VA Recommendations to the

# ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022

# VISN 12

Market Recommendations

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# VISN 12 Central Market

The Veterans Integrated Service Network (VISN) 12 Central Market serves Veterans in southern and eastern Wisconsin. 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 Central Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 12's Central 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 enrollee population in the Central Market is projected to decrease between fiscal year (FY) 2019 and FY 2029. While demand for inpatient medical and surgical services and inpatient mental health services is projected to decrease, demand for long-term care and outpatient services is projected to increase. There is a need to invest in new outpatient facilities to meet the existing and projected Veteran demand, as well as modernize facilities to meet current design standards. The strategy for the market is intended to provide Veterans 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 considers 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 and establishes three new community-based outpatient clinics (CBOCs). Additionally, one multi-specialty community-based outpatient clinic (MS CBOC) will be relocated to an area more proximate to where Veteran enrollees live. Outpatient services will also be

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

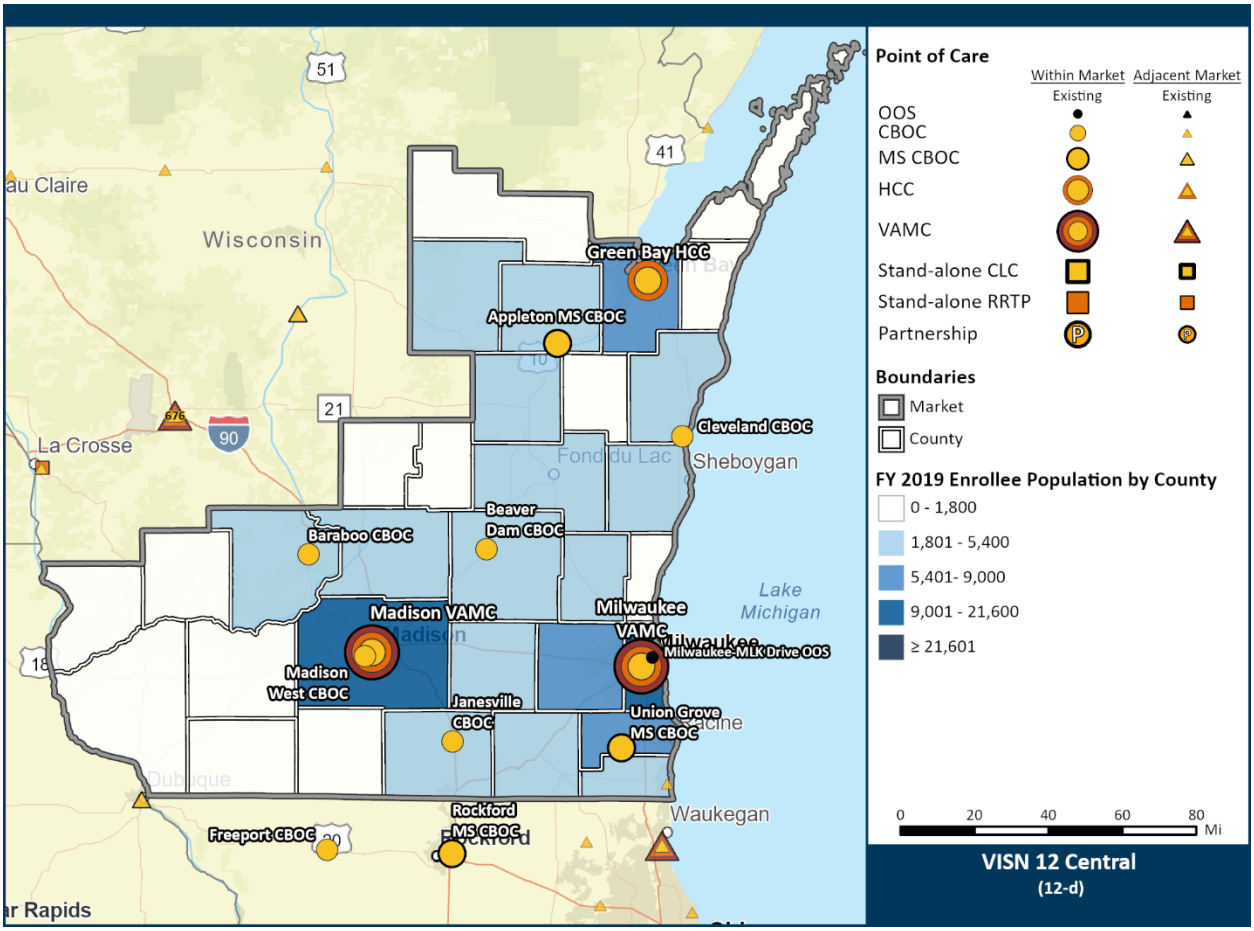
provided through the Madison VAMC, Green Bay Health Care Center (HCC), and a new, modern clinical facility at the Milwaukee VAMC.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a modern community living center (CLC) facility at the Milwaukee VAMC to maintain care for Veterans with the most complex needs and maintains inpatient mental health and residential rehabilitation treatment program (RRTP) services at both the Madison and Milwaukee VAMCs. Inpatient spinal cord injuries and disorders (SCI/D) and rehabilitation medicine services will be maintained at the Milwaukee VAMC. Demand for inpatient blind rehabilitation services will be met through the Hines VAMC in Hines, Illinois.
- **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 a replacement main clinical facility at the Milwaukee VAMC that will include inpatient medical and surgical services and best meet design standards for delivering modern health care. Inpatient medical and surgical services will also be maintained at the Madison VAMC.

# Market Overview

The market overview includes a map of the Central 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.

**Enrollees:** In FY 2019, the market had 106,642 enrollees and is projected to experience an 8.9% decrease in enrolled Veterans by FY 2029. The largest enrollee populations within the market reside in the counties of Milwaukee, Dane, and Waukesha, Wisconsin.

**Demand:** Demand[2] in the market for inpatient medical and surgical services is projected to decrease by 3.4% and demand for inpatient mental health services is projected to decrease by 11.8% through FY 2029. Demand for long-term care[3] is projected to increase by 42.9%. Demand for all outpatient

[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.

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

**Rurality:** 34.8% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

**Access:** 77.4% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 87.9% of enrollees live within a 60-minute drive time of a VA secondary care site.

**Community Capacity:** As of 2019, community providers[5] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[6] of 59.7% (1,994 available beds) [7] and an inpatient mental health occupancy rate of 64.0% (21 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 76.5% (782 available beds). Community residential rehabilitation programs[8] 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 Wisconsin and the Medical College of Wisconsin. The Madison VAMC is ranked 37 out of 154 VA training sites based on the number of trainees, and the Milwaukee VAMC is ranked 11 out of 154. The Madison VAMC ranks 33 out of 103 VAMCs with research funding and the Milwaukee VAMC is ranked 36 out of 103. Neither VAMC holds an emergency designation.[9]

## Facility Overviews

**Madison VAMC:** The Madison VAMC is located in Madison, Wisconsin, and offers inpatient medical and surgical, inpatient mental health, CLC, and outpatient services. In FY 2019, the Madison VAMC had an inpatient medical and surgical average daily census (ADC) of 60.7, an inpatient mental health ADC of 9.4, and a CLC ADC of 21.4.

The Madison VAMC was built in 1951 on 20.0 acres, with the most recent renovations to the main hospital building completed in 1992. Facility condition assessment (FCA) deficiencies are approximately $73.3M, and annual operations and maintenance costs are an estimated $10.0M.

**Milwaukee VAMC:** The Milwaukee VAMC is located in Milwaukee, Wisconsin, and offers inpatient medical and surgical, inpatient mental health, SCI/D, rehabilitation medicine, CLC, RRTP, and outpatient services. In FY 2019, the Milwaukee VAMC had an inpatient medical and surgical ADC of 85.4, an inpatient mental health ADC of 18.2, a SCI/D ADC of 19.0, a rehabilitation medicine ADC of 7.2, a CLC ADC of 92.0, and an RRTP ADC of 103.1.

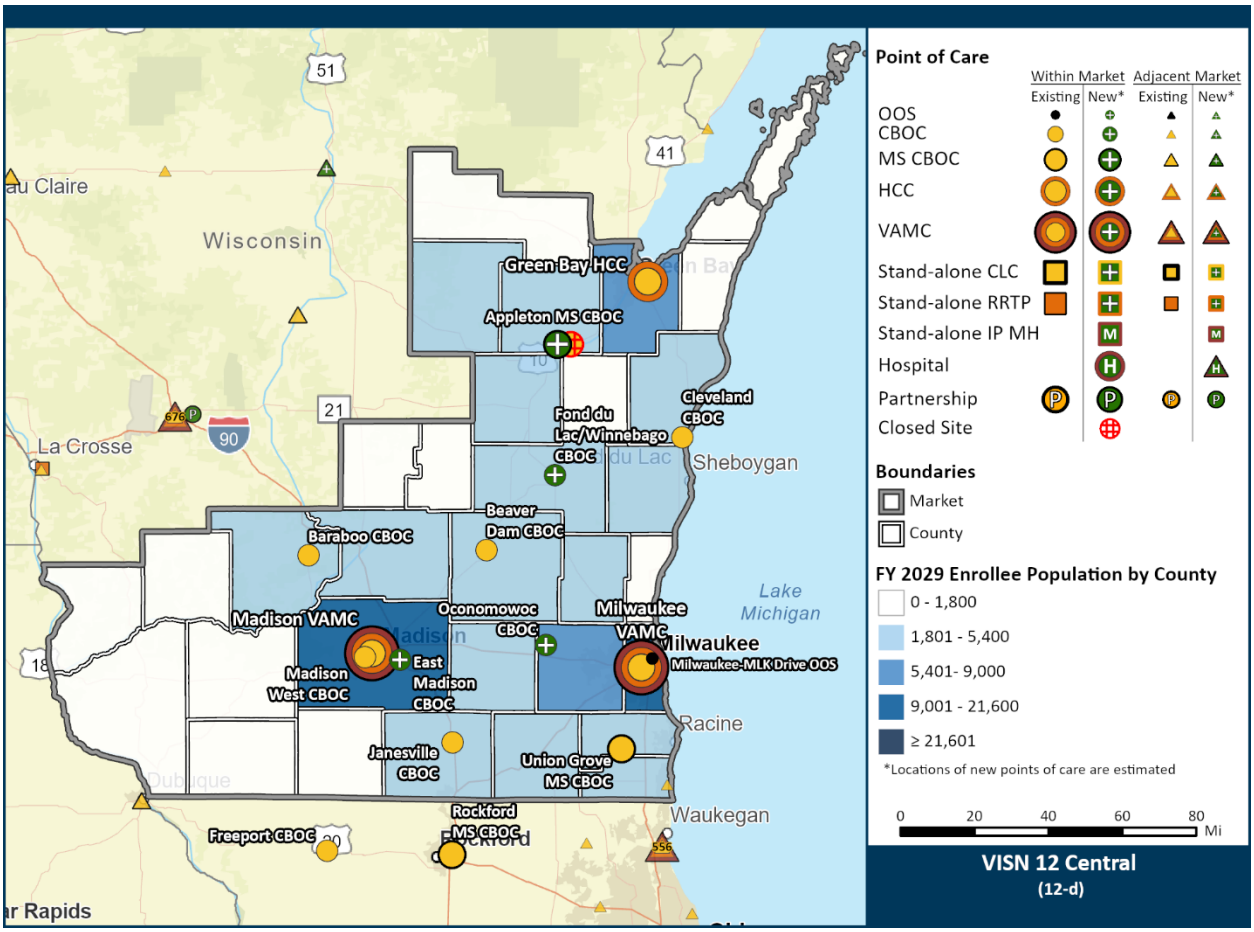
[4] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[5] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[6] Occupancy rates are calculated by dividing the total average daily census (ADC) 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.

