



VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022



VISN 01

Market Recommendations



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VISN 01 East Market

The Veterans Integrated Service Network (VISN) 01 East Market serves Veterans in eastern Massachusetts and Rhode Island. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.¹

VA's Commitment to Veterans in the East Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 01's East Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Veteran population in the East Market is projected to decrease, but VA still projects more than 100,000 Veteran enrollees in the market by fiscal year (FY) 2029. As that population ages and health care delivery methods continue to shift from inpatient to outpatient platforms, overall demand for outpatient care and long-term care services is projected to increase. In addition to maintaining and modernizing VA's inpatient care platforms in the market, there is a need to ensure availability of outpatient and long-term sites of care. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation addresses the increased demand for outpatient services and improves access by investing in modern facilities with an expanded range of outpatient services close to where Veterans live. The recommendation enhances access to care in the market by consolidating two clinics into a single more sustainable location with expanded specialty services in Salem, Massachusetts. The recommendation adds services and relocates a clinic to a more accessible location in South Weymouth, Massachusetts. The recommendation also establishes new strategic collaborations for providing outpatient

¹ Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

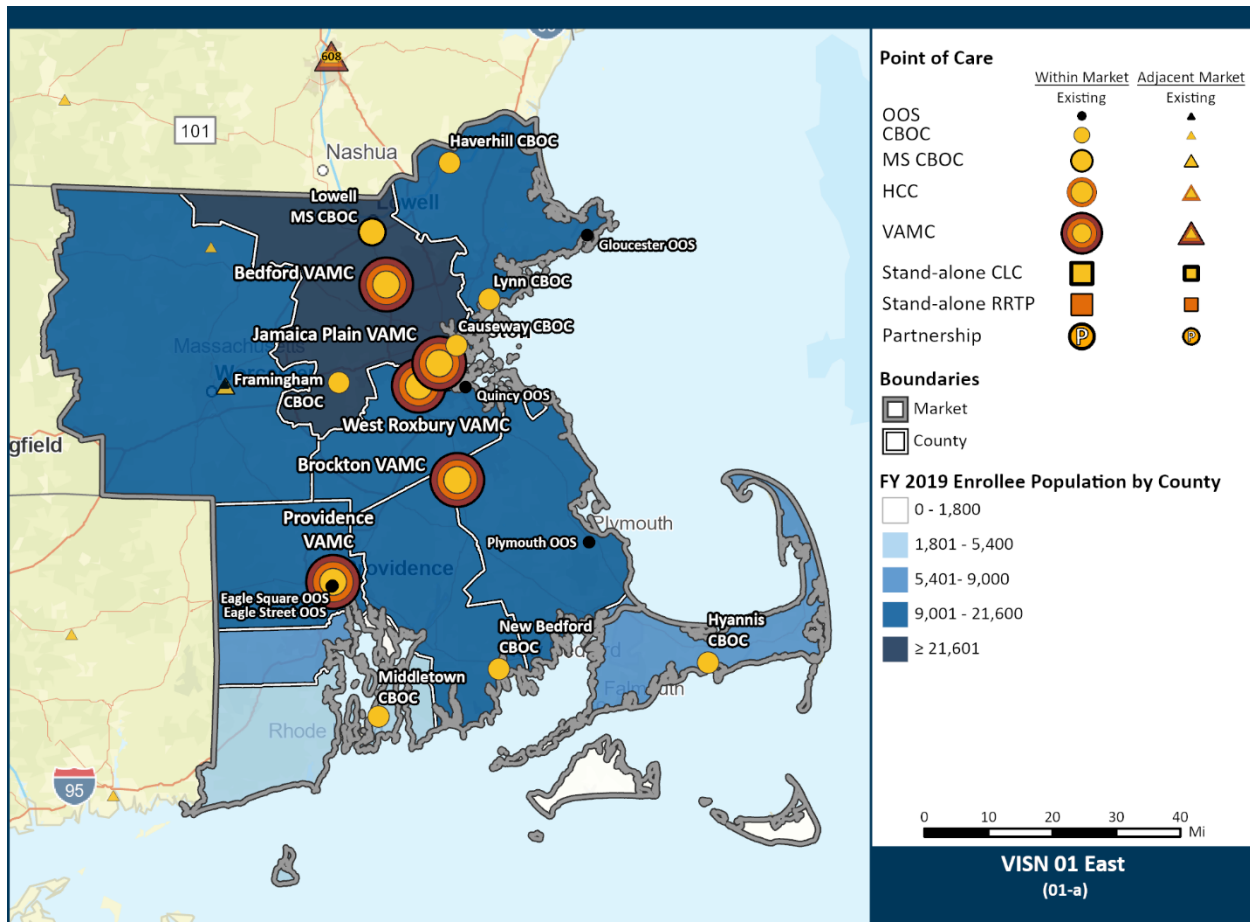
surgical and endoscopy services in the Bedford and Brockton, Massachusetts areas, improving Veteran access to care.

- **Enhance VA’s unique strengths in caring for Veterans with complex needs:** VA’s recommendation improves access to care by investing in new inpatient mental health, community living center (CLC), and residential rehabilitation treatment program (RRTP) facilities at the Bedford, Massachusetts VAMC. The recommendation modernizes the CLC and RRTP facilities at the Brockton, Massachusetts VAMC and invests in a new RRTP and modernizes the inpatient mental health facility at the Providence, Rhode Island VAMC. VA’s recommendation supports Veterans in need of inpatient spinal cord injuries and disorders (SCI/D) services by modernizing the West Roxbury VAMC. Inpatient blind rehabilitation services will be available to VISN 01 Veterans through the modernized regional facility at the West Haven VAMC in the West Market.
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA’s recommendation invests in modernized acute medical and surgical care facilities at the West Roxbury, Massachusetts VAMC and the Providence, Rhode Island VAMC, which will meet current design standards for delivering modern health care.

Market Overview

The market overview includes a map of the East Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has five VAMCs (Bedford, Jamaica Plain, West Roxbury, Brockton, and Providence), one multi-specialty community-based outpatient clinic (MS CBOC), seven community-based outpatient clinics (CBOCs), and five other outpatient services (OOS) sites.

Enrollees: In FY 2019, the market had 132,367 enrollees and is projected to experience a 14.0% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Middlesex, Massachusetts; Worcester, Massachusetts; and Providence, Rhode Island.

Demand: Demand² in the market for inpatient medical and surgical services is projected to decrease by 11.3% and demand for inpatient mental health services is projected to decrease by 15.7% between FY 2019 and FY 2029. Demand for long-term care³ is projected to decrease by 2.8%. Demand for all

² Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).

³ Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,⁴ including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 4.7% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 89.2% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 92.1% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers⁵ in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate⁶ of 71.8% (1,945 available beds)⁷ and an inpatient mental health occupancy rate of 80.6% (63 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 87.7% (876 available beds). Community residential rehabilitation programs⁸ that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include Boston University, Brown University, Rhode Island Hospital, Harvard University, Tufts University, and multiple Boston-area academic medical centers. The Bedford VAMC is ranked 93 out of 154 VA training sites based on the number of trainees, the Jamaica Plain and West Roxbury VAMCs are ranked 3 out of 154, the Brockton VAMC is ranked 153 out of 154, and the Providence VAMC is ranked 77 out of 154. The Bedford VAMC is ranked 41 out of 103 VAMCs with research funding, the Jamaica Plain and West Roxbury VAMCs are ranked 1 out of 103, the Brockton VAMC is ranked 27 out of 103, and the Providence VAMC is ranked 30 out of 103. The Bedford, Jamaica Plain, Brockton, and Providence VAMCs do not have an emergency designation. The West Roxbury VAMC is designated as a Primary Receiving Center.⁹

Facility Overviews

Bedford VAMC: The Bedford VAMC is located in Bedford, Massachusetts, and offers inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Bedford VAMC had an inpatient mental health average daily census (ADC) of 29.7, an RRTP ADC of 67.6, and a CLC ADC of 224.0.

The Bedford VAMC was built in 1928 on 181.0 acres. Facility condition assessment (FCA) deficiencies are approximately \$345.2M and annual operations and maintenance costs are an estimated \$12.4M. The

⁴ Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).

⁵ Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

⁶ Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.

⁷ Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.

⁸ Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

⁹ VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

infrastructure does not meet current design standards¹⁰ for modern health care and presents challenges to VA's ability to make necessary upgrades.

Jamaica Plain VAMC: The Jamaica Plain VAMC is located in Boston, Massachusetts, and offers RRTP and outpatient services. In FY 2019, the Jamaica Plain VAMC had an RRTP ADC of 38.1.

The Jamaica Plain VAMC was built in 1952 on 16.0 acres. FCA deficiencies are approximately \$561.6M and annual operations and maintenance costs are an estimated \$16.3M. The infrastructure has architectural, utility, plumbing, and electrical challenges across many campus buildings.

West Roxbury VAMC: The West Roxbury VAMC is located in Boston, Massachusetts, and offers inpatient medical and surgical, SCI/D, and outpatient services. In FY 2019, the West Roxbury VAMC had an inpatient medical and surgical ADC of 98.3 and an SCI/D ADC of 29.3.

The West Roxbury VAMC was built in 1943 on 30.0 acres. FCA deficiencies are approximately \$136.1M and annual operations and maintenance costs are an estimated \$9.5M.

Brockton VAMC: The Brockton Plain VAMC is located in Brockton, Massachusetts, and offers inpatient mental health, RRTP, SCI/D, CLC, and outpatient services. In FY 2019, the Brockton VAMC had an inpatient mental health ADC of 100.4, an RRTP ADC of 53.1¹¹, an SCI/D ADC of 16.4, and a CLC ADC of 85.4.

The Brockton VAMC was built in 1955 on 146.0 acres. FCA deficiencies are approximately \$203.8M and annual operations and maintenance costs are an estimated \$15.2M.

Providence VAMC: The Providence VAMC is located in Providence, Rhode Island, and offers inpatient medical and surgical, inpatient mental health, and outpatient services. In FY 2019, the Providence VAMC had an inpatient medical and surgical ADC of 33.1 and an inpatient mental health ADC of 13.4.

The Providence VAMC was built in 1948 on 46.0 acres. FCA deficiencies are approximately \$218.3M and annual operations and maintenance costs are an estimated \$13.7M.

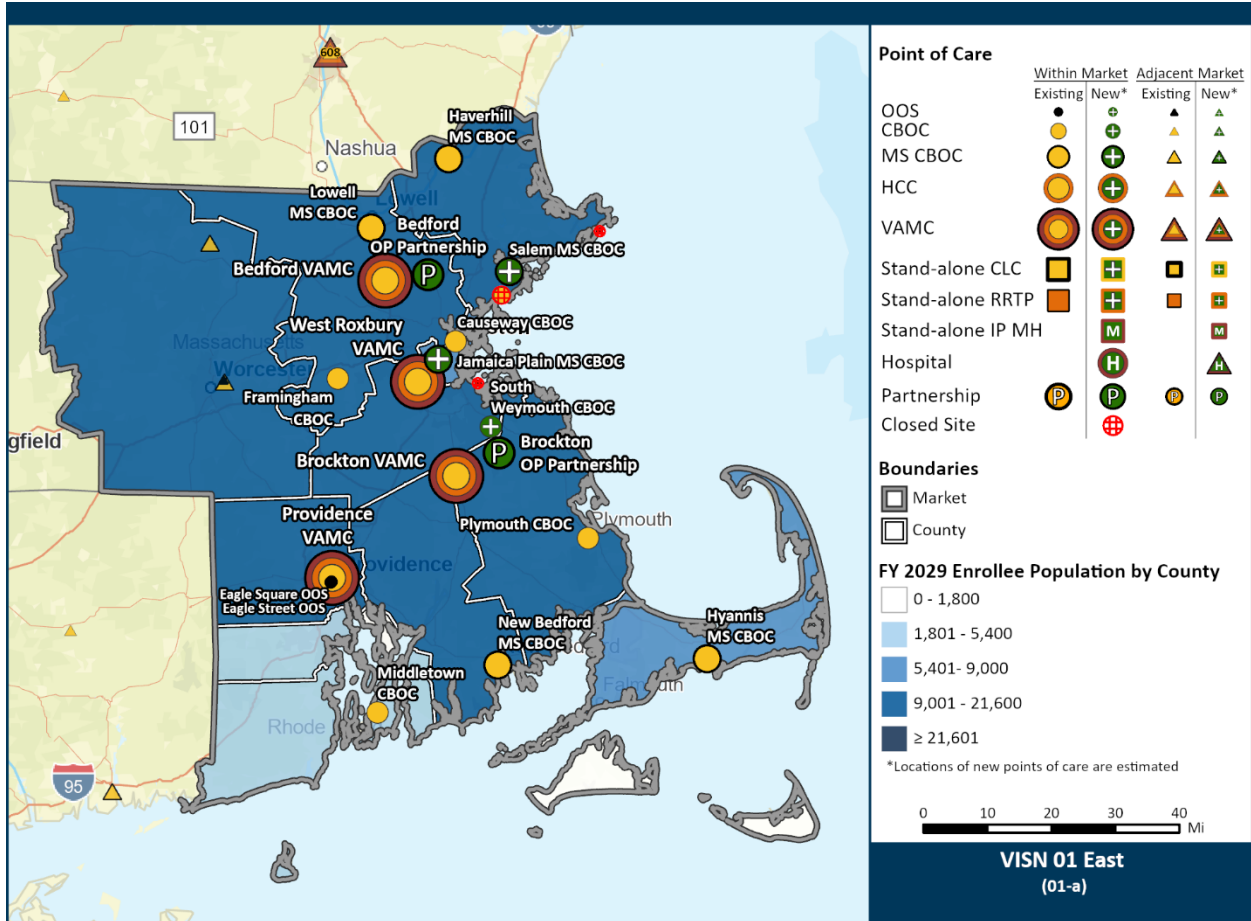
¹⁰ Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

¹¹ The data reflects the VA Boston Healthcare System (West Roxbury, Jamaica Plain, and Brockton VAMCs).

