Capital Asset Realignment for Enhanced Services (CARES)

Stage I Report
Site: Muskogee

June 2006

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1.0 Introduction

CARES (Capital Asset Realignment for Enhanced Services) is the Department of Veterans Affairs' (VA) effort to produce a logical, national plan for modernizing healthcare facilities. The objective is to identify the optimal approach to provide current and future veterans with healthcare equal to or better than is currently provided in terms of access, quality, and cost effectiveness. 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.

Muskogee, Oklahoma is one of the CARES study sites and consists of a healthcare delivery study, but not capital planning and re-use plans. The Secretary's CARES Decision includes the following directives for Muskogee, Oklahoma:

- The Muskogee VAMC currently has excess capacity, while the region's patient population growth is focused in the Tulsa area.
- The study will assess the demand for healthcare in the Muskogee/Tulsa region and recommend a plan to best meet the healthcare needs of veterans, while maximizing use of resources.
- VA will study the needs in the region, including the potential for expansion of inpatient psychiatry at the Muskogee VAMC, and develop a strategy to more effectively manage the vacant space at the Muskogee VAMC and enhance services in the region.
- While the study is underway, VA will plan for the closure of the Muskogee VAMC's five-bed inpatient surgery program.
- The Muskogee VAMC will retain ambulatory surgery and have observation beds available.

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 developed and assessed a broad range of potentially viable business plan options (BPOs) that meet the forecasted healthcare needs for the study sites. Based upon an initial analysis of these BPOs, Team PwC recommended up to six BPOs to be taken forward for further development and assessment in Stage II. VA will use this report to help decide 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 will recommend 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 Management Assistance Council (MAC) at Muskogee has been utilized 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 developed at the conceptual level and represent feasible choices that have the potential to meet VA objectives. In Stage II, Team PwC will further develop BPOs selected by the Secretary through technical data driven analyses towards a recommended primary BPO.

3.0 Site Overview

The Muskogee Veterans Affairs Medical Center (VAMC) is located in the Upper-Western market of Veterans Integrated Service Network (VISN) 16.

Current Healthcare Provision

The Muskogee VAMC is a primary and secondary level medical center. It provides primary and consultative care in medicine, surgery and mental health. Healthcare is provided through primary care, medicine, surgery, psychiatry, physical medicine and rehabilitation, oncology, dentistry, and geriatrics. Ambulatory services available at the Muskogee campus include medicine, surgery, mental health, physical medicine, and rehabilitation. There is an urgent care center onsite, but no emergency department.

Capacity

The Muskogee facility was built to support a larger number of veterans than it currently serves. The facility is authorized for 140 beds, but currently operates 51 beds. Significant vacant space exists in the medical center's new bed tower (completed in 1998). The projected decline in demand for inpatient services over the next 20 years will increase the surplus capacity at Muskogee VAMC (see: Section 4.0). Projected increases in outpatient utilization have the potential to absorb some of this excess capacity.

Since the Secretary's CARES Decision of May 2004, VA has studied the need for inpatient psychiatry and rehabilitation services at Muskogee VAMC. This analysis was conducted outside of the CARES study process.

According to VA, both the States of Okalahoma and Arkansas have seen a steep decline in inpatient psychiatry providers and services. The extreme shortage of inpatient psychiatry beds in the community is expected to impact future veteran demand for these services in the Upper Western market of VISN 16. Additionally, the VISN has sought to reduce space congestion at the Oklahoma City facility and to strengthen collaboration between Oklahoma City VAMC and Muskogee VAMC. In order to address these issues, VA authorized the Muskogee VAMC to expand its inpatient psychiatry program.

Muskogee VAMC has developed and approved plans to expand inpatient psychiatry and inpatient rehabilitation services. This expansion will result in the addition of 20 inpatient

psychiatry beds and 15 inpatient rehabilitation beds at Muskogee. The planned program expansion at Muskogee will absorb vacant space at the facility and, therefore, appears to address the Secretary's May 2004 directive concerning options for utilizing excess space at the facility.

Access

Access is the determination of the numbers of actual enrollees who are within defined travel time parameters for primary care, acute hospital care, and tertiary care after adjusting for differences in population and density and types of road.

The CARES Commission Report to the Secretary of Veterans Affairs in 2004 concluded that a plan is needed to best meet the healthcare needs of veterans in two adjacent population centers of the Upper Western market - Muskogee and Tulsa. Veterans in the Upper Western market have access to primary and specialty care facilities at Muskogee VAMC, Tulsa CBOC and contracted McAlester CBOC. Veterans in this market have access to acute care services at Muskogee VAMC. Tertiary services are provided at the Oklahoma VAMC. Analysis of drive time information for enrollees in the Upper Western Market indicates that VA's drive time guideline is met for acute and tertiary care (provided at Oklahoma VAMC), but not for primary care (see Table 1). Drive time guidelines are at the market level and provide minimum travel times for enrolled veterans for access to primary, acute, and tertiary care. The guidelines stipulate that a certain percentage of enrolled veterans should be able to access VA healthcare services within minimum drive time guidelines. The percentages are 70%, 65% and 65% for primary, acute, and tertiary care, respectively. Currently, the Upper Western market area exceeds the access guideline for acute care by 0.2% and tertiary care by 35%. For primary care, the percentage of enrollees within the driving time threshold falls short of the access guideline by 16.7%.

Table 1: Percentage of Enrollees Meeting VA Access Guideline Drive Times for Upper Western Market

VA Drive Time Guidelines					
Primary Care		Acute Hospital		Tertiary Care[1]	
Current Level	Meets Threshold	Current Level	Meets Threshold	Current Level	Meets Threshold
53.3%	No	65.2%	Yes	100%	Yes

Patient Origin

The Secretary's CARES Decision document of May 2004 directs VA to examine veteran population growth in the Tulsa and Muskogee areas. As Figure 1 indicates, there are more enrolled veterans living in the Tulsa area than in the Muskogee area. However, while there are more enrolled veterans living in the Tulsa area, patient *origin* data for Muskogee VAMC indicates that the majority (48% compared to 13%) of enrolled veterans who access Muskogee VAMC for services live in the Muskogee area.

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

Figure 1: Vet Enrollees By County - VISN 16 (2003)

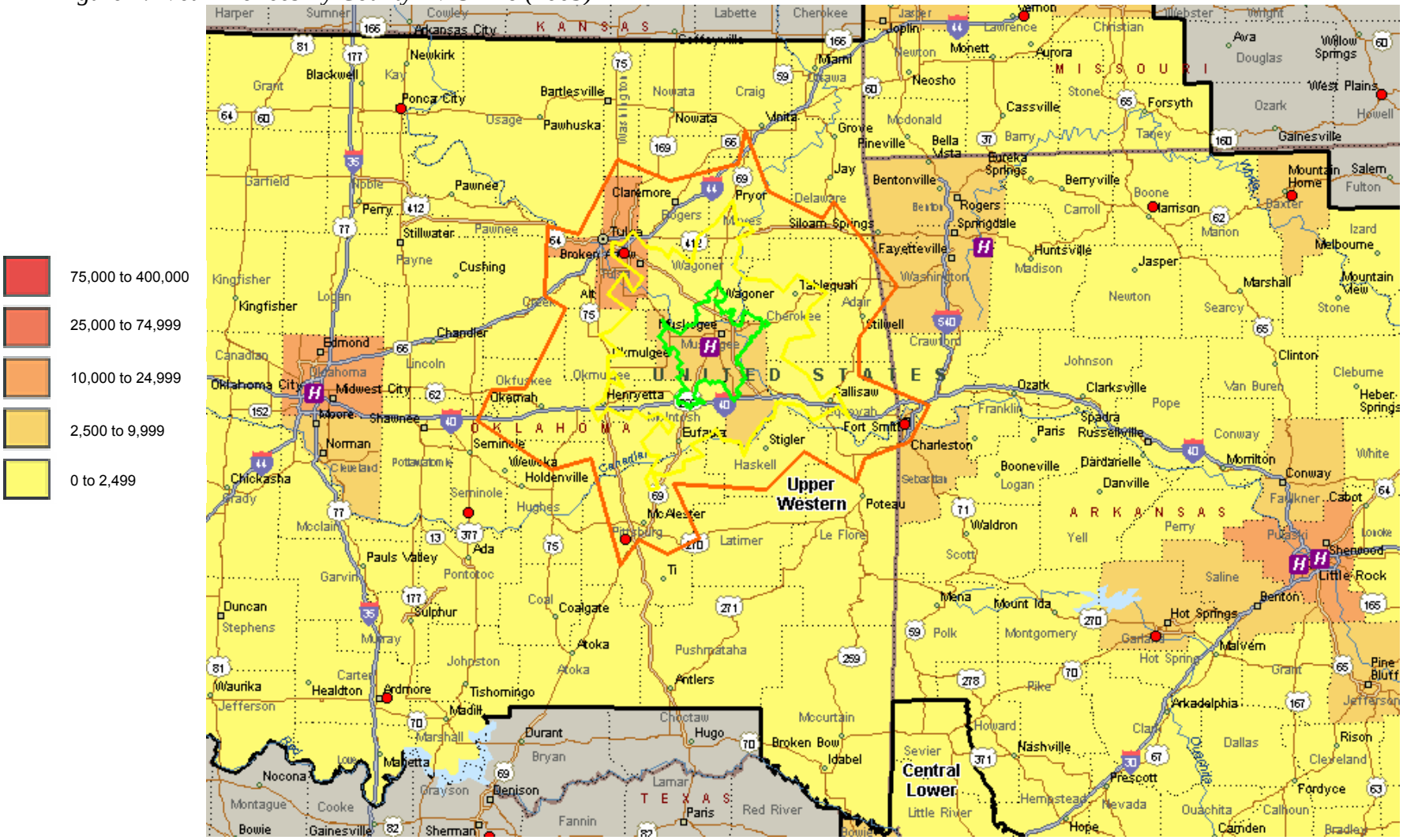


Figure 2: Patient origin data for the Upper Western Market of VISN 16 per VA data source

