Department of Veterans Affairs

Capital Asset Realignment for Enhanced Services

VISN 1

Market Plans

Attention

The VISNs developed the initial CARES Market plans under direction from the National CARES Program Office (NCPO). After these were submitted by the VISN, they were utilized as the basis for the National CARES Plan. However, the CARES National Plan includes policy decisions and plans made at the National Level which differ from the detailed Network Market Plans. Therefore, some National policy decisions that are in the National Plan are not reflected in the Network Market Plans. These initial VISN Market Plans have detailed narratives and data at the VISN, Market and Facility level and are available on the National CARES Internet Site : <<http://www.va.gov/CARES/>>.

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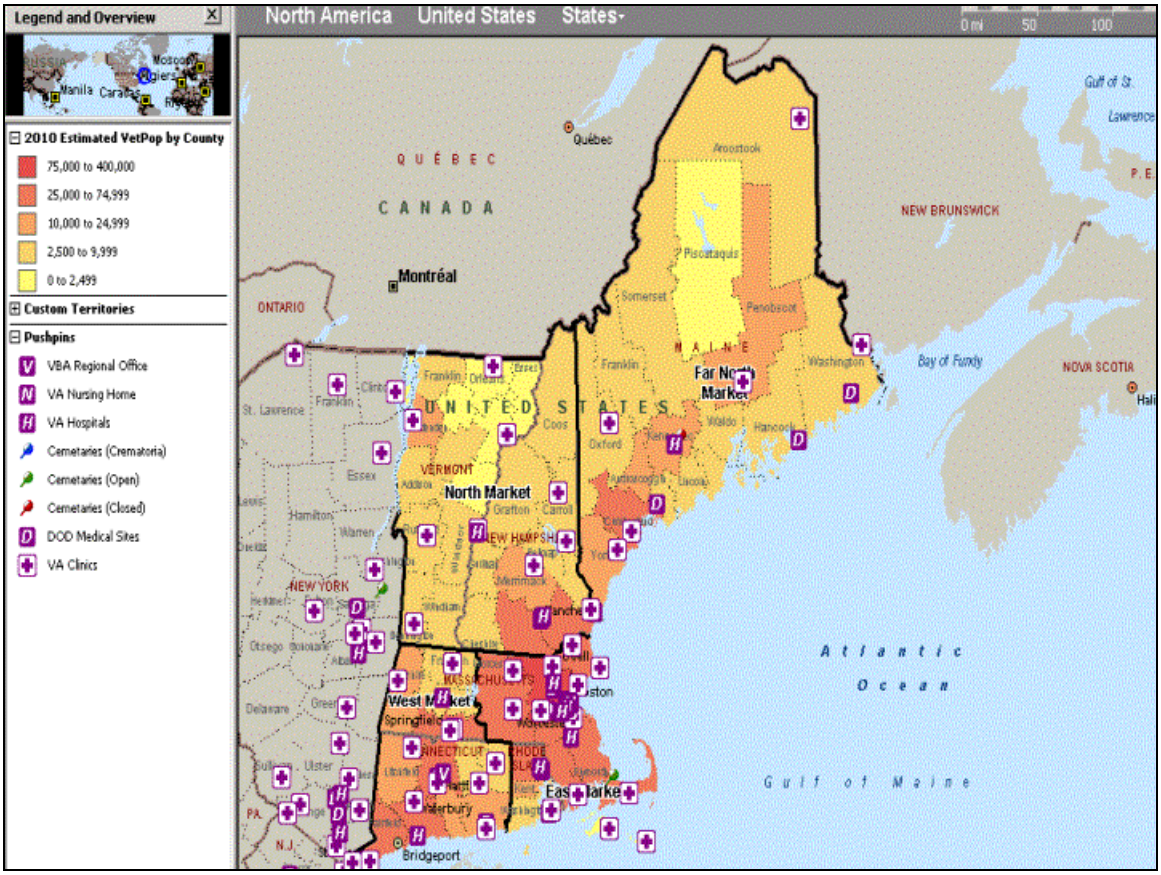
I. VISN Level Information

A. Description of the Network/Market/Facilities

1. Map of VISN Markets



2. Market Definitions

Market Designation: The VA New England Healthcare System (VISN 1) proposes four CARES markets as follows:

Market	Includes	Rationale	Shared Counties
West Market **Code: 1D**	4 counties in western Massachusetts and all 8 counties making up the state of Connecticut 12 Total Counties	Western Massachusetts and all of Connecticut fall together naturally because of the historical referral of western Massachusetts veterans for specialty care at VA Connecticut. Veterans in western Massachusetts have expressed a preference for this referral pattern partly because of convenience, their association with CBOCs near borders and the existence of north-south highway system and the sharing of a major airport (Bradley Field). **Facilities:** West Haven, CT; Northampton, MA; Newington, CT	Berkshire, MA -Many patients prefer to use Albany in VISN 2 over Northampton due to distance and travel convenience. However, this represented less than 30% of users in FY2001. It was concluded that a shared market was not necessary.
East Market Code: 1A	10 counties in eastern Massachusetts and all 5 counties making up the state of Rhode Island 15 Total Counties	(Eastern Massachusetts and Rhode Island) has not been a single planning entity historically as in the North. Rhode Island and Southeastern Massachusetts have, in recent years, pursued some joint planning activities for veteran populations in adjacent counties. There exists significant patient referrals between Rhode Island and Boston and there is already sharing of staff in at least one CBOC. There is good availability of public transportation between Rhode Island and Boston with hourly bus and hourly commuter trains contributing to the patient and provider preference for healthcare referral to Boston over Connecticut. While there was discussion of considering Rhode Island as a sub-market of the EAST, the healthcare planning for the veteran population in this small geographical area will be enhanced if Rhode Island and eastern Massachusetts are one. **Facilities:** West Roxbury, MA; Boston, MA; Brockton, MA; Bedford, MA; Providence, RI	

Market	Geographic Area	Rationale	Shared Counties
North Market **Code: 1C**	14 counties making up the state of Vermont and 10 counties making up the state of New Hampshire 24 Total Counties	(Vermont and New Hampshire) exists as a natural market because residents and veterans of the two states share many characteristics. Existing VA resources in the North have developed effective relationships resulting in many cooperative planning initiatives to address the unique needs of the area. A cluster of population in southern New Hampshire travels to Boston for business and work. However, surveys conducted by the VA in New Hampshire and Vermont have clearly identified that veterans in that area prefer their healthcare to be available locally. Facilities: White River Junction, VT; Manchester, NH	**Bennington, VT – The Bennington CBOC began as a joint CBOC with patients from both VISN 1 and VISN 2. However, VISN 1 treated over 76% of users in FY2001. It was concluded that a shared market is not necessary.** Fairfield, CT – The Danbury CBOC is across the river from Castle Point in VISN 2. VISN 1 treated over 86% of FY2001 users and it was also concluded that a shared market was not necessary.
Far North Market **Code: 1B**	16 counties making up the state of Maine 16 Total Counties *2010 projected enrollees: 57,522* vet. pop.: 132,593	(Maine) has vast land area and little concentration of population. The population is centered around the north-south I-95 Interstate in the eastern part of the state. There is a natural boundary (north-south mountain range) that prevents veterans from easy access to the west (New Hampshire facilities). Maine exists as a single market area. Facilities: Togus, ME	