The Milwaukee VAMC was built in 1965 on 198.0 acres, with the most recent renovations to the main hospital building completed in 2019. FCA deficiencies are approximately $297.3M, and annual operations and maintenance costs are an estimated $23.5M.

# Recommendation and Justification

This section details the VISN 12 Central Market recommendation and justification for each element of the recommendation.

## Future Market Map




**1.1. Modernizing the operating rooms at the Milwaukee VAMC:** The operating rooms at the Milwaukee VAMC do not meet current design standards[10] for modern health care. Construction of a hybrid operating room in the short term will increase surgical services complexity and advance tertiary capabilities of the Milwaukee VAMC. Modernization in the surgical suite will

[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, columns 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.

improve the care of the Veterans at the existing facility and increase access for Veterans to VA-provided, complex care.

1.2. **Modernizing the CLC at the Milwaukee VAMC:** The Milwaukee VAMC has three small house model CLCs on campus. Additionally, there are 65 CLC beds located in the main hospital building (Building 111) which do not meet current design standards for modern health care. Relocating the beds from the main hospital building to small house model CLCs will improve safety provisions and the environment of long-term Veteran care. In FY 2019, the Milwaukee CLC had 113 beds with an ADC of 92.0, and it is projected to increase to 104.0 by FY 2029. The modernized CLC will maintain CLC beds at 113.

1.3. **Constructing a new main clinical facility at the Milwaukee VAMC and relocating inpatient and outpatient services from the existing main clinical facility to the new replacement facility:** In FY 2019, the Milwaukee VAMC had an inpatient medical and surgical ADC of 85.4. ADC is projected to decrease to 83.2 by FY 2029. The main hospital building (Building 111) was built in 1965 and has FCA deficiencies of $144.5M. The old hospital building (Building 70) was built in 1922 and has FCA deficiencies of $59.9M. The main hospital building requires utility and electrical updates to continue to provide modern health care. By building a new, modernized main clinical facility on the existing campus and combining the services offered in buildings 111 and 70, VA's recommendation will resolve these issues while improving the environment of care at the VAMC.

2. ***Modernize and realign the Madison VAMC by modernizing the emergency department (ED) at the Madison VAMC:*** The ED at the Madison VAMC is limited in space and not optimally structured to meet workflow demand. Hallways are used for patient overflow and the current layout leads to inefficiencies between ED and fast track. Adding observation beds to the Madison VAMC's ED will enable the medical staff to decrease the number of potentially unnecessary admissions while improving Veteran patient satisfaction.

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

3.1. **Establishing a new CBOC in the vicinity of East Madison, Wisconsin**: A new CBOC in the vicinity of East Madison, Wisconsin (Dane County) will improve access to primary care and outpatient mental health services. In FY 2019, there were 9,506 Veteran enrollees within a 30-minute drive time of the proposed site. Dane County is projected to have an FY 2029 population of more than 9,700 Veteran enrollees. The new site of care will provide Veterans with an additional access point proximate to the city and allow VA to shift a portion of outpatient demand from the Madison VAMC.

3.2. **Establishing a new CBOC in the vicinity of Fond du Lac, Wisconsin:** There is currently no VA site of care within a 30-minute drive time of Fond du Lac, Wisconsin. A new CBOC in the vicinity of Fond du Lac, Wisconsin (Fond du Lac County) will improve access to primary care and outpatient mental health services. In FY 2019, there were 4,646 Veteran enrollees within a 30-minute drive time of the proposed site. Fond du Lac County is projected to have an FY 2029 population of more than 2,200 Veteran enrollees.

3.3. **Relocating the Appleton MS CBOC to a new site in the vicinity of Appleton, Wisconsin and closing the existing Appleton MS CBOC:** Shifting facility placement to a better market location

and larger site in the vicinity of Appleton, Wisconsin (Outagamie County) will allow for an integrated facility, combining the current Appleton MS CBOC and the Appleton site of care (SOC) Annex. The new site will provide improved access to primary care, outpatient mental health, and specialty care services for 11,749 Veteran enrollees within a 30-minute drive time and 28,086 Veteran enrollees within a 60-minute drive time of the proposed site.

# 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:

## Central Market

- **Realign market boundaries of the Central and Northern markets to reflect the north/south referral patterns between the Tomah VAMC and Madison VAMC areas and the Iron Mountain VAMC and Milwaukee VAMC areas:** The Madison and Milwaukee VAMCs of the Central Market, which are tertiary medical facilities, and the Tomah and Iron Mountain VAMCs of the Northern Market, closely collaborate across market boundaries. The VISN is currently in the process of realigning the Northern and Central markets into four individual markets. Realigning market boundaries will reflect Veteran referral patterns as well as offer administrative efficiencies through streamlined budget decision making and better financial resource allocation for inpatient and outpatient care.
- **Seek partnerships with federally qualified health center (FQHC) facilities in the submarket west of the Madison VAMC to provide services in this highly rural area:** Highly rural counties and areas in the Central Market that are not proximate to VA primary and secondary care facilities will benefit from partnerships with FQHCs, addressing service gaps and reducing travel burden for Veterans.

## Madison VAMC

- **Expand home-based primary care (HBPC) coverage to the Rockford MS CBOC, Freeport CBOC, and Janesville CBOC:** The expansion of the HBPC program will benefit Veterans by decreasing Veteran travel requirements to receive care, reducing overall readmission rates, and reducing ambulatory care sensitive condition hospitalizations. The HBPC program will also contribute to shorter length of stay of required admissions, leading to improved quality of care and patient satisfaction for Veterans.
- **Develop a Facility Master Plan for the Madison VAMC:** The Madison VAMC campus dates to 1951, has no additional acreage on campus for expansion, and shares a physical connection with the main affiliate, the University of Wisconsin. This plan will address physical adjacencies between inpatient (inpatient medical and surgical, inpatient mental health, CLC, and RRTP), outpatient, and support, including Sterile Processing Services, imaging, and pharmacy services. The plan will also incorporate a programmatic emphasis on strengthening tertiary services, including transplant services, in conjunction with the University of Wisconsin.

- **Improve inpatient medical and surgical and inpatient mental health bed availability by identifying distinct bed or service location to support detox patients, including building appropriate transition of care protocols:** In FY 2019, the Madison VAMC had a total of 87 inpatient medical and surgical and mental health operating beds with a total ADC of 70.1. Of the total inpatient operating beds in FY 2019, mental health had 14 beds with an ADC of 9.4. Having distinct detoxification beds will ensure that these inpatient medical and surgical and mental health beds are available and staffed appropriately for appropriate patient populations.

## Milwaukee VAMC

- **Increase the complexity level of the Green Bay HCC from an ambulatory basic to an ambulatory advanced designation to allow the expansion of the surgical services program:** Surgical demand in the Central Market is projected to increase over the next 10 years. The Green Bay HCC opened in 2013 and currently operates at an ambulatory basic designation. The expansion of the surgical services program will allow additional, more complex surgical procedures to be performed under the higher designation, improving VA's ability to recruit and retain providers and increase access to ambulatory procedures for Veterans.
- **Decompress primary care services from the Milwaukee VAMC to other Milwaukee-area outpatient sites including the planned new Oconomowoc CBOC:** The Milwaukee VAMC is near or at capacity for its primary care patient aligned care teams (PACT) space. Relocating a portion of primary care services off campus will decompress the Milwaukee VAMC and increase access for Veterans closer to Veteran population centers. Efforts to establish the new Oconomowoc CBOC are underway.
- **Expand open access schedule slots for primary care and extend hours to provide urgent care services at the Green Bay HCC:** The Green Bay HCC does not currently provide urgent care services. Expanding open access schedule slots for primary care and extending hours will increase access for Veterans in need of same day services.
- **Integrate nurse practitioner-driven, physician-integrated, primary care PACT team model at Green Bay HCC:** Integrating nurse practitioners in the primary care PACT team model will allow clinicians to work at the top of their licensure, maximizing ability to impact and coordinate a large patient panel. This will improve VA's ability to recruit and retain providers and positively impact overall hospitalization, readmission rates, and quality of care.
- **Add additional women's health services to the Milwaukee VAMC:** With approximately 8,281 women Veterans enrolled in the market in FY 2019, and a projected increase of 26.1% in FY 2029, VA will expand services to meet the needs of women Veterans.
- **Develop a Facility Master Plan for the Milwaukee VAMC:** The Milwaukee VAMC campus dates to 1965 and has FCA deficiencies of $297.3M spread across a large 198-acre campus. Alongside the proposed replacement of the main hospital buildings, developing a Facility Master Plan will address consolidating services into a limited number of contemporary buildings and consider the future of historical, outdated, and non-essential buildings and infrastructure contributing to overall FCA deficiencies.

- **Reduce the RRTP capacity at the Milwaukee VAMC to align with demand:** The Milwaukee VAMC has 125 RRTP beds, with an FY 2019 ADC of 103.1**.** The Central Market is projected to have an RRTP bed need of 80 by FY 2028. The number of beds at the Milwaukee RRTP will be reduced based on the projected demand and allocation of beds across the Central Market. This change will require the Milwaukee VAMC to decrease the number of RRTP beds from 125 to 78.

# Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 12 Central 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 cost[11] 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 12 Central Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

| VISN 12 Central Market | Status Quo | Modernization | VA Recommendation |
|---|---|---|---|
| **Total Cost** | $30,632,887,633 | $32,659,489,427 | $32,829,103,804 |
| Capital Cost | $2,442,218,534 | $4,468,820,328 | $4,638,434,706 |
| Operational Cost | $28,190,669,098 | $28,190,669,098 | $28,190,669,098 |
| **Total Benefit Score** | 8 | 11 | 13 |
| **CBI (normalized in $B)** | **3.83** | **2.97** | **2.53** |

**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.

[11] 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 16 VA points of care offering outpatient services, including the proposed new East Madison, Wisconsin CBOC; Fond du Lac/Winnebago, Wisconsin CBOC; planned Oconomowoc, Wisconsin CBOC; and proposed relocated Appleton, Wisconsin MS CBOC; as well as community providers in the market.
- **CLC**: Long-term care demand will be met through the Madison, Wisconsin VAMC and the Milwaukee, Wisconsin 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 Milwaukee, Wisconsin VAMC.
- **RRTP:** RRTP demand will be met through the Milwaukee, Wisconsin VAMC; and other facilities within VISN 12 offering RRTP, including the Danville, Illinois VAMC; Tomah, Wisconsin VAMC; Captain James A. Lovell Federal Health Care Center (Lovell FHCC) in North Chicago, Illinois; and proposed replacement Hines, Illinois VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the proposed replacement Hines, Illinois VAMC (VISN 12).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Madison, Wisconsin VAMC and the Milwaukee, Wisconsin 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 92,743 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care*:*** Following the 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 92,748 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 12. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with the University of Wisconsin and Medical College of Wisconsin.
- **Research:** This recommendation does not impact the research mission in the market and allows the Madison, Wisconsin and Milwaukee, Wisconsin VAMCs to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Madison, Wisconsin and Milwaukee, Wisconsin 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 East Madison, Wisconsin CBOC and Fond du Lac/Winnebago, Wisconsin CBOC; the planned Oconomowoc, Wisconsin CBOC; the proposed relocated Appleton, Wisconsin MS CBOC; and the proposed replacement of Milwaukee, Wisconsin VAMC Buildings 70 and 111; as well as the modernization of the CLC at the Milwaukee, Wisconsin VAMC and the emergency department at the Madison, Wisconsin 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:** In addition, 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 (2.53 for VA Recommendation versus 3.83 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 East Madison, Wisconsin CBOC and Fond du Lac/Winnebago, Wisconsin CBOC; the planned Oconomowoc, Wisconsin CBOC; the proposed relocated Appleton, Wisconsin MS CBOC; and the proposed replacement of Milwaukee, Wisconsin VAMC Buildings 70 and 111; as well as the modernization of the CLC at the Milwaukee, Wisconsin VAMC and the emergency department beds at the Madison, Wisconsin 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.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today ($32.8B for VA Recommendation versus $32.7B 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 (2.53 for VA Recommendation versus 2.97 for Modernization), reflecting effective stewardship of taxpayer dollars.

