VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022

VISN 19

Market Recommendations

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VISN 19 Grand Junction Market

The Veterans Integrated Service Network (VISN) 19 Grand Junction Market serves Veterans in western Colorado and southeastern Utah. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[1]

VA's Commitment to Veterans in the Grand Junction Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Grand Junction Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Grand Junction Market is small, highly rural, and experiencing decreasing market enrollment with low demand for inpatient acute services and increasing demand for long-term care and outpatient services. The Grand Junction VAMC will be modernized and include inpatient mental health and expanded subacute services. Outpatient services will be expanded, while inpatient medical and surgical services will be transitioned to the local community hospital by expanding the strong partnership already in place. The strategy for the market is intended to provide Veterans with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation improves access to care by expanding the Montrose other outpatient services (OOS) site into a community-based outpatient clinic (CBOC) at a new, more easily accessible location.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a new modern residential rehabilitation treatment program (RRTP)

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

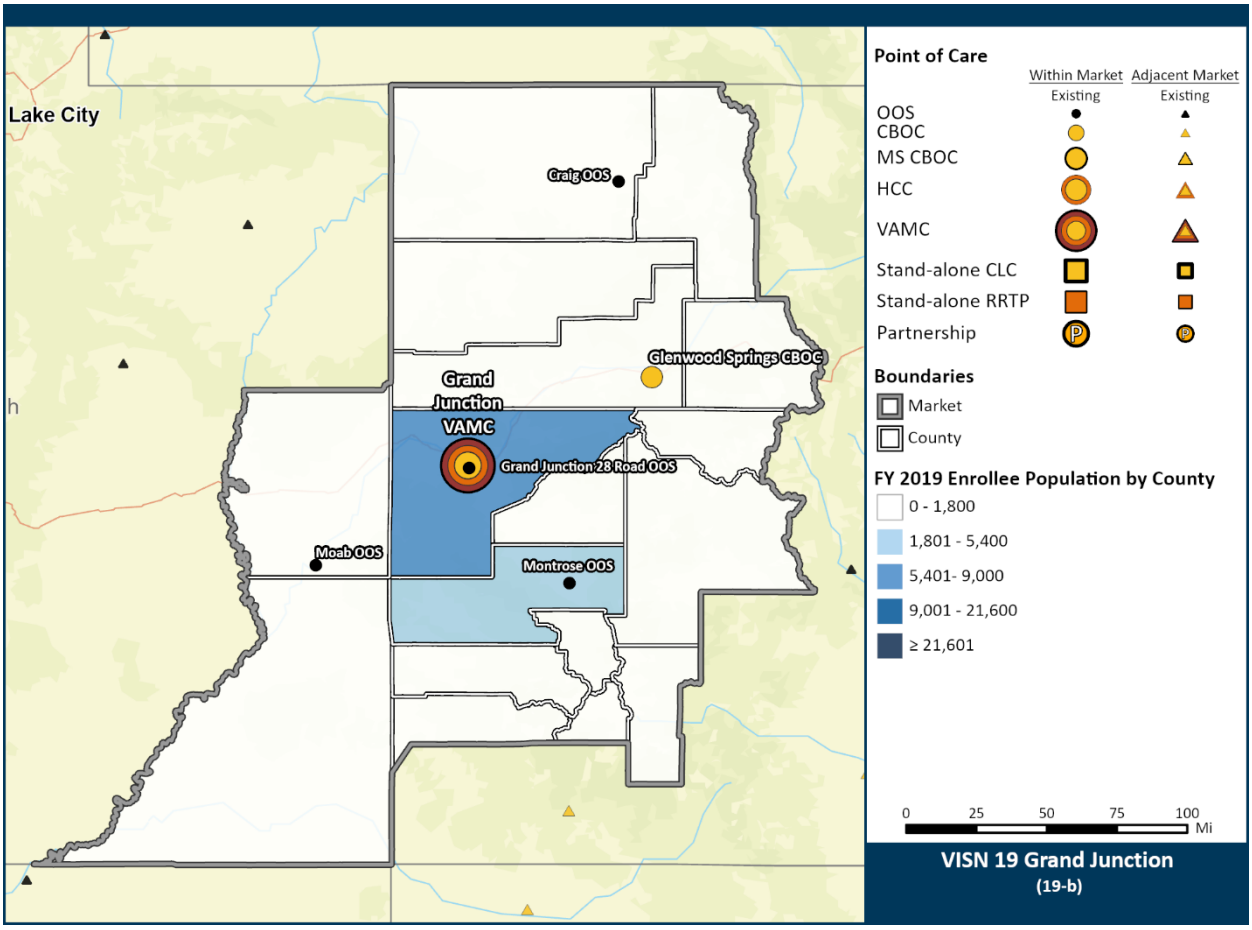
to provide specialized care for substance use disorders, which is currently not readily available in the community. The recommendation maintains sustainable inpatient mental health and invests in community living center (CLC) services through a modernized and expanded CLC offering geropsychiatry and medical psychiatry services. The Aurora VAMC in the Denver Market is the inpatient spinal cord injuries and disorders (SCI/D) specialty hub for the Grand Junction Market. Demand for inpatient blind rehabilitation services will be met at the Palo Alto, California VAMC (VISN 21).

- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains access to quality inpatient medical and surgical care through a strategic collaboration to allow VA providers to deliver care in the partner's space. A strong foundation for strategic collaboration already exists between the Grand Junction VAMC and the local community hospital.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Grand Junction), one CBOC, and four OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 15,791 enrollees and is projected to experience a 1.2% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Mesa and Montrose, Colorado.

Demand: Demand[2] in the market for inpatient medical and surgical services is projected to increase by 0.2% and demand for inpatient mental health services is projected to increase by 3.3% between FY 2019 and FY 2029. Demand for long-term care[3] is projected to increase by 5.9%. Demand for all outpatient

[2] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[3] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

services,[4] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 56.2% of enrollees live in rural areas compared to the VA national average of 32.5%.

Access: 52.8% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 57.1% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[5] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[6] of 57.5% (101 available beds)[7]. Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 81.4% (47 available beds). Community residential rehabilitation programs[8] that match the breadth of services provided by VA are not widely available in the market.

Mission: The market has academic affiliations that include SCL Health St. Mary's Medical Center and allied health training programs. The Grand Junction VAMC is ranked 103 out of 154 VA training sites based on the number of trainees. The Grand Junction VAMC conducts limited or no research and has no emergency designation.[9]

Facility Overview

Grand Junction VAMC: The Grand Junction VAMC is located in Grand Junction, Colorado, and offers inpatient medical and surgical services, inpatient mental health care, CLC, and outpatient services. In FY 2019, the Grand Junction VAMC had an inpatient medical and surgical average daily census (ADC) of 10.4, an inpatient mental health ADC of 2.2, and a CLC ADC of 28.3.

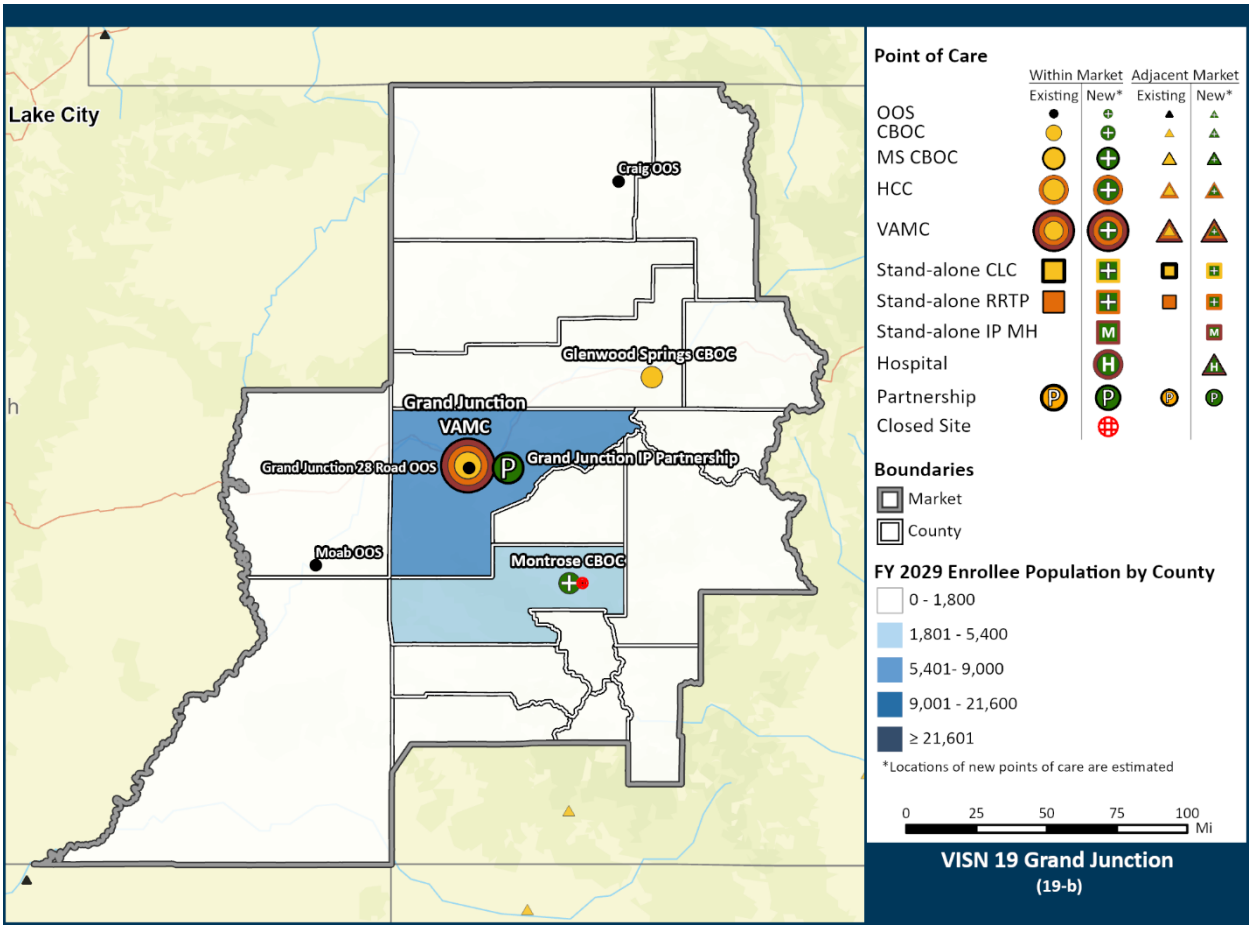
The Grand Junction VAMC was built in 1948 on 20.0 acres and does not meet current design standards.[10] Facility condition assessment (FCA) deficiencies are approximately $46.9M, and annual operations and maintenance costs are an estimated $6.2M.

[4] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[5] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[6] Occupancy rates are calculated by dividing the total average daily census (ADC) by the number of total operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[7] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[8] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[9] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.
[10] Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

Recommendation and Justification

This section details the VISN 19 Grand Junction Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Grand Junction VAMC by:***

   1.1. **Establishing a strategic collaboration for relocating inpatient medical and surgical services and discontinuing these services at the Grand Junction VAMC:** The Grand Junction Market is situated on the western slope of the Rocky Mountains, geographically separated from the Denver Market. Enrollees in the Grand Junction Market are projected to decrease by 1.2% between FY 2019 and FY 2029. The Grand Junction VAMC was built in 1948 and had its last major renovation in 1988. The facility does not meet modern design standards and requires significant investment for its size. There are an approximate $46.9M in FCA deficiencies and estimated operations and maintenance costs total $6.2M. There is no major academic affiliate in Grand Junction; however, there is a strong relationship with a community hospital – a Level 2

trauma center[11] – located two miles away. A strong foundation for strategic collaboration already exists between the Grand Junction VAMC and this facility through current physician sharing arrangements, cooperative programs, and joint recruitment.

Inpatient medical and surgical demand has historically decreased at the Grand Junction VAMC. The FY 2019 ADC was 10.4. Inpatient medical and surgical demand is projected to continue to decrease from 10.4 in FY 2019 to 7.8 in FY 2029. In addition to the low census, inpatient surgical case volume is low, with 74 inpatient cases in FY 2019. Current and increasingly declining demand poses a challenge to maintaining safe practices and staff competency. The Grand Junction Market has approximately 101 acute beds available in the community with a 57.5% occupancy rate. A strategic collaboration to allow VA providers to deliver medical and surgical services in the community provider space will improve quality and provide Veterans with access to more modern facilities.

1.2. **Converting the emergency department at the Grand Junction VAMC to an urgent care center:** Utilizing convenient community access points to provide emergency department services and rescoping to an urgent care center will allow the Grand Junction VAMC to align with the appropriate level of care needed to treat Veterans. The emergency department demand is low. With no ability to admit patients due to the recommended relocation of inpatient medical and surgical services, VA will discontinue emergency services.

1.3. **Establishing an RRTP at the Grand Junction VAMC:** A new RRTP with a focus on substance use disorder (SUD) will allow Veterans to receive highly individualized treatment close to home. In FY 2019, there were 8,982 enrollees within 60 minutes. The new Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) will include 20 beds to accommodate the projected FY 2028 Grand Junction Market SUD demand of 3 beds and additional SUD demand from the Denver Market (19 beds).

1.4. **Modernizing the CLC at the Grand Junction VAMC:** Modernizing the facility will increase privacy, patient satisfaction, and bring care delivery up to modern health care standards.

2. ***Modernize and realign outpatient facilities in the market by relocating the Montrose OOS site to a new site in the vicinity of Montrose, Colorado, and closing the Montrose OOS site:*** In FY 2019, the Montrose OOS served 2,310 core uniques,[12] a 10.5% increase from FY 2015. As of FY 2019, there were 2,249 enrollees within 30 minutes. The lack of community alternatives and growing demand support primary care and mental health expansion. Replacing the facility with a CBOC in the vicinity of Montrose, Colorado (Montrose County) will provide enrollees with a rightsized access point.

Complementary Strategy

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

[11] Trauma center levels refer to the kinds of resources available in a trauma center and the number of patients admitted yearly. A Level 2 Trauma Center is able to initiate definitive care for all injured patients.
[12] VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

Grand Junction Market

- **Partner with Federally Qualified Health Centers (FQHCs) and Indian Health Service (IHS) facilities in the market to expand access to primary care and specialty telehealth services:** There are 13 FQHCs and 5 IHS facilities dispersed throughout the market. These facilities could fill coverage gaps and provide enrollees with a viable health care option closer to home.
- **Leverage the new SARRTP, which is currently being established, to serve the Denver Market and other VISN 19 markets to meet substance use treatment demand in the region, as space allows:** The Denver Market only offers post-traumatic stress disorder (PTSD) RRTP, while substance use RRTP is an unmet need. Leveraging Grand Junction's new SARRTP for the Denver Market, and other VISN 19 markets, will meet the projected RRTP bed demand for SUD.
- **Increase availability of ophthalmology across the Grand Junction Market to address the potential lack of high-quality ophthalmologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists. Increased availability may be achieved through a variety of tactics, such as telehealth, recruitment of providers to the Veteran Community Care Program (VCCP), and hiring additional VA providers, as appropriate.

Grand Junction VAMC

- **Provide the Glenwood Springs CBOC (Garfield County) with a full-time provider augmented by telehealth in lieu of clinic expansion:** Outpatient encounters at Glenwood Springs have been increasing over the past three years. Currently, a provider is on-site only three days per week and a full-time provider may more appropriately address demand.
- **Relocate the Craig OOS (Moffat County) to a telehealth-only clinic to include primary care, mental health, and specialty care telehealth offerings:** The rurality of Moffat County makes it difficult to maintain a consistent provider presence. Relocating the Craig OOS to telehealth-only will reduce the need to staff a full-time provider and enhance access in this region.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Grand Junction Market: Status Quo, Full Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[13] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of existing facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA

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

care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).

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

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Grand Junction Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 19 Grand Junction Market	Status Quo	Modernization	VA Recommendation
Total Cost	$4,584,062,101	$4,990,288,322	$4,786,262,581
Capital Cost	$147,478,260	$553,704,481	$588,849,913
Operational Cost	$4,436,583,840	$4,436,583,840	$4,197,412,668
Total Benefit Score	7	10	14
CBI (normalized in $B)	**0.65**	**0.50**	**0.34**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through six VA points of care offering outpatient services, including the proposed replacement Montrose, Colorado CBOC, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Grand Junction, Colorado VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Aurora, Colorado VAMC (VISN 19).

Demand

- **RRTP:** RRTP demand will be met through the proposed new RRTP at the Grand Junction, Colorado VAMC and the other facilities within VISN 19 offering RRTP, including the Aurora, Colorado VAMC; the Sheridan, Wyoming VAMC; the Valor Point, Colorado stand-alone RRTP; the Salt Lake City, Utah, VAMC; the Cheyenne, Wyoming, VAMC; the Fort Harrison, Montana VAMC; the Oklahoma City, Oklahoma VAMC; and the proposed new Tulsa, Oklahoma stand-alone RRTP.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21) and the American Lake, Washington VAMC (VISN 20).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the proposed new Grand Junction, Colorado partnership, as well as through community providers; inpatient mental health demand will be met through the Grand Junction, Colorado VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to increase, with 14,710 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 15,074 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with SCL Health-St. Mary's.
- **Research:** This recommendation does not impact its research mission in the market; the Grand Junction, Colorado VAMC does not have a research program.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Grand Junction, Colorado VAMC is not designated as a Primary Receiving Center.

