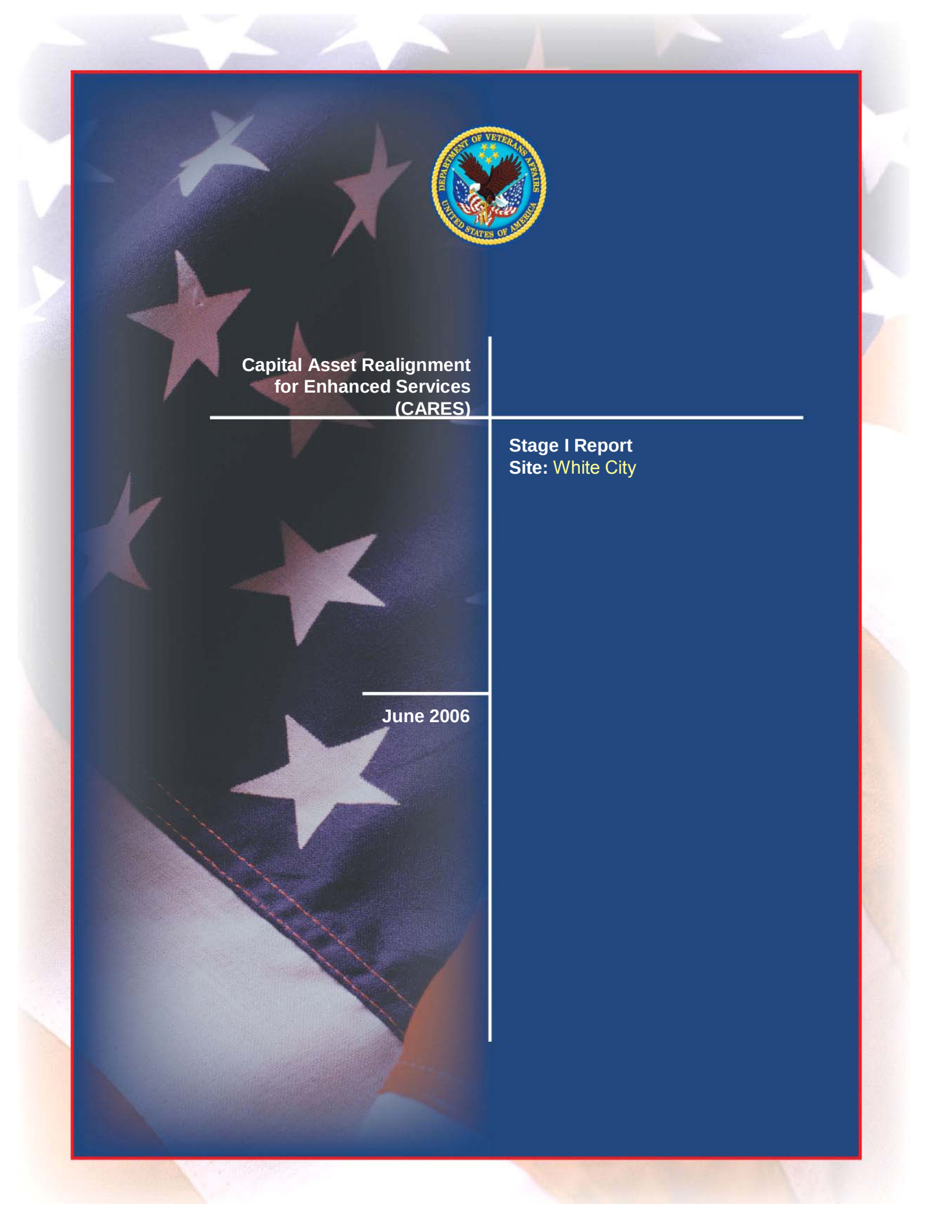

Capital Asset Realignment for Enhanced Services (CARES)

Stage I Report
Site: White City

June 2006

This report was produced under the scope of work and related terms and conditions set forth in Contract Number V776P-0515. PricewaterhouseCoopers LLP's (PwC's) work was performed in accordance with Standards for Consulting Services established by the American Institute of Certified Public Accountants (AICPA). PwC's work did not constitute an audit conducted in accordance with generally accepted auditing standards, an examination of internal controls or other attestation service in accordance with standards established by the AICPA. Accordingly, we do not express an opinion or any other form of assurance on the financial statements of the Department of Veterans Affairs (VA) or any financial or other information or on internal controls of VA.

VA has also contracted with another government contractor, S&S Construction/ACG Joint Venture, to develop re-use options for inclusion in this study. S&S Construction/ACG Joint Venture issued its report, *Technical, Financial and Legal Assistance and Support for Property Re-use/Redevelopment Plans, Phase 1 Report, Data Collection and Planning Analysis, VA Medical Center, White City, Oregon,* and as directed by VA, PwC has included information from its report in the following sections in this report: Recent and Planned Capital Improvements, Outleased Areas/Use Agreements, Real Estate Market, and Re-Use Potential. PwC was not engaged to review and, therefore, makes no representation regarding the sufficiency of nor takes any responsibility for any of the information reported within this study by S&S Construction/ACG Joint Venture.

This report was written solely for the purpose set forth in Contract Number V776P-0515 and, therefore, should not be relied upon by any unintended party who may eventually receive this report.

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1.0 Introduction

CARES (Capital Asset Realignment for Enhanced Services) is the Department of Veterans Affairs' (VA's) effort to produce a logical, national plan for modernizing healthcare facilities. The objective is to identify the optimal approach to provide current and projected veterans with healthcare equal to or better than is currently provided in terms of access, quality, and cost effectiveness, while maximizing any potential re-use of all or portions of the current real property inventory owned by VA. The Secretary's Decision Document of May 2004 called for additional studies in certain geographic locations to refine the analyses developed in Phase I of the CARES planning and decision-making process. Team PricewaterhouseCoopers (Team PwC) is assisting VA in conducting VA CARES Business Plan Studies at 17 sites around the United States as selected by the Secretary, which include site-specific requirements for Healthcare Delivery Studies, Capital Plans, and Re-use Plans.

White City Southern Oregon Rehabilitation Center and Clinics (SORCC), Oregon, is one of the CARES study sites and includes capital planning and re-use planning studies, but not healthcare delivery. The Secretary's Decision Document of May 2004 makes the following decisions for White City:

- VA will maintain all current services at the SORCC.
- VA will pursue opportunities to reduce the footprint of the campus.
- To ensure that VA makes the most effective use of existing buildings and land, VA will develop a Master Plan for the White City campus.
- The Master Plan will propose an efficient, cost-effective, and appropriately sized infrastructure design that will reduce vacant and underused space on the campus. It also will consider enhanced use lease opportunities.

2.0 Purpose of this Report

The CARES studies are being performed in three stages: an initial planning phase and two phases centered on option development and selection. This report presents the results of Stage I (option development). In Stage I, Team PwC develops and assesses a broad range of potentially viable business plan options (BPOs) that meet the forecast healthcare needs for the study sites. Based upon an initial analysis of these BPOs, Team PwC recommends up to six BPOs to be taken forward for further development and assessment in Stage II. VA decides which BPOs should be studied further in Stage II. During Stage II, a more detailed assessment is conducted including a financial analysis with refined inputs and consideration of second-order impacts such as the implications on the community. After Stage II, Team PwC recommends a single BPO to the Secretary.

Stakeholder input from veterans, veterans advocates, and the community play an important role in BPO development and assessment. A Local Advisory Panel (LAP) has been established at each study site to ensure veterans' issues and concerns are heard throughout the study process.

Veterans' and other stakeholder views are presented at a series of public meetings and through written and electronic communication channels.

Team PwC has prepared this report in accordance with the CARES Business Plan Studies Methodology and Statement of Work (SOW) for the CARES studies. The SOW calls for submission in Stage I of a range of BPOs that are at the concept stage and represent feasible choices that have the potential to meet VA objectives. In Stage II, Team PwC will further develop selected BPOs into technical data driven analyses and a recommended primary BPO.

3.0 Site Overview

The SORCC is located in White City, near Medford in southwestern Oregon. The SORCC is part of Veterans Integrated Service Network (VISN) 20, which comprises five markets: Alaska, Inland North, and Inland South Idaho, South Cascades, and Western Washington market. White City is in the South Cascades market.

Current Healthcare Provision

The SORCC, as VA's only free standing rehabilitation center, serves as a regional and national resource for underserved special populations (e.g., homeless, chronically mentally ill, and substance abuse). It provides quality residential treatment in psychiatry, addictions, medicine, and bio-psychosocial, physical, and vocational rehabilitation. Residential treatment provides 24-hour care, yet no medical acute inpatient care is provided. In addition, the SORCC and the Klamath Falls Community Based Outpatient Clinic (CBOC) offer primary outpatient medical and mental healthcare to over 11,000 enrolled veterans living in southern Oregon and northern California. The SORCC is authorized to operate 831 beds, although it currently is operating 500 beds with an average daily census of between 400 and 450 patients. The SORCC maintains several program affiliations with educational institutions, including programs with Oregon Health Sciences University, Portland State University, and Rogue Community College.

Facilities

The SORCC campus consists of approximately 145 acres (gross) situated along the west side of Highway 62 (Crater Lake Highway) in the unincorporated area of White City, Jackson County, Oregon. This location is toward the central area of Jackson County, approximately six miles north of the City of Medford. The property has 2,491 feet frontage along Highway 62, with excellent visibility and access. All acreage is usable and at grade with Highway 62. The campus is directly accessible from Highway 62, an open access, four-lane highway. There are two main points of access at the intersections of Veterans Memorial Drive and Andries Way.

The campus contains 59 buildings totaling 887,339 building gross square feet (BGSF), the largest of which is Building 201, the ambulatory care clinic (35,494 BGSF). The buildings are described in Table 1 and the distribution of buildings is depicted in Figure 1. The buildings are arranged in a grid pattern in a park-like setting and have well maintained brick exterior walls.

Figure 1: Existing Building Distribution

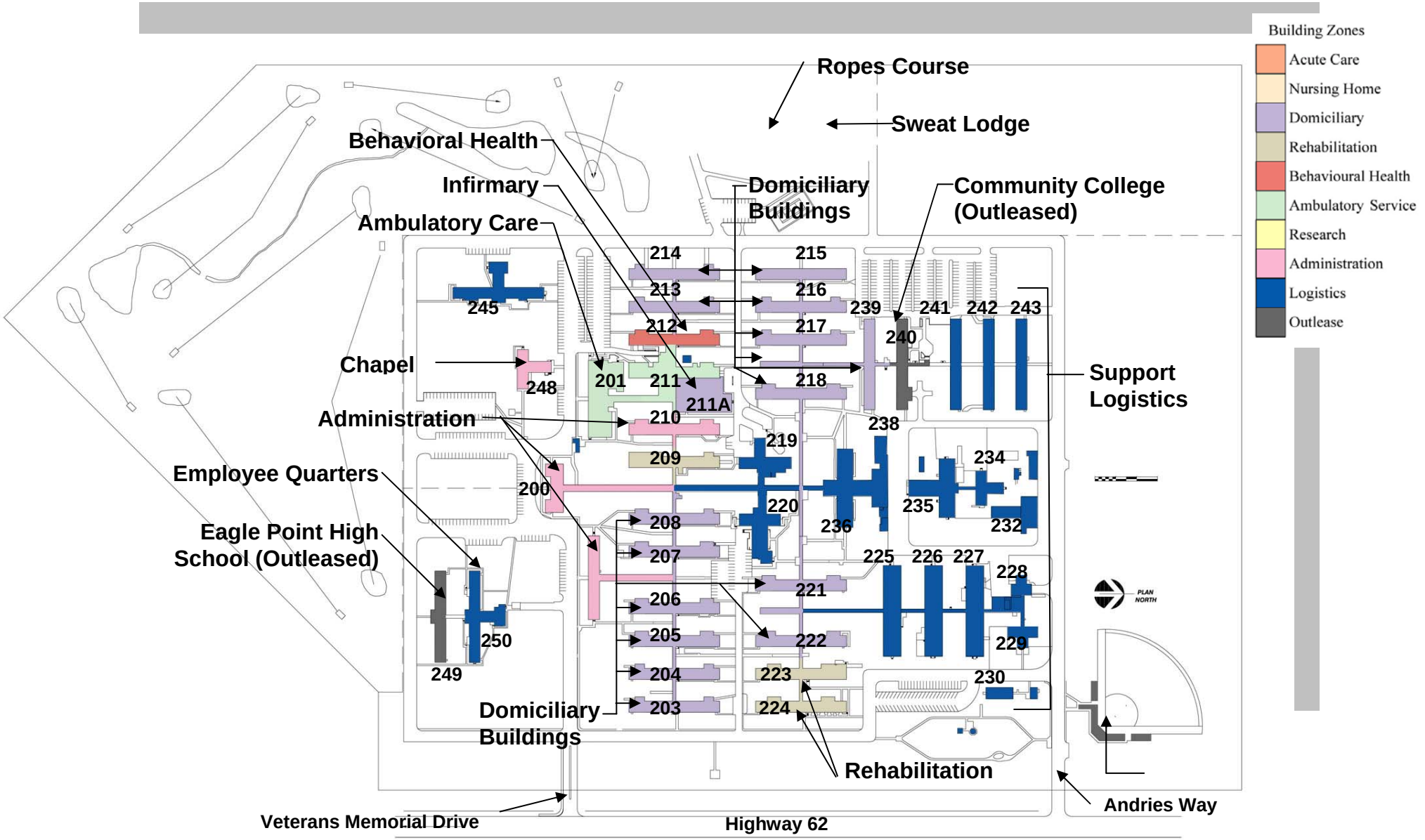


Table 1: Existing Departmental Distribution by Building[1]

Building	Function	Year Built	Year Renovation	Floors	Building Total GSF
200	ADMINISTRATION	1942		2	12,580
201	AMBULATORY CARE CLINIC	1942	1994	2	35,494
202	ACTIVITIES BUILDING	1942		2	15,649
203	DOMICILIARY BED	1942	1996	2	18,308
204	DOMICILIARY BED	1942	1984	2	18,308
205	DOMICILIARY BED	1942	1987	2	18,883
206	DOMICILIARY BED	1942	1987	2	18,883
207	DOMICILIARY BED	1942	1988	2	18,883
208	DOMICILIARY BED	1942	2000	2	18,595
209	SAVR, PHYSICAL MED., REC.	1942		2	19,516
210	LIBRARY/IRM	1942	1993	2	18,883
211	CLINICAL SUPP., HEALTH MGT.	1942		2	23,623
211A	INFIRMARY	1996		1	16,496
212	DOM. BED, PSYCHIATRY, SPD	1942	1985	2	18,883
213	DOMICILIARY BED	1942	1994	2	18,308
214	DOMICILIARY BED	1942		2	18,308
215	DOMICILIARY BED	1942		2	16,943
216	DOMICILIARY BED	1942		2	18,308
217	DOMICILIARY BED	1942		2	18,308
218	DOMICILIARY BED	1942	1996	2	18,883
219	CANTEEN	1942		2	13,531
220	THEATER, CANTEEN RETAIL	1942		2	19,810
221	DOMICILIARY BED	1942	1990	2	18,883
222	DOMICILIARY BED	1942		2	18,883
223	OCCUPATIONAL, VOC. REHAB.	1942	1981	2	18,883
224	A&MMS, SOCIAL WORK, GRILL	1942	1985	2	18,883
225	ELEC. SHOP, WAREHOUSE	1942		1	26,855
226	A&MMS WAREHOUSE	1942		1	26,825
227	CARPENTER SHOP, GROUNDS	1942		1	26,825
228	FMS/SAFETY	1942		1	2,706
229	FACILITIES MANAGEMENT OFF.	1942		1	3,725
230	MOWER STORAGE	1942		1	2,547
231	SMALL ENGINE SHOP	1942		1	689
232	BOILER PLANT	1942		2	13,419
233	GARAGE	1942		1	2,129
234	PLUMBING SHOP	1942		2	9,592
235	PAINT SHOP, REFR SHOP	1942		1	13,242
236	NUTRITION & FOOD SERVICE	1942		1	19,912
238	NUTRITION & FOOD SERVICE	1942		1	1,962
239	DOMICILIARY BED	1942	1997	2	16,953
240	ROGUE COMMUNITY COLLEGE	1942	1996	2	17,436
241	PAP SUPPLIES, BAGGAGE	1942		2	16,953
242	FACILITIES MANAGEMENT STOR.	1942		2	16,953
243	COMMUNITY RESOURCES	1942		2	16,953
245	VACANT	1942		2	24,784
248	CHAPEL	1942		1	5,841

[1] Source: VA Capital Asset Inventory Database

Building	Function	Year Built	Year Renovation	Floors	Building Total GSF
249	EAGLE POINT ALT. SCH./STOR.	1942		1	8,958
250	PERSONNEL QUARTERS	1942		2	22,188
251	TRANSPORTATION CENTER	1952	1994	1	571
256	WATER METER	1942			146
259	PAINT/PESTICIDE STORAGE	1942		1	608
260	WATER METER	1942			181
261	NUTRITION & FOOD SERVICE	1955		1	1,282
262	FIRE DEPARTMENT GARAGE	1955		1	2,331
264	GREEN HOUSE	1957		1	2,915
270	FMS STORAGE	1957		1	499
272	FMS EMERGENCY EQUIPMENT	1995		1	494
273	FMS EMERGENCY EQUIPMENT	1957		1	485
CC	CONNECTING CORRIDORS	1942		1	97,460

with composition shingle roofs. Most buildings were constructed in 1942 and comprised the majority of then-Camp White (a World War II-era army training camp), with a few constructed in the 1950s. The storage areas of the property are developed with one-story wood and shingle buildings, some of which date back to the Camp White era. Parking is dispersed throughout the campus and includes street parking and parking lots at the perimeter of campus facilities.

