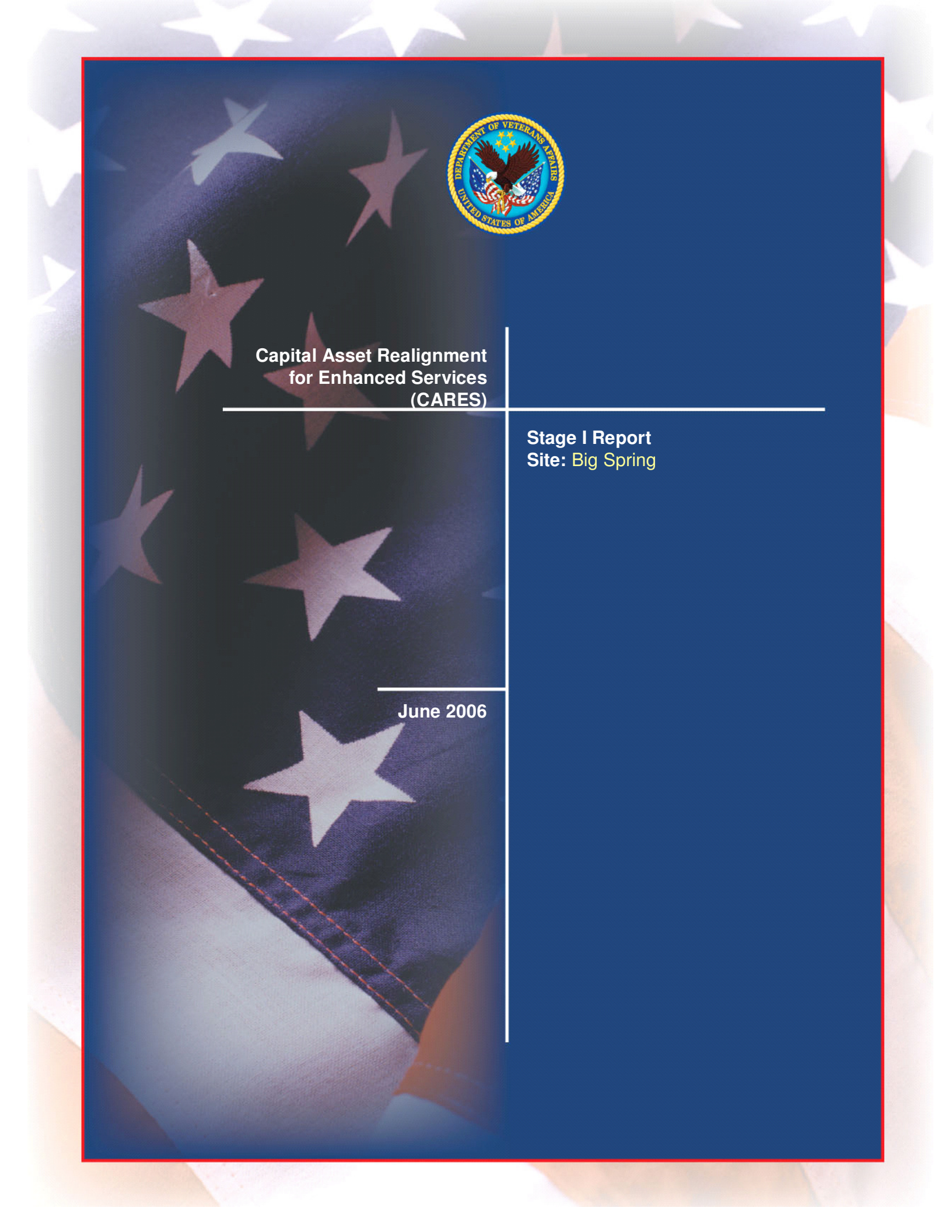

Capital Asset Realignment for Enhanced Services (CARES)

Stage I Report
Site: Big Spring

June 2006

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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.

Big Spring, Texas is one of the CARES study sites and includes each of the study types referenced above. The Secretary's CARES Decision Document of May 2004 includes the following directives for Big Spring, Texas:

- VA will proceed with a feasibility study to close inpatient care and transfer inpatient services from the Big Spring VAMC to the Midland/Odessa area.
- The study will include analysis of what type of facility should be developed in the Midland/Odessa area.
- VA will complete the "Veterans Rural Access Hospital" (VRAH) policy that provides a detailed definition and framework for assessing the clinical and operational characteristics of small and rural facilities.
- VA will use the VRAH policy framework to determine if the Midland/Odessa area would be an appropriate location and has the appropriate scope of practice based on projected demand for care.

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 Big Spring Veterans Affairs Medical Center (VAMC) is located in the New Mexico-West Texas market of Veterans Integrated Service Network (VISN) 18.

Current Healthcare Provision

The Big Spring VAMC is a secondary care level facility offering primary care, subspecialties in medicine and surgery, and mental health. Additionally, Big Spring provides nursing home care. Big Spring VAMC houses 69 inpatient beds comprised of acute medicine (14), surgery (4), medical ICU (4), surgical ICU (2), intermediate care (5), and extended care (40). All inpatient psychiatry beds at the Big Spring facility were closed in fiscal year (FY) 2003 and now acute psychiatry needs are purchased from a local community provider (Big Spring State Hospital and Scenic Mountain Medical Center) or referred to the Waco VAMC. Similarly, inpatient surgery closed in FY 2004, and surgical cases are referred to Scenic Mountain Medical Center or a VA tertiary care center. Domiciliary care is currently being provided in Prescott, AZ, which is Big Spring's assigned network VA resource for domiciliary care. By 2023, inpatient medicine bed needs[1] are projected to decline from 16 to 11, surgery beds to decline from 4 to 2, and inpatient psychiatry beds to increase from 2 to 18.

Ambulatory services available at the Big Spring campus include medicine, surgery, mental health, physical medicine, and rehabilitation. Outpatient services include audiology, dentistry, geriatric, mental health and substance abuse, pharmacy, rehabilitation, and an amputee clinic. Tertiary services are referred to other VAMCs, primarily Albuquerque, or purchased from local community providers. In addition, a CBOC is located in the Midland/Odessa service area.

Veterans Rural Access Hospital Directive

The clinical and operational characteristics of small and rural facilities are defined through the VRAH Directive, which defines quality standards and thresholds for the Big Spring VAMC. The policy serves as a critical reference in the formulation of the business plan options.

[1] Assumes 85% occupancy rate for acute inpatient beds.

"The Capital Asset Realignment for Enhanced Services (CARES) Commission Report to the Secretary of Veterans Affairs, dated February 2004, recommended that the Department of Veterans Affairs (VA) should establish a clear definition and policy on the Critical Access Hospital (CAH) designation prior to making decisions on the use of this designation. A task force was appointed to define guidance on the appropriate scope of services that should be provided at small and rural facilities within VHA, and to determine an appropriate designation for these facilities. The VHA Directive 2004-061 establishes policy defining the clinical and operational characteristics of small and rural facilities within VHA. These facilities are referred to as a Veterans Rural Access Hospital (VRAH)."[2]

A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to healthcare is limited. Attributes include:

- The market area cannot support more than 40 beds.
- The facility is limited to not more than 25 acute medical and/or surgical beds.
- The facility must be part of a network of healthcare that provides an established referral system for tertiary or other specialized care not available at the rural facility.
- The facility should be part of a system of primary healthcare community based outpatient clinics (CBOCs).
- The facility must be a critical component of providing access to timely, appropriate, and cost-effective healthcare for the veteran population served.

Big Spring VAMC is a small facility which presently runs an average daily census of approximately 15 inpatient beds (excluding nursing home). The Secretary's CARES Decision directed VA to consider VRAH policy as it evaluated the healthcare options for the Big Spring VAMC location. Team PwC reviewed the policy and incorporated its broader attributes into the BPOs developed for this site, specifically as location and scope of services were determined. Thereby, the BPOs take into account the VRAH policy and are sensitive to providing safe, quality care in a rural market facility.

Access

The CARES Commission Report to the Secretary of Veterans Affairs in 2004 concluded that West Texas has a major access problem for acute as well as tertiary care because the population in that region is too dispersed, and, therefore, no one location can solve the access issue.

[2] VHA Directive 2004-061 – Veterans Rural Access Hospitals

Analysis of drive time information for enrollees in the New Mexico-West Market indicates that VA's drive time guideline is met for primary care, but not for acute and tertiary care (see Table 1). Drive time guidelines at the market level are as follows: 70% of enrollees for primary care and 65% of enrollees for acute hospital and tertiary care should be within the minimum travel times to a VA facility. Currently the New Mexico-West Texas Market area exceeds the access guideline for primary care by 6%. For acute and tertiary hospital care, the percent of enrollees within the driving time threshold falls short of the access guideline by 10%.

Table 1: Percentage of Enrollees Meeting VA Access Guideline Drive Times for New Mexico-West Texas Market

VA Drive Time Guidelines					
Primary Care		**Acute Hospital**		**Tertiary Care[3]**	
Current Level	**Meets Threshold**	**Current Level**	**Meets Threshold**	**Current Level**	**Meets Threshold**
75.6%	Yes	54.7%	No	55%	No

Complementary to the drive time analysis, patient origin data, which indicates which portions of the service area actually use the services at the facility, was also considered. Patient origin data for the Big Spring facility shows current users are more heavily weighted towards the Big Spring area than the Midland/Odessa area.

Quality

The measures listed below (see Table 2) provide a selective description of current healthcare clinical quality at Big Spring VAMC, along with corresponding results at the VISN and national levels. This set of measures was selected by PwC and VA experts based on available internal VA data, and compatibility with Centers for Medicare and Medicaid Services (CMS) and industry standards. These quality measures in relation to the CARES healthcare study serve as a benchmark for comparison with the BPOs that transfer care to a community provider to determine the potential for any significant quality impacts when care is not directly provided by VA, or when one VA facility is transferring care to another VA facility. Although the quality measures gathered for analysis are based on 2004 data, for the evaluation of quality of care for the year 2023, Team PwC will assume a linear relationship to this current data.

According to 2004 data, the Big Spring site achieved higher selected quality scores for inpatient, behavioral health services, and patient satisfaction (inpatient care) as compared to both the VISN and overall national scores. However, Big Spring achieved the same or lower quality scores on four clinical setting measures: nursing home care (pressure sores), heart failure, ambulatory care, and patient satisfaction (ambulatory care).

[3] Tertiary care data is based on 2001 figures. All other information is based on 2003 figures.

Table 2: Quality Measures

Clinical Setting	Indicator	Indicator Origin	Study Site '04 Result	VISN #18 04 Result	VA National '04 Result
Inpatient Care					
Heart Failure	Ace inhibitor for left ventricular dysfunction as a key inpatient measure	VA, CMS[4]	**83%**	**94%**	**93%**
Ambulatory Care					
Colorectal Cancer	Screening rates as a key ambulatory indicator	VA, HEDIS[5]	**54%**	**64%**	**72%**
Endocrinology	Full lipid profile in the past two years	VA, HEDIS	**96%**	**96%**	**96%**
Mental Health					
Major Depressive Disorder	% of patients with a new diagnosis of depression -- medication coverage	VA, HEDIS	**69%**	**64%**	**67%**
Global Index	Weighted average of seven mental health indicators[6]	VA	**66%**	**64%**	**67%**
Nursing Home Care					
Nursing Home Care	% of high risk patients with pressure sores	VA, CMS	**39%**	**18%**	**22%**
Nursing Home Care	% of residents physically restrained	VA, CMS	**0%**	**1%**	**1%**
Patient Satisfaction					
Ambulatory Care	% of surveyed patients rating overall Ambulatory Care Services as very good or excellent	VA, Industry	**73%**	**79%**	**76%**
Inpatient Care	% of surveyed patients rating overall Inpatient Services as very good or excellent	VA, Industry	**83%**	**80%**	**74%**

In Stage II, Team PwC will continue to conduct a comparable assessment to determine the impacts on quality of care by investigating additional quality measures pertinent to the various BPOs selected for further study. In addition, Team PwC will assess the impacts on quality by studying the impact on specialized services, continuity of care, and enhancement of services. All of these studies will provide information on the potential impacts to quality and aid Team PwC in recommending a BPO for implementation at the conclusion of Stage II.

[4] CMS stands for Centers for Medicare and Medicaid Services.

[5] HEDIS stands for Health Plan Employer Data and Information Set, which is a set of standardized performance measures used to compare performance of managed health care plans.

[6] See Glossary for description of indicators.