Recommendation and Justification

This section details the VISN 01 East Market recommendation and justification for each element of the recommendation.

Future Market Map



1. Modernize and realign the Bedford VAMC by:

1.1. Constructing a replacement VAMC with inpatient mental health, CLC, RRTP, urgent care, and outpatient services in the vicinity of Bedford, Massachusetts: There are significant facilities maintenance issues, investment requirements, and architectural and engineering challenges at the existing Bedford VAMC, originally built in 1928. The physical layout of the buildings creates inefficiencies that are impacting clinical, administrative, and facility support services. Services are distributed among multiple buildings, requiring Veterans, providers, and staff to travel through antiquated tunnels to access and provide care. The Bedford VAMC campus is located on a 181-acre property with only 25 acres available for future development. By building a replacement VAMC, VA will resolve infrastructure issues while maintaining the ability to provide inpatient and outpatient care in the market and across VISN 01. The Bedford VAMC will include inpatient mental health, CLC, RRTP, urgent care, primary care, outpatient mental health services, and outpatient specialty care. The replacement VAMC has a projected inpatient

mental health ADC of 13.4 and CLC ADC of 197.1 in FY 2029. The East Market projects an overall RRTP ADC of 122.8 in FY 2028. Outpatient specialty care demand is projected to increase by 45.4% across the market from FY 2019 to FY 2029. In FY 2019, there were 81,063 enrollees within 60 minutes of the proposed VAMC replacement site.

1.2. Establishing a strategic collaboration to add outpatient surgical and endoscopy services. If unable to enter into a strategic collaboration, continue to utilize community providers:

Creating a strategic collaboration through a sharing agreement allows the Bedford VAMC to supplement its capabilities with outpatient surgical and endoscopy services. VA providers from the greater Boston area would provide cardiology, ophthalmology, dermatology, general surgery, neurology, and otolaryngology services in the Bedford area, improving access for Veterans living north of Boston, Massachusetts.

1.3. Closing the existing Bedford VAMC: Relocating all existing services to a replacement facility will allow for closing of the existing Bedford VAMC.

2. Modernize the inpatient medical and surgical and SCI/D facilities at the West Roxbury VAMC:

Modernizing the inpatient medical and surgical and SCI/D facilities at the West Roxbury VAMC campus with private rooms will improve patient satisfaction, reduce infection rates, and increase operational flexibility. The West Roxbury VAMC is part of the Boston Health Care System (HCS) and is the only VA site of care that provides inpatient medical and surgical services in the system. Though demand for inpatient medical and surgical services in the Boston HCS is projected to decrease from FY 2019 to FY 2029, there is sufficient demand for providing inpatient acute care in a modern facility, with an ADC of 85.6 projected for the Boston HCS.

3. Modernize and realign the Jamaica Plain VAMC by:

3.1. Relocating RRTP, outpatient surgical, and high complexity outpatient services to existing or future VA facilities and discontinuing these services at the Jamaica Plain VAMC: At the Jamaica Plain VAMC, built in 1952, there are ongoing maintenance challenges caused by aging infrastructure spread across multiple buildings. The Jamaica Plain VAMC had 45 RRTP beds with an ADC of 38.1 in FY 2019. Relocating RRTP services to VA sites at Bedford to the north and Brockton to the south maintains access for Veterans living in the greater Boston area. Outpatient surgery volumes are declining. Consolidating outpatient surgery and high-complexity specialty services at the West Roxbury VAMC facilitates high-quality care at a more accessible location for Veterans. Lower complexity outpatient services will be retained on the Jamaica Plain VAMC campus to serve Veterans living nearby.

3.2. Relocating urgent care services currently offered at the Jamaica Plain VAMC to community providers and discontinuing those services at the Jamaica Plain VAMC: There is capacity in the community to absorb projected urgent care demand when the VAMC discontinues the service. The VA patient-aligned care teams (PACT) will also offer same day appointments to maintain Veteran access to rapid care at the Jamaica Plain facility.

3.3. Maintaining research and education, the Brain Bank, and the Million Veteran Program services at the Jamaica Plain VAMC while establishing a strategic collaboration to consolidate services into remaining buildings at the Jamaica Plain VAMC: Establishing a strategic collaboration and consolidating the remaining Jamaica Plain VAMC functions into fewer buildings allows for the disposal or transfer of outdated and/or unnecessary buildings and infrastructure and reduced operations and maintenance costs. Space must be retained by VA for non-clinical services including research and education, the Brain Bank, and the Million Veteran Program. Lower complexity outpatient services will also be retained on the Jamaica Plain VAMC campus to serve Veterans living nearby. The existing location of the Jamaica Plain VAMC campus is close to major community health care organizations, academic partners, and research organizations.

4. Modernize and realign the Providence VAMC by:

4.1. Establishing RRTP services at the Providence VAMC: The closest VA point of care with RRTP services is 45 minutes away at the Brockton VAMC. In the Providence, Rhode Island, community there are limited high-quality alternatives for RRTP services. Projected demand from Veterans living in the Providence VAMC area supports approximately 20 General Domiciliary beds. Establishing an RRTP at or proximate to the Providence VAMC will allow Veterans to receive highly individualized treatment close to home.

4.2. Modernizing the existing inpatient medical, surgical, and mental health patient rooms at the Providence VAMC by converting to private rooms: VA recommends modernizing the facility to include private inpatient medical, surgical, and mental health rooms, which reflects modern design standard. With demand for inpatient medical and surgical care projected to decrease by 14.6%, this modernization reduces the number of beds from 56 to 52. Demand for inpatient mental health services is projected to decrease by 18.8%. This modernization decreases the number of beds from 17 to 16.

5. Modernize and realign the Brockton VAMC by:

5.1. Establishing a strategic collaboration to add outpatient surgical and endoscopy services. If unable to enter into a strategic collaboration, continue to utilize community providers:

Creating a strategic collaboration through a sharing agreement allows the Brockton VAMC to supplement its capabilities with outpatient surgical and endoscopy services. VA providers from the greater Boston area will provide cardiology, ophthalmology, dermatology, general surgery, neurology, and otolaryngology services in the Brockton area, improving access for Veterans living south of Boston, Massachusetts.

5.2. Modernizing the Brockton VAMC: The existing inpatient mental health bed tower was constructed in 1955 and the existing building is not conducive to providing quality care in a modern environment. Modernizing the inpatient mental health patient rooms by converting to private rooms will rightsize inpatient mental health space and improve patient satisfaction, reduce infection rates, increase operational flexibility, and adhere to national health care planning standards. At the Brockton VAMC, the existing CLC building is not conducive to providing quality care in a modern environment. It has semi-private rooms accessible via public corridors with bathrooms shared between two rooms. Modernizing the CLC at the Brockton

VAMC by converting to private rooms will rightsize the CLC space and maintain short-term and long-term CLC capabilities. Modernization will increase RRTP beds to 90.

6. **Modernize and realign outpatient facilities in the market by:**

- 6.1. Establishing a new MS CBOC in the vicinity of Salem, Massachusetts:** A new site in the vicinity of Salem, Massachusetts, replaces the existing Lynn CBOC and Gloucester OOS, providing primary care, outpatient mental health, and specialty care services in a more convenient and sustainable location for Veterans. In FY 2019, there were 10,970 enrollees within 30 minutes and 46,452 enrollees within 60 minutes of the proposed site.
- 6.2. Relocating all services to the proposed Salem MS CBOC and closing the Lynn CBOC:** Relocating services from the Lynn CBOC to the proposed new Salem MS CBOC places the care in a better market location for Veteran access. In FY 2019, there were 10,970 enrollees within 30 minutes and 46,452 enrollees within 60 minutes of the proposed new Salem MS CBOC site. There were 2,141 core uniques¹² at the Lynn CBOC, which is approximately 23 minutes from Salem, Massachusetts.
- 6.3. Relocating all services to the proposed Salem MS CBOC and closing the Gloucester OOS:** Relocating services from the Gloucester OOS to the proposed new Salem MS CBOC places the care in a better market location for Veteran access. In FY 2019, there were 10,970 enrollees within 30 minutes and 46,452 enrollees within 60 minutes of the newly proposed Salem MS CBOC. There were 1,371 core uniques at the Gloucester OOS, which is approximately 33 minutes from Salem, Massachusetts.
- 6.4. Relocating the Quincy OOS to a new site in the vicinity of South Weymouth, Massachusetts, and closing the Quincy OOS:** Veterans living in South Shore communities have significant difficulty accessing the Quincy OOS because of the traffic patterns around Boston. The proposed new site in South Weymouth offers greater accessibility from the South Shore area. In FY 2019, the proposed site had 19,395 enrollees within a 30-minute drive time. Expanding primary care, outpatient mental health, and optometry services at this new site may result in reclassification as a CBOC.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

East Market

- **Consolidate the leadership team and CBOCs aligned to the Bedford VAMC into the VA Boston Health System and assign the West Roxbury VAMC as the parent facility:** The Bedford and West Roxbury VAMCs are 21 miles apart and offer complementary, not overlapping, services.

¹² VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

Consolidating the administrative teams will eliminate unnecessary redundancy, especially with provider credentialing and Veterans Community Care Program consult management.

Bedford VAMC

- **Reduce the urgent care center hours currently offered at the Bedford VAMC to regular business hours to remain a same day access point:** The urgent care center had 10,868 encounters in FY 2019. Most occurred on weekdays, so maintaining a same day access point within regular business hours will accommodate Veterans seeking care while improving efficiency.
- **Expand specialty care services at the Haverhill CBOC, which may result in classification of facility as an MS CBOC:** In FY 2019, there were 2,287 core uniques at the Haverhill CBOC and there were 13,097 enrollees within 30 minutes of the Haverhill CBOC. Demand for outpatient rehabilitation therapies is projected to increase by 38.3% in the market between FY 2019 and FY 2029. Adding high-volume, low-complexity services like physical therapy and optometry to the CBOC improves Veteran access to care.
- **Expand RRTP capacity at the proposed replacement Bedford VAMC:** In response to bed realignment from Jamaica Plain, the number of RRTP beds at the proposed replacement Bedford VAMC will increase from 98 to 110.

West Roxbury VAMC

- **Increase capacity at the West Roxbury VAMC to absorb outpatient specialty and outpatient surgical services from the Jamaica Plain VAMC:** Demand for outpatient medical specialties is projected to increase by 44.2% and demand for outpatient surgical specialties is projected to increase by 51.9% in the market between FY 2019 and FY 2029. With the proposed realignment of the Jamaica Plain VAMC, workload for these specialties is consolidated at the West Roxbury VAMC.
- **Supplement the Lowell MS CBOC services with additional specialty care services:** In FY 2019, there were 19,338 enrollees within 30 minutes and 82,682 enrollees within 60 minutes of the Lowell CBOC. Demand for outpatient specialty care is projected to increase by 45.4% between FY 2019 and FY 2029. Expanding outpatient mental health services, optometry, physical therapy, audiology, podiatry, and geriatric psychiatry will improve Veteran access to care.
- **Expand outpatient services at the Plymouth OOS within its existing footprint, which may result in the classification of the facility as a CBOC:** The Plymouth OOS is approximately 33 miles from the Brockton VAMC. In FY 2019, there were 7,910 enrollees within 30 minutes of the Plymouth OOS. Expanding primary care, outpatient mental health, and optometry services to this point of care reduces Veteran travel time to the Brockton VAMC, improving access.

Providence VAMC

- **Expand specialty care services at the New Bedford CBOC, which may result in classification of the facility as an MS CBOC. Ensure there is additional space for visiting outpatient specialty care providers from the Providence VAMC:** The New Bedford CBOC is approximately 33 miles

from the Providence VAMC. In FY 2019, there were 57,007 enrollees within 60 minutes of the New Bedford CBOC. Expanding optometry, physical therapy, audiology, and podiatry services to this point of care reduces Veteran travel time to the Providence VAMC and decompresses the campus.

- **Expand the emergency department (ED) and implement an ED fast track to improve throughput at the Providence VAMC:** The ED had 19,083 encounters in FY 2019. Implementing an ED fast track will create a separate process for patients with less serious conditions who can be treated quickly and released, reducing Veteran wait times.
- **Locate Home-Based Primary Care (HBPC) hubs in Hyannis, Massachusetts; New Bedford, Massachusetts; and Providence, Rhode Island. A minimal capability will also be required in Middletown, Rhode Island:** In FY 2019, 55.1% of Veteran enrollees in the East Market were at least 65 years old. The Providence submarket is subdivided into four geographic sections with natural and human-made barriers between them. Establishing HBPC hubs in each section will allow health care teams to better serve Veterans with mobility and other issues that are barriers to accessing care.
- **Expand specialty care services at the Hyannis CBOC, which may result in classification of the facility as an MS CBOC:** In FY 2019, there were 5,047 enrollees within 30 minutes and 15,252 within 60 minutes of the Hyannis CBOC. Expanding optometry, physical therapy, audiology, and podiatry services to this point of care will help decant these services from the Providence VAMC.
- **Identify community providers such as Indian Health Service (IHS), Federally Qualified Health Centers (FQHCs), or other community providers in southern Rhode Island to provide primary care and mental health services to the local Veterans in the potential service gaps of Westerly and Wakefield, Rhode Island:** Westerly and Wakefield are located in Washington County, Rhode Island, the most rural county in the market. There is insufficient demand to support a VA point of care. The closest VA point of care for Veterans living in Westerly is the Providence VAMC, 57 minutes away. The closest VA point of care for Veterans living in Wakefield is the Middletown CBOC, 35 minutes away. There are several FQHCs and IHS facilities in Washington County. Developing partnerships with them will improve Veteran access to care in these areas.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 01 East Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost¹³ over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of

¹³ The present value cost is the current value of future costs discounted at the defined discount rate.

new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs includes direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).

- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 01 East Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 01 East Market	Status Quo	Modernization	VA Recommendation
Total Cost	\$36,192,188,287	\$37,742,052,891	\$38,622,608,798
Capital Cost	\$4,994,397,399	\$6,544,262,003	\$7,492,913,799
Operational Cost	\$31,197,790,888	\$31,197,790,888	\$31,129,694,999
Total Benefit Score	8	11	15
CBI (normalized in \$B)	4.52	3.43	2.57

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand
<p><i>This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.</i></p> <ul style="list-style-type: none"> • Summary: Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand. • Outpatient: Outpatient demand will be met through 19 VA points of care offering outpatient services, including the proposed new Salem, Massachusetts MS CBOC; the South Weymouth, Massachusetts CBOC; the Brockton, Massachusetts and Bedford, Massachusetts partnerships; the proposed replacement Bedford, Massachusetts VAMC; and the proposed expanded Haverhill, Massachusetts MS CBOC; New Bedford,

Demand

Massachusetts MS CBOC; Hyannis, Massachusetts MS CBOC; and Plymouth, Massachusetts CBOC; as well as community providers in the market.

- **CLC:** Long-term care demand will be met through the Brockton, Massachusetts VAMC and proposed replacement Bedford, Massachusetts VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the West Roxbury, Massachusetts and Brockton, Massachusetts VAMCs.
- **RRTP:** RRTP demand will be met through the Brockton, Massachusetts VAMC; proposed replacement Bedford, Massachusetts VAMC; proposed new RRTP at the Providence, Rhode Island VAMC; and the other facilities within VISN 01 offering RRTP, including the White River Junction, Vermont VAMC; the proposed new RRTPs at the Manchester, New Hampshire VAMC and Togus, Maine VAMC; and the proposed new Newington, Connecticut VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 4); and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the West Roxbury, Massachusetts VAMC and Providence, Rhode Island VAMC, as well as through community providers. Mental health demand will be met through the Brockton, Massachusetts VAMC; Providence, Rhode Island VAMC; and proposed replacement Bedford, Massachusetts VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 105,191 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and quality community providers is projected to be maintained, with 105,252 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 01. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with Boston University, Rhode Island Hospital, Harvard Medical School, Tufts University, and Brown University.
- **Research:** This recommendation does not impact the research mission in the market and allows the Boston, Massachusetts HCS; Providence, Rhode Island; and Bedford, Massachusetts VAMCs to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the West Roxbury, Massachusetts VAMC will maintain its status as a Primary Receiving Center.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Salem, Massachusetts MS CBOC; South Weymouth, Massachusetts CBOC; RRTP at the Providence, Rhode Island VAMC; Brockton, Massachusetts and Bedford, Massachusetts partnerships; and the proposed replacement Bedford, Massachusetts VAMC; as well as the modernization of patient rooms at the West Roxbury, Massachusetts VAMC; the mental health rooms and CLC at the Brockton, Massachusetts VAMC; and the inpatient medicine, surgery, and mental health rooms at the Providence, Rhode Island VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (2.57 for VA Recommendation versus 4.52 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Salem, Massachusetts MS CBOC; South Weymouth, Massachusetts CBOC; RRTP at the Providence, Rhode Island VAMC; Brockton, Massachusetts and Bedford, Massachusetts partnerships; and the proposed replacement Bedford, Massachusetts VAMC; as well as the modernization of patient rooms at the West Roxbury, Massachusetts VAMC; the mental health rooms and CLC at the Brockton, Massachusetts VAMC; and the inpatient medicine, surgery, and mental health rooms at the Providence, Rhode Island VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community partner space.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today (\$38.6B for VA Recommendation versus \$37.7B for Modernization), there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (2.57 for VA Recommendation versus 3.43 for Modernization), reflecting effective stewardship of taxpayer dollars.



VISN 01 Far North Market

The Veterans Integrated Service Network (VISN) 01 Far North Market serves Veterans in the state of Maine. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.¹⁴

VA's Commitment to Veterans in the Far North Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 01's Far North Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The enrolled Veteran population in the largely rural Far North Market is projected to decrease. Demand for inpatient mental health is projected to decrease, while demand for inpatient medical and surgical care, community living center (CLC) services, and outpatient care is projected to increase.

The Togus VAMC in Augusta, Maine, is oversized for current health care practices and is no longer in an optimal location for Veteran access because the population has largely shifted over time to the Portland, Maine, area to the south. Outpatient care sites face similar challenges with low enrollee populations in their existing locations. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation addresses the increased demand for outpatient services and improves access to care by investing in modern facilities close to where Veterans live. The recommendation maintains all sustainable outpatient points of care in the market. It also consolidates one clinic and a mobile unit into a

¹⁴ Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

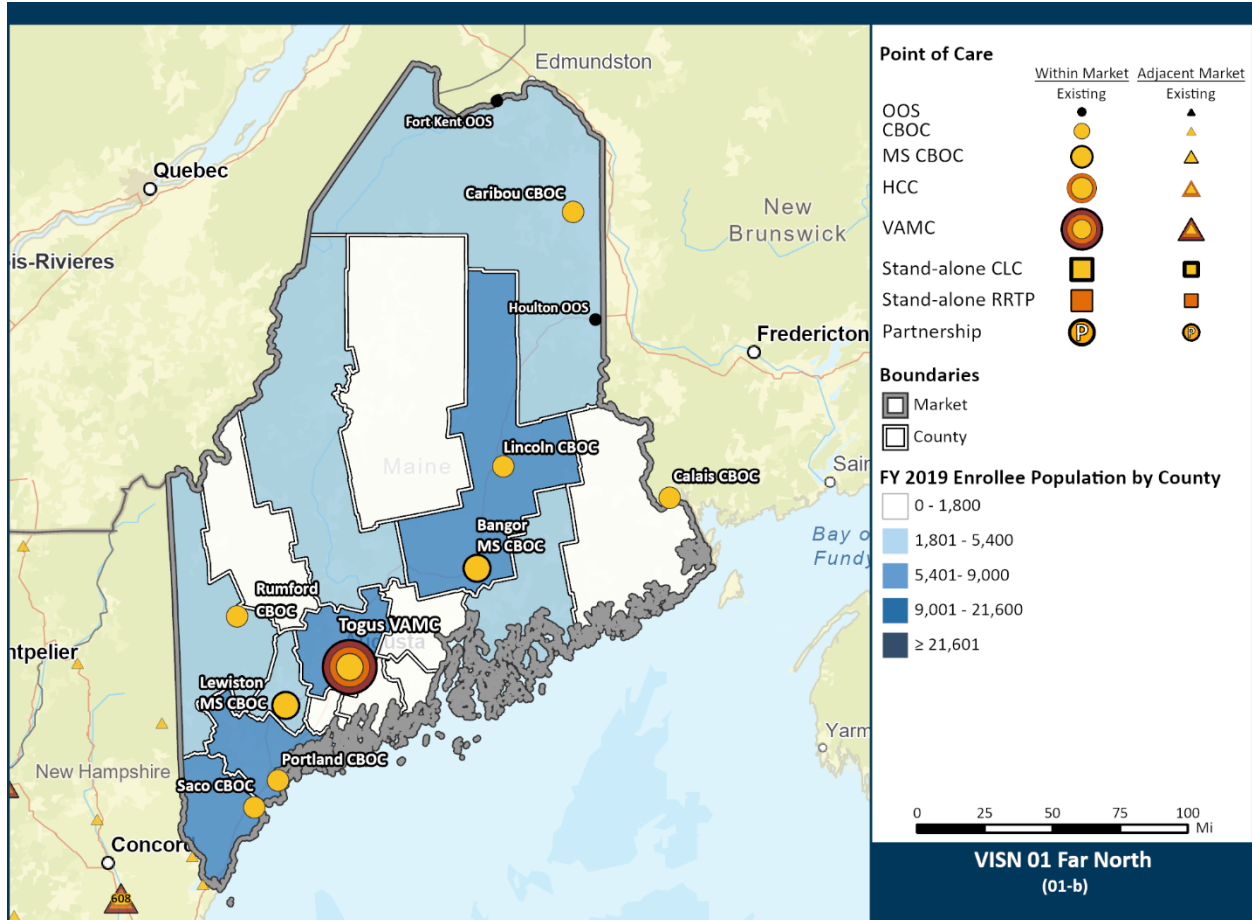
new, modern facility in Farmington, Maine, and consolidates two clinics into a larger, more convenient facility in Portland, Maine.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation improves access to care by investing in a new CLC in the Portland, Maine, area and a new residential rehabilitation treatment program (RRTP) in Togus, Maine. The inpatient mental health program at the Togus VAMC will be maintained. Demand for inpatient spinal cord injuries and disorders (SCI/D) services will be met through regional hubs at the West Roxbury, Massachusetts, and Brockton, Massachusetts, VAMCs. Inpatient blind rehabilitation services will be available to VISN 01 Veterans through the modernized regional facility at the West Haven VAMC in the West Market.
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation discontinues medical and surgical services at the Togus VAMC and establishes a strategic collaboration through which VA providers will deliver these services in the Portland, Maine, area. This locates the care closer to the highest concentration of the market's Veteran population to best meet projected demand.

Market Overview

The market overview includes a map of the Far North Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has one VAMC (Togus), two multi-specialty community-based outpatient clinics (MS CBOCs), six community-based outpatient clinics (CBOCs), and two other outpatient services (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 54,462 enrollees and is projected to experience a 10.4% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Cumberland, Maine; York, Maine; and Penobscot, Maine.

Demand: Demand¹⁵ in the market for inpatient medical and surgical services is projected to increase by 7.6%, and demand for inpatient mental health services is projected to decrease by 7.1% between FY

¹⁵ Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).

2019 and FY 2029. Demand for long-term care¹⁶ is projected to increase by 22.3%. Demand for all outpatient services,¹⁷ including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 75.7% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 55.0% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 40.6% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers¹⁸ in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate¹⁹ of 61.2% (176 available beds)²⁰ and an inpatient mental health occupancy rate of 54.9% (8 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 89.8% (11 available beds). Community residential rehabilitation programs²¹ that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include Maine Medical Center and Tufts University, as well as multiple Associated Health programs. The Togus VAMC is ranked 124 out of 154 VA training sites based on the number of trainees and is ranked 87 out of 103 VAMCs with research funding. The VAMC does not have an emergency designation.²²

Facility Overview

Togus VAMC: The Togus VAMC is located in Augusta, Maine, and offers inpatient medical and surgical, inpatient mental health, CLC, and outpatient services. In FY 2019, the Togus VAMC had an inpatient medical and surgical average daily census (ADC) of 19.0, an inpatient mental health ADC of 8.8, and a CLC ADC of 59.7.

The Togus VAMC was built in 1933 on 476.0 acres and does not meet current design standards.²³ The SCI/D building was constructed in 1986 and the inpatient bed tower was constructed in 2000. Facility condition assessment (FCA) deficiencies are approximately \$101.0M and annual operations and maintenance costs are an estimated \$9.3M.

¹⁶ Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

¹⁷ Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).

¹⁸ Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

¹⁹ Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.

²⁰ Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.

