VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022

VISN 09

Market Recommendations

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VISN 09 Central Market

The Veterans Integrated Service Network (VISN) 09 Central Market serves Veterans in central Tennessee, parts of southern Kentucky, and northeastern Georgia. 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 Central Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 09's Central Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by the 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 Central Market has a large and growing enrollee population. The Nashville, Tennessee, metropolitan area is at the heart of the market, and the most significant growth is occurring in the communities of Clarksville, Tennessee, and Chattanooga, Tennessee. 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 modernized outpatient sites offering primary care, mental health, and low-acuity specialty services to better distribute care and decompress the existing Nashville, Tennessee VAMC campus. It establishes one new multi-specialty community-based outpatient clinic (MS CBOC) and one new community-based outpatient clinic (CBOC). It also relocates and expands one MS CBOC and five CBOCs to modernized facilities proximate to where Veterans live.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a new stand-alone modern community living center (CLC) in Clarksville, Tennessee and a modernized CLC facility at the Murfreesboro, Tennessee VAMC to

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

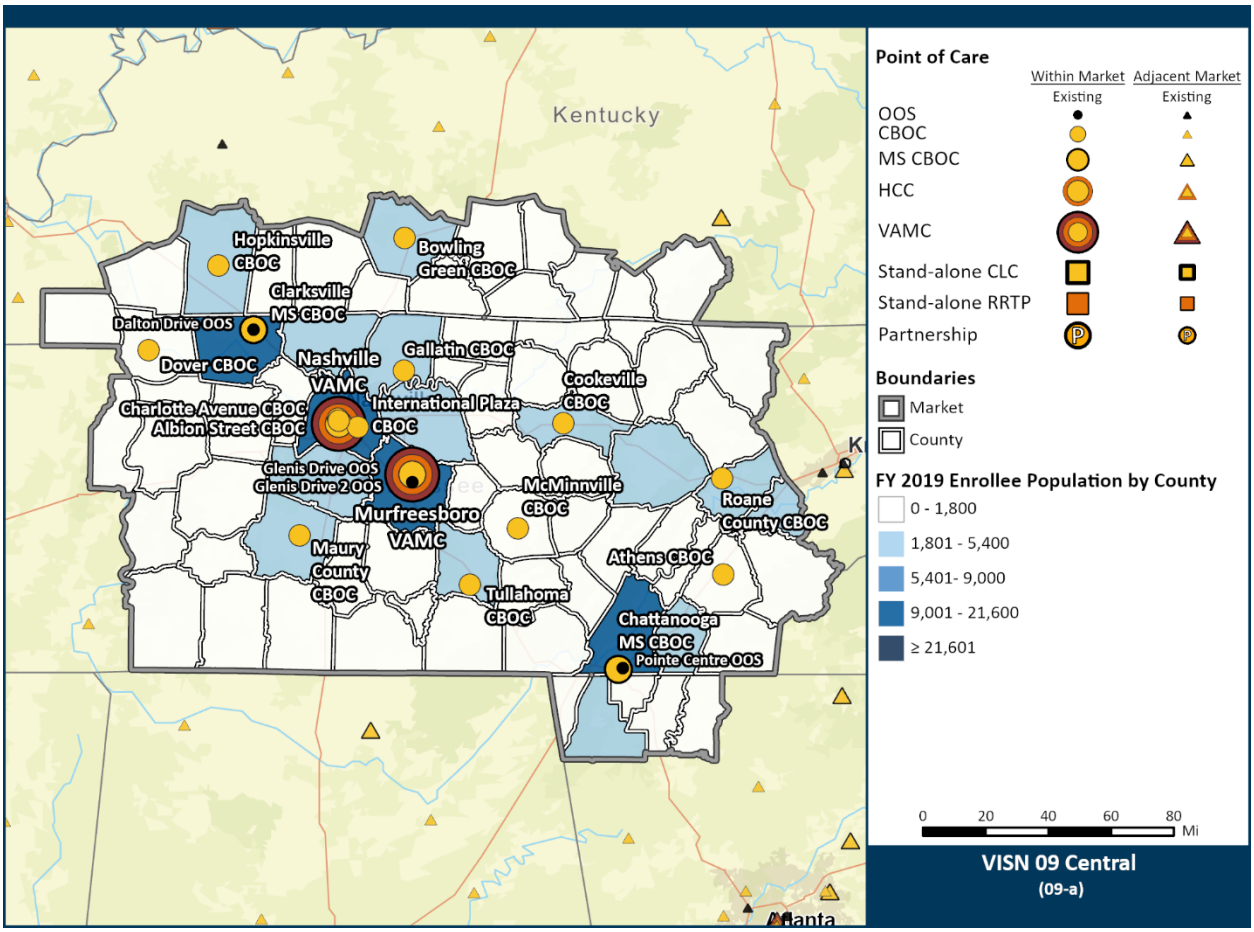
maintain care for Veterans with the most complex needs. VA's recommendation also invests in modern residential rehabilitation treatment program (RRTP) facilities at the Murfreesboro, Tennessee VAMC to provide comprehensive care that may not be readily available in the community. VA's recommendation will modernize services for inpatient spinal cord injuries and disorders (SCI/D) at the Memphis, Tennessee VAMC in the neighboring Western Market. Inpatient blind rehabilitation services will be supported by any of the regional centers in the Southeast, which include the Augusta, Georgia VAMC (VISN 07) and the West Palm Beach, Florida VAMC (VISN 08). Inpatient mental health demand will be met through the Nashville, Tennessee, and Murfreesboro, Tennessee VAMCs.

- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains sustainable programs at the Nashville, Tennessee VAMC and expands utilization of regional or local partnerships with community providers in Chattanooga, Tennessee, and Clarksville, Tennessee, to provide inpatient medical and surgical care.

Market Overview

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

Market Map



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

Enrollees: In fiscal year (FY) 2019, the market had 135,626 enrollees and is projected to experience an 11.7% increase in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Montgomery, Davidson, and Rutherford, Tennessee.

Demand: Demand[2] in the market for inpatient medical and surgical services is projected to increase by 16.8% and demand for inpatient mental health services is projected to increase by 21.1% between FY 2019 and FY 2029. Demand for long-term care[3] is projected to increase by 28.7% over the same period.

[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.

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

Rurality: 49.8% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 72.7% of enrollees in the market live within a 30-minute drive time of VA primary care site and 44.6% of enrollees live within a 60-minute drive time of 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 66.8% (778 available beds)[7] and an inpatient mental health occupancy rate of 57.7% (78 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 80.3% (410 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 the Vanderbilt University Medical Center, the Meharry Medical College, and the University of Tennessee – Chattanooga. The Nashville VAMC is ranked 36 out of 154 training sites based on the number of trainees and the Murfreesboro VAMC is ranked 79 out of 154. The Nashville VAMC is ranked 20 out of 103 VAMCs with research funding, while the Murfreesboro VAMC supports either limited or no research. The Nashville VAMC is designated as a Federal Coordinating Center and the Murfreesboro VAMC has no emergency designation.[9]

Facility Overviews

Nashville VAMC: The Nashville VAMC is located in Nashville, Tennessee, and offers inpatient medical and surgical, inpatient mental health, and outpatient services. In FY 2019, the Nashville VAMC had an inpatient medical and surgical average daily census (ADC) of 76.2 and an inpatient mental health ADC of 5.0.

The Nashville VAMC was built in 1960 on 17.2 acres and does not meet current design standards.[10] Facility condition assessment (FCA) deficiencies are approximately $109.8M and annual operations and maintenance costs are an estimated $11.3M.

[4] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[5] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[6] Occupancy rates are calculated by dividing the total average daily census (ADC) by the number of total actual 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% (90% for community nursing homes).
[8] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[9] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.
[10] Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, columns 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.

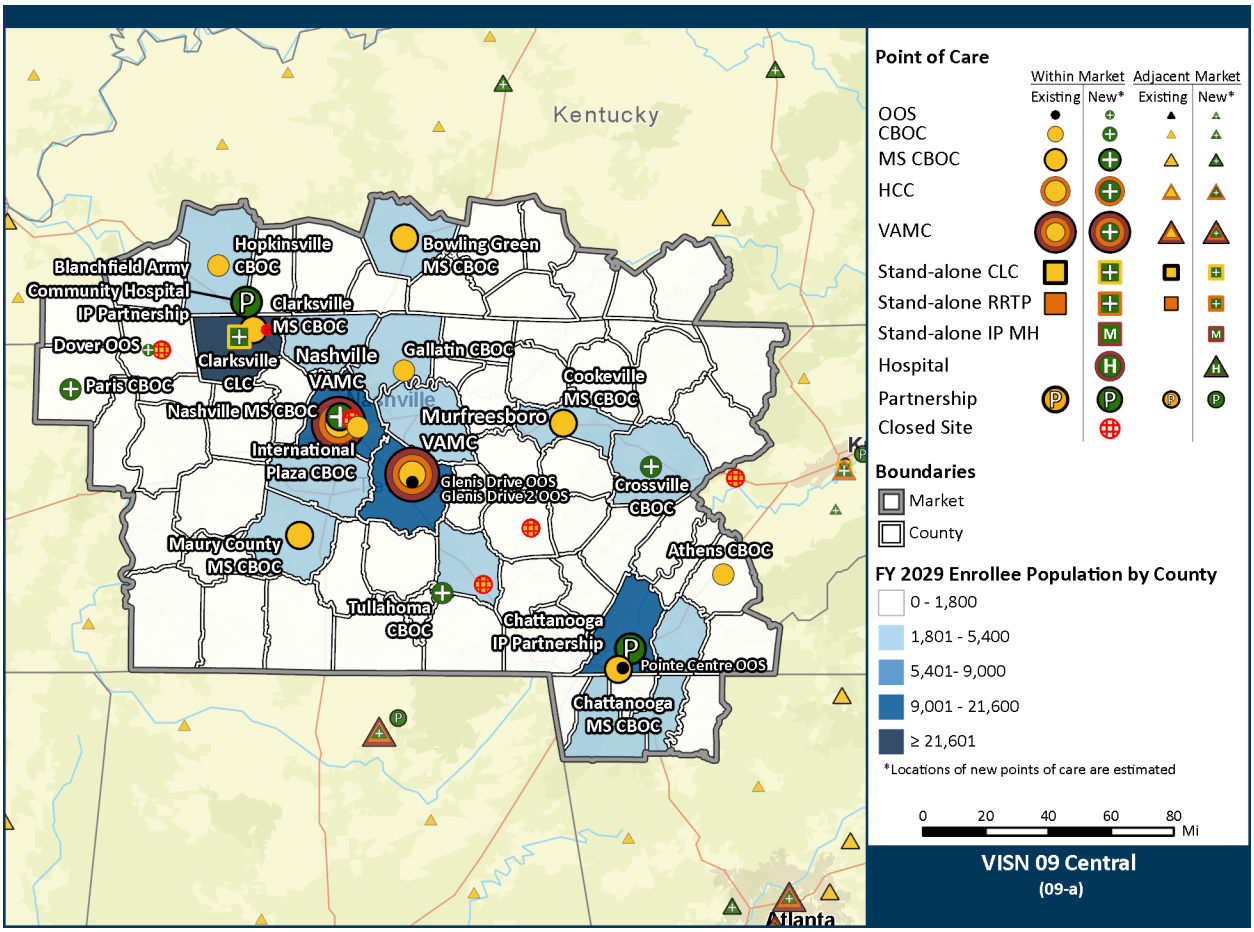
Murfreesboro VAMC: The Murfreesboro VAMC is located in Murfreesboro, Tennessee, and offers inpatient medicine, inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Murfreesboro VAMC had an inpatient medicine ADC of 15.0, an inpatient mental health ADC of 33.2, an RRTP ADC of 24.3, and a CLC ADC of 152.9.

The Murfreesboro VAMC was built in 1939 on 389.1 acres and does not meet current design standards. FCA deficiencies are approximately $134.1M and annual operations and maintenance costs are an estimated $16.1M.