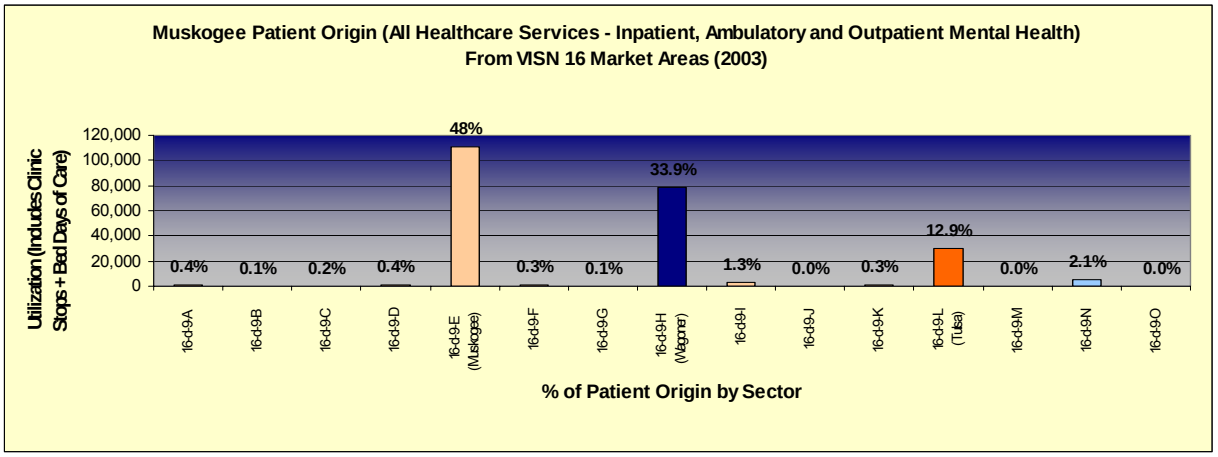


Figure 2 above shows that the largest proportion (48%) of patients who utilize VA for inpatient, outpatient, and mental health services originate from the Muskogee area (sector 16-d-9-E). The next largest population of veterans who access the VA for healthcare services come from an area that lies between Muskogee and Tulsa (sector 16-d-9-H). Tulsa area veterans (sector 16-d-9-L) make up just 13% of total utilization.

There are several contributing factors to this trend. Other than the Muskogee VAMC, the city of Muskogee currently has only one acute care facility offering services similar to VA. In the city of Tulsa, on the other hand, there are at least six other acute care facilities. Even when considering healthcare facilities located in the larger metropolitan areas of both cities, veterans living in the Tulsa area have more healthcare options than veterans living in the Muskogee area.

Other factors that might affect veteran access to VA healthcare facilities include median income and access to employer health insurance coverage. The median household income in Muskogee is approximately $28,000 and 18% of the population is below the poverty line. In Tulsa, the median household income is $35,000 and 14% of the population is below the poverty line[2]. Therefore, it is more likely that Tulsa area veterans, based upon financial means testing, would qualify for priority groups 7 or 8 which are required to pay specified co-payments. In addition, compared to the Muskogee area, Tulsa has many more large employers. Several of the large car rental agencies including Dollar, Budget, Thrifty and National are based in Tulsa and other large employers such as American Airlines, MCI, Boeing and CITGO have a significant presence in the area. The larger an organization is the more likely it is to provide health insurance coverage to its employees. It is, therefore, likely that more veterans in the Tulsa area have access to alternative forms of healthcare coverage than veterans living in the Muskogee area.

Patient origin data suggests that BPOs that seek to move services closer to Tulsa, while potentially improving access for Tulsa area veterans, might also result in decreasing access for veterans who live in the Muskogee area. Furthermore, although the veteran population is higher in Tulsa, moving services too close to Tulsa would result in an overall decrease in access for this market.

[2] U.S. Census (2000)

Quality

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

According to 2004 data, the Muskogee VAMC achieved higher selected quality scores for heart failure, colorectal cancer, endocrinology, major depressive disorder, and patient satisfaction (inpatient care) than overall national scores. However, the Muskogee VAMC achieved the same or lower quality scores for mental health global index and patient satisfaction (ambulatory care).

Table 2: Quality Measures

Clinical Setting	Indicator	Indicator Origin	Muskogee '04 Result	VISN #16 04 Result	VA National '04 Result
Inpatient Care					
Heart Failure	Ace inhibitor for left ventricular dysfunction as a key inpatient measure	VA, CMS	**94%**	**92%**	**93%**
Ambulatory Care					
Colorectal Cancer	Screening rates as a key ambulatory indicator	VA, HEDIS[3]	**77%**	**75%**	**72%**
Endocrinology	Full lipid profile in the past two years	VA, HEDIS	**99%**	**64%**	**96%**
Mental Health					
Major Depressive Disorder	% of patients with a new diagnosis of depression -- medication coverage	VA, HEDIS	**77%**	**60%**	**67%**
Global Index	Weighted average of seven mental health indicators[4]	VA	**54%**	**N/A**	**54%**
Patient Satisfaction					
Ambulatory Care	% of surveyed patients rating overall Ambulatory Care Services as very good or excellent	VA, Industry	**70%**	**72%**	**76%**
Inpatient Care	% of surveyed patients rating overall Inpatient Services as very good or excellent	VA, Industry	**76%**	**72%**	**74%**

[3] 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.

[4] See Glossary for description of indicators.

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 local healthcare market presents limited alternative options for veterans living in the Muskogee and Tulsa areas. There are no VA, Department of Defense (DoD), or Indian Health Service (IHS) facilities located within the drive time requirements for the Muskogee/Tulsa area. There are a number of private healthcare facilities located in the area but only two were deemed able to potentially meet or perhaps exceed the healthcare needs of veterans in terms of access, quality and use of VA resources. These facilities are located in Wagoner and Broken Arrow, OK.

Wagoner Community Hospital, Wagoner, OK

Wagoner Community Hospital is a 100-bed acute care facility offering services ranging from inpatient medicine and surgery to radiology, orthopedics, physical therapy, and other ambulatory care services. The latest available data indicated six ICU beds and an occupancy rate of approximately 27%.[5] It is managed by a voluntary non-profit organization, accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and certified by Medicare and Medicaid[6].

Saint Francis Hospital, Broken Arrow, OK

Saint Francis Hospital at Broken Arrow is a 64-bed acute care facility offering services ranging from inpatient medicine and surgery to a variety of ambulatory care services. The latest available data indicated that there were 28 non-acute and 36 acute beds with 10 ICU beds included in the acute bed total. Total facility occupancy was approximately 63%.[7] It is managed by a voluntary non-profit organization, accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and certified by Medicare. Saint Francis Hospital at Broken Arrow is located relatively equidistant between the cities of Tulsa and Muskogee[8].

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

[5] Solucient, 2003

[6] American Hospital Directory (AHD), 2005.

[7] Solucient, 2003

[8] American Hospital Directory (AHD), 2005.

is based upon market demand allocated to the Muskogee and Tulsa facilities. The following section describes the long-term trends for veteran enrollment and utilization for healthcare services at Muskogee VAMC and Tulsa CBOC.

Enrollment Trends

Muskogee VAMC is located in the Upper Western market of VISN 16. The Upper Western market contains approximately 210,000 enrolled veterans. The number of enrolled veterans for the Upper Western market is expected to decline 10% from 210,000, to approximately 190,000 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 10%, while enrollment for Priority 7-8 veterans is projected to decrease by 66% for the same period (see Table 3). The enrollment forecast for Priority 7-8 veterans assumes an annual enrollment fee, and the continued freeze on P8 enrollment. The enrolled veteran population is also aging. Enrolled veterans aged 65 and over will increase from 91,000 to 100,000 by 2023.

Table 3: Projected Veteran Enrollment for the Upper Western Market by Priority Group

Fiscal Year	Enrolled 2003	Projected 2013	% Change (2003 to 2013)	Projected 2023	% Change (2003 to 2023)
Priority 1-6	156,227	182,954	17%	171,183	10%
Priority 7-8	53,933	22,012	-59%	18,514	-66%
Total	**210,160**	**204,966**	**-2%**	**189,697**	**-10%**

Utilization Trends

Utilization was analyzed for those CARES Implementation Categories (CICs) for which the Muskogee and Tulsa facilities have 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. A summary of utilization data is provided for each CIC. As demonstrated in Table 4, inpatient bed need is projected to decrease by 18% from 51 to 42 beds in 2023, while outpatient clinic stops (including radiology and pathology) are expected to remain relatively stable over the same time horizon.

Table 4: Inpatient and Outpatient Utilization Summary

MUSKOGEE	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Total Inpatient Beds	51	46	42	-10%	-9%	-18%
Total Clinic Stops	222,961	234,797	223,321	5%	-5%	0%

Utilization Trends for Muskogee

The demand for inpatient services varies by CIC (see Table 5). The demand for both medicine/observation and surgery steadily declines over the forecast period. Medicine/ observation beds decrease by 20% to 34 beds, while surgery beds decrease from 8 to 6 beds by

2023. Current projected demand for psychiatry and substance abuse beds remains small (an increase from 1 to 2 beds by 2023). However, declining state psychiatry inpatient services are expected to impact future veteran demand for these services.