²¹ Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

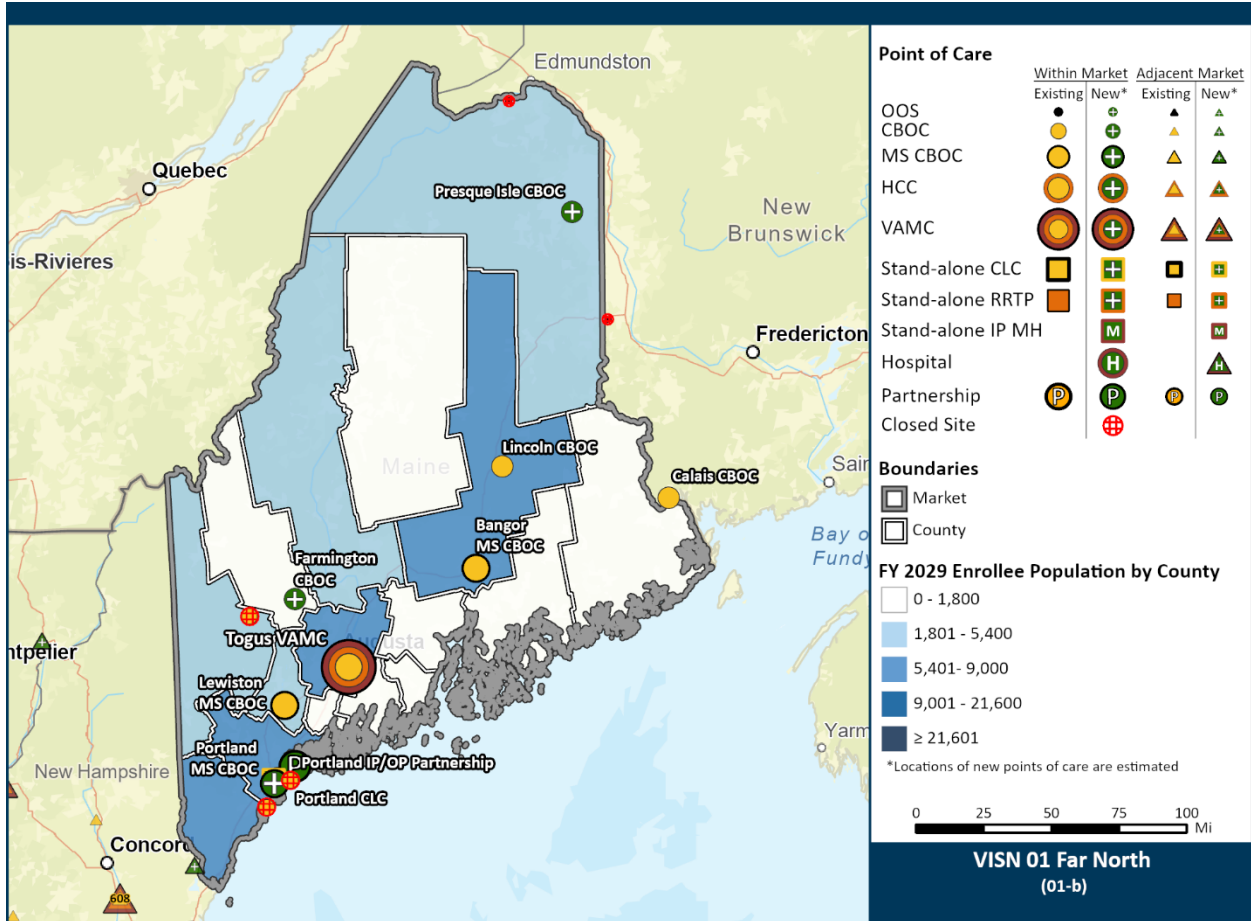
²² VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

²³ Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

Recommendation and Justification

This section details the VISN 01 Far North Market recommendation and justification for each element of the recommendation.

Future Market Map



1. Modernize and realign the Togus VAMC by:

- 1.1. **Relocating CLC services at the Togus VAMC to current or future VA facilities and discontinuing CLC services at the Togus VAMC:** The existing CLC space at the Togus VAMC consists of shared patient rooms not designed for contemporary health care delivery. The enrollee population in Kennebeck County, Maine, where the Togus VAMC is located, is projected to decrease by 7.7% between FY 2019 and FY 2029. Relocating CLC care to the Portland, Maine, area, approximately 60 minutes south of the Togus VAMC, positions it in an area of higher enrollment density and improves Veteran access.
- 1.2. **Establishing RRTP services at the Togus VAMC:** The Togus VAMC does not currently offer RRTP, with the closest VA point of care with RRTP services approximately 150 minutes away at the Bedford VAMC. There are limited high-quality alternatives in the community. A new RRTP will allow Veterans to receive highly individualized treatment closer to home. In FY 2028, the Far North Market has a projected need for 22 RRTP beds.

- 1.3. Establishing a strategic collaboration to provide inpatient medical care and inpatient/outpatient surgical care and discontinuing those services at the Togus VAMC. If unable to enter into a strategic collaboration, continue to provide those services at the VAMC:** While the total market demand for inpatient medical and surgical care is projected to increase, the in-house Togus VAMC demand is projected to experience a slight decrease. The Togus VAMC had an inpatient medical and surgical ADC of 19.0 in FY 2019, and demand is projected to decrease to 18.0 in FY 2029. VA recommends establishing a partnership with the academic affiliate to allow VA providers to deliver inpatient medical and surgical care in the Portland, Maine, area, which is more convenient for a larger concentration of the Veteran population. Leaving stand-alone outpatient surgery services will not be sustainable based on a low Veteran enrollee population in the Togus area. A strategic collaboration in the Portland area, where acute care is planned to be relocated through partnering with academic affiliates, will allow VA providers to deliver outpatient surgical care to Veterans through a sharing arrangement. In FY 2019, there were 24,396 enrollees within 60 minutes of the Portland, Maine MS CBOC, and 20,884 enrollees within 60 minutes of the Togus VAMC.
- 1.4. Converting the emergency department to an urgent care center and discontinuing emergency department services at the Togus VAMC:** Given the recommendation to relocate inpatient medical and surgical services from the Togus VAMC to a strategic collaboration in Portland, Maine, emergency department services will no longer be needed at the Togus VAMC. Converting the existing emergency department to an urgent care center supplies the appropriate level of care for the Veteran population. The VAMC has an adequate population to support an urgent care center. Currently, most emergency department visits occur on weekdays during the hours of 8:00 am and 10:00 pm, and most are low to moderate complexity. With no ability to admit patients, VA recommends discontinuing this resource intensive service.
- 2. Modernize by establishing a new stand-alone CLC in the vicinity of Portland, Maine:** In FY 2019, 53.8% of Veterans enrolled in the Far North Market were at least 65 years old. The market has a projected CLC ADC of 61.7 in FY 2029, a 4.8% increase from FY 2019. A new CLC in Portland, Maine, improves Veteran access by locating these services in an area with higher enrollment density than the existing facility. In FY 2019, there were 25,050 enrollees within 60 minutes of the proposed site. This recommendation allows VA to deliver CLC services using the latest design standard.
- 3. Modernize and realign outpatient facilities in the market by:**
- 3.1. Establishing a new CBOC in the vicinity of Farmington, Maine:** A new CBOC in the vicinity of Farmington, Maine, will improve access to primary care and mental health at a location close to where Veterans live and eliminate the need for those services at the Rumford CBOC and Bingham Mobile OOS. In FY 2019, there were 1,720 enrollees within 30 minutes of the proposed site.
- 3.2. Relocating all services to the proposed Farmington CBOC and closing the Rumford CBOC:** The new Farmington CBOC is approximately 43 minutes from the Rumford CBOC. In FY 2019, there were 1,720 enrollees within 30 minutes of the proposed new Farmington, Maine CBOC and 946 enrollees within 30 minutes of the existing Rumford CBOC. Relocating services from the Rumford CBOC to the new CBOC in Farmington, Maine provides access to more Veterans.

- 3.3. Discontinuing the use of the Bingham Mobile unit:** In FY 2019, there were 1,720 enrollees within 30 minutes of the proposed Farmington, Maine CBOC, and 325 core uniques²⁴ were seen at the Bingham Mobile unit. Relocating services from the Bingham Mobile unit to the new CBOC in Farmington, Maine will provide Veterans with nearby access to the new CBOC and increase system sustainability.
- 3.4. Relocating all services to the Portland MS CBOC and closing the Saco CBOC:** The Saco CBOC is experiencing declining enrollment and workload and is not in a location convenient for the Veteran population. The Saco CBOC is approximately 22 minutes from Portland, Maine. Consolidating the Saco CBOC into the nearby, larger MS CBOC in Portland, Maine places primary care and outpatient mental health services in the larger Cumberland County area. The Portland MS CBOC is expected to open in early 2022. In FY 2019, there were 24,396 enrollees within 60 minutes of the Portland MS CBOC.
- 3.5. Relocating all services at the Houlton OOS and closing the Houlton OOS:** The operational size and scale of the OOS does not support the patient-aligned care team (PACT) model. Closing the OOS and relocating services to community providers, Indian Health Service facilities, or Federally Qualified Health Centers (FQHCs) allows VA to maintain access and improve sustainability. The Houlton OOS had 612 enrollees within a 30-minute drive time and 211 core uniques in FY 2019.
- 3.6. Relocating all services at the Fort Kent OOS and closing the Fort Kent OOS:** The operational size and scale of the OOS does not support the PACT model. Closing the OOS and relocating services to the FQHC in Fort Kent, Maine allows VA to maintain access and improve sustainability. The Fort Kent OOS had 613 enrollees within a 30-minute drive time and 233 core uniques in FY 2019.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

Far North Market

- **Allocate the current leadership at the Togus VAMC as appropriate between the Togus VAMC and the Portland MS CBOC:** Shifting some leadership positions to the Portland MS CBOC will improve collaboration and enhance partnerships with Maine Medical Center, an academic affiliate. The distance between the Togus VAMC and the Maine Medical Center is approximately 57 miles, while the distance between the Portland MS CBOC and Maine Medical Center is 1.7 miles.
- **Expand use of Home-Based Primary Care services to the Presque Isle CBOC and maximize use of virtual technologies:** In FY 2019, 53.8% of Veteran enrollees in the Far North Market were at

²⁴ VA core unique patients exclude Veterans who have only used VA telephone triage, pharmacy, and laboratory services.

least 65 years old. Expanding into Aroostook County will allow health care teams to better serve Veterans with mobility and other barriers to accessing care.

- **Expand telehealth and VA Video Connect use to rural areas in as many specialties as possible. Continue to work to expand bandwidth in conjunction with the state.** The Far North Market is one of the most rural markets in the VA network. Telehealth utilization is below the VA national utilization rate, indicating an opportunity for improvement.
- **Expand staffing to address new Veterans Community Care Program demand:** Providing care coordination and utilization management will improve access, continuity of care for Veterans, and cost control.
- **Continue to partner with community providers throughout the state recognizing distinct needs for rural health, community, and tertiary levels of care:** The Far North Market is one of the most rural in the VA network. Partnering with critical access hospitals and other community providers will improve access to care for Veterans.

Togus VAMC

- **Relocate medical and surgical providers currently at the Togus VAMC to the Portland MS CBOC:** In FY 2019, there were 24,396 enrollees within 60 minutes of the Portland, Maine MS CBOC, which is 3,512 more than the Togus VAMC. Shifting specialty providers to the Portland MS CBOC allows them to serve a larger concentration of the Veteran population in the market and improves recruitment. This will likely result in an additional space need at the Portland MS CBOC.
- **Identify community partners such as local FQHCs in the Greenville, Blue Hill, Booth Bay Harbor, and Bar Harbor Maine areas to provide primary care and outpatient mental health to the local enrollee population:** These areas are outside the 30-minute drive time radius to a VA point of care but lack sufficient population to establish a VA point of care. The closest VA point of care for Veterans living in Greenville is the Lincoln CBOC, 98 minutes away. The closest VA point of care for Veterans living in Blue Hill and Bar Harbor is the Bangor MS CBOC, 55 minutes from Blue Hill and 75 minutes from Bar Harbor. The closest VA point of care for Veterans living in Booth Bay is the Togus VAMC, 51 minutes away. Partnerships will improve access to care for Veterans.
- **Develop a long-term Facility Master Plan for the Togus VAMC, based on an updated service plan. The plan will consolidate services and modernize the facility; maintain capacity for primary care, inpatient and outpatient mental health, and low acuity high volume specialties; and add RRTP services. It will maintain support for the cemetery:** This plan will consider space requirements for services identified to remain on the Togus VAMC campus and develop a strategy for consolidating them into modernized facilities.
- **Expand partnerships with Tufts University (affiliate of Maine Medical Center) to allow for staffing flexibility:** Shared VA/affiliate physicians will hold clinics at the Portland MS CBOC and perform outpatient surgeries/procedures in the local affiliated community hospital. The Maine Medical Center is only 1.7 miles from the Portland MS CBOC, which will improve collaborative

efforts. A stronger academic affiliation improves recruitment and increases opportunities for VA-delivered care.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 01 Far North Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost²⁵ over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs includes direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is the preferred COA. The results of the CBA for the VISN 01 Far North Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 01 Far North Market	Status Quo	Modernization	VA Recommendation
Total Cost	\$10,680,415,937	\$11,131,296,516	\$10,741,609,354
Capital Cost	\$748,457,364	\$1,199,337,943	\$1,341,345,826
Operational Cost	\$9,931,958,573	\$9,931,958,573	\$9,400,263,528
Total Benefit Score	7	10	13
CBI (normalized in \$B)	1.53	1.11	0.83

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

²⁵ The present value cost is the current value of future costs discounted at the defined discount rate.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through nine VA points of care offering outpatient services, including the proposed new Farmington, Maine CBOC; Presque Isle, Maine CBOC; Portland, Maine MS CBOC; and partnership in Portland, Maine, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed new stand-alone CLC in Portland, Maine, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the West Roxbury, Massachusetts and Brockton, Massachusetts VAMCs.
- **RRTP:** RRTP demand will be met through the proposed new RRTP at the Togus, Maine VAMC and the other facilities within VISN 01 offering RRTP, including the Brockton, Massachusetts VAMC; White River Junction, Vermont VAMC; proposed replacement Bedford, Massachusetts VAMC; proposed new Newington, Connecticut VAMC; and proposed new RRTPs at the Manchester, New Hampshire VAMC and Providence, Rhode Island VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the proposed new partnership in Portland, Maine, as well as through community providers; mental health demand will be met through the Togus, Maine VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 50,476 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 50,626 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 01. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Tufts University.
- **Research:** This recommendation does not impact the research mission in the market and allows the Togus, Maine VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Togus, Maine VAMC is not designated as a Primary Receiving Center.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new stand-alone CLC in Portland, Maine; the Farmington, Maine CBOC; Presque Isle, Maine CBOC; Portland, Maine MS CBOC; partnership in Portland, Maine; and RRTP at the Togus, Maine VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.83 for VA Recommendation versus 1.53 for Status Quo), indicating that VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new stand-alone CLC in Portland, Maine; Farmington, Maine CBOC; Presque Isle, Maine CBOC; Portland, Maine MS CBOC; partnership in Portland, Maine; and RRTP at the Togus, Maine VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in a community partner space.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today (\$10.7B for VA Recommendation versus \$11.1B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.83 for VA Recommendation versus 1.11 for Modernization), reflecting effective stewardship of taxpayer dollars.