There are no listed historical buildings or parcels located on the campus of the SORCC, yet many of the buildings were built over 55 years ago. Neither the site nor the buildings are registered or listed as historical by any local, state, or federal agency.

The campus includes a 44-acre nine-hole golf course, a baseball diamond, and two vacant parcels totalling approximately 52 acres. Site features include a “Ropes Course”, Veteran’s Garden, Blue Star Memorial and sweat lodge. Most areas on the campus are cleared and have well-maintained lawns and landscaping. Large, old growth trees line the walkways and are situated near buildings across the campus. The frontage along Highway 62 includes a green (partially treed) buffer zone. The northernmost (L-shaped) parcel has been cleared of foliage and has been graded for development.

Seismic Considerations

Veterans Health Administration (VHA) directives establish policy on the seismic safety of VHA buildings; thereby ensuring that VA provides adequate life-safety protection to veterans, employees, and other building occupants.

The SORCC campus contains 18 buildings in the Exceptionally High Risk and six buildings in the High Risk categories of seismic risk. Some of these building have been renovated since the original construction dates, and the renovations have included structural upgrades. However, the upgrades were conducted to achieve compliance with dated standards for building codes with lower seismic design criteria than is applicable today.

Determination of specific structural deficiencies for the brick buildings on campus is outside the scope of this study. Typically, detailed material testing and structural analysis are conducted to determine if structural upgrades are possible for these types of masonry buildings. For the purposes of this study, it is assumed that some of the brick buildings can be upgraded, based on the two-story height and corresponding relatively low lateral forces. Access to construction drawings of previous structural and/or seismic upgrades performed on site will be provided by VA as part of Stage II work. These drawings, as well as additional detailed structural analysis, are required to definitely validate the assumption that the buildings can be upgraded.

Facilities Condition

The buildings have received ratings between 2.3 and 3.9 on a scale of "5" for critical values such as accessibility, code, functional space, and facility conditions[2], which is generally acceptable for the mainly residential use of the campus. Team PwC assumes that many buildings can be structurally upgraded to comply with seismic requirements. Other upgrades to current VA standards and applicable building codes must also be performed (for example, single accommodation resident rooms, private bathrooms, Americans with Disability Act compliance, fire/life safety system upgrades, etc.). Mechanical systems are at the end of their useful life, but have been well maintained. Existing heating, ventilation, and air conditioning (HVAC) systems will require replacement and upgrades to keep pace with the other needed facility upgrades through the projection period.

Environment

No significant environmental concerns were identified at the site. However, non-friable asbestos and lead paint will need to be abated or remediated in many key structures.

[2] VA Capital Asset Inventory (CAI) Database

Outleased Areas/Use Agreements[3]

One non-federal organization has entered into a use agreement with the SORCC. The agreement includes ongoing and periodic uses of the SORCC facilities. This agreement is summarized below:

- Rogue Community College (RCC): Classrooms are located in Building 240. RCC's agreement with the SORCC is to lease approximately 5,163 usable square feet. RCC is expected to soon relocate the classrooms into a non-VA facility (privately owned and leased to RCC), off the SORCC campus. RCC will retain a smaller presence at White City after the move, expecting to then occupy the entire 2,547 square feet of Building 230 for use as a welding shop.

Other non-federal uses of the SORCC facilities include Eagle Point High School, Camp White Museum, and some local police force training. No use or cooperative sharing agreements were available from VA related to these uses or others; however, these other affiliations will be investigated in Stage II with regard to implications they may have in implementing any of the selected BPOs.

Current and Forecast Investment Requirements

Significant capital expenditure is required to renovate and upgrade facilities to modern, safe, and secure standards. VA has identified a total of $111 million in building condition corrections, which includes periodic and recurring maintenance and renovation costs. These renovation costs include structural (seismic) upgrades and "non-structural" rehabilitation of 40 buildings at the SORCC campus.

VA has also developed proposed (unfunded) plans to reduce the overall footprint of the SORCC campus. According to these VA plans, the domiciliary functions will continue to be provided at the site, generally in the current location, either in renovated or replaced facilities at the center of the campus. Security measures will be enhanced to comply with security requirements for federal facilities. The footprint reduction plan will support the redevelopment of vacant parcels on the campus. Five proposed projects are identified as part of the footprint reduction plan:

- Phase 1: Two dorm-type residential buildings (Buildings 215 and 216) will be demolished and rebuilt into the northern-most one-third of a new, larger dormitory building.
- Phase 2: A third dorm-type residential building (Building 217) will be demolished and replaced with the middle one-third of the new dormitory (commenced in Phase 1 above).
- Phase 3: A fourth dorm-type residential building (Building 218) will be demolished and replaced with the final one-third of the new dormitory (commenced in Phases 1 and 2 above).

[3] Source: S&S Construction/ACG Joint Venture Report, *Technical, Financial and Legal Assistance and Support for Property Re-use/Redevelopment Plans, Phase 1 Report, Data Collection and Planning Analysis, VA Medical Center, White City, Oregon*

- Footprint Reduction Program: Reduce the total square footage of the campus through consolidation, more efficient space utilization and demolition of five buildings (Buildings 242, 243, 245, 249, and 250) with a combined total of almost 90,000 BGSF. The underlying land will be available for enhanced use leasing.
- Outpatient Clinic Expansion: A 12,000 square foot addition to Building 201 for use as an outpatient clinic.

The discussion of the baseline BPO does not include these proposed new construction projects, since baseline capital investments include the necessary investments to assure a modernized, safe, and secure environment without any new construction. However, business plan option (BPO) 3 (Phased Domiciliary Replacement and Renovations - Moderate New Construction; Addition for Outpatient Care) does incorporate several elements of these proposed capital projects. Team PwC examined the site zoning and potential building locations proposed by the site. Although projected space needs, seismic issues, and construction/renovation phasing considerations were the principal drivers of BPO 3, Team PwC incorporated the following elements from the site's proposed plans: replacement of several domiciliary buildings through new construction, and expansion of ambulatory specialities and outpatient mental health services into a new addition to Building 201.

Summary of Current Surplus / Vacant Space

The SORCC campus contains approximately 52 acres of vacant land area.[4] The CAI database indicates that there is currently 30,577 square feet of vacant building space on the campus.

Campus space requirements for the planning horizon of 2023 compared to the baseline year of 2003 indicates an overall campus surplus of 270,171 gross square feet. Relatively significant areas of surplus or shortage includes domiciliary and ambulatory services.

Declining demand for domiciliary beds, and associated requirements between 2003 and 2023 (see: Section 4.0), results in a surplus of 206,248 square feet.

Increasing demand for specialty ambulatory services (cardiology, eye clinic, orthopedics, and surgical and related specialties) between 2003 and 2023 (see: Section 4.0), results in a shortage of 26,860 square feet.

Re-Use

This section describes the real estate market and re-use potential of the White City campus.

Real Property[5]

The SORCC site is located along a major commercial corridor in Southeastern Oregon. The campus is surrounded primarily by industrial land, with the supply of land plentiful and demand for land and buildings not as robust as in major urban markets. Portions of the campus front on

[4] Ibid.

[5] Ibid.

Highway 62, a major commercial thoroughfare that connects Medford to its northern suburban communities of White City and Eagle Point.

Industrial buildings in White City consist mainly of corrugated metal structures, many of which are located in industrial parks or industrial development districts. The Medford and White City markets consists mainly of Class B office space, at over 7.6 million square feet. Most of that square footage is located outside of a central business district. Supply and demand appear to be balanced, resulting from steady growth in employment requiring this type of space.

In terms of the residential market, prices continue to increase for both vacant lots and improved single-family properties. New construction continues, as additional phases of existing developments break ground, connecting one residential community to another. While this occurs, vacant land and underutilized land (with older mobile homes) is being converted to densely developed housing developments. Local market sources indicate that the market for multifamily housing in White City is minimal and that this type of residential product would be ill-received. Several sizable vacant parcels zoned for multifamily development exist in White City, but little multifamily development has occurred.

There is a range of senior housing types from nursing homes to senior assisted living facilities to condominiums or apartments targeting senior citizens. There appears to be demand in White City for housing that caters to the elderly. One such facility, Laurel Care, opened in White City in 2005. Additionally, the Housing Authority of Jackson County has expressed interest in sponsoring more of this type of development on the SORCC property. The senior population in Southern Oregon is growing and will fuel demand regionally in the near-term.

It is reported that sizable retail properties (those that could support a "big box" retailer or grocery store) are in high demand regionally. The increase in population and areas of disposable income drive this demand. An example of such demand is the new Super Wal-Mart, to be located in Eagle Point. Although there are smaller Wal-Marts, a super store will be opened to capture the demand for retail services. Small retail parcels with desirable road frontage are still in demand, but there is an abundance of available parcels along Highway 62 and other regional roadways.

Overall demand in the hospitality market is low with several hoteliers in the Medford area exiting the business because oversupply of rooms is driving down occupancy rates and revenues. Without demand related to tourism and business travel, the market for room nights is limited. In addition, another driver of hotel demand in some markets can be proximity to hospitals where long-stay patients are receiving care. Sources in the Medford market do not think that the SORCC will create such demand in the near or mid-term.

Regulatory Environment

White City is predominately zoned for industrial uses and contains hundreds of acres of vacant land zoned for industrial uses. Development of surrounding properties along Highway 62 is moving toward the SORCC campus. As adjacent communities build out and major thoroughfare frontage becomes more expensive or scarce, the commercial corridor in SORCC's immediate neighborhood will be developed.

Key Observations from Other Government Contractor

There is a considerable amount of available land within the immediate and greater competitive market areas. This land is zoned for general industrial and commercial use, which therefore competes for potential occupants with the SORCC campus. The White City/Jackson County real estate market does not have the depth of a market with large urban areas or active development. While the market for commercial and industrial properties does exist, the preliminary research did not identify any significant events that would accelerate or vastly increase demand for properties in the area. The federal government does not have a significant presence in the area. State and local governments have some presence, but initial research did not identify any great increases in space demands by government entities.

The strip of land fronting along Highway 62 may be narrow for a large commercial use (see Figure 2). However, the strip has the same approximate depth as Parcel 4 and benefits from the highway frontage. Because it is uncertain how the market would perceive the depth considerations of this parcel, it is considered to have low potential re-use value.

Potential for Non-VA Re-use/Redevelopment[6]

Figure 2 illustrates the parcels of land on the current SORCC campus. (Note that these parcels will be referenced in the BPO Development section of this report and in the corresponding re-use options for assessment in Stage I.) Parcels have been identified as discrete portions of the campus with relatively unique characteristics based on location, topography and, importantly, re-use/redevelopment potential. For White City, ten parcels are identified on the site plan below.

[6] Ibid.

Figure 2: Map of Campus Parcels

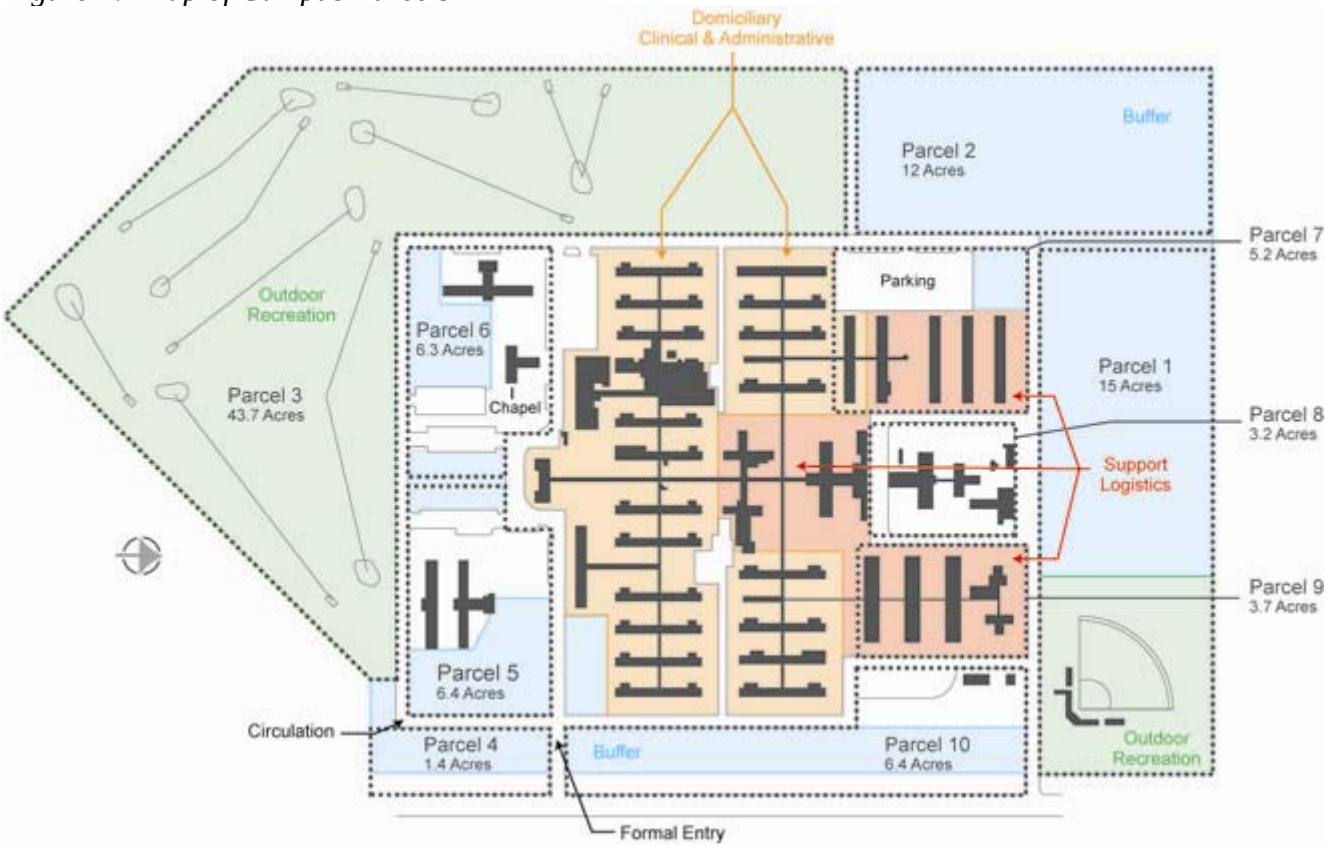


Table 2 identifies the parcels for potential re-use. The parcels have been identified based on both the existing vacant land of the SORCC campus and the changed footprint of the campus structures based on implementation of the capital planning options prepared by Team PwC.

Table 2: Re-use Options, White City

Name	Description	Acreage	Re-use Potential
Parcel 1	Re-use/redevelopment of NE outer perimeter vacant parcel, including ballpark.	15	Recreational (e.g., multi-purpose recreation center)
Parcel 2	Re-use/redevelopment of NNE outer perimeter vacant parcel.	12	Multifamily housing (e.g., senior citizen-oriented apartments)
Parcel 3	Re-use/redevelopment of golf course.	43.7	Recreational (e.g., multi-purpose recreation center) or Multifamily housing (e.g., senior citizen-oriented apartments)
Parcel 4	Re-use/redevelopment of south outer perimeter vacant parcel along Crater Lake Highway.	1.4	Small retail use
Parcel 5	Re-use/redevelopment of Buildings 249 and 250.	6.4	Institutional (e.g., educational or medical uses)
Parcel 6	Re-use/redevelopment of Buildings 245 and 248.	6.3	Institutional (e.g., educational or medical uses)
Parcel 7	Re-use/redevelopment of Buildings 241, 242, and 243.	5.2	Institutional (e.g., educational or medical uses)
Parcel 8	Re-use/redevelopment of Buildings 233, 234, 235, 259, 264, and 270.	3.2	Institutional (e.g., educational or medical uses)

Name	Description	Acreage	Re-use Potential
Parcel 9	Re-use/redevelopment of Buildings 226, 227, 228, 229, and 262.	3.7	Institutional (e.g., educational or medical uses)
Parcel 10	Re-use/redevelopment of east outer perimeter vacant parcel along Crater Lake Highway.	6.4	Small retail use

For the available re-use parcels, there are a limited number of development options that are viable at this site. The likelihood that the entire site and buildings, minus property to be used for VA's operations, would be developed under a lease to a single entity is low given the diversity of the potential development options. The property would likely be sub-divided, re-used, and/or redeveloped by multiple entities. Potential parcels or sub-divisions of the campus could include the following:

- Road frontage along Crater Lake Highway (Highway 62), especially at a signalized intersection, is ideal for a small retail use (Parcels 4 and 10).
- The nine-hole golf course, driving range, tennis courts, and ballpark that ring the campus may be of interest to a recreational operator or the local county parks and recreation department for a multi-purpose recreational center (Parcel 3 and ballpark).