Table 5: Projected Utilization for Inpatient CICs for Muskogee

CARES Implementation Category (CIC)	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Medicine and Observation	42	37	34	-13%	-8%	-20%
Psychiatry and Substance Abuse	1	2	2	100%	0%	100%
Surgery	8	7	6	-13%	-14%	-25%
Total Number of Beds	**51**	**46**	**42**	**-10%**	**-9%**	**-18%**

Utilization of ambulatory CICs at Muskogee increases by 13% through 2023. The majority of the increase in ambulatory utilization (not including radiology and pathology) is due to large increases in demand for specialty areas such as: cardiology, orthopedics, eye clinic and urology. This can be explained by the needs of an aging veteran population, together with the trend towards using specialty over primary care services. Rehabilitation medicine remains constant during the projected period due to a planning assumption by VA.

Table 6: Projected Utilization for Ambulatory CICs for Muskogee

CARES Implementation Category (CIC)	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Cardiology	3,698	7,608	7,009	106%	-8%	90%
Eye Clinic	6,799	8,465	8,174	25%	-3%	20%
Non-Surgical Specialties	7,465	16,246	15,391	118%	-5%	106%
Orthopedics	2,614	9,075	8,631	247%	-5%	230%
Primary Care & Related Specialties	51,315	48,624	42,375	-5%	-13%	-17%
Rehab Medicine	14,684	14,684	14,684	0%	0%	0%
Surgical & Related Specialties	13,136	15,003	14,009	14%	-7%	7%
Urology	1,469	4,674	4,552	218%	-3%	210%
Total Number of Stops	**101,180**	**124,379**	**114,825**	**23%**	**-8%**	**13%**

Utilization of outpatient mental health CICs at Muskogee shows significant increases over the 20-year forecast period. These increases reflect assumptions concerning the utilization rates for these services consistent with the VA Mental Health Strategic Plan. Demand for behavioral health services increases by 30% through 2023. The homeless mental health program increases by 23 to 86 clinic stops by 2023.

Table 7: Projected Utilization for Outpatient Mental Health CICs for Muskogee

CARES Implementation Category (CIC)	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Behavioral Health	12,798	17,076	16,653	33%	-2%	30%
Mental Health Program: Homeless	23	97	86	322%	-11%	274%
Total Number of Stops	**12,821**	**17,173**	**16,739**	**34%**	**-3%**	**31%**

Ambulatory Utilization Trends for Tulsa

The majority of the increase in ambulatory utilization (excluding radiology and pathology) is due to large increases in demand for cardiology, non-surgical specialties, orthopedics, and urology. The only CIC to show a decrease over the 20-year horizon is surgical and related specialties.

Table 8: Projected Utilization for Ambulatory CICs for Tulsa CBOC

CARES Implementation Category (CIC)	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Cardiology	1,484	4,220	4,107	184%	-3%	177%
Eye Clinic	2,347	5,236	5,410	123%	3%	131%
Non-Surgical Specialties	2,429	4,681	4,640	93%	-1%	91%
Primary Care & Related Specialties	40,655	47,692	44,663	17%	-6%	10%
Rehab Medicine	7,135	7,135	7,135	0%	0%	0%
Surgical & Related Specialties	3,171	2,234	2,201	-30%	-1%	-31%
Urology	978	2,497	2,602	155%	4%	166%
Total Number of Stops	**58,199**	**73,695**	**70,758**	**27%**	**-4%**	**22%**

Utilization of ambulatory CICs at Tulsa CBOC increases by 22% through 2023. The long term patterns of utilization are similar to those at Muskogee VAMC, with the exception of primary care (10% increase) and related specialities and surgical and related specialties (31% decrease).

Outpatient Mental Health Utilization Trends for Tulsa CBOC

The expected utilization for outpatient mental health CIC at Tulsa is expected to increase by 40% over the 20-year time period. This increase will be driven by an increase of 38% in behavioral health as well as a 195% increase through 2023 in the mental health homeless care program.

Table 9: Projected Utilization for Outpatient Mental Health CICs for Tulsa CBOC

CARES Implementation Category (CIC)	2003 Actual	2013 Projected	2023 Projected	% Change (2003 to 2013)	% Change (2013 to 2023)	% Change (2003 to 2023)
Mental Health Program: Homeless	302	993	892	229%	-10%	195%
Behavioral Health	16,990	22,608	23,402	33%	4%	38%
Total Number of Stops	**17,292**	**23,601**	**24,294**	**36%**	**3%**	**40%**

In summary, projected utilization for healthcare services appears to vary over the next 20 years, which presents opportunities and challenges. Specifically, with regards to inpatient care, both

medicine/observation and surgery demand steadily declines over the projected period; current projected demand for psychiatry and substance abuse beds remains small (1 bed in 2003, increasing to 2 beds needed in 2023). However, changes to state inpatient psychiatry services are expected to impact future veteran demand. With regards to ambulatory and outpatient mental health services at both the Muskogee VAMC and Tulsa CBOC, demand is increasing for several categories of care associated with the needs of aging veterans, such as: cardiology, orthopedics, eye clinic, non-surgical specialties and urology. Demand is also increasing for behavioral health and mental health programs for the homeless. The long term trends for primary care and related specialties show different patterns at Muskogee VAMC and Tulsa CBOC. Muskogee experiences a decline, while Tulsa CBOC experiences an equivalent increase over the forecast period.

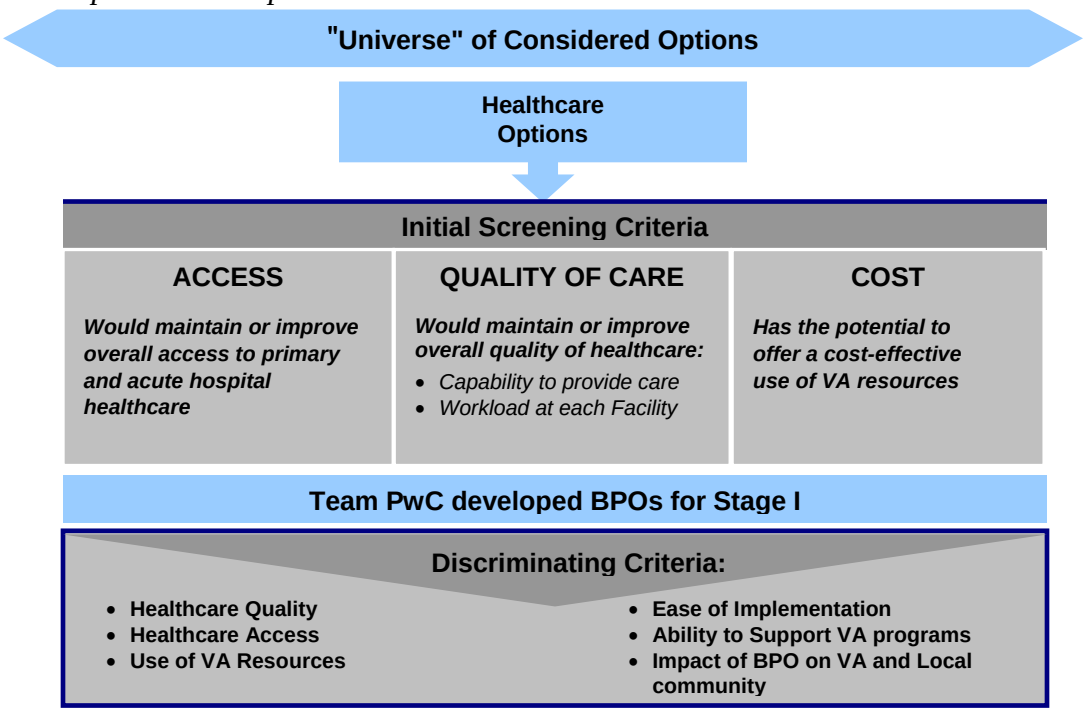
5.0 Business Plan Option Development Approach

Options Development Process

Using VA furnished information, site tours and interviews, as well as stakeholder and MAC member input, Team PwC developed a broad range of discrete and credible healthcare options. A review panel of experienced Team PwC consultants, including medical practitioners, considered the assessment results and recommended BPOs. Each of the BPOs was then assessed at a more detailed level according to a set of discriminating criteria.

The following diagram illustrates the complete options development process:

Figure 3: Options Development Process



Initial Screening Criteria

Discrete healthcare options were developed for the Muskogee VAMC and were subsequently screened to determine whether 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 was 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 currently no 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.

  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

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

study of the impact on continuity of care for each of the options will be conducted in the Stage II assessments of the options.

- **Cost**: *Has the potential to offer a cost-effective use of VA resources* – This was assessed as part of Team PwC's initial cost effectiveness analysis. A 30-year planning period was used in the cost effectiveness analysis. Any option that did not have the potential to provide a cost effective 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.
- **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 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.
  - Overall Cost Effectiveness: The initial estimate of net present cost as compared to the baseline.
- **Ease of Implementation** – These criteria assess the risk of implementation associated with each BPO. The following major risk areas were considered:

[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.

- 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 consist of operating costs. 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.