Quality

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

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

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.34 for VA Recommendation versus 0.65 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed replacement Montrose, Colorado CBOC; the proposed new RRTP at the Grand Junction, Colorado VAMC; and the Grand Junction, Colorado partnership, as well as the modernization of the CLC at the Grand Junction, Colorado VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community partner space.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($4.8B for VA Recommendation versus $5.0B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.34 for VA Recommendation versus 0.50 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 19 Salt Lake City Market

The Veterans Integrated Service Network (VISN) 19 Salt Lake City Market serves Veterans in Utah, southeast Idaho, and northeast Nevada. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[14]

VA's Commitment to Veterans in the Salt Lake City Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Salt Lake City Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

Market enrollment is increasing, with decreasing yet sufficient demand for inpatient medical and surgical services and increasing demand for inpatient mental health, long-term care, and outpatient care. VA recommends that the aging Salt Lake City VAMC develop a new bed tower with acute services and rehabilitation medicine. A new standalone community living center (CLC) will be developed, and outpatient services will be expanded. The recommendation closes the poorly utilized low demand and unsustainable Roosevelt and Price other outpatient services (OOS) sites and maintains access by relocating care to the community. The strategy for the market is intended to provide Veterans with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation invests in one additional community-based outpatient clinic (CBOC) in the vicinity of Salt Lake City, Utah, to alleviate space constraints and accommodate service expansion, and expands the St. George CBOC into a

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

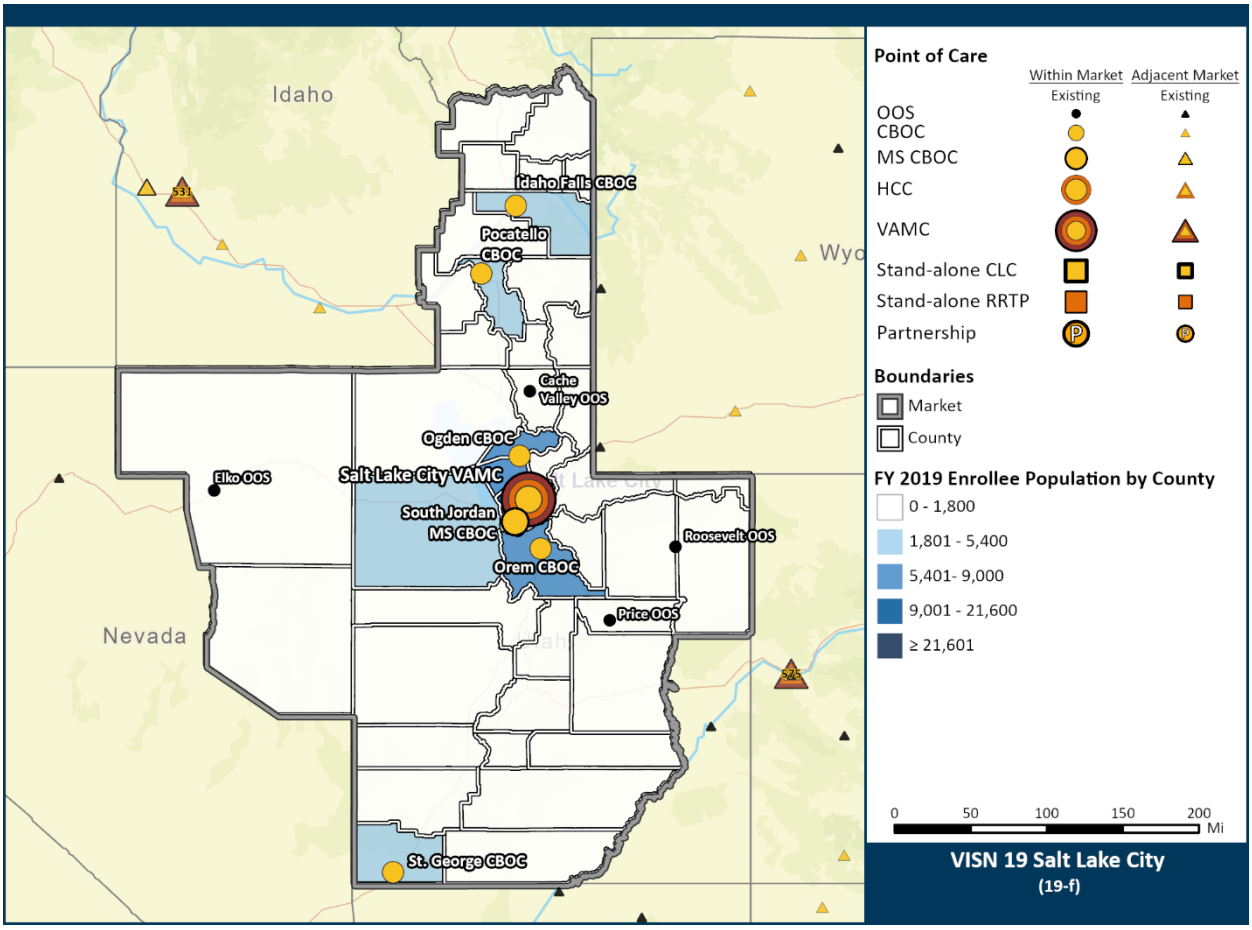
multi-specialty community-based outpatient clinic (MS CBOC) offering primary care, mental health, and specialty services to improve access to care.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a modern standalone CLC facility to maintain care for Veterans with the most complex needs, expands residential rehabilitation treatment program (RRTP) beds at the Salt Lake City RRTP, and maintains inpatient mental health services at the Salt Lake City VAMC. The Aurora VAMC in the Denver Market is the inpatient spinal cord injuries and disorders (SCI/D) specialty hub for the Salt Lake City Market. Demand for inpatient blind rehabilitation services will be met at the Palo Alto, California VAMC (VISN 21).
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation establishes a new, modern inpatient medical and surgical bed tower on the Salt Lake City VAMC campus to improve quality and patient satisfaction.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Salt Lake City), one MS CBOC, five CBOCs, and four OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 68,864 enrollees and is projected to experience a 1.0% increase in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Salt Lake, Davis, and Weber, Utah.

Demand: Demand[15] in the market for inpatient medical and surgical services is projected to decrease by 5.9% and demand for inpatient mental health services is projected to increase by 7.8% between FY 2019 and FY 2029. Demand for long-term care[16] is projected to increase by 43.7%. Demand for all outpatient

[15] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).

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

services,[17] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 24.8% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 78.0% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 63.6% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[18] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[19] of 61.2% (712 available beds)[20] and an inpatient mental health occupancy rate of 77.8% (8 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 71.7% (527 available beds). Community residential rehabilitation programs[21] that match the breadth of services provided by VA are not widely available in the market.

Mission: The market has academic affiliations that include the University of Utah. The Salt Lake City VAMC is ranked 46 out of 154 VA training sites based on the number of trainees and is ranked 5 out of 103 VAMCs with research funding. The Salt Lake City VAMC is designated as a Federal Coordinating Center.[22]

Facility Overview

Salt Lake City VAMC: The Salt Lake City VAMC is located in Salt Lake City, Utah, and offers inpatient medical and surgical, inpatient mental health care, RRTP, rehabilitation medicine, and outpatient services. In FY 2019, the Salt Lake City VAMC had an inpatient medical and surgical average daily census (ADC) of 44.9, an inpatient mental health ADC of 24.0, an RRTP ADC of 13.0, and a rehabilitation medicine ADC of 2.6.

The Salt Lake City VAMC was built in 1949 on 81.0 acres; zero acres are available for additional development. The VAMC's last major renovation was in 1988, when a building was constructed for outpatient, diagnostic, and therapeutic services. The inpatient beds remain in the original hospital building from 1949, which does not meet current design standards.[23] Facility condition assessment (FCA) deficiencies are approximately $225.9M and annual operations and maintenance costs are an estimated $13.4M.

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

[18] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.

[19] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.

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

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

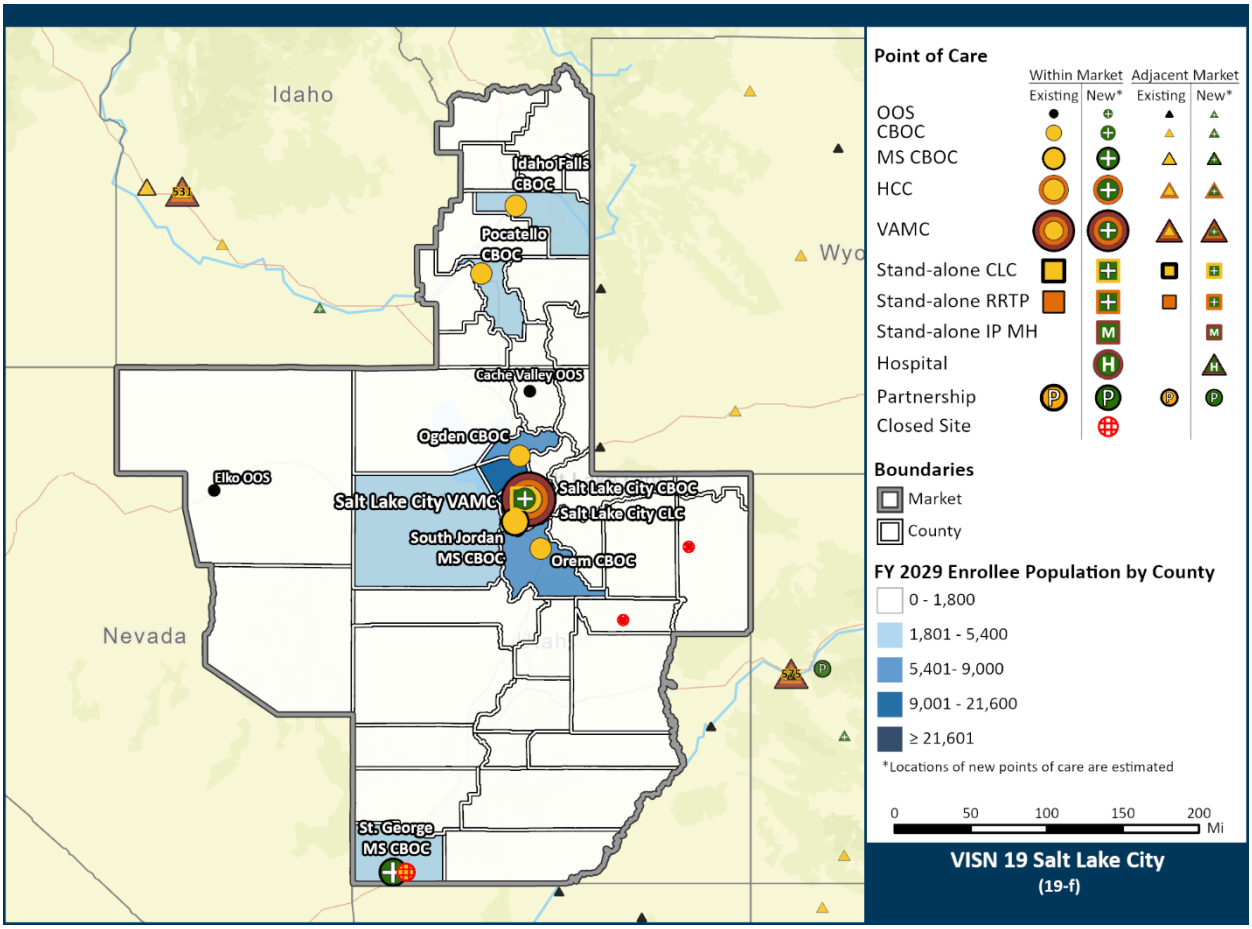
[22] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

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

Recommendation and Justification

This section details the VISN 19 Salt Lake City Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Salt Lake City VAMC by:***

   1.1. Constructing a new bed tower at the Salt Lake City VAMC: The enrollees in the Salt Lake City Market are projected to increase by 1.0%, from 68,864 in FY 2019 to 69,576 by FY 2029. In FY 2019, there were 42,815 enrollees within a 60-minute drive time of the Salt Lake City VAMC. Enrollees are clustered in the counties around the VAMC and are highly reliant on this facility. The existing medical and surgical bed tower at the VAMC was constructed in 1949; the configuration and aging infrastructure are not conducive to providing quality care in a modern environment. It has semi-private rooms accessed from public corridors and has an inefficient layout with long, narrow units and poor sight lines. Additionally, the property is rated as high seismic risk. The Salt Lake City VAMC has 77 inpatient medical and surgical beds with an FY 2019 ADC of 44.9. Although inpatient medical and surgical demand at the VAMC is projected to decrease from 44.9 in FY 2019 to 38.9 in FY 2029, there is still sufficient demand to maintain these services. Construction of a new inpatient medical and surgical bed tower with

private rooms and a modern, appropriately sized, and seismically resilient structure, will improve patient experience, safety, and care delivery.

1.2. Modernizing the RRTP at the Salt Lake City VAMC: The Salt Lake City Market has a projected RRTP bed need of 52 beds in FY 2028. Expanding beds from 15 to 48 at the Salt Lake City RRTP will meet the projected demand in the market for the specific RRTP bed types. This will include 17 General Domiciliary beds, 15 Domiciliary Care for Homeless Veterans (DCHV) beds, and 16 substance use disorder (SUD) beds. The remainder of Salt Lake City's RRTP bed demand will be met at the Sheridan VAMC RRTP.

2. ***Modernize by establishing a new stand-alone CLC in the vicinity of Salt Lake City, Utah*****:** Currently, there are no CLC services offered in the Salt Lake City Market. The in-house and community CLC demand in the market is projected to increase by 43.7% between FY 2019 and FY 2029, indicating a need for 48 CLC beds. Opening a new 48-bed CLC in the vicinity of Salt Lake City will expand access to long-term care and reduce the reliance on community care to provide CLC services. There is no available development space on the Salt Lake City VAMC campus for this project.

3. ***Modernize and realign outpatient facilities in the market by:***

3.1. Establishing a new CBOC in the vicinity of Salt Lake City, Utah: The Salt Lake City VAMC served 58,978 core uniques[24] in FY 2019, which was an 18.4% increase in core uniques since FY 2015. In FY 2019, there were 75,540 primary care encounters at the Salt Lake City VAMC. Current primary care clinics are space-constrained, with insufficient exam rooms to effectively support the patient-aligned care team (PACT) model, thus limiting panel sizes and efficiency. Establishing a new CBOC in the vicinity of Salt Lake City, Utah, will help decompress the Salt Lake City VAMC and allow for improved Veteran access, an increased number of PACTs with appropriate panel sizes, and appropriate clinic space designed for PACT utilization. In FY 2019, there were 24,095 enrollees within 30 minutes of the proposed new CBOC.

3.2. Relocating the St. George CBOC to a new site in the vicinity of St. George, Utah, and closing the St. George CBOC: In FY 2019, the St. George CBOC had 7,127 enrollees within 60 minutes and 4,252 enrollees within 30 minutes, and it served 4,447 core uniques. Washington County is projected to experience a 6.5% increase in enrollment between FY 2019 and FY 2029. From FY 2017 to FY 2019 outpatient encounters have increased by 18.0% for primary care, 61.7% for mental health, and 7.1% for outpatient specialty care. The existing CBOC is undersized and inadequate to accommodate this increasing demand. There is a projected market primary care demand increase of 64.9% and outpatient specialty care demand increase of 69.1% by FY 2029. Expanding and reclassifying the St. George CBOC to an MS CBOC in the vicinity of St. George, Utah, will provide enrollees with an appropriately sized access point and increase access to outpatient specialty care.

3.3. Relocating all services at the Roosevelt OOS and closing the Roosevelt OOS: The Roosevelt OOS had 505 enrollees within 30 minutes and served 744 core uniques in FY 2019. The number of enrollees in Duchesne County is projected to decrease by 6.2% between FY 2019 and FY 2029. The Indian Health Service (IHS) facility at Fort Duchesne in Roosevelt, Utah, and other

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

community providers will serve the Veteran enrollees in the area, maintaining access and enabling the deactivation of this low demand, contracted point of care.

3.4. **Relocating all services at the Price OOS and closing the Price OOS:** The Price OOS had 603 enrollees within 30 minutes and served 487 core uniques in FY 2019. The number of enrollees in Carbon County is projected to decrease by 7.3% between FY 2019 and FY 2029. Two Federally Qualified Health Centers (FQHCs) in Price, Utah, and other community providers will serve the Veteran population in the area, maintaining access and enabling the deactivation of this low demand point of care.

Complementary Strategy

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

Salt Lake City VAMC

- **Add home-based primary care (HBPC) services to the Pocatello CBOC (Bannock County) and the proposed expanded St. George MS CBOC (Washington County):** Home-based primary care (HBPC) encounters in the market increased by 51.0%, from 2,665 encounters in FY 2015 to 4,024 in FY 2018. Adding HBPC to the Pocatello and St. George CBOCs will allow a greater number of enrollees to access this service.
- **Expand the psychiatry rotation to the St. George CBOC (Washington County):** The existing training program sends third- and fourth-year psychiatry residents from the Salt Lake City VAMC to the Pocatello CBOC. Expanding this program to the St. George CBOC will offer additional outpatient training experiences to postgraduates, rounding out their exposure to a broad range of mental health conditions.
- **Improve access to physical therapy services at the Pocatello CBOC (Bannock County) by staffing the program:** The Pocatello CBOC was built with dedicated space for physical therapy, but it has not been activated due to lack of funding for necessary full-time equivalents (FTEs). Total market Veteran demand for physical therapy is projected to increase significantly, so staffing the program will reduce the need to rely on physical therapy services in the community.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Salt Lake City Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[25] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of

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

new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).

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

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Salt Lake City Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 19 Salt Lake City Market	Status Quo	Modernization	VA Recommendation
Total Cost	$18,842,245,625	$19,583,031,855	$19,743,983,103
Capital Cost	$1,115,616,379	$1,856,402,609	$2,017,353,856
Operational Cost	$17,726,629,246	$17,726,629,246	$17,726,629,246
Total Benefit Score	8	11	12
CBI (normalized in $B)	**2.36**	**1.78**	**1.65**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA-facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 10 VA points of care offering outpatient services, including the proposed replacement St. George, Utah MS CBOC and the proposed new Salt Lake City, Utah CBOC, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed new Salt Lake City, Utah stand-alone CLC, as well as community nursing homes.

Demand

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Aurora, Colorado VAMC (VISN 19).
- **RRTP:** RRTP demand will be met through the Salt Lake City, Utah VAMC and the other facilities within VISN 19 offering RRTP, including the Sheridan, Wyoming VAMC; the Cheyenne, Wyoming, VAMC; the Fort Harrison, Montana VAMC; the proposed new RRTP at the Grand Junction, Colorado VAMC; the Aurora, Colorado VAMC; the Valor Point, Colorado stand-alone RRTP; the Oklahoma City, Oklahoma VAMC; and the proposed new Tulsa, Oklahoma stand-alone RRTP.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21) and the American Lake, Washington VAMC (VISN 20).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Salt Lake City, Utah VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 69,129 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 69,764 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Utah.
- **Research:** This recommendation does not impact the research mission in the market and allows the Salt Lake City, Utah VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Salt Lake City, Utah VAMC is not designated as a Primary Receiving Center.