Vacant land towards the rear of the site may be developed for multifamily housing, especially senior citizen-oriented apartments. However, the location of industrial uses adjacent to the available parcels could be a hurdle to implementing such a use without allowing lands for a buffer zone (Parcels 1 and 2).

4.0 Overview of Healthcare Demand and Trends

Veteran enrollment and utilization for healthcare services was projected for 20 years, using 2003 data as supplied by VA as the base year and projecting through 2023. Projected utilization data is based upon market demand allocated to the SORCC facility. The following section describes these long term trends for veteran enrollment and utilization for healthcare services at the SORCC.

Enrollment Trends

The SORCC is located in the South Cascades market of VISN 20. The South Cascades market contains 105,648 enrolled veterans. As can be seen in Table 3, over the next 20 years, the number of enrolled veterans in Priority Groups 1-6 (veterans with the greatest service-connected needs) is expected to increase by 15%, from 75,183 to 86,382, while enrollment for Priority 7-8 veterans is projected to decrease by 55% for the same period. The enrollment forecast for Priority 7-8 veterans assumes an annual enrollment fee, and the continued freeze on new Priority 8 enrollment.

Table 3: Projected Veteran Enrollment for South Cascades Market by Priority Group

Fiscal Year	2003	2013	% Change (2003 to 2013)	2023	% Change (2003 to 2023)
Priority 1-6	75,183	92,185	23%	86,382	15%
Priority 7-8	30,465	14,536	-52%	13,820	-55%
Total	**105,648**	**106,721**	**1%**	**100,202**	**-5%**

Utilization Trends

Utilization was analyzed for those Cares Implementation Categories (CICs) for which the SORCC has projected demand. It should be noted that the demand for domiciliary and mental health services at the SORCC is driven by regional and national referrals in addition to local veteran populations.

A summary of utilization data is provided for each CIC in the following tables. Inpatient utilization is measured in number of beds, while both ambulatory and outpatient mental health utilization is measured in number of clinic stops. A clinic stop is a visit to a clinic or service rendered to a patient.

Considering overall demand for outpatient services (Table 4), outpatient clinic stops (including radiology and pathology) are expected to increase 24% over the 2023 time horizon. These outpatient trends are further described in the tables below.

Table 4: SORCC Outpatient Summary

White City	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Total Clinic Stops	108,045	147,738	134,419	37%	-9%	24%

* *Total clinic stop volume includes Radiology & Pathology data.*

Table 5: Projected Utilization for Inpatient CICs for White City

CIC	2003 Actual Beds	2013 Beds Needed	2023 Beds Needed	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Other: VA Mental Health Inpatient Programs	0	233	275	N/A	18%	N/A
DOM-PRRP-PRRTP	755	325	325	-57%	0%	-57%
Total	**755**	**558**	**600**	**-26%**	**8%**	**-21%**

The domiciliary CIC includes: Domiciliary, Psychosocial Residential Program (PRRP) and Psychiatric Residential Rehabilitation Treatment Program (PRRTP). The planned decrease in domiciliary beds (DOM-PRRP-PRRTP) at the SORCC is a result of both decreasing future demand for domiciliary care in the VISN (due to decreases in length of stay), and a VA plan to increase the number of domiciliary facilities nationally and locate domiciliary beds nearer to veteran population centers. The reduction at the SORCC will be accomplished by adding a Substance Abuse Residential Rehabilitation Program (SARRT) at the facility and distributing up to 275 domiciliary beds by 2023 to other VA market areas. The addition of the SARRT is

reflected through the increase in Other VA Mental Health Inpatient Programs from 2003 through 2023. The remaining 150 surplus beds will be closed.

Considering outpatient trends (see Table 6), there is a small (3%) increase in the overall demand for ambulatory services over the forecast period. However, there are large increases projected for some specialty ambulatory care services, reflecting the healthcare needs of an aging veteran population. There are significant increases indicated for the following specialty ambulatory care services:

- Cardiology
- Eye Clinic
- Orthopedics
- Surgical and related specialties

There is a net decrease (-35%) indicated for non-surgical specialties and a small net decrease (-3%) for primary care and related specialties projected for 2023 as compared to 2003. Demand for rehabilitation medicine remains constant over the forecast period.

Table 6: Projected Utilization for Ambulatory CICs for White City

CIC	2003 Actual Stops	2013 Projected Stops	2023 Projected Stops	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Cardiology	1,178	2,578	2,532	119%	-2%	115%
Eye Clinic	4,028	5,745	6,008	43%	5%	49%
Non-Surgical Specialties	5,365	3,500	3,486	-35%	0%	-35%
Orthopedics	1,239	1,678	1,681	35%	0%	36%
Primary Care & Related Specialties	23,292	24,599	22,609	6%	-8%	-3%
Rehab Medicine	24,437	24,437	24,437	0%	0%	0%
Surgical & Related Specialties	601	1,294	1,269	115%	-2%	111%
Total	**60,140**	**63,831**	**62,022**	**6%**	**-3%**	**3%**

Considering the expected utilization of outpatient mental health services (see Table 7), demand for several categories of care will increase substantially over the forecast period. There are net increases indicated for the following outpatient mental health services:

- Community mental health residential care
- Homeless
- Work therapy

These are the VA outpatient mental health programs for which there is no private sector benchmark. These increased utilization projections reflect assumptions used in the development of the VA Mental Health Strategic Plan. Some areas in which refinements were made include:

- Utilization rates for special mental health programs begin at current actual rate and are brought up to the nationwide 85th percentile utilization rate by fiscal year 2012
- Age cohort adjustments to reflect anticipated increased use of certain mental health services by aging veterans from Vietnam and later eras

- Expanding outpatient mental health programs to reflect a recovery model

Table 7: Projected Utilization for Outpatient Mental Health CICs for White City

CIC	2003 Actual Stops	2013 Projected Stops	2023 Projected Stops	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Behavioral Health	13,662	12,409	12,714	-9%	2%	-7%
Community MH Residential Care	129	1,306	864	912%	-34%	570%
Day Treatment	7,949	11,660	7,502	47%	-36%	-6%
Homeless	1,028	2,195	1,797	114%	-18%	75%
Work Therapy	5,940	29,964	22,936	404%	-23%	286%
Total	**28,708**	**57,534**	**45,813**	**100%**	**-20%**	**60%**

In summary, the analysis of the projected enrollment and utilization data highlights several opportunities and challenges for the SORCC. Opportunities exist to address the market need for inpatient mental health services as well as outpatient services for an aging veteran population, such as cardiology, eye clinic, orthopedics, surgical and related specialties, and mental health. The SORCC will need to be right-sized and reconfigured to meet the revised requirements for domiciliary beds and the expansion of the SARRT program. Additionally, the significant costs involved in renovating current facilities and addressing seismic issues present an added impetus to consolidate under-used domiciliary facilities and make future capital investments in the most cost effective manner.

The space requirements to deliver the projected volume of healthcare services in a modern, safe, and secure environment were calculated using Team PwC's capital planning methodology. The SORCC currently has surplus space to accommodate the projected utilization of inpatient domiciliary, rehabilitation, and behavioural health services projected through 2023. However, it is expected that some of this surplus building stock will not be cost effective to retrofit to a modern, safe, and secure environment.

Additional space is required to address projected increases in demand for specialty ambulatory care services (cardiology, eye clinic, orthopedics, and surgical and related specialties) in an appropriate setting. Continuity of care can be enhanced by consolidating and co-locating these services into an addition to the current ambulatory care building (Building 201). Surplus buildings are available to accommodate projected additional administrative support functions. A surplus of logistics support square footage is projected mainly due to the age of the existing building infrastructure. It is expected that much of this logistics support surplus building stock will not be cost effective to retrofit to a modern, safe, and secure environment. BPOs will consider current clinical inventory and the impacts of changes in demand on the space requirements for these services.

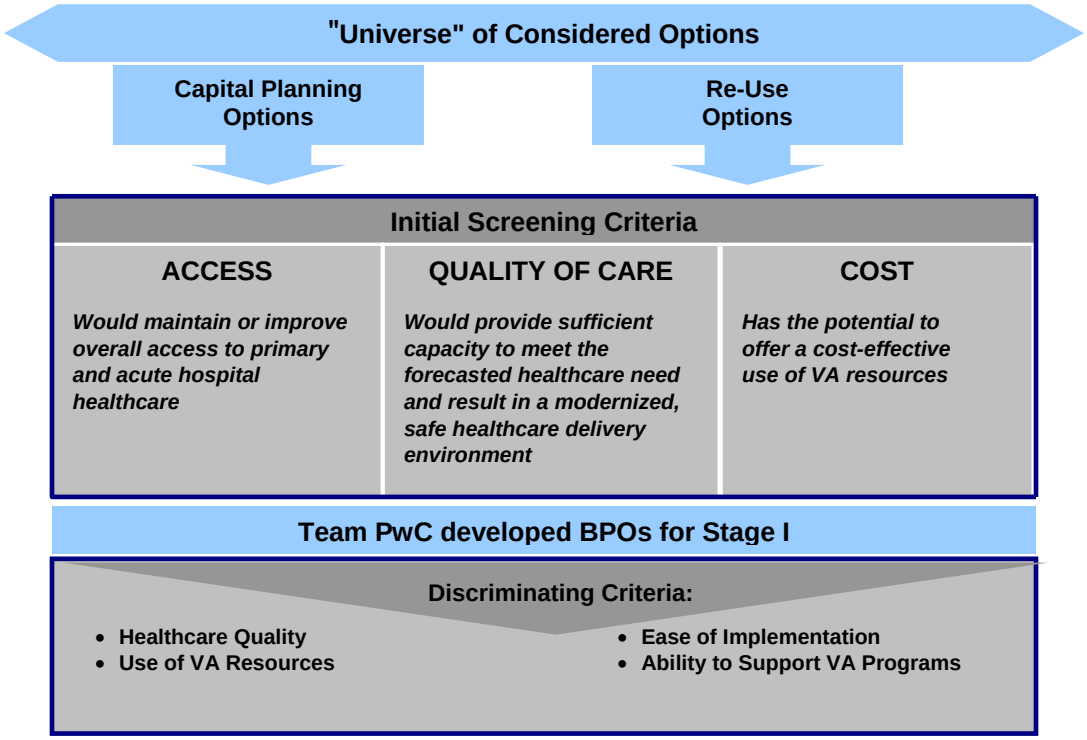
5.0 Business Plan Option Development Approach

Options Development Process

Using VA furnished information, site tours and interviews, as well as stakeholder and LAP member input, Team PwC developed a broad range of discrete and credible capital planning options and associated re-use plans. Each capital planning option that passed the initial screening served as a potential component of BPOs. A review panel of experienced Team PwC consultants, including capital planners, and real estate advisors considered the assessment results and recommended the BPOs. Each of the BPOs was then assessed at a more detailed level according to a set of discriminating criteria.

The following diagram illustrates the complete options development process:

Figure 3: Options Development Process



Initial Screening Criteria

Discrete capital planning options were developed for the SORCC and were subsequently screened to determine whether or not a particular option had the potential to meet or exceed the CARES objectives. The following describes the initial screening criteria that were used during this process:

- **Access**: *Would maintain or improve overall access to primary and acute hospital healthcare* – No capital planning study sites involve relocation of healthcare services unless directed by the Secretary's Decision Document, May 2004. If relocation of

healthcare services is directed by the Secretary, the relocation would be reflected in the baseline BPO. Although the baseline BPO may result in a change to access from the current state, the CARES methodology states that all options should be compared to the baseline BPO. Therefore, access should be maintained for all capital options as compared to the baseline. Drive-time analysis was not performed to measure impact on access to care for capital planning study sites.

- **Quality of Care:** *Would provide sufficient capacity to meet the forecasted healthcare need and result in a modernized, safe healthcare delivery environment that is compliant with existing laws, regulations, and VA requirements* – This was assessed by consideration of whether the option provides sufficient capacity (space) to meet the CIC workload requirements. Additionally, the physical environment proposed in the option was considered and any material weaknesses identified in VA's space and functional surveys, facilities' condition assessments, and seismic assessments for existing facilities, and application of a similar process to any alternative facilities proposed.

- **Cost**: *Has the potential to offer a cost-effective use of VA resources* – This was assessed as part of Team PwC's initial cost effectiveness analysis. A 30-year planning period was used in the cost effectiveness analysis. Any option that did not have the potential to provide a cost effective physical and operational configuration of VA resources as compared to the baseline[7] failed this test.

Discriminating Criteria

After passing the initial screening, BPOs were developed and the following discriminating criteria were applied to assess the overall attractiveness of the BPO.

- **Healthcare Quality** – These criteria assess the following:
  - If the BPO can ensure the forecasted healthcare need is appropriately met.
  - Whether each BPO will result in a modernized, safe, and secure healthcare delivery environment.

- **Use of VA Resources** – These criteria assess the cost effectiveness of the physical and operational configuration of the BPO over a 30-year planning horizon. Costs were assessed at an "order of magnitude" level of analysis in Stage I. Detailed costing will be conducted in Stage II. These criteria include:

  - Operating Cost Effectiveness: The ability of the BPO to provide recurring/operating cost increases or savings as compared to the baseline.
  - Level of Capital Expenditures: The amount of investment required relevant to the baseline based on results of initial capital planning estimates.
  - Level of Re-use Proceeds: The amount of re-use proceeds and/or demolition/clean-up cost based on results of the initial re-use study.

[7] Baseline describes the current state applying utilization projected out to 2023, without any changes to facilities, programs, or locations. Baseline assumes same or better quality, and accounts for any necessary maintenance for a modern, safe, and secure healthcare environment.

  - Cost Avoidance: The ability to obtain savings in necessary capital investment as compared to the baseline BPO.
  - Overall Cost Effectiveness: The initial estimate of net present cost as compared to the baseline.

- **Ease of Implementation** – These criteria assess the risk of implementation associated with each BPO. The following major risk areas were considered:

  - Reputation
  - Continuity of Care
  - Organization & Change
  - Legal & Contractual
  - Compliance
  - Security
  - Political
  - Infrastructure
  - Financial
  - Technology
  - Project Realization

- **Ability to Support VA programs** – These criteria assess how the BPO would impact the sharing of resources with DoD, enhance One-VA integration, and impact special considerations, such as DoD contingency planning, Homeland Security needs, or emergency need projections.

Operational Costs

The objective of the cost analysis in Stage I is to support the comparison of the estimated cost effectiveness of the baseline with each BPO. The Study Methodology calls for an "order of magnitude" level of analysis in Stage I and detailed costing in Stage II. The total estimated costs include operating costs, initial capital planning costs, re-use opportunities, and any cost avoidances. The operating costs for the baseline and each BPO are a key input to the financial analysis for Stage II. Operating costs considered for the Stage I analysis include direct medical care, administrative support, engineering and environmental management, and miscellaneous benefits and services.

The baseline operating costs were provided to Team PwC by VA. The 2004 costs were obtained from the Decision Support System (DSS), VA's official cost accounting system. This information was selected for use because DSS provides the best available data for identifying fixed direct, fixed indirect, and variable costs. The data can be rolled up to the CIC level and the data is available nationally for all VAMCs and CBOCs. These costs are directly attributable costs and generally do not reflect the total costs of the operation.

The costs were obtained for each facility within the study scope and were aggregated into the CICs. The costs were categorized as total variable (per unit of care), total fixed direct, and total fixed indirect costs. The definition of each cost category is as follows:

- Total Variable (Direct) Cost: The costs of direct patient care that vary directly and proportionately with fluctuations in workload. Examples include salaries of providers and the cost of medical supplies. Variable direct cost = variable supply cost + variable labor cost. The cost of purchased care is considered a variable direct cost.

