Capital Asset Realignment for Enhanced Services (CARES)

Stage I Report
Site: CAVHCS, Montgomery Division

June 2006

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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.

CAVHCS, Montgomery Division is one of the CARES study sites and includes healthcare delivery and capital planning studies, but does not include re-use planning. The Secretary's CARES Decision Document of May 2004 includes the following directives for CAVHCS, Montgomery Division:

- VA will proceed with a feasibility study of converting the Montgomery Central Alabama Veterans Health Care System (CAVHCS) to an outpatient-only facility as part of the CARES implementation process.
- The study will examine the impact of mission change on access to and quality of care as well as the cost-effectiveness of potential realignment. VA will consider comments from stakeholders as it conducts the study.
- The VISN will develop new Community Based Outpatient Clinics (CBOCs) through the National CBOC Approval Process. Of the 16 new CBOCs targeted for priority implementation by 2012, two are in Montgomery's service area: Enterprise and Opelika.

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

CAVHCS, Montgomery Division is located in the Alabama market of Veterans Integrated Service Network (VISN) 7.

Current Healthcare Provision

CAVHCS, Montgomery Division, also known as the "West Campus" of CAVHCS, houses 45 inpatient beds for acute medicine[1] (32), surgery (4), medical ICU (7), and surgical ICU (2). The facility also offers an extensive array of ambulatory services, including medicine, surgery, and behavioral health. There is an urgent care center on site, but no true emergency department.

Primary care clinics include a clinical preventive services program, a weight management program, and a tobacco cessation program. General medicine clinics are supplemented by specialty referrals as needed. Surgical specialties offered on site include orthopedics, urology, and ophthalmology.

Ambulatory and inpatient medicine and surgery services are supported by basic diagnostic ancillaries, including computed tomography (CT) scan, ultrasound, echocardiography, electromyography, and nerve conduction velocity. Diagnostics not provided on campus are magnetic resonance imaging (MRI), mammography, angiography, and most nuclear medicine studies. Clinical laboratory services include routine hematology, chemistry, cytopathology, microbiology, tissue typing, and toxicology. Specialized diagnostic testing is referred out.

Other notable outpatient services provided at the Montgomery campus include audiology, dentistry, geriatrics, mental health and substance abuse, pharmacy, prosthetics, rehabilitation, and a women's health clinic. The site also has emergency preparedness capability in decontamination and pharmacy cache.

The outpatient podiatry service was relocated to Maxwell Air Force Base in 2004 as part of a broad agreement to share services and facilities between CAVHCS, Montgomery Division and

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

Maxwell. The podiatry clinic represents the first implementation of the Memorandum of Understanding (MOU) between Maxwell Air Force Base and CAVHCS, Montgomery Division.

The Tuskegee facility, or "East Campus", provides CAVHCS with all inpatient psychiatry/substance abuse, nursing home, rehabilitation, and domiciliary services. The two campuses are approximately 40 miles apart and are closely integrated.

Currently, there are two CBOCs in the CAVHCS System. The Columbus CBOC is approximately 85 miles from Montgomery and provides ambulatory primary care and related specialities, non-surgical specialties, and outpatient behavioral health and mental health intensive case management services. CAVHCS operates a contracted CBOC in Dothan, AL, approximately 100 miles from Montgomery, which provides ambulatory primary care and related specialties, pathology and radiology services, non-surgical specialties, and outpatient behavioral health services.

Per the Secretary's CARES Decision, new CBOCS at Enterprise, Alabama and Opelika, Alabama (both within Montgomery's service area) are targeted for implementation by 2012. These CBOCs may absorb some of the primary care demand for CAVHCS, Montgomery Division that is projected to increase over the projection period. However, these CBOCs may also generate their own demand for primary care services for veterans who live in closer proximity to Enterprise or Opelika than Montgomery. The volume of primary care services that would be redirected from CAVHCS, Montgomery Division would affect the amount of space required for the VAMC campus in 2023. However, the distribution of demand between the two sources (that demand absorbed from the CAVHCS, Montgomery Division and that newly generated demand from the CBOC service area) is undeterminable based on currently available information.

Specialty services not provided at Montgomery campus are referred either to other VAMCs, primarily Birmingham and Atlanta, or contracted out to local community providers. Examples of these referred services include oncology, rheumatology, infectious disease, allergy, dermatology, nephrology, dialysis, otolaryngology, invasive cardiology, cardiac surgery, neurology, neurosurgery, vascular surgery, hematology/oncology, and transplants. VA specialized programs in blind rehabilitation and spinal cord injury are provided at other VA centers.

Access

Access is the determination of the numbers of actual enrollees who are within defined travel time parameters for primary care, acute hospital care, and tertiary care after adjusting for differences in population density and types of road. Analysis of drive time information for enrollees in the Alabama market indicates that VA's drive time guideline is met for tertiary care, but not for primary and acute 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 Alabama Market area falls short of the access guideline for primary care by 7% and for acute hospital care by 10%. For tertiary care, 100% of the enrollees in the Alabama market meet the drive time guideline.

Table 1: Percentage of Enrollees Meeting VA Access Guideline Drive Times for the Alabama Market

VA Drive Time Guidelines					
Primary Care		**Acute Hospital**		**Tertiary Care[2]**	
Current Level	**Meets Threshold**	**Current Level**	**Meets Threshold**	**Current Level**	**Meets Threshold**
62.8%	No	55.0%	No	100%	Yes

Quality

The measures listed below (see Table 2) provide a selective description of current healthcare clinical quality at CAVHCS, Montgomery Division, along with corresponding results at the VISN and national levels. This set of measures was chosen by PwC and VA experts based on available internal VA data, and compatibility with the 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 community providers 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 assumes a linear relationship with this current data.

According to 2004 data, CAVHCS, Montgomery Division achieved higher selected quality scores for heart failure, colorectal cancer, and endocrinology as compared to both the VISN and overall national scores. However, the site achieved the same or lower quality scores for behavioral health, mental health, as well as ambulatory and inpatient patient satisfaction.

Table 2: Quality Measures

Clinical Setting	Indicator	Indicator Origin	Study Site '04 Result	VISN #7 '04 Result	VA National '04 Result
Inpatient Care					
Heart Failure	Ace inhibitor for left ventricular dysfunction as a key inpatient measure	VA, CMS[3]	**100%**	**92%**	**93%**
Ambulatory Care					
Colorectal Cancer	Screening rates as a key ambulatory indicator	VA, HEDIS[4]	**75%**	**72%**	**72%**
Endocrinology	Full lipid profile in the past two years	VA, HEDIS	**100%**	**98%**	**96%**

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

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

[4] 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.

Clinical Setting	Indicator	Indicator Origin	Study Site '04 Result	VISN #7 '04 Result	VA National '04 Result
Behavioral Health					
Major Depressive Disorder	% of patients with a new diagnosis of depression -- medication coverage	VA, HEDIS	**58%**	**57%**	**67%**
Mental Health					
Global Index	Weighted average of seven mental health indicators[5]	VA	**54%**	**53%**	**54%**
Patient Satisfaction					
Ambulatory Care	% of surveyed patients rating overall Ambulatory Care Services as very good or excellent	VA, Industry	**70%**	**70%**	**76%**
Inpatient Care	% of surveyed patients rating overall Inpatient Services as very good or excellent	VA, Industry	**53%**	**70%**	**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.

Local Healthcare Market

The population of Montgomery, AL is served by various community hospitals, including tertiary care, general medical/surgical, and specialty facilities.

Jackson Hospital, Montgomery, AL[6]

Jackson Hospital is a tertiary care facility with 277 beds, and nearly 15,000 admissions in 2003. The occupancy rate for that year was 67%, down from 79% in 2001. Of all inpatient days, 58% are from Medicare patients. The top five diagnosis related groups (DRGs) in 2003 were heart failure, pneumonia, major joint and limb procedures, intracranial hemorrhage and stroke, and chronic obstructive pulmonary disease. In 2003, 64 coronary artery bypass grafts (CABGs) were performed. Jackson offers a full range of diagnostic and therapeutic services, but that range does not include neurosurgery.

[5] See Glossary for description of indicators.

[6] Source: Solucient

Baptist Health System, Montgomery, AL[7]

Baptist Health System is comprised of the following three hospitals: Baptist South, Baptist East, and Baptist Downtown. The largest of these is Baptist South, a tertiary care facility, and the only one for which data is provided. Baptist South has 382 beds, with 20,552 admissions in 2003. The occupancy rate was approximately 68% for the years 2000 through 2003. Of all inpatient days, 40% are Medicare. The top five DRGs in 2003 were heart failure, angioplasty, major joint and limb procedures, psychoses, and cardiac pacemaker insertion. In 2003, 120 CABGs were performed.

Department of Defense (DoD) Healthcare Facilities – Maxwell Air Force Base

In accordance with the President's Management Agenda for "Coordination of VA and DoD Programs and Systems", which was announced in 2001, CAVHCS has been involved in active planning with DoD facilities in its service area. These include the 42nd Medical Group, Maxwell Air Force Base (MAFB); Lyster Army Hospital, Fort Rucker; and Martin Army Hospital, Fort Benning, GA. A joint venture with CAVHCS and MAFB in podiatry has been implemented. This provides needed services to DoD beneficiaries, and provides larger and more efficient space and equipment for the podiatry residency program in the MAFB ambulatory facility, which was built in 2002 and is underutilized. The number of patient visits for this podiatry joint venture, for both VA and Maxwell beneficiaries, was over 5,280 for the period August 2004 to April 2005. Additional joint sharing initiatives are being investigated, including those for urgent care, audiology, mammography, women's health, and rheumatology.

Facilities

CAVHCS, Montgomery Division is located at 215 Perry Hill Road in Montgomery, Alabama and contains 18 buildings on 50.3 acres. The facility is close to downtown and is easily accessible from I-85. Building 1, which is the primary building containing patient care services, and Building 4, which provides support services for Building 1, together comprise approximately 80% of the building area on the campus. Buildings 1 and 4 were built in 1939 and renovated in 1993 and 1987 respectively. Several buildings are eligible for inclusion on the National Register of Historic Places, but none are listed in the Register. Figure 1 presents a site plan for the Montgomery campus. A list of the buildings on campus, their size, and function are presented in Table 3.

