\$76,000	Most finishes very good except: Replace approx 10,000 sq ft of corridor clg. Replace approx 5,000 sq ft of carpeting. Replace approx 500 sq ft of floor tile. Seal around marble panels in Surgery. Repair approx 6 spot leaks in Surgery clg. Paint 6 stairways.		
Exterior Walls	C/D	\$6,000	Brickwork in good condition. Repair, clean & tuck point glazed terra cotta trim. Refinish silver penthouse to match into bldg. Regrade S exit at Amb Care to stop water problem.		
Fixed Equipment	B/D	\$24,000	Most equip very good. Update casework in 5 Dental operatories.		
Lighting & Power	D	\$489,000	Replace F40-T2 lamps with T-8 types & electronic ballasts.		
Air Handling Equip	B/ D	\$121,000	Replace single pane windows with double pane windows. Most of the mid 80's AHU in average condition except for SPD & MICU/SICU. These units need to be replaced 1 - 5		
Air Handling Equip	C/D	\$311,000	Replace single pane windows with double pane windows. Most of the mid 80s AHU are in average condition except for SPD & MICU/SICU. These units needs to be replaced in 1- 5 years.		
Room Air Dist/Term	D	\$1,175,00	Convert 100 induction units into fan coil units. Interlock fan coil unit with existing convector controls so that one thermostat controls heat/cool.		
Elevators	D-	\$260,000	A wing, traction elevators P-1, P-2. Elevators need replacement. Cannot get parts and becoming unreliable and unsafe.		
Roof	D	\$52,000	Replace approx 9,500 sq ft of roof at C.		
<b>Building</b>	<b>10</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Vacant</b>		<b>\$7,000</b>	<b>\$356,000</b>	<b>0.02</b>	<b>3,591</b>
Lighting & Power	D	\$7,000	Existing T-12, F40 lamps needs to be replaced with T-8 types and electronic ballasts.		
<b>Building</b>	<b>11</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Engineering/Grounds</b>		<b>\$20,800</b>	<b>\$546,000</b>	<b>0.04</b>	<b>4,581</b>
Exterior Walls	B/D	\$800	Brickwork in very good condition. Repair minor cracks & paint wood trim.		
Roof	D	\$14,000	Replace antiquated asbestos shingle roof.		
Lighting & Power	D	\$6,000	Existing T-12, F40 lamps have to be replaced with t-8 types and electronic ballasts.		
Lightning Protect		\$0	Determine need by Risk Assessment guide.		
Lighting & Power		\$0	Has one small panel in this building. The building is insignificant in terms of electrical		
<b>Building</b>	<b>18</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Shops/EMS/Boiler Plant</b>		<b>\$533,500</b>	<b>\$5,483,000</b>	<b>0.10</b>	<b>16,872</b>
Interior Finish/Door	C/D	\$14,000	Most finishes good. Paint approx 1/4 of shops & upgrade bathrooms.		
Exterior Walls	B/D	\$16,000	Brickwork is very good. Tuck point approx 100 sq ft. Paint ext wood. Repair dock concrete beams at E side.		
Roof	D	\$32,000	Antique asbestos shingles need replaced.		
Lighting & Power	D	\$23,000	Exixting T-12 F40 lamps have to be replaced with T-8 types & Electronic Ballasts.		
Secondary Dist.	F	\$67,000	NOTE: 70% of all Federal Pacific Panels in all buildings prior to 1997 must be replaced as there are no more replacement parts available.		
Lightning Protect		\$0	Determine the need by Risk Assessment Guide.		

Condition	Correction \$	Description			
<b>Building</b>	<b>18</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Shops/EMS/Boiler Plant</b>	<b>\$533,500</b>	<b>\$5,483,000</b>	<b>0.10</b>	<b>16,872</b>	
Instruments	F	\$320,000	Obsolete, not accurate, parts not available. PC system could be installed at lower cost than listed above.		
Comb. Controls	F	\$54,000	Out of service. Obsolete, parts not available.		
Burner Controls	D	\$7,500	Obsolete. Should be replaced with microprocessor-type.		
Elec/Tele Closets		\$0			
Transformer		\$0	1500 KVA @ 480 V is in good condition.		
<b>Building</b>	<b>52</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Chiller Plant</b>		<b>\$148,000</b>	<b>\$7,081,000</b>	<b>0.02</b>	<b>9,611</b>
Lightning Protect		\$0	Determine need by Risk Assessment Guide.		
Lighting & Power	D	\$26,000	Existing F40,T12 Fluorescent Lamps must be replaced with T-8 types with Electronic		
Engr. Control syst.	C/D	\$122,000	Extend exist DDC controls to all AHUs, about 20 require DDC controls		
<b>Building</b>	<b>53</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>New Bed Building</b>		<b>\$0</b>	<b>\$31,691,000</b>	<b>0.00</b>	<b>166,450</b>
Fixed Equipment	A/D	\$0	All equipment is excellent. Adjust sink sensors for temp & duration.		
Fire Sprinkler/Pump	C/F	\$0	Pressure for sprinkler systems on 6th floor is low. Tie fire pump in Bldg. 53 to sprinkler system Bldg.1, 22, and 24. Completion item.		
<b>Building</b>	<b>6</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Administrative Offices</b>		<b>\$6,000</b>	<b>\$410,000</b>	<b>0.01</b>	<b>3,451</b>
Lighting & Power	D	\$6,000	Replace existing T-12, F-40 lamps with T-8 types and electronic ballasts.		
<b>Building</b>	<b>7</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Vacant</b>		<b>\$6,000</b>	<b>\$376,000</b>	<b>0.02</b>	<b>3,394</b>
Lightning Protect	D	\$6,000	Existing T-12, F40 lamps must be replaced with T-8 types and electronic ballasts.		
<b>Building</b>	<b>8</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>HRM</b>		<b>\$49,000</b>	<b>\$488,000</b>	<b>0.10</b>	<b>4,122</b>
Accessibility	C/D	\$41,000	Bldg access is good, but bathrooms are not accessible.		
Lighting & Power	D	\$8,000	Existing T-12,F40 lamps have to be replaced with T-8 types with electronic ballasts.		
<b>Building</b>	<b>9</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>	<b>Bldg Ratio</b>	<b>GSF</b>
<b>Vacant</b>		<b>\$0</b>	<b>\$393,000</b>	<b>0.00</b>	<b>3,330</b>
<b>Building</b>	<b>Site</b>	<b>Bldg Correction</b>	<b>Bldg Replacement</b>		<b>GSF</b>
<b>Site Utilities</b>		<b>\$0</b>	<b>\$0</b>		<b>0</b>
Incineration	D	\$0	Existing incinerator is not operational and may be demolished.		

**FIGURE 4D:** Templates to Assist in Collecting Additional Supply Data Survey of Community Resources

**Sample Data Collection Formats**

<b>Community Hospital</b>	<b>Total beds</b>	<b>Occupancy Range</b>	<b>Occupancy Average</b>	<b>Available Beds</b>
<b>Market #1</b>	<i>Data Source: AHA Guidebook</i>			
Hospital A				
Hospital B				
Hospital C				

<b>PHONE SURVEY Community Hospital</b>	<b>Acute Medicine</b>				
<b>(within a 15 mile radius of VHA facility or sub-market population cluster)</b>	<b># Staffed Beds</b>	<b>ADC</b>	<b>Occupancy Rate</b>	<b>Vacancy Rate</b>	<b>Available Beds</b>
Hospital A					
Hospital B					
Hospital C					
	<b>Acute Surgery</b>				
	<b># Staffed Beds</b>	<b>ADC</b>	<b>Occupancy Rate</b>	<b>Vacancy Rate</b>	<b>Available Beds</b>
Hospital A					
Hospital B					
Hospital C					
	<b>Acute Psychiatry</b>				
	<b># Staffed Beds</b>	<b>ADC</b>	<b>Occupancy Rate</b>	<b>Vacancy Rate</b>	<b>Available Beds</b>
Hospital A					
Hospital B					
Hospital C					
	<b>Intermediate Care</b>				
	<b># Staffed Beds</b>	<b>ADC</b>	<b>Occupancy Rate</b>	<b>Vacancy Rate</b>	<b>Available Beds</b>
Hospital A					
Hospital B					
Hospital C					

<b>PHONE SURVEY: Skilled Nursing Home Facility</b>					
<b>(within a 15 mile radius of VHA facility or sub-market population cluster)</b>	<b># Staffed Beds</b>	<b>ADC</b>	<b>Occupancy Rate</b>	<b>Vacancy Rate</b>	<b>Available Beds</b>
SNHF1					
SNHF 2					
SNHF3					

**Additional Sample Data Collection Formats**

<b>PHONE SURVEY: Non-Hospital Based Nursing Home Facility</b>			
<b>(Within a 15 mile radius of VHA facility or sub-market population cluster)</b>	<b>Bed Capacity</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
NH1			
NH2			
NH3			

<b>PHONE SURVEY RRFT</b>	<b>Psychiatry</b>				
<b>(Within a 15 mile radius of VHA facility or sub-market population cluster)</b>	<b># Staffed Beds</b>	<b>ADC</b>	<b>Occupancy Rate</b>	<b>Vacancy Rate</b>	<b>Available Beds</b>
Hospital A					
Hospital B					
Hospital C					
	<b>Substance Abuse</b>				
	<b># Staffed Beds</b>	<b>ADC</b>	<b>Occupancy Rate</b>	<b>Vacancy Rate</b>	<b>Available Beds</b>
Hospital A					
Hospital B					
Hospital C					

### - Community Assessment Telephone Survey -

The purpose of this telephone survey is to gather capacity information from community hospital, nursing home and skilled nursing facilities. Networks will use this information to assess community capacity and any potential for partnerships, collaborations or contracting as they develop Planning Initiatives for the CARES process. The survey establishes baseline information for determining the potential for future availability of community resources that could become available through joint planning by VHA and the local health care system.

Following are example questions for use when surveying local community hospitals:

1. INTRO: My name is \_\_\_\_\_, and I am the administrator at the VA Medical Center - \_\_\_\_\_. We are in the process of assessing the availability of services in the community as we develop alternatives to ensure that our patients' health care needs are being met.
2. We are surveying all local community hospitals, nursing homes and skilled nursing facilities to determine any possible available services.
3. We would like to get some basic information on the services you offer:
  - a. For your acute medicine department:
    - 1 - What are the number of staffed beds? \_\_\_\_\_
    - 2 - What is your ADC? \_\_\_\_\_
    - 3 - What are the occupancy and vacancy rates? \_\_\_\_\_
    - 4 - Do you have available beds? IF YES what is the average # of available beds? \_\_\_\_\_
  - b. For your acute surgery department:
    - 1 - What are the number of staffed beds? \_\_\_\_\_
    - 2 - What is your ADC? \_\_\_\_\_
    - 3 - What are the occupancy and vacancy rates? \_\_\_\_\_
    - 4 - Do you have available beds? IF YES what is the average # of available beds? \_\_\_\_\_
  - c. Do you offer acute psychiatry services? IF YES ASK FOR THE FOLLOWING INFO:
    - 1 - What are the number of staffed beds? \_\_\_\_\_
    - 2 - What is your ADC? \_\_\_\_\_
    - 3 - What are the occupancy and vacancy rates? \_\_\_\_\_

4 - Do you have available beds? IF YES what is the average # of available beds? \_\_\_\_\_

**For Skilled Nursing Home Telephone Survey**

- a. How many staffed beds are there at your facility? \_\_\_\_\_
- b. What is your ADC? \_\_\_\_\_
- c. What are your occupancy and vacancy rates? \_\_\_\_\_
- d. Do you have available beds? IF YES what is the average # of available beds? \_\_\_\_\_

**Non-Hospital Based Nursing Home Facility**

- a. What is your bed capacity? \_\_\_\_\_
- b. Do you have vacancies? YES or NO
- c. What is your vacancy rate? \_\_\_\_\_

Thank you for your time. We appreciate your willingness to provide us with this information.

**FIGURE 4E: Clinical Inventory****CARES CLINICAL INVENTORY TEMPLATE****Purpose**

This Clinical Inventory template is intended as a tool for Networks for the development of CARES Planning Initiatives (PI). This template should assist with evaluating current service supply in the CARES planning process.

**Instructions**

The following is a clinical inventory. Please enter the codes that apply to how each VAMC provides a particular service listed on the inventory. Please add any additional services not captured on this inventory.

**Codes for how services are provided**

NC= service provided by Non-VA through a Contract/Consult/Fee

O= service on site

P=Planned Program (listed must have prior HQ/ISN approval)

SC= service provided through community provider sharing agreement

SD= service provided through DoD sharing agreements

SM= service provided through medical school affiliate sharing agreement

V= referral to other VAMC in Network where service provided

X= service not provided

Figure 4E cont'd.

<b>DRAFT Clinical Inventory -VA Health Care Network XX FY XXXX</b>							
<i>Market Area:</i>							
<b>Codes for how services are provided</b>							
NC= service provided by Non-VA through a Contract/Consult/Fee							
O= service on site							
P=Planned Program (listed must have prior HQ/VISN approval)							
SC= service provided through community provider sharing agreement							
SD= service provided through DoD sharing agreements							
SM= service provided through medical school affiliate sharing agreement							
V= referral to other VAMC in Network where service provided							
X= service not provided							
<b>Program</b>	<b>VAMC A</b>	<b>VAMC B</b>	<b>VAMC C</b>	<b>VAMC D</b>	<b>VAMC E</b>	<b>VAMC F</b>	<b>VAMC G</b>
<b>Ancillary Support</b>							
Chaplain							
Hoptel beds							
Nutrition/Dietetics							
Readjustment Counsel.							
Social Work							
<b>Audiology&amp;Speech Pathology</b>							
Assistive Listening Devices							
Auditory Rehabilittation							
Audiology							
Augmentative and alternative comm. Devices							
Balance Assessment							
Cochlear Implant							
Cognitive Disordwer Clinic							
Compensation and Pension Exams							
Dysfluency Clinic							
Dysphagia Management Team							
Electrophysiology (ABR, MLR, OAE)							
Hearing Aid Clinic							
Hearing Conservation Program							
Instrumented swallowing exams (MBS, FEES)							
Neurogenic speech/language							
Speech Lab							
Speech Pathology							
Tinnitus Management							
Voice Disorder Clinic							
Voice Prostheses							
<b>Blind Rehabilitation</b>							
Blind Rehab. Center *							
Blind Rehab. Clinic *							
BROS*							
VIST*							
VICTORS							
<b>Dentistry</b>							
Dental Hygeine							
Endodontics							
Facility Dental Lab service							
General Dentistry							
Gerodontics							
Oral/Maxil Surgery							
Periodontics							
Prosthodontics							
<b>Diagnostic-Radiology</b>							
Angiography							
Contrast Procedures/Routine Xray							
CT Scan							
Diagnostic Imaging							
Diagnostic neuroradiology							
Interventional							
Mammography							

Figure 4E cont'd.

<b>Clinical Inventory -VA Health Care Network XX FY XXXX</b>							
<i>Market Area:</i>							
<b>Codes for how services are provided</b>							
NC= service provided by Non-VA through a Contract/Consult/Fee O= service on site P=Planned Program (listed must have prior HQ/VISN approval) SC= service provided through community provider sharing agreement SD= service provided through DoD sharing agreements SM= service provided through medical school affiliate sharing agreement V= referral to other VAMC in Network where service provided X= service not provided							
<b>Program</b>	<b>CBOC A</b>	<b>CBOC B</b>	<b>CBOC C</b>	<b>CBOC D</b>	<b>CBOC E</b>	<b>CBOC F</b>	<b>CBOC G</b>
<b>Ancillary Services</b>							
Chaplain							
Nutrition Services							
Social Work							
<b>Diagnostic-Imaging</b>							
Radiology-Xray							
Ultrasound							
MRI							
Mammography							
<b>Diagnostic-Laboratory&amp;Pathology</b>							
Chemistry (Routine)							
Chemistry (Point of Care)							
Coagulation (Routine)							
Coagulation (Point of Care)							
Fecal Occult Blood							
Hematology (Routine)							
Hematology (Point of Care)							
Microbiology (Routine/BSL 1 or 2)							
Microbiology (Point of Care)							
Provider Performed Microscopy Procedures							
Urinalysis (Routine)							
Urine Dip Stick Procedures (only)							
Urine Microscopic Procedures							
Whole Blood Glucose Procedure (Glucometer)							
<b>Mental Health Services</b>							
Behavioral Medicine(including biofeedback)							
Case Management , Intensive (MHICM)*							
Case Management Standard							
Community Residential Care (CRC)							
Day Treatment							
Family education/therapy							
HCHV Contract Residential Program*							
Homeless and grant per diem*							
Homeless HUD/VASH*							
Homeless Outreach*							
Mental Health Clinic							
Mental Health Consultation-liaison							
Mental Health emergency							
Mental Health Primary Care Clinic							
Neuropsychology/Neurobehavioral exam (Psychology)							
Opiod Substitution							
Psychiatry Group/Individual							
Psychogeriatric Clinic							
Psychology Group/Individual							
Psychosocial Rehabilitation (outpatient)							
PTSD outpatient clinics (including PTSD Clinical teams*)							
Sleep Disorder Clinics							
Substance Use Disorders-outpatient*(including intensive outpatient)							
Tele-mental health							
Vocational Rehabilitation (CWT:IT)							
<b>Primary Care Services/Medical Services</b>							
Comprehensive Tobacco Cessation Prog							
ECHO							
EKG							
General Medical							
Prevention Clinical team							
Preventive Care Program							
Preventive Health							
Primary Prevention Program (Immuniz/screening)							
Treadmill Testing							
Weight Program							
Women's Clinic							
<b>Other</b>							
Tele home Care							
Audiology							
Occupational Rherapy							
Physical Therapy							
Speech Pathology							
Eye Care							
Pharmacy							
Podiatry							

## **Step Five - Identifying Planning Initiatives:**

### **A. Analyze Gaps Between Supply And Demand**

The NCPO will analyze the gaps and redundancies in services between current supply and future demand to develop the specific Planning Initiatives that the Networks will address in their CARES Market Plans. Future demand will be analyzed for the years 2012 and 2022.

The Planning Initiative will specifically require that the solution developed ensure a cost effective response to the expected 2022 demand. The analysis will include the rate of change between 2012 and 2022. This will ensure that capital realignments have the flexibility to meet any significant changes between 2012 and 2022.

Gaps are defined as significant positive or negative variances of current supply from future demand. The gap analysis entails aggregating the total projected demand within each Network, market and facility by type of care, assigning this demand to existing facilities, and analyzing the ability of the facilities to meet the demand based on travel distances, service mix and/or condition of infrastructure. Levels of analysis include: total Network level to provide an overview of gaps and redundancies in beds and space; the need for additional primary care; the market level to identify gaps in geographic areas; and the facility level to identify specific gaps in services and infrastructure. The NCPO gap analysis will include a review of several components of service delivery; however, it will not include an analysis of sub-markets. If needed, sub-market analyses will be done by the Network and will use the information provided in Step 2 (Define Markets) to ensure consideration of specific sub-market travel times and geographic barriers.

The gap analysis is broken into three major components:

1. Amount of service capacity required to meet future demand
2. Appropriate location of facilities in relation to future service demand
  - a. Infrastructure present without sufficient demand or unnecessary redundancy of infrastructure
  - b. Underserved population without infrastructure present
3. Condition of current infrastructure to meet future demand

Selected variances that the NCPO identifies as significant will require Networks to develop a full market Planning Initiative response. This measure of variance is expressed as  $[(\text{Current supply units} - \text{future demand units}) / \text{future demand units}]$ . Networks may be required to address other variances in a short narrative explanation, describing how they will bridge the identified gaps. Networks may also identify other issues and, with NCPO approval, develop Planning Initiatives for them. An outcome of the mandatory meeting between the NCPO and each VISN will be a list of required Planning Initiatives to be addressed in Network Cares Market Plans.

Specific gap analysis components, steps and example tables are described in the following sections:

**Component #1: Do our current health care facilities provide the amount of services to meet forecasted demand for Primary, Specialty, Outpatient care, Acute inpatient care, Long term care and the Special Emphasis Programs (subject to capacity maintenance requirements)?**

To address this question, the NCPO will conduct both VISN and Market level analyses.

The NCPO will complete a **VISN-level analysis** first as an overview of where gaps will exist in the VISN as a whole. This analysis will identify changes in enrollees, significant variances between current supply and future demand for beds and space for inpatient care, long term care, outpatient care, and non-clinical services (Administrative, Research and vacant space). It will generate flags for further analysis and discussion between NCPO and the VISN's primarily in the area of special disability programs and nursing home beds. Variances in capacity will be measured against Congressional requirements; Planning Initiatives may be required to address negative variances.

In the **market level analysis**, the NCPO will identify significant changes in enrollees, variances in future beds, outpatient workload, users, long term care and space for services and beds in a specific market. This analysis primarily identifies gaps in current supply of total acute beds and total outpatient workload when compared to future demand. The NCPO must approve any proposed variances in the time and distance criteria and will determine which of the identified gaps need to be addressed through Planning Initiatives. The list of Planning Initiatives will be finalized after a meeting with the Networks.

**Figure 5A: Workload Gap Analysis**

<b>TIENT CARE (Market Level)</b>	<b>Operating Beds in FY 2001 (Bed Control Database)</b>	<b>Operating Beds (Fee)</b>	<b>Total Operating Beds 2001</b>	<b>Operating Beds Projected for FY 2012</b>	<b>Variance</b>	<b>Significant Gap</b>
Medicine						
Surgery						
Intermediate Care Beds						
Psychiatry						
PRRTP						
Long Term Care						
Domiciliary program						
Spinal Cord Injury						
Blind Rehab						

<b>OUTPATIENT CARE (Market Level)</b>	<b>Clinic Stops in FY 2001 (In- house)</b>	<b>Clinic Stops in FY 2001 (Fee)</b>	<b>Total Clinic Stops in FY 2001</b>	<b>Clinic Stops in FY 2012</b>	<b>Variance</b>	<b>Significant Gap</b>
Primary Care						
Specialty Care						
Mental Health						
Geriatrics						
Ancillary and Diagnostics						
All Other						
Total						

<b>SPECIAL DISABILITY PROGRAMS (Network level)</b>	<b>Uniques in FY 2001</b>	<b>Millennium Bill Requirements</b>	<b>Variance</b>	<b>Significant Gap</b>
Blind Rehabilitation				
Spinal Cord Injury				
Substance Abuse				
Traumatic Brain Injury				
Homeless				
Seriously Mentally Ill				

**Component #2a: Are VA inpatient facilities located in areas that do not have sufficient enrolled populations (workload) to support their continued presence in the future and/or is there unnecessary redundancy in infrastructure?**

The first step of this specific market-level gap analysis concentrates on projected demand for acute inpatient beds. A Station Gap Analysis, similar to Figure 5A above, displays data to identify gaps at the facility level. The NCPO will identify a gap if projected enrolled population does not meet the threshold for maintaining a minimum of 50 beds in 2012 and 2022. As shown in the Criteria & Process To Identify Gaps (Attachment 5A), this equates to 28,000 projected enrollees based on national utilization projections. The drastic change in BDOC/1000 between 2001 and 2012 is due to the projected continued decline in inpatient utilization and the increase in the Priority 7 population enrollees. (Priority 7 veterans utilize fewer inpatient services) The NCPO will utilize Network specific data provided by Condor/Milliman USA for conducting this analysis, rather than National averages. The projected BDOC per 1000 enrollees is expected to vary by Network based on percent of Priority 7 enrollees, age of enrollees, and geographic variation in inpatient utilization. As a result, the number of enrollees required to support a 50-bed facility in 2012 and 2022 will vary.

The second step of this analysis focuses on geographic areas where two VA hospitals in close proximity offer a potential for consolidation and infrastructure realignment, while maintaining access standards. The NCPO will initially flag VA hospitals that are located within 60 miles of each other or tertiary hospitals that are located within 120 miles of each other. These sites will be targeted for Planning Initiatives if the scope of services is found to be duplicative.

**Component #2b: Are VA health care facilities situated in the right locations to meet future demands for services?**

This analysis identifies areas with significant enrolled veteran populations where travel times to VA services exceed national or local guidelines. NCPO will use a minimum standard of 28,000 enrollees (equating to 50 beds) located outside the travel access guidelines to identify markets that potentially require new inpatient facilities. For new outpatient clinics, NCPO will use a minimum standard of 5,000 enrollees located within defined communities outside of access guidelines (this is not a detailed CBOC analysis, but will identify areas with significant outpatient access constraints).