VISN 01 North Market

The Veterans Integrated Service Network (VISN) 01 North Market serves Veterans in Vermont and New Hampshire. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.²⁶

VA's Commitment to Veterans in the North Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 01's North Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The North Market, a largely rural market encompassing Vermont and New Hampshire, is projected to experience a decrease in the number of enrolled Veterans by fiscal year (FY) 2029. At the same time, demand for acute inpatient services, long-term care, and outpatient services is projected to increase.

White River Junction VAMC, the VA's acute inpatient care platform, is located centrally in the market in White River Junction, Vermont, near its academic affiliate at Dartmouth, while the largest and growing concentration of Veteran enrollees now resides in the Manchester, New Hampshire, area. Some outpatient clinics are not in the optimal locations to serve Veterans.

The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation addresses the increased demand for outpatient services and improves access to care by investing in modern facilities close to where Veterans live. The recommendation maintains all sustainable outpatient points of care in the market. It also consolidates two clinics into a new, more modern facility in Dover,

²⁶ Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

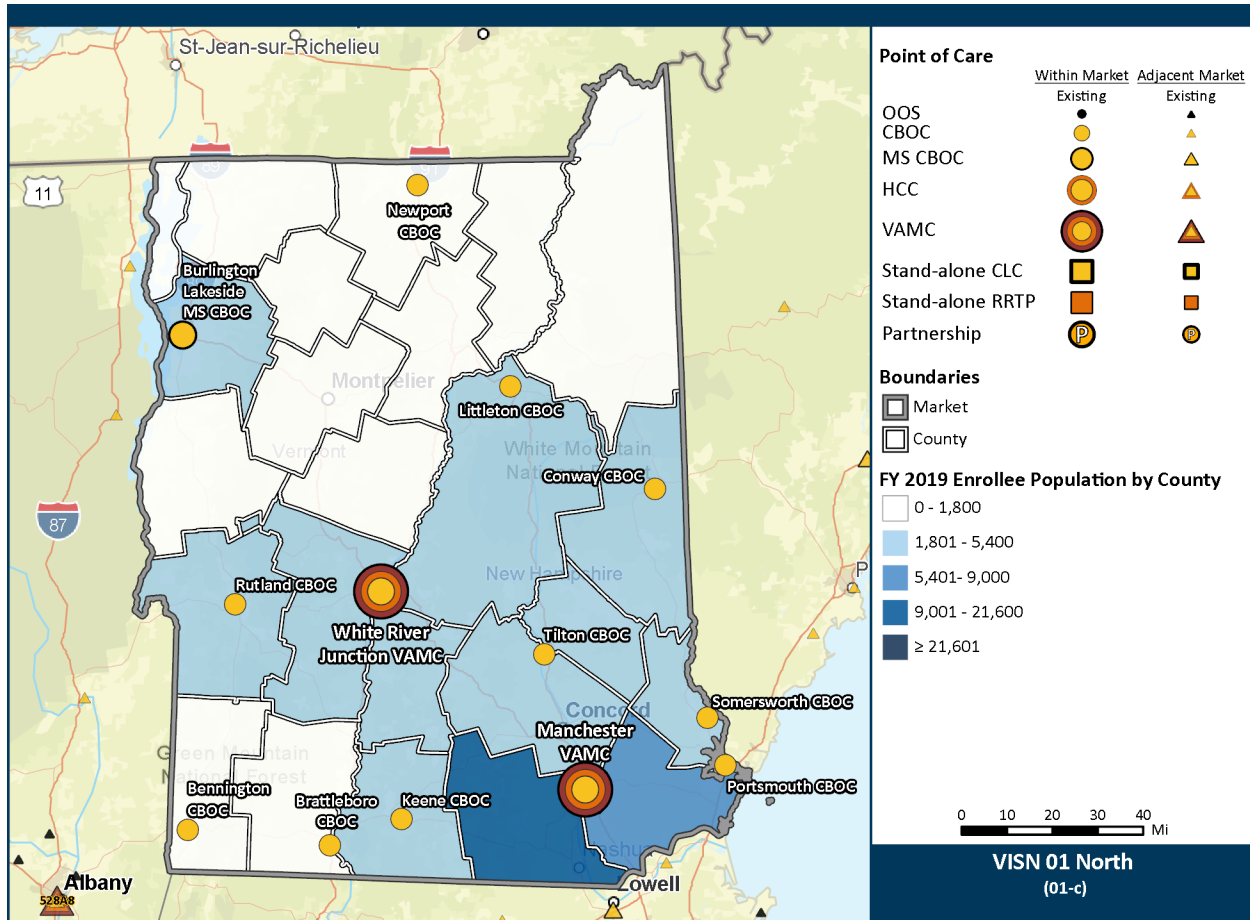
New Hampshire, and two others into a new, more modern facility in St. Johnsbury, Vermont. The recommendation establishes a new site of care in Montpelier, Vermont, while closing two clinics in Brattleboro, Vermont, and Conway, New Hampshire. At the White River Junction VAMC, VA's recommendation relocates emergency services to community providers and invests in a more sustainable urgent care center.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation improves access to care by investing in a new residential rehabilitation treatment program (RRTP) at the Manchester VAMC. The recommendation also modernizes the existing community living center (CLC) at the Manchester VAMC. The recommendation retains the inpatient mental health program at the White River Junction VAMC. Demand for inpatient spinal cord injuries and disorders (SCI/D) services will be met through regional hubs at the West Roxbury, Massachusetts, and Brockton, Massachusetts, VAMCs. Inpatient blind rehabilitation services will be available to VISN 01 Veterans through the modernized regional facility at the West Haven VAMC in the West Market.
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains the inpatient medical and surgical program at the White River Junction VAMC.

Market Overview

The market overview includes a map of the North Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has 2 VAMCs (White River Junction and Manchester), 1 multi-specialty community-based outpatient clinic (MS CBOC), and 10 community-based outpatient clinics (CBOCs).

Enrollees: In FY 2019, the market had 63,233 enrollees and is projected to experience a 10.3% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Hillsborough, New Hampshire; Rockingham, New Hampshire; and Merrimack, New Hampshire.

Demand: Demand²⁷ in the market for inpatient medical and surgical services is projected to increase by 5.2% and demand for inpatient mental health services is projected to increase by 4.5% between FY 2019 and FY 2029. Demand for long-term care²⁸ is projected to increase by 34.7%. Demand for all outpatient

²⁷ Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).

²⁸ Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

services,²⁹ including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 62.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 72.0% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 68.5% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers³⁰ in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate³¹ of 75.2% (1,030 available beds)³² and an inpatient mental health occupancy rate of 78.2% (45 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 88.7% (117 available beds). Community residential rehabilitation programs³³ that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include Dartmouth College and Mary Hitchcock Memorial Hospital. The White River Junction VAMC is ranked 87 out of 154 VA training sites based on the number of trainees and the Manchester VAMC is ranked 132 out of 154. The White River Junction is ranked 40 out of 103 VAMCs with research funding and the Manchester VAMC is ranked 97 out of 103. Neither VAMC holds an emergency designation.³⁴

Facility Overviews

White River Junction VAMC: The White River Junction VAMC is located in White River Junction, Vermont, and offers inpatient medical and surgical, inpatient mental health, RRTP, and outpatient services. In FY 2019, the White River Junction VAMC had an inpatient medical and surgical average daily census (ADC) of 24.4, an inpatient mental health ADC of 8.9, and an RRTP ADC of 11.5.

The White River Junction VAMC was built in 1974 on 64.0 acres and does not meet current design standards.³⁵ Facility condition assessment (FCA) deficiencies are approximately \$98.9M and annual operations and maintenance costs are an estimated \$8.5M.

Manchester VAMC: The Manchester VAMC is located in Manchester, New Hampshire, and offers CLC and outpatient services. For FY 2019, the Manchester VAMC had a CLC ADC of 30.3.

²⁹ Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).

³⁰ Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

³¹ Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.

³² Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.

³³ Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

³⁴ VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

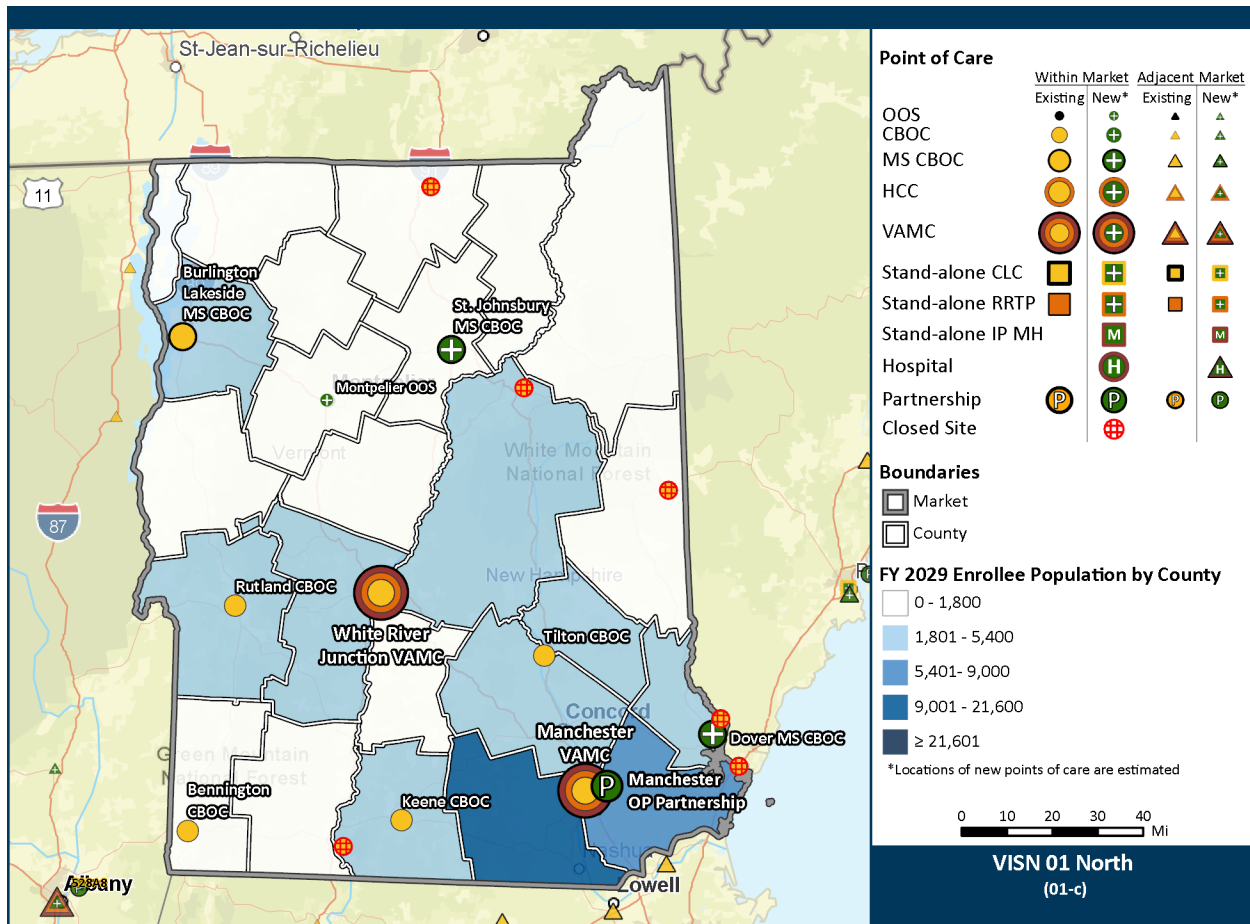
³⁵ Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

The Manchester VAMC was built in 1949 on 30.0 acres and does not meet current design standards. FCA deficiencies are approximately \$70.5M and annual operations and maintenance costs are an estimated \$6.9M.

Recommendation and Justification

This section details the VISN 01 North Market recommendation and justification for each element of the recommendation.

Future Market Map



1. Modernize and realign the Manchester VAMC by:

- 1.1. **Establishing RRTP services at the Manchester VAMC:** The VAMC does not currently offer RRTP, while the closest VA point of care with RRTP services is approximately 73 minutes away at the White River Junction VAMC. There are limited high-quality alternatives in the community. Projected market demand supports a 20-bed program, which will allow Veterans to receive highly individualized treatment close to home.
- 1.2. **Establishing a strategic collaboration to provide outpatient surgical and endoscopy services and discontinuing those services at the Manchester VAMC.** If unable to enter into a strategic collaboration, consider maintaining services or referring to community providers: Outpatient

surgical and endoscopy volumes at the VAMC are low, posing challenges to maintaining safe practices and provider competencies. From the Manchester VAMC, Dartmouth-Hitchcock Manchester is 10 minutes away and another community hospital is 8 minutes away. A sharing agreement to allow VA providers to deliver care at these community facilities, which have higher volumes and sufficient capacity, will improve Veteran access to high-quality surgical and procedural care.