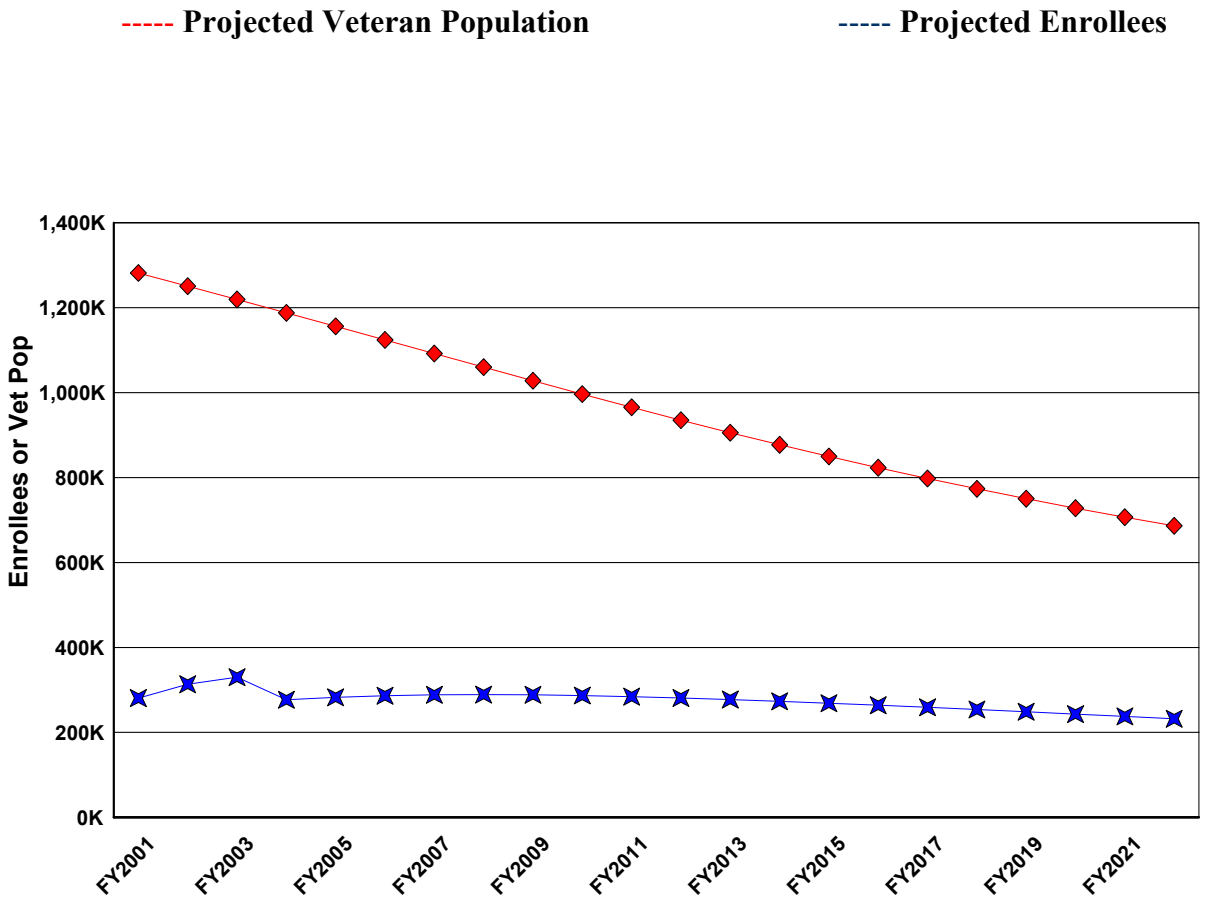
3. Facility List

VISN : 1				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Bedford				
518 Bedford	✔	-	-	-
518GA North Shore/Lynn	✔	-	-	-
518GB Haverhill	✔	-	-	-
518GD Lowell	✔	-	-	-
518GE Gloucester	✔	-	-	-
518GG Fitchburg	✔	-	-	-
Boston				
523 VA Boston HCS- Boston Div.	✔	-	-	-
523BY Lowell	✔	-	-	-
523BZ Causeway Clinic (Boston)	✔	-	-	-
523GA Framingham VA Primary Care Unit	✔	-	-	-
523GC Quincy	✔	-	-	-
523GE Dorchester	✔	-	-	-
Brockton				
523A5 Brockton VAMC	✔	✔	-	-
Manchester				
608 Manchester	✔	-	-	-
608GA Portsmouth	✔	-	-	-
608GC Wolfeboro	✔	-	-	-
608GD Conway	✔	-	-	-
608HA Tilton	✔	-	-	-
Newington				
689A4 Newington Campus	✔	-	-	-

Facility	Primary	Hospital	Tertiary	Other
Northampton				
631 Northampton	✓	-	-	-
631BY Springfield (Main St)	✓	-	-	-
631GB Springfield (State St.)	✓	-	-	-
631GC Pittsfield Veterans Community Care Center	✓	-	-	-
631GD Greenfield (Franklin County)	✓	-	-	-
Providence				
650 Providence	✓	✓	-	-
650GA New Bedford Primary Care Ctr.	✓	-	-	-
650GB Hyannis Primary Care Center	✓	-	-	-
650GC Oaks Bluffs (Martha's Vineyard)	✓	-	-	-
650GD Middletown	✓	-	-	-
650GE Nantucket	✓	-	-	-
Togus				
402 Togus	✓	✓	-	-
402GA01 Aroostook County (Caribou)	✓	-	-	-
402GA02 Fort Kent	✓	-	-	-
402GB Calais	✓	-	-	-
402GC Rumford	✓	-	-	-
402GD Saco	✓	-	-	-
402HB Bangor	✓	-	-	-
402HC CDRP Satellite South	-	-	-	✓
402HK Machias	✓	-	-	-

Facility	Primary	Hospital	Tertiary	Other
West Haven				
689 West Haven	✓	✓	✓	-
689GA Waterbury VA Primary Care Center	✓	-	-	-
689GB Stamford VA Primary Care Center	✓	-	-	-
689GC Windham VA Primary Care	✓	-	-	-
689GD Winsted VA Primary Care	✓	-	-	-
689GE Danbury VA Primary Care	✓	-	-	-
689HB Norwich Screening Clinic	-	-	-	✓
689HC New London VA Primary Care Center	✓	-	-	-
West Roxbury				
523A4 VA Boston HCS-West Roxbury Div.	✓	✓	✓	-
523GB Worcester	✓	-	-	-
White River Junction				
405 White River Jct	✓	✓	-	-
405GA Bennington	✓	-	-	-
405HA Burlington (Appletree Bay)	✓	-	-	-
405HC Littleton/St. Johnsbury CBOC	✓	-	-	-
405HD VICC - Newport	-	-	-	✓
405HF Rutland	✓	-	-	-
405HG Wilder	-	-	-	✓

4. VISN 01 Veteran Population and Enrollment Trends



5. Planning Initiatives and Collaborative Opportunities

a. Effective Use of Resources

Effective Use of Resources		
PI?	**Issue**	**Rationale/Comments Re: PI**
N	Small Facility Planning Initiative	Boston-Jamaica Plains: Acute Medicine and Surgery beds at the Boston - Jamaica Plains campus have already been consolidated into the large Boston - West Roxbury campus.
N	Small Facility Planning Initiative	Manchester, NH: Acute Medicine and Surgery beds at the Manchester, NH facility have already been closed. Manchester is currently an outpatient facility.
N	Small Facility Planning Initiative	Newington, CT: Acute Medicine and Surgery beds at the Newington, NH facility have already been closed. Newington is currently an outpatient facility.
Y	Proximity 60 Mile Acute	VISN 1 will look at mission integrations of the following three facilities that are within 60 miles of each other: Boston: West Roxbury and Boston: Brockton (20 miles) Boston: West Roxbury and Providence, RI (42 miles) Boston: Brockton and Providence, RI (34 miles) In addition, VISN 1 will look at the Bedford, MA facility (primarily psych) with the above three mission integrations.
N	Proximity 120 Mile Tertiary	West Haven, CT and Bronx, NY (VISN 3). West Haven, CT is needed to meet the workload demands and tertiary care programs for the West Market. The drive from western Massachusetts into the congestion of New York/New Jersey urban areas is prohibitive.
N	Proximity 120 Mile Tertiary	West Haven, CT and New Jersey HCS-East Orange (VISN 3). Rationale same as above.
N	Proximity 120 Mile Tertiary	West Haven, CT and New York Harbor HC-NY Division (VISN 3). Rationale same as above.
N	Proximity 120 Mile Tertiary	West Haven, CT and New York Harbor HCS-Northport, NY (VISN 3). Rationale same as above.
N	Proximity 120 Mile Tertiary	West Haven, CT and New York Harbor HCS-Brooklyn (VISN 3). Rationale same as above.
Y	Vacant Space	All VISNs will need to explore options and develop plans to reduce vacant space by 10% in 2004 and 30% by 2005.

b. Special Disabilities

Special Disability Programs		
PI?	**Other Issues**	**Rationale/Comments**
N	Blind Rehabilitation	
N	Spinal Cord Injury and Disorders	

c. Collaborative Opportunities

Collaborative Opportunities for use during development of Market Plans		
CO?	**Collaborative Opportunities**	**Rationale/Comments**
N	Enhanced Use	No sites on top national lists of High-Potential EU Lease Opportunities.
Y	VBA	VA Connecticut HCS (Newington); Providence, RI; Boston HCS
N	NCA	No sites identified.
N	DOD	No opportunities identified at this time.

d. Other Issues

Other Gaps/Issues Not Addressed By CARES Data Analysis		
PI?	**Other Issues**	**Rationale/Comments**
Y	Space/Infrastructure Condition Planning Initiative	CARES data show most clinical programs in VISN 1 being sustained or expanded. Facilities in VISN 1 have significant infrastructure needs that need addressing now. Many systems have problems which prohibit appropriate functioning with current workload demands. These infrastructure issues need to be addressed prior to consideration of program expansions indicated in the CARES Planning Initiatives.

e. Market Capacity Planning Initiatives

West Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	191,499		**77,389**	**40%**	8,873	**5%**
	Treating Facility Based **	192,397		**73,907**	**38%**	8,018	**4%**
Specialty Care	Population Based *	163,724		**136,627**	**83%**	70,004	**43%**
	Treating Facility Based **	158,384		**132,406**	**84%**	69,497	**44%**
Medicine	Population Based *	17,664		**12,075**	**68%**	3,980	**23%**
	Treating Facility Based **	17,125		**12,255**	**72%**	4,403	**26%**

North Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Specialty Care	Population Based *	96,771		**64,203**	**66%**	43,261	**45%**
	Treating Facility Based **	92,008		**72,548**	**79%**	51,326	**56%**
Mental Health	Population Based *	47,404		**23,476**	**50%**	4,696	**10%**
	Treating Facility Based **	40,332		**22,023**	**55%**	6,719	**17%**
Medicine	Population Based *	8,799		**7,726**	**88%**	4,870	**55%**
	Treating Facility Based **	7,187		**6,423**	**89%**	3,974	**55%**

East Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Mental Health	Population Based *	363,327		-	**0%**	-	**0%**
	Treating Facility Based **	379,700		4,729	**1%**	(365)	**0%**
Medicine	Population Based *	27,465		26,341	**96%**	13,355	**49%**
	Treating Facility Based **	28,474		27,352	**96%**	14,312	**50%**
Surgery	Population Based *	15,507		6,494	**42%**	866	**6%**
	Treating Facility Based **	18,892		7,740	**41%**	1,242	**7%**
Psychiatry	Population Based *	97759		-4151	**-4%**	-13516	**-14%**
	Treating Facility Based **	98796		-3774.17	**-4%**	-12522.32	**-13%**

Far North Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	90,465		66,811	**74%**	37,053	**41%**
	Treating Facility Based **	88,519		51,867	**59%**	24,559	**28%**
Specialty Care	Population Based *	68,800		98,300	**143%**	76,600	**111%**
	Treating Facility Based **	63,966		86,799	**136%**	66,430	**104%**
Mental Health	Population Based *	49,408		20,626	**42%**	2,382	**5%**
	Treating Facility Based **	47,667		18,226	**38%**	1,463	**3%**
Medicine	Population Based *	5655		10975	**194%**	7887	**139%**
	Treating Facility Based **	4601		9624	**209%**	6939	**151%**

* – Population Based: Sum of the workload demand based on where the enrollee lives. Sum of the workload projections for the enrollees living in the counties geographically located in the Market. This is not necessarily where they go for care.

** – Treating Facility Based: Sum of the workload demand based on where the enrollee goes for care. Sum of the facility data for the facilities geographically located in the Market. (Due to the traffic or ever referral patterns, the population based and treating facility projections will not match at the market level, although nationally they will be equal)

*** – Modeled data is the Consultants projection based on what the workload **would have been if adjusted for community standards**.

6. Stakeholder Information

Summary narrative on key stakeholder issues by Market, and how the comments/concerns were incorporated in the Market Plan.