The conditions of buildings and components of buildings vary widely throughout the Montgomery campus. The exterior walls and roofs of Buildings 1 and 4 are in average to poor condition. Mechanical systems within Building 1 are in very poor condition, requiring immediate attention. While the cooling towers were replaced in 2001, all other components of the mechanical system require upgrades. The majority of plumbing and mechanical piping systems within Building 1 are in poor to failing condition, requiring upgrades. Electrical systems within Building 1 are in average to poor condition, and in conjunction with mechanical system

[7] *Ibid.*

replacement, should be upgraded at the same time. Elevators within Building 1 are in poor condition and require upgrades.

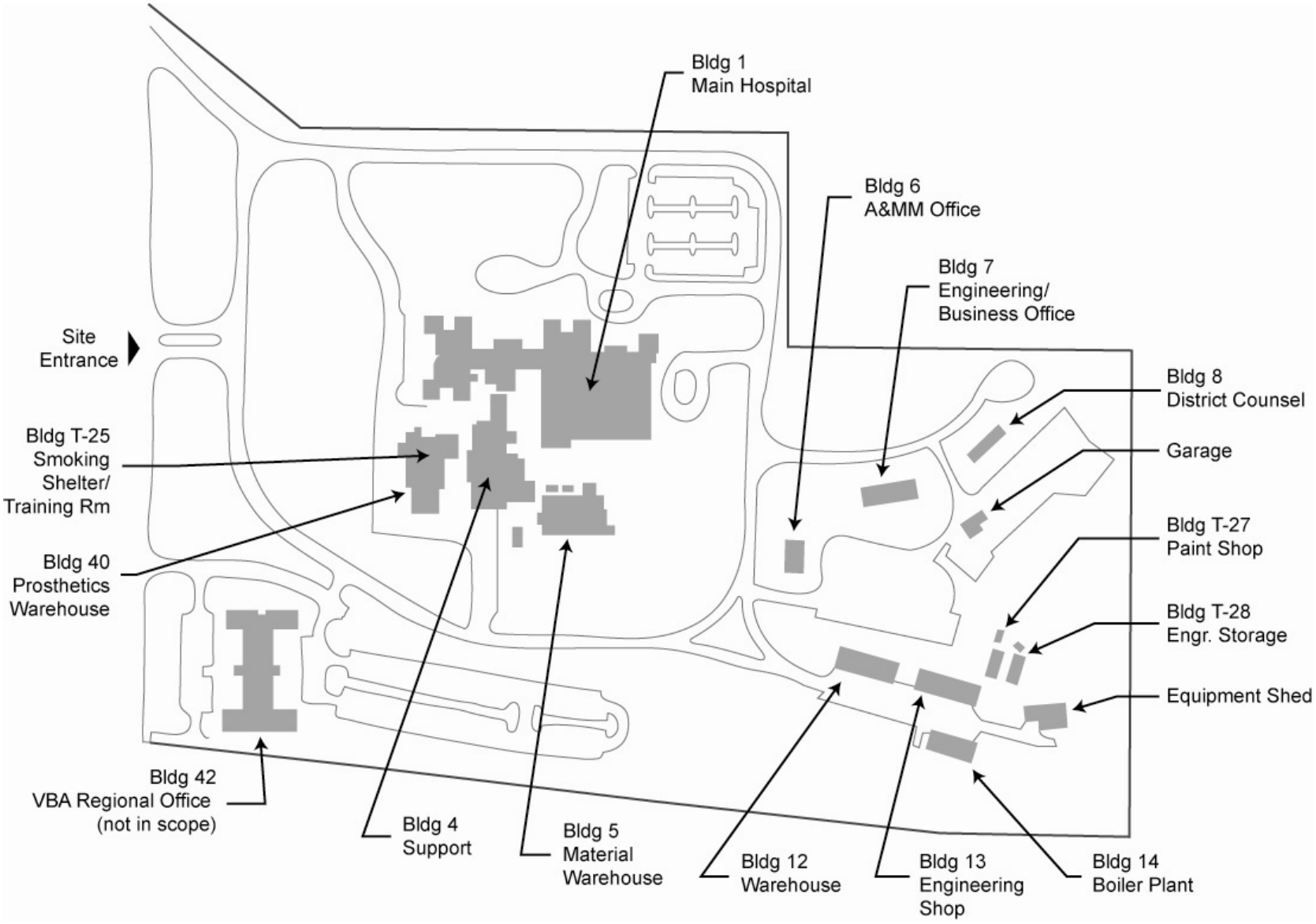
Vehicular access and surface parking are distributed throughout the site, with all patients and visitors entering from the northeast side of the campus. VA has negotiated with the adjacent middle school on the north side of the property to provide overflow parking.

The Veterans Benefit Administration (VBA) Regional Office is located on the southwest corner of the site.

Table 3: Existing Departmental Distribution by Building

Building	Floor	Function	Sq. Ft.
Building 1	Ground	Primary, Specialty & Urgent Care, Radiology, Dental, Pharmacy, Nuclear Medicine, Pathology, Medical Admin, Canteen	34,948
	First	Audiology, Pathology, Pharmacy, Rehab Medicine, Education	46,644
	Second	Inpatient Surgical, Medical Intensive & Surgical Intensive Care, 23 Hour Observation/Care, Pulmonary/Respiratory Care, Surgical Program	42,370
	Third	Inpatient Medical Care, Specialty Care, Eye Clinic	24,800
	Fourth	Primary Care, Hoptel/Respite Care, Mental Health Clinic	19,125
	Fifth	Specialty Care (Diabetic Clinic)	2,107
Building 4	Ground	IRM, Environmental Mgmt, Engineering Svc, Linen, Freezers	9,161
	First	IRM, Nutrition/Food, Education Program, Medical Admin	14,784
Building 5		Warehouse	7,000
Building 6		A&MM Admin	6,804
Building 7		Admin/Engineering Admin	11,281
Building 8		Admin	5,800
Building 12		Warehouse	5,500
Building 13		Engineering Shops	5,000
Building 14		Boiler Plant	4,712
Building 20		Engineering Lockshop	216
Building 21		Engineering Storage	360
Building 37		High Voltage Building	0
Building 40		Prosthetics	6,003
Building 44		Incinerator	1,000
Bldg 25T		General Storage	3,900
Bldg 27T		Paint Shop	1,120
Bldg 28T		Engineering Storage	1,120
Bldg 35T		Storage	1,800

Figure 1: Site Plan - CAVHCS Montgomery Division



Current and Forecast Investment Requirements

Moderate capital investments are required to correct building deficiencies identified by VA for CAVHCS, Montgomery Division. As of February 2003, VA's Facility Condition Assessment Database indicates that costs to correct deficiencies will total $18.6 million. Of this amount, $12.9 million is allocated to air handling equipment and $1.3 million for upgrades to lighting and power in the main hospital building.

Summary of Current Surplus / Vacant Space

VA's Capital Asset Inventory (CAI) database indicates that there is currently 22,038 square feet of vacant building space (7% of total building square footage) on the Montgomery campus.

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 Montgomery facility. The following section describes these long-term trends for veteran enrollment and utilization for healthcare services at CAVHCS, Montgomery Division.

Enrollment Trends

CAVHCS, Montgomery Division is located in the Alabama market of VISN 7. The Alabama market contains approximately 123,000 enrolled veterans. The number of enrolled veterans for the Alabama market is expected to decline 1% from 123,000, to approximately 121,000 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 increase by 15% by 2023, while enrollment for Priority 7 - 8 veterans is projected to decrease by 55% for the same period (see Table 4). The enrollment forecast for Priority 7-8 veterans assumes an annual enrollment fee, and the continued freeze on P8 enrollment.

Table 4: Projected Veteran Enrollment for the Alabama Market by Priority Group

Fiscal Year	Enrolled 2003	Projected 2013	% Change (2003 to 2013)	Projected 2023	% Change (2003 to 2023)
Priority 1-6	93,565	113,381	21%	107,678	15%
Priority 7-8	29,222	14,213	-51%	13,278	-55%
Total	**122,787**	**127,594**	**4%**	**120,956**	**-1%**

Utilization Trends

Utilization was analyzed for those CARES Implementation Categories (CICs) for which CAVHCS, Montgomery Division 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 5, inpatient bed need is projected to decrease by 23% by 2023, yet outpatient clinic stops (including radiology and pathology) are expected to increase by 21% over the same time horizon.

Table 5: Inpatient and Outpatient Utilization Summary

Montgomery	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Total Inpatient Beds	39	33	30	-15%	-9%	-23%
Total Clinic Stops[8]	209,378	249,668	254,039	19%	2%	21%

Demand for inpatient services varies by CIC (see Table 6). The demand for medicine/observation beds decreases by 25% to 24 beds, while the demand for surgery beds decreases by two beds over the projected period. Psychiatry and substance abuse remains relatively constant through 2023, with only an increase from two to three beds.

Table 6: Projected Utilization for Inpatient CICs for CAVHCS, Montgomery Division

CIC	2003 Actual Beds	2013 Beds Needed	2023 Beds Needed	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Medicine & Observation	32	27	24	-16%	-11%	-25%
Psychiatry & Substance Abuse	2	3	3	50%	0%	50%
Surgery	5	3	3	-40%	0%	-40%
Total	**39**	**33**	**30**	**-15%**	**-9%**	**-23%**

The majority of the increase in ambulatory utilization (not including radiology and pathology) is due to primary care (see Table 7). In contrast to the decrease in demand for inpatient services, the demand for ambulatory health services (with the exception of eye clinic, orthopedics, and rehab medicine) increases over the 20-year period, with a spike in demand for primary care services in the interim. Other services expected to experience significant increases in demand, particularly through 2013, include cardiology and non-surgical specialties. Demand for urology services has the largest increase over the 20-year period (275%).

[8] Total clinic stop volume includes Radiology and Pathology data.

Table 7: Projected Utilization for Ambulatory CICs for CAVHCS, Montgomery Division

CIC	2003 Actual Stops	2013 Projected Stops	2023 Projected Stops	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Cardiology	6,264	8,668	8,584	38%	-1%	37%
Eye Clinic	6,621	6,128	6,368	-7%	4%	-4%
Non-Surgical Specialties	14,402	17,449	17,689	21%	1%	23%
Orthopedics	5,889	5,592	5,693	-5%	2%	-3%
Primary Care & Related Specialties	48,933	59,059	56,291	21%	-5%	15%
Rehab Medicine	20,637	20,637	20,637	0%	0%	0%
Surgical & Related Specialties	15,612	16,373	16,090	5%	-2%	3%
Urology	2,335	8,135	8,747	248%	8%	275%
Total	**120,693**	**142,041**	**140,099**	**18%**	**-1%**	**16%**

Demand for behavioral health services increases by 46% over the 20-year projected period, while community mental health residential care declines from 590 clinic stops to 308 clinic stops during the same period. The majority, if not all of MHCIM care is likely provided at the CAVHCS, Tuskegee campus.

