VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022

VISN 21

Market Recommendations

Table of Contents

VISN 21 South Coast Market

The Veterans Integrated Service Network (VISN) 21 South Coast Market serves Veterans along the central coast of California. 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 South Coast Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 21's South Coast 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 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 Veteran population in the South Coast Market is projected to decrease. Demand for acute inpatient and residential rehabilitation treatment program (RRTP) services is also projected to decrease, while community living center (CLC) and outpatient demand is projected to increase. The Palo Alto VA Health Care System, which consists of three medical centers, offers the full range of VA-delivered inpatient and outpatient services, but some services are better provided in a more distributed manner. 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 expanded outpatient sites offering primary care, mental health, and low-acuity specialty services to better distribute care and decompress existing campuses. The recommendation establishes a new multi-specialty community-based outpatient clinic (MS CBOC) in Pleasanton, California, and relocates a community-based outpatient clinic (CBOC) to Santa Cruz, California, closer to where Veterans live.

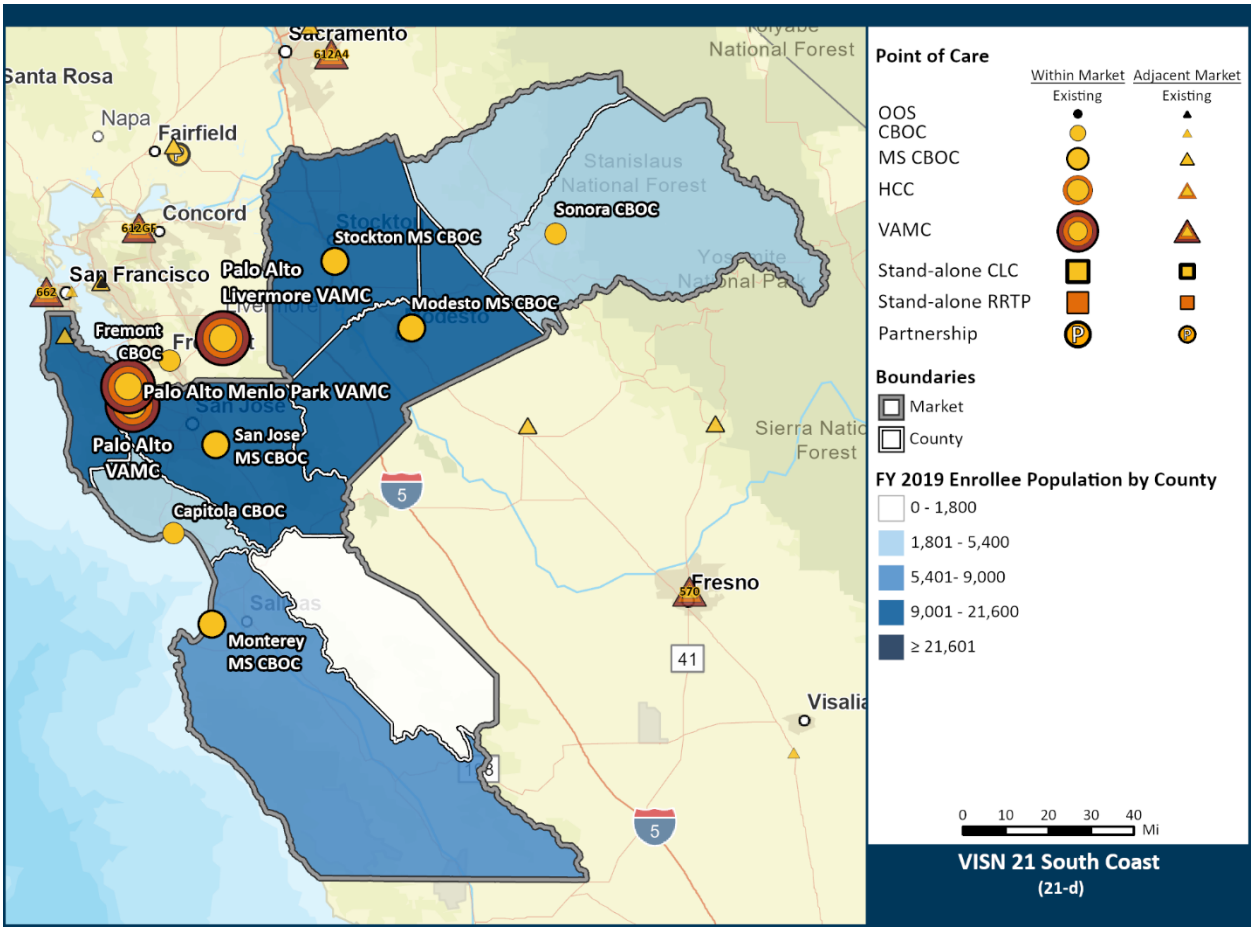
[1] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation maintains the inpatient mental health service at the Palo Alto VAMC. The recommendation modernizes the CLC facility at the Palo Alto Menlo Park VAMC to maintain care for Veterans with the most complex needs. The recommendation also modernizes the RRTP facility at the Palo Alto Menlo Park VAMC to provide comprehensive care that may not be readily available in the community. Inpatient blind rehabilitation demand is met through the Palo Alto Menlo Park VAMC, and inpatient spinal cord injuries and disorders (SCI/D) care demand is met through the regional hub at the Palo Alto, California, VAMC.
- **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 the inpatient medical and surgical program at the Palo Alto VAMC and also provides access to inpatient medical and surgical services through community providers throughout the market.

Market Overview

The market overview includes a map of the South Coast 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 three VAMCs (Palo Alto, Palo Alto Menlo Park, and Palo Alto Livermore), four MS CBOCs, and three CBOCs.

Enrollees: In fiscal year (FY) 2019, the market had 73,517 enrollees and is projected to experience a 17.0% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Santa Clara, California; San Joaquin, California; and Stanislaus, California.

Demand: Demand[2] in the market for acute inpatient medical and surgical services is projected to decrease by 27.1% and demand for inpatient mental health services is projected to decrease by 13.3% between FY 2019 and FY 2029. Demand for long-term care[3] is projected to increase by 9.0%. Demand

[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.

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

Rurality: 16.3% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 92.6% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 62.0% 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 VAMCs had an inpatient acute occupancy rate[6] of 59.3% (2,047 available beds)[7] and an inpatient mental health occupancy rate of 70.1% (35 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 86.4% (362 available beds). Community residential rehabilitation programs[8] 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 Stanford University. The three Palo Alto VAMCs are ranked 41 out of 154 VA training sites based on the number of trainees and are ranked 3 out of 103 VAMCs with research funding. The VAMCs do not hold an emergency designation.[9]

Facility Overviews

Palo Alto VAMC: The Palo Alto VAMC, located in Palo Alto, California, offers inpatient medical and surgical care, inpatient mental health services, RRTP[10], CLC, rehabilitative medicine, SCI/D, and outpatient services. In FY 2019, the Palo Alto VAMC had a medical and surgical average daily census (ADC) of 69.7, a mental health ADC of 29.1, an RRTP ADC of 0.9, a CLC ADC of 24.1, a rehabilitative medicine ADC of 14.5, and an SCI/D ADC of 19.4.

The Palo Alto VAMC was built in 1997 on 109.0 acres and does not meet current design standards.[11] Facility condition assessment (FCA) deficiencies are approximately $381.6M, and annual operations and maintenance costs are an estimated $44.1M.

Palo Alto Livermore VAMC: The Palo Alto Livermore VAMC, located in Livermore, California, offers CLC and outpatient services. In FY 2019, the Palo Alto Livermore VAMC had a CLC ADC of 74.2.

[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 total number of 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] RRTP is located at the Palo Alto Menlo Park VAMC. The 19 beds at the Palo Alto VAMC are not active.
[11] 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, columns spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be conducive or ideal for the delivery of modern health care.

The Palo Alto Livermore VAMC was built in 1949 on 112.0 acres and does not meet current design standards. FCA deficiencies are approximately $63.9M, and annual operations and maintenance costs are an estimated $6.2M.

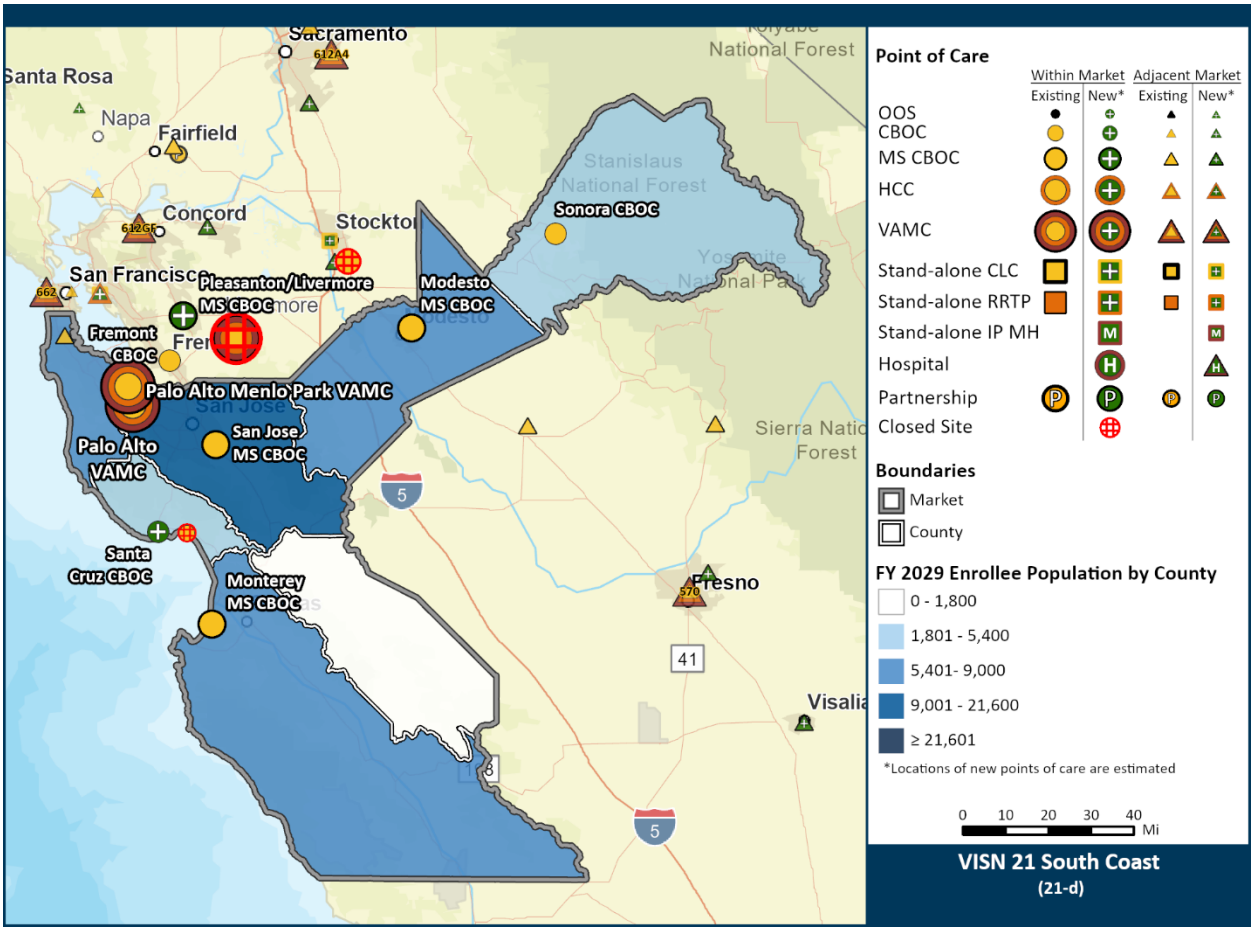
Palo Alto Menlo Park VAMC: The Menlo Park VAMC, located in Menlo Park, California, offers RRTP, CLC, blind rehabilitation, and outpatient services. In FY 2019, the Palo Alto Menlo Park VAMC had an RRTP ADC of 109.7, a CLC ADC of 136.4, and a blind rehabilitation ADC of 12.8.

The Palo Alto Menlo Park VAMC was built in 1985 on 96.0 acres and does not meet current design standards. FCA deficiencies are approximately $186.5M, and annual operations and maintenance costs are an estimated $20.9M.

Recommendation and Justification

This section details the VISN 21 South Coast Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Palo Alto Livermore VAMC by:***

   1.1. **Relocating CLC and outpatient services to existing or future VA facilities and discontinuing these services at the Palo Alto Livermore VAMC:** The Palo Alto Livermore VAMC was built in 1949 and is located on a 112-acre campus with one road providing access in and out of the campus that is not easily accessible from nearby population centers where Veterans live. The campus has parking limitations, outdated buildings that are not suited for modern health care delivery, and an aging sewage treatment plant. The VAMC's services will be relocated to other VA points of care in Palo Alto and VISN 21 to improve quality and access to care. The closest CLC points of care from the Palo Alto Livermore VAMC are less than 60 minutes away at the Palo Alto VAMC and Palo Alto Menlo Park VAMC, which are part of the Palo Alto Health Care System. The Palo Alto Health Care System had a CLC ADC of 234.7 in FY 2019, which is projected to decrease slightly to an ADC of 231.9 in FY 2029.

   1.2. **Closing the Palo Alto Livermore VAMC:** Distributing services to locations more convenient for Veterans will allow for closure of the existing VAMC.

2. ***Modernize and realign the Palo Alto Menlo Park VAMC by:***

   2.1. **Modernizing the CLC:** The two CLC buildings at the Palo Alto Menlo Park VAMC are not designed for modern health care delivery. The modernization of existing CLC buildings at Palo Alto Menlo Park will include the conversion to private rooms and alignment of capacity with current and projected demand for CLC services in the South Coast Market. In FY 2019, the Palo Alto Menlo Park VAMC had a CLC ADC of 136.4, and long-term care demand in the South Coast Market is projected to increase by 9.0% between FY 2019 and FY 2029.

   2.2. **Modernizing the RRTP:** Four RRTP buildings and a domiciliary building at the Palo Alto Menlo Park VAMC are not designed for modern health care delivery. The modernization of existing RRTP buildings at Palo Alto Menlo Park will include the conversion to private rooms and alignment of capacity with current and projected demand for RRTP services in the South Coast Market. In FY 2019, the Palo Alto Menlo Park VAMC had an RRTP ADC of 109.7. The RRTP will continue to support Veterans living in the adjacent North Valley, South Valley, and North Coast markets.

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

   3.1. **Establishing a new MS CBOC in the vicinity of Pleasanton, California:** A new MS CBOC in the vicinity of Pleasanton, California, will improve access to primary care, mental health, and outpatient specialty services at a location close to where Veterans live and eliminate the need for those services at the Livermore VAMC. In FY 2019, there were 16,002 enrollees within 30 minutes and 94,207 enrollees within 60 minutes of the proposed site. Placement near major highways will increase access for all Veterans in the surrounding area.

   3.2. **Relocating the Capitola CBOC to a new site in the vicinity of Santa Cruz, California, and closing the existing Capitola CBOC:** The existing CBOC is not in a location central to Veterans living in Santa Cruz County. Relocation to the vicinity of Santa Cruz places primary care and outpatient mental health services in a more accessible and sustainable location and places it in the area where community residents typically seek care. In FY 2019, there were 4,592 enrollees within 30 minutes of the proposed site.

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:

South Coast Market

- **Realign Calaveras and San Joaquin counties in California from the VISN 21 South Coast Market to the VISN 21 North Valley Market:** Calaveras and San Joaquin counties are closer to the Sacramento VAMC in the North Valley Market than the Palo Alto VAMC in the South Coast Market. San Andreas, California, the county seat of Calaveras County, is located 54 miles from the Sacramento VAMC, compared to 124 miles from the Palo Alto VAMC. Stockton, California, the county seat of San Joaquin County, is located 63 miles from the Sacramento VAMC compared to 77 miles from the Palo Alto VAMC.
- **Realign the Stockton MS CBOC to the Sacramento VAMC in the VISN 21 North Valley Market**: The Stockton MS CBOC is closer to the Sacramento VAMC than the Palo Alto VAMC in the South Coast Market. The Stockton CBOC is 63 miles from the Sacramento VAMC compared to 77 miles from the Palo Alto VAMC. Realigning the Stockton MS CBOC with the Sacramento VAMC will improve specialty care support to the Stockton MS CBOC.

Palo Alto VAMC

- **Establish strategic collaborations with community providers, Federally Qualified Health Centers (FQHCs), and Indian Health Service (IHS) facilities to expand access to primary care and outpatient mental health services in King City, Hollister, and San Andreas, California**: These three areas lack enough Veteran enrollees to sustain VA points of care. The closest VA point of care for Veterans living in King City and Hollister is the Monterey CBOC, 65 minutes from King City and 40 minutes from Hollister. The closest VA point of care for Veterans living in San Andreas is the Sonora CBOC, 44 minutes away. Strategic collaborations with local community providers, FQHCs, and IHS facilities are needed to provide care to Veterans in those areas.
- **Establish a strategic collaboration with Stanford Health Care's Valley Care Medical Center in Pleasanton, California, to deliver outpatient surgical services currently offered at the Palo Alto VAMC:** This strategy will allow VA providers from the Palo Alto VAMC to utilize the Stanford Valley Ambulatory Surgery Center to provide outpatient procedures closer to Veterans living in that area. There was a 3.8% decrease in surgical cases in the South Coast Market between FY 2015 and FY 2019.
- **Strengthen the existing Veterans Community Care Program (VCCP) for inpatient mental health services in the Modesto and Salinas Hospital Referral Regions (HRRs):**[12] Demand for inpatient mental health is projected to decrease by 13.3% in the South Coast Market from FY 2019 to FY 2029. Both Modesto and Monterey, California, are more than 60 minutes from the Palo Alto VAMC, so partnerships will improve Veteran access to care closer to home.

[12] Hospital referral regions (HRRs) represent regional health care markets for tertiary medical care.