Stakeholder Narrative:

Stakeholders in the VA New England Healthcare System have been kept involved and informed throughout the progression of the CARES process. The VISN held regular briefings with Network-level groups such as the Management Assistance Council, Academic Advisory Board, Labor Management Council, New England Congressional delegation and the Executive Leadership Council. Communication modes consisted of face-to-face briefings, distribution of newsletters and bulletins, e-mails, mailings (newsletters), conference calls, employee meetings and Web site postings. At the Market level, a wide variety of stakeholders have been extensively briefed, including veterans service organizations, veterans groups, medical school affiliates, staff members and volunteers, local stakeholders, and union representatives. Information has been provided to these groups through town hall meetings, employee newsletters, e-mail notices, mailings, committee and staff meetings, Dean's Committee meetings, and veteran council meetings. Comments were solicited through these forums as well as through encouragement of phone calls, letters, and the electronic CARES Comment Card on the VISN Internet and Intranet Web sites.

Overall, the process has been viewed positively from the stakeholders. Some of the more frequent comments and questions included (with Network responses in parentheses):

1. Concern about possible facility closures—(Stakeholders were reassured that the data projections generally show increases in the Northeast and do not indicate the need for facility closures at this time.)

2. Location of services--desire for access over long distances has resulted in requests for more CBOCs. (The CARES process provides data projections that help determine what health services veterans will need and where those services will be needed. For example, Planning Initiatives in the Far North Market identified perhaps one CBOC location and a presence in several areas that may utilize the Maine telemedicine capability or a part-time contract site. The implementation plans will be more specific about actual location of CBOCs.)

3. Contracting versus use of VA staff to provide services—some veterans see contracting as a step toward privatization. (Stakeholders were reassured that contracting with local providers is an important option in areas where VA services are not available and/or where shortage of certain specialty providers exists.)

4. Concern that the needs of specific populations such as geriatric and extended care patients and the mentally ill are addressed. (Planning for health care for veterans with serious mental illness was based on specific models developed in consultation with specialty clinicians and veterans' advocates. A detailed analysis of the projected demand and capacity involving VA's long-term care program is being undertaken.)

5. Whether sufficient funding would be allocated for CARES (Indicated that once the Secretary makes his decision about the national CARES Plan in October 2003, funding needs will be determined and funding requests submitted to Congress.)

6. Potential impact of war on data projections. (Present data projections do not include potential war impact, however, data will be re-run on an annual basis and adjustments made as needed. This is a long-term strategic planning process.)

Input provided by our stakeholders was considered throughout the CARES planning process by the Market teams.

7. Collaboration with Other VISNs

Summary narrative of collaborations with neighboring VISNs, and result of collaborations. Include overview of Proximity issues across VISNs.

Collaboration with Other VISNs Narrative:

VISN 1 collaborated closely with the two VISN that are next to the New England Healthcare Network (VISN 1). Proximity issues were carefully scrutinized to ensure that all facilities and CBOC's met the requirement for separation. Extensive collaboration centered on the New York area in VISN 3 and Albany area in VISN 2. The net result were present location choices are appropriate for primary care access for veterans in the entire region. There were also a number of discussions with regard to the types of services that would be offered at the various CBOC's and any inter-Market impact that could possibly arise from those decisions.

Clearly, the need and coordination of special populations' services was closely reviewed and analyzed. No significant changes are recommended in the CARES Market Plans. All VISNs agreed to work closely together in the CARES process.

B. Resolution of VISN Level Planning Initiatives

1. Proximity Planning Initiatives (if appropriate)

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

Proximity Narrative:

Market Planning Team was appointed consisting of representatives from each VISN Service Line and each facility within the Market and through a series of brainstorming and prioritization sessions developed alternatives for this PI. The VISN CARES Steering Committee as well as the VISN Executive Leadership Council (ELC) reviewed progress and proposed alternatives. Throughout the process meetings were held with all Stakeholder groups to inform them of the status and proposals as well as to obtain their input.

As the Market Team proceeded it was determined that in consideration of the substantial projected increases, provision of Outpatient Specialty and Primary Care services would be required to be continued at all existing Parent Facilities and CBOCs. It was further determined that the VISN's prior decisions to consolidate Inpatient Medicine and Surgery at the Providence and West Roxbury facilities and Inpatient Acute Spinal Cord Injury at the West Roxbury facility was not duplicative and was necessary to meet the projected workload for these areas.

Alternatives were then considered to consolidate Long Term Care (including the Alzheimer's and SCI Units) and Psychiatry inpatient beds from the Bedford to Brockton facilities, LTC and Psychiatry inpatient beds from the Brockton to Bedford facilities, Long Term Care inpatient beds from the Bedford to Brockton facilities, LTC inpatient beds from the Brockton to Bedford facilities, Psychiatry inpatient beds from the Bedford to Brockton facilities and Psychiatry inpatient beds from the Brockton to Bedford facilities.

As final projections are not available for LTC inpatient beds and earlier projections indicated a substantial increase in LTC beds it was determined to utilize current capacities, while CARES projections for Psychiatry acute and SCI long-term care beds would be utilized in these categories. Vacant space at the Bedford and Brockton facilities was reviewed and allocated to meet the needs of the remaining CARES planning categories and remaining, if any, vacant space was considered for these alternatives and renovation and/or new construction costs were developed for each alternative.

After considering construction costs, programmatic improvements, programmatic detriments and Stakeholder reactions to these alternatives it was determined that maintaining the current missions and bed allocations was the proper approach towards achieving the overall goal of CARES.

The principle reasons for this decision are a) pre-CARES VISN initiated actions to adjust the missions of these facilities have already resulted in reduction of all duplication in Inpatient Medicine, Surgery and Acute SCI, b) in the absence of the final projections for LTC beds, it is impossible to determine if any duplication in this category actually exists, c) workload projections for Acute Psychiatry will not result in the elimination of the need for services at any facility, d) substantial increases in projected workload for the remaining CARES categories mandates the continuation and expansion of these services at all four facilities which will utilize all current vacant space, e) projections consistently demonstrate increases in workloads that are evenly distributed throughout the Market and f) the amount of space at any facility vacated by the alternatives would be insufficient to close that facility or be sufficient to generate sufficient income to offset the costs of the alternative.

2. Special Disability Planning Initiative (if appropriate)

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

Your analysis should include the following:

1. Describe the impact that the planning initiative will have on the mandated funding levels for special disability programs:

   - SCI
   - Blind Rehab
   - SMI
   - TBI
   - Substance Abuse
   - Homeless
   - PTSD

2. Discuss how the planning initiative may affect, complement or enhance special disability services.

3. Describe any potential stakeholder issues revolving around special disabilities related to the planning initiative.

Special Disability Narrative:

Blind Rehabilitation:

The Eastern Blind Rehabilitation Center (EBRC) is located at the West Haven facility of the West Market. This intensive inpatient unit provides rehabilitative services to blinded veterans across markets within VISN 1, as well as serves as a referral site for VISN 2-5 and parts of 6. The EBRC serves this special population with 34 beds and an extensive network of VIST programs for support in the veterans' community. With the projected increases for this special population, it is anticipated that the 34 beds will be fully utilized throughout the 20 year planning cycle. As demand is extremely high in some years, additional bed space may be required at EBRC, but there is no PI in place for this currently.

Spinal Cord Injury:

Inpatient Spinal Cord Injury (SCI) care for the VA New England Healthcare System is provided at the West Roxbury Campus (acute SCI) and the Brockton Campus (chronic SCI) of the VA Boston Healthcare System. Workload in the IBM model database reflects FY01 actual workload through FY22. Demand projections developed by VHA (offline) reflect the following:

West Roxbury: Inpatient acute SCI demand is expected to increase by 3,957 BDOC (+84%) from FY01 to FY12 and increase by 4,267 BDOC (+90%) in FY22. This translates to an increase of 13 beds (in-house) above the FY01 baseline for FY12 and an increase of 14 beds (in-house) for FY22. Revised SCI demand projections as of 2/14/03 reflect a need for 28 acute SCI beds for FY12 (8687 BDOC) and 29 acute SCI beds in FY 22 (8997 BDOC). The current SCI ward at West Roxbury (B2, A2) has the capacity for 36 beds which is sufficient to meet the projected demand for both FY12 and FY22. An additional 1,500 GSF of new space (undeveloped) was added to SCI in FY03 (B1, 2nd fl) vice Minor Project 525-403 "MRI" which was activated in FY03. The projected demand for acute SCI care supports the continued viability of the inpatient program at West Roxbury.

Brockton: Inpatient chronic SCI demand is expected to increase by 12,987 BDOC (+147%) from FY01 to FY12 and increase by 13,680 BDOC (+154%) in FY22. This translates to an increase of 37 beds (in-house) above the FY01 baseline for FY12 and an increase of 39 beds (in-house) for FY22. FY01 workload reflects 8,858 BDOC which equates to 25.5 beds at 95% occupancy. Current capacity is 30 beds (10,402 BDOC/yr). Revised SCI demand projections as of 2/14/03 reflect a need for 63 chronic SCI beds for FY12 (21,845 BDOC) and 65 chronic SCI beds in FY 22 (22,538 BDOC). The projected workload and space gap (54,000 SF) to be addressed via a Major Construction Project with FY06 Design/Construction and FY09 Activation (previously planned Major Project #525-119 Renovate/Expand SCI Bldg 8). A total of 103,464 SF of space is needed to accommodate the 65 chronic SCI beds projected for FY22. The scope of services provided in the East Market includes acute medical/neurosurgical management, acute rehabilitation, sustaining care for medical complications, preventive health care with annual evaluations, and long-term care.

3. VISN Identified Planning Initiatives

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria. (See Chapter 5 Attachment 3 guidebook and Market Plan handbook.)

Your analysis should include the following:

1. List all of the VISN PIs and provide a short summary. Post the entire summary documentation on the portal.

VISN Planning Initiatives Narrative:

Space/Infrastructure Condition Planning Initiative - VISN 1

The integrity of the infrastructure systems for the VA New England Healthcare System (VANEHS) was studied by the VA Office of Facility Management (OFM) in 2001. As expected the systems for the over 8,000,000 square feet of building space ranged from poor to good condition. However there were a significant number of the systems that were below par. The number of current systems deteriorating below par will increase if not accelerate as we continue to use the buildings at the growing activity level. The funds we receive to repair these systems is insufficient to stem the tide of deterioration. We must receive an influx of significant funds to bring these systems up to par and local community standards.