Table 8: Projected Utilization for Outpatient Mental Health CICs for CAVHCS, Montgomery Division

CIC	2003 Actual Stops	2013 Projected Stops	2023 Projected Stops	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Behavioral Health	7,684	10,569	11,196	38%	6%	46%
Community MH Residential Care	590	443	308	-25%	-30%	-48%
Mental Health Intensive Case Management (MHICM)	954	0	0	-100%	N/A	-100%
Total	**9,228**	**11,012**	**11,504**	**19%**	**4%**	**25%**

In summary, the analysis of the projected enrollment and utilization data highlights several opportunities and challenges for CAVHCS, Montgomery Division. The projected decrease in inpatient utilization coupled with an increase in ambulatory utilization supports the exploration of transitioning CAVHCS, Montgomery Division to an outpatient facility, as suggested by the Secretary's Decision Document, May 2004. This would present an opportunity to better address the market need for ambulatory services such as cardiology, primary care, non-surgical specialties, urology, and behavioral health.

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. CAVHCS, Montgomery Division currently does not have enough space to accommodate the utilization for inpatient and ambulatory services projected through 2023. BPOs will consider

current clinical inventory and the impacts of changes in demand on the space requirements for these services.

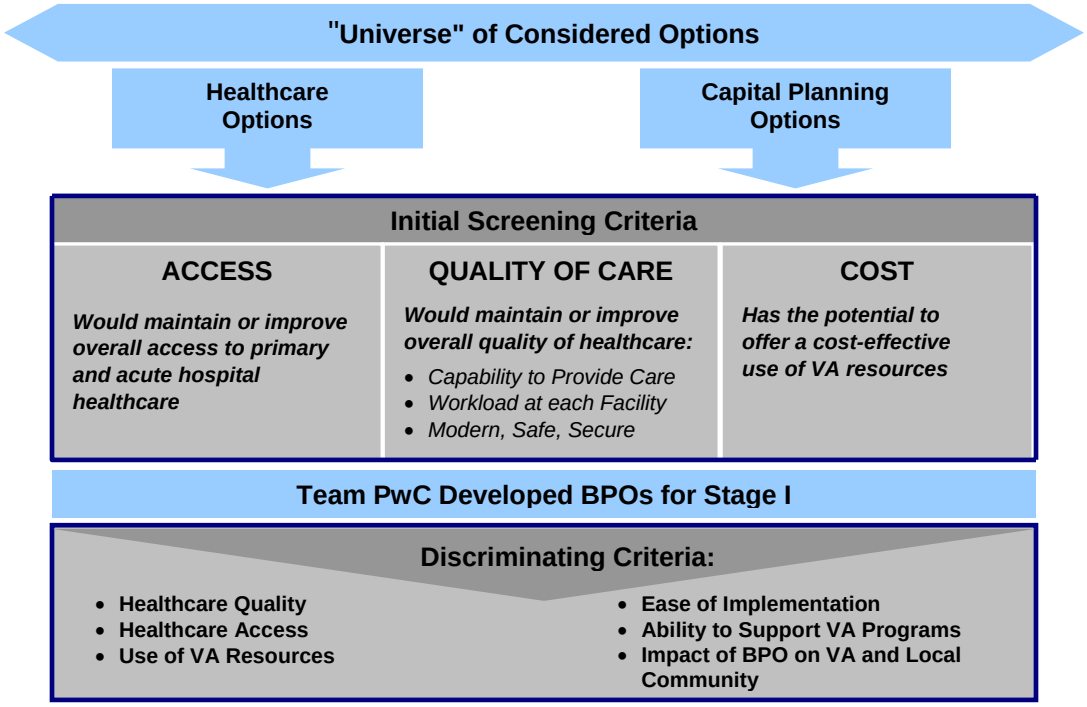
5.0 Business Plan Option Development Approach

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. 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 and capital planners 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 2: Options Development Process



Initial Screening Criteria

Discrete healthcare and capital planning options were developed for CAVHCS, Montgomery Division 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*[9] *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

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

provide a cost effective physical and operational configuration of VA resources as compared to the baseline[10] 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.

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.
- **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 relative to the baseline based on results of initial capital planning estimates.
  - 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.

[10] 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.

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

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

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

Operational Costs

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

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

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

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

- Total Fixed Direct Cost: The costs of direct patient care that do not vary in direct proportion to the volume of patient activity. The word "fixed" does not mean that the costs do not fluctuate, but rather that they do not fluctuate in direct response to workload

changes. Examples include depreciation of medical equipment and salaries of administrative positions in clinical areas.

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

FY 2004 operating costs from DSS were deflated to FY 2003 dollars to create the costs for FY 2003 which is the base date for current cost comparison. These costs (fixed and variable) were then inflated for each year of the study period. Variable costs were multiplied by the forecasted workload for each CIC and summed to 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.

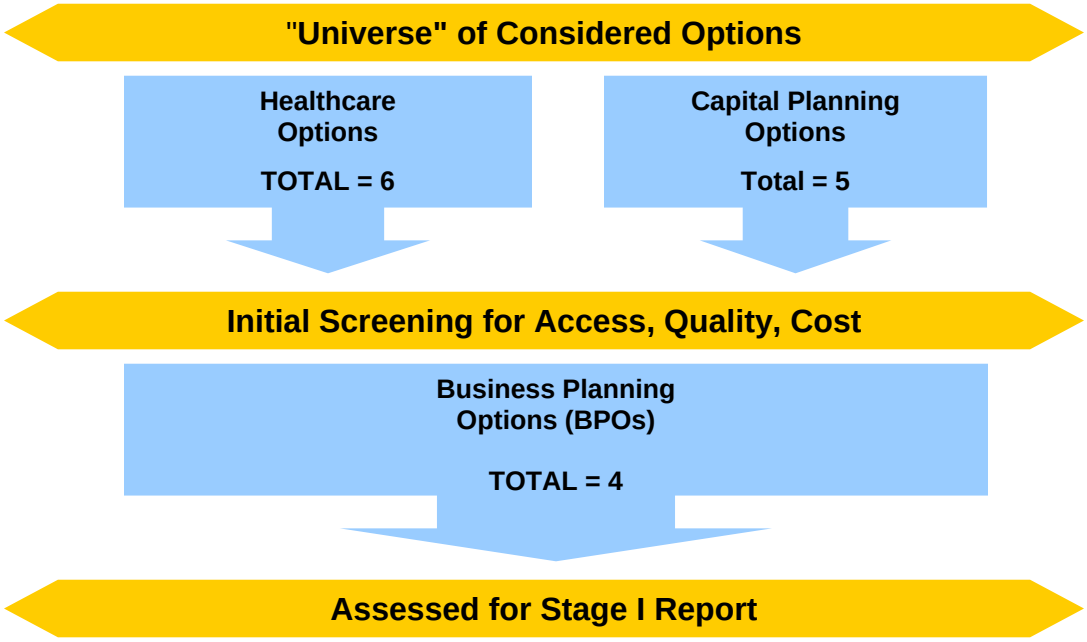
Summary of Business Plan Options

The individual healthcare and capital planning 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. Therefore, the formula for a BPO is:

BPO = Healthcare option + Capital Planning option(s)

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

Figure 3: Final Screening Results of Alternate 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 9 below details the results of the initial screening and the reasons why these options were not selected.

Table 9: Options Not Selected for Assessment

Label	Description	Screening Results
Transfer inpatient services and ambulatory surgery services to Atlanta VAMC	Inpatient medical and surgical services to be provided at Atlanta VAMC. All ambulatory surgery services to be provided at Atlanta VAMC. Existing outpatient services remain at CAVHCS, Montgomery Division	Failed drive time guidelines for acute care.
Transfer inpatient services and ambulatory surgery to Birmingham VAMC	Inpatient medical and surgical services to be provided at Atlanta VAMC. All ambulatory surgery services to be provided at Birmingham VAMC. Existing outpatient services remain at CAVHCS, Montgomery Division	Failed drive time guidelines for acute care.

Label	Description	Screening Results
Renovation to accommodate existing services for non-surgical ambulatory services	Expand existing facility to accommodate increased non-surgical ambulatory utilization projected for year 2023	A replacement option was selected instead of this renovate option; it provided far greater cost efficiency potential.

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.

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 10: 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 compared to 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 compared to 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 compared to the baseline BPO (>5%)
↓↓	The BPO has the potential to require slightly higher operating costs compared to the baseline BPO (>10%)
↓↓↓	The BPO has the potential to require slightly higher operating costs compared to the baseline BPO (>15%)
Level of capital expenditure estimated	
↓↓↓↓	Very significant investment required compared to the baseline BPO **(≥ 200%)**
↓↓	Significant investment required compared to the baseline BPO **(121% to 199%)**
-	Similar level of investment required compared to the baseline BPO **(80% to 120% of Baseline)**
↑↑	Reduced level of investment required compared to the baseline BPO **(40%-80%)**
↑↑↑↑	Almost no investment required **(≤ 39%)**
Cost avoidance (based on comparison to baseline BPO)	
-	No cost avoidance opportunity
↑↑	Significant savings in necessary capital investment compared to the baseline BPO
↑↑↑↑	Very significant savings in essential capital investment compared the baseline BPO
Overall cost effectiveness (based on initial net present cost calculations)	
↓↓↓↓	Very significantly higher net present cost compared to the baseline BPO (>1.15 times)
↓↓	Significantly higher net present cost compared to the baseline BPO (1.10 – 1.15 times)
↓	Higher net present cost compared to the baseline BPO (1.05 – 1.09 times)
-	Similar level of net present cost compared to the baseline (+/- 5% of baseline)

↑	Lower net present cost compared to the baseline (90-95% of Baseline)
↑↑	Significantly lower net present cost compared to the baseline BPO (85-90% of baseline)
↑↑↑↑	Very significantly lower net present cost compared to the baseline BPO (<85% of baseline)
Ease of Implementation of the BPO	
↑	The BPO has the potential to provide a slightly improved state compared to the baseline BPO based upon the level of impact and likelihood of occurrence of risks to its implementation plan.
↔	The BPO has the potential to provide materially the same state as the baseline based upon the level of impact and likelihood of occurrence of risks to its implementation plan.
↓	The BPO has the potential to provide a slightly lower or reduced state compared to the baseline BPO based upon the level of impact and likelihood of occurrence of risks to its implementation plan.
Overall "Attractiveness" of the BPO compared to the baseline	
↑↑↑↑	Very "attractive" – highly likely to offer a solution that improves quality and/or access compared to the baseline while appearing significantly more cost effective than the baseline
↑↑	"Attractive" - likely to offer a solution that at least maintains quality and access compared to the baseline while appearing more cost effective than the baseline
-	Generally similar to the baseline
↓↓	Less "attractive" than the baseline - likely to offer a solution that while maintaining quality and access compared to the baseline appears less cost effective 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 LAP 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 with a brief description of the BPOs and asked to indicate whether they favored the option, were neutral about the option, or did not favor the option. Ten days after the second LAP meeting was held, Team PwC summarized all of the stakeholder views that were received during Input Period Two (Input Period One had been previously summarized), and this information is included in this report.