Local Healthcare Market

The population of Big Spring, TX is supported by community healthcare services appropriate to its size and demographic composition which are highlighted below:

Lamun-Lusk-Sanchez Texas State Veterans Home, Big Spring, TX

Created through a partnership between the State of Texas and the Department of Veterans Affairs, this 160-bed Medicare and Medicaid certified nursing home is operated by the Texas Veterans Land Board. One factor in deciding where to locate the Texas State Veterans Home was the existence and location of the Big Spring VAMC. Occupancy in 2003 was 67%[7].

One feature of the Texas State Veterans Home is that both the spouse and veteran are eligible for care. Veterans who use this facility have ready access to the healthcare services offered at the Big Spring VAMC which is located three miles from the Texas State Veterans Home. Presently, approximately 100 veterans who reside at the Texas State Veterans Home also qualify to receive services at the Big Spring VAMC, including the nursing home.

Scenic Mountain Medical Center, Big Spring, TX

Scenic Mountain Medical Center (SMMC) is a 155-bed acute care community hospital located within one mile of the Big Spring VAMC. SMMC is owned by Community Health Systems, Inc., an operator of general acute care hospitals in non-urban U.S. markets. SMMC offers an array of general medical, surgical, and diagnostic services including a 25-bed geriatric psychiatric inpatient service. Occupancy in 2003 was approximately 30.2%[8]. Presently, veterans utilize SMMC for surgical, diagnostic, and psychiatry services. In addition, SMMC and Big Spring VAMC partner to recruit physicians who are difficult to recruit independently, as is the case with a radiologist on staff at both facilities.

Big Spring State Hospital, Big Spring, TX

Big Spring State Hospital (BSSH) is a 170-bed psychiatric hospital serving 58 counties in West Texas and the Texas Panhandle. It is managed by the Department of State Health Services, accredited by the Joint Commission on Accreditation on Healthcare Organizations (JCAHO), and certified by Medicare and Medicaid.

VISN 18 contracts with BSSH to provide psychiatric hospitalization for veterans. Veterans from this area, which includes Big Spring, may be admitted to BSSH by a formal referral from one of the seven VA hospitals in VISN 18. These veterans have access to the same array of services offered to any hospital patient. BSSH occupancy is 93%[9].

[7] http://www.nursing-homes.biz

[8] Solucient, 2003.

[9] Ibid.

Memorial Hospital & Medical Center, Midland/Odessa, TX

In addition to the facilities in Big Spring, there are also three general acute care facilities in the Midland/Odessa area. These include Memorial Hospital & Medical Center in Midland, TX, with an occupancy rate of 64.93%, Medical Center Hospital in Odessa, TX, with an occupancy rate of 59.94% and Odessa Regional Hospital in Odessa, TX, with an occupancy rate of 38.19%[10].

Facilities

The Big Spring VAMC site is located at the northwest corner of Gregg Street (HWY 87) and Ryon Street in Big Spring, TX within Howard County. The Big Spring VAMC site is rectangular in shape, containing a total area of approximately 31 acres. The campus is composed of 13 buildings which were constructed over a period of several years beginning in 1948. The facilities were developed to provide health services including ambulatory and acute care, psychiatry, research, and other medical uses. None of the buildings are considered historic. Figure 1 presents a site plan for the Big Spring campus. A list of the buildings on campus, their size and function are presented in Table 3.

The buildings on the Big Spring campus are generally of masonry construction with brick exterior. Buildings 1 through 10 were built in the 1950s and have had multiple renovations since that time. Under VA standards, the Big Spring VAMC facility is considered to be in good condition, rating 4.4 out of 5 for critical values such as accessibility, code, functional space, and facility conditions. All buildings used for patient care or administration are reported to be in average to good condition, reflecting consistent and ongoing maintenance practices over time. Other ancillary buildings, such as those used for maintenance or storage purposes, are reported to be in similar condition. Mechanical systems are reported to be in good condition. Asbestos, lead in surface paint, and potential radon have been identified in some of the older buildings and surrounding community.

[10] Ibid.

Figure 1: Existing Building Distribution

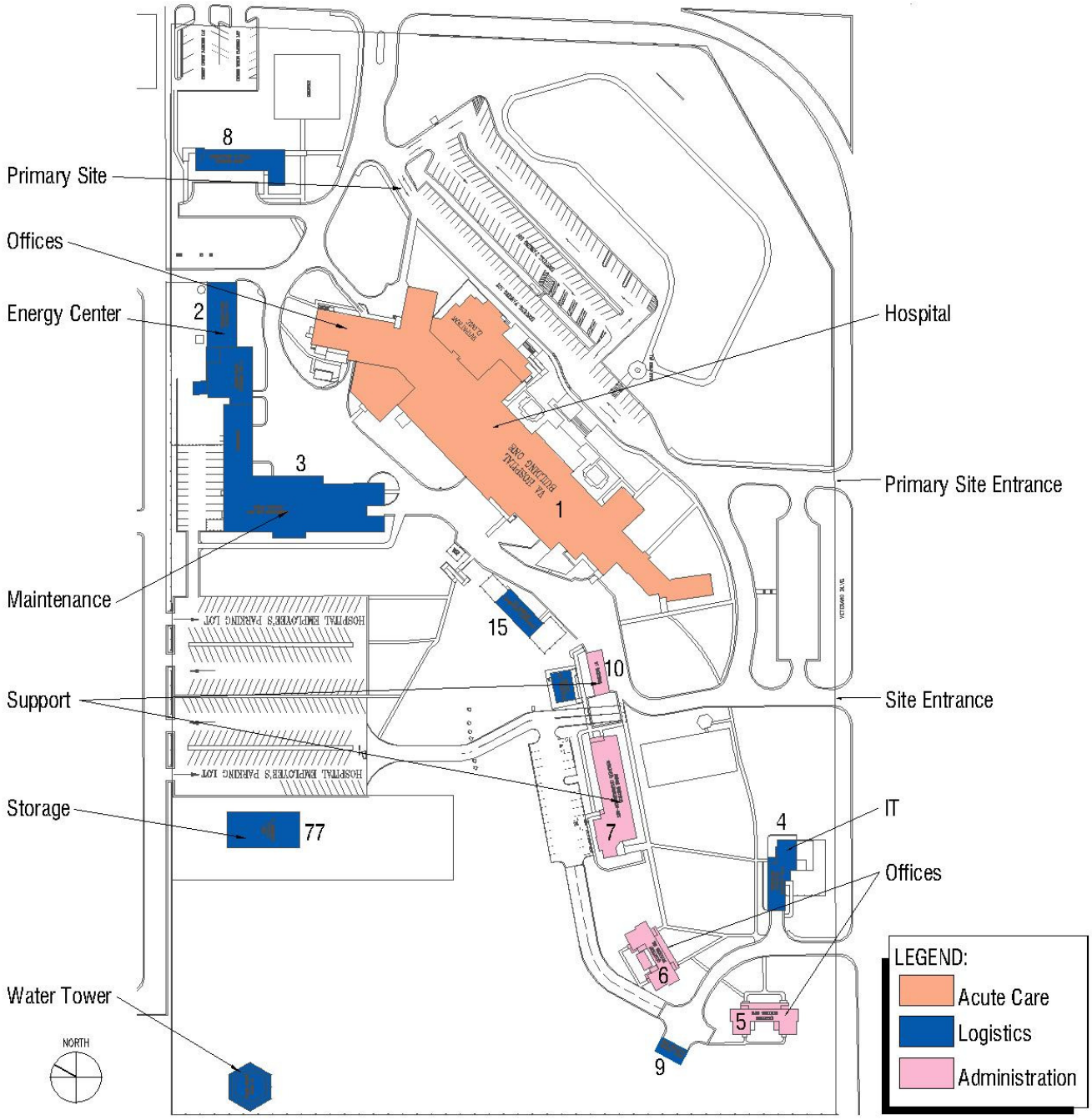


Table 3: Existing Departmental Distribution by Building

Building	Floor	Building Gross Square Feet (BGSF)	Function
Building 1		212,000	Hospital and Outpatient Center
	Basement		Pathology, Engineering, Storage
	First Floor		ACS Primary, Specialty, and Urgent Care; Pharmacy, Nutrition / Food
	Second Floor		Dental, Pathology, Radiology, PT / OT, Surgery
	Third Floor		23-bed Medical / Surgical Unit, six-Bed ICU
	Fourth Floor		Mental Health and Substance Abuse clinics
	Fifth Floor		40-bed Nursing Home Care Unit
	Sixth Floor		Outleased to VISN Business Office
Building 2		9,235	Boiler / Chiller Plant
Building 3		19,936	Engineering / Warehouse
Building 4		7,426	Information Resources Management (Information Technology)
Building 5		4,700	Education / Acquisition & Materiel Management
Building 6		4,342	Human Resources and Medical Care Cost Fund
Building 7		4,477	Education / On-Call Program
Building 8		3,887	Medical Administration Service / Fiscal Offices
Building 9		860	Information Resources Management Storage
Building 10		1,290	Education (Computer Training)
Building 15		1,746	Emergency Generator
Building 16		600	Pharmacy Storage space
Building 17		5,000	Acquisition and Materiel Management / Emergency Management Storage

Current and Forecast Investment Requirements

Moderate capital investments are required for the facility to meet modern, safe, and secure standards. $21 million has been identified within VA's Capital Asset Inventory (CAI) database as being required to correct the Big Spring campus deficiencies. Included in this estimate is $11 million for upgrading finishes, painting, and renovation of four patient nursing units which will eliminate multi-bed wards and shared patient bathrooms. According to VAMC engineering staff, there are no other property or site-specific capital improvement projects currently being considered.

Summary of Current Surplus / Vacant Space

Seven acres (22%) of the 31-acre campus are vacant. As for vacant building space, the CAI database indicates that there is currently only 320 square feet of vacant space.

Real Estate Market and Re-Use Potential

Analysis of the re-use potential for the Big Spring VAMC must consider the economic environment in Big Spring/Howard County. Since the Air Force closed its base that was proximate to the VAMC property, the economy of the area has been stagnant. There has been substantially no population growth in the last decade or more, and the real estate market has characteristics that reflect limited demand and soft performance.

The community has limited new demand for residential space, substantially lower than other Texas communities with vacancy rates higher than 16%. Rents are very low and their level would have implications for the market to support new multifamily construction.

The office market has had consistently high vacancy rates since the Air Force base was closed, leaving some buildings vacant for many years. Furthermore, discussions indicate that office rents have stayed low and there is little new leasing activity in the community or new construction of office space. The site could feasibly accommodate a limited amount of new office space, perhaps build-to-suit for businesses that are looking for new and higher quality space.

High vacancy rates exist in the College Park Shopping Center, which when combined with the nearby vacant Wal-Mart space, would translate into retail vacancy rates in the order of 20%. However, retail and service activity surrounds the VA site from three corners of the hospital's intersection, indicating that the location is considered a good retail area. Better restaurants are also nearby, identifying the area as appealing for restaurant dining. Thus, the site could feasibly accommodate retail or restaurant development, but the level of demand would be tied to the ultimate staffing levels of the realigned VAMC, and the resulting population base and household spending.

The occupancy rate for local hotels is 50.5%, the average daily room rate is $65.58, with very low revenue per room of $32.12. The hotel market cannot support additional room construction, given the low occupancy and average daily rate (ADR). While there is a limited-service hotel nearby, the VA site is not an optimal hotel location given its distance from the interstate and the possibility of future development that would be targeted along the interstate.

To summarize, the current real estate market indicates that there is little demand for land to support development of housing, office retail, or hotels.

Re-Use Potential

Multiple portions of the Big Spring campus have been evaluated for re-use potential. The Big Spring VAMC site was terraced in order to construct the buildings, parking areas, etc. While the land is not located in any flood plains, related slopes to the east and west may impact re-use potential. In particular, slopes to the west appear prohibitive for development.