Of the 6747 systems studied 2207 were rated below par. The systems include but were not limited to site, architectural, HVAC, electrical, plumbing, structural, elevators, etc. It was a comprehensive look at the state of VISN 1's infrastructure systems.

This Planning Initiative has the following impact on the CARES Criteria:

1. Healthcare Quality and Need- Positive impact on the quality of the services that we will be able to provide. It will also help meet the "need" since there will be less building and system downtime.

2. Safety and Environment- We must develop this influx of infrastructure funds to improve the Safety and Environment of our facilities. Without the funds only emergencies will be accommodated thus increasing our exposure risk.

3. Research and Affiliations- Properly maintained buildings can provide additional opportunities to house Research and Affiliations due to efficiency and desirability of space.

4. Staffing and Community- Proper environment and facility condition increases employee satisfaction. This eliminates one layer of frustration for our workforce.

5. Optimizing Use of Resources- Without the influx of these funds we will not be able to utilize our resources effectively. Poorly maintained infrastructure leads to space closure and other downtime.

6. Support of all other VA Missions- A properly maintained infrastructure supports all the VA missions. Poorly maintained facilities detracts form all the missions.

At the completion of the survey cost estimates were developed to determine the overall expenditure required to bring the systems to a par condition.

VISN 1 Total Cost (8/2001):	$529,000,000
VISN 1 Total Inflated to FY 2005:	$578,000,000
VISN 1 Total Inflated to FY 2012:	$725,000,000

Below is a table showing the per Facility Totals for the necessary work.

402	Inflated to FY 2005 (6.12%)	$41,647,540
405	Inflated to FY 2005 (6.12%)	$35,903,094
518	Inflated to FY 2005 (6.12%)	$102,816,424
523	Inflated to FY 2005 (6.12%)	$74,906,294
523A4	Inflated to FY 2005 (6.12%)	$51,948,028
523A5	Inflated to FY 2005 (6.12%)	$96,428,128
608	Inflated to FY 2005 (6.12%)	$18,264,506
631	Inflated to FY 2005 (6.12%)	$36,571,379
650	Inflated to FY 2005 (6.12%)	$39,786,794
689	Inflated to FY 2005 (6.12%)	$57,489,109
689A4	Inflated to FY 2005 (6.12%)	$22,245,163

This CARES planning cycle is indicating a need for increased space to support our current and projected workload. We will not have the luxury of moving activities to vacant or underutilized space that is well maintained and suites the purpose. As indicated in several of our planning initiatives we will be adding additional space to support some of our future needs. If we do not receive a significant influx of infrastructure correction funds to improve the existing facilities in this VISN continued infrastructure deterioration will lead to the inability to support the projected workload. Eventually significant amounts of new construction will be required to replace the infrastructure that is beyond repair. The changes that will be made effect all facilities across the VISN.

C. VISN Level Data Summary of Post Market Plan (Workload, Space, & Costs)

1. Inpatient Summary

a. Workload

	BDOC Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
INPATIENT CARE	Baseline FY 2001 BDOC	FY 2012 BDOC	FY 2022 BDOC	In House BDOC	Other BDOC	In House BDOC	Other BDOC	Net Present Value
Medicine	57,387	113,040	87,014	87,735	25,309	73,202	13,817	$ 97,616,556
Surgery	34,600	47,355	35,629	36,975	10,384	31,793	3,841	$ (88,097,233)
Psychiatry	160,457	167,467	147,132	156,226	11,245	140,660	6,475	$ 94,937,797
PRRTP	4,125	4,125	4,125	4,125	-	4,125	-	$ (794,098)
NHCU/Intermediate	729,026	729,026	729,026	290,741	438,285	290,741	438,285	$ (10,880,154)
Domiciliary	39,932	39,932	39,932	39,932	-	39,932	-	$ (491,399)
Spinal Cord Injury	13,588	13,588	13,588	13,588	-	13,588	-	$ (3,803,901)
Blind Rehab	9,785	9,785	9,785	9,785	-	9,785	-	$ (3,948,259)
Total	**1,048,900**	**1,124,318**	**1,066,231**	**639,107**	**485,223**	**603,826**	**462,418**	**$ 84,539,309**

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
INPATIENT CARE	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Medicine	118,366	283,518	217,800	247,417	204,472	$ 97,616,556
Surgery	49,560	92,845	69,427	77,247	67,200	$ (88,097,233)
Psychiatry	145,213	278,214	242,874	258,958	231,913	$ 94,937,797
PRRTP	94,036	26,653	26,653	32,653	32,653	$ (794,098)
NHCU/Intermediate	344,809	347,975	347,975	347,970	347,970	$ (10,880,154)
Domiciliary	43,242	36,222	36,222	39,222	39,222	$ (491,399)
Spinal Cord Injury	45,371	45,380	45,380	45,380	45,380	$ (3,803,901)
Blind Rehab	31,106	31,106	31,106	31,106	31,106	$ (3,948,259)
Total	**871,703**	**1,141,913**	**1,017,437**	**1,079,953**	**999,916**	**$ 84,539,309**

2. Outpatient Summary

a. Workload

	Clinic Stop Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
Outpatient CARE	Baseline FY 2001 Stops	FY 2012 Stops	FY 2022 Stops	In House Stops	Other Stops	In House Stops	Other Stops	Net Present Value
Primary Care	701,090	1,011,403	786,452	969,835	41,573	762,001	24,456	$ (20,840,839)
Specialty Care	599,625	1,105,447	905,247	934,869	170,582	801,491	103,760	$ (33,945,438)
Mental Health	651,712	697,970	659,571	660,718	37,259	636,104	23,471	$ (10,575,856)
Ancillary& Diagnostic	769,387	1,154,882	991,317	896,222	258,667	809,342	181,981	$ (87,102,485)
Total	**2,721,813**	**3,969,702**	**3,342,587**	**3,461,644**	**508,081**	**3,008,938**	**333,668**	**$ (152,464,618)**

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
Outpatient CARE	**Baseline FY 2001 DGSF**	**FY 2012 DGSF**	**FY 2022 DGSF**	**FY 2012 Projection**	**FY 2022 Projection**	**Net Present Value**
Primary Care	348,823	557,389	432,715	552,592	436,229	$ (20,840,839)
Specialty Care	566,992	1,351,437	1,107,621	1,196,517	1,029,259	$ (33,945,438)
Mental Health	295,784	404,343	382,213	391,540	376,941	$ (10,575,856)
Ancillary& Diagnostic	508,405	825,496	708,649	669,215	602,589	$ (87,102,485)
Total	**1,720,004**	**3,138,664**	**2,631,199**	**2,809,864**	**2,445,018**	**$ (152,464,618)**

3. Non-Clinical Summary

	Space Projections (from demand)			Post CARES (from solution)		
NON-CLINICAL	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Research	402,414	402,414	402,414	504,204	504,204	$ (39,617,996)
Admin	1,831,553	3,007,674	2,594,663	2,595,878	2,374,014	$ (33,256,832)
Outleased	314,917	314,917	314,917	400,874	400,874	N/A
Other	421,400	421,400	421,400	358,028	358,028	$ (8,572,717)
Vacant Space	526,674	-	-	91,657	207,558	$ 194,993,498
Total	**3,496,958**	**4,146,405**	**3,733,394**	**3,950,641**	**3,844,678**	**$ 113,545,953**

II. Market Level Information

A. East Market

1. Description of Market

a. Market Definition

Market	Includes	Rationale	Shared Counties
East Market Code: 1A	10 counties in eastern Massachusetts and all 5 counties making up the state of Rhode Island 15 Total Counties	(Eastern Massachusetts and Rhode Island) has not been a single planning entity historically as in the North. Rhode Island and Southeastern Massachusetts have, in recent years, pursued some joint planning activities for veteran populations in adjacent counties. There exists significant patient referrals between Rhode Island and Boston and there is already sharing of staff in at least one CBOC. There is good availability of public transportation between Rhode Island and Boston with hourly bus and hourly commuter trains contributing to the patient and provider preference for healthcare referral to Boston over Connecticut. While there was discussion of considering Rhode Island as a sub-market of the EAST, the healthcare planning for the veteran population in this small geographical area will be enhanced if Rhode Island and eastern Massachusetts are one. **Facilities:** West Roxbury, MA; Boston, MA; Brockton, MA; Bedford, MA; Providence, RI	

