



VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022



VISN 06

Market Recommendations



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VISN 06 Northeast Market

The Veterans Integrated Service Network (VISN) 06 Northeast Market serves Veterans in parts of eastern Virginia and northeastern North Carolina. 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 Northeast Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 06's Northeast 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

Veteran enrollment in the Northeast Market is projected to increase, and demand for inpatient medical and surgical services, inpatient mental health care, long-term care, and outpatient care is also projected to increase. There is a need to relocate services closer to Veterans, improve infrastructure, and expand access to VA health care to meet existing and projected Veteran demand. 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 to care by investing in modern facilities close to where Veterans live and shifting care from the crowded Richmond VAMC campus to more convenient locations. The recommendation establishes two new community-based outpatient clinics (CBOCs) to expand access to primary care and mental health services; establishes one new multi-specialty community-based outpatient clinic (MS CBOC) to expand access to primary care, mental health, and specialty care services; and relocates and expands two CBOCs into MS CBOCs. The recommendation maintains all sustainable outpatient points of care in the market and consolidates three CBOCs into a single new health care center (HCC) in

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

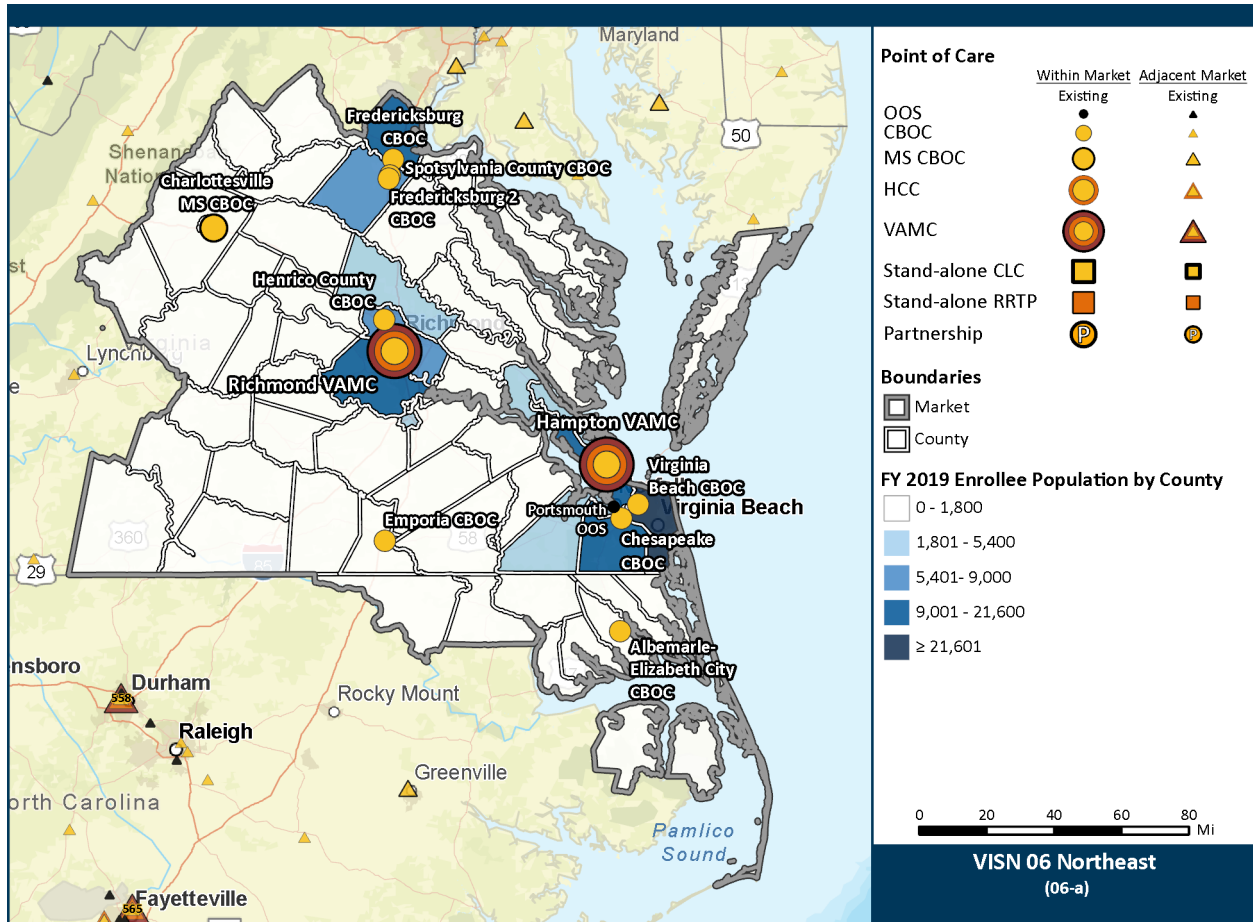
Fredericksburg, Virginia to provide Veterans with access to more services at a single location. Finally, VA's recommendation establishes outpatient services in two new VAMCs in Newport News and Norfolk/Tidewater, Virginia.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in two new VAMCs in Newport News and Norfolk/Tidewater, Virginia, both of which will provide community living center (CLC) and residential rehabilitation treatment program (RRTP) services. The recommendation also maintains sustainable CLC and RRTP at the existing Richmond VAMC. Inpatient mental health services will be established at the new Norfolk/Tidewater VAMC and maintained at the existing Richmond VAMC. Inpatient spinal cord injuries and disorders (SCI/D) services will be consolidated in a modern facility at the existing Richmond VAMC. VA's recommendation maintains inpatient blind rehabilitation services in the Northeast Region, including at the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains inpatient medical and surgical care at the Richmond VAMC. It also relocates a low volume program at the existing Hampton VAMC to a strategic collaboration with community providers in Norfolk/Tidewater, Virginia, which will deliver VA-provided acute care services closer to where Veterans live.

Market Overview

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

Market Map



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

Facilities: The market has two VAMCs (Hampton and Richmond), one MS CBOC, eight CBOCs, and one other outpatient services (OOS) site.

Enrollees: In fiscal year (FY) 2019, the market had 169,814 enrollees and is projected to experience a 13.7% increase in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Virginia Beach City, Chesterfield, and Chesapeake City, Virginia.

Demand: Demand² in the market for inpatient medical and surgical services is projected to increase by 7.3% and demand for inpatient mental health services is projected to increase by 6.4% between FY 2019 and FY 2029. Demand for long-term care³ is projected to increase by 69.1%. 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, and rehabilitation therapies, is projected to increase.

Rurality: 23.7% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 76.8% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 77.8% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers⁵ in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate⁶ of 69.3% (797 available beds)⁷ and an inpatient mental health occupancy rate of 72.1% (39 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 83.0% (320 available beds). Community residential rehabilitation programs⁸ that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include Virginia Commonwealth University and Eastern Virginia Medical School. The Hampton VAMC is ranked 83 out of 154 VA training sites based on the number of trainees, and the Richmond VAMC is ranked 59 out of 154. The Hampton VAMC is ranked 91 out of 103 VAMCs with research funding, and the Richmond VAMC is ranked 34 out of 103. The Richmond VAMC is designated as a Primary Receiving Center, and the Hampton VAMC holds no emergency designation.⁹

Facility Overviews

Hampton VAMC: The Hampton VAMC is located in Hampton, Virginia, and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, SCI/D, and outpatient services. In FY 2019, the Hampton VAMC had an inpatient medical and surgical average daily census (ADC) of 19.9, an inpatient mental health ADC of 23.9, an RRTP ADC of 129.0, a CLC ADC of 56.2, and an SCI/D ADC of 36.9.

The Hampton VAMC was built in 1940 on 84.2 acres and the most recent renovation was in 2012. Facility condition assessment (FCA) deficiencies are approximately \$172.9M, and annual operations and maintenance costs are an estimated \$20.8M.

Richmond VAMC: The Richmond VAMC is located in Richmond, Virginia, and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, SCI/D, rehabilitative medicine, and outpatient services. In FY 2019, the Richmond VAMC had an inpatient medical and surgical ADC of 67.1, an inpatient mental health ADC of 16.0, an RRTP ADC of 8.0, a CLC ADC of 43.8, an SCI/D ADC of 48.5, and a rehabilitative medicine ADC of 26.4.

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.

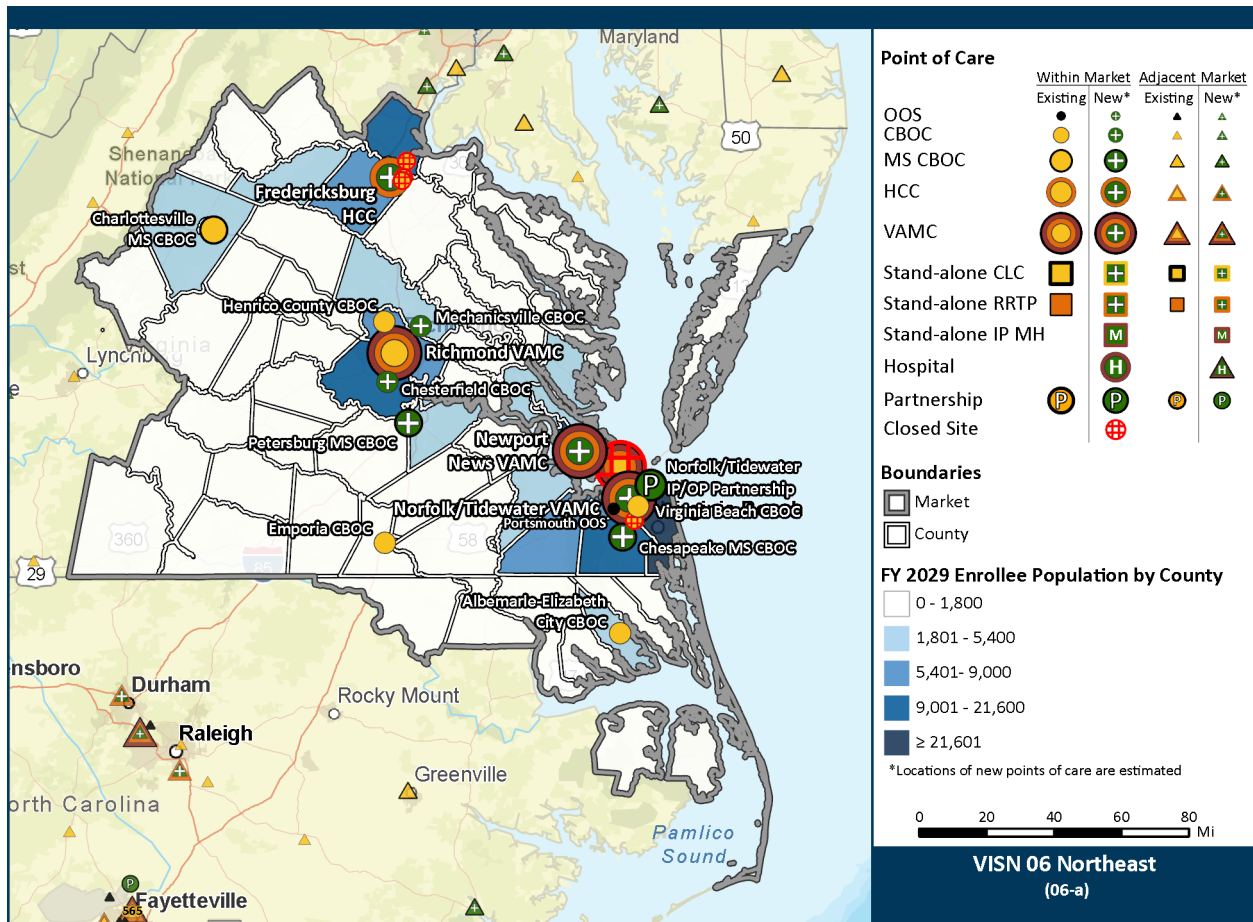
⁹ VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

The Richmond VAMC was built in 1984 on 111.4 acres. FCA deficiencies are approximately \$316.6M, and annual operations and maintenance costs are an estimated \$20.7M.

Recommendation and Justification

This section details the VISN 06 Northeast Market recommendation and justification for each element of the recommendation.

Future Market Map



- 1. Modernize and realign the market by constructing a new VAMC with RRTP, CLC, and outpatient services in the vicinity of Newport News, Virginia:** The existing Hampton VAMC faces many challenges, such as frequent flooding and severe access challenges for a large portion of the Veterans it serves due to heavy traffic in the bridge and tunnel infrastructure connecting the Norfolk area to the VAMC. The Hampton VAMC’s aging infrastructure does not meet current design standards¹⁰ and has major architecture and engineering challenges that make it impractical and

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

inefficient to continue investing in the facility to provide patient care. The Hampton VAMC offers inpatient medical and surgical care, inpatient mental health, RRTP, CLC, SCI/D, and outpatient services. Establishing a new VAMC in Newport News, Virginia (Warwick County) will provide Veterans in the upper peninsula area with improved access to RRTP, CLC, primary care, outpatient mental health, and outpatient specialty care services. In FY 2019, there were 84,853 enrollees within a 60-minute drive time of the proposed VAMC, indicating sufficient demand in the Newport News area.