- Total Fixed Direct Cost: The costs of direct patient care that do not vary in direct proportion to the volume of patient activity. The word "fixed" does not mean that the costs do not fluctuate, but rather that they do not fluctuate in direct response to workload changes. Examples include depreciation of medical equipment and salaries of administrative positions in clinical areas.

- Total Fixed Indirect Cost: The costs not directly related to patient care, and, therefore, not specifically identified with an individual patient or group of patients. These costs are an allocation of the total other costs (i.e. not direct costs) associated with the operation of the facility. These costs are allocated to individual medical departments through VA's existing indirect cost allocation process. Examples of indirect costs include utilities, maintenance, and administration costs.

FY 2004 operating costs from DSS were deflated to FY 2003 dollars to create the costs for FY 2003 which is the base date for current cost comparison. These costs (fixed and variable) were then inflated for each year of the study period. Variable costs were multiplied by the forecasted workload for each CIC and summed to estimate total variable costs. Variable costs were also provided by VA for non-VA care. These are based on VA's actual expenses and are used in the BPOs where care is contracted.

These costs are used together with initial capital investment estimates as the basis for both the baseline option and each BPO with adjustments made to reflect the impact of implementation of the capital option being considered. Potential re-use proceeds are added to provide an overall indication of the cost of each BPO.

Summary of Business Plan Options

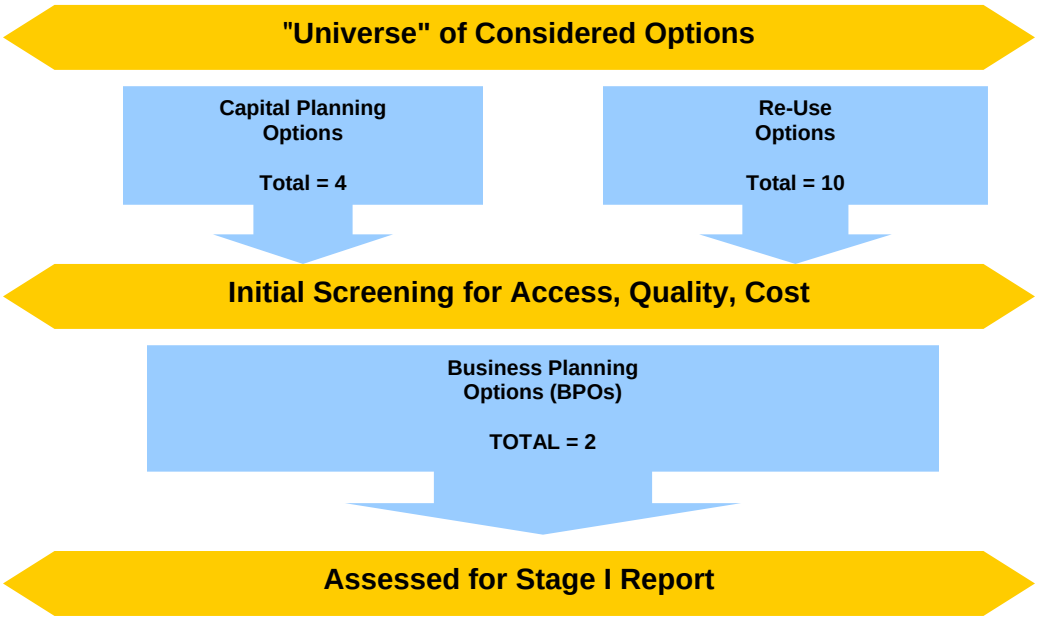
The individual capital planning and re-use options that passed the initial screening were further considered as options to comprise a BPO. A BPO is defined as consisting of a single capital option and its associated re-use option(s)[8]. Therefore, the formula for a BPO is:

BPO = Capital Planning option + Re-use option(s)

The following diagram illustrates the final screening results of all alternate BPOs given consideration:

[8] In Stage I, re-use options are described in terms of available re-use parcels, their potential re-use (residential, office, etc.), and their potential re-use value (high, medium, low).

Figure 4: Final Screening Results of Alternate BPOs



Options Not Selected for Assessment

Two additional capital options created during the option development process did not pass the initial screening criteria. These are listed in the table below, together with an explanation for their rejection.

Table 8: Capital Options Not Selected for Assessment

Label	Description	Screening Results
Demolish Campus and Replace with New Facility	Build a new facility on the White City campus and demolish domiciliary and inpatient/outpatient buildings.	Option was rejected due to the extensive costs of replacement that would not be offset by the limited re-use potential of the site.
Contract Domiciliary Services	Contract current domiciliary services to other community providers and make the entire campus available for re-use.	Option was rejected as alternative sources of comparable domiciliary care are not available in the market.

Baseline BPO

Based upon Team PwC's methodology, the baseline BPO advances in the Stage I process. The baseline is the BPO under which there would not be significant changes in either the location or type of services provided at the SORCC campus. In the baseline BPO, the Secretary's May 2004 Decision and forecasted long-term healthcare demand forecasts and trends, as indicated by the demand forecasted for 2023, are applied to the existing healthcare provision solution for the SORCC campus.

Specifically, the baseline BPO is characterized by the following:

- Healthcare continues to be provided as currently delivered, except to the extent healthcare volumes for particular procedures fall below key quality or cost effectiveness thresholds.
- Capital planning investments rectify any material deficiencies (e.g., seismic deficiencies) in the existing facilities in order to provide a modern, safe, and secure healthcare delivery environment.
- Life cycle capital costs provide on-going preventative maintenance and life-cycle maintenance of existing facilities.
- Buildings and/or land that become surplus as a result of changes in demand for healthcare services and/or capital plans for facilities are made available for re-use.

Evaluation System for BPOs

Each BPO is evaluated against the baseline option in an assessment table providing comparative rankings across several categories and an overall attractiveness rating. The results of the BPO assessment and the Team PwC recommendation are provided in subsequent sections.

Table 9: Evaluation System Used to Compare BPOs to baseline BPO

Ratings to assess Quality and Ability to Support VA Programs	
↑	The BPO has the potential to provide a slightly improved state compared to the baseline BPO for the specific discriminating criteria (e.g., quality and ability to support VA programs)
↔	The BPO has the potential to provide materially the same state compared to the baseline BPO for the specific discriminating criteria (e.g., quality and ability to support VA programs)
↓	The BPO has the potential to provide a slightly lower or reduced state compared to the baseline BPO for the specific discriminating criteria (e.g., quality and ability to support VA programs)
Operating cost effectiveness (based on results of initial healthcare/operating costs)	
↑↑↑	The BPO has the potential to provide significant recurring operating cost savings compared to the baseline BPO (>15%)
↑↑	The BPO has the potential to provide significant recurring operating cost savings compared to the baseline BPO (>10%)
↑	The BPO has the potential to provide some recurring operating cost savings compared to the baseline BPO (5%)
-	The BPO has the potential to require materially the same operating costs as the baseline BPO (+/- 5%)
↓	The BPO has the potential to require slightly higher operating costs compared to the baseline BPO (>5%)
↓↓	The BPO has the potential to require slightly higher operating costs compared to the baseline BPO (>10%)
↓↓↓	The BPO has the potential to require slightly higher operating costs compared to the baseline BPO (>15%)
Level of capital expenditure estimated	
↓↓↓↓	Very significant investment required compared to the baseline BPO **(≥ 200%)**
↓↓	Significant investment required compared to the baseline BPO **(121% to 199%)**
-	Similar level of investment required compared to the baseline BPO **(80% to 120% of Baseline)**
↑↑	Reduced level of investment required compared to the baseline BPO **(40%-80%)**
↑↑↑↑	Almost no investment required **(≤ 39%)**
Level of re-use proceeds relative to baseline BPO (based on results of initial re-use study)	
↓↓	High demolition/clean-up costs, with little return anticipated from re-use
-	No material re-use proceeds available
↑	Similar level of re-use proceeds compared to the baseline (+/- 20% of baseline)
↑↑	Higher level of re-use proceeds compared to the baseline (e.g., 1-2 times)
↑↑↑	Significantly higher level of re-use proceeds compared to the baseline (e.g., 2 or more times)
Cost avoidance (based on comparison to baseline BPO)	
-	No cost avoidance opportunity
↑↑	Significant savings in necessary capital investment compared to the baseline BPO
↑↑↑↑	Very significant savings in essential capital investment compared the baseline BPO

Overall cost effectiveness (based on initial net present cost calculations)	
↓↓↓↓	Very significantly higher net present cost compared to the baseline BPO (>1.15 times)
↓↓	Significantly higher net present cost compared to the baseline BPO (1.10 – 1.15 times)
↓	Higher net present cost compared to the baseline BPO (1.05 – 1.09 times)
-	Similar level of net present cost compared to the baseline (+/- 5% of baseline)
↑	Lower net present cost compared to the baseline (90-95% of Baseline)
↑↑	Significantly lower net present cost compared to the baseline BPO (85-90% of baseline)
↑↑↑↑	Very significantly lower net present cost compared to the baseline BPO (<85% of baseline)
Ease of Implementation of the BPO	
↑	The BPO has the potential to provide a slightly improved state compared to the baseline BPO based upon the level of impact and likelihood of occurrence of risks to its implementation plan.
↔	The BPO has the potential to provide materially the same state as the baseline based upon the level of impact and likelihood of occurrence of risks to its implementation plan.
↓	The BPO has the potential to provide a slightly lower or reduced state compared to the baseline BPO based upon the level of impact and likelihood of occurrence of risks to its implementation plan.
Overall "Attractiveness" of the BPO Compared to the baseline	
↑↑↑↑	Very "attractive" – highly likely to offer a solution that improves quality and/or access compared to the baseline while appearing significantly more cost effective than the baseline
↑↑	"Attractive" - likely to offer a solution that at least maintains quality and access compared to the baseline while appearing more cost effective than the baseline
-	Generally similar to the baseline
↓↓	Less "attractive" than the baseline - likely to offer a solution that while maintaining quality and access compared to the baseline appears less cost effective compared to the baseline
↓↓↓↓	Significantly less "attractive" – highly likely to offer a solution that may adversely impact quality and access compared to the baseline and appearing less (or much less) cost effective than the baseline

Stakeholder Input: Purpose and Methods

VA determined at the beginning of the CARES process that it would use the Federal Advisory Committee Act (FACA) process to solicit stakeholder input and to provide a public forum for discussion of stakeholder concerns because "the gathering and consideration of stakeholder input in this scope of work is of great importance." According to the Statement of Work, the purpose of the Local Advisory Panel (LAP) appointed under the FACA is to

> provide the Contractor with a perspective on previous CARES local planning products, facility mission and workload, facility clinical issues, environmental factors, VISN referral and cross cutting issues in order to assist the Contractor in the refinement of the options the Contractor shall recommend. The Federal Advisory Committee will also provide feedback to the Contractor on proposed options and recommendations.

The Local Advisory Panel is required to hold at least four public meetings at which stakeholders would have an opportunity to present testimony and comment on the work performed by Team PwC and the deliberations of the LAP.

Team PwC also devised methods for stakeholders to communicate their views without presenting testimony at the LAP meetings. Throughout Stage I, a comment form was available electronically via the CARES website and in paper form at the first LAP public meeting. In addition, stakeholders were advised that they could submit any written comments or proposals to a central mailing address, and a number of stakeholders used this method as well.

The time in which stakeholder input was collected during Stage I can be divided into two input periods – Input Period One and Input Period Two. The intent of Input Period One was to collect general stakeholder input to assist in the development of potential BPOs, while Input Period Two allowed stakeholders to comment on the specific BPOs presented at the public LAP meeting. Input Period One started in April 2005 and ended on the day that the comment form with specific BPOs was available for public comment on the CARES website. For both periods, stakeholder input was reviewed and categorized into nine categories of concern which are summarized in Table 10.

For Input Period Two, stakeholders were provided with a brief description of the BPOs and asked to indicate whether they favored the option, were neutral about the option, or did not favor the option. Ten days after the second LAP meeting was held, Team PwC summarized all of the stakeholder views that were received during input periods one and two, and this information is included in this report.

Table 10: Definitions of Categories of Stakeholder Concern

Stakeholder Concern	*Definition*
Effect on Access	Involves a concern about traveling to another facility or the location of the present facility.
Maintain Current Service/Facility	General comments related to keeping the facility open and maintaining services at the current site.
Support for Veterans	Concerns about the federal government/VA's obligation to provide health care to current and future veterans.
Effect on Healthcare Services & Providers	Concerns about changing services or providers at a site.
Effect on Local Economy	Concerns about loss of jobs or local economic effects of change.
Use of Facility	Concerns or suggestions related to the use of the land or facility.
Effect on Research & Education	Concerns about the impact a change would have on research or education programs at the facility.
Administration's Budget or Policies	Concerns about the effects of the administration's budget or other policies on health care for veterans.
Unrelated to the Study Objectives	Other comments or concerns that are not specifically related to the study.

Summarized stakeholder views were available to LAP members for their review and consideration when evaluating BPOs as well as in defining new BPOs.

Stakeholder Input to Business Plan Option Development

Approximately 40-50 members of the public attended the first LAP meeting held on May 10, 2005. Approximately 40-50 members of the public attended the second LAP meeting held on September 8, 2005. A total of 61 forms of stakeholder input (general comments on the study as well as specific BPOs) were received between April 20 and September 11, 2005. The concerns of stakeholders who submitted general comments not related to specific BPOs are summarized in the following table:

Table 11: Analysis of General Stakeholder Concerns (Periods One and Two)

Key Concern	Number of Comments		
	Oral	Written and Electronic	**Total**
Effect on Access	2	2	**4**
Maintain Current Service/ Facility	9	5	**14**
Support for Veterans	5	2	**7**
Effect on Healthcare Services and Providers	3	2	**5**
Effect on Local Economy	1	2	**3**
Use of Facility	4	10	**14**
Effect on Research and Education	4	4	**8**
Administration's Budget or Policies	0	2	**2**
Unrelated to the Study Objectives	2	4	**6**

6.0 Business Plan Options

The option development process resulted in a multitude of discrete capital and re-use options, which were subsequently screened to determine whether a particular option had the potential to meet or exceed the CARES objectives (i.e., access, quality, and cost). Overall, there were two BPOs (comprising capital and re-use components) which passed initial screening and were developed for Stage I (see Figure 4).

Each BPO was assessed at a more detailed level according to the discriminating criteria. Each BPO examines renovating and upgrading facilities to modern, safe and secure standards, while at the same time consolidating the footprint of the campus in order to make surplus land available for potential non-VA re-use (see: Table 12).

Four additional BPOs (BPOs 4, 4A, 5 and 5A) were proposed by the LAP at the second LAP Public Meeting. These options were variations of two Team PwC-proposed options.

Site plans have been included for the BPOs developed by Team PwC (see Figures 5 and 6). The site plan for the baseline BPO (BPO 1) is the existing site plan (see Figure 1). The site plans are for reference only. They illustrate the magnitude of land and buildings required to meet projected utilization and are not designs.