The NCPO will use markets identified in the demand analysis to establish variances from time and distance criteria (example shown in Step 2, Define Markets). This entails a listing of the location of VA healthcare facilities and their geographic relationship to the projected enrollee population by market. The time guidelines, and translation into miles, may vary based on geographic areas. Analysis of community practice in markets can be utilized to refine these access guidelines. However the Network must request that NCPO use different travel times in calculating access. Wherever possible, travel time guidelines that are prescribed by state policy, law or regulation should be provided as a basis for the request. As indicated in Step 2,

Define Markets, highly rural areas are specifically eligible for changes. The request must explicitly state proposed travel time guidelines and how they were determined. The NCPO will identify gaps at the market level for acute inpatient, outpatient and nursing home services.

Networks, if appropriate, may determine additional access gaps that exist for Long-term care and outpatient services at the market and sub-market levels, based on the criteria included in the VHA CBOC Directive and the LTC Planning model.

**Figure 5B: Access Gap Analysis**

Service Type	FY 2001 Data	FY 2012 Data	Variance (+/-)
	% of patients within travel guidelines	% of patients within travel guidelines	% of patients within travel guidelines
Primary Care			
Specialty Amb Care			
Extended Care			
Hospital Care			
Tertiary Care			
<b>Other</b>		<b>Y/N</b>	<b>Locations</b>
<b>More than one care site within Travel Guidelines?</b>			

The purpose of this analysis is to establish areas for improvement. There is no requirement that 100% of all enrollees are within travel guidelines.

### **Component #3: Do our existing facilities have right infrastructure to meet projected future workload?**

This NCPO gap analysis identifies where there will be excess space and/or unsuitable space for future operations. Figure 5C, which is the Facility Gap Analysis, displays the data necessary to match current space with projected demand and provides an indication of the condition of available space. The VA Space Driver gives an approximation of needed infrastructure space based on projected workload of unique patients, beds and services. Figure 5C identifies gaps in the condition and functionality of space. Larger facilities may have multiple wards (in Medicine for example), with one ward having deficient conditions and others that meet criteria. When this occurs, the cell(s) under the Space Condition/Functionality Column will be marked with an "X" on the list that the NCPO provides to Networks.

**Figure 5C: Infrastructure Gap Analysis**

	# Beds (from demand projections)			Space (GSF) (from demand projections)				
<b>INPATIENT CARE</b>	FY 2001	FY 2012	Variance from 2001 (+/-)	FY 2012	Variance from 2001 (+/-)	Space Functionality	Space Condition	Significant Gap
Medicine								
Surgery								
Intermediate Care Beds								
Psychiatry								
PRRTP								
Nursing Home Care								
Domiciliary program								
Spinal Cord Injury								
Blind Rehab								
	Clinic Stops (from demand projections)			Space (GSF) (from demand projections)				
<b>OUTPATIENT CARE</b>	FY 2001	FY 2012	Variance from 2001 (+/-)	FY 2012	Variance from 2001 (+/-)	Space Functionality	Space Condition	Significant Gap
Primary Care								
Specialty Care								
Mental Health								
Geriatrics								
Ancillary and Diagnostics								
All Other								
Total								
<b>NON-CLINICAL</b>				FY 2012	Variance from 2001 (+/-)	Space Functionality	Space Condition	Significant Gap
Research								
Other Administrative								
Vacant Space								

**B. Identify Issues From Network Strategic Plans, VACO Program Offices, NCA VBA and DoD.:**

NCPO will review current Network Strategic Plans (submitted to VACO April 15 2002) to identify significant issues that may warrant inclusion in a CARES Market Planning Initiative. DoD will assist in identifying sharing opportunities. Program offices will provide to NCPO any major strategic issues that are appropriate for a Planning Initiative in the context of CARES Market Plans. VBA and NCA will also provide input regarding opportunities for co locations and space planning. The Office of Asset Enterprise Management will assist in identifying Enhanced Use Leasing opportunities. All Network CARES plans will analyze long term care service gaps, particularly the consideration of alternatives to institutional long-term care

**Steps:**

1. NCPO will identify gaps and redundancies between supply and demand in of location, levels and mix of care and facility infrastructure to be addressed in CARES Market Planning Initiatives.
2. NCPO with other VACO offices will identify issues and gaps to be addressed from the Network Strategic Plans, DoD, other VACO Offices, VBA and NCA.
3. NCPO will identify long term care gaps to be addressed in planning initiatives.
4. NCPO and Networks will meet to
  - a. Review all of the data and analyses
  - b. Identify any issues with the gap analysis and Planning Initiatives
  - c. Develop a final listing of market-based CARES Planning Initiatives to be developed in the Market Plans
5. Networks will explain gaps not identified as significant market Planning Initiatives at the meeting
6. Networks will develop CARES Market Plans that complete the specific Planning Initiatives with proposed solutions. Chapter 5 of this Guidebook provides the detailed requirements for CARES Market Plans.
7. Identify any existing enhanced-use lease and their site location on the facility condition assessment map. Also identify any sharing agreements that outlease facility space to external organizations and energy savings performance contracts (ESPCs) at the facility that obligate the Department for over five years.

**Expected outcomes:**

- Identified Gaps and redundancies between supply and expected demand of beds, outpatient visits and other services indicated
- Identified gaps, if any, due to inappropriate mix of services in a market
- Identified gaps in long term care services to be addressed in Planning Initiatives
- Identified facilities, if any, with insufficient workload to support a continued presence

- Identified facilities, if any, where opportunities exist for consolidation and infrastructure realignment due to close geographic proximity
- Identified pockets, if any, of underserved populations due to location of current facilities
- Identified infrastructure needs to ensure current facilities are suitable to provide needed services in FY2012 and 2022
- Identified DoD, Enhanced Use, VBA, NCA and other program Planning Initiatives
- Identified list of CARES market planning initiatives

## Criteria & Process To Identify Gaps

**Acute Inpatient:** These services will be market-based and the NCPO will provide an assessment of gaps based on market enrollees and travel time. The gap analysis for acute beds is based on the projected bed days of care per 1000 enrollees, converted to average daily census and beds, using an 85% occupancy rate. When addressing the question of sufficient future enrollment to sustain an inpatient facility, the NCPO will use 50 beds as the threshold to identify a gap that Networks must address as a planning initiative. The threshold of fifty beds is derived from the DoD BRAC analysis, which identified 50 beds as the threshold for detailed review and analysis. The average bed days of care for VHA acute services and enrollment for 2010 yielded the number of enrollees to support a 50 bed facility as  $28,000 (42.5 \text{ ADC} * 365 = 15,512 / 553.6 \text{ BDOC per 1000 enrollees} = 28,000 \text{ enrollees to support 50 beds})$ . The final BDOC per 1000 enrollees will vary by VISN depending on percent of Priority 7s, age of population, and geographic variance in inpatient utilization patterns.

**Special Disabilities Programs:** This analysis will be at the market, multi-market, Network, or multiple Network level. Networks will record results for programs without mandated bed levels as presence/absence. For special capacity programs with mandated bed levels; Networks will submit their plans for increasing existing beds to meet the mandates. Networks will need to document their approaches to obtaining those special capacity program services that are not present in the Network.

**VA Nursing Home Care:** The gap analysis for VA nursing home beds targets Congressionally mandated VISN level average daily census (ADC) to identify the ADC floors that Networks will use to plan capacity for VA Nursing Home Care.  $(\text{Assigned ADC} / 95\% \text{ Occupancy Rate}) = \text{minimum beds required}$ .

**Long Term Psychiatry and Domiciliary:** For long term psychiatry and domiciliary (non –homeless) beds, no standards exist to establish thresholds; therefore, presence/absence criteria are used to identify the potential need for a market planning initiative.

**Ambulatory Care:** Due to the difficulty in determining local travel times and knowing local geographic barriers for specific sub-markets, NCPO will not identify gaps in service location for sub-markets. Specifically, the NCPO will only identify gaps in location of outpatient services at the Market level and will include an analysis of locations where a minimum of 5,000 enrollees in communities reside outside of travel times/distances guidelines. If Networks determine a CBOC analysis and plan are necessary to address identified space and functional issues, the Network will use the criteria from the CBOC Directive 2001-060, which requires 1,300 enrollees as a minimum. Networks may complete an ambulatory care analysis, using data from the table in Step 2 (Define Markets).

## Chapter 5. CARES MARKET PLAN

### A. Background:

The purpose of this chapter is to provide standard expectations and requirements for the development and submission of Network CARES Market Plans (NCMPs). The chapter describes NCMP deliverables including standardized submission requirements, alternative analyses, data sources, templates, and costing methodologies.

### B. Market Plan Definition:

Network CARES Market Plans are composed of completed Planning Initiatives. Network CARES Market Plans (NCMPs) provide a roadmap for addressing the specific gaps in services, facilities and/or infrastructure and other strategic issues identified by VACO determined Planning Initiatives. NCMPs emphasize the delivery of high quality care in the most cost-effective manner for projected enrollees based upon VA's medical benefits package.

Planning Initiatives are responses to market-based gaps in services, facilities and /or infrastructure (including duplication and redundancies in services and/or infrastructure) and other strategic program issues identified by VACO. In the NCMPs, Networks complete these Planning Initiatives, providing preferred solutions and detailing proposed actions to include information on how, when, where care will be provided to meet future demand and at what cost.

A market plan is developed for each Network market with a Planning Initiative identified by VACO.

The NCMPs are to be limited to the VACO defined Planning Initiatives provided by the NCPO unless there are Network identified Planning Initiatives agreed to by the NCPO at the mandatory meeting to finalize the Planning Initiatives (Chapter 4, Step 5).

### C. Planning Criteria for Market Plans:

Each Market Plan and component planning initiative(s) must address these planning criteria. These criteria are translated into evaluation criteria that will be used in the VACO review process to develop an overall assessment of each Planning Initiative/Market Plan. The criteria require that the Market Plans and, to the extent applicable, each Planning Initiative will:

#### **Health Care Quality and Need**

1. Address the impact on quality of care, including any relationships between quantity of services/procedures and volume, continuity and coordination of care due to realignments, and performance improvement issues from alignments where there are different levels of performance on selected quality indicators.
2. Meet the forecasted need for veteran services identified as gaps in the CARES planning process and translated into Planning Initiatives.

### **Safety and Environment**

3. Ensure the safety of the physical healthcare environment

### **Health Care Quality as Measured by Access**

4. Provide appropriate veteran access to healthcare services, using VA standards

### **Research and Academic Affiliations**

5. Minimize adverse impact on Research and Education

### **Staffing and Community Impact**

6. Minimize the impact of potential changes on employees and communities
7. Minimize the impact on community healthcare delivery systems

### **Support Other VA Missions**

8. Promote VA/DoD collaboration
9. Promote VBA/NCA co-location
10. Ensure VA's ability to provide back-up to DoD
11. Ensure VA's ability to meet Homeland Security needs, emergency preparedness and contingency back-up.

### **Optimizing Use of Resources**

12. Maximize life cycle cost savings by the completed planning initiative
13. Right-size and realign VA healthcare facilities based on future demand and needs

See the following attachments for criteria and guidelines to be used as appropriate in the development of CARES Market Plans:

**Attachment 4** for Patient Care Services Planning Criteria to be used as appropriate in the development of Market Plans.

**Attachment 5** for an overview of Section 106, USC for requirements related to historical preservation of buildings

**Attachment 6** for a summary of the National Long Term Care Strategic Plan

**Attachment 7** for a summary of VACO program offices Guiding Principles and Criteria

**Attachment 8** for a summary of the enhanced-use leasing process.

## **D. Overview of Market Plan Submission Requirements:**

### **1. General**

- a. For shared markets, NCMPs and PIs will be developed jointly with an identified Lead Network. At a minimum, this will require that all VA resources are taken into account regardless of organizational alignment and that gaps, duplication and overlaps are addressed in a coordinated fashion.
- b. Each Market Plan will provide an analyses of how expected demand for services will be met, in terms of capacity, location, capital, cost (See sections 2 and 3 on capital and financial analysis), access, and impact on all of the planning criteria for each Planning Initiative identified.
- c. Each Market Plan will be developed to meet variations in demand to 2022. That variation should be reflected in the selection of actions and phasing of the approved initiatives when an implementation plan is developed.
- d. Each Planning Initiative will include a description of at least one alternative that was analyzed but not selected to be a Planning Initiative with supporting justification.

## **2. Capital Analysis**

- a. The capital analysis will include not only space, but also the quality of space. Tools available to assist with this analysis include the Space & Functional Surveys and the Facility Condition Assessment. (See attachment 4A to Chapter 4 for descriptions).
- b. When determining service location, the analysis includes the appropriateness of space, in accordance with the planning criteria, as well as the cost to prepare space to meet community standards. The cost template outlined below will estimate renovation costs based on type, condition and location of space.
- c. When determining service location, identification of space and excess space, consideration must be given to historical resources. (See Attachment 5)
- d. The Market Plan will include a Capital Asset Realignment Plan (CAR) (See Chapter 2 CARES Directive) that summarizes all Capital Asset changes and will contain a Planned Capital Investments and Divestments GANT chart.
- e. Analyses of how the Enhanced Use Program will make better use of underutilized or unnecessary capital assets identified in the Planning Initiatives or as a result of the Planning Initiatives completion.

### **3. Financial Analysis**

As part of the CARES process a costing template is being developed for use by Networks. This template will be used to analyze the cost of the Planning Initiatives that will make up the overall Market Plans, the costs associated with alternatives considered and the savings available to enhance services from the completed planning initiative. This template will utilize standardized VA data elements for all identified markets, facilities, and Networks. Where possible, the template will be pre-populated and all calculations will be done automatically through the template based on the selected parameters input by the Network.

Factors that are to be built into the costing template will include:

- a. Adjusted DSS Unit Costs
- b. Current Utilized Space
- c. Condition of Current Utilized Space
- d. Amount of Vacant Space Available
- e. Condition of Vacant Space
- f. Unit Cost of Leasing Space (by type of space)
- g. Unit Cost of Constructing New Space
- h. Unit Cost of Renovating Existing Space (Low/Medium/High)
- i. Cost of Contracting for Services

It is intended that this costing template will provide the ability to adjust the locations, phasing and/or quantity of services in order to meet the demand projected for each market in 2012 and 2022. As the Networks develop these adjustments, the costing template will calculate the Life Cycle cost increases or Life Cycle cost savings resulting from the individual Planning Initiative. This template will also provide various reporting capabilities on the different initiatives that make up the overall market plan.

### **E. Market Plan Submission Requirements:**

#### **1. Network Summary of Market Plans (See Attachment 1):**

The summary will contain the following information:

- a. Identification and description of each market in the Network and summary of the Planning Initiatives (gaps in services, facilities and/or infrastructure) identified by VACO.
- b. An overview of each Market Plan and the specific solutions in the Planning Initiatives.
- c. A summary of the impact of each Market Plan on other Network Markets.
- d. A summary of how the Network will provide appropriate capacity and services for Special Disability Groups.

- f. A summary of stakeholder input and how it was utilized in arriving at the Planning Initiatives.
- g. A Summary Template for each Market, showing proposed service capacity, space/capital changes and estimated costs/savings including a Capital Asset Realignment (CAR) Plan.
- h. A summary of the use of the Enhanced Use Program in the Market Plan.
- i. A summary of the impact upon DoD sharing, Homeland Security, Emergency Preparedness and Contingency back-up.

## **2. Individual Market Plan (See Attachment 2)**

### PART I: Executive Summary

- a. Description of the Market and the Planning Initiatives that were identified for the Market by VACO
- b. Description of the NCMP and the component Planning Initiative(s) completed by the Network. This should address how the Planning Initiative(s) enables VA to meet projected changes in demand, impact on existing facilities and plans for new facilities. For shared markets, the Executive Summary should address linkages with other Network(s) NCMPs.
- c. Description of stakeholder involvement and how stakeholder issues were addressed.
- d. Discussion of how the NCMP responds to the planning criteria.
- e. Summary of major strengths, weaknesses, opportunities and obstacles associated with the NCMP.
- f. Summary Template showing, by Service Category, the NCMP capacity, space/capital changes and estimated costs including a CAR Plan.
- g. A summary of the use of the Enhanced Use Program in the Market Plan.
- h. A summary of the impact upon DoD sharing, Homeland Security, Emergency Preparedness and Contingency back-up.

### PART II: Individual Market Plan Information

- a. A description of the actions that comprise the completed planning initiative.
- b. A description of stakeholder involvement for the specific planning initiative.
- c. Provide detailed information for each Planning Initiative within the market for the following planning criteria impact analysis:

**Health Care Quality and Need**

- 1) The impact on Quality of Care as follows:
  - Describe the analysis of the impact of volume on quality in determining realignment decisions.
  - Describe the impact of realignment decisions on continuity and coordination of care.
  - Describe the impact of realignment decisions on sites with lower quality performance measures and how performance would be improved.
- 2) How the projected need identified in the CARES Planning Process and gap analysis translated into Planning Initiatives will be met.

**Safety and Environment**

- 3) Describe the impact on the safety of the healthcare environment and outline improvements planned to maintain community standards.

**Healthcare Quality as Measured by Access**

- 4) The impact on access to healthcare services, using VA guidelines when available.
  - Describe changes to Facility Clinical inventories for all facilities in the market, including additions and deletions of programs, services and/or beds.
  - Describe changes to each facility's capacity for each of the Service Categories (i.e. medicine, surgery, psychiatry, intermediate care and NHC beds).
  - Describe the impact on the percentage of the market area enrollees meeting travel distance/times for accessing different levels of care (i.e., primary, secondary, tertiary, NHC).

**Research and Academic Affiliations**

- 5) Explain the impact on Research and Education opportunities and how any negative impact will be minimized.

**Staffing and Community Impact**

- 6) Indicate current levels of staffing and explain the impact on employees and communities and describe the strategy to minimize any negative impact.

- Describe how the VISN has communicated the potential impact of the staffing changes to the current employees.
- 7) Characterize and quantify the potential impact on community healthcare delivery systems.

### **Support of Other Missions of VA**

- 8) Describe how the Planning Initiative proposes to impact the sharing of resources with DoD and enhance One-VA opportunities and collaborations with VBA and NCA.
- Indicate current and planned collaboration/sharing activities and describe anticipated impact.
  - Consider opportunities to utilize DoD especially as new needs arise.
- 9) Describe the impact on VBA/NCA and how co-location will be promoted.
- Indicate existing co-location and describe any planned co-location.
- 10) Describe the impact on VA's ability to provide back up to DoD.
- 11) Describe the impact on VA's ability to participate in Homeland Security and Emergency Preparedness.

### **Optimizing Use of Resources**

- 12) Maximizes the life cycle cost savings by the completed planning initiative.
- For each Planning Initiative, attach the output spreadsheet(s) from the Costing Template that show the data analysis conducted for each alternative and that costs have been reduced for maintaining excess space.
- 13) Right-size and re-align VA healthcare facilities based on future demand and needs as described in the Planning Initiative.
- For each facility that is included in a planning initiative, show current and planned utilization of all buildings.
  - For each facility and service category impacted by a Planning Initiative, indicate all capital investments required in the Planning Initiative.
  - Leverage current assets to the extent feasible, utilizing current assets to the extent feasible and developing Enhanced Use proposals.
  - Describe and quantify how the PI will reduce vacant space.

- 14) Expected Savings
  - For each Planning Initiative use the cost template and any associated algorithms to quantify the expected savings.

- d. Alternative Solutions

Describe at least one alternative solution analyzed using the same analysis as described in c. 1-14 for the planning initiative solution selected for completion and provide justification for why the solution selected to complete the Planning Initiative was considered the best based upon the planning/evaluation criteria.

#### **F. Long term Care/Extended Care:**

The aging of the veteran population, particularly the needs of the veteran population 75 and above present considerable challenges in realigning health care services to meet these needs. The Mill Bill expands adult day health care, outpatient geriatric evaluation, and emphasizes approaches to provide non-institutional services for the frail elderly as part of the continuum of extended care services. These needs and programs must be considered in the development of Planning Initiatives and Market Plans.

Consideration should include the space requirements to make services fully accessible to the elderly recognizing the space requirements of a population with some physical limitations and challenges. Space considerations should also include the space needs of program staff that will be required for community and home based programs and that may be required in CBOCs and other settings. Attachment 5 provides a summary of the key planning considerations extracted from the approved National Long Term Care Strategic Plan.

#### **G. Electronic Submission:**

It is anticipated that a relational web-based database will be developed for submission of the Market Plans. Information will be input by the Network onto the CARES web site in the database, or provided as a hard copy template. The outputs from that electronic document could then be tailored for the user to allow for planning and review. The report can be displayed/printed by Service Category, Facility, Market, VISN, and for each of the Guiding Principles. Therefore, each action identified in the Planning Initiative will be tied to a Facility, Market, VISN and Service Category.

**Attachment 1 in this chapter contains sample templates for the Network Plan.**

**Attachment 2 contains sample templates for networks to utilize in the development of market plans.**

**ATTACHMENT 1****Network Summary of Market Plan:**

Following is the type and samples of information that will be required to respond to selected elements described in the Market Plan Submission Requirements. Additional examples will be provided by the NPCO and VSSC.

1. Identification and description of each of the Markets for which planning was conducted (narrative and chart)

Market	Urban, Suburban or Rural	Projected Enrollees	Facilities providing services in the Market	Type/Mission of Facility	If market shared indicate VISN #
Market A	Urban	28,000	Facility 1	Tertiary	
			Facility 2	Outpatient	
Market B	Rural	30,000	Facility 4	Tertiary	

2. The VACO identified Planning Initiatives for which planning was conducted. (Narrative)
3. An overview of each Market Plan and the component Planning Initiatives developed by the Network. (Narrative and chart-sample located on next page)
4. A summary of the impact of each Market Plan on other Markets and Networks. (Narrative)
5. A summary of stakeholder input and how it was utilized in arriving at Planning Initiatives (Narrative)
6. Overview of impact on the delivery of care to Special Disability Groups
7. Summary data as in the template shown on the next page (Network Summary of Market Plan Changes) showing, by Service Category, the VISN capacity, space/capital changes and life cycle cost variance.
8. A summary of the use of the Enhanced Use Program in the Market Plan.
9. A summary of the impact upon DoD sharing, Homeland Security, Emergency Preparedness and Contingency back-up.

Item 7 *cont'd.* from previous page (Summary Data Template).