2. Modernize and realign the market by constructing a new VAMC with inpatient mental health, CLC, RRTP, and outpatient services in the vicinity of Norfolk/Tidewater, Virginia:

The existing Hampton VAMC faces many challenges, such as frequent flooding and severe access challenges for a large portion of the Veterans it serves due to heavy traffic in the bridge and tunnel infrastructure connecting the Norfolk area to the VAMC. The existing Hampton VAMC's aging infrastructure has major architecture and engineering challenges that make it impractical and inefficient to continue investing in the facility to provide patient care. The Hampton VAMC offers inpatient medical and surgical care, inpatient mental health, RRTP, CLC, SCI/D, and outpatient services. Establishing a new VAMC in Norfolk/Tidewater, Virginia, will provide Veterans with access to inpatient mental health, CLC, RRTP, primary care, outpatient mental health, outpatient specialty care, outpatient surgical care, and urgent care services. In FY 2019, there were 84,261 enrollees within a 60-minute drive time of the proposed VAMC, indicating sufficient demand in the Norfolk/Tidewater area.

3. Modernize and realign the Hampton VAMC by:

3.1. Relocating inpatient mental health, CLC, RRTP, SCI/D, and outpatient services provided at the Hampton VAMC to current or future VA facilities and discontinuing those services at the Hampton VAMC:

The existing Hampton VAMC faces many challenges, such as frequent flooding and severe access challenges for a large portion of the Veterans it serves due to heavy traffic in the bridge and tunnel infrastructure connecting the Norfolk area to the VAMC. The existing Hampton VAMC's aging infrastructure has major architecture and engineering challenges that make it impractical and inefficient to continue investing in the facility to provide patient care. Services will be redistributed between the Newport News and Norfolk/Tidewater areas. The proposed Newport News VAMC will absorb a portion of CLC, RRTP, primary care, outpatient mental health, and outpatient specialty care services. The proposed Norfolk/Tidewater VAMC will absorb all the inpatient mental health services and the remaining CLC, RRTP, primary care, outpatient mental health, outpatient specialty care, and outpatient surgical services. Inpatient SCI/D services will be relocated to the Richmond VAMC. Relocating Veteran care to modern points of care closer to where Veterans live will improve access, patient safety, and quality of care.

3.2. Establishing a strategic collaboration with the Department of Defense's (DoD) Naval Hospital Portsmouth to provide inpatient medical and surgical care and emergency department services and discontinuing those services at the Hampton VAMC. If unable to enter into strategic collaborations, utilize community providers:

The existing Hampton VAMC faces many challenges, such as frequent flooding and severe access challenges for a large portion of the Veterans it serves due to heavy traffic in the bridge and tunnel infrastructure connecting the Norfolk area to the VAMC. The existing Hampton VAMC's aging infrastructure has major

architecture and engineering challenges that make it impractical and inefficient to continue investing in the facility to provide patient care. The Hampton VAMC had an inpatient medical and surgical ADC of 19.9 in FY 2019, and demand is projected to decrease to 15.4 ADC in FY 2029. Establishing a strategic collaboration with Naval Hospital Portsmouth to develop a joint DoD and VA acute medical and surgical program will allow VA to relocate many acute medical and surgical inpatients out of the Hampton VAMC to deliver VA-provided acute care services closer to where Veterans live. Community providers have adequate capacity to absorb Veteran demand. As of FY 2019, community providers within a 60-minute drive time of the Hampton VAMC had an inpatient acute occupancy rate of 69.6% (2,917 total beds). Collaborating with a leading community provider in the Hampton Roads/Newport News (Northside) and Norfolk/Virginia Beach/Chesapeake (Southside) market areas provides Veterans with more convenient options for inpatient medical and surgical care in both areas and will provide Veterans with a safe, modern health care environment.

3.3. Closing the Hampton VAMC: Relocating services to more modern and conveniently located facilities for Veterans will allow for closure of the existing Hampton VAMC.

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

4.1. Establishing a new CBOC in the vicinity of Mechanicsville, Virginia: A new CBOC in the vicinity of Mechanicsville, Virginia (Hanover County) will expand access to primary care and outpatient mental health services and will decompress those services from the Richmond VAMC. Enrollees in Hanover County are expected to increase by 14.2% from 2,467 to 2,818 between FY 2019 and FY 2029. In FY 2019, there were 19,752 enrollees within a 30-minute drive time of the proposed site.

4.2. Establishing a new MS CBOC in the vicinity Petersburg, Virginia: A new MS CBOC in the vicinity of Petersburg, Virginia (Petersburg County) will expand access to primary care, outpatient mental health, and outpatient specialty care services and will decompress those services from the Richmond VAMC. Enrollees in Petersburg City are expected to increase by 12.1% from 3,148 to 3,527 between FY 2019 and FY 2029. In FY 2019, there were 14,524 enrollees within a 30-minute drive time and 40,310 enrollees within a 60-minute drive time of the proposed site.

4.3. Establishing a new CBOC in the vicinity of Chesterfield, Virginia: A new CBOC in the vicinity of Chesterfield, Virginia, will expand access to primary care and outpatient mental health services and will decompress those services from the Richmond VAMC. Enrollees in Chesterfield County are expected to increase by 9.3% from 11,885 to 12,996 between FY 2019 and FY 2029. In FY 2019, there were 28,418 enrollees within a 30-minute drive time of the proposed site.

4.4. Relocating all services to the planned Fredericksburg HCC and closing the Fredericksburg 2 CBOC: The Fredericksburg HCC, which is currently under development, will consolidate primary care and outpatient mental health services from the existing Fredericksburg CBOC, Fredericksburg 2 CBOC, and Spotsylvania County CBOC. Relocating services to the planned Fredericksburg HCC will allow for the closing of the Fredericksburg 2 CBOC.

4.5. Relocating all services to the planned Fredericksburg HCC and closing the Fredericksburg CBOC: The Fredericksburg HCC, which is currently under development, will consolidate primary care and outpatient mental health services from the existing Fredericksburg CBOC,

Fredericksburg 2 CBOC, and Spotsylvania County CBOC. The Fredericksburg CBOC is located an estimated 10 minutes (5.2 miles) from the planned Fredericksburg HCC. Enrollees in Fredericksburg City County are expected to increase by 17.8% from 960 to 1,130 between FY 2019 and FY 2029. Relocating services to the planned Fredericksburg HCC will allow for closure of the Fredericksburg CBOC.

- 4.6. Relocating all services to the planned Fredericksburg HCC and closing the Spotsylvania County CBOC:** The Fredericksburg HCC, which is currently under development, will consolidate primary care and outpatient mental health services from the existing Fredericksburg CBOC, Fredericksburg 2 CBOC, and Spotsylvania County CBOC. The Spotsylvania County CBOC is located an estimated 4 minutes (1.4 miles) from the planned Fredericksburg HCC. Enrollees in Fredericksburg City are expected to increase by 17.8% from 960 to 1,130 between FY 2019 and FY 2029. Relocating services to the planned Fredericksburg HCC will allow for closure of the Spotsylvania County CBOC.
- 4.7. Relocating all services to the planned Chesapeake MS CBOC and closing the Chesapeake CBOC:** The Chesapeake MS CBOC, which is currently under development, will absorb primary care and outpatient mental health services from the existing Chesapeake CBOC. Enrollees in Chesapeake City County are expected to increase by 25.6% from 11,849 to 14,881 between FY 2019 and FY 2029. Relocation of services to the Chesapeake MS CBOC will allow for closure of the Chesapeake 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:

Northeast Market

- **Develop an inter-VA and cross-VA/DoD sharing arrangement that replicates the Fayetteville VAMC/Womack Army Medical Center Model:** The Fayetteville VAMC/Womack Army Medical Center Model allows physicians to access the medical records of patients within the same markets and across facilities. The lack of privileging at other DoD facilities hinders access to medical records and collaboration between VA and DoD sites of care. There are four DoD/TRICARE¹¹ clinics located in the south bay and three DoD clinics located in the north bay of the Northeast Market.

Newport News VAMC and Norfolk/Tidewater VAMC

- **Establish a women's health patient aligned care team (PACT) in the proposed Newport News VAMC and proposed Norfolk/Tidewater VAMC:** A women's health PACT in the new proposed VAMCs will allow for expanded women's health services to serve the increasing women Veteran population. Women enrollees are projected to increase by 26.9% between 2019 and FY 2029 to a total of 34,372 women enrollees in the Northeast Market.

¹¹ TRICARE is the health care program for uniformed service members, retirees, and their families and provides comprehensive insurance coverage to all beneficiaries.

Hampton VAMC

- **Relocate the research program currently at the Hampton VAMC to alternative facilities within the VISN, such as the proposed Newport News VAMC, the proposed Norfolk/Tidewater VAMC, or other facilities within the market:** Upon the closure of the Hampton VAMC, VA will relocate the research program to the proposed new Newport News VAMC or the proposed new Norfolk/Tidewater VAMC. The Office of Research and Development will engage in the planning to identify the optimal location to maintain existing research programs.

Richmond VAMC

- **Strengthen the academic affiliation with Virginia Commonwealth University (VCU) Medical Center to grow and sustain medical and surgical specialty services where VA has recruiting challenges:** VA will strengthen the academic affiliation relationship with VCU Medical Center to strengthen the recruitment pipeline for both physicians and other health care professionals. Currently, the Richmond VAMC has difficulty recruiting and retaining providers due to strong competition in the community health care market. Improved recruitment is necessary to meet the demand for VA-delivered care.
- **Establish a new HCC in the vicinity of Fredericksburg, Virginia (in progress):** The Fredericksburg HCC, which is currently under development, will consolidate primary care and outpatient mental health services from the existing Fredericksburg CBOC, Fredericksburg 2 CBOC, and Spotsylvania County CBOC. The HCC will also provide specialty care and ambulatory surgical services. Enrollees in Fredericksburg City, Virginia are projected to increase by 17.8% from 960 to 1,130 enrollees between FY 2019 and FY 2029. In FY 2019, there were 16,473 enrollees within a 30-minute drive time and 57,567 enrollees within a 60-minute drive time of the proposed site.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 06 Northeast 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 cost¹² 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).

¹² The present value cost is the current value of future costs discounted at the defined discount rate.

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

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 06 Northeast Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 06 Northeast Market	Status Quo	Modernization	VA Recommendation
COA Present Value (\$)	\$34,851,698,208	\$36,520,823,568	\$36,056,367,311
Capital Costs	\$2,313,752,613	\$3,982,877,972	\$3,751,212,051
Operational Costs	\$32,537,945,596	\$32,537,945,596	\$32,305,155,259
Total Benefit Score	7	10	15
CBI (normalized in \$B)	4.98	3.65	2.40

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 the nearest dollar.

Section 203 Criteria Analysis

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

Demand
<p><i>This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.</i></p> <ul style="list-style-type: none"> • Summary: Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand. • Outpatient: Outpatient demand will be met through 15 VA points of care offering outpatient services, including the proposed new Norfolk/Tidewater, Virginia VAMC; Naval Hospital Portsmouth partnership (Emergency Department); Newport News, Virginia VAMC; Mechanicsville, Virginia CBOC; Chesterfield, Virginia CBOC; Petersburg, Virginia MS CBOC; Fredericksburg, Virginia HCC; and Chesapeake, Virginia MS CBOC; as well as community providers in the market. • CLC: Long-term care demand will be met through the Richmond, Virginia VAMC; the proposed new Norfolk/Tidewater, Virginia VAMC; and the proposed new Newport News, Virginia VAMC; as well as community nursing homes. <p><i>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.</i></p> <ul style="list-style-type: none"> • SCI/D: Demand for inpatient SCI/D will be met through the SCI/D Hub at the Richmond, Virginia VAMC.

Demand

- **RRTP:** RRTP demand will be met through the Richmond, Virginia VAMC; proposed new Norfolk/Tidewater, Virginia VAMC; proposed new Newport News, Virginia VAMC; and the other facilities within VISN 06 offering RRTP, including the Salisbury, North Carolina VAMC; Asheville, North Carolina VAMC; proposed new Raleigh/Durham, North Carolina VAMC; and proposed new Roanoke, Virginia VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the Richmond, Virginia VAMC and proposed new Naval Hospital Portsmouth partnership, as well as through community providers. Inpatient mental health demand will be met through the Richmond, Virginia VAMC and proposed new Norfolk/Tidewater, Virginia 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 194,277 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 194,408 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 06. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Virginia Commonwealth University and Eastern Virginia Medical School.
- **Research:** This recommendation does not impact the research mission in the market and allows the VAMCs in this market to maintain the current research mission by maintaining the Richmond, Virginia VAMC research program and relocating the research program currently at the Hampton, Virginia VAMC to alternative facilities within the VISN, such as the proposed new Newport News, Virginia VAMC, the proposed new Norfolk, Virginia VAMC, or other facilities within the market as applicable.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Richmond, Virginia VAMC will maintain its status as a Primary Receiving Center.