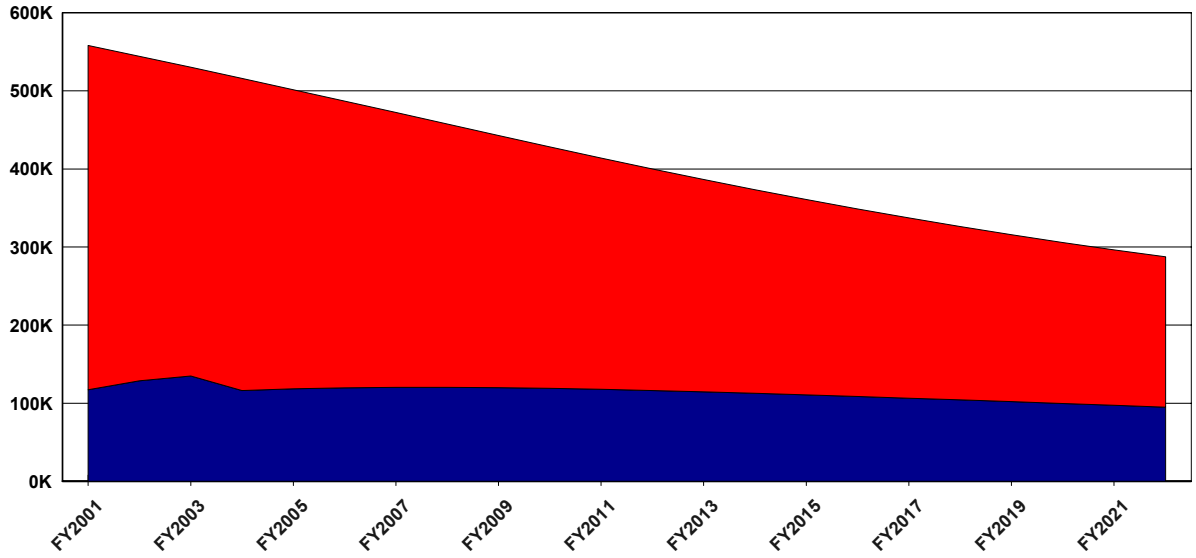
b. Facility List

VISN : 1				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Bedford				
518 Bedford	✔	-	-	-
518GA North Shore/Lynn	✔	-	-	-
518GB Haverhill	✔	-	-	-
518GD Lowell	✔	-	-	-
518GE Gloucester	✔	-	-	-
518GG Fitchburg	✔	-	-	-
Boston				
523 VA Boston HCS- Boston Div.	✔	-	-	-
523BY Lowell	✔	-	-	-
523BZ Causeway Clinic (Boston)	✔	-	-	-
523GA Framingham VA Primary Care Unit	✔	-	-	-
523GC Quincy	✔	-	-	-
523GE Dorchester	✔	-	-	-
Brockton				
523A5 Brockton VAMC	✔	✔	-	-
Providence				
650 Providence	✔	✔	-	-
650GA New Bedford Primary Care Ctr.	✔	-	-	-
650GB Hyannis Primary Care Center	✔	-	-	-
650GC Oaks Bluffs (Martha's Vineyard)	✔	-	-	-
650GD Middletown	✔	-	-	-
650GE Nantucket	✔	-	-	-

Facility	Primary	Hospital	Tertiary	Other
West Roxbury				
523A4 VA Boston HCS-West Roxbury Div.	✔	✔	✔	-
523GB Worcester	✔	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
East Market			Februrary 2003 (New)			
Market PI	Category	CARES Workload Category	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care (129,148)					
	Access to Hospital Care (129,148)					
	Access to Tertiary Care (129,148)					
PI	Medicine Inpatient Beds	Population Based	85	96%	43	49%
		Treating Facility Based	88	96%	46	50%
PI	Specialty Care Outpatient Stops	Population Based	216,112	81%	119,694	45%
		Treating Facility Based	214,075	75%	118,375	41%
PI	Psychiatry Inpatient Beds	Population Based	-13	-4%	-44	-14%
		Treating Facility Based	-12	-4%	-40	-13%
PI	Primary Care Outpatient Stops	Population Based	156,310	55%	51,406	18%
		Treating Facility Based	157,200	54%	53,162	18%
	Surgery Inpatient Beds	Population Based	21	42%	3	6%
		Treating Facility Based	25	41%	4	7%
	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	4,731	1%	-362	0%

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

Numerous meetings were held with stakeholders of the VA Boston Healthcare System, Bedford and Providence VA Medical Centers. The various stakeholders include employees, volunteers, VSO leadership, Veteran Service Officers, State Commanders, congressional aides and veterans.

Information regarding the CARES process was distributed to the different groups via briefings, forums, and informational mailings. Congressional aides were briefed on CARES during the regularly scheduled quarterly briefings. Their concerns focused on hospital closures and if this was the intended result for the CARES process. Employees were briefed on the CARES process during employee forums, which are conducted on a regular basis; through newsletter articles; via electronic messages and updates; and through the distribution of CARES Bulletins.

a. Employees were concerned about the potential integration of the Brockton Campus and the Bedford VAMC. Employees were concerned how this would impact their jobs, and the services/programs currently offered to the veterans that utilize the Brockton Campus. Their concerns were centered on mental health programs moving to a location 40 miles away.

b. Employees expressed concern regarding the future of the Jamaica Plain Campus and its viability under the CARES process. Concern was also expressed by local MA Congressional staff with regard to the relocation of outpatient programs from the Causeway Street Clinic located in downtown Boston to the Jamaica Plain Campus when the current lease expires (Clinic) in March 2005.

c. Consideration of contracting versus use of VA staff to provide services—some veterans see contracting as a step toward privatization.

d. Concern that the needs of specific populations such as geriatric and extended care patients were not addressed. It was explained that a detailed analysis of the projected demand and capacity involving VA's long-term care program is being undertaken.

e. Concern as to whether sufficient funding would be allocated for CARES (Indicated that once the Secretary makes his decision about the national CARES Plan in October 2003, funding needs will be determined and funding requests submitted to Congress.)

Additional comments received from various service organizations, including members of the Sub-Central Mini-MAC and the town Veteran Service Officers included concerns dealing with access to healthcare, VERA reimbursement, and concerns with the way the process would deal with "gaps". CARES information has been supplied to the Sub-Central Mini-MAC on an ongoing basis as this group meets monthly. Town Hall meetings were held for the veterans at VA BHS, Bedford and Providence. In addition, a briefing was held for State Commander and Town Veteran Service Officers of MA. Issues of accessibility, continuation of services and closure of facilities were brought forward. Issues rose at this meeting included concerns regarding driving distance between facilities, closure of facilities, and cuts in programs.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

Inpatient SCI care for the VA New England Healthcare System is provided at the West Roxbury Campus (acute SCI) and the Brockton Campus (chronic SCI) of the VA Boston Healthcare System. The SCI program is a referral center for the treatment of patients with spinal cord injury/dysfunction for veterans throughout New England and surrounding VISNs. Referral patterns are expected to remain the same.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

The East Market has high densities in both general and veteran populations with ample availability of public transportation and major North-South and East-West highways. Facilities include the VA Boston Healthcare System (West Roxbury, Brockton, and Jamaica Plain), Bedford, and Providence. Access is excellent (Primary Care: 96%; Hospital Care: 90%; and Tertiary Care 100%). Four PIs were identified: Specialty Care, Primary Care, Medicine and Psychiatry. A summary of demand follows:

Specialty Care demand to increase by 75%) from FY01 to FY12 and by 41% in FY22. The most significant increases in specialty care workload are in cardiology and GI/endoscopy;

Primary Care is expected to increase by 54% from FY01 to FY12 and by 18% in FY22 (there are 5 parent facilities and 15 CBOCs that provide primary care: Bedford (Lynn, Haverhill, Gloucester, and Fitchburg), Jamaica Plain (Lowell, Causeway Street, Framingham, Quincy & Dorchester), West Roxbury (Worcester), Brockton and Providence (New Bedford, Hyannis, Oak Bluffs, Middletown, and Nantucket). Additional CBOCs are not planned.

Inpatient Medicine is expected to increase by 93% from FY01 to FY12 and by 48% in FY22. This translates to an increase of 85 beds (contract and in-house) above the FY01 baseline for FY12 and an increase of 44 beds (contract and in-house) for FY22. Acute inpatient Medicine capacity is available at West Roxbury (a tertiary referral center) and Providence.

Inpatient Psychiatry demand is expected to decrease by 4% from FY01 to FY12 and decrease by 13% in FY22. This translates to a decrease of 12 beds (contract and in-house) below the FY01 baseline for FY12 and a decrease of 40 beds (contract and in-house) for FY22. Acute inpatient Psychiatry capacity is available at Bedford, Brockton and Providence. Projected demand for Jamaica Plain was allocated to Brockton where inpatient psychiatry was consolidated in JUL 2002. Workload for Residential Care (13,831 BDOC) is included in the total BDOC for Psychiatry at Bedford.

Inpatient Surgery demand is expected to increase by 41% from FY01 to FY12 and increase by 7% in FY22. This translates to an increase of 25 beds (contract and in-house) above the FY01 baseline for FY12 and an increase of 4 beds (contract and in-house) for FY22. Acute inpatient Surgery capacity is available at West Roxbury and Providence.

Domiciliary care provided at Bedford and Brockton is flat-lined at the FY01 level of 39,932 BDOC through FY12 and FY22 (current capacity is 110 beds).

Intermediate Med/NHCU demand has been flat-lined at the FY01 level of 348,605 BDOCs/1,005 beds at 95% occupancy (contract and in-house) for FY12 and FY22. Intermediate Medicine/NHCU capacity is available at Bedford, West Roxbury, Brockton, &Providence.

Ancillary/Diagnostic demand is expected to increase by 55% from FY01 to FY12 and by 32% in FY22.

Inpatient SCI care for the VISN is provided at the West Roxbury Campus (acute SCI) and the Brockton Campus (chronic SCI) of the VA Boston Healthcare System. Revised SCI demand projections as of 2/14/03 reflect a need at West Roxbury for 28 acute beds for FY12 and 29 beds in FY 22 . Revised SCI demand projections for Brockton reflect a need for 63 chronic SCI beds for FY12 and 65 chronic SCI beds in FY 22.

Residential Care is provided at Bedford, Jamaica Plain and Brockton. A total of 115 Residential Care beds are located in the East Market (52 @ Bedford, 48 @ Jamaica Plain, and 15 @ Brockton). Although space is assigned to these programs in the space and functional database, workload data for residential care is not reflected for any of the facilities in the East Market.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**96%**	5,184	**93%**	8,144	**92%**	7,608
Hospital Care	**90%**	12,960	**92%**	9,307	**92%**	7,608
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information - Bedford

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity PI Narrative:

Market Planning Team was appointed consisting of representatives from each VISN Service Line and each facility within the Market and through a series of brainstorming and prioritization sessions developed alternatives for this PI. The VISN CARES Steering Committee as well as the VISN Executive Leadership Council (ELC) reviewed progress and proposed alternatives. Throughout the process meetings were held with all Stakeholder groups to inform them of the status and proposals as well as to obtain their input.

As the Market Team proceeded it was determined that in consideration of the substantial projected increases, provision of Outpatient Specialty and Primary Care services would be required to be continued at all existing Parent Facilities and CBOCs.

Alternatives were then considered to consolidate Long Term Care (including the Alzheimer's and SCI Units) and Psychiatry inpatient beds from the Bedford to Brockton facilities, LTC and Psychiatry inpatient beds from the Brockton to Bedford facilities, Long Term Care inpatient beds from the Bedford to Brockton facilities, LTC inpatient beds from the Brockton to Bedford facilities, Psychiatry inpatient beds from the Bedford to Brockton facilities and Psychiatry inpatient beds from the Brockton to Bedford facilities.