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

Table 11: 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.

Stakeholder Input to Business Plan Option Development

Approximately 100 members of the public attended the first LAP meeting held on May 4, 2005 as well as the second LAP meeting held on September 1, 2005. A total of 163 forms of stakeholder input (general comments on the study as well as specific BPOs) were received between April 20 and September 11, 2005. The concerns of stakeholders who submitted general comments not related to specific BPOs are summarized in the following table:

Table 12: Analysis of General Stakeholder Concerns (Periods One and Two)

Key Concern	Number of Comments		
	Oral	Written and Electronic	**Total**
Effect on Access	3	6	**9**
Maintain Current Service/ Facility	9	17	**26**
Support for Veterans	13	18	**31**
Effect on Healthcare Services and Providers	13	12	**25**
Effect on Local Economy	0	1	**1**
Use of Facility	5	9	**14**
Effect on Research and Education	0	2	**2**
Administration's Budget or Policies	7	3	**10**
Unrelated to the Study Objectives	7	11	**18**

6.0 Business Plan Options

The option development process resulted in a multitude of discrete healthcare and capital planning 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 four BPOs (comprising healthcare and capital components) which passed initial screening and were developed for Stage I (see Figure 3).

Each BPO was assessed at a more detailed level according to the discriminating criteria. The BPOs reflect options related to provision of inpatient services, or inpatient services and ambulatory surgical services through local community providers (see Table 13).

Three additional BPOs (BPOs 6, 7, and 8) were proposed by the LAP at the second LAP Public Meeting. Two of these BPOs retain all services at CAVHCS, Montgomery Division, while the third proposes that some inpatient surgical services be provided by local community providers.

Table13: 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 and upgrades for a safe, secure, and modern healthcare environment. Any demand that cannot be accommodated in the existing space will be contracted out to local community providers. Some non-hazardous, but less than ideal existing conditions will be "grandfathered" and not updated.
BPO 2: Contract with Local Community Providers – Inpatient Surgery & Ambulatory Surgery; Renovation for Inpatient Medicine; Construction for Ambulatory Care Facility
Inpatient surgery services, as well as ambulatory surgery, to be provided by local community providers. All other services remain at current location of provision. Construct new space for Ambulatory Care and renovate vacated areas previously occupied by surgical related services. Construct new parking deck to accommodate increased parking demand.
BPO 3: Contract with Local Community Providers – Inpatient Medicine & Surgery; Ambulatory Surgery Remains; Renovation for Ambulatory Care
Inpatient medicine and surgery services to be provided by local community providers. Ambulatory surgery and all other ambulatory services remain at current location of provision. Renovate the existing inpatient areas of Building 1 and other mothballed space to accommodate increased ambulatory utilization. Construct new parking area to accommodate increased parking demand.
BPO 4: Contract with Local Community Providers – Inpatient Medicine & Surgery, Ambulatory Surgery; Build New Facility for Ambulatory Care; Demolish all Facilities
Inpatient medicine and surgery services, as well as ambulatory surgery, to be provided by local community providers. All other services remain at current location of provision. Construct a new Ambulatory Care facility on the Perry Hill Campus, consolidating functions contained throughout the site into one building. Demolish the existing facility. Construct new parking deck to accommodate increased parking demand.
BPO 5: Contract with Local Community Providers – Inpatient Medicine & Surgery, Expand Ambulatory Surgery Services to Maxwell Air Force Base Through Service Sharing Agreement; Renovation for Ambulatory Care
Inpatient medicine and surgery services to be provided by local community providers. Ambulatory surgery services provided to Maxwell Air Force Base beneficiaries at CAVHCS, Montgomery Division. Renovate the existing inpatient areas of Building 1 and other mothballed space to accommodate increased ambulatory utilization. Construct new parking area to accommodate increased parking demand.
BPO 6: Baseline + Additional Inpatient Beds to Accommodate Projections Utilized by the LAP[11]
Inpatient medicine and surgery services to remain at CAVHCS, Montgomery Division. Existing ambulatory and outpatient mental health services would continue to be provided at CAVHCS, Montgomery Division. Expand inpatient capacity to accommodate utilization projections utilized by the LAP. Conduct normal maintenance and upgrades necessary to provide a modern, safe, and secure environment for healthcare. Some non-hazardous, but less than ideal existing conditions will be "grandfathered" and not updated.
BPO 7: Baseline + Renovation for Inpatient Care; Construction of New Ambulatory Facility; Demolition of Outlying Facilities
All services currently provided at CAVHCS, Montgomery Division remain. Construct a new Ambulatory Care facility on the Perry Hill Campus, consolidating functions contained throughout the site into one building. Demolish the outlying facilities. Remodel the existing structure for inpatient care.
BPO 8: Contract with Local Community Providers – Select Inpatient Surgery; Construction of New Ambulatory Facility; Renovation of Inpatient Areas
Inpatient medicine services and all ambulatory services currently provided at CAVHCS, Montgomery Division remain at the Montgomery campus. Some inpatient surgery services[12] to be provided by local community providers. Construct a new Ambulatory Care facility on the Perry Hill Campus, consolidating functions contained throughout the site into one building. Demolish the outlying facilities. Remodel the existing structure for inpatient care.

[11] LAP projected utilization used to develop this BPO was not provided to Team PwC. Team PwC developed and evaluated BPOs using the utilization data approved by VA.

[12] Specific surgical services were not identified by the LAP during the development of this BPO.

Assessment Drivers

Over the next 20 years, the number of enrolled veterans for the Alabama market is expected to decline 1% from approximately 123,000 to approximately 121,000. Enrollment of Priority 1-6 veterans (those veterans with the greatest service-connected needs) is projected to increase by 15% by 2023, while enrollment for Priority 7-8 veterans is projected to decrease by 55% for the same period.

These long-term healthcare trends for the Alabama market, together with three assessment drivers were considered for the Montgomery study site. These drivers represent factors particularly noticeable at the CAVHCS, Montgomery Division that must be balanced in the development and evaluation of business plan options. They are:

1). Inpatient bed need is projected to decrease by 23%, yet outpatient clinic stops (including radiology and pathology) are expected to increase by 21% over the same time horizon.
2.) The existing conditions of the facilities are poor and require investment to meet modern, safe, and secure standards.
3). CAVHCS, Montgomery Division is engaged in a joint venture with MAFB and has the potential to engage in further DoD sharing agreements.

These three drivers are described further below.

Projected Utilization - The projected utilization for CAVCHS, Montgomery Division varies among CICs during the projection period. Inpatient bed need is projected to decrease by 23%, yet outpatient clinic stops (including radiology and pathology) are expected to increase by 21% over the same time horizon. The current facilities cannot accommodate this projected increase in ambulatory utilization. Thus, the projected decrease in inpatient utilization coupled with an increase in ambulatory utilization supports the exploration of transitioning CAVHCS, Montgomery Division to an outpatient facility, as suggested by the Secretary's Decision Document, May 2004. This presents an opportunity to better address the market need for ambulatory services such as cardiology, primary care, non-surgical specialties, urology, and behavioral health.

Cost Effectiveness - The facility's systems are generally in poor condition, inefficient to maintain, and require capital investment to upgrade in the baseline. The exterior walls and roofs of Buildings 1 and 4 are reported as being in average to poor condition. Mechanical and plumbing systems within Building 1 are reported as being in very poor condition, requiring immediate attention. Electrical systems within Building 1 are reported as being in average to poor condition, and in conjunction with mechanical system replacement, should be upgraded at the same time. The need to upgrade facilities, and the associated cost implications, should be considered in the evaluation of BPOs.

Wider Program Support – The outpatient podiatry service was relocated to MAFB in 2004 as part of a broad agreement to share services and facilities between CAVHCS, Montgomery Division and MAFB. The podiatry clinic represents the first implementation of the MOU between MAFB and CAVHCS, Montgomery Division. Additional joint sharing initiatives are being investigated, including those for urgent care, audiology, mammography, women's health, and rheumatology. Colonel Bart O. Iddins, the Commander of the 42nd Medical Group at MAFB, submitted a letter expressing their positive view of their current partnering arrangement and their openness to expand those arrangements. MAFB does have ambulatory surgery space, however, this space has been mothballed and thus, ambulatory surgery cases are currently being provided to Maxwell beneficiaries by local community providers. This creates an opportunity for VA and MAFB to collaborate in providing ambulatory surgery services. The impact of BPOs on these service sharing arrangements and the potential to expand this relationship should be considered in the evaluation of BPOs.

Assessment Results

The following tables (14 and 15) detail the results of applying discriminating criteria and comparison against the baseline in accordance with the Evaluation System for BPOs (Table 10).