# VISN 12 Central Illinois Market

The Veterans Integrated Service Network (VISN) 12 Central Illinois Market serves Veterans in central, northwestern, and eastern Illinois. 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.[12]

## VA's Commitment to Veterans in the Central Illinois Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 12's Central Illinois Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, coordination across 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 ensures that VA can continue 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 sequenced so that facilities or partnerships to which care will be realigned must be fully established before the proposed realignment occurs.

## Market Strategy

The Veteran enrollee population in the Central Illinois market is projected to decrease between fiscal year (FY) 2019 and FY 2029. Demand for inpatient medical and surgical services, inpatient mental health, long-term care, and outpatient services is projected to increase. There is a need to invest in outpatient facilities to meet existing and projected Veteran demand while rightsizing services at the Danville VAMC. The strategy for the market is intended to provide Veterans 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 close to where Veterans live. The recommendation maintains all sustainable points of care in the market and establishes one new multi-specialty community-based outpatient clinic (MS CBOC). Additionally, the recommendation will relocate one community-based outpatient clinic (CBOC) closer to where Veterans live and expand the site to an MS CBOC, add outpatient services at one CBOC and expand the site to an MS CBOC, and add outpatient specialty services to one MS

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

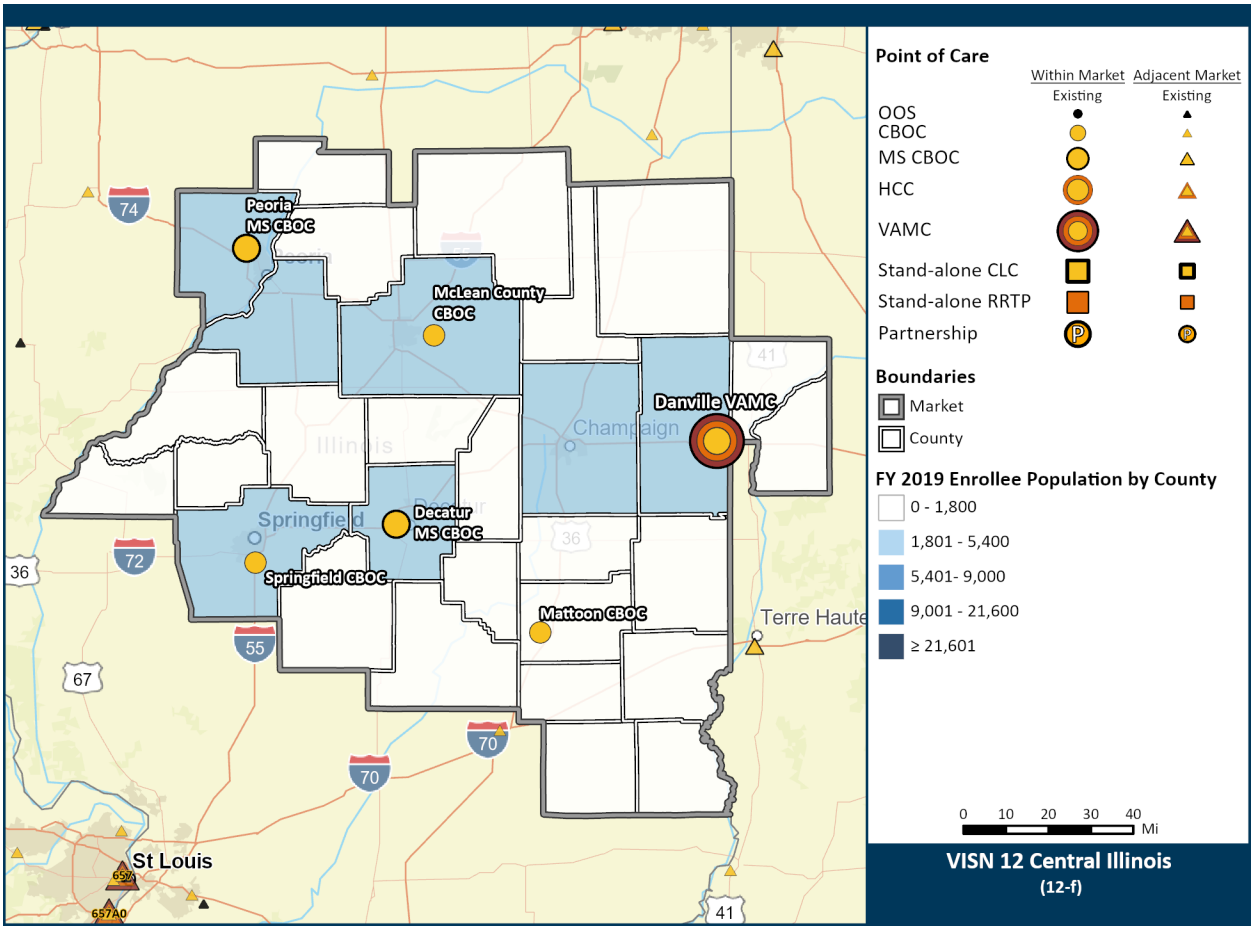
CBOC. Outpatient specialty care services will transition from the Danville VAMC to outpatient sites within the market and a partnership with community providers will be established to provide outpatient surgical services.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation maintains inpatient mental health, community living center (CLC), and residential rehabilitation treatment program (RRTP) services at the Danville VAMC. Demand for inpatient blind rehabilitation and spinal cord injuries and disorders (SCI/D) services will be met through the Hines VAMC in Hines, Illinois.
- **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 establishes a strategic partnership to allow VA providers to deliver inpatient medical services within a partner space. Inpatient surgical services will continue to be provided by community providers.

# Market Overview

The market overview includes a map of the Central Illinois 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 includes one VAMC (Danville), two MS CBOCs, and three CBOCs.

**Enrollees:** In FY 2019, the market had 38,465 enrollees and is projected to experience an 8.3% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Sangamon, Peoria, and Tazewell, Illinois.

**Demand:** Demand[13] in the market for inpatient medical and surgical services is projected to increase by 15.1% and demand for inpatient mental health services is projected to increase by 13.5% through FY 2029. Demand for long-term care[14] is projected to increase by 5.7%. Demand for all outpatient

[13] 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).

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

services[15], including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

**Rurality:** 47.0% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

**Access:** 68.1% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 21.4% of enrollees live within a 60-minute drive time of a VA secondary care site. The Danville VAMC is located in the far eastern portion of the market, away from city centers with larger populations, leading to gaps in service delivery and longer drive times for Veterans to receive care.

**Community Capacity:** As of FY 2019, community providers[16] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[17] of 70.7% (93 available beds)[18] and an inpatient mental health occupancy rate of 48.6% (3 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 82.1% (41 available beds). Community residential rehabilitation[19] programs that match the breadth of services provided by VA are not widely available in the market.

**Mission:** VA has an academic affiliation in the market that include the University of Illinois and Carle Foundation Hospital. The Danville VAMC is ranked 107 out of 154 training sites based on number of trainees and conducts limited or no research. The Danville VAMC holds no emergency designation.[20]

## Facility Overview

**Danville VAMC:** The Danville VAMC is located in Danville, Illinois, and offers inpatient medicine, inpatient mental health care, CLC, RRTP, and outpatient services. In FY 2019, the Danville VAMC had an inpatient medicine average daily census (ADC) of 5.0, an inpatient mental health ADC of 12.0, a CLC ADC of 86.1, and an RRTP ADC of 30.3.

The Danville VAMC was built in 1934 on 216.0 acres, with the most recent renovations to the main hospital building completed in 1981. Facility condition assessment (FCA) deficiencies are approximately $93.5M, and annual operations and maintenance costs are an estimated $11.5M.

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

[16] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

[17] 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.

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

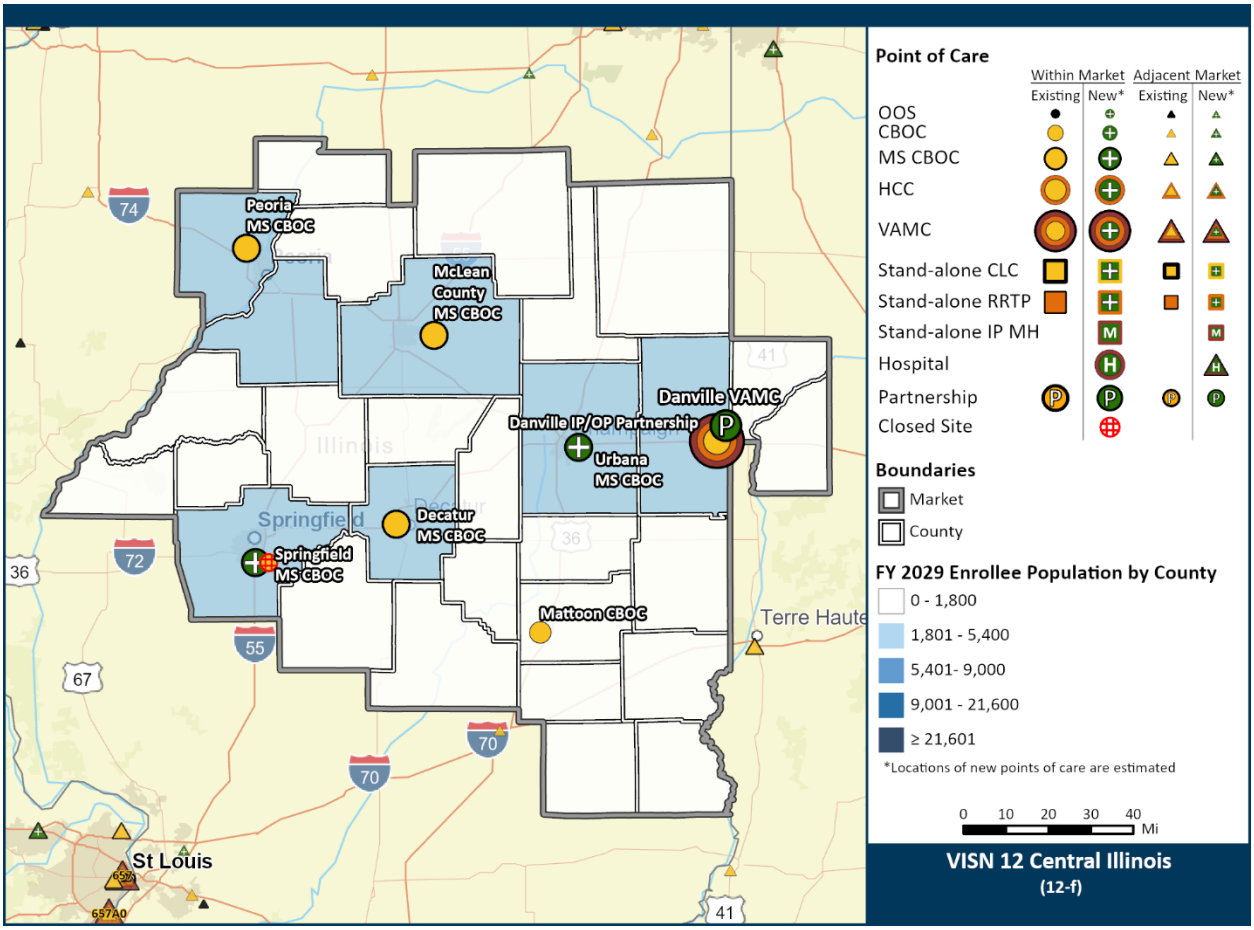
[19] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

[20] 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.