Table12: Business Plan Options

BPO 1: Baseline
Renovation and maintenance of existing buildings for a modern, safe, and secure healthcare environment. Current buildings retrofitted to meet modern seismic standards. Ambulatory specialties and outpatient mental health services are expanded into underutilized ambulatory and domiciliary space. Under this BPO, one building is demolished (Building 245), four buildings are vacated (Buildings 242, 243, 249, 250), and the remaining 54 buildings are renovated. Parking space around campus is considered adequate. Parcels 1, 2, 3, 4, 5, 6, 7, and 10 are available for re-use. Such potential re-uses include: recreational, multi-family housing, small retail and institutional.
BPO 2: Renovate Domiciliary - Minimal New Construction; Addition for Outpatient Care
This BPO emphasizes renovation over new construction of domiciliary buildings to achieve modern, safe, and secure standards. Ambulatory specialties and outpatient mental health services are expanded into a new addition to the ambulatory care building (Building 201). Support buildings (boiler plant, maintenance shops, warehouses, and facilities group) on the northern side of the campus are demolished and consolidated into a new facility in the center of the campus. All other services remain at current location of provision. Two new buildings are constructed, 22 buildings are demolished (Buildings 225 through 235, Buildings 239 through 245, and Buildings 249, 250, 259, 262 and 270) and the remaining 37 buildings are renovated. Parking space around campus is considered adequate. Depending on the location chosen for new construction, as well as site work, utilities, landscaping, and parking will need to be reconfigured. Parcels 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 are available for re-use. Such potential re-uses include: recreational, multi-family housing, small retail, and institutional.
BPO 3: Phased Domiciliary Replacements and Renovations - Moderate New Construction; Addition for Outpatient Care
This BPO uses a combination of new construction and renovation of domiciliary buildings to achieve modern, safe, and secure standards. It is similar to the capital improvement plans originally proposed by the site, in that it replaces several domiciliary buildings through new construction and expands ambulatory specialities and outpatient mental health services into a new addition to Building 201. Eight domiciliary buildings are selected for demolition based upon a building assessment. They are replaced with four new domiciliary buildings in the central portion of the campus. Support buildings on the northern side of the campus are demolished and consolidated into a new facility in the center of campus. All other services remain at current location of provision. Six new buildings are constructed, 29 buildings are demolished (Buildings 213 through 218, Building 221, Buildings 225 through 235, Buildings 239 through 245, and Buildings 249, 250, 259, 262, and 270), and the remaining 30 buildings are renovated. Parking space around the campus is considered adequate. Depending on the location chosen for new construction, as well as site work, utilities, landscaping, and parking will need to be reconfigured. Parcels 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 are available for re-use. Such potential re-uses include: recreational, multi-family housing, small retail, and institutional.
BPO 4: Phased Renovations of Domiciliary and Support Facilities - Minimal New Construction; Addition for Outpatient Care
This BPO is similar to BPO 2. However, it proposes renovating (rather than replacing) the support buildings on the northern portion of the campus. As compared to BPO 2, fewer parcels are available for re-use. Under this modified BPO, re-use/redevelopment of Parcels 1, 2, 5, and 7 would be permitted. Such potential re-uses include: recreational, multi-family housing, small retail, and institutional.
BPO 4A: Phased Domiciliary Renovations - Minimal New Construction, Support Facilities Replacement in Current Location; Addition for Outpatient Care
This BPO is similar to BPO 2. However, it proposes replacing the support buildings in their current location on the northern portion of the campus. As compared to BPO 2, fewer parcels are available for re-use. Under this modified BPO, re-use/redevelopment of Parcels 1, 2, 5, and 7 would be permitted. Such potential re-uses include: recreational, multi-family housing, small retail, and institutional.
BPO 5: Phased Domiciliary Replacements and Renovations - Moderate New Construction, Support Facilities Renovation; Addition for Outpatient Care
This BPO is similar to BPO 3. However, it proposes renovating (rather than replacing) the support buildings on the northern portion of the campus. As compared to BPO 3, fewer parcels are available for re-use. Under this modified BPO, re-use/redevelopment of Parcels 1, 2, 5, and 7 would be permitted. Such potential re-uses include: recreational, multi-family housing, small retail, and institutional.
BPO 5A: Phased Domiciliary Replacements and Renovations - Moderate New Construction, Support Facilities Replacement; Addition for Outpatient Care
This BPO is similar to BPO 3. However, it proposes replacing the support buildings in their current location on the northern portion of the campus. As compared to BPO 3, fewer parcels are available for re-use. Under this modified BPO, re-use/redevelopment of Parcels 1, 2, 5, and 7 would be permitted. Such potential re-uses include: recreational, multi-family housing, small retail, and institutional.

BPO Site Plans

Figure 5: Proposed Site Plan - BPO 2 (Renovate Domiciliary - Minimal New Construction; Addition for Outpatient Care)

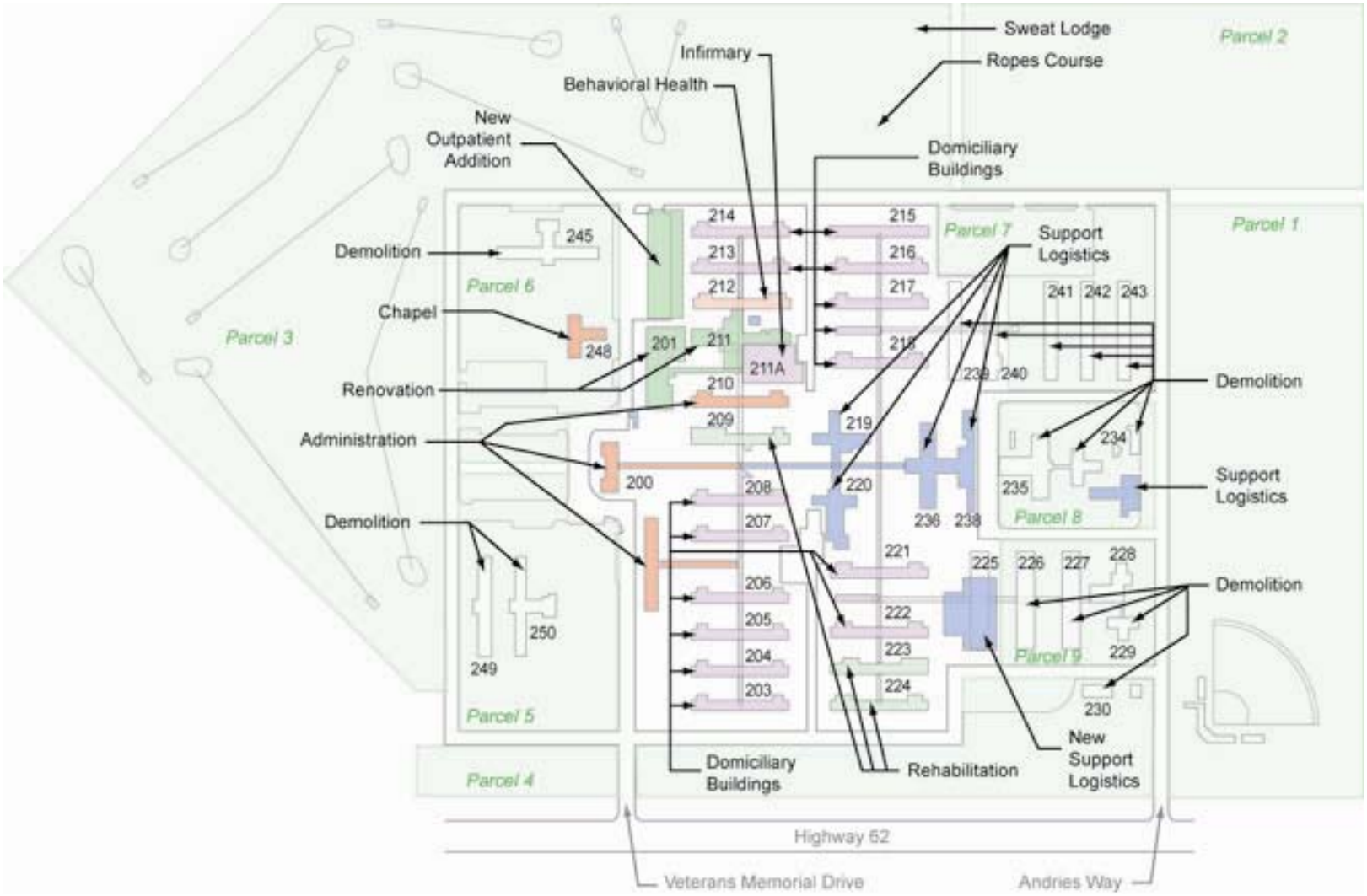
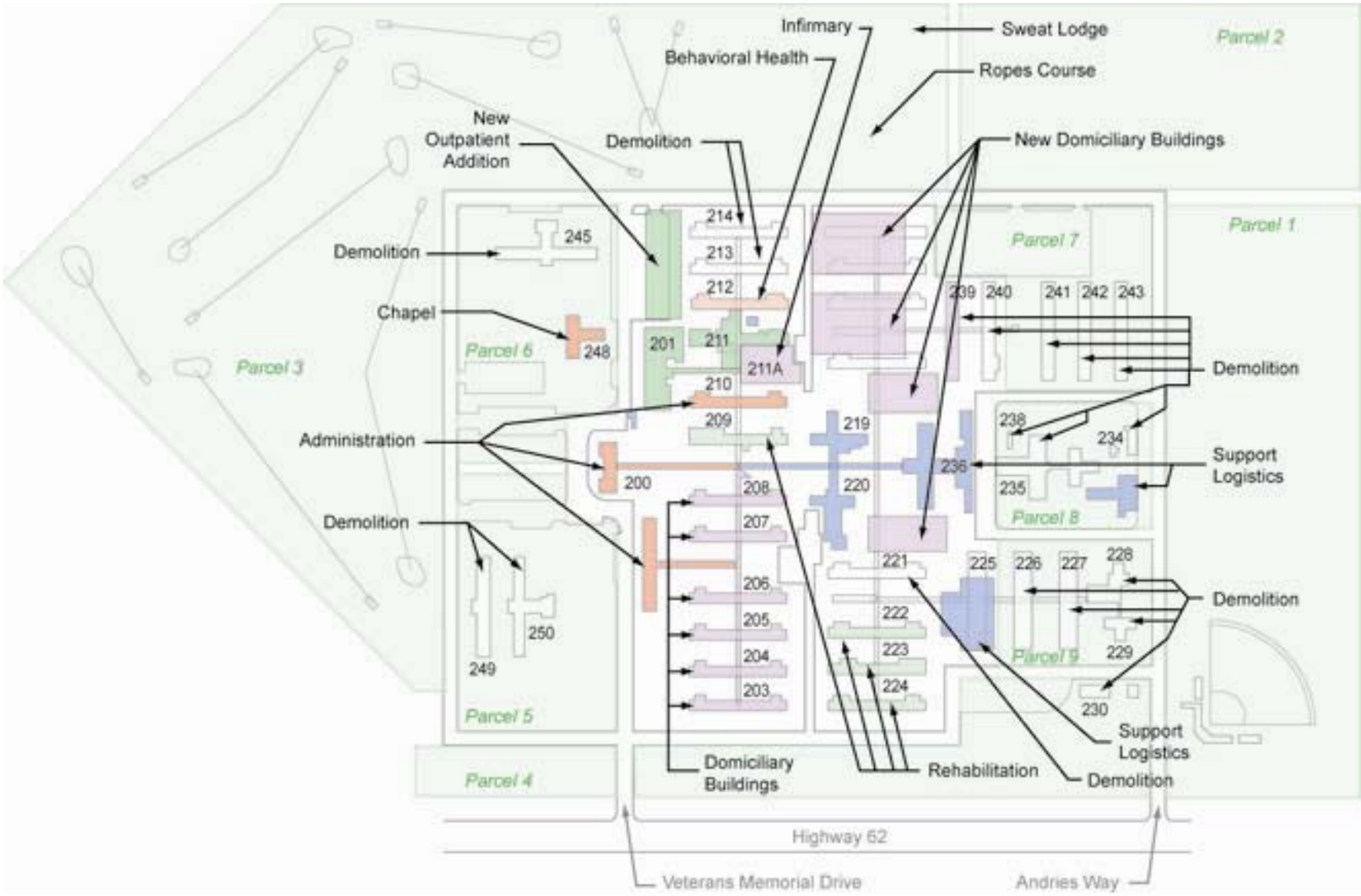


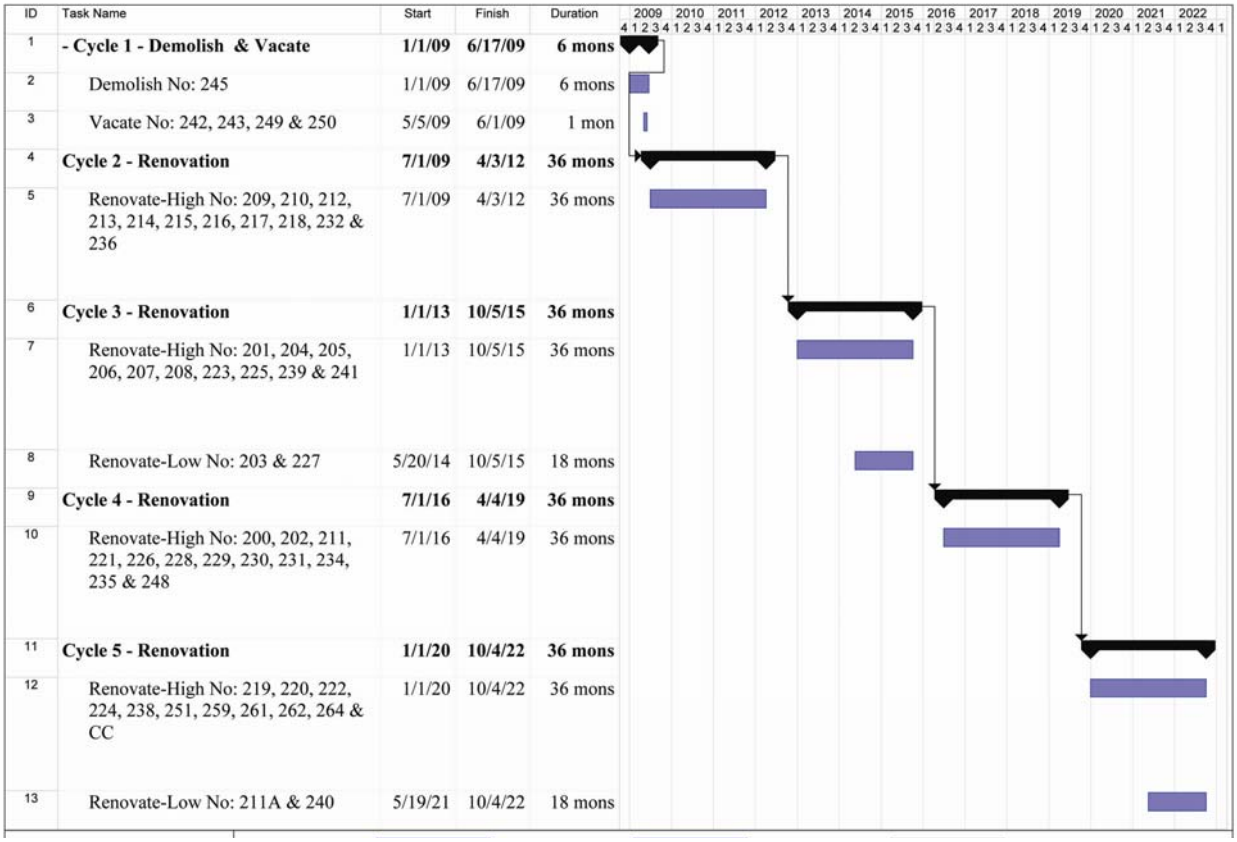
Figure 6: Proposed New Site Plan - BPO 3 (Phased Domiciliary Replacements and Renovations - Moderate New Construction; Addition for Outpatient Care)



BPO Schedules

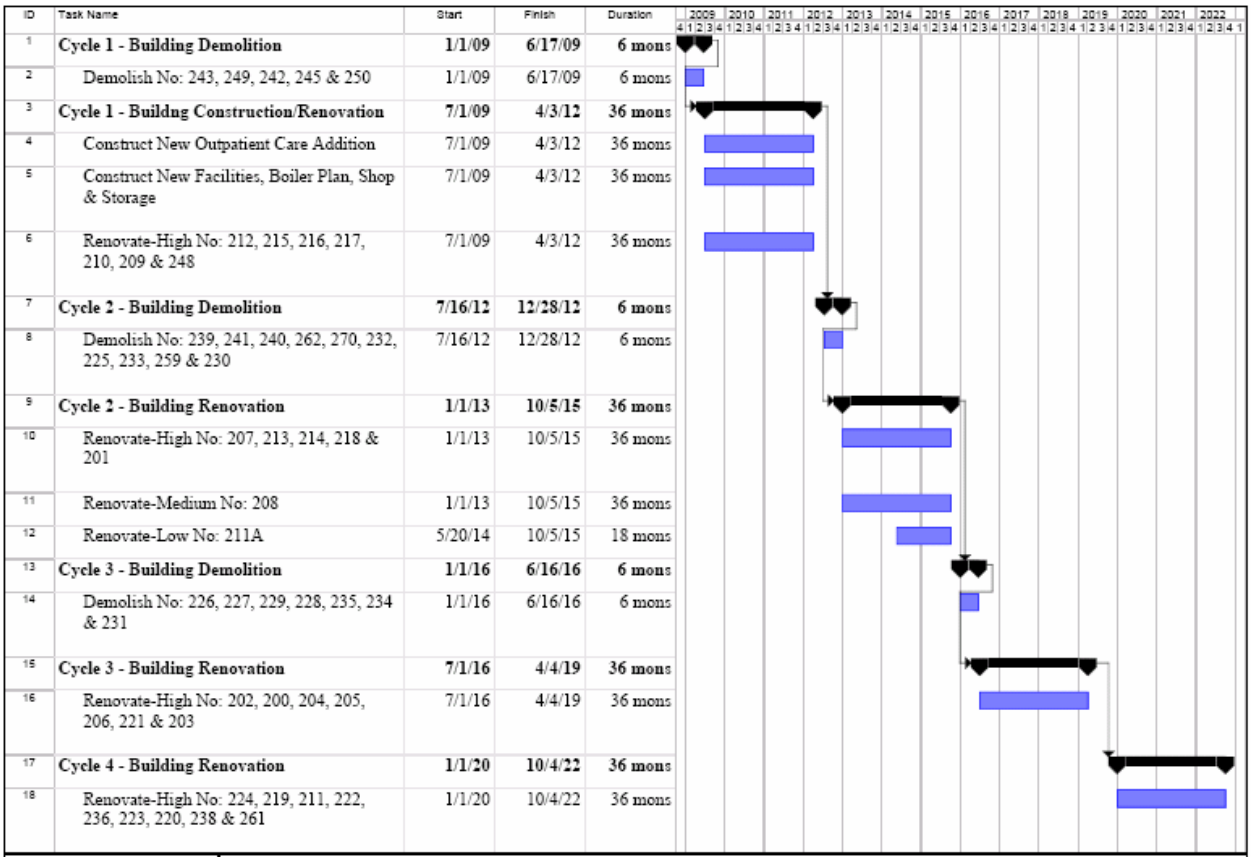
The following schedules were developed for the baseline and the alternate BPOs. All schedules are preliminary and tentative.