Table 14: Baseline Assessment

Assessment Summary	Baseline
Healthcare Access	
Primary	62.8% of enrollees are within the drive time guidelines. The primary care access drive time threshold is 70%; therefore, CAVHCS, Montgomery Division does not meet drive time access guideline for primary care.
Acute	55% of enrollees are within the drive time guidelines. The acute care access drive time threshold is 65%; therefore, CAVHCS, Montgomery Division does not meet drive time access guidelines for acute care.
Tertiary	100% of enrollees are within the drive time guideline. The tertiary care access drive time threshold is 65%; therefore, CAVHCS, Montgomery Division meets the drive time access guideline for tertiary care.
Healthcare Quality	
Quality of medical services	Achieved, higher selected quality scores for inpatient and ambulatory care as compared to both the VISN and overall national scores. Achieved the same or lower quality scores for behavioral health, mental health, and patient satisfaction. The baseline has the potential to provide materially the same level of quality as is currently provided and assessed using these select quality measures.
Modern, safe, and secure environment	The conditions of buildings on the Montgomery campus vary. The majority of buildings have ratings between 3.0 and 3.8 for critical values such as accessibility, code, functional space, and facility conditions. With renovation, the baseline conforms to current industry standards and code requirements for healthcare environments, and allows exception for non-hazardous existing conditions which were code compliant at the time of their construction. In addition, there are some non-hazardous violations of the Federal Uniform Accessibility Standards related to handicap accessibility issues.
Ensures forecast	Assumes that in order to maintain quality of care and meet VA thresholds for

Assessment Summary	Baseline
healthcare need is appropriately met	clinical volume, 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 an increase of approximately 7% in the number of FTEEs needed.
Recruitment / retention	CAVHCS, Montgomery Division is located in a highly competitive market and this impacts its ability to recruit and retain highly competitive positions. Generally, it takes six months to recruit and place physicians. 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	CAVHCS, Montgomery Division trains 17 residents, who primarily support the inpatient services. The site also trains 250 allied health professionals annually. Affiliation agreements exist with the following schools: Morehouse School of Medicine, Alabama State University, and Auburn University.
Use of VA Resources	
Operating cost effectiveness	CAVHCS, Montgomery Division's operating costs include those costs associated with providing care onsite at the Montgomery facility, as well as purchasing care for any specialty services provided by local community providers. Many building systems (including mechanical and electrical) are reported in poor condition, however, renovations to these systems should improve the operating efficiency of the facilities. Therefore, baseline cost effectiveness may be expected to be slightly better than current operating cost effectiveness.
Level of capital expenditures estimated	Current facilities conditions vary, however, most mechanical, electrical, and elevator systems are in poor condition. Thus, capital expenditure is required to upgrade facilities to meet modern, safe, and secure standards
Cost avoidance	In the baseline, it is assumed that the $18.6 million identified in the CAI database identified by the facility as essential maintenance would be fully expended.
Overall cost effectiveness	Not applicable for the baseline.
Ease of Implementation	
Ease of BPO implementation	The risk factor for implementation is low since the baseline represents the current state with improvements to meet modern, safe, and secure standards and meet projected demand projections. The baseline option presents implementation risk in terms of the following major risk areas: 1. Continuity of care, since heavy renovations may disrupt provision of care to patients and utilization will exceed the capacity of the baseline facility 2. Infrastructure, given facilities may unveil unforeseen environmental, systematic, or structural issues during renovation, and existing space used for acute care is not ideal for providing these services 3. Project realization, since renovations present exposure to delays, budget variance, and transition complications.

Assessment Summary	Baseline
Ability to Support VA Programs	
DoD sharing	CAVHCS, Montgomery Division is presently involved in active planning with DoD facilities in its service area including the 42nd Medical Group, Maxwell Air Force Base (MAFB), Lyster Army Hospital, Fort Rucker, and Martin Army Hospital, Fort Benning, GA. A joint venture with CAVHCS and MAFB in podiatry has been implemented that provides needed services to DoD beneficiaries and provides larger and more efficient space and equipment for the podiatry residency program in the MAFB ambulatory facility. Additional joint sharing initiatives are being investigated, including those for urgent care, audiology, mammography, women's health, and rheumatology. The baseline does not impact this arrangement or any future collaboration between VA and DoD. Some healthcare delivery space at MAFB, including the ambulatory surgery suite, has been mothballed and is not currently being used. Therefore, MAFB beneficiaries are receiving ambulatory services from the local community.
One-VA Integration	There is a VBA office co-located at the CAVHS, Montgomery Division site. The baseline does not affect this arrangement and thus has the potential to provide materially the same level of One-VA integration.
Special Considerations	The collaboration between DoD and CAVHCS, Montgomery Division allows for effective cooperation in response to National Emergency Management needs.

Table 15 provides an overall summary of the BPOs assessed for comparative purposes.

Table 15: BPO Assessment Summary[13]

Assessment Summary	BPO 2	BPO 3	BPO 4	BPO 5
	Contract with Local Community Providers – Inpatient Surgery & Ambulatory Surgery; Renovation for Inpatient Medicine; Construction for Ambulatory Care Facility	Contract with Local Community Providers – Inpatient Medicine & Surgery; Ambulatory Surgery Remains; Renovation for Ambulatory Care	Contract with Local Community Providers – Inpatient Medicine & Surgery, Ambulatory Surgery; Build New Facility for Ambulatory Care; Demolish all Facilities	Contract with Local Community Providers – Inpatient Medicine & Surgery; Expand Ambulatory Surgery Services to Maxwell Air Force Base Through Service Sharing Agreement; Renovation for Ambulatory Care
Health Care Access				
Primary	↔	↔	↔	↔
Acute	↔	↔	↔	↔
Tertiary	↔	↔	↔	↔
Healthcare Quality				
Quality of medical services	↔	↔	↔	↔
Modern, safe, and secure environment	↑	↔	↑	↔
Ensures forecast healthcare need is appropriately met	↔	↔	↔	↔
Impact on VA and Local Community				
Human Resources: FTEE need (based on volume)	Decrease	Decrease	Decrease	Decrease
Recruitment / retention	↓	↓	↓	↓
Research	↔	↔	↔	↔
Education and Academic Affiliations	↓	↓	↓	↓
Cost Effectiveness				
Operating cost effectiveness	-	-	↑	-
Level of capital expenditures estimated	-	-	↓↓	-
Cost avoidance	-	-	-	-
Overall cost effectiveness	-	-	↑	-
Ease of Implementation				
Ease of BPO implementation	↓	↓	↑	↓
Wider VA Program Support				
DoD sharing	↔	↔	↔	↑
One-VA Integration	↓	↓	↓	↓
Special Considerations	↓	↓	↓	↓
Overall Attractiveness	↑↑	-	↑↑↑↑	-

[13] BPOs 6, 7, and 8 are not included in the Assessment Summary Table. They were created during the second LAP meeting at the suggestion of the LAP and, therefore, only the initial screening criteria of access, quality, and cost were applied to determine if the BPOs have the potential to meet or exceed the CARES objectives. If BPO 6, 7, or 8 is selected for Stage II, a more detailed analysis will be completed.

BPO 6: Baseline + Additional Inpatient Beds to Accommodate Projections Utilized by the LAP

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. The results of the application of these initial screening criteria are summarized in Table 16.

Table 16: Screening Results for BPO 6

Criteria	BPO 6 Screening Result
Access	Since all services will remain at CAVHCS, Montgomery Division, this BPO will provide the same level of access as the baseline.
Quality	Quality will be comparable to baseline since the renovation of space will improve the facility standards of modern, safe, and secure as is also expected with the renovations in the baseline.
Cost	The overall effectiveness is expected to be comparable to the baseline. Some capital investment will be required to upgrade facilities to a modern, safe, and secure environment. Operating renovated or newly constructed facilities is typically more cost-effective.

BPO 7: Baseline + Renovation for Inpatient Care; Construction of New Ambulatory Facility; Demolition of Outlying Facilities

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. The results of the application of these initial screening criteria are summarized in Table 17.

Table 17: Screening Results for BPO 7

Criteria	BPO 7 Screening Result
Access	Since all services will remain at CAVHCS, Montgomery Division, this BPO will provide the same level of access as the baseline.
Quality	New construction allows for facilities to meet all modern, safe, and secure standards. With renovation, the baseline conforms to current industry standards and code requirements for healthcare environments, but allows exception for non-hazardous existing conditions which were code compliant at the time of their construction. Thus, new construction would provide an improvement in quality over the baseline, but BPOs involving just renovation would not.
Cost	The overall effectiveness is expected to be comparable to the baseline. Some capital investment will be required to upgrade facilities to a modern, safe, and secure environment. Operating renovated or newly constructed facilities is typically more cost-effective.

BPO 8: Local Community Providers – Select Inpatient Surgery; Construction of New Ambulatory Facility; Renovation of Inpatient Areas

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. The results of the application of these initial screening criteria are summarized in Table 18.

Table 18: Screening Results for BPO 8

Criteria	BPO 8 Screening Result
Access	Since almost all services will remain at CAVHCS, Montgomery Division, this BPO will provide the same level of access as the baseline.
Quality	New construction allows for facilities to meet all modern, safe, and secure standards. With renovation, the baseline conforms to current industry standards and code requirements for healthcare environments, but allows exception for non-hazardous existing conditions which were code compliant at the time of their construction. Thus, new construction would provide an improvement in quality over the baseline, but BPOs involving just renovation would not.
Cost	The overall effectiveness is expected to be comparable to the baseline. Some capital investment will be required to upgrade facilities to a modern, safe, and secure environment. Operating renovated or newly constructed facilities is typically more cost-effective.

Local Advisory Panel and Stakeholder Reactions/Concerns

Local Advisory Panel Feedback

The Montgomery LAP consists of six members: Linda F. Watson (Chair), Rao Chava, M.D., Barbara S. Witt, Frank D. Wilkes, Jeanne M. Charbonneau, and Xavier Lewis.

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 three new options, BPOs 6, 7, and 8. Table 19 presents the results of the LAP deliberations. BPOs that were not seconded did not move on to a formal vote (indicated by "n/a" in the table). BPOs 1, 6, 7, and 8 were recommended by the LAP for further study, while BPOs 2, 3, 4, and 5 were not.

Table 19: LAP BPO Voting Results

BPO	Label	Seconded	Yes	No
1, as amended	Baseline	Yes	5	0
2	Contract with Local Community Providers – Inpatient Surgery & Ambulatory Surgery; Renovation for Inpatient Medicine; Construction for Ambulatory Care Facility	No	n/a	n/a
3	Contract with Local Community Providers – Inpatient Medicine & Surgery; Ambulatory Surgery Remains; Renovation for Ambulatory Care	No	n/a	n/a
4	Contract with Local Community Providers – Inpatient Medicine & Surgery, Ambulatory Surgery; Build New Facility for Ambulatory Care; Demolish all Facilities	Yes	2	3
5	Contract with Local Community Providers – Inpatient Medicine & Surgery, Expand Ambulatory Surgery Services to Maxwell Air Force Base Through Service Sharing Agreement; Renovation for Ambulatory Care	Yes	2	3

BPO	Label	Seconded	Yes	No
6[14]	Baseline + Additional Inpatient Beds to Accommodate Projections Utilized by the LAP	Yes	4	1
7	Baseline + Renovation for Inpatient Care; Construction of New Ambulatory Facility; Demolition of Outlying Facilities	Yes	5	0
8	Local Community Providers – Select Inpatient Surgery; Construct New Ambulatory Facility; Renovate Inpatient Areas	Yes	5	0

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 4.