### Overview of Planning Initiatives

INPATIENT CARE	Baseline Workload Units (FY 2001)	Projected Workload Units (FY 2012)	Projected Workload Units (FY 2022)	Planning Initiative
Medicine				
Surgery				
Intermediate Care Beds				
Psychiatry				
PRRTP				
Long Term Care				
Domiciliary program				
Spinal Cord Injury				
Blind Rehab				
OUTPATIENT CARE				
Primary Care				
Specialty Care				
Mental Health				
Geriatrics				
Ancillary and Diagnostics				
All Other				
Total				
SPECIAL DISABILITY PROGRAMS (FY 2012)				
Blind Rehabilitation				
Spinal Cord Injury				
Substance Abuse				
Traumatic Brain Injury				
Homeless				
Seriously Mentally Ill				
Post Traumatic Stress Disorder				

**ATTACHMENT 1**

**NETWORK SUMMARY OF MARKET PLAN CHANGES**

	Changes in the # beds required in 2012		# Beds proposed by Market Plans in VISN in 2012	Post MP Life Cycle Cost variance (+/-) as a result of changes	Changes in Space (GSF) requirements in 2012 (from demand projections)		Space (GSF) proposed by Market Plans in VISN	Post MP Life Cycle Cost variance (+/-)
	FY 2012	Variance from 2001 (+/-)	Total Beds	FY 2012	FY 2012	Variance from 2001 (+/-)	In-house GSF	FY 2012
<b>INPATIENT CARE</b>								
Medicine								
Surgery								
Intermediate Care								
Psychiatry								
Total Acute Care Beds								
PRRTP								
Nursing Home Care								
Domiciliary program								
Spinal Cord Injury								
Blind Rehab								
	Changes in Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plan	Post MP Life Cycle Cost variance (+/-)	Changes in Space (GSF) Requirements in 2012 (from demand projections)		Space (GSF) proposed by Market Plan	Post MP Life Cycle Cost variance (+/-)
<b>OUTPATIENT CARE</b>	FY 2012	Variance from 2001 (+/-)	In-house 2012	FY 2012	FY 2012	Variance from 2001 (+/-)	In-house GSF	FY 2012
Primary Care								
Specialty Care								
Mental Health								
Geriatrics								
Ancillary and Diagnostics								
All Other								
Total								
<b>NON-CLINICAL</b>					Changes in Space (GSF) Requirements in 2012 (from demand projections)		Space (GSF) proposed by Market Plan	Post MP Life Cycle Cost variance (+/-)
					FY 2012	FY 2012 Variance from 2001 (+/-)	In-house GSF	FY 2012
Research								
Other Administrative								
Vacant Space								

## **MARKET PLAN SUBMISSION**

### **PART I: EXECUTIVE SUMMARY OF MARKET PLAN**

1. A brief description of the Market, highlighting major characteristics, including sub-markets (as appropriate), current VA healthcare services and other significant factors (i.e. DoD facilities, unique community or geographic features, etc.)
2. Highlights of the planning initiatives, issues and NCPO identified information about gaps/duplication/overlaps that must be addressed by the Network based on the CARES planning process.
3. A Description of the Market Plan, including how it enables VA to meet projected changes in demand, impact on existing facilities and plans for new facilities; for shared markets, provide linkages with other Network(s) MPs.
4. Summarize the major strengths, weaknesses, opportunities and obstacles associated with the MP:
5. Summarize how the Market Plan responds to the planning criteria.
6. Describe stakeholder involvement and how stakeholder issues were addressed.
7. Describe the impact of the Market Plan on Homeland Security and Emergency Preparedness.
8. Complete one summary table for each Market and each Facility addressing workload/cost and space/cost. See samples on the following pages:

**Sample Summary Table.**

<b>WORKLOAD CAPACITY</b>								
	<b>Changes in # Beds</b>		<b># Beds proposed by Market Plans in VISN</b>					
<b>INPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001 (+/-)</b>	<b>In House in 2012</b>	<b>Contracted in 2012</b>	<b>Leased in 2012</b>	<b>Shared in 2012</b>	<b>Total Beds</b>	<b>Post MP Life Cycle Cost variance (+/-)</b>
Medicine								
Surgery								
Intermediate Care								
Psychiatry								
PRRTP								
Nursing Home Care								
Domiciliary program								
Spinal Cord Injury								
Blind Rehab								
	<b>Changes in # Clinic Stops</b>		<b>Clinic Stops proposed by Market Plans in VISN</b>					
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001 (+/-)</b>	<b>In House in 2012</b>	<b>Contracted in 2012</b>	<b>Leased in 2012</b>	<b>Shared in 2012</b>	<b>Total Beds</b>	<b>Post MP Life Cycle Cost variance (+/-)</b>
Primary Care								
Specialty Care								
Mental Health								
Geriatrics								
Ancillary and Diagnostics								
All Other								
Total								
<b>SPECIAL DISABILITY PROGRAMS (NETWORK LEVEL ONLY)</b>	<b>Millennium Bill Requirements</b>	<b>Variance from 2001 (+/-)</b>	<b>Total proposed by Market Plan</b>	<b>Post MP Life Cycle Cost variance (+/-)</b>				
Blind Rehabilitation								
Spinal Cord Injury								
Substance Abuse								
Traumatic Brain Injury								
Homeless								
Seriously Mentally Ill								
Post Traumatic Stress Disorder								
Post Traumatic Stress Disorder - SMI								

## ATTACHMENT 2

## Sample summary table.

## PROPOSED CHANGES IN SPACE

	Changes in Space (GSF) from demand projections		Space (GSF) proposed by Market Plans in VISN				
INPATIENT CARE	FY 2012	Variance from 2001 (+/-)	In-house GSF	Leased GSF	SF Not used due to Leased	SF Not used due to Sharing or Contracted	Post MP Life Cycle Cost variance (+/-)
Medicine							
Surgery							
Intermediate Care							
Psychiatry							
PRRTP							
Nursing Home Care							
Domiciliary program							
Spinal Cord Injury							
Blind Rehab							
	Changes in Space (GSF) from demand projections		Space (GSF) proposed by Market Plan				
OUTPATIENT CARE	FY 2012	Variance from 2001 (+/-)	In-house GSF	Leased GSF	SF Not used due to Leased	SF Not used due to Sharing or Contracted	Post MP Life Cycle Cost variance (+/-)
Primary Care							
Specialty Care							
Mental Health							
Geriatrics							
Ancillary and Diagnostics							
All Other							
Total							
	Changes in Space (GSF) from demand projections		Space (GSF) proposed by Market Plan				
NON-CLINICAL	FY 2012	Variance from 2001 (+/-)	In-house GSF	Leased GSF	SF Not used due to Leased	SF Not used due to Sharing or Contracted	Post MP Life Cycle Cost variance (+/-)
Research							
Other Administrative							
Vacant Space							

**ATTACHMENT 2****Individual Market Plan Requirements:  
Planning Initiative Impact Analysis**

For each of the planning initiatives, describe the current situation and how that will be impacted by the planning initiative. The same information is required for at least one alternative solution considered to complete the Planning Initiative.

**Healthcare Quality and Need**

1. Discuss the impact of Quality of Care as follows:
  - Describe the analysis of the impact of volume on quality in determining realignment decisions.
  - Describe the impact of realignment decisions on continuity and coordination of care.
  - Describe the impact of realignment decisions on sites with lower quality performance measures and how performance would be improved.
2. Discuss how the forecasted need identified in the CARES Planning Process will be met.

**Safety And Environment:**

3. Discuss the impact on the safety of the healthcare environment and outline improvements planned to maintain community standards.

Facility	Service Category	Major Functional Deficiencies	MP Impact	Major Condition Deficiencies	MP Impact
	Type	Layout, adequacy of space, adjacencies, code compliance, accessibility, privacy,		Building systems by discipline	
Facility A	Inpatient,				
Facility A	Outpatient				
Facility A	Special Disability				
Facility B	Inpatient				
Etc					

**Healthcare Quality as Measured by Access**

4. Discuss the impact on access to healthcare services, using VA standards when available.
  - A. Clinical Inventory

**ATTACHMENT 2**

For each facility in the market, update the Clinical Inventory database to note changes in availability and delivery of services. Outline changes to Facility Clinical inventories, including additions and deletions of programs, services and/or beds.

B. Capacity to Meet Needed Services

Outline changes to each facility's capacity for each of the Service Categories Appropriate to the Planning Initiative. Provide comments where proposed capacity is met outside the market or is not met.

**PROPOSED MARKET CAPACITY**

<b>INPATIENT CARE</b>	<b># Beds from Demand Projections</b>	<b># Beds proposed in Market Plan</b>	<b>Comments</b>
Medicine			
Surgery			
Intermediate Care			
Psychiatry			
Total Acute Care Beds			
PRRTP			
Nursing Home Care Unit			
Domiciliary program			
Spinal Cord Injury			
Blind Rehab			
<b>OUTPATIENT CARE</b>	<b>Clinic Stops (From demand Projections)</b>	<b>Clinic Stops proposed in Market Plan</b>	<b>Comments</b>
Primary Care			
Specialty Care			
Mental Health			
Geriatrics			
Ancillary and Diagnostics			
All Other			

C. Access to Care

Indicate the impact on achieving travel distance/times guidelines for different levels of care (i.e., primary, secondary, tertiary, NHC). Specify travel distance/time guidelines that were used in planning for this market (or sub-market if appropriate). If travel guidelines differ from the

**ATTACHMENT 2**

guidelines provided in Chapter 4, Step Two (Miles and Travel Time Guidelines), prior approval is required.

Service Type	Travel Guidelines	Current	Post Market Plan
Type (Urban/ Rural or Highly Rural)	**	% of patients within travel guidelines	% of patients within travel guidelines
Primary Care			
Specialty Ambulatory Care			
Extended Care			
Hospital Care			
Tertiary Care			

**\*\* See Chapter 4, Step Two (Miles and Travel Time Guidelines)**

**Research and Academic Affiliations**

- Describe/Explain how the impact on research and education opportunities will be minimized.

**Research**

Facility	Current Research SF	MP Research SF	Current Research \$\$	MP Impact	Comments/Strategy to address impact
				(None Increase Decrease Eliminate)	

**Academic Affiliations**

Facility	Affiliation	Current # of Residents	MP Impact (None Increase Decrease Eliminate)	Comments/Strategy to address impact

**Staffing and Community Impact**

- 6. Indicate current staffing levels, describe anticipated impact, and explain strategy used to minimize impact.

Facility	2001 Baseline FTE	Estimated Market Plan Impact on FTE - +/- FTE	Comments/Strategy to address impact

- A. Describe how the VISN has communicated the potential impact of the staffing changes to the current employees.

- 7. Characterize and quantify the potential impact on community healthcare delivery systems.

Facility	Current/Projected Contracted Care	Projected Gains and Losses	Comments/Strategy to address impact

**Support of Other Missions of VA**

- 8. Describe how the Planning Initiative proposes to impact the sharing of resources with DoD and enhance One-VA opportunities and collaborations with VBA and NCA.

- A. Indicate current and planned collaboration/sharing activities and describe anticipated impact.

Facility	DoD or Community Sites	Description of Current Sharing/Collaboration	Descriptions of Post MP Sharing	Issues

**ATTACHMENT 2**

B. Consider opportunities to utilize DoD especially as new needs arise.

9. Indicate existing co-location and describe any planned co-location and describe the impact on VBA/NCA and how co-location will be promoted.

Facility	Current Co-location	Current Sq. Footage	MP Impact None Increase Decrease Eliminate	Comments/Strategies

10. Describe the impact on VA's ability to provide back up to DoD.

Facility	Current Role (PRC, SSC, FCC, ISC)	Post Market Plan Role(PRC, SSC, FCC, ISC)	Current Beds Available to DoD	Impact of MP on Beds Available to DoD

**Note:** PRC – Primary Receiving Center  
 SSC – Secondary Support Center  
 FCC – Full Coordinating Center  
 ISC – Installation Support Center

11. Describe the impact on VA's ability to participate in Homeland Security and Emergency Preparedness.

**Optimizing Use of Resources**

12. Maximize life cycle cost savings by the completed planning initiative.

a. For each Planning Initiative, there will be output spreadsheet from the Costing Template that show the data analysis conducted for each alternative similar to the sample below.

**LIFE-CYCLE COSTS**

Service Category = Medicine, Surgery, Psych, etc.	Current Workload	Change in Workload	LCC of Workload Variance (DSS)	LCC to Use available Space without renovation	LCC to Use available space WITH Renovation	LCC to use New Space	LCC to Lease	LCC for Purchase of Services	LCC for EU or Sharing	LCC for Revenue Generated from Lease of Excess Space	LCC for Revenue generated from sale of capital or services
Facility A (Alt 1)											
Facility A (Alt 2)											
Facility A (Alt 3)											
Facility B (Alt 1)											
Facility B (Alt 2)											
Facility B (Alt 3)											
Sum effect for Planning Initiative:											

**ATTACHMENT 2**

13. Utilization of Capital: Right-size and realign VA healthcare facilities based on future demand and needs as described in the Planning Initiative

a. For each facility impacted by the Planning Initiative, show a current and planned utilization of all buildings, similar to the sample below:

Building Number	Current Function Title	Proposed Utilization	Total GSF	Planned Utilized SF	Planned Vacant SF	Name of Planning Initiative(s) impacting building	Investment plan (List of projects by building)
5	Auditorium		19,258				
6	Education		7,518				
7	Warehouse		17,460				
8	Boiler Plant/Incinerator		8,110				
9	Research		23,860				
10	Administration		22,620				
20	Shops/Engineering		9,414				
22	Administration		33,749				
23	Storage		2,068				
25T	FMS Shops		1,150				
28T	Research		20,000				
34T	Storage		2,170				
100	Main Hospital		581,580				
101	Outleased		48,000				
103	NHCU		64,883				
104	Lecture Hall		7,000				
105	Warehouse		4,200				
106	Psychiatry Bldg.		76,100				
114	MRI Bldg.		3,040				

b. For each facility and service category, indicate all capital investments required in the Planning initiative, and phasing similar to the example below:

Market	Facility	Bldg	Cost	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
<b>Primary Care</b>														
Expand Pod A	Facility A	2	\$2 M											
Improve Patient Privacy	Facility B	6	\$1.5 M											
<b>Specialty Care</b>														
<b>Mental Health</b>														
<b>Geriatrics</b>														
<b>Ancillary &amp; Diagnostic</b>														
<b>Other</b>														
<b>Misc</b>														
Demo Building 8	Facility B	8	\$1 M											

**ATTACHMENT 2**

- c. Enhanced Use: For each potential/planned Enhanced Use initiative related to the Planning Initiative, complete the following charts indicating its status, scope and value:

Network	Facility	EU Initiative – Name	EU Initiative – Brief Description	Status – Business Plan Submitted to VACO (date)	Status - Business Plan Approved (date)	Status - EU Delegation Approved (date)	Status –EU lease Execution (date)	Status –EU Operational (date)

EU Initiative – Name	Facility	Will EU be Located in Existing Space	Amount of Existing Space Utilized	Is the EU Revenue Generating (yes/no)	Value of Consideration in \$'s	Potential to Dispose Property? (yes/no)	Disposal Value in \$'s	Comments

- d. Describe and quantify how the PI will reduce vacant space.

14. Quantify the expected costs savings that could be used to enhance services using the standardized costing template.

**Alternatives Analysis**

To assist in understanding the reason for selecting the solution used to complete the Planning Initiative utilize Attachment 3 to summarize the comparison between the planning initiative alternative solution and the one selected.

## Alternatives Analysis

For each Planning Initiative one alternative must be considered using the planning criteria and sub criteria.

### Description:

**Status Quo:** Describe the existing situation.

**Proposed PI:** Describe the proposed PI solution.

**Alternate:** Describe the alternative considered.

## Healthcare Quality and Need

### HealthCare Quality

**Status Quo:**

**Proposed PI:**

**Alternate:**

### HealthCare Need

**Status Quo:**

**Proposed PI:**

**Alternate:**

## Safety and Environment

### Health Care Services to Veterans, Visitors and Staff in a Safe and Suitable Environment:

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Healthcare Quality as Measured by Access**

<b>Program</b> (Primary, Specialty, Inpatient, etc)	<b>Status Quo</b>	<b>Proposed PI</b>	<b>Alternative</b>
<b>Guidelines</b> (ie. 30 minutes, 60 minutes, etc)	<b>% of patients within guidelines</b>	<b>% of patients within guidelines</b>	<b>% of patients within guidelines</b>

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Research and Academic Affiliations**

**Research Programs and Services**

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Research space and funding**

	<b>Status Quo</b>	<b>Proposed PI</b>	<b>Alternative</b>
<b>Research Space (SF)</b>			
<b>Estimated Research funding (\$)</b>			

**Academic Affiliations Programs and Services**

**Education Programs and Services:**

**Status Quo:**

**Proposed PI:**

**Alternate:**

	Status Quo	Proposed PI	Alternative
<b># of residents slots</b>			
<b>Number and type of programs?</b>			

**Staffing and Community Impact**

	Status Quo	Proposed PI	Alternative
<b>FTEE level</b>			

**Staffing:**

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Community Impact:**

**Status Quo:**

**Proposed PI:**

**Alternate:**

## **Support of other Missions of VA**

### **Maximizing Program or Service Sharing Arrangements with the Department of Defense**

#### **Sharing with DoD:**

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Maximizing One-VA- Integration:** Describe in narrative the impact on enhancing One-VA opportunities and integrations with VBA, NCA and other VHA programs.

**Status Quo:**

**Proposed PI:**

**Alternate:**

#### **Department of Defense Contingency Planning:**

**Status Quo:**

**Proposed PI:**

**Alternate:**

#### **Homeland Security and Emergency Preparedness:**

**Status Quo:**

**Proposed PI:**

**Alternate:**

## Optimizing Use of Resources

### Life Cycle Cost

	Status Quo	Proposed PI	Alternative
Life Cycle Costs			

### Utilization of Capital

	Status Quo	Proposed PI	Alternative
SF utilized for program			
Vacant space in SF			

### Enhanced-Use Leasing Initiatives

	Status Quo	Proposed EU for PI	Alternative Considered
Available vacant space in SF			

### Expected Cost Savings as a Result of Planning Initiative

Proposed PI

Alternative

### **CARES Planning Criteria Criteria and References for Clinical Services**

The purpose of this attachment is to provide a summary of Patient Care Services guiding principles, criteria where available, and pertinent references for the CARES planning process.

#### **General Principles:**

- Clinical planning and service assessments must comply with the medical benefits package (38 CFR 17.38), mandated capacity requirements (PL107-135 and PL106-117), as well as existing VHA Directives and Handbooks.
- Potential changes in clinical services should be evaluated in a comprehensive manner. This should include, as appropriate, an analysis of the number of patients impacted, outcome measures for interventions of concern at current program levels with other programs/facilities, impact of proposal on other services or programs, fiscal considerations, impact of proposal on graduate medical education, staffing, VA/DoD sharing.
- Quality of care and patient safety are paramount. For proposed contract services, appropriate and enforceable quality and safety provisions should be addressed. When community treatment is provided, mechanisms must be in place to assure that services are delivered as planned and according to VA requirements.
- Integration of healthcare services across the continuum of care should be assured, including integration of mental health, geriatric/extended care and primary care.

#### **General References:**

The following are key VHA directives that pertain to program clinical changes and capacity:

- VHA Directive 1000.1, Program Restructuring and Inpatient Bed Change Policy, Jan 31, 2001
- VHA Directive 99-030, Authority for Mental Health Program Changes, June 30, 1999
- VHA Directive 99-013, Decision-Making Authority for the Spinal Cord Injury and Disorder Program, Mar 29, 1999
- VHA Directive 99-017, Spinal Cord Injury Service Staffing standards for Services provided by Nursing, April 22, 1999
- VHA Directive 2000-022, Spinal Cord Injury Center Staffing and Beds, July 26, 2000
- VHA Long Term Care Planning Model
- Statement of USH on Non-Institutional Long-Term Care before the Senate Committee on Veterans' Affairs, April, 2002

### 1. Acute Care Services:

Planning for acute care services should include an assessment and comparison of quality outcomes among clinical programs within a VISN and nationally. This can be done using a variety of approaches, including Community Standards, NSPIC and CSPIC, Observed/Expected ratios, national performance measures/monitors, patient satisfaction survey results, etc.

The following are general guidelines that should be used for planning new clinical programs in VA and provide one reference point for CARES when planning new programs (Note: these are not intended for use in evaluating continuation/closure of programs). Additional detail and guidance is available from the Patient Care Services Program Office:

- Cardiology: Catheterization-250 per facility per year; Angioplasty: 75 per facility per year; Pacemaker: 15 per facility per year; American College of Cardiology and American Hospital Association Guidelines
- Endoscopy (any type): minimum of 50 per year per facility; general guideline is one procedure per week
- Oncology: Minimum of 200 new diagnoses of cancer (non-skin) per year per facility
- Cardiac Surgery: 100 cases/year
- Thoracic Surgery: 100 cases/year
- Vascular Surgery: 100 cases/year; vascular lab 300/year
- Transplants: 12 cases/year VA guideline
- Dialysis: minimum of 1000 treatments per year

### 2. Blind Rehabilitation:

- Networks must comply with capacity legislation requirements. Any changes to Blind Rehabilitation programs must be made in consultation with the National Program Office.
- In addition to Blind Rehabilitation Centers, Networks must provide blind rehab services across the continuum of care including Visual Impairment Services Teams (VIST), Blind Rehabilitation Outpatient Specialists (BROS), Visual Impairment Services Outpatient Rehabilitation (VISOR) models, and Visual Impairment Center for Optimizing Residual Sight (VICTORS).

### 3. Long Term Care:

- Networks must maintain the level of Long Term Care services mandated in Millennium Act. This includes maintaining capacity of the GEC programs. Specifically, staffing and level of extended care services as measured by FTEE, dollars, number of programs, number of unique veterans served, and Average Daily Census are to be no less than they were during fiscal year 1998

**ATTACHMENT 4**

for Geriatric Evaluation, Home-Based Primary Care, Nursing Home Care Unit, Domiciliary, and Adult Day Health Care.

- Networks must maintain access for staff and veterans to supportive clinical services that assist Geriatric and long term care programs and services, such as allied health services.
- Capacity must accommodate anticipated expansion of populations, as projected by VA demographic analyses and the Long-Term Care planning model. The most vulnerable of our older veteran population, those over 75 and particularly those over 85, will continue to increase into the next decade. This is notable since these persons are especially likely to require institutional care and to need healthcare of all types.
- VA's approach to extended care has evolved from an institutionally-focused care model to one that includes a complete continuum of home and community-based extended care services in addition to nursing home care. VA's standard benefit package requires access to non-institutional extended care services, including home care, hospice/palliative care, and inpatient respite care

**References:**

- VHA Long Term Care Planning Model
- Statement of USH on Non-Institutional Long-Term Care before the Senate Committee on Veterans' Affairs, April, 2002

**4. Mental Health Services:**

- Each network must provide all elements of the continuum of mental health care including screening; acute, high intensity inpatient services; longer term, lower intensity inpatient services; psychogeriatric nursing home care; outreach to homeless veterans residential rehabilitation; community residential care; vocational rehabilitation; case management; intensive case management (see VHA Directive 2000-034); partial hospitalization; and general outpatient clinic care including mental health services within CBOCs. (see VHA Program Guide 1103.3, Mental Health Program Guidelines, June 3, 1999 for a comprehensive listing of mental health programs and further details).
- Networks must comply with all applicable law and VHA regulation and related directives as referenced below.
- Planning for mental health care services should include an assessment and comparison of quality outcomes among programs within a VISN and nationally, including use of benchmarks available through NEPEC, PERC, national performance measures/monitors, patient satisfaction, etc.
- When considering disposition of underutilized or unutilized property, VA medical centers should consider making such property available to non-VA organizations that can use the property to develop residential services for

**ATTACHMENT 4**

homeless veterans. VA property can be made available through enhanced use lease or other methods. **(38 U.S.C. Section 8162 (b)(1)(B))**

*References:*

- PL 104-262 and PL 107-135, Directive 1000.1 (Program Restructuring And Inpatient Bed Change Policy)
- Directive 99-030 (Mental Health program changes)
- Directive 99-018 (Mental Health leadership)
- Directive 2000-034 (Mental Health Intensive Case Management).
- VHA Program Guide 1103.3, Mental Health Program Guidelines in the New Veterans Health Administration, June 3, 1999.
- Assistant Deputy Under Secretary for Health (ADUSH memoranda: August 24, 2001 regarding mental health intensive case management, opiate substitution therapy and mental health services in CBOCs;

**5. Outpatient Care:**

- Service delivery should include non-face to face activities. Telephone is key tool and should be integrated. Visits/day is not ideal measurement. Panel size is preferred method for primary care and specialty care
- Panel sizes should be based on the number of patients seen in primary care in the preceding 24 months. Nationally, for estimating primary care capacity, VHA utilizes a panel size of 1,200 for a full time physician and 1,000 for mid-level practitioner. Adequate support infrastructure and exam rooms are required to achieve optimal panel sizes.
- The concept of advanced access scheduling and good primary care practice requires same day/walk in access to the patient's care clinician/team. Thus, free standing 'walk in' or 'urgent care' clinics are discouraged. A true Emergency Department is still needed in larger (e.g. hospital) facilities.
- Patient disease burden is not dependent upon location of care; community practices (CBOCs) have more complex operational and patient care challenges than facility-based practices, with patients who are indistinguishable from patients seen in facility-based practices.
- Space planning in Ambulatory Care should include two examining rooms per clinician ( at a minimum) in all outpatient practice settings; the Ambulatory Care Infrastructure Study suggests productivity is enhanced dramatically at three exam rooms per clinician.
- Process of care drives space/staff, not vice versa

*References:*

- Primary and Ambulatory Care has a web site that includes a document library with the latest reports, standards and recommendations regarding the organization and provision of ambulatory care. <http://vawww.va.gov/primary/>

**ATTACHMENT 4**

- Ambulatory Care Infrastructure Space and Patient Flow Assessment Guide  
<http://vaww.va.gov/primary/page.cfm?pg=42>
- Practice Management Guide [vaww.va.gov/med/clinicare/c\\_primary\\_care.ctm](http://vaww.va.gov/med/clinicare/c_primary_care.ctm)
- VHA CBOC Directive

**6. Spinal Cord Injury and Disorders:**

- Services provided to veterans with SCI&D should conform to VHA Directive 1176 and VA Handbook 1176.1, Spinal Cord Injury and Disorders System of Care.
- Full continuum of care as described in M-2, Part XXIV
- Maintain capacity for the SCI specialty program as measured by the monthly VA/PVA beds and staffing survey and VHA Directive 2000-022.

*References:*

- VHA Directive 99-013, Decision Making Authority for the SCI&D Program.
- VHA Directive 1176 and VA Handbook 1176.1, Spinal Cord Injury and Disorders System of Care.
- VHA Directive 2000-022
- M-2, Part XXIV

**7. Allied Clinical Services (Social Work, Nutrition & Food Service & Chaplain):**

Although the CARES Planning process will not specifically address all Clinical services, when programmatic and space planning do impact these service areas, the following considerations should be taken into account:

- Networks must ensure a continuum of care, including spiritual and pastoral care from qualified chaplains, social work services provided in an environment that meets professional practice requirements, and quality nutritional care for patients.
- Planned changes in Nutrition and Food Service delivery options, such as consolidation of services, mergers, or outsourcing, should be based on analysis of impact on patient satisfaction, quality, and the cost/benefits of implementation. (Refer to GAO Report No. 01-64, November 2000).
- Chaplain office space should be located close to the sites of care in order to provide counseling for patients and families in an appropriate, private setting. Existing chapel space will not be altered without the concurrence of the Director, Chaplain Service at the National Chaplain Center. (VHA Manual M-2, Part II, Chapter 5, paragraph 5.01)

**8. Anesthesia Service:**

- At facilities where veterans require surgical care, anesthesia services must be maintained at a level sufficient to support the anesthesia and pain control

**ATTACHMENT 4**

needs of the surgical patient through the full continuum of care. Meeting this need requires 24-hour availability.

