

TABLE 18.1.—CHANGE IN NATIONAL WORKLOAD DEMAND 2001 THROUGH 2022 IN BED DAYS OF CARE AND VISITS

Planning category	FY 2001 workload	FY 2012		FY 2022	
		Total demand	% change	Total demand	% change
Primary Care (Visits)	12,972,821	20,451,216	58	17,211,299	33
Specialty Care (Visits)	10,950,477	22,112,050	102	19,657,531	80
Mental Health (Visits)	7,621,946	10,091,975	32	9,310,644	22
Ancillary/Diagnostic (Visits)	14,756,388	25,952,483	76	24,260,090	64
Medicine (BDOC)	1,794,836	2,533,902	41	2,036,878	13
Surgery (BDOC)	821,656	949,937	16	764,596	-7
Psychiatry (BDOC)	1,599,750	2,130,950	33	1,819,064	14

Costs To Implement CARES Market Plans

Cost Minimization in Managing Workload

Planning guidance encouraged the VISNs to select the most viable options for meeting projected care demands. For managing workload, this was accomplished by selecting one of the following options: in-house, contracting, sharing and joint ventures, or a combination of these options. VISNs were provided through the IBM Market Template with a systematic tool to evaluate the costs of the options.

Initially, for CARES planning purposes, in-house workload costs were assumed to be equal to unit costs obtained from VHA's Decision Support System (DSS) database for each facility. During the review process, the methodology for measuring in-house costs was improved to allow for marginal costs to be used for marginal gaps in workload. Contracting costs

were set equal to Medicare (provider and facility) costs in each county and were provided by CACI/Milliman (Appendix O).

A basic assumption of the CARES planning model was that the cost of additional workload performed in-house would be equal to the associated DSS unit, variable, and indirect fixed costs, as appropriate, multiplied by the additional workload units. If workload was moved between facilities, savings at the transferring facility were calculated on the basis of these costs. Additional costs at the receiving facility were calculated using the same costing rules with the receiving facility's unit costs. There were no economies of scale assumed in the model. Any efficiencies resulting from reallocation of workload had to be estimated and entered into the model by the VISNs.

Analysis of the cost of alternative options for the Planning Initiatives indicates that 60 percent of the options

selected were the lower cost option. However, the cost of alternative options was based upon unit costing this will change when VISNs have the opportunity to re-evaluate their selections prior to final approval of the plan.

Flexibility

Utilization of resources is optimized when flexibility is maintained in the face of peak workload and variable workload. VISNs smoothed out variation in in-house workloads to avoid unnecessary fixed construction costs by the use of contracts. In general, VISN CARES Market Plans reflect increased utilization of contract care during periods of peak demand. The amount of care that would be contracted would then decline as workload fell to the point at which the VISNs were able to accommodate demand within their existing infrastructure. This is reflected in the two graphs below.

Figure 18.1 Forecasted Contract Workload FY 2002

Amount of Inpatient Care Contracted