Stakeholders reviewed the BPOs before the second public LAP meeting and were overwhelmingly supportive of any BPO that kept services on site. There continued to be great dissatisfaction with the decision to move inpatient services. Given that BPOs 6, 7, and 8 emerged as a result of LAP deliberations, stakeholders did not have the opportunity to provide feedback specific to these options.

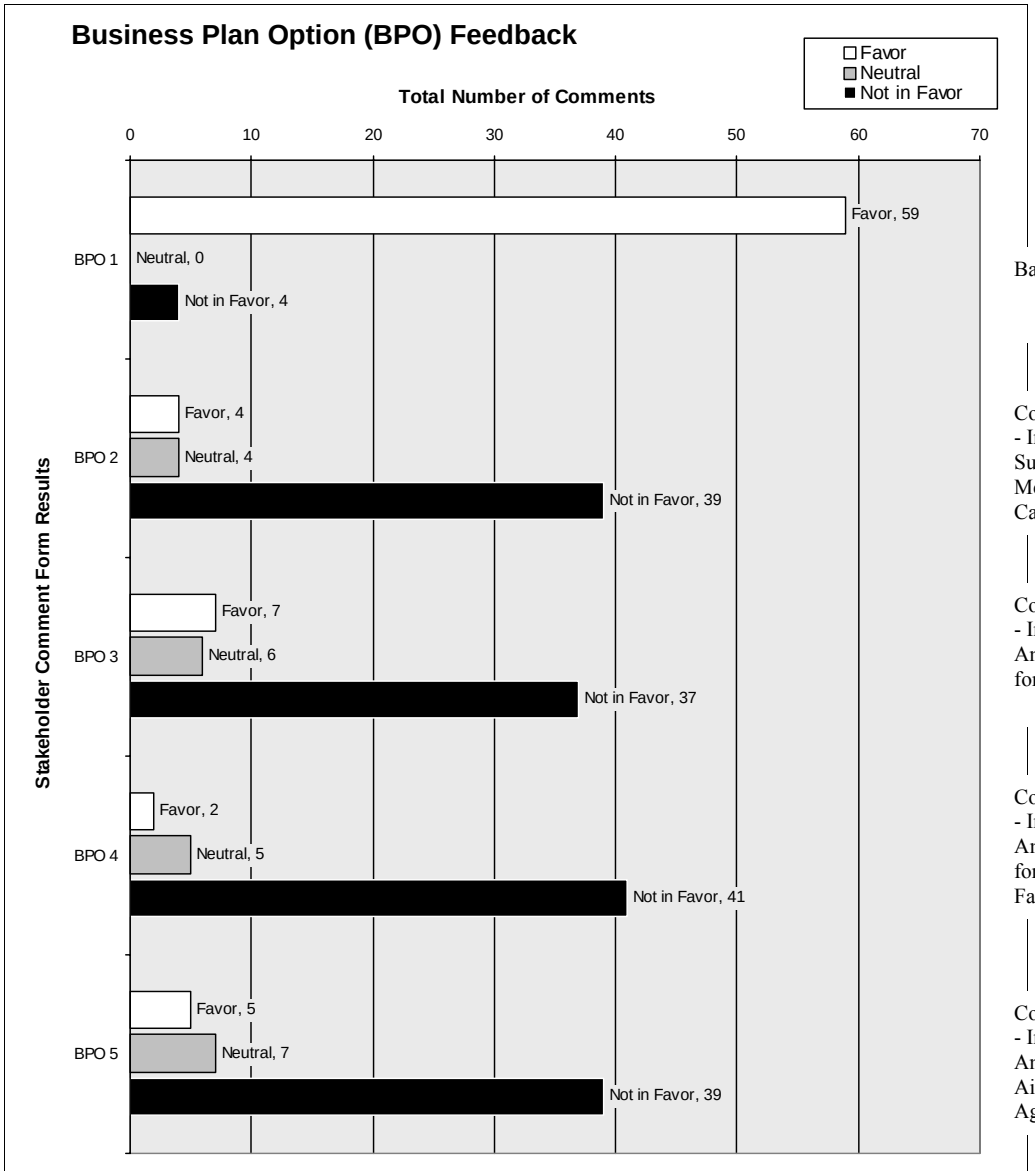
[14] BPOs 6 -8 are new BPOs proposed by LAP at second public LAP meeting held September 1, 2005.

Figure 4: Stakeholder Feedback on BPOs[15]

VA CARES BUSINESS PLAN STUDIES
STAKEHOLDER INPUT ANALYSIS REPORT
Montgomery Study Site

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

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



Baseline

Contract with Local Community Providers - Inpatient Surgery & Ambulatory Surgery; Renovation for Inpatient Medicine; Construction for Ambulatory Care Facility

Contract with Local Community Providers - Inpatient Medicine & Surgery; Ambulatory Surgery Remains; Renovation for Ambulatory Care

Contract with Local Community Providers - Inpatient Medicine & Surgery, Ambulatory Surgery; Build New Facility for Ambulatory Care; Demolish all Facilities

Contract with Local Community Providers - Inpatient Medicine & Surgery, Expand Ambulatory Surgery Services to Maxwell Air Force Base Through Service Sharing Agreement; Renovation for Ambulatory

[15] Stakeholder feedback is reflected in this chart only for the BPOs which were presented by Team PwC at the LAP meeting (BPOs 1-5), and not the ones created by the LAP at the second public LAP meeting. Any stakeholder feedback regarding additional options was captured in the open text boxes on the comment forms.

BPO Recommendations for Assessment in Stage II

Team PwC's recommendation of BPOs to be further assessed in Stage II was determined based on several factors. Team PwC considered the pros and cons of each option, together with the results of assessments against discriminating criteria to determine the overall attractiveness of each BPO. Views and opinions of the LAP and oral and written testimony received from veterans and other interested groups were also considered. All of these inputs contributed to the selection of the BPOs to be recommended for further study in Stage II, which are summarized in Table 19 with pros and cons identified for each option.

The BPOs recommended for further study share some key similarities. All of them would:

- Maintain drive time access to care;
- Maintain or improve quality of care; and
- Right-size the campus for future demand, and achieve modern, safe, and secure facilities through renovation, consolidation, or new construction.

The BPOs which Team PwC eliminated from further consideration were not recommended because they either were based on differing utilization projections from the approved data set (BPO 6) or were very similar to another BPO (BPO 8). Thus, it is expected that sufficient development and assessment of options can be accomplished through the BPOs recommended for further study.

Table 20: BPO Recommendations

BPO	Pros	Cons	Rationale
BPOs Recommended by Team PwC for Further Study			
BPO 1: Baseline	• Maintains integrated service capabilities with Tuskegee for medical and behavioral health services • Maintains quality of care – Montgomery CAVHCS scored higher than VISN and National VA on select quality indicators	• Investment needed to bring the facility up to modern, safe, and secure standards, and yet some non-hazardous violations will remain • Higher maintenance costs persist for older buildings	• The baseline is the BPO against which all other BPOs are assessed
BPO 2: Contract with Local Community Providers – Inpatient Surgery & Ambulatory Surgery; Renovation for Inpatient Medicine; Construction for Ambulatory Care Facility	• Requires similar capital expenditure as the baseline • New construction improves quality through increased adherence to the facility standards of modern, safe, and secure	• Recruitment and retention challenges exacerbated by reduction in service mix • Disrupts coordination of VBA services for beneficiaries receiving contracted services • Does not eliminate all inpatient services and thus does not comply with the Secretary's Decision	• Aligns service mix to accommodate projected increase in ambulatory and outpatient mental health care demand and projected decrease in inpatient surgery demand • Requires similar capital expenditure as the baseline and achieves modern, safe, and secure environment • New construction may provide for some operating efficiencies
BPO 3: Contract with Local Community Providers - Inpatient Medicine & Surgery; Renovation for Ambulatory Care	• Requires similar capital expenditure as the baseline	• Splitting inpatient medicine and ambulatory surgical services may disrupt continuity of care • Recruitment and retention challenges exacerbated by reduction in service mix • Eliminates inpatient health professional training programs • Disrupts coordination of VBA services for beneficiaries receiving contracted services	• Aligns service mix to accommodate projected increase in ambulatory and outpatient mental health care demand and projected decrease in inpatient medicine and surgery demand • Requires similar capital expenditure as the baseline and achieves a modern, safe, and secure environment
BPO 4: Contract with Local Community Providers - Inpatient Medicine & Surgery, Ambulatory Surgery; Build New Facility for Ambulatory Care; Demolish all Facilities	• New construction results in greater operating efficiencies and thus lower operating costs • New construction improves quality through increased adherence to the facility standards of modern, safe, and secure • Lower implementation risk compared to the baseline	• Requires more capital expenditure than the baseline • Eliminates inpatient health professional training programs • Recruitment and retention challenges exacerbated by reduction in service mix • Disrupts coordination of VBA services for beneficiaries receiving contracted services	• Aligns service mix to accommodate projected increase in ambulatory and outpatient mental health care demand and projected decrease in inpatient medicine, inpatient surgery, and ambulatory surgery demand • New construction may provide for greater operating efficiencies and thus lower operating costs • New construction improves quality by achieving a modern, safe, and secure environment
BPO 5: Contract with Local Community Providers - Inpatient Medicine & Surgery, Expand Ambulatory Surgery Services to Maxwell Air Force Base Through Service Sharing Agreement; Renovation for Ambulatory Care	• Requires similar capital expenditure as the baseline • Closer coordination with Maxwell Air Force Base provides a wider array of services and leverages existing service-sharing arrangements	• Splitting inpatient medicine and ambulatory surgical services may disrupt continuity of care • Eliminates inpatient health professional training program • Recruitment and retention challenges exacerbated by reduction in service mix • Disrupts coordination of VBA services for beneficiaries receiving contracted services	• Aligns service mix to accommodate projected increase in ambulatory and outpatient mental health care demand and projected decrease in inpatient medicine and surgery demand • Requires similar capital expenditure as the baseline and achieves a modern, safe, and secure environment • Expands DoD service-sharing with Maxwell Air Force Base