Figure 7: BPO 1 (Baseline)



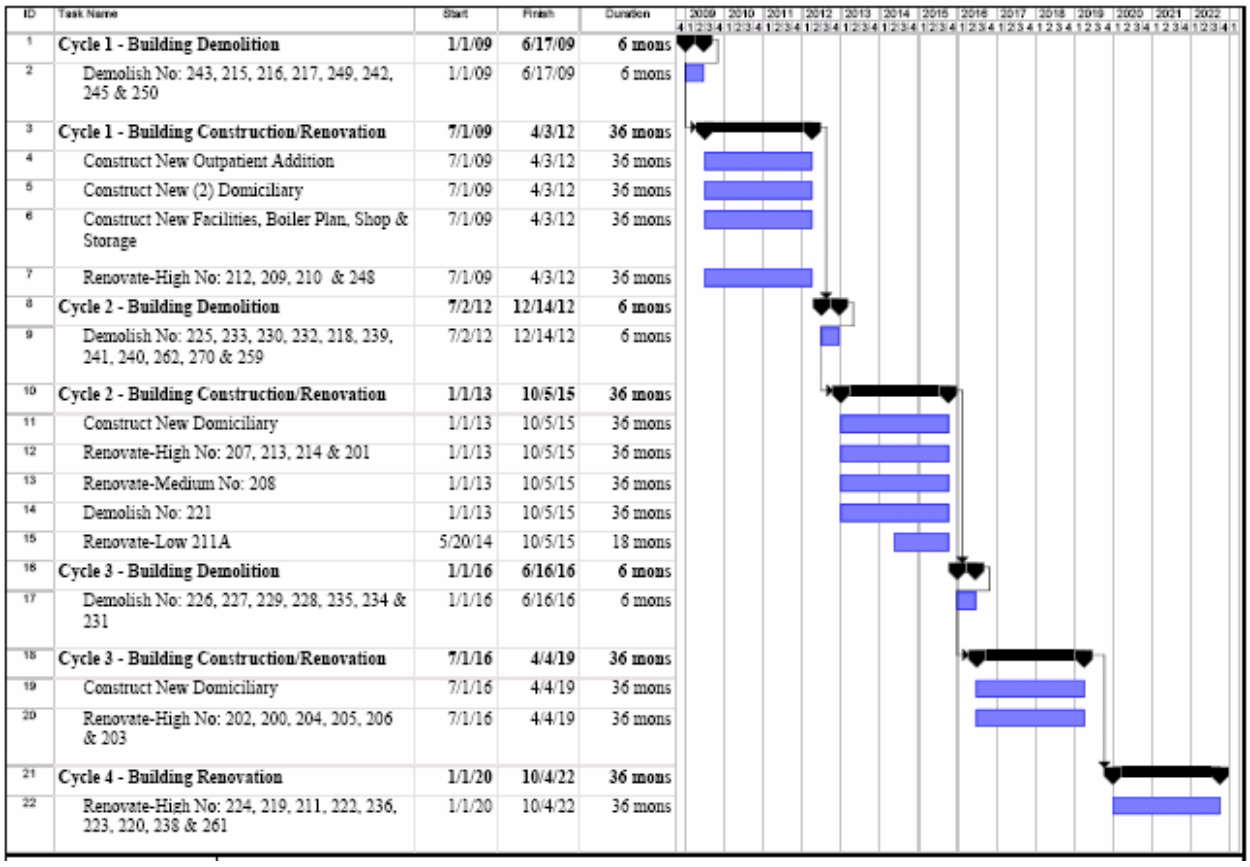
ID	Task Name	Start	Finish	Duration
1	**- Cycle 1 - Demolish & Vacate**	**1/1/09**	**6/17/09**	**6 mons**
2	Demolish No: 245	1/1/09	6/17/09	6 mons
3	Vacate No: 242, 243, 249 & 250	5/5/09	6/1/09	1 mon
4	**Cycle 2 - Renovation**	**7/1/09**	**4/3/12**	**36 mons**
5	Renovate-High No: 209, 210, 212, 213, 214, 215, 216, 217, 218, 232 & 236	7/1/09	4/3/12	36 mons
6	**Cycle 3 - Renovation**	**1/1/13**	**10/5/15**	**36 mons**
7	Renovate-High No: 201, 204, 205, 206, 207, 208, 223, 225, 239 & 241	1/1/13	10/5/15	36 mons
8	Renovate-Low No: 203 & 227	5/20/14	10/5/15	18 mons
9	**Cycle 4 - Renovation**	**7/1/16**	**4/4/19**	**36 mons**
10	Renovate-High No: 200, 202, 211, 221, 226, 228, 229, 230, 231, 234, 235 & 248	7/1/16	4/4/19	36 mons
11	**Cycle 5 - Renovation**	**1/1/20**	**10/4/22**	**36 mons**
12	Renovate-High No: 219, 220, 222, 224, 238, 251, 259, 261, 262, 264 & CC	1/1/20	10/4/22	36 mons
13	Renovate-Low No: 211A & 240	5/19/21	10/4/22	18 mons

Figure 8:BPO 2 (Renovate Domiciliary - Minimal New Construction; Addition for Outpatient Care)



ID	Task Name	Start	Finish	Duration
1	**Cycle 1 - Building Demolition**	**1/1/09**	**6/17/09**	**6 mons**
2	Demolish No: 243, 249, 242, 245 & 250	1/1/09	6/17/09	6 mons
3	**Cycle 1 - Building Construction/Renovation**	**7/1/09**	**4/3/12**	**36 mons**
4	Construct New Outpatient Care Addition	7/1/09	4/3/12	36 mons
5	Construct New Facilities, Boiler Plan, Shop & Storage	7/1/09	4/3/12	36 mons
6	Renovate-High No: 212, 215, 216, 217, 210, 209 & 248	7/1/09	4/3/12	36 mons
7	**Cycle 2 - Building Demolition**	**7/16/12**	**12/28/12**	**6 mons**
8	Demolish No: 239, 241, 240, 262, 270, 232, 225, 233, 259 & 230	7/16/12	12/28/12	6 mons
9	**Cycle 2 - Building Renovation**	**1/1/13**	**10/5/15**	**36 mons**
10	Renovate-High No: 207, 213, 214, 218 & 201	1/1/13	10/5/15	36 mons
11	Renovate-Medium No: 208	1/1/13	10/5/15	36 mons
12	Renovate-Low No: 211A	5/20/14	10/5/15	18 mons
13	**Cycle 3 - Building Demolition**	**1/1/16**	**6/16/16**	**6 mons**
14	Demolish No: 226, 227, 229, 228, 235, 234 & 231	1/1/16	6/16/16	6 mons
15	**Cycle 3 - Building Renovation**	**7/1/16**	**4/4/19**	**36 mons**
16	Renovate-High No: 202, 200, 204, 205, 206, 221 & 203	7/1/16	4/4/19	36 mons
17	**Cycle 4 - Building Renovation**	**1/1/20**	**10/4/22**	**36 mons**
18	Renovate-High No: 224, 219, 211, 222, 236, 223, 220, 238 & 261	1/1/20	10/4/22	36 mons

Figure 9: BPO 3 (Phased Domiciliary Replacements and Renovations - Moderate New Construction; Addition for Outpatient Care)



ID	Task Name	Start	Finish	Duration
1	**Cycle 1 - Building Demolition**	**1/1/09**	**6/17/09**	**6 mons**
2	Demolish No: 243, 215, 216, 217, 249, 242, 245 & 250	1/1/09	6/17/09	6 mons
3	**Cycle 1 - Building Construction/Renovation**	**7/1/09**	**4/3/12**	**36 mons**
4	Construct New Outpatient Addition	7/1/09	4/3/12	36 mons
5	Construct New (2) Domiciliary	7/1/09	4/3/12	36 mons
6	Construct New Facilities, Boiler Plan, Shop & Storage	7/1/09	4/3/12	36 mons
7	Renovate-High No: 212, 209, 210 & 248	7/1/09	4/3/12	36 mons
8	**Cycle 2 - Building Demolition**	**7/2/12**	**12/14/12**	**6 mons**
9	Demolish No: 225, 233, 230, 232, 218, 239, 241, 240, 262, 270 & 259	7/2/12	12/14/12	6 mons
10	**Cycle 2 - Building Construction/Renovation**	**1/1/13**	**10/5/15**	**36 mons**
11	Construct New Domiciliary	1/1/13	10/5/15	36 mons
12	Renovate-High No: 207, 213, 214 & 201	1/1/13	10/5/15	36 mons
13	Renovate-Medium No: 208	1/1/13	10/5/15	36 mons
14	Demolish No: 221	1/1/13	10/5/15	36 mons
15	Renovate-Low 211A	5/20/14	10/5/15	18 mons
16	**Cycle 3 - Building Demolition**	**1/1/16**	**6/16/16**	**6 mons**
17	Demolish No: 226, 227, 229, 228, 235, 234 & 231	1/1/16	6/16/16	6 mons
18	**Cycle 3 - Building Construction/Renovation**	**7/1/16**	**4/4/19**	**36 mons**
19	Construct New Domiciliary	7/1/16	4/4/19	36 mons
20	Renovate-High No: 202, 200, 204, 205, 206 & 203	7/1/16	4/4/19	36 mons
21	**Cycle 4 - Building Renovation**	**1/1/20**	**10/4/22**	**36 mons**
22	Renovate-High No: 224, 219, 211, 222, 236, 223, 220, 238 & 261	1/1/20	10/4/22	36 mons

Assessment Drivers

The SORCC, as VA's only free standing rehabilitation center, serves as a regional and national resource for underserved special populations (e.g., homeless, chronically mentally ill, and substance abuse), providing quality residential treatment in psychiatry, addictions, medicine, and bio-psychosocial, physical, and vocational rehabilitation.

Over the next 20 years, the number of enrolled veterans for the South Cascades market is expected to decline by 5% from 105,648 to 100,202. However, enrollment of Priority 1-6 veterans (those with the greatest service-connected needs) is projected to increase by 15% by 2023.

Projected utilization for inpatient services appears to vary over the next 20 years, which presents both opportunities and challenges. Specifically with regard to inpatient care:

- Inpatient mental health beds increase to 275 in 2023
- Domiciliary beds decrease from 755 in 2003 to 325 in 2023

Opportunities exist to address the market needs for inpatient mental health services as well as outpatient services for an aging veteran population, such as cardiology, eye clinic, orthopedics, surgical and related specialties, and mental health.

These long term healthcare trends for the South Cascades market, together with three major drivers were considered for the White City study site. These drivers represent factors particularly noticeable at the SORCC that must be balanced in the development and evaluation of business plan options. They are:

1). The SORCC requires significant capital expenditure over the next 20 years to upgrade facilities to modern, safe, and secure standards – in particular, seismic upgrades to many structures.
2). Facilities need to be right-sized to meet projected demand for healthcare services through 2023.
3). The footprint of the SORCC campus needs to be reduced in order to provide more cost effective healthcare delivery and to maximize the potential for re-use.

These three drivers are described further below.

Capital Investment to Achieve Modern, Safe, and Secure Standards – The SORCC requires significant capital investment to upgrade to modern, safe, and secure standards. The buildings have received ratings between 2.3 and 3.9 on a scale of "5" based on VA's CAI database, which is generally acceptable for the mainly residential use of the campus. However, seismic retrofits will be required of most buildings. Other upgrades to current VA standards and applicable building codes must also be performed. Non-friable asbestos and lead paint will need to be abated or remediated in many key structures. Mechanical systems are at the end of their useful life and will need upgrading to keep pace with the other needed facility upgrades through the projection period. Additionally, the campus will need to meet federal security requirements. The cost effectiveness of renovating versus constructing new facilities will need to be determined based upon a building assessment and detailed cost analysis.

Right-Size Facilities to Meet Projected Demand – Over the next 20 years, the South Cascades market will experience a modest decline in overall enrollment, but a 15% increase in enrollment by veterans in priority groups 1-6 (those with the greatest service-connected needs). Long term utilization trends for the SORCC facility indicate a shift to inpatient mental health beds and a decrease in domiciliary beds, creating an overall surplus in bed space. Over the same period, several categories of outpatient care (ambulatory and mental health) will experience increases in demand, creating additional space requirements. These changes in service needs over the forecast period will require right-sizing and reconfiguration of the campus. If VA makes no changes to the SORCC campus, it will operate with substantial vacant and underused space that is costly to maintain and diverts patient care resources to building and grounds maintenance.

Re-Use Potential – Analysis of the re-use potential for the SORCC indicates that it is reasonably well located for a variety of re-use plans; however, the real estate market characteristics of the campus reveal that it would require a significant period of time to market the property. The campus is surrounded primarily by industrially-developed land with the supply of land plentiful and demand for land and buildings not as robust as in other major urban markets. Those parcels of the campus that front on Highway 62, a major commercial thoroughfare, have the greatest attractiveness for non-VA re-use. Parcels currently used for recreational purposes (golf course, driving range, and ballpark) also have some appeal to non-VA entities. Sites with similar characteristics generally attract interest not from the typical market participants, such as major office and residential developers, but from entities with a unique use or multiple uses for the property.

Assessment Results

The following section summarizes the results of applying discriminating criteria to each BPO and comparing them to the baseline in accordance with the Evaluation System for BPOs (Table 9). Subsequent sections describe the reactions of the Local Advisory Panel and Stakeholders to these BPOs, Team PwC's screening assessment of LAP BPOs, and Team PwC's overall recommendations for each BPO.

Table 13: Baseline Assessment

Assessment Summary	Baseline
Healthcare Quality	
Ensures forecast healthcare need is appropriately met	There will be no material differences in the accommodation of projected demand. Demand is expected to not exceed site capacity for inpatient and outpatient care and will be accommodated on site through the projection period. The facility is sized to meet the projected patient demand volumes.
Modern, safe, and secure environment	Conditions of buildings on the White City campus vary. The buildings have ratings between 2.3 and 3.9 for critical values such as accessibility, code, functional space, and facility conditions. The baseline improves site safety by addressing seismic deficiencies and bringing buildings up to code.
Use of VA Resources	
Operating cost effectiveness	Renovations to the facilities should improve facility operating costs from the current state. However, given the original design limitations of the existing facilities, renovations to achieve a modern, safe, and secure environment do not realize efficiencies in staffing, supplies, heating, and power, which would be available under new construction alternatives.
Level of capital expenditure anticipated	Significant capital expenditure is required to renovate and upgrade facilities to modern, safe and secure standards.
Level of re-use proceeds	Parcels 1, 2, 3, 4, 5, 6, 7, and 10 are available for re-use which are large, contiguous, rectangular, and functional configurations. The re-use of these parcels is not inhibited by topography, environment, zoning, or buildings with historical designation. These re-use parcels could be attractive to a variety of non-VA entities. However, analysis of the real estate market characteristics for this campus reveals that the supply of land is plentiful and demand for land and buildings is not as robust as in other urban markets. Additionally, re-use proceeds from Parcel 10, which has highway frontage, may be limited by the narrowness of the parcel. Therefore, it may take a significant amount of time to market the property and re-use proceeds will be limited.
Cost avoidance opportunities	In the baseline, it is assumed that renovation and periodic and recurring maintenance costs for some vacated buildings (Buildings 245, 249, 250, 242 and 243) would be eliminated. The majority of the $111 million identified in the CAI database for facility improvements would be expended.
Overall cost effectiveness	Not applicable for the baseline.
Ease of Implementation	
Ease of BPO implementation	The risk factor for implementation is low since the baseline represents the current state with improvements to meet modern, safe, and secure standards and meet demand projections. These risks are minimal since the facility is currently in good condition, but this BPO does present implementation risk in terms of the following major areas: ▪ Continuity of care, since renovation of the patient care facilities may disrupt provision of care to patients and utilization will exceed the capacity of the baseline facility in ambulatory care services; however, no movement of patients off the White City campus is expected ▪ Infrastructure, since facilities may unveil unforeseen environmental, systematic, and/or structural issues during renovation ▪ Security, since renovation may not be able to conform the building to all code requirements given physical constraints of the buildingsProject realization, since renovations present exposure to delays, budget variances, and transition complications.