The parcels and their potential re-uses (see Figure 2) can be summarized as follows:

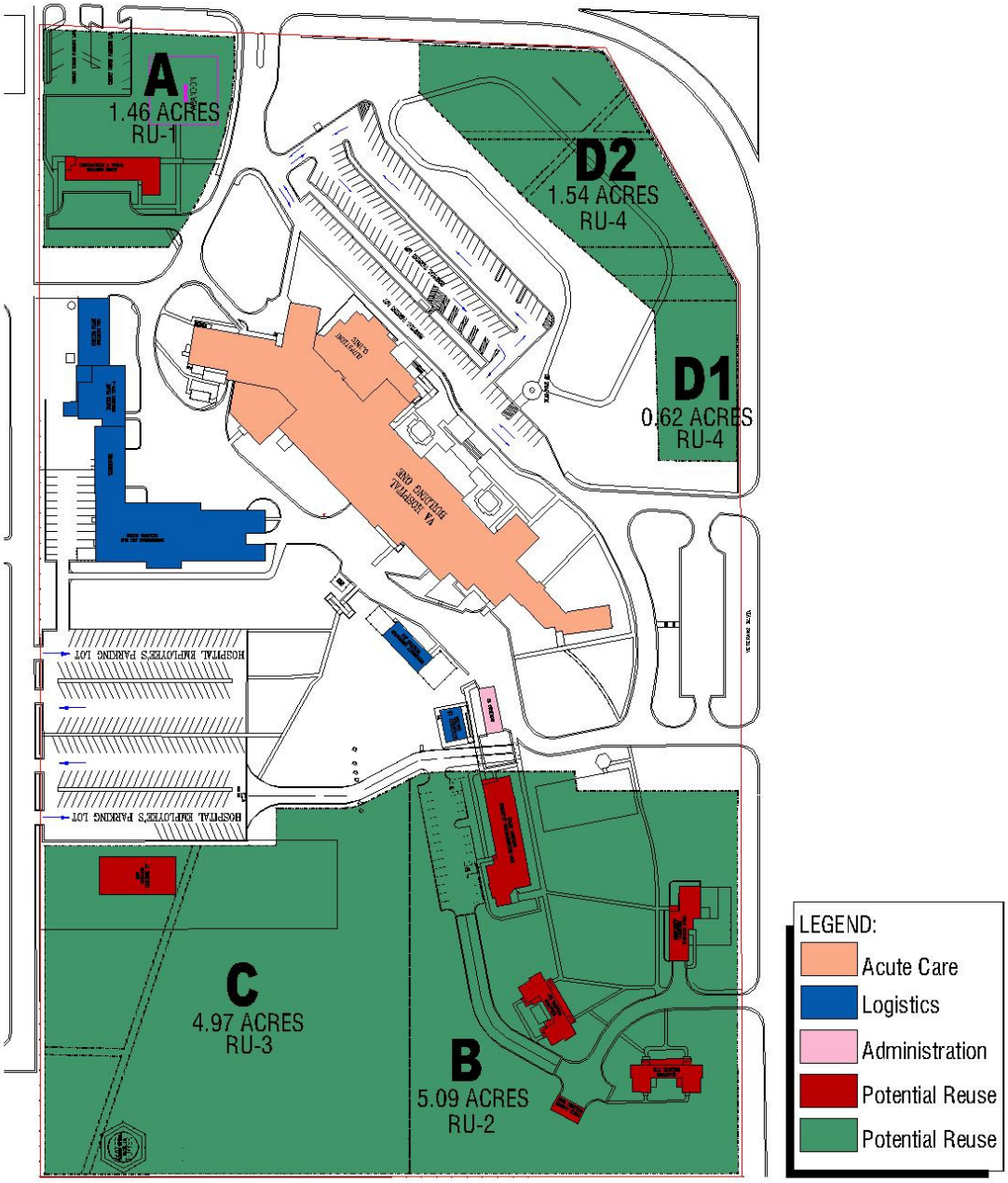
Table 4: Re-use Parcels and Descriptions

Parcel	Description
Parcel A	1.46 acres on the northeast corner of the campus. Possible retail or office.
Parcel B	5.09 acres on the southwest corner of the campus. Possible retail, service or office.
Parcel C	4.97 acres on the northwest corner of the campus. Possible residential, with focus on single family units.
Parcel D1/D2	(0.62 acres) and (1.54 acres) on the southeast corner of the campus. Possible retail, restaurant or office.
All Campus	Parcels A, B, C, D1, D2 as related uses apply. No foreseeable use for the hospital building unless it is demolished.

Analysis of re-use potential for the VAMC indicates that it is reasonably well located for a variety of re-use plans; however, the current real estate market condition reveals that it would require a significant period of time to market the property. Further, there are not likely to be prospects for the hospital building as is, and the cost of demolition is expected to exceed the revenues that re-use could generate.

Therefore, re-use is not a determining factor in evaluating business plan options. However, this would not preclude VA from attempting to generate income from excess property once the final decision has been made.

Figure 2: Potential Land or Buildings for Re-use



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 Big Spring facility. The following section describes these long term trends for veteran enrollment and utilization for healthcare services at Big Spring VAMC.

Enrollment Trends

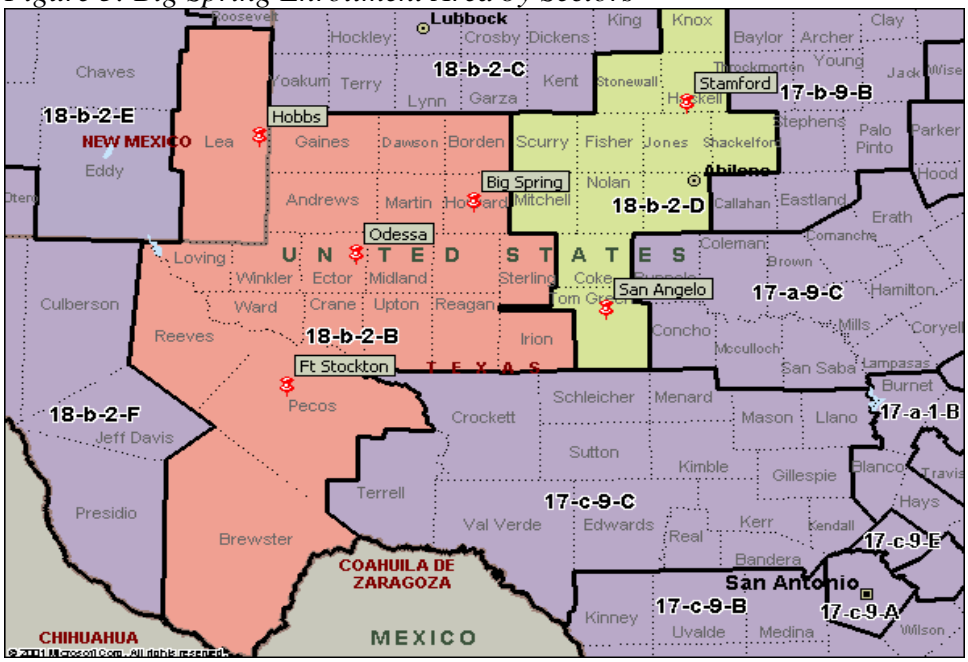
Big Spring VAMC is located in the New Mexico-West Texas market of VISN 18. The New Mexico-West Texas market contains approximately 131,000 enrolled veterans or roughly 46% of all enrollees within VISN 18. Overall, the number of enrolled veterans for the New Mexico-West Texas market is expected to decline 21% from 131,000 to approximately 104,000 by 2023. Enrollment projections for the market differ by priority group. Enrollment of Priority 1-6 veterans (those veterans with the greatest service-connected needs) is projected to modestly decline (3%) by 2023, while enrollment for Priority 7-8 veterans is projected to decrease by 64% for the same period (see Table 5). The enrollment forecast for Priority 7-8 veterans assumes an annual enrollment fee, and the continued freeze on new P8 enrollment.

Table 5: Projected Veteran Enrollment for the New Mexico-West Texas Market by Priority Group

Priority Group	Enrolled 2003	Projected 2013	% Change (2003 to 2013)	Projected 2023	% Change (2003 to 2023)
Priority 1-6	93,518	101,920	9%	91,162	-3%
Priority 7-8	35,442	14,724	-58%	12,730	-64%
Total	**128,960**	**116,644**	**-11%**	**103,892**	**-21%**

The market is divided into 11 sectors, two of which comprise the Big Spring enrollment area (see Figure 3). Sector 18-b-2-B is located to the west of Big Spring, while sector 18-b-2-D is located to the east.

Figure 3: Big Spring Enrollment Area by Sectors



More specifically, the decline in enrolled veterans is expected to be greater (35%) in the sector west of Big Spring compared to the east sector (25%), so that the difference between the two sectors at the end of the forecast period (2023) will be negligible. As illustrated in Table 4 below, by 2023, the projected enrollment figures for both sectors are expected to be comparable. Thus, the comparable veteran enrollment for 2023 does not strongly support the relocation of healthcare services to Midland/Odessa.

Table 6: Total Projected Veteran Enrollment for the New Mexico-West Texas Market and Big Spring Sectors

Market / Sector	Enrolled 2003	Projected 2013	% Change (2003 to 2013)	Projected 2023	% Change (2003 to 2023)
New Mexico-West Texas Market	**130,960**	**116,644**	**-11%**	**103,892**	**-21%**
Sector 18-b-2-B (West of Big Spring VAMC)	11,430	8,938	-22%	7,439	-35%
Sector 18-b-2-D (East of Big Spring VAMC)	9,688	8,373	-14%	7,271	-25%

Utilization Trends

Utilization was analyzed for those Cares Implementation Categories (CICs) for which Big Spring VAMC has projected demand. 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. As demonstrated in Table 7, inpatient bed need is projected to increase by 43% by 2023, yet outpatient clinic stops (including radiology and pathology) are expected to decline by 9% over the same time horizon.

Table 7: Inpatient and Outpatient Utilization Summary

BIG SPRING	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Total Acute Inpatient Beds	22	38	31	45%	-18%	43%
Total Clinic Stops	128,499	127,659	117,302	-1%	-8%	-9%

The demand for inpatient services (acute and long term) varies by CIC (see Table 8). Both medicine/observation and surgery demand steadily decline over the projected period. Psychiatry and substance abuse demand increases through 2013, then declines, yet still remains higher than the current bed need, reflecting assumptions concerning increased utilization rates of inpatient psychiatry services consistent with the VA Mental Health Strategic Plan. Nursing home VA bed requirements remain constant throughout the 20-year forecast period reflecting a policy decision to encourage the use of State Nursing Homes and increased home health services. Domiciliary utilization is expected to grow to 35 beds by 2008, and remains constant at 35 beds between 2013 and 2023.

Table 8: Projected Utilization for Inpatient CICs for Big Spring VAMC[11]

CIC	2003 Actual Beds	2013 Beds Modeled	2023 Beds Modeled	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Medicine & Observation	16	14	11	-13%	-17%	-28%
Psychiatry & Substance Abuse	2	21	18	>300%	-17%	>300%
Surgery	4	3	2	-13%	-23%	-33%
Nursing Home[12]	40	40	40	0%	0%	0%
DOM-PRRP-PRRTP	0	35	35	NA	0%	NA

The majority of ambulatory utilization (not including diagnostics) is due to primary care (see Table 9). Specialty areas such as cardiology, orthopedics, and urology show an increase in utilization; however, there is a substantial decrease in demand for primary care and surgery, with the largest decline projected for primary care.

[11] Calculated inpatient beds are rounded to the nearest whole bed.

[12] Projected VA nursing home bed requirements is based on current nursing home policy.

Table 9: Projected Utilization for Ambulatory CICs for Big Spring VAMC

CIC	2003 Actual Stops	2013 Projected Stops	2023 Projected Stops	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Cardiology	3,018	5,829	5,083	93%	-13%	68%
Eye Clinic	7,359	7,385	6,857	0%	-7%	-7%
Non-Surgical Specialties	3,270	4,398	3,940	34%	-10%	20%
Orthopedics	158	3,749	3,338	>300%	-11%	>300%
Primary Care & Related Specialties	27,174	19,537	16,262	-28%	-17%	-40%
Rehab Medicine	3,128	3,128	3,128	0%	0%	0%
Surgical & Related Specialties	7,248	6,716	5,889	-7%	-12%	-19%
Urology	2,088	4,835	4,501	132%	-7%	116%
Total	**53,443**	**55,577**	**48,998**	**4%**	**-12%**	**-8%**

Except for behavioral health, expected demand for outpatient mental health services overall shows an upward trend in 2013 followed by a decline in 2023 that remains above 2003 values (see Table 10). Behavioral health shows a sharp decline (11%) in demand over the first 10 years.