- The anesthesia services need to be delivered at a level equivalent to local community practice for a similarly sized facility.

**9. Audiology and Speech-Language Pathology:**

- Audiology services include diagnostic hearing and balance assessment, amplification (hearing aids and assistive listening devices), auditory rehabilitation, and compensation & pension exams.
- Networks must comply with medical benefits package and 38 CFR 17.149 on the issuance of sensory-neural aids (hearing aids).
- Network must comply with capacity requirements to provide for the specialized treatment and rehabilitative needs of veterans, including prosthetic and sensory aids.
- Networks must provide access to cochlear implants for veterans with severe to profound hearing loss who do not benefit from other treatment alternatives though designated Cochlear Implant Centers, sharing agreements with other networks, or contractual arrangements.
- Networks must maintain appropriate levels of rehabilitative care across the continuum of care for neurogenic communication disorders, laryngectomy rehabilitation, voice disorders, and swallowing disorders which can be associated with a variety of conditions (stroke, brain injury, Parkinson's Disease, etc.).

**10. Dentistry:**

- All eligible dental Class I-VI and long term care patients must receive dental/oral health care consistent with the intent of legislation (Ref: T38, Chapter 17, sections 17.160 through 17.165, VHA Handbook 1130).
- Dental service laboratories must be established and maintained at all VA health care facilities where dental services are provided (Ref: VHA Handbook 1130).

*References:*

- Chapter 17, sections 17.160 through 17.165, VHA Handbook 1130
- VHA Handbook 1130

**11. Nuclear Medicine & Radiation Safety Service:**

The following are general guidelines that have been used for planning new Nuclear Medicine services in VA and provide one reference point for CARES planning (Note: these are not intended for use in evaluating continuation/closure of programs).

Additional detail and guidance is available from the Patient Care Services Program Office:

Bone densitometry = <b>B</b>		Nuclear Medicine Diagnostic Imaging = <b>I</b> Nuclear Medicine, Diagnostic Non-Imaging (In-vitro) = <b>V</b> Telenuclear Medicine Interpretation (Nuclear Network) = <b>N</b>
Positron Emission Tomography (PET) = <b>P</b>		
Nuclear Medicine Therapy = <b>T</b>		
• <b>Outpatient facility</b>	B, I, V, T	
• <b>CBOC</b>	I, V	
• <b>Telenuclear affiliate</b> (image acquiring but not interpreting) site	I, V	
• <b>Inpatient facility</b>	B, I, P, V, T, N	
• <b>Tertiary facility</b>	B, I, P, V, T, N	

Workload Thresholds:

- **Bone densitometry – no minimum caseload**, inexpensive device, increased utilization with increased volume of women and aging veterans, should be one available per VISN
- **Nuclear Medicine Diagnostic Imaging** – screening, and at times emergency non-invasive diagnostic modality that is less expensive than many alternatives and does not produce need for radioactive waste disposal. **Minimum caseload 1.000 procedures per annum** but may be less with no availability or demonstrable cost and quality advantage to purchase services locally. For quality purposes must be able to have a representative sample (10%) of high volume, problems prone nuclear scans double read either by another nuclear qualified physician, a telenuclear arrangement or contract that includes an appropriate quality management program. Failure to be compliant with Nuclear Regulatory Commission requirements can result in involuntary closure of operations; planned closure necessitates a NRC decommissioning of laboratory.
- **P.E.T.– confine to tertiary facilities**. Clinical volume growing with approval received from accrediting/regulatory agencies such as FDA and HICFA. Oncology is primary area of usage followed by neurologic and cardiac indications.
- **Nuclear Medicine, Diagnostic Non-Imaging (In-vitro)** – involves infrequent bench work procedures that include thyroid uptake, blood volume determinations, C14 urea breath test and Schilling's tests. Would not occur as an independent entity.
- **Nuclear Medicine Therapy** – requires dosimetry calculation by qualified nuclear physician. System-wide volume not high but is done where there is access to inpatient settings should dosage or veteran social situation not be amenable to discharge home until radioactive emissions within acceptable range. Not done in telenuclear network affiliate settings.

**ATTACHMENT 4**

- **Telenuclear Medicine Interpretation** – done where there is availability of qualified nuclear physician, usually tertiary facilities. Affiliate (acquisition of images) site should have a projected minimum caseload of 800 procedures per annum or should be contracted out.

Closing or combining nuclear medicine services, requires decommission of the existing laboratory by the National Health Physics Program (NHPP) or Nuclear Regulatory Commission (NRC)

Contracts/fee-for-service purchase of nuclear medicine services must include provision for emergency studies for ventilation/perfusion lung scans, bone scans for intractable pain, myocardial perfusion scans, hepatobiliary and testicular scans.

**12. Nursing:**

- Space planning should ensure information technology and support services are available at all points of care and on all “worked” shifts.

**13. Optometry Service:**

- Networks are encouraged to maintain at least one in-house interdisciplinary low vision rehabilitation eye clinic program to care for the growing number of visually impaired and legally blind veterans through the year 2020.
- All enrolled veterans are eligible for a comprehensive eye examination regardless of their eyeglasses eligibility status (USC, Title 38, Veterans' Benefits, 1701, 1762, 1763).

*References:*

- USC, Title 38, Veterans' Benefits, 1701, 1762, 1763).

**14. Pathology and Laboratory Medicine Services:**

- If contracted, laboratory services will be provided under the same umbrella of patient safety initiatives, standards, regulations, and directives as if the services were directly provided by VHA. (e.g. Public Law 102-139 and VHA Directive 1106 and VHA Handbook 1106.1).

*References:*

- Public Law 102-139 and VHA Directive 1106 and VHA Handbook 1106.1
- Public Law 102-139, Title I, Section 101, 105 Stat 742 (1991)
- Clinical Laboratory Improvement Amendments of 1988
- Title 42 Code of Federal Regulations, Part 493
- VHA Directive 1106
- VHA Handbook 1106.1

**15. Pharmacy Benefits Management:**

- All facilities with a pharmacy residency should have a risk Level II Intravenous room defined by the American Society of Hospital Pharmacists and remaining facilities with inpatient care should have at least a Level I Intravenous room.
- Inpatient pharmacies should be open a minimum 16 hrs per day/7 days per week. All tertiary care facilities and those with medical affiliations should be open 24 hours per day/7 days per week.
- Outpatient pharmacies should include automated outpatient prescription dispensing equipment.

**16. Physical Medicine and Rehabilitation:**

- Patients shall receive all rehabilitative services that are medically necessary in accordance with the Medical Benefits Package. Networks must ensure a sufficient number of designated inpatient rehabilitation beds to meet the rehabilitation needs of the veteran population.
- Providers of rehabilitation services must have access to a full complement of ancillary services, e.g. Neuropsychology, Prosthetics, Orthotics, and Neuro-ophthamology that may be needed to support the rehabilitative care of a variety of conditions (stroke, amputation, brain injury).
- All VA medical centers will have a PACT program (VHA Directive 2001-030).
- Traumatic Brain Injury (TBI) is designated as one of VHA's special disability populations. P.L. 107-135 requires the Department to maintain its capacity to provide for the specialized treatment and rehabilitative needs of these veterans.
- Driver Rehabilitation Programs were established under Public Law 93-538, and will be maintained within the Network in accordance with the VHA Program Guide 1173.2.

*References:*

- VHA Directive 2001-030
- VHA Program Guide 1173.2

**17. Prosthetic and Sensory Aids Service:**

- The **Prosthetic and Sensory Aids Service** (PSAS) consists of prosthetic eligibility, prescription/selection, purchase, training, and maintenance/repair of prosthetic appliances.
- Networks must ensure that national prosthetic policies are followed at all VA facilities in planning for prosthetic services. Planning for prosthetic services should be on the basis of patient need.

*References:*

- National Prosthetic policies (VHA Handbook 1173.1-1173.15)

## 18. Radiology:

The following are general guidelines that have been used for planning NEW Radiology services in VA and provide one reference point for CARES planning (Note: these are not intended for use in evaluating continuation/closure of program). These are only guidelines and workloads that may be less where cost/ benefit analyses preclude referring to other VA facilities and/or contracting for the services in the community. Additional detail and guidance is available from the Patient Care Services Program Office:

- **Outpatient Facility-** Routine, possible US, Mammography and CT if adequate workload.
- **CBOC-** Typically **no** on-site radiology. Either contracted for in the community or referred to a nearby VA facility.
- **Inpatient/Tertiary Facility-** Routine, Interventional, MRI, CT, US, Mammography

### Workload Thresholds:

- **Routine** - 2,000 Dx exams per annum. Additional rooms of equipment ( R&F, Gen . Purpose, Chest, Bucky Tomo) may be added for every 4,000 – 6,000 exams depending on case mix.
- **Interventional/Angio/Neuro** - 300 exams/procedures per annum. Additional systems may be added for every 1,000-1,500 exams depending on case mix.
- **MRI** - 1,500 exams per annum.
- **CT** - 1,200 –2,000 exams per annum. Additional systems may be added for every 4,000-5,000 exams. Typically Spiral CT at 1,200-2,000 exams per annum and a Multi-Slice CT when workload justifies a second scanner.
- **US** - 2,000 exams per annum per system.
- **Mammography** - 500 exams per annum.

### *References:*

- Public Laws 102-539, 104-262,105-248 and VHA Directive 10-95-066 for Mammography

## 19. Recreation Therapy :

- Recreation/creative arts therapies should be included as integral parts of treatment programs in planning strategies

## 20. Telemedicine:

- Telemedicine provides an opportunity for VA to expand care of veterans in the home and other community settings. Interactive technology to coordinate care and monitor veterans in the home environment significantly reduces

**ATTACHMENT 4**

hospitalizations, emergency room visits, and prescription drug requirements, while improving patient satisfaction with the care they receive. Use of technology not only reduces the need for institutional long-term care, but also provides veterans with a more rewarding quality of life and greater functional independence.

**“Section 106”****PROCEDURES FOR COMPLIANCE WITH  
36 CFR 800, PROTECTION OF HISTORIC PROPERTIES**

The following is intended to be a step-by-step review of the Council’s regulations, “Protection of Historic Properties” (36 CFR Part 800).

1. The VA must first determine if the proposed action is an undertaking. As defined by the NHPA, and undertaking is a project, activity, or program funded in whole or in part under the direct or indirect jurisdiction of a Federal agency, including--

- a. Those carried out by or on behalf of an agency;
- b. Those carried out with Federal financial assistance;
- c. Those requiring a Federal permit, license, or approval; and,
- d. Those subject to State or local regulation administered pursuant to a delegation or approval by a Federal agency.

2. Examples of undertakings include, but are not limited to:

- a. construction
- b. land alterations
- c. building demolition
- d. building renovation
- e. building or landscape maintenance and management
- f. building abandonment or termination of maintenance
- g. changing the use of a facility in a way that could alter its character
- h. transfer of property out of Federal ownership
- i. transfer of property between Federal agencies where such transfer changes its use
- k. operation that involves use of land, airspace over land areas, or buildings

3. If the action is an undertaking, the VA must then define the “area of potential effect.” The regulations define the APE as the geographic area or areas within which an undertaking may cause changes in the character or use of historic properties, if any such properties exist. It is not necessary to know if there are any historic properties in order to define the APE, nor is it based on ownership. All alternative locations under consideration for the project or undertaking must also be considered and the APE may not be the same area of effect as defined under NEPA.

4. There are several key players in the Section 106 review process. It is important to the success of the process that appropriate parties are consulted. The regulations specify when Federal agencies must seek the views of, or consult with, the various players. They are:

- a. the VA: responsible for compliance with Section 106 and 36 CFR Part 800;

**ATTACHMENT 5**

- b. the Council: independent Federal agency that oversees review of Federal undertakings under Section 106 pursuant to 36 CFR Part 800;
- c. the SHPO: coordinates the national historic preservation program at the State level and is responsible for consulting with Federal agencies in the Section 106 review process;
- d. interested persons, to include:
  - local governments when the project affects historic properties under their jurisdiction;
  - applicants for Federal assistance, permits, licenses (proponents such as Government-owned, contractor-operated); and,
  - Indian tribes, Native Hawaiian organizations, and other Native Americans.
- e. the public.

### 5. The Five Step Process

Once the area of potential effect is defined, the VA must begin the identification and evaluation process.

a. **Identification and evaluation** is done in consultation with the SHPO and other interested parties (as appropriate). It typically involves some level of professionally supervised background research and field survey, but there is no standard requirement for survey. The level and kind of work to be done depends on the probable nature of the historic properties and the kinds of expected effects on them. 36 CFR Part 800 requires a “reasonable and good faith effort.”

Evaluation involves comparing the property with the National Register criteria. If the VA and the SHPO agree that a property meets the criteria, it is considered eligible for the National Register for purposes of Section 106. If the VA and the SHPO do not agree about eligibility, or if the Council or the Keeper of the National Register request, the VA must seek a formal determination of eligibility from the Keeper. If the VA and the SHPO agree that a property does not meet the criteria, the property is not considered eligible, and the VA does not need to consider the effects on it further under Section 106, except if the Council or the Keeper so request.

Determining the eligibility of properties less than 50 years old poses special challenges, since so little time has passed that objective judgments about significance are difficult. National Register Bulletin #22, “Guidelines for Evaluating and Nominating Properties that have Achieved Significance Within the Last Fifty Years” provides guidance in addition to the VA’s interim policy.

b. **Assessing effects** is also done in consultation with the SHPO and interested parties and involves applying the Criteria of Effect and Adverse Effect found in 36 CFR Section 800.9:

#### **Criteria of Effect**

1. Altering the characteristics of a property that may qualify it for the National Register

**ATTACHMENT 5**

2. Altering features of a property's location, setting, or use that contribute to its significance

**Criteria of Adverse Effect**

1. Physical destruction, damage, or alteration
2. Isolation from or alteration of the setting
3. Introduction of visual, audible, or atmosphere elements that are out of character
4. Neglect
5. Transfer, lease, or sale of property

If the VA and the SHPO agree that the undertaking will have *no effect* of any kind on historic properties, the VA formally notifies the SHPO and other interested parties of this finding and can then proceed without further review under Section 106, unless someone objects to the Council, which investigates and may advise the VA to do something else.

If the VA and the SHPO agree that the undertaking will have *no adverse effect*, then the VA files documentation supporting this finding with the Council, which has 30 days to review it. If the Council does not object, the VA can proceed with no further review, subject to any conditions to which the VA may have agreed.

If the VA determines that there will be an *adverse effect*, or if the Council objects to the VA's *no adverse effect* finding, then the VA notifies the Council and consults with the SHPO and interested parties to resolve the adverse effect. The Council may, at its discretion, participate in the consultation.

c. **Consultation** to resolve adverse effects involves the consideration of alternatives, in consultation with the SHPO, other parties, and sometimes the Council. It can take whatever form the consulting parties agree to and has no time limits.

Resolution of adverse effects may include eliminating the adverse effect, reducing the severity, mitigating the adverse effect, or accepting it in the public interest. It is perfectly appropriate at this point in the Section 106 process to consider cost factors and mission requirements when trying to decide how to carry out the undertaking with the least possible harm to historic properties.

In most cases, consultation results in consensus, which is embodied in a Memorandum of Agreement (MOA), executed by all the consulting parties, that specifies what the VA (or others such as a proponent) will do to avoid, reduce, or mitigate the effect. An MOA must be signed by the VA, the SHPO, the Council, and any other party that is assigned responsibility in the MOA.

d. An MOA is evidence of **Council comment** on the effects of the VA's undertaking on historic properties. It is a legally binding document that commits the VA to a course of action.

**ATTACHMENT 5**

If the VA does not reach agreement with the other parties, the VA (or the SHPO or Council) can terminate consultation. The Council will then provide advisory comments to the VA. The comments are rendered by the Council members-the 20 Presidential appointees, agency heads, etc.- to the Secretary of the VA, who must give the comments personal attention. The effect of Council comment is the same as that of an MOA-it evidences that the VA has fulfilled the requirements of Section 106. The difference is that these comments are not legally binding; the VA is only required to consider the comments in making its decision about the undertaking.

e. Once Council comment has been received, the VA can, subject to the terms of any agreement that has been reached, **proceed**.

6. An alternative to the standard Section 106 review process can be accomplished through a Programmatic Agreement (PA). 36 CFR Section 800.13 outlines when a PA can be used and, in very general terms, how one is negotiated and finalized. The review process for PAs is intentionally vague to allow maximum flexibility for this alternative Section 106 tool. A PA can be negotiated for an individual project or for an entire program. A project specific PA is appropriate when the undertaking is complex with many actions that will happen over a period of time, or, when the VA needed to approve an undertaking before the Section 106 process could be completed. Such a PA might outline the consultation process rather than specific mitigation measures or alternatives. An example of a PA for an entire program is the World War II temporary structures PA.

Another application of a PA is to develop management and alternative review procedures for your installation that can substitute for the standard Section 106 review process. The advantage of such a PA is that maintenance standards, design guidelines, and review procedures can be tailored to your installation to improve efficiency and minimize conflicts between mission needs and historic preservation responsibilities. Standards for such things as curation, building maintenance, and Native American consultation guidelines and a model PA, currently under development, can provide the foundation for alternative procedures. Some considerations in developing a programmatic agreement:

- A PA is appropriate when the installation has many historic properties to manage.

- The PA should be appropriate to the installation resources, i.e. don't need a big section addressing archeological resources if the likelihood of finding such resources is slim.

- The PA should be realistic; don't commit to more than the installation can do, i.e. complete the survey vs. establish a program for surveying.

The effect of a PA, whether for a single undertaking or a program, is the same as an MOA. It also evidences that the VA has satisfied the requirements of Section 106 and documents Council comment for individual actions covered by the PA.

**ATTACHMENT 5**

7. The Council has numerous fact sheets on all aspects of the Section 106 process. For copies of these publications, contact the Publications Office at (202) 606-8503, or, browse the Council's website at [WWW.ACHP.GOV](http://WWW.ACHP.GOV).

**Long Term Care Planning Considerations  
(Extracted from the long term care strategic plan)**

The following summarizes planning considerations that are included in the VHA Long Term Care Strategic Plan and should be factored into the development of CARES Market Plans. For additional information, consult the Office of Patient Care Services:

- The critical need for long-term care services will continue to increase through 2008 and remain a priority for several decades. As a comprehensive healthcare system which has primary responsibility for enrolled veterans -- nearly 40% of whom are over age 65 -- VHA must provide LTC for the effective management of patients who are living longer, often with chronic diseases. The principle articulated in the Millennium Act is that LTC is an essential component of VA's healthcare system, having parity with acute, outpatient and other care
- The goals of care are to improve outcomes, and to optimize function and quality of life for veteran patients through the end of life. LTC when appropriately delivered is a system of primary care for the frail and the elderly. Our system must be defined by consistent access to high quality care, given equal need among patients, to the extent reasonably possible
- Each network must provide the full array of mandated LTC services (institutional and non-institutional) to veterans throughout the network. With three-quarters of VA's long-term care services provided in institutional settings, and the need for long-term care projected to increase by 20% over the next five years, Networks will meet new need for long-term care through non-institutional options.
- The following are specific goals that should be considered:
  - ADC for NHCUs must be maintained, as a minimum, at levels approved by the Policy Board on June 29, 2001.
  - NHCUs should capitalize on their clinical strengths, targeting those veterans who can most benefit from the intensity of rehabilitative and medical services available in hospital-based units, as well as those veterans who are not effectively managed in other settings.
  - Continue to enhance and expand partnerships with community nursing homes, to help match the geographic preferences and institutional long-term care needs of each veteran.
  - Offer Geriatric Evaluation and Management services at all sites, in either/both inpatient and outpatient settings, to provide comprehensive assessment necessary for the effective management of complex, frail elderly veterans.
  - Extend Home Based Primary Care (HBPC) services to meet the needs of homebound and chronically ill veterans - beyond current geographic

**ATTACHMENT 6**

- limits, including the use of satellite bases at State Homes & CBOCs for HBPC practitioners.
- Expand Adult Day Health Care (ADHC)
  - Promote models of pooled resources for in-home long-term care such as the medical foster home program
  - Strengthen and facilitate community partnerships to increase the accessibility to nursing home, hospice, respite and adult day health care services, through sharing agreements, special contractual agreements, and/or enhanced used leasing arrangements. These partnerships will support the provision of the continuum of care when offering VA-operated services is not efficient or effective.
  - Develop innovative outreach methods, including telemedicine, to bring geriatric expertise and consultation into facilities and geographic areas where geriatric specialty care is unavailable.
  - Designate inpatient beds for hospice & palliative care, or provide access to these services in the community.
- VHA's Special Emphasis Programs focus on meeting the care needs of particular groups of patients such as the spinal cord injured/disabled, the seriously mentally ill and the homeless. As the entire cohort of veterans ages, attention must be given to those who are aging with special needs. Additionally, the future cohorts of veterans, as they age, may have needs and preferences for LTC which may be decidedly different than those of the World War II and Korean Era veterans who comprise the majority of those enrollees currently using VA LTC services.

## **CARES Guiding Principles, Criteria and References for VACO Program Offices**

The following summarizes input received from various Central Office Program Offices that Networks should consider in developing their CARES plans. The full documents are available from the National CARES Program Office.

### **Office of Academic Affairs (14)**

Title 38 U.S.C mandates that VA assist in the training of health professionals for its own needs and for those of the nation. By means of partnerships with affiliated academic institutions, VA conducts the largest education and training effort for health professionals in the nation. The training of future health professionals determines in large measure how healthcare will be provided in the future.

In developing Market Plans, Networks should fully consider the academic mission and impact of alternative planning initiatives on that mission. This includes considerations of the important partnership between VA and academic affiliates; recognition of pressures facing academic affiliates; need for early involvement of affiliates in the CARES planning process; recognition of the role of associated health trainees; recognition of new opportunities for sharing;

### **Office of the CFO (17)**

#### General:

Networks should utilize the Networks Strategic Planning Guidance (2002-2007) and associated financial planning guidance as a framework for development of CARES plans.

#### Medical Sharing:

Use of sharing authority (title 38 U.S.C. Section 8153) has increased over 34% a year and this trend is expected to continue into the future. Sharing is an effective planning tool that should be considered and explored in the CARES Process. There are many innovative sharing arrangements in place, uniquely responding to local VA needs and local community resources and relationships. Information on Sharing arrangements can be acquired from the Medical Sharing Office.

Networks and facilities entering into sharing arrangements need to ensure that cost-effectiveness and quality of services provided are adequately assessed and monitored.

Networks currently have authority to approve non-competitively awarded sharing agreements below \$500,000 and competitively awarded sharing agreements below \$1.5 million. Renting resources under sharing authority requires approval of the concept from the Rapid Response Team (RRT). VHA Directive 1660.1 should be reviewed for these requirements.

**Office of Facility Management (18)**

In developing Market Plans and, specifically, Capital Realignment Plans, Networks need to evaluate future disposition of buildings and facilities in light of historical designation or potential.

The impact of CARES Market Plans on Enhanced Use Sharing Agreements and Enhanced-Use leases should be factored into the evaluation of alternatives.

When considering Enhanced Use lease projects, to the extent feasible, they should be sited on severable parcels at the periphery of the main campus' operations.

The design and operation of facilities critically affect the effectiveness and efficiency of mission performance. VHA facilities must present an environment that is competitive with other providers and that promotes quality health care, allows staff to maximize patient care, enables efficient health care services, is user friendly to patients and staff, is open and inviting yet secure, promotes the principles of sustainability, offers best value for construction dollars, meets standards for maintainability and allows for future change. This level of quality is defined by VA's design and construction standards and reflects VA's values as a long-term owner/operator responsible for operational and maintenance costs. In addition, VA facilities must comply with numerous statutes, Executive Orders, regulations, national codes, etc. These are all reflected in VA's design and construction standards. Some significant design issues unique to VA include:

- Barrier Free Design Standards: VA facilities are required by law to comply with minimum Uniform Federal Accessibility Standards (UFAS). UFAS is often more restrictive than the Americans with Disabilities Act Guidelines (ADAG) which govern non-Federal facilities. VA's standards also consider the special requirements of our patients, the staff who serve them and other operational issues.
- Natural Hazard Mitigation Standards: Federal law and Executive Orders require VHA medical facilities to be available for veterans, military and community services during and after a natural disaster.
- Seismic Standards: VHA facilities must comply with Earthquake Resistant Design Requirements for VA Hospital Facilities (H-08-8). VHA's critical facilities must remain operational after an earthquake and less critical VHA facilities must meet life safety requirements.