Recommendation and Justification

This section details the VISN 09 Central Market recommendation and justification for each element of the recommendation.

Future Market Map



1.1. **Modernizing the inpatient medical and surgical space:** The inpatient medical and surgical units were built in 1960 as part of the original hospital. Located on the Vanderbilt University campus, the Nashville VAMC provides the highest complexity of care in VISN 09, including cardiac, neuro, and transplant surgeries. Modernization is required to replace shared patient rooms and

bathrooms with single patient rooms and private bathrooms, and to expand support space to meet modern operational requirements. The effort will maintain 127 inpatient medical and surgical beds. The forecasted increase of inpatient medical and surgical demand across the market will be addressed with proposed inpatient partnerships in Clarksville, Tennessee, and Chattanooga, Tennessee.

1.2. **Modernizing the emergency department (ED):** The Nashville VAMC ED is one of the largest in VISN 09 with 23,636 encounters in FY 2019. The current ED is undersized with long wait times and a shortage of staff and support space. Adding observation beds will improve inpatient medical, surgical and ED efficiency, while aligning with the recommendation to modernize the existing medical and surgical space.

1.3. **Modernizing the operating rooms:** The operating rooms were built in 1960 as part of the original hospital. Working closely with their academic affiliate, Vanderbilt University, the Nashville surgical team provides a wide variety of surgery types, including cardiac, neuro, orthopedic, vascular, thoracic, and transplants. Demand for ambulatory surgical specialty care is projected to increase by 112.2% between FY 2019 and FY 2029, and demand for inpatient medical and surgical care is projected to increase by 16.8% between FY 2019 and FY 2029. Modernization will address the limitations of the space and infrastructure and expand the number of operating rooms from 8 to 10-12 to meet complex surgical requirements, which include robotic equipment, cardiothoracic dedicated equipment, and hybrid surgery platforms.

2. ***Establish a strategic collaboration to provide inpatient medical and outpatient surgical services in the vicinity of Clarksville, Tennessee. If unable to enter into a strategic collaboration, utilize community providers:*** The VISN 09 Central Market inpatient medical and surgical ADC is projected to increase to 177.2 between FY 2019 and FY 2029. VA will pursue a strategic collaboration with Department of Defense's (DoD) Blanchfield Army Community Hospital. With a projected increase in inpatient medical and outpatient surgical services demand, establishing a partnership with Blanchfield Army Community Hospital will better serve the Clarksville (Montgomery County) area. Montgomery County enrollees are projected to increase by 53.7% from 19,233 to 29,557 between FY 2019 and FY 2029, indicating a sizable and increasing population. Clarksville is 65 minutes (51.8 miles) from the Nashville VAMC, so establishing a strategic collaboration to provide inpatient medicine and outpatient services will improve access to care in the market.

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

3.1. **Relocating inpatient medical and outpatient surgical services to existing or future VA facilities and discontinuing those services at the Murfreesboro VAMC:** The Murfreesboro VAMC is located less than 40 miles from the Nashville VAMC on a large campus with aging infrastructure. The FY 2019 inpatient medical and surgical ADC was 15.2 and a clinical restructuring letter has been approved to relocate services to the Nashville VAMC for greater operational efficiencies and higher acuity capabilities. Ongoing efforts by the VAMC's leadership have been refocusing the Murfreesboro mission on rehabilitation services, extended care, mental health, and whole health services. The Murfreesboro VAMC averaged 984 outpatient surgery cases between FY 2015 and FY 2019. Relocating outpatient surgery services to the Nashville VAMC will consolidate the inpatient medicine and surgery and outpatient

surgery service lines in the Nashville VAMC, where the VAMC's leadership is focusing on higher acuity care and a strong academic affiliation with Vanderbilt University.

3.2. Modernizing the RRTP: Increasing RRTP beds at the Murfreesboro VAMC from 34 to 96 will support increased demand in the market and align with a need to diversify the type of RRTP services offered in the program. The Nashville VAMC does not currently have any RRTP beds, and the FY 2019 RRTP ADC at the Murfreesboro VAMC was 24.3. The market RRTP ADC is projected to be 94.6 by FY 2028.

3.3. Modernizing the CLC: The Murfreesboro VAMC has 178 CLC beds. In FY 2019, there was an ADC of 152.9 and long-term care in-house demand for the market is projected to decrease to an ADC of 150.0 by FY 2029. The Murfreesboro VAMC was constructed in 1939. CLC services on the campus are using original buildings with modest renovations. Decreasing the number of CLC beds from 178 to 162 will simplify the modernization of facilities at the Murfreesboro VAMC and shift some of the increasing CLC demand to the proposed Clarksville CLC. A new stand-alone Clarksville CLC will increase access to patients beyond Murfreesboro's current access point.

4. ***Modernize and realign by establishing a new stand-alone CLC in the vicinity of Clarksville, Tennessee:*** Total in-house and community demand for long-term care in the VISN 09 Central Market is projected to increase to an ADC of 325.5 between FY 2019 and FY 2029. There is a separate recommendation to modernize and reduce CLC beds at the Murfreesboro VAMC, so additional beds will be needed in the market to support the increasing CLC demand. The proposed 40-bed stand-alone CLC in Clarksville, Tennessee (Montgomery County), is more than 80 miles from Murfreesboro VAMC and will extend access to the largest and fastest increasing county in the Central Market. There are 21,565 enrollees within 30 minutes and 37,143 enrollees within 60 minutes of the proposed site.

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

5.1. Establishing a new MS CBOC in the vicinity of Nashville, Tennessee: A new MS CBOC in Nashville, Tennessee (Davidson County), will decompress clinic space at the Nashville VAMC and improve access to primary care, outpatient mental health, and specialty care services in the Nashville metropolitan area. Enrollees in Davidson County are projected to decrease by 6.0% between FY 2019 and FY 2029; however, in FY 2019 there were 19,047 enrollees within 30 minutes and 62,709 enrollees within 60 minutes of the proposed site.

5.2. Establishing a new CBOC in the vicinity of Paris, Tennessee: A new CBOC in Paris, Tennessee (Henry County), will improve access to primary care and outpatient mental health in the rural county with a rapidly increasing enrollee population, which is located more than 30 minutes away from the nearest VA facility. In FY 2019 there were 2,590 enrollees within 30 minutes of the proposed location. In addition to Henry County, the clinic will draw from surrounding counties for a combined FY 2019 enrollee population of more than 5,800.

5.3. Establishing a new CBOC in the vicinity of Crossville, Tennessee: A new CBOC in Crossville, Tennessee (Cumberland County), will improve access to primary care and outpatient mental health in the county, which is located more than 30 minutes away from the nearest VA facility. In FY 2019 there were 3,509 enrollees within 30 minutes of the proposed location.

5.4. Relocating the Clarksville MS CBOC to a new site within the vicinity of Clarksville, Tennessee, and closing the existing Clarksville MS CBOC: The existing Clarksville MS CBOC (Montgomery County) is undersized to meet the patient demand in the county with the largest number of enrollees and the highest projected growth rate in the market. In FY 2019, the Clarksville MS CBOC saw 13,352 core uniques.[11] In FY 2019, 22,532 enrollees lived within 30 minutes, and 43,391 enrollees lived within 60 minutes of the proposed site. A new facility will improve access to primary care, outpatient mental health, and outpatient specialty care services.

5.5. Relocating the Bowling Green CBOC to a new site within the vicinity of Bowling Green, Kentucky, and closing the existing Bowling Green CBOC: Demand for outpatient services is increasing and relocating to a VA-staffed site in the vicinity of Bowling Green will allow for the expansion of outpatient specialty care services and will be more cost-effective and operationally efficient. The Bowling Green CBOC had 4,188 core uniques in FY 2019. In FY 2019, there were 3,976 enrollees within 30 minutes and 15,874 enrollees within 60 minutes of the proposed site. The Bowling Green CBOC will be reclassified to an MS CBOC after increasing its capacity to provide specialty care services.

5.6. Relocating the Maury County CBOC to a new site within the vicinity of Maury County, Tennessee, and closing the existing Maury County CBOC: Demand for outpatient services is increasing and relocating the Maury County CBOC will allow for additional space to increase the number of service lines at the proposed Maury County MS CBOC. In FY 2019, there were 4,222 enrollees within 30 minutes and 33,512 enrollees within 60 minutes of the proposed site. The Maury County CBOC had 3,865 core uniques in FY 2019. The Maury County CBOC will be reclassified to an MS CBOC after increasing its capacity to provide specialty care services.

5.7. Relocating the Cookeville CBOC to a new site within the vicinity of Cookeville, Tennessee, and closing the existing Cookeville CBOC: Demand for outpatient services is increasing and relocating the Cookeville CBOC will allow for additional space to increase the number of service lines at the proposed Cookeville MS CBOC. In FY 2019, there were 4,333 enrollees within 30 minutes and 15,102 enrollees within 60 minutes of the proposed site. The Cookeville CBOC had 5,138 core uniques in FY 2019. The Cookeville CBOC will be reclassified to an MS CBOC after increasing its capacity to provide specialty care services.

5.8. Relocating the Tullahoma CBOC to a new site in the vicinity of Tullahoma, Tennessee, and closing the existing Tullahoma CBOC: The existing facility is located on Arnold Air Force Base where access is slowed by Air Force security provisions and some Veterans are denied access. Relocating the facility in the vicinity of Tullahoma, Tennessee, will ease security restrictions and improve access to a greater number of Veterans. In FY 2019, there were 4,480 enrollees within 30 minutes and 17,916 enrollees within 60 minutes of the proposed site. The Tullahoma CBOC had 1,567 core uniques in FY 2019.

5.9. Relocating the Hopkinsville CBOC to a new site in the vicinity of Hopkinsville, Tennessee, and closing the existing Hopkinsville CBOC: The Hopkinsville CBOC (Christian County) has historically had below average patient satisfaction scores in areas such as access, care

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

coordination, communication, provider ratings, and overall satisfaction. Changing from a contracted site to a VA-staffed site will help improve care coordination and quality. The Hopkinsville CBOC saw 4,322 core uniques in FY 2019. Primary care encounters increased from 23,020 to 23,412 between FY 2018 and FY 2019, indicating increasing demand for primary care services. Enrollees in Christian County are projected to increase by 19.1% between FY 2019 and FY 2029. In FY 2019, there were 11,108 enrollees within 30 minutes and 32,036 enrollees within 60 minutes of the proposed site.

5.10. **Relocating all services to the proposed Nashville MS CBOC and closing the Albion Street CBOC:** The Albion Street CBOC is in poor condition and is located less than five minutes from the proposed Nashville MS CBOC. The proposed MS CBOC will have capacity to absorb the primary care and outpatient mental health current and projected demand.

5.11. **Relocating all services to the proposed Nashville MS CBOC and closing the Charlotte Avenue CBOC:** The Charlotte Avenue CBOC is in poor condition and is located less than five minutes from the proposed Nashville MS CBOC. The proposed MS CBOC will have capacity to absorb the primary care and outpatient mental health current and projected demand.

5.12. **Relocating all services to the proposed Clarksville MS CBOC and closing the Dalton Drive OOS:** The proposed Clarksville MS CBOC will have sufficient space to absorb the current and projected demand from the Dalton Drive OOS, which is one minute away.

5.13. **Relocating all services to the proposed Paris CBOC and the proposed Clarksville MS CBOC and closing the Dover CBOC:** The Dover CBOC had 1,757 core uniques and 5,755 primary care encounters in FY 2019. The primary users are coming from counties east of Dover, indicating the proposed CBOC in Paris, Tennessee, will be better placed to meet demand. The proposed CBOC in Paris, Tennessee, is 32 minutes away from the Dover CBOC.