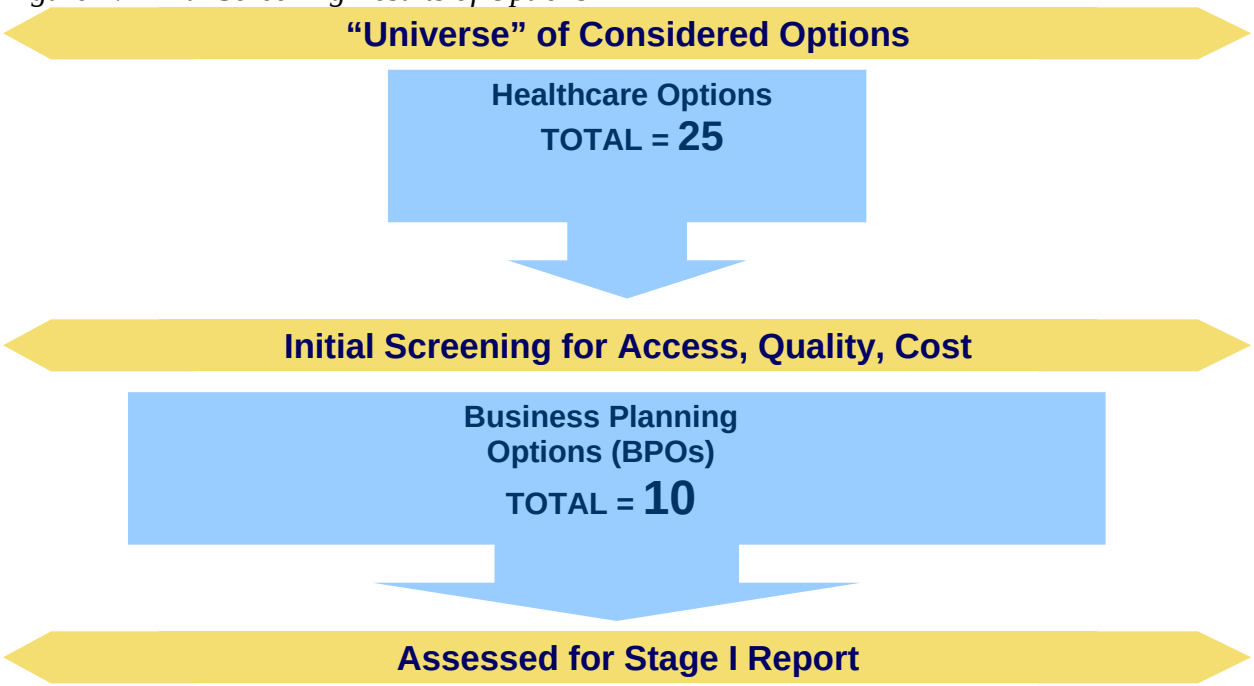
FY 2004 operating costs from DSS were deflated to FY 2003 dollars to create the costs for FY 2003 which is the base date for current cost comparison. These costs (fixed and variable) were then inflated for each year of the study period. Variable costs were multiplied by the forecasted workload for each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

Summary of Business Plan Options

The individual healthcare options that passed the initial screening were further considered as options to comprise a BPO. A BPO at this study site consists of a single healthcare option. The following diagram illustrates the final screening results of all options given consideration:

Figure 4: Final Screening Results of Options



Options Not Selected for Assessment

Several of the options created during the option development process did not pass the initial screening criteria. The following table lists those options that either did not pass the initial screening criteria or were deemed inferior to other options that did pass the initial screening. Table 10 below details the results of the initial screening and the reasons why these options were not selected.

Table 10: Options Not Selected for Assessment

Option Description	Reason(s) Not Selected
Three options re-locating care from other area VA facilities	Option did not pass initial access screening criteria and, therefore, was not selected for further study
Five options collocating or collaborating with DoD or IHS facilities	Option did not pass initial access screening criteria and, therefore, was not selected for further study
Six options purchasing care from a local community provider	Option did not pass initial access and/or quality screening criteria and, therefore, was not selected for further study
One option transferring care to another VA facility	Option did not pass initial access screening criteria and, therefore, was not selected for further study

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. In the baseline BPO, 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.

Evaluation System for BPOs

Each BPO is evaluated against the baseline BPO 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 11: 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%)
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 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." At Muskogee, VA determined it would leverage an existing Management Assistance Council (MAC) to support this function. According to the Statement of Work, the purpose of the MAC 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 MAC will also provide feedback to the Contractor on proposed options and recommendations.

The MAC 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 MAC.

Team PwC also devised methods for stakeholders to communicate their views without presenting testimony at the MAC meetings. Throughout Stage I, a comment form was available electronically via the CARES website and in paper form at the first MAC 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 MAC meeting. Input Period One started in April 2005 and ended on the day that the comment form with specific BPOs was available for public comment on the CARES website. For both periods, stakeholder input was reviewed and categorized into nine categories of concern which are summarized in Table 12.

For Input Period Two, stakeholders were provided with a brief description of the BPOs and asked to indicate whether they favored the BPO, were neutral about the BPO, or did not favor the BPO. Ten days after the second MAC meeting was held, Team PwC summarized all of the stakeholder views that were received during Input Period Two (Input Period One had been previously summarized), and this information is included in this report.

Table 12: Definitions of Categories of Stakeholder Concern

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

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

Stakeholder Input to Business Plan Option Development

Approximately ten members of the public attended the first MAC meeting held on June 16, 2005, as well as the second MAC meeting held on September 15, 2005. A total of 107 forms of stakeholder input (general comments on the study as well as specific BPOs) were received between April 20 and September 25, 2005. Although stakeholders had the opportunity to submit oral testimony at the first and second public MAC meeting, the only input received consisted of written and electronic comments. The concerns of stakeholders who submitted general comments not related to specific BPOs are summarized in the following table:

Table 13: Analysis of General Stakeholder Concerns

Key Concern	Number of Comments	
	Written and Electronic	**Total**
Effect on Access	12	**12**
Maintain Current Service/ Facility	18	**18**
Support for Veterans	16	**16**
Effect on Healthcare Services and Providers	19	**19**
Effect on Local Economy	2	**2**
Use of Facility	5	**5**
Effect on Research and Education	0	**0**
Administration's Budget or Policies	7	**7**
Unrelated to the Study Objectives	3	**3**

6.0 Business Plan Options

The option development process resulted in a multitude of discrete healthcare 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 10 BPOs which passed initial screening and were developed for Stage I (see Figure 4).

Each BPO was assessed at a more detailed level according to the discriminating criteria. The BPOs reflect options related to contracting portions of the clinical inventory at Muskogee to community providers in either Wagoner, OK or Broken Arrow, OK (see Table 14). Different BPOs seek to address either the decline in demand for inpatient surgery and inpatient medicine in Muskogee, and/or the desire to improve access to primary care services for veterans in the Tulsa and Muskogee areas.

Table14: Business Plan Options

BPO 1: Baseline
Current state projected out to 2013 and 2023 without any changes to facilities or programs, but accounting for projected utilization changes, and assuming same or better quality, and necessary maintenance for a safe, secure, and modern healthcare environment. Inpatient medicine and observation and psychiatry services provided at Muskogee VAMC, as well as existing ambulatory and outpatient mental health services. Existing services at Tulsa and McAlester CBOCs also continue.
BPO 2: Inpatient Surgery Contracted to Community Provider in Wagoner, OK
Inpatient surgery provided by the local community provider. Outpatient surgery, inpatient medicine, inpatient psychiatry, and ambulatory care services provided by the Muskogee VAMC.
BPO 3: Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK
Inpatient surgery provided by the local community provider. Outpatient surgery, inpatient medicine, inpatient psychiatry, and ambulatory care services provided by the Muskogee VAMC.
BPO 4: Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK
Ambulatory care (including outpatient mental health) services provided by the local community provider. Inpatient medicine, inpatient psychiatry, inpatient surgery, and outpatient surgery provided by the Muskogee VAMC.
BPO 5: Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK
Ambulatory care (including outpatient mental health) services provided by the local community provider. Inpatient medicine, inpatient psychiatry, inpatient surgery, and outpatient surgery provided by the Muskogee VAMC.
BPO 6: Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Wagoner, OK
Inpatient medicine and inpatient surgery to be provided by the local community provider. Inpatient psychiatry, outpatient surgery, and ambulatory care services to be provided by the Muskogee VAMC.
BPO 7: Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK
Inpatient medicine and inpatient surgery to be provided by the local community provider. Inpatient psychiatry, outpatient surgery, and ambulatory care services to be provided by the Muskogee VAMC.
BPO 8: Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK
Inpatient surgery and ambulatory care (including outpatient mental health) services provided by the local community provider. Inpatient medicine, inpatient psychiatry and outpatient surgery provided by the Muskogee VAMC.
BPO 9: Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK
Inpatient surgery and ambulatory care (including outpatient mental health) services provided by the local community provider. Inpatient medicine, inpatient psychiatry, and outpatient surgery provided by the Muskogee VAMC.
BPO 10: Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK
Inpatient medicine, inpatient surgery, and ambulatory care (including outpatient mental health) services to be provided by the local community provider. Inpatient psychiatry and outpatient surgery to be provided at the Muskogee VAMC.
BPO 11: Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK
Inpatient medicine, inpatient surgery, and ambulatory care (including outpatient mental health) services to be provided by the local community provider. Inpatient psychiatry and outpatient surgery to be provided at the Muskogee VAMC.

Assessment Drivers

Over the next 20 years, the number of enrolled veterans for the Upper Western market of VISN 16 is expected to decline 10% from approximately 210,000 to approximately 190,000. At the same time, enrollment of Priority 1-6 veterans (those veterans with the greatest service-connected needs) is projected to increase by 10%, from 156,000 to 171,000 by 2023. The enrolled veteran population is also aging. Enrolled veterans aged 65 and over will increase from 91,000 to 100,000 by 2023.