Quality

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

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed replacement St. George, Utah MS CBOC; the proposed new Salt Lake City, Utah CBOC; and the stand-alone CLC in Salt Lake City, Utah; as well as the modernization of the RRTP at the Salt Lake City, Utah VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (1.65 for VA Recommendation versus 2.36 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed replacement St. George, Utah MS CBOC; the proposed new Salt Lake City, Utah CBOC; and the stand-alone CLC in Salt Lake City, Utah; as well as the modernization of the RRTP at the Salt Lake City, Utah VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today ($19.7B for VA Recommendation versus $19.6B for Modernization), there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.65 for VA Recommendation versus 1.78 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 19 Sheridan Market

The Veterans Integrated Service Network (VISN) 19 Sheridan Market serves Veterans in north-central and western Wyoming. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[26]

VA's Commitment to Veterans in the Sheridan Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Sheridan Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Sheridan Market, smallest in the nation and the second most rural, faces markedly decreasing market enrollment. While demand for inpatient medical and surgical services is increasing, current and projected demand is unsustainably low. Inpatient medical and surgical services will be transitioned to a community provider, maintaining Veteran access in the Sheridan area. Inpatient mental health, long-term care, and outpatient care demand are sustainable and increasing. The Sheridan VAMC has a large campus in a tranquil rural setting and will be transformed into a destination mental health and rehabilitation facility. The strategy for the market is intended to provide Veterans with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation maintains sustainable outpatient services at nine outpatient facilities in the market.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation develops the Sheridan VAMC into a destination mental health facility with expanded inpatient mental health beds, outpatient mental health, and a walk-in mental health clinic. The recommendation maintains the community living center (CLC) and also develops a

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

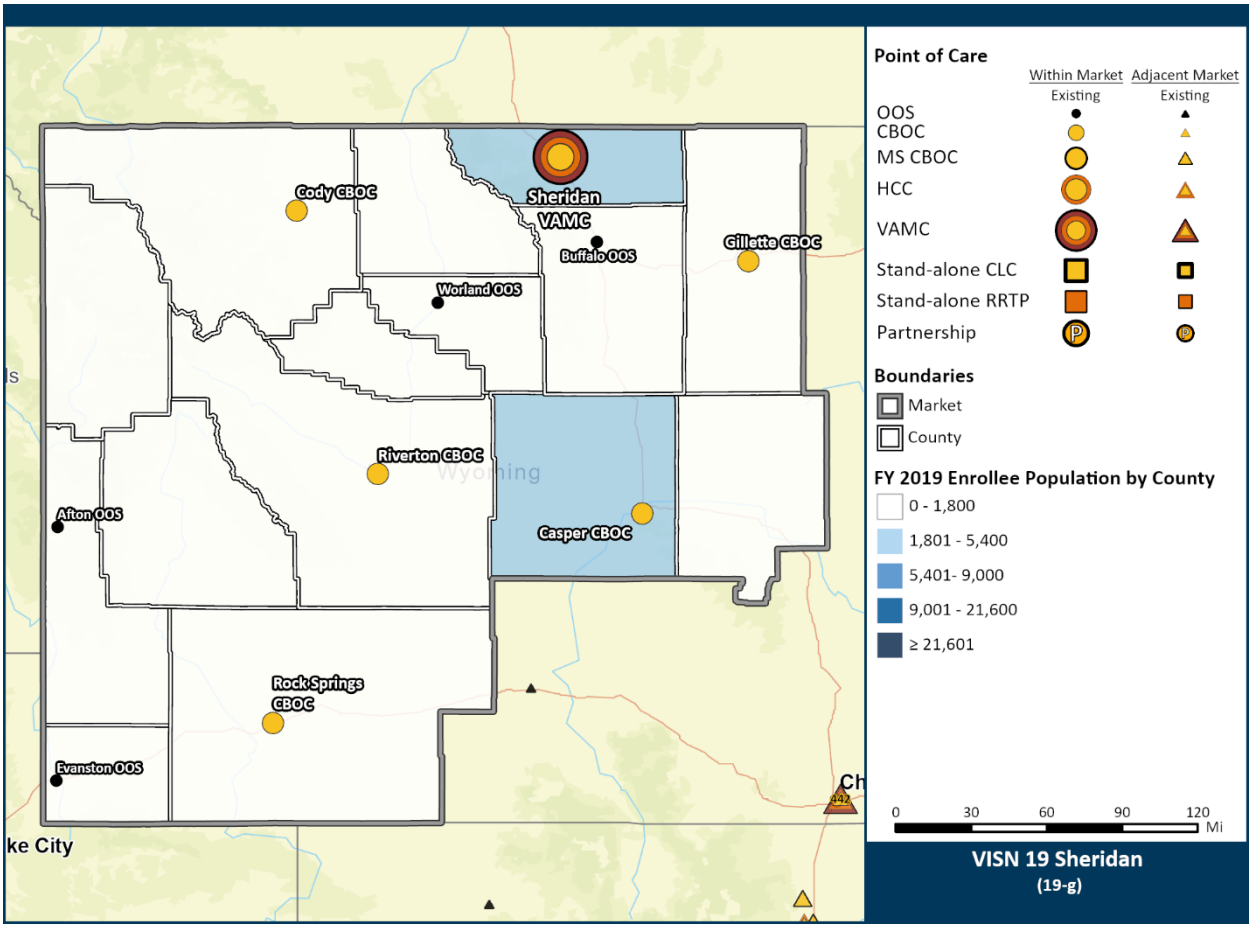
rightsized comprehensive residential rehabilitation treatment program (RRTP) providing access and sustainability as the VISN's destination RRTP. The Aurora VAMC in the Denver Market is the inpatient spinal cord injuries and disorders (SCI/D) specialty hub for the Sheridan Market. Demand for inpatient blind rehabilitation services will be met at the American Lake, Washington VAMC (VISN 20).

- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains access and optimizes care by relocating care to sustainable inpatient medical programs at community providers.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Sheridan), five CBOCs, and four other outpatient service (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 14,496 enrollees and is projected to experience a 5.8% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Natrona and Sheridan, Wyoming.

Demand: Demand[27] in the market for inpatient medical services is projected to increase by 12.2% and demand for inpatient mental health services is projected to increase by 13.8% between FY 2019 and FY 2029. Demand for long-term care[28] is projected to increase by 6.2%. Demand for all outpatient services,[29] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 83.8% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 63.5% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 18.5% of enrollees live within a 60-minute drive time of a VA secondary care site. Secondary care sites include health care centers (HCCs), VAMCs, and VA Hospitals only. Enrollees have access to outpatient specialty care services in this market, including at the Sheridan VAMC, the Buffalo OOS, and the Casper CBOC.

Community Capacity: As of 2019, community providers[30] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[31] of 31.6% (45 available beds). [32] Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 68.5% (46 available beds). Community residential rehabilitation programs[33] that match the breadth of services provided by VA are not widely available in the market.

Mission: The Sheridan Market has academic affiliations that include the University of Wyoming. The market has a small education mission. The Sheridan VAMC is ranked 118 of 154 VA training sites based on the number of trainees. The Sheridan VAMC conducts limited or no research, and the VAMC has no emergency designation.[34]

Facility Overview

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

[27] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[28] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[29] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[30] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[31] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[32] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[33] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[34] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

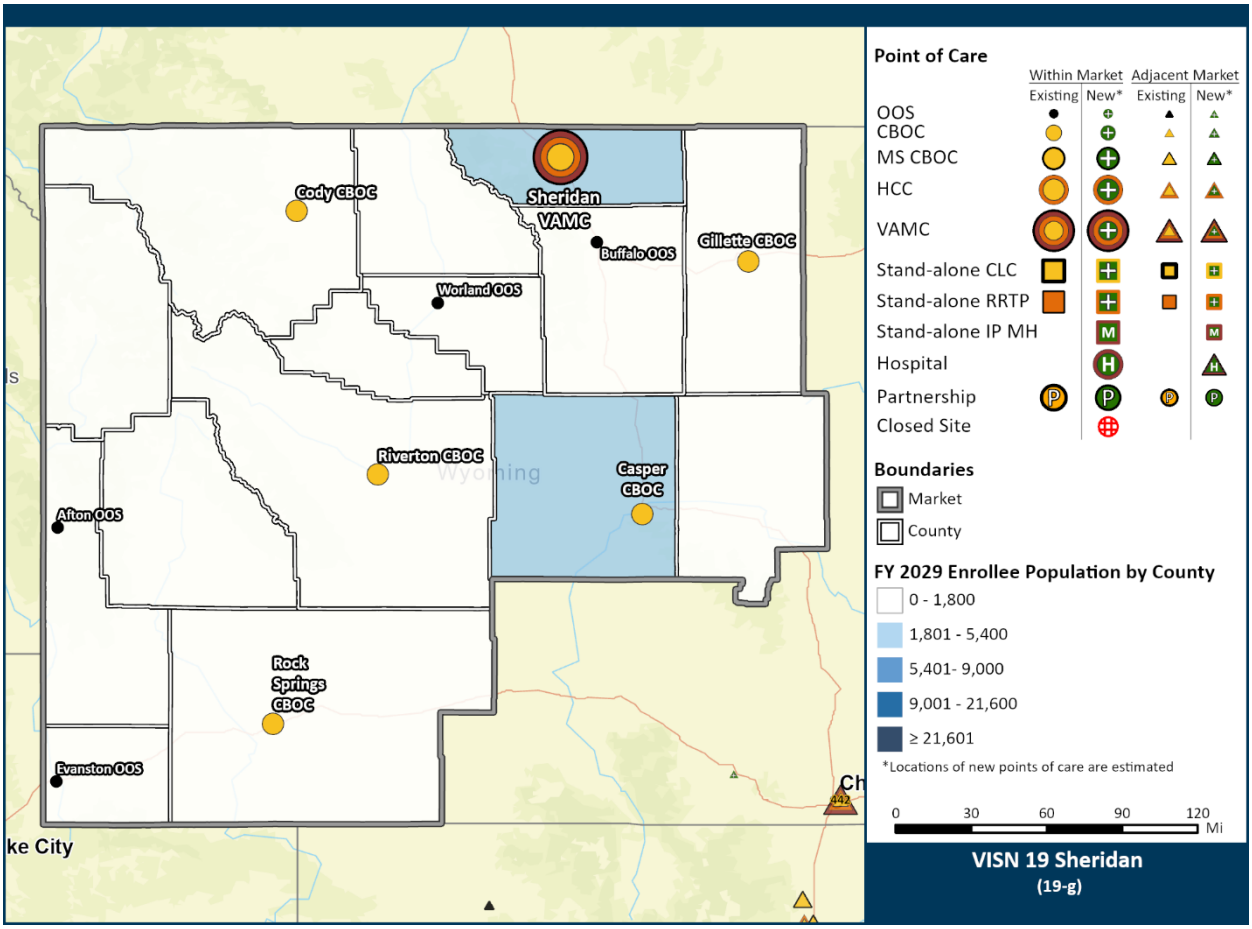
inpatient medical average daily census (ADC) of 4.0, an inpatient mental health ADC of 11.2, a CLC ADC of 31.7, and an RRTP ADC of 73.9.

The Sheridan VAMC was built in 1932 on 272 acres and does not meet current design standards.[35] Buildings dating back to the 1900s are in use on the campus. Facility condition assessment (FCA) deficiencies are approximately $72.9M, and annual operations and maintenance costs are an estimated $6.4M.

Recommendation and Justification

This section details the VISN 19 Sheridan Market recommendation and justification for each element of the recommendation.

Future Market Map



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

1. ***Modernize and realign the Sheridan VAMC by relocating inpatient medical and urgent care services provided at the Sheridan VAMC to community providers and discontinuing these services at the Sheridan VAMC:*** VA recommends changing the mission of the Sheridan VAMC to a destination mental health facility for VISN 19, offering acute and subacute psychiatric care and residential rehabilitation treatment. Many of the surrounding VISN 19 markets have unmet demand for RRTP services. RRTP demand from the Salt Lake City, Grand Junction, Cheyenne, Muskogee, Oklahoma City, and Fort Harrison VAMCs will be supported by the Sheridan VAMC. CLC services will also remain and leverage a recently built long-term care facility.

   The repurposed Sheridan VAMC will offer a well-developed array of high-quality mental health services, including inpatient mental health, with the capability to support the medical needs of patients and specialized RRTP tracks. Rightsizing RRTP beds from 115 to 95 will meet the current and projected RRTP needs for General Domiciliary, Domiciliary Care for Homeless Veterans (DCHV), substance use disorder (SUD), and post-traumatic stress disorder (PTSD) beds.

   The Sheridan VAMC had 10 inpatient medical beds with an ADC of 4.0 in FY 2019; there are no surgical beds. The low inpatient medical demand at the Sheridan VAMC poses a challenge to maintaining safe practices and staff competencies. While in-house and community inpatient medical demand in the market is projected to increase by 15.9% between FY 2019 and FY 2029, low current and future demand at the Sheridan VAMC could be absorbed by community providers. The VAMC currently admits surgical and higher acuity medical patients to a nearby community provider, suggesting a smooth transition to community providers of all inpatient medical services. Realigning medical and surgical care to community providers in this rural market will contribute to overall rural health care sustainability.

   The existing urgent care at the Sheridan VAMC is underutilized, with 1,841 encounters in FY 2019. Additionally, most after-hours cases seen in urgent care were related to mental health needs. Low encounters volumes do not justify the maintenance of urgent care services and the community can provide non-psychiatric urgent and emergent services. Converting urgent care to a 24/7 mental health walk-in and triage service will allow Veterans to be served as they present and will augment the proposed mental health mission of the Sheridan VAMC, while reducing the resources needed to maintain urgent care services.

Complementary Strategy

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

Sheridan Market

- **Actively partner with other VISN markets to address mental health needs in the region:** The Sheridan VAMC offers a well-developed array of high-quality mental health services through six specialized RRTP tracks that include SUD and PTSD care, a serious mental illness program, and a homeless program. Better communication and case management with other VAMCs will raise awareness and enhance the utilization of Sheridan's mental health programs.

- **Continue to seek opportunities to share services and resources between the VISN 19 Montana and Sheridan markets without a formalized clinical or administrative merger:** The Montana Market already leverages the Sheridan VAMC for mental health services. Given that the Sheridan VAMC is successfully executing its mission and resource sharing is already occurring, the two markets can improve clinical service delivery without the need for an administrative merger.
- **Increase home based primary care (HBPC) coverage across the market by expanding into Gillette (Campbell County) and Riverton (Fremont County) and continuing expanding in Casper (Natrona County). Offer more complex services, consistent with a hospital-at-home program:** The Sheridan Market is one of the most rural markets across VA's network. Mountain terrain and challenging winter conditions contribute to physical access issues, making it difficult for older and higher-acuity enrollees to travel for care. Expanding HBPC from outlying clinics for primary care as well as augmenting services will enhance access to care.
- **Explore Federally Qualified Health Center (FQHC) strategic collaborations in the market to increase primary care access. Additionally, expand partnerships with Indian Health Service (IHS) facilities in Fremont County:** There are 12 FQHCs and 3 IHS facilities dispersed throughout the market. These facilities will fill coverage gaps and provide enrollees with a viable health care option closer to home.
- **Strengthen academic partnerships in the region to expand mental health residency training programs:** Given the mental health mission and robust mental health expertise at the Sheridan VAMC, it will be beneficial to expand mental health training programs. Potential regional partners include the University of Wyoming; the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) medical education program; and other VA markets.
- **Increase availability of ophthalmology across the Sheridan Market to address the potential lack of high-quality ophthalmologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists. Increased availability may be achieved through a variety of tactics, such as telehealth, Veterans Community Care Program (VCCP) recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of dermatology across the Sheridan Market to address the potential lack of high-quality dermatologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality dermatologists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of urology across the Sheridan Market to address the potential lack of high-quality urologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality urologists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of physical medicine and rehabilitation across the Sheridan Market to address the potential lack of high-quality physical medicine and rehabilitation specialists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality physical medicine and rehabilitation specialists. Increased availability may be achieved through a variety

of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.

Sheridan VAMC

- **Convert inpatient medical beds to inpatient mental health beds that can support the treatment of medical comorbidities at the Sheridan VAMC (Sheridan County) and staff accordingly:** As inpatient medical services will be provided in the community, converting those beds into inpatient mental health beds will allow the Sheridan VAMC to focus on the inpatient mental health mission.
- **Reduce the RRTP services at the Sheridan VAMC (Sheridan County):** The Sheridan RRTP had an ADC of 73.9 in FY 2019. Reducing RRTP beds at the Sheridan VAMC from 115 to 95 will meet the projected demand in the market for specific RRTP bed types, as well as demand from other markets, making the Sheridan VAMC a rightsized destination RRTP. This will include 35 General Domiciliary beds, 10 Domiciliary Care for Homeless Veterans (DCHV) beds, 10 SUD beds, and 40 PTSD beds.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Sheridan Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[36] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Sheridan Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

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

VISN 19 Sheridan Market	Status Quo	Modernization	VA Recommendation
Total Cost	$4,364,810,446	$4,512,516,225	$4,493,601,069
Capital Cost	$481,221,718	$628,927,497	$688,308,060
Operational Cost	$3,883,588,728	$3,883,588,728	$3,805,293,009
Total Benefit Score	7	10	11
CBI (normalized in $B)	**0.62**	**0.45**	**0.41**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 10 VA points of care offering outpatient services, including community providers in the market.
- **CLC:** Long-term care demand will be met through the Sheridan, Wyoming VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Aurora, Colorado VAMC (VISN 19).
- **RRTP:** RRTP demand will be met through the Sheridan, Wyoming VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21) and the American Lake, Washington VAMC (VISN 20).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through community providers; inpatient mental health demand will be met through the Sheridan, Wyoming VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 13,107 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 13,532 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Wyoming.
- **Research:** This recommendation does not impact the research mission in the market; the Sheridan, Wyoming VAMC does not have a research program.[37]
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Sheridan, Wyoming VAMC is not designated as a Primary Receiving Center.

Quality

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

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

[37] Research programs were determined by FY 2021 total VA-funded research dollars per the Research and Development Information System (RDIS).

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.41 for VA Recommendation versus 0.62 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Reflects stewardship of taxpayer dollars**: The cost of the market recommendation is less than the cost to modernize facilities in the market today ($4.49B for VA Recommendation versus $4.51B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.41 for VA Recommendation versus 0.45 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 19 Cheyenne Market

The Veterans Integrated Service Network (VISN) 19 Cheyenne Market serves Veterans in southeastern Wyoming, northeastern Colorado, and part of western Nebraska. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[38]

VA's Commitment to Veterans in the Cheyenne Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Cheyenne Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Cheyenne Market is facing increasing Veteran enrollment. The market is projected to experience increased demand for inpatient medical and surgical, inpatient mental health, long-term care, and outpatient services. There is a need to expand outpatient services and maintain inpatient services to meet Veteran demand. The unsustainable Sidney OOS will be closed, and VA will maintain Veteran access by relocating care to the community. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation improves access to care in modern facilities by establishing one other outpatient services (OOS) site in the vicinity of Laramie, Wyoming, which will allow the consolidation and closure of the Rawlins OOS.
- **Enhance VA's unique strengths in caring for Veterans with complex needs**: VA's recommendation maintains residential rehabilitation treatment program (RRTP) and long-term care services within the Cheyenne VAMC. The Sheridan VAMC in the adjacent Sheridan Market will provide inpatient mental health services for the Cheyenne Market. The Aurora VAMC in the adjacent Denver Market is the inpatient spinal cord injuries and disorders (SCI/D) specialty hub

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

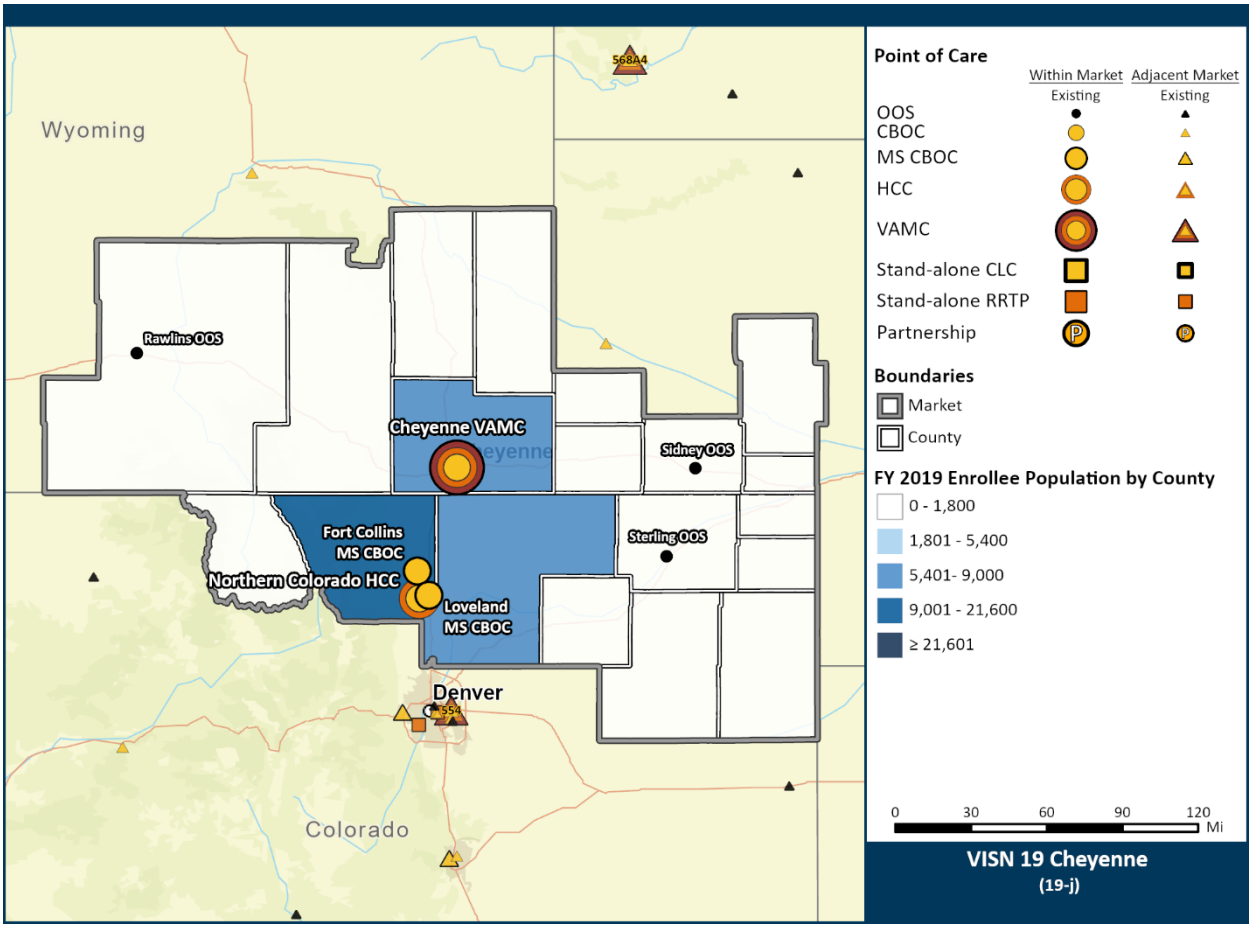
for the Cheyenne Market. Demand for inpatient blind rehabilitation services will be met at the Palo Alto, California VAMC (VISN 21) and the Long Beach, California VAMC (VISN 22).

- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains inpatient medical and surgical services at the Cheyenne VAMC.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Cheyenne), one health care center (HCC), two multi-specialty community-based outpatient clinics (MS CBOCs), and three OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 29,772 enrollees and is projected to experience a 7.1% increase in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Larimer and Weld, Colorado; and Laramie, Wyoming.

Demand: Demand[39] in the market for inpatient medical and surgical services is projected to increase by 5.2% and demand for inpatient mental health services is projected to increase by 24.6% between FY 2019 and FY 2029. Demand for long-term care[40] is projected to increase by 41.3%. Demand for all outpatient services,[41] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 39.1% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 74.6% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 66.8% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[42] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[43] of 52.6% (210 available beds)[44] and an inpatient mental health occupancy rate of 57.8% (15 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 85.2% (19 available beds). Community residential rehabilitation programs[45] that match the breadth of services provided by VA are not widely available in the market.

Mission: The market has academic affiliations that include the University of Wyoming and Rocky Vista University. The Cheyenne VAMC is ranked 126 of 154 VA training sites based on the number of trainees. The Cheyenne VAMC conducts limited or no research, and the VAMC has no emergency designation.[46]

Facility Overview

Cheyenne VAMC: The Cheyenne VAMC is located in Cheyenne, Wyoming, and offers inpatient medical and surgical services, RRTP, CLC, and outpatient services. In FY 2019, the Cheyenne VAMC had an inpatient medical and surgical average daily census (ADC) of 14.6, an RRTP ADC of 7.7, and a CLC ADC of 33.7.

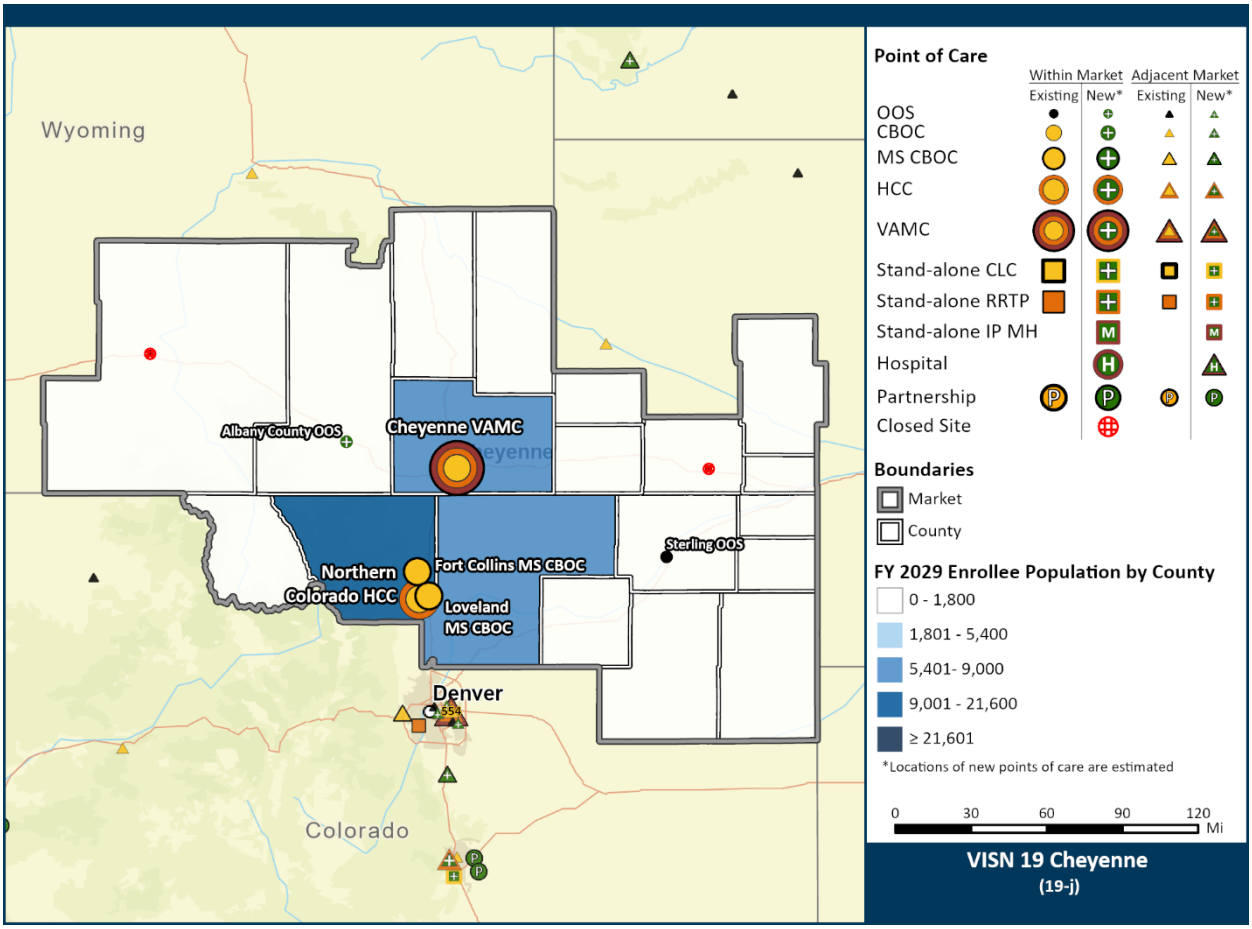
The Cheyenne VAMC was built in 1932 on 51.0 acres. Facility condition assessment (FCA) deficiencies are approximately $34.2M, and annual operations and maintenance costs are an estimated $6.2M.

[39] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[40] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC
[41] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[42] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[43] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[44] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[45] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[46] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

Recommendation and Justification

This section details the VISN 19 Cheyenne Market recommendation, and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Cheyenne VAMC by converting the emergency department at the Cheyenne VAMC to an urgent care center:*** Emergency department demand is low. Utilizing convenient community access points to provide emergency department services and rescoping services to an urgent care center will allow the Cheyenne VAMC to align with the appropriate level of care needed to treat Veterans.

2. ***Modernize and realign outpatient facilities in the market by:***

   2.1. Establishing a new OOS in the vicinity of Laramie, Wyoming: The in-house and commercial demand for primary care services in the Cheyenne market is projected to increase by 74.4% from FY 2019 to FY 2029. A new OOS in Albany County, which is in the vicinity of Laramie, Wyoming, will increase access to primary care and mental health services for enrollees in Albany County (1,115 enrollees within 30 minutes in FY 2019) and the counties beyond.

2.2. **Relocating all services to the proposed new Albany County OOS and closing the Rawlins OOS site:** In FY 2019, the Rawlins OOS had 269 enrollees within 30 minutes of the site. With a low enrollee population, deactivating the facility and relocating care to the proposed new Albany County OOS and community providers in Rawlins will allow the small enrollee population to have local, convenient access. The proposed Albany County OOS places care near Laramie, Wyoming, where there are more Veterans. In FY 2019, there were 1,115 enrollees within 30 minutes of the proposed site in Laramie, Wyoming.

2.3. **Relocating all services at the Sidney OOS and closing the Sidney OOS:** The Sidney OOS had 404 enrollees within 30 minutes in FY 2019 and served 663 core uniques in FY 2019. Additionally, the Sidney OOS has seen a historical decrease in outpatient encounters. Primary care encounters decreased by 25.6%, from 3,797 in FY 2017 to 2,825 in FY 2019, and mental health encounters decreased by 36.9% from 461 in FY 2017 to 291 in FY 2019. There is a critical access hospital in Sidney that offers primary care services. With low utilization, deactivating the facility and relocating care to community providers will allow the small enrollee population to have local, convenient access.

Complementary Strategy

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

Cheyenne Market

- **Increase availability of rheumatology across the Cheyenne Market to address the potential lack of high-quality rheumatologists**: As identified in the Section 203 criteria analysis, there is a potential lack of high-quality rheumatologists. Increased availability may be achieved through a variety of tactics, such as telehealth, Veterans Community Care Program (VCCP) recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of ophthalmology across the Cheyenne Market to address the potential lack of high-quality ophthalmologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of critical care/pulmonary disease services across the Cheyenne Market to address the potential lack of high-quality critical care/pulmonary disease specialists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality critical care/pulmonary disease specialists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of physical medicine and rehabilitation services across the Cheyenne Market to address the potential lack of high-quality physical medicine and rehabilitation specialists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality physical medicine and rehabilitation specialists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.

Cheyenne VAMC

- **If gastrointestinal (GI) endoscopy demand reaches 3,200 cases per year, include GI practice and procedure space in the Program for Design (PFD) for the new Loveland MS CBOC (Larimer County) to address access, wait times, and operational challenges at the Cheyenne VAMC (Laramie County):** The Cheyenne VAMC is the most commonly used facility for specialty care in Larimer County, where demand for gastroenterology increased significantly between FY 2015 and FY 2019. Offering gastroenterology in Loveland will enable enrollees to access these procedures closer to home and help decompress the Cheyenne VAMC.
- **Reevaluate the planned closure of the Fort Collins MS CBOC (Larimer County) after opening a new HCC in Northern Colorado to ensure the new facility can meet demand:** Enrollees in Larimer County, where the Fort Collins MS CBOC is located, are projected to increase significantly along with demand for outpatient primary care, mental health care, and specialty care. VA is planning to close the existing Fort Collins MS CBOC; however, reevaluating the need to close the Fort Collins MS CBOC will ensure VA can meet the projected demand.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Cheyenne Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[47] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Cheyenne Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

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

VISN 19 Cheyenne Market	Status Quo	Modernization	VA Recommendation
Total Cost	$6,482,228,170	$6,996,432,416	$6,954,967,194
Capital Cost	$159,523,312	$673,727,557	$675,861,754
Operational Cost	$6,322,704,859	$6,322,704,859	$6,279,105,440
Total Benefit Score	7	10	11
CBI (normalized in $B)	**0.93**	**0.70**	**0.63**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through six VA points of care offering outpatient services, including the proposed new Albany County, Wyoming OOS site, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Cheyenne, Wyoming VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Aurora, Colorado VAMC (VISN 19).
- **RRTP:** RRTP demand will be met through the Cheyenne, Wyoming, VAMC, and the other facilities within VISN 19 offering RRTP, including the Sheridan, Wyoming VAMC; the Aurora, Colorado VAMC; the Valor Point, Colorado stand-alone RRTP; the proposed new RRTP at the Grand Junction, Colorado VAMC; the Salt Lake City, Utah VAMC; the Fort Harrison, Montana VAMC; the Oklahoma City, Oklahoma VAMC; and the proposed new Tulsa, Oklahoma stand-alone RRTP.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21), and the American Lake, Washington VAMC (VISN 20).

Demand

- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the Cheyenne, Wyoming VAMC, as well as through community providers; inpatient mental health demand will be met through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 31,195 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 31,721 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Wyoming and Rocky Vista University
- **Research:** This recommendation does not impact its research mission in the market; the Cheyenne, Wyoming VAMC does not have a research program. [48]
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Cheyenne, Wyoming VAMC is not designated as a Primary Receiving Center.

[48] Research programs were determined by FY 2021 total VA-funded research dollars per the Research and Development Information System (RDIS).

Quality

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

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

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.63 for VA Recommendation versus 0.93 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Albany County, Wyoming OOS. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($6.95B for VA Recommendation versus $7.00B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.63 for VA Recommendation versus 0.70 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 19 Denver Market

The Veterans Integrated Service Network (VISN) 19 Denver Market serves Veterans in the state of Colorado and western Kansas. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[49]

VA's Commitment to Veterans in the Denver Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Denver Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Denver Market is facing significantly increasing market enrollment. Demand for inpatient medical and surgical services continues to decrease, while demand for inpatient mental health, long-term care, and outpatient care is increasing. There is a large concentration of Veterans in the Colorado Springs area, which has experienced significant enrollee growth and is projected to grow more quickly than the Denver metropolitan area. While inpatient medical and surgical demand in the Denver Market is projected to decrease, Colorado Springs will have a larger share of future demand. In the Colorado Springs area, VA recommends developing an inpatient medical and surgical partnership with the Department of Defense (DoD) and an inpatient mental health partnership with a high-quality community partner. Long-term care investments will be made in Denver and Colorado Springs. Outpatient services will be appropriately aligned with demand across the Denver Market. One unsustainable CBOC and three unsustainable other outpatient services (OOS) sites will close, and access will be maintained by relocating care to the community in La Junta, Salida, Lamar, and Burlington, respectively. The strategy for the market is intended to provide Veterans with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

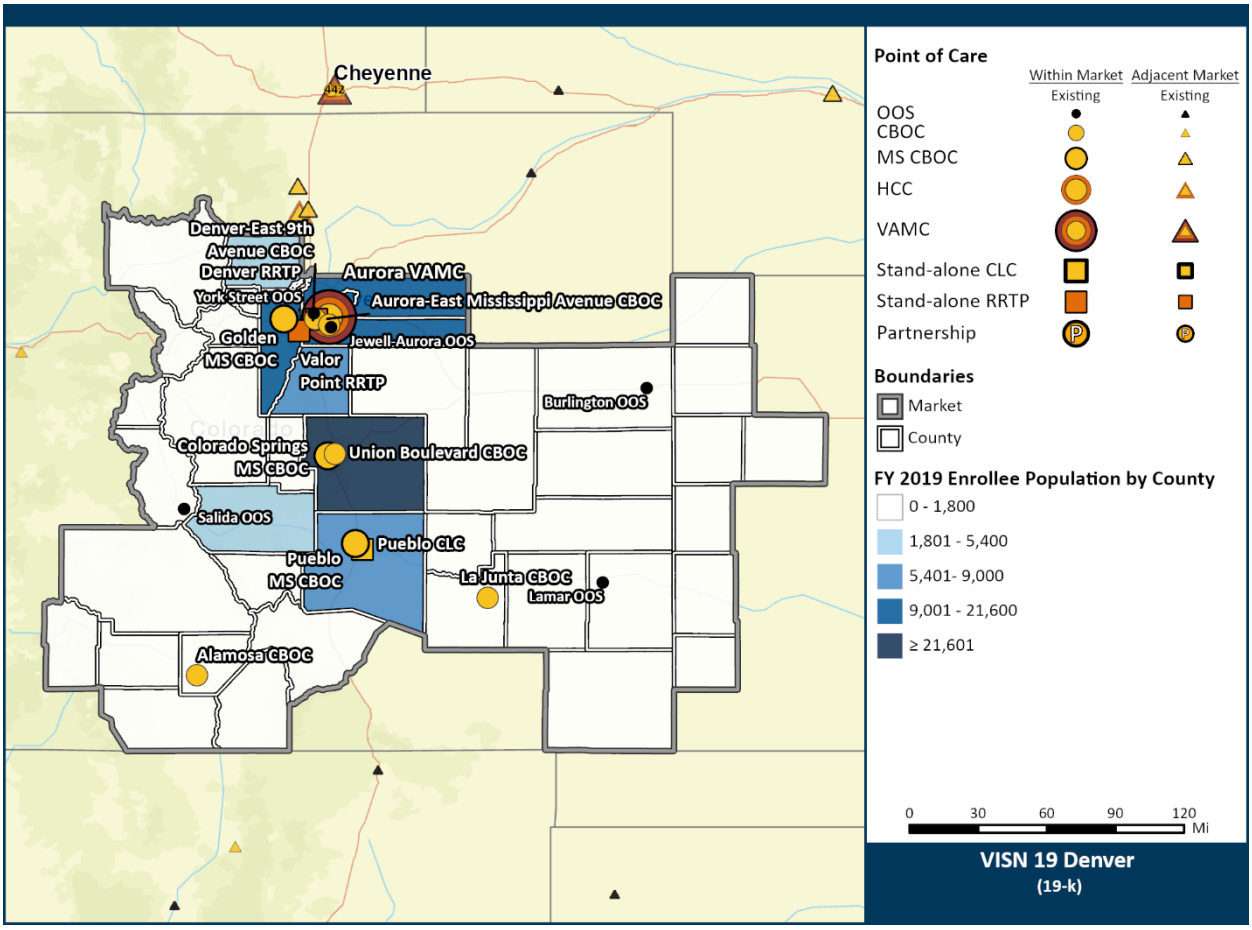
[49] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation establishes one new multi-specialty community-based outpatient clinic (MS CBOC) in the vicinity of Castle Rock, offering a convenient access point for primary care, mental health, and specialty care services between Denver and Colorado Springs. A community-based outpatient clinic (CBOC) will be relocated and expanded in the vicinity of Aurora, Colorado, to decompress the Aurora VAMC, while another will be relocated from an as-built lease to a new expanded site on VA property in Denver, Colorado.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation establishes an expanded replacement community living center (CLC) facility in a more accessible location, maintaining care for Veterans with the most complex needs. The recommendation transitions inpatient mental health services to a new partnership until a new VA Medical Center is constructed in the vicinity of Colorado Springs, Colorado. A sustainable and rightsized residential rehabilitation treatment program (RRTP) will expand its service line offerings to provide more comprehensive care. Inpatient spinal cord injuries and disorders (SCI/D) services will be maintained within the Aurora VAMC. Demand for inpatient blind rehabilitation services will be met at the Palo Alto, California VAMC (VISN 21).
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains quality inpatient medical and surgical care at the Aurora VAMC and improves access to quality inpatient medical and surgical care by establishing a strategic collaboration that will allow VA providers to deliver care in Colorado Springs.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Aurora), one stand-alone CLC, two stand-alone RRTPs, three MS CBOCs, five CBOCs, and five OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 134,151 enrollees and is projected to experience a 9.9% increase in enrolled Veterans by FY 2029. The largest populations of enrollees are in the counties of El Paso, Arapahoe, and Jefferson, Colorado.