Quality

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

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Norfolk/Tidewater, Virginia VAMC; Newport News, Virginia VAMC; Mechanicsville, Virginia CBOC; Chesterfield, Virginia CBOC; Petersburg, Virginia MS CBOC; Fredericksburg, Virginia HCC; Chesapeake, Virginia MS CBOC; and Naval Hospital Portsmouth partnership. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (2.40 for VA Recommendation versus 4.98 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 Norfolk/Tidewater, Virginia VAMC; Newport News, Virginia VAMC; Mechanicsville, Virginia CBOC; Chesterfield, Virginia CBOC; Petersburg, Virginia MS CBOC; Fredericksburg, Virginia HCC; Chesapeake, Virginia MS CBOC; and Naval Hospital Portsmouth partnership. 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 (\$36.1B for VA Recommendation versus \$36.5B 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 (2.40 for VA Recommendation versus 3.65 for Modernization), reflecting effective stewardship of taxpayer dollars.



VISN 06 Southwest Market

The Veterans Integrated Service Network (VISN) 06 Southwest Market serves Veterans in western North Carolina. 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.¹³

VA's Commitment to Veterans in the Southwest Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 06's Southwest 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 Southwest Market is facing slightly decreasing market enrollment. Demand for inpatient medical and surgical services and inpatient mental health care is decreasing, while demand for long-term care and outpatient care is increasing. There is a need to relocate low-volume acute services to enrollee population centers and expand outpatient care capabilities to meet existing and projected Veteran demand. 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 to care by investing in modern facilities close to where Veterans live. The recommendation establishes a new community-based outpatient clinic (CBOC) to expand access to primary care and mental health services and provides a new ambulatory care building to provide primary care, outpatient mental health, and specialty care services at the Salisbury VAMC.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation improves access to care by maintaining inpatient mental health and community living center (CLC) services as well as modernizing and expanding residential

¹³ Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

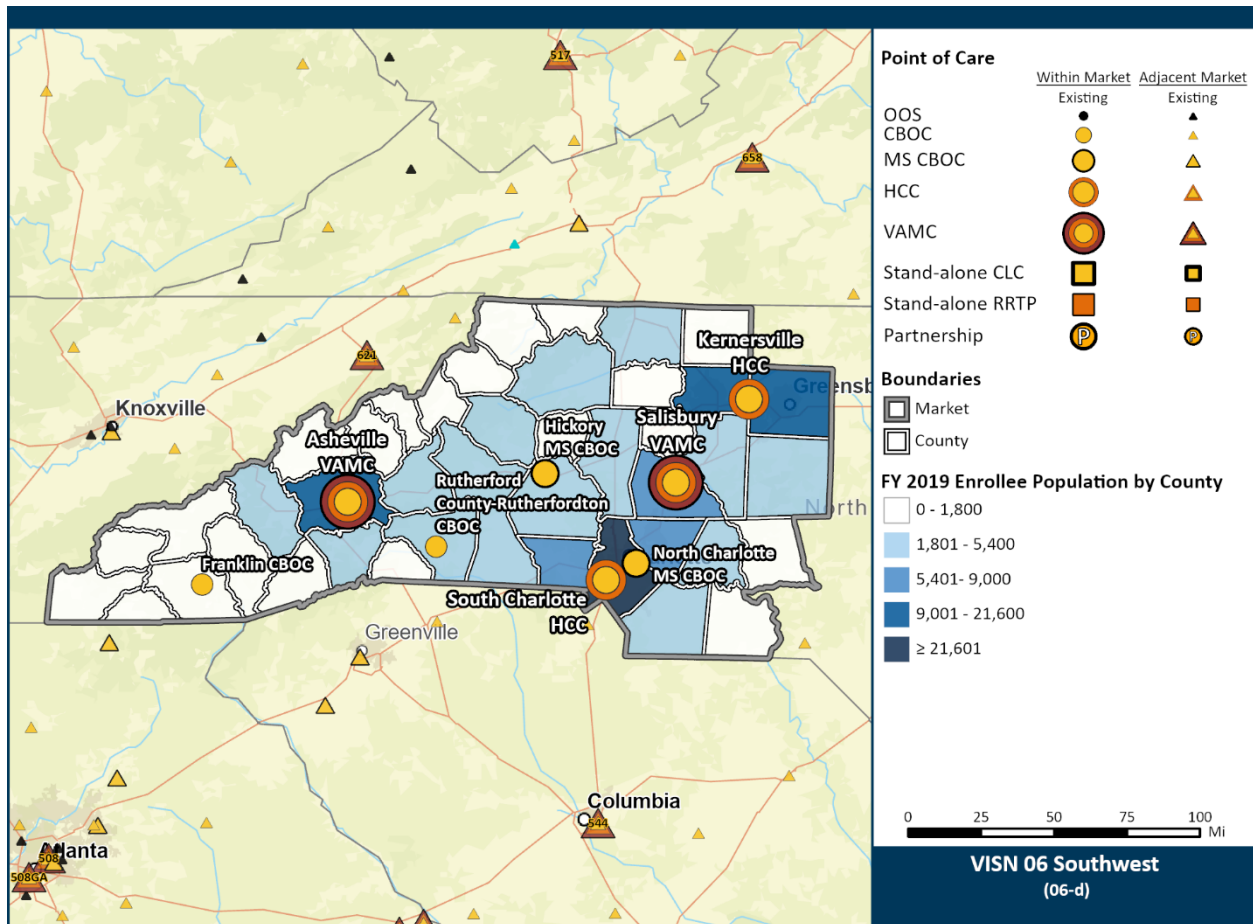
rehabilitation treatment program (RRTP) services at both the Salisbury and Asheville VAMCs. VA's recommendation maintains inpatient spinal cord injuries and disorders (SCI/D) programs at the SCI/D Hubs at the Richmond, Virginia VAMC in the VISN 06 Northeast Market and the Augusta, Georgia VAMC in the VISN 07 Georgia Market. Inpatient blind rehabilitation services will be maintained at facilities in the Northeast Region, including the West Haven, Connecticut VAMC in VISN 01; the proposed new King of Prussia, Pennsylvania VAMC in VISN 04; and the Cleveland, Ohio VAMC in VISN 10.

- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains inpatient medical and surgical care at the Asheville VAMC. It also relocates the low volume program at the Salisbury VAMC to a strategic collaboration with the academic affiliate and their partner hospital, which will allow VA providers to deliver acute care services in Charlotte, North Carolina, closer to where Veterans live.

Market Overview

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

Market Map



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

Facilities: The market has two VAMCs (Asheville and Salisbury), two health care centers (HCCs), two multi-specialty community-based outpatient clinics (MS CBOCs), and two CBOCs.

Enrollees: In fiscal year (FY) 2019, the market had 144,549 enrollees, and is projected to experience a 2.8% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Mecklenburg, Guilford, and Forsyth, North Carolina.

Demand: Demand¹⁴ in the market for inpatient medical and surgical services is projected to decrease by 7.8% and demand for inpatient mental health services is projected to decrease by 3.5% between FY 2019 and FY 2029. Demand for long-term care¹⁵ is projected to increase by 22.5%. Demand for all

¹⁴ 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).

¹⁵ Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,¹⁶ including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 35.1% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 65.3% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 85.6% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers¹⁷ in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate¹⁸ of 66.8% (1,575 available beds)¹⁹ and an inpatient mental health occupancy rate of 76.1% (73 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 84.7% (640 available beds). Community residential rehabilitation programs²⁰ 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 Wake Forest University, the University of North Carolina Chapel Hill, Edward Via Virginia College of Osteopathic Medicine, and the Carolinas Medical Center. The Asheville VAMC is ranked 82 out of 154 VA training sites based on the number of trainees, and the Salisbury VAMC is ranked 64 out of 154. The Asheville VAMC is ranked 89 out of 103 VAMCs with research funding, and the Salisbury VAMC is ranked 76 out of 103. The Salisbury VAMC is designated as a Federal Coordinating Center, and the Asheville VAMC holds no emergency designation.²¹

Facility Overviews

Asheville VAMC: The Asheville VAMC is located in Asheville, North Carolina, and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Asheville VAMC had an inpatient medical and surgical average daily census (ADC) of 53.6, an inpatient mental health ADC of 14.0, an RRTP ADC of 11.9, and a CLC ADC of 61.1.

The Asheville VAMC was built in 1967 on 65.0 acres and the most recent renovation was in 2018. Facility condition assessment (FCA) deficiencies are approximately \$98.8M, and annual operations and maintenance costs are an estimated \$10.4M.

Salisbury VAMC: The Salisbury VAMC is located in Salisbury, North Carolina, and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Salisbury VAMC had an inpatient medical and surgical ADC of 26.1, an inpatient mental health ADC of 32.8, an RRTP ADC of 45.9, and a CLC ADC of 103.3.

¹⁶ Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).

¹⁷ Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

¹⁸ 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.

¹⁹ Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.

²⁰ Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

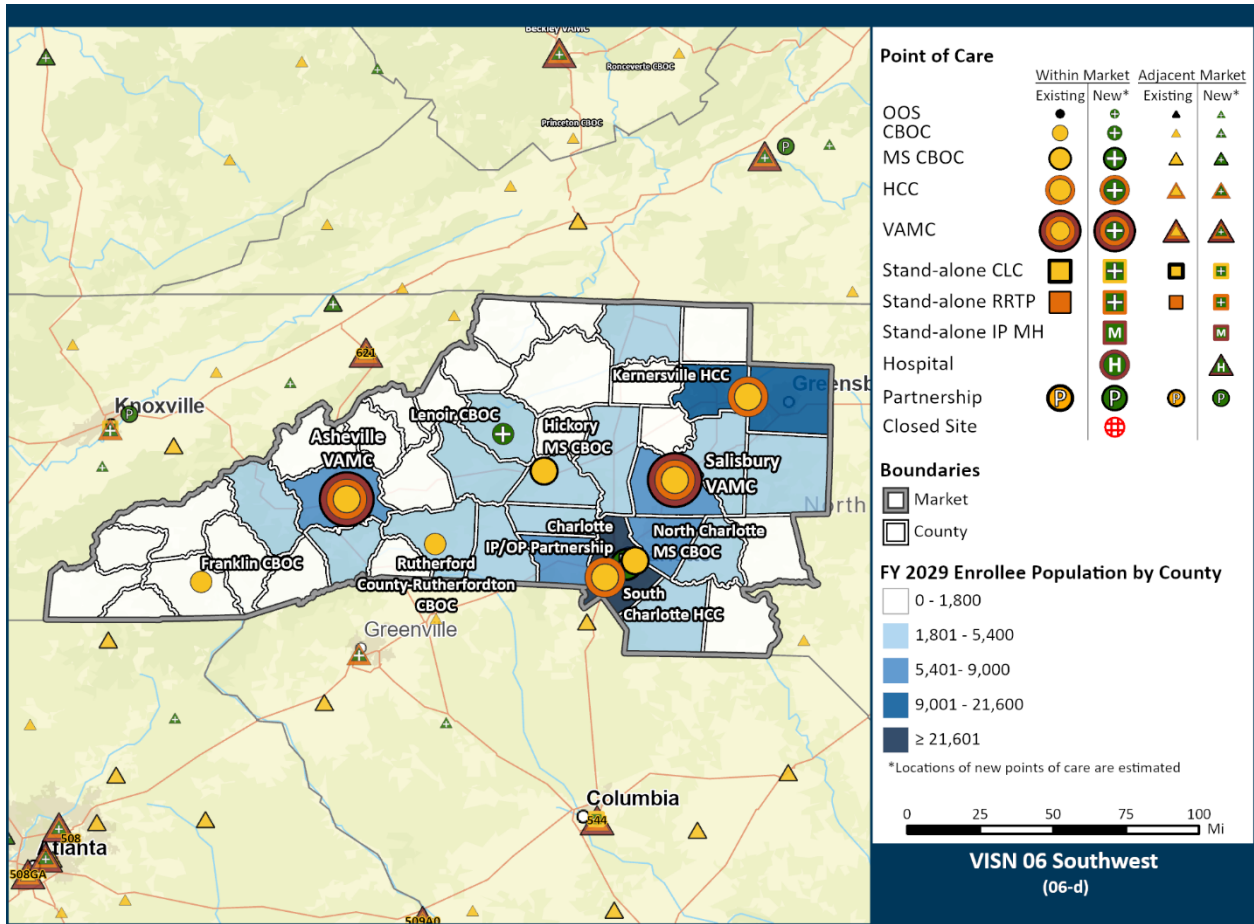
²¹ VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

The Salisbury VAMC was built in 1951 on 91.0 acres and the most recent renovation was in 1999. FCA deficiencies are approximately \$163.1M, and annual operations and maintenance costs are an estimated \$11.0M.