# Recommendation and Justification

This section details the VISN 12 Central Illinois Market recommendation and justification for each element of the recommendation.

## Future Market Map




1. ***Modernize and realign the Danville VAMC by:***

   1.1. **Establishing a strategic collaboration to provide inpatient medical and outpatient surgical services and discontinuing those services at the Danville VAMC. If unable to enter a strategic collaboration for inpatient medical and outpatient surgical services, utilize community providers:** At the Danville VAMC, there is low inpatient medical demand with an FY 2019 ADC of 5.0. Demand is projected to decrease to an ADC of 4.5 by FY 2029. The Danville VAMC had 1,025 outpatient surgical cases in FY 2019. Operating rooms and preparation and recovery areas are provided in facilities over 50 years old with noted physical challenges (e.g., floor to ceiling heights and large beams across surgical service areas). The Danville VAMC is located near the eastern boundary of the market, creating an access burden for enrollees due to significant drive times to the VAMC. To partner, VA will consider establishing a sharing arrangement or lease to deliver inpatient medical and outpatient surgical services currently

offered at the Danville VAMC. This will provide a space that meets current design standards[21] for modern health care, enhance the environment of care for Veterans, and maintain access while minimizing quality risks associated with low patient census and low surgical volumes. There is adequate community capacity for acute inpatient medical and surgical services in the Central Illinois Market. As of FY 2019, community providers within a 60-minute drive time of the Danville VAMC had an acute inpatient medical and surgical occupancy rate of 70.7% (93 available beds). The Danville VAMC will retain inpatient mental health, CLC, RRTP, primary care, outpatient mental health, and urgent care services. Outpatient specialty care services will be relocated to several outpatient clinics in the market.

1.2. **Relocating outpatient specialty care services at the Danville VAMC to current or future VA facilities and discontinuing those services at the Danville VAMC:** The Danville VAMC is located near the eastern boundary of the market, which creates an access burden for enrollees due to significant drive times to the VAMC. Because of this accessibility issue, outpatient specialty care services will transition to the proposed expanded Urbana MS CBOC, the proposed expanded McLean County MS CBOC, and the proposed expanded Springfield MS CBOC, which are all closer to where Veterans in the market reside. The Danville VAMC will continue to provide inpatient mental health, CLC, RRTP, primary care, outpatient mental health, and urgent care services.

2. ***Modernize and realign outpatient facilities in the market by relocating the Springfield CBOC to a new site in the vicinity of Springfield, Illinois, and closing the existing Springfield CBOC:*** Shifting facility placement to a better market location and larger site in the vicinity of Springfield, Illinois (Sangamon County), will increase access to primary care and outpatient mental health services. In FY 2019, there were 5,287 Veteran enrollees within a 30-minute drive time and 13,786 Veteran enrollees within a 60-minute drive time of the proposed site. The facility will include specialty care services, which may result in reclassification of the facility as an MS 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:

## Central Illinois Market

- **Expand the planned Urbana CBOC in Urbana, Illinois (Champaign County), increase capacity to provide primary care and outpatient mental health, and add outpatient specialty care services, which may result in the classification of the facility as an MS CBOC (in progress):** Although the enrollee population of Champaign County is projected to decrease by FY 2029, the planned Urbana MS CBOC has a population of over 3,700 Veteran enrollees within a 30-minute drive time and over 15,400 Veteran enrollees within a 60-minute drive time of the proposed

[21] 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, columns 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.

site. Market demand for primary care, outpatient mental health, and outpatient specialty care services is projected to increase over the next 10 years.

- **Add physical medicine and rehabilitation, audiology, and optometry care services to the McLean County CBOC, which may result in the classification of the facility as an MS CBOC:** Although the enrollee population of McLean County is projected to decrease by FY 2029, the proposed McLean County MS CBOC has a population of over 3,200 Veteran enrollees within a 30-minute drive time and over 16,900 Veteran enrollees within a 60-minute drive time of the existing site. Market demand for physical medicine and rehabilitation, audiology, and optometry services is projected to increase over the next 10 years.
- **Add outpatient specialty services to the Decatur MS CBOC:** Although the enrollee population of Macon County is projected to decrease by FY 2029, the Decatur MS CBOC has a population of over 3,700 Veteran enrollees within a 30-minute drive time and over 16,300 Veteran enrollees within a 60-minute drive time of the existing site. Market demand for outpatient specialty care services is projected to increase over the next 10 years.
- **Expand telehealth services with a focus on chronic disease management:** In FY 2019, 31.9% of enrollees in the Central Illinois Market lived outside of a 30-minute drive time from a VA primary care site, and 78.6% lived outside of a 60-minute drive time from a VA secondary care site. The expansion of telehealth and focus on chronic disease management will provide more accessible care to Veterans and reduce hospital admissions and readmissions, improving quality of care for Veterans.
- **Incorporate Whole Health best practice elements in primary care delivery across CBOC locations:** Incorporating Whole Health best practice elements into delivery of primary care services is an effective method to manage chronic conditions and improve overall quality of life for Veterans.

### Danville VAMC

- **Develop a Facility Master Plan for the Danville VAMC:** The Danville VAMC was built in 1934, with most recent renovations to the main hospital building completed in 1981. Many of the current buildings are not conducive or ideal for the delivery of modern health care. Development of a long-term plan for the campus will allow for infrastructure updates, consolidation of services, and modernization, while maintaining capacity for inpatient mental health, CLC, RRTP, primary care, outpatient mental health, and urgent care services.

## Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COA) for the VISN 12 Central Illinois 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 cost[22] 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 is the preferred COA. The results of the CBA for the VISN 12 Central Illinois Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

| VISN 12 Central Illinois Market | Status Quo | Modernization | VA Recommendation |
|---|---|---|---|
| **Total Cost** | $7,535,470,317 | $7,925,829,680 | $7,772,173,112 |
| Capital Cost | $633,585,546 | $1,023,944,910 | $1,219,465,494 |
| Operational Cost | $6,901,884,770 | $6,901,884,770 | $6,552,707,618 |
| **Total Benefit Score** | 7 | 10 | 15 |
| **CBI (normalized in $B)** | **1.08** | **0.79** | **0.52** |

**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.

[22] 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 seven VA points of care offering outpatient services, including the proposed new Urbana, Illinois MS CBOC; the proposed relocated and expanded Springfield, Illinois, MS CBOC; and the proposed expanded McLean County, Illinois, MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Danville, Illinois 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 proposed replacement Hines, Illinois VAMC.
- **RRTP:** RRTP demand will be met through the Danville, Illinois VAMC, and the other facilities within VISN 12 offering RRTP, including the Milwaukee, Wisconsin VAMC; Tomah, Wisconsin VAMC; Lovell FHCC in North Chicago, Illinois, and proposed replacement Hines, Illinois VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the proposed replacement Hines, Illinois VAMC.
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the proposed new partnership in Danville, Illinois, as well as through community providers. Inpatient mental health demand will be met through the Danville, Illinois 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 34,005 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 34,010 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 12. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with the University of Illinois and Carle Foundation Hospital.
- **Research:** This recommendation does not impact the research mission in the market; the Danville, Illinois VAMC does not have a research program.[23]
- **Emergency preparedness**: This recommendation maintains VA's ability to execute its emergency preparedness mission; the Danville, Illinois VAMC is not designated as a Primary Receiving Center.

[23] Research programs were determined by FY 2021 total VA-funded research dollars per the Research and Development Information System (RDIS).

## 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 Urbana, Illinois MS CBOC and Danville, Illinois inpatient partnership; and proposed relocated and expanded Springfield, Illinois MS CBOC. 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 is a key for both recruiting and retaining quality providers and staff.

## 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 (0.52 for VA Recommendation versus 1.08 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 Urbana, Illinois MS CBOC and Danville, Illinois inpatient partnership; and the proposed relocated and expanded Springfield, Illinois, MS CBOC. 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 partnership also helps VA in recruiting and retaining staff, by embedding providers in 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 ($7.8B for VA Recommendation versus $7.9B 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 (0.52 for VA Recommendation versus 0.79 for Modernization), reflecting effective stewardship of taxpayer dollars.

# VISN 12 Southern Market

The Veterans Integrated Service Network (VISN) 12 Southern Market serves Veterans in northeastern Illinois. 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.[24]

## VA's Commitment to Veterans in the Southern Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 12's Southern 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, coordination across 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 ensures that VA can continue 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 sequenced so that facilities or partnerships to which care will be realigned must be fully established before the proposed realignment occurs.