Demand: Demand[50] in the market for inpatient medical and surgical services is projected to decrease by 14.1% and demand for inpatient mental health services is projected to increase by 14.3% between FY 2019 and FY 2029. Demand for long-term care[51] is projected to increase by 83.2%. Demand for all

[50] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[51] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,[52] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 14.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 86.8% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 55.1% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[53] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[54] of 65.8% (858 available beds) [55] and an inpatient mental health occupancy rate of 58.5% (51 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 81.0% (710 available beds). Community residential rehabilitation programs[56] that match the breadth of services provided by VA are not widely available in the market.

Mission: The market has academic affiliations that include the University of Colorado. The Aurora VAMC is ranked 34 out of 154 VA training sites based on number of trainees and is ranked 16 out of 103 VAMCs with research funding. The Aurora VAMC is designated as a Primary Receiving Center.[57]

Facility Overview

Aurora VAMC: The Aurora VAMC is located in Aurora, Colorado, directly east of Denver, and adjacent to its academic affiliate. The VAMC offers inpatient medical and surgical, inpatient mental health, SCI/D, rehabilitation medicine, and outpatient services. In FY 2019, the Aurora VAMC had an inpatient medical and surgical average daily census (ADC) of 62.9, inpatient mental health ADC of 26.8, an SCI/D ADC of 3.8, and a rehabilitation medicine ADC of 6.6.

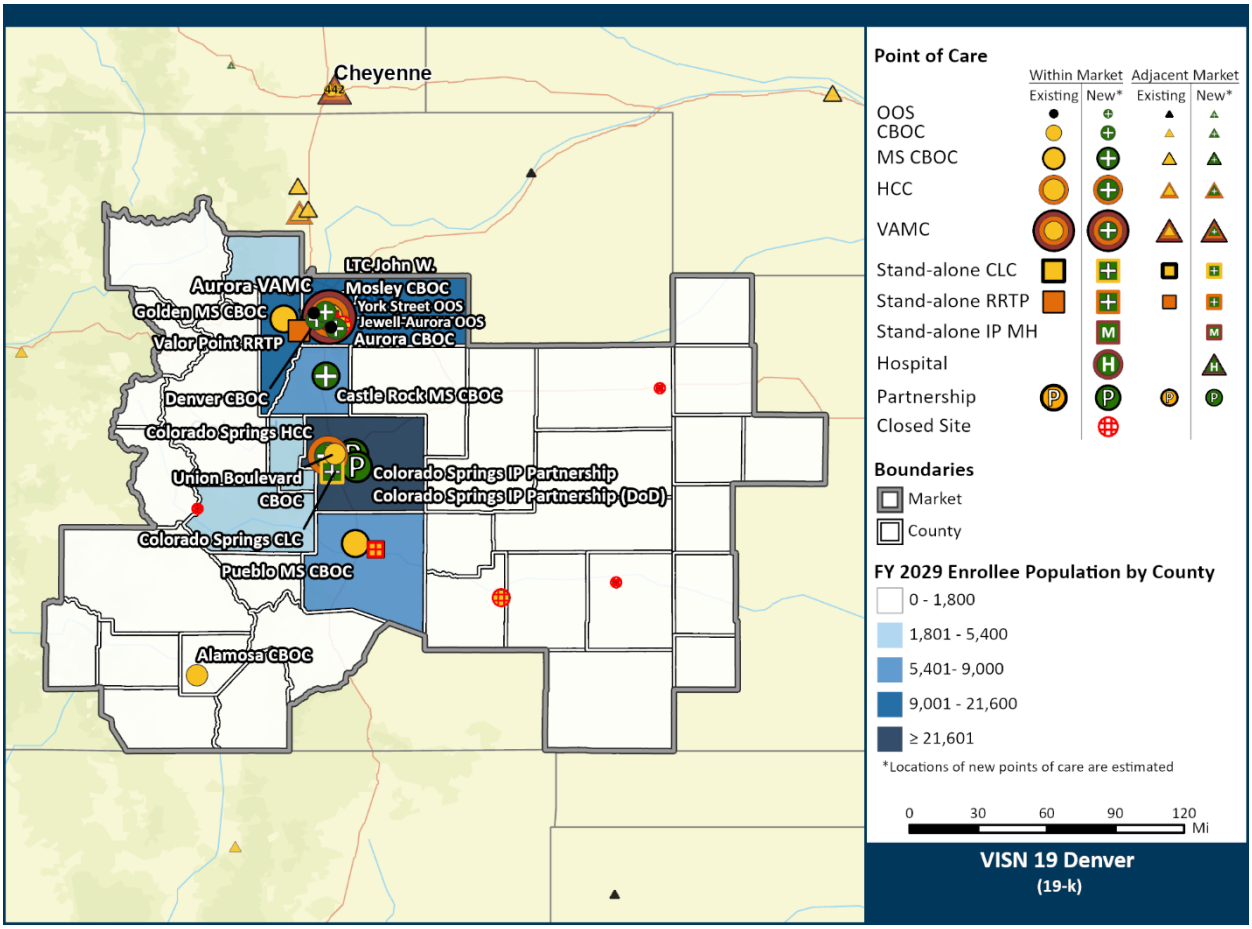
The Aurora VAMC was built in 2017 on 12.0 acres; zero acres are available for additional development. Facility condition assessment (FCA) deficiencies are approximately $143.2M, and annual operations and maintenance costs are an estimated $28.4M.

[52] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[53] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[54] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[55] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[56] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[57] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

Recommendation and Justification

This section details the VISN 19 Denver Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the market by:***

   1.1. **Establishing a strategic collaboration to provide inpatient medical and surgical services in the vicinity of Colorado Springs, Colorado. If unable to enter into a strategic collaboration, construct a new VA Medical Center in the vicinity of Colorado Springs:** Colorado Springs has experienced significant enrollee growth and is projected to grow more quickly than the Denver metropolitan area. Enrollees in El Paso County, where Colorado Springs is located, are projected to increase by 23.8% between FY 2019 and FY 2029. Currently, enrollees residing in El Paso County must travel approximately 70 miles north to the Aurora VAMC to receive inpatient VA care.

   While the in-house and commercial inpatient medical and surgical demand in the Denver Market is projected to decrease by 14.1%, Colorado Springs will have a larger share of future demand. With strong projected enrollee growth in Colorado Springs, projected inpatient medical and surgical demand suggests a need for approximately 15 beds.

VA will pursue a partnership with DoD to provide VA-delivered inpatient medical and surgical services. The Evans Army Hospital is located in El Paso County approximately 13 miles from the existing Colorado Springs MS CBOC and has capacity to meet the enrollee inpatient medical and surgical demand in Colorado Springs. The hospital is well-maintained and is positioned in an accessible location on the Fort Carson installation. Additionally, the United States Air Force Academy is located approximately 14 miles from the existing Colorado Springs MS CBOC and has partnered with VA to provide outpatient surgical services. Both could offer education partnership opportunities.

1.2. **Establishing a strategic collaboration to provide inpatient mental health services in the vicinity of Colorado Springs, Colorado. If unable to enter into a strategic collaboration, continue to utilize community providers and the Aurora VAMC until a new VA Medical Center is constructed in the vicinity of Colorado Springs, Colorado:** VA will seek a strategic collaboration with a provider that is Joint Commission accredited, provides a full array of services including acute psychiatric, psychiatric rehabilitative and intensive outpatient care. The partner will ideally also accept TRICARE.[58] In FY 2019, the Aurora VAMC had 30 mental health beds with an ADC of 26.8. There is a projected in-house mental health bed need of 37 in FY 2029. This recommendation is contingent on the outcome of the proposed strategic collaboration with DoD. In the event a strategic collaboration with DoD to provide inpatient medical and surgical services is not successful, and a VA Medical Center is built in the vicinity of Colorado Springs, Colorado, inpatient mental health services will be transitioned to the new VA Medical Center.

2. ***Modernize by establishing a new stand-alone CLC in the vicinity of Colorado Springs, Colorado:*** The infrastructure at the Pueblo CLC is aging and poorly maintained, affecting sustainability of the facility. In addition, the Pueblo CLC has capacity for 40 beds but only 30 are operational due to persistent staffing challenges. In FY 2019, the Pueblo CLC had an ADC of 29.9. The projected in-house FY 2029 CLC ADC for the market is 53.2. Enrollees in El Paso County, where Colorado Springs is located, are projected to increase by 23.8% between FY 2019 and FY 2029 whereas enrollees in Pueblo County, where the Pueblo CLC is located, are projected to decrease by 1.8% between FY 2019 and FY 2029. The lease at the existing Pueblo CLC will be renewed for the short term and services will be transitioned to the proposed new CLC in Colorado Springs for the long term. A new stand-alone CLC with 48 beds in the vicinity of Colorado Springs will improve access and reduce reliance on CLC care in the community.

3. ***Modernize and realign outpatient facilities in the market by:***

3.1. **Establishing a new MS CBOC in the vicinity of Castle Rock, Colorado:** Demand for primary care services is projected to increase by 81.2% from FY 2019 to FY 2029 across the Denver Market. In FY 2019, there were 108,227 enrollees within 60 minutes and 24,824 enrollees within 30 minutes of the proposed new Castle Rock MS CBOC. The proposed clinic will be the first and only site of care in Douglas County, which is located between Denver and Colorado Springs. Strategically located along highway I-25 between Denver (30 miles north) and Colorado Springs

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

(42 miles south), Castle Rock is easily accessible and will be convenient for Veterans to access. It will also decompress the Colorado Springs MS CBOC and the Aurora VAMC.

3.2. **Relocating the Aurora East Mississippi Avenue CBOC to a new site in the vicinity of Aurora, Colorado, and closing the Aurora East Mississippi Avenue CBOC:** The Aurora East Mississippi Avenue CBOC is the most utilized facility for Veterans residing in Arapahoe County. However, the existing facility is in disrepair with plumbing and flooding issues, negatively impacting patient and staff satisfaction. Enrollees in Arapahoe County are projected to increase by 3.0% between FY 2019 and FY 2029, from 15,728 enrollees in FY 2019 to 16,205 projected enrollees in FY 2029. There were 47,415 enrollees within 30 minutes of the Aurora East Mississippi Avenue CBOC in FY 2019. In addition to supporting the current and projected enrollee demand, expansion of primary care services with a new, rightsized CBOC in the vicinity of Aurora, Colorado, will decompress primary care services from the Aurora VAMC.

3.3. **Relocating the Denver E. 9th Avenue CBOC to the Denver hospital property in Denver, Colorado, and closing the temporarily deactivated Denver E. 9th Avenue CBOC:** Until recently, the Denver E. 9th Avenue CBOC was a primary care site occupying as-built leased space, across the street from the decommissioned VA Denver hospital. It had 48,337 enrollees within 30 minutes in FY 2019. Due to space constraints at the Aurora VAMC, the Denver E. 9th Avenue CBOC was a temporary solution to accommodate six patient-aligned care teams (PACTs). Relocating the CBOC to a portion of the former VA Denver hospital in the downtown Denver area creates a long-term solution to meet the projected increase in primary care demand in the market of 81.2% between FY 2019 and FY 2029.

3.4. **Relocating all services at the La Junta CBOC and closing the La Junta CBOC:** In FY 2019, the La Junta CBOC had 957 enrollees within 30 minutes and served 865 core uniques.[59] In FY 2019, there were 3,127 primary care encounters and 2,175 outpatient mental health encounters. Otero County, where the La Junta CBOC is located, had 814 enrollees in FY 2019, which are projected to decrease by 4.4% by FY 2029. There are several community providers serving Otero County in close proximity to the La Junta CBOC. A local critical access hospital offers an array of primary care and specialty care services. With low utilization, deactivating the facility and relocating care to community providers will allow the small enrollee population to have local, convenient access.

3.5. **Relocating all services at the Salida OOS and closing the Salida OOS:** In FY 2019, the Salida OOS had 627 enrollees within 30 minutes and served 518 core uniques. Additionally, primary care encounters at the Salida OOS decreased by 16.6% between FY 2018 and FY 2019. There are several community providers serving Chaffee County located near the Salida OOS. A local critical access hospital offers primary care services and is adjacent to the existing Salida OOS facility. With low utilization, deactivating the OOS and relocating care to community providers will allow the small enrollee population to have local, convenient access.

3.6. **Relocating all services at the Lamar OOS and closing the Lamar OOS:** In FY 2019, the Lamar OOS had 337 enrollees within 30 minutes and served 383 core uniques. Additionally, the Lamar

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

OOS had only 153 specialty care encounters in FY 2019, and primary care encounters decreased by 21.2% between FY 2017 and FY 2019. Prowers County, where the Lamar OOS is located, had 361 enrollees in FY 2019, which are projected to decrease by 7.2% by FY 2029. With low utilization, deactivating the facility and relocating care to community providers will allow the small enrollee population to have local, convenient access.

3.7. **Relocating all services at the Burlington OOS and closing the Burlington OOS:** In FY 2019, the Burlington OOS had 230 enrollees within 30 minutes and served 713 core uniques. The Burlington OOS had 374 mental health encounters, 2,140 primary care encounters, and 76 specialty care encounters in FY 2019. Kit Carson County, where the Burlington OOS is located, had 195 enrollees in FY 2019, which are projected to decrease by 12.7% by FY 2029. With low utilization, deactivating the facility and relocating care to community providers will allow the small enrollee population to have local, convenient access.

Complementary Strategy

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

Denver Market

- **Partner with the VISN 19 Grand Junction Market's new Substance Abuse Recovery and Rehabilitation Treatment Program (SARRTP) for substance use recovery needs:** The Denver Market only offers post-traumatic stress disorder (PTSD) RRTP; substance use disorder (SUD) RRTP is an unmet enrollee need. Leveraging Grand Junction's SARRTP will meet the projected RRTP bed demand for substance use.

Aurora VAMC

- **Expand the Colorado Springs MS CBOC (El Paso County) to increase capacity to provide primary care, outpatient mental health, outpatient specialty care, and women's health services, and add outpatient surgical services, which may result in the classification of the facility as a health care center (HCC):** Colorado Springs has seen significant enrollee growth and is projected to grow more quickly than the Denver metropolitan area. Adding outpatient surgical services to the Colorado Springs MS CBOC will help meet the future demand and reduce reliance on care in the community.
- **Use a portion of the under-utilized SCI/D beds at the Aurora VAMC (Adams County) to address increasing demand for short-stay CLC:** Given the low SCI/D ADC, the underutilized SCI/D beds could be designated to accommodate clinically appropriate short-stay patients. To accommodate the proposed short-stay beds, the existing facility will not need any retrofitting or construction for use, although staffing may have to be addressed.
- **Expand the relationship with an academic affiliate in order to increase the complexity of inpatient acute medical and surgical services:** University of Colorado Hospital (UCH) has a large proportion of dually appointed physicians who are accustomed to higher complexity care delivery. Expanding the relationship with UCH will enable the Aurora VAMC to move ambulatory

surgery and low complexity inpatient surgery off-site to the University, allowing the VAMC to utilize its operating rooms for the more complex surgical cases and function as a true tertiary regional medical center.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Denver Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[60] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Denver Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 19 Denver Market	Status Quo	Modernization	VA Recommendation
Total Cost	$27,183,932,086	$27,748,755,984	$27,781,952,955
Capital Cost	$1,121,554,593	$1,686,378,491	$1,719,575,462
Operational Cost	$26,062,377,494	$26,062,377,494	$26,062,377,494
Total Benefit Score	10	11	15
CBI (normalized in $B)	**2.72**	**2.52**	**1.85**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

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

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA- facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 12 VA points of care offering outpatient services, including the proposed new Castle Rock, Colorado MS CBOC; the Aurora, Colorado CBOC; the Denver, Colorado CBOC; and the Lieutenant Colonel John W. Mosley CBOC in Aurora, Colorado, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed new Colorado Springs, Colorado stand-alone CLC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Aurora, Colorado VAMC.
- **RRTP:** RRTP demand will be met through the Aurora, Colorado VAMC; the Valor Point, Colorado stand-alone RRTP; and the other facilities within VISN 19 offering RRTP, including the Sheridan, Wyoming VAMC; the Cheyenne, Wyoming, VAMC; the proposed new RRTP at the Grand Junction, Colorado VAMC; the Salt Lake City, Utah VAMC; the Oklahoma City, Oklahoma VAMC; the proposed new Tulsa, Oklahoma stand-alone RRTP; and the RRTP at the Fort Harrison, Montana VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21) and the American Lake, Washington VAMC (VISN 20).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the Aurora, Colorado VAMC, and the proposed new DoD partnership in Colorado Springs, as well as through community providers. Inpatient mental health will be met through the Aurora, Colorado VAMC, and the proposed new inpatient mental health partnership in Colorado Springs, Colorado as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 141,850 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 143,280 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Colorado.
- **Research:** This recommendation does not impact the research mission in the market and allows the Aurora, Colorado VAMC to maintain its current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Aurora, Colorado VAMC will maintain its status as a Primary Receiving Center.