Recommendation and Justification

This section details the VISN 06 Southwest Market recommendation and justification for each element of the recommendation.

Future Market Map



- 1. Modernize the RRTP at the Asheville VAMC:** The Asheville VAMC has 14 RRTP beds and the Salisbury VAMC has 64 RRTP beds for a total of 78 beds in the market. The projected FY 2028 demand indicates that the Southwest Market needs 97 RRTP beds to meet future demand. VA will increase substance use disorder (SUD) bed capacity at the Asheville VAMC from 14 to 20 beds to meet future demand. As of FY 2019, the Asheville VAMC had 25,080 enrollees within a 60-minute drive time.

2. Modernize the Salisbury VAMC by:

- 2.1. Establishing a strategic collaboration to provide inpatient medical and surgical care and emergency department services and discontinuing those services at the Salisbury VAMC:** In FY 2019, the Salisbury VAMC had 44 inpatient medical and surgical beds and an inpatient medical and surgical ADC of 26.1. However, the in-house inpatient medical and surgical demand is projected to decrease to 16.7 ADC by FY 2019. The Salisbury ADC includes demand from a large number of enrollees that are on the fringe of 60-minute drive times in Kernersville, North Carolina, and Charlotte, North Carolina. Total inpatient medical and surgical care demand at the Salisbury VAMC is projected to decrease by 1.8% from FY 2019 to FY 2029. The Salisbury VAMC has had difficulties in recruiting and retaining providers. There is high-quality care in the Salisbury, North Carolina, area. Establishing a partnership with the academic affiliate in Charlotte, North Carolina, to deliver inpatient medical and surgical and emergency department services will provide access to care for Veterans in the Charlotte area. To partner, VA will consider establishing a sharing arrangement or lease that will allow VA providers to deliver inpatient medical and surgical care. Utilizing the community providers in the Salisbury, North Carolina, area and the existing academic affiliate's hospital partner in Kernersville, North Carolina, to deliver inpatient medical and surgical care services will provide access to care for Veterans in those two areas. Community providers have adequate capacity to absorb Veteran demand. As of 2019, community providers within a 60-minute drive time of the Salisbury VAMC had an inpatient acute occupancy rate of 71.8% (651 available beds).
- 2.2. Relocating outpatient surgical services currently provided at the Salisbury VAMC to current or future VA facilities and discontinuing those services at the Salisbury VAMC:** In FY 2019, the Salisbury VAMC had 2,258 outpatient surgical cases. However, the surgical programs at the Kernersville and South Charlotte HCCs were implemented in FY 2019. Those HCCs are expected to absorb workload previously provided by the Salisbury VAMC. As of FY 2019, the Kernersville HCC had 51,409 enrollees and the South Charlotte HCC had 68,846 enrollees within a 60-minute drive time. Relocating outpatient surgical services to the Kernersville HCC and Charlotte HCC will maintain Veteran access to outpatient surgical services within VA.
- 2.3. Converting the emergency department at the Salisbury VAMC to an urgent care center:** Given the proposed opportunity to relocate inpatient medical and surgical care services from the existing Salisbury VAMC to the proposed strategic collaboration, the existing emergency department at the Salisbury VAMC will be rescoped to an urgent care center, and convenient community access points will be utilized to provide emergency department services. This will allow the Salisbury VAMC services to align with the appropriate level of care needed to treat Veterans.
- 2.4. Establishing a new outpatient facility at the Salisbury VAMC:** Establishing a new ambulatory care building on the existing Salisbury VAMC campus (Rowan County) will expand access to primary care, outpatient mental health, outpatient specialty care, and urgent care services. The existing outpatient clinics are housed in the original 1951 hospital building on the Salisbury VAMC campus and the current outpatient clinic configuration is not conducive to fully implementing the patient aligned care team (PACT) model.

- 2.5. Modernizing the RRTP:** The Salisbury VAMC has 64 RRTP beds and the Asheville VAMC has 14 RRTP beds for a total of 78 beds in the market. The projected FY 2028 demand indicates that the Southwest Market will need 97 RRTP beds to meet future demand. VA will increase general domiciliary, Domiciliary Care for Homeless Veterans (DCHV), and posttraumatic stress disorder (PTSD) beds from 56 to 70 beds at the Salisbury VAMC to meet future demand. This expansion includes 30 general domiciliary, 30 DCHV, and 10 PTSD beds. As of FY 2019, the Salisbury VAMC had 70,071 enrollees within a 60-minute drive time.
- 3. Modernize and realign outpatient facilities in the market by establishing a new CBOC in the vicinity of Lenoir, North Carolina:** Establishing a new CBOC in Lenoir, North Carolina (Caldwell County) will expand access to primary care and outpatient mental health services. As of FY 2019, there were 5,779 enrollees within a 30-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:

Southwest Market

- **Utilize Nurse Practitioners and Physician Assistants to address primary care physician gaps and shortages:** Advanced practice providers operating at the full extent of their education and training will add VA capacity in a market that has difficulty recruiting and retaining providers.
- **Expand outpatient mental health capabilities and capacity for outpatient services across the system:** As a core competency of VA, the Southwest Market will expand outpatient mental health services across the system.
- **Expand partnerships with community providers in Asheville and leverage community providers to expand access in the community to audiology, dental, optometry, and rehabilitation therapy services:** Demand for outpatient services is projected to increase in the market. VA will utilize community providers for rehabilitative care, audiology, dental, and optometry services to focus VA providers on the core medical needs of Veterans.
- **Accelerate telehealth programs in audiology, dermatology, mental health, nutrition, primary care, pharmacology, and speech services:** VA will expand telehealth usage in the market which is currently below the national average.
- **Expand home-based primary care (HBPC) into VA outpatient clinics to provide access for outlying communities:** VA will expand HBPC to bring primary care access to the many market enrollees in rural areas.
- **Strengthen relationships with community nursing homes to provide long-term care closer to Veterans' homes:** VA will use community nursing homes to supplement VA's delivery of long-term care closer to where Veterans live.
- **Seek out and strengthen relationships with Indian Health Service (IHS) facilities and Federally Qualified Health Centers (FQHCs) to improve Veteran access to care:** VA will work with the

estimated 22 FQHCs in the Southwest market and with IHS and/or tribal health organizations to improve access to care for Veterans.

Salisbury VAMC

- Expand affiliation with Wake Forest in Kernersville, North Carolina to increase the availability of specialty care with more dually appointed physicians and work with Wake Forest to develop training opportunities at the South Charlotte HCC as the new satellite medical school comes onboard:** Wake Forest is planning a new medical school campus in conjunction with Atrium Health, which is planning to open an academic teaching hospital in the vicinity of Charlotte, North Carolina. VA will expand the affiliation with Wake Forest University to recruit more dually appointed physicians and more training positions to enhance care options at the South Charlotte and Kernersville HCCs.
- Expand and integrate interventional cardiology with Wake Forest to increase use of the cardiac catheterization and electrophysiology labs at the Kernersville HCC:** The volume of outpatient surgical cases at the Kernersville HCC is indicative of a startup program as the surgical program was implemented in FY 2019. Specialty care encounters at the Kernersville HCC increased by 39.8% from FY 2017 to FY 2019. As of FY 2019, there were 51,409 enrollees within a 60-minute drive time of the Kernersville HCC, which indicates sufficient demand to support outpatient surgical specialties. In the Southwest Market, demand for outpatient surgical specialties and outpatient specialty care is projected to increase by 58.1% and 50.2% respectively from FY 2019 to FY 2029.
- Strengthen the partnership between the Charlotte HCC and the new joint Wake Forest/Atrium Health Medical School:** Wake Forest is planning a new medical school campus in conjunction with Atrium Health, which is planning to open an academic teaching hospital in the vicinity of Charlotte, North Carolina. The Wake Forest medical school is located in Winston-Salem, North Carolina, near the Kernersville HCC and will have a satellite medical school in Charlotte, North Carolina, near the Charlotte HCC. Strengthening the partnership will allow VA to recruit and retain more physicians in the market.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COA) for the Southwest 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 cost²² 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

²² The present value cost is the current value of future costs discounted at the defined discount rate.

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 06 Southwest Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 06 Southwest Market	Status Quo	Modernization	VA Recommendation
COA Present Value (\$)	\$30,610,828,871	\$31,900,614,524	\$31,666,270,967
Capital Costs	\$2,506,267,001	\$3,796,052,655	\$3,773,698,399
Operational Costs	\$28,104,561,869	\$28,104,561,869	\$27,892,572,568
Total Benefit Score	7	10	14
CBI (normalized in \$B)	4.37	3.19	2.26

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 the nearest dollar.

Section 203 Criteria Analysis

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

Demand
<p><i>This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.</i></p> <ul style="list-style-type: none"> • Summary: Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand. • Outpatient: Outpatient demand will be met through 10 VA points of care offering outpatient services, including the proposed new Lenoir, North Carolina CBOC and partnership in Charlotte, North Carolina, as well as community providers in the market. • CLC: Long-term care demand will be met through the Salisbury, North Carolina VAMC and Asheville, North Carolina VAMC, as well as community nursing homes.

Demand

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 Hubs at the Richmond, Virginia VAMC and Augusta, Georgia VAMC (VISN 07).
- **RRTP:** RRTP demand will be met through the Salisbury, North Carolina VAMC; Asheville, North Carolina VAMC; and the other facilities within VISN 06 offering RRTP, including the Richmond, Virginia VAMC; and the proposed new Raleigh/Durham, North Carolina VAMC; Norfolk/Tidewater, Virginia VAMC; Newport News, Virginia VAMC; and Roanoke, Virginia VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the Asheville, North Carolina VAMC and the partnership in Charlotte, North Carolina, as well as through community providers. Mental health demand will be met through the Salisbury, North Carolina VAMC and Asheville, North Carolina 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 147,932 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 148,353 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 06. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Wake Forest University, University of North Carolina Chapel Hill, and Edward Via Virginia College of Osteopathic Medicine.
- **Research:** This recommendation does not impact the research mission in the market and allows the Salisbury, North Carolina VAMC and Asheville, North Carolina VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Salisbury, North Carolina VAMC and Asheville, North Carolina VAMC 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 Lenoir, North Carolina CBOC and Charlotte, North Carolina, partnership. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (2.26 for VA Recommendation versus 4.37 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 Lenoir, North Carolina CBOC and Charlotte, North Carolina partnership. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community partner space.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today (\$31.7B for VA Recommendation versus \$31.9B 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 (2.26 for VA Recommendation versus 3.19 for Modernization), reflecting effective stewardship of taxpayer dollars.



VISN 06 Northwest Market

The Veterans Integrated Service Network (VISN) 06 Northwest Market serves Veterans in western Virginia. 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.²³

VA's Commitment to Veterans in the Northwest Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 06's Northwest 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 Northwest Market is facing decreasing market enrollment. Demand for inpatient medical and surgical services, inpatient mental health services, and long-term care is decreasing while demand for outpatient care is increasing. There is a need to expand access to VA health care to meet the existing and projected demand and to modernize facilities to meet current design standards. The strategy for the Northwest Market invests in modern facilities in a strong health care market and relocates sustainable services from aging infrastructure at the Salem VAMC to appropriately sized facilities in the vicinity of the academic affiliate in Roanoke. The strategy 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 to care by investing in modern facilities close to where Veterans live. The recommendation establishes one new community-based outpatient clinic (CBOC) to expand access to primary care and mental health services, maintains all sustainable outpatient points of care in the market, and provides outpatient services in a new VAMC in Roanoke, Virginia.