Ability to Support Wider VA Programs	
DoD sharing	No DoD sharing arrangements are expected in the baseline.
One-VA Integration	The baseline environment does not further One-VA integration nor has any requirement to coordinate with other VA administrations been identified.
Special Considerations	The baseline does not impact DoD contingency planning, Homeland security needs, or emergency need projections.
Overall Attractiveness	Not applicable for the baseline.

Table 14 provides an overall summary of the BPOs assessed for comparative purposes.

Table 14: BPO Assessment Summary[9]

Assessment Summary	BPO 2	BPO 3
	Renovate Domiciliary - *Minimal* New Construction; Addition for Outpatient Care	**Phased Domiciliary Replacements and Renovations - *Moderate* New Construction; Addition for Outpatient Care**
Healthcare Quality		
Ensures forecast healthcare need is appropriately met	↑	↑
Modern, safe, and secure environment	↑	↑
Use of VA Resources		
Operating cost effectiveness	—	—
Level of capital expenditure anticipated	—	—
Level of re-use proceeds	↑	↑
Cost avoidance opportunities	—	—
Overall cost effectiveness	—	—
Ease of Implementation		
Ease of BPO implementation	↓	↓
Ability to Support VA Programs		
DoD sharing	↔	↔
One-VA Integration	↔	↔
Special Considerations	↔	↔
Overall Attractiveness	↑↑	↑↑

[9] BPOs 4, 4A, 5 and 5A are not included in the Assessment Summary Table. They were created during the second LAP meeting at the suggestion of the LAP and, therefore, only the initial screening criteria of access, quality, and cost were applied to determine if the BPOs have the potential to meet or exceed the CARES objectives. If BPO 4A or 5A are selected for Stage II, a more detailed analysis will be completed.

BPO 4: Phased Renovations of Domiciliary and Support Facilities - Minimal New Construction; Addition for Outpatient Care

The initial screening criteria of access, quality, and cost were applied to this new BPO to determine if this BPO, created by the LAP, has the potential to meet or exceed the CARES objectives.

Table 15: Screening Results for BPO 4

Criteria	Screening Result
Access	Since all services will remain on the campus, assume current access levels will be maintained.
Quality	Similar to BPO 2, this BPO improves site safety by addressing seismic deficiencies and bringing buildings up to code. New construction of the outpatient addition provides physical layouts and unit sizes that reflect modern healthcare practice.
Cost	This BPO will likely be similar to BPO 2 in overall cost-effectiveness; however, recurring maintenance costs for support buildings will be higher and re-use proceeds will be diminished. A financial analysis would be required to more properly assess the impact of these factors on the overall cost effectiveness of this BPO.

BPO 4A: Phased Domiciliary Renovations – Minimal New Construction, Support Facilities Replacement in Current Location; Addition for Outpatient Care

The initial screening criteria of access, quality, and cost were applied to this new BPO to determine if this BPO, created by the LAP, has the potential to meet or exceed the CARES objectives.

Table 16: Screening Results for BPO 4A

Criteria	Screening Result
Access	Since all services will remain on the campus, assume access quality levels will be maintained.
Quality	Similar to BPO 2, this BPO improves site safety by addressing seismic deficiencies and bringing buildings up to code. New construction of the outpatient addition provides physical layouts and unit sizes that reflect modern healthcare practice.
Cost	This BPO will likely be similar to BPO 2 in overall cost-effectiveness; however, re-use proceeds will be diminished. A financial analysis would be required to more properly assess the impact of this factor on the overall cost effectiveness of this BPO.

BPO 5: Phased Domiciliary Replacements and Renovations – Moderate New Construction, Support Facilities Renovation; and Addition for Outpatient Care

The initial screening criteria of access, quality, and cost were applied to this new BPO to determine if this BPO, created by the LAP, has the potential to meet or exceed the CARES objectives.

Table 17: Screening Results for BPO 5

Criteria	Screening Result
Access	Since all services will remain on the campus, assume current access levels will be maintained.
Quality	Similar to BPO 3, this BPO improves site safety by addressing seismic deficiencies and bringing buildings up to code. New construction of the outpatient addition and domiciliary buildings provides physical layouts and unit sizes that reflect modern healthcare practice.
Cost	This BPO will likely be similar to BPO 3 in overall cost-effectiveness; however, recurring maintenance costs for support buildings will be higher and re-use proceeds will be diminished. A financial analysis would be required to more properly assess the impact of these factors on the overall cost effectiveness of this BPO.

BPO 5A: Phased Domiciliary Replacements and Renovations – Moderate New Construction, Support Facilities Replacement; and Addition for Outpatient Care

The initial screening criteria of access, quality, and cost were applied to this new BPO to determine if this BPO, created by the LAP, has the potential to meet or exceed the CARES objectives.

Table 18: Screening Results for BPO 5A

Criteria	Screening Result
Access	Since all services will remain on the campus, assume current access levels will be maintained.
Quality	Similar to BPO 3, this BPO improves site safety by addressing seismic deficiencies and bringing buildings up to code. New construction of the outpatient addition and domiciliary buildings provides physical layouts and unit sizes that reflect modern healthcare practice.
Cost	This BPO will likely be similar to BPO 3 in overall cost-effectiveness; however, re-use proceeds will be diminished. A financial analysis in Stage II is required to more properly assess the impact of this factor on the overall cost effectiveness of this BPO.

Local Advisory Panel and Stakeholder Reactions/Concerns

Local Advisory Panel Feedback

The White City LAP consists of six members: Les Burger, M.D. (Chair), Hank Collins, Madeline Winfrey, Donna Markle, Marty Kimmel, and Andrew Mebane, M.D. Two of the members are VA staff, the rest are representatives of the community, veteran service organizations, and where appropriate, medical affiliates and Department of Defense.

At the second LAP meeting on September 8, 2005, following the presentation of public comments, the LAP conducted its deliberation on the BPOs. At that time, the LAP proposed four alternative BPOs which represent modifications to two BPOs presented by Team PwC. The LAP favored several features of BPO 2 and 3 but wanted to consider fewer re-use parcels and alternate ways of addressing the future of the support buildings.

The LAP recommended:

> *"Substitute [option 2] with [a] new option, BPO 2 without parcels 3, 4, 6, and 10 and also with an option to either renovate or rebuild boiler plant, warehouse, and facilities in Parcels 8 and 9."* [10]

The LAP proposed a similar modification to BPO 3, with alternate options to renovate or rebuild support buildings in Parcels 8 and 9. The reasoning behind the LAP's recommendations can be explained as follows:

- The LAP was concerned that consolidation of the campus would take away parking space
- The LAP wanted to preserve land for future enhanced use of the facility
- The LAP wanted to retain frontage (Parcel 10) for VA ceremonies
- The LAP believed that while some equipment was aging and in need of replacement, the support buildings themselves were viable and serviceable
- The LAP was interested in the cost comparison between leaving the support buildings alone or constructing them new in their existing location.

Table 19 presents the results of LAP deliberations. Overall, the LAP shared the sentiment of the public that services should remain on site and favors the renovation or replacement of existing facilities, while preserving surrounding grounds for patient use.

Table 19: LAP BPO Voting Results

BPO	Label	Yes	No
1	Baseline	0	6
2	Renovate Domiciliary – *Minimal* New Construction; Addition for Outpatient Care	0	6
3	Phased Domiciliary Replacements and Renovations – *Moderate* New Construction; Addition for Outpatient Care	0	6
4	Phased Renovations of Domiciliary and Support Facilities – *Minimal* New Construction; Addition for Outpatient Care	6	0
4A	Phased Domiciliary Renovations – *Minimal* New Construction, Support Facilities Replacement in Current Location; Addition for Outpatient Care	6	0
5	Phased Domiciliary Replacements and Renovations – *Moderate* New Construction, Support Facilities Renovation; Addition for Outpatient Care	6	0
5A	Phased Domiciliary Replacements and Renovations – *Moderate* New Construction, Support Facilities Replacement; Addition for Outpatient Care	6	0

[10] Meeting Summary: White City VA Medical Center Local Advisory Panel Public Meeting September 8, 2005.

Stakeholder Feedback on BPOs

In addition to raising specific concerns, stakeholders were provided with the opportunity to provide feedback regarding the specific BPOs presented at the second LAP meeting. Through the VA CARES website and comment forms distributed at the public meeting, stakeholders were able to indicate if they "favor", are "neutral", or are "not in favor" of each of the BPOs. The results of this written and electronic feedback are provided in Figure 10.

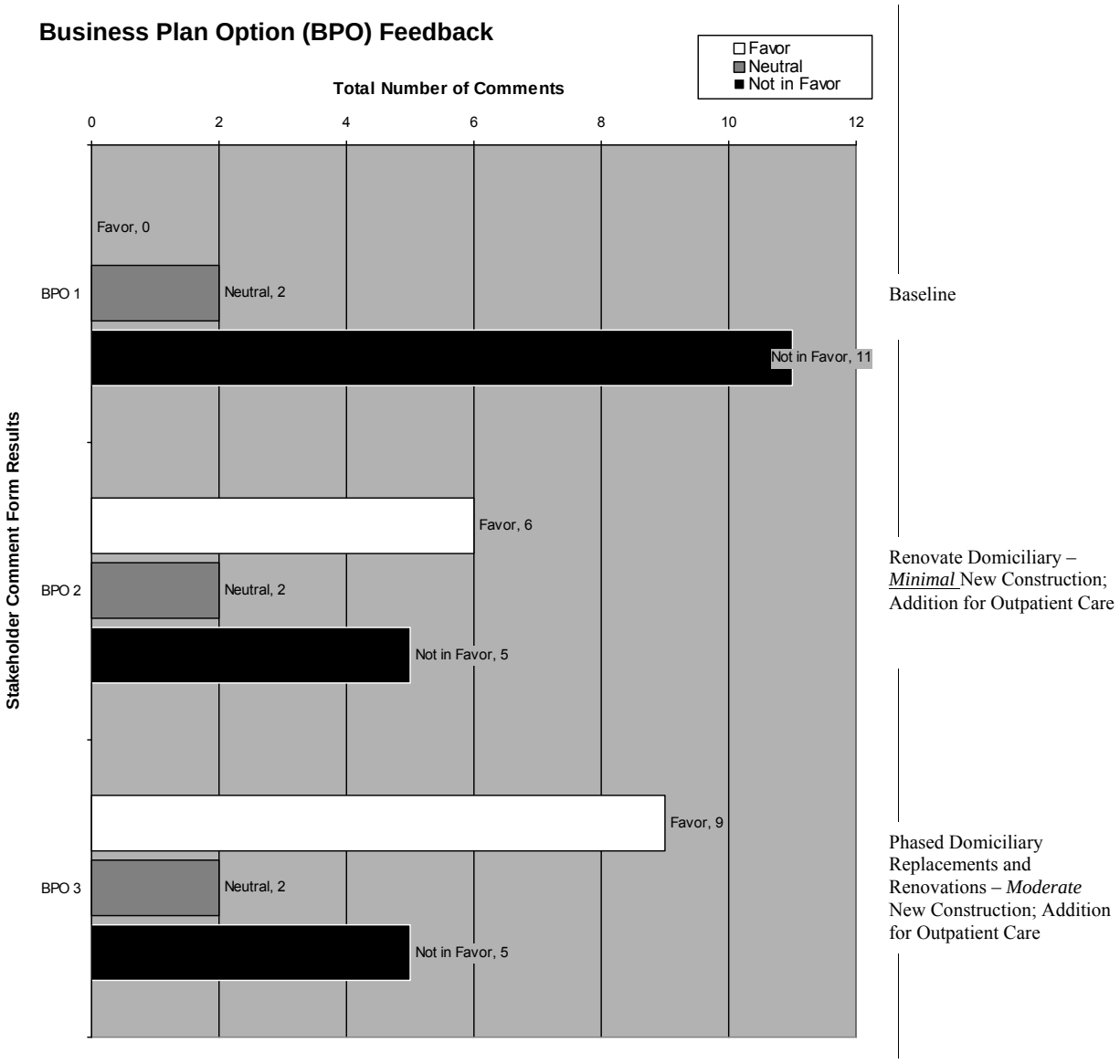
Multiple stakeholders expressed distress about the ability of the facility to provide inpatient care including medical services under the baseline. Stakeholders were overwhelmingly supportive of any BPO that kept services on site. There was great dissatisfaction with the proposal to make Parcels 3 (golf course), 4 (vacant south outer perimeter), and 10 (vacant east outer perimeter) available for re-use opportunities.

Figure 10: Stakeholder Feedback on BPOs[11]

VA CARES BUSINESS PLAN STUDIES
STAKEHOLDER INPUT ANALYSIS REPORT
White City Study Site (8/31/2005 to 9/18/2005)

Analysis of Written and Electronic Inputs (Written and Electronic Only):

The feedback received from the Options Comment Forms for the White City study site is as follows:



[11] Stakeholder feedback is reflected in this chart only for the BPOs which were presented by Team PwC at the LAP meeting (BPOs 1-3), and not the ones created by the LAP at the second public LAP meeting. Any stakeholder feedback regarding additional options was captured in the open text boxes on the comment forms.

BPO Recommendations for Assessment in Stage II

Team PwC's recommendation of BPOs to be further assessed in Stage II was determined based on several factors. Team PwC considered the pros and cons of each option, together with the results of assessments against discriminating criteria to determine the overall attractiveness of each BPO. Views and opinions of the LAP and oral and written testimony received from veterans and other interested groups were also considered. All of these inputs contributed to the selection of the BPOs to be recommended for further study in Stage II, which are summarized in Table 20 with pros and cons identified for each option.

The BPOs recommended for further study share some key similarities. All of them would provide an attractive solution to upgrading the campus to modern, safe, and secure standards, while right-sizing the campus for future demand.

The BPOs which Team PwC eliminated from further consideration were BPO 4 and BPO 5. Both BPOs were proposed by the LAP and involved renovation of the existing wooden support buildings in their current location. Team PwC eliminated these BPOs because: single story wooden support buildings are inefficient infrastructure; higher maintenance costs are associated with wooden support buildings; and the difficulty in making support buildings modern, safe, and secure.

Table 20: BPO Recommendations

BPO	Pros	Cons	Rationale
BPOs Recommended by Team PwC for Further Study			
BPO 1: Baseline	• Achieves some consolidation of the campus • Permits potential re-use/redevelopment of Parcels 1-7, and 10 • The least disruptive option to the site	• Operating inefficiencies and higher maintenance costs persist for older buildings • Existing footprint, building heights, and floor layouts prevent most effective consolidation	• The baseline is the BPO against which all other BPOs are assessed
BPO 2: Renovate Domiciliary – *Minimal* New Construction; Addition for Outpatient Care	• Enables further consolidation of the campus than the baseline • New buildings are more efficient to operate • Potential re-use/redevelopment of Parcels 1-10	• More site disruption from renovation, demolition, and new construction • Operating inefficiencies and higher maintenance costs persist for older buildings	• Improves campus safety by addressing seismic deficiencies • Achieves greater consolidation of existing campus than the baseline • Permits re-use/redevelopment of underutilized buildings and land • A structural assessment of buildings and a detailed cost assessment are required to further differentiate these two BPOs.
BPO 3: Phased Domiciliary Replacements and Renovations – *Moderate* New Construction; Addition for Outpatient Care	• Enables further consolidation of the campus than the baseline or BPO 2 • New buildings are more efficient to operate • Potential re-use/redevelopment of Parcels 1-10	• More site disruption from renovation, demolition, and new construction • Operating inefficiencies and higher maintenance costs persist for older buildings	
BPO 4A: Phased Domiciliary Renovations – Minimal New Construction, Support Facilities Replacement in Current Location; Addition for Outpatient Care	• Enables further consolidation of the campus than the baseline • New buildings are more efficient to operate • Potential re-use/redevelopment of Parcels 1, 2, 5, and 7	Similar to BPO 3 with the following exception: • Provides more space than is needed for future VA use and does not maximize re-use proceeds	Similar rationale to BPO 2 and BPO 3, considering limited re-use potential
BPO 5A: Phased Domiciliary Replacements and Renovations – Moderate New Construction, Support Facilities Replacement; Addition for Outpatient Care	• Enables further consolidation of the campus than the baseline or BPO 2 • New buildings are more efficient to operate • Potential re-use/redevelopment of Parcels 1, 2, 5, and 7	Similar to BPO 3 with the following exception: • Provides more space than is needed for future VA use and does not maximize re-use proceeds	Similar rationale to BPO 2 and BPO 3, considering limited re-use potential
BPOs Not Recommended by Team PwC for Further Study			
BPO 4: Phased Renovations of Domiciliary and Support Facilities - *Minimal* New Construction; Addition for Outpatient Care	• Enables further consolidation of the campus than the baseline • New buildings are more efficient to operate • Potential re-use/redevelopment of Parcels 1, 2, 5, and 7	Similar to BPO 2 with the following exceptions: • Provides more space than is needed for future VA use and does not maximize re-use proceeds • Existing support facilities not easily integrated with new facilities • Wooden support buildings are not easily rendered modern, safe, and secure	• Single story wooden support buildings are inefficient infrastructure • Higher maintenance costs of wooden support buildings • Difficult to make support buildings modern, safe, and secure
BPO 5: Phased Domiciliary Replacements and Renovations – Moderate New Construction, Support Facilities Renovation; Addition for Outpatient Care	• Enables further consolidation of the campus than the baseline or BPO 2 • New buildings are more efficient to operate • Potential re-use/redevelopment of Parcels 1, 2, 5, and 7	Similar to BPO 3 with the following exceptions: • Provides more space than is needed for future VA use and does not maximize re-use proceeds • Existing support facilities not easily integrated with new facilities • Wooden support buildings are not easily rendered modern, safe, and secure	