- **Strengthen the existing VCCP for inpatient surgical services offered at the Palo Alto VAMC with community providers in the Modesto and Salinas HRRs:** Demand for inpatient medical and surgical services is projected to decrease by 27.1% in the South Coast Market from FY 2019 to FY 2029. Both Modesto and Monterey, California, are more than 60 minutes from the Palo Alto VAMC, so partnerships will improve Veteran access to care closer to home.
- **Activate Building 500 for physical medicine and rehabilitation (PM&R), polytrauma, blind rehabilitation, and physical therapy:** The Palo Alto VAMC is currently known as one of the few regional tertiary hubs for both SCI/D and polytrauma. Building 500 was recently constructed to consolidate the rehabilitation programs into one state-of-the-art facility. The consolidation includes moving blind rehabilitation from the Palo Alto Menlo Park VAMC to the Palo Alto VAMC. These moves will free up space in Building 7 needed for dedicated SCI/D care and the consolidation of services will improve efficiencies of shared staff such as nursing, physical therapy, occupational therapy, speech therapy and recreational therapy. Outpatient rehabilitation therapy demand at the South Coast Market is projected to increase by 38.2% between FY 2019 and FY 2029, and blind rehabilitation demand at the Palo Alto VAMC is projected to increase by 17.4%.
- **Establish telehealth hubs at the Palo Alto VAMC to expand access to outpatient specialty care services for VISN 21:** Veterans living in the eastern sector of the South Coast Market and outside the market have difficulty accessing providers with specialties such as cardiology, gastroenterology, hematology, nephrology, cardiothoracic surgery, and orthopedic surgery. Creating telehealth hubs at the Palo Alto VAMC will expand access to key services.
- **Expand primary care and outpatient mental health capacity and add optometry services at the Fremont CBOC:** Market demand for primary care services is projected to increase by 42.6%% between FY 2019 and FY 2029. Market demand for outpatient mental health services is projected to increase by 32.3%. The Fremont CBOC in Alameda County is well-positioned to absorb the additional demand but requires more space.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 21 South Coast 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[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 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

[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 South Coast Market are provided on the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 21 South Coast Market	Status Quo	Modernization	VA Recommendation
Total Cost	$28,057,621,354	$27,086,645,494	$26,668,742,411
Capital Cost	$3,274,159,374	$2,303,183,514	$1,885,280,431
Operational Cost	$24,783,461,980	$24,783,461,980	$24,783,461,980
Total Benefit Score	9	11	13
CBI (normalized in $B)	**3.12**	**2.46**	**2.05**

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 nine VA points of care offering outpatient services, including the proposed new Santa Cruz, California CBOC and Pleasanton/Livermore, California MS CBOC, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Palo Alto, California VAMC and Palo Alto Menlo Park, California 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.

Demand

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D hub at the Palo Alto, California VAMC.
- **RRTP:** RRTP demand will be met through the RRTP at the Palo Alto Menlo Park, California VAMC and the other facilities within VISN 21 offering RRTP, including the North Las Vegas, Nevada VAMC; proposed new RRTP at the Sacramento, California VAMC; and the proposed new stand-alone RRTP in Honolulu, Hawaii.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest region, including the American Lake, Washington VAMC (VISN 20) and the Palo Alto, California VAMC.
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Palo Alto, California 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 to 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 43,090 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 43,363 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 21. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Stanford University.
- **Research:** This recommendation does not impact the research mission in the market and allows the Palo Alto, California VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; no VAMCs in this market are 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 Santa Cruz, California CBOC and Pleasanton/Livermore, California MS CBOC, as well as the modernization of the CLC and RRTP at the Palo Alto Menlo Park, California 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 (2.05 for VA Recommendation versus 3.12 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 Santa Cruz, California CBOC and Pleasanton/Livermore, California MS CBOC, as well as the modernization of the CLC and RRTP at the Palo Alto Menlo Park, California 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:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($26.7B for VA Recommendation versus $27.1B 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 (2.05 for VA Recommendation versus 2.46 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 21 Sierra Nevada Market

The Veterans Integrated Service Network (VISN) 21 Sierra Nevada Market serves Veterans in northern Nevada and northeastern California. 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 Sierra Nevada Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 21's Sierra Nevada 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 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 Sierra Nevada Market is projected to experience a slight decrease in the number of enrolled Veterans. Demand for inpatient medical and surgical and outpatient services is projected to increase, while demand for inpatient mental health is projected to decrease. The Reno VAMC is constrained in seismically deficient facilities on a residential neighborhood campus bisected by a major commuting street. A number of the market's outpatient clinics serve small, decreasing populations. 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 expanded outpatient sites offering primary care, mental health, and low-acuity specialty services to better distribute care and decompress existing campuses. The recommendation establishes one new multi-specialty outpatient clinic (MS CBOC) in Carson City, Nevada; relocates another community-based outpatient clinic (CBOC) closer to where Veterans live in Sparks, Nevada; and relocates care provided at two remote clinics to community providers.

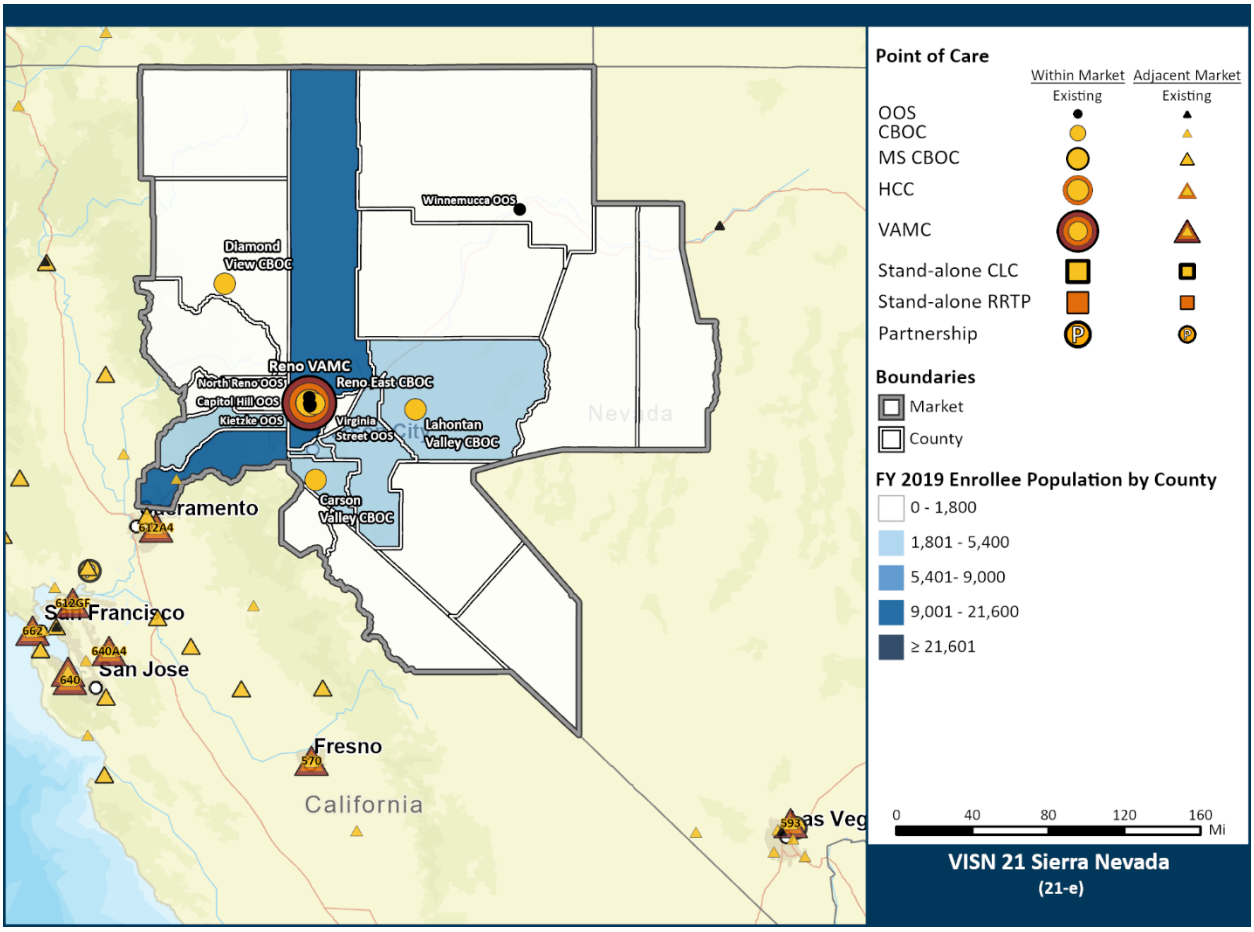
[14] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in inpatient mental health services and in modern community living center (CLC) facilities to maintain care for Veterans with the most complex needs in the new replacement Reno VAMC. The new Sacramento residential rehabilitation treatment program (RRTP) will provide improved access to a modern, distributed facility with comprehensive care that may not be readily available in the community. Inpatient blind rehabilitation demand is met through the Palo Alto Menlo Park VAMC, and inpatient spinal cord injuries and disorders (SCI/D) care demand is met through the regional hub at the Palo Alto, California, VAMC.
- **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 invests in a new VA-owned replacement facility in Reno to optimize VA-delivered inpatient medical and surgical services.

Market Overview

The market overview includes a map of the Sierra Nevada 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 (Reno), four CBOCs, and five other outpatient services (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 47,915 enrollees and is projected to experience a 3.9% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Washoe, Nevada; Placer, California; and Lyon, Nevada.

Demand: Demand[15] in the market for acute inpatient medical and surgical services is projected to increase by 1.9% and demand for inpatient mental health services is projected to decrease by 3.6% between FY 2019 and FY 2029. Demand for long-term care[16] is projected to increase by 28.0%. Demand

[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.

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

Rurality: 39.9% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 78.7% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 79.2% 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 66.0% (217 available beds)[20] and an inpatient mental health occupancy rate of 64.4% (14 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 67.9% (247 available beds). Community residential rehabilitation programs[21] 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 the University of Nevada Reno School of Medicine and has an extensive nurse training program and multiple affiliations, providing nurse training at all levels. The Reno VAMC is ranked 89 out of 154 VA training sites based on the number of trainees and is ranked 81 out of 103 VAMCs with research funding. The Reno VAMC is designated as a Federal Coordinating Center.[22]

Facility Overview

Reno VAMC: The Reno VAMC is located in Reno, Nevada, and offers inpatient medical and surgical, CLC, and outpatient services. In FY 2019, the Reno VAMC had an inpatient medical and surgical average daily census (ADC) of 41.6, an inpatient mental health ADC of 12.9, and a CLC ADC of 52.7.

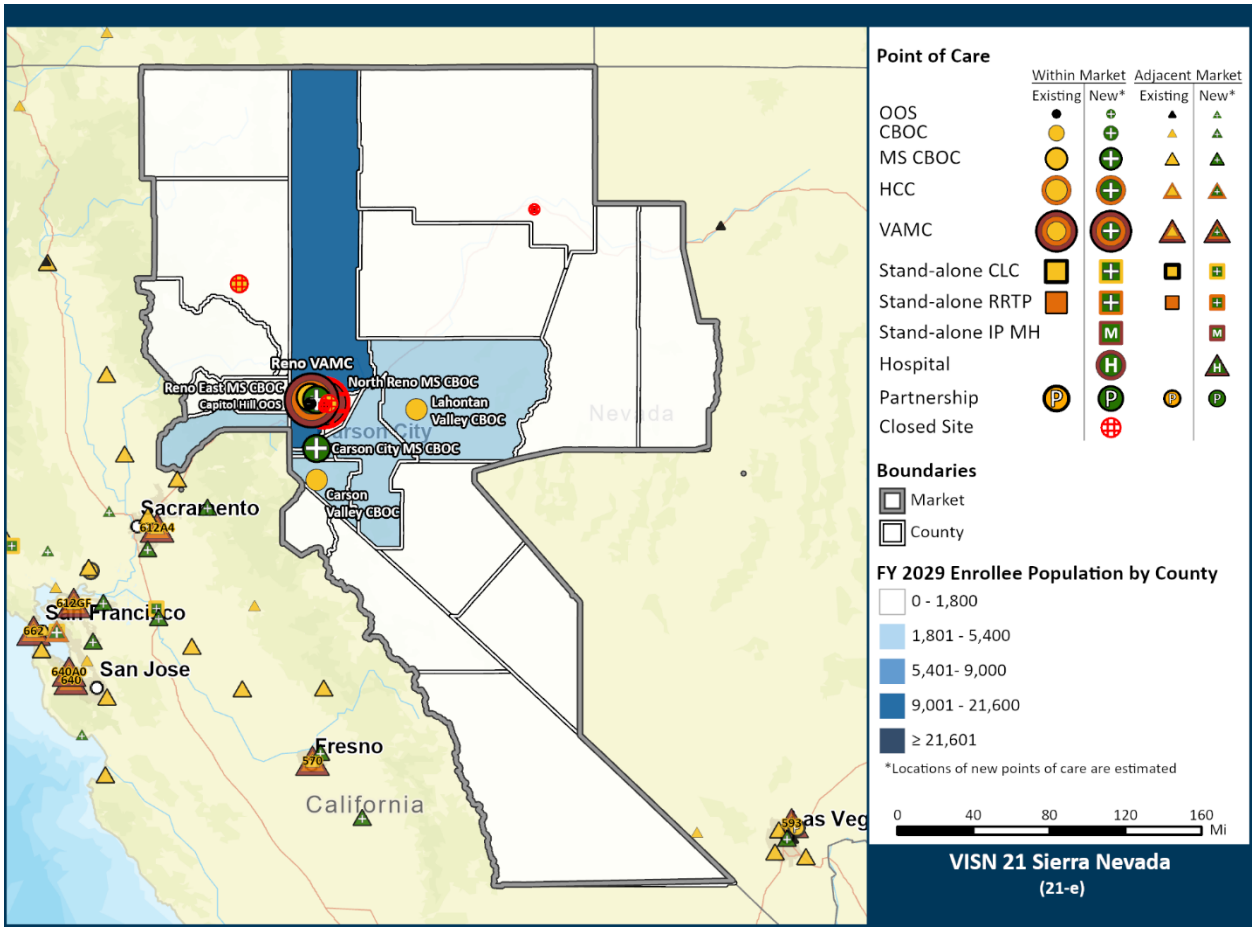
The Reno VAMC was built in 1939 on 13 acres and does not meet current design standards.[23] The majority of facilities on campus are not seismically compliant and require major structural improvements to remain safe for Veteran care. Limited expansion space on and surrounding the campus presents challenges to VA's ability to make necessary upgrades. Facility condition assessment (FCA) deficiencies are approximately $59.3M, and annual operations and maintenance costs are an estimated $10.3M.

[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. While some buildings prior to this era can be in good condition, they may not be conducive or ideal for the delivery of modern health care.

Recommendation and Justification

This section details the VISN 21 Sierra Nevada Market recommendation and justification for each element of the recommendation.

Future Market Map



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

   1.1. **Constructing a replacement VAMC with inpatient medical and surgical, inpatient mental health, CLC, outpatient surgical, emergency department, and outpatient services in the vicinity of Reno, Nevada:** The current VAMC is seismically compromised and has ongoing maintenance challenges. There is limited room for expansion on its current site. A replacement facility is the most cost effective and implementable solution. The relocation will be in the Greater Reno area. The replacement VAMC will include inpatient medical and surgical, inpatient mental health, CLC, and outpatient services. The VAMC has a projected FY 2029 inpatient medical and surgical ADC of 34.8, inpatient mental health ADC of 17.2, and CLC ADC of 54.6. As of FY 2019, there were 27,367 enrollees within 60 minutes of the proposed site.

   1.2. **Closing the existing Reno VAMC:** Relocating all existing services to a replacement facility will allow for closing of the existing Reno VAMC.

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

   2.1. Establishing a new MS CBOC in the vicinity of Carson City, Nevada: An MS CBOC in Carson City, Nevada, will alleviate long wait times and space constraints at the Carson Valley CBOC and improve access for Veterans living in Carson City, Nevada, and the growing population east of Carson City, Nevada. As of FY 2019, there were 9,069 enrollees within 30 minutes and 27,194 enrollees within 60 minutes of the proposed site.

   2.2. Relocating the Reno East CBOC to the vicinity of Sparks, Nevada, and closing the existing Reno East CBOC: Despite the presence of a VA point of care in Reno, Nevada, at the Reno VAMC, the Reno East CBOC is one of the most frequently used facilities and was opened recently to support the Reno VAMC's efforts to shift primary care services due to space constraints. A relocated facility will improve access and be more sustainable in the vicinity of Sparks, Nevada. The new facility will be an MS CBOC. As of FY 2019, there were 17,751 enrollees within 30 minutes and 26,834 enrollees within 60 minutes of the proposed site.

   2.3. Relocating all services at the Kietzke OOS and closing the Kietzke OOS: The Kietzke OOS is primarily an eye clinic. Relocating optometry services from the Kietzke OOS to all VA points of care in the market will allow for more distributed services, providing better access and a full complement of eye care. In FY 2019, the Kietzke OOS served 7,543 core unique patients.[24]

   2.4. Relocating all services to the proposed new Reno VAMC and closing the Virginia Street OOS: The Virginia Street OOS is primarily a dental clinic and is located six minutes from the Reno VAMC. Relocating dental services from the Virginia Street OOS to the new replacement Reno VAMC will allow for a more centralized offering for dental services and help with staffing and recruitment. In FY 2019, the Virginia Street OOS served 2,359 core unique patients.

   2.5. Relocating all services at the Diamond View CBOC and closing the Diamond View CBOC: Relocating services from the Diamond View CBOC to community providers is driven by low utilization of the facility and the projected 14.2% enrollment decrease over the next 10 years in the highly rural area of Lassen County, where the Diamond View CBOC is located. In FY 2019, the Diamond View CBOC served 1,082 core unique patients. Veteran access will be maintained through the use of community alternatives for primary care and outpatient mental health services in the area surrounding the Diamond View CBOC.

   2.6. Relocating all services at the Winnemucca OOS and closing the Winnemucca OOS: Relocating services from the Winnemucca OOS to community providers is driven by low utilization of the facility and the projected 15.0% decrease in the number of enrollees over the next 10 years in the highly rural area of Humboldt County, where the Winnemucca OOS is located. In FY 2019, this site served 422 core unique patients. Veteran access will be maintained through the use of community alternatives for primary care and outpatient mental health services in the area surrounding the Winnemucca OOS.

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

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:

Sierra Nevada Market

- **Realign Placer County, California, from the VISN 21 Sierra Nevada Market to the VISN 21 North Valley Market**: Veterans living in Placer County most frequently used the Sacramento VAMC for outpatient specialty care services. It is a 40-minute drive time, instead of 90 minutes to the Reno VAMC. The Sierra Foothills CBOC in Placer County is located within the Sacramento Hospital Referral Region (HRR)[25], indicating referral patterns for the general population go toward the Sacramento area.
- **Realign Inyo County, California, from the VISN 22 Loma Linda Market to the VISN 21 Sierra Nevada Market**: Referral patterns indicate that Veterans from Inyo County in VISN 22 are already traveling to VISN 21 to receive care. Realigning Inyo County to VISN 21 would have minimal impact on the Loma Linda and Sierra Nevada Markets because there were 611 enrollees in the county in FY 2019. Most enrollees live within the Bishop Hospital Service Area, which is part of the Reno HRR, indicating referral patterns for the general population go toward the Reno area.
- **Continue to expand internet bandwidth in conjunction with the state of Nevada. Expand telehealth use to rural areas in the Sierra Nevada Market for as many specialties as possible (in progress)**: The Reno VAMC's telehealth utilization rate is slightly below the national average, indicating an opportunity for improvement as internet bandwidth is strengthened in rural areas.