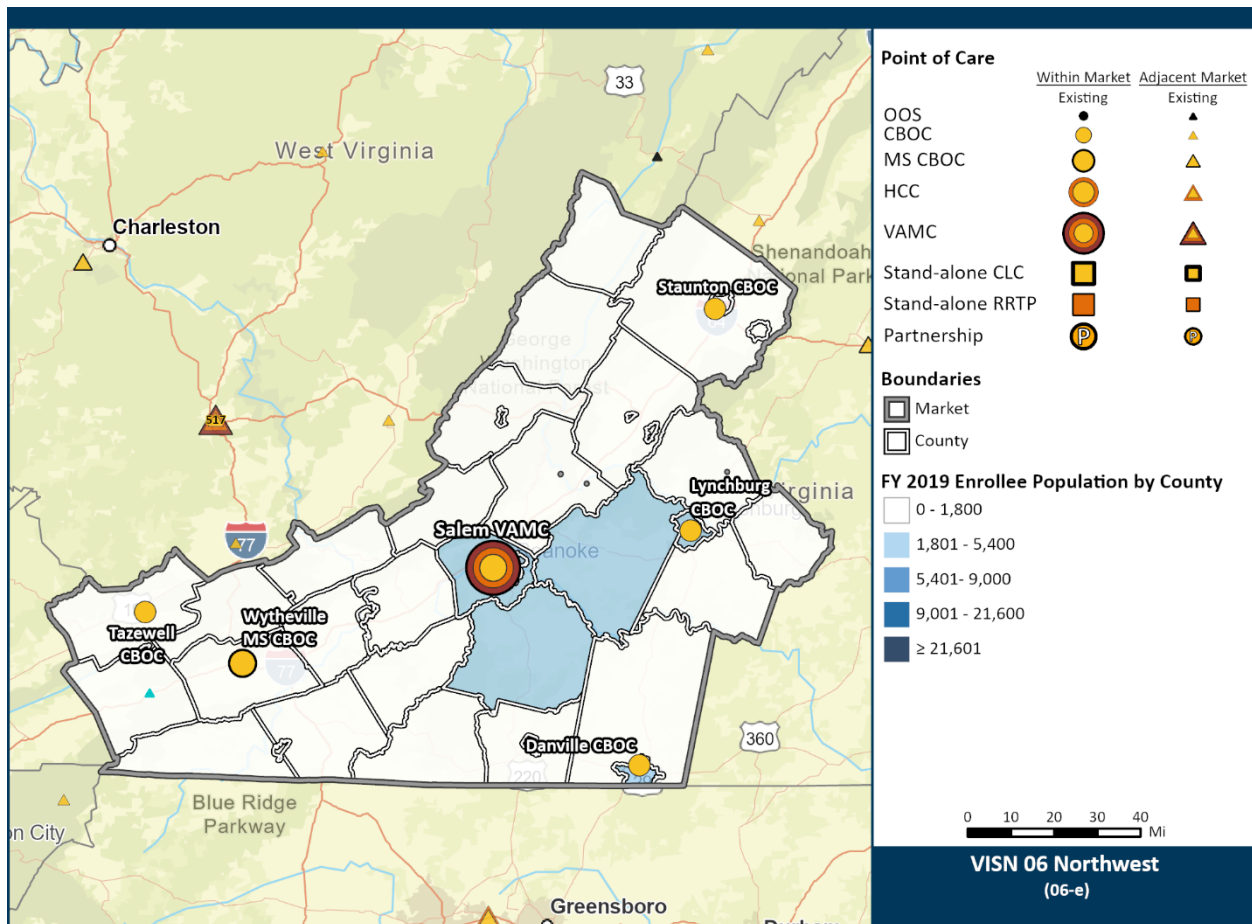
²³ Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- Enhance VA’s unique strengths in caring for Veterans with complex needs:** VA’s recommendation invests in a new VAMC in Roanoke, Virginia, which will have a community living center (CLC) and residential rehabilitation treatment program (RRTP) services. VA’s recommendation maintains an inpatient spinal cord injuries and disorders (SCI/D) program at the SCI/D Hub at the Richmond VAMC in the VISN 06 Northeast Market. Inpatient blind rehabilitation services will be maintained through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).
- 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 relocates the inpatient medical and surgical program at the Salem VAMC to a strategic collaboration with a community provider, which will allow VA to deliver acute care services within a partner’s facility closer to where Veterans live.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Salem), one multi-specialty community-based outpatient clinic (MS CBOC), and four CBOCs.

Enrollees: In fiscal year (FY) 2019, the market had 43,289 enrollees and is projected to experience a 9.3% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in Roanoke City, Roanoke County, and Lynchburg City in Virginia.

Demand: Demand²⁴ in the market for inpatient medical and surgical services is projected to decrease by 6.1% and demand for inpatient mental health services is projected to decrease by 11.0% between FY 2019 and FY 2029. Demand for long-term care²⁵ is projected to decrease by 14.1%. Demand for all outpatient services,²⁶ including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 62.8% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 57.3% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 44.4% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers²⁷ in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate²⁸ of 67.4% (165 available beds)²⁹ and an inpatient mental health occupancy rate of 73.8% (6 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 90.7% (16 available beds). Community residential rehabilitation programs³⁰ 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 Virginia, Edward Via College of Osteopathic Medicine, Virginia Tech, Carilion Clinic, and LewisGale Medical Center. The Salem VAMC is ranked 60 out of 154 VA training sites based on the number of trainees. The Salem VAMC is ranked 72 out of 103 VAMCs with research funding. The Salem VAMC holds no emergency designation.³¹

Facility Overview

Salem VAMC: The Salem VAMC is located in Salem, Virginia, and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Salem VAMC had an

²⁴ 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).

²⁵ Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

²⁶ Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).

²⁷ Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

²⁸ 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.

²⁹ Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.

³⁰ Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

³¹ 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.

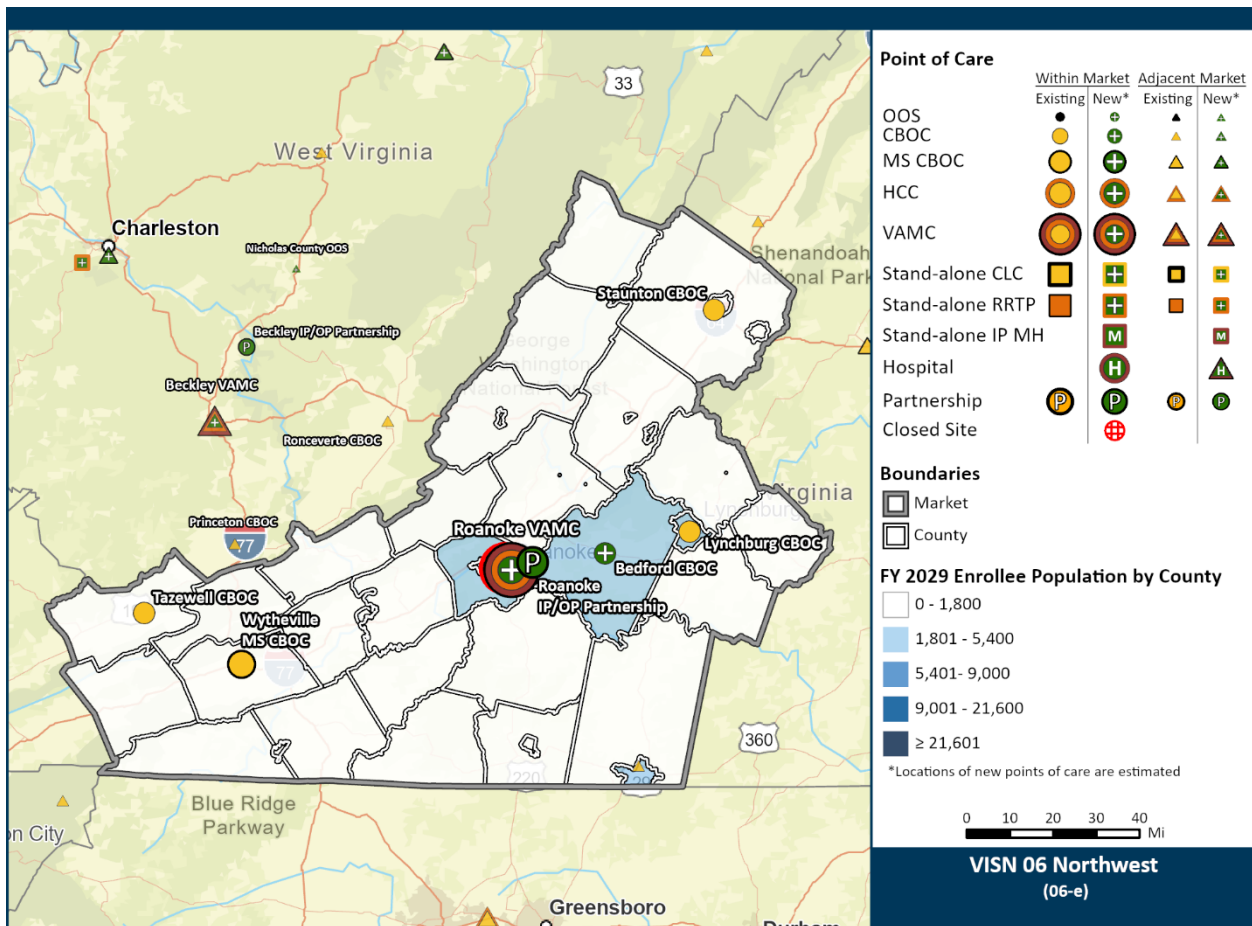
inpatient medical and surgical average daily census (ADC) of 54.3, an inpatient mental health ADC of 24.6, an RRTP ADC of 30.5, and a CLC ADC of 50.3.

The Salem VAMC was built in 1992, but much of the 215-acre campus was established in the 1930s. Facility condition assessment (FCA) deficiencies are approximately \$291.3M, and annual operations and maintenance costs are an estimated \$14.1M. Over 60% of the building gross square feet are on the National Historical Register.

Recommendation and Justification

This section details the VISN 06 Northwest Market recommendation and justification for each element of the recommendation.

Future Market Map



1. Modernize and realign the Salem VAMC by:

- 1.1. **Constructing a replacement VAMC with inpatient mental health, RRTP, CLC, and outpatient services in the vicinity of Roanoke, Virginia:** The Salem VAMC offers inpatient medical and surgical care, inpatient mental health, RRTP, CLC, and outpatient services. While the main Salem VAMC hospital building was built in 1992, many of the campus buildings are significantly

older, are on the historical register, and do not meet modern health care standards.³² Dating back to the 1930s, the campus has severe infrastructure issues and faces high operating and maintenance costs and over \$291.3M in FCA deficiencies. The proposed new Roanoke VAMC (Roanoke City) will provide access to inpatient services, including inpatient mental health, RRTP, and CLC services, and outpatient services, including primary care, outpatient mental health, urgent care, and outpatient specialty care services. In FY 2019, there were 19,177 enrollees within a 60-minute drive time of the proposed Roanoke VAMC. Demand for inpatient mental health services in the Northwest Market is projected to decrease by 11.0% to 18.2 ADC and demand for long-term care is projected to decrease by 14.1% to 60.7 ADC by FY 2029. Demand for RRTP services in the Northwest Market is projected to be 23 beds (20.0 ADC) by FY 2028.

1.2. Establishing a strategic collaboration to provide inpatient medical and surgical services, outpatient surgical services, and emergency department services and discontinuing those services at the Salem VAMC. If unable to enter into a strategic collaboration, utilize community providers:

The Salem VAMC has difficulty recruiting and retaining specialty care providers and the current multi-building layout, aging infrastructure, and major architectural engineering challenges on the campus make it impractical and inefficient for continued future capital investments. The Salem VAMC has 56 inpatient medical and surgical beds, and in FY 2019 had an ADC of 54.3 and a projected FY 2029 ADC of 35.0. VA recommends creating a strategic collaboration to allow VA providers to deliver inpatient medical and surgical care, outpatient surgical services, and emergency department services through a sharing agreement or lease. This will allow for the shift of acute inpatient services away from the outdated Salem VAMC and into a properly sized, modern facility that will provide continued access to VA-delivered inpatient medical and surgical care. Market enrollment and total demand for inpatient medical and surgical care services are projected to decrease by 9.3% and 6.1% respectively from FY 2019 to FY 2029. Establishing a new VAMC to provide inpatient mental health, CLC, RRTP, and outpatient services and a strategic collaboration to deliver VA-provided inpatient medical and surgical and outpatient surgical services in Roanoke, Virginia, will improve access, safety, and quality of care for Veterans in a modern health care environment, while reducing ongoing maintenance costs.

1.3. Closing the Salem VAMC: Relocating services from the Salem VAMC to the new Roanoke VAMC and establishing a strategic collaboration with an academic affiliate and community providers will allow for the closure of the existing VAMC.

2. Modernize and realign outpatient facilities in the market by establishing a new CBOC in the vicinity of Bedford, Virginia: A new CBOC in Bedford, Virginia (Bedford County), will allow VA to expand access to primary care and outpatient mental health services to Veterans in the Bedford area, as there are currently no facilities within a 30-minute drive time. As of FY 2019, there were 3,824 enrollees within 30 minutes of the proposed site.

³² Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

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:

Northwest Market

- Increase availability of neurosurgery across the Northwest Market to address the potential lack of high-quality neurosurgeons:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality neurosurgeons that requires increased availability of neurosurgery services across points of care in the Northwest Market. Increased availability may be achieved through a variety of tactics, such as telehealth and recruitment of providers to the Veterans Community Care Program (VCCP), as appropriate.
- Increase availability of ophthalmology across the Northwest Market to address the potential lack of high-quality ophthalmologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists that requires increased availability of ophthalmology services across points of care in the Northwest Market. Increased availability may be achieved through a variety of tactics, such as telehealth, recruitment of providers to the VCCP, and hiring additional VA providers, as appropriate.
- Realign the Danville CBOC to the Raleigh/Durham VAMC in the VISN 06 Southeast Market:** The Danville CBOC is 2 hours from the Salem VAMC and 1.5 hours from the new proposed Raleigh/Durham VAMC. Realigning the Danville CBOC to the Raleigh/Durham VAMC in the VISN 06 Southeast Market will rationalize referral patterns and allow Veterans to receive specialty care closer to where they live.