Table 10: Projected Utilization for Outpatient Mental Health CICs for Big Spring

CIC	2003 Actual Stops	2013 Projected Stops	2023 Projected Stops	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Behavioral Health	22,289	19,836	19,565	-11%	-1%	-12%
Community MH Residential Care	66	185	115	180%	-38%	74%
Homeless	231	488	395	111%	-19%	71%
Total	**22,586**	**20,509**	**20,075**	**-9%**	**-2%**	**-11%**

In summary, the analysis of the projected enrollment and utilization data highlights several opportunities and challenges for Big Spring VAMC. Opportunities exist to address the market need for inpatient services such as domiciliary and mental health. There are also unmet market needs in outpatient areas such as urology, mental health, and orthopedics. However, Big Spring faces challenges resulting from the significant drop in its primary care utilization and modest or slight decreases in specialty care. In addition, given the size of the veteran population in Big Spring and its primary service area coupled with the overall size of the New Mexico-West Texas market, it is likely that this VAMC will be confronted with challenges facing many small rural hospitals in America — the ability to deliver on its mission while operating in a cost effective manner and recruiting and retaining talented staff.

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 Big Spring VAMC currently has enough space to accommodate the utilization for inpatient and ambulatory services projected through 2023, with the exception of inpatient psychiatry. BPOs will consider current clinical inventory and the impacts of changes in demand on the space requirements for these services.

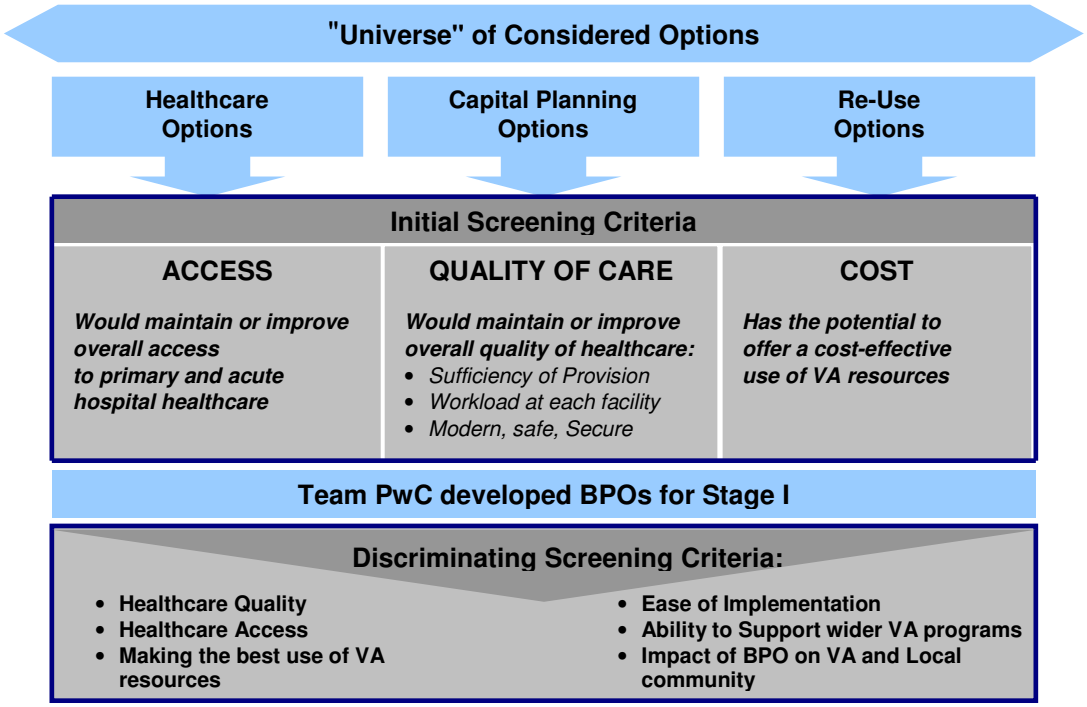
5.0 Business Plan Option Development Approach

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 healthcare and capital planning options and associated re-use plans. Each healthcare and capital planning option that passed the initial screening served as potential components of BPOs. A review panel of experienced Team PwC consultants, including medical practitioners, 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 4: Options Development Process



Initial Screening Criteria

Discrete healthcare and capital options were developed for the Big Spring VAMC 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* – During Stage I, primary care access is evaluated using VA's Primary Care Access Tool and a base year of 2001. If an option resulted in a change in location for primary care, the new location would be evaluated using the Primary Care Access Tool.

Acute Care access was evaluated using data provided by VA using its ArcView Tool to recalculate the new location's impact on access.

- **Quality of Care:** *Would maintain or improve the overall quality[13] of healthcare* – This is assessed by consideration of the site's ability to provide services and the level of workload at any facility compared to utilization thresholds. Quality concerns may also occur if it is assumed that VA would contract with a non-VA provider for specific services but there is no current proven healthcare provider for those required services within that particular location. In such a case, assumptions may be required regarding the likelihood of such a provider emerging. Therefore, any option that relied upon patient care being provided by an emergent third party failed this quality test. An option would pass the quality test only in cases when a compelling reason could be identified to assert that services would be provided.

  Additionally, the following was included as part of the quality measure:

  - **Modern, Safe, Secure**: *Would result in a modernized, safe healthcare delivery environment that is compliant with existing laws, regulations, and VA requirements* – This was assessed by consideration of the physical environment proposed in the option 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.

  It should be noted that the disruption to continuity of care is not an explicit criteria utilized in the initial screening process; however, the impact on continuity of care was used to further narrow the broad range of options to be assessed in Stage I. A separate study of the impact on continuity of care for each of the options will be conducted in the Stage II assessments of the options.

- **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[14] failed this test.

All identified options were screened against these criteria. If an option failed the initial access test, then no other tests were applied. Those passing the access test were then further screened against quality and cost. Screening was halted when the option failed to meet one of the initial screening criteria.

[13] Quality includes clinical proficiency across the spectrum of care, safe environment, and appropriate facilities.

[14] 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.

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:

  - How the BPO sustains or enhances the quality of healthcare delivery.
  - If the BPO can ensure that forecasted healthcare need is appropriately met.
  - Whether each BPO will result in a modernized, safe, and secure healthcare delivery environment.

- **Healthcare Access** – These criteria assess how the BPO impacts the percentage of the patients meeting access guidelines by describing the current percentage and the expected percentage of patients meeting this guideline.

- **Impact on VA and Local Community** – These criteria assess the impact on staffing, as well as research and clinical education programs.

- **Making Best 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.
  - 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 Wider 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 current state 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 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.

FY2004 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 estimated 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.

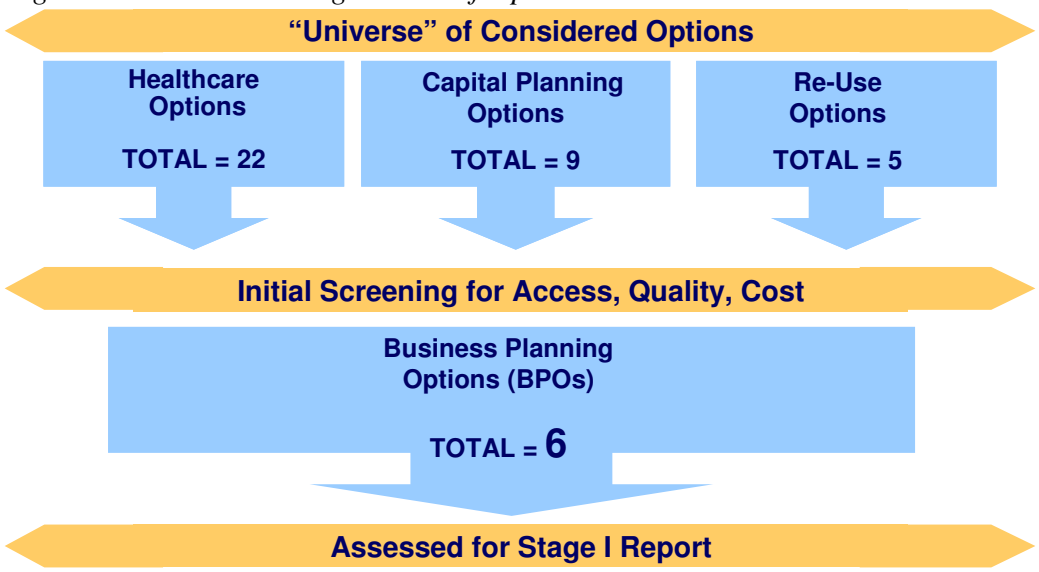
Summary of Business Plan Options

The individual healthcare, 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 healthcare option, combined with at least one associated capital planning option and re-use parcel. Therefore, the formula for a BPO is:

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

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

Figure 5: Final Screening Results of Options



Options Not Selected for Assessment

Several of the options created during the option development process did not pass the initial screening criteria. The following table lists those options that either did not pass the initial screening criteria or were deemed inferior to other options that did pass the initial screening. Table 11 details the results of the initial screening and the reasons why these options were not selected.

Table 11: Options Not Selected for Assessment

Option Description	Reason(s) Not Selected
13 Options to move a combination of services to Midland/Odessa	• Inferior to another option if inpatient services were split • Did not pass primary care access guideline threshold • Did not pass quality and volume screening
1 Option to purchase all services from other providers	Did not pass cost screening criteria
1 Option to expand service at the Big Spring VAMC	Failed quality and volume screening
1 Option to move some services to Dyess AFB	Did not have inpatient capability
1 Option to build domiciliary facility on Big Spring campus	Inferior to other capital planning options
2 Options for relocation of outpatient services	▪ 1 failed the cost screening criteria ▪ 1 was rejected due to limited re-use opportunities

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 change in either the location or type of services provided in the study site. In the baseline BPO, the Secretary's Decision and forecasted healthcare demand and trends from the demand forecast for 2023 are applied to the current healthcare provision solution for the study site. Additionally, capital improvements required to meet modern, safe, and secure standards are factored into the current state assessment to develop this BPO.

Specifically, the baseline BPO is characterized by the following:

- Healthcare continues to be provided as currently delivered, except to the extent that healthcare volume for particular procedures fall below key quality or cost effectiveness threshold levels.
- Capital costs allow for current facilities to receive such investment as is required to rectify any material deficiencies (e.g., in safety or security) such that they would provide a safe healthcare delivery environment as required in the Secretary's Decision.
- Life cycle capital costs allow for ongoing preventative maintenance and life-cycle maintenance of major and minor building elements.
- Re-use plans use such vacant space in buildings and/or vacant land or buildings emerge as a result of the changes in demand for services and the facilities in which they sit.

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 12: Evaluation System Used to Compare BPOs to baseline BPO

Ratings to assess Access, Quality, Local Community, and Ability to Support VA Programs	
↑	The BPO has the potential to provide a slightly improved state than the baseline BPO for the specific discriminating criteria (e.g., access, quality, etc)
↔	The BPO has the potential to provide materially the same state as the baseline BPO for the specific discriminating criteria (e.g., access, quality, etc)
↓	The BPO has the potential to provide a slightly lower or reduced state than the baseline BPO for the specific discriminating criteria (e.g., access, quality, etc).
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 than the baseline BPO (>5%)
↓↓	The BPO has the potential to require slightly higher operating costs than the baseline BPO (>10%)
↓↓↓	The BPO has the potential to require slightly higher operating costs than the baseline BPO (>15%)
Level of capital expenditure anticipated (based on results of initial capital planning costs)	
↓↓↓↓	Very significant investment required relative to the baseline BPO **(≥ 200%)**
↓↓	Significant investment required relative to the baseline BPO **(121% to 199%)**
-	Similar level of investment required relative to the baseline BPO **(80% to 120% of Baseline)**
↑↑	Reduced level of investment required relative 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 relative to the baseline BPO (>1.15 times)
↓↓	Significantly higher net present cost relative to the baseline BPO (1.10 – 1.15 times)
↓	Higher net present cost relative 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 relative to the baseline (90-95% of Baseline)
↑↑	Significantly lower net present cost relative to the baseline BPO (85-90% of baseline)
↑↑↑↑	Very significantly lower net present cost relative to the baseline BPO (<85% of baseline)
Ease of Implementation of the BPO	
↑	The BPO has the potential to provide a slightly improved state than 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 state of 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 than 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 than 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 "[t]he 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 the table below.

For Input Period Two, stakeholders were provided 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 Period Two (Input Period One had been previously summarized), and this information is included in this report.