Quality

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

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Castle Rock, Colorado MS CBOC; the Aurora, Colorado CBOC; the Lieutenant Colonel John W. Mosley CBOC in Aurora, Colorado; the Denver, Colorado CBOC; the stand-alone CLC in Colorado Springs, Colorado; the proposed new inpatient mental health partnership in Colorado Springs, Colorado; and the proposed new DoD partnership in Colorado Springs, Colorado. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (1.85 for VA Recommendation versus 2.72 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Castle Rock, Colorado MS CBOC; the Aurora, Colorado CBOC; the Lieutenant Colonel John W. Mosley CBOC in Aurora, Colorado; the Denver, Colorado CBOC; the stand-alone CLC in Colorado Springs, Colorado; the proposed new inpatient mental health partnership in Colorado Springs, Colorado; and the DoD partnership in Colorado Springs, Colorado. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community partner space.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today ($27.8B for VA Recommendation versus $27.7B for Modernization), there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.85 for VA Recommendation versus 2.52 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 19 Oklahoma City Market

The Veterans Integrated Service Network (VISN) 19 Oklahoma City Market serves Veterans in western Oklahoma. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[61]

VA's Commitment to Veterans in the Oklahoma City Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Oklahoma City Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Oklahoma City Market is experiencing strong enrollee growth, with decreasing demand for inpatient medical and surgical care and increasing demand for inpatient mental health, long-term care, and outpatient care. VA recommends building a new bed tower at the Oklahoma City VAMC to provide modern, appropriately sized inpatient mental health services. Outpatient services will be expanded. The recommendation also closes the unsustainable Blackwell OOS and maintains access by relocating care to the community. The strategy for the market is intended to provide Veterans with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation establishes a new other outpatient services (OOS) site in the vicinity of Woodward, Oklahoma, offering primary care and mental health services to provide improved access.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a new, modern inpatient mental health facility to improve access to

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

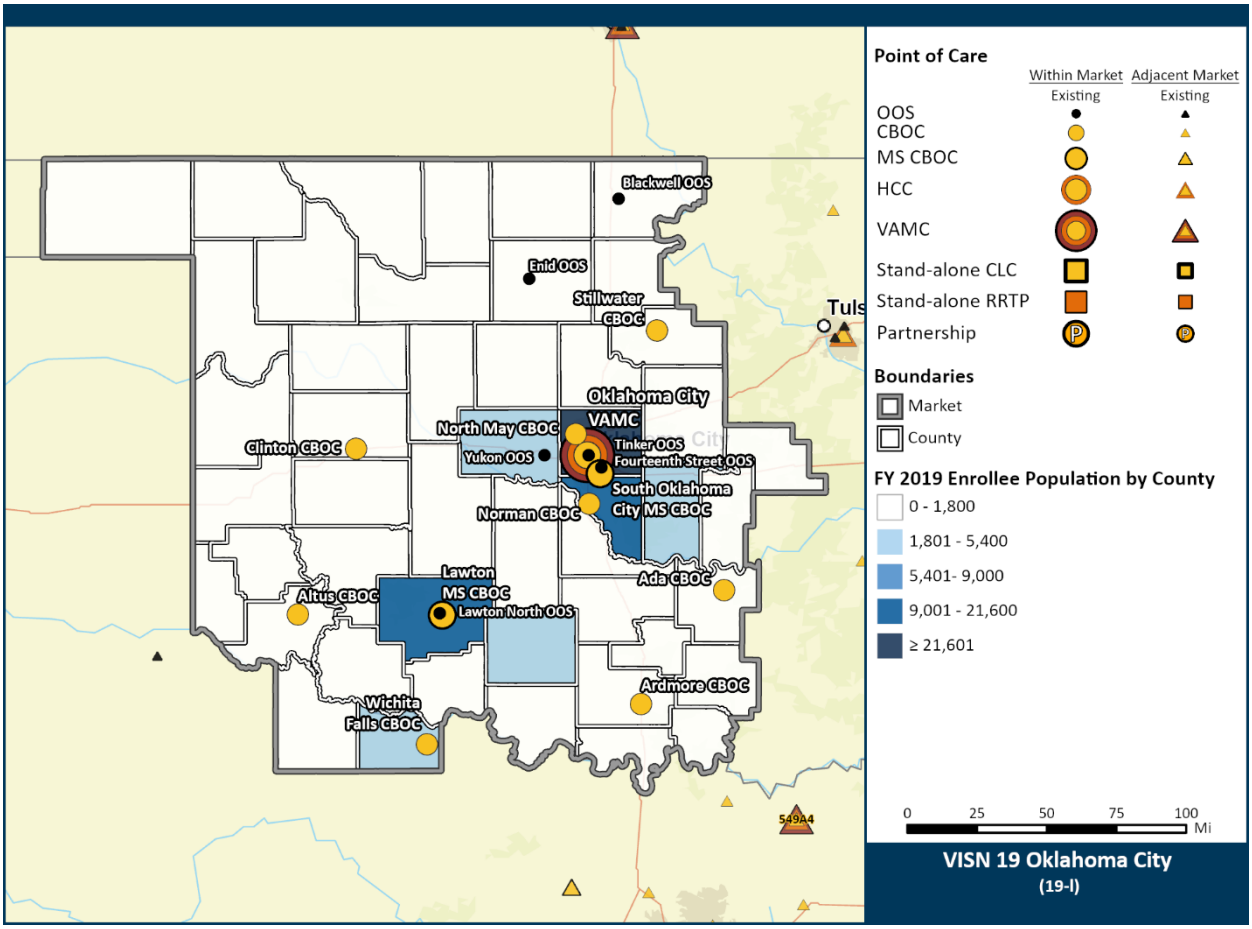
high-quality mental health care. The recommendation maintains sustainable long-term care at the Oklahoma City VAMC and creates partnerships with community providers to increase access to community living center (CLC) care. The Houston VAMC (VISN 16) in the East Texas Market is the inpatient spinal cord injuries and disorders (SCI/D) specialty hub for the Oklahoma City Market. Demand for inpatient blind rehabilitation services will be met at the Palo Alto, California VAMC (VISN 21) and the Long Beach, California VAMC (VISN 22).

- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains sustainable inpatient medical and surgical services at the Oklahoma City VAMC.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Oklahoma City), two multi-specialty community-based outpatient clinics (MS CBOCs), eight community-based outpatient clinics (CBOCs), and six OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 86,619 enrollees and is projected to experience a 14.0% increase in enrolled Veterans by FY 2029. The largest populations of enrollees are in the counties of Oklahoma, Cleveland, and Comanche, Oklahoma.

Demand: Demand[62] in the market for inpatient medical and surgical services is projected to decrease by 11.5% and demand for inpatient mental health services is projected to increase by 1.9% between FY 2019 and FY 2029. Demand for long-term care[63] is projected to increase by 62.9%. Demand for all outpatient services,[64] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 44.0% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 72.7% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 58.5% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[65] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[66] of 63.9% (528 available beds) [67] and an inpatient mental health occupancy rate of 58.4% (13 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 71.4% (452 available beds). Community residential rehabilitation programs[68] that match the breadth of services provided by VA are not widely available in the market.

Mission: The market has academic affiliations that include the University of Oklahoma (OU) and Oklahoma State University (OSU). The Oklahoma City VAMC is ranked 52 out of 154 VA training sites based on the number of trainees and is ranked 56 out of 103 VAMCs with research programs. The Oklahoma City VAMC is designated as a Federal Coordinating Center.[69]

Facility Overview

Oklahoma City VAMC: The Oklahoma City VAMC is located in Oklahoma City, Oklahoma, and offers inpatient medical and surgical, inpatient mental health care, long-term care, residential rehabilitation treatment program (RRTP), rehabilitation medicine, and outpatient services. In FY 2019, the Oklahoma VAMC had an inpatient medical and surgical average daily census (ADC) of 70.2, an inpatient mental health ADC of 20.9, a CLC ADC of 27.1, an RRTP ADC of 15.3, and a rehabilitation medicine ADC of 2.6.

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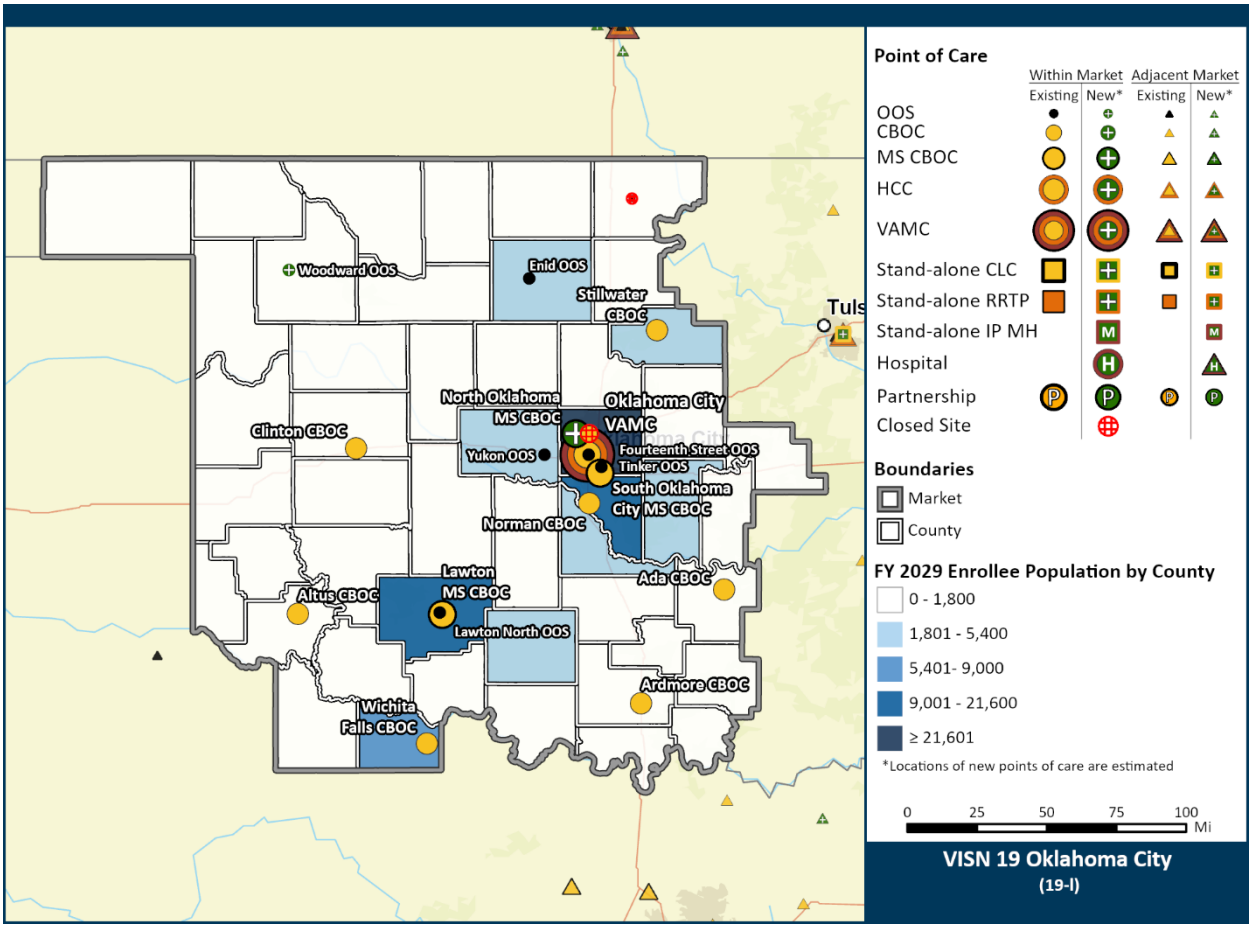
[62] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[63] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[64] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[65] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[66] Occupancy rates are calculated by dividing the total average daily census (ADC) by the number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[67] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[68] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[69] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

The Oklahoma City VAMC was built in 1950 on 14.0 acres and does not meet current design standards;[70] zero acres are available for additional development. Facility condition assessment (FCA) deficiencies are approximately $120.4M, and annual operations and maintenance costs are an estimated $15.3M.

Recommendation and Justification

This section details the VISN 19 Oklahoma City Market recommendation and justification for each element of the recommendation.

Future Market Map



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

1. ***Modernize and realign the Oklahoma City VAMC by building a new mental health facility on the Oklahoma City VAMC:*** The enrollees in the Oklahoma City Market are projected to increase by 14.0%, from 86,619 enrollees in FY 2019 to 98,769 by FY 2029. Enrollees are concentrated in the counties around the VAMC and are highly reliant on this facility. Core uniques at the Oklahoma City VAMC have increased by 4.2%, from 51,666 core uniques in FY 2015 to 53,842 in FY 2019. The Oklahoma City VAMC has 25 inpatient mental health beds with an ADC of 20.9 in FY 2019. The in-house and commercial inpatient mental health demand in the market is projected to increase by 1.9% from FY 2019 to FY 2029.

   There are plans for a two-phase mental health expansion project to replace inpatient mental health beds. Construction of a new mental health facility, with outpatient services and 30 private rooms for inpatient mental health, will strengthen the mental health service line for this market and help improve care coordination, patient experience, safety, and care delivery.

2. ***Modernize and realign outpatient facilities in the market by:***

   2.1. Establishing a new OOS in the vicinity of Woodward, Oklahoma: The nine northwestern counties in the market currently do not have a VA primary care facility. Together, these nine counties account for 1,390 enrollees in FY 2029. Woodward is the largest city in these counties, and enrollees in Woodward County are projected to increase by 8.5%, from 402 enrollees in FY 2019 to 436 enrollees in FY 2029. The new OOS site will increase access to primary care and mental health services for enrollees in Woodward (468 enrollees within 30 minutes in FY 2019) and the counties beyond. There is interest from a community provider to place the OOS on their campus, which allows for enrollee demand to be tested in this portion of the market.

   2.2. Relocating the North May CBOC to a new site in the vicinity of northern Oklahoma City, Oklahoma, and closing the North May CBOC: There are many infrastructure and space issues at the current North May CBOC. Expanding and reclassifying the North May CBOC to an MS CBOC will provide specialty care services and increase primary care and mental health access to enrollees. This will also help alleviate space constraints at the Oklahoma City VAMC and meet the projected outpatient demand in the market. There is a planned North Oklahoma City clinic that has an expected activation date of September 2022. This clinic is expected to replace the North May CBOC.

   2.3. Relocating all services at the Blackwell OOS and closing the Blackwell OOS: The Blackwell OOS had 1,518 enrollees within 30 minutes in FY 2019 and served 626 core uniques in FY 2019, a 2.6% decrease since FY 2015. Within approximately 20 miles of the existing Blackwell OOS facility, there are two Indian Health Service (IHS) facilities and one Federally Qualified Health Center (FQHC). From FY 2017 to FY 2019, outpatient specialty care encounters decreased by 38.8%. Given the low enrollee population and declining demand, deactivating the facility and relocating care to community providers or other Federal providers will allow the small enrollee population to have local, convenient access.

Complementary Strategy

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

Oklahoma City Market

- **Maintain strong Indian Health Service (IHS) partnerships, with care coordination, throughout the market to ensure access:** There is a strong IHS presence in the Oklahoma City Market, with many facilities located in areas where there is a VA presence. Partnering with IHS to share facility space and providers can increase access for all Veteran enrollees.
- **Expand Veteran Express program to clinics in the greater Oklahoma City area. Adjust the planned emergency department project size accordingly:** Overall, the number of encounters at the Oklahoma City emergency department has increased. Expanding the Veteran Express program will help to decompress the existing emergency department and accommodate the urgent care needs of Veterans.
- **Enhance provider productivity to improve patient access with current resources:** There is an opportunity to improve provider efficiency at the Oklahoma City VAMC. Improving provider productivity will expand capacity to meet Veteran demand.
- **Work with existing/new academic affiliates to fill/expand primary care residency training slots:** With 34 hospitals in Oklahoma City, Oklahoma, VA has difficulty developing a provider pipeline to compete with market salaries. The OSU Medical Center is another potential partner that could provide trainees.

Oklahoma City VAMC

- **Create partnerships with community providers to meet projected demand for CLC services in the Oklahoma City Market; maintain CLC services currently offered at the Oklahoma City VAMC (Oklahoma County). To partner, consider establishing a CLC within a community nursing home or creating another type of partnership**: The current supply of CLC beds at the Oklahoma City VAMC does not meet the current or future demand. Additionally, although there are seven State Veteran Homes in Oklahoma, they are all at or near capacity. Partnerships with community providers will be crucial to meet future demand.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Oklahoma City Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[71] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of existing facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g.,

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

administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).

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

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Oklahoma City Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 19 Oklahoma City Market	Status Quo	Modernization	VA Recommendation
Total Cost	$15,588,836,021	$17,058,875,047	$17,065,410,318
Capital Cost	$436,831,120	$1,906,870,146	$1,913,405,418
Operational Cost	$15,152,004,901	$15,152,004,901	$15,152,004,901
Total Benefit Score	8	11	12
CBI (normalized in $B)	**1.95**	**1.55**	**1.42**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 17 VA points of care offering outpatient services, including the proposed new North, Oklahoma MS CBOC and Woodward, Oklahoma OOS, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Oklahoma City, Oklahoma VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Houston, Texas VAMC (VISN 17).
- **RRTP:** RRTP demand will be met through the Oklahoma City, Oklahoma VAMC, and the other facilities within VISN 19 offering RRTP, including the Sheridan, Wyoming VAMC; the proposed new Tulsa, Oklahoma stand-alone RRTP; the Aurora, Colorado VAMC; the Valor Point, Colorado stand-alone RRTP; the Cheyenne, Wyoming, VAMC; the proposed new RRTP at the Grand Junction, Colorado VAMC; the Salt Lake City, Utah VAMC; and the RRTP at the Fort Harrison, Montana VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21), and the American Lake, Washington VAMC (VISN 20).
- **Inpatient Acute:** Inpatient medicine, surgery, and mental health demand will be met through the Oklahoma City, Oklahoma VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 96,004 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 96,097 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Oklahoma and the Oklahoma State University.
- **Research:** This recommendation does not impact the research mission in the market and allows the Oklahoma City, Oklahoma VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Oklahoma City, Oklahoma VAMC is not designated as a Primary Receiving Center.

Quality

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

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new North Oklahoma, Oklahoma MS CBOC and the Woodward, Oklahoma OOS, as well as the new inpatient mental health facility on the Oklahoma City VAMC campus (in progress). This new infrastructure will aid in improving the patient experience, with care delivery provided in modern spaces, and aid in the recruitment of staff, with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (1.42 for VA Recommendation versus 1.95 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new North Oklahoma, Oklahoma MS CBOC and the Woodward, Oklahoma OOS, as well as the new inpatient mental health facility on the Oklahoma City VAMC campus (in progress). This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today ($17.07B for VA Recommendation versus $17.06B for Modernization), there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.42 for VA Recommendation versus 1.55 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 19 Eastern Oklahoma Market

The Veterans Integrated Service Network (VISN) 19 Eastern Oklahoma Market serves Veterans in eastern Oklahoma. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[72]

VA's Commitment to Veterans in the Eastern Oklahoma Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Eastern Oklahoma Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Eastern Oklahoma Market is facing decreasing enrollment. Demand for inpatient medical, surgical, and mental health services is decreasing while demand for long-term care and outpatient care is increasing. The Veteran population is concentrated in the Tulsa area, where a new VA hospital will be developed as part of a proposed Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016 (CHIP-IN Act 2016) project with the academic affiliate. Once the new VA hospital is developed, the aging Muskogee VAMC will decant inpatient services to the new hospital and all other services to other VA locations, and close. Outpatient services will be expanded. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation invests in a new, modernized multi-specialty community-based outpatient clinic (MS CBOC) offering primary care, mental health, and specialty care services and maintains all sustainable clinics.

