

Similarly, the VISNs were advised that legislative capacity requirements for Blind Rehabilitation (BR) programs must be met.<sup>32</sup> However, since the CARES process set out to review the allocation and distribution of health care services throughout the VA system, an attempt was made to develop projections that would include an assessment of the SDPs. Program officials and clinical experts from the involved SDPs were consulted and participated actively throughout the process.

#### Workload Projections

Hitherto, VA has had no agreed-upon methods of projecting the needs of populations served by the SDPs. In general, the CARES planning model/process used an actuarial forecasting model (supplied by CACI/Milliman) with:

- VA and National Census databases to project enrollment and market share annually through 2022;
- Actuarial survival/mortality data and new active duty military separations;
- Private sector databases to predict healthcare utilization, with adjustments for VA experience (lack of co-pay, male predominance, higher co-morbidity, use of Medicare and private sector health care and management efficiency);
- Criteria for access (travel time), safety, quality of care, impact on affiliations, research, and other missions (DoD contingency support and Homeland Security); and
- Survey of space, beds, and clinical services in all VA facilities and VISNs.

However, since VA programs to serve special disability populations are so unique, no comparable private sector utilization benchmarks were available for the SDPs; VA services continue to be the only benchmarks. Since projections for special disability programs therefore were based solely on VA utilization data, the SDP projections used in the CARES process in general were subject to several limitations:

- Some of the advantage of the Milliman forecasting model would be lost, since the VA workload data may be subject to supply constraints.<sup>33</sup>
- CARES models were not designed for service-level planning. They were configured for larger scale planning for

capital asset needs. Smaller numbers tend to show wider variation and less reliability.

- In addition, internal variables, such as VA-specific factors like public policy decisions and the vision of the administration at any one time, may affect the planning assumptions used in the model.

#### Process and Procedures for Special Disability Program CARES Planning

The National CARES Program Office (NCPO) engaged the clinical leaders of the SDPs as active participants in the development of CARES planning models for SDPs. A Planning Initiative Selection Team made up of SDP representatives reviewed national data as projected using the CARES model from the existing Milliman categories.

In the areas of Mental Health and Traumatic Brain Injury, a number of consultations, discussions, and on-going investigation of the general CARES model did not lead to an alternative methodology to project needs for those specific SDPs. It was decided that specific recommendations from Mental Health would be further explored with representatives of the Mental Health Strategic Healthcare Group (SHG) and the Committee on the Care of Veterans with Serious Mental Illness (SMIC). Further progress in this area would be channeled into the strategic planning process that incorporates CARES.

However, in the areas of Blind Rehabilitation and Spinal Cord Injury & Disorders, the NCPO and SDP leaders were able to develop acceptable alternative data analyses and forecasting methodologies to enable inclusion of these SDPs in CARES. Subject matter experts working with actuarial and data management support personnel produced these pioneering approaches:<sup>34</sup> Which were generally based on:

- The prevalence of the Special Disability Group (SDG) in the veteran population as derived from external studies.
  - Enrollment projections by health care priority group used in the overall CARES demand model as applied to the target group to obtain estimates of the enrolled SDG by VISN.
  - Utilization rates based on actual FY2001 experience by VISN.
- Appropriate utilization rates were then applied to each projection year through 2022.

Planning Initiative selections for the Special Disability Programs were based upon the revised projections and were

incorporated into the VISN-level Market Plans by February 2003. SCI/D and BR program representatives worked with the VISN-level CARES Steering Committees or Task Forces to resolve the proposed planning initiatives and met with VISN-level staff and involved veterans service organizations (VSOs).

#### *Blind Rehabilitation (BR) Forecasts and Planning Initiatives*

The BR projections, Planning Initiatives, planning recommendations, and final recommendations for CARES are summarized in Appendix Q. Briefly, two new Blind Rehabilitation Centers (BRCs) were proposed and will be forwarded for approval as follows:

- 36-bed BRC in Biloxi (VISN 16)
- 24-bed BRC in Long Beach (VISN 22)

Nevertheless, over the past several years, the BR program has increasingly emphasized the establishment of outpatient rehabilitation services in the continuum of care for visually impaired veterans. The BR program is designed to improve the quality of life for blinded and severely visually impaired veterans through the development of skills and capabilities needed for personal independence, emotional stability, and successful integration into the community and family environment.

Prior to the CARES process, the BR program was comprised of 10 Inpatient BRCs (in 8 VISNs), 92 full-time Visual Impairment Services Team (VIST) Coordinators, 20 Blind Rehabilitation Outpatient Specialists (BROS), 5 National Program Consultants, and Inpatient Computer Access Training programs at medical centers throughout the country and Puerto Rico. Services are provided using a multi-disciplinary team approach. In addition, there are currently one Visual Impairment Services Outpatient Rehabilitation Program (VISOR) and three Visual Impairment Centers to Optimize Remaining Sight (VICTORS) programs.

#### *Spinal Cord Injury Forecasts and Planning Initiatives*

The SCI/D program is a network of services provided in a "hub-and-spokes" format; the hubs are the SCI Centers and the spokes are non-center facilities. Interdisciplinary and coordinated services utilize referral guidelines to determine the appropriate site of care.

Prior to the CARES process, there were 23 SCI Centers in 15 VISNs. Due to the sizable increase in users of specialty services over the last 6 years, the CARES recommendations call for additional future capacity. The SCI/D projections, planning initiatives,

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; and M-2, Part XXIV.

<sup>32</sup> See Reference Section: CARES Guidebook Phase II (June 2002, Chapter 5, Market Plans).

<sup>33</sup> **Note:** private sector utilization is also constrained by the benefits packages that third-party payers are willing to fund.

<sup>34</sup> A detailed description of the methods and projections used can be found in Appendix Q.