5.14. **Relocating all services to the proposed Crossville CBOC and the proposed Knoxville HCC and closing the Roane County CBOC:** The Roane County CBOC is a contracted site located in a small community that has historically had below average patient satisfaction scores. While the site saw 1,843 core uniques in FY 2019, it has struggled to retain providers. The majority of primary care and outpatient mental health encounters were sent out of the county to the Knoxville MS CBOC. In a separate recommendation, a new VA-staffed CBOC has been proposed in the larger community of Crossville, Tennessee, an estimated 30 miles west of the Roane County CBOC. Additionally, the proposed Knoxville HCC will provide access to more primary care, outpatient mental health, outpatient specialty care, and outpatient surgical services an estimated 36 miles to the east.

5.15. **Relocating all services to the proposed Cookeville MS CBOC, the proposed Tullahoma CBOC, and the Murfreesboro VAMC and closing the McMinnville CBOC:** The McMinnville CBOC is a contracted site that has historically had below average patient satisfaction scores. In FY 2019 it saw 1,979 core uniques but struggled to maintain providers and improve patient satisfaction. In separate recommendations, VA is relocating existing VA-staffed CBOCs in Cookeville and Tullahoma to expand services and improve access. Transferring care to the proposed sites and the Murfreesboro VAMC will improve quality and care coordination. The McMinnville CBOC has 2,691 enrollees within 30 minutes, while the proposed Cookeville CBOC and Tullahoma sites

will have 4,333 and 4,480 enrollees within 30 minutes, respectively. The Cookeville MS CBOC and Tullahoma CBOC are 50 and 39 minutes away from the McMinnville CBOC, respectively.

Complementary Strategy

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

Central Market

- **Realign Henry County, Tennessee, from the VISN 09 Western Market to the Central Market:** VA will realign Henry County to the Central Market from the Western Market to best support the Veterans' preferred direction for referrals to the next level of health care services.
- **Realign Roane, Loudon, and Monroe counties in Tennessee from the VISN 09 Central Market to the VISN 09 Eastern Market:** VA will realign Roane, Loudon, and Monroe counties from the Central Market to the Eastern Market to best support the Veterans' preferred direction for referrals to the next level of health care services.

Nashville VAMC

- **Establish a new outpatient mental health OOS in Dover, Tennessee (Stewart County), to fill a potential gap in outpatient mental health services. To establish a new point of care, consider a mobile clinic, creating a strategic collaboration with a community provider to support visiting mental health providers, telehealth, or some combination of the two:** A new OOS in Dover, Tennessee (Stewart County), will fill a potential gap in outpatient mental health services as identified through the Section 203 criteria analysis. In FY 2019 there were over 1,000 enrollees within a 30-minute drive time of the proposed facility. To establish a new point of care, VA will consider a mobile clinic, creating a partnership with a community provider to support visiting mental health providers, telehealth, or some combination of the two.

Murfreesboro VAMC

- **Relocate outpatient mental health services currently provided at the Pointe Centre OOS to the new Chattanooga MS CBOC; maintain optometry and add outpatient specialty care services at the Point Centre OOS:** The new Chattanooga MS CBOC (Hamilton County) will have the space and capacity to support and provide outpatient mental health services, meaning that providing this care at the Pointe Centre OOS (Hamilton County) is no longer needed. With the relocation of outpatient mental health services, VA will expand specialty care services at the Pointe Centre OOS to address other increasing outpatient demands in the community.
- **Expand the existing collaboration with the University of Tennessee Chattanooga Medical School to deliver inpatient medical and surgical services in Chattanooga, Tennessee (Hamilton County):** With a projected increase in inpatient medical and surgical services demand, expanding the current collaboration with University of Tennessee Chattanooga Medical School will better serve the increasing number of projected enrollees in the market and improve access to care for Veterans in the surrounding areas.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three of courses of action (COA) for the VISN 09 Central 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[12] 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 cost 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 the 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 Central Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 09 Central Market	Status Quo	Modernization	VA Recommendation
Total Cost	$ 29,793,388,527	$ 31,872,882,312	$ 32,166,504,659
Capital Costs	$ 1,509,826,660	$ 3,589,320,445	$ 3,882,942,792
Operational Costs	$ 28,283,561,867	$ 28,283,561,867	$ 28,283,561,867
Total Benefit Score	7	10	14
CBI (normalized in $B)	**4.26**	**3.19**	**2.30**

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.

[12] 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 19 VA points of care offering outpatient services, including the proposed new Crossville, Tennessee CBOC; Paris, Tennessee CBOC; Tullahoma, Tennessee CBOC; Nashville, Tennessee MS CBOC; and Dover, Tennessee OOS; the proposed expanded Cookeville, Tennessee MS CBOC; Maury County, Tennessee MS CBOC; and Bowling Green, Kentucky MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Murfreesboro, Tennessee VAMC and the proposed new stand-alone CLC in Clarksville, Tennessee, as well as community nursing homes.

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

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Memphis, Tennessee VAMC (VISN 09).
- **RRTP:** RRTP demand will be met through the Murfreesboro VAMC and the other facilities within VISN 09 offering RRTP, including the Lexington-Leestown, Kentucky VAMC; Memphis, Tennessee VAMC; Mountain Home, Tennessee VAMC; and in-progress replacement Louisville, Kentucky VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Southeast Region, including the West Palm Beach, Florida VAMC (VISN 08) and Augusta-Uptown, Georgia VAMC (VISN 07).
- **Inpatient acute:** Inpatient medicine demand will be met through the Nashville, Tennessee VAMC; the proposed new Blanchfield Army Community Hospital partnership in Tennessee; and the proposed new Chattanooga, Tennessee, partnership; as well as through community providers. Inpatient surgery demand will be met through the Nashville, Tennessee VAMC and the proposed new Chattanooga, Tennessee, partnership, as well as through community providers. Inpatient mental health demand will be met through the Murfreesboro, Tennessee VAMC and Nashville, Tennessee 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 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 147,729 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 147,860 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 09. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with the Meharry Medical College, Vanderbilt University, and the University of Tennessee.
- **Research:** This recommendation does not impact the research mission in the market and allows the Nashville, Tennessee VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Nashville, Tennessee 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 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 Crossville, Tennessee CBOC; Paris, Tennessee CBOC; Tullahoma, Tennessee CBOC; Nashville, Tennessee MS CBOC; Dover, Tennessee OOS; stand-alone CLC in Clarksville, Tennessee; Chattanooga, Tennessee partnership; and Blanchfield Army Community Hospital partnership in Tennessee; as well as the modernization of the emergency department, medicine and surgery patient rooms, and operating rooms at the Nashville, Tennessee VAMC, and the CLC at the Murfreesboro, Tennessee 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.

Quality

- **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 (2.30 for VA Recommendation versus 4.26 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 Crossville, Tennessee CBOC; Paris, Tennessee CBOC; Tullahoma, Tennessee CBOC; Nashville, Tennessee MS CBOC; Dover, Tennessee OOS; stand-alone CLC in Clarksville, Tennessee; Chattanooga, Tennessee, partnership; and Blanchfield Army Community Hospital partnership in Tennessee; as well as the modernization of the emergency department, medicine and surgery patient rooms, and operating rooms at the Nashville, Tennessee VAMC, and the CLC at the Murfreesboro, Tennessee VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community provider space.
- **Reflects stewardship in taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today ($32.2B for VA Recommendation versus $31.9B 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 (2.30 for VA Recommendation versus 3.19 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 09 Eastern Market

The Veterans Integrated Service Network (VISN) 09 Eastern Market serves Veterans in eastern Tennessee, southeastern Kentucky, and southwestern Virginia. 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.[13]

VA's Commitment to Veterans in the Eastern Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 09's Eastern 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 sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Eastern Market has two sizable urban centers: Knoxville, Tennessee, and the Tri Cities area of Tennessee (Johnson City, Kingsport, and Bristol). Beyond these urban centers the market quickly becomes highly rural. The market has a modestly decreasing enrollee population, but significant growth in the Knoxville, Tennessee, area offsets the decreasing populations found across the rural counties. 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 modernized outpatient sites offering primary care, mental health, and low-acuity specialty services to better distribute care and decompress existing campuses, including two new community-based outpatient clinics (CBOCs), one new multi-specialty community-based outpatient clinic (MS CBOC), and one new health care center (HCC).
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a new stand-alone modern community living center (CLC) in

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

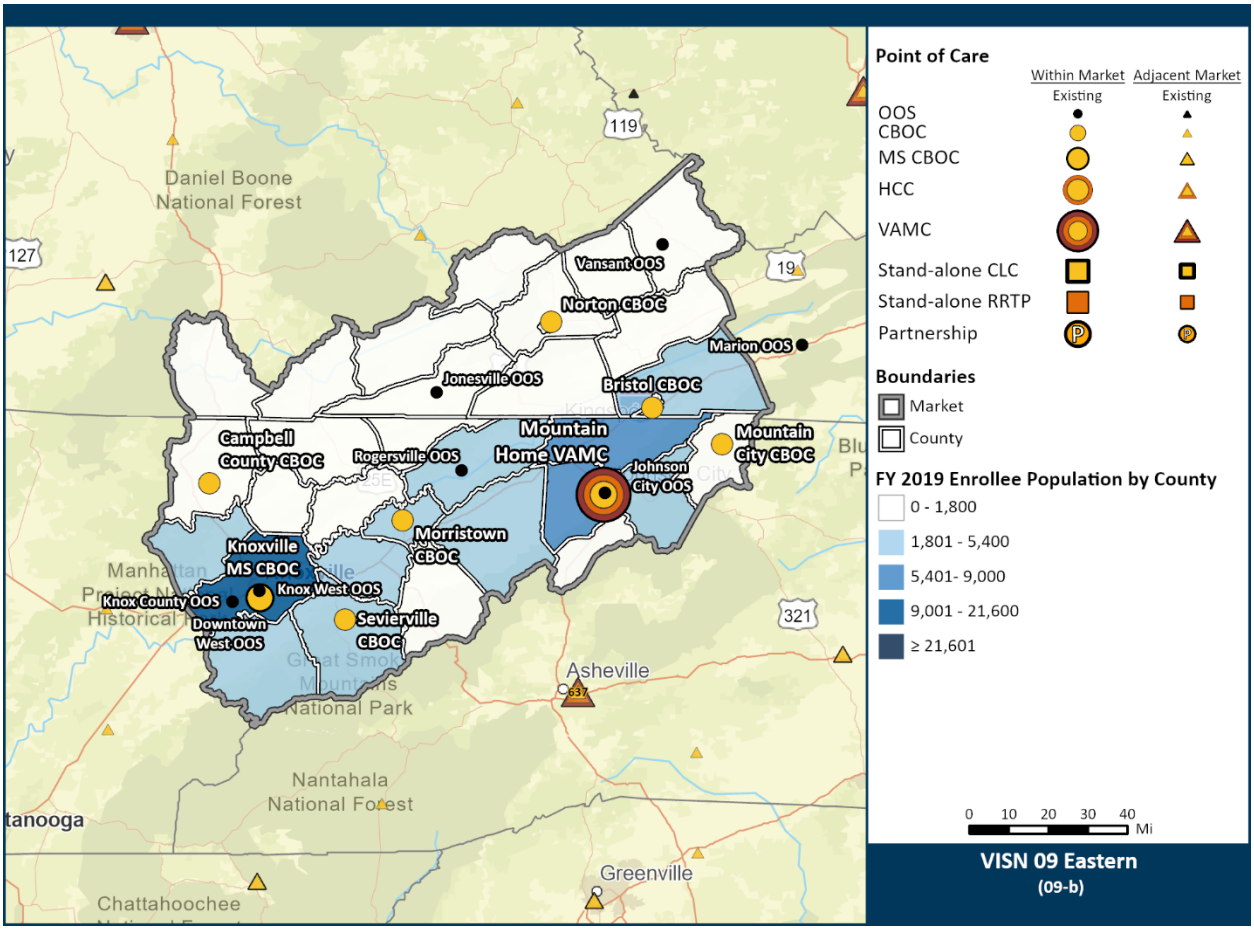
Knoxville, Tennessee and a modernized CLC facility at the Mountain Home, Tennessee VAMC to maintain care for Veterans with the most complex needs. It also invests in modern, residential rehabilitation treatment program (RRTP) facilities at the Mountain Home, Tennessee VAMC to provide comprehensive care that may not be readily available in the community. It will also maintain inpatient mental health services at the Mountain Home, Tennessee VAMC. VA's recommendation will modernize services for inpatient spinal cord injuries and disorders (SCI/D) at the Memphis, Tennessee VAMC in the neighboring Western Market. Demand for inpatient blind rehabilitation services will be met by any of the regional centers in the Southeast, which include the Augusta, Georgia VAMC (VISN 07) and the West Palm Beach, Florida VAMC (VISN 08).