Reno VAMC

- **Increase availability of neurosurgery services across the Sierra Nevada market to address the potential lack of high-quality neurosurgeons:** As identified by the Section 203 criteria analysis, there is a potential lack of high-quality neurosurgeons. Increased availability may be achieved through a variety of tactics, such as telehealth, recruitment of providers to the Veterans Community Care Program (VCCP), and hiring additional VA providers, as appropriate**.**
- **Increase availability of ophthalmology across the Sierra Nevada Market to address the potential lack of high-quality ophthalmologists:** As identified by 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 VCCP, and hiring additional VA providers, as appropriate.
- **Increase availability of plastic surgery across the Sierra Nevada Market to address the potential lack of high-quality plastic surgeons:** As identified by the Section 203 criteria analysis, there is a potential lack of high-quality plastic surgeons. Increased availability may be achieved through a variety of tactics, such as telehealth, recruitment of providers to the VCCP, and hiring additional VA providers, as appropriate.

[25] Hospital referral regions (HRRs) represent regional health care markets for tertiary medical care.

- **Increase availability of neurology across the Sierra Nevada Market to address the potential lack of high-quality neurologists:** As identified by the Section 203 criteria analysis, there is a potential lack of high-quality neurologists. Increased availability may be achieved through a variety of tactics, such as telehealth, recruitment of providers to the VCCP, and hiring additional VA providers, as appropriate.
- **Establish strategic collaborations with community providers, Federally Qualified Health Centers (FQHCs), and Indian Health Services (IHS) facilities in the following northern California areas: Portola, Quincy, Greenville, Chester, Truckee, Alturas, and Cedarville to expand access to primary care and outpatient mental health services**: These hospital service areas (HSAs)[26] lack the Veteran enrollee population needed to establish a VA point of care but are outside 30-minute drive times to other VA sites. The closest VA point of care for Veterans living in Quincy, Greenville, Chester, Alturas, and Cedarville is the Diamond View CBOC. Quincy is 96 minutes from the Diamond View CBOC; Greenville is 63 minutes; Chester is 45 minutes; Alturas is 103 minutes; and Cedarville is 130 minutes. The closest VA point of care for Veterans living in Portola and Truckee is the Reno VAMC in the Sierra Nevada Market. Portola is 57 minutes and Truckee is 39 minutes from the Reno VAMC. Strategic collaborations with local community providers, FQHCs, and IHS facilities are needed to provide care to Veterans in those areas.
- **Establish strategic collaborations with community providers, FQHCs, and IHS facilities in the Hawthorne, Nevada, area to expand access to primary care and outpatient mental health services:** Hawthorne, Nevada, is in Mineral County, Nevada. Hawthorne had 330 enrollees in FY 2019, which is not enough to establish a VA point of care but is 85 minutes from the closest VA point of care at the Lahontan Valley CBOC. There are existing community providers, FQHCs, and IHS facilities to fill gaps in services and improve Veteran access to care in these areas.
- **Coordinate with the VISN 21 North Valley Market to manage patient referrals from the Reno, Nevada, area to the new proposed RRTP at the Sacramento VAMC:** The Reno VAMC does not have any RRTP beds, and there are limited quality alternatives for RRTP services in the community. The Sacramento VAMC in VISN 21 is the closest VAMC (139 minutes away) with a proposed new RRTP to accommodate Veterans from the Reno, Nevada, area.
- **Ensure adequate space to support the research initiative at the proposed new replacement Reno VAMC:** The Office of Research and Development will be consulted in the planning for the proposed replacement Reno VAMC to ensure there is space to maintain existing research programs.
- **Add Home Based Primary Care (HBPC) services to the new proposed Carson City MS CBOC**: The extension of primary care delivery through HBPC may contribute to the reduction of hospitalizations, leading to overall improved quality of life for Veterans. The expansion of the HBPC program will benefit Veterans who are isolated and unable to keep their clinic visits due to their complex health care needs.
- **Establish outpatient specialty care services at the North Reno OOS which may result in its reclassification as an MS CBOC:** Demand for high-volume low-acuity specialties, including

[26] Hospital service areas (HSAs) are local health care markets for hospital care.

mental health, optometry, and physical therapy, is projected to increase significantly across the Reno VAMC area. Market demand for outpatient mental health is projected to increase 61.3% from FY 2019 to FY 2029, and market demand for outpatient rehabilitation therapies is projected to increase 55.1% in the same period. Expanding services in the outlying clinics near the Reno VAMC will help decant some outpatient services to free up space at the VAMC and provide the care close to where Veterans live.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 21 Sierra Nevada 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[27] 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 21 Sierra Nevada Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 21 Sierra Nevada Market	Status Quo	Modernization	VA Recommendation
Total Cost	$10,249,435,802	$10,962,969,689	$11,527,426,277
Capital Cost	$414,941,939	$1,128,475,826	$1,692,932,414
Operational Cost	$9,834,493,863	$9,834,493,863	$9,834,493,863
Total Benefit Score	10	11	14
CBI (normalized in $B)	**1.02**	**1.00**	**0.82**

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

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 seven VA points of care offering outpatient services, including the proposed replacement Reno, Nevada VAMC; the proposed new Carson City, Nevada MS CBOC and Reno East, Nevada MS CBOC; and the proposed expanded North Reno, Nevada MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed replacement Reno, Nevada 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 Palo Alto, California VAMC (VISN 21).
- **RRTP:** RRTP demand will be met through facilities within VISN 21 offering RRTP, including the Palo Alto-Menlo Park, California VAMC; the North Las Vegas, Nevada VAMC; proposed new RRTP at the Sacramento, California VAMC; and the proposed new stand-alone RRTP in Honolulu, Hawaii.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the American Lake, Washington VAMC (VISN 20) and the Palo Alto, California VAMC (VISN 21).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the proposed replacement Reno, Nevada 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 to 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 34,880 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 35,665 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 21. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Nevada Reno.
- **Research:** This recommendation does not impact the research mission in the market and allows the Reno, Nevada VAMC to maintain the current research mission by ensuring there is adequate space to support research at the proposed new Reno, Nevada VAMC to maintain all existing programs.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Reno, Nevada 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 Reno, Nevada VAMC; and the proposed new Carson City, Nevada MS CBOC and Reno East, Nevada MS CBOC. 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 (0.82 for VA Recommendation versus 1.02 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 Reno, Nevada VAMC and the proposed new Carson City, Nevada MS CBOC and Reno East, Nevada MS CBOC. 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 ($11.5B for VA Recommendation versus $11.0B 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 (0.82 for VA Recommendation versus 1.00 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 21 South Valley Market

The Veterans Integrated Service Network (VISN) 21 South Valley Market serves Veterans in the southern end of California's central valley. 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.[28]

VA's Commitment to Veterans in the South Valley Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 21's South Valley 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 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 South Valley Market is projected to experience an increase in the number of enrolled Veterans. Demand for community living center (CLC) and outpatient services is projected to increase, but inpatient medical and surgical and inpatient mental health demand is projected to decrease. Points of care are generally well positioned but lack the capacity to address the growing outpatient demand. 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 expanded outpatient sites offering primary care, mental health, and low-acuity specialty services to better distribute care and decompress existing campuses. The recommendation includes relocating and expanding a community-based outpatient clinic (CBOC) in Visalia to improve access and establishing another new CBOC in Clovis to shift demand from the Fresno VAMC.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in modernizing the inpatient mental health facility and maintains the

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

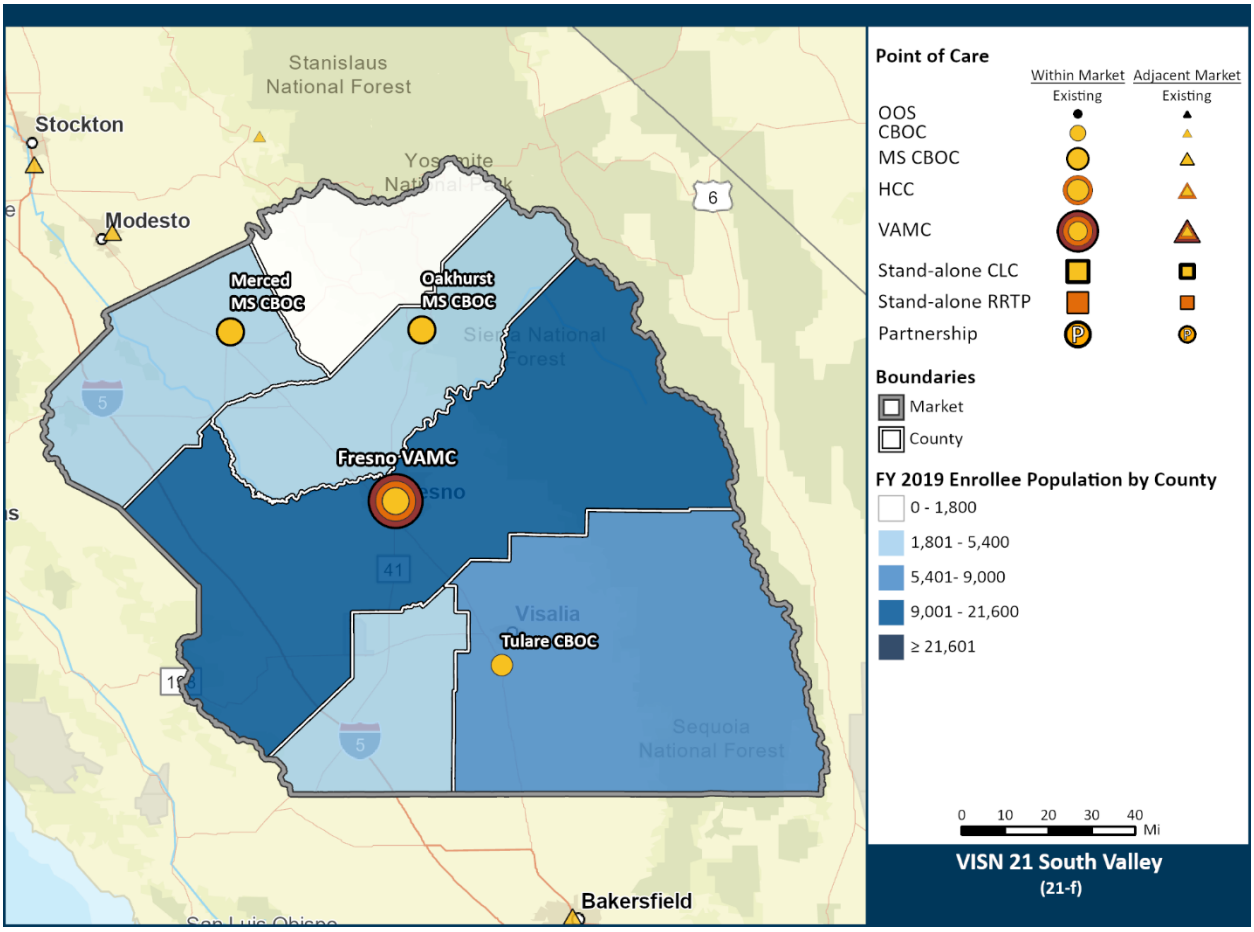
CLC at the Fresno VAMC for Veterans with the most complex needs. VA also recommends a new rehabilitation treatment program (RRTP) facility in Sacramento, California, to provide comprehensive care that may not be readily available in the community. Inpatient blind rehabilitation demand is met through the Palo Alto Menlo Park VAMC, and inpatient spinal cord injuries and disorders (SCI/D) care demand is met through the regional hub at the Palo Alto, California, VAMC.

- **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 invests in modernizing the inpatient medical and surgical facilities at the Fresno VAMC to optimize VA-delivered inpatient medical and surgical services, while expanding local strategic collaborations to expand the availability of higher acuity inpatient care in the market.

Market Overview

The market overview includes a map of the South Valley 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 (Fresno), two multi-specialty community-based outpatient clinics (MS CBOCs), and one CBOC.

Enrollees: In fiscal year (FY) 2019, the market had 41,757 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 Fresno, California; Tulare, California; and Merced, California.

Demand: Demand[29] in the market for acute inpatient medical and surgical services is projected to decrease by 8.1% and demand for inpatient mental health services is projected to decrease by 9.2% between FY 2019 and FY 2029. Demand for long-term care[30] is projected to increase by 21.3%. Demand

[29] 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).
[30] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

for all outpatient services,[31] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 24.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 81.4% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 85.5% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[32] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[33] of 69.9% (287 available beds)[34] and an inpatient mental health occupancy rate of 73.9% (4 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 89.1% (53 available beds). Community residential rehabilitation programs[35] 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 the University of California, San Francisco. The Fresno VAMC is ranked 78 out of 154 VA training sites based on the number of trainees and is ranked 92 out of 103 VAMCs with research funding. The VAMC does not have an emergency designation.[36]

Facility Overview

Fresno VAMC: The Fresno VAMC is located in Fresno, California, and offers inpatient medical and surgical, inpatient mental health, CLC, and outpatient services. In FY 2019, the Fresno VAMC had an inpatient medical and surgical average daily census (ADC) of 42.5, an inpatient mental health ADC of 6.6, and a CLC ADC of 55.1.

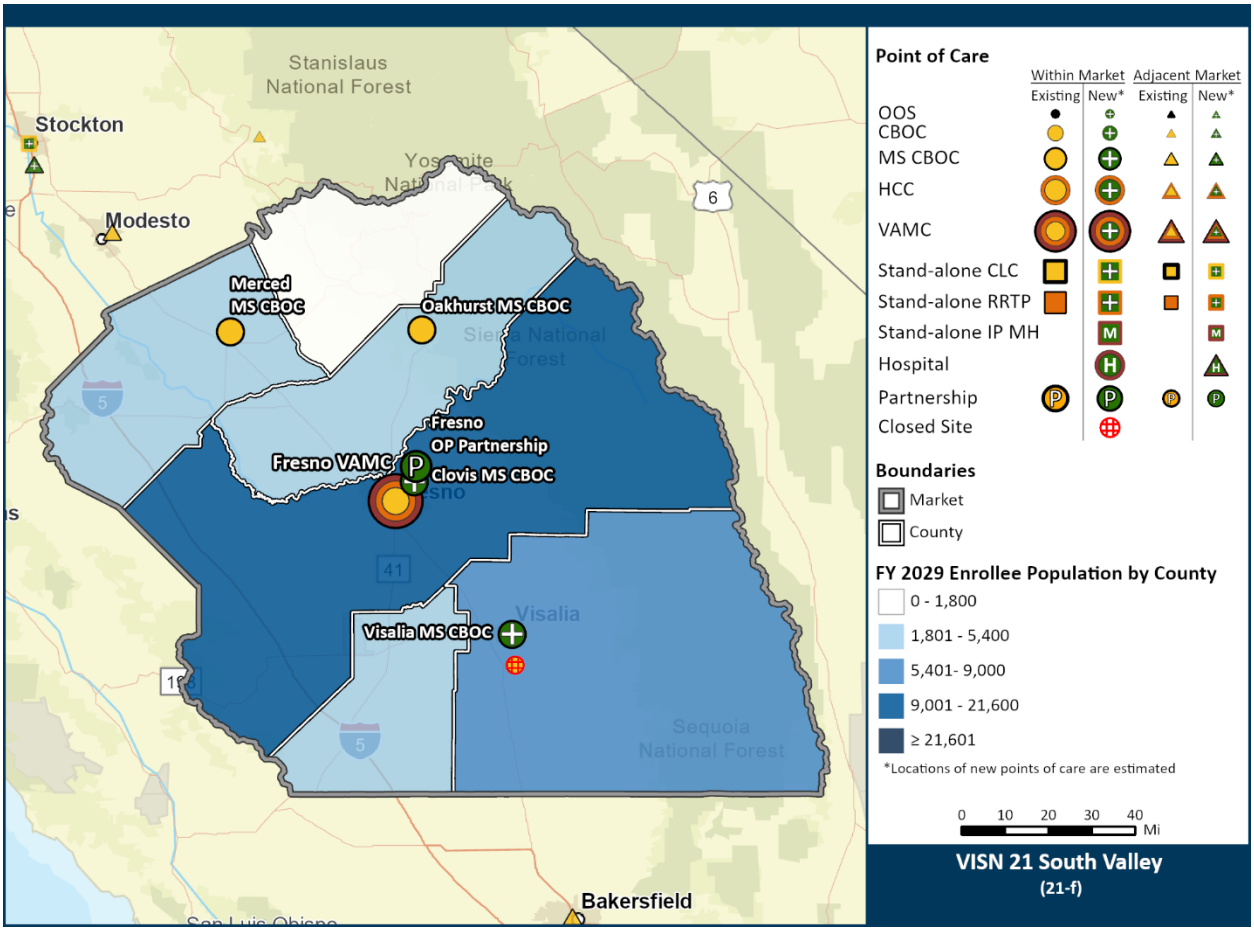
The Fresno VAMC was built in 1940 on 29.0 acres and does not meet current design standards.[37] Facility condition assessment (FCA) deficiencies are approximately $113.1M, and annual operations and maintenance costs are an estimated $12.0M.

[31] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[32] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers
[33] 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.
[34] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[35] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[36] 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.
[37] 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 21 South Valley Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize the inpatient medical and surgical space at the Fresno VAMC:*** The Fresno VAMC faces infrastructure challenges. The existing inpatient medical and surgical building has shared patient rooms, and it is not aligned with modern design standards. The modernization of the existing medical and surgical patient rooms at the Fresno VAMC will include the conversion to private rooms. In FY 2019, the Fresno VAMC had an inpatient medical and surgical ADC of 42.5, and demand is projected to decrease to 35.5 in FY 2029. As of FY 2019, there were 33,573 enrollees within 60 minutes of the Fresno VAMC.

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

    2.1. Establishing a new MS CBOC in the vicinity of Clovis, California: Demand for outpatient services is expected to increase in the Fresno metropolitan area. The VISN is developing plans for a new site in Clovis, California, which will allow the Fresno VAMC to decompress high-volume low-acuity outpatient services to free up space on the landlocked campus. In FY 2019

there were 18,193 enrollees within 30 minutes of the proposed site and 32,303 enrollees within 60 minutes.

2.2. **Relocating the Tulare CBOC to a new site in the vicinity of Visalia, California, and closing the existing Tulare CBOC:** The Tulare CBOC is undersized for its local population and upgrading to an appropriately sized MS CBOC will require a new location. In FY 2019, the CBOC served 5,149 core unique patients.[38] Shifting the Tulare CBOC to the vicinity of Visalia, directly adjacent to major highways, will provide better access and sustainability. In FY 2019, there were 9,379 enrollees within 30 minutes and 31,255 enrollees within 60 minutes of the proposed site.