Table 13: 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 140-150 members of the public attended the first LAP meeting held on May 18, 2005. Approximately 900-950 members of the public attended the second LAP meeting held on September 1, 2005. A total of 1,123 forms of stakeholder input were received between April 20 and September 11, 2005. Over 600 BPO comment forms were filled out and submitted by stakeholders at the second LAP meeting. The concerns of stakeholders who submitted more general written or electronic comments or presented oral testimony throughout Stage I are summarized in the following table:

Table 14: Analysis of Stakeholder Concerns

Key Concern	Number of Comments		
	Oral	Written and Electronic	**Total**
Effect on Access	9	190	**199**
Maintain Current Service/ Facility	24	200	**224**
Support for Veterans	2	57	**59**
Effect on Healthcare Services and Providers	3	32	**35**
Effect on Local Economy	4	71	**75**
Use of Facility	11	63	**74**
Effect on Research and Education	5	4	**9**
Administration's Budget or Policies	1	46	**47**
Unrelated to the Study Objectives	1	40	**41**

BPO Proposals from Stakeholders

Team PwC received three proposals for BPOs from the public. These included proposals from a specially formed Big Spring Chamber of Commerce Task Force, Texas Tech University in Odessa, Texas, and from Scenic Mountain Medical Center in Big Spring, Texas.

Big Spring Chamber of Commerce Task Force

The proposal from the Big Spring Chamber of Commerce Task Force recommended expansion of Big Spring services and collaborative relationships with local providers. A specific "City BPO" was not developed because this proposal's elements mirror BPO 4 and BPO 5, which were already developed by Team PwC and are discussed later in this report.

Texas Tech University

The proposal from Texas Tech University Health Science Center (TTUHSC) recommended establishing collaborative relationships with TTUHSC and Medical Center Hospital, Odessa, Texas. The proposal would provide contracted services for inpatient and outpatient services at TTUHSC and provide lease space for 20-30 dedicated inpatient beds at Medical Center Hospital. A specific BPO was not developed because this proposal's elements mirror BPO 3 and BPO 6, which were already developed by Team PwC and are discussed later in this report.

Scenic Mountain Medical Center

Scenic Mountain Medical Center is presently an active partner with the Big Spring VAMC providing emergency surgical services and psychiatry services in addition to joint physician recruiting. This proposal offered continued support in addition to assisting the Big Spring VAMC in expanding services including re-establishing inpatient surgical services. The proposal suggests possible relationships including accommodating the VAMC by providing dedicated space and ancillary support at its facility and expanding cross coverage recruiting activities. This proposal's elements mirror BPO 3 and BPO 6 already developed by Team PwC and, therefore, a specific BPO was not developed.

6.0 Business Plan Options

The option development process resulted in a multitude of discrete healthcare, 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 six BPOs (comprising healthcare, capital, and re-use components) which passed initial screening and were developed for Stage I (see Figure 5).

Each BPO was assessed at a more detailed level according to the discriminating criteria. The BPOs reflect options related to provision of inpatient services through relocating services in the Midland/Odessa market, contracting for care, or providing care in the Big Spring VAMC, and consider the increased need for domiciliary and inpatient psychiatry care (see Table 15).

One additional option (BPO 7) was proposed by the LAP at the second LAP Public Meeting. This option was a combination of two BPOs presented by Team PwC to the LAP and which passed initial screening.

Table15: Business Plan Options

BPO 1: Baseline
Current state projected out to 2013 and 2023 without any changes to facilities or programs, but accounting for projected utilization changes, and assuming same or better quality, and necessary maintenance for a safe, secure, and modern healthcare environment. Inpatient medicine and nursing home care services provided at Big Spring. Inpatient surgery and inpatient psychiatry are purchased from local community providers or referred to tertiary VAMCs. Domiciliary services are transferred to other VAMCs (currently Prescott VAMC in Arizona). Existing ambulatory and outpatient mental health services remain at current location of provision. Parcels D1/D2 on the southeast corner of the campus available for potential retail, restaurant or office re-use.
BPO 2: Inpatient Services Relocated to Midland/Odessa. Renovate Existing Multi-Specialty Clinic in the Big Spring VAMC
Inpatient medicine and psychiatry, nursing home, and domiciliary services to be provided in a new hospital built in Midland/Odessa. All other services to remain at current location of provision. Parcels A, B, C, D1/D2 on the northeast, northwest, southeast and southwest corners of the campus to be available for potential retail, office, service, restaurant, and residential re-use.
BPO 3: Inpatient Services Transferred to Local Community Providers. Big Spring Becomes a Multi-Specialty Clinic
Inpatient services to be purchased from local community providers. Ambulatory and outpatient mental health services to remain at Big Spring and Midland/Odessa provided through CBOCs. Consolidation and renovation of existing space on the Big Spring campus. Parcels A, B, C, D1/D2 on the northeast, northwest, southeast and southwest corners of the campus to be available for potential retail, office, service, restaurant, and residential re-use.
BPO 4: Baseline plus Increase Services through Adding a 35-bed Domiciliary Unit at Big Spring VAMC
Add domiciliary services to existing Big Spring campus. Requires renovation of facility for domiciliary. All other services to remain at current location of provision. Parcels A, C, D1/D2 on the northeast, northwest and southeast corners of the campus to be available for potential retail, office, restaurant, and residential re-use.
BPO 5: Baseline plus Increase Services through Adding a 35-bed Domiciliary Unit and 18 Psychiatry Beds at Big Spring VAMC
Add inpatient psychiatry and domiciliary services to existing Big Spring campus. Requires renovation and construction of new facilities for domiciliary and inpatient psychiatry. All other services to remain at current location of provision. Parcels A and C on the northeast and northwest corners of the campus to be available for potential retail, office, or residential re-use.
BPO 6: Lease Space for Inpatient Services in Big Spring and Midland/Odessa; Close the Big Spring Campus and Lease Space for CBOC
Lease space at local facilities to provide all inpatient services including nursing home and psychiatry care. Ambulatory and outpatient mental health services to relocate off campus to new leased CBOC. Parcels A, B, C, D1, D2 and their related re-uses apply. No foreseeable re-use for the hospital building. Demolition of the hospital would make the site available for re-use.
BPO 7: Baseline plus Add 35 Domiciliary and 18 Psychiatry Beds; Expand Inpatient Services Purchased from Local Community Providers
Add inpatient psychiatry and domiciliary services to existing Big Spring campus. Contract with community providers rather than referring to other VAMCs. Requires renovation and construction of new facilities for domiciliary and inpatient psychiatry.

Assessment Drivers

Over the next 20 years, the number of enrolled veterans for this market is expected to decline 21% from 131,000 to approximately 104,000. However, enrollment of Priority 1-6 veterans is projected only to modestly decline (3%) 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:

- Both medicine/observation and surgery demand steadily declines over the projected period resulting in a 30% decrease by 2023.
- Psychiatry and substance abuse demand increases through 2013, and although demand then declines, it still remains significantly higher than the current bed need.

Opportunities exist to address the market needs for inpatient services such as domiciliary and mental health. The projected demand for inpatient psychiatry creates a patient volume that may justify providing this service at the Big Spring VAMC. There are also unmet market needs in outpatient areas such as urology, mental health, and orthopedics. However, Big Spring faces challenges resulting from the significant drop in its primary care utilization with modest or slight decreases in specialty care. In addition, given the size of the veteran population in Big Spring and its primary service area coupled with the overall size of the New Mexico-West Texas market, it is likely that this VAMC will be confronted with challenges facing many small rural hospitals in America — the ability to deliver on its mission while operating in a cost effective manner and recruiting and retaining talented staff.

These long term healthcare trends for the New Mexico-West Texas Market, together with four major drivers were considered for the Big Spring study site. These drivers represent factors particularly noticeable at the Big Spring VAMC that must be balanced in the development and evaluation of business plan options. They are:

1). Based upon current analysis of user origin and future enrollment projections, relocation of the facility to Midland/Odessa is not anticipated to significantly increase use.
2). The Big Spring campus can support future expansion of services through renovation and development.
3). The Big Spring community leverages multiple providers focused upon care to veterans and currently supports contracting for inpatient psychiatry care.
4). Re-use opportunities are extremely limited based on the local economy and current economic development.

These four drivers are described further below.

Healthcare Access – Currently, there are proportionally greater numbers of enrolled veterans in the sector west (and closer to Midland/Odessa) than east of Big Spring. However, enrollment trends show that by the end of the forecast period (2023), the difference between the two sectors will be negligible. Additionally, patient origin data for the Big Spring facility shows current users are more heavily weighted towards the Big Spring area. Therefore, despite greater numbers of enrolled veterans in Midland/Odessa today, access is not likely to be improved in the future by relocating services away from Big Spring.

Re-Use Potential – Based upon re-use analysis, re-use potential for the current Big Spring medical center campus is extremely limited due to a low demand in the local market. Therefore, potential re-use revenue is not influential in developing and recommending options.

Level of Capital Expenditure Anticipated – The Big Spring VAMC does not require significant capital expenditure to upgrade to modern, safe, and secure standards ($21 million over 30 years). A $1 million remediation effort will be required to address asbestos. However, consideration of establishing new services at Big Spring VAMC will require renovation and/or new construction on the current site, while consideration of relocating inpatient services to Midland/Odessa will require construction of a new facility. The renovation and new construction efforts are significant drivers for capital investment for Big Spring.

Impact on VA and Local Community – The veteran community benefits from complementary relationships between healthcare providers currently providing inpatient psychiatry and nursing home care in Big Spring. VA is a major employer in the Big Spring area representing employment for 483 full time employee equivalents (FTEEs) and providing limited educational support.

Assessment Results

The following tables (16 and 17) detail the results of applying discriminating criteria and comparison against the baseline in accordance with the Evaluation System for BPOs (Table 12).

Table 16: Baseline Assessment

Assessment Summary	Baseline
Healthcare Access	
Primary care	76% of enrollees are within drive time guidelines. The primary care access drive time threshold is 70%; therefore, Big Spring meets the access guideline for primary care.
Acute care	55% of enrollees are within the drive time guidelines. The acute care drive time threshold is 65%; therefore, Big Spring does not meet the access guideline for acute care.
Tertiary care	55% of enrollees are within the drive time guidelines. The tertiary care drive time threshold is 65%; therefore, Big Spring does not meet the access guideline for tertiary care.
Healthcare Quality	
Quality of medical services	Achieved higher selected quality scores for the following clinical settings: mental health (major depressive disorder), nursing home care (pressure sores), and patient satisfaction (inpatient care) as compared to both the VISN and overall national scores. Achieved the same or lower quality scores on four clinical setting measures: inpatient care, ambulatory care, mental health (global index), nursing home care (physically restrained patients), and patient satisfaction (ambulatory care).
Modern, safe, and secure environment	Big Spring VAMC facility is in good condition, rating 4.4 out of 5 for critical values such as accessibility, code, functional space, and facility conditions. .
Ensures forecast healthcare need is appropriately met	Assumes that in order to maintain quality of care and meet VA thresholds for clinical volume (e.g., VRAH guidelines), VA will make necessary operational adjustments (e.g., staffing or contract arrangements).
Impact on Local Community	
Human Resources:	
FTEE need (based on volume)	With the projected changes in utilization, it is anticipated that the baseline results in a 6% decrease in the number of FTEEs needed.
Recruitment / retention	Despite being in a remote location, Big Spring typically has not had many problems recruiting positions. Pharmacists and sub specialties in radiology and urology are currently the most difficult positions to recruit. Big Spring has worked with local healthcare providers to jointly recruit physicians, and presently has a radiologist who splits time with Scenic Mountain Medical Center. The current recruitment environment is expected to be maintained in the baseline.
Research	Research is currently not performed at this location.
Education and Academic Affiliations	Big Spring's graduate medical education program is small in size, totaling three resident FTEEs per year. The ophthalmology service receives the greatest benefit from the existence of residency programs. Allied health training programs are important avenues for recruitment of future employees. The education programs and academic affiliations are expected to be maintained in the baseline.
Use of VA Resources	
Operating cost effectiveness	Big Spring's operating costs include those costs associated with providing care onsite at the Big Spring VAMC, as well as purchasing care for tertiary services provided by a local community provider. Buildings and mechanical systems are reported to be in good condition which would result in reasonable maintenance costs for the facilities in the baseline. Since Big Spring currently operates a single facility, it is expected that staffing and facility operations are fairly efficient thus not inflating operating costs. Renovations in the baseline should not significantly reconfigure space to impact these operations. Therefore, the operating cost effectiveness is not expected to be significantly different than the current state.
Level of capital expenditure anticipated	Approximately $21 million has been identified in the CAI database as being required for capital improvements to bring the facility up to modern, safe, and secure standards. Additional minimal expenditures beyond routine maintenance would also be required.
Level of re-use proceeds	Parcels D1 and D2 are available for re-use in the baseline; however, because of the underground utilities and slope change, the only viable re-use of this land is for parking lots. Given current market conditions and lack of demand for parking, the likelihood of material re-use proceeds is limited.
Cost avoidance opportunities	In the baseline, it is assumed that all of the $21 million identified by the facility as essential maintenance and upgrades will be expended.
Overall cost effectiveness	Not applicable for the baseline.
Ease of Implementation	
Riskiness of BPO implementation	The risk factor for implementation is very 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. The baseline option does present implementation risk in terms of the following major risk areas: 1. Compliance, since there is implementation risk associated with the required remediation to remove asbestos, lead, and potentially radon 2. Continuity of care, since meeting future demand requirements for inpatient psychiatry is reliant on Big Spring State Hospital which had an occupancy rate of 93% in 2003
Ability to Support VA Programs	
DoD sharing	Big Spring presently provides pre-discharge physicals and Compensation & Pension exams to Dyess Air Force Base in Abilene and Goodfellow in San Angelo. The baseline does not impact any future potential collaboration between VA and DoD.
One-VA Integration	The baseline environment does not further One–VA integration nor has any requirement to coordinate with other VA

Assessment Summary	Baseline
	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 17 provides an overall summary of the BPOs assessed for comparative purposes.