- **Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:** VA's recommendation maintains inpatient medical and surgical programs at the Mountain Home, Tennessee VAMC and establishes partnerships in Knoxville, Tennessee, for inpatient medical and surgical programs that will allow VA providers to care for Veterans in partner space.

Market Overview

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

Market Map



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

Facilities: The market has one VAMC (Mountain Home), one MS CBOC, six CBOCs, and eight other outpatient services (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 67,069 enrollees and is projected to experience a 1.8% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Knox, Washington, and Sullivan, Tennessee.

Demand: Demand[14] in the market for inpatient medical and surgical services is projected to increase by 4.2% and demand for inpatient mental health services is projected to decrease by 3.7% between FY 2019 and FY 2029. Demand for long-term care[15] is projected to increase by 17.3%. Demand for all

[14] 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).

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

outpatient services,[16] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 43.6% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 69.5% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 37.7% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[17] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[18] of 59.0% (346 available beds)[19] and an inpatient mental health occupancy rate of 77.0% (4 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 76.9% (309 available beds). Community residential rehabilitation programs[20] 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 East Tennessee State University. The Mountain Home VAMC is ranked 65 out of 154 VA training sites based on the number of trainees and is ranked 58 out of 103 VAMCs with research funding. The Mountain Home VAMC has no emergency designation.[21]

Facility Overview

Mountain Home VAMC: The Mountain Home VAMC is located in Johnson City, Tennessee, and offers inpatient medical and surgical, inpatient mental health, RRTP, CLC, and outpatient services. In FY 2019, the Mountain Home VAMC had an inpatient medical and surgical average daily census (ADC) of 51.4, an inpatient mental health ADC of 18.3, an RRTP ADC of 103.5, and a CLC ADC of 67.0.

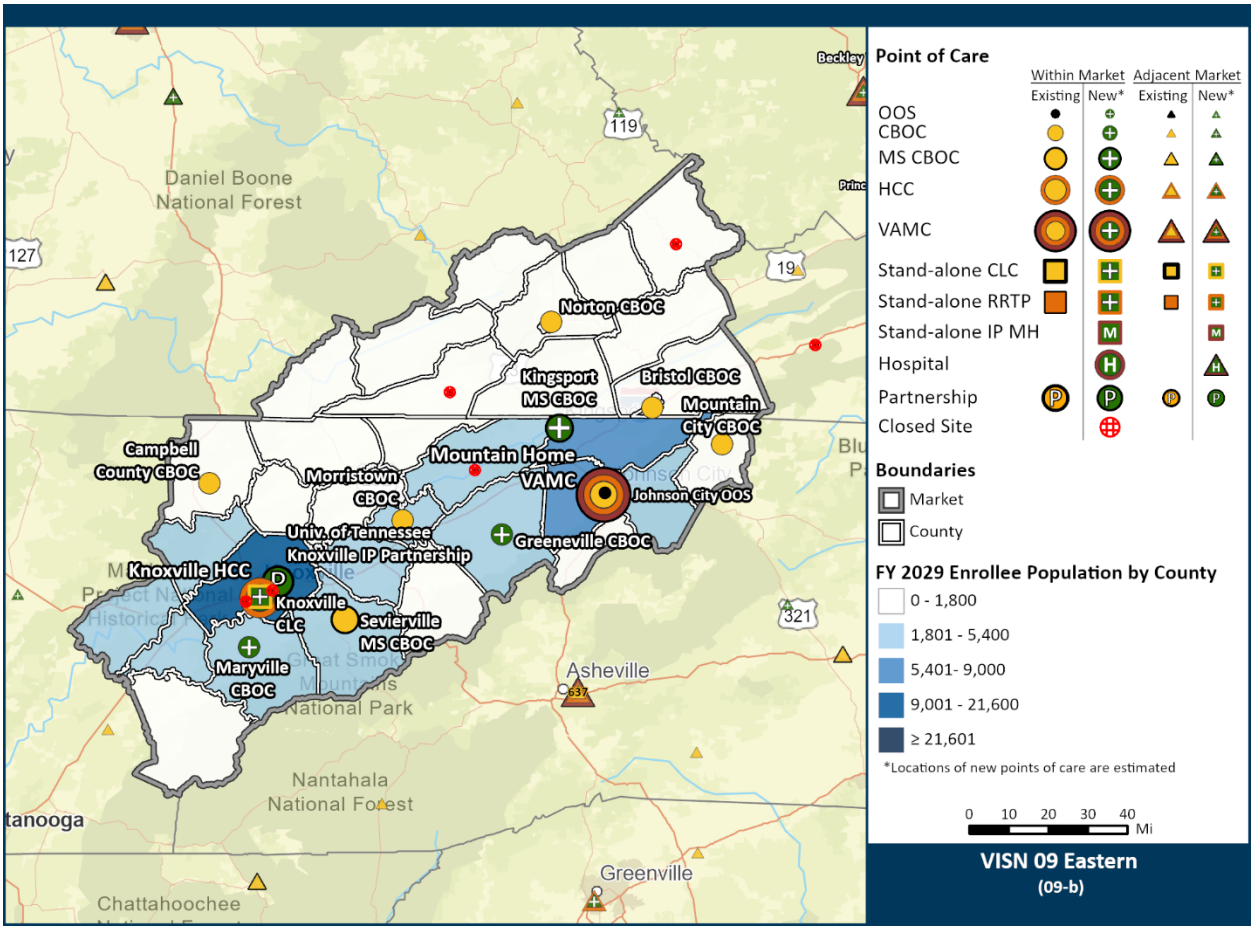
The Mountain Home VAMC was built in 1990 on 156.0 acres. Facility condition assessment (FCA) deficiencies are approximately $139.7M and annual operations and maintenance costs are an estimated $11.9M.

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

Recommendation and Justification

This section details the VISN 09 Eastern Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Mountain Home VAMC by:***

   1.1. Modernizing the CLC: The combined long-term care in-house and community demand in the Eastern Market is projected to increase by 17.3%; however, the in-house ADC at Mountain Home VAMC is projected to decrease to an FY 2029 ADC of 56.9. Utilization of CLC services has remained stable at the VAMC with an FY 2019 ADC of 67.0. The enrollee population within 60 minutes of the facility is 26,751. Modernization of the CLC will correct deficiencies of shared patient rooms, shared patient bathrooms, and undersized patient support spaces to meet VA design guidelines. Reducing the CLC beds from 102 to 72 will ease efforts to complete renovations while providing capacity to meet Mountain Home VAMC's demand. Additionally, a proposed 36-bed stand-alone CLC in Knoxville will address increasing demand and increase access to patients approximately two hours away from the VAMC.

   1.2. Modernizing the RRTP: The ADC for RRTP services for the Eastern Market is projected to be 40.0 by FY 2028. The ADC for RRTP services at the Mountain Home VAMC has steadily

decreased from 115.1 to 89.1 between FY 2015 and FY 2018 as new RRTPs open in neighboring markets and fewer patients are referred from out of market. Modernization of the RRTP is needed to correct deficiencies of shared rooms and shared bathrooms and update patient support spaces to meet current VA design standards. Reducing the RRTP beds from 150 to 85 will ease the effort to renovate and allow VA to adjust capacity to meet future demand. As part of the recommendations for Central and Western markets in VISN 09, additional RRTP beds are being added in Memphis and Murfreesboro to better distribute care.

2. ***Modernize and realign by establishing a new stand-alone CLC in the vicinity of Knoxville, Tennessee:*** Long-term care demand in the Eastern Market is projected to increase by 17.3% to an ADC of 217.0 between FY 2019 and FY 2029. Creating a 36-bed stand-alone CLC in Knoxville will increase access to growing populations in Knox, Blount, Sevier, Anderson, Union, and Campbell counties with a combined increase of 7.0% from FY 2019 to FY 2029. In FY 2019 there were 34,950 enrollees within 60 minutes of the proposed location. The next closest site for CLC services is the Mountain Home VAMC, an estimated two hours away.

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

   3.1. Establishing a new MS CBOC in the vicinity of Kingsport, Tennessee: The nearest point of VA care for outpatient specialty services is the Mountain Home VAMC, which is roughly 30-40 minutes away. In FY 2019 there were 10,338 enrollees within 30 minutes of the proposed clinic, and 27,970 enrollees within 60 minutes. A site in Kingsport, the second largest of the tri-cities of eastern Tennessee, extends access to many of the rural counties of the Eastern Market.

   3.2. Establishing a new CBOC in the vicinity of Greeneville, Tennessee: A new CBOC in Greeneville, Tennessee (Greene County), will improve access to primary care and outpatient mental health in the county which is located more than 30 minutes away from the nearest VA facility. In FY 2019 there were 3,975 enrollees within 30 minutes of the proposed clinic.

   3.3. Establishing a new CBOC in the vicinity of Maryville, Tennessee: A new CBOC in Maryville, Tennessee (Blount County), will improve access to primary care and outpatient mental health in a county with a rapidly increasing number of projected enrollees. The proposed site of the Maryville CBOC is located about 20 miles or 30 minutes away from the proposed Knoxville HCC. In FY 2019 there were 11,460 enrollees within 30 minutes of the proposed clinic.

   3.4. Establishing a new HCC in the vicinity of Knoxville, Tennessee: The proposed Knoxville HCC will allow for upgrades and expansions, which will improve access to primary care, outpatient mental health, specialty care, and outpatient surgical services. Enrollees in Knox County and the surrounding Blount, Sevier, Anderson, Union, and Campbell counties are collectively projected to increase by 7.0% from FY 2019 to FY 2029. In FY 2019 there were 16,508 enrollees within 30 minutes and 34,744 enrollees within 60 minutes of the proposed clinic. The existing Knoxville MS CBOC saw 16,960 core uniques[22] in FY 2019.

   3.5. Relocating all services to the proposed Knoxville HCC and closing the Knoxville MS CBOC: The Knoxville MS CBOC will be upgraded to an HCC by adding outpatient specialty care and

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

outpatient surgery services. Ambulatory surgical specialties are projected to increase by 88.9% between FY 2019 and FY 2029. Upgrading the Knoxville MS CBOC to an HCC will help VA create additional capacity to meet increasing demand.

3.6. **Relocating all services to the proposed Knoxville HCC and closing the Knox County OOS:** The Knox County OOS is located three minutes from the Knoxville MS CBOC. The Knox County OOS was opened to alleviate space constraints at the Knoxville MS CBOC. The proposed Knoxville HCC will have sufficient space and staffing to absorb the additional demand. As a result, the Knox County OOS can be deactivated.

3.7. **Relocating all services to the proposed Knoxville HCC and closing the Downtown West OOS:** The Downtown West OOS is located three minutes from the Knoxville MS CBOC. The Downtown West OOS was opened to alleviate space constraints at the Knoxville MS CBOC. The proposed Knoxville HCC will have sufficient space and staffing to absorb the additional demand. As a result, the Downtown West OOS can be deactivated.

3.8. **Relocating all services to the proposed Knoxville HCC and closing Knox West OOS:** The Knox West OOS is located one to two minutes from the Knoxville MS CBOC. The Knox West OOS was opened to alleviate space constraints at the Knoxville MS CBOC. The proposed Knoxville HCC will have sufficient space and staffing to absorb the additional demand. As a result, the Knox West OOS can be deactivated.