BPO	Pros	Cons	Rationale
BPO 7: Baseline + Renovation for Inpatient Care; Construction of New Ambulatory Facility; Demolition of Outlying Facilities	• New construction improves quality through increased adherence to the facility standards of modern, safe, and secure • Lower implementation risk compared to the baseline	• May require more capital expenditure as compared to the baseline • Does not eliminate all inpatient services and thus does not comply with the Secretary's Decision	• Maintains current array of services and accommodates projected increases in ambulatory care in a new facility • New construction may provide for greater operating efficiencies • Achieves modern, safe, and secure environment
BPOs Not Recommended by Team PwC for Further Study			
BPO 6: Baseline + Additional Beds to Accommodate Projections Utilized by the LAP	• Potentially expands service offerings	• May require more capital expenditure as compared to the baseline • Does not eliminate all inpatient services and thus does not comply with the Secretary's Decision	• Expands inpatient services which, according to the projected utilization, are expected to decline through 2023
BPO 8: Local Community Providers - Select Inpatient Surgery; Construction of New Ambulatory Facility; Renovation of Inpatient Areas	• New construction improves quality through increased adherence to the facility standards of modern, safe, and secure • Lower implementation risk compared to the baseline	• Splitting inpatient medicine and surgical services may disrupt continuity of care • Recruitment and retention challenges exacerbated by reduction in service mix • Although reduces some inpatient services, does not fully comply with the Secretary's Decision	• Deemed to be not significantly different than BPO 7

Appendix A - Assessment Tables

BPO 1: Baseline

Assessment Summary	Baseline
Healthcare Access	
Primary	62.8% of enrollees are within the drive time guidelines. The primary care access drive time threshold is 70%; therefore, CAVHCS, Montgomery Division does not meet drive time access guideline for primary care.
Acute	55% of enrollees are within the drive time guidelines. The acute care access drive time threshold is 65%; therefore, CAVHCS, Montgomery Division does not meet drive time access guidelines for acute care.
Tertiary	100% of enrollees are within the drive time guideline. The tertiary care access drive time threshold is 65%; therefore, CAVHCS, Montgomery Division meets the drive time access guideline for tertiary care.
Healthcare Quality	
Quality of medical services	Achieved higher selected quality scores for inpatient and ambulatory care as compared to both the VISN and overall national scores. Achieved the same or lower quality scores for behavioral health, mental health, and patient satisfaction. The baseline has the potential to provide materially the same level of quality as is currently provided and assessed using these select quality measures.
Modern, safe, and secure environment	The conditions of buildings on the Montgomery campus vary. The majority of buildings have ratings between 3.0 and 3.8 for critical values such as accessibility, code, functional space, and facility conditions. With renovation, the baseline conforms to current industry standards and code requirements for healthcare environments, and allows exception for non-hazardous existing conditions which were code compliant at the time of their construction. In addition, there are some non-hazardous violations of the Federal Uniform Accessibility Standards related to handicap accessibility issues.
Ensures forecast healthcare need is appropriately met	Assumes that in order to maintain quality of care and meet VA thresholds for clinical volume, 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 an increase of approximately 7% in the number of FTEEs needed.
Recruitment / retention	CAVHCS, Montgomery Division is located in a highly competitive market and this impacts its ability to recruit and retain highly competitive positions. Generally, it takes six months to recruit and place physicians. 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	CAVHCS, Montgomery Division trains 17 residents, who primarily support inpatient services. The site also trains 250 allied health professionals annually. Affiliation agreements exist with the following schools: Morehouse School of Medicine, Alabama State University, and Auburn University.

Assessment Summary	Baseline
Use of VA Resources	
Operating cost effectiveness	CAVHCS, Montgomery Division's operating costs include those costs associated with providing care onsite at the Montgomery facility, as well as purchasing care for any specialty services provided by local community providers. Many building systems (including mechanical and electrical) are reported in poor condition, however, renovations to these systems should improve the operating efficiency of the facilities. Therefore, baseline cost effectiveness may be expected to be slightly better than current operating cost effectiveness.
Level of capital expenditures estimated	Current facilities conditions vary, however, most mechanical, electrical, and elevator systems are in poor condition. Thus, capital expenditure is required to upgrade facilities to meet modern, safe, and secure standards.
Cost avoidance	In the baseline, it is assumed that the $18.6 million identified in the CAI database identified by the facility as essential maintenance would be fully expended.
Overall cost effectiveness	Not applicable for the baseline.
Ease of Implementation	
Ease of BPO implementation	The risk factor for implementation is low since the baseline represents the current state with improvements to meet modern, safe, and secure standards and meet projected demand projections. The baseline option presents implementation risk in terms of the following major risk areas: • Continuity of care, since heavy renovations may disrupt provision of care to patients and utilization will exceed the capacity of the baseline facility • Infrastructure, given facilities may unveil unforeseen environmental, systematic, or structural issues during renovation, and existing space used for acute care is not ideal for providing these services • Project realization, since renovations present exposure to delays, budget variance, and transition complications.
Ability to Support VA Programs	
DoD sharing	CAVHCS, Montgomery Division is presently involved in active planning with DoD facilities in its service area including the 42nd Medical Group, MAFB, Lyster Army Hospital, Fort Rucker, and Martin Army Hospital, Fort Benning, GA. A joint venture with CAVHCS and MAFB in podiatry has been implemented that provides needed services to DoD beneficiaries and provides larger and more efficient space and equipment for the podiatry residency program in the MAFB ambulatory facility. Additional joint sharing initiatives are being investigated, including those for urgent care, audiology, mammography, women's health, and rheumatology. The baseline does not impact this arrangement or any future collaboration between VA and DoD. Some healthcare delivery space at MAFB, including the ambulatory surgery suite, has been mothballed and is not currently being used. Therefore, MAFB beneficiaries are receiving ambulatory services from the local community.
One-VA Integration	There is a VBA office co-located at the CAVHS, Montgomery Division site. The baseline does not affect this arrangement and thus has the potential to provide materially the same level of One-VA integration.
Special Considerations	The collaboration between DoD and CAVHCS, Montgomery Division allows for effective cooperation in response to National Emergency Management needs.

BPO 2: Contract with Local Community Providers – Inpatient Surgery & Ambulatory Surgery; Renovation for Inpatient Medicine; Construction for Ambulatory Care Facility

Assessment of BPO 2	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for primary care, since primary care services will remain at the baseline location of services.
Acute	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care. Although inpatient surgery is to relocate, it will be provided through local community providers in close proximity to CAVHCS, Montgomery Division.
Tertiary	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for tertiary care, since tertiary care services will remain at the baseline location of services.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since the applicable quality measures for area providers suggest these organizations provide comparable quality of care.
Modern, safe, and secure environment	↑	New construction improves adherence to modern, safe, and secure facility standards.
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 needed would decrease since inpatient and ambulatory surgery would be provided through local community providers rather than being provided onsite, thereby eliminating the need for surgical staff.
Recruitment / retention	↓	A reduction in the service mix, specifically elimination of inpatient and ambulatory surgery, would negatively affect the ability to recruit and retain staff at the CAVHCS, Montgomery Division.

Assessment of BPO 2	Comparison to Baseline	Description of Impact
Research	↔	No material impact is expected on research programs since research programs currently are not performed at this location
Education and Academic Affiliations	↓	Training programs related to inpatient and ambulatory surgical service, notably podiatry, would be eliminated.
Use of VA Resources		
Operating cost effectiveness	-	The BPO has the potential to require materially the same operating costs as the baseline. Although costs for providing inpatient and ambulatory surgery onsite are reduced, these savings are offset by the contract fees associated with purchasing these services from local community providers.
Level of capital expenditures estimated	-	This BPO requires similar renovation in Buildings 1 and 4 as the baseline, with some new construction for ambulatory care. Therefore, the level of capital expenditure required is similar to the baseline.
Cost avoidance	-	Since this option requires the same level of capital investment to renovate and add minimal new construction, there are no cost avoidance opportunities.
Overall cost effectiveness	-	As noted earlier, both operating costs and capital expenditures are relatively the same as for the baseline. Thus, this BPO results in a similar level of net present cost as compared to the baseline.
Ease of Implementation		
Ease of BPO implementation	↓	The BPO is riskier than the baseline in terms of the following major risk categories: • Continuity of care, if veterans receive inpatient care from a community provider, then return to VA for post-hospitalization follow-up. Immediate follow-up care could possibly be provided by a community provider, but the veteran would eventually return to VA for ongoing care. This creates a situation in which a portion of the patient's care is outside the clinical management and medical records system of VA • Reputation, since the effect on medical education may compromise VA's image as a training center • Organization and change, due to the possible misperception that the VA mission is compromised by contracting for care • Political, given political support will be required for successful implementation

Assessment of BPO 2	Comparison to Baseline	Description of Impact
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with DoD facilities as joint sharing arrangements are not inhibited through the relocation of surgical services.
One-VA Integration	↓	Beneficiaries needing to receive inpatient and/or ambulatory surgical services in the community would no longer have the ability to receive VBA services and meet with benefits representatives at the same facility.
Special Considerations	↓	Reduces the number of local VA inpatient beds, and thus diminishes the flexibility in responding to national emergencies.
Overall Attractiveness	↑↑	This BPO maintains access and cost, yet improves quality. Thus, BPO 2 is attractive compared to the baseline.

BPO 3: Contract with Local Community Providers – Inpatient Medicine & Surgery; Ambulatory Surgery Remains; Renovation for Ambulatory Care

Assessment of BPO 3	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary	↔	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 services.
Acute	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for acute care. Although inpatient surgery and medicine is to relocate, they will be provided through local community providers in close proximity to CAVHCS, Montgomery Division.
Tertiary	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care, since tertiary care services will remain at the baseline location of services.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since the applicable quality measures for area providers suggest these organizations provide comparable quality of care.
Modern, safe, and secure environment	↔	No material impact is expected since only renovations will be completed, as in the baseline. Thus, non-hazardous existing conditions which were code compliant at the time of their construction will remain.
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 needed would decrease since inpatient surgery and medicine would be provided through local community providers rather than being provided onsite, thereby eliminating the need for these inpatient staff.