As final projections are not available for LTC inpatient beds and earlier projections indicated a substantial increase in LTC beds it was determined to utilize current capacities, while CARES projections for Psychiatry acute and SCI long-term care beds would be utilized in these categories. Vacant space at the Bedford and Brockton facilities was reviewed and allocated to meet the needs of the remaining CARES planning categories and remaining, if any, vacant space was considered for these alternatives and renovation and/or new construction costs were developed for each alternative.

After considering construction costs, programmatic improvements, programmatic detriments and Stakeholder reactions to these alternatives it was determined that maintaining the current missions and bed allocations was the proper approach towards achieving the overall goal of CARES.

The principle reasons for this decision are a) pre-CARES VISN initiated actions to adjust the missions of these facilities have already resulted in reduction of all duplication in Inpatient Medicine, Surgery and Acute SCI, b) in the absence of the final projections for LTC beds, it is impossible to determine if any duplication in this category actually exists, c) workload projections for Acute Psychiatry will not result in the elimination of the need for services at any facility, d) substantial increases in projected workload for the remaining CARES categories mandates the continuation and expansion of these services at all four facilities which will utilize all current vacant space, e) projections consistently demonstrate increases in workloads that are evenly distributed throughout the Market and f) the amount of space at any facility vacated by the alternatives would be insufficient to close that facility or be sufficient to generate sufficient income to offset the costs of the alternative.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

No Impact.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

DoD: There were no collaborative opportunities identified. Only a few small DoD facilities remain in Massachusetts. None of these facilities have excess capacity or plans for expansion of existing services that will allow for their incorporation into our market strategy.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

VBA: The relocation of the Regional VBA office currently located in downtown Boston to the Jamaica Plain Campus was not considered viable due to functional space and parking requirements that could not be accommodated at the Jamaica Plain Campus.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

The integrity of the infrastructure systems for the VA New England Healthcare System (VANEHS) was studied by the VA Office of Facility Management (OFM) in 2001. As expected the systems ranged from poor to good condition. However there were a significant number of the systems that were below par. The number of current systems deteriorating below par will increase if not accelerate as we continue to use the buildings at the growing activity level. The funds we receive to repair these systems is insufficient to stem the tide of deterioration. We must receive an influx of significant funds to bring these systems up to par and local community standards. The systems include but were not limited to site, architectural, HVAC, electrical, plumbing, structural, elevators, etc. It was a comprehensive look at the state of VISN 1's infrastructure systems. The preferred alternative is to develop a significant influx of funds to accomplish necessary capital maintenance, repair, and improvementThis Planning Initiative has the following impact on the CARES Criteria:

§ Healthcare Quality and Need- Positive impact on the quality of the services that we will be able to provide. It will also help meet the "need" since there will be less building and system downtime

§ Safety and Environment- We must develop this influx of infrastructure funds to improve the Safety and Environment of our facilities. Without the funds only emergencies will be accommodated thus increasing our exposure risk.

§ Research and Affiliations- Properly maintained buildings can provide additional opportunities to house Research and Affiliations due to efficiency and desirability of space.

§ Staffing and Community- Proper environment and facility condition increases employee satisfaction. This eliminates one layer of frustration for our workforce.

§ Optimizing Use of Resources- Without the influx of these funds we will not be able to utilize our resources effectively. Poorly maintained infrastructure leads to space closure and other downtime.

§ Support of all other VA Missions- A properly maintained infrastructure supports all the VA missions. Poorly maintained facilities detracts form all the missions.

Below is a table showing totals for the necessary work.

Station Number	Data Total	
518	Correction Total FY 2001	$94,884,510
	Inflated to FY 2005 (6.12%)	$102,816,424
	Inflated to FY 2012 (33.26)	$129,111,540
	Inflated to FY 2005 (6.12%)	$39,786,794
	Inflated to FY 2012 (33.26)	$49,962,195

This CARES planning cycle is indicating a need for increased space to support our current and projected workload. We will not have the luxury of moving activities to vacant or under utilized space that is well maintained and suites the purpose. As indicated in several of our planning initiatives we will be adding additional space to support some of our future needs. If we do not receive a significant influx of infrastructure correction funds to improve the existing facilities in this VISN continued infrastructure deterioration will lead to the inability to support the projected workload. Eventually significant amounts of new construction will be required to replace the infrastructure that is beyond repair. For detailed information see
http://vaww.va.gov/budget/capital/eu/cares_valuation_reports/Bedford.pdf

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	545	274	3	(268)	3	-	-	-	-	-	-	$ 13,914,065
Surgery	52	(29)	16	(65)	8	-	-	-	-	-	8	$ 1,643,529
Intermediate/NHCU	162,037	-	162,037	-	58,334	-	-	-	-	-	103,703	$ -
Psychiatry	35,634	(549)	35,634	(549)	-	-	-	-	-	-	35,634	$ (3,049,419)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	13,962	-	13,962	-	-	-	-	-	-	-	13,962	$ (491,399)
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**212,230**	**(304)**	**211,652**	**(882)**	**58,345**	**-**	**-**	**-**	**-**	**-**	**153,307**	**$ 12,016,776**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	72,784	40,658	72,784	40,658	728	-	-	-	-	-	72,056	$ (5,657,927)
Specialty Care	65,352	47,640	65,352	47,640	654	-	-	-	-	-	64,698	$ (2,640,140)
Mental Health	116,800	737	102,801	(13,262)	-	-	-	-	-	-	102,801	$ 21,680,327
Ancillary & Diagnostics	66,460	21,726	66,461	21,727	-	-	-	-	-	-	66,461	$ (1,545,666)
Total	**321,395**	**110,760**	**307,398**	**96,763**	**1,382**	**-**	**-**	**-**	**-**	**-**	**306,016**	**$ 11,836,594**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	351	351	-	-	-	-	-	-	-	-	-	-
Surgery	44	44	13	13	-	-	-	-	-	-	-	(13)
Intermediate Care/NHCU	104,429	-	104,428	(1)	104,429	-	-	-	-	-	104,429	1
Psychiatry	57,727	35,080	57,727	35,080	22,647	37,070	-	-	-	-	59,717	1,990
PRRTP	-	(37,070)	-	(37,070)	37,070	-	-	-	-	-	37,070	37,070
Domiciliary program	14,386	-	14,386	-	14,386	-	-	-	-	-	14,386	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**176,938**	**(1,594)**	**176,554**	**(1,978)**	**178,532**	**37,070**	**-**	**-**	**-**	**-**	**215,602**	**39,048**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	54,042	23,217	54,042	23,217	30,825	-	-	-	13,879	-	44,704	(9,338)
Specialty Care	78,285	68,302	78,285	68,302	9,983	52,000	-	-	-	-	61,983	(16,302)
Mental Health	64,240	21,339	56,541	13,640	42,901	-	-	5,000	-	-	47,901	(8,640)
Ancillary and Diagnostics	59,150	21,908	59,150	21,908	37,242	9,000	-	-	-	-	46,242	(12,908)
Total	**255,718**	**134,767**	**248,018**	**127,067**	**120,951**	**61,000**	**-**	**5,000**	**13,879**	**-**	**200,830**	**(47,188)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	61,719	-	55,349	(6,370)	61,719	-	-	-	-	-	61,719	6,370
Administrative	262,018	69,077	254,358	61,417	192,941	-	-	-	-	-	192,941	(61,417)
Other	66,681	-	66,681	-	66,681	-	-	-	-	-	66,681	-
Total	**390,418**	**69,077**	**376,388**	**55,047**	**321,341**	**-**	**-**	**-**	**-**	**-**	**321,341**	**(55,047)**

4. Facility Level Information - Boston

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

None.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

DoD: There were no collaborative opportunities identified. Only a few small DoD facilities remain in Massachusetts. None of these facilities have excess capacity or plans for expansion of existing services that will allow for their incorporation into our market strategy.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

VBA: The relocation of the Regional VBA office currently located in downtown Boston to the Jamaica Plain Campus was not considered viable due to functional space and parking requirements that could not be accommodated at the Jamaica Plain Campus.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

Enhanced Use: There were no specific PIs identified for Enhanced Use. With regard to enhanced use potential, interest has been expressed by our affiliates and state/local government agencies to utilize vacant space in Building 9 (38,629 SF) for medical offices and research activities. The plan reflects a gradual occupancy of this space in FY05-22.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

The integrity of the infrastructure systems for the VA New England Healthcare System (VANEHS) was studied by the VA Office of Facility Management (OFM) in 2001. As expected the systems ranged from poor to good condition. However there were a significant number of the systems that were below par. The number of current systems deteriorating below par will increase if not accelerate as we continue to use the buildings at the growing activity level. The funds we receive to repair these systems is insufficient to stem the tide of deterioration. We must receive an influx of significant funds to bring these systems up to par and local community standards. The systems include but were not limited to site, architectural, HVAC, electrical, plumbing, structural, elevators, etc. It was a comprehensive look at the state of VISN 1's infrastructure systems. The preferred alternative is to develop a significant influx of funds to accomplish necessary capital maintenance, repair, and improvementThis Planning Initiative has the following impact on the CARES Criteria:

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	5,875	2,813	81	(2,981)	5	-	-	-	-	-	76	$ 233,843,971
Surgery	679	(195)	5	(869)	-	-	-	-	-	-	5	$ 34,977,161
Intermediate/NHCU	23,387	-	19,652	(3,735)	17,884	-	-	-	-	-	1,768	$ -
Psychiatry	36,945	(913)	211	(37,647)	211	-	-	-	-	-	-	$ 85,491,403
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ (794,098)
Domiciliary	1,870	-	-	(1,870)	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	19	-	2	(17)	-	-	-	-	-	-	2	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**68,775**	**1,705**	**19,951**	**(47,119)**	**18,100**	**-**	**-**	**-**	**-**	**-**	**1,851**	**$ 353,518,437**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	133,472	35,360	152,672	54,560	13,741	-	-	-	-	-	138,931	$ (41,069,487)
Specialty Care	156,652	27,559	140,348	11,255	7,018	-	-	-	-	-	133,330	$ 108,492,078
Mental Health	119,422	2,897	133,985	17,460	4,020	-	-	-	-	-	129,965	$ (23,475,966)
Ancillary & Diagnostics	133,913	38,769	141,280	46,136	18,367	-	-	-	-	-	122,913	$ -
Total	**543,459**	**104,585**	**568,285**	**129,411**	**43,146**	**-**	**-**	**-**	**-**	**-**	**525,139**	**$ 43,946,625**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	11,518	2,994	158	(8,366)	8,524	-	-	-	-	-	8,524	8,366
Surgery	994	994	8	8	-	-	-	-	-	-	-	(8)
Intermediate Care/NHCU	3,166	3,166	3,165	3,165	-	-	-	-	-	-	-	(3,165)
Psychiatry	10,270	10,270	-	-	-	-	-	-	-	-	-	-
PRRTP	-	(15,313)	-	(15,313)	15,313	-	-	-	-	-	15,313	15,313
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	9	9	-	-	-	-	-	-	-	(9)
Blind Rehab	9	9	-	-	-	-	-	-	-	-	-	-
Total	**25,957**	**2,120**	**3,340**	**(20,497)**	**23,837**	**-**	**-**	**-**	**-**	**-**	**23,837**	**20,497**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	63,096	10,034	69,466	16,404	53,062	-	-	-	4,580	-	57,642	(11,824)
Specialty Care	169,548	4,768	146,663	(18,117)	164,780	-	-	-	-	-	164,780	18,117
Mental Health	64,013	43,613	71,481	51,081	20,400	35,000	-	-	-	-	55,400	(16,081)
Ancillary and Diagnostics	88,498	1,591	88,497	1,590	86,907	-	-	-	-	-	86,907	(1,590)
Total	**385,155**	**60,006**	**376,107**	**50,958**	**325,149**	**35,000**	**-**	**-**	**4,580**	**-**	**364,729**	**(11,378)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	126,881	-	107,125	(19,756)	126,881	-	-	-	-	-	126,881	19,756
Administrative	220,577	24,738	199,495	3,656	195,839	-	-	-	-	-	195,839	(3,656)
Other	46,860	-	46,860	-	46,860	-	-	-	-	-	46,860	-
Total	**394,318**	**24,738**	**353,480**	**(16,100)**	**369,580**	**-**	**-**	**-**	**-**	**-**	**369,580**	**16,100**

5. Facility Level Information - Brockton

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

Market Planning Team was appointed consisting of representatives from each VISN Service Line and each facility within the Market and through a series of brainstorming and prioritization sessions developed alternatives for this PI. The VISN CARES Steering Committee as well as the VISN Executive Leadership Council (ELC) reviewed progress and proposed alternatives. Throughout the process meetings were held with all Stakeholder groups to inform them of the status and proposals as well as to obtain their input.

As the Market Team proceeded it was determined that in consideration of the substantial projected increases, provision of Outpatient Specialty and Primary Care services would be required to be continued at all existing Parent Facilities and CBOCs. Alternatives were considered to consolidate Long Term Care (including the Alzheimer's and SCI Units) and Psychiatry inpatient beds from the Bedford to Brockton facilities, LTC and Psychiatry inpatient beds from the Brockton to Bedford facilities, Long Term Care inpatient beds from the Bedford to Brockton facilities, LTC inpatient beds from the Brockton to Bedford facilities, Psychiatry inpatient beds from the Bedford to Brockton facilities and Psychiatry inpatient beds from the Brockton to Bedford facilities. As final projections are not available for LTC inpatient beds and earlier projections indicated a substantial increase in LTC beds it was determined to utilize current capacities, while CARES projections for Psychiatry acute and SCI long-term care beds would be utilized in these categories. Vacant space at the Bedford and Brockton facilities was reviewed and allocated to meet the needs of the remaining CARES planning categories and remaining, if any, vacant space was considered for these alternatives and renovation and/or new construction costs were developed for each alternative.

After considering construction costs, programmatic improvements, programmatic detriments and Stakeholder reactions to these alternatives it was determined that maintaining the current missions and bed allocations was the proper approach towards achieving the overall goal of CARES. The principle reasons for this decision are a) pre-CARES VISN initiated actions to adjust the missions of these facilities have already resulted in reduction of all duplication in Inpatient Medicine, Surgery and Acute SCI, b) in the absence of the final projections for LTC beds, it is impossible to determine if any duplication in this category actually exists, c) workload projections for Acute Psychiatry will not result in the elimination of the need for services at any facility, d) substantial increases in projected workload for the remaining CARES categories mandates the continuation and expansion of these services at all four facilities which will utilize all current vacant space, e) projections consistently demonstrate increases in workloads that are evenly distributed throughout the Market and f) the amount of space at any facility vacated by the alternatives would be insufficient to close that facility or be sufficient to generate sufficient income to offset the costs of the alternative.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

DoD: There were no collaborative opportunities identified. Only a few small DoD facilities remain in Massachusetts. None of these facilities have excess capacity or plans for expansion of existing services that will allow for their incorporation into our market strategy.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

VBA: There were no collaborative opportunities identified.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

Enhanced Use: There were no specific PIs identified for Enhanced Use. Development of enhanced lease opportunities to utilize vacant space at Brockton is in various stages of development. Negotiations are underway with McLean Hospital to develop a 25-bed inpatient Mental Health Unit and state-of-the-art outpatient Behavioral Health Program by FY05 to be located on the 2nd floor of Building 7 (25,132 SF formerly utilized as an inpatient psychiatry ward) that would serve the psychiatric needs of consumers throughout Southeastern Massachusetts. A collaborative opportunity with the State and the City of Brockton is under development to lease approximately 12,159 SF in Building 61 for a shelter for homeless Women Veterans with Dependent Children (targeted for FY05 enhanced use). Interest has also been expressed between the Mayor's Office of the City of Brockton and Stonehill College to lease 39,186 SF (targeted in FY05) in Building 21 (former Theater) as a center for the arts/cultural center (an economic grant proposal is being developed to renovate, expand and operate the theater as a community resource which would also provide a benefit to veterans who would be offered free or reduced cost access to the entertainment activities). In total, approximately 76,477 SF of vacant space has been targeted for enhanced use.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

The integrity of the infrastructure systems for the VA New England Healthcare System (VANEHS) was studied by the VA Office of Facility Management (OFM) in 2001. As expected the systems ranged from poor to good condition. However there were a significant number of the systems that were below par. The number of current systems deteriorating below par will increase if not accelerate as we continue to use the buildings at the growing activity level. The funds we receive to repair these systems is insufficient to stem the tide of deterioration. We must receive an influx of significant funds to bring these systems up to par and local community standards. The systems include but were not limited to site, architectural, HVAC, electrical, plumbing, structural, elevators, etc. It was a comprehensive look at the state of VISN 1's infrastructure systems. The preferred alternative is to develop a significant influx of funds to accomplish necessary capital maintenance, repair, and improvementThis Planning Initiative has the following impact on the CARES Criteria:

§ Healthcare Quality and Need- Positive impact on the quality of the services that we will be able to provide. It will also help meet the "need" since there will be less building and system downtime

§ Safety and Environment- We must develop this influx of infrastructure funds to improve the Safety and Environment of our facilities. Without the funds only emergencies will be accommodated thus increasing our exposure risk.

§ Research and Affiliations- Properly maintained buildings can provide additional opportunities to house Research and Affiliations due to efficiency and desirability of space.

§ Staffing and Community- Proper environment and facility condition increases employee satisfaction. This eliminates one layer of frustration for our workforce.

§ Optimizing Use of Resources- Without the influx of these funds we will not be able to utilize our resources effectively. Poorly maintained infrastructure leads to space closure and other downtime.

§ Support of all other VA Missions- A properly maintained infrastructure supports all the VA missions. Poorly maintained facilities detracts form all the missions.

Below is a table showing totals for the necessary work.

Station Number	Data	Total
523A5	Correction Total FY 2001	$88,989,048
	Inflated to FY 2005 (6.12%)	$96,428,128
	Inflated to FY 2012 (33.26)	$121,089,449

This CARES planning cycle is indicating a need for increased space to support our current and projected workload. We will not have the luxury of moving activities to vacant or underutilized space that is well maintained and suites the purpose. As indicated in several of our planning initiatives we will be adding additional space to support some of our future needs. If we do not receive a significant influx of infrastructure correction funds to improve the existing facilities in this VISN continued infrastructure deterioration will lead to the inability to support the projected workload. Eventually significant amounts of new construction will be required to replace the infrastructure that is beyond repair. For more detailed information see:
http://vaww.va.gov/budget/capital/eu/cares_valuation_reports/BrocktonVISN1.pdf