## Market Strategy

The Veteran enrollee population in the Southern Market is projected to decrease between fiscal year (FY) 2019 and FY 2029. While demand for inpatient medical and surgical services and inpatient mental health is projected to decrease, demand for long-term care and outpatient services is projected to increase. As a result, there is a need to expand access to VA health care to meet the existing and projected Veteran demand and modernize facilities to meet current design standards. The strategy for the market is intended to provide Veterans 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 considers the increased demand for outpatient services in the market and improves access to care by investing in modern facilities close to where Veterans live, including replacing the main clinical facility at the Hines VAMC and developing a new ambulatory care facility on or in the vicinity of the existing Chicago VAMC campus. The recommendation maintains all sustainable outpatient points of care in the market, establishes two new community-based outpatient clinics (CBOCs), and relocates

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

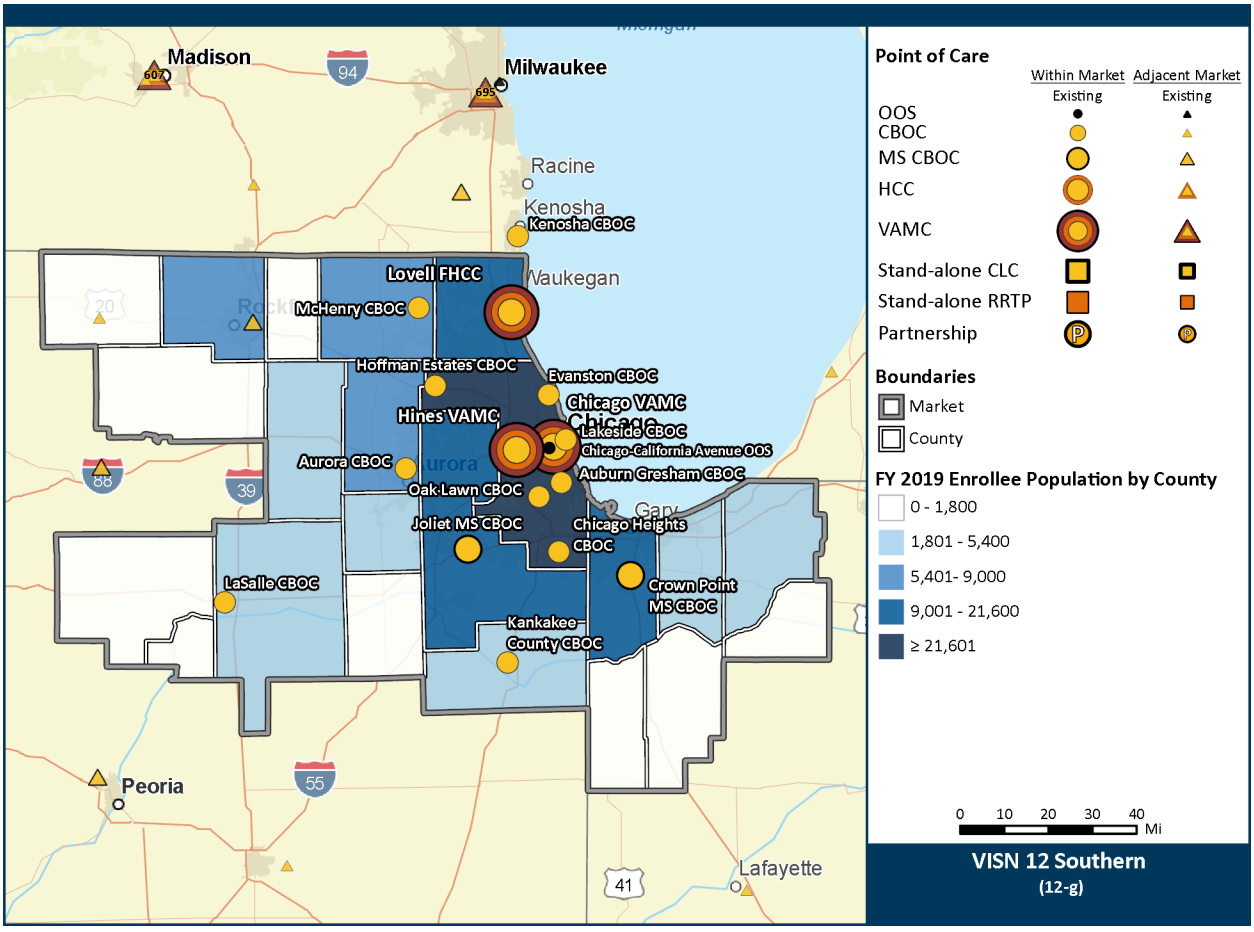
one multi-specialty community-based outpatient clinic (MS CBOC) more proximate to where Veterans live and expands services.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in modern community living center (CLC) facilities at the Hines VAMC and the Captain James A. Lovell Federal Health Care Center (Lovell FHCC) to maintain care for Veterans with the most complex needs. Additionally, there is investment in modern, distributed residential rehabilitation treatment program (RRTP) facilities at the Hines VAMC and Lovell FHCC to provide comprehensive residential mental health care that may not be readily available in the community. The recommendation also maintains inpatient mental health services at the Chicago VAMC, Hines VAMC, and Lovell FHCC; and spinal cord injuries and disorders (SCI/D), blind rehabilitation, and rehabilitation medicine services at the Hines 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 invests in a replacement main clinical facility at the Hines VAMC that best meets design standards for delivering modern health care. It also continues to strengthen regional partnerships with the Department of Defense (DoD) and existing academic affiliates. Inpatient medical and surgical services will be maintained at all three VAMCs in the Southern Market.

# Market Overview

The market overview includes a map of the Southern 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 includes 2 VAMCs (Chicago and Hines) and the Lovell FHCC. VA also operates 2 MS CBOCs, 11 CBOCs, and 1 other outpatient services (OOS) site.

**Enrollees:** In FY 2019, the market had 171,576 enrollees, the tenth highest number of enrollees of 95 markets, and is projected to experience a 12.7% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in Cook, Lake, and DuPage counties in Illinois.

**Demand:** Demand[25] in the market for inpatient medical and surgical services is projected to decrease by 14.1%, and demand for inpatient mental health services is projected to decrease by 10.4% through FY 2029. Demand for long-term care[26] is projected to increase by 14.7%. Demand for all outpatient

[25] 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).

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

services[27], including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

**Rurality:** 13.0% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

**Access:** 93.9% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 83.9% of enrollees live within a 60-minute drive time of a VA secondary care site.

**Community Capacity:** As of FY 2019, community providers[28] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[29] of 63.6% (3,136 available beds)[30] and an inpatient mental health occupancy rate of 57.8% (189 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 76.3% (2,734 available beds). Community residential rehabilitation[31] programs 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 Illinois at Chicago, Loyola University, Rosalind Franklin University, and Northwestern University. The Chicago VAMC is ranked 5 out of 154 training sites based on the number of trainees, the Hines VAMC is ranked 28 out of 154, and the Lovell FHCC is ranked 72 out of 154. The Chicago VAMC is ranked 31 out of 103 VAMCs with research funding, the Hines VAMC is ranked 21 out of 103, and the Lovell FHCC conducts limited or no research. The Hines VAMC is designated as a Federal Coordinating and Primary Receiving Center.[32] The Chicago VAMC and the Lovell FHCC hold no emergency designation.

## Facility Overviews

**Chicago VAMC:** The Chicago VAMC is located in Chicago, Illinois, and offers inpatient medical and surgical, inpatient mental health, rehabilitation medicine, RRTP, CLC, and outpatient services. In FY 2019, the Chicago VAMC had an inpatient medical and surgical average daily census (ADC) of 80.0, an inpatient mental health ADC of 26.8, a rehabilitation medicine ADC of 2.5, an RRTP ADC of 30.7, and a CLC ADC of 19.3.

The Chicago VAMC was built in 1955,[33] with a bed tower addition completed in 2008, on 14.0 acres. Facility condition assessment (FCA) deficiencies are approximately $198.7M, and annual operations and maintenance costs are an estimated $24.5M.

[27] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[28] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[29] 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.
[30] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[31] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[32] 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.
[33] 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, columns 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.

**Lovell FHCC:** The Lovell FHCC is located in North Chicago, Illinois, and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Lovell FHCC had an inpatient medical and surgical ADC of 28.8, an inpatient mental health ADC of 23.8, an RRTP ADC of 98.8, and a CLC ADC of 100.7.

The Lovell FHCC was built in 1961, with a joint, contemporary ambulatory center completed in 2010, on 228.0 acres, with the most recent renovations to the main hospital building completed in 1996. FCA deficiencies are approximately $176.5M, and annual operations and maintenance costs are an estimated $10.1M.

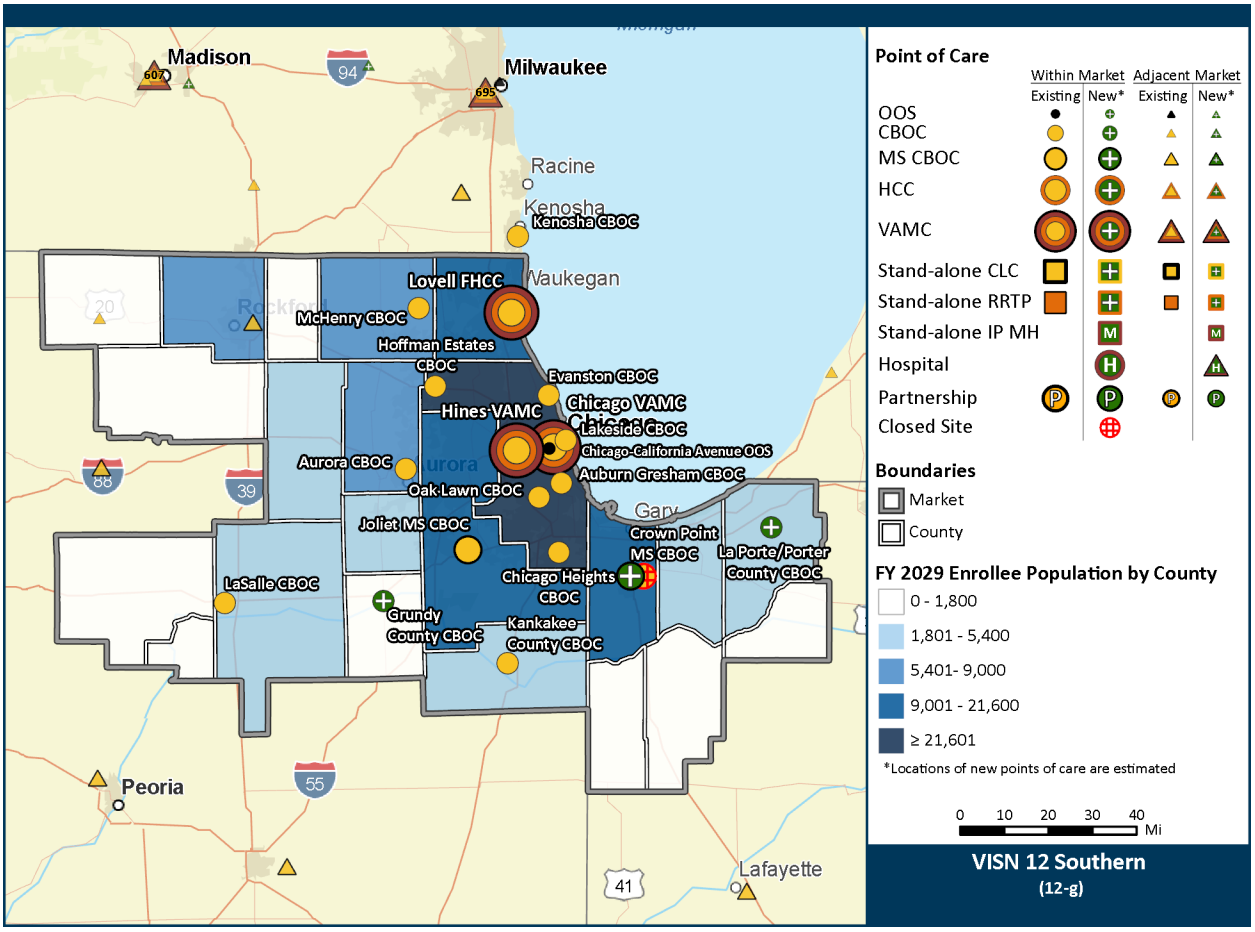
**Hines VAMC:** The Hines VAMC is located in Hines, Illinois, and offers inpatient medical and surgical, inpatient mental health, SCI/D, blind rehabilitation, rehabilitation medicine, RRTP, CLC, and outpatient services. In FY 2019, the Hines VAMC had an inpatient medical and surgical ADC of 92.2, an inpatient mental health ADC of 16.5, a blind rehabilitation ADC of 29.5, an SCI ADC of 37.4, a rehabilitation medicine ADC of 4.5, an RRTP ADC of 20.2, and a CLC ADC of 126.7.

