

indicates that more than 6.5 million contacts were directly sent information about CARES or received CARES information in face-to-face meetings.¹⁷ This number of contacts represents the entire gamut of CARES stakeholders, including veterans, employees, union members among VA employees, congressional staff, affiliates, Department of Defense representatives, and members of the public.

Most of the VISNs relied heavily on communication modes, such as briefings, web sites, e-mails and mailings. Overall, of the 6,598,201 total stakeholder contacts, nearly 42 percent were in the form of mail-outs (e-mails, brochures, and newsletters).¹⁸ More than 1.1 million or 16 percent were employee contacts, which accounted for the second largest category. The third largest category, at a little more than 1 million (or 2 percent), was VSO contacts.

Summary of Stakeholder Involvement

A thorough review was conducted of the Stakeholder Narratives that were a part of the VISN CARES Market Plans submitted April 15, 2003. Specifically, the review team looked at whether there was adequate outreach, whether input was solicited and received, and whether the input influenced the Market Plans. A thorough analysis of each market is available in Appendix M.

All VISNs reported extensive and intensive contacts with stakeholders, documenting a wide array of steps taken to apprise these groups of possible future changes in VA health care services. These contacts included both systematic and one-time efforts to solicit concerns and recommendations. Appendix M sets forth details by VISN and market.

A multiplicity of interactions disclosed recurrent concerns relating to such issues as access to care and facility closures from veterans, and job security from employees. See Appendix M for a listing of expressed concerns.

When evaluating all twenty-one (21) VISNs, no major "red flags" were discerned in the context of unanticipated stakeholder concerns. However, in some instances there were indications that VISNs and facilities did not fully address potential mission changes or realignments with stakeholders, preferring instead to wait until more formal decisions were made. These were relatively rare occurrences confined primarily to the Small Facilities and Proximity Planning Initiatives, since most planning initiatives dealt with expansions in outpatient care. In most cases, stakeholders were asked to respond to alternative solutions proposed for these Proximity and Small Facilities Planning Initiatives, and their concerns were described in solutions to those initiatives.

In summary, stakeholder narratives in the VISN CARES Market Plans showed that, across the board, VISNs made a concerted effort to inform their stakeholders of the CARES process, and to obtain and consider input from these stakeholders on controversial planning initiatives.

Chapter 4: Enhancing Access to Health Care Services

Clear and Compelling Purpose: Outpatient Access and Inpatient Capacity

The growth of Community-Based Outpatient Clinics (CBOCs) has improved access to services for veterans. CARES provided a mechanism to measure progress towards its stated goal of "improving quality as measured by access."¹⁹ Complementary to this stated goal was the intention to ensure that the current and future acute care infrastructure is capable of meeting the needs of veterans who access health care services. The CARES process enabled VA to develop a cost effective investment strategy to improve access in selected markets and ensure the

availability of the acute care infrastructure.

Measuring Veteran Access to Care

The traditional way of measuring access in VHA was through determining where patients from a given county seek specific types of treatment, such as primary care, inpatient acute care, mental health care and specialized services. Episodes of treatment at all VA facilities in that county were tallied over a three-year period, and the proportional use of each VA facility was determined, *i.e.*, which percent used facility "A" vs. facility "B," etc. Travel time to obtain services was not measured.

As previously noted, the planning focus of the CARES process was the "market," or a distinct veteran population in a defined geographic area. The state-of-the-art methodology used in CARES not only was capable of greater precision in measuring access, but also provided more information to support planning decisions. The CARES approach involved determining the percentage of enrollees living within specific travel times to the nearest, appropriate VHA facility.

The new data allowed access within each market to be scored with regard to two "thresholds:" first, a minimum percentage of enrollees living within a specified travel time to obtain VA primary care; second, notwithstanding the percentage of enrollees living within these travel times, the total number living outside the guidelines could not exceed a specified number. In other words, to qualify as an "access" planning initiative according to the criteria developed for CARES, a market had to first meet a relative standard (percentage living within access guidelines) as well as an absolute standard (a specified number of enrollees living outside access guidelines). Table 4.1 presents the specific criteria.

TABLE H.1.—ACCESS CRITERIA

Type of care	Time criteria (minutes)	Threshold criteria (%)	Number of enrollees outside of guidelines	#PIs
Primary Care	30 Min.—Urban	70	Less Than 11,000	27
	30 Min.—Rural			
	60 Min.—Highly Rural			
Acute Hospital	60 Min.—Urban	65	Less Than 12,000	24
	90 Min.—Rural			

¹⁷ Note: the large numbers are in part due to potential briefing and/or mail-outs to the individuals on multiple occasions. In addition, some media releases were counted as part of the "contacts" submitted by the VISNs and VA facilities. Due to the complex nature of the CARES process and the projection models, multiple

briefings and educational sessions were not only desirable and necessary to convey the scope of the enterprise, but also to create "educated publics" who could be more actively involved as stakeholders.

¹⁸ Again, as noted above, some of the contacts were via local media in the form of news coverage.

The volume is indicative of the extensive local efforts (see Appendix M) to engage various stakeholder groups in a dialogue on the CARES process and to receive their input into the planning.

¹⁹ VHA Directive 2002–032, June 5, 2002; "Capital Asset Realignment for Enhanced Services (CARES) Program".