Salem VAMC

- Expand access to primary care through new strategic collaborations with Federally Qualified Health Centers (FQHCs), area universities, telehealth, and new VA points of care to improve access to care for Veterans:** To meet projected increases in demand for primary care services, VA will partner with FQHCs, academic affiliates, and community providers.
- Establish home-based primary care (HBPC) at the Lynchburg CBOC to provide better access to care for Veterans in outlying communities:** Primary care encounters at the Lynchburg CBOC increased by 12.3% from 13,363 to 15,006 between FY 2017 and FY 2019. Demand for primary care in the Northwest Market is projected to increase by 70.5% between FY 2019 and FY 2029. As of FY 2019, there were 10,564 enrollees within a 60-minute drive time of the Lynchburg CBOC. As of FY 2019, 55.7% of enrollees in the Northwest Market were over the age of 65. Expanding HBPC will meet the increasing demand for primary care services.
- Expand the VCCP and leverage community resources to expand access to inpatient medical and surgical services for areas outside of Roanoke, Virginia:** The community has the capacity to accommodate Veteran demand for inpatient medical and surgical care. VA will leverage community resources to provide these services to enrollees in communities located outside of a 60-minute drive time to Roanoke, Virginia.

- **Expand academic affiliations; consider dual-appointed staff:** The proposed new Roanoke VAMC will strengthen the existing relationship with academic affiliates further to relieve persistent staffing difficulties.
- **Expand research and strengthen academic affiliations to obtain clinical trial studies:** The Salem VAMC has significant training and research programs. The proposed new Roanoke VAMC will strengthen the existing relationships to further expand research and obtain clinical trial studies.
- **Strengthen relationships with community nursing homes to provide extended care services closer to the Veterans' homes whenever possible:** VA will strengthen existing relationships with community providers to expand access to high-quality long-term care services throughout the market.
- **Ensure there is adequate space to support the research initiative at the proposed Roanoke VAMC:** To ensure that the existing research mission at the Salem VAMC is maintained within the Northwest Market upon the closure of the Salem VAMC, VA will relocate the research programs from the Salem VAMC to the proposed new Roanoke VAMC and other facilities within the market. The Office of Research and Development will be consulted in the planning for the proposed Roanoke VAMC to ensure there is space to maintain existing research programs.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 06 Northwest 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 cost³³ 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 06 Northwest Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

³³ The present value cost is the current value of future costs discounted at the defined discount rate.

VISN 06 Northwest Market	Status Quo	Modernization	VA Recommendation
COA Present Value (\$)	\$10,429,394,645	\$10,358,234,257	\$8,826,246,376
Capital Costs	\$1,211,584,384	\$1,140,423,997	\$450,695,618
Operational Costs	\$9,217,810,260	\$9,217,810,260	\$8,375,550,758
Total Benefit Score	10	11	15
CBI (normalized in \$B)	1.04	0.94	0.59

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 the nearest dollar.

Section 203 Criteria Analysis

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

Demand
<p><i>This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.</i></p> <ul style="list-style-type: none"> • Summary: Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand. • Outpatient: Outpatient demand will be met through seven VA points of care offering outpatient services, including the proposed new Roanoke, Virginia VAMC; Bedford, Virginia CBOC; and Roanoke, Virginia partnership, as well as community providers in the market. • CLC: Long-term care demand will be met through the proposed new Roanoke, Virginia VAMC, and community nursing homes. <p><i>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.</i></p> <ul style="list-style-type: none"> • SCI/D: Demand for inpatient SCI/D will be met through the SCI/D Hub at the Richmond, Virginia VAMC. • RRTP: RRTP demand will be met through the proposed new Roanoke, Virginia VAMC and the other facilities within VISN 06 offering RRTP, including the Richmond, Virginia VAMC; Salisbury, North Carolina VAMC; Asheville, North Carolina VAMC; and proposed new Raleigh/Durham, North Carolina VAMC; Norfolk/Tidewater, Virginia VAMC; and Newport News, Virginia VAMC. • Blind rehabilitation: Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).

Demand

- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the proposed new partnership in Roanoke, Virginia, as well as through community providers. Inpatient mental health demand will be met through the proposed new Roanoke, Virginia 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 39,638 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 39,947 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 06. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Virginia Tech, the University of Virginia, and Edward Via College of Osteopathic Medicine.
- **Research:** This recommendation does not impact the research mission in the market and allows the market to maintain the current research mission by ensuring there is adequate space to support research at the proposed new Roanoke, Virginia VAMC.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; no VAMCs in this market are designated as a Primary Receiving Center.

Quality

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

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

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.59 for VA Recommendation versus 1.04 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 Roanoke, Virginia VAMC; Bedford, Virginia CBOC; and Roanoke, Virginia partnership. 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 (\$8.8B for VA Recommendation versus \$10.4B 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 (0.59 for VA Recommendation versus 0.94 for Modernization), reflecting effective stewardship of taxpayer dollars.



VISN 06 Southeast Market

The Veterans Integrated Service Network (VISN) 06 Southeast Market serves Veterans in eastern North Carolina. 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.³⁴

VA's Commitment to Veterans in the Southeast Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 06's Southeast 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

Veteran enrollees in the Southeast Market are projected to increase rapidly. Demand for all services is also projected to increase. There is a need to relocate acute services closer to Veterans, move care out of outdated and space-constrained infrastructure, and expand outpatient services to increase access to VA health care to meet the existing and projected Veteran demand. The strategy for the Southeast 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 to care by investing in modern facilities close to where Veterans live and consolidating care into appropriately sized facilities. The recommendation relocates one new multi-specialty community-based outpatient clinic (MS CBOC) to improve access to primary care, mental health, and specialty care services. The recommendation expands one MS CBOC into a health care center (HCC) to increase access to outpatient surgical care. The recommendation maintains all sustainable outpatient points of care in the market and consolidates three community-based outpatient clinics (CBOCs) and four other outpatient services (OOS) sites into three HCCs to provide expanded outpatient services.

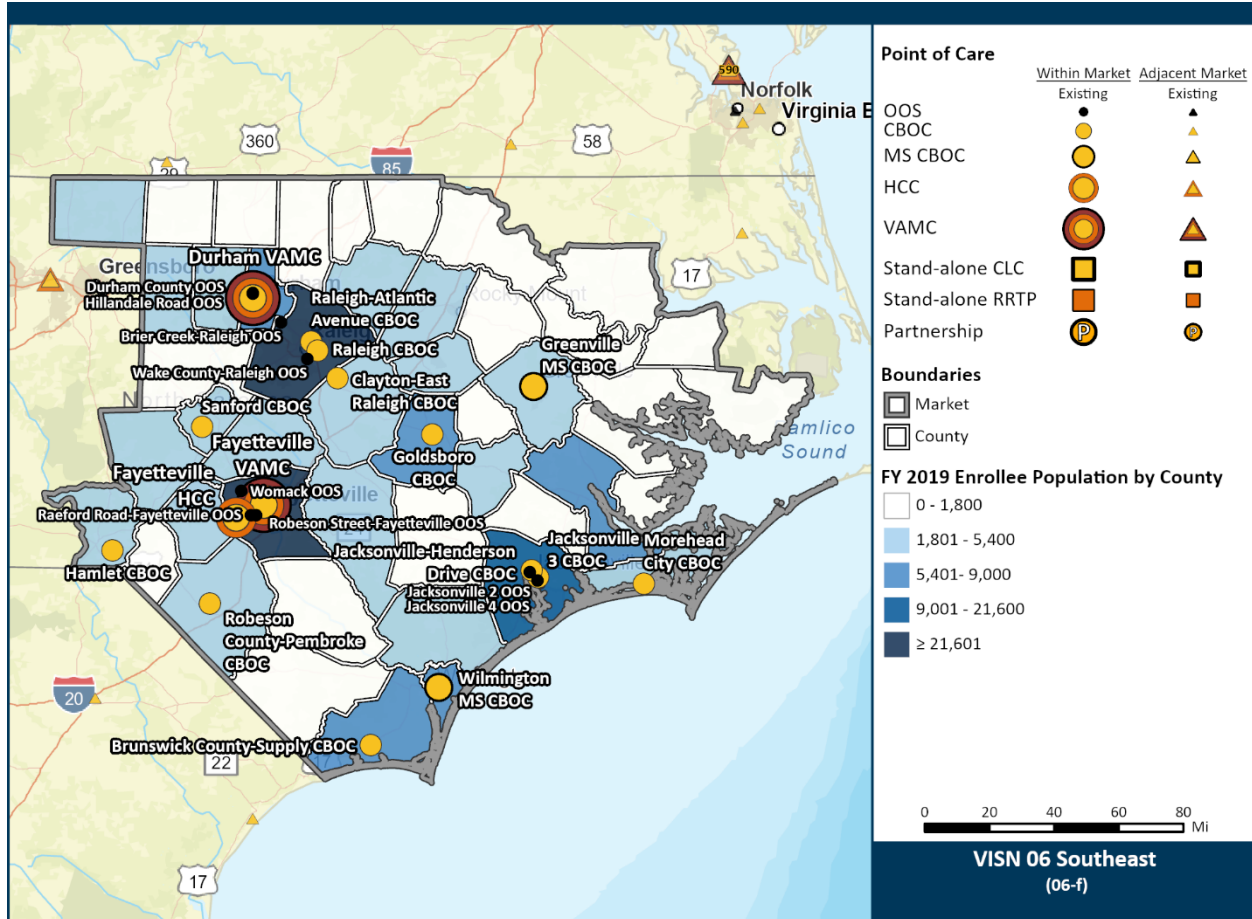
³⁴ Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA’s unique strengths in caring for Veterans with complex needs:** VA’s recommendation invests in a new VAMC in Raleigh/Durham, North Carolina, which will provide community living center (CLC) and residential rehabilitation treatment program (RRTP) services and modernizes the CLC at the Fayetteville VAMC. Inpatient mental health services will be provided at the new VAMC in Raleigh/Durham, North Carolina, and maintained at the Fayetteville VAMC. VA’s recommendation maintains an inpatient spinal cord injuries and disorders (SCI/D) program at the SCI/D Hub at the Richmond VAMC in the VISN 06 Northeast Market. Inpatient blind rehabilitation services will be maintained through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC in VISN 01; the proposed new King of Prussia, Pennsylvania VAMC in VISN 04; and the Cleveland, Ohio VAMC in VISN 10.
- **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 modern health care facilities by constructing a new VAMC in Raleigh/Durham, North Carolina. It also relocates a low-volume inpatient medical and surgical care program at the Fayetteville VAMC to a strategic collaboration to allow VA providers to deliver these services, which will maintain Veteran access in the Fayetteville area.

Market Overview

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

Market Map



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

Facilities: The market has 2 VAMCs (Durham and Fayetteville), 1 HCC, 2 MS CBOCs, 11 CBOCs, and 9 OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 186,782 enrollees and is projected to experience a 20.1% increase in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Cumberland, Wake, and Onslow, North Carolina.

Demand: Demand³⁵ in the market for inpatient medical and surgical services is projected to increase by 13.1% and demand for inpatient mental health services is projected to increase by 15.6% between FY 2019 and FY 2029. Demand for long-term care³⁶ is projected to increase by 67.5%. Demand for all

³⁵ 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).

³⁶ Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,³⁷ including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 45.0% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 75.7% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 60.0% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers³⁸ in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate³⁹ of 75.5% (584 available beds)⁴⁰ and an inpatient mental health occupancy rate of 72.0% (33 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 84.1% (216 available beds). Community residential rehabilitation programs⁴¹ 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 Duke University and East Carolina University. The Durham VAMC is ranked 19 out of 154 VA training sites based on the number of trainees, and the Fayetteville VAMC is ranked 80 out of 154. The Durham VAMC is ranked 13 out of 103 VAMCs with research funding, and the Fayetteville VAMC conducts limited or no research. The Durham VAMC is designated as a Federal Coordination Center, and the Fayetteville VAMC holds no emergency designation.⁴²

Facility Overviews

Durham VAMC: The Durham VAMC is located in Durham, North Carolina, and offers inpatient medical and surgical, inpatient mental health, CLC, and outpatient services. In FY 2019, the Durham VAMC had an inpatient medical and surgical average daily census (ADC) of 91.5, an inpatient mental health ADC of 26.2, and a CLC ADC of 49.5.

The Durham VAMC was built in 1953 on 18.5 acres and was most recently renovated in 1991. Facility condition assessment (FCA) deficiencies are approximately \$191.2M, and annual operations and maintenance costs are an estimated \$13.0M.

Fayetteville VAMC: The Fayetteville VAMC is located in Fayetteville, North Carolina, and offers inpatient medical and surgical, inpatient mental health, CLC, and outpatient services. In FY 2019, the Fayetteville VAMC had an inpatient medical ADC of 13.5, an inpatient mental health ADC of 17.0, and a CLC ADC of 44.9.