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:

Fresno VAMC

- **Establish a strategic collaboration to expand outpatient surgical services at the Fresno VAMC:** There are quality community providers in the Fresno, California, area with under-utilized outpatient surgical centers and hybrid operating rooms. A partnership with community providers through a sharing arrangement will expand surgical services currently offered at the Fresno VAMC and improve access for Veterans seeking high-quality surgical care. From FY 2015 to FY 2019, demand for outpatient surgical cases increased by 4.9%.
- **Supplement the Fresno VAMC capabilities by coordinating with the Palo Alto and San Francisco VAMCs on outreach and telehealth options**: Several specialty services are already referring to the Palo Alto VAMC and San Francisco VAMC for higher complexity procedures, telehealth, and mentoring. Demand for outpatient specialty care is projected to increase by 53.8% from FY 2019 to FY 2029.
- **Identify local Federally Qualified Health Centers (FQHCs) or other community providers in the Los Banos and Porterville Hospital Service Areas (HSAs)[39] to provide primary care and outpatient mental health to the local enrollee population**: There are not enough enrollees in the Los Banos and Porterville HSAs to support a VA point of care. The closest VA point of care for Veterans living in Los Banos is the Merced MS CBOC, 50 minutes away. The closest VA point of care for Veterans living in Porterville is the Tulare CBOC, 36 minutes away. Community providers will be identified to provide Veterans with access to care closer to home.
- **Add Home Based Primary Care (HBPC) services to the Oakhurst MS CBOC, Tulare MS CBOC (proposed to be relocated within Tulare County), and Merced MS CBOC**: These three CBOCs are located in counties where a portion of the Veteran enrollee population lives beyond 30-

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

[39] Dartmouth Atlas hospital service areas (HSAs) are local health care markets for hospital care. An HSA is a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area.

minute drive times. The expansion of the HBPC program will benefit Veterans who are isolated and unable to keep their clinic visits due to their complex health care needs.

- **Establish a strategic collaboration with community providers to deliver high complexity inpatient medical and surgical services currently not offered at the Fresno VAMC**: Community providers have adequate capacity to absorb Veteran demand for high complexity services. As of 2019, community providers within a 60-minute drive time of the Fresno VAMC had an inpatient acute occupancy rate of 69.9% (287 available beds).
- **Relocate administrative services from the Fresno VAMC to the proposed new Clovis MS CBOC:** The majority of the Fresno's VAMC's facility issues cannot be appropriately resolved without expanding the space. Decanting administrative services from the Fresno VAMC campus will free up space for clinical operations.
- **Expand the strategic collaboration with the University of California, San Francisco (UCSF) Fresno School of Medicine:** All current graduate medical education (GME) providers are from the UCSF Fresno School of Medicine. Expanding the relationship with UCSF Fresno School of Medicine will enhance the academic and research mission of VA Central California Health Care System.
- **Expand the partnership with the Accessing Telehealth through Local Area Stations Project (ATLAS) to deliver telehealth access to Los Banos and Porterville, California:** Telehealth utilization has increased substantially during the COVID-19 pandemic and is expected to continue to be an increasingly used tool for access to care. VA Central California Health Care System has partnered with ATLAS to open a site of care at a local Veterans of Foreign Wars post in Los Banos, California.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 21 South Valley 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[40] 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).

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

- **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 21 South Valley Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 21 South Valley Market	Status Quo	Modernization	VA Recommendation
Total Cost	$10,257,236,914	$10,908,602,577	$10,927,899,806
Capital Cost	$631,616,575	$1,282,982,239	$1,302,279,468
Operational Cost	$9,625,620,338	$9,625,620,338	$9,625,620,338
Total Benefit Score	8	11	15
CBI (normalized in $B)	**1.28**	**0.99**	**0.73**

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 Clovis, California MS CBOC; Visalia, California MS CBOC; and Fresno, California, outpatient surgical partnership, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Fresno, California 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 Palo Alto, California VAMC (VISN 21).
- **RRTP:** RRTP demand will be met through the other facilities within VISN 21 offering RRTP, including the Palo Alto-Menlo Park, California VAMC; North Las Vegas, Nevada VAMC; proposed new RRTPs at the Sacramento, California VAMC; and proposed new stand-alone RRTP in Honolulu, Hawaii.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the American Lake, Washington VAMC (VISN 20) and the Palo Alto, California VAMC (VISN 21).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Fresno, California 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 to 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 39,953 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 40,407 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 21. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of California San Francisco.
- **Research:** This recommendation does not impact the research mission in the market and allows the Fresno, California VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Fresno, California 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 Clovis, California MS CBOC; Visalia, California MS CBOC; and Fresno, California partnership, as well as the modernization of the inpatient medical and surgical rooms at the Fresno, California 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 (0.73 for VA Recommendation versus 1.28 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 Clovis, California MS CBOC; Visalia, California MS CBOC; and Fresno, California partnership; as well as the modernization of the inpatient medical and surgical rooms at the Fresno, California 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 a 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 ($10.93B for VA Recommendation versus $10.91B 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 (0.73 for VA Recommendation versus 0.99 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 21 North Coast Market

The Veterans Integrated Service Network (VISN) 21 North Coast Market serves Veterans on California's northern coast. 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.[41]

VA's Commitment to Veterans in the North Coast Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 21's North Coast 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 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

While the enrollee population and acute inpatient, community living center (CLC) and residential rehabilitation treatment program (RRTP) demand is projected to decrease in the North Coast Market, outpatient demand is projected to increase. Alameda County has the largest enrollee population of the counties in the market and is served by three distinct VA health care systems, which results in complex Veteran referral patterns. The San Francisco VAMC is landlocked and has significant facility maintenance issues. 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 expanded outpatient sites offering primary care, mental health, and low-acuity specialty services to better distribute care and decompress existing campuses. The recommendation establishes a new health care center (HCC) in Oakland/Alameda Point, California, and relocates the Clearlake multi-specialty community-based outpatient clinic (MS CBOC) to a new site in Lakeport, California.

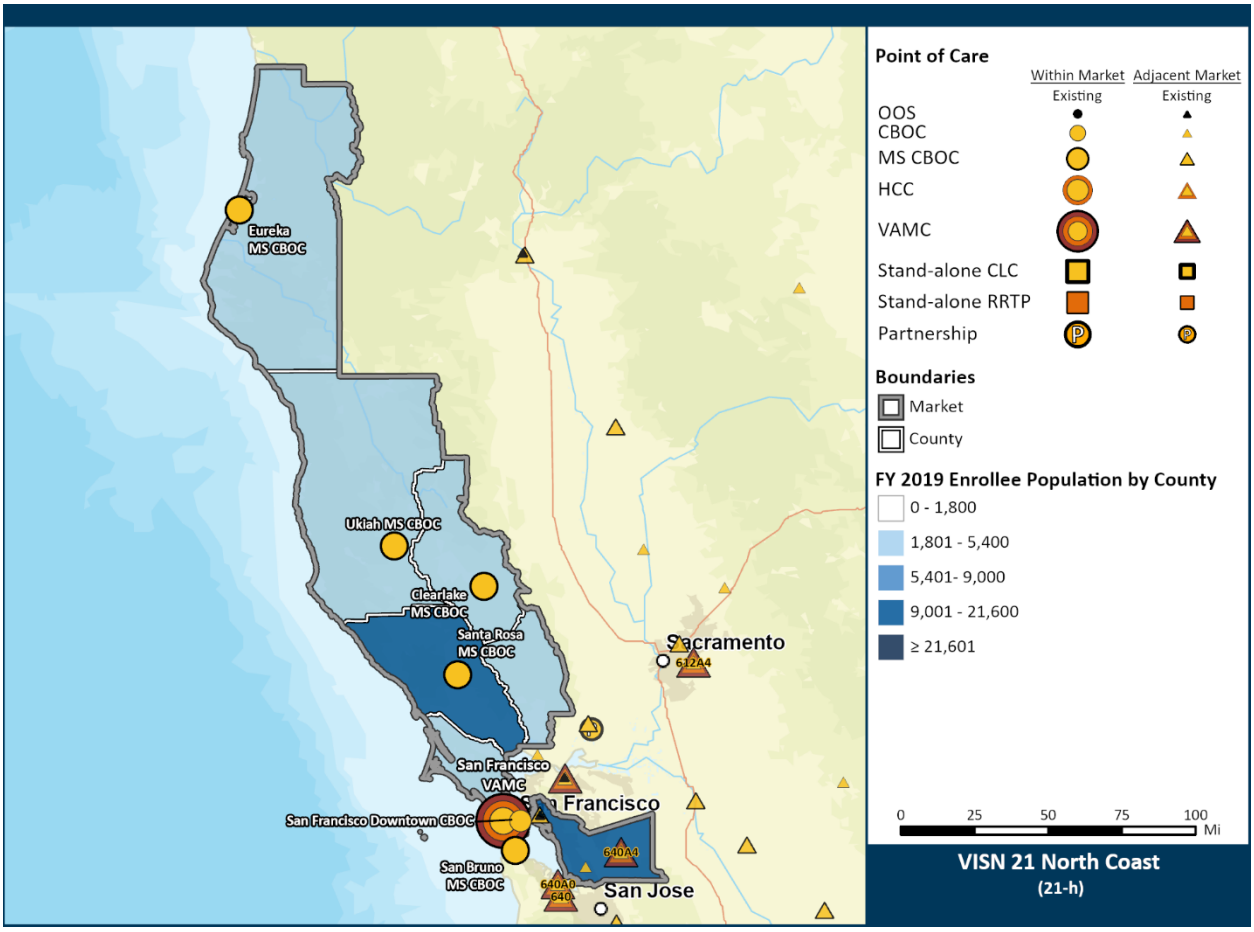
[41] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in inpatient mental health services within the San Francisco VAMC and invests in modern CLC facilities in Santa Rosa, California, and Alameda County, California, to maintain care for Veterans with the most complex needs. The recommendation relocates the residential rehabilitation treatment program (RRTP) to community providers with capabilities to support Veterans and facilitate integration back into their communities. Inpatient blind rehabilitation demand is met through the Palo Alto Menlo Park VAMC, and inpatient spinal cord injuries and disorders (SCI/D) care demand is met through the regional hub at the Palo Alto, California, VAMC.
- **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 invests in modernizing and right sizing the programs within the San Francisco VAMC to optimize VA-delivered inpatient medical and surgical services.

Market Overview

The market overview includes a map of the North Coast 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 (San Francisco), five MS CBOCs, and one community-based outpatient clinic (CBOC).

Enrollees: In fiscal year (FY) 2019, the market had 55,961 enrollees and is projected to experience a 18.1% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Alameda, California; San Francisco, California; and Sonoma, California.

Demand: Demand[42] in the market for acute inpatient medical and surgical services is projected to decrease by 21.6% and demand for inpatient mental health services is projected to decrease by 17.3% between FY 2019 and FY 2029. Demand for long-term care[43] is projected to decrease by 2.4%. Demand

[42] 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).
[43] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

for all outpatient services,[44] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 26.0% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 90.4% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 71.2% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[45] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[46] of 58.2% (1,854 available beds)[47] and an inpatient mental health occupancy rate of 66.1% (35 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 81.5% (301 available beds). Comprehensive community residential rehabilitation programs are available in the market.

Mission: The market has academic affiliations that include the University of California San Francisco. The San Francisco VAMC is ranked 27 out of 154 VA training sites based on the number of trainees and is ranked 2 out of 103 VAMCs with research funding. The San Francisco VAMC is designated as a Federal Coordinating Center.[48]

Facility Overview

San Francisco VAMC: The San Francisco VAMC is located in San Francisco, California, and offers inpatient medical and surgical, inpatient mental health, CLC, RRTP, rehabilitative medicine, and outpatient services. In FY 2019, the San Francisco VAMC had an inpatient medical and surgical average daily census (ADC) of 87.7, an inpatient mental health ADC of 7.4, a CLC ADC of 97.8, and a RRTP ADC of 8.4.

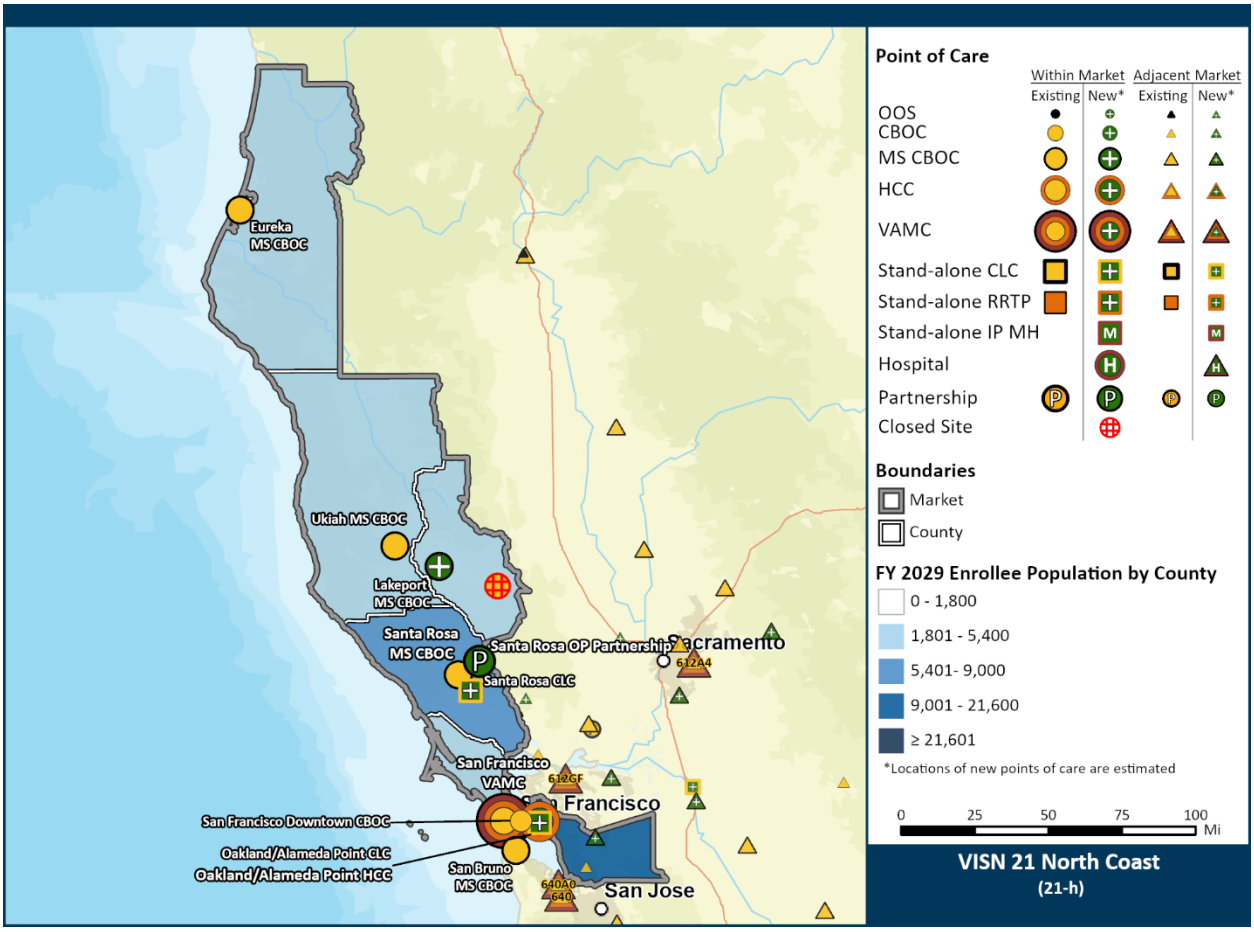
The San Francisco VAMC was built in 1976 on 31 acres and does not meet current design standards.[49] The campus is landlocked, with no room to expand. Facility condition assessment (FCA) deficiencies are approximately $680.7M, and annual operations and maintenance costs are an estimated $19.1M.

[44] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[45] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[46] 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.
[47] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[48] 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.
[49] 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 21 North Coast Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the San Francisco VAMC by:***

   1.1. Modernizing the inpatient medical and surgical space: The VAMC's intensive care units and patient preparation and recovery areas are in facilities over 40 years old with physical challenges that suggest less than optimal ability to accommodate significant future surgical caseloads. Modernizing the peri-operative and critical care areas at the San Francisco VAMC will decrease the total inpatient medical surgical beds from 109 to 92 while providing an appropriately sized structure to provide inpatient and complex outpatient care in the market and across VISN 21. In FY 2019, there were 52,499 enrollees within 60 minutes of the VAMC.

   1.2. Relocating RRTP services from stand-alone VA facilities in San Francisco to community providers and discontinuing those services within the stand-alone VA facilities in San Francisco: In the North Coast Market, Veteran enrollee population is expected to decrease by 18.1% between FY 2019 and FY 2029, while demand for RRTP services is expected to decrease

by 25.4%. The San Francisco VAMC is currently engaged with several successful RRTP alternatives in the community.

2. ***Modernize and realign services by establishing a new stand-alone CLC in the vicinity of Santa Rosa, California:*** The Santa Rosa, California, area does not have a CLC. Sonoma County is projected to have 7,573 enrollees in FY 2029. The San Francisco VAMC is space constrained with limited room for expansion. Relocating long-term CLC from the VAMC to the newly proposed CLC in Santa Rosa, California, will improve access where Veterans and their families live and allow VA to modernize the San Francisco VAMC.
3. ***Modernize and realign services by establishing a new stand-alone CLC in the vicinity of Oakland/Alameda Point, California:*** The Oakland/Alameda Point, California, area does not have a CLC. Alameda County is projected to have 15,872 enrollees in FY 2029. The San Francisco VAMC campus is space constrained and has limited room for expansion. Relocating long-term CLC from the VAMC to the newly proposed CLC in Oakland/Alameda Point, California, will improve access where Veterans and their families live and allow VA to modernize the San Francisco VAMC.
4. ***Modernize and realign outpatient facilities in the market by:***
    - **4.1. Establishing a new HCC in the vicinity of Oakland/Alameda Point, California:** A new HCC in the vicinity of Oakland/Alameda Point, California, will expand access to primary care, specialty care, outpatient mental health, and outpatient surgical services. In the North Coast Market, demand for primary care is projected to increase by 21.0%, specialty care by 29.5%, and outpatient mental health by 18.3% from FY 2019 to FY 2029. In FY 2019, there were 2,139 outpatient surgical cases in the market, and 76,031 enrollees within 60 minutes of the proposed site.
    - **4.2. Relocating the Clearlake MS CBOC to a new site in the vicinity of Lakeport, California, and closing the existing Clearlake MS CBOC:** Relocating the Clearlake MS CBOC to the vicinity of Lakeport, California, near the junction of CA-29 and State Route 175 will improve access for enrollees and increase long-term sustainability of the facility. In FY 2019, there were 3,333 enrollees within 60 minutes of the Clearlake MS CBOC, and there were 4,654 enrollees within 60 minutes of the newly proposed site in Lakeport, California.
    - **4.3. Relocating all services to the proposed San Francisco/Alameda Point HCC and closing the Oakland MS CBOC:** The new proposed HCC in the vicinity of San Francisco/Alameda Point will have sufficient space and staffing to absorb the demand from the Oakland MS CBOC. This improves Veteran access to more outpatient services in a centralized, modern facility near the existing MS CBOC.
    - **4.4. Relocating all services to the proposed San Francisco/Alameda Point HCC and closing the Twenty First Street OOS:** The new proposed Oakland/Alameda Point HCC will have sufficient space and staffing to absorb the demand from the Twenty First Street OOS. This improves Veteran access to more outpatient services in a centralized, modern facility near the existing OOS.