Table 17: BPO Assessment Summary[15]

Assessment Summary	BPO 2	BPO 3	BPO 4	BPO 5	BPO 6
	IP Services Relocated to Midland/ Odessa; Renovate Existing Multi-Speciality Clinic	**IP Services Provided by Community; Big Spring Becomes Multi-Specialty Clinic**	**Baseline + Domiciliary Beds**	**Baseline + Domiciliary Beds and Psychiatry Beds**	**Lease Space for Inpatient Services and for CBOC**
Healthcare Access					
Primary care	↔	↔	↔	↔	↔
Acute care	↔	↑	↔	↔	↔
Tertiary care	↔	↔	↔	↔	↔
Healthcare Quality					
Quality of medical services	↔	↔	↔	↔	↔
Modern, safe, and secure environment	↑	↑	↔	↔	↑
Ensures forecast healthcare need is appropriately met	↔	↔	↔	↔	↔
Impact on Local Community					
Human Resources:					
FTEE need (based on volume)	Increase	Decrease	Increase	Increase	Decrease
Recruitment / retention	↓	↓	↔	↔	↓
Research	↔	↔	↔	↔	↔
Education and Academic Affiliations	↓	↔	↔	↔	↔
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					
Riskiness of BPO implementation	↓	↓	↓	↓	↓
Ability to Support VA Programs					
DoD sharing	↔	↔	↔	↔	↔
One-VA Integration	↔	↔	↔	↔	↔
Special Considerations	↔	↔	↔	↔	↔
Overall Attractiveness	↓↓	↑↑	-	-	↓↓

[15] BPO 7 is not included in the Assessment Summary Table. It was 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 BPO has the potential to meet or exceed the CARES objectives. If BPO 7 is selected for Stage II, a more detailed analysis will be completed.

BPO 7: Baseline plus add 35 domiciliary beds and 18 psychiatry beds; expands inpatient services purchased from local community providers

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 7

Criteria	Screening Result
Access	Since all ambulatory and outpatient mental health services will remain on the campus, this BPO will provide the same level of primary care access as the baseline. However, expanding inpatient medicine to other geographic areas through purchasing arrangements with local providers should improve acute and tertiary access compared to the baseline.
Quality	As this BPO is very similar to BPO 5 with respect to the facilities created, changes in clinical volumes for baseline services should not have a negative impact on quality of care, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Cost	This BPO will likely be similar to BPO 5 in terms of cost. Cost associated with purchasing services from local community providers will need to be further evaluated during Stage II, once an understanding of the potential volume of services being purchased is determined. Therefore, operating costs, re-use proceeds, and overall cost effectiveness is expected to be similar to BPO 5. Capital investment required is anticipated to be higher relative to the baseline.

Local Advisory Panel and Stakeholder Reactions/Concerns

Local Advisory Panel Feedback

The Big Spring LAP consists of 11 members: John Fears, Carl Hayden, Wilfredo Rodriguez, M.D., Russ McEwen, Mike Pruitt, Jim Defoor, Kent Sharp, Bill Crooker, Russell Myers, David McCartney, M.D., and Tom Ivey.

At the second LAP meeting on September 1, 2005, following the presentation of public comments, the LAP conducted its deliberation on the BPOs. At that time, the LAP proposed one new option, BPO 7, which combined BPO 5 and BPO 3. The LAP members then chose to rank each of the seven BPOs in order to indicate the strength of their support or opposition for each BPO. Table 19 presents the results of LAP deliberations, with the exception of the baseline option which is automatically included for further study. It should be noted that the LAP ranked the baseline option as preferable over BPOs 2, 3 and 6. The LAP was strongly opposed to BPO 2 and discussed ways to make the Secretary understand its opposition. Overall, the LAP shared the sentiment of the public that services should stay on site with as little change to the campus as possible.

Table 19: LAP BPO Voting Results

BPO	Label	Ranking	Recommends Further Study
2	IP Services Relocated to Midland/Odessa; Renovate Existing Multi-Specialty Clinic	6	No
3	IP Services Provided by Community; Big Spring Becomes Multi-Specialty Clinic	4	No
4	Baseline + Domiciliary Beds	3	Yes
5	Baseline + Domiciliary Beds and Psychiatry Beds	2	Yes
6	Lease Space for Inpatient Services and for CBOC	5	No
7[16]	Baseline + Domiciliary Beds and Psychiatry Beds; Expand Inpatient Services Purchased from Community	1	Yes

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 6.

Stakeholders reviewed the BPOs before the second public LAP meeting and chose one, BPO 5, to emphatically endorse. Stakeholders were vested in their choice and began a campaign to support BPO 5 that included a billboard, signs, and buttons which they wore at the LAP meeting. Analysis of written and electronic correspondence received from stakeholders during this period indicates overwhelming support for BPO 5. Public testimony at the LAP meeting also voiced consistent, strong support for BPO 5.

A significant number of stakeholders also supported BPO 4 which is similar to the BPO 5, but adds only domiciliary services to the campus. The overwhelming majority of stakeholders did not favor BPO 2 which involves moving inpatient services to a newly built facility in the Midland/Odessa area. The stakeholders also did not favor BPO 3, which involves purchasing inpatient services from the local community, and BPO 6, which involves leasing beds for inpatient services from local community providers. Given that BPO 7 emerged as a result of LAP deliberations, stakeholders did not have the opportunity to provide feedback specific to this option.

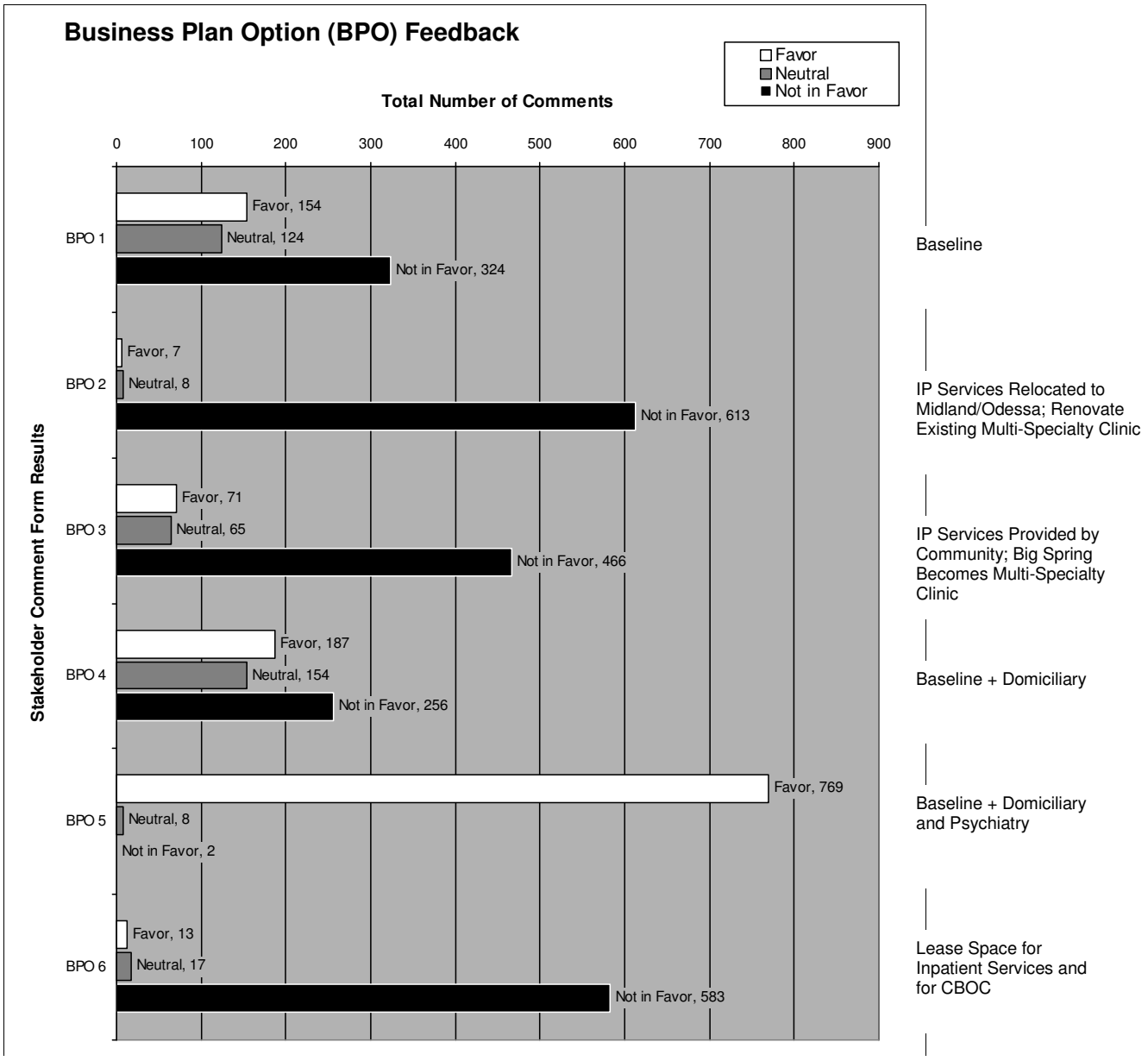
[16] New BPO proposed by LAP at second public LAP meeting held September 1, 2005.

Figure 6: Stakeholder Feedback on BPOs[17]

Big Spring Study Site (8/19/2005 to 9/11/2005)

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

The feedback received from the Options Comment Forms for the Big Spring study site is as follows:



[17] Stakeholder feedback is reflected in this chart only for the BPOs which were presented by Team PwC at the LAP meeting (BPOs 1-6), and the one 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:

- Meet increased demand for domiciliary and inpatient psychiatry care;
- Maintain continuity of inpatient and outpatient services on the Big Spring VAMC;
- Right-size the campus for future demand, and achieve modern, safe, and secure facilities through renovation, consolidation, or new construction; and
- Permit re-use and/or redevelopment of a majority of the campus.

BPO 2 which Team PwC eliminated from further consideration involved moving all or a subset of services to new facilities off campus and redeveloping a majority of the campus. The LAP and veterans strongly opposed this approach.