3.9. **Relocating all services to the Morristown CBOC, the proposed Kingsport MS CBOC, and the proposed Greeneville CBOC and closing the Rogersville OOS:** The Rogersville OOS is a small clinic that has faced challenges with recruitment of mental health providers. While the clinic saw 1,490 core uniques in FY 2019, the majority of outpatient mental health encounters occurred at the Mountain Home VAMC more than an hour away. In separate recommendations, new clinics are proposed in the larger communities of Kingsport, Tennessee, and Greeneville, Tennessee, where increasing mental health services will be more sustainable. The Morristown CBOC proposed Kingsport MS CBOC, and proposed Greeneville CBOC will have sufficient space and staffing to absorb the additional primary care and outpatient mental health demand. The distances between the Rogersville OOS and the Morristown CBOC, proposed Kingsport MS CBOC, and proposed Greeneville CBOC are approximately 34 minutes, 38 minutes, and 39 minutes, respectively.

3.10. **Relocating all services at the Jonesville OOS and closing the Jonesville OOS:** The Jonesville OOS is open only two days per week, limiting patient access and choice. Located in Lee County, Virginia, the clinic saw 477 core uniques in FY 2019 and the county had 786 enrollees with a projected decrease of 10.9% from FY 2019 to FY 2029. Closing the OOS and relocating services to community providers or Federally Qualified Health Centers (FQHCs) will provide Veterans improved access and expanded scheduling. It will also allow VA to close an operationally inefficient facility that is unable to support VA's patient-aligned care team (PACT) model. There are existing community providers and FQHC options within 20 minutes of the existing facility.

3.11. **Relocating all services at the Vansant OOS and closing the Vansant OOS:** The Vansant OOS is open only one day a week, limiting patient access and choice. Located in Buchanan County the clinic saw 251 core uniques in FY 2019 and the county had 488 enrollees with a projected decrease of 8.0% from FY 2019 to FY 2029. Closing the Vansant OOS and relocating services to

community providers or FQHCs will provide Veterans with improved access and expanded scheduling. It will also allow VA to close an operationally inefficient facility that is unable to meet VA's PACT model. There are existing community provider and FQHC options within 15 minutes of the existing facility.

3.12. **Relocating all services at the Marion OOS and closing the Marion OOS:** The Marion OOS is open only two days per week limiting patient access and choice. The clinic is located in Smyth County outside VISN 09 in the neighboring Northwest Market of VISN 06. The clinic saw 432 core uniques in FY 2019. In FY 2019, the county had 1,026 enrollees, and the enrollee population is projected to decrease by 9.2% between FY 2019 and FY 2029. Closing the OOS and relocating services to the Wytheville CBOC, community providers, or FQHCs will provide Veterans improved access and expanded scheduling. It will also allow VA to close an operationally inefficient facility that is unable to meet VA's PACT model. There are existing community provider and FQHC options within 10 minutes of the existing facility, and VA's Wytheville CBOC is less than 30 minutes from the existing facility.

Complementary Strategy

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

Eastern Market

- **Realign Roane, Loudon, and Monroe counties from the VISN 09 Central Market to the Eastern Market:** VA will realign Roane, Loudon, and Monroe counties to the Eastern Market from the Central Market to best support the Veterans' preferred direction for referrals to the next level of health care services.
- **Realign Whitley County, Kentucky, from the VISN 09 Eastern Market to the VISN 09 Northern Market:** VA will realign Whitley County to the Northern Market from the Eastern Market to best support the Veterans' preferred direction for referrals to the next level of health care services.
- **Increase availability of ophthalmology and across the Eastern 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 Veterans Community Care Program, and hiring additional VA providers, as appropriate.
- **Increase availability of neurosurgery and across the Eastern 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 Veterans Community Care Program, as appropriate.

Mountain Home VAMC

- **Expand inpatient medical and surgical services by forming a strategic collaboration with the University of Tennessee Medical Center in Knoxville, Tennessee (Knox County):** With a

projected increase in inpatient medical and surgical services demand, establishing a strategic collaboration with the University of Tennessee Medical Center will better serve the Knoxville area and provide opportunities for further collaboration.

- **Add optometry and physical therapy services to the Sevierville CBOC (Sevier County), which may result in the classification of the facility as an MS CBOC:** As specialty care services are projected to increase, reestablishing this facility as an MS CBOC by adding optometry and physical therapy services will better support the increasing needs of the community and increase access to care for Veterans.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COA) for the VISN 09 Eastern 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[23] 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 cost 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 the 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 Eastern Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 09 Eastern Market	Status Quo	Modernization	VA Recommendation
Total Cost	$ 15,087,979,978	$ 15,880,064,584	$ 16,114,994,946
Capital Costs	$ 652,189,008	$ 1,444,273,614	$ 1,679,203,976
Operational Costs	$ 14,435,790,970	$ 14,435,790,970	$ 14,435,790,970
Total Benefit Score	10	11	15
CBI (normalized in $B)	**1.51**	**1.44**	**1.07**

[23] 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 12 VA points of care offering outpatient services, including the proposed new Kingsport, Tennessee MS CBOC; Greeneville, Tennessee CBOC; Maryville, Tennessee CBOC; the proposed expanded Knoxville, Tennessee HCC; and Sevierville, Tennessee MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Mountain Home VAMC and proposed new stand-alone CLC in Knoxville, Tennessee, 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 Augusta, Georgia VAMC (VISN 07).
- **RRTP:** RRTP demand will be met through the Mountain Home, Tennessee VAMC and the other facilities within VISN 09 offering RRTP, including the Lexington-Leestown, Kentucky VAMC; Memphis, Tennessee VAMC; Murfreesboro, Tennessee VAMC; and in-progress replacement Louisville, Kentucky VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Southeast Region, including the West Palm Beach, Florida VAMC (VISN 08) and Augusta-Uptown, Georgia VAMC (VISN 07).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the Mountain Home, Tennessee VAMC and new partnership in Knoxville, Tennessee, as well as through community providers. Inpatient mental health demand will be met through the Mountain Home, Tennessee 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 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 71,634 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 71,753 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 09. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the East Tennessee State University. In addition, this recommendation expands the academic partnership in the market by proposing a new partnership with University of Tennessee in Knoxville, Tennessee.
- **Research:** This recommendation does not impact the research mission in the market and allows the Mountain Home, Tennessee VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Mountain Home, Tennessee 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 Kingsport, Tennessee MS CBOC; Greeneville, Tennessee CBOC; Maryville, Tennessee CBOC; stand-alone CLC in Knoxville, Tennessee; and partnership in Knoxville, Tennessee; as well as the modernization of the CLC and RRTP at the Mountain Home, Tennessee 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 (1.07 for VA Recommendation versus 1.51 for Status Quo), indicating that 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 Kingsport, Tennessee MS CBOC; the Greeneville, Tennessee CBOC; the Maryville, Tennessee CBOC; a stand-alone CLC in Knoxville, Tennessee; and the partnership in Knoxville, Tennessee; as well as the modernization of the CLC and RRTP at the Mountain Home, Tennessee VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community provider 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 ($16.1B for the VA Recommendation versus $15.9B 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 (1.07 for the VA Recommendation versus 1.44 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 09 Western Market

The Veterans Integrated Service Network (VISN) 09 Western Market serves Veterans in western Tennessee, northeastern Arkansas, and northern Mississippi. 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.[24]

VA's Commitment to Veterans in the Western Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 09's Western 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 sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Western Market is centered on the sizable urban center of Memphis, Tennessee. Roughly a third of the enrollee population resides in Memphis' Shelby County. The remainder of the population is distributed amongst the communities of Jonesboro, Arkansas; Jackson, Tennessee; Tupelo, Mississippi; and numerous rural communities and counties. While the Market's enrollee population is modestly decreasing there is some growth in the counties scattered across Tennessee and Mississippi, most notably Tipton County, Tennessee, and DeSoto County, Mississippi, bordering the Memphis, Tennessee, metropolitan area. 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 the existing Memphis, Tennessee VAMC campus. The recommendation establishes one new community-based outpatient clinic (CBOC) and relocates two CBOCs to expand services closer to where Veterans live.

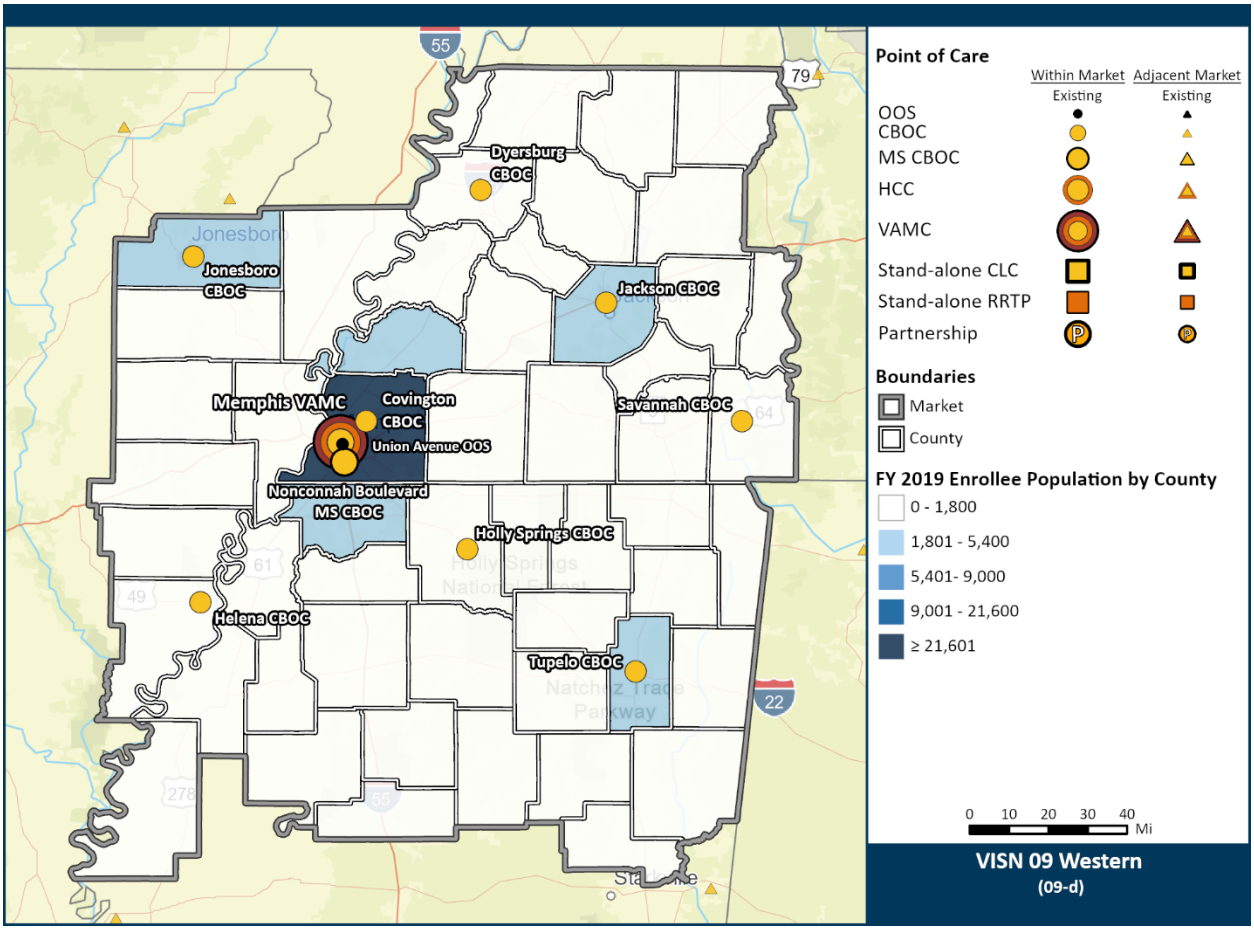
[24] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation maintains inpatient mental health services within the Memphis, Tennessee VAMC, invests in a new stand-alone modern community living center (CLC) in Memphis, Tennessee, to maintain care for Veterans with the most complex needs, and invests in modern, residential rehabilitation treatment program (RRTP) facilities in Memphis, Tennessee, to provide comprehensive care that may not be readily available in the community. VA's recommendation will modernize services for inpatient spinal cord injuries and disorders (SCI/D) at the Memphis, Tennessee VAMC. Demand for inpatient blind rehabilitation services will be supported by any of the regional centers in the Southeast, which include the Augusta, Georgia VAMC (VISN 07) and the West Palm Beach, Florida VAMC (VISN 08).
- **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 inpatient medical and surgical services at the Memphis, Tennessee VAMC.