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

- Both medicine/observation and surgery demand steadily declines over the projected period
- Current projected demand for psychiatry and substance abuse beds remains small (one bed in 2003, increasing to two beds needed in 2023). However, changes in state inpatient psychiatry services are expected to impact future veteran demand.

With regards to ambulatory and outpatient mental health services at both the Muskogee VAMC and Tulsa CBOC:

- Demand is increasing for several categories of care associated with the needs of aging veterans, such as cardiology, orthopedics, eye clinic, non-surgical specialties, and urology
- Demand is increasing for behavioral health and mental health programs for the homeless

The long-term trends for primary care and related specialties show different patterns at Muskogee VAMC and Tulsa CBOC. Muskogee experiences a decline, while Tulsa CBOC experiences an equivalent increase over the forecast period.

These long-term healthcare trends for the Upper Western market, together with four major drivers were considered for the Muskogee study site. These drivers represent factors particularly noticeable at the Muskogee VAMC that must be balanced in the development and recommendation of business plan options. They are as follows:

1). Based upon current analysis of future enrollment projections and demand for healthcare services, Muskogee VAMC has excess capacity for inpatient services
2). The Upper Western market fails to meet national guidelines for access to primary care services
3). There are more enrolled veterans in the Tulsa area as compared to Muskogee; however, the majority of enrolled veterans who access the Muskogee VAMC live in the Muskogee area
4). There are limited alternatives in the community for healthcare services

These four drivers are described further below.

Excess Capacity - The Muskogee facility was built to support a larger number of veterans than it currently serves. The facility is authorized for 140 beds, but currently operates 51 beds. Significant vacant space exists in the medical center's new bed tower (completed in 1998). The projected decline in demand for inpatient services over the next 20 years will increase the surplus capacity at Muskogee VAMC and consequently lower the operating efficiency of this facility. The Secretary's CARES Decision of May 2004 called for the study of ways to address this surplus capacity. VISN 16 examined trends in state inpatient psychiatry services and observed a sharp decline in these services in the community. VA believes this decline in state inpatient psychiatry beds will impact future veteran demand for these services at Muskogee VAMC. Additionally, the VISN is seeking to reduce overcrowding at the Oklahoma City VAMC and to increase collaboration with Muskogee VAMC. In response to these issues, Muskogee VAMC has developed and approved plans to expand inpatient psychiatry and inpatient rehabilitation services. This expansion will result in the addition of 20 inpatient psychiatry beds and 15 inpatient rehabilitation beds at Muskogee. The planned program expansion at Muskogee will absorb vacant space at the facility and, therefore, appears to address the Secretary's May 2004 directive concerning options for utilizing excess space at the facility.

Access to Primary Care - Primary care is provided to enrollees of the Upper Western market at Muskogee VAMC, Tulsa CBOC or contracted McAlester CBOC. Analysis of drive time information for enrollees in this market indicates that the percentage of enrollees within minimum travel times for primary care falls short of VA's access guideline by 17%. Improving access to primary care services is a significant driver for developing and evaluating BPOs.

Patient Origin - While a larger number of veterans live in the Tulsa metropolitan area, the majority of enrolled veterans who access the VA for medical services live in the Muskogee area (48% in Muskogee versus 13% in Tulsa). Tulsa is an urban area where it is more likely that veterans are younger, employed with organizations that offer alternative (commercial) health insurance, have incomes that place them in higher veteran categories (e.g., Priority Groups 7 and 8) and have greater access to alternative healthcare providers (e.g., local community provider hospitals). Veterans living in the predominantly rural area of Muskogee are more likely to qualify for eligibility in Priority Groups 1-6, less likely to work for medium- to large-sized organizations that offer alternative health insurance, and less likely to have alternative sources for healthcare services. Therefore, although veteran population is higher in the Tulsa area, any BPO that would move services further away from the Muskogee area (e.g., a local community provider hospital located in Tulsa) would negatively affect overall access to healthcare services.

Local Healthcare Market - There are limited alternate community providers in the Muskogee region. Except for the Tulsa and McAlester CBOCs, the next closest VA, DoD, or IHS facility is more than two hours away from Muskogee VAMC in terms of drive time. Using the VA's national guidelines for drive time requirements, all VAMC, DoD, and IHS facilities significantly exceed access requirements for ambulatory and acute care services. This strictly limits options involving the collocation of services or collaboration attempts with other VA, DoD, or IHS medical facilities in the area. The community facilities in Wagoner, OK and Broken Arrow, OK are determined to be relatively equidistant between Tulsa and Muskogee and are potentially geographically accessible for both communities.

Assessment Results

The following tables (15 and 16) detail the results of applying discriminating criteria and comparison against the baseline in accordance with the Evaluation System for BPOs (Table 11).

Table 15: Baseline Assessment

Assessment Summary	Baseline
Healthcare Access	
Primary care	53.3% of enrollees are within the drive time guidelines. The primary care access drive time threshold is 70%; therefore, Muskogee VAMC does not meet drive time access guideline for primary care.
Acute care	65.2% of enrollees are within the drive time guidelines. The acute care access drive time threshold is 65%; therefore, Muskogee VAMC meets drive time access guidelines for acute care.
Tertiary care	100% of enrollees are within the drive time guidelines for obtaining services at Oklahoma VAMC. The tertiary care access drive time threshold is 65%; therefore, Oklahoma VAMC meets the drive time access guideline for tertiary care.
Healthcare Quality	
Quality of medical services	The Muskogee site achieved higher selected quality scores for inpatient care, ambulatory care, mental health services, and inpatient satisfaction as compared to VISN and overall national scores. On the contrary, Muskogee scored lower on ambulatory patient satisfaction than VISN or overall national results. The baseline has the potential to provide materially the same level of quality of care as is currently provided.
Ensures forecast healthcare need is appropriately met	Assumes that in order to maintain quality of care and meet VA thresholds for clinical volume (e.g., VRAH guidelines), VA will make necessary operational adjustments (e.g., staffing or contract arrangements). Muskogee VAMC will have no difficulty meeting all demand onsite.
Impact on Local Community	
Human Resources:	
FTEE need (based on volume)	With a marginal decrease in workload, it is anticipated that baseline results in a marginal decrease in the number of FTEEs. The baseline results in materially the same number of FTEEs.
Recruitment / retention	Muskogee is a rural area, yet Muskogee administrative staff report that, in general, Muskogee does not have difficulty recruiting hospital staff. The baseline has the potential to provide materially the same level of recruitment and retention of employees.
Research	Currently, there is a limited research program focused on inpatient medicine. The baseline has the potential to provide materially the same level of access to and support of the established research programs.
Education and Academic Affiliations	With no changes to programs or services, it is anticipated that established training programs would remain in place. The baseline has the potential to provide materially the same level of support to established training programs.
Use of VA Resources	
Operating cost effectiveness	Muskogee's operating costs include those costs associated with providing care onsite at the Muskogee VAMC, as well as purchasing care for inpatient, outpatient, and ambulatory services from a local community provider. As utilization of the facility declines over the forecast period, surplus capacity may reduce operating efficiency.
Overall cost effectiveness	Not applicable for the baseline.
Ease of Implementation	
Ease of BPO Implementation	The risk factor for implementation is very low since the baseline represents the current state with operational adjustments to meet demand projections.

Assessment Summary	Baseline
Ability to Support VA Programs	
DoD sharing	There is currently no collaboration between Muskogee VAMC and DoD. The baseline does not impact any future potential collaboration between Muskogee VAMC and DoD.
One-VA integration	The baseline environment neither furthers One-VA integration nor has any requirement to coordinate with other VA administrations been identified.
Special considerations	The baseline does not impact DoD contingency planning, Homeland Security needs, or emergency need projections.
Overall Attractiveness	Not applicable for the baseline.

Table 16 provides an overall summary of the BPOs assessed for comparative purposes.

Table 16: BPO Assessment Summary

Assessment Summary	BPO 2	BPO 3	BPO 4	BPO 5	BPO 6	BPO 7	BPO 8	BPO 9	BPO 10	BPO 11
	Inpatient Surgery Contracted to Community Provider in Wagoner, OK	Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK	Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Wagoner, OK	Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK	Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	Inpatient Medicine, Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK
Healthcare Access										
Primary	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Acute	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Tertiary	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Healthcare Quality										
Quality of medical services	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Ensures forecast healthcare need is appropriately met	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Impact on VA and Local Community										
Human Resources: FTEE need (based on volume)	Decrease	Decrease	Decrease	Decrease	Decrease	Decrease	Decrease	Decrease	Decrease	Decrease
Recruitment / retention	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
Research	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Education and Academic Affiliations	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓

Assessment Summary	BPO 2	BPO 3	BPO 4	BPO 5	BPO 6	BPO 7	BPO 8	BPO 9	BPO 10	BPO 11
	Inpatient Surgery Contracted to Community Provider in Wagoner, OK	Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK	Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Wagoner, OK	Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK	Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	Inpatient Medicine, Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK
Use of VA Resources										
Operating cost effectiveness	-	-	-	-	-	-	-	-	-	-
Overall cost effectiveness	-	-	-	-	-	-	-	-	-	-
Ease of Implementation										
Ease of BPO implementation	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
Ability to Support VA Programs										
DoD sharing	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
One-VA integration	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Special considerations	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Overall Attractiveness	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓

Management Assistance Council and Stakeholder Reactions/Concerns

Management Assistance Council Feedback

The MAC consists of 17 members of the Muskogee community; the MAC Chair is Benjamin Campeau, Acting Medical Center Director of the Muskogee VAMC.