Assessment of BPO 3	Comparison to Baseline	Description of Impact
Recruitment / retention	↓	A reduction in the service mix, specifically elimination of inpatient surgery and medicine, would negatively affect the ability to recruit and retain staff at the CAVHCS, Montgomery Division.
Research	↔	No material impact is expected on research programs since research programs currently are not performed at this location.
Education and Academic Affiliations	↓	Training programs related to inpatient surgery and medicine, such as nursing, podiatry, geriatrics, and mental health, would be eliminated
Use of VA Resources		
Operating cost effectiveness	-	The BPO has the potential to require materially the same operating costs as the baseline. Although costs for providing inpatient surgery and medicine services onsite are reduced, these savings are offset by the contract fees associated with purchasing these services from local community providers.
Level of capital expenditures estimated	-	This BPO requires similar renovation in Buildings 1 and 4 as the baseline; therefore, the level of capital expenditure required is similar to the baseline.
Cost avoidance	-	Since this BPO requires the same level of capital investment to renovate and add minimal new construction, there are no cost avoidance opportunities.
Overall cost effectiveness	-	As noted earlier, both operating costs and capital expenditures are relatively the same as for the baseline. Thus, the BPO results in a similar level of net present cost as compared to the baseline.
Ease of Implementation		
Ease of BPO implementation	↓	The BPO is riskier than the baseline in terms of the following major risk categories: • Continuity of care, if veterans receive inpatient care from a community provider, then return to VA for post-hospitalization follow-up. Immediate follow-up care could possibly be provided by a community provider, but the veteran would eventually return to VA for ongoing care. This creates a situation in which a portion of the patient's care is outside the clinical management and medical records system of VA • Reputation, since the effect on medical education may compromise VA's image as a training center • Continuity of care, since no inpatient medicine services are available onsite if

Assessment of BPO 3	Comparison to Baseline	Description of Impact
		needed for ambulatory surgery patients • Organization and change, due to the possible misperception that the VA mission is compromised by contracting for care • Political, given political support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with DoD facilities as joint sharing arrangements are not inhibited through the relocation of inpatient surgery and medicine services.
One-VA Integration	↓	Beneficiaries needing to receive inpatient surgery and medicine services in the community would no longer have the ability to receive VBA services and meet with benefits representatives at the same facility.
Special Considerations	↓	Reduces the number of local VA inpatient beds, and thus diminishes the flexibility in responding to national emergencies.
Overall Attractiveness	-	This BPO provides generally the same access, quality, and cost effectiveness as the baseline, therefore, BPO 3 is generally the same attractiveness as the baseline.

BPO 4: Contract with Local Community Providers – Inpatient Medicine & Surgery, Ambulatory Surgery; Build New Facility for Ambulatory Care; Demolish all Facilities

Assessment of BPO 4	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary	↔	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 services.
Acute	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for acute care. Although inpatient surgery and medicine is to relocate, they will be provided through local community providers in close proximity to CAVHCS, Montgomery Division.
Tertiary	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care, since tertiary care services will remain at the baseline location of services.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since the applicable quality measures for area providers suggest these organizations provide comparable quality of care.
Modern, safe, and secure environment	↑	New construction improves adherence to modern, safe, and secure facility standards.
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 needed would decrease since inpatient surgery and medicine, as well as ambulatory surgery, would be provided through local community providers rather than being provided onsite, thereby eliminating the need for these inpatient staff.
Recruitment / retention	↓	A reduction in the service mix, specifically elimination of inpatient surgery and medicine, as well as ambulatory surgery, would negatively affect the ability to recruit and retain staff at the CAVHCS, Montgomery Division.

Assessment of BPO 4	Comparison to Baseline	Description of Impact
Research	↔	No material impact is expected on research programs since research programs currently are not performed at this location.
Education and Academic Affiliations	↓	Training programs related to inpatient surgery and medicine, as well as ambulatory surgery, such as nursing, podiatry, geriatrics, and mental health, would be eliminated
Use of VA Resources		
Operating cost effectiveness	↑	The BPO has the potential to require a reduced level of operating costs as compared to the baseline. This is a result of the operating efficiencies gained through new construction.
Level of capital expenditures estimated	↓↓	This BPO involves the construction of a new hospital and requires more capital expenditure than the renovations required in the baseline.
Cost avoidance	-	Since the capital expenditures required for the newly constructed facility are greater than the baseline, there are no cost avoidance opportunities.
Overall cost effectiveness	↑	As noted earlier, operating costs are reduced as compared to the baseline, while the cost of constructing a new facility is greater than the renovations in the baseline. However, the increase in capital expenditures does not completely offset the operating cost savings. Therefore, the BPO results in an overall lower level of net present cost as compared to the baseline.

Assessment of BPO 4	Comparison to Baseline	Description of Impact
Ease of Implementation		
Ease of BPO implementation	↑	The BPO is riskier to implement as compared to the baseline in terms of • One aspect of continuity of care, if veterans receive inpatient care from a community provider, then return to VA for post-hospitalization follow-up. Immediate follow-up care could possibly be provided by a community provider, but the veteran would eventually return to VA for ongoing care. This creates a situation in which a portion of the patient's care is outside the clinical management and medical records system of VA • Political risk, given political support will be required for successful implementation. However, the BPO is less risky to implement as compared to the baseline in terms of • Another aspect of continuity of care, since patients can be transferred to the new facility upon completion thus minimizing disruption to care • Infrastructure, given that the new facility can provide better operational configuration for the best use of space Overall, the risk associated with BPO 4 is expected to be lower than for the baseline.
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected to the relationship with DoD facilities as joint sharing arrangements are not inhibited through the relocation of inpatient surgery and medicine, as well as ambulatory surgery services
One-VA Integration	↓	Beneficiaries needing to receive inpatient and/or ambulatory surgical services in the community would no longer have the ability to receive VBA services and meet with benefits representatives at the same facility.
Special Considerations	↓	Reduces the number of local VA inpatient beds, and thus diminishes the flexibility in responding to national emergencies.
Overall Attractiveness	↑↑↑↑	This BPO maintains access, yet improves quality and overall cost effectiveness. Thus, BPO 4 is very attractive compared to the baseline.

BPO 5: Contract with Local Community Providers – Inpatient Medicine & Surgery, Expand Ambulatory Surgery Services to Maxwell Air Force Base Through Service Sharing Agreement; Renovation for Ambulatory Care

Assessment of BPO 5	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary	↔	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 services.
Acute	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for acute care. Although inpatient surgery and medicine is to relocate, they will be provided through local community providers in close proximity to CAVHCS, Montgomery Division.
Tertiary	↔	No material change is expected to the percentage of enrollees meeting the VA drive time access guidelines for tertiary care, since tertiary care services will remain at the baseline location of services.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected to the quality of medical services since the applicable quality measures for area providers suggest these organizations provide comparable quality of care.
Modern, safe, and secure environment	↔	No material impact is expected since only renovations will be completed, as in the baseline. Thus, non-hazardous existing conditions which were code compliant at the time of their construction will remain.
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 needed would decrease since inpatient surgery and medicine would be provided through local community providers rather than being provided onsite, thereby eliminating the need for these inpatient staff. Additional staff may be needed to support the provision of ambulatory surgery to the DoD

Assessment of BPO 5	Comparison to Baseline	Description of Impact
		beneficiaries at CAVHCS, Montgomery Division, however, it is unexpected this would exceed the reduction in inpatient staff.
Recruitment / retention	↓	A reduction in the service mix, specifically elimination of inpatient surgery and medicine, would negatively affect the ability to recruit and retain staff at the CAVHCS, Montgomery Division.
Research	↔	No material impact is expected on research programs since research programs currently are not performed at this location.
Education and Academic Affiliations	↓	Training programs related to inpatient surgery and medicine, such as nursing, podiatry, geriatrics, and mental health, would be eliminated
Use of VA Resources		
Operating cost effectiveness	-	The BPO has the potential to require materially the same operating costs as the baseline. Although costs for providing inpatient surgery and medicine services onsite are reduced, these savings are offset by the contract fees associated with purchasing these services from local community providers.
Level of capital expenditures estimated	-	This BPO requires similar renovation in Buildings 1 and 4 as the baseline, therefore, the level of capital expenditure required is similar to the baseline.
Cost avoidance	-	Since this BPO requires the same level of capital investment to renovate and add minimal new construction, there are no cost avoidance opportunities.
Overall cost effectiveness	-	As noted earlier, both the operating costs and capital expenditures are relatively the same as for the baseline. Thus, the BPO results in a similar level of net present cost as compared to the baseline.
Ease of Implementation		
Ease of BPO implementation	↓	The BPO is riskier than the baseline in terms of the following major risk categories: • Continuity of care, if veterans receive inpatient care from a community provider, then return to VA for post-hospitalization follow-up. Immediate follow-up care could possibly be provided by a community provider, but the veteran would eventually return to VA for ongoing care. This creates a situation in which a portion of the patient's care is outside the clinical management and medical records system of VA • Reputation, since the effect on medical

Assessment of BPO 5	Comparison to Baseline	Description of Impact
		education may compromise VA's image as a training center • Continuity of care, since no inpatient medicine services are available onsite if needed for ambulatory surgery patients • Organization and change, due to the possible misperception that the VA mission is compromised by contracting for care • Legal and contractual as an agreement would need to be established with Tricare to provide services to DoD beneficiaries • Political, given political support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↑	The BPO will increase cooperation with DoD since DoD beneficiaries would be able to receive ambulatory surgery services from CAVHCS, Montgomery Division.
One-VA Integration	↓	Beneficiaries needing to receive inpatient surgery and medicine services in the community would no longer have the ability to receive VBA services and meet with benefits representatives at the same facility.
Special Considerations	↓	Reduces the number of local VA inpatient beds, and thus diminishes the flexibility in responding to national emergencies.
Overall Attractiveness	-	This BPO provides generally the same access, quality, and cost effectiveness as the baseline, therefore, BPO 5 is generally the same attractiveness as the baseline.

Appendix B - Glossary

Acronyms

AFB	Air Force Base
AMB	Ambulatory
BPO	Business Plan Option
CAI	Capital Asset Inventory
CAP	College of American Pathologists
CARES	Capital Asset Realignment for Enhanced Services
CBOC	Community Based Outpatient Clinic
CIC	CARES Implementation Category
DoD	Department of Defense
FTEE	Full Time Employee Equivalent
GFI	Government Furnished Information
HEDIS	Health Plan Employer Data and Information Set
ICU	Intensive Care Unit
IP	Inpatient
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
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, acute hospital care, and tertiary 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)*
Mental Health Indicators	**See the end of this document.**
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.

Mental Health Indicators

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