Market Overview

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

Market Map



Facilities: The market has one VAMC (Memphis), one multi-specialty community-based outpatient clinic (MS CBOC), eight CBOCs, and one other outpatient services (OOS) site.

Enrollees: In fiscal year (FY) 2019, the market had 69,638 enrollees and is projected to experience a 2.9% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Shelby, Tennessee; De Soto, Mississippi; and Craighead, Arkansas.

Demand: Demand[25] in the market for inpatient medical and surgical services is projected to decrease by 0.7% and demand for inpatient mental health services is projected to decrease by 8.1% between FY 2019 and FY 2029. Demand for long-term care[26] is projected to increase by 30.2%. Demand for all

[25] 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).
[26] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,[27] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 51.9% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 67.5% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 53.7% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[28] in the market within a 60-minute drive time of the VAMC had an inpatient acute occupancy rate[29] of 69.1% (469 available beds)[30] and an inpatient mental health occupancy rate of 60.4% (44 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 83.3% (218 available beds). Community residential rehabilitation programs[31] 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 Tennessee. The Memphis VAMC is ranked 31 out of 154 VA training sites based on the number of trainees and is ranked 32 out of 103 VAMCs with research funding. The Memphis VAMC is designated as a Federal Coordinating Center.[32]

Facility Overview

Memphis VAMC: The Memphis VAMC is located in Memphis, Tennessee, and offers inpatient medical and surgical, inpatient mental health, RRTP, SCI/D, and outpatient services. In FY 2019, the Memphis VAMC had an inpatient medical and surgical average daily census (ADC) of 69.0, an intermediate ADC of 12.3, an inpatient mental health ADC of 35.0, an RRTP ADC of 23.6, and an SCI/D ADC of 16.5.

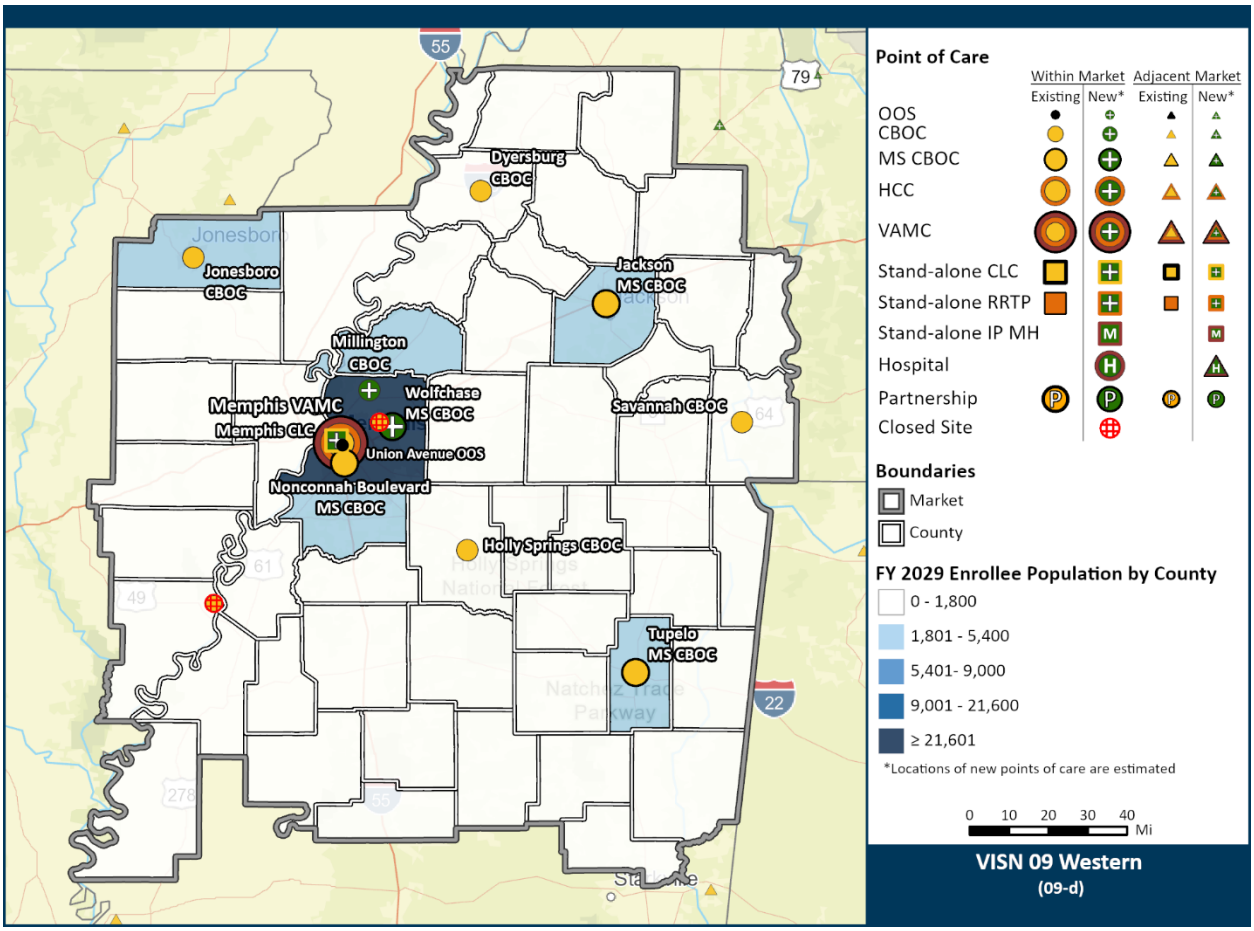
The Memphis VAMC was built in 1967 on 33.0 acres. The spinal cord injuries building was constructed in 1986 and the inpatient bed tower was constructed in 2000. While many of the facilities were renovated and rebuilt to address seismic deficiencies in 2000, the older facilities do not meet current design standards.[33] Facility condition assessment (FCA) deficiencies are approximately $133.0M and annual operations and maintenance costs are an estimated $16.7M.

[27] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[28] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[29] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of actual operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[30] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[31] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[32] 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.
[33] Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (for example, 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 09 Western Market recommendation and justification for each element of the recommendation.

Future Market Map



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

   1.1. Modernizing the RRTP at the Memphis VAMC: Currently, the Memphis VAMC's RRTP has 26 operational beds with existing substance use disorder (SUD) and posttraumatic stress disorder (PTSD) programs. The ADC for RRTP services has moderately increased from 20.5 in FY 2015 to 23.6 in FY 2019. Modernizing and expanding will increase the number of beds from 26 to 42 and address demand for additional RRTPs in the market, including Domiciliary Care for Homeless Veterans.

   1.2. Modernizing the inpatient medicine and surgical space at the Memphis VAMC: The inpatient medical and surgical space was built in 2000 with many shared patient rooms and shared bathrooms. Modernizing will bring the inpatient unit up to current VA design standards with private patient rooms and private bathrooms. The modernized unit will have adequate support space. It will reduce the total inpatient medical and surgical beds from 138 to 84, simplifying

renovation efforts. The reduced number of beds will meet the projected demand for inpatient medicine and surgery.

1.3. **Modernizing the SCI/D space at the Memphis VAMC:** The SCI/D program at the Memphis VAMC focuses on acute care services with more patients opting to stay closer to home and family for long-term care. As a result, the utilization of SCI/D services has decreased from an FY 2015 ADC of 32.8 to an FY 2019 ADC of 16.5. Modernizing the SCI/D space will reduce beds from 70 to 26 while maintaining adequate capacity to support demand from the Memphis SCI/D region and VISN 09.

2. ***Modernize and realign by establishing a new stand-alone CLC in the vicinity of Memphis, Tennessee:*** Currently the Memphis VAMC and the Western Market have no CLC beds. Across the market, long-term care demand is projected to increase by 30.2% for a total ADC of 177.8 beds between FY 2019 and FY 2029. The proposed 64-bed CLC in the vicinity of Memphis will reduce difficulties currently encountered with discharges to the community and increased length of stay.

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

3.1. **Establishing a new CBOC in the vicinity of Millington, Tennessee:** A new CBOC in northern Shelby County will increase access to primary care and outpatient mental health for Shelby County and the increasing enrollee population of Tipton County. In FY 2019 there were 18,395 enrollees within 30 minutes of the proposed site. The proposed Wolfchase MS CBOC and the Memphis VAMC are both 25 minutes away from the proposed site.

3.2. **Relocating the Covington CBOC to a new site in the vicinity of Wolfchase, Tennessee, and closing the existing Covington CBOC:** Relocating the Covington CBOC to the vicinity of Wolfchase places primary care, outpatient mental health, and new specialty care services in a more accessible and sustainable location. In FY 2019, the existing facility served 5,908 core uniques;[34] however, at 9,975 square feet, the current location lacks space to meet the increasing demand for outpatient services and will be unable to decompress clinical services from the Memphis VAMC. In FY 2019 there were 23,449 enrollees within 30 minutes of the proposed site which is more proximate to major thoroughfares leading into Memphis. With the relocation and addition of specialty care services, the Covington CBOC will be renamed and reclassified to the Wolfchase MS CBOC.

3.3. **Relocating the Tupelo CBOC to a new site in the vicinity of Tupelo, Mississippi, and closing the existing Tupelo CBOC:** Relocating from a contract clinic to a VA-staffed site will be more cost-effective and operationally efficient for the Tupelo CBOC. In FY 2019 there were 3,078 enrollees within 30 minutes of the proposed site and 8,564 enrollees within 60 minutes. In FY 2019, the existing facility served 4,513 core uniques. Demand for outpatient services is increasing; relocating the site will allow for the expansion of specialty care services at the proposed VA-staffed Tupelo MS CBOC.

3.4. **Relocating all services at the Helena CBOC and closing the Helena CBOC:** In FY 2019 the Helena CBOC in Phillips County, Arkansas, served 1,004 core unique patients but frequently

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

diverted patients due to staffing shortages. Enrollees are projected to decrease in the highly rural Phillips County from 517 in FY 2019 to 441 in FY 2029. There are community alternatives for primary care and outpatient mental health services in the area surrounding the Helena CBOC.

Complementary Strategy

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

Western Market

- **Realign Henry County, Tennessee, from the VISN 09 Western Market to the VISN 09 Central Market:** VA will realign Henry County from the Western Market to the Central Market to align with Veterans' choice for care and strengthen the referral path to the next level of care.

Memphis VAMC

- **Add physical therapy, audiology, and visiting specialty services to the Jackson CBOC, which may result in the classification of the facility as an MS CBOC:** As specialty care services are projected to increase, reestablishing this facility as an MS CBOC will better support the increasing needs of the Veterans in the community. In FY 2019, there were 4,062 enrollees within 30 minutes of the proposed site and 11,471 enrollees within 60 minutes. In FY 2019, the existing facility served 5,424 core uniques.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three of courses of action (COAs) for the VISN 09 Western 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[35] 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).

[35] 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 Western Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H

VISN 09 Western Market	Status Quo	Modernization	VA Recommendation
Total Cost	$ 14,185,562,184	$ 14,913,554,010	$ 15,172,954,034
Capital Costs	$ 501,661,692	$ 1,229,653,518	$ 1,489,053,542
Operational Costs	$ 13,683,900,492	$ 13,683,900,492	$ 13,683,900,492
Total Benefit Score	8	11	14
CBI (normalized in $B)	**1.77**	**1.36**	**1.08**

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 11 VA points of care offering outpatient services, including the proposed new Wolfchase, Tennessee MS CBOC; Millington, Tennessee CBOC; the proposed expanded Tupelo, Mississippi MS CBOC; and Jackson, Mississippi MS CBOC, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the proposed new stand-alone CLC in Memphis, Tennessee, as well as community nursing homes.