³⁷ Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).

³⁸ Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

³⁹ 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.

⁴⁰ Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.

⁴¹ Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.

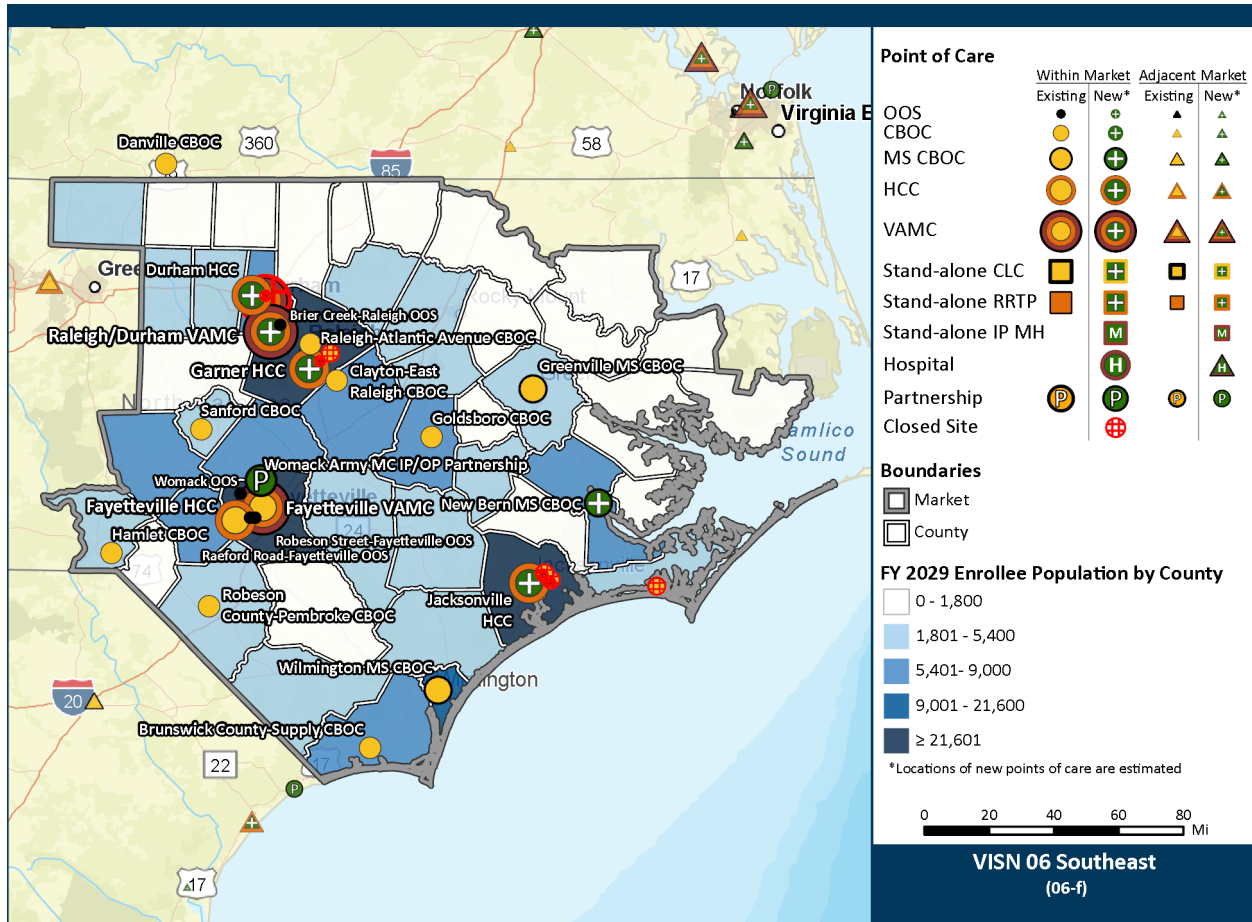
⁴² VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

The Fayetteville VAMC was built in 1939 on 47.3 acres with the most recent renovations in 1988. FCA deficiencies are approximately \$89.5M, and annual operations and maintenance costs are an estimated \$4.9M.

Recommendation and Justification

This section details the VISN 06 Southeast Market recommendation and justification for each element of the recommendation.

Future Market Map



1. Modernize and realign the Durham VAMC by:

- 1.1. **Constructing a replacement VAMC in the Raleigh/Durham metropolitan area:** The Durham VAMC (Durham County) currently provides robust inpatient medical and surgical care, inpatient mental health care, CLC, primary care, outpatient mental health care, outpatient specialty care, outpatient surgical, and emergency department services. However, the facility is landlocked, surrounded completely by Duke University-owned properties. The Durham VAMC cannot support additional expansion and has several infrastructural challenges, including insufficient parking, electrical, heating, ventilation, and air conditioning (HVAC), and wayfinding on the campus. The current infrastructure requires renovation, and considerable financial investment

would be required to bring the facility up to modern health care standards. Demand for inpatient medical and surgical care and other services is projected to increase beyond current VA capacity. Consolidating services at a new, optimally located site of care will provide Veterans with access to a state-of-the-art facility. The proposed Raleigh/Durham VAMC (Wake/Durham counties) will provide inpatient medical and surgical care, inpatient mental health, emergency department, CLC, RRTP, outpatient surgical, and outpatient specialty care services. Enrollees in the Southeast Market are projected to increase by 20.1% between FY 2019 and FY 2029. The largest enrollee populations are centered around the Raleigh, North Carolina, area in Wake, Harnett, Johnston, and Franklin counties. In FY 2019, Durham County had 7,421 enrollees in FY 2019 that are projected to increase to 7,496 by FY 2029. Wake County had 23,888 enrollees in FY 2019 that are projected to increase to 26,137 in FY 2029. Constructing a new VAMC in the Raleigh/Durham metropolitan area in North Carolina will provide a modern health care setting for Veterans while maintaining academic affiliations. In FY 2019, there were over 58,580 enrollees within a 60-minute drive time of the proposed Raleigh/Durham VAMC site.

- 1.2. Closing the Durham VAMC:** Relocating services from the Durham VAMC to the new Raleigh/Durham VAMC and new Durham HCC will allow for closure of the existing Durham VAMC.

2. Modernize and realign the market by:

- 2.1. Establishing a new HCC in the vicinity of the Duke University in Durham, North Carolina:** A new HCC in Durham, North Carolina (Durham County), will provide a replacement facility for a portion of outpatient ambulatory services provided at the Durham VAMC. The Durham HCC will deliver primary care, outpatient mental health, outpatient specialty care, and outpatient surgical services. Much of Durham HCC specialty physicians will be dual-appointed physicians with Duke University. As of FY 2019, there were 16,703 enrollees within a 30-minute drive time and 57,972 enrollees within a 60-minute drive time of the proposed HCC site.

3. Modernize and realign the Fayetteville VAMC by:

- 3.1. Modernizing CLC and inpatient mental health services at the Fayetteville VAMC:** The Fayetteville VAMC provides inpatient medical and surgical, inpatient mental health, CLC, primary care, outpatient mental health, outpatient specialty care, and urgent care services. The Fayetteville HCC is located nine minutes from the VAMC and provides primary care, outpatient mental health, outpatient specialty care, and outpatient surgical care services. Inpatient medical and surgical care at the Fayetteville VAMC had been closed for four years for remodeling and Veterans have successfully sought care for these services from community providers and Womack Army Hospital. The main patient care facility was constructed in 1939 and was last renovated in 1988. Major challenges include electrical, plumbing, and HVAC. The location and facility layout complicate renovation and limit new construction. The Fayetteville VAMC campus is outdated and does not conform to modern environment of care standards. In 2021, a new stand-alone small-home model CLC with 24-beds was opened on a corner of the site independent from the existing site utilities plant. VA recommends adding 45 beds to the CLC for a 69-bed count and a new 20-bed inpatient mental health service, which will be the only remaining services on the campus. Distributing CLC and inpatient mental health services to

modern and conveniently located facilities for Veterans will allow for closure of the existing hospital building of the Fayetteville VAMC.

- 3.2. Establishing a strategic collaboration to provide inpatient medical and surgical services and outpatient surgical services and discontinuing those services at the Fayetteville VAMC. If unable to enter into a strategic collaboration for inpatient medical and surgical services, utilize community providers to provide the services:** In FY 2019, the Fayetteville VAMC had 28 inpatient medical and surgical beds and an inpatient medical and surgical ADC of 13.5. Given the low ADC, VA recommends relocating inpatient medical and surgical services to a partnership. VA will pursue a partnership with the Department of Defense’s (DoD) Womack Army Medical Center. The partnership would expand the existing sharing arrangement to allow VA providers to deliver inpatient medical and surgical care. Currently, the Fayetteville HCC and the Womack Army Medical Center have a sharing arrangement for outpatient surgical services. There is capacity available at the Womack Army Medical Center to provide quality care to Veterans. Relocating care away from the existing aged Fayetteville VAMC will deliver high-quality care to Veterans and improve efficiency, while decreasing the ongoing maintenance and FCA costs for the VAMC.
- 3.3. Relocating primary care, outpatient mental health, outpatient specialty care, and urgent care services provided at the Fayetteville VAMC to current or future VA facilities and discontinuing those services at the Fayetteville VAMC:** The Fayetteville VAMC campus is outdated and does not meet current design standards.⁴³ In 2017, the Fayetteville HCC was opened and all ambulatory care – primary care, outpatient mental health, outpatient specialty care services – is in the process of relocating to this new HCC. The Fayetteville HCC is located within an approximately 9-minute drive time of the VAMC. In the Southeast Market, demand for primary care is projected to increase by 110.1% and outpatient mental health is projected to increase by 92.1% between FY 2019 and FY 2029. Urgent care encounters have increased by 8.6% between FY 2017 and FY 2019. Enrollees in the Southeast Market are projected to increase by 20.1% from 186,782 to 224,391 between FY 2019 and FY 2029. Moving these services to a new site that meets modern design standards will increase the quality of care Veterans are receiving in a growing market.

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

- 4.1. Establishing a new MS CBOC in the vicinity of New Bern, North Carolina:** A new MS CBOC in New Bern, North Carolina (Craven County), will replace the existing Morehead CBOC (Carteret County) and expand access to primary care, outpatient mental health, and outpatient specialty care services. Carteret County (Morehead City) is projected to have 4,031 enrollees in FY 2029, while Craven County (New Bern) is projected to have 7,116 enrollees in FY 2029. Enrollees in Craven County are projected to increase by 21.6% from 5,854 enrollees to 7,116 enrollees between FY 2019 and FY 2029. In FY 2019, there were 5,548 enrollees within a 30-minute drive time and 30,778 enrollees within a 60-minute drive time of the proposed site.

⁴³ Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

- 4.2. Establishing outpatient surgical services at the planned Jacksonville MS CBOC:** The Jacksonville MS CBOC, which is currently under development, will be expanded to include outpatient surgical care services, which may result in the classification of the facility as an HCC. The proposed Jacksonville HCC will consolidate services from the Jacksonville 2 OOS, Jacksonville 3 CBOC, and Jacksonville 4 CBOC, which will maintain access while allowing for the closure of those facilities.
- 4.3. Relocating all services to the planned Garner HCC and closing the Wake County-Raleigh OOS:** Relocating primary care and outpatient mental health services currently offered at the Wake County-Raleigh OOS to the planned Garner HCC, which is currently under development, will allow for the closure of the Wake County-Raleigh OOS. The Wake County-Raleigh OOS is located an estimated seven minutes (3.3 miles) from the planned Garner HCC. Consolidating services at a new optimally located site of care will provide Veterans with access to a state-of-the-art facility and will support increased operational efficiencies.
- 4.4. Relocating all services to the planned Garner HCC and closing the Raleigh CBOC:** Relocating primary care and outpatient mental health services currently offered at the Raleigh CBOC to the planned Garner HCC, which is currently under development, will allow for the closure of the Raleigh CBOC. The Raleigh CBOC is located an estimated 18 minutes (8.0 miles) from the planned Garner HCC. Consolidating services at a new optimally located site of care will provide Veterans with access to expanded services at a state-of-the-art facility and will support increased operational efficiencies.
- 4.5. Relocating all services to the proposed Durham HCC and closing the Durham County OOS:** Relocating primary care and outpatient mental health services currently offered at the Durham County OOS to a new HCC in Durham, North Carolina, or to other VA sites of care, will allow for the closure of the Durham County OOS. The proposed Durham HCC will expand access to care for Veterans in the Durham area. In FY 2019, there were 16,703 enrollees within a 30-minute drive time and 57,972 enrollees within a 60-minute drive time of the proposed HCC site.
- 4.6. Relocating all services to the proposed Durham HCC and closing the Hillandale Road OOS:** Relocating primary care and outpatient mental health services currently offered at the Hillandale Road OOS to a new HCC in Durham, North Carolina, or to other VA sites of care, will allow for the closure of the Hillandale OOS. The Hillandale Road OOS is located an estimated one minute (0.1 miles) from the proposed Durham HCC. The proposed Durham HCC will expand access to care for Veterans in the Durham area. In FY 2019, there were 16,703 enrollees within a 30-minute drive time and 57,972 enrollees within a 60-minute drive time of the proposed HCC site.
- 4.7. Relocating all services to the proposed Jacksonville HCC and closing the Jacksonville-Henderson Drive CBOC:** Relocating primary care and outpatient mental health services currently offered at the Jacksonville-Henderson Drive CBOC to the proposed Jacksonville HCC will allow for the closure of the Jacksonville-Henderson Drive CBOC. The proposed Jacksonville HCC (Onslow County) will expand services and access to care for Veterans in the Jacksonville, North Carolina, area. Enrollees in Onslow County are projected to increase by 59.6% from FY 2019 to FY 2029 to more than 25,000 enrollees. In FY 2019 there were 15,526 enrollees within

a 30-minute drive time and 28,810 enrollees within a 60-minute drive time of the proposed site.