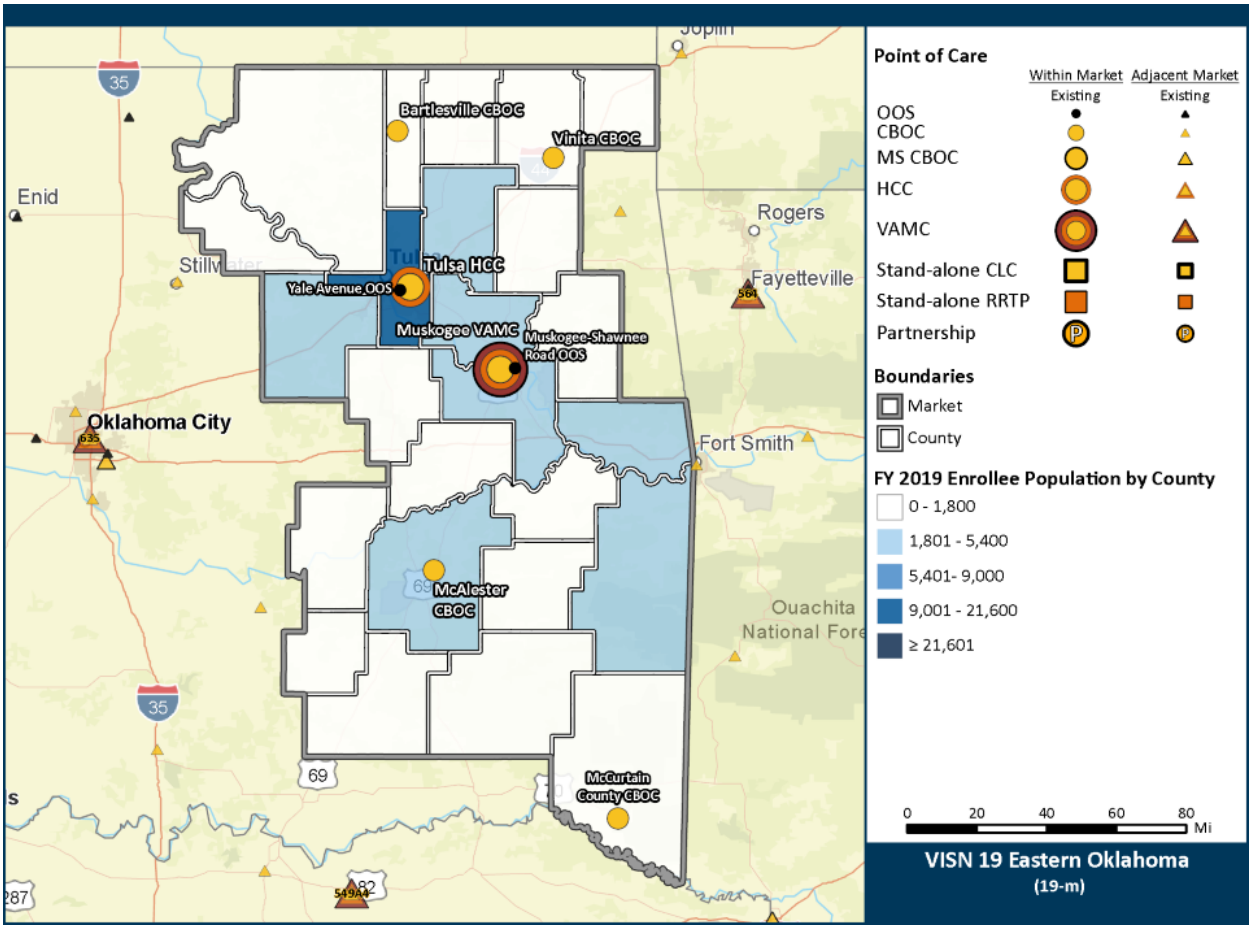
[72] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation establishes a new, modernized community living center (CLC) facility in the vicinity of Tulsa. The recommendation also establishes a new, modernized residential rehabilitation treatment program (RRTP) facility in Tulsa focused on substance use disorder (SUD) treatment and meets demand for other RRTP services at VA facilities in nearby markets. The recommendation also transitions inpatient mental health to community providers, alleviating the challenges VA has recruiting and retaining psychiatrists that impact the market's ability to consistently maintain services. The Memphis, Tennessee VAMC (VISN 09) is the inpatient spinal cord injuries and disorders (SCI/D) specialty hub for the Eastern Oklahoma Market. Demand for inpatient blind rehabilitation services will be met at the Palo Alto, California VAMC (VISN 21).
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains quality inpatient medical and surgical care by entering into a public-private partnership with the Oklahoma State University (OSU) Board of Regents and the Oklahoma State University Medical Authority to provide inpatient medical and surgical care on the Oklahoma State University Medical Campus.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Muskogee), one health care center (HCC), four CBOCs, and two other outpatient services (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 51,390 enrollees and is projected to experience a 1.0% decrease in enrolled Veterans by FY 2029. The largest populations of enrollees are in the counties of Rogers, Tulsa, and Muskogee, Oklahoma.

Demand: Demand[73] in the market for inpatient medical and surgical services is projected to decrease by 12.4% and demand for inpatient mental health services is projected to decrease by 6.4% between FY 2019 and FY 2029. Demand for long-term care[74] is projected to increase by 27.8%. Demand for all

[73] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[74] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,[75] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 61.1% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 67.3% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 66.0% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[76] in the market within a 60-minute drive time of the Muskogee VAMC and the Tulsa MS CBOC had an inpatient acute occupancy rate[77] of 61.2% (657 available beds) [78] and an inpatient mental health occupancy rate of 57.3% (12 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 72.4% (468 available beds). Community residential rehabilitation programs[79] that match the breadth of services provided by VA are not widely available in the market.

Mission: The market has academic affiliations that include the University of Oklahoma (OU) and Oklahoma State University (OSU). The Muskogee VAMC is ranked 109 out of 154 VA training sites based on the number of trainees. The VAMC is ranked 94 out of 103 VAMCs with research funding. The VAMC has no emergency designation.[80]

Facility Overview

Muskogee VAMC: The Muskogee VAMC is located in Muskogee, Oklahoma, and offers inpatient medical and surgical, inpatient mental health, rehabilitation medicine, and outpatient services. In FY 2019, the Muskogee VAMC had an inpatient medical and surgical average daily census (ADC) of 26.6, an inpatient mental health ADC of 11.5, and a rehabilitation medicine ADC of 9.8.

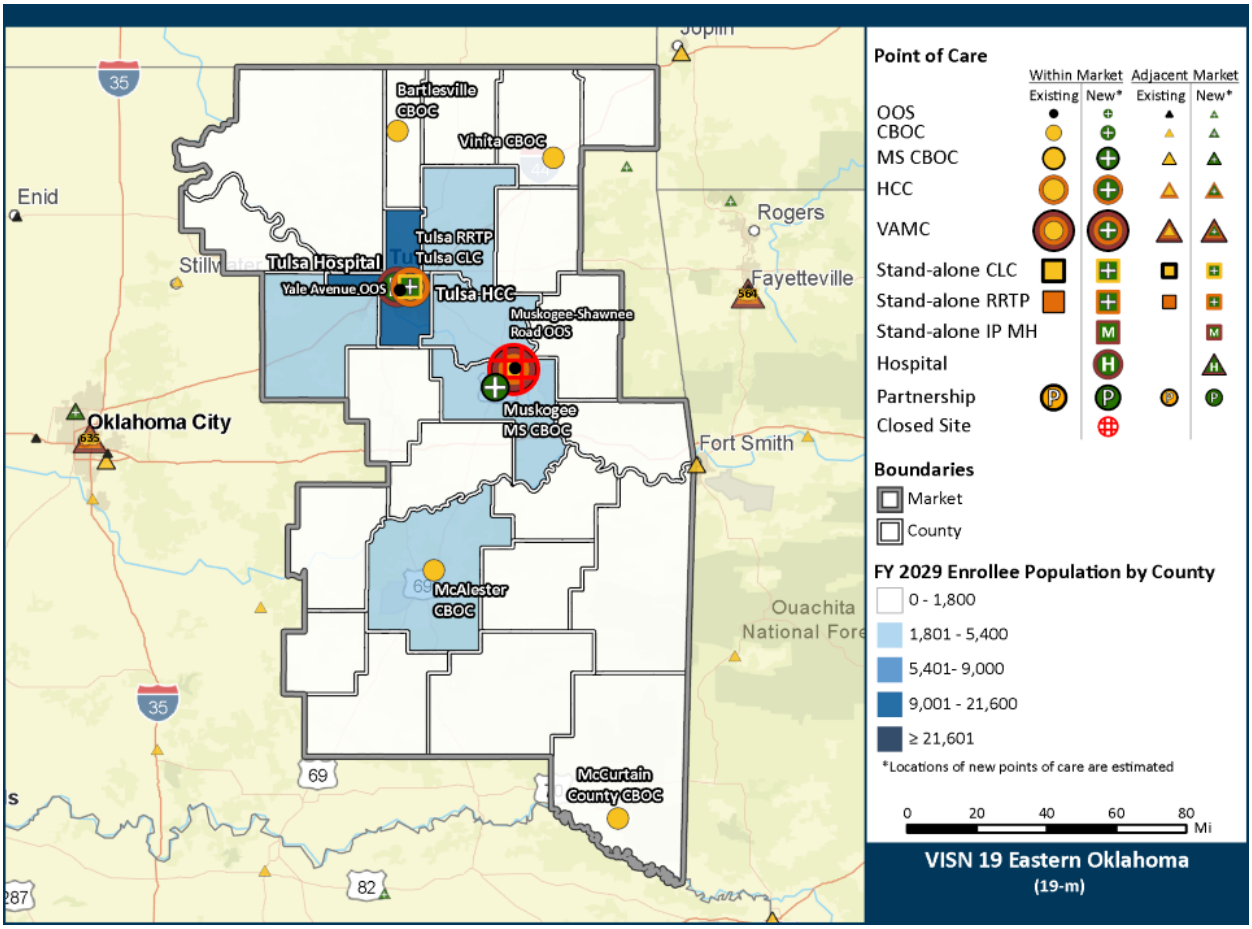
The Muskogee VAMC dates back to the 1920s and was built on a 17.0 acres campus. The main bed tower was built in 1998. The last major renovation was in 2008. Facility condition assessment (FCA) deficiencies are approximately $67.9M, and annual operations and maintenance costs are an estimated $8.0M.

[75] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[76] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[77] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[78] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[79] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[80] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

Recommendation and Justification

This section details the VISN 19 Eastern Oklahoma Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Muskogee VAMC by:***

   1.1 Relocating inpatient medical and surgical, rehabilitation medicine, emergency department, and outpatient surgical services provided at the Muskogee VAMC to current or future VA facilities and discontinuing these services at the Muskogee VAMC: The in-house and commercial inpatient medical and surgical demand is projected to decrease by 12.4% between FY 2019 and FY 2029. The Muskogee VAMC had 42 inpatient medical and surgical beds in FY 2019, and inpatient medical and surgical ADC at the Muskogee VAMC is projected to decrease from 26.6 in FY 2019 to 22.6 in FY 2029. The facility has approximately $67.9M in FCA deficiencies. Challenges at the Muskogee VAMC range from aged domestic water and steam distribution infrastructure to slope destabilization and poor electrical distribution. Estimated annual operations and maintenance costs are $8.0M.

   In the Eastern Oklahoma Market, enrollees are largely concentrated in Tulsa, Oklahoma. Given the low inpatient medical and surgical demand and the misalignment of the current VAMC with

the Veteran population in Tulsa, VA recommends that services be relocated to a rightsized VA Hospital in the vicinity of Tulsa, Oklahoma. The proposed new Tulsa VA Hospital site has 22,722 enrollees within 30 minutes and 35,873 enrollees within 60 minutes. In contrast, the Muskogee VAMC has 5,008 enrollees within 30 minutes and 34,026 enrollees within 60 minutes. Inpatient rehabilitation medicine will be relocated to the new VA Hospital in Tulsa.

VA is securing private support and coordinating project development with the OSU Board of Regents and OSU Medical Authority as authorized by the CHIP-IN Act of 2016.[81] The proposed project will provide 58 inpatient acute medical and surgical beds and associated diagnostic/therapeutic services in Tulsa. This project could significantly strengthen research and academic programming with OSU.

A new MS CBOC in Muskogee will accommodate outpatient services from the Muskogee VAMC, which is proposed to be closed. Outpatient services are also available in Tulsa, where the market has made significant investments.

Given the proposed relocation of inpatient medical and surgical services and that current emergency department demand has remained flat, maintaining an emergency department is not warranted.

1.2 Relocating inpatient mental health services at the Muskogee VAMC to community providers and discontinuing these services at the Muskogee VAMC: The in-house and commercial inpatient mental health demand in the Eastern Oklahoma Market is projected to decrease by 6.4% from FY 2019 to FY 2029. The Muskogee VAMC had 16 inpatient mental health beds with an ADC of 11.5 in FY 2019. There were 37 mental health beds with an ADC of 25.1 in the community. Inpatient mental health demand will be accommodated by community care providers in the area until the second phase of the CHIP-IN project – a behavioral health hospital – is completed. Additionally, the re-missioned Sheridan VAMC, in the VISN 19 Sheridan Market, will offer a well-developed array of mental health services and will serve as the mental health destination campus for VISN 19.

1.3 Closing the Muskogee VAMC: Following the realignment of services to the replacement facility in Tulsa and other points of care, the existing Muskogee VAMC will be closed.

2. ***Modernize by establishing a new stand-alone RRTP in the vicinity of Tulsa, Oklahoma:*** The Eastern Oklahoma Market currently does not have an RRTP. The Eastern Oklahoma Market has a projected total bed need of 27 RRTP beds in FY 2028. Veteran enrollee population is largely concentrated in Tulsa. In FY 2019, there were 35,873 enrollees within 60 minutes of the proposed new Tulsa RRTP site. Projected demand and increased access to residential mental health services are the major drivers for the recommendation to establish an RRTP focused specifically on substance use. The new, 24-bed RRTP will meet the demand for substance use treatment for both the Eastern Oklahoma and Oklahoma City markets.

[81] Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016 (CHIP-IN Act). https://www.cfm.va.gov/realproperty/CHIP_IN.asp

3. ***Modernize by establishing a new stand-alone CLC in the vicinity of Tulsa, Oklahoma:*** The Eastern Oklahoma Market currently does not have a CLC program. The in-house and commercial CLC market demand is projected to increase by 27.8% between FY 2019 and FY 2029. The eligible Veteran enrollee population is largely concentrated in Tulsa. In FY 2019, there were 35,914 enrollees within 60 minutes of the proposed new Tulsa CLC site. A CLC will reduce out of market travel and allow Veterans to receive long-term care closer to where they live.
4. ***Modernize and realign outpatient facilities in the market by establishing a new MS CBOC in the vicinity of Muskogee, Oklahoma:*** A new MS CBOC in the vicinity of Muskogee will replace the outpatient services located at the Muskogee VAMC, which is proposed to be closed. It will provide convenient access close to home for Veterans in the vicinity of Muskogee, Oklahoma. Primary care demand is projected to increase by 56.6% between FY 2019 and FY 2029 across the Eastern Oklahoma Market. In FY 2019, the proposed Muskogee MS CBOC had 4,467 enrollees within 30 minutes and 31,267 within 60 minutes.

Complementary Strategy

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

Eastern Oklahoma Market

- **Explore strategic collaborations with the Indian Health Service (IHS) in the Eastern Oklahoma Market to increase access to primary care:** There are 26 IHS facilities dispersed throughout the market. These facilities could fill coverage gaps and provide enrollees with a viable health care option closer to home.
- **Increase home-based primary care (HBPC) coverage across the market, including more specialized geriatric care:** Expanding HBPC to outlying clinics for primary care as well as augmenting services for elderly Veterans will enhance access to care.
- **Increase availability of ophthalmology across the Eastern Oklahoma Market to address the potential lack of high-quality ophthalmologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists. Increased availability may be achieved through a variety of tactics, such as telehealth, Veterans Community Care Program (VCCP) recruitment, and hiring additional VA providers, as appropriate.
- **Ensure there is adequate space to support the research initiative at the proposed new Tulsa VA Hospital (Tulsa County) to maintain and potentially expand all existing programs.** The Office of Research and Development (ORD) will be consulted in the planning for the proposed new Tulsa VA Hospital to ensure there is adequate space to maintain existing research programs and education capabilities in the Eastern Oklahoma Market area.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Eastern Oklahoma Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[82] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Eastern Oklahoma Market are provided in the table below. For more detailed information on the market CBA, please see Appendix H.

VISN 19 Eastern Oklahoma Market	Status Quo	Modernization	VA Recommendation
Total Cost	$8,560,676,284	$8,873,550,362	$8,778,833,000
Capital Cost	$501,141,903	$814,015,981	$795,560,846
Operational Cost	$8,059,534,381	$8,059,534,381	$7,983,272,153
Total Benefit Score	9	10	10
CBI (normalized in $B)	**0.95**	**0.89**	**0.88**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

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

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA-facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through nine VA points of care offering outpatient services, including the proposed new Tulsa, Oklahoma Hospital and the Muskogee, Oklahoma MS CBOC, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed new Tulsa, Oklahoma stand-alone CLC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Memphis, Tennessee VAMC (VISN 09).
- **RRTP:** RRTP demand will be met through the proposed new Tulsa, Oklahoma stand-alone RRTP and the other facilities within VISN 19 offering RRTP, including the Sheridan, Wyoming VAMC; the Oklahoma City, Oklahoma VAMC; the Aurora, Colorado VAMC; the Valor Point, Colorado stand-alone RRTP; the Cheyenne, Wyoming, VAMC; the proposed new RRTP at the Grand Junction, Colorado VAMC; the Salt Lake City, Utah VAMC; and the RRTP at the Fort Harrison, Montana VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21) and the American Lake, Washington VAMC (VISN 20).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the proposed new Tulsa, Oklahoma Hospital, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 50,376 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 50,550 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Oklahoma State University and the University of Oklahoma at Tulsa.
- **Research:** This recommendation does not impact the research mission in the market and allows the Muskogee, Oklahoma VAMC to maintain its current research mission by ensuring there is adequate space to support the research initiative at the proposed new Tulsa, Oklahoma VA Hospital, to maintain and potentially expand all existing programs.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Muskogee, Oklahoma VAMC is not designated as a Primary Receiving Center.

Quality

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

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

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.88 for VA Recommendation versus 0.95 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Tulsa, Oklahoma Hospital; the Muskogee, Oklahoma MS CBOC; the stand-alone CLC in Tulsa, Oklahoma; and the stand-alone RRTP in Tulsa, Oklahoma. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($8.78B for VA Recommendation versus $8.87B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.88 for VA Recommendation versus 0.89 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 19 Montana Market

The Veterans Integrated Service Network (VISN) 19 Montana Market serves Veterans in Montana. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[83]

VA's Commitment to Veterans in the Montana Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 19's Montana Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Montana Market is one of the largest VA markets geographically and is highly rural, with the Veteran population dispersed across the market. With flat market enrollment, demand for inpatient acute services, long-term care, and outpatient care is increasing. Inpatient acute services will be maintained, and residential rehabilitation treatment program (RRTP) services will be expanded at the Fort Harrison VAMC. To allow Veterans to receive long-term care closer to home, VA community living center (CLC) services will be provided by State Veterans Homes and other community providers located across the state. Outpatient services will be appropriately aligned with demand across the Montana Market. The recommendation closes the Plentywood, Browning, and Glasgow other outpatient services (OOS) sites that do not have sustainable demand and maintains access by relocating care to community providers. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation establishes one modern community-based outpatient clinic (CBOC) in the vicinity of Butte, Montana, and relocates the Missoula multi-specialty community-based outpatient clinic (MS CBOC) to an expanded facility.