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

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Memphis, Tennessee VAMC.

Demand

- **RRTP:** RRTP demand will be met through the Memphis, Tennessee VAMC and the other facilities within VISN 09 offering RRTP, including the Lexington-Leestown, Kentucky VAMC; Mountain Home, Tennessee VAMC; the Murfreesboro, Tennessee VAMC; and in-progress replacement Louisville, Kentucky VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Southeast Region, including the West Palm Beach, Florida VAMC (VISN 08) and the Augusta Uptown, Georgia VAMC (VISN 07).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Memphis, Tennessee 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 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 66,289 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 66,333 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 09. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Tennessee.
- **Research:** This recommendation does not impact the research mission in the market and allows the Memphis VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Memphis 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 stand-alone CLC in Memphis, Tennessee; Wolfchase, Tennessee MS CBOC; and Millington, Tennessee CBOC; as well as the modernization of the inpatient medical and surgical patient rooms and inpatient SCI/D unit at the Memphis, Tennessee 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 (1.08 for VA Recommendation versus 1.77 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 stand-alone CLC in Memphis, Tennessee; Wolfchase, Tennessee MS CBOC; and Millington, Tennessee CBOC; as well as the modernization of the inpatient medical and surgical patient rooms and inpatient SCI/D unit at the Memphis, Tennessee 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 ($15.2B for VA Recommendation versus $14.9B 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 (1.08 for VA Recommendation versus 1.36 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 09 Northern Market

The Veterans Integrated Service Network (VISN) 09 Northern Market serves Veterans in central and eastern Kentucky, and parts of southern Indiana. 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.[36]

VA's Commitment to Veterans in the Northern Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 09's Northern 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 sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Northern Market is comprised of two submarkets centered around the Louisville and Lexington metropolitan areas in Kentucky. The market's overall enrollee population is modestly growing; however, the growth is most significant in the Louisville, Kentucky, submarket while the population of the eastern counties of the Lexington, Kentucky, submarket are largely decreasing. 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 and the associated justification 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 three additional outpatient sites, including one multi-specialty community-based outpatient clinic (MS CBOC) and two community-based outpatient clinics (CBOCs), offering primary care, mental health, and low-acuity specialty services to better distribute care and decompress the existing Louisville, Kentucky, campus. It also relocates two outpatient sites, including one MS CBOC and one CBOC, more proximate to where Veterans live.

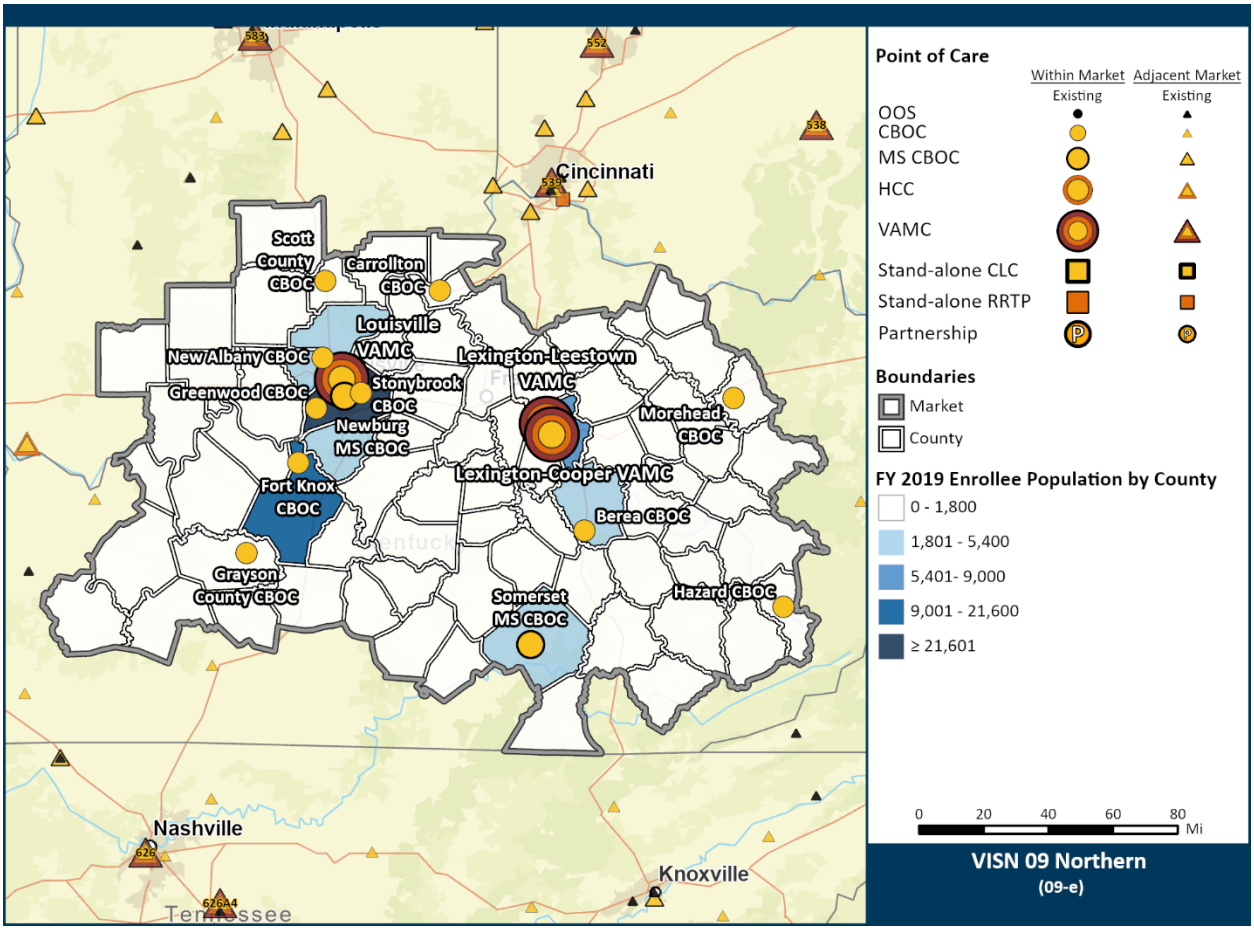
[36] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in modern community living center (CLC) facilities in Louisville, Kentucky, to maintain care for Veterans with the most complex needs. VA's recommendation also maintains inpatient mental health services at the Louisville, Kentucky, and Lexington-Cooper, Kentucky VAMCs, as well as modern, residential rehabilitation treatment program (RRTP) facilities at the Louisville, Kentucky, and Lexington-Leestown, Kentucky VAMCs to provide comprehensive care that may not be readily available in the community. VA's recommendation will modernize services for inpatient spinal cord injuries and disorders (SCI/D) at the Memphis, Tennessee VAMC in the neighboring Western Market. Demand for inpatient blind rehabilitation services will be supported by any of the regional centers in the Southeast, which includes the Augusta, Georgia VAMC (VISN 07) and the West Palm Beach, Florida VAMC (VISN 08).
- **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 medical and surgical programs at the Louisville, Kentucky VAMC, maintains inpatient medical and surgical programs at the Lexington-Cooper, Kentucky VAMC and expands utilization of community providers to provide inpatient medical and surgical care where programs would be unsustainable due to low Veteran demand.

Market Overview

The market overview includes a map of the Northern Market, key metrics for the market, ad select considerations used in forming the market recommendations.

Market Map



Facilities: The market has 3 VAMCs (Lexington-Leestown, Lexington-Cooper, and Louisville), 2 MS CBOCs, and 10 CBOCs.

Enrollees: In fiscal year (FY) 2019, the market had 100,143 enrollees and is projected to experience a 0.3% increase in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Jefferson, Hardin, and Fayette in Kentucky.

Demand: Demand[37] in the market for inpatient medical and surgical services is projected to increase by 2.5% and demand for inpatient mental health services is projected to decrease by 3.5% between FY

[37] 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).

2019 and FY 2029. Demand for long-term care[38] is projected to increase by 33.9%. Demand for all outpatient services,[39] including primary care, mental health, specialty care, dental, and rehabilitation therapies, is projected to increase.

Rurality: 55.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 73.3% of enrollees in the market live within a 30-minute drive time of VA primary care site and 76.6% of enrollees live within a 60-minute drive time of VA secondary care site.

Community Capacity: As of 2019, community providers[40] in the market within a 60-minute drive time of the VAMCs had an inpatient acute occupancy rate[41] of 64.7% (1,022 available beds)[42] and an inpatient mental health occupancy rate of 47.5% (48 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an occupancy rate of 83.2% (450 available beds). Community residential rehabilitation programs[43] 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 Kentucky and the University of Louisville. The Lexington-Leestown VAMC and the Lexington-Cooper VAMC combined education program is ranked 23 out of 154 VA training sites based on the number of trainees, and the Louisville VAMC is ranked 47 out of 154. The Lexington-Leestown VAMC, in collaboration with the Lexington-Cooper VAMC, is also ranked 59 out of 103 VAMCs with research funding, and the Louisville VAMC is ranked 78 out of 103. The Louisville VAMC is designated as a Federal Coordinating Center and the Lexington-Cooper VAMC is designated as a Primary Receiving Center. The Lexington-Leestown VAMC has no emergency designation.[44]

Facility Overviews

Lexington-Leestown VAMC: The Lexington-Leestown VAMC, located only seven miles from the Lexington-Cooper VAMC, is located in Lexington, Kentucky, and offers RRTP, CLC, and outpatient services. In FY 2019, the Lexington-Leestown VAMC had an RRTP average daily census (ADC) of 20.6 and a CLC ADC of 30.1.

The Lexington-Leestown VAMC was built in 1930 on 134.9 acres. Facility condition assessment (FCA) deficiencies are approximately $85.7M and annual operations and maintenance costs are an estimated $6.6M.

[38] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[39] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[40] Community providers include Veterans Community Care Program providers and potential VCCP providers.
[41] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of actual operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[42] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[43] Includes community residential rehabilitation programs similar to VA's RRTP, blin rehabilitation, and rehabilitative SCI/D services.
[44] 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.

Lexington-Cooper VAMC: The Lexington-Cooper VAMC, attached to the University of Kentucky and located only seven miles from the Lexington-Leestown VAMC, is located in Lexington, Kentucky, and offers inpatient medical and surgical care, inpatient mental health, and outpatient services. In FY 2019, the Lexington-Cooper VAMC had an inpatient medical and surgical ADC of 55.9 and an inpatient mental health ADC of 7.7.

The Lexington-Cooper VAMC was built in 1973 on 4.8 acres. FCA deficiencies are approximately $67.6M and annual operations and maintenance costs are an estimated $6.8M.

Louisville VAMC: The Louisville VAMC is located in Louisville, Kentucky, and offers inpatient medical and surgical care, inpatient mental health, RRTP, and outpatient services. In FY 2019, the Louisville VAMC had an inpatient medical and surgical ADC of 54.2, an inpatient mental health ADC of 11.9, and an RRTP ADC of 11.3.