- 1.3. Modernizing the CLC at the Manchester VAMC:** The existing CLC space at the Manchester VAMC consists of shared patient rooms not designed for contemporary health care delivery. Current design standards include private rooms to reduce infection and improve patient satisfaction. The CLC modernization increases the number of beds from 41 to 50 to accommodate Veterans from the White River Junction VAMC, which does not have a CLC and relies on the Bedford VAMC, 165 miles away, when local community nursing homes cannot accommodate Veterans. Increasing bed capacity at a modernized Manchester VAMC CLC will improve access for Veterans from the White River VAMC area seeking short-stay care.
- 2. *Modernize and realign the White River Junction VAMC by converting the emergency department to an urgent care center and relocating the emergency department services to community providers:*** The Emergency Department had 5,583 encounters in FY 2019, which is below the recommended planning guideline of 13,000 needed to sustain that service. Converting the existing emergency department to an urgent care center and relocating emergency department services to the community provides the appropriate level of care for the Veterans seeking same day access. The VAMC has adequate population to support an urgent care center.
- 3. *Modernize and realign outpatient facilities in the market by:***

 - 3.1. Establishing a new MS CBOC in the vicinity of Dover, New Hampshire:** A new point of care in the vicinity of Dover, New Hampshire, will provide primary care, outpatient mental health, and outpatient specialty services in Stafford County. In FY 2019, there were 7,956 enrollees within 30 minutes and 37,460 enrollees within 60 minutes of the new proposed site in Dover, New Hampshire.
 - 3.2. Establishing a new other outpatient services (OOS) site in the vicinity of Montpelier, Vermont:** A new point of care in Montpelier, Vermont, will improve access to primary care and outpatient mental health services for Veterans in Washington County. In FY 2019, there were 1,969 enrollees within 30 minutes of the new proposed site, which is inadequate to sustain a CBOC, but supports an OOS.
 - 3.3. Relocating all services to the proposed Dover MS CBOC and closing the Somersworth CBOC:** The new proposed Dover MS CBOC is located 9 minutes from the Somersworth CBOC. In FY 2019, there were 7,956 enrollees within 30 minutes and 37,460 enrollees within 60 minutes of the new proposed site in Dover, New Hampshire, and 2,750 core uniques³⁶ at the Somersworth CBOC. Relocating services from the Somersworth CBOC to the new Dover MS CBOC maintains access and increases system sustainability.

³⁶ VA core unique patients exclude Veterans who have only used VA telephone triage, pharmacy, and laboratory services.

3.4. Relocating all services to the proposed Dover MS CBOC and closing the Portsmouth CBOC:

The new proposed Dover MS CBOC is located 14 minutes from the Portsmouth CBOC. In FY 2019, there were 7,956 enrollees within 30 minutes and 37,460 enrollees within 60 minutes of the new proposed site in Dover, New Hampshire, and 2,249 core uniques at the Portsmouth CBOC. Relocating services from the Portsmouth CBOC to the new Dover MS CBOC maintains access and increases system sustainability.

3.5. Establishing a new MS CBOC in the vicinity of St. Johnsbury, Vermont: A new point of care in the vicinity of St. Johnsbury, Vermont, adjacent to Interstate 91, will improve access to primary care, outpatient mental health, and outpatient specialty care services to Veterans in Caledonia County. In FY 2019, there were 1,801 enrollees within 30 minutes and 6,869 enrollees within 60 minutes of the new proposed site in St. Johnsbury, Vermont.**3.6. Relocating all services to the proposed St. Johnsbury MS CBOC and closing the Littleton CBOC:**

The new proposed St. Johnsbury MS CBOC is located 22 minutes from the Littleton CBOC. In FY 2019, there were 6,869 enrollees within 60 minutes of the proposed site in St. Johnsbury, Vermont, while there were 2,445 core uniques at the Littleton CBOC. Relocating services from the Littleton CBOC to the new St. Johnsbury MS CBOC maintains access and increases system sustainability.

3.7. Relocating all services to the proposed St. Johnsbury MS CBOC and closing the Newport CBOC:

The new proposed St. Johnsbury MS CBOC is located 50 minutes from the Newport CBOC. In FY 2019, there were 6,869 enrollees within 60 minutes of the new proposed site in St. Johnsbury, Vermont, and 832 core uniques at the Newport CBOC. Relocating services from the Newport CBOC to the new MS CBOC in the vicinity of St. Johnsbury maintains Veteran access while increasing system sustainability.

3.8. Relocating all services to the Keene CBOC and closing the Brattleboro CBOC: The Brattleboro CBOC is approximately 23 miles from the Keene CBOC, with primary care and outpatient mental health services offered at both locations. There were 1,363 core uniques at the Brattleboro CBOC in FY 2019. Consolidating care at the Keene CBOC maintains Veteran access and increases system sustainability.**3.9. Relocating all services at the Conway CBOC and closing the Conway CBOC:** The Conway CBOC had 1,089 enrollees within a 30-minute drive in FY 2019, and the enrollee population is projected to decrease 10.1% in Carroll County through FY 2029. Relocating services to Veterans Community Care Program providers, Federally Qualified Health Centers (FQHCs), and Indian Health Service (IHS) facilities maintains Veteran access and is more sustainable. There is a critical access hospital and a FQHC in Carroll County.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

North Market

- **Consolidate leadership teams from the White River Junction VAMC and Manchester VAMC:** The White River and West Roxbury VAMCs are 77 miles apart, and offer complementary, not overlapping, services. Maintaining a strong leadership presence in White River Junction is important for maintaining the synergy with Dartmouth-Hitchcock Medical Center.

Manchester VAMC

- **Add physical therapy services to the Home-Based Primary Care (HBPC) team at the Tilton CBOC. The physical therapists should also provide care at the Tilton CBOC:** The Tilton CBOC is located on the border of Merrimack and Belknap counties in New Hampshire, both of which are rural. In FY 2019, 53.2% of Veteran enrollees in the North Market were at least 65 years old. Demand for outpatient rehabilitation therapies is projected to increase by 49.8% in the market between FY 2019 and FY 2029. Adding physical therapy to the HBPC as well as the CBOC will better serve Veterans with mobility and other issues that are barriers to accessing care.
- **Identify community partners such as local FQHCs in the Wolfeboro, New Hampshire; New London, New Hampshire; and Plymouth, Vermont Hospital Service Areas; as well as the community of Milford, New Hampshire, to provide primary care and outpatient mental health services to local Veterans:** These areas do not have adequate Veteran enrollee populations to support VA points of care and are located beyond 30-minute drive times to the closest VA points of care. The closest VA point of care for Veterans living in Wolfeboro is the Tilton CBOC, 55 minutes away. The closest VA point of care for Veterans living in New London is the Tilton CBOC, 36 minutes away. The closest VA point of care for Veterans living in Plymouth is the White River Junction VAMC, 46 minutes away. The closest VA point of care for Veterans living in Milford is the Manchester VAMC, 35 minutes away. There are two FQHCs within 30 minutes of Milford. Developing partnerships will improve Veteran access to care in those areas.
- **Partner with the Dartmouth-Hitchcock Medical Center to enhance the research and education mission in the Manchester, New Hampshire, area:** Expanding partnerships with Dartmouth-Hitchcock allows for staffing flexibility. Shared VA/affiliate physicians will be able to see clinic patients at the Manchester VAMC and perform outpatient surgeries/procedures in the local affiliated community hospital. The Manchester VAMC was ranked 97 out of 103 research sites in FY 2019, with no graduate medical education (GME) programs.

White River Junction VAMC

- **Partner with local community providers and FQHCs to provide primary care and outpatient mental health services to Veterans in the Middlebury, Vermont; Colebrook, New Hampshire; and Berlin, New Hampshire, areas:** These areas do not have adequate Veteran enrollee populations to support VA points of care and are located beyond 30-minute drive times to the closest VA points of care. The closest VA point of care for Veterans living in Middlebury is the

Rutland CBOC, 49 minutes away. The closest point of care for Veterans living in Colebrook is the Newport CBOC, 70 minutes away. The closest VA point of care for Veterans living in Berlin is the Littleton CBOC, 54 minutes away. Developing partnerships will improve Veteran access to care in those areas.

- **Reduce the RRTP capacity at the White River Junction VAMC to align with demand:** The White River VAMC has 14 RRTP beds and the ADC in FY 2019 was 11.5. While demand for RRTP services is projected to increase slightly across the market, it is projected to decrease by 16.9% in the White River VAMC area between FY 2019 and FY 2029. This strategy decreases the number of RRTP beds to 12.
- **Develop a long-term Facility Master Plan for the White River Junction VAMC, based on an updated service plan, to consolidate services into a limited number of contemporary buildings to allow for disposal of outdated and unnecessary buildings and infrastructure:** This plan will consider space requirements for the White River Junction VAMC campus and develop a strategy for consolidating them into modernized facilities. Buildings 1 (Clinical Support), 8 (Outpatient Psychology), 2 (boiler plant), 4 (business office), 9 (Quality Scholars) and 6 (fiscal services) are historic and date from 1938 to 1942. The buildings have exceeded their useful life as modern health care facilities and are unable to provide a contemporary health care setting with appropriate amenities and safety provisions for Veteran care.
- **Expand community care utilization staffing to include social work and pharmacy capabilities:** This additional expertise for Veterans Community Care Program utilization management will help manage increasing costs of home health aide and skilled nursing authorizations.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 01 North Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost³⁷ over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs includes direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).

³⁷ The present value cost is the current value of future costs discounted at the defined discount rate.

- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 01 North Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 01 North Market	Status Quo	Modernization	VA Recommendation
Total Cost	\$12,476,449,621	\$13,216,286,319	\$13,269,143,753
Capital Cost	\$435,211,280	\$1,175,047,977	\$1,296,254,615
Operational Cost	\$12,041,238,341	\$12,041,238,341	\$11,972,889,138
Total Benefit Score	7	10	12
CBI (normalized in \$B)	1.78	1.32	1.11

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 11 VA points of care offering outpatient services, including the proposed new Dover, New Hampshire MS CBOC; St. Johnsbury, Vermont MS CBOC; Montpelier, Vermont OOS; and Manchester, New Hampshire partnership; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Manchester, New Hampshire VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the West Roxbury, Massachusetts and Brockton, Massachusetts VAMCs.
- **RRTP:** RRTP demand will be met through the White River Junction, Vermont VAMC, proposed new RRTP at the Manchester, New Hampshire VAMC, and the other facilities within VISN 01 offering RRTP, including the Brockton, Massachusetts VAMC; proposed replacement Bedford, Massachusetts VAMC; proposed new Newington, Connecticut VAMC; and proposed new RRTPs at the Providence, Rhode Island VAMC and Togus, Maine VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the White River Junction, Vermont VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 57,098 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 57,147 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, supporting VA's education at a national level, research at a VISN level, and VA's emergency preparedness mission at a regional level.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 01. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with Dartmouth College and Mary Hitchcock Memorial Hospital.
- **Research:** This recommendation does not impact the research mission in the market and allows the White River Junction, Vermont VAMC; and Manchester, New Hampshire VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the White River Junction, Vermont; and Manchester, New Hampshire VAMCs are not designated as Primary Receiving Centers.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all community providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Dover, New Hampshire MS CBOC; St. Johnsbury, Vermont MS CBOC; Montpelier, Vermont OOS; RRTP at the Manchester, New Hampshire VAMC; and Manchester, New Hampshire partnership; as well as the modernization of the CLC at the Manchester, New Hampshire VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (1.11 for VA Recommendation versus 1.78 for Status Quo), indicating that VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Dover, New Hampshire MS CBOC; St. Johnsbury, Vermont MS CBOC; Montpelier, Vermont OOS; RRTP at the Manchester, New Hampshire VAMC and Manchester, New Hampshire partnership; as well as the modernization of the CLC at the Manchester, New Hampshire VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community partner space.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today (\$13.3B for VA Recommendation versus \$13.2B for Modernization), there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.11 for VA Recommendation versus 1.32 for Modernization), reflecting effective stewardship of taxpayer dollars.



VISN 01 West Market

The Veterans Integrated Service Network (VISN) 01 West Market serves Veterans in Connecticut and Western Massachusetts. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.³⁸

VA's Commitment to Veterans in the West Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 01's West Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The enrolled Veteran population in the West Market is projected to decrease. Demand for acute inpatient care is also projected to decrease; however, demand for long-term care and outpatient services is projected to increase.

The Central Western Massachusetts VAMC, located in Northampton, Massachusetts, was built in 1923 and has significant facilities maintenance issues and investment requirements. As the population shifted over time, the facility is no longer in the optimal location to serve Veterans. The market's heaviest concentrations of Veteran enrollee population reside along a largely urban corridor that runs from Springfield, Massachusetts, down through Hartford, Connecticut, and on to the Greater New Haven, Connecticut, area. The West Haven VAMC, in West Haven, Connecticut, which provides acute inpatient care and has significant research and education missions, faces similar issues with aging infrastructure. Several outpatient clinics in the market are no longer well-located to best support the Veteran population.