**Chief Information Office (19)**

Information technology must be considered in planning for the future. This includes consideration of the impact of CARES plans on VISN information infrastructure and requirements for new information technology.

**ATTACHMENT 7**

To the extent feasible, VISNs should assess the degree to which veterans utilize the Internet for seeking information and services and should consider the future opportunities and impact of information technology on service delivery.

**Office of Public Health and Environmental Hazards (13)**

VA assets should be viewed within the context of their value to the Nation in response to domestic events requiring mass casualty medical care and quarantine, as well as their value to DoD in response to casualties resulting from traditional overseas military operations.

The needs of women veterans should be factored into future healthcare planning. In particular, inpatient psychiatric care for women veterans should be provided through dedicated women's psychiatric units within VA or contracted from community providers able to provide a treatment program and environment responsive to the needs of women veterans.

**Office of Research and Development (12)**

Research and Education are critical missions of VHA, with important impacts in terms of specific research accomplishments, training of physicians and providing high quality care for veterans.

In developing market plans, Networks must consider the impact of all alternatives on the Research and Academic environment. This includes considerations of the size and of the academic program at each VA facility and opportunities to expand the academic mission by expanding the patient base; relationship between VA facilities and affiliates and the impact of realignment plans on that relationship, including considerations of travel distances between VA facilities and medical schools; opportunities to provide for quality research space through capital asset plans, including plans for co-location of research offices with patient care for clinical trials; and both the costs and benefits of maintaining, expanding and/or reducing/eliminating the affiliation.

**Office of Access Management and Facilities (201F)**

To the extent that CARES Plans impact VBA entities, VBA's facility standards must be incorporated. The Department's VA Regional Office Design Guide (November, 2001) provides full information.

**Deputy Under Secretary for Management (402)**

From the perspective of the National Cemetery Administration, consideration should be given to: 1) potential opportunities for establishing or expanding VA cemeteries where a need exists and VA-owned land is not needed for the delivery of healthcare services, and 2) impact of proposed Market Plans on the ability of VHA facilities to provide continued administrative support to National cemeteries in the areas of

**ATTACHMENT 7**

finance, contracting, human resources and engineering. Information regarding the strategic direction of NCA within the geographical boundaries of a VISN can be obtained from Dan Tucker, Director, Office of Finance and Planning at 202.273.5157.

**Principal Deputy Assistant Secretary for Policy and Planning (008)**

CARES is a VA project and the future needs of VBA and NCA should be considered. The potential co-location of VBA and VHA facilities should be factored into considerations of alternative uses for vacant space.

## Enhanced Use

### 1. Program Description

The intention of the CARES Directive is to create a process that would provide better use of our capital assets. Enhanced Use initiatives are another option available to be considered in our efforts to meet the Directive.

Enhanced-Use Leasing is a mechanism for obtaining facilities and services for VA activities. Enhanced-Use Leasing is a cooperative arrangement between the Department and the private sector (or another government entity) for the use of Department-controlled property. In this arrangement both the private sector and VA contribute something of value. VA may offer “non-cash” assets such as unused land, facilities, or access to a revenue producing market. In return, the private sector may provide facilities for VA use or provide certain services or products to VA activities at no or reduced cost. To be effective, the cost to VA (and to the Government), including the value of the out-leased land, for obtaining the facilities or services must be less than by any other means for acquiring such products or services. This program’s authority rests with the Secretary of Veterans Affairs and therefore the Secretary of Veterans Affairs must authorize all delegations of that authority. Enhanced-Use initiatives should be coordinated through the Office of Asset Enterprise Management.

The basic operating elements of the Enhanced-Use Leasing program are:

- VA makes unused or underutilized lands and/or buildings available to the private or public sector on a long-term basis (up to 75 years) for development purposes;
- In addition to, or in lieu of an up-front or on-going cash payment, VA can obtain necessary services, facilities or other benefits from the operation of such business for the duration of the lease;
- The consideration to VA must be “fair consideration,” and the private or public business operation conducted on land leased from VA must be compatible with the on-going mission of the Department and with the goals and mission of that VA facility.

The benefits of the Enhanced-Use Leasing program can be multi-fold:

- DISPOSITION OF UNDERUTILIZED OR UNUSED VA LAND, FACILITIES OR SPACE THAT CANNOT BE REALISTICALLY SOLD OR OTHERWISE TRANSFERRED, CONVEYED OR DISPOSED.
- Lease of up to 75 years is recognized in real estate and financial industry as marketable and finance able.
- In return VA can receive cash, services, facilities or anything else of value either up-front or over a term of years.

- VA need not retain any VA activity on the leased property so long as the lease results in an improvement of services to eligible veterans in the geographic service area where the property is located.
  - Unused and costly property can be converted to generate revenues or be used to obtain needed facilities, services, equipment or other items.
  - VA can convey “title” to the property to the lessee during or at the end of the lease.
  - All revenues are returned to medical care.
  - Minor Construction funding can be used as a VA capital contribution into the lease.
- 
- ENABLES VA TO OBTAIN NECESSARY SERVICES, FACILITIES, SPACE, EQUIPMENT, OR ANY OTHER ITEMS AT SUBSTANTIAL DISCOUNT OR AT NO COST BASIS.
  - Allowing lessee to use VA property to obtain access to a local community or private (non-VA market) can result in substantial benefits to VA.
  - In return for this benefit, VA can obtain required services, facilities or other benefits at discounted or, in some cases, no cost.
  - Leasing structure enables VA to obtain favorable arrangements as to duration and limitations of any VA commitments.
  - Leasing structure also provides opportunity to directly negotiate with and obtain low-cost financing for the transaction through the municipal bond market or similar low-cost mechanism. Lower cost financing results in lower costs to VA.
  - VA stimulates private sector growth (capital investment and jobs) by making business opportunities available with significant local and federal tax revenue implications.
  - All revenues generated are returned to medical care.
  - Minor Construction funding can be used as a VA capital contribution into the lease.

## 2. Responsibilities

The Network Director is responsible for ensuring the best use of capital assets within his or her network. He or she has the responsibility to ensure that Enhanced-Use leasing is considered in evaluating alternative use of land and space. (The enhanced use program offers another tool to assist in implementing realigning imbalances or inequities between network capital assets and those strategic goals and objectives as identified in the Network Strategic Business Plan).

## 3. Procedures

**Determine if there is an Enhanced-Use Leasing opportunity that is worth pursuing:** This is done in two steps:

Step one; perform a preliminary assessment to determine if there is a potential opportunity. This assessment requires review of three considerations:

**ATTACHMENT 8**

- Does VA have unused or underutilized assets which could be made available to a non-VA user?
- Is there an unmet requirement in terms of space, facilities, services, products and/or revenue for the facility?
- Is there a non-VA market that has a demand for the VA asset in the local community?
- Is there a well-developed industry which can satisfy the market?

Step two; if the responses to the questions above yield a positive assessment, there are several factors, which can be used to determine whether a proposed project is a good candidate for Enhanced-Use Leasing as opposed to other acquisition/disposal method. These factors are site, intended use, market, and budget factors. (These criteria are intended to guide the facility in making a preliminary judgment as to whether to pursue Enhanced-Use Leasing and, consequently, to prepare a Business Plan).

**Contact Office of Asset Enterprise Management (004B)** – This Office is available to provide assistance and is a valuable resource in assisting you throughout the process. This office has a library of templates and model documents (statements of work for appraisers, feasibility studies, market studies, public hearing notices, solicitations, etc.) that can be used in development of a enhanced-use leasing project.

**Create a concept or business plan** – This is the initial step for a successful Enhanced-Use project. It is an action document consisting of detailed narrative which describes in clear, concise terms, the underlying concept of the proposed venture, how it will meet defined VA requirements or needs, its economic aspects, the real property and any financial resources necessary to obtain the objective, and how the proponent plans to undertake and execute the project. While this document is an “internal” document, in that it is not being prepared for review by parties outside the Department, the importance of a properly prepared business plan cannot be overstressed. The plan will become the basis for the initial Secretarial approval to proceed with the project, the Department’s public hearing on the proposal, Secretarial Designation of the project for Enhance-Use leasing, subsequent Congressional notification and ultimately solicitation and of the project.

**Submit business plan to the Secretary of Veterans Affairs for approval** – The approval of the plan is for concept only. Final approval of the proposed initiative will come after the public hearing and all feedback external to the VA has been received. Projects are submitted through the Network.

**Public hearing** – Once the business plan has been approved, the law mandates that the Department hold a public hearing in the project’s locality for the purpose of soliciting the views and input of the veteran groups and the local community on the project and its possible effects on the local commerce, the local community, Department programs and services to veterans in the community. It

**ATTACHMENT 8**

is recommended that the public hearing be publicized through a combined effort of newspaper publication and written notice to individual or groups known to have an interest in the project or its potential impacts. These can include national or local chapters of veteran service organizations, community associations, employee associations, etc. OAEM staff can assist in planning and carrying out the public hearing. "Public hearing" kits are also available.

**Request to approve the Enhanced-Use initiative** - Following the public hearing, should you determine that you wish to proceed with the initiative, you are to forward your request along with a summary of the public hearing proceedings with a copy of a recorded transcript of the proceeding to OAEM. Upon receipt of this request, the OAEM will prepare a Notice of Designation package for the Secretary's approval. (The Notice of Designation is a formal determination made by the Secretary to proceed with a specific Enhanced-Use project at the facility).

**Secretary of Veterans Affairs approves request** – This is done by the Secretary's signature on the Notice of Designation package. Once signed, copies go forward for notification to VA's congressional oversight committees and for publication in the Federal Register. While no approval by Congress or its committees is required, VA must wait at least 60 days while Congress is in session prior to entering into an Enhanced-Use lease. During this time period, VA can proceed with soliciting for and negotiating an Enhanced-Use lease. Simultaneously, OAEM will work with the VA activity in identifying and implementing any environmental and historic reviews and compliance requirements.

**Solicit Enhanced-Use proposals** – The responsibility for the development and execution of the Enhanced-Use leasing program lies with the Secretary for Veterans Affairs. As a matter of general practice, OAEM acts the Leasing Agent for the Secretary and will work with the VA activity involved to proceed with the solicitation package. Generally, Enhanced-Use leases are obtained through a competitive negotiation process though it is not a FAR procurement or process. Enhanced-Use leases may be directly entered into with affiliates, States or local governments. In addition, there are some conditions that could allow for direct negotiation with the lessee or other methods of procuring the lease. Leasing authority may be re-delegated to the office or activity that has the capability to undertake, execute and administer the lease.

**Select and negotiate all business and legal terms with selected Enhanced-Use proposal/developer** – An Evaluation Criteria Plan is to be created by the Leasing Agent. The plan is for internal purposes and is to identify who will do the proposal evaluation and how negotiations will be conducted. In addition, the plan is to provide milestones from the accomplishment of the required steps or events of the selection process that occur between the time the proposals are received and the signing of the lease. Upon selection, a team composed of the

**ATTACHMENT 8**

VA activity involved, along with OAEM and General Counsel's office will negotiate all business and legal aspects of the transaction.

**Re-examine the project's economics** – The economics of the proposed project should be reexamined once proposals are received. If the project is "Significant" pursuant to the policies and procedures of the Capital Investment Board (CIB) program, the project may require review by the Capital Investment Board at this time. This application for review is governed by the policies of the CIB. Upon agreement with the CIB, enhanced-use leasing projects will be reviewed by the CIB on an "as needed" basis instead of on an annual basis. OAEM has a library of completed and approved CIB applications for review and information. Projects obtaining CIB approval are submitted for OMB review. This review is on an expedited basis.

**Final Notification to Congress** - Prior to award, OAEM will prepare a second notification to VA's congressional oversight committees which will detail the terms of the lease. This notification will be attached to any CIB application, and approval of that application will result in Secretarial approval of this notice. For projects that do not require CIB review, OAEM will obtain the necessary reviews and concurrences in VA headquarters for signature by the Secretary. This notice is a simple, 30-calendar day notice and is also used by the selected lessee to make final arrangements for closing and obtaining financing.

**Make lease award** - After completing the final notifications and all environmental or other requirements, the selected developer will be notified by the Leasing Agent, in writing whereupon both parties shall undertake the necessary action to enter into an Enhanced-Use lease.

Helpful hints

- a. Obtaining an appraisal of the value of the property to be leased is essential. It will be used to justify the economics of the project (e.g., CIB or headquarters review) as well as a negotiation tool in VA negotiations with the selected developer. Obtaining an accurate appraisal that reflects VA's business objects is critical. OAEM can assist in providing scopes of work or in obtaining the appraiser.
- b. When the Enhanced-Use lease involves an affiliate, state or local government, negotiations can proceed immediately after business plan approval and both congressional notifications can be combined into a single notification upon conclusion of the negotiations. This can result in significant savings in time.
- c. Get the staff at OAEM involved as soon in the process as possible. They can help walk you through the process and provide samples of business plans, scopes of work, CIB applications, etc. to assist you in creating yours.
- d. Be aware that the process can take several months to complete. You should use this fact in your decision-making and any discussions that you may have with others during the process.

## CHAPTER 6: COMMISSION CHARTER

### DEPARTMENT OF VETERANS AFFAIRS

#### CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

#### COMMISSION CHARTER

**A. OFFICIAL DESIGNATION:** Department of Veterans Affairs Capital Asset Realignment for Enhanced Services (CARES) Commission, consisting of nine members appointed by the Secretary of the Department of Veterans Affairs.

**B. OBJECTIVES AND SCOPE OF ACTIVITY:** The Commission will provide objectivity, bring an external perspective to the CARES planning process, and make specific recommendations to the Secretary regarding the realignment and allocation of capital assets. In making its recommendations, the Commission will focus on the accessibility and cost effectiveness of care to be provided, while ensuring that the integrity of VA's health care and related missions is maintained, and any adverse impact on VA staff and affected communities are minimized.

**C. DUTIES FOR WHICH THE COMMISSION IS RESPONSIBLE:** The Commission will consider recommendations submitted by the Under Secretary for Health designed to meet the above objectives, along with data and analysis in support of such recommendations. The Commission will also consider views and concerns expressed in writing during a 60-day period after the Under Secretary for Health makes his recommendations, or in public hearings held by the Commission, from veterans service organizations, Congress, medical school affiliates, VA employees, local government entities, affected community groups and other interested parties.

The Commission may accept, modify, or reject with supporting comments, the recommendations received from the Under Secretary for Health.

**D. PERIOD OF TIME NECESSARY FOR THE COMMISSION TO CARRY OUT ITS PURPOSE:** Unless a different date is specified by the Secretary, the Commission recommendations shall be submitted in writing to the Secretary not later than **July 30, 2003**, and the Commission shall cease to function not later than December 31, 2003.

**E. OFFICIAL TO WHOM THE COMMISSION REPORTS:** The Commission shall report to the Secretary of Veterans Affairs. Members shall serve as objective advisors to the Secretary, and not as representatives of any organization for which they may otherwise be serving.

**F. AGENCY RESPONSIBLE FOR PROVIDING NECESSARY SUPPORT TO THE COMMISSION:**

Subject to the availability of appropriations, the Department shall provide the Commission with such resources as may be necessary for the performance of its duties and functions. The Veterans Health Administration shall provide such services and personnel as may be necessary to enable the Commission to perform its duties. Upon request of the Secretary, the head of any Federal department or agency, where legally authorized, may detail, on a non-reimbursable basis, any personnel of the department or agency to the Commission to assist in performing its functions. The staff director of the Commission, appointed by the Secretary, is assigned the responsibilities of the Designated Federal Officer (DFO) for the Commission.

**G. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS:** Meetings of the Commission shall be convened at the call of the Chair. Meetings of any subcommittees or site visitation groups shall be convened as necessary. A federal government official shall be present at all meetings. All formal meetings and hearings of the Commission shall be held in conformance with the requirements of the Advisory Committee Act.

**H. COMMITTEE TERMINATION DATE:** The Commission is authorized through December 31, 2003, unless extended by the Secretary.

**I. DATE CHARTER FILED:** \_\_\_\_\_

APPROVED:

\_\_\_\_\_  
Secretary of Veterans Affairs

\_\_\_\_\_  
Date

## CHAPTER 7: CONTRACTING GUIDE

**A. PURPOSE:** The purpose of this chapter is to provide a standardized process for Networks who require contract support in the development of their Network CARES Market Plans. This chapter describes VA standardized procedures including eligible criteria, approval, suggested contract sources, and a Statement of Work template.

**B. GUIDANCE:** It is the Department of Veterans Affairs policy that external contracts will not be used in support of the National CARES Program except in unusual or extraordinary circumstances. This includes consultants, studies, analyses, and advisory assistance. In the event a Network determines that a contract is essential in their development of a Network CARES Market Plan, this chapter applies.

**C. RESPONSIBILITIES:** Contract requests are to be forwarded to the National CARES Program Office for approval prior to any written or oral contract obligations with external contractors/vendors. The National CARES Program Office will review and approve contract requests and, when appropriate, forward to the Deputy Secretary for approval. Approved contract requests will follow Federal and VA Acquisition Regulations and utilize the Statement of Work provided in Attachment C of this chapter. *Networks are to capture all contract expenditures including contract changes.*<sup>1</sup>

**D. ELIGIBLE CONTRACT REQUEST CRITERIA:** Network or Medical Center contract requests may be considered if one or more of the following apply:

- Specialized clinical studies
- Enhanced Use
- Property Development
- Homeland Security
- Bio Terrorism
- Infrastructure analyses
- Historic considerations

**E. APPROVAL PROCEDURES:** Contract requests will be submitted to the National CARES Program Office utilizing the standardized format in attachment A or B, as appropriate. Contract requests will include a description of the requirement, expected outcome, estimated price, funding source, performance period, Statement of Work and justification. The justification is required and will provide in detail the

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<sup>1</sup> This will require another tracking work sheet and a roll up for reporting on the Detailed Operating Plan. Consider amortizing these costs in the Network CARES Market Plans or a segment in the cost methodologies. Some how we need to know all costs associated with CARES PIs and address accountability. These are costs that can slip or fall out very easy.

contract purpose and explain why the services will not be performed utilizing internal VA resources, e.g., Network or Medical Center staff.

**F. SUGGESTED CONTRACT SOURCES:**

1. VA Management Studies

Point of Contact: Terry Anderson, Administrative Contracting Officer  
Telephone: (202) 273-8827  
Address: 810 Vermont Ave NW  
Washington, DC 20420

2. GSA/FSS Management, Organizational and Business Improvement Services  
FSS Schedule 874

Contractor's profiles and labor rates are available on-line at:  
<http://www.gsaadvantage.gov/>

**Contract Approval Form**  
**(REQUESTS above \$50,000)**

**PART I: DESCRIPTION**

Network: \_\_\_\_\_ Planning Initiative: \_\_\_\_\_ # \_\_\_\_\_

Title: \_\_\_\_\_

Estimated Price: \_\_\_\_\_ Funding Source: \_\_\_\_\_

Period of Performance: \_\_\_\_\_

Description of requirement: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Expected Outcome: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART II: JUSTIFICATION**

Purpose: \_\_\_\_\_

\_\_\_\_\_

Relationship to Planning Initiative: \_\_\_\_\_

\_\_\_\_\_

Explanation for need to outsource in lieu of utilizing in-house resources: \_\_\_\_\_

\_\_\_\_\_

**RECOMMEND APPROVAL**

\_\_\_\_\_  
Network Director date

**RECOMMEND APPROVAL/DISAPPROVAL**

\_\_\_\_\_  
Director National CARES Program Office date

**APPROVE/DISAPPROVE**

\_\_\_\_\_  
Deputy Secretary date

**Contract Approval Form**  
**(REQUESTS less than \$50,000)**

**PART I: DESCRIPTION**

Network: \_\_\_\_\_ Planning Initiative: \_\_\_\_\_ # \_\_\_\_\_

Title: \_\_\_\_\_

Estimated Price: \_\_\_\_\_ Funding Source: \_\_\_\_\_

Period of Performance: \_\_\_\_\_

Description of requirement: \_\_\_\_\_

\_\_\_\_\_

Expected Outcome/Return on Investment: \_\_\_\_\_

\_\_\_\_\_

**PART II: JUSTIFICATION**

Purpose: \_\_\_\_\_

\_\_\_\_\_

Relationship to Planning Initiative: \_\_\_\_\_

\_\_\_\_\_

Explanation for need to outsource in lieu of utilizing in-house resources: \_\_\_\_\_

\_\_\_\_\_

**RECOMMEND APPROVAL**

\_\_\_\_\_  
Network Director date

**RECOMMEND APPROVAL/DISAPPROVAL**

\_\_\_\_\_  
Director National CARES Program Office date

## Statement Of Work

### GUIDANCE FOR PREPARING STATEMENT OF WORK (SOW)

As you begin writing the statement of work, here are a few basic principles to keep in mind.

- Get your Acquisition staff involved before you even begin writing the statement of work. Your requirement should be discussed with personnel who will ultimately have to acquire the needed products and/or services. By doing this, strategies and a timeline can be determined to accomplish the acquisition up front, avoiding possible delays.
- Do not discuss your requirements with contractors. Especially, do not call a contractor and ask for a “ball park cost estimate” for a particular effort for “budgetary purposes.” Your Acquisition staff can provide you with contractors’ rates that will help you develop your independent government estimate. Cost estimating is inherently a government function.
- The requirements should be written in results-oriented terms. In other words, describe the functionality or capability required as the final deliverable. For example: If we dictate to the contractor how a study should be conducted the end product is flawed, the Government must compensate the contractor to resolve the problem because the contractor implemented the Government’s solution. If you spell out functionally what you want as the end product, and there are problems, the contractor will be held accountable to resolve the problem at no additional cost to the Government because the contractor’s solution is offered and accepted by the Government on a firm-fixed-price basis.
- If you anticipate that your project will require a significant level of effort and expertise, include in the SOW a requirement for a detailed project implementation plan. You can monitor the contractor’s progress against the contractor’s own plan from personal observations and periodic progress reports. Also, keep the COTR/TOPM informed of the contractor’s progress during the performance period.

*Note: You will observe the use of Contracting Officer Technical Representative (COTR) or Task Order Project Manager (TOPM) throughout this guide. If your contract is issued against the suggested sources identified in this chapter the use of TOPM will apply since you are writing a Task Order against an established contract vehicle and Contracting Officers are established. Secondly, these contract vehicles already have existing Contracting Officer Technical Representatives; accordingly, your program official assigned to this effort will be defined as a Task Order Project Manager who will serve as your liaison between the Contracting Officer and Contracting Officer Technical Representative.*

**SOW cont'd.**

*Network program offices will have a significant role in the contract performance, communication and outcome of the work. The established Contracting Officer and COTR will provide additional support to the TOPM for contract administration.*

The following guidance will follow each section of the SOW format, which is included in this attachment. Keep in mind that these are the basic sections of a typical SOW. Other sections may be added as project requirements dictate.

**A. GENERAL INFORMATION:**

1. Title of Project: Self-explanatory.

2. Scope of Work: The purpose of this section is to create only the framework of the contractor's responsibility. For example: The contractor shall provide all labor, supervision and all other resources required to deliver the requirements stated herein, except as may otherwise be specified in this statement of work. Keep the scope of work as brief as possible.

3. Background: In this section you can assist the contractor in understanding your requirement by giving some details about any existing environment issues. Remember that you want the contractor to propose the best solution possible, so you should give the contractor a clear picture of the existing issues or environment.

4. Performance Period: Under a firm-fixed-price task order, the performance period is the timeline for the project. Here, it is specified when the contractor's work shall begin and when it must be completed for the agreed fixed price. For a time and materials contract, specify the Government's workweek and the hours of operation. Also, specify whether the contractor is required to work when the Government is closed for Government holidays.

5. Type of Contract: A firm-fixed-price agreement is always preferred. A firm-fixed-price contract places the risk with the contractor rather than the Government. A firm-fixed-price contract is only possible, however, when the Government can document very definitive specifications with a stable work environment for the contractor. Time and Materials' contracting is used when it is impossible to determine the functional specifications such as research and development or if the Government is unable to provide a stable work environment.

**B. CONTRACT AWARD MEETING:**

In this section, the standard SOW language specifies that the contractor shall commence work only when the contracting officer has conducted a "kick-off"

**SOW cont'd.**

meeting or has elected to waive the meeting. This meeting is very beneficial to the success of the project. Various aspects of the work details can be discussed so there is a consistent understanding among all parties. The roles and responsibilities of the COTR and the TOPM are discussed and presented in the delegation of authority letters issued by the contracting officer at the meeting. The nature of some small projects may not require a “kick-off” meeting with the contracting officer. This will be determined on a case-by-case basis and the Network contracting activity should be consulted.