The Hines VAMC was built in 1968 on 147.0 acres, and aside from a 2020 upgrade to the main building 200 façade, the most recent renovations to the main hospital building were completed in 2014. FCA deficiencies are approximately $527.6M, and annual operations and maintenance costs are an estimated $29.2M.

# Recommendation and Justification

This section details the VISN 12 Southern Market recommendation and justification for each element of the recommendation.

## Future Market Map




1.1. **Modernizing the ambulatory facility at the Chicago VAMC:** The Southern Market is projected to experience an increase in demand for outpatient services by FY 2029. In FY 2019, the Chicago VAMC had 57,385 primary care encounters, 147,677 outpatient mental health encounters, and 483,086 outpatient specialty care encounters. The current ambulatory facilities have ongoing challenges and have limited room for expansion. By building a new, modernized ambulatory care space, VA's recommendation will resolve these issues, improve the environment of care for Veterans, and provide increased access to outpatient services in the market. The modernized ambulatory facility will provide primary care, outpatient mental health, outpatient specialty care, outpatient surgery, and emergency department services.

1.2. **Relocating long-term care, RRTP, and rehabilitation medicine services currently at the Chicago VAMC to current or future VA facilities and discontinuing those services at the Chicago VAMC:** Extended care and rehabilitation services in the market are included at both

the Chicago VAMC and Hines VAMC facilities. Consolidation of these services will provide more centralized, full-service long-term and residential rehabilitation care platforms. The relocation of long-term care, RRTP, and rehabilitation medicine to the replacement Hines VAMC will provide a modern, contemporary environment of care that maximizes economies of scale for these services in the market.

2. ***Modernize and realign the Hines VAMC by constructing a new replacement Hines VAMC with inpatient medical and surgical services, inpatient mental health services, CLC, RRTP, SCI/D, blind rehabilitation, and rehabilitation medicine:*** The current Hines VAMC campus has ongoing facility challenges, high operating and maintenance costs, and several buildings that do not meet modern health care standards. The campus provides significant volume of care across the care continuum including inpatient, outpatient, and other specialized services (RRTP, SCI/D, blind rehabilitation, and long-term care). It also serves as a major teaching hub located contiguous to Loyola University School of Medicine. In addition, the Hines VAMC submarket includes over 120,000 enrollees, which overlap with the Chicago VAMC due to the highly urban Chicago area, supporting the need for a contemporary clinical facility. By building a replacement clinical facility, VA's recommendation will resolve significant facility issues, improve the environment of care for Veterans, and maintain VA's ability to provide tertiary inpatient care and complex outpatient care in the market and across VISN 12. The new replacement clinical facility(ies) relocates inpatient medical and surgical and supportive ancillary services, inpatient mental health, CLC, RRTP, SCI/D, blind rehabilitation, and rehabilitation medicine services to the new facility(ies) and absorbs CLC, RRTP, and rehabilitation medicine services from the Chicago VAMC.

3. ***Modernize and realign the Lovell FHCC by:***

   3.1. **Modernizing the CLC at the Lovell FHCC:** The Lovell FHCC has CLC beds located in several different buildings on campus. There is a CLC located within the main hospital, which was built in 1961 and has FCA deficiencies of $3.9M. The CLC located within the main hospital does not meet current VA design standards for modern health care. The Lovell FHCC has 104 CLC beds. In FY 2019, there was an ADC of 100.7 and it is projected to decrease to 89.7 by FY 2029. The modernization will maintain 104 CLC beds, including dedicated hospice beds, and improve safety provisions for long-term care for Veterans with complex needs.

   3.2. **Modernizing the RRTP at the Lovell FHCC:** The current RRTP buildings (buildings 7 and 66) at the Lovell FHCC were built in 1926 and 1928, respectively, with combined FCA deficiencies of over $14.3M and do not meet the current VA design standards for modern health care. Modernization will improve safety provisions and environment of care for Veterans receiving mental health residential rehabilitation services while maintaining bed counts. The Lovell FHCC has 99 RRTP beds with an FY 2019 ADC of 98.8. The Southern Market is projected to have an RRTP bed need of 111 by FY 2028. The modernization will maintain 99 RRTP beds based on projected demand and allocation of beds across the Southern Market.

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

   4.1. **Establishing a new CBOC in the vicinity of La Porte, Indiana:** A new CBOC in the vicinity of La Porte, Indiana (La Porte County), will improve access to primary care and outpatient mental health. In FY 2019, there were for 4,628 Veteran enrollees within a 30-minute drive time of the

proposed site. La Porte County is projected to have an FY 2029 population of more than 2,700 Veteran enrollees.

4.2. **Establishing a new CBOC in the vicinity of Morris, Illinois:** A new CBOC in the vicinity of Morris, Illinois (Grundy County), will improve access to primary care and outpatient mental health. In FY 2019, there were 6,748 Veteran enrollees within a 30-minute drive time of the proposed site. Grundy County is projected to have an FY 2029 population of more than 1,100 enrollees.

4.3. **Relocating the Crown Point MS CBOC to a new site in the vicinity of Crown Point, Indiana, and closing the existing the Crown Point MS CBOC:** Shifting facility placement to a better market location and larger site in the vicinity of Crown Point, Indiana (Lake County), site will increase access to primary care, outpatient mental health, and outpatient specialty care services. In FY 2019, there were 14,629 Veteran enrollees within a 30-minute drive time and 61,458 Veteran enrollees within a 60-minute drive time of the proposed site.

4.4. **Modernizing the existing Joliet MS CBOC:** Modernizing the Joliet MS CBOC will improve access to outpatient specialty services. In FY 2019, there were 18,675 Veteran enrollees within a 30-minute drive time and 105,084 Veteran enrollees within a 60-minute drive time of the existing site. Currently at the Joliet MS CBOC, only 25% of the 63,292 square feet are utilized for outpatient services. There is vacant space available within the building for expansion of outpatient specialty 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:

## Southern Market

- **Identify and partner with Federally Qualified Health Centers (FQHCs) in order to support primary care and outpatient mental health service gaps:** Within the Southern Market there are numerous FQHCs, suggesting an opportunity to expand partnerships to fill service gaps and increase Veteran access to primary care and mental health services. In FY 2019, there were 11,031 enrollees outside of a 30-minute drive time of a VA primary care site, located in more rural areas, where the population may not support placement of a VA outpatient facility.
- **Consolidate the Hines and Chicago VAMC leadership, administrative, logistics, and ancillary support services into a single Health Care System with two separate VAMCs:** The combination of leadership, administrative, and logistic services will allow for the repurposing of space for clinical and support services, streamlining operational costs, and improving operational efficiency. Consolidation of leadership will drive better coordination of care for enrollees in the combined submarket areas by managing all VA clinics in the Southern Market.
- **Expand advanced practice provider use:** Expanding the use of nurse practitioners and physician assistants will alleviate the challenges of recruiting physicians for outpatient sites and improve the coverage of access gaps in the market.

## Chicago VAMC

- **Expand home-based primary care (HBPC) services to the Crown Point MS CBOC and Chicago Heights CBOC:** The expansion of the HBPC program will benefit Veterans by decreasing Veteran travel requirements to receive care, reducing overall readmission rates, and reducing ambulatory care sensitive condition hospitalizations. The HBPC program will also contribute to shorter length of stay of required admissions, leading to improved quality of care and patient satisfaction for Veterans.

## Hines VAMC

- **Establish a mammography program at the Hines VAMC:** There are no mammography services offered at the women's clinic at the Hines VAMC. Offering mammography services will improve VA's ability to support women's health across the continuum. The women Veteran enrollee population in the market is projected to increase to more than 15,500 women Veteran enrollees by FY 2029.
- **Create a Facility Master Plan for the Hines VAMC:** The high VAMC FCA deficiencies of $527.6M suggests a large capital investment over time. Most of the patient care buildings are well maintained but do not meet modern building physical standards. Other buildings on campus have dated interiors and outdated building systems and reflect a deferred maintenance mode of operation. A Facility Master Plan will provide a roadmap to address potential future options for renewal or replacement of these primary Hines facilities.

## Lovell FHCC

- **Establish transitional care beds to provide lower-level complexity care for recruits who are unable to be discharged to barracks and occupy inpatient medical and surgical beds, and to support other Veteran intermediate care needs:** Working in tandem with Great Lakes Naval Station, there are situations when recruits or active-duty personnel require acute care services. Properly supporting these patients, given the challenge and/or inability to discharge them to the barracks or general populace, may limit the supply of beds to Veterans. A transitional care unit will provide an appropriate setting for lower complexity recruits or active-duty patients.
- **Create a Facility Master Plan for the Lovell FHCC:** Due to the unique relationship between VA and DoD, key leadership roles rotate on a two-to-three-year basis. As a by-product of this rotation cycle, there is a focus on immediate impact versus long term planning and future state. Site utilities are dated, and appropriate levels of redundant services are of concern. Development of a long-term plan for the campus will allow for consistent progress to meet Veterans' needs, regardless of the leadership rotation cycle.
- **Advance implementation of the Cerner Electronic Health Record (EHR) at the Lovell FHCC earlier in the national implementation queue:** The Lovell FHCC operates with a dyad structure utilizing both VA and DoD staff. Due to different information systems, staff are required to operate in two systems. Efficiencies can be gained through the implementation of the new EHR in the near term, which will aid in addressing operational challenges and ultimately lead to better care for enrollees, active duty and their families, and recruits

# Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COA) for the VISN 12 Southern 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 cost[34] 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 is the preferred COA. The results of the CBA for the VISN 12 Southern Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

| VISN 12 Southern Market | Status Quo | Modernization | VA Recommendation |
|---|---|---|---|
| **Total Cost** | $40,647,368,839 | $42,373,390,042 | $41,995,538,287 |
| Capital Cost | $4,656,045,604 | $6,382,066,807 | $6,004,215,051 |
| Operational Cost | $35,991,323,235 | $35,991,323,235 | $35,991,323,235 |
| **Total Benefit Score** | 7 | 10 | 12 |
| **CBI (normalized in $B)** | **5.81** | **4.24** | **3.50** |

**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.

[34] 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 19 VA points of care offering outpatient services, including the proposed new La Porte/Porter County, Indiana CBOC and Grundy County, Illinois CBOC; the proposed replacement Hines, Illinois VAMC; and the proposed relocated Crown Point, Indiana MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Lovell FHCC in North Chicago, Illinois and the proposed replacement Hines, Illinois 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 proposed replacement Hines, Illinois VAMC.
- **RRTP:** RRTP demand will be met through the Lovell FHCC in North Chicago, Illinois; the proposed replacement Hines, Illinois VAMC; and the other facilities within VISN 12 offering RRTP, including the Danville, Illinois VAMC; Milwaukee, Wisconsin VAMC, and Tomah, Wisconsin VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the proposed replacement Hines, Illinois VAMC.
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Lovell FHCC in North Chicago, Illinois; Chicago, Illinois VAMC; and the proposed replacement Hines, Illinois 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 143,323 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 143,323 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 12. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with Loyola University, Rosalind Franklin University, University of Illinois, and Northwestern University.
- **Research:** This recommendation does not impact the research mission in the market and allows the Chicago, Illinois VAMC and the Hines, Illinois VAMC to maintain the current research mission; the Lovell FHCC does not have a research program.[35]
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Hines, Illinois 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 replacement Hines, Illinois VAMC; Chicago ambulatory facility; and Crown Point, Indiana MS CBOC; proposed new La Porte/Porter County, Indiana CBOC; and Grundy County, Illinois CBOC; as well as the modernization of the Joliet, Illinois MS CBOC, and the RRTP and CLC at the Lovell FHCC. This new infrastructure will aid in

[35] Research programs were determined by FY 2021 total VA-funded research dollars per the Research and Development Information System (RDIS).