Appendix A - Assessment Tables

BPO 1: Baseline

Assessment of BPO 1	Description of Impact
Healthcare Quality	
Ensures forecast healthcare need is appropriately met	There will be no material differences in the accommodation of projected demand. Demand is expected to not exceed site capacity for inpatient and outpatient care and will be accommodated on site through the projection period. The facility is sized to meet the projected patient demand volumes.
Modern, safe, and secure environment	Conditions of buildings on the White City campus vary. The buildings have ratings between 2.3 and 3.9 for critical values such as accessibility, code, functional space, and facility conditions. The baseline improves site safety by addressing seismic deficiencies and bringing buildings up to code.
Use of VA Resources	
Operating cost effectiveness	Renovations to the facilities should improve facility operating costs from the current state. However, given the original design limitations of the existing facilities, renovations to achieve a modern, safe, and secure environment do not realize efficiencies in staffing, supplies, heating, and power, which would be available under new construction alternatives.
Level of capital expenditure anticipated	Significant capital expenditure is required to renovate and upgrade facilities to modern, safe, and secure standards.
Level of re-use proceeds	Parcels 1, 2, 3, 4, 5, 6, 7 and 10 are available for re-use which are large, contiguous, rectangular and functional configurations. The re-use of these parcels is not inhibited by topography, environment, zoning, or buildings with historical designation. These re-use parcels could be attractive to a variety of non-VA entities. However, analysis of the real estate market characteristics for this campus reveals that the supply of land is plentiful and demand for land and buildings is not as robust as in other urban markets. Additionally, re-use proceeds from Parcel 10, which has highway frontage, may be limited by the narrowness of the parcel. Therefore, it may take a significant amount of time to market the property and re-use proceeds will be limited.
Cost avoidance opportunities	In the baseline, it is assumed that renovation and periodic and recurring maintenance costs for some vacated buildings (Buildings 245, 249, 250, 242 and 243) would be eliminated. The majority of the $111 million identified in the CAI database for facility improvements would be expended.
Overall cost effectiveness	Not applicable for the baseline.

Ease of Implementation	
Ease of BPO implementation	The risk factor for implementation is low since the baseline represents the current state with improvements to meet modern, safe, and secure standards and meet demand projections. These risks are minimal since the facility is currently in good condition, but this option does present implementation risk in terms of the following major areas: ▪ Continuity of care, since renovation of the patient care facilities may disrupt provision of care to patients and utilization will exceed the capacity of the baseline facility in Ambulatory Care services; however, no movement of patients off the White City campus is expected ▪ Infrastructure, since facilities may unveil unforeseen environmental, systematic and/or structural issues during renovation ▪ Security, since renovation may not be able to conform the building to all code requirements given physical constraints of the buildings ▪ Project realization, since renovations present exposure to delays, budget variances and transition complications.
Ability to support VA Programs	
DoD sharing	No DoD sharing arrangements are expected in the baseline.
One-VA Integration	The baseline environment does not further One-VA integration nor has any requirement to coordinate with other VA administrations been identified.
Special Considerations	The baseline does not impact DoD contingency planning, Homeland security needs, or emergency need projections.
Overall Attractiveness	Not applicable to the baseline.

BPO 2: Renovate Domiciliary – *Minimal* New Construction; Addition for Outpatient Care

Assessment of BPO 2	Impact on Baseline	Description of Impact
Healthcare Quality		
Ensures forecast healthcare need is appropriately met	↑	Facility is sized to meet projected demand. Further consolidation of the campus is achieved than is possible under the baseline.
Modern, safe, and secure environment	↑	Renovation and minimal construction improves site safety by addressing seismic deficiencies and bringing buildings up to code. New construction provides physical layouts and unit sizes that reflect modern healthcare practice.
Use of VA Resources		
Operating cost effectiveness	—	Results in potentially the same operating costs as the baseline. Staffing efficiencies may be achieved for the new outpatient mental health facility; other renovated domiciliary buildings will have equivalent operating costs to the baseline.
Level of capital expenditure anticipated	—	Combination of new construction and renovation results in similar level of investment required relative to the baseline (80% - 120% of baseline) since the baseline already requires heavy renovation of existing facilities to make them modern, safe, and secure.
Level of re-use proceeds	↑	Additional re-use potential is afforded by making parcels available for re-use; however, a similar level of re-use proceeds compared to the baseline (+/- 20% of baseline) is still expected.
Cost avoidance opportunities	—	Given the type of buildings and the nature of the healthcare services provided at the campus, only marginal benefits from eliminating recurring maintenance costs on some buildings exists. Therefore, no significant cost avoidance opportunities are expected.
Overall cost effectiveness	—	The extent of renovation and upgrades in this option is similar to the baseline, resulting in similar operating costs and capital expenditure as the baseline. Additionally, re-use proceeds are not expected to be significantly different than the baseline. Thus, the BPO results in a similar level of net present cost as the baseline.

Ease of Implementation		
Ease of BPO implementation	↓	The BPO is riskier than the baseline in terms of the following major risk categories: • Continuity of care, slightly higher than the baseline in terms of transitioning patients within White City facilities to accommodate the renovation of the domiciliary and rehabilitation facilities and new Ambulatory Care facility • Infrastructure, given the incrementally greater amount of renovation and new construction when compared to baseline yielding unforeseen environmental, systematic, and/or structural issues • Project realization, in terms of incremental project management required to control new, though *minimal*, construction, and demolition which may be more vulnerable to delays, budget variance, and transition complications than renovation to modern, safe, and secure standard of the baseline. .
Wider VA Program Support		
DoD sharing	↔	No material impact is expected since no DoD relationships are expected. However, the BPO does not preclude any potential collaboration between VA and DoD.
One-VA Integration	↔	No material impact is expected that would affect One-VA integration since there are no significant VBA or NCA relationships in the baseline which could be disrupted. Furthermore, the BPO neither precludes nor enhances future, potential VBA or NCA relationships.
Special Considerations	↔	No material impact expected in terms of special considerations since the capital plan neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↑↑	BPO 2 is attractive compared to the baseline. This BPO is likely to offer a solution that at least maintains access and improves quality for a similar net present cost as the baseline.

BPO 3: Phased Domiciliary Replacements and Renovations – *Moderate* New Construction, Addition for Outpatient Care

Assessment of BPO 2	Impact on Baseline	Description of Impact
Healthcare Quality		
Ensures forecast healthcare need is appropriately met	↑	The facility is sized to meet projected demand. Further consolidation of the campus is achieved than is possible under the baseline.
Modern, safe, and secure environment	↑	Renovation and construction improves site safety by addressing seismic deficiencies and bringing buildings up to code. New construction provides physical layouts and unit sizes that reflect modern healthcare practice.
Use of VA Resources		
Operating cost effectiveness	—	Results in potentially the same operating costs as the baseline. Staffing efficiencies may be achieved for the new outpatient mental health facility and new domiciliary buildings; Remaining renovated domiciliary buildings will have equivalent operating costs to the baseline.
Level of capital expenditure anticipated	—	Combination of new construction and renovation results in similar level of investment required relative to the baseline (80% - 120% of baseline) since the baseline already requires heavy renovation of existing facilities to make modern, safe, and secure.
Level of re-use proceeds	↑	Additional re-use potential is afforded by making parcels available for re-use; however, a similar level of re-use proceeds compared to the baseline (+/- 20% of baseline) is still expected.
Cost avoidance opportunities	—	Given the type of buildings and the nature of the healthcare services provided at campus, only marginal potential benefits from eliminating recurring maintenance costs on some buildings exist. Therefore, no significant cost avoidance opportunity is expected.
Overall cost effectiveness	—	The extent of renovation and upgrades is similar to the baseline resulting in similar operating costs and capital expenditure as the baseline. Additionally, re-use proceeds are not expected to be significantly different than the baseline. Thus, the BPO results in a similar level of net present cost as the baseline.

Ease of Implementation		
Ease of BPO implementation	↓	The BPO is riskier than the baseline in terms of the following major risk categories: • Continuity of care, slightly higher than the baseline in terms of transitioning patients within White City facilities to accommodate the renovation of the domiciliary and rehabilitation facilities and new addition for Outpatient Care • Infrastructure, given the incrementally greater amount of renovation and new construction when compared to baseline (and BPO 2) yielding unforeseen environmental, systematic,and/or structural issues • Project realization, in terms of incremental project management and activity required to control new, *moderate* construction, and demolition which may be more vulnerable to delays, budget variance, and transition complications than renovation to modern, safe,and secure standard of the baseline.
Wider VA Program Support		
DoD sharing	↔	No material impact is expected since no DoD relationships are expected. However, the BPO does not preclude any potential collaboration between VA and DoD.
One-VA Integration	↔	No material impact is expected that would affect One-VA integration since there are no significant VBA or NCA relationships in the baseline which could be disrupted. Furthermore, the BPO neither precludes nor enhances future, potential VBA or NCA relationships.
Special Considerations	↔	No material impact expected in terms of special considerations since the capital plan neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↑↑	BPO 3 is attractive as compared to the baseline. This BPO is likely to offer a solution that at least maintains access and improves quality for a similar net present cost as the baseline.

Appendix B - Glossary

Acronyms

AFB	Air Force Base
AMB	Ambulatory
BPO	Business Plan Option
CAI	Capital Asset Inventory
CAP	College of American Pathologists
CARES	Capital Asset Realignment for Enhanced Services
CBOC	Community Based Outpatient Clinic
CIC	CARES Implementation Category
DoD	Department of Defense
FTEE	Full Time Employee Equivalent
GFI	Government Furnished Information
HEDIS	Health Plan Employer Data and Information Set
ICU	Intensive Care Unit
IP	Inpatient
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
OP	Outpatient
MH	Mental Health
MOU	Memorandum of Understanding
N/A	Not Applicable
NFPA	National Fire Protection Association

PTSD	Post Traumatic Stress Disorder
SOW	Statement of Work
VA	Department of Veterans Affairs
VACO	VA Central Office
VAMC	Veterans Affairs Medical Center
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Definitions

Access	Access is the determination of the numbers of actual enrollees who are within defined travel time parameters for primary care, acute hospital care, and tertiary care after adjusting for differences in population and density and types of road.
Alternative Business Plan Options	Business Plan Options generated as alternatives to the baseline Business Plan Option providing other ways VA could meet the requirements of veterans at the Study Site.
Ambulatory Services	Services to veterans in a clinic setting that may or not be on the same station as a hospital, for example, a Cardiology Clinic. The grouping as defined by VA also includes several diagnostic and treatment services, such as Radiology.
Baseline Business Plan Option	The Business Plan Option for VA which does not change any element of the way service is provided in the study area. "Baseline" describes the current state projected out to 2013 and 2023 without any changes to facilities or programs or locations and assumes no new capital expenditure (greater than $1 million). Baseline state accounts for projected utilization changes, and assumes same or better quality, and necessary maintenance for a safe, secure, and modern healthcare environment.

Business Plan Option (BPO)	The options developed and assessed by Team PwC as part of the Stage I and Stage II Option Development Process. A business plan option consists of a credible healthcare plan describing the types of services, and where and how they can be provided and a related capital plan, and an associated reuse plan.
Capital Asset Inventory (CAI)	The CAI includes the location and planning information on owned buildings and land, leases, and agreements, such as enhanced-use leases, enhanced sharing agreements, outleases, donations, permits, licenses, inter- and intra-agency agreements, and ESPC (energy saving performance contracts) in the VHA capital inventory.
CARES Implementation Category (CIC)	One of 25 categories under which workload is aggregated in VA demand models. *(See Workload)*
Clinic Stop	A visit to a clinic or service rendered to a patient.
Clinical Inventory	The listing of clinical services offered at a given station.
Code	Compliance with auditing/reviewing bodies such as JCAHO, NFPA Life Safety Code or CAP.
Community Based Outpatient Clinic (CBOC)	An outpatient facility typically housing clinic services and associated testing. A CBOC is VA operated, contracted, or leased and is geographically distinct or separate from the parent medical facility.
Cost Effectiveness	A program is cost-effective if, on the basis of life-cycle cost analysis of competing alternatives, it is determined to have the lowest costs expressed in present value terms for a given amount of benefits.
Domiciliary	A VA facility that provides care on an ambulatory self-care basis for veterans disabled by age or diseases who are not in need of acute hospitalization and who do not need the skilled nursing services provided in a nursing home.
Enhanced Use Lease	A lease of real property to non-government entities, under the control and/or jurisdiction of the Secretary of Veterans Affairs, in which monetary or "in-kind" consideration (i.e., the provision of goods, facilities, construction, or services of the benefit to the Department) is received. Unlike traditional federal leasing authorities in which generated proceeds must be deposited into a general treasury account, the enhanced-use leasing authority

	provides that all proceeds (less any costs than can be reimbursed) are returned to medical care appropriations.
Good Medical Continuity	A determination that veterans being cared for a given condition will have access to the appropriate array of primary, secondary, and tertiary care services required to treat that condition.
Initial Screening Criteria	A series of criteria used as the basis of the assessment of whether or not a particular Business Plan Option has the potential to meet or exceed the CARES objectives.
Inpatient Services	Services provided to veterans in the hospital or an inpatient unit, such as a Surgical Unit or Spinal Cord Injury Unit.
Market Area	Geographic areas or boundaries (by county or zip code) served by that Network's medical facilities. A Market Area is of a sufficient size and veteran population to benefit from coordinated planning and to support the full continuum of healthcare services. (*See Sector)*
Mental Health Indicators	See the end of this document.
Multispecialty Clinic	A VA medical facility providing a wide range of ambulatory services such as primary care, specialty care, and ancillary services usually located within a parent VA facility.
Nursing Home	The term "nursing home care" means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care. Such term includes services furnished in skilled nursing care facilities, in intermediate care facilities, and in combined facilities. It does not include domiciliary care.
Primary Care	Healthcare provided by a medical professional with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment. *(See Secondary Care and Tertiary Care)*
Re-use	An alternative use for underutilized or vacant facility space or VA owned land.

Risk	Any barrier to the success of a Business Planning Option's transition and implementation plan or uncertainty about the cost or impact of the plan.
Secondary care	Medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialized knowledge, skill, or equipment than the primary care physician has. *(See Primary Care and Tertiary Care)*
Sector	Within each Market Area are a number of sectors. A sector is one or more contiguous counties. *(See Market Area)*
Stakeholder	A person or group who has a relationship with VA facility being examined or an interest in what VA decides about future activities at the facility.
Tertiary care	High specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists. *(See Primary Care and Secondary Care)*
Workload	The amount of CIC units by category determined for each market and facility by the Demand Forecast.

Mental Health Indicators

Indicator	Description
New Dx Dep - F/U X3 (mdd6n)	Percentage of patients with a new diagnosis of depression who have at least three clinical follow-up visits in the 12 acute periods after diagnosis (current PM)
New Dx Dep - Meds (mdd7n)	Percentage of patients with a new diagnosis of depression who have medication for at least 84 days in the acute treatment period (current PM)
Homeless Dchg Indep (fnct2n)	Percentage of veterans discharged from a domiciliary care for homeless veterans (DCHV), grand and per diem program, or healthcare for homeless veterans community-based contract residential care program to independent living
Screen for Alcohol (sa3)	Percentage of patients screened for high risk alcohol use with the AUDIT-C instrument (past and current PM)
Screen for MHICM (mhc1)	Percentage of psychiatry patients with high utilization of inpatient psychiatry services who are screened for mental health intensive care case management (past and current PM)
Screen for PTSD (ptsd1)	Percentage of all veterans screened for post traumatic stress disorder (PTSD) in the previous 12 months (SI)
SUD Cont of Care (sa5)	Percentage of patients entering specialty substance abuse treatment who maintain continuity of care for at least 90 days (past and current PM)