**C. GENERAL REQUIREMENTS:**

Section C prescribes what will be required when the deliverables specified in section D are provided. Be careful not to specify more detail than is really required. Remember that keeping requirements to a minimum will lower the cost of the contract.

**D. SPECIFIC MANDATORY TASKS AND ASSOCIATED DELIVERABLES:**

This is the heart of the SOW. The standard SOW document already provides general guidance for this section. This section drives the entire project. Once a contract is awarded, the requirements shall not be changed for the contractor in any way whatsoever by anyone other than the contracting officer. When making contractual commitments, there should be only one focal point for the Government for maximum control and accountability. Not only should this be the practice, this process is mandated by Federal statute. Any reputable company will likewise follow the same practice.

**E. SCHEDULE FOR DELIVERABLES:**

This section provides direction to the contractor for completing the proposal. If you feel the language in the standard SOW is not appropriate, the recommended changes should be discussed with your Network contracting activity.

**F. CHANGES TO THE STATEMENT OF WORK:**

The process for making changes to the statement of work is presented in this section. Making change by any other means may require a ratification of an unauthorized action requiring the approval of the Network Director and or the National CARES Program Office.

**G. REPORTING REQUIREMENTS:**

This section spells out to the contractor the Government’s requirements for progress reporting. The report is submitted to the COTR/TOPM who then

**SOW cont'd.**

disseminates the information to the interested parties including the Network contracting activity.

**H. TRAVEL:**

Self-explanatory – See the guidance in the standard SOW.

**I. GOVERNMENT RESPONSIBILITIES:**

As applicable, following the guidance in the standard SOW, specify to the contractor what the Government will provide in support of the project. Government-furnished equipment and/or references may be included. One crucial point to consider when stating what the Government will provide is that if the Government fails to provide any portion of the commitment, the contractor may be financially damaged and will likely file a claim with the Contracting Officer. Anything specified here must be treated as a firm and legally binding contractual commitment on the part of the Government. If there is any doubt whether the Government can keep this commitment, it must be discussed with the COTR/TOPM and the Network contracting activity before the contract is awarded.

**J. CONTRACTOR EXPERIENCE REQUIREMENTS:**

1. Time and Materials Task Orders: When anticipating a time and materials task order, describe the level of expertise that is required of contractor personnel. Take care only to require expertise that is commensurate with the current functional requirement. Also, ask the contractor to provide references of all work underway and completed over the last few years that is of the same nature and level of effort as the anticipated work. Notice that it is recommended that references be sought for all work over the past few years. By requesting references from all of the contractor's clients, past and present, you remove the contractor's ability to eliminate bad references. This is a way to weed-out contractors who lack the needed expertise for your project.

2. Firm-Fixed-Price Task Orders: Typically, the Government does not mandate a particular level of expertise for firm-fixed-price task orders. The reason is that the Government specifies a functional end result for which the contractor proposes a firm-fixed-price. The contractor assumes all risk to provide the specified deliverable by the due date with the proposed technical team or may be charged liquidated damages. The better approach is to require the contractor to provide details of the proposed personnel's experience so that the Government can make a judgment as to whether the contractor has adequately staffed the project. Then, if the Government's evaluation team has an issue with the proposed team, the issue can be raised with the contractor during the pre-award phase of the acquisition process.

If the Government concludes that the contractor's workforce is lacking the appropriate experience, your Network contracting staff may reject the proposal.

**K. CONFIDENTIALITY AND NONDISCLOSURE:**

Standard mandatory language for all contracts.

**L.** New contractor personnel security requirements, which facilitate the security programs for computer systems and automated information systems implemented by the Office of Security and Law Enforcement and Veterans Health Administration.

## Statement Of Work Template

### A. GENERAL INFORMATION

1. Title of Project: [Title]

2. Scope of Work: The contractor shall provide all resources necessary to accomplish the deliverables described in this statement of work (SOW), except as may otherwise be specified. [Include a brief statement (2 or 3 sentences) of the overall project purpose and objectives.]

3. Background: [Briefly explain the history of this requirement, what exists currently and your vision of the future as it relates to the work at hand. If information technology related, present pertinent technical facts.]

4. Performance Period: [Firm-Fixed-Price] The contractor shall complete the work required under this SOW in \_\_\_ calendar days or less from date of award, unless otherwise directed by the Contracting Officer. If the contractor proposes an earlier completion date, and the Government accepts the contractor's proposal, the contractor's proposed completion date shall prevail. [Time and materials] The work shall begin within \_\_\_ calendar days of award, unless otherwise specified. [Both] Work at the government site shall not take place on Federal holidays or weekends unless directed by the Contracting Officer.

5. Type of Contract: [Firm-Fixed-Price or Time and Materials]. [Refer to the guidance that accompanies this SOW to determine the appropriate contract.]

### B. CONTRACT AWARD MEETING:

The contractor shall not commence performance on the tasks in this SOW until the Contracting Officer has conducted a kick off meeting or has advised the contractor that a kick off meeting is waived.

### C. GENERAL REQUIREMENTS:

1. For every task, the contractor shall identify in writing all necessary subtasks (if any), associated costs by task, together with associated submilestone dates. The contractor's subtask structure shall be reflected in the technical proposal and detailed work plan.

2. All written deliverables shall be phrased in layperson language. Statistical and other technical terminology shall not be used without providing a glossary of terms.

3. Where a written milestone deliverable is required in draft form, the VA will

**ATTACHMENT D**

complete their review of the draft deliverable within \_\_\_ calendar days from date of receipt. The contractor shall have \_\_\_ calendar days to deliver the final deliverable from date of receipt of the government's comments.

**D. SPECIFIC MANDATORY TASKS AND ASSOCIATED DELIVERABLES:**

1. Description of Tasks and Associated Deliverables: The contractor shall provide the specific deliverables described below within the performance period stated in Section A.4 of this SOW. [For most requirements, concentrate on describing functionally the final end product. Allow the contractor to devise and propose one or more solutions to satisfy the requirements. VERY IMPORTANT: NEVER DICTATE TO THE CONTRACTOR IN THIS STATEMENT OF WORK, OR WHILE THE CONTRACTOR IS PERFORMING THE WORK, HOW TO ACCOMPLISH THE DELIVERABLE(S). ONLY DESCRIBE WHAT IS DESIRED WHEN THE CONTRACTOR IS FINISHED.]

2. Task One: Optional - The Contractor shall provide a detailed work plan and briefing for the VA project team, which presents the contractor's plan for completing the task order. The contractor's plan shall be responsive with this SOW and describe, in further detail, the approach to be used for each aspect of the task order as defined in the technical proposal.

Deliverable One: A detailed work plan and briefing.

Task Two:

Deliverable Two:

**E. SCHEDULE FOR DELIVERABLES:**

1. The contractor shall complete the Delivery Date column in Attachment A for each deliverable specified.

2. Unless otherwise specified, the number of draft copies and the number of final copies shall be the same.

3. If for any reason any deliverable cannot be delivered within the scheduled time frame, the contractor is required to explain why in writing to the Contracting Officer, including a firm commitment of when the work shall be completed. This notice to the Contracting Officer shall cite the reasons for the delay, and the impact on the overall project. The Contracting Officer will review the facts and issue a response in accordance with applicable regulations.

**F. CHANGES TO STATEMENT OF WORK:**

Any changes to this SOW shall be authorized and approved only through written correspondence from the Contracting Officer. A copy of each change will be kept

**ATTACHMENT D**

in a project folder along with all other products of the project. Costs incurred by the contractor through the actions of parties other than the Contracting Officer shall be borne by the contractor.

**G. REPORTING REQUIREMENTS:**

1. SAMPLE LANGUAGE ONLY. Case-by-case circumstances may reduce suggested timeframe specified. The contractor shall provide the TOPM/COTR with monthly [frequency determined by project's duration] written progress reports (original plus \_\_\_ copies). These are due to the TOPM/COTR by the second workday following the end of each calendar month throughout the project's duration. The TOPM is required to provide monthly progress reports to the Contracting Officer's Technical Representative (COTR) by the fifth workday of the new calendar month.

2. The progress report shall cover all work completed during the preceding month and shall present the work to be accomplished during the subsequent month. This report shall also identify any problems that arose and a statement explaining how the problem was resolved. This report shall also identify any problems that have arisen but have not been completely resolved with an explanation.

**H. TRAVEL: [If applicable]**

[Discuss any anticipated travel. Include the VA site locations, number of trips and duration of travel anticipated.] [When travel is applicable include the following language]– **Travel** and per diem shall be reimbursed in accordance with VA and Federal Travel Regulations.

**I. GOVERNMENT RESPONSIBILITIES: [If applicable]**

[Tells what the government will provide, for example: office space, telephone service, and government-furnished equipment; and procedural guides, reference materials and program documentation.]

**J. CONTRACTOR EXPERIENCE REQUIREMENTS: [If applicable]****K. CONFIDENTIALITY AND NONDISCLOSURE:**

It is agreed that:

1. The preliminary and final deliverables and all associated working papers, and other material deemed relevant by VA which have been generated by the contractor in the performance of this task order are the exclusive property of the U.S. Government and shall be submitted to the Contracting Officer at the conclusion of the task order.

**ATTACHMENT D**

2. The Contracting Officer will be the sole authorized official to release verbally or in writing, any data, the draft deliverables, the final deliverables, or any other written or printed materials pertaining to this contract. The contractor shall release no information. Any request for information relating to this task order presented to the contractor shall be submitted to the Contracting Officer for response.

3. Press releases, marketing material or any other printed or electronic documentation related to this project, shall not be publicized without the written approval of the Contracting Officer.

**L. CONTRACTOR PERSONNEL SECURITY REQUIREMENTS<sup>2</sup>**

All contractor employees who require access to the Department of Veterans Affairs' computer systems shall be the subject of a background investigation and must receive a favorable adjudication from the VA Office of Security and Law Enforcement prior to contract performance. This requirement is applicable to subcontractor personnel requiring the same access.

1. Position Sensitivity: The position sensitivity has been designated as \_\_\_\_\_ (VA TOPM insert High Risk, Moderate Risk or Low Risk.)

2. Background Investigation: The level of background investigation commensurate with the required level of access is \_\_\_\_\_ (VA TOPM insert Background Investigation, Minimum Background Investigation or National Agency Check with Written Inquiries).

3. Contractor Responsibilities:

A. The contractor shall prescreen all personnel requiring access to the computer systems to ensure they maintain a U.S. citizenship, and are able to read, write, speak and understand the English language.

B. The contractor shall submit or have their employees submit the required forms (SF 86 or SF 85P, SF 85P-S, FD 258, Contractor Fingerprint Chart, VA Form 0710, Authority for Release of Information Form, and Optional Forms 306 and 612) to the VA Office of Security and Law Enforcement within 30 days of receipt.

C. The contractor, when notified of an unfavorable determination by the Government, shall withdraw the employee from consideration from working under the contract.

D. Failure to comply with the contractor personnel security requirements may result in termination of the contract for default.

4. Government Responsibilities:

A. The VA Office of Security and Law Enforcement will provide the necessary forms to the contractor or to the contractor's employees after receiving a list of names and addresses.

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<sup>2</sup> Reference IL 90-01-6, Contractor Personnel Security Requirements

**ATTACHMENT D**

B. Upon receipt, the VA Office of Security and Law Enforcement will review the completed forms for accuracy and forward the forms to the office of Personnel Management (OPM) to conduct the background investigation.

C. The VA Office of Security and Law Enforcement will notify the contracting officer and contractor adjudicating the results of the background investigations received from OMB.

D. Upon being notified about a favorable determination, the contracting officer may issue a notice to proceed to the contractor.

**Schedule of Deliverables**

<b>Deliverable No.</b>	<b>Item</b>	<b>Quantity</b>	<b>Delivery Date</b>
<b>One</b>	A detailed work plan and briefing for the VA project team		Within ___ calendar days after award
<b>Two</b>	etc.		

## CHAPTER 8: IMPLEMENTATION GUIDE

### A. Background:

Upon receiving authorization to proceed with implementation of their Market Plan, each Network will develop, within 45 days, a comprehensive plan, with timelines, for the implementation of the Planning Initiatives within their market plans. The VISN Support Service Center (VSSC) will assist the Network in developing an implementation plan.

The CARES implementation guidance is to be used in concert with existing federal and VA policies and procedures. Moreover, the Network's implementation plan for CARES should support the decision made by the Secretary and also be integrated into the Network Strategic Plan. This guide, along with existing policies and procedures and the assistance from the VISN Support Service Center (VSSC), should provide the Network with sufficient direction to develop a plan which will outline how the Network will reallocate resources, re-align services and programs, identify and pursue the divesture of capital assets and/or capital asset initiatives so that the approved Market Plan Initiatives are realized.

VACO will need to periodically brief national stakeholders on the progress VA has made in implementing the approved Planning Initiatives. The appropriate VA Congressional committees, national VSO representatives, and other national stakeholders will need to be kept abreast of progress on substantial, Network-specific, CARES-related initiatives and overall progress on implementing the approved CARES recommendations across VHA. Substantial, Network-specific, CARES-related initiatives could include VHA facility mission changes and Major construction projects. Communications between VA and national stakeholders may take the form of periodic briefings dedicated to the status of the rollout of CARES, including CARES as a standing agenda item on regularly scheduled meetings, news releases, and other communication venues. The foundation of these national communications are the Network CARES implementation plans and their quarterly reports to VACO (Section C).

There are essentially four main steps to developing a CARES implementation plan:

- Step 1:** Establish a CARES Implementation Steering Committee
- Step 2:** Develop a Communication Plan
- Step 3:** Develop the Implementation Plan - Mapping out a sequence of necessary changes to programs and services, allocation of resources and realignment of capital assets
- Step 4:** Realign Network programs, services, and capital assets

- (1) Capital Divestitures: Enhanced Use Lease and Selling, Transferring or Demolishing VA assets
- (2) Capital Investments: Major and Minor Construction, NRM, Leasing, and Purchase of Real Property
- (3) Sharing Agreements and Contracting for Services
- (4) Partnering with the Department of Defense
- (5) Service program development to enhance the delivery of health care services, i.e., mental health, long term care.

The approved Market Plan Initiatives are strategic, broad in focus, and address major realignments. However, since many of the detailed service delivery changes may not be fully addressed in the planning initiatives, it is important that the detailed CARES implementation plan is consistent with the intent of the Secretary's approval of the CARES Market Plan.

Each step provides an overview of the subject area, a description of appropriate guidance, listing of sources for further reference, and points of contact of those who can be of further assistance.

## **B. Implementation Steps:**

### **Step 1: Establish a CARES Implementation Steering Committee**

It is important that a structure be put in place to ensure that all facets of the Market Plans are being addressed and that implementation is proceeding as planned. For this reason, Networks should establish a CARES Implementation Steering Committee to monitor and coordinate activities related to the implementation of the CARES Market Plans. This Network-level committee will assure that changes in veterans' programs and services are conducted in a manner consistent with the objectives of the CARES Program, internal and external stakeholder are kept informed throughout the implementation process, relevant timelines - particularly for capital investment initiatives - are met, and the Under Secretary for Health is periodically updated on the progress.

#### ▪ **Guidance**

Although the membership of the CARES Implementation Steering Committee is at the discretion of the Network Director, it is suggested that the committee include sufficient clinical representation as well as subject matter experts in planning, fiscal management and facilities management.

The Network should be aware that it is expected that union representatives will be provided the opportunity for input into the implementation plan. Although the Network has discretion on whether to include union representatives on the Steering

Committee, they should make a concerted effort to periodically brief their unions on progress being made and allow for union input into the process.

▪ **For Assistance Contact**

Jill Powers, VISN Support Service Center, (678) 924-5793

Bonnie Kerber, VHA HRM Group (760) 643-2057

**Step 2: Develop a Communication Plan**

Developing a clear and comprehensive communication plan and following that plan is crucial to the successful implementation of the CARES Market Plans.

▪ **Guidance**

The communication plan will need to address how internal (i.e., employees, unions, volunteers, etc.) and external stakeholders (i.e., medical affiliates, veterans service organizations, congressional staff, etc.) are kept informed of progress made, as well as how stakeholder input is fed into the implementation process. The list of stakeholders developed for the planning phase will need to be updated as appropriate.

The Network's communication plan should address the following issues:

- a. How the Network intends to coordinate its efforts with the VHA Office of Communications and the VA Office of Public Affairs.
- b. How inquiries will be handled from local and national media concerning implementation initiatives and changes in veterans' services.
- c. How local and national stakeholders will be informed about initiatives effecting veterans' programs and services.
- d. How will the Network office and VISN facilities document concerns and input from stakeholders regarding the manner and scope of implementation initiatives.

The Network will need to assure that VA's stakeholder constituency is kept fully informed throughout the process and that appropriate input is obtained. This can be accomplished through a number of forums including town hall meetings, focus groups, interviews, presentations, position papers, and the Internet.

▪ **For Further Reference**

CARES Guidebook, Chapter 3- Communication Plan

▪ **For Assistance Contact**

Jim Holley and John Patrick in the VHA Office of Communication (202) 273-8591

**Step 3: Plan Development - Map out a sequence of the changes to programs and services, allocation of resources within the Network, and alignment of capital assets, necessary to realize the approved CARES Market Plans**

The approved CARES Market Plan is made up of Planning Initiatives that involve significant changes in veterans' programs and services. Careful planning is essential to assure the smooth phasing and transition of realigning services consistent with the Planning Initiatives. There are significant clinical, operational, fiscal and infrastructure implications in how, when and in what sequence services are realigned.

The Network's CARES Implementation Plan, and initiatives undertaken as part of the implementation plan should be developed and sequenced so that the intent of the market plans are fully realized. If the intended outcome of a market plan or planning initiative is unclear or if it is not evident how the Network should proceed with implementing an option, the Network should contact the Undersecretary for Health's CARES liaison for clarification.

**▪ Guidance**

The Network's Strategic Plan serves as a roadmap for how the VISN intends to provide care to their enrolled veterans both in the short-term and long-term. The Network's Strategic Plan articulates strategic goals for medical care, research, education and support to DoD and the National Disaster Medical System (NDMS) in times of national emergency. With this in mind, the Network's Implementation Plan for CARES should complement the Network's strategic plan. Much of the information, such as the actuarial projections and facility assessments, obtained during the CARES planning process as well as the narrative from the Network's CARES Implementation Plan can be incorporated into the Network's strategic plan. Similar to the Network's Strategic Plan, the CARES Implementation Plan should advance the stated mission and four corporate goals of the Department and VHA's Six for 2007 Strategic Objectives and performance measures. If the CARES Market Plan necessitates it, the Strategic Plan should be revised to reflect the Secretary's decision.

The implementation of the approved Market Plans may require a number of types of strategic initiatives such as: realigning of clinical and administrative services and programs, Major and Minor construction projects, Non-recurring Maintenance (NRM) projects, divestiture of capital assets, collaboration with DoD, and other sharing initiatives. For each Planning Initiative the Network's Implementation Plan should clearly map out the actions that have a higher priority and should be accomplished first. Whether or not they can be initiated in the short-term, all planning initiatives required to achieve the approved market plans should be included in the plan. When determining the timing and phasing of initiatives, consideration should be given to the impact on operations, linkages with other parts of the approved CARES initiatives, required changes to management structures and staffing, and the availability of resources necessary to implement the initiative. The implementation plan should

clearly demonstrate the conversion of the market plans to an operational action plan with specific strategic initiatives, resource requirements, timeframes for accomplishment, and assigned responsibilities.

The CARES Market Plan suggests timelines for each of the capital projects that implement the Planning Initiatives. The VISN may find it necessary to re-evaluate the proposed schedule(s) for capital and other actions given the availability of resources, the relationship with other Planning Initiatives within the Network, stakeholder interest and past experience with managing construction projects. The CARES Implementation Steering Committee should use the Microsoft Project software to develop an implementation plan timeline (Gantt chart) showing the sequencing of capital and other initiatives. The plan should be developed to provide the most cost-effective and shortest implementation mechanism to achieving the approved CARES Planning Initiatives.

▪ **For Assistance Contact**

Jill Powers and Jim Schiller, VISN Support Service Center, (678) 924-5793

**Step 4: Realign Network programs, services, and capital needs**

**(1) Capital Divestitures: Enhanced-Use Lease and Selling, Transferring or Demolishing VA assets**

Since VA has limited authority to dispose of real property and demolish VA assets, the Enhanced-Use Lease Program may be a viable alternative in divesting of VA assets identified in the CARES Market Plans.

▪ **Guidance:**

– Selling, Transferring or Demolishing VA Assets:

Unless a disposal of real property is specifically legislated by Congress, VA's disposal authority is very limited. Consequently, for the vast majority of disposals, VA must determine that the property is excess to VA's needs and inform the GSA of its desire to dispose of it. The Secretary must approve the disposal and Congress must be notified. VA commences environmental and historical clearances after Secretarial approval to excess is made. Prior to selling the property on the open market, GSA must first clear the property through other federal agencies that might have an interest. This includes notification to HUD to determine if use by the homeless is suitable. If there is no federal interest, the property is offered to state or local governments before it is offered to private bidders. Per VA law, the property must be sold for an amount equal to fair market value. VA's proceeds will be limited to the amount of sale less carrying and disposal expenses incurred by GSA. In most cases the funds must be deposited into the Nursing Home Revolving Fund.

– Out-leasing VA Assets:

Out-leasing is the leasing of VA owned real property to public or private interests outside of VA. In such cases VA is the lessor. VA's out-leasing authority is cited in 38 U.S.C. 8122 and is limited to a term no greater than three years. The authority has been delegated to VA Medical Center Directors per VHA Directive 98-014. Medical Center Directors must determine if there is a VA, Government, or public interest to be served by the proposed request and that the purpose is not adverse to the interests of the United States. The proposed out-lease must also be consistent with the mission and program responsibilities of the VA. All out-leases must be reviewed and concurred in by the Office of Regional Counsel prior to execution. The Office of Facilities Management Leasing Staff, and the Capital Programs Staff in the VISN Support Service Center are available for advice and guidance as requested.

– Enhanced Use Leasing

Enhanced-Use Leasing is a mechanism for obtaining facilities and services for VA activities. Enhanced-Use Leasing is a cooperative arrangement between the Department and the private sector (or another government entity) for the use of Department-controlled property. In this arrangement both the private sector and VA contribute something of value. VA may offer "non-cash" assets on a long-term basis (up to 75 years) such as unused land, facilities, or access to a revenue producing market. In return, the private sector may provide facilities for VA use or provide certain services or products to VA activities at no or reduced cost. To be effective, the cost to VA (and to the Government), including the value of the out-leased land, for obtaining the facilities or services must be less than any other means for acquiring such products or services. This program's authority rests with the Secretary of Veterans Affairs and therefore the Secretary of Veterans Affairs must authorize all delegations of that authority.

Execution of Enhanced-Use Leases involve approval of a concept or business plan, a public hearing, competitive selection of a developer, two (2) oversight reviews by VA's Congressional Committees, and oversight review and approval by VA's internal CIB process and OMB concurrence for "significant" (over \$4.0M value) projects. Guidance and assistance with the reviews and approvals is available from the Office of Asset Enterprise Management (004B), Capital Asset Management and Planning Service (CAMPS), within the Office of Facilities Management, in Central Office.

▪ **For Further Reference**

VA Directive 7415.1. Financial and Program Policies Regarding Enhanced-Use Leasing Program

▪ **For Assistance Contact**

General questions - Jill Powers and Jim Schiller, VISN Support Service Center (678) 924-5793

VHA Capital Asset Management and Planning Service- Anthony DiStasio  
(202) 565-4092

Leases - Amelia McLellan, Office of Lease Management (183C) 202-565-7001  
Enhanced Use Leasing - Brian McDaniel in the Office of Asset Enterprise  
Development (004B2) (202) 273-9492

**(2) Capital Investments: Major and Minor Construction, NRM, Leasing and Purchase of Real Property**

Some Market Plans will involve the Network developing capital investment initiatives. A Capital Investment Proposal (CIP) will need to be completed for each capital investment initiative requiring VACO approval. A summary of each capital investment initiative, along with timelines and an estimated cost, should be included in your implementation plan.

▪ **Guidance**

The Network is to identify capital initiatives required to implement the approved CARES Planning Initiatives. This may involve Major or Minor Construction, Non-recurring Maintenance, leasing or the purchase of real property. The Network may immediately implement capital initiatives using Network funds that fall below the established thresholds for VA Central Office review. Capital asset investment applications that require VA Central Office review, but do not require a submission to the VA Capital Investment Board, will be coordinated with the VHA Capital Asset Management and Planning Service. The following table illustrates the criteria that institute a VA CIB Review or a VHA CO Review.