The second public MAC meeting for Muskogee was held on Thursday, September 15, 2005 at the Muskogee VAMC. Eight members of the MAC were present during the meeting. In addition to the MAC members, there were representatives from the VA, as well as Team PwC. Finally, there were approximately 10 other attendees in the audience representing veterans, VAMC employees, the media, and interested community members. Team PwC presented 11 BPOs in detail at the meeting, and the public and MAC members had the opportunity to ask questions and make comments throughout the session. During the MAC deliberations, MAC members had an opportunity to vote on each BPO presented. The results are presented in Table 17. Overall, the MAC shared the sentiment of the public that services should stay on site with as little change to the campus as possible. Notwithstanding the MAC's preference for retaining services at Muskogee VAMC, the MAC did support further study of BPOs that group contracted out services together since they believed that this would result in better continuity of care for veterans.

Table 17: MAC BPO Voting Results

BPO	Description	Yes	No
BPO 2	Inpatient Surgery Contracted to Community Provider in Wagoner, OK	0	8
BPO 3	Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	0	8
BPO 4	Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	0	8
BPO 5	Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK	0	8
BPO 6	Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Wagoner, OK	8	0
BPO 7	Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	8	0
BPO 8	Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	0	8
BPO 9	Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK	0	8
BPO 10	Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK	8	0
BPO 11	Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK	8	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 MAC 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 5.

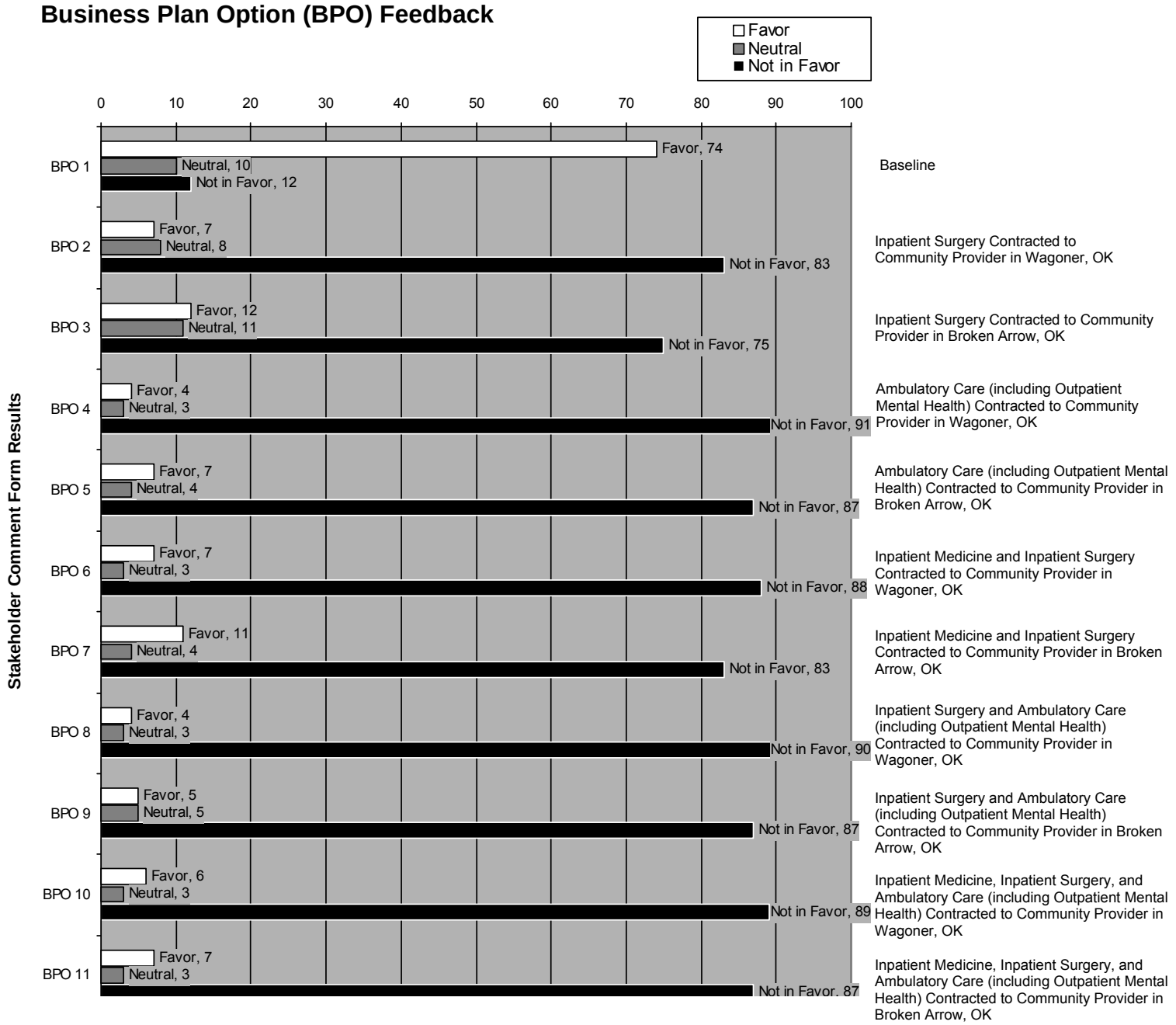
No stakeholders chose to provide oral testimony at the first or second public meetings; however 107 forms of written and electronic comments were received. Through these comments, stakeholders voiced their overwhelming preference for BPO 1 which is the baseline BPO that involves maintaining the current state of the hospital while accounting for projected utilization changes. Of the 96 stakeholders who commented on the baseline BPO (BPO 1), 77% indicated they favored the baseline BPO. The overwhelming majority of stakeholders voiced that they were not in favor of the remaining 10 BPOs, which involve moving various combinations of services to local community providers in either Wagoner, OK or Broken Arrow, OK.

Figure 5: Stakeholder Feedback on BPOs

Muskogee Study Site (08/31/2005 to 09/25/2005)

nalysis of Written and Electronic Inputs
Written and Electronic Only):

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



BPO Recommendations for Assessment in Stage II

Team PwC's recommendations for Muskogee VAMC were determined based on several factors. Team PwC considered the pros and cons of each BPO, together with the results of assessments against discriminating criteria to determine the overall attractiveness of each BPO. Views and opinions of the MAC and written and electronic comments received from veterans and other interested groups were also considered. All of these inputs contributed to the recommendations for Muskogee VAMC, which are summarized in Table 18 with pros and cons and rationale identified for each BPO.

Based upon Team PwC's assessment of each BPO, none of the alternate BPOs is considered to be as favorable as the baseline. Consequently, Team PwC recommends that only the baseline BPO go forward. The reasons for rejecting the alternate BPOs can be summarized as:

- Failure to improve access, quality and cost effectiveness
- In most cases BPOs increase, rather than decrease, the surplus capacity at Muskogee VAMC and do not effectively utilize the large capital investment made in this facility
- Limited community alternatives to provide equivalent healthcare services for veterans living in the Muskogee area.

Table 18: BPO Recommendations

BPO	Pros	Cons	Rationale
BPOs Recommended by Team PwC for Further Study			
BPO 1: Baseline	• The Muskogee facility has the capacity to meet projected increases in demand for ambulatory and outpatient mental health services • High quality levels for inpatient, ambulatory, and behavioral health services will likely continue	• Primary care access remains below national drive time guidelines	• The baseline is the BPO against which all other BPOs are assessed
BPO Not Recommended by Team PwC for Further Study			
BPO 2: Inpatient Surgery Contracted to Community Provider in Wagoner, OK	• Addresses declining inpatient surgery volume at the Muskogee VAMC	• Adversely affects access to acute care for veterans who live closer to Muskogee • Primary care access remains below national drive time guidelines • Negatively impacts nursing training program • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment in this facility	• Does not improve primary or acute care access • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment made in this facility
BPO 3: Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	• Addresses declining inpatient surgery volume at the Muskogee VAMC	• Adversely affects access to acute care for veterans who live closer to Muskogee • Primary care access remains below national drive time guidelines • Negatively impacts nursing training program • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment in this facility	• Does not improve primary or acute care access • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment made in this facility
BPOs 4 and 5: Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK or Broken Arrow, OK	• Potential to improve access to ambulatory services for Tulsa area veterans	• Adversely affects access to primary care for veterans who live closer to Muskogee • Negatively impacts nursing training program • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment in this facility	• Negative impacts on access to primary care services for Muskogee area veterans • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment made in this facility

BPO	Pros	Cons	Rationale
BPO 6: Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Wagoner, OK	• Addresses declining inpatient (medicine and surgery) volume at the Muskogee VAMC	• Adversely affects access to acute care for veterans who live closer to Muskogee • Primary care access remains below national drive time guidelines • Negatively impacts nursing training program • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment in this facility	• Does not improve primary or acute care access • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment made in this facility
BPO 7: Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK	• Addresses declining inpatient (medicine and surgery) volume at the Muskogee VAMC	• Adversely affects access to acute care for veterans who live closer to Muskogee • Primary care access remains below national drive time guidelines • Negatively impacts nursing training program • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment in this facility • Community provider may not have sufficient capacity	• Does not improve primary or acute care access • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment made in this facility • Community provider may not have sufficient capacity to support workload from Muskogee VAMC
BPOs 8 and 9: Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK or Broken Arrow, OK	• Addresses declining inpatient surgery volume at Muskogee VAMC • Potential to improve access to ambulatory services for Tulsa area veterans	• Adversely affects access to primary and acute care services for Muskogee area veterans • Negatively impacts nursing training program • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment in facility	• Negative impacts on access to primary and acute care services for Muskogee area veterans • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment made in this facility
BPOs 10 and 11: Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK or Broken Arrow, OK	• Addresses declining inpatient (medicine and surgery) volume at Muskogee VAMC • Potential to improve access to ambulatory services for Tulsa area veterans	• Potential to further decrease access to primary and acute care services for Muskogee area veterans • Negatively impacts nursing training program • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment in facility • Community provider in Broken Arrow may not have sufficient capacity	• Negatively impacts access to primary and acute care services for Muskogee area veterans • Increases surplus capacity at Muskogee and does not effectively utilize significant capital investment made in this facility • Community provider may not have sufficient capacity to support workload from Muskogee