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:

North Coast Market

- **Realign Napa County from the VISN 21 North Coast Market to the VISN 21 North Valley Market:** Napa County, where Yountville, California, and the site of the California State Veterans Home are located, is 40 minutes from the David Grant Medical Center located on Travis Air Force Base in Fairfield, California. Napa County is 45 minutes from the Martinez VAMC in Martinez, California, compared to 70 minutes from the San Francisco VAMC in San Francisco, California. The Veterans living in Napa County most frequently use the Mare Island CBOC in VISN 21's North Valley Market for primary care services.
- **Realign the Oakland MS CBOC and the Twenty First Street OOS from the VISN 21 North Valley Market to the VISN 21 North Coast Market (until deactivations of these sites)**: The Oakland MS CBOC and the Twenty First Street OOS in Oakland, California, are located in the Alameda County Hospital Referral Region, indicating referral patterns for the general population go toward the San Francisco VAMC for specialty and high complexity care. Those two sites of care are also significantly closer to the San Francisco VAMC than the Sacramento VAMC in VISN 21 North Valley.
- **Expand outpatient surgical capacity through a strategic collaboration in Santa Rosa, California:** Adding outpatient surgical services by allowing VA providers to treat Veterans in community hospitals or creating a sharing arrangement will expand Veteran access to high-quality surgical care. Outpatient surgical specialty care is projected to increase by 45.8% from FY 2019 to FY 2029 in the North Coast Market.

San Francisco VAMC

- **Relocating long-term CLC services to current or future VA facilities and discontinuing those services at the San Francisco VAMC:** In FY 2019, the San Francisco VAMC had a CLC ADC of 97.8, and demand is projected to decrease to an ADC of 88.9 in FY 2029. The San Francisco VAMC campus is constrained in space and has limited room for expansion. Relocating long-term CLC services from the San Francisco VAMC to the new proposed CLCs in Santa Rosa, California, and Alameda Point, California, and maintaining short-stay CLC services at the San Francisco VAMC will improve access where Veterans and their families live and allow VA to modernize the VAMC campus.
- **Convert a portion of inpatient medical beds to inpatient mental health beds that can support the treatment of medical comorbidities at the San Francisco VAMC and staff accordingly:** Providing dedicated beds for the treatment of psychiatric patients with medical comorbidities complements the mental health mission, addresses an unmet need, and decreases diversions to other VAMCs and the community.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 21 North Coast 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[50] 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 21 North Coast Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 21 North Coast Market	Status Quo	Modernization	VA Recommendation
Total Cost	$18,068,183,759	$18,747,973,233	$19,080,878,147
Capital Cost	$2,028,914,398	$2,708,703,873	$3,098,399,092
Operational Cost	$16,039,269,361	$16,039,269,361	$15,982,479,055
Total Benefit Score	8	11	13
CBI (normalized in $B)	**2.26**	**1.70**	**1.47**

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.

[50] 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 Lakeport, California MS CBOC; Oakland/Alameda Point, California HCC; and Santa Rosa, California partnership; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the San Francisco, California VAMC (short-stay services) and the proposed new stand-alone CLCs in Santa Rosa, California and Oakland/Alameda Point, California, 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 Palo Alto, California VAMC (VISN 21).
- **RRTP:** RRTP demand will be met through the other facilities within VISN 21 offering RRTP, including the Palo Alto-Menlo Park, California VAMC; North Las Vegas, Nevada VAMC; proposed new RRTP at the Sacramento, California VAMC; and proposed new stand-alone RRTP in Honolulu, Hawaii.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the American Lake, Washington VAMC (VISN 20), and the Palo Alto, California VAMC (VISN 21).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the San Francisco, California 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 to 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

- **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 39,170 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 39,426 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 21. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of California San Francisco.
- **Research:** This recommendation does not impact the research mission in the market and allows the San Francisco, California VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the San Francisco, California 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 Lakeport, California MS CBOC; Oakland/Alameda Point, California HCC; Santa Rosa, California partnership; and the proposed new stand-alone CLCs in Santa Rosa, California and Oakland/Alameda Point, California; as well as the modernization of the inpatient medical and surgical units at the San Francisco, California 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 (1.47 for VA Recommendation versus 2.26 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 Lakeport, California MS CBOC; Oakland/Alameda Point, California HCC; Santa Rosa, California partnership; and the proposed new stand-alone CLCs in Santa Rosa, California and Oakland/Alameda Point, California as well as the modernization of the inpatient medical and surgical units at the San Francisco 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 a 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 ($19.1B for VA Recommendation versus $18.7B 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 (1.47 for VA Recommendation versus 1.70 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 21 North Valley Market

The Veterans Integrated Service Network (VISN) 21 North Valley Market serves Veterans in the northern end of California's central valley. 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.[51]

VA's Commitment to Veterans in the North Valley Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 21's North Valley 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 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 enrollee population in the North Valley Market is projected to decrease. While acute inpatient and residential rehabilitation treatment program (RRTP) demand is projected to decrease in the North Valley Market, community living center (CLC) and outpatient demand is projected to increase. The market stretches from the North San Francisco Bay to the Oregon border and is served by two VAMCs, Sacramento and Martinez, and a significant outpatient and inpatient Department of Defense (DoD) partner in David Grant Medical Center. Historically, the market has relied on the San Francisco VAMC and Palo Alto VAMC to accommodate large portions of its RRTP, CLC, and outpatient specialty care demand. The distribution of services and primary care facilities has not kept up with the historical suburban growth of this market. The strategy for the North Valley 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 expanded outpatient sites offering primary care, mental health, and low-acuity specialty services to better

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

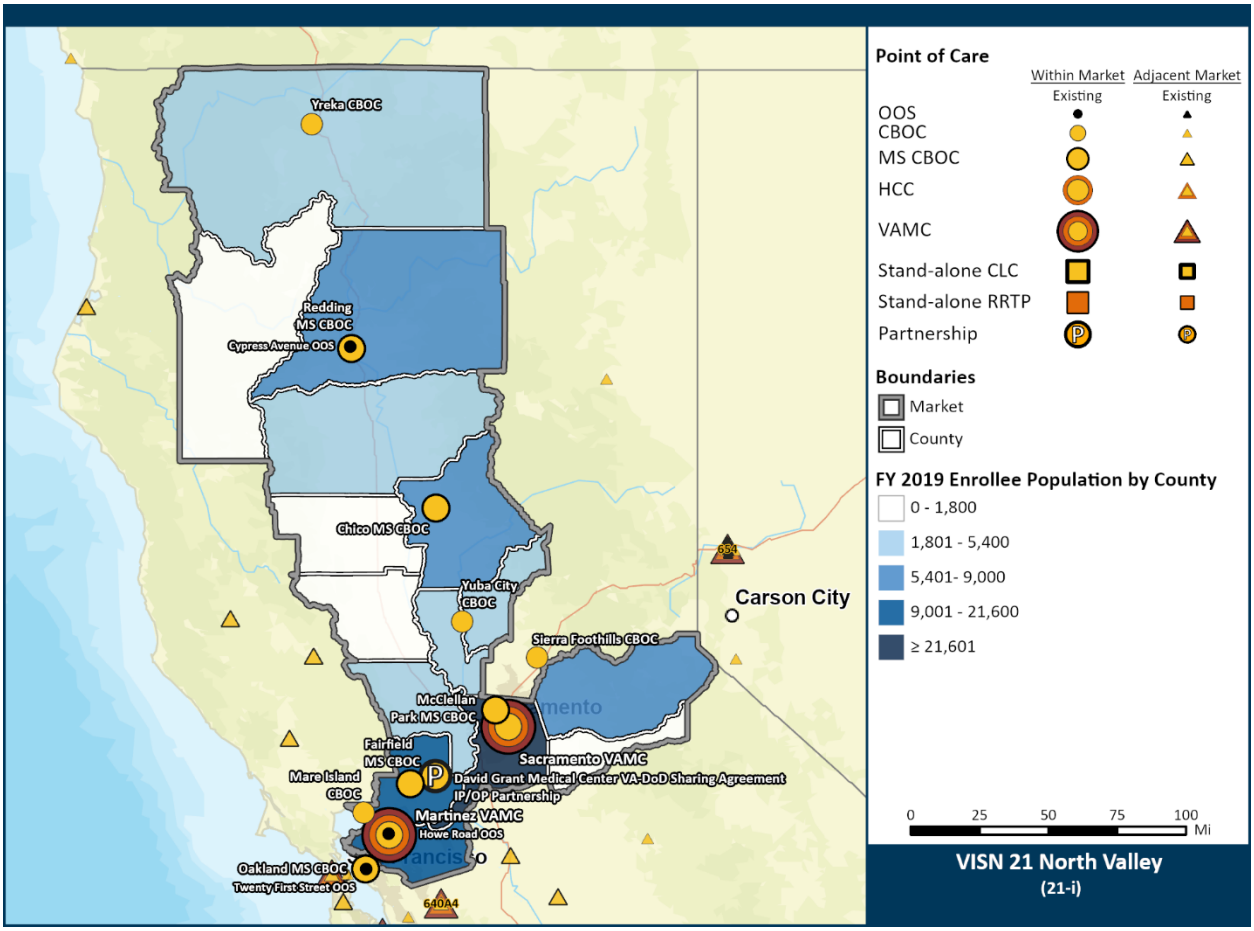
distribute care and decompress existing campuses. VA's recommendation establishes new outpatient facilities in Elk Grove, Placerville, Antioch, Woodland, and Yountville, California.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation maintains the inpatient mental health program at the Sacramento VAMC and invests in new and modernized CLC facilities in Sacramento, Stockton, and at the Martinez VAMC to maintain care for Veterans with the most complex needs. The recommendation invests in a new, well located RRTP facility in Sacramento to provide comprehensive care that may not be readily available in the community. Inpatient blind rehabilitation demand is met through the Palo Alto Menlo Park VAMC, and inpatient spinal cord injuries and disorders (SCI/D) care demand is met through the regional hub at the Palo Alto, California, VAMC.
- **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 modernizes the Sacramento VAMC's inpatient medical and surgical facility to optimize VA-delivered care while increasing access to inpatient and specialty care in Chico and Redding through community partnerships.

Market Overview

The market overview includes a map of the North Valley 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 two VAMCs (Sacramento and Martinez), five multi-specialty community-based outpatient clinics (MS CBOCs), four community-based outpatient clinics (CBOCs), and three other outpatient services (OOS) sites. The Martinez VAMC has a strong sharing agreement with the nearby DoD David Grant Medical Center at Travis Air Force Base for inpatient medical and surgical care and outpatient specialty care.

Enrollees: In fiscal year (FY) 2019, the market had 107,003 enrollees and is projected to experience a 6.8% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Sacramento, California; Contra Costa, California; and Solano, California.

Demand: Demand[52] in the market for acute inpatient medical and surgical services is projected to decrease by 2.3% and demand for inpatient mental health services is projected to decrease by 1.2%

[52] 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).

between FY 2019 and FY 2029. Demand for long-term care[53] is projected to increase by 48.1%. Demand for all outpatient services,[54] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 21.1% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 86.6% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 78.6% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[55] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[56] of 59.9% (2,468 available beds)[57] and an inpatient mental health occupancy rate of 63.8% (32 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 86.7% (386 available beds). Community residential rehabilitation programs[58] 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 the University of California Davis School of Medicine. The Sacramento VAMC is ranked 44 out of 154 VA training sites based on the number of trainees and is ranked 53 out of 103 VAMCs with research funding. The Martinez VAMC does not have a training mission and conducts limited or no research. Neither VAMC holds an emergency designation.[59]

Facility Overviews

Sacramento VAMC: The Sacramento VAMC, located in Mather, California, offers inpatient medical and surgical care, inpatient mental health services, and outpatient services. In FY 2019, the Sacramento VAMC had an inpatient medical and surgical average daily census (ADC) of 47.2 and an inpatient mental health ADC of 10.9.

The Sacramento VAMC was built in 2002 on 47.0 acres and does not meet current design standards.[60] Facility condition assessment (FCA) deficiencies are approximately $58.4M, and annual operations and maintenance costs are an estimated $4.6M.

[53] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[54] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[55] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[56] 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.
[57] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[58] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[59] 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.
[60] 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.

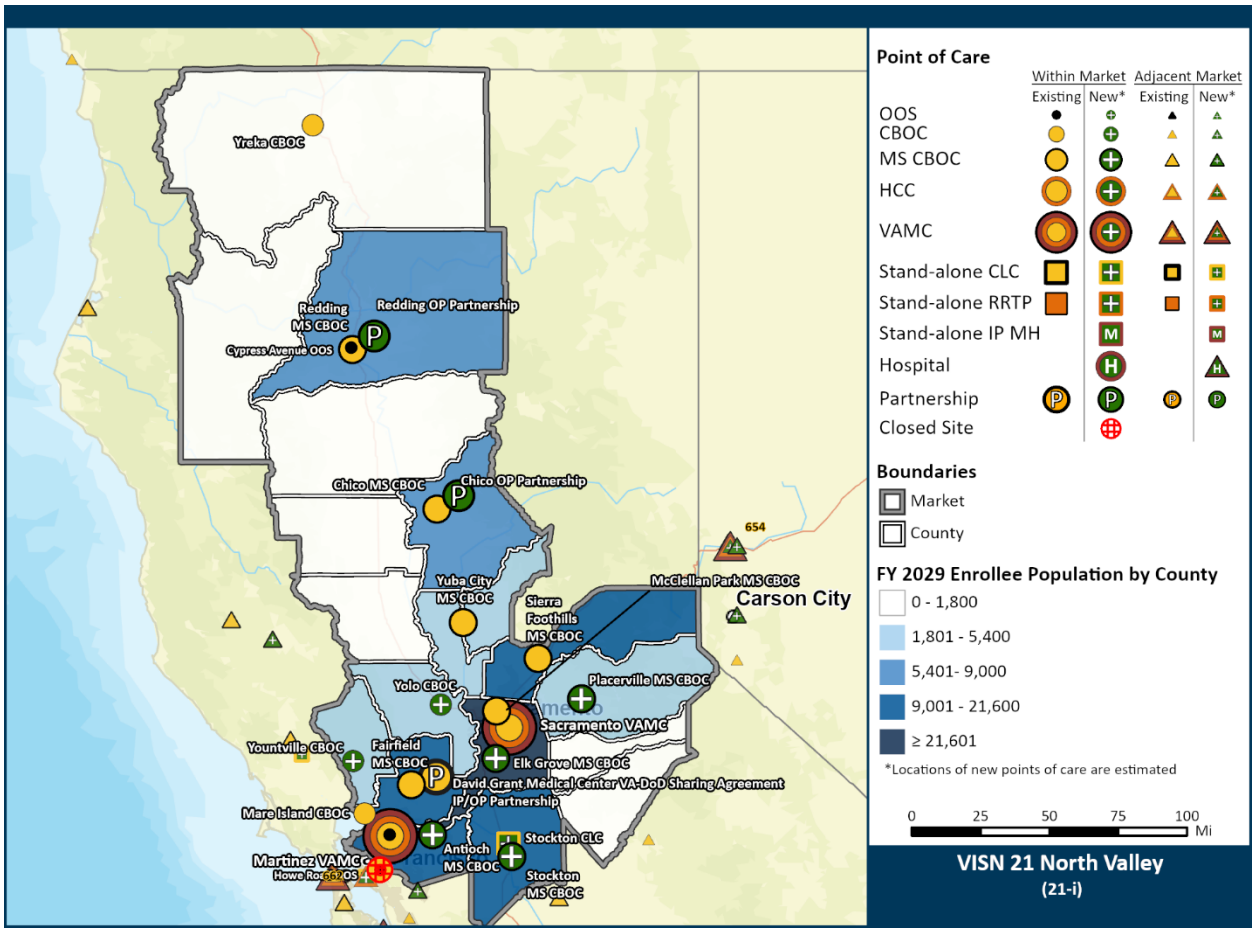
Martinez VAMC: The Martinez VAMC, located in Martinez, California, offers CLC and outpatient services. In FY 2019, the Martinez VAMC had a CLC ADC of 116.1.

The Martinez VAMC was built in 1992 on 23.0 acres and does not meet current design standards. FCA deficiencies are approximately $33.5M, and annual operations and maintenance costs are an estimated $3.1M.

Recommendation and Justification

This section details the VISN 21 North Valley Market recommendation and justification for each element of the recommendation.

Future Market Map



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

   1.1. **Modernizing the inpatient medical and surgical space:** The existing inpatient medical and surgical unit at the Sacramento VAMC has shared patient rooms with up to two patients sharing each bathroom. The space is not conducive to providing quality care. The renovation would replace existing rooms with a modern, appropriately sized space, improving patient experience, safety, and care delivery. In FY 2019, the Sacramento VAMC had an inpatient

medical and surgical ADC of 47.2, and demand is projected to decrease to an ADC of 39.5 in FY 2029. In FY 2019, there were 73,795 enrollees within 60 minutes of the Sacramento VAMC.

1.2. **Establishing a new RRTP:** The North Valley Market does not currently offer RRTP services and the closest VA point of care for RRTP services is the Palo Alto Menlo Park VAMC, which is 128 minutes away from the Sacramento VAMC. The new 60 bed RRTP will improve access for Veterans in the Sacramento, California, area and across VISN 21. In FY 2019, there were 73,795 enrollees within 60 minutes of the Sacramento VAMC.

1.3. **Establishing a new CLC:** The closest VA point of care for CLC services in the Sacramento, California, area is 70 minutes away at the Martinez VAMC in Martinez, California. In FY 2019, there were 35,876 enrollees in Sacramento County, California. Market demand for long-term care is projected to increase by 48.1%. A CLC program on a new VA-owned 23.9-acre site adjacent to the Sacramento campus will increase access to enrollees for CLC services in the North Valley Market.

1.4. **Constructing a new research building:** The research department is currently in the main building of the Sacramento VAMC that was originally designed for inpatient medical and surgical beds. Moving the research out of the main building to the adjacent 23.9-acre site will allow for the modernization of private patient rooms at the Sacramento VAMC. The VAMC has $4.0M in VAMC supported research projects. The Sacramento VAMC will continue to develop its facility master plan to utilize its newly acquired acres, and VA recommends a new research building as a part of the master plan.

2. ***Modernize and realign services by establishing a new CLC in the vicinity of Stockton, California:*** The planned Stockton CLC is on a VA-owned site with expansion capabilities adjacent to a community hospital. Stockton, California, is southeast of the Sacramento VAMC and is an enrollee-dense area easily accessible from nearby highways. With the majority of CLC beds on the campuses of the Palo Alto Menlo Park VAMC, Palo Alto VAMC, and Palo Alto Livermore VAMC, a move to establish new CLC beds in the small home model in Stockton supports a growing need for CLC service in the valley where Veterans live and enables the closure of the Palo Alto Livermore VAMC. In FY 2019, the North Valley Market had a CLC ADC of 116.1, and demand is projected to increase to an ADC of 143.4 in FY 2029.