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

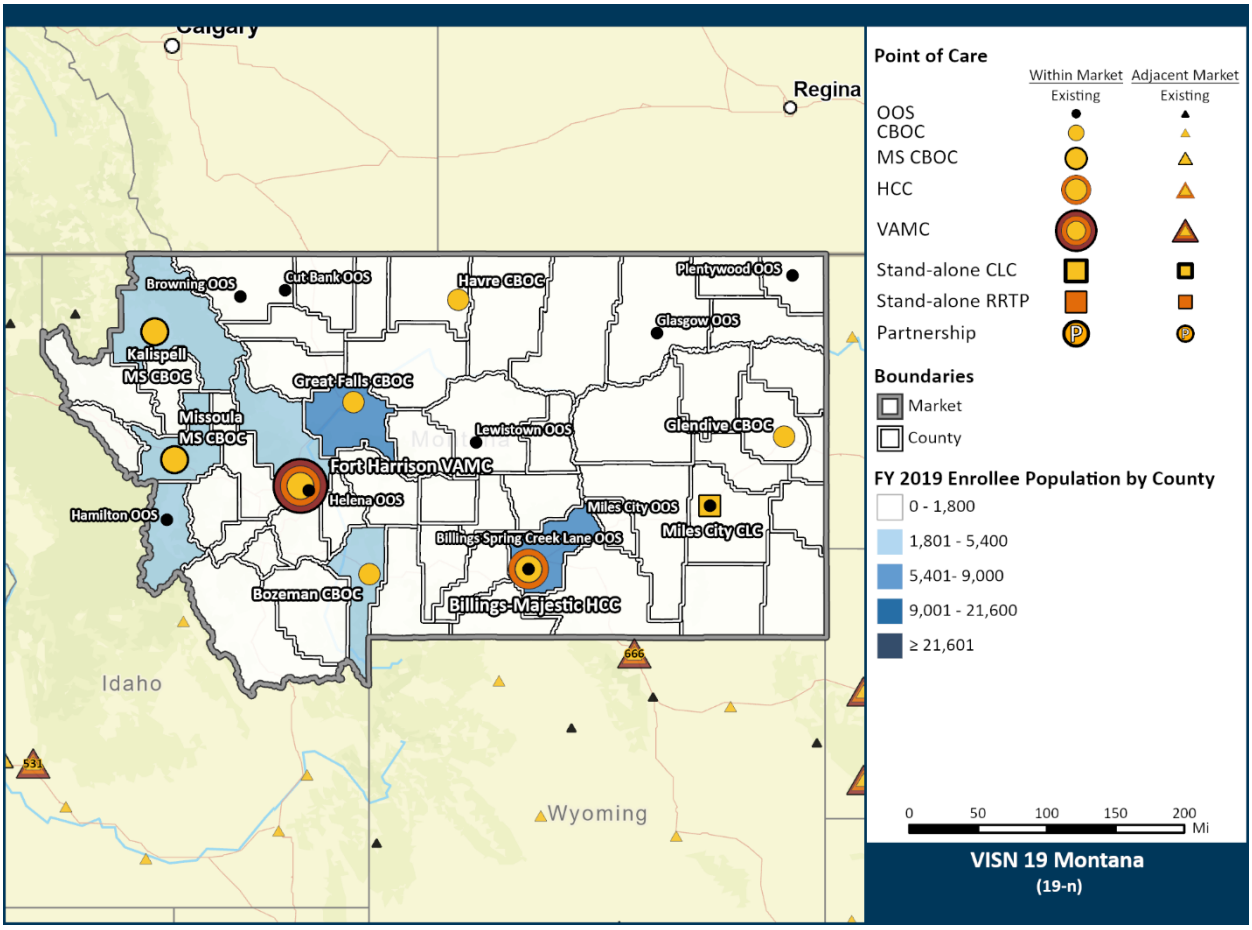
Outpatient services at the Kalispell MS CBOC, Bozeman CBOC, and Great Falls CBOC will be expanded to meet Veteran service needs.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation will provide a more sustainable long-term program across the state by transitioning CLC services from the Miles City CLC to community providers. The recommendation maintains RRTP services at the Fort Harrison VAMC. The Sheridan VAMC in the Sheridan Market will provide inpatient mental health services for the Montana Market. The Montana Market currently offers primary care for inpatient spinal cord injuries and disorders (SCI/D) and refers Veterans to the Puget Sound, Washington VAMC (VISN 20) for acute, sustaining, and rehabilitative care. Demand for inpatient blind rehabilitation services will be met at the American Lake, Washington VAMC (VISN 20).
- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains inpatient medical and surgical services at the Fort Harrison VAMC.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Fort Harrison), one stand-alone CLC, one health care center (HCC), two MS CBOCs, four CBOCs, and nine OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 46,673 enrollees and is projected to experience a 2.6% decrease in enrolled Veterans by FY 2029. The largest populations of enrollees are in the counties of Yellowstone, Cascade, and Flathead, Montana.

Demand: Demand[84] in the market for inpatient medical and surgical services is projected to increase by 9.3% and demand for inpatient mental health services is projected to increase by 21.9% between FY 2019 and FY 2029. Demand for long-term care[85] is projected to increase by 40.2%. Demand for all

[84] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[85] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,[86] including primary care, mental health, specialty care, dental care, and rehabilitation therapies is projected to increase.

Rurality: 72.6% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 60.9% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 26.9% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[87] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[88] of 60.1% (159 available beds) [89] and an inpatient mental health occupancy rate of 46.2% (8 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 62.2% (245 available beds). Community residential rehabilitation programs[90] that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include Carroll College, Pacific Northwest University, and allied health training programs. The Fort Harrison VAMC is ranked 123 out of 154 VA training sites based on the number of trainees. The Fort Harrison VAMC conducts limited or no research and has no emergency designation.[91]

Facility Overview

Fort Harrison VAMC: The Fort Harrison VAMC is located in Fort Harrison, Montana, and offers inpatient medical and surgical, RRTP, and outpatient services. In FY 2019, the Fort Harrison VAMC had an inpatient medical and surgical average daily census (ADC) of 9.5 and an RRTP ADC of 17.0.

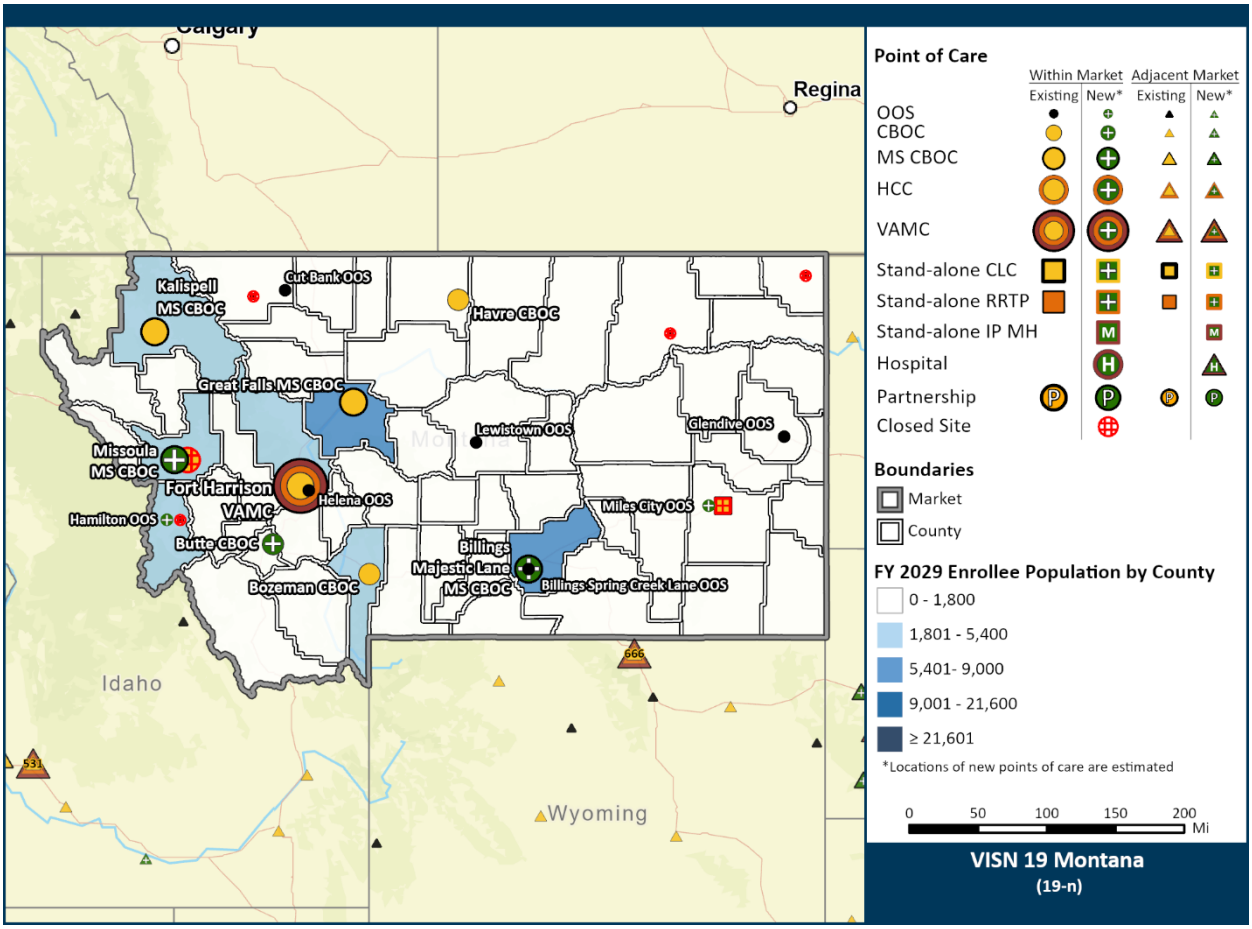
The Fort Harrison VAMC was established in 1892, and the main hospital building was built in 1963. On the 135.0-acre campus, 42.0 acres are available for additional development. The last major renovation was in 2016. Buildings are in use from the 1890s and the 1930s and do not meet current design standards.[92] Facility condition assessment (FCA) deficiencies are approximately $74.6M, and annual operations and maintenance costs are an estimated $4.0M.

[86] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[87] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[88] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[89] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[90] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[91] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.
[92] Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, column spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

Recommendation and Justification

This section details the VISN 19 Montana Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Fort Harrison VAMC by:***

   1.1. **Converting the emergency department at the Fort Harrison VAMC to an urgent care center:** Currently, most emergency department visits occur on weekdays during the hours of 8:00 am and 10:00 pm, and most are low-to-moderate complexity. Utilizing convenient community access points to provide emergency department services and rescoping services to provide urgent care will allow the Fort Harrison VAMC to align with the appropriate level of care needed to treat Veterans.

   1.2. **Modernizing the RRTP at the Fort Harrison VAMC:** The Fort Harrison VAMC had an RRTP ADC of 17.0 in FY 2019. Expanding RRTP beds from 24 to 36 at the Fort Harrison VAMC will meet the projected demand in the market. This will include 9 General Domiciliary beds, 15 Domiciliary Care for Homeless Veterans (DCHV) beds, 8 substance use disorder (SUD) beds, and 4 post-traumatic stress disorder (PTSD) beds.

2. ***Modernize and realign the Miles City CLC by relocating CLC services from the Miles City CLC to State Veterans Homes and community providers and discontinuing these services at the Miles City CLC:*** The Miles City CLC occupancy is low. In FY 2019, there were 29 CLC beds with an ADC of 15.9. With the exception of Yellowstone County, counties in the eastern region of the market have low enrollee populations, many with fewer than 100 enrollees. The number of enrollees in these counties are projected to decrease by FY 2029. Providing care at any single location will necessitate that many Veterans leave their home communities for long-term care.

   FCA deficiencies are approximately $22.3M, and the campus is located on a floodplain, which complicates the long-term use of this facility. The Miles City campus has been conveyed to Custer County, with a leaseback agreement for a minimum of three years. VA recommends that the lease at the Miles City CLC campus not be renewed.

   Following the opening of the Southwest Montana State Veterans Home, there will be a total of 257 State Veterans Homes beds in the market. Within 70 miles of Miles City there is one nursing home with 107 beds and an occupancy rate of 44.0%, indicating there are approximately 49 available beds.

3. ***Modernize and realign outpatient facilities in the market by:***

   3.1. Relocating outpatient surgical services provided at the Billings-Majestic HCC to community providers and discontinuing these services at the Billings-Majestic HCC: The Billings-Majestic HCC has low outpatient surgical caseload; in FY 2019, there were 485 outpatient surgical cases at the HCC. Relocating outpatient surgical services to the community will allow Veteran access to outpatient surgical services while maintaining other outpatient specialty services at the facility. Additionally, this may result in the classification of the facility as an MS CBOC.

   3.2. Establishing a new CBOC in the vicinity of Butte, Montana: In FY 2019, there were 1,665 enrollees in Silver Bow County, where Butte is located. Demand for outpatient services is projected to increase across the market. In FY 2019, there were 1,965 enrollees within 30 minutes of the proposed new site, which will expand access to primary care services in the southwest portion of the market.

   3.3. Relocating the Missoula MS CBOC to a new site in the vicinity of Missoula, Montana, and closing the Missoula MS CBOC: In FY 2019, the Missoula MS CBOC served 6,443 core uniques,[93] a 4.8% decrease from FY 2015. The existing location of the Missoula MS CBOC is outside of the population center. In FY 2019, there were 4,119 enrollees within 30 minutes and 6,595 enrollees within 60 minutes of the Missoula MS CBOC. Replacing the Missoula MS CBOC with a facility where Veteran population is more concentrated will improve access and Veteran satisfaction.

   3.4. Relocating all services at the Plentywood OOS and closing the Plentywood OOS: The Plentywood OOS had 90 enrollees within 30 minutes and served 110 core uniques in FY 2019. Outpatient demand at the Plentywood OOS is low; in FY 2019, there were 39 mental health encounters and 369 primary care encounters. Deactivating the facility and relocating care to

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

community providers and VA telehealth services will allow the small enrollee population to have local, convenient access.

3.5. **Relocating all services at the Glasgow OOS and closing the Glasgow OOS:** The Glasgow OOS had 250 enrollees within 30 minutes and served 741 core uniques in FY 2019. Outpatient demand at the Glasgow OOS is low; in FY 2019, there were 150 mental health encounters, 2,001 primary care encounters, and 63 specialty care encounters. Deactivating the facility and relocating care to community providers and VA telehealth services will allow the small enrollee population to have local, convenient access.

3.6. **Relocating all services to the Cut Bank OOS and closing the Browning OOS:** Enrollees in Glacier County, where the Browning OOS is located, are projected to decrease by 3.4%, from 442 in FY 2019 to 427 in FY 2029. Deactivating the facility and relocating access to U.S. Department of Housing and Urban Development – VA Supportive Housing (HUD VASH) services via videotelephony will reflect use patterns and maintain access.

Complementary Strategy

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

Montana Market

- **Continue to seek opportunities to share services and resources between the Montana and Sheridan Markets without a formalized clinical or administrative merger:** The Montana Market currently leverages the Sheridan VAMC for a broad array of mental health services. Given that Sheridan is successfully executing their mission, and sharing is already occurring, the two markets can improve clinical service delivery without the need for an administrative merger.
- **Expand telehealth services throughout the market:** Enrollees in the market are utilizing telehealth services far above the national average. Expanding telehealth services in the market will increase access to care for services such as RRTP after care appointments, diabetes education classes, and Whole Health education.

Fort Harrison VAMC

- **Expand physical therapy and audiology services at the Kalispell MS CBOC (Flathead County):** Demand for outpatient rehabilitation therapy is projected to increase significantly in the market. Expanding outpatient physical therapy and audiology services at the Kalispell MS CBOC will reduce the reliance on care in the community.
- **Assess the need to relocate the Kalispell MS CBOC (Flathead County) to a larger facility in Kalispell, Montana, following the completion of the expanded Missoula MS CBOC (Missoula County):** The Kalispell MS CBOC pre-dates the patient-aligned care team (PACT) model and was sized for four providers. The Missoula MS CBOC, located two hours south of Kalispell, is currently slated for a major expansion. Assessing the need to relocate the Kalispell location to a larger facility will ensure services are being provided efficiently in the market.

- **Expand outpatient specialty care services at the Great Falls CBOC (Cascade County), which may result in the classification of the facility as an MS CBOC:** In FY 2019, the Great Falls CBOC had 5,303 enrollees within 30 minutes and served 6,181 core uniques. In FY 2019, there were 5,765 specialty care encounters with an 89.0% increase from FY 2017. Expanding outpatient specialty care services at the Great Falls CBOC will reduce the reliance on care in the community.
- **Expand physical therapy and audiology services at the Bozeman CBOC (Gallatin County):** In FY 2019, the Bozeman CBOC had 2,990 enrollees within 30 minutes and served 3,127 core uniques. In FY 2019, there were 332 outpatient rehabilitation encounters. Outpatient rehabilitation therapy demand is projected to increase in the market. Expanding outpatient physical therapy and audiology services at the Bozeman CBOC will reduce the reliance on care in the community.
- **Reclassify the Glendive CBOC (Dawson County) as an OOS:** In FY 2019, the Glendive CBOC had 354 enrollees within 30 minutes and served 512 core uniques. In FY 2019, there were 810 primary care encounters, an 10.7% decrease from FY 2017, and 65 specialty care encounters, an 54.5% decrease from FY 2017. Mental health encounters have remained flat between FY 2017 and FY 2019. Reclassifying the facility as an OOS will better align the facility to its future demand.
- **Increase availability of critical care/pulmonology across the Montana Market to address the potential lack of high-quality critical care/pulmonology specialists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality critical care/pulmonology specialists. Increased availability may be achieved through a variety of tactics, such as telehealth, Veterans Community Care Program (VCCP) recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of endocrinology across the Montana Market to address the potential lack of high-quality endocrinologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality endocrinologists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of ophthalmology across the Montana Market to address the potential lack of high-quality ophthalmologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of cardiology across the Montana Market to address the potential lack of high-quality cardiologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality cardiologists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 19 Montana Market: Status Quo, Full Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[94] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs includes direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate a Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI is the preferred COA. The results of the CBA for the VISN 19 Montana Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 19 Montana Market	Status Quo	Full Modernization	VA Recommendation
Total Cost	$10,238,251,988	$10,526,785,701	$10,305,132,438
Capital Cost	$629,877,076	$918,410,790	$862,074,985
Operational Cost	$9,608,374,911	$9,608,374,911	$9,443,057,453
Total Benefit Score	7	10	10
CBI (normalized in $B)	**1.46**	**1.05**	**1.03**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

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

Section 203 Criteria Analysis

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

Demand

This recommendation is consistent with the Demand criterion, aligning VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the market.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 15 VA points of care offering outpatient services, including the proposed replacement Great Falls, Montana MS CBOC; the proposed new Missoula, Montana MS CBOC; Bozeman, Montana CBOC; Butte, Montana CBOC; Hamilton, Montana OOS; and Miles City, Montana OOS, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through State Veterans Homes and other community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Seattle, Washington VAMC (VISN 20).
- **RRTP:** RRTP demand will be met through the Fort Harrison, Montana VAMC, and the other facilities within VISN 19 offering RRTP, including the Sheridan, Wyoming VAMC; the Salt Lake City, Utah VAMC; the Cheyenne, Wyoming, VAMC; the proposed new RRTP at the Grand Junction, Colorado VAMC; the Aurora, Colorado VAMC; the Valor Point, Colorado stand-alone RRTP; the Oklahoma City, Oklahoma VAMC; and the proposed new Tulsa, Oklahoma stand-alone RRTP.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the Palo Alto, California VAMC (VISN 21) and the American Lake, Washington VAMC (VISN 20).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the Fort Harrison, Montana VAMC, as well as through community providers; inpatient mental health demand will be met through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers in receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and outpatient specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 44,365 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 46,166 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 19. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with Carroll College and Pacific Northwest University.
- **Research:** This recommendation does not impact the research mission in the market; the Fort Harrison, Montana VAMC does not have a research program.[95]
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Fort Harrison, Montana VAMC is not designated as a Primary Receiving Center.

[95] Research programs were determined by FY21 total VA-funded research dollars per the Research and Development Information System (RDIS).

Quality

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

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

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo (1.03 for VA Recommendation versus 1.46 for Status Quo), indicating that the VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed replacement Great Falls, Montana MS CBOC; the proposed new Missoula, Montana MS CBOC; Bozeman, Montana CBOC; Butte, Montana CBOC; Hamilton, Montana OOS; and Miles City, Montana OOS. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($10.3B for VA Recommendation versus $10.5B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.03 for VA Recommendation versus 1.05 for Modernization), reflecting effective stewardship of taxpayer dollars.