	VA CIB Review	VHA CO Review (CAMPS)
<b>Construction</b>	Over \$4 million	NRM over \$2 million All Minor Projects
<b>Leases</b>	Over \$600,000/year	Over \$300,000/year
<b>Medical Equipment</b>	Over \$1 million	Over \$500,000
<b>Non Medical Equipment</b>	Over \$500,000	
<b>Information Technology</b>	All purchases	
<b>Enhanced Sharing</b>	NPV over \$4 million	NPV over \$2 million
<b>Enhanced Use Leasing</b>	\$ 4 million	ALL

– Major Construction

Construction projects that exceed \$4 million in total project cost are considered Major Construction. A capital investment application must be completed, approved by the

Network, and forwarded to the VHA Office of Facilities Management (OFM). By the end of November each year, the Network should submit a listing of major construction needs for the next budget cycle. This listing is to be followed by detailed submissions by the end of February.

The Office of Facility Management (OFM), VHA Capital Asset Management and Planning Service and the VA Capital Investment Board (CIB) are to give special consideration to those Major Construction projects that are required to implement approved CARES Market Plans.

– Minor Construction

This category of construction projects includes all construction, renovation and building/land purchases over \$500,000 in Minor improvements, but less than \$4 million. Submissions for new minor construction projects as part of the Market Plans should be submitted as soon as possible. Due to the importance of implementing the CARES-related capital investment initiatives in a timely manner, minor project submissions can be considered out of cycle for the first year of implementation.

– NRM Construction

Non-recurring Maintenance Projects are construction and renovation initiatives that are less than \$500,000 in minor improvements, primarily for the purpose of maintaining the existing buildings and structures. The Network may request additional NRM funding for the implementation of CARES Planning Initiatives. This request should be coordinated with the VHA Capital Asset Management and Planning Service (CAMPS).

– Leasing

VA has delegated authority from the GSA to enter into lease agreements for medical care related space. Leases are funded from the VHA health care budget. The level of review and approval for leases is determined by the cost of the lease under consideration.

Leases costing less than \$300,000 per year, less than 10,000 net square feet and less than three years in duration can be executed by a Medical Center without VA Headquarters involvement.

Leases costing between \$300,000 and \$600,000 per year must be reviewed and approved through a Network level concurrence process and pass through Congressional notification before VA enters into the lease.

For leases costing more than \$600,000 a year, a capital investment application should be submitted to the VHA Office of Lease Management (18) and will require approval by the VA CIB. The VHA Office of Facilities Management will assist the VHA facilities in completing an application and also manages the submission of the application through the CAMPS to the VA CIB. Approved leases are included in the

VA budget submission to Congress and Congress must pass legislation authorizing the lease.

- Enhanced Use Leasing - VA has the authority to enter into enhanced use leases. (See Chapter 5; Attachment 8 for full description.)
- Purchase of Real Property

VA has direct real property acquisition authority. In order to initiate an acquisition action, the field VHA facilities must contact Real Property Management Service (RPMS) in the Office of Facilities Management and request the desired action. Funding must be available in a Major Construction Project, Minor Construction Project or the Parking Revolving Fund. A Cost Benefit Analysis must be prepared to determine if acquisition is, in fact, the most economic method of obtaining the property. An appraisal, boundary survey, and a title search must be ordered to determine the value of the property, ascertain the meets and bounds, and determine if there are any significant encumbrances upon the title. RPMS will assist and provide expert guidance in acquiring all these items. RPMS will then prepare a package for the Secretary's approval.

▪ **For Further Reference**

- Major Construction

Capital Investment Methodology Guide, dated May 2000

Guidance is available for the preparation of capital investment applications from OFM and over the VA Intranet.

- Minor Construction and NRM Projects

VSSC Construction and Capital Asset Management Guidebook  
VSSC website: <http://vssc.med.va.gov>

▪ **For Assistance Contact**

Jill Powers and Jim Schiller, VISN Support Service Center, (678) 924-5793

VHA Capital Asset Management and Planning Service- Anthony DiStasio  
(202) 565-4092

Major Projects - William B. Webb (182B) 202-565-6173 and Anthony DiStasio  
202-565-4092

Leases - Amelia McLellan, Office of Lease Management (183C) 202-565-7001

Enhanced Use Leasing - Anthony DiStasio 202-565-4092 and Jim Sullivan 202-273-5254, Office of Asset Enterprise Management (004B)

### **(3) Sharing Agreements and Contracting for Services**

As part of implementing a CARES Market Plan, the Network may determine that contracting with a local health care provider can best provide the health care services needed by the veterans in the market. The Network may deem contracting for non-medical services such as infrastructure, equipment, and support services, is a viable

route to carry out a strategic initiative. This process is handled through your local acquisition office, CAMPS and the VHA Medical Sharing Office, if necessary. The guidance below may be helpful when pursuing these types of initiatives.

#### ▪ **Guidance**

Current policy for purchasing and selling resources under Title 38, Section 8153 is contained in VHA Directive 97-015. When pursuing sharing agreements it is important to remember:

- All proposals to sell or lease VHA healthcare resources (services, space, medical equipment, land, etc.) must receive concept approval from the Rapid Response Team (RRT). This team is composed of staff from the Medical Sharing Office, CAMPS, General Counsel and Acquisitions and Material Management (90). A concept proposal is a brief summary of the main aspects of the proposal to sell VA healthcare resources.
- All sharing agreements to sell VA laundry service, and administrative services must be reviewed and approved by Medical Sharing Office (176B). Concept approval is usually granted the same day. Concept approval is not the same as formal VHA Headquarters' review and approval of a formal Sharing Agreement.
- All sharing agreements in excess of \$500,000 must be reviewed and approved by the Medical Sharing Office (175), including the Office of General Counsel, Acquisition and Material Management, with concurrence from the appropriate Headquarters' program office.
- All sharing agreements that involve inpatient care for non-veterans require the approval of the Under Secretary for Health and or the Secretary. The Medical Sharing Office can provide a template of information required for review and approval.
- Proposals to purchase health care resources under this authority do not require concept approval.
- Sharing agreements below \$500,000 including option years can be approved locally. However, Regional Counsel must concur. This dollar threshold does not apply to agreements for space, laundry, administrative services or the use of medical equipment that might require inpatient care for non-veterans.
- Proposals for sharing agreements that involve space must be reviewed and approved by the VHA Capital Asset Management and Planning Service.

▪ **For Further Reference**

VHA Directive 97-015 – Enhanced Health Care Resources Sharing Authority

IL 10-2001-004 - Health Care Contracts Address Quality and Safety for All Veterans

▪ **For Assistance Contact**

Rose Quicker, Director, Medical Sharing Office at (202) 273-5514

VHA Capital Asset Management and Planning Service- Anthony DiStasio (202) 565-4092

**(4) Partnering with the Department of Defense**

CARES Market Plans are expected to enhance collaboration with the DoD wherever possible.

▪ **Guidance**

Planning Initiatives, which further the sharing of health care resources and services between the VHA and DoD facilities, are highly encouraged. These efforts include the sharing of medical and administrative services, health care delivery infrastructure, and staff with DoD facilities.

The DoD/VA Executive Council is overseeing a number of focused initiatives between VA and DoD facilities. If relevant, the Market Implementation plans should acknowledge and fully support the realization of these efforts. Approved recommendations from the DoD/VA Executive Council should be integrated into the Network CARES Implementation Plan.

▪ **For Further Reference**

DoD/VA Executive Council minutes and Statements of Work concerning VHA facilities within your VISN.

▪ **For Assistance Contact**

Sheila McCready, Coordinator of the VA/DoD Executive Council, (202) 273-5608

Rose Quicker, Director, Medical Sharing Office at (202) 273-5514

**C. Reporting Requirements**

**45 days following the Secretary’s approval of the CARES Market Plan for the Network:**

- The Network will submit a preliminary implementation plan to the Under Secretary for Health for approval.

**The first week of the quarter for each quarter thereafter:**

- The Network will submit a quarterly implementation status report to the Assistant Deputy Under Secretary for Health using the format outlined in the attachment.

**At the date designated for submission of the Network Strategic Plan:**

- The Network will submit their Network Strategic Plan to VHA Central Office, incorporating much of the information from the CARES Market Plans and the CARES implementation plan and including refinements to the implementation plan.

## CHAPTER 9: CARES Outcomes

### A. Overall Outcome

The desired outcome of the CARES process is to ensure that the Department of Veterans Affairs has the physical infrastructure and services to provide cost effective quality of care to veterans now and in the future. The changes in the delivery of health care over the past decade and the expected future changes in health care require VA to re-examine the type and location of its capital assets. The CARES process will describe the number, type, and location of capital assets and services that are required to improve access to care and VHA's delivery of health care by maintaining an environment that maximizes quality of health care for veterans through the strategic planning years of 2012 and 2022.

The overall approach to producing these desired outcomes is to maximize the positive improvements to access, to the health care facility environment, and cost effective resource use of any capital realignments while mitigating any potential negative impact of these realignments. The CARES process has built these outcome objectives into the development and selection of Planning Initiatives through their incorporation into planning and evaluation criteria. In addition, other important criteria such as maximizing DoD partnering and minimizing any negative impact that the CARES process may have on affiliates, research, and employees are also incorporated.

### B. Key Outcomes

- **Enhanced Services**

The realignment of capital assets is expected to identify savings that can be translated into enhanced services. Each market plan and Planning Initiative will calculate the expected cost savings that could be converted into enhanced services. The Planning Initiatives may also describe the enhancement of services through additional CBOC's, LTC, etc. in the Planning Initiative proposed actions in their market plans.

- **Meeting Future Need, and Improved Quality in a Safe Environment**

The first criterion of the CARES evaluation is to meet the forecasted need for services in the market area. CARES will "enhance VHA's delivery of health care by maintaining an environment and infrastructure that maximizes quality of health care". While quality is measured by specific measures of health care delivery processes, the first step in quality is to ensure that a safe physical plant with adequate physical capacity is available to deliver needed services in a safe physical environment.

Additionally, in determining the future location of services it is expected that knowledge of the relationship of the volume of services/procedures and outcomes and location to continuity of care will be key element in the completion and evaluation of Planning Initiatives.

- **Improved Access**

The CARES process will measure expected improvements in access as a result of completed Planning Initiatives. Baseline measures and changes in access will be assessed by the percentage of enrollees who meet travel time guidelines. Access will be considered in the selection, completion and evaluation of Planning Initiatives.

- **Effective Resource Use**

The CARES process will measure the life cycle cost of the completed Planning Initiatives and alternatives considered. This will ensure that the capital plans selected fully reflect the impact upon costs of the proposed changes. In addition, specific projects that are submitted to fully implement the CARES plan will be subject to a detailed cost effectiveness review by the Capital Investment Board (CIB).

- **Improved Stakeholder Participation and Support**

The systematic inclusion of stakeholders in the CARES planning process will provide stakeholders with an improved understanding in each market area of future health care needs as well as the planning process used to address those needs. The input of stakeholders will be part of each Network CARES Market Plan. The evaluation criteria utilized to develop each Network CARES Market Plan will assure stakeholders that the plans submitted address needs, access, community resources, and collaboration with key partners such as the Department of Defense health care delivery sites within each market area. Stakeholders will also be included in the implementation process using tools and methods similar to those used in plan development.

### **C. Evaluation Criteria**

The planning criteria (Chapter 5) and evaluation criteria (Chapter 10) used to plan and evaluate the Network CARES Market Plans and Planning Initiatives are:

#### **Threshold Criteria**

1. Health Care Quality and Need
2. Safety and Environment

#### **Impact Criteria**

3. Quality as Measured By Access
4. Research and Academic Affiliations
5. Staffing and Community Impact
6. Support of VA's other Missions including DoD collaboration

## 7. Optimizing the Use of Resources

Sub criteria that operationalize these seven categories are described in Chapters 4 and 10 of this guide.

### **D. VA Strategic Management Outcomes**

An outcome of the CARES process is the expected positive impact of the CARES process on key Department strategic management functions such as planning and budgeting.

#### **▪ Improved Capital Planning and Budgeting**

The CARES process systematically assesses the entire VHA health care system by using a uniform methodology and centrally determined forecasts of future need. That process systematically identifies and proposes Planning Initiatives that will realign the capital infrastructure so that it will deliver cost effective, accessible, high quality care to veterans in each health care market. As a result, the Department will have an improved database and process to develop capital funding proposals to submit to Congress.

#### **▪ Improved Strategic Program/Service Planning**

The CARES approach to developing system-wide realignment will be linked to a revised strategic planning process. The approach of using system-wide methodologies, clearly identified required outcomes and evaluation criteria will be incorporated into future network planning processes. Successive cycles of strategic planning will refine the types and location of programs and services proposed in the approved market plans and Planning Initiatives.

## CHAPTER 10: Review and Evaluation

### A. Background

The CARES process requires the balancing of multiple factors in the development, review, and approval of CARES Market Plan Initiatives. Review of the Planning Initiatives using evaluation criteria that address these factors, is a systematic approach to addressing these factors. Evaluation criteria link Planning Initiative completion with subsequent review and evaluation. Evaluation criteria serve as the framework for both Planning Initiative development and the review and evaluation process. The evaluation criteria are termed planning criteria for the completion of the Market Plan Initiative by the Networks (Chapter 5, Market Plans).

The evaluation criteria were developed for the Phase 1 CARES pilot and modified slightly to reflect the experience gained in the pilot. Since the Networks no longer submit multiple options for VACO selection, it is no longer necessary to establish and apply weights to the criteria to rank market area Planning Initiative solutions. The weighting process was also not effective in discriminating between projects and detracted from focusing on the broader issues that needed to be addressed. In addition, the sub-criteria for each of the major criteria have been modified to make it easier for them to be used by the Networks and VACO.

### B. Evaluation Process

1. Goals: The goals of the evaluation process are to:
  - a. Ensure that the Secretary has available to him a full understanding of the benefits and any potential negative impacts of the Network Planning Initiatives that are in the Draft National CARES Plan.
  - b. Ensure that the completion of the Planning Initiatives from the Networks fully considered the impact of the Planning Initiative and have a strategy to minimize any negative impact.
  - c. Ensure that the cost savings of the Planning Initiatives are quantified to the maximum extent feasible, so that savings can be redirected towards enhancing services and improvements in access.
2. Criteria: Evaluation criteria are divided into threshold and impact criteria as follows and are fully described in Attachment 10A with accompanying sub criteria.
  - a. Threshold Criteria
    - 1) Health Care Quality and Need

2) Safety and Environment

b. Impact Criteria

- 1) Quality as Measured By Access
- 2) Research and Academic Affiliations
- 3) Staffing and Community Impact
- 4) Support of VA's other VA Missions including DoD collaboration
- 5) Optimizing the Use of Resources

Threshold criteria describe aspects of the Planning Initiative that are so fundamental to the development of an acceptable Market Plan that they must be met for the review process to continue. The threshold criteria of need, quality, and safety ensure that no Planning Initiative will be considered for inclusion in the National CARES Plan unless they are adequately addressed.

Impact criteria provide an assessment of a broad scope of attributes that are important to an overall assessment of the Planning Initiative and Market Plan. They provide a basis for assessing the positive and/or potential negative impact on selected areas of research, access, staffing, community, DoD collaboration, homeland security and emergency preparedness and optimizing the use of resources. These are important considerations in making a determination for inclusion of the initiative in the National Care Market Plan. Access and life cycle costing are evaluated through VACO standardized methodologies that ensure an objective determination of these key impact evaluation criteria.

3. Use of the Evaluation Criteria:

A. Networks

The evaluation criteria are incorporated in the CARES Planning Model as planning criteria. In order to complete the Planning Initiatives selected by VACO, the Networks will be required to utilize the criteria in their analysis of the solutions they consider to complete the planning initiative. The results of the analysis will be submitted in a standard format. In order to ensure that other alternatives were considered, the results of the analysis for at least one other solution that was considered will be submitted for each Planning Initiative within the market plan, using a standard format described in Attachment 10B.

4. VACO Review and Evaluation:

A. NCPO Staff Review

The NCPO staff review will assess the Planning Initiatives against the evaluation criteria and produce review documents for the reviews by the Under

Secretary for Health's Clinical CARES Advisory Group (CCAG), the CARES One VA Committee (COVAC), and the CARES Commission. The review documents will at a minimum address the following:

- 1) Assess whether the threshold criteria for safety, quality, and need have been adequately addressed such that the Initiative can continue in the review process or be sent back to the Network.
- 2) Review the VISN response to the impact evaluation criteria and prepare Planning Initiative and Market Plan Assessments based upon the impact and threshold criteria.
- 3) Identify significant issues raised by the Planning Initiative / Market Plans based upon the evaluation criteria and other review considerations such as stakeholder input.
- 4) Organize Market Plans into groupings that reflect some of the key objectives of the CARES process. This may assist future decisions by highlighting market plans that stand out with respect to these objectives. Areas that will be included as a minimum are:
  - a. Magnitude of cost savings available for enhancing services
  - b. Size of realignment gap addressed in Planning Initiative (relative and/or absolute)
  - c. CBOC requirements
  - d. Magnitude of vacant space
  - e. Unmet need (i.e. population outside of access standards)
  - f. DoD sharing
- 5) Assess the use of stakeholder input into the Planning Initiative.

**B. Clinical CARES Advisory Group (CCAG)**

The Clinical Cares Advisory Group will review the Planning Initiatives and Market Plans and will focus on the clinical impact that are suggested by the criteria and any other changes described in the market plans that would impact quality. The CCAG will prepare a report of their findings and recommendations to the Undersecretary for Health.

**C. CARES One VA Committee (COVAC)**

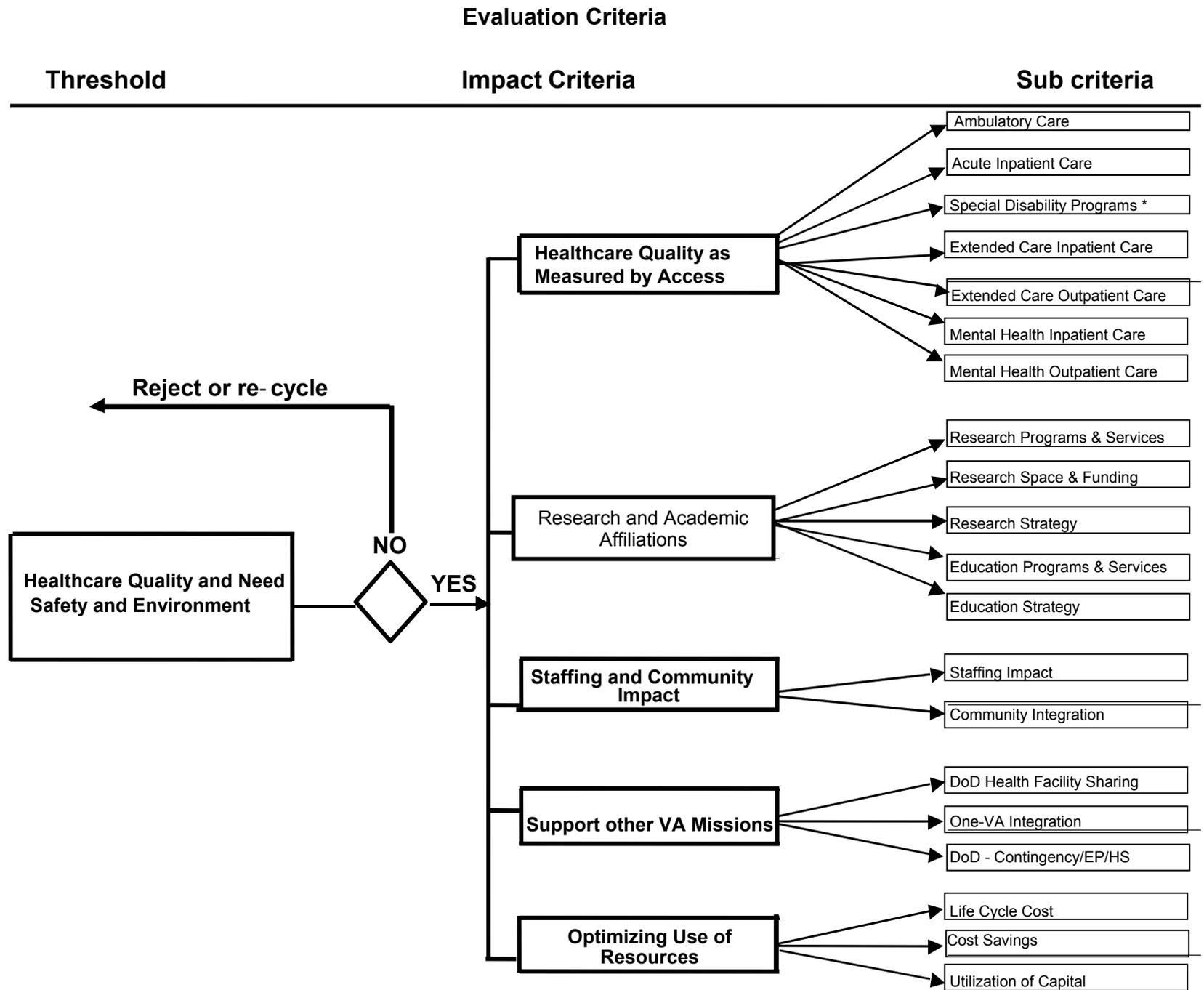
The CARES One VA Committee (COVAC) review will focus on the significant issues raised in staff reviews, selected Planning Initiatives, the results of the CCAG, selected evaluation criteria, and their independent analysis of the Market Plans. A key perspective will be how the Market Plans impact on all VA missions and specific areas such as co-locations. The COVAC will prepare a report of their findings and recommendations to the Undersecretary for Health.

**D. Undersecretary for Health**

The Undersecretary for Health will consider the NCPO staff review, the recommendations of CCAG, the COVAC and other input in determining the recommendations to be included in the Draft National CARES Plan.

E. CARES Commission

The CARES Commission will provide an external review of the Draft National CARES Plan. The review is intended to focus on selected evaluation criteria and stakeholder involvement in the process. The Planning Initiatives and Market Plans are required to specify how stakeholder inputs were used in completing the specific Planning Initiative. The Commission will also review comments from the 60-day public comment period that follows the Undersecretary's publication of the Draft National CARES Market Plan. The Commission may hold selected regional public hearings in order to gather further stakeholder input. After consulting with the Undersecretary for Health, the Commission will make recommendations to the Secretary that accept, modify, or reject with supporting comments the recommendations contained within the Draft National CARES Plan.



**Evaluation Criteria****A. Threshold Criteria****Healthcare Quality and Need****HealthCare Quality**

- How does the Planning Initiatives demonstrate the use of methods and techniques that improve the quality of care such as the relationship of volume of services and outcomes, alternatives to institutional care, and improved information transfer?

*For example: Describe any changes that would increase volume of procedures at a facility to the point that it has a positive impact on quality based on knowledge of the relationship of healthcare delivery outcomes and volume of procedures or services.*

- Impact on the relationships where there are key interdependencies on services – such as ICU & Cardiac Surgery, Specialty Clinics and availability of Inpatient Care, MH clinic & availability of MH beds.

*For example: The availability and location of outpatient oncology services to follow-up inpatient oncology care.*

**HealthCare Need**

*For the services below, you have forecasts of demands expected for 2002-2022. For those services where a planning initiative has been identified, you must realign capacity to meet those needs in the most appropriate setting. This may be a reduction, expansion and or a change in the mechanism to provide the resource. You will need to show the capacity and array of services as described in Chapter 4 of the CARES Guide. Respond to the criteria that follow that apply to the planning initiative.*

**Ambulatory Care Services: Primary/Specialty/Urgent**

- The Planning Initiative must demonstrate the appropriate capacity to meet the forecasted need (provided by VACO) for ambulatory service visits and procedures.
- The Planning Initiative must demonstrate the appropriate mix of delivery settings.

**Acute Inpatient Care: Medicine/Surgery**

- The Planning Initiative must demonstrate the appropriate capacity to meet the forecasted need (provided by VACO) for acute inpatient care (beds).

**Special Disability Programs: Seriously Mentally Ill/PTSD/Homeless/SCI-SCD/Substance Abuse/Blind Rehabilitation/TBI/Amputations (PACT)**

- The Planning Initiative must provide for a full continuum and array of care for special disability program patients. It must demonstrate sensitivity to the special needs of this group of veterans.
- The Planning Initiative must demonstrate the appropriate mix of delivery settings.

**Extended Care Inpatient Services: Nursing Home Care/Domiciliary Beds**

- The Planning Initiative must demonstrate the appropriate capacity to meet the forecasted need (provided by VACO) for Extended Inpatient Care (beds).
- The Planning Initiative must demonstrate the appropriate mix of delivery settings.

**Extended Care Outpatient Services: Adult Day Health Care/Home Care/Geriatric Evaluation Management (GEM)**

- The Planning Initiative must demonstrate the appropriate capacity to meet the forecasted need (provided by VACO) for Extended Outpatient Care.
- The Planning Initiative must demonstrate the appropriate mix of delivery settings.