4.8. Relocating all services to the proposed Jacksonville HCC and closing the Jacksonville 2 OOS:

Relocating primary care and outpatient mental health services currently offered at the Jacksonville 2 OOS to the proposed Jacksonville HCC or to other VA sites of care, will allow for the closure of the Jacksonville 2 OOS. The proposed Jacksonville HCC (Onslow County) will expand services and access to care for Veterans in the Jacksonville, North Carolina, area. Enrollees in Onslow County are projected to increase by 59.6% from FY 2019 to FY 2029 to more than 25,000 enrollees. In FY 2019 there were 15,526 enrollees within a 30-minute drive time and 28,810 enrollees within a 60-minute drive time of the proposed site.

4.9. Relocating all services to the proposed Jacksonville HCC and closing the Jacksonville 3 CBOC:

Relocating primary care and outpatient mental health services currently offered at the Jacksonville 3 CBOC to the proposed Jacksonville HCC or to other VA sites of care, will allow for the closure of the Jacksonville 3 CBOC. The proposed Jacksonville HCC (Onslow County) will expand services and access to care for Veterans in the Jacksonville, North Carolina, area. Enrollees in Onslow County are projected to increase by 59.6% from FY 2019 to FY 2029 to more than 25,000 enrollees. In FY 2019 there were 15,526 enrollees within a 30-minute drive time and 28,810 enrollees within a 60-minute drive time of the proposed site.

4.10. Relocating all services to the proposed Jacksonville HCC and closing the Jacksonville 4 OOS:

Relocating primary care and outpatient mental health services currently offered at the Jacksonville 4 OOS to the proposed Jacksonville HCC (Onslow County) will allow for the closure of the Jacksonville 4 OOS. The proposed Jacksonville HCC will expand services and access to care for Veterans in the Jacksonville, North Carolina, area. Enrollees in Onslow County are projected to increase by 59.6% from FY 2019 to FY 2029 to more than 25,000 enrollees. In FY 2019 there were 15,526 enrollees within a 30-minute drive time and 28,810 enrollees within a 60-minute drive time of the proposed site.

4.11. Relocating all services to the proposed New Bern MS CBOC and closing the Morehead City CBOC:

Relocating primary care and outpatient mental health services currently offered at the Morehead City CBOC to a new MS CBOC in New Bern, North Carolina, will expand access to primary care, outpatient mental health, and outpatient specialty care services in the New Bern area. In FY 2019, the Morehead City CBOC (Carteret County) had 4,507 core uniques⁴⁴. However, there is a separate opportunity to establish a more centrally located VA site in Craven County (New Bern). The proposed MS CBOC in New Bern, North Carolina, will be an estimated 46-minute drive time from the Morehead City CBOC. Carteret County (Morehead City) is projected to have 4,031 enrollees in FY 2029, while Craven County (New Bern) is projected to have 7,116 enrollees in FY 2029. In FY 2019, there were 5,772 enrollees within a 30-minute drive time and 21,268 enrollees within a 60-minute drive time of the Morehead City CBOC, and 5,548 enrollees within a 30-minute drive time and 30,778 enrollees within a 60-minute drive time of the proposed site.

⁴⁴ VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

Complementary Strategy

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

Southeast Market

- **Leverage Federally Qualified Health Centers (FQHCs), area universities, telehealth, and new points of care to expand access to primary care services:** To meet the projected increase in demand in the market for primary care, VA will partner with FQHCs, academic affiliates, and community providers.
- **Expand home-based primary care (HBPC) into the Wilmington MS CBOC, proposed Jacksonville HCC, Goldsboro CBOC, and Greenville MS CBOC to provide access to outlying communities:** Across the market, total demand for outpatient primary care is projected to increase by 110.1% by FY 2029. Expanding HBPC to outpatient sites that can provide access to outlying communities will meet the increasing demand for primary care services.
- **Strengthen relationships with community nursing homes for Veterans to live closer to home:** Across the market, total demand for long-term care is projected to increase by 67.5% by FY 2029. VA will strengthen existing relationships with community nursing homes to expand access to long-term care services.
- **Leverage community resources to expand access to acute inpatient medical and surgical care:** Community providers in the Southeast Market have the capacity to provide inpatient medical and surgical care in areas where VA does not have facilities (Greenville, Jacksonville, and Wilmington, North Carolina). VA will leverage the community resources to provide these services.
- **Realign the Danville CBOC to the Raleigh/Durham VAMC in the VISN 06 Southeast Market:** The Danville CBOC (Danville County) is two hours from the Salem VAMC and 90 minutes from the new proposed Raleigh/Durham VAMC. Realigning the Danville CBOC to the Raleigh/Durham VAMC in the VISN 06 Southeast Market will rationalize referral patterns and allow Veterans to receive specialty care closer to where they live.

Durham VAMC

- **Integrate high-complexity outpatient and inpatient medical and surgical services with academic and community providers in the Eastern Coastal region as a local alternative to delivering this care at the Raleigh/Durham VAMC:** Inpatient medical and surgical services will be relocated from the Durham VAMC, which is intended for closure, to the Raleigh/Durham VAMC. To meet the increasing demand, VA also recommends enhancing partnerships with academic affiliates and other community providers in the Eastern Coastal region (Greenville, Jacksonville, and Wilmington areas) as a local alternative to VA care at the Raleigh/Durham VAMC.
- **Create a community liaison role at the Greenville MS CBOC:** VA will create a community liaison role that will help improve care coordination between the Greenville MS CBOC and the adjacent East Carolina University at Vidant Medical Center.

- Expand physical therapy services at the Greenville MS CBOC, as well as all of the future MS CBOCs and HCCs in the market:** Across the Southeast Market, total outpatient physical therapy encounters increased 16.5% from 77,383 to 92,674 from FY 2017 to FY 2019. Expanding physical therapy services to VA sites across the market will allow Veterans to receive this care close to where they live.
- Expand academic affiliations with East Carolina University (ECU)/Vidant Medical Center and consider dual-appointed staff at the Greenville MS CBOC:** East Carolina University sponsors a graduate medical education (GME) residency program with their partner Vidant Medical Center in Greenville, North Carolina. Vidant Medical Center is adjacent to the Greenville MS CBOC. By expanding the academic affiliation and dual-appointing staff with ECU/Vidant Medical Center, additional residency rotations will take place at the Greenville MS CBOC, which will improve the ability of VA to recruit and retain providers in the eastern coastal region of North Carolina. As of FY 2019, 110 health professions trainees within the Durham VA Health Care System were sponsored by ECU/Vidant Medical Center.
- Ensure there is adequate space to support the research initiative in the vicinity of Raleigh/Durham to maintain all existing programs at the Durham VAMC:** The Office of Research and Development will be consulted in the planning for the proposed Raleigh/Durham VAMC to ensure there is space to maintain existing research programs.
- Establish a new HCC in the vicinity of Garner, North Carolina (in progress):** The Garner HCC, which is currently under development, will consolidate primary care and outpatient mental health services from the existing Raleigh CBOC and Wake County-Raleigh OOS. Enrollees in Wake County are expected to increase by 9.4% from 23,888 to 26,137 enrollees between FY 2019 and FY 2029. In FY 2019, there were 23,681 enrollees within a 30-minute drive time and 62,541 enrollees within a 60-minute drive time of the proposed site.

Fayetteville VAMC

- Establish a strategic collaboration with DoD's Womack Army Medical Center to provide inpatient medical and surgical services and outpatient surgical services:** VA will pursue a partnership with DoD's Womack Army Medical Center. The partnership would expand the existing sharing arrangement to allow VA providers to deliver inpatient medical and surgical care. Currently, the Fayetteville HCC and the Womack Army Medical Center have a sharing arrangement for outpatient surgical services. There is capacity available at the Womack Army Medical Center to provide quality care to Veterans.
- Strengthen relationships with community providers by expanding continuing medical education (CME) and sharing staff:** VA will expand CME relationships with community providers in the vicinity of Fayetteville, North Carolina, to improve recruitment and retention.
- Replicate the Fayetteville HCC/Womack Army Medical Center relationship between the proposed Jacksonville HCC and Naval Medical Center Camp Lejeune and create a strategic plan to share Federal staff and resources:** To improve recruitment and retention, VA will create a strategic plan for sharing Federal staff between the proposed Jacksonville HCC and Naval Medical Center Camp Lejeune.

- **Expand academic affiliations with University of North Carolina and the Womack Army Medical Center GME programs and consider dual-appointed staff at the HCC:** To improve recruitment and retention, VA will expand GME relationships with University of North Carolina and the Womack Army Medical Center.
- **Ensure there is adequate space to support the research initiative in the vicinity of Raleigh/Durham to maintain all existing programs at the Fayetteville VAMC:** The Office of Research and Development will be consulted in the planning for the proposed new Raleigh/Durham research site to ensure there is space to maintain existing research programs.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 06 Southeast 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 cost⁴⁵ 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 06 Southeast Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 06 Southeast Market	Status Quo	Modernization	VA Recommendation
COA Present Value (\$)	\$41,218,771,368	\$44,053,553,010	\$41,790,420,529
Capital Costs	\$1,591,456,370	\$4,426,238,013	\$4,294,614,959
Operational Costs	\$39,627,314,998	\$39,627,314,998	\$37,495,805,570
Total Benefit Score	7	10	14
CBI (normalized in \$B)	5.89	4.41	2.99

⁴⁵ The present value cost is the current value of future costs discounted at the defined discount rate.

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 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 22 VA points of care offering outpatient services, including the proposed new Raleigh/Durham, North Carolina VAMC; New Bern, North Carolina MS CBOC; Durham, North Carolina HCC; Garner, North Carolina HCC; and Jacksonville, North Carolina HCC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed new Raleigh/Durham, North Carolina VAMC and the Fayetteville, North Carolina 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 Richmond, Virginia VAMC.
- **RRTP:** RRTP demand will be met through the proposed new Raleigh/Durham, North Carolina VAMC and the other facilities within VISN 06 offering RRTP, including the Richmond, Virginia VAMC; Salisbury, North Carolina VAMC; Asheville, North Carolina VAMC; and proposed new Norfolk/Tidewater, Virginia VAMC; Newport News, Virginia VAMC; and Roanoke, Virginia VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01); the proposed new King of Prussia, Pennsylvania VAMC (VISN 04); and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the proposed new Raleigh/Durham, North Carolina VAMC, as well as through community providers. Inpatient mental health demand will be met through the proposed new Raleigh/Durham, North Carolina VAMC, the Fayetteville, North Carolina 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 229,201 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 229,683 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 06. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Duke University and East Carolina University.
- **Research:** This recommendation does not impact the research mission in the market and allows the market to maintain the current research mission by ensuring there is adequate space to support research at the proposed new Raleigh/Durham, North Carolina research site to maintain all existing programs and relocates the research program currently at the Fayetteville VAMC to the closest appropriate VA site, such as the proposed new Raleigh/Durham VAMC, or other facilities within the market or VISN 06 as applicable.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; no VAMCs in this market are designated as a Primary Receiving Center.

Quality

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

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Raleigh/Durham, North Carolina VAMC; New Bern, North Carolina MS CBOC; Durham, North Carolina HCC; Garner, North Carolina HCC; Jacksonville, North Carolina HCC; the modernized Fayetteville, North Carolina VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (2.99 for VA Recommendation versus 5.89 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 Raleigh/Durham, North Carolina VAMC; New Bern, North Carolina CBOC; Durham, North Carolina HCC; Garner, North Carolina HCC; Jacksonville, North Carolina HCC; and the modernized Fayetteville, North Carolina 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:** The cost of the market recommendation is less than the cost to modernize facilities in the market today (\$41.8B for VA Recommendation versus \$44.1B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (2.99 for VA Recommendation versus 4.41 for Modernization), reflecting effective stewardship of taxpayer dollars.