Table 20: BPO Recommendations

BPO	Pros	Cons	Rationale
BPOs Recommended by Team PwC for Further Study			
BPO 1: Baseline	• Would maintain only VA inpatient medicine beds in West Texas (other than those in Amarillo, TX) • Facility conditions are rated 4.4 on a scale of 5 • The VA is the fourth largest employer in the community • Community and state providers demonstrate commitment to serving veterans	• Domiciliary needs remain unaddressed locally (currently provided in Prescott, AZ which is 875 miles away)	• Facility and associated campus can accommodate current and future utilization • Condition of existing facility is good • The Big Spring community offers synergistic services complementing veterans' care
BPO 3: IP Services Provided by Community; Big Spring Becomes Multi-Specialty Clinic	• Current square footage will accommodate future ambulatory and outpatient volumes • Makes portions of the site available for re-use • Potential for operating cost savings • Acute care access is improved as a result of contracting for inpatient services closer to veterans' homes	• Disruptive to the workforce in Big Spring • Fragmented healthcare service resulting from contracting for care • Asbestos issues may impact re-use potential • Relies on local community's ability to accommodate increased demand for services	• Improved access and offers flexibility through contracting for care with local providers in Midland/Odessa, Big Spring, and potentially other communities • Maintains outpatient services in the Big Spring community • Locally addresses projected domiciliary and inpatient psychiatry needs • Limited re-use potential associated with the Big Spring campus
BPO 4: Baseline + Domiciliary	• Improves access to domiciliary services • Current square footage will accommodate future ambulatory and outpatient volumes	• Limited or no improvement in overall cost effectiveness • Continued reliance on local providers for clinical services • Capital investment required is greater than the baseline option	• Locally addresses projected domiciliary needs • Facility and associated campus can accommodate future utilization • Condition of existing facility is good and requires limited upgrades and capital improvements • Big Spring community offers synergistic services complementing veterans' care
BPO 5: Baseline + Domiciliary and Psychiatry	• Improves access to domiciliary services • Adding psychiatry services increases array of services and impacts continuity of care	• Limited or no improvement in overall cost effectiveness • Increased capital investment • Significant construction required • Could adversely affect relationships with state and local providers	• Locally addresses projected domiciliary and inpatient psychiatry needs • Facility and associated campus can accommodate future utilization • Condition of existing facility is good and requires limited upgrades and capital improvements • Big Spring community offers synergistic services complementing veterans' care

BPO	Pros	Cons	Rationale
BPO 6: Lease Space for Inpatient Services and for CBOC	• Capital investment significantly less than baseline • Enhances working relationships between the community and VA healthcare providers • Improves access	• Reduction of workforce of Big Spring VAMC • Higher net present cost compared to baseline • Demolition and clean up costs would exceed current land value of the property • Fragmentation of inpatient and outpatient services • Costs increase through managing multiple sites (CBOC in Big Spring, leased beds in Big Spring, and leased beds in Midland/Odessa)	• Improves acute care access by providing greater flexibility in meeting local demand for care
BPO 7: Baseline + Domiciliary and Psychiatry; Expand Inpatient Services Purchased from Community	• Increases access to acute and tertiary inpatient services • Adds domiciliary services • Adding psychiatry services increases array of services and impacts continuity of care	• Limited or no improvement in overall cost effectiveness • Fragments healthcare services as a result of contracting • Increased capital investment • Approach is inconsistent with current local VA practice • Would alter volume at VA referral sites • May reduce volume requirements for medicine beds at Big Spring leading to impacts on quality	• Replicates features of BPOs 3 and 5 with addition of specifying tertiary care
BPO Not Recommended by Team PwC for Further Study			
BPO 2: IP Services Relocated to Midland/Odessa	• Larger employment pool for recruitment • All inpatient services are provided in one location, maximizing the use of associated ancillary services • New hospital facility offers opportunities to increase modernization	• Potential negative impact on relationships with Big Spring State Hospital and the Texas Veterans Home • Fragmented healthcare service due to the split campus • Reduction of workforce at Big Spring VAMC • Higher capital expenditure requirements • Decline in overall cost effectiveness	• Requires significant capital investment in building a new facility in Midland/ Odessa • Enrollment projections indicate that current and future access is not significantly improved through relocating services to Midland/Odessa

Appendix A - Assessment Tables

BPO 1: Baseline

Assessment of BPO 1	Description
Healthcare Access	
Primary care	76% of enrollees are within drive time guidelines. The primary care access drive time threshold is 70%; therefore, Big Spring meets the access guideline for primary care.
Acute care	55% of enrollees are within the drive time guidelines. The acute care drive time threshold is 65%; therefore, Big Spring does not meet the access guideline for acute care.
Tertiary care	55% of enrollees are within the drive time guidelines. The tertiary care drive time threshold is 65%; therefore, Big Spring does not meet the access guideline for tertiary care.
Healthcare Quality	
Quality of medical services	Achieved higher selected quality scores for the following clinical settings: mental health (major depressive disorder), nursing home care (pressure sores), and patient satisfaction (inpatient care) as compared to both the VISN and overall national scores. Achieved the same or lower quality scores on four clinical setting measures: inpatient care, ambulatory care, mental health (global index), nursing home care (physically restrained patients), and patient satisfaction (ambulatory care). The baseline has the potential to provide materially the same level of quality of care as is currently provided as assessed using these select quality measures.
Modern, safe, and secure environment	Big Spring VAMC facility is in good condition, rating 4.4 out of 5 for critical values such as accessibility, code, functional space, and facility conditions. .
Ensures forecast healthcare need is appropriately met	Assumes that in order to maintain quality of care and meet VA thresholds for clinical volume (e.g., VRAH guidelines), VA will make necessary operational adjustments (e.g., staffing or contract arrangements).
Impact on VA and Local Community	
Human Resources:	
FTEE need (based on volume)	With the projected changes in utilization, it is anticipated that the baseline results in a 6% decrease in the number of FTEEs needed.
Recruitment / retention	Despite being in a remote location, Big Spring typically has not had many problems recruiting positions. Pharmacists and sub specialties in radiology and urology are currently the most difficult positions to recruit. Big Spring has worked with local healthcare providers to jointly recruit physicians, and presently has a radiologist who splits time with Scenic Mountain Medical Center. The current recruitment environment is expected to be maintained in the baseline.
Research	Research is currently not performed at this location.
Education and Academic Affiliations	Big Spring's graduate medical education program is small in size, totaling three resident FTEEs per year. The ophthalmology service receives the greatest benefit from the existence of residency programs. Allied health training programs are important avenues for recruitment of future employees. The education programs and academic affiliations are expected to be maintained in the baseline.
Use of VA Resources	
Operating cost effectiveness	Big Spring's operating costs include those costs associated with providing care onsite at the Big Spring VAMC, as well as purchasing care for tertiary services

Assessment of BPO 1	Description
	provided by a local community provider. Buildings and mechanical systems are reported to be in good condition which would result in reasonable maintenance costs for the facilities in the baseline. Since Big Spring currently operates a single facility, it is expected that staffing and facility operations are fairly efficient thus not inflating operating costs. Renovations in the baseline should not significantly reconfigure space to impact these operations. Therefore, the operating cost effectiveness is not expected to be significantly different than the current state.
Level of capital expenditure anticipated	Approximately $21 million has been identified in the CAI database as being required for capital improvements to bring the facility up to modern, safe, and secure standards. Additional minimal expenditures beyond routine maintenance would also be required.
Level of re-use proceeds	Parcels D1 and D2 are available for re-use in the baseline; however, because of the underground utilities and slope change, the only viable re-use of this land is for parking lots. Given current market conditions and lack of demand for parking, the likelihood of material re-use proceeds is limited.
Cost avoidance	In the baseline, it is assumed that all of the $21 million identified by the facility as essential maintenance and upgrades will be expended.
Overall cost effectiveness	Not applicable for the baseline.
Ease of Implementation	
Riskiness of BPO implementation	The risk factor for implementation is very 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. The baseline option does present implementation risk in terms of the following major risk areas: 1. Compliance, since there is implementation risk associated with the required remediation to remove asbestos, lead, and potentially radon 2. Continuity of care, since meeting future demand requirements for inpatient psychiatry is reliant on Big Spring State Hospital which had an occupancy rate of 93% in 2003
Ability to Support VA Programs	
DoD sharing	Big Spring presently provides pre-discharge physicals and Compensation & Pension exams to Dyess Air Force Base in Abilene and Goodfellow in San Angelo. The baseline does not impact any future potential collaboration between VA and DoD.
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.

BPO 2: Inpatient Services Relocated to Midland/Odessa; Renovate Existing Multi-Speciality Clinics in Big Spring VAMC

Assessment of BPO 2	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for primary care, since primary care services will remain at the baseline location of provision.
Acute care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for acute care. Although inpatient services provided at Big Spring are to be relocated to the Midland/Odessa area, this geography is in close enough proximity to the baseline location of provision as not to affect drive time access.
Tertiary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care since tertiary care will continue to be referred to other VAMCs or purchased from the local community.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to quality of medical services since all services will continue to be provided by the VA.
Modern, safe, and secure environment	↑	The Big Spring VAMC facility is in good condition, rated 4.4 out of 5, and renovations required are comparable to those required of the baseline. Additionally, new construction would allow for the facility to meet all Homeland Security requirements.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volume should maintain quality of care, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Increase	The FTEE need would increase as a result of splitting the campus, since multiple campuses would necessitate the duplication of certain personnel (e.g. administration, engineering, etc).
Recruitment / retention	↓	There would be a need to recruit personnel to staff a new hospital in Midland/Odessa. The area is characterized by low unemployment, thereby resulting in a potential difficulty in recruiting.
Research	↔	No material impact is expected on research since research programs are currently not performed at this location. This BPO neither precludes nor enhances potential, future research programs.
Education and Academic Affiliations	↓	Education programs should be able to relocate to Midland/Odessa; however, allied health students from Big Spring schools will likely not travel to Midland/Odessa for clerkships. This would negatively affect the education program. Also, the RRC may look unfavorably on the splitting of inpatient and outpatient services in terms of the resident training program.
Use of VA Resources		
Operating cost effectiveness	↓↓↓	Higher operating costs (>15% higher) compared to the baseline would result. This is most likely due to the inefficiencies associated with operating services in two locations. Inefficiencies may include duplication of staff (i.e. administrative and engineering personnel) resulting in higher indirect costs, as well as duplication of support services resulting in higher variable costs.
Level of capital expenditure anticipated	↓↓	Significantly higher investment (21% to 99% higher) relative to the baseline is required to fund both the construction of the new hospital in Midland/Odessa as well as the heavy renovations to Building 1 at

Assessment of BPO 2	Comparison to Baseline	Description of Impact
		the Big Spring VAMC in order to accommodate outpatient services and administration.
Level of re-use proceeds	-	Given modest lease rates for existing buildings and minimal value achieved if buildings were to be demolished for new construction, no material re-use proceeds are available.
Cost avoidance opportunities	-	The BPO requires the construction of a new facility in addition to renovation of the existing buildings. Therefore, there are no cost avoidance opportunities in terms of capital investment.
Overall cost effectiveness	↓↓↓↓	The operating inefficiencies resulting in higher operating costs, coupled with the significant capital investment required for both new construction and heavy renovation result in substantially higher net present costs (>15% higher) relative to the baseline.
Ease of Implementation		
Riskiness of BPO implementation	↓	This option is riskier than the baseline in terms of the following major risk areas: 1) Organization and change, due to the change management issues associated with relocating services to a new facility 2) Compliance, since a building permit would be required for construction of a new Midland/Odessa facility 3) Political, given the local stakeholders have voiced their disapproval with moving services to an offsite location 4) Project realization, since new construction is more vulnerable to delays, budget variance, and transition complications.
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with Dyess Air Force Base (in which the VA provides physical examinations to beneficiaries as noted in the baseline), since these ambulatory services would remain at Big Spring. Also, the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA Integration	↔	No material impact is expected that would affect One-VA opportunities since there are no significant VBA or NCA relationships in the baseline which could be disrupted. Furthermore, the BPO neither precludes nor enhances any potential, future VBA or NCA relationships.
Special Considerations	↔	No material impact expected in terms of special considerations since the contracting of inpatient services from a local community provider neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↓↓	Access and quality would be maintained; however, compared to the baseline, this BPO appears to be less cost effective. Therefore, BPO 2 is less attractive than the baseline

BPO 3: Inpatient Services Transferred to Local Community Provider; Big Spring Becomes A Multi-Specialty Clinic

Assessment of BPO 3	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for primary care, since primary care services will remain at the baseline location of provision.
Acute care	↑	This BPO is expected to increase the percentage of enrollees meeting VA drive time access guidelines for acute care, since acute care will be purchased from a local community provider.
Tertiary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care since tertiary care will continue to be referred to other VAMCs or purchased from the local community.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since the inpatient care quality measures for area providers suggest these organizations provide comparable quality of inpatient care.
Modern, safe, and secure environment	↑	The Big Spring VAMC facility is in good condition, rated 4.4 out of 5, and renovations required are comparable to those required of the baseline. Additionally, heavy renovation of space for a multi-specialty clinic could allow for the facility to meet all Homeland Security requirements thereby improving standards of modern, safe, and secure.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volume should maintain quality of care, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time. Assumes local community providers will be selected that have clinical experience and sufficient volumes to maintain quality of care.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	The number of FTEEs would decrease since inpatient services would be contracted from the local community rather than provided onsite, thereby eliminating the need for many inpatient staff at the Big Spring VAMC.
Recruitment / retention	↓	A reduction in the service mix would negatively affect the ability to recruit personnel at the Big Spring VAMC.
Research	↔	No material impact is expected on research since research programs are currently not performed at this location. This BPO neither precludes nor enhances potential, future research programs.
Education and Academic Affiliations	↔	No material impact is expected on education or academic affiliations since these educational programs should be able to relocate to community providers. Since inpatient services are expected to relocate to a community provider in the Big Spring area, travel time should not significantly change and thus not deter allied health from training at a local facility. However, it should be noted that the Residency Review Committee (RRC) may look unfavorably on the arrangement to split inpatient and outpatient services.
Use of VA Resources		
Operating cost effectiveness	↑↑	Results in potential operating cost savings (>10% lower costs than the baseline). These savings are most likely due to a reduction in direct and indirect costs for the inpatient services that are to be purchased from local community providers.