**Mental Health Inpatient Services: Mental Health and Behavioral Health/PRRTP**

- The Planning Initiative must demonstrate the appropriate capacity to meet the forecasted need (provided by VACO) for Mental Health Inpatient Care.
- The Planning Initiative must demonstrate the appropriate mix of delivery settings.

**Mental Health Outpatient Services: Mental Health Clinic/Substance Abuse/Day Treatment**

- The Planning Initiative must demonstrate the appropriate capacity to meet the forecasted need (provided by VACO) for Mental Health Outpatient Care.
- The Planning Initiative must demonstrate the appropriate mix of delivery settings

**Safety and Environment**

**Health Care Services to Veterans, Visitors and Staff in a Safe and Suitable Environment:**

- Each Planning Initiative must ensure that all services it encompasses, including research, are delivered in safe and appropriate facilities to assure patient, visitor

and staff safety, regardless of whether they are provided in a VA or non-VA owned and operated environment as measured by:

- **Layout:** viability of current physical layout
- **Enough space:** Adequate quantity of space for capacity of care
- **Adjacency:** location of service with respect to other services to which it is functionally related
- **Code:** compliance with auditing/review bodies such as JCAHO, NFPA Life Safety Code or CAP
- **Accessibility:** Compliance with handicap accessibility standards (ADA, UFAS)
- **Privacy:** compliance with patient privacy standards
- Major building system condition
- Condition of major medical equipment

**\* COMPLIANCE IS DETERMINED BASED ON DATA IN SPACE AND FUNCTIONAL SURVEYS AND FACILITY CONDITION SURVEYS AND CRITICAL VALUES OF SCORES. (I.E.: IF THERE ARE LOW SCORES (1'S OR F'S) FOR PORTIONS OF SPACE, THIS SHOULD BE ADDRESSED, NOT JUST THE AVERAGE SCORES)**

For each service identified as a realignment gap, show the following information from the Space and Functional Survey and the Facility Condition Assessment: Current and proposed Square Footage on all space proposed to be utilized in the Planning Initiative. Address each critical value and provide a summary of the space layout utilized and proposed.

## **B. Impact Criteria**

### **Healthcare Quality as Measured by Access**

#### **Primary Care Outpatient Services**

- Demonstrate how the Planning Initiative impacts the percentage of the patients meeting access guidelines by describing the current percentage and the expected percentage of patients meeting this guideline.

#### **Specialty Care Outpatient Services**

- Demonstrate how the Planning Initiative impacts the percentage of the patients meeting access guidelines by describing the current percentage and the expected percentage of patients meeting this guideline.

#### **Inpatient Services**

**ATTACHMENT 10A**

- Demonstrate how the Planning Initiative impacts the percentage of the patients meeting access guidelines by describing the current percentage and the expected percentage of patients meeting this guideline.

**Special Disability Programs**

- Demonstrate how the Planning Initiative impacts access to specialty care. (This group includes: Spinal Cord Injury and Dysfunction (SCI-SCD), Blind Rehabilitation, Traumatic Brain Injury, Substance Abuse, Homeless, Amputations [PACT], Seriously Mentally Ill, and Post Traumatic Stress Disorder.)

**Research and Academic Affiliations**

**Research**

Research Programs and Services

- Describe how the Planning Initiative maintains and impacts the opportunities for Research programs. Include description of impact on neighboring facilities and VISNs.

Research Space and Funding

- Describe and quantify the changes in adequate Research space due to the changes in programs and services.
- Describe and quantify how the Planning Initiative impacts opportunities for Research funding.

Research Impact Strategy

- Describe the strategy the VISN will use to minimize any potential negative impact on the Research programs.

**Academic Affiliations**

Education Programs and Services

- Describe how the Planning Initiative maintains and impacts the opportunities for clinical education programs include description of impact on neighboring facilities and VISNs.
- Quantify how the Planning Initiative impacts opportunities for Academic Affiliations (Resident slots, numbers and types of education programs, etc)

Education Strategy

- Describe the strategy the VISN will use to minimize any potential negative impact on the Academic Affiliations/clinical education.

### Staffing and Community Impact

#### **Staffing Impact**

- Characterize and if feasible quantify the potential impact of the Planning Initiative on staffing (current and projected # of FTEE, significant increases or decreases, minimal impact).
- Describe the strategy the VISN will use to reduce the potential impact of staffing changes on current staff, minimizing the downsizing and relocation problems.
- Describe how the VISN has communicated the potential impact of the staffing changes to the current employees.

#### **Community Impact**

- Characterize and quantify if feasible the potential impact of the Planning Initiative on community healthcare delivery systems (current and projected contracted care) and potential impact on the community economy (projected gain or loss due to projected staffing changes)
- Describe the strategy the VISN will use to minimize any potential negative impact on the community healthcare delivery systems and economy.
- Describe the strategy VISN will use to communicate the potential impact on the community.

### Support of other Missions of VA

#### **Maximizing Program or Service Sharing Arrangements with the Department of Defense**

##### **Outpatient Services**

- Describe how the Planning Initiative proposes to impact the sharing of resources with DoD with respect to Outpatient Care.

##### **Inpatient Services**

- Describe how the Planning Initiative proposes to impact the sharing of resources with DoD with respect to Inpatient Care.

##### **Special Disability Care**

- Describe how the Planning Initiative proposes to impact the sharing of resources with DoD with respect to Special Disability Care.

### **Extended Care Services**

- Describe how the Planning Initiative proposes to impact the sharing of resources with DoD with respect to Extended Care.

### **Mental Health Services**

- Describe how the Planning Initiative proposes to impact the sharing of resources with DoD with respect to Mental Health Care.

### **Maximizing One-VA- Integration**

- Describe how the Planning Initiative proposes to enhance One-VA opportunities and integrations with VBA and NCA.
- Describe how the Planning Initiative will facilitate continuing existing One-VA co-locations and/or establishing new ones.

### **Department of Defense Contingency Planning**

- Describe the strategy the VISN will use to meet a realistic estimate of demands by DoD contingency needs

### **Homeland Security**

- Describe how the Planning Initiatives will impact on any known Homeland Security needs.

### **Emergency Preparedness**

- Describe how the Planning Initiative will impact on the emergency need projections provided by VA's Emergency Management Strategic Health Group.

### **Optimizing Use of Resources**

#### **Life Cycle Cost**

- Quantify the life cycle cost of the Planning Initiative, including all Operating and Capital costs and the revenue generated in Nominal and Present Value dollars using the Costing and CEA Templates. Compare this life cycle cost to the life cycle cost of Status Quo. This will provide the cost/savings over 20 years. This shall be provided for all changes/actions in the following categories:

- Primary Care
- Specialty Care
- Acute Inpatient
- Special Disability Programs
- Extended Care
- Mental Health and Behavioral Health Care

**Utilization of Capital**

- Quantify the square footage utilized for each VA owned property, and the change proposed in the Planning Initiative in that utilization.
- Describe and quantify how the Planning Initiative will reduce vacant space to include a discussion of how the change will take place (EU, demolition, improved utilization, etc)
- Describe how the Enhanced Use Leasing program will be utilized to reduce the amount of underutilized space identified in the Planning Initiative and/or any unnecessary space created as result of the Planning Initiative.
- Describe impact on any historical structures.

**Expected Savings**

- Utilizing the cost template, quantify the expected savings from the Planning Initiatives
- Attach the output from the PI and CEA templates that analyze the cost savings.

## Alternatives Analysis

**For each Planning Initiative one alternative must be considered using the planning criteria and sub criteria.**

### **Description:**

**Status Quo:** Describe the existing situation and the Planning Initiative.

**Proposed PI:** Describe the proposed solution to the identified GAP

**Alternate:** Describe the alternative considered

### **Healthcare Quality and Need:**

#### **HealthCare Quality**

**Status Quo:**

**Proposed PI**

**Alternate:**

**HealthCare Need** (See criteria for specific requirements by type of service – Ambulatory, Acute Inpatient, etc. Respond to appropriate criteria. Appropriate capacity is determined from calculations of the number of projected enrollees plus an estimate of non-enrolled eligible veterans. Projected patients/users are derived from these enrollment projections. Capacity is based upon VA standards / private sector standards as described in the planning section of the guide.)

**Status Quo:**

**Proposed PI:**

**Alternate:**

### **Safety and Environment**

**Health Care Services to Veterans, Visitors and Staff in a Safe and Suitable Environment:** For each alternative, summarize the impact on the following – layout, adequacy of space, adjacencies, code compliance, accessibility, privacy, and condition of major building systems or major equipment.

**Status Quo:**

**Impact Criteria:**

**Proposed PI:**

**Alternate:**

**Healthcare Quality as Measured by Access**

<b>Program</b> (Primary, Specialty, Inpatient, etc)	<b>Status Quo</b>	<b>Proposed PI</b>	<b>Alternative</b>
<b>Criteria</b> (ie. 30 minutes, 60 minutes, etc)	<b>% of patients within guidelines</b>	<b>% of patients within guidelines</b>	<b>% of patients within guidelines</b>

**Summarize the impact (narrative) on access and travel times for each alternative:**

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Research and Academic Affiliations**

**Research Programs and Services:** Describe how each alternative maintains and impacts the opportunities for Research programs.

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Research space and funding**

	Status Quo	Proposed PI	Alternative
Research Space (SF)			
Estimated Research funding (\$)			

**Academic Affiliations Programs and Services**

**Education Programs and Services:** Describe how each alternative maintains and impacts the opportunities for Education programs.

Status Quo:

Proposed PI:

Alternate:

	Status Quo	Proposed PI	Alternative
# of residents slots			
Number and type of programs			

**Staffing and Community Impact**

**Staffing Impact**

	Status Quo	Proposed PI	Alternative
FTEE level			

**Staffing:** Describe in narrative the impact on staffing for each alternative

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Community Impact:** Describe in narrative the impact on the community for each alternative

**Status Quo:**

**Proposed PI:**

**Alternate:**

## **Support of other Missions of VA**

### **Maximizing Program or Service Sharing Arrangements with the Department of Defense**

**Sharing with DoD:** Describe in narrative the impact on maximizing the Program or Service Sharing Arrangements with the Department of Defense.

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Maximizing One-VA- Integration:** Describe in narrative the impact on enhancing One-VA opportunities and integrations with VBA, NCA and other VHA programs.

**Status Quo:**

**Proposed PI:**

**Alternate:**

**Department of Defense Contingency Planning:** Describe in narrative the impact on meeting a realistic estimate of demands by DoD contingency needs and those contingency needs provided by VA's Emergency Management Strategic Health Care Groups.

Status Quo:

Proposed PI:

Alternate:

Optimizing Use of Resources

**Life Cycle Cost**

	Status Quo	Proposed PI	Alternative
Life Cycle Costs			

**Utilization of Capital**

	Status Quo	Proposed PI	Alternative
SF utilized for program			
Vacant space in SF			

**Enhanced Use Leasing Initiatives**

	Status Quo	Proposed EU for PI	Alternative Considered
Available vacant space in SF			

**Expected Savings from Planning Initiatives**

Proposed PI

Alternative

## CHAPTER 11: Glossary

**Base Realignment and Closure (BRAC):** A centralized process used by the Department of Defense to establish the required number of military bases to be located throughout the United States. The process includes a standardized methodology and the analysis determines both the number and type of bases required. The BRAC also includes an independent commission to review its process and determine its final recommendations.

**Capital Assets:** Capital assets are land, structures, leases, medical equipment, non-medical equipment, and intellectual property (information technology). They have an estimated useful life of more than two years.

**Capital Asset Realignment (CAR) Plan:** A CAR plan summarizes changes to all identified capital assets associated with specific clinical or services planning initiatives. Changes may include increased investments, divestments or realignments of capital assets.

**Capital Asset Realignment for Enhanced Services (CARES):** The specific process associated with market planning at the Network level that incorporates a CAR Plan as a component of the process. The CARES process: 1) assesses veteran expected future health care needs in VHA Networks, 2) identifies planning initiatives required to meet those needs, 3) utilizes stakeholder input and 4) guides the realignment and allocation of capital assets to support the delivery of health care services. Savings from using this integrated planning process are expected to enhance services to veterans.

**Capital Divestment:** Selling, transferring ownership, or exchanging excess or underutilized land, structures or equipment. These options result in a change of ownership. Another capital assets disposal option is to allow utilization of assets by an outside entity over an extended period without transfer of ownership. Examples of this type of divestment include enhanced use leases and sharing agreements.

**Capital Infrastructure:** The entirety of the owned capital asset.

**Capital Investment:** An investment to acquire new capital assets, replace existing capital assets, and/or expand or improve an existing capital asset through purchase, lease, sharing with another health care partner or through contracting for services.

**Capital Investment Proposal (CIP):** A proposal for investment to acquire new capital assets, replace existing capital assets, and/or expand or improve an existing capital asset as described above.

**Capital Realignment:** A change in form of ownership, control, size, location or

use of a capital asset in order to better support the delivery of health care services to veterans.

**CARES Clinical Evaluation:** The review by the VHA Clinical CARES Advisory Group (CCAG) for the purpose of ensuring that each proposed CARES Market Plan supports clinical quality of care, as well as, the other VA missions of research and education.

**CARES Commission:** The CARES Commission is a critical element in the CARES process. The CARES Commission will consist of nine members of the community who will provide objectivity and an external perspective to the CARES planning process and will ensure that stakeholder concerns are adequately addressed. The Commission will become involved after the National CARES Program Office, Clinical CARES Advisory Group, the CARES One VA Committee, and the Under Secretary for Health have reviewed the Networks' CARES Market Plans; and the draft National CARES Plan has been prepared. The Commission will review and evaluate the draft National CARES Plan, interact with stakeholders, conduct regional public hearings, and evaluate comments received during the public comment period. Based upon its review, the Commission will make recommendations to the Secretary regarding the composition of the National CARES Plan.

**CARES Communication Coordinator:** A key NCPO team member who will coordinate the CARES Communication Plan implementation with the VHA Communications Office, the Office of Public and Intergovernmental Affairs, Network and regional communications staff.

**CARES Guidebook:** A reference for network/facility staff to assist them with CARES Program implementation. The Guidebook is also a communication vehicle to stakeholders. The Guidebook contains the detailed program requirements, planning methodologies, market plan requirements, communications plan requirements and a description of the role of the CARES Commission.

**CARES Network Steering Committee:** The CARES Steering Committee is the Network-level oversight group for the CARES process. Developing a CARES Network Steering Committee is the first step in the process for Networks. The CARES Network Steering Committee will monitor and coordinate activities related to implementation of the CARES planning initiatives.

**CARES One VA Committee (COVAC):** VHA will convene a CARES One VA Committee to serve as an advisor to the Under Secretary for Health during the CARES process. Membership will be comprised of VHA senior managers, senior clinical program managers, and VA department senior managers including the Office of Management and Budget and the Office of Policy and Planning. The committee will review and evaluate the draft National CARES Plan and coordinate it with VA's strategic plan. The COVAC will also advise the USH prior to final endorsement of the

draft National CARES plan and will make recommendations concerning any elements of the draft National CARES plan that transcend VHA.

**CARES Phase 2:** CARES Phase 1 was a pilot program that used the CARES process to develop Market Plans for Network 12. As described below in CARES Pilot, it was conducted using a contractor. CARES Phase 2 will extend the CARES Program to the remaining 20 VHA Networks. CARES Phase 2 will rely primarily upon VACO and Network staff to develop the Network CARES Market Plans.

**CARES Pilot:** Network 12 piloted the first CARES study by using a contractor to develop both an objective assessment of veterans' health care needs and plans to meet those needs. The contractor made recommendations to the Secretary, Department of Veteran Affairs, and he, in turn, selected an option after consulting with stakeholders.

**CARES Process:** The CARES Process integrates health care planning and capital asset realignment (CAR) planning to maximize efficiency and provide the best quality health care services to veterans. An analysis of VHA's health care markets will be completed for each network. This analysis begins with a system wide determination of markets and identification of gaps and redundancies made by VACO. The gaps are determined in part by comparing the expected need and location of services by veterans in years 2012 through 2022 with the current location and capacity of VA health care services within each Network. This becomes the basis for the Planning Initiatives that are to be completed by the Networks. The Networks complete the Planning Initiatives by developing solutions that will result in efficiently providing the required services and an optimal alignment of capital assets to best support those services. These solutions incorporate ongoing efforts to collaborate with DoD and also include assessment and utilization of community resources. The solutions are developed as Network Market Plans. The Market Plans are submitted to VACO and incorporated into the draft VHA National CARES Plan. The CARES Commission will then review the draft National CARES Plan and their recommendations will be submitted to the Secretary Department of Veteran Affairs.

**Clinical CARES Advisory Group (CCAG):** The CCAG will be comprised of VACO clinical leaders and other consultants appointed by the Under Secretary for Health (USH). The CCAG will advise the USH on the National CARES plan and will develop recommendations regarding all clinical, research and educational issues within the draft National CARES plan.

**Cost-Benefit Analysis:** A systematic quantitative method of assessing project costs against the efficiencies or benefits that result from the project. It is a measure of efficiency.

**Demand Analysis:** An assessment of expected or future need for services. The CARES process includes a demand analysis in each market to the year 2022.

**Enhanced-Use Leasing:** A mechanism for obtaining facilities and services for VA activities by forming a cooperative arrangement between the Department and the

private sector (or another government entity) for the use of Department-controlled property. In this arrangement both the private sector and VA contribute something of value. The Secretary of Veterans Affairs must authorize all delegations of this authority.

**Enrollment Projection Models:** A model that uses recent enrollment rates as the basis for projecting enrollment. These models include actuarial projections, utilization models and are based on quantitative methodologies that match expected VA utilization to private sector utilization.

**Evaluation Criteria:** The expected outcomes and performance results that will serve as the basis for evaluating the CARES process. They are divided into threshold and impact criteria. They are also translated into planning criteria used in the development of solutions to the Planning Initiatives.

**Facility Condition Assessment (FCA):** An evaluation tool that assess the condition of capital infrastructure, identifies technical problems with facilities, and grades each building system. The FCA also identifies costs associated with corrective action or replacement.

**Gaps:** These are differences between current supply of and projected demand for services, location, type and adequacy of space. They include potential redundancies in capital assets as well as undersupplies; and strategic gaps defined by program offices and Network strategic plans. In some cases, an identified gap may be an overlap.

**Impact Evaluation Criteria:** Criteria that allow Planning Initiatives to be evaluated for their impact upon key CARES goals and objectives. Impact criteria include: 1) health care quality as measured by access; 2) staffing and community impact; 3) support of other VA missions; and 4) optimizing use of resources. They are also translated into planning criteria used in the development of solutions to Planning Initiatives.

**JCAHO:** Joint Commission on Accreditation of Healthcare Organizations

**Life Cycle Costs:** The expected costs that will occur over the life of a capital asset or a clinical program.

**Major Construction Project:** A construction project that exceeds \$4 million in total project costs.

**Minor Construction Project:** A construction project that includes all construction, renovation, and building/land purchases over \$500,000 in Minor Improvements, but less than \$4 million.

**Market Share Analysis:** An analysis that estimates the percentage of the projected demand for healthcare services by veterans that will be met by each VA or coordinated by VA with a non-VA provider.

**Market Plan:** Market Plans will be produced at the Network level based upon health care markets within that Network. Each market plan is composed of the completed planning initiatives that solve each identified gap or redundancy identified for that market.

**NFPA:** National Fire Protection Association

**National CARES Communication Plan:** Input from and discussion with a broad range of internal and external stakeholders is a critical element of the CARES process. The National Communication Plan presents the structured approach to sustaining that dialogue throughout CARES Phase 2. The plan describes the intensive effort to reach out to stakeholders and support continuous discussion as the project proceeds. National CARES Program Office will oversee the CARES communications process. The National Communication Plan is built upon Network level coordination and ongoing collaboration with VHA Office of Communications and the Office of Public and Intergovernmental Affairs in conducting communications activities.

**National CARES Plan:** The National CARES Plan is the compilation of the Planning Initiatives approved by the Secretary into an integrated and structured approach to providing health care services to veterans. The National CARES Plan is designed to optimize capital realignment to ensure that VA infrastructure supports the expected need by veterans for services through 2012 to 2022.

**National CARES Program Office (NCPO):** The VHA's National CARES Program Office (NCPO) consists of a multidisciplinary team with varied technical skills. The NCPO manages the CARES Program and develops the National CARES Plan. The NCPO is the main coordinating body that integrates the work of the other CARES groups involved. NCPO is responsible for coordinating the CARES process with VACO, assisting Networks by providing data and analysis, collaborating with VHA Office of Communications and Office of Public Affairs, developing and maintaining a CARES Guidebook, identifying Network market gaps, reviewing Network Planning Initiatives, coordinating with VBA, NCS, and DoD, preparing a draft National CARES Plan, preparing the final report and recommendations from the CARES Commission, and performing an evaluation of the CARES process.

**Network CARES Communication Coordinator:** A key member of the Network CARES Steering Committee designated by the Network Director to ensure that VA's stakeholder constituency is kept fully informed throughout the process and that appropriate input is obtained. Communication with stakeholders includes meetings, written communications at all key milestones of the process and at other points in the process as requested. This person will ensure that all stakeholder comments and

concerns are communicated to both the Network CARES Steering Committee for consideration and will document stakeholder comments and concerns, along with action taken by the Network in response to stakeholder input.

**Network CARES Implementation Plan:** The Network detailed plan to implement the approved Market plans within a Network. It is prepared after the Secretary has decided upon the composition of the National CARES Plan.

**Network Communication Plan:** The plan prepared by each Network to encourage and sustain stakeholder communication and participation in the CARES process.

**Non-Recurring Maintenance:** Construction and renovation initiatives that are less than \$500,000 in minor improvements, primarily for the purpose of maintaining the existing buildings and structures.

**Out-Leasing:** The leasing of VA owned real property to public or private interests outside of VA. VA's out-leasing authority is cited in 38 U.S.C. 8122 and is limited to a term no greater than 3 years.

**Planning Initiatives:** Planning initiatives are the issues identified by VACO that must be resolved to ensure that the capital infrastructure and programs required to meet the future health care needs of veterans will be available. They are the components of the individual Network Market Plans.

**Planning Criteria:** The criteria to be utilized by the Networks in completing the planning initiatives. The criteria are the same as the evaluation criteria to ensure an alignment between the planning and the review and evaluation process. The criteria include health care quality and need, safety and environment, access, research and affiliation, staffing and community impact, support other VA missions and optimizing resources.

**Service Category:** Those categories at which level the Market planning will be conducted:

**Inpatient Services:** Inpatient services will include Medicine, Surgery, Psychiatry, Intermediate Care, PR RTP, Long Term Care, Domiciliary Program

**Special Disability Programs:** Special Disability programs will include Spinal Cord Injury, Blind Rehabilitation, Substance Abuse, Traumatic Brain Injury, Homeless Program, Seriously Mentally Ill, Post Traumatic Stress Disorder

**Outpatient Care:** Outpatient Care programs will include Primary Care, Specialty Care, Mental Health, Geriatrics, and Ancillary and Diagnostics services

**Non-Clinical Services:** Non Clinical Services will include Research, Other Administrative, and Vacant Space

**Sharing Agreement:** Sharing agreements are a type of enhanced use asset management. It is a mechanism for obtaining facilities and services for VA activities by forming an agreement to share VA-controlled property equipment or services between the VA and a private sector or other government entity. In this Arrangement, both the private sector and VA contribute something of value. The Secretary of Veterans Affairs must authorize all delegations of this authority.

**Space and Functional Surveys:** An assessment of VA owned space.

**Stakeholders:** Key entities and organizations interacting with VA including, but not limited to, veterans service organizations, employee unions, affiliated medical schools, and state and local health care entities, community or neighborhood organizations, state/city/county governments, and congressional delegations.

**Strategic Planning Cycle:** The time frame that VA uses to conduct its strategic planning. The strategic planning cycle is established in VA strategic planning guidance.

**Strategic Planning Guidance:** VHA's strategic planning guidance sets forth the requirements to clearly identify health care needs of the veteran population served by the Networks, and articulates a framework and timeframe for developing strategic plans to address those needs.

**Threshold Evaluation Criteria:** These are "pass/fail" criteria that must be met for any planning initiative to be included in a market plan. The threshold criteria are defined as quality, need and safety of the health care environment.

**VA Strategic Management Council (SMC):** The SMC reviews, approves, and oversees all VA Capital Programs. It is composed of selected Assistant Secretaries and Administration Heads and is chaired by the Deputy Secretary of Veterans Affairs.

**VHA's Six for 2007:** The six VHA strategic objectives used to align the VHA strategic planning system for planning to the year 2007.

**VISN Support Service Center (VSSC):** A VHA organizational unit that provides assistance to the field and VACO in developing and analyzing data bases, preparing and analyzing survey data and providing assistance in capital and program planning to field units.