The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

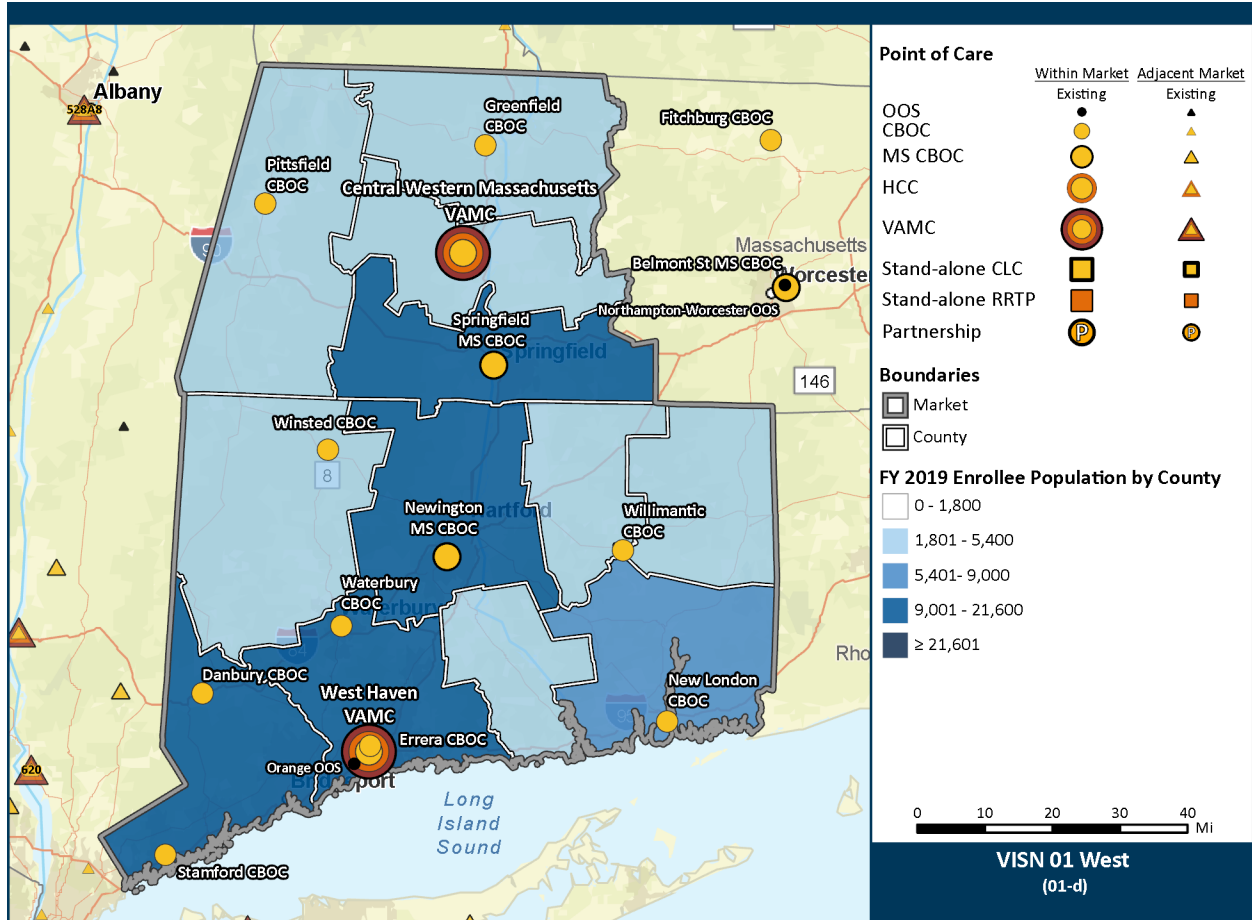
³⁸ Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation addresses the increased demand for outpatient services and improves access to care by investing in modern facilities close to where Veterans live. The recommendation maintains all sustainable outpatient points of care in the market. It relocates three clinics closer to where Veterans live in Torrington, Connecticut; Norwalk, Connecticut; and Springfield, Massachusetts. This allows VA to provide care in new, more modern facilities.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation improves access to care by investing in new community living center (CLC) and residential rehabilitation treatment program (RRTP) facilities in Newington, Connecticut. These modern facilities will replace the outdated ones at both the Central Western Massachusetts and West Haven VAMCs. VA's recommendation establishes a strategic collaboration for inpatient mental health services to maintain access for Veterans living in Central and Western Massachusetts. Demand for inpatient spinal cord injuries and disorders (SCI/D) services will be met through regional hubs at the West Roxbury, Massachusetts and Brockton, Massachusetts VAMCs. The recommendation includes modernizing the inpatient blind rehabilitation facility at the West Haven VAMC.
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation modernizes the inpatient medical and surgical facility at the West Haven VAMC.

Market Overview

The market overview includes a map of the West Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has two VAMCs (West Haven and Central Western Massachusetts), three multi-specialty community-based outpatient clinics (MS CBOCs), ten community-based outpatient clinics (CBOCs), and two other outpatient services (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 90,881 enrollees and is projected to experience a 17.0% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of New Haven, Connecticut; Hartford, Connecticut; and Hampden, Massachusetts.

Demand: Demand³⁹ in the market for inpatient medical and surgical services is projected to decrease by 8.8% and demand for inpatient mental health services is projected to decrease by 12.9% between FY

³⁹ Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).

2019 and FY 2029. Demand for long-term care⁴⁰ is projected to increase by 22.2%. Demand for all outpatient services,⁴¹ including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 17.2% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 91.9% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 92.7% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers⁴² in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate⁴³ of 71.9% (805 available beds)⁴⁴ and an inpatient mental health occupancy rate of 79.0% (55 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 86.1% (476 available beds). Community residential rehabilitation programs⁴⁵ that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include the University of Massachusetts, Yale University, and the University of Connecticut. The West Haven VAMC is ranked 16 out of 154 VA training sites based on the number of trainees and the Central Western Massachusetts VAMC is ranked 121 out of 154. The West Haven VAMC is ranked 9 out of 103 VAMCs with research funding and the Central Western Massachusetts VAMC is ranked 79 out of 103. Neither VAMC holds an emergency designation.⁴⁶

Facility Overviews

West Haven VAMC: The West Haven VAMC is located in West Haven, Connecticut, and offers inpatient medical and surgical, inpatient mental health, RRTP, blind rehabilitation, CLC, and outpatient services. In FY 2019, the West Haven VAMC had an inpatient medical and surgical average daily census (ADC) of 40.2, an inpatient mental health ADC of 13.2, an RRTP ADC of 23.3, a blind rehabilitation ADC of 9.1, and a CLC ADC of 19.1.

⁴⁰ Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

⁴¹ Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).

⁴² Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

⁴³ Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.

⁴⁴ Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.

⁴⁵ Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

⁴⁶ VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

The West Haven VAMC was built in 1955 on 44.0 acres and does not meet current design standards.⁴⁷ Facility condition assessment (FCA) deficiencies are approximately \$323.0M and annual operations and maintenance costs are an estimated \$14.9M.

Central Western Massachusetts VAMC: The Central Western Massachusetts, VAMC is located in Leeds Massachusetts and offers inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Central Western Massachusetts VAMC had an inpatient mental health ADC of 21.0⁴⁸, an RRTP ADC of 13.7, and a CLC ADC of 28.0.

The Central Western Massachusetts VAMC was built in 1923 on 105.0 acres and does not meet current design standards. FCA deficiencies are approximately \$121.0M and annual operations and maintenance costs are an estimated \$7.5M.

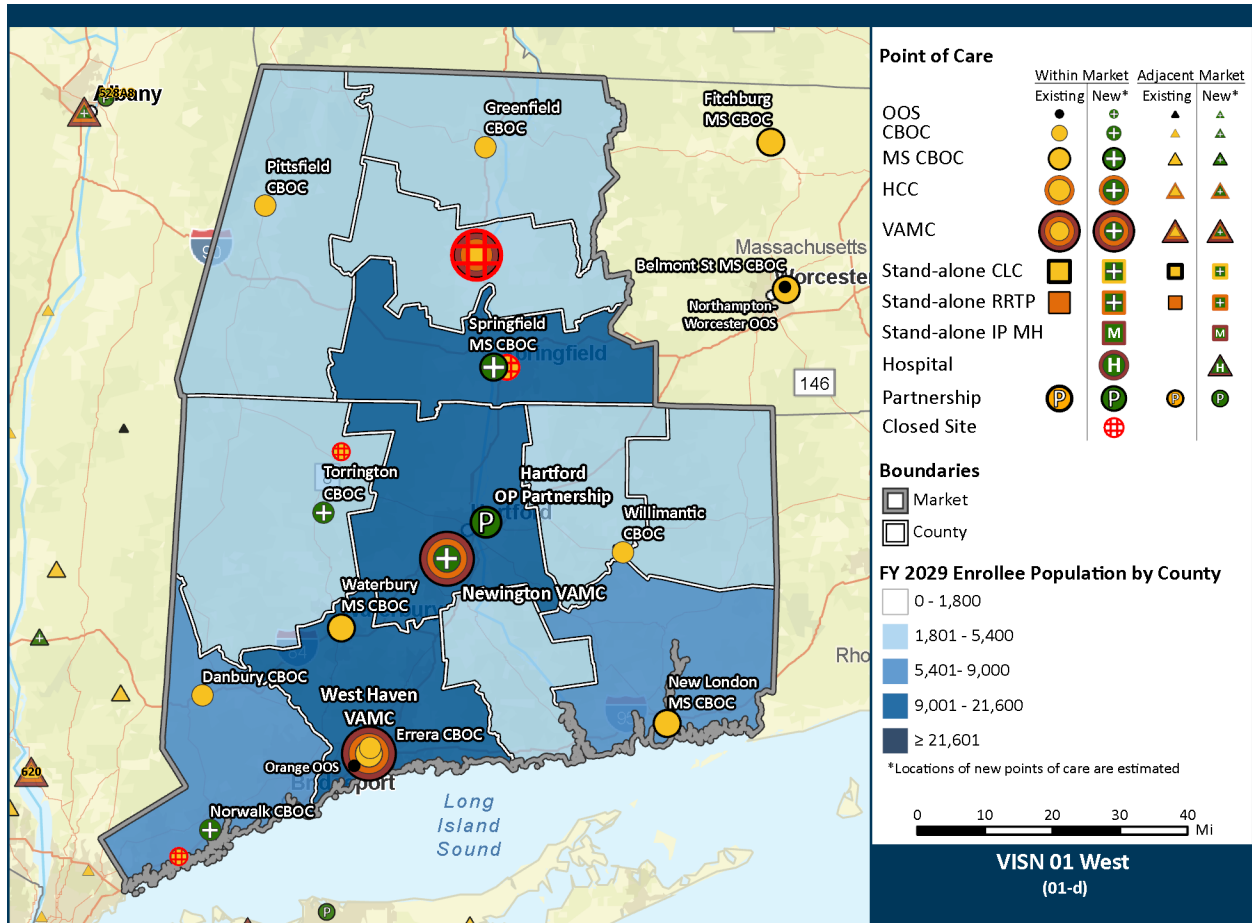
⁴⁷ Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

⁴⁸ Inpatient mental health ADC is based on the EHCPM, not Managerial Cost Accounting Office (MCAO) Discharge Cube data, because some RRTP bed days of care are included in the MCAO data set.

Recommendation and Justification

This section details the VISN 01 West Market recommendation and justification for each element of the recommendation.

Future Market Map



1. Modernize and realign Central Western Massachusetts VAMC by:

- 1.1. Relocating CLC, RRTP, and outpatient services currently provided at the Central Western Massachusetts VAMC to current or future VA facilities and discontinuing those services at the Central Western Massachusetts VAMC: There are significant facilities maintenance issues, investment requirements, and architectural and engineering challenges at the existing Central Western Massachusetts VAMC, built in 1923. The physical layout of the buildings creates inefficiencies that are impacting clinical, administrative, and facility support services. Relocation of services from the Central Western Massachusetts VAMC is based on moving outpatient services to the Springfield MS CBOC and distributing RRTP and CLC services to the Newington MS CBOC campus. This relocates the care to sustainable locations, which are closer to larger concentrations of the Veteran population within the market. In FY 2019, there were 48,183 enrollees within 60 minutes of the Springfield MS CBOC, and 67,180 within 60 minutes of the

Newington MS CBOC. There were 28,049 enrollees within 60 minutes of the Central Western Massachusetts VAMC.

- 1.2. Establishing a strategic collaboration to provide inpatient mental health services and discontinuing those services at the Central Western Massachusetts VAMC. If unable to enter into a strategic collaboration, utilize community providers:** In FY 2019, the Central Western Massachusetts VAMC had an inpatient mental health ADC of 21.0 and is projected to decrease to 4.9 by FY 2029. A strategic collaboration with an academic affiliate will maintain access for Veterans and improve system sustainability. If the VAMC is unable to enter into a strategic collaboration for inpatient mental health services, community providers have adequate capacity to absorb Veteran demand. As of 2019, community providers within a 60-minute drive time of the Central Western Massachusetts VAMC had an inpatient mental health occupancy rate of 73.2% (35 available beds). The West Haven VAMC will maintain its inpatient mental health services.
- 1.3. Relocating urgent care services to community providers and discontinuing those services at the Central Western Massachusetts VAMC:** Urgent care volumes have been declining at the Central Western Massachusetts VAMC, with 5,543 encounters in FY 2019, lower than what is needed to sustain that service. There are two community urgent care centers within seven minutes of the VAMC, with capacity to absorb the additional workload.
- 1.4. Closing the Central Western Massachusetts VAMC:** Distributing services to more modern and conveniently located facilities for Veterans will allow for closure of the existing VAMC.