## Quality

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 (3.50 for VA Recommendation versus 5.81 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 replacement Hines, Illinois VAMC; Chicago ambulatory facility; and Crown Point, Indiana MS CBOC; and the proposed new La Porte/Porter County, Indiana CBOC; and Grundy County, Illinois CBOC; as well as the modernization of the Joliet, Illinois MS CBOC, and the RRTP and CLC at the Lovell FHCC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($42.0B for VA Recommendation versus $42.4B 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 (3.50 for VA Recommendation versus 4.24 for Modernization), reflecting effective stewardship of taxpayer dollars.

# VISN 12 Northern Market

The Veterans Integrated Service Network (VISN) 12 Northern Market serves the central and northern parts of Wisconsin and the Upper Peninsula of Michigan. 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.[36]

## VA's Commitment to Veterans in the Northern Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 12's Northern 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, coordination across 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 ensures that VA can continue 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 sequenced so that facilities or partnerships to which care will be realigned must be fully established before the proposed realignment occurs.

## Market Strategy

The Veteran enrollee population in the Northern Market is projected to decrease between fiscal year (FY) 2019 and FY 2029. While demand for inpatient medical and surgical services, long-term care, and outpatient services is projected to increase, demand for inpatient mental health is projected to remain stable. There is a need to invest in long-term care and outpatient facilities to meet existing and projected Veteran demand while rightsizing services at the Iron Mountain and Tomah VAMCs. The strategy for the market is intended to provide Veterans 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 considers increased market demand for outpatient services and improved 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 and relocates one community-based outpatient clinic (CBOC) more proximate to where Veteran enrollees live and expands the site to a multi-specialty community-based outpatient clinic (MS CBOC). Additionally, a partnership with community providers will be established to provide outpatient surgical and emergency department services.

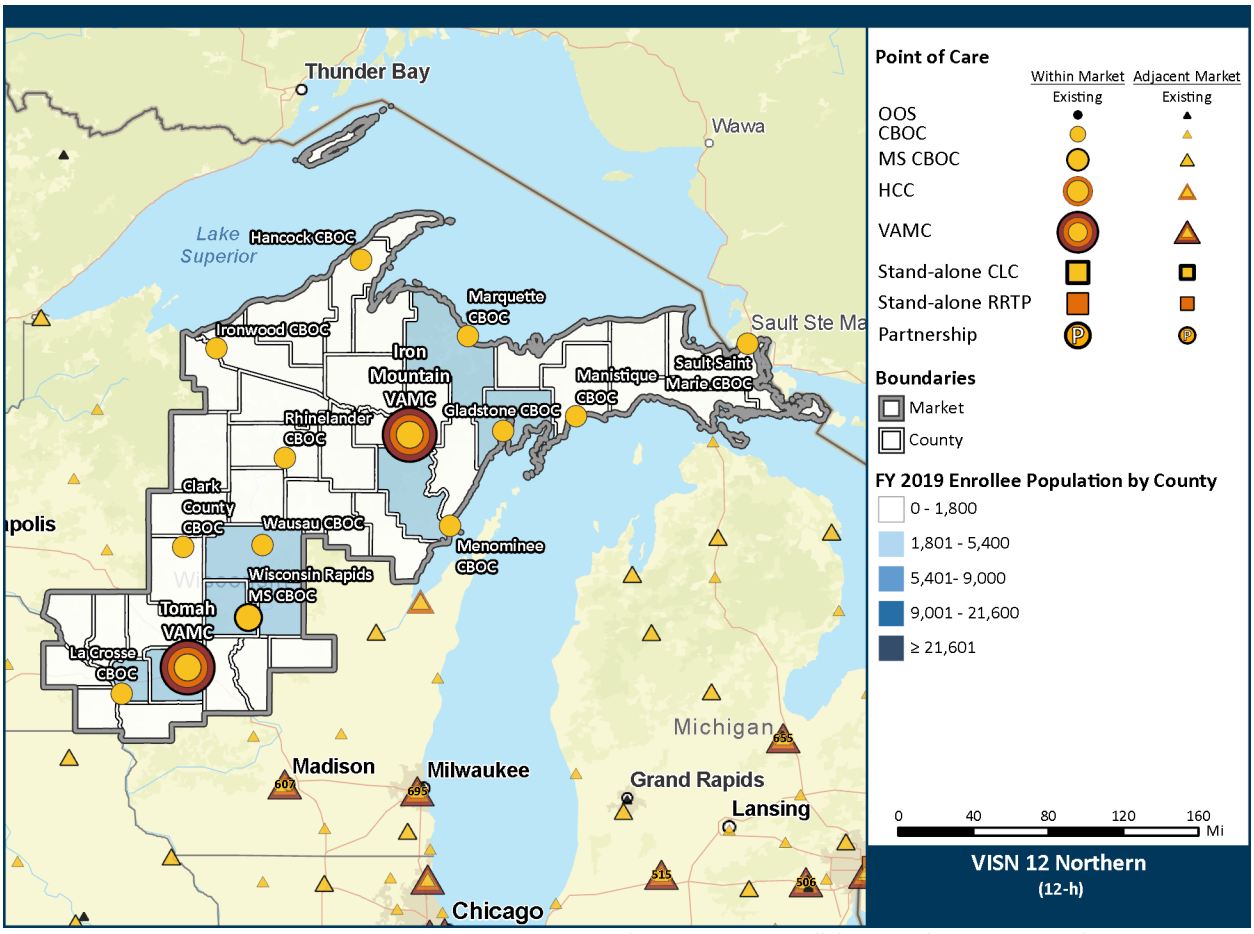
[36] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a modern community living center (CLC) at the Tomah VAMC while continuing CLC services at the Iron Mountain VAMC to maintain care for Veterans with the most complex needs. It maintains inpatient mental health and residential rehabilitation treatment program (RRTP) services at the Tomah VAMC. Demand for inpatient spinal cord injuries and disorders (SCI/D) services will be met through the SCI/D Hub at the Milwaukee, Wisconsin, VAMC and demand for blind rehabilitation services will be met through the Hines VAMC in Hines, Illinois.
- **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 establishes strategic collaborations to allow VA providers to deliver acute inpatient medical care in Tomah, Wisconsin, and acute inpatient medical care in Iron Mountain, Michigan within a partner space. Demand for inpatient surgical services in the Northern Market will continue to be met by community providers.

# Market Overview

The market overview includes a map of the Northern 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 includes 2 VAMCs (Tomah and Iron Mountain), 1 MS CBOC, and 11 CBOCs.

**Enrollees:** In FY 2019, the market had 52,925 enrollees and is projected to experience a 11.5% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in La Crosse, Marathon, and Monroe counties in Wisconsin.

**Demand:** Demand[37] in the market for inpatient medical and surgical services is projected to increase by 4.1%, and demand for inpatient mental health services is projected to increase by 0.5% through FY 2029. Demand for long-term care[38] is projected to increase by 13.7%. Demand for all outpatient services[39], including primary care, mental health, specialty care, dental, rehabilitation therapies, is projected to increase.

**Rurality:** 87.1% of enrollees live in rural areas compared to the VA national average of 32.5%.

**Access:** 58.2% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 37.2% of enrollees live within a 60-minute drive time of a VA secondary care site.

**Community Capacity:** As of 2019, community providers[40] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[41] of 44.2% (275 available beds).[42] There are no available inpatient mental health beds at community providers within a 60-minute drive time of the VAMCs. Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 81.6% (45 available beds). Community residential rehabilitation[43] programs that match the breadth of services provided by VA are not widely available in the market.

**Mission:** VA has education affiliations in the market that include nursing and allied health programs. The Iron Mountain VAMC is ranked 151 out of 154 VA training sites based on number of trainees and the Tomah VAMC is ranked 128 out of 154. These VAMCs conduct limited or no research. Neither VAMC holds an emergency designation.[44]

## Facility Overviews

**Iron Mountain VAMC:** The Iron Mountain VAMC is located in Iron Mountain, Michigan, and offers inpatient medical and surgical, CLC, and outpatient services In FY 2019, the Iron Mountain VAMC had an inpatient medical and surgical ADC of 3.9 and a CLC ADC of 36.4.

[37] 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).
[38] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[39] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[40] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[41] 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.
[42] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[43] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[44] 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 Iron Mountain VAMC was built in 1948 on 26.0 acres, with the most recent renovation to the main hospital building completed in 2019. Facility condition assessment (FCA) deficiencies are approximately $4.3M, and annual operations and maintenance costs are an estimated $4.9M.