3. ***Modernize and realign the Martinez VAMC by:***

3.1. **Modernizing the CLC:** The existing CLC building at the Martinez VAMC does not meet current design standards. The CLC currently has semi-private rooms. The modernization of the existing CLC at the Martinez VAMC will include the conversion to private rooms, decreasing CLC bed capacity. This is tied to the VISN-wide redistribution of CLC beds to better align bed availability to the locations where the Veterans reside. The redistribution of CLC beds includes an increase in total beds to meet the projected FY 2029 market-wide ADC of 143.4. In FY 2019, there were 70,455 enrollees within 60 minutes of the Martinez VAMC.

3.2. **Relocating outpatient surgical services to current or future VA facilities or a strategic collaboration and discontinuing those services at the Martinez VAMC:** In FY 2019, there were 70,455 enrollees within 60 minutes of the Martinez VAMC, and enrollees in the North Valley Market are projected to decrease 6.8% in FY 2029. The Martinez VAMC is in proximity to and

has a strong sharing agreement with DoD's David Grant Medical Center at Travis Air Force Base that includes outpatient surgery. The proposed Alameda Point Health Care Center (HCC) can also absorb outpatient surgical volume. The elimination of the outpatient surgery program will maintain access while preventing overlapping outpatient surgical services and ensuring that the David Grant Medical Center, Sacramento VAMC, and new Alameda HCC programs are more efficient. It will also free up space to allow the Martinez VAMC campus to modernize CLC beds.

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

   4.1. Establishing a new MS CBOC in the vicinity of Elk Grove, California: A new MS CBOC in the vicinity of Elk Grove, California, adjacent to major highways, will allow the Sacramento VAMC to decompress high-volume low-acuity outpatient services and increase access for Veterans in Elk Gove, California. In FY 2019, there were 28,483 enrollees within 30 minutes and 76,250 enrollees within 60 minutes of the proposed site.

   4.2. Establishing a new MS CBOC in the vicinity of Placerville, California: A new MS CBOC in the vicinity of Placerville, California, will expand access to outpatient services for Veterans living in Placerville. In FY 2019, there were 6,632 enrollees within 30 minutes and 51,858 enrollees within 60 minutes of the proposed site.

   4.3. Establishing a new MS CBOC in the vicinity of Antioch, California: A new MS CBOC in the vicinity of Antioch, California, will allow the Martinez VAMC to decompress primary care, optometry, and outpatient mental health services and increase access for Veterans in the vicinity of Antioch, California. In FY 2019, there were 13,163 enrollees within 30 minutes and 67,975 enrollees within 60 minutes of the proposed site.

   4.4. Establishing a new CBOC in the vicinity of Woodland, California: A new CBOC will improve access to primary care and outpatient mental health for Veterans living in Woodland, California (Yolo County). In FY 2019, there were 11,829 enrollees within 30 minutes of the proposed site.

   4.5. Establishing a new CBOC in the vicinity of Yountville, California: A new CBOC will expand access to primary care and outpatient mental health services for Veterans in Yountville, California. The closest VA point of care for outpatient services is 45 minutes away at the Martinez VAMC. In FY 2019, there were 3,482 enrollees within 30 minutes of the proposed site.

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:

North Valley Market

- **Realign Calaveras and San Joaquin counties in California from the VISN 21 South Coast Market to the VISN 21 North Valley Market:** San Andreas, California, the county seat of Calaveras County, is 65 minutes from the Sacramento VAMC compared to 130 minutes to the Palo Alto VAMC. Stockton, California, the county seat of San Joaquin County, is 59 minutes from the Sacramento VAMC compared to 129 minutes to the Palo Alto VAMC.

- **Realign the Stockton MS CBOC to the Sacramento VAMC in the VISN 21 North Valley Market:** The Stockton MS CBOC is 62 minutes from the Sacramento VAMC compared to 89 minutes from the Palo Alto VAMC.
- **Realign Placer County, California, from the VISN 21 Sierra Nevada Market to the VISN 21 North Valley Market:** The Sierra Foothills CBOC in Auburn, California (Placer County), is located in the Sacramento Hospital Referral Region (HRR)[61] indicating referral patterns for the general population go toward the Sacramento VAMC. The Sierra Foothills CBOC is 40 minutes from the Sacramento VAMC compared to 90 minutes from the Reno VAMC.
- **Realign Napa County from the VISN 21 North Coast Market to the VISN 21 North Valley Market**: The Veterans living in Napa County most frequently used the Mare Island CBOC in the North Valley Market for primary care services. Napa County is 45 minutes from the Martinez VAMC compared to 70 minutes from the San Francisco VAMC.
- **Realign the Oakland MS CBOC and the Twenty First Street OOS from the VISN 21 North Valley Market to the VISN 21 North Coast Market (until site deactivations occur):** The Oakland MS CBOC and the Twenty First Street OOS are located in the Alameda County which is part of the North Coast Market. The Oakland MS CBOC and the Twenty First Street OOS are 89 minutes from the Sacramento VAMC and 30 minutes from the San Francisco VAMC.
- **Expand telehealth and VA Video Connect to improves access**: Telehealth utilization has increased substantially during the COVID-19 pandemic and is expected to continue to be an important way to increase access to care.
- **Continue to expand research and education to include all new medical schools within the North Valley Market**: Multiple academic partnerships across the entire market area will enhance the research and education mission and access to specialty care.

Sacramento VAMC

- **Strengthen inpatient and specialty care partnerships with community providers in the Chico HRR and the Redding HRR**: The Chico CBOC is 110 minutes from the Sacramento VAMC and is in the Chico HRR, indicating referral patterns for the general population go toward this community for inpatient medical and surgical care. The Redding MS CBOC is 159 minutes from the Sacramento VAMC and is in the Redding HRR, indicating referral patterns for the general population go toward this community for inpatient medical and surgical care. Strengthening existing community provider partnerships will improve access for Veterans living in those areas.
- **Add specialty care services to the Sierra Foothills CBOC, which may result in its reclassification as an MS CBOC:** Expanding services at the Sierra Foothills CBOC will help decant some outpatient services from the Sacramento VAMC to free up space. Demand for outpatient specialty care is projected to increase by 51.8% across the market from FY 2019 to FY 2029. In FY 2019, there were 13,605 enrollees within 30 minutes and 56,968 within 60 minutes of the Sierra Foothills CBOC.

[61] Hospital referral regions (HRRs) represent regional health care markets for tertiary medical care.

- **Add specialty care services to the Yuba City CBOC, which may result in its reclassification as an MS CBOC:** Expanding services at the Yuba City CBOC will help decant some outpatient services to free up space at the Sacramento VAMC. Demand for outpatient specialty care is projected to increase by 51.8% across the market from FY 2019 to FY 2029. In FY 2019, there were 5,234 enrollees within 30 minutes and 52,259 within 60 minutes of the Yuba City CBOC.
- **Establish a new Accessing Telehealth Through Local Area Stations (ATLAS) site or strategic collaboration with federal or community providers in the Weaverville Hospital Service Area (HSA)[62] for primary care and outpatient mental health services**: To continue to support rural Veterans, VA plans to expand its partnerships and telehealth capabilities to fill gaps in service and improve access. Weaverville, California, is 65 minutes from the Redding MS CBOC, which is the closest VA point of care.
- **Establish a new ATLAS site or strategic collaboration with federal or community providers in the Fall River Mills HSA for primary care and outpatient mental health services:** To continue to support rural Veterans, VA plans to expand its partnerships and telehealth capabilities to fill gaps in service and improve access. Fall River Mills, California, is 90 minutes from the Redding MS CBOC, which is the closest VA point of care.
- **Improve outpatient surgical access by establishing a strategic collaboration in Redding, California:** The closest point of care for outpatient surgical services for Veterans living in Redding is the Sacramento VAMC which is 159 minutes away. Outpatient surgical cases increased by 25.5% in the North Valley Market from FY 2015 to FY 2019. A strategic collaboration will improve access for Veterans living in Redding.
- **Improve outpatient surgical access by establishing a strategic collaboration in Chico, California:** The closest VA point of care for outpatient surgical services for Veterans living in Chico is the Sacramento VAMC, which is 110 minutes away. Outpatient surgical cases increased by 25.5% in the North Valley Market from FY 2015 to FY 2019. A strategic collaboration will improve access for Veterans living in Chico.
- **Continue to develop the Facility Master Plan for the recently acquired 23.9-acre site adjacent to the Sacramento VAMC:** The Sacramento VAMC will continue to develop its Facility Master Plan to ensure that the proposed movement of current campus clinics to the newly acquired 23.9 acres supports and improves Veteran access and campus adjacencies.

Martinez VAMC

- **Add specialty care services at the Fairfield MS CBOC:** Demand for outpatient specialty care services is projected to increase by 51.8% across the market from FY 2019 to FY 2029. Expanding optometry, audiology and geriatrics services at the Fairfield MS CBOC will improve Veteran access to care.
- **Add inpatient dialysis at the Martinez VAMC to prevent CLC patients from having to travel to David Grant Medical Center at Travis Air Force Base to receive treatment in order to increase**

[62] Dartmouth Atlas hospital service areas (HSAs) are local health care markets for hospital care. An HSA is a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area.

access and improve rehabilitation and treatment consistency: Veterans at the Martinez VAMC CLC travel to the David Grant Medical Center at Travis Air Force Base multiple times per week to receive dialysis treatment. Providing inpatient dialysis at the CLC will improve patient care as rehabilitation and treatment will not be interrupted.

- **Ensure that all parking and walkways are compliant with the Americans with Disabilities Act (ADA) of 1990:** The Martinez VAMC will ensure that all parking and walkways are ADA compliant to improve safety and accessibility.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 21 North Valley 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[63] 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 21 North Valley Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 21 North Valley Market	Status Quo	Modernization	VA Recommendation
Total Cost	$23,087,966,764	$25,316,141,343	$25,688,187,966
Capital Cost	$630,205,259	$2,858,379,838	$3,230,426,462
Operational Cost	$22,457,761,505	$22,457,761,505	$22,457,761,505
Total Benefit Score	10	11	15
CBI (normalized in $B)	**2.31**	**2.30**	**1.71**

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

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 21 VA points of care offering outpatient services, including the proposed replacement Stockton, California MS CBOC; the proposed new Placerville, California MS CBOC; Elk Grove, California MS CBOC; Antioch, California MS CBOC; Yolo, California CBOC; Yountville, California CBOC; Chico, California partnership; and Redding, California partnership; and the proposed expanded Sierra Foothills, California MS CBOC; and Yuba City, California MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Martinez, California VAMC; proposed new stand-alone CLC in Stockton, California; and proposed new CLC at the Sacramento, California 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 Palo Alto, California VAMC (VISN 21).
- **RRTP:** RRTP demand will be met through the proposed new RRTP at the Sacramento, California VAMC and the other facilities within VISN 21 offering RRTP, including the North Las Vegas, Nevada VAMC; Palo Alto-Menlo Park, California VAMC and proposed new stand-alone RRTP in Honolulu, Hawaii.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest Region, including the American Lake, Washington VAMC (VISN 20) and the Palo Alto, California VAMC (VISN 21).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Sacramento, California VAMC and David Grant Medical Center, California, 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 to 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 123,808 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 124,581 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 21. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of California at Davis.
- **Research:** This recommendation does not impact the research mission in the market and allows the Sacramento, California VAMC to maintain the current research mission by establishing a new research building at the Sacramento, California VAMC.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Sacramento, California, and Martinez, California VAMCs are not designated as Primary Receiving Centers.

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 Stockton, California MS CBOC; the proposed new Placerville, California MS CBOC; Elk Grove, California MS CBOC; Antioch, California MS CBOC; Yolo, California CBOC; Yountville, California CBOC; Chico, California partnership; Redding, California partnership; stand-alone CLC in Stockton, California; and CLC and RRTP at the Sacramento, California VAMC; as well as the modernization of the CLC at the Martinez, California VAMC and the inpatient medical and surgical rooms at the Sacramento, California VAMC. This new infrastructure

Quality

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 (1.71 for VA Recommendation versus 2.31 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 Stockton, California MS CBOC; the proposed new Placerville, California MS CBOC; Elk Grove, California MS CBOC; Antioch, California MS CBOC; Yolo, California CBOC; Yountville, California CBOC; Chico, California partnership; Redding, California partnership; stand-alone CLC in Stockton, California; and CLC and RRTP at the Sacramento, California VAMC; as well as the modernization of the CLC at the Martinez, California VAMC, and the inpatient medical and surgical rooms at the Sacramento, California 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 a 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 ($25.7B for VA Recommendation versus $25.3B 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 (1.71 for VA Recommendation versus 2.30 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 21 Pacific Islands Market

The Veterans Integrated Service Network (VISN) 21 Pacific Islands Market serves Veterans in Hawaii, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands (Saipan). 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.[64]

VA's Commitment to Veterans in the Pacific Islands Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 21's Pacific Islands 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 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 Pacific Islands Market's enrollee population and demand for acute inpatient, community living center (CLC), and all outpatient services are projected to increase. The Honolulu VAMC is collocated with the Department of Defense's (DoD) Tripler Army Medical Center with numerous service sharing agreements in place. The shared site is dense, so minimizing primary care at the facility allows for it to accommodate the growth of future outpatient specialty care. 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 community-based outpatient clinic (CBOC) in Haleiwa, Hawaii, offering primary care and mental health to better distribute care and decompress the Honolulu VAMC campus.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation maintains the VA-operated inpatient mental health services within Tripler

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

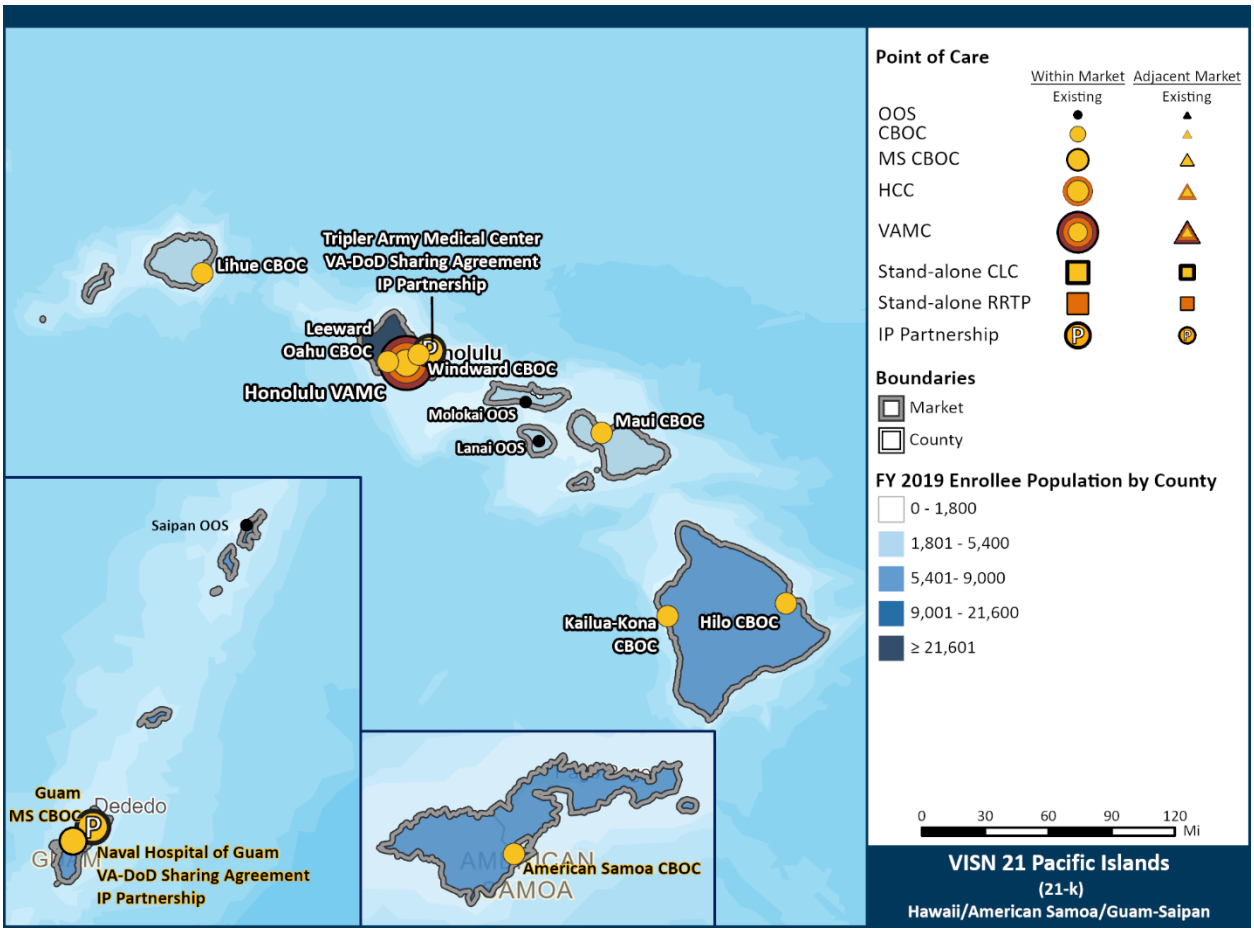
Army Medical Center, invests in the modernization of the CLC to maintain care for Veterans with the most complex needs, and invests in a new off-campus residential rehabilitation treatment program (RRTP) facility to provide comprehensive care that may not be readily available in the community. Inpatient blind rehabilitation demand is met through the Palo Alto Menlo Park VAMC, and inpatient spinal cord injuries and disorders (SCI/D) care demand is met through the regional hub at the Palo Alto, California VAMC.

- **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 and enhances the programs within Tripler Army Medical Center to optimize federally delivered inpatient medical and surgical services, while pursuing strategic collaborations throughout the Pacific Islands to provide local quality care.

Market Overview

The market overview includes a map of the Pacific Islands 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 (Honolulu), one multi-specialty community-based outpatient clinic (MS CBOC), seven CBOCs, and three other outpatient services (OOS) sites. The Honolulu VAMC has a significant sharing agreement with Tripler Army Medical Center for inpatient medical and surgical care.

Enrollees: In fiscal year (FY) 2019, the market had 53,923 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 Honolulu, Hawaii; Hawaii, Hawaii; and Maui, Hawaii.

Demand: Demand[65] in the market for acute inpatient medical and surgical services is projected to increase by 28.0%, and demand for inpatient mental health services is projected to increase by 26.5% between FY 2019 and FY 2029. Demand for long-term care[66] is projected to increase by 22.5%. Demand for all outpatient services,[67] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 40.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 86.2% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 64.4% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[68] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[69] of 62.0% (306 available beds)[70] and there were no inpatient mental health beds at community providers available within a 60-minute drive time. Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 86.5% (107 available beds). Community residential rehabilitation programs[71] 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 the University of Hawaii. The Honolulu VAMC is ranked 100 out of 154 VA training sites based on the number of trainees and is ranked 67 out of 103 VAMCS with research funding. The VAMC does not have an emergency designation.[72]

Facility Overview

Honolulu VAMC: The Honolulu VAMC is located in Honolulu, Hawaii, on the Tripler Army Medical Center campus. The Honolulu VAMC offers inpatient mental health, CLC, RRTP, and outpatient services. In FY

[65] 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).
[66] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[67] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[68] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[69] 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.
[70] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[71] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[72] 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.