Assessment of BPO 3	Comparison to Baseline	Description of Impact
Level of capital expenditure anticipated	↑↑	A reduced level of investment is required relative to the baseline BPO (20%-60% lower capital costs). Although Building 1will still need to be heavily renovated, nine buildings will be vacated and thus will not require renovation.
Level of re-use proceeds	-	Given modest lease rates for existing buildings and minimal value achieved if buildings were to be demolished for new construction, no material re-use proceeds are available.
Cost avoidance opportunities	↑↑	As previously noted, not all buildings will require renovation as they would in the baseline. Thus, there is opportunity for savings with respect to capital investments.
Overall cost effectiveness	↑↑	Lower operating costs associated with transferring inpatient services to the community, compounded with a reduction in the capital investment required to renovate a smaller set of buildings, may result in a lower net present cost (15 – 10% lower costs) relative to the baseline.
Ease of Implementation		
Riskiness of BPO implementation	↓	This option is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care, since local community providers may not be able to accommodate inpatient psychiatry and nursing home volumes 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given the local stakeholders have voiced their disapproval with moving services to an offsite location
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with Dyess Air Force Base (in which the VA provides physical examinations to beneficiaries as noted in the baseline), since these ambulatory services would remain at Big Spring. Also, the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA Integration	↔	No material impact is expected that would affect One-VA opportunities since there are no significant VBA or NCA relationships in the baseline which could be disrupted. Furthermore, the BPO neither precludes nor enhances any potential, future VBA or NCA relationships.
Special Considerations	↔	No material impact expected in terms of special considerations since the contracting of inpatient services from a local community provider neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↑↑	This BPO is likely to improve access and maintain quality while appearing to be more cost effective than the baseline. Thus, BPO 3 is attractive as compared to the baseline.

BPO 4: Baseline plus Increase Services through Adding a 35-Bed Domiciliary Unit at Big Spring VAMC

Assessment of BPO 4	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for primary care, since primary care services remain at the baseline location of provision.
Acute care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for acute care since acute care services remain at the baseline location of provision.
Tertiary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care since tertiary care continues to be referred to other VAMCs or purchased from the local community.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since services remain at the baseline location of provision. Although the continuity of care could be expected to be improved, this will be formally evaluated in Stage II.
Modern, safe, and secure environment	↔	No impact is expected on modern, safe, and secure standards since the Big Spring VAMC facility is in good condition, rated 4.4 out of 5, and renovations required are comparable to those required of the baseline.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes for baseline services should maintain quality of care, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Increase	FTEE need would increase due to the need to support the domiciliary patient population.
Recruitment / retention	↔	No material impact is expected on recruitment / retention efforts as the location of services and service mix remains very similar to that provided in the baseline.
Research	↔	No material impact is expected on research since research programs are currently not performed at this location. This BPO neither precludes nor enhances potential, future research programs.
Education and Academic Affiliations	↔	No material impact is expected on the education programs and academic affiliations since baseline services remain at current location of provision. Education programs in ophthalmology, internal medicine, and allied health would not be impacted by the addition of domiciliary services.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the cost of providing domiciliary services is included in both the baseline and this option.
Level of capital expenditure anticipated	↓↓	Requires significant level of investment (21 – 99% higher) relative to the baseline. Renovation will not only be required of Building 1, but also of Buildings 4, 5, 6, 7, and 9 (which currently house administrative functions) to accommodate the new domiciliary unit.

Assessment of BPO 4	Comparison to Baseline	Description of Impact
Level of re-use proceeds	-	Given modest lease rates for existing buildings and minimal value achieved if buildings were to be demolished for new construction, no material re-use proceeds are available..
Cost avoidance opportunities	-	The BPO requires the construction of a new facility in addition to renovation of the existing buildings. Therefore, there are no cost avoidance opportunities in terms of capital investment.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline. Although the total capital expenditure required is higher than the baseline, due to the need to renovate buildings for the new domiciliary service, it is not significant enough to increase the overall net present cost. Thus, the BPO results in a similar level of net present cost compared to the baseline.
Ease of Implementation		
Riskiness of BPO implementation	↓	This option is riskier than the baseline in terms of project realization, since new construction is more vulnerable to delays, budget variance, and transition complications.
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with Dyess Air Force Base (in which the VA provides physical examinations to beneficiaries as noted in the baseline), since these ambulatory services would remain at Big Spring. Also, the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA Integration	↔	No material impact is expected that would affect One-VA opportunities since there are no significant VBA or NCA relationships in the baseline which could be disrupted. Furthermore, the BPO neither precludes nor enhances any potential, future VBA or NCA relationships.
Special Considerations	↔	No material impact expected in terms of special considerations since the contracting of inpatient services from a local community provider neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	-	BPO 4 is generally similar to the baseline in terms of access, quality, and cost, and thus has similar attractiveness as the baseline.

BPO 5: Baseline plus Increase Services through Adding a 35-Bed Domiciliary Unit and 18 Psychiatry Beds at Big Spring VAMC

Assessment of BPO 5	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for primary care, since primary care services remain at the baseline location of provision.
Acute care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for acute care since acute care services remain at the baseline location of provision.
Tertiary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care since tertiary care continue to be referred to other VAMCs or purchased from the local community.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since services remain at the baseline location of provision. Although the continuity of care could be expected to be improved, this will be formally evaluated in Stage II.
Modern, safe, and secure environment	↔	No impact is expected on modern, safe, and secure standards since the Big Spring VAMC facility is in good condition, rated 4.4 out of 5, and renovations required are comparable to those required of the baseline.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes for baseline services should not have a negative impact on quality of care, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Increase	FTEE need increases as a result of adding both domiciliary and psychiatry services.
Recruitment / retention	↔	No material impact is expected on overall recruitment / retention efforts as the location of services and service mix remains similar to that provided in the baseline. However, there will potentially be recruitment challenges to staff the expanded psychiatry services.
Research	↔	No material impact is expected on research since research programs are currently not performed at this location. This BPO neither precludes nor enhances potential, future research programs
Education and Academic Affiliations	↔	No material impact is expected on the education programs and academic affiliations since baseline services remain at current location of provision. Education programs in ophthalmology, internal medicine, and allied health would not be impacted by the addition of domiciliary and psychiatry services.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the cost of providing domiciliary and psychiatry services is included in both the baseline and this option. Since psychiatry services are added to the Big Spring service mix, these services would no longer be purchased from the

Assessment of BPO 5	Comparison to Baseline	Description of Impact
		community. Any increase in costs to provide these services in-house would be offset by the elimination of the cost to purchase these services.
Level of capital expenditure anticipated	↓↓	Requires a significant level of investment (21 – 99% higher) relative to the baseline BPO to fund the construction of a new domiciliary unit and renovation for the inpatient psychiatry unit.
Level of re-use proceeds	-	Given modest lease rates for existing buildings and minimal value achieved if buildings were to be demolished for new construction, no material re-use proceeds are available.
Cost avoidance opportunities	-	The BPO requires the construction of a new facility in addition to renovation of the existing buildings. Therefore, there are no cost avoidance opportunities in terms of capital investment.
Overall cost effectiveness	-	Capital expenditure is required to build the new domiciliary and renovate for the inpatient psychiatry unit; however, the cost for purchasing inpatient psychiatry services from a local community provider is eliminated. Thus, the BPO results in a similar level of net present cost compared to the baseline.
Ease of Implementation		
Riskiness of BPO implementation	↓	This option is riskier than the baseline in terms of project realization, since new construction is more vulnerable to delays, budget variance, and transition complications.
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with Dyess Air Force Base (in which the VA provides physical examinations to beneficiaries as noted in the baseline), since these ambulatory services would remain at Big Spring. Also, the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA Integration	↔	No material impact is expected that would affect One-VA opportunities since there are no significant VBA or NCA relationships in the baseline which could be disrupted. Furthermore, the BPO neither precludes nor enhances any potential, future VBA or NCA relationships.
Special Considerations	↔	No material impact expected in terms of special considerations since the contracting of inpatient services from a local community provider neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	-	BPO 5 is generally similar to the baseline in terms of access, quality, and cost, and thus has similar attractiveness as the baseline.

BPO 6: Lease Space for Inpatient Services in Big Spring and Midland/Odessa. Close the Big Spring Campus and Lease Space for CBOC

Assessment of BPO 6	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for primary care, since primary care services are provided through a CBOC in the Big Spring area.
Acute care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for acute care. Although inpatient services will be provided at both Big Spring and the Midland/Odessa area, these geographies are in close enough proximity to the baseline location of provision as not to affect drive time access.
Tertiary care	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care since tertiary care will continue to be referred to other VAMCs or purchased from the local community.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since all services will continue to be provided by the VA in leased space.
Modern, safe, and secure environment	↑	Heavily renovated space or newly constructed facilities (the more likely scenario) would allow for CBOC facility to fully meet requirements for modern, safe, and secure.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes for baseline services should not have a negative impact on quality of care, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	Decrease in FTEE need likely in the leasing arrangement. The reduction in need most likely to occur for administration, ancillary support, and engineering staff.
Recruitment / retention	↓	There would be a need to recruit personnel to staff leased facilities in Midland/Odessa. The area is characterized by low unemployment, thereby resulting in a potential difficulty in recruiting.
Research	↔	No material impact is expected on research since research programs are currently not performed at this location. This BPO neither precludes nor enhances potential, future research programs
Education and Academic Affiliations	↔	No material impact is expected on education programs and academic affiliations since teaching programs should be able to be transferred to the leased space. However, it should be noted that the RRC may look unfavorably on the arrangement to split inpatient and outpatient services..
Use of VA Resources		
Operating cost effectiveness	-	Operating costs will be similar to those in the baseline. Any savings achieved through reduction of staff or vacating facilities would be offset by the cost of lease payments for the space in which to provide services.

Assessment of BPO 6	Comparison to Baseline	Description of Impact
Level of capital expenditure anticipated	↑↑↑↑	Almost no investment is required compared to the baseline (≤ 39% of baseline capital expenditure) since services are to be provided in leased space. Existing buildings will be vacated and thus will not require the extensive renovations as in the baseline to bring facilities up to modern, safe, and secure standards.
Level of re-use proceeds	↓↓	All parcels are made available for re-use. The main hospital will most likely need to be demolished which will exceed the value of the land by more than $1 million. Therefore, the probability of realizing re-use proceeds is highly unlikely.
Cost avoidance opportunities	↑↑↑↑	Significant savings in capital investment result, as compared to the baseline, since facilities will be divested.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline. Although the total capital expenditure required is lower than the baseline, due to the divestiture of all Big Spring buildings, it is not enough to significantly decrease the overall net present cost. Thus, the BPO results in a similar level of net present cost compared to the baseline.
Ease of Implementation		
Riskiness of BPO implementation	↓	This option is riskier than the baseline in terms of the following major risk areas: 1. Continuity of care, since the VA is dependent upon the local community providers for leased space for inpatient services 2. Legal & Contractual, due to the need to develop leasing arrangements with local community providers 3. Security, given medical records and information systems will be housed and hosted in third party space rather than a VA facility 4. Compliance, since the RRC may look unfavourably on the splitting of inpatient and outpatient services 5. Political, given the local stakeholders have voiced their disapproval with moving services to an offsite location
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with Dyess Air Force Base (in which the VA provides physical examinations to beneficiaries as noted in the baseline), since these ambulatory services would remain at Big Spring. Also, the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA Integration	↔	No material impact is expected that would affect One-VA opportunities since there are no significant VBA or NCA relationships in the baseline which could be disrupted. Furthermore, the BPO neither precludes nor enhances any potential, future VBA or NCA relationships.
Special Considerations	↔	No material impact expected in terms of special considerations since the contracting of inpatient services from a local community provider neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↓↓	This BPO will likely maintain quality and access; however, compared to the baseline, appears to be less cost effective. Thus, BPO 6 is less attractive than 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
LAP	Local Advisory Panel
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	A determination of the numbers of actual enrollees who are within defined travel time parameters for primary care and acute hospital care after adjusting for differences in population density and types of roads.
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 health care 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 disease 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)*
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	Method of satisfying future space requirements that involves reusing space currently in use or space currently vacant.
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.