Appendix A - Assessment Tables

BPO 1: Baseline

Assessment of BPO 1	Description
Healthcare Access	
Primary	53.3% of enrollees are within the drive time guidelines. The primary care access drive time threshold is 70%; therefore, Muskogee VAMC does not meet drive time access guideline for primary care.
Acute	65.2% of enrollees are within the drive time guidelines. The acute care access drive time threshold is 65%; therefore, Muskogee VAMC meets drive time access guidelines for acute care.
Tertiary	100% of enrollees are within the drive time guidelines for obtaining services at Oklahoma VAMC. The tertiary care access drive time threshold is 65%; therefore, Muskogee VAMC meets the drive time access guideline for tertiary care.
Healthcare Quality	
Quality of medical services	The Muskogee site achieved higher selected quality scores for inpatient care, ambulatory care, mental health services, and inpatient satisfaction as compared to VISN and overall national scores. However, Muskogee scored lower on ambulatory patient satisfaction than VISN or overall national results. The baseline has the potential to provide materially the same level of quality of quality of care as is currently provided as assessed using these select quality measures.
Ensures forecast healthcare need is appropriately met	Assumes that in order to maintain quality of care and meet VA thresholds for clinical volume (e.g., VRAH guidelines), VA will make necessary operational adjustments (e.g., staffing or contract arrangements). Muskogee VAMC will have no difficulty meeting all demand onsite.
Impact on VA and Local Community	
Human Resources: FTEE need (based on volume)	With a marginal decrease in workload, it is anticipated that the baseline results in a marginal decrease in the number of FTEEs.
Recruitment / retention	Muskogee is a rural area, yet Muskogee administrative staff report that, in general, Muskogee does not have difficulty recruiting hospital staff. The baseline has the potential to provide materially the same level of recruitment and retention of employees.
Research	Currently, there is a limited research program focused on inpatient medicine. The baseline has the potential to provide materially the same level of access to and support of the established research programs.
Education and Academic Affiliations	With no changes to programs or services, it is anticipated that established training programs would remain in place. The baseline has the potential to provide materially the same level of access and support to established training programs.

Assessment of BPO 1	Description
Use of VA Resources	
Operating cost effectiveness	Muskogee's operating costs include those costs associated with providing care onsite at the Muskogee VAMC, as well as purchasing care for inpatient, outpatient, and ambulatory services from a local community provider. As utilization of the facility declines over the forecast period, surplus capacity may reduce operating efficiency.
Overall cost effectiveness	Not applicable for the baseline.
Ease of Implementation	
Ease of BPO Implementation	The risk factor for implementation is very low since the baseline represents the current state with operational adjustments to meet demand projections.
Ability to Support VA Programs	
DoD sharing	There is currently no collaboration between Muskogee VAMC and DoD. The baseline does not impact any future potential collaboration between Muskogee VAMC and DoD.
One-VA integration	The baseline environment neither furthers One-VA integration nor has any requirement to coordinate with other VA administrations been identified.
Special considerations	The baseline does not impact DoD contingency planning, Homeland Security needs, or emergency need projections.
Overall Attractiveness	Not applicable for the baseline.

BPO 2: Inpatient Surgery Contracted to Community Provider in Wagoner, OK

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 acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
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 baseline location of services.
Healthcare Quality		
Quality of medical services	↔	No material impact is expected overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources: FTEE need (based on volume)	Decrease	With the transfer of inpatient surgery to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Splitting inpatient surgery from OP surgery threatens retention of surgical staff.
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient surgery to a local community provider would not result in a material impact. In addition, the protocols do not relate to the services being relocated.
Education and Academic Affiliations	↓	With the transfer of inpatient surgery to a local community provider, the nursing training program would be negatively impacted, as those students interested in inpatient surgery would no longer have access to such training at the Muskogee VAMC.

Assessment of BPO 2	Comparison to Baseline	Description of Impact
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the cost of providing inpatient surgery services in the baseline BPO is relatively similar to the costs of contracting for care in the Wagoner, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care is potentially negatively impacted if veterans receive inpatient surgery from a community provider, then return to VAMC for post-surgical follow-up. This could be done by the community provider, but in either case creates a situation in which a portion of the patient's care is outside the management and medical records of VA. 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 3: Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK

Assessment of BPO 3	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 acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa is offset by the percentage decrease due to enrollees living near Muskogee.
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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources: FTEE need (based on volume)	Decrease	With the transfer of inpatient surgery to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Splitting inpatient surgery from outpatient surgery threatens retention of surgical staff.
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient surgery to a local community provider would not result in a material impact. In addition, the protocols do not relate to the services being relocated.
Education and Academic Affiliations	↓	With the transfer of inpatient surgery to a local community provider, the nursing training program would be negatively impacted, as those students interested in inpatient surgery would no longer have access to such training at the Muskogee VAMC.

Assessment of BPO 3	Comparison to Baseline	Description of Impact
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the cost of providing inpatient surgery services in the baseline BPO is relatively similar to the costs of contracting for care in the Broken Arrow, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care is potentially negatively impacted if veterans receive inpatient surgery from a community provider, then return to VAMC for post-surgical follow-up. This could be done by the community provider, but in either case creates a situation in which a portion of the patient's care is outside the management and medical records of VA. 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 4: Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK

Assessment of BPO 4	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. Although primary care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa is offset by the percentage decrease due to enrollees living near Muskogee.
Acute	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care, since acute care services will remain at the baseline location of services.
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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources: FTEE need (based on volume)	Decrease	With the transfer of ambulatory care to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since ambulatory care will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted.
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of ambulatory care to a local community provider would not result in a material impact. In addition, the protocols do not relate to ambulatory care.
Education and Academic Affiliations	↓	With the transfer of ambulatory care to a local community provider, the nursing training program would be negatively impacted, as those students interested in ambulatory care would no longer have the access to such training at the Muskogee VAMC.

Assessment of BPO 4	Comparison to Baseline	Description of Impact
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the cost of providing ambulatory care in the baseline BPO is relatively similar to the costs of contracting for care in the Wagoner, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care is potentially negatively impacted even more so than with BPO 2 & 3. This scenario would require regular hand-offs between community providers and VA staff in terms of clinical management, medical records, pharmacy, et al 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 5: Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK

Assessment of BPO 5	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. Although primary care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offset the percentage decrease due to enrollees living near Muskogee.
Acute	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care, since acute care services will remain at the baseline location of services.
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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources: FTEE need (based on volume)	Decrease	With the transfer of ambulatory care to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since ambulatory care will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted.
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of ambulatory care to a local community provider would not result in a material impact. In addition, the protocols do not relate to ambulatory care.

Assessment of BPO 5	Comparison to Baseline	Description of Impact
Education and Academic Affiliations	↓	With the transfer of ambulatory care to a local community provider, the nursing training program would be negatively impacted, as those students interested in ambulatory care would no longer have access to such training at the Muskogee VAMC.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the cost of providing ambulatory care in the baseline BPO is relatively similar to the costs of contracting for care in the Broken Arrow, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care is potentially negatively impacted even more so than with BPO 2 & 3. This scenario would require regular hand-offs between community providers and VA staff in terms of clinical management, medical records, pharmacy, et al 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.

Assessment of BPO 5	Comparison to Baseline	Description of Impact
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 6: Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Wagoner, OK

Assessment of BPO 6	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for primary care, since primary care services will remain at the baseline location of services.
Acute care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care. Although acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Tertiary care	↔	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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	With the transfer of inpatient medicine and inpatient surgery to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since inpatient medicine and inpatient surgery services will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted. Splitting inpatient surgery from outpatient surgery threatens retention of surgical staff.
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient medicine and inpatient surgery to a local community provider would not result in a material impact.

Assessment of BPO 6	Comparison to Baseline	Description of Impact
Education and Academic Affiliations	↓	With the transfer of inpatient medicine and inpatient surgery to a local community provider, the nursing training program would be negatively impacted, as those students interested in inpatient medicine and inpatient surgery would no longer have access to such training at the Muskogee VAMC.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the costs of providing inpatient medicine and inpatient surgery services in the baseline BPO is relatively similar to the costs of contracting for care in the Wagoner, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care is potentially negatively impacted at a level between BPOs 2 & 3 and BPOs 4 & 5. While coordination of care would still be required for those cases hospitalized in the community, the bulk of services are outpatient, which would remain in VA. 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.

Assessment of BPO 6	Comparison to Baseline	Description of Impact
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 7: Inpatient Medicine and Inpatient Surgery Contracted to Community Provider in Broken Arrow, OK

Assessment of BPO 7	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	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 care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care. Although acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Tertiary care	↔	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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	With the transfer of inpatient medicine and inpatient surgery to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since inpatient medicine and inpatient surgery services will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted. Splitting inpatient surgery from outpatient surgery threatens retention of surgical staff.
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient medicine and inpatient surgery to a local community provider would not result in a material impact.