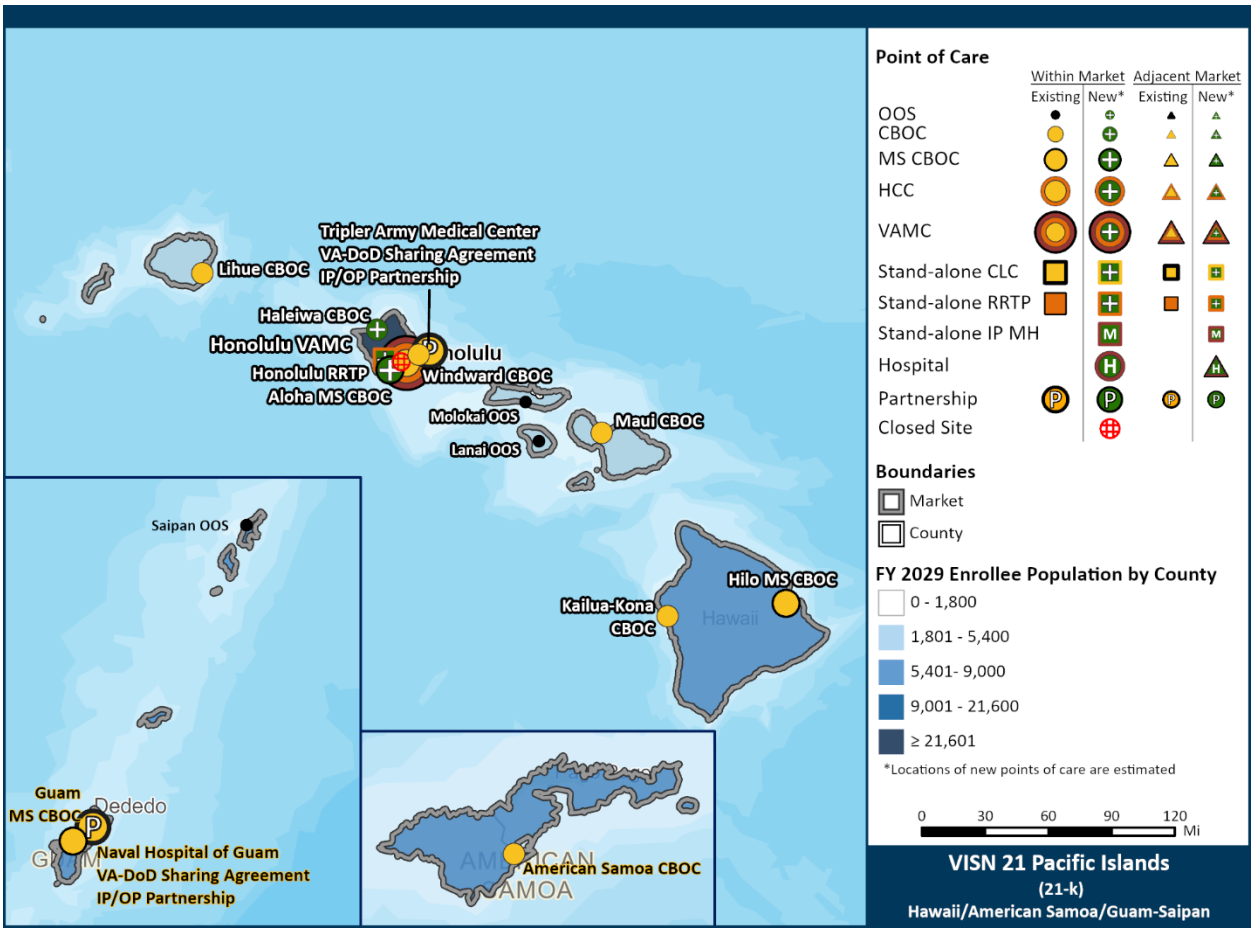
2019, the Honolulu VAMC had an inpatient mental health average daily census (ADC) of 4.5, a CLC ADC of 45.6, and an RRTP ADC of 9.5.

The Honolulu VAMC was built in 1999 on 14.0 acres and does not meet current design standards.[73] Facility condition assessment (FCA) deficiencies are approximately $20.4M, and annual operations and maintenance costs are an estimated $6.8M.

Recommendation and Justification

This section details the VISN 21 Pacific Islands Market recommendation and justification for each element of the recommendation.

Future Market Maps



[73] 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, columns spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be conducive or ideal for the delivery of modern health care.

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

   1.1. **Modernizing the CLC:** The existing CLC building is not designed for modern health care delivery. The CLC has shared patient rooms accessed from corridors with bathrooms shared between two rooms. The modernization of the existing CLC at the Honolulu VAMC will include the conversion to private rooms. In FY 2019, the Honolulu VAMC had a CLC ADC of 45.6, and demand is projected to increase to an ADC of 51.0 in FY 2029.

   1.2. **Relocating RRTP services to a new stand-alone RRTP in the vicinity of Honolulu, Hawaii, and closing the existing RRTP:** In FY 2019, the Honolulu VAMC had an RRTP ADC of 9.5, and demand is projected to increase to an ADC of 21.5 in FY 2028. A new, stand-alone site of care for RRTP services will allow VA and DoD to better modernize the shared campus by expanding other services into space vacated by the RRTP. The new RRTP will meet modern design standards and be located in an area of Honolulu that is most convenient to the Veteran population in need of those services.

   1.3. **Enhancing the strategic collaboration with DoD's Tripler Army Medical Center to improve the delivery of inpatient medical and surgical and outpatient surgical services:** The Honolulu VAMC is collocated with Tripler Army Medical Center with numerous service sharing agreements in place. The Honolulu VAMC does not have an inpatient facility or procedural capabilities. Demand in the market for acute inpatient medical and surgical services is projected to increase by 28.0% between FY 2019 and FY 2029.

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

   2.1. **Establishing a new CBOC in the vicinity of Haleiwa, Hawaii:** A new CBOC in the vicinity of Haleiwa on the North Shore will improve access to primary care and outpatient mental health services. It will decompress the VAMC campus by moving some high-volume, low-acuity services off the constrained site. In FY 2019, there were 5,099 enrollees within 30 minutes of the proposed site.

   2.2. **Relocating all services to the in-progress Kalaeloa MS CBOC and closing the Leeward CBOC:** VA is in the process of constructing a new MS CBOC in Kalaeloa, Hawaii, to serve Veterans living on the leeward side of the island. This is a better market location than the Leeward CBOC and will allow VA to provide care proximate to a larger projected enrollee population than the current location. In FY 2019, there were 3,037 core uniques[74] at the Leeward CBOC, while there were 17,697 enrollees within 30 minutes and 33,822 enrollees within 60 minutes of the new MS CBOC in Kalaeloa, HI.

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

Complementary Strategy

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

Honolulu VAMC

- **Modernize the ACC at the Honolulu VAMC to allow for full implementation of the PACT model:** The ACC is space constrained. After the Honolulu VAMC is decompressed by the openings of the proposed new MS CBOC in Kalaeloa, Hawaii, and CBOC in Haleiwa, Hawaii, the ACC can be modernized according to the PACT model of care. Primary care demand is projected to increase by 72.2% from FY 2019 to FY 2029.
- **Establish a new MS CBOC in the vicinity of Kalaeloa, Hawaii (in progress):** A new MS CBOC in the vicinity of Kalaeloa, Hawaii, will improve access to primary care, outpatient mental health, and outpatient specialty care services. It decompresses the VAMC campus by moving some high-volume, low-acuity services off the constrained site. As of FY 2019, there were 33,822 enrollees within 60 minutes of the proposed site. Establishment of this new MS CBOC, named the Advanced Leeward Outpatient Healthcare Access (ALOHA) project, is in progress.
- **Add specialty care services to the Hilo CBOC, which may result in its reclassification as an MS CBOC:** Currently, outpatient specialty care services at the Hilo CBOC are mostly delivered by telehealth. Demand for outpatient specialty care is projected to increase by 71.8% across the market from FY 2019 to FY 2029.
- **Develop a strategic collaboration with a Federally Qualified Health Center (FQHC) facility in Kohala, Hawaii (Hawaii County), on the northwestern tip of the island of Hawaii for primary care and outpatient mental health services:** The closest VA points of care for primary care and outpatient mental health services from Kohala, Hawaii, are the Kailua-Kona CBOC and the Hilo CBOC, located approximately 70 minutes and 108 minutes away respectively. Strategic collaborations will improve access for Veterans living in Kohala.
- **Add physical therapy services to the Honolulu VAMC:** Physical therapy is currently offered at the CLC only. Demand for outpatient rehabilitation therapies is projected to increase by 45.8% in the Pacific Islands Market from FY 2019 to FY 2029.
- **Expand Home Based Primary Care (HBPC) services in Guam:** Guam is 100% rural. There is a lack of community nursing homes in Guam. The HBPC nurses in Guam provide expanded care beyond what would be provided on the mainland, such as home health and hospice care.
- **Identify new and strengthen existing strategic collaborations in distant Pacific Islands locations, such as Guam Naval Hospital or community partners in Guam, Saipan, and American Samoa:** Strategic collaborations are critical in the Pacific Islands Market given its wide geography. The identification and utilization of consistent outpatient specialty care and inpatient partners in remote locations across the Pacific Islands will strengthen efforts for enhancing access and quality care for Veteran enrollees.
- **Manage the community provider relationships on the Hawaiian Islands to improve quality and access:** Enhancing collaborative efforts with community providers such as hospitals and large

multi-specialty physician groups on the islands of Hawaii will ensure that Veterans continue to have access to high-quality medical care close to where they live.

- **Expand telehealth relationships with the Palo Alto VAMC and the San Francisco VAMC:** The widespread geography across oceans and long flights present access issues. To keep non-acute care as local as possible for Veterans, telehealth use will be expanded.
- **Expand education training positions for advanced practice providers and nurses:** There is a reported shortage of physicians in the Pacific Islands Market. Additional advanced practice providers and nurses will enhance clinical capacity.
- **Explore options for medicine sub-specialty fellowships with Tripler Army Medical Center:** Additional options for medicine sub-specialty training will increase Veteran access to specialty care and enhance VA's capabilities within medicine disciplines.
- **Explore opportunity to construct a parking garage on the Tripler Army Medical Center site:** Explore the opportunity with Tripler Army Medical Center to build a parking garage near the ACC as the existing parking is limited, spread throughout the campus, and difficult to walk due to steep gradients and distance.
- **Increase availability of ophthalmology across the Pacific Islands Market to address the potential lack of high-quality ophthalmologists:** As identified by 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 Veterans Community Care Program, 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 21 Pacific Islands 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[75] 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).

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

- **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 21 Pacific Islands Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 21 Pacific Islands Market	Status Quo	Modernization	VA Recommendation
Total Cost	$13,274,822,617	$14,024,801,244	$14,126,239,470
Capital Cost	$130,602,570	$880,581,198	$982,019,423
Operational Cost	$13,144,220,046	$13,144,220,046	$13,144,220,046
Total Benefit Score	10	11	15
CBI (normalized in $B)	**1.33**	**1.27**	**0.94**

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 15 VA points of care offering outpatient services, including the in-progress ALOHA project MS CBOC in Kalaeloa, Hawaii; the proposed new Haleiwa, Hawaii CBOC; and the proposed expanded Hilo, Hawaii MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Honolulu, Hawaii 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 Palo Alto, California VAMC (VISN 21).

Demand

- **RRTP:** RRTP demand will be met through the proposed new Honolulu, Hawaii stand-alone RRTP and the other facilities within VISN 21 offering RRTP, including North Las Vegas, Nevada VAMC; Palo Alto-Menlo Park, California VAMC; and proposed new RRTP at the Sacramento, California VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northwest region, including the American Lake, Washington VAMC (VISN 20) and the Palo Alto, California VAMC (VISN 21).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the partnerships with Tripler Army Medical Center in Honolulu, Hawaii, and the Naval Hospital of Guam, as well as through community providers; inpatient mental health demand will be met through the partnerships with Tripler Army Medical Center in Honolulu, Hawaii, 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 to 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 53,702 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 54,110 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 21. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with University of Hawaii School of Medicine.
- **Research:** This recommendation does not impact the research mission in the market and allows the Honolulu, Hawaii VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Honolulu, Hawaii 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 in-progress ALOHA project MS CBOC in Kalaeloa, Hawaii; the proposed new Haleiwa, Hawaii CBOC and stand-alone RRTP in Honolulu, Hawaii; as well as the modernization of the ACC and CLC at the Honolulu, Hawaii 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 (0.94 for VA Recommendation versus 1.33 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 in-progress ALOHA project MS CBOC in Kalaeloa, Hawaii; and the proposed new Haleiwa, Hawaii CBOC and stand-alone RRTP in Honolulu, Hawaii; as well as the modernization of the ACC and CLC at the Honolulu, Hawaii 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 ($14.1B for VA Recommendation versus $14.0B 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 (0.94 for VA Recommendation versus 1.27 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 21 Southern Nevada Market

The Veterans Integrated Service Network (VISN) 21 Southern Nevada Market serves Veterans in the greater Las Vegas area. 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.[76]

VA's Commitment to Veterans in the Southern Nevada Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 21's Southern Nevada 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 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 Southern Nevada Market's enrollee population is projected to increase as is demand for acute inpatient, community living center (CLC), and all outpatient care. Primary care points of care are well distributed but undersized in this fast-growing region. The relatively new VAMC is still growing its market share, and the community offers limited specialty care. 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 multiple expanded outpatient sites offering primary care, mental health, and low-acuity specialty services to better distribute care, while ensuring the VAMC campus remains unencumbered with primary care and low-acuity, high-volume outpatient services. VA's recommendation establishes a new community-based outpatient clinic (CBOC) in the Las Vegas Medical District and relocates and expands five other CBOCs.

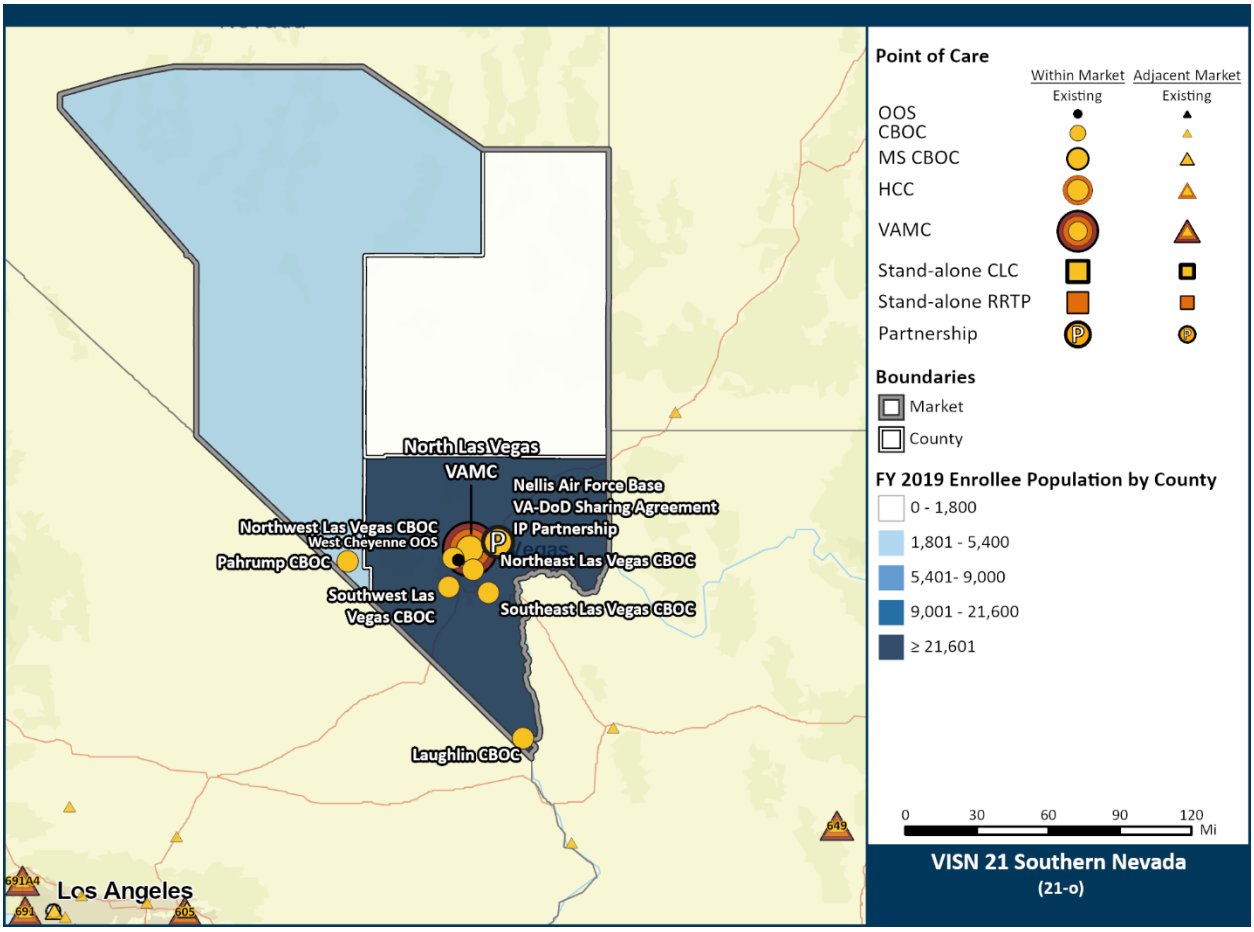
[76] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in the modernization of the inpatient mental health facilities within the North Las Vegas VAMC and invests in the addition of a modern CLC facility at the North Las Vegas VAMC to maintain care for Veterans with the most complex needs. The recommendation maintains the residential rehabilitation treatment program (RRTP) at the North Las Vegas VAMC. Inpatient blind rehabilitation demand is met through the Palo Alto Menlo Park VAMC, and inpatient spinal cord injuries and disorders (SCI/D) care demand is met through regional hubs at the Palo Alto, California VAMC and Long Beach, California VAMC in 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 the programs within the North Las Vegas VAMC to optimize VA-delivered inpatient medical and surgical services, while increasing strategic collaboration both with Nellis Air Force Base and the members of the new Las Vegas Medical District for the expansion of Veteran access to specialty care.

Market Overview

The market overview includes a map of the Southern Nevada 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 (North Las Vegas), six CBOCs, and one other outpatient services (OOS) site.

Enrollees: In fiscal year (FY) 2019, the market had 79,383 enrollees and is projected to experience a 7.6% increase in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Clark, Nevada; Nye, Nevada; and Lincoln, Nevada.