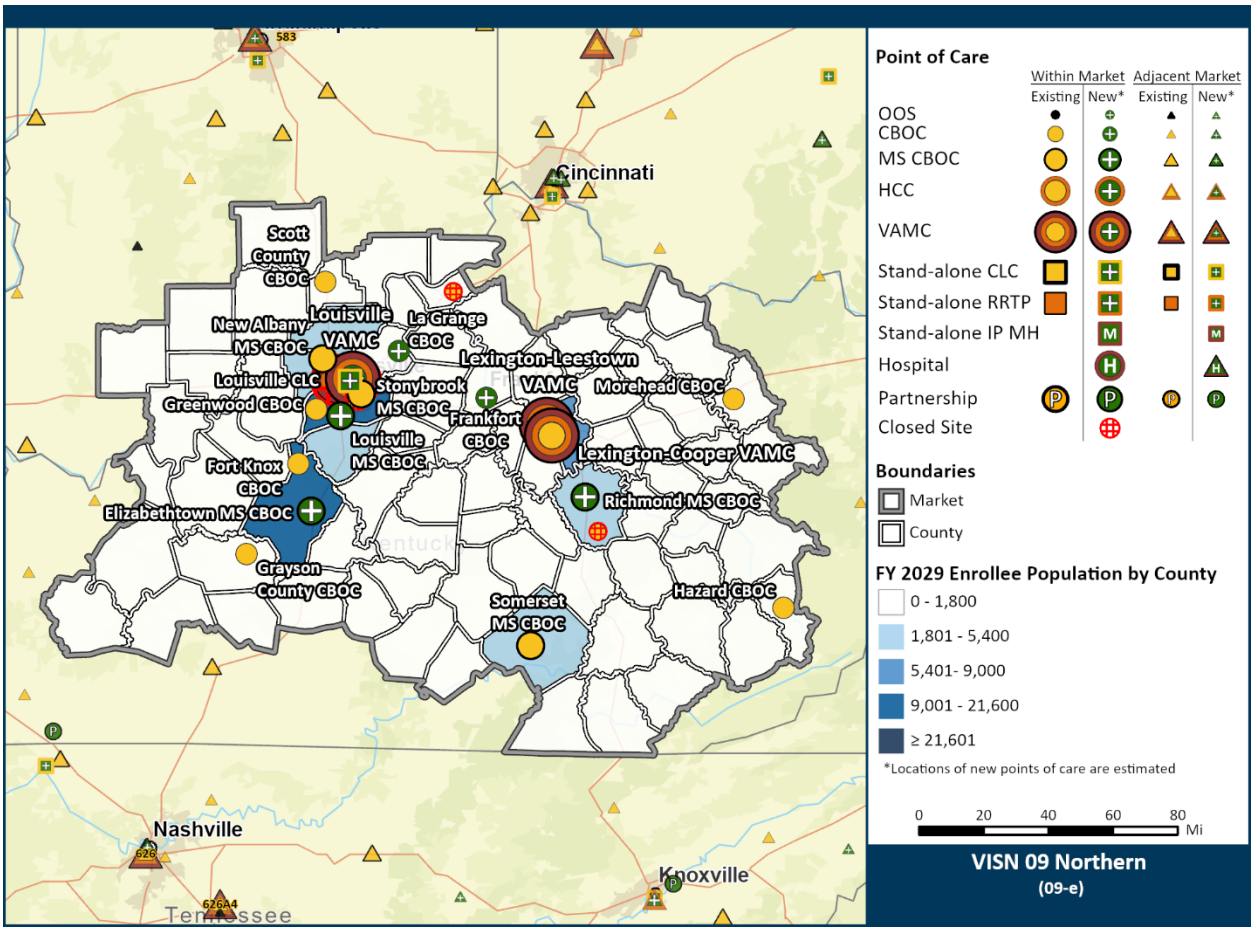
The Louisville VAMC was built in 1952 on 81.9 acres and does not meet current design standards. [45] A construction contract for a replacement hospital on a new campus was awarded in 2021. FCA deficiencies are approximately $75.1M and annual operations and maintenance costs are an estimated $9.4M.

[45] Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (for example, 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 well suited for the delivery of modern health care.

Recommendation and Justification

This section details the VISN 09 Northern Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Louisville VAMC by closing the existing Louisville VAMC upon completion of the replacement medical center VAMC:*** There is an ongoing major construction project for a replacement hospital. There are utility and architectural issues with the current main hospital building that render it unsuitable for continued clinical services. Once all the services have been relocated to the replacement medical center, the Louisville VAMC can be closed.

2. ***Modernize and realign by establishing a new stand-alone CLC in the vicinity of Louisville, Kentucky:*** Currently the Louisville VAMC has no CLC beds. Across the market, long-term care demand is projected to increase by 33.9% for an ADC of 175.9 between FY 2019 and FY 2029. In FY 2019 there were 52,202 enrollees within 60 minutes of the proposed site. The proposed 48-bed CLC in the vicinity of Louisville will provide a high quality of care by reducing difficulties currently encountered with discharges to the community and increased length of stay.

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

   3.1. Establishing a new CBOC in the vicinity of Frankfort, Kentucky: A new CBOC in Franklin County will improve access to primary care and outpatient mental health for enrollees in the area. In FY 2019 there were 5,194 enrollees within 30 minutes of the proposed site.

   3.2. Establishing a new MS CBOC in the vicinity of Elizabethtown, Kentucky: A new MS CBOC in Hardin County will improve access to primary care, outpatient mental health, and outpatient specialty care services in the second largest and most rapidly increasing county within the Northern Market. In FY 2019 there were 12,052 enrollees within 30 minutes and 47,291 enrollees within 60 minutes of the proposed site.

   3.3. Establishing a new CBOC in the vicinity of La Grange, Kentucky: A new CBOC in Oldham County will improve access to primary care and outpatient mental health for enrollees in the area. In FY 2019 there were 14,425 enrollees within 30 minutes of the proposed site.

   3.4. Relocating the Berea CBOC to a new site in the vicinity of Richmond, Kentucky, and closing the existing Berea CBOC: The existing CBOC is located 15 miles south of the larger Veteran population in Richmond. Relocating to the vicinity of Richmond places primary care, outpatient mental health, and outpatient specialty care services in a more accessible and sustainable location. Richmond is also home to Eastern Kentucky University where affiliated training programs can strengthen staff recruitment and younger Veteran outreach. In FY 2019 there were 8,231 enrollees within 30 minutes of the proposed site and 27,902 enrollees within 60 minutes, as opposed to 4,258 enrollees within 30 minutes of the current site and 27,467 enrollees within 60 minutes. With the relocation and addition of specialty care services, the Berea CBOC will be renamed and reclassified to the Richmond MS CBOC.

   3.5. Relocating the Newburg MS CBOC to a new site in the vicinity of south Louisville, Kentucky, and closing the existing Newburg MS CBOC: The existing MS CBOC is at the end of its lease and does not meet current VA design standards. The existing location has overlap with the new Greenwood CBOC and Stonybrook MS CBOC. Relocating to the vicinity of south Louisville places primary care, outpatient mental health, and outpatient specialty care services in an appropriately designed facility and will extend access to the rapidly increasing enrollee population in counties south of Louisville. In FY 2019, there were 24,110 enrollees within 30 minutes of the proposed site and 50,492 enrollees within 60 minutes.

   3.6. Relocating all services to the proposed La Grange CBOC and closing the Carrollton CBOC: The existing CBOC is not conveniently located for Veterans, or sustainable for staffing. In FY 2019, there were 3,056 core uniques[46] but only 2,375 enrollees lived within 30 minutes of the current location. Enrollees in Carroll County are projected to decrease by 0.9% from 356 to 353 between FY 2019 and FY 2029. The Carrollton CBOC is within 30 minutes of the proposed La Grange CBOC with 14,425 enrollees within 30 minutes in FY 2019. The larger La Grange health

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

care community will improve stability of staffing, and its proximity to the Louisville VAMC will improve the ability to support more services with visiting providers.

Complementary Strategy

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

Northern Market

- **Realign Whitley County, Kentucky, from the VISN 09 Eastern Market to the VISN 09 Northern Market:** VA will realign Whitley County to the Northern Market from the Eastern Market to best support the Veterans' preferred direction for referrals to the next level of health care services.

Lexington Health Care System

- **Relocating a portion of outpatient specialty care from the Lexington-Cooper VAMC to the Lexington-Leestown VAMC campus to reduce constraints on acute care and ancillary services; retain medical and surgical specialties closely connected to the inpatient medical and surgical services:** The Lexington-Cooper VAMC is space constrained, limiting the ability to renovate and modernize acute care and ancillary services. Relocating a portion of outpatient specialty services allows the facility to retain medical and surgical specialties closely connected to the inpatient medical and surgical services while renovating within the existing VAMC.
- **Establish a Virtual Living Room with a community provider in Campbellsville, Kentucky, to provide a VA Video Connect location for the surrounding rural counties with poor bandwidth:** Over 50% of the enrolled Veteran population in the market live in rural areas. Many of the rural counties suffer from poor internet access, and enrolled Veteran populations are too small to support a VA site of care. Providing a virtual option will bridge the gap of coverage for Veterans who live far from a VA site.

Louisville VAMC

- **Add physical therapy services to the New Albany CBOC, which may result in classification of the facility as an MS CBOC:** As specialty care services are projected to increase, including physical therapy capabilities at the New Albany CBOC will better support the increasing needs of Veterans in this community.
- **Support ongoing and growing research initiatives with the relocation to the new Louisville VAMC. Continue to increase the research program in strategic collaborations with academic and community providers:** Research is essential in further growth and development to best serve the enrollee population. Supporting the research initiatives will strengthen the new VAMC and introduce further collaboration opportunities.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 09 Northern 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 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 Northern Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 09 Northern Market	Status Quo	Modernization	VA Recommendation
Total Cost	$ 20,693,655,075	$ 22,417,380,514	$ 22,273,402,468
Capital Costs	$ 997,473,976	$ 2,721,199,414	$ 2,577,221,368
Operational Costs	$ 19,696,181,099	$ 19,696,181,099	$ 19,696,181,099
Total Benefit Score	8	11	13
CBI (normalized in $B)	**2.59**	**2.04**	**1.71**

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 operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

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

Demand

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

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 17 VA points of care offering outpatient services, including the proposed new Frankfort, Kentucky CBOC; La Grange, Kentucky CBOC; Elizabethtown, Kentucky MS CBOC; Louisville, Kentucky MS CBOC; and Richmond, Kentucky MS CBOC; the in-progress replacement Louisville, Kentucky VAMC; and the proposed expanded New Albany, Indiana MS CBOC and Stonybrook, Kentucky MS CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Lexington-Leestown, Kentucky VAMC and proposed new stand-alone CLC in Louisville, Kentucky, 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 St. Louis, Missouri VAMC (VISN 15).
- **RRTP:** RRTP demand will be met through the Lexington-Leestown, Kentucky VAMC; the in-progress replacement Louisville, Kentucky VAMC; and the other facilities within VISN 09 offering RRTP, including the Memphis, Tennessee VAMC; Mountain Home, Tennessee VAMC; and Murfreesboro, Tennessee VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Southeast Region, including the West Palm Beach, Florida VAMC (VISN 08) and Augusta-Uptown, Georgia VAMC (VISN 07).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Lexington-Cooper, Kentucky VAMC and the in-progress replacement Louisville, Kentucky 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 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 102,830 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 102,856 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 09. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliations with the University of Kentucky and University of Louisville.
- **Research:** This recommendation does not impact the research mission in the market and allows the Lexington-Leestown, Kentucky VAMC; Lexington-Cooper, Kentucky VAMC; and new Louisville, Kentucky VAMC to maintain the current research mission by supporting ongoing and growing research initiatives with the transition to the new Louisville, Kentucky VAMC and continuing to grow the research program in partnerships with academic and community partners.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Lexington-Leestown, Kentucky VAMC and Lexington-Cooper, Kentucky VAMC will maintain the 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 in-progress replacement Louisville, Kentucky VAMC and the proposed new stand-alone CLC in Louisville, Kentucky; Frankfort, Kentucky CBOC; Elizabethtown, Kentucky MS CBOC; Louisville, Kentucky MS CBOC; La Grange, Kentucky CBOC; and Richmond, Kentucky MS CBOC. This new infrastructure will aid in improving the patient

Quality

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 of top clinical and non-clinical talent.

Cost Effectiveness

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

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo (1.71 for VA Recommendation versus 2.59 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 replacement Louisville, Kentucky VAMC and the proposed new stand-alone CLC in Louisville, Kentucky; Frankfort, Kentucky CBOC; Elizabethtown, Kentucky MS CBOC; Louisville, Kentucky MS CBOC; La Grange, Kentucky CBOC; and Richmond, Kentucky 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:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($22.3B for the VA Recommendation versus $22.4B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.71 for VA Recommendation versus 2.04 for Modernization) reflecting effective stewardship of taxpayer dollars.