Assessment of BPO 7	Comparison to Baseline	Description of Impact
Education and Academic Affiliations	↓	With the transfer of inpatient medicine and inpatient surgery to a local community provider, the nursing training program would be negatively impacted, as those students interested in inpatient medicine and inpatient surgery would no longer have access to such training at the Muskogee VAMC.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the costs of providing inpatient medicine and inpatient surgery services in the baseline BPO is relatively similar to the costs of contracting for care in the Broken Arrow, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care is potentially negatively impacted at a level between BPOs 2 & 3 and BPOs 4 & 5. While coordination of care would still be required for those cases hospitalized in the community, the bulk of services are outpatient, which would remain in VA. Additionally, the local community provider in Broken Arrow may not be able to accommodate the volume of services 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.

Assessment of BPO 7	Comparison to Baseline	Description of Impact
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 8: Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK

Assessment of BPO 8	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for primary care. Although primary care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Acute care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care. Although acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Tertiary care	↔	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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	With the transfer of inpatient surgery and ambulatory care to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since inpatient surgery and ambulatory care will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted.
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient surgery and ambulatory care to a local community provider would not result in a material impact.

Assessment of BPO 8	Comparison to Baseline	Description of Impact
Education and Academic Affiliations	↓	With the transfer of inpatient surgery and ambulatory care to a local community provider, the nursing training program would be negatively impacted as those students interested in inpatient surgery and ambulatory care would no longer have access to such training at the Muskogee VAMC.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the cost of providing inpatient surgery and ambulatory care in the baseline BPO is relatively similar to the costs of contracting for care in the Wagoner, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care; this BPO poses generally the same negative potential for continuity of care as does BPOs 4 & 5 because of the coordination of care challenges 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.

Assessment of BPO 8	Comparison to Baseline	Description of Impact
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 9: Inpatient Surgery and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK

Assessment of BPO 9	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for primary care. Although primary care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Acute care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care. Although acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Tertiary care	↔	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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	With the transfer of inpatient surgery and ambulatory care to a local community provider, there would be a decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since inpatient surgery and ambulatory care will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted.

Assessment of BPO 9	Comparison to Baseline	Description of Impact
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient surgery and ambulatory care to a local community provider would not result in a material impact. In addition, the protocols do not relate to inpatient surgery or ambulatory care.
Education and Academic Affiliations	↓	With the transfer of inpatient surgery and ambulatory care to a local community provider, the nursing training program would be negatively impacted, as those students interested in inpatient surgery and ambulatory care would no longer have the access to such training at the Muskogee VAMC.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the costs of providing inpatient surgery and ambulatory care in the baseline BPO is relatively similar to the costs of contracting for care in the Broken Arrow, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care; this BPO poses generally the same negative potential for continuity of care as does BPOs 4 & 5 because of the coordination of care challenges 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.

Assessment of BPO 9	Comparison to Baseline	Description of Impact
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 10: Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Wagoner, OK

Assessment of BPO 10	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for primary care. Although primary care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Acute care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care. Although acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offset the percentage decrease due to enrollees living near Muskogee.
Tertiary care	↔	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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	With the transfer of inpatient medicine, inpatient surgery, and ambulatory care to a local community provider, there would be a significant decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since inpatient medicine, inpatient surgery, and ambulatory care will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted.

Assessment of BPO 10	Comparison to Baseline	Description of Impact
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient medicine, inpatient surgery, and ambulatory care to a local community provider would not result in a material impact.
Education and Academic Affiliations	↓	With the transfer of inpatient medicine, inpatient surgery, and ambulatory care to a local community provider, the nursing training program would be negatively impacted as those students interested in the transferred services would no longer have access to such training at the Muskogee VAMC.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the costs of providing inpatient medicine, inpatient surgery, and ambulatory care in the baseline BPO is relatively similar to the costs of contracting for care in the Wagoner, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care; the continuity of care issues in the other BPOs may be mitigated somewhat in this BPO because it comes close to contracting for all services, therefore transferring coordination of care to the community. The retention by VA of inpatient psychiatry and outpatient surgery, however, would continue to create coordination challenges in terms of clinical management, recordkeeping, pharmacy, et al. 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.

Assessment of BPO 10	Comparison to Baseline	Description of Impact
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

BPO 11: Inpatient Medicine, Inpatient Surgery, and Ambulatory Care (including Outpatient Mental Health) Contracted to Community Provider in Broken Arrow, OK

Assessment of BPO 11	Comparison to Baseline	Description of Impact
Healthcare Access		
Primary care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for primary care. Although primary care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Acute care	↔	No material change is expected to the percentage of enrollees meeting VA drive time access guidelines for acute care. Although acute care is to relocate closer to Tulsa, the percentage increase of enrollees meeting VA drive time access guidelines due to enrollees living near Tulsa offsets the percentage decrease due to enrollees living near Muskogee.
Tertiary care	↔	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 overall to the quality of medical services since the quality measures for area providers suggest these organizations provide comparable quality of care.
Ensures forecast healthcare need is appropriately met	↔	Changes in clinical volumes should maintain quality of care as compared to the baseline, assuming VA makes necessary operational adjustments to maintain appropriate thresholds over time.
Impact on VA and Local Community		
Human Resources:		
FTEE need (based on volume)	Decrease	With the transfer of inpatient medicine, inpatient surgery, and ambulatory care to a local community provider, there would be a significant decrease in FTEEs at the Muskogee VAMC.
Recruitment / retention	↓	Since inpatient medicine, inpatient surgery, and ambulatory care will be provided in the local community, recruitment and retention of employees at the Muskogee VAMC would be negatively impacted.

Assessment of BPO 11	Comparison to Baseline	Description of Impact
Research	↔	Because the number of active protocols and the number of veteran participants enrolled in research study at the Muskogee VAMC is so low, transfer of inpatient medicine, inpatient surgery, and ambulatory care to a local community provider would not result in a material impact.
Education and Academic Affiliations	↓	With the transfer of inpatient medicine, inpatient surgery, and ambulatory care to a local community provider, the nursing training program would be negatively impacted, as those students interested in the transferred services would no longer have the access to such training at the Muskogee VAMC.
Use of VA Resources		
Operating cost effectiveness	-	Results in potentially the same operating costs as the baseline since the costs of providing inpatient medicine, inpatient surgery, and ambulatory care in the baseline BPO is relatively similar to the costs of contracting for care in the Broken Arrow, OK community.
Overall cost effectiveness	-	As noted earlier, the operating costs are relatively the same as the baseline and result in a similar level of net present cost.
Ease of Implementation		
Ease of BPO Implementation	↓	This BPO is riskier than the baseline in terms of the following major risk areas: 1) Continuity of care; the continuity of care issues in the other BPOs may be mitigated somewhat in this BPO because it comes close to contracting for all services, therefore transferring coordination of care to the community. The retention by VA of inpatient psychiatry and outpatient surgery, however, would continue to create coordination challenges in terms of clinical management, recordkeeping, pharmacy, et al. In addition, the local community provider in Broken Arrow may not be able to accommodate the volume of services 2) Organization and change, due to a possible perception that the VA mission to care for veterans is compromised by contracting for care 3) Political, given local support will be required for successful implementation
Ability to Support VA Programs		
DoD sharing	↔	No material impact is expected since the BPO is not expected to affect any potential, future DoD sharing opportunities.

Assessment of BPO 11	Comparison to Baseline	Description of Impact
One-VA integration	↔	No material impact is expected since the BPO neither precludes nor enhances any potential, future One-VA relationships.
Special considerations	↔	No material impact is expected in terms of special considerations since the BPO neither precludes nor enhances DoD contingency planning, Homeland Security needs, or emergency preparedness.
Overall Attractiveness	↓↓	Less "attractive" than the baseline - likely to offer a solution that, while maintaining quality and cost, may negatively affect access to those veterans living in the Muskogee area where the majority of enrolled veterans utilizing VA services originate. In addition, this BPO appears less "attractive" in terms of impact on VA and local community and ease of implementation.

Appendix B - Glossary

Acronyms

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

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

Definitions

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

Business Plan Option (BPO)	The options developed and assessed by Team PwC as part of the Stage I and Stage II Option Development Process. A business plan option consists of a credible 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.
Multispecialty Clinic	A VA medical facility providing a wide range of ambulatory services such as primary care, specialty care, and ancillary services usually located within a parent VA facility.
Nursing Home	The term "nursing home care" means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care. Such term includes services furnished in skilled nursing care facilities, in intermediate care facilities, and in combined facilities. It does not include domiciliary care.
Primary Care	Healthcare provided by a medical professional with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment. *(See Secondary Care and Tertiary Care)*
Re-use	An alternative use for underutilized or vacant facility space or VA owned land.

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

Mental Health Indicators

Indicator	Description
New Dx Dep - F/U X3 (mdd6n)	Percentage of patients with a new diagnosis of depression who have at least three clinical follow-up visits in the 12 acute periods after diagnosis (current PM)
New Dx Dep - Meds (mdd7n)	Percentage of patients with a new diagnosis of depression who have medication for at least 84 days in the acute treatment period (current PM)
Homeless Dchg Indep (fnct2n)	Percentage of veterans discharged from a domiciliary care for homeless veterans (DCHV), grand and per diem program, or 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)