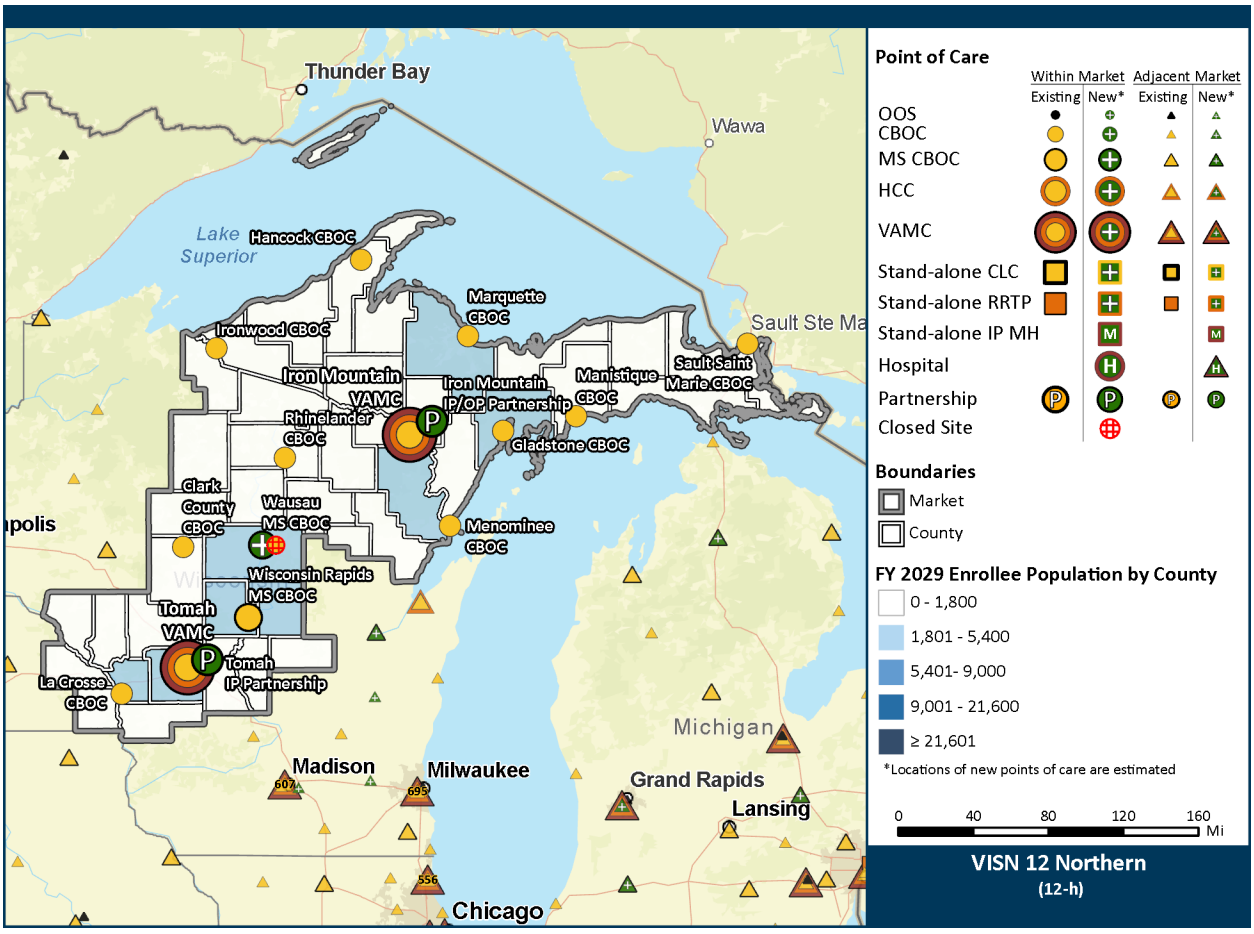
**Tomah VAMC:** The Tomah VAMC is located in Tomah, Wisconsin and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Tomah VAMC had an inpatient medical and surgical ADC of 3.4, an inpatient mental health ADC of 4.4, an RRTP ADC 56.5, and a CLC ADC of 130.4.

The Tomah VAMC was built in 1946 on 174.0 acres, with the most recent renovation to the main hospital building completed in 2014. FCA deficiencies are approximately $110.8M, and annual operations and maintenance costs are an estimated $7.6M.

# Recommendation and Justification

This section details the VISN 12 Northern Market recommendation and justification for each element of the recommendation.

## Future Market Map



1. ***Modernize and realign the Tomah VAMC by:***

   1.1. **Establishing a strategic collaboration to provide acute inpatient medical services and discontinuing acute inpatient medical services at the Tomah VAMC. If unable to enter into a strategic collaboration for acute inpatient medical services, utilize community providers:** At the Tomah VAMC, there is currently low acute inpatient medical demand with an FY 2019 ADC of 3.4 and the ADC is projected to decrease to 2.0 in FY 2029. To partner, VA will consider establishing a sharing arrangement or lease to deliver acute inpatient medical services currently offered at the Tomah VAMC to maintain access and a VA presence in the area. Establishing this strategic collaboration will allow VA to minimize risks associated with low patient census including challenges with preserving staff competencies, maintaining quality and patient safety, and supporting recruitment and retention. There is adequate community capacity for acute inpatient medical and surgical services in the Northern Market. As of FY 2019, community providers within a 60-minute drive time of the Tomah VAMC had an acute inpatient medical and surgical occupancy rate of 44.2% (254 available beds). The current inpatient medical unit at the Tomah VAMC will be utilized as a transitional unit of up to 10 beds, including detox services.

   1.2. **Modernizing the CLC at the Tomah VAMC:** The Tomah VAMC has a number of CLC buildings across campus that were built between 1946 and 1947 with a combined FCA deficiencies of over $21.0M. These older CLC buildings on campus do not meet current design standards for modern health care[45]. While there are a few more contemporary CLC small house model facilities on campus, modernization of the older CLC buildings on campus or development of additional small house model facilities will allow for the integration of a subacute unit and improve safety provisions and environment of care for long-term Veteran care. The Tomah VAMC continues to be a Veteran destination site for long-term care services. The Tomah VAMC has 145 CLC beds. In FY 2019, there was an ADC of 130.4, and it is projected to increase to 131.1 by FY 2029. The modernization will maintain 145 CLC beds.

2. ***Modernize and realign the Iron Mountain VAMC by establishing a strategic collaboration with a community provider to provide inpatient medical and surgical services, outpatient surgery, and emergency services. If unable to enter into a strategic collaboration for those services, continue to provide these services at the VAMC:*** In Iron Mountain, Michigan, the long-term sustainability of the community hospitals is uncertain. With recruitment and retention challenges at the Iron Mountain VAMC, a clinical services partnership for inpatient medical and surgical services, outpatient surgery, and emergency services is the strongest option to maintain a long-term VA presence. Integrating resources and leveraging the strengths of both VA and the community will create a collaborative VA and commercial safety net hospital and sustainable presence in the Upper Peninsula area, improving access to care for Veteran enrollees and benefiting the larger community. At the Iron Mountain VAMC, there is low inpatient medical and surgical demand with an FY 2019 ADC of 3.9, and demand is projected to decrease to an ADC of 3.4 by FY 2029. There is adequate inpatient medical and

[45] 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, columns 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.

surgical capacity in the community to absorb the low demand for these services. In FY 2019, community providers within a 60-minute drive time of the Iron Mountain VAMC had an occupancy rate of 44.0% (21 available beds). The Iron Mountain VAMC will retain key services with clinical strengths including primary care, outpatient mental health, outpatient specialty care, CLC, and urgent care services and should a partnership not be possible, the Iron Mountain VAMC will retain all services.

3. ***Modernize and realign outpatient facilities in the market by relocating the Wausau CBOC to a new site in the vicinity of Wausau, Wisconsin and closing the existing CBOC:*** Shifting facility placement to a better market location and a larger site in the vicinity of Wausau, Wisconsin (Marathon County) will increase access to primary care, outpatient mental health, and specialty care services. In FY 2019, there were 4,185 Veteran enrollees within a 30-minute drive time and 12,735 Veteran enrollees within a 60-minute drive time of the proposed site. The new site will include specialty services, which may result in reclassification of the facility as an MS 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:

## Northern Market

- **Realign market boundaries of the Northern and Central markets to better reflect the north/south referral patterns between the Madison VAMC and Tomah VAMC areas, and the Milwaukee VAMC and Iron Mountain VAMC areas:** The Madison and Milwaukee VAMCs of the Central Market, which are tertiary medical facilities, and the Tomah and Iron Mountain VAMCs of the Northern Market closely collaborate across market boundaries. The VISN is currently in the process of realigning the Northern and Central markets to four individual markets. Realigning market boundaries will reflect Veteran referral patterns as well as offer administrative efficiencies through streamlined budget decision making and better financial resource allocation for inpatient and outpatient care.
- **Increase home-based primary care (HBPC) coverage in the Northern Market:** HBPC services are currently located out of the Tomah VAMC (covering a 50-mile radius), the Iron Mountain VAMC (covering a 60-mile radius), and the Wisconsin Rapids CBOC. The expansion of the HBPC program will benefit Veterans by decreasing Veteran travel requirements to receive care, reducing overall readmission rates, and reducing ambulatory care sensitive condition hospitalizations. The HBPC program will also contribute to shorter length of stay of required admissions, leading to improved quality of care and patient satisfaction for Veterans.
- **Seek potential partnerships with Federally Qualified Health Centers (FQHC) and Indian Health Service (IHS) facilities:** The Northern Market is highly rural. There are numerous FQHC and IHS locations and most of them are in locations with little or no VA presence. Partnerships with FQHC and IHS facilities will address service gaps and reduce travel burdens for enrollees in remote, rural areas.

- **Increase availability of ophthalmology across the Northern Market:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists. Increased availability may be achieved through a variety of tactics (e.g., telehealth, VCCP recruitment, hiring additional VA providers) as appropriate.

### Tomah VAMC

- **Establish a partnership with the community fire department to provide fire services to the Tomah VAMC:** There is potential for an agreement to partner with a community fire department to provide fire services to the Tomah VAMC. The current fire department on the Tomah campus has aging infrastructure and will be costly to replace. A partnership with the community would remove the need for VA to operate a fire department on campus and reduce FCA deficiencies at the Tomah VAMC.

## Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COA) for the VISN 12 Northern 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 cost[46] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost included costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational costs included 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 include 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 12 Northern Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

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

| VISN 12 Northern Market | Status Quo | Modernization | VA Recommendation |
|---|---|---|---|
| **Total Cost** | $11,222,911,658 | $11,964,974,308 | $11,704,559,660 |
| Capital Cost | $763,480,806 | $1,505,543,456 | $1,524,495,328 |
| Operational Cost | $10,459,430,851 | $10,459,430,851 | $10,180,064,331 |
| **Total Benefit Score** | 7 | 10 | 13 |
| **CBI (normalized in $B)** | **1.60** | **1.20** | **0.90** |

**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 15 VA points of care offering outpatient services, including the proposed relocated and expanded Wausau, Wisconsin MS CBOC and partnership in Iron Mountain, Michigan, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Iron Mountain, Michigan VAMC and the Tomah, Wisconsin 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 Milwaukee, Wisconsin, VAMC.
- **RRTP:** RRTP demand will be met through the Tomah, Wisconsin VAMC; and the other facilities within VISN 12 offering RRTP, including the Milwaukee, Wisconsin VAMC; Lovell FHCC in North Chicago, Illinois; Danville VAMC in Danville, Illinois; and proposed replacement Hines, Illinois VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the proposed replacement Hines, Illinois VAMC.
- **Inpatient acute:** Inpatient medicine demand will be met through proposed new partnerships in Iron Mountain, Michigan and Tomah, Wisconsin, as well as through community providers; inpatient surgical demand will be met through the proposed new partnership in Iron Mountain, Michigan, as well as through community providers; and mental health demand will be met through the Tomah, Wisconsin 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 46,042 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 maintained, with 46,760 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 12. The recommendation allows for continued relationships with key academic partners.
- **Research:** This recommendation does not impact the research mission in the market; the Tomah, Wisconsin and Iron Mountain, Michigan VAMCs do not have research programs.[47]
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Tomah, Wisconsin and Iron Mountain, Michigan VAMCs are not designated as Primary Receiving Centers.

[47] Research programs were determined by FY 2021 total VA-funded research dollars per the Research and Development Information System (RDIS).

## 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 Iron Mountain, Michigan partnership; Tomah, Wisconsin inpatient partnership; proposed relocated and expanded Wausau, Wisconsin MS CBOC; as well as the modernization of the CLC at the Tomah, Wisconsin 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:** In addition, 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 (0.90 for VA Recommendation versus 1.60 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 Iron Mountain, Michigan partnership; Tomah, Wisconsin partnership; proposed relocated and expanded Wausau, Wisconsin MS CBOC; as well as the modernization of the CLC at the Tomah, Wisconsin 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 quality 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 ($11.7B for VA Recommendation versus $12.0B 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 (0.90 for VA Recommendation versus 1.20 for Modernization), reflecting effective stewardship of taxpayer dollars.