2. Modernize and realign the West Haven VAMC by:

- 2.1. Relocating CLC and RRTP services currently provided at the West Haven VAMC to current or future VA facilities and discontinuing those services at the West Haven VAMC:** The West Haven VAMC's CLC and RRTP infrastructure is aging and not properly configured for modern care. Patient rooms are multiple-occupancy and bathrooms are shared. The Newington MS CBOC is well-positioned for major enrollee population densities and is easily accessible from nearby highways. The campus has room for a new CLC and RRTP. Consolidating CLC and RRTP beds at the Newington MS CBOC campus provides a modern health care setting, improves access to services, and decreases redundancy of staffing and support services.
- 2.2. Modernizing the West Haven VAMC:** At the West Haven VAMC, the main hospital was constructed in 1955 and the existing building is not conducive to providing care in a modern environment. The infrastructure is undersized to meet demand, has shared patient rooms accessed from public corridors, and has an inefficient layout with long narrow ward hallways with poor sight lines. Modernizing by constructing new inpatient acute care space at the West Haven VAMC campus will consolidate clinical and ancillary functions and convert to private rooms. This will ensure all inpatient medical and surgical, inpatient mental health, and blind rehabilitation beds are appropriately sized and seismically supported, improving patient experience, safety, and care delivery. The West Haven VAMC has a projected inpatient medical and surgical ADC of 30.5, inpatient mental health ADC of 13.1, and blind rehabilitation ADC of 11.1 in FY 2029.

3. **Modernize and realign the Newington MS CBOC by:**

- 3.1. Establishing a new CLC at the existing Newington MS CBOC:** Establishing CLC capacity at the Newington MS CBOC will allow the facility to appropriately absorb CLC services that are being relocated from West Haven VAMC and Central Western Massachusetts VAMC. The Newington MS CBOC is well-positioned for major enrollee population densities and accessible from nearby highways. The facility is located on a 49-acre campus that has enough space to accommodate a CLC sized to meet demand. The West Market's projected FY 2029 inpatient long-term services and supports (LTSS) ADC is 362.6. This may result in its reclassification as a VAMC.
- 3.2. Establishing a new RRTP at the existing Newington MS CBOC:** Establishing RRTP capacity at the Newington MS CBOC will allow the facility to appropriately absorb RRTP services that are being relocated from the West Haven VAMC and Central Western Massachusetts VAMC. The Newington MS CBOC is well-positioned for major enrollee population densities and accessible from nearby highways. The facility is located on a 49-acre campus that has enough space to accommodate an RRTP sized to meet demand. The West Market's projected FY 2028 RRTP ADC is 71.4. This may result in its reclassification as a VAMC.

4. **Modernize and realign outpatient facilities in the market by:**

- 4.1. Relocating the Winsted CBOC to a new site in the vicinity of Torrington, Connecticut, and closing the existing Winsted CBOC:** The newly relocated point of care in the vicinity of Torrington, Connecticut, will expand access to primary care and outpatient mental health services in Litchfield County. In FY 2019, there were 1,758 core uniques⁴⁹ at the Winsted CBOC. In FY 2019, there were 3,359 enrollees within 30 minutes of the Winsted CBOC and 7,632 enrollees within 30 minutes of the proposed site in the Torrington, Connecticut, area.
- 4.2. Relocating the Stamford CBOC to a new site in the vicinity of Norwalk, Connecticut, and closing the existing Stamford CBOC:** The newly relocated point of care in the vicinity of Norwalk, Connecticut, will expand access to primary care and outpatient mental health services in Fairfield County. In FY 2019, there were 1,562 core uniques at the Stamford CBOC. In FY 2019, there were 6,046 enrollees within 30 minutes of the Stamford CBOC and 7,101 enrollees within 30 minutes of the proposed site in the Norwalk, Connecticut, area.
- 4.3. Relocating the Springfield MS CBOC to a new site in the vicinity of Springfield, Massachusetts, and closing the existing Springfield MS CBOC:** The existing MS CBOC location is not convenient to main thoroughfares or public transportation. The newly relocated point of care, located directly adjacent to I-90 and I-91, will improve access for Veterans living in Hampden County and the surrounding western Massachusetts area. In FY 2019, there were 16,383 enrollees within 30 minutes and 48,183 enrollees within 60 minutes of the proposed site.

⁴⁹ VA core unique patients exclude Veterans who have only used VA telephone triage, pharmacy, and laboratory services.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

West Market

- **Relocate leadership at the Central Western Massachusetts VAMC to the new relocated Springfield MS CBOC:** With the proposed closure of the Central Western Massachusetts VAMC, the Springfield MS CBOC provides a central location for leadership functions. The two points of care are approximately 29 minutes from each other.

Central Western Massachusetts VAMC

- **Expand specialty care services at the Fitchburg CBOC, which may result in classification of facility as an MS CBOC:** In FY 2019, there were 6,737 enrollees within 30 minutes and 44,437 enrollees within 60 minutes of the Fitchburg CBOC. Adding high-volume low-complexity outpatient services will improve Veteran access to care in the Fitchburg area. Market demand for outpatient specialty care is projected to increase by 48.2% between FY 2019 and FY 2029.
- **Expand Home Based Primary Care (HBPC) services at the Pittsfield CBOC:** In FY 2019, 56.4% of Veteran enrollees in the West Market were at least 65 years old. The Pittsfield CBOC is in rural Berkshire County. Expanding HBPC will allow health care teams to better serve Veterans with mobility and other issues that are barriers to accessing care.
- **Expand relationship with UMass by initiating joint appointment provider positions, establishing sharing relationships, and establishing new graduate medical education (GME) slots in Worcester and with Baystate/UMass campus in Springfield, MA:** UMass Medical School is 1.2 miles from the existing Belmont St. MS CBOC, and the new UMass Medical School-Baystate Campus is 1.5 miles from the existing Springfield MS CBOC. Proximity to these academic affiliates will help alleviate challenges with the recruitment and retention of providers.
- **Relocate the research program currently at the Central Western Massachusetts VAMC to alternative facilities within the VISN, such as the Springfield MS CBOC, Belmont St. MS CBOC, West Roxbury VAMC:** With the closure of the Central Western Massachusetts VAMC, other facilities in the market will provide space for its relocated research programs. The Office of Research and Development will be consulted to identify the most optimal location.

West Haven VAMC

- **Expand specialty care services at the Waterbury CBOC, which may result in classification of facility as an MS CBOC:** In FY 2019, there were 18,473 enrollees within 30 minutes and 55,376 enrollees within 60 minutes of the Waterbury CBOC. Expanding optometry, physical therapy, audiology, podiatry, women's health, and outpatient mental health services at this point of care will improve access for Veterans living in New Haven County and decongest the West Haven VAMC.
- **Expand specialty care services at the New London CBOC, which may result in classification of facility as an MS CBOC:** In FY 2019, there were 8,450 enrollees within 30 minutes and 39,116

enrollees within 60 minutes of the New London CBOC. Expanding optometry, physical therapy, audiology, podiatry, women’s health, and outpatient mental health services at this point of care will improve access for Veterans living in New London County and decongest the West Haven VAMC.

- **Expand outpatient specialty offerings at the Newington MS CBOC to improve access and strengthen partnership with the University of Connecticut (UConn):** The Newington MS CBOC is approximately 8 miles from the UConn School of Medicine in Farmington, Connecticut, and in FY 2019 there were 67,180 enrollees within 60 minutes. A stronger partnership improves recruitment and increases opportunities for VA-delivered care.
- **Establish a strategic collaboration to add outpatient surgical and endoscopy services in the vicinity of Hartford, Connecticut. If unable to enter into a strategic collaboration, continue to utilize community providers:** Creating a strategic collaboration through a sharing arrangement allows VA to supplement its capabilities with outpatient surgical and endoscopy services in the Hartford, Connecticut, area. This arrangement allows VA providers to deliver outpatient surgical and endoscopy services to Veterans living in the Hartford area. In FY 2019, there were 17,417 enrollees in Hartford County. Hartford, Connecticut, is approximately 42 minutes from the West Haven VAMC.
- **Establish strategic collaborations with appropriate Federally Qualified Health Centers (FQHCs) and community providers in Putnam (Windham County), Stafford Springs (Tolland County), and Sharon (Litchfield County) Hospital Service Areas to improve primary care and outpatient mental health access for rural Veteran population:** These areas are outside the 30-minute drive time radius to a VA point of care but lack sufficient population to establish a VA point of care. The closest VA point of care for Veterans living in Putnam is the Willimantic CBOC, 43 minutes away. The closest VA point of care for Veterans living in Stafford Springs is the Springfield MS CBOC, 36 minutes away. The closest VA point of care for Veterans living in Sharon is the Winstead CBOC, 45 minutes away. There are several FQHCs that are closer than the VA points of care. Partnerships will improve access to care for Veterans.
- **Establish a residency program with the UConn School of Medicine and the Newington MS CBOC in Hartford, Connecticut (Hartford County), to develop a pipeline for physicians and surgeons:** Expanding partnerships with UConn in Hartford, Connecticut, will improve recruitment and allow for staffing flexibility. Shared VA/affiliate physicians can hold clinics at the Newington MS CBOC and perform outpatient surgeries and procedures in the local affiliated community hospital.
- **Align the leadership team at the Newington MS CBOC to continue to report to the West Haven VAMC:** Currently, the leadership team at the Newington MS CBOC reports to the West Haven VAMC. If the Newington MS CBOC is reclassified as a VAMC, VA recommends keeping the existing administrative structure to avoid the expense of additional administrative staff.

- **At the Newington MS CBOC, relocate Veterans Benefits Administration (VBA) and Community Care functions to vacant areas of VA land to free up space for clinical services in new addition:** VBA is currently located on the third and fourth floor of the new clinic addition at the Newington MS CBOC. This area would be ideal for the expansion of primary and specialty care services. There are vacant spaces in several buildings on campus which could be re-purposed to support VBA.
- **Establish utilization management standards for the use of physical medicine and rehabilitation services within Community Care:** Physical therapy has had one of the largest increases in Veterans Community Care Program (VCCP) authorizations, and demand for outpatient rehabilitation therapy is projected to increase 75.8% between FY 2019 and FY 2029. Providing care coordination and utilization management will improve access and continuity of care for Veterans and reduce VCCP costs.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 01 West Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost⁵⁰ over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs includes direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

⁵⁰ The present value cost is the current value of future costs discounted at the defined discount rate.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 01 West Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 01 West Market	Status Quo	Modernization	VA Recommendation
Total Cost	\$23,539,147,658	\$24,273,363,301	\$24,496,690,934
Capital Cost	\$2,556,802,691	\$3,291,018,334	\$3,845,914,625
Operational Cost	\$20,982,344,967	\$20,982,344,967	\$20,650,776,309
Total Benefit Score	7	10	11
CBI (normalized in \$B)	3.36	2.43	2.23

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 17 VA points of care offering outpatient services, including the proposed new Norwalk, Connecticut CBOC; Torrington, Connecticut CBOC; Hartford, Connecticut partnership; the proposed replacement Springfield, Massachusetts MS CBOC; and the proposed expanded New London, Connecticut MS CBOC; Fitchburg, Massachusetts MS CBOC; and Waterbury, Connecticut MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed expanded Newington, Connecticut VAMC, as well as community nursing home.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the West Roxbury, Massachusetts and Brockton, Massachusetts VAMCs.
- **RRTP:** RRTP demand will be met through the proposed new Newington, Connecticut VAMC and the other facilities within VISN 01 offering RRTP, including the Brockton, Massachusetts VAMC and White River Junction, Vermont VAMC; proposed replacement Bedford, Massachusetts VAMC; and proposed new RRTPs at the Providence, Rhode Island VAMC; Togus, Maine VAMC; and Manchester, New Hampshire VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the West Haven, Connecticut VAMC and other facilities in the Northeast Region, including the proposed new King of Prussia, Pennsylvania VAMC (VISN 04) and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the West Haven, Connecticut VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 73,190 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 73,208 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 01. The recommendation allows for continued relationships with key academic partners, including but not limited to, affiliations with Yale University, University of Massachusetts, and the University of Connecticut.
- **Research:** This recommendation maintains the research mission in the market by maintaining the research program at the West Haven, Connecticut VAMC and relocating the research program at the Central Western Massachusetts VAMC to other facilities within the VISN, such as the Springfield, Massachusetts MS CBOC; the Belmont St MS CBOC; the West Roxbury, Massachusetts VAMC; or other facilities within the market as applicable.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the West Haven, Connecticut; and Central Western Massachusetts, Massachusetts VAMCs are not designated as Primary Receiving Centers.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Norwalk, Connecticut CBOC; Torrington, Connecticut CBOC; Hartford, Connecticut partnership; and proposed replacement Springfield, Massachusetts MS CBOC; as well as the proposed modernization and expansion of the Newington, Connecticut VAMC to absorb CLC and RRTP services from West Haven and Central Western Massachusetts VAMCs. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (2.23 for VA Recommendation versus 3.36 for Status Quo), indicating that VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Norwalk, Connecticut CBOC; Torrington, Connecticut CBOC; Hartford, Connecticut partnership; and proposed replacement Springfield, Massachusetts MS CBOC; as well as the proposed modernization and expansion of the Newington, Connecticut VAMC to absorb CLC and RRTP services from the West Haven and Central Western Massachusetts VAMCs. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in a community partner space.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today (\$24.5B for VA Recommendation versus \$24.3B for Modernization), there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (2.23 for VA Recommendation versus 2.43 for Modernization), reflecting effective stewardship of taxpayer dollars.