Demand: Demand[77] in the market for acute inpatient medical and surgical services is projected to increase by 1.2% and demand for inpatient mental health services is projected to increase by 9.7% between FY 2019 and FY 2029. Demand for long-term care[78] is projected to increase by 48.6%. Demand

[77] 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).
[78] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

for all outpatient services,[79] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 9.3% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 97.1% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 92.0% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[80] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[81] of 73.7% (404 available beds)[82] and an inpatient mental health occupancy rate of 86.0% (6 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 86.9% (95 available beds). Community residential rehabilitation programs[83] 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 the University of Nevada and Touro University. The North Las Vegas VAMC is ranked 76 out of 154 VA training sites based on the number of trainees and is ranked 90 out of 103 VAMCs with research funding. The VAMC does not have an emergency designation.[84]

Facility Overview

North Las Vegas VAMC: The North Las Vegas VAMC is located in Las Vegas, Nevada, and offers inpatient medical and surgical, inpatient mental health care, RRTP, and outpatient services. In FY 2019, the North Las Vegas VAMC had an inpatient medical and surgical average daily census (ADC) of 58.6 and an inpatient mental health ADC of 16.0. The RRTP was not activated until FY 2020.

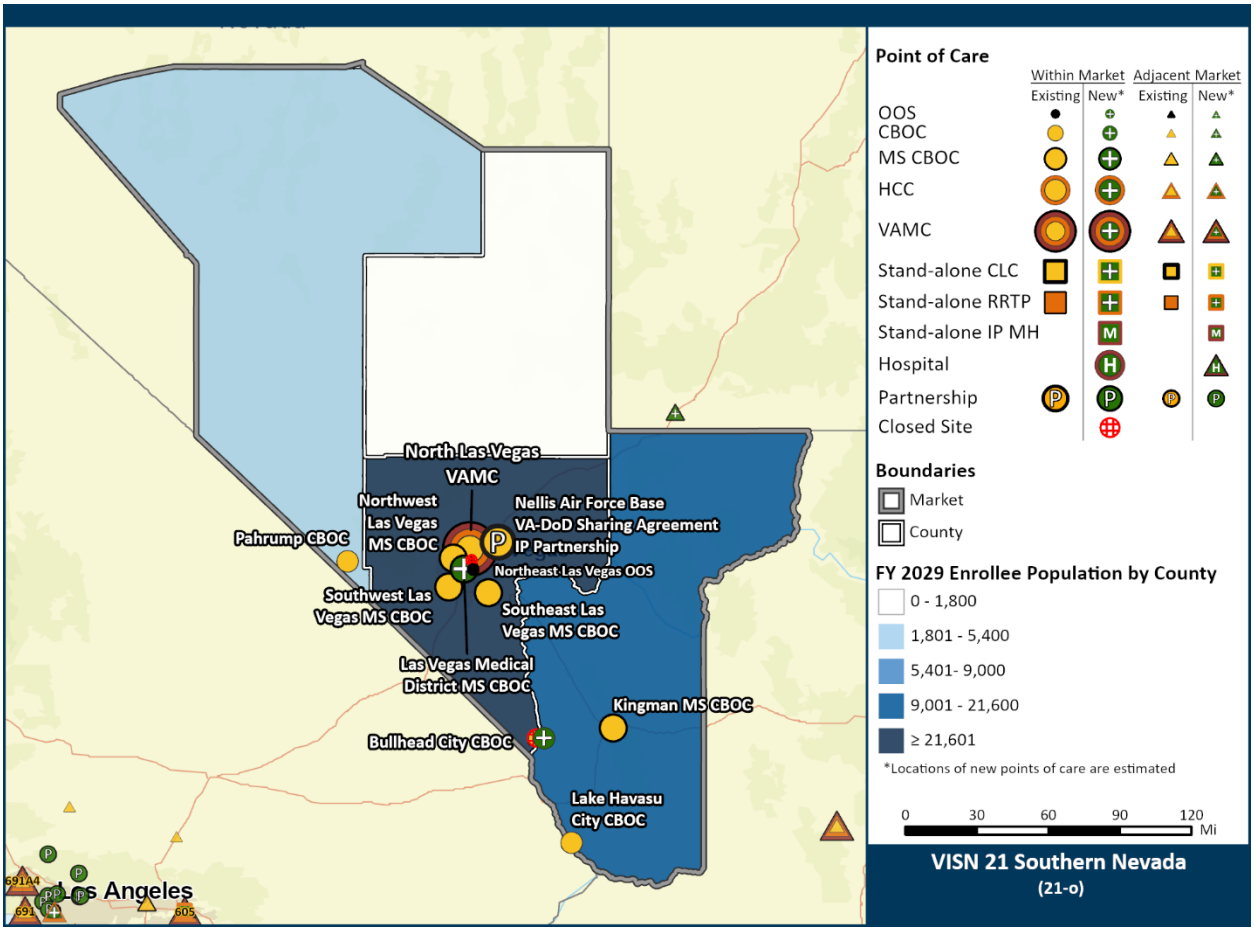
The North Las Vegas VAMC was built in 2012 on 169.0 acres and includes shared patient rooms, which is not consistent with current design standards.[85] Facility condition assessment (FCA) deficiencies are approximately $46.0M, and annual operations and maintenance costs are an estimated $17.1M.

[79] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[80] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[81] 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.
[82] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[83] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[84] 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.
[85] 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, columns spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be conducive or ideal for the delivery of modern health care.

Recommendation and Justification

This section details the VISN 21 Southern Nevada Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the North Las Vegas VAMC by:***

   1.1. **Establishing CLC services at the North Las Vegas VAMC:** The VAMC does not currently have any CLC beds, and the closest VA point of care for those services is more than three hours away. In FY 2019, 35,278 enrollees were at least 65 years old, and demand for nursing home care is projected to increase substantially. As of 2019, community nursing homes within a 30-minute drive time of the VAMC had an occupancy rate of 86.9%, indicating limited availability. The North Las Vegas VAMC campus has room for growth. In FY 2019, there were 71,419 enrollees within 60 minutes of the North Las Vegas VAMC.

   1.2. **Modernizing the inpatient mental health facility:** Including private rooms on inpatient mental health units improves patient satisfaction, increases operational flexibility, and enhances the environment of care. This modernization converts 6 of the 14 rooms to private rooms and maintains its 20-bed capacity. In FY 2019, the VAMC had an inpatient mental health ADC of

16.0, and demand is projected to increase to an ADC of 17.6 in FY 2029. In FY 2019, there were 71,419 enrollees within 60 minutes of the North Las Vegas VAMC.

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

   2.1. **Establishing a new multi-specialty community-based outpatient clinic (MS CBOC) in the vicinity of Las Vegas, Nevada:** Establishing a new site of care places primary care, outpatient mental health, specialty care, diagnostic imaging, and the Veterans Recovery Program in the Las Vegas Medical District. This expands VA's offering of specialty care services and builds academic relationships in proximity to the Kirk Kerkovian School of Medicine at University of Nevada, Las Vegas. In FY 2019, there were 69,480 enrollees within 30 minutes and 71,228 enrollees within 60 minutes of the proposed site.

   2.2. **Relocating the Laughlin CBOC to a new site in the vicinity of Bullhead City, Arizona and closing the existing Laughlin CBOC:** This new site replaces the existing Laughlin CBOC, providing primary care and outpatient mental health services in a more convenient and sustainable location for Veterans. In the Southern Nevada Market, primary care demand is projected to increase by 65.2%, and outpatient mental health services demand is projected to increase by 54.1% from FY 2019 to FY 2029. Enrollment in Mohave County, where Bullhead City is located, is projected to increase by 1.8% from FY 2019 to FY 2029. In FY 2019, the Laughlin CBOC supported 1,745 core unique patients,[86] and there were 4,604 enrollees within 30 minutes of the proposed site.

   2.3. **Relocating the Lake Havasu City CBOC to a new site in the vicinity of Lake Havasu City, Arizona, and closing the existing Lake Havasu City CBOC:** The Lake Havasu CBOC needs a larger leased space to improve access to primary care and outpatient mental health services. In the Southern Nevada Market, primary care demand is projected to increase by 65.2%, and outpatient mental health services demand is projected to increase by 54.1% from FY 2019 to FY 2029. Enrollment in Mohave County, where Lake Havasu City is located, is projected to increase by 1.8% from FY 2019 to FY 2029. In FY 2019, the Lake Havasu City CBOC supported 3,279 core unique patients, and there were 3,273 enrollees within 30 minutes of the proposed site.

   2.4. **Relocating the Southeast Las Vegas CBOC to a new site in the vicinity of Southeast Las Vegas, Nevada, and closing the existing Southeast Las Vegas CBOC:** To meet the projected demand for primary care and outpatient mental health services, the Southeast Las Vegas CBOC needs a larger leased space. In the Southern Nevada Market, primary care demand is projected to increase by 65.2%, and outpatient mental health services demand is projected to increase by 54.1% from FY 2019 to FY 2029. Enrollment in Clark County, where the Southeast Las Vegas CBOC is located, is projected to increase by 7.8% from FY 2019 to FY 2029. In FY 2019, the Southeast Las Vegas CBOC supported 13,177 core unique patients, and there were 40,796 enrollees within 30 minutes and 71,226 enrollees within 60 minutes of the proposed site. This may result in the facility's reclassification as an MS CBOC.

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

2.5. **Relocating the Southwest Las Vegas CBOC to a new site in the vicinity of Southwest Las Vegas, Nevada, and closing the existing Southwest Las Vegas CBOC:** The Southwest Las Vegas CBOC needs a larger leased space to meet the growing demand for primary care, outpatient mental health, expanded specialty care, and urgent care services. Enrollment in Clark County, where the Southwest Las Vegas CBOC is located, is projected to increase by 7.8% from FY 2019 to FY 2029. In FY 2019, the Southwest Las Vegas CBOC supported 13,374 core unique patients, and there were 62,906 enrollees within 30 minutes and 73,552 enrollees within 60 minutes of the proposed site. This may result in its reclassification as an MS CBOC.

2.6. **Relocating the Northwest Las Vegas CBOC to a new site in the vicinity of Northwest Las Vegas, Nevada, and closing the existing Northwest Las Vegas CBOC:** The Northwest Las Vegas CBOC needs a larger leased space to improve access to primary care, outpatient mental health, and expanded specialty care. Enrollment in Clark County, where the Northwest Las Vegas CBOC is located, is projected to increase by 7.8% from FY 2019 to FY 2029. In FY 2019, the Northwest Las Vegas CBOC supported 15,204 patients, and there were 58,041 enrollees within 30 minutes and 71,206 enrollees within 60 minutes of the proposed site. This may result in its reclassification as an MS CBOC.

2.7. **Relocating all services to the proposed Las Vegas MS CBOC and closing the West Cheyenne OOS:** This OOS operates the Veteran Recovery Center, which is being relocated to the proposed new MS CBOC in downtown Las Vegas. This strategy maintains access while consolidating services for Veterans and reducing the number of leases.

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:

Southern Nevada Market

- **Realign the Kingman CBOC and the proposed expanded Lake Havasu City CBOC from the VISN 22 Prescott VAMC to the North Las Vegas VAMC in the VISN 21 Southern Nevada Market:** The Kingman CBOC is 143 minutes from the Prescott VAMC and only 120 minutes from the North Las Vegas VAMC. The Lake Havasu City CBOC is 196 minutes from the Prescott VAMC and 123 minutes from the North Las Vegas VAMC. Mohave County is located in the VISN 22 Prescott Market. The Kingman, Lake Havasu City, and proposed relocated Laughlin CBOC are all in Mohave County.
- **Realign Mohave County, Arizona from the VISN 22 Prescott Market to the VISN 21 Southern Nevada Market**: The realignment of Mohave County to the VISN 21 Southern Nevada Market will allow the North Las Vegas VAMC to optimize resource planning between the three points of care in Mohave County.
- **Increase availability of allergy and immunology services across the Southern Nevada Market to address the potential lack of high-quality allergists and immunologists:** As identified by the Section 203 criteria analysis, there is a potential lack of high-quality allergists and immunologists. Increased availability may be achieved through a variety of tactics, such as

telehealth, recruitment of providers to the Veterans Community Care Program (VCCP), and hiring additional VA providers, as appropriate.

- **Increase availability of ophthalmology across the Southern Nevada Market to address the potential lack of high-quality ophthalmologists:** As identified by 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 VCCP, and hiring additional VA providers, as appropriate.
- **Increase the availability of otolaryngology across the Southern Nevada Market to address the potential lack of high-quality otolaryngologists**: As identified by the Section 203 criteria analysis, there is a potential lack of high-quality otolaryngologists. Increased availability may be achieved through a variety of tactics, such as telehealth, recruitment of providers to the VCCP, and hiring additional VA providers, as appropriate.
- **Increase availability of gastroenterology across the Southern Nevada Market to address the potential lack of high-quality gastroenterologists**: As identified by the Section 203 criteria analysis, there is a potential lack of high-quality gastroenterologists. Increased availability may be achieved through a variety of tactics, such as telehealth, recruitment of providers to the VCCP, and hiring additional VA providers, as appropriate.

North Las Vegas VAMC

- **Relocate primary care and outpatient mental health services currently provided at the Northeast Las Vegas CBOC to the proposed new Las Vegas Medical District MS CBOC and establish a women's health clinic at the Northeast Las Vegas CBOC, which may result in a classification as an OOS**: The new Las Vegas Medical District MS CBOC will absorb primary care and outpatient mental health services from the Northeast Las Vegas CBOC. This will allow VA to convert the existing Northeast Las Vegas CBOC to a women's health clinic. A 38.1% increase in women Veterans is projected for the Southern Nevada Market.
- **Establish a strategic collaboration in the new Las Vegas Medical District to improve enrollee access to outpatient surgical providers in a long-term effort to recruit surgical specialists and sub-specialists to VA for dual appointments or joint hire opportunities**: An outpatient surgical sharing arrangement in the Las Vegas Medical District will begin to address VA's challenges in recruiting specialists. This location will attract specialists who may be drawn to the academic mission and dual appointments. Demand for outpatient surgical cases at the North Las Vegas VAMC increased by 4.4% from FY 2015 to FY 2019.
- **Establish strategic collaborations with Federally Qualified Health Centers (FQHCs) and/or community providers to expand access to primary care and outpatient mental health services in the Tonopah Hospital Service Area (HSA)[87]:** The Tonopah HSA does not have a sufficient enrollee population to support a VA point of care and is more than three hours from the closest

[87] Dartmouth Atlas hospital service areas (HSAs) are local health care markets for hospital care. An HSA is a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area.

VA point of care in Las Vegas, Nevada. As a result, partnerships with the local community providers and FQHCs are needed to provide care to Veterans in these areas.

- **Add Home Based Primary Care (HBPC) services to the Pahrump CBOC**: The Pahrump CBOC is highly rural and 88 minutes from the North Las Vegas VAMC. Adding HBPC services to the Pahrump CBOC will improve access for Veterans living in that area.
- **Strengthen existing partnership with Nellis Air Force Base (AFB) to deliver trauma intensive care unit (ICU) and cardiothoracic (CT) surgical services at the North Las Vegas VAMC. This may include allowing VA providers and DoD providers to deliver care at both the VA and DoD sites:** There is a shortage in the community for cardiothoracic surgery, emergency services, and critical care. This partnership would assist Nellis AFB with their readiness mission, improve Veteran access to surgical services, and increase the number of ICU beds available for Las Vegas Veterans.
- **Expand RRTP capacity at the North Las Vegas VAMC**: There is more projected demand for RRTP services than the VAMC's 20 beds can accommodate. The FY 2028 projected bed need for the Southern Nevada Market is 57. This strategy expands the number of beds within the existing facilities to increase capacity and reduce lengthy travel times to other VA points of care.
- **Realign the Institutional Review Board (IRB) to the Palo Alto VAMC or the San Francisco VAMC**: Research is currently approved through the San Diego VAMC which serves as the IRB. However, both the San Francisco VAMC and the Palo Alto VAMC have two of the most highly funded VA research programs. Partnering with an IRB associated with either the University of California San Francisco or Stanford University in VISN 21 will provide greater collaboration and support to expand the research mission at the North Las Vegas VAMC rather than depend on research support from a market outside of the VISN.
- **Expand outpatient specialty care services at the Kingman CBOC, which may result in its reclassification as an MS CBOC**: In FY 2019, there were 4,069 enrollees within 30 minutes and 8,598 enrollees within 60 minutes of the Kingman CBOC. Offering high-volume, low-acuity specialty care at the CBOC reduces congestion at the VAMC and locates the care closer to where Veterans live.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 21 Southern Nevada 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[88] 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

[88] 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 included 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 benefit 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 21 Southern Nevada Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 21 Southern Nevada Market	Status Quo	Modernization	VA Recommendation
Total Cost	$18,035,360,257	$19,260,283,578	$19,724,422,871
Capital Cost	$349,780,066	$1,574,703,387	$2,038,842,680
Operational Cost	$17,685,580,191	$17,685,580,191	$17,685,580,191
Total Benefit Score	10	11	15
CBI (normalized in $B)	**1.80**	**1.75**	**1.31**

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 new Las Vegas Medical District, Nevada MS CBOC and Bullhead City, Arizona CBOC; and proposed expanded Northwest Las Vegas, Nevada MS CBOC; Southeast Las Vegas, Nevada MS CBOC; Southwest Las Vegas, Nevada MS CBOC; and Kingman, Arizona MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed new CLC at the North Las Vegas, Nevada 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 Long Beach, California VAMC (VISN 22).
- **RRTP:** RRTP demand will be met through the North Las Vegas, Nevada VAMC and the other facilities within VISN 21 offering RRTP, including the Palo Alto-Menlo Park, California VAMC; proposed new RRTP at the Sacramento, California VAMC; and proposed new stand-alone RRTP in Honolulu, Hawaii.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the northwest region, including the American Lake, Washington VAMC (VISN 20) and the Palo Alto, California VAMC (VISN 21).
- **Inpatient acute:** Inpatient medicine, and surgery demand will be met through the North Las Vegas, Nevada VAMC and the partnership with Nellis Air Force Base, Nevada, as well as through community providers; inpatient mental health demand will be met through the North Las Vegas, Nevada 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 to 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 93,374 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 93,524 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 21. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Nevada and Touro University.
- **Research:** This recommendation does not impact the research mission in the market and allows the North Las Vegas, Nevada VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the North Las Vegas, Nevada 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 Las Vegas Medical District, Nevada MS CBOC; Bullhead City, Arizona CBOC; and CLC at the North Las Vegas, Nevada VAMC; as well as the modernization of the inpatient mental health rooms at the North Las Vegas, Nevada 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 (1.31 for VA Recommendation versus 1.80 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 Las Vegas Medical District, Nevada MS CBOC; Bullhead City, Arizona CBOC; and CLC at the North Las Vegas, Nevada VAMC; as well as the modernization of the inpatient mental health rooms at the North Las Vegas, Nevada 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 recruit and retain staff by embedding providers in a 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 ($19.7B for VA Recommendation versus $19.3B 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 (1.31 for VA Recommendation versus 1.75 for Modernization), reflecting effective stewardship of taxpayer dollars.