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	130	16	65	(49)	4	-	-	-	-	-	61	$ 41,070,192
Surgery	170	(120)	86	(204)	-	-	-	-	-	-	86	$ 54,982,794
Intermediate/NHCU	7,740	-	75,510	67,770	24,919	-	-	-	-	-	50,591	$ -
Psychiatry	5,803	(519)	52,651	46,329	-	-	-	-	-	-	52,651	$ (33,462,935)
PRRTP	-	-	221	221	-	-	-	-	-	-	221	$ -
Domiciliary	3,740	-	25,970	22,230	-	-	-	-	-	-	25,970	$ -
Spinal Cord Injury	34	-	8,858	8,824	-	-	-	-	-	-	8,858	$ (3,803,901)
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**17,618**	**(622)**	**163,361**	**145,121**	**24,923**	**-**	**-**	**-**	**-**	**-**	**138,438**	**$ 58,786,150**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	3,648	(2,364)	50,850	44,838	-	-	-	-	-	-	50,850	$ (1,651,228)
Specialty Care	3,874	942	54,591	51,659	-	-	-	-	-	-	54,591	$ (2,785,512)
Mental Health	9,866	1,982	83,079	75,195	-	-	-	-	-	-	83,079	$ (2,534,066)
Ancillary & Diagnostics	5,976	2,584	46,839	43,447	-	-	-	-	-	-	46,839	$ -
Total	**23,364**	**3,144**	**235,359**	**215,139**	**-**	**-**	**-**	**-**	**-**	**-**	**235,359**	**$ (6,970,806)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	4,519	4,519	127	127	-	-	-	-	-	-	-	(127)
Surgery	2,551	2,551	143	143	-	-	-	-	-	-	-	(143)
Intermediate Care/NHCU	59,078	-	59,077	(1)	59,078	-	-	-	-	-	59,078	1
Psychiatry	78,170	23,506	85,295	30,631	54,664	-	-	13,000	-	-	67,664	(17,631)
PRRTP	21,372	-	18,372	(3,000)	21,372	-	-	-	-	-	21,372	3,000
Domiciliary program	21,836	-	24,836	3,000	21,836	3,000	-	-	-	-	24,836	-
Spinal Cord Injury	-	(21,540)	21,540	-	21,540	-	-	-	-	-	21,540	-
Blind Rehab	21,540	21,540	-	-	-	-	-	-	-	-	-	-
Total	**209,066**	**30,576**	**209,390**	**30,900**	**178,490**	**3,000**	**-**	**13,000**	**-**	**-**	**194,490**	**(14,900)**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	38,138	21,729	38,138	21,729	16,409	15,000	-	-	-	-	31,409	(6,729)
Specialty Care	60,050	29,520	60,050	29,520	30,530	16,500	-	-	-	-	47,030	(13,020)
Mental Health	45,693	(20,869)	45,693	(20,869)	66,562	-	-	-	-	-	66,562	20,869
Ancillary and Diagnostics	44,965	(15,182)	44,965	(15,182)	60,147	-	-	-	-	-	60,147	15,182
Total	**188,846**	**15,198**	**188,846**	**15,198**	**173,648**	**31,500**	**-**	**-**	**-**	**-**	**205,148**	**16,302**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	14,474	-	15,736	1,262	14,474	10,117	-	-	-	-	24,591	8,855
Administrative	280,423	32,162	281,501	33,240	248,261	-	-	-	-	-	248,261	(33,240)
Other	29,984	-	29,984	-	29,984	-	-	-	-	-	29,984	-
Total	**324,881**	**32,162**	**327,221**	**34,502**	**292,719**	**10,117**	**-**	**-**	**-**	**-**	**302,836**	**(24,385)**

6. Facility Level Information - Providence

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

Market Planning Team was appointed consisting of representatives from each VISN Service Line and each facility within the Market and through a series of brainstorming and prioritization sessions developed alternatives for this PI. The VISN CARES Steering Committee as well as the VISN Executive Leadership Council (ELC) reviewed progress and proposed alternatives. Throughout the process meetings were held with all Stakeholder groups to inform them of the status and proposals as well as to obtain their input.

As the Market Team proceeded it was determined that in consideration of the substantial projected increases, provision of Outpatient Specialty and Primary Care services would be required to be continued at all existing Parent Facilities and CBOCs. It was further determined that the VISN's prior decisions to consolidate Inpatient Medicine and Surgery at the Providence and West Roxbury facilities and Inpatient Acute Spinal Cord Injury at the West Roxbury facility was not duplicative and was necessary to meet the projected workload for these areas.

It was determined that maintaining the current missions and bed allocations was the proper approach towards achieving the overall goal of CARES. The principle reasons for this decision are a) workload projections for Acute Psychiatry will not result in the elimination of the need for services at any facility, b) substantial increases in projected workload for the remaining CARES categories mandates the continuation and expansion of these services at all four facilities which will utilize all current vacant space, c) projections consistently demonstrate increases in workloads that are evenly distributed throughout the Market and d) the amount of space at any facility vacated by the alternatives would be insufficient to close that facility or be sufficient to generate sufficient income to offset the costs of the alternative.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

DoD: There were no collaborative opportunities identified. Only a few small DoD facilities remain in Rhode Island. None of these facilities have excess capacity or plans for expansion of existing services that will allow for their incorporation into our market strategy.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

VBA: Based on a feasibility analysis conducted by the Maguire Group, Inc., co-location of the Providence VBA on the grounds of the Providence VA Medical Center (new construction) is not supportable (see VISN narrative).

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

Enhanced Use: There were no specific PIs identified for Enhanced Use. This is because there is no existing underutilized and/or vacant space or acreage.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

The integrity of the infrastructure systems for the VA New England Healthcare System (VANEHS) was studied by the VA Office of Facility Management (OFM) in 2001. As expected the systems ranged from poor to good condition. However there were a significant number of the systems that were below par. The number of current systems deteriorating below par will increase if not accelerate as we continue to use the buildings at the growing activity level. The funds we receive to repair these systems is insufficient to stem the tide of deterioration. We must receive an influx of significant funds to bring these systems up to par and local community standards. The systems include but were not limited to site, architectural, HVAC, electrical, plumbing, structural, elevators, etc. It was a comprehensive look at the state of VISN 1's infrastructure systems. The preferred alternative is to develop a significant influx of funds to accomplish necessary capital maintenance, repair, and improvementThis Planning Initiative has the following impact on the CARES Criteria:

Healthcare Quality and Need- Positive impact on the quality of the services that we will be able to provide. It will also help meet the "need" since there will be less building and system downtime

§ Safety and Environment- We must develop this influx of infrastructure funds to improve the Safety and Environment of our facilities. Without the funds only emergencies will be accommodated thus increasing our exposure risk.

§ Research and Affiliations- Properly maintained buildings can provide additional opportunities to house Research and Affiliations due to efficiency and desirability of space.

§ Staffing and Community- Proper environment and facility condition increases employee satisfaction. This eliminates one layer of frustration for our workforce.

§ Optimizing Use of Resources- Without the influx of these funds we will not be able to utilize our resources effectively. Poorly maintained infrastructure leads to space closure and other downtime.

§ Support of all other VA Missions- A properly maintained infrastructure supports all the VA missions. Poorly maintained facilities detracts form all the missions.

Below is a table showing totals for the necessary work.

Station Number	Data	Total
650	Correction Total FY 2001	$35,112,488
	Inflated to FY 2005 (6.12%)	$39,786,794
	Inflated to FY 2012 (33.26)	$49,962,195

This CARES planning cycle is indicating a need for increased space to support our current and projected workload. We will not have the luxury of moving activities to vacant or underutilized space that is well maintained and suites the purpose. As indicated in several of our planning initiatives we will be adding additional space to support some of our future needs. If we do not receive a significant influx of infrastructure correction funds to improve the existing facilities in this VISN continued infrastructure deterioration will lead to the inability to support the projected workload. Eventually significant amounts of new construction will be required to replace the infrastructure that is beyond repair. For more detailed information, see
http://vaww.va.gov/budget/capital/eu/cares_valuation_reports/ProvidenceVISN1.pdf

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	17,526	8,256	17,527	8,257	526	-	-	-	-	-	17,001	$ (13,712,449)
Surgery	7,703	3,268	7,704	3,269	78	-	-	-	-	-	7,626	$ (20,406,941)
Intermediate/NHCU	76,770	-	76,770	-	75,235	-	-	-	-	-	1,535	$ -
Psychiatry	390	(163)	6,392	5,839	-	-	-	-	-	-	6,392	$ (69,088)
PRRTP	6,002	949	-	(5,053)	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**108,391**	**12,310**	**108,393**	**12,312**	**75,839**	**-**	**-**	**-**	**-**	**-**	**32,554**	**$ (34,188,478)**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	127,530	43,894	127,531	43,895	2,551	-	-	-	-	-	124,980	$ (1,925,565)
Specialty Care	139,415	73,357	139,416	73,358	2,789	-	-	-	-	-	136,627	$ (20,210,253)
Mental Health	54,655	(121)	54,655	(120)	1,094	-	-	-	-	-	53,561	$ (1,342,622)
Ancillary & Diagnostics	147,161	60,778	147,161	60,778	4,415	-	-	-	-	-	142,746	$ (16,921,976)
Total	**468,761**	**177,908**	**468,763**	**177,910**	**10,849**	**-**	**-**	**-**	**-**	**-**	**457,914**	**$ (40,400,416)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	45,223	30,176	45,223	30,176	15,047	7,276	-	10,000	9,000	-	41,323	(3,900)
Surgery	12,661	8,655	12,659	8,653	4,006	3,500	-	2,000	-	-	9,506	(3,153)
Intermediate Care/NHCU	2,063	-	2,062	(1)	2,063	-	-	-	-	-	2,063	1
Psychiatry	11,570	4,667	11,570	4,667	6,903	4,000	-	-	-	-	10,903	(667)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**71,516**	**43,497**	**71,514**	**43,495**	**28,019**	**14,776**	**-**	**12,000**	**9,000**	**-**	**63,795**	**(7,719)**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	62,490	28,523	62,490	28,523	33,967	-	-	-	13,885	-	47,852	(14,638)
Specialty Care	165,319	125,537	165,319	125,537	39,782	-	82,000	-	7,000	-	128,782	(36,537)
Mental Health	29,459	11,739	29,459	11,739	17,720	5,000	-	-	-	-	22,720	(6,739)
Ancillary and Diagnostics	91,358	58,800	91,357	58,799	32,558	-	30,000	10,000	-	-	72,558	(18,799)
Total	**348,626**	**224,599**	**348,625**	**224,598**	**124,027**	**5,000**	**112,000**	**10,000**	**20,885**	**-**	**271,912**	**(76,713)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	22,385	-	32,011	9,626	22,385	-	2,400	-	-	-	24,785	(7,226)
Administrative	256,666	154,731	262,247	160,312	101,935	-	34,000	-	-	-	135,935	(126,312)
Other	8,481	-	8,481	-	8,481	-	-	-	-	-	8,481	-
Total	**287,532**	**154,731**	**302,739**	**169,938**	**132,801**	**-**	**36,400**	**-**	**-**	**-**	**169,201**	**(133,538)**

7. Facility Level Information – West Roxbury

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

Market Planning Team was appointed consisting of representatives from each VISN Service Line and each facility within the Market and through a series of brainstorming and prioritization sessions developed alternatives for this PI. The VISN CARES Steering Committee as well as the VISN Executive Leadership Council (ELC) reviewed progress and proposed alternatives. Throughout the process meetings were held with all Stakeholder groups to inform them of the status and proposals as well as to obtain their input.

As the Market Team proceeded it was determined that in consideration of the substantial projected increases, provision of Outpatient Specialty and Primary Care services would be required to be continued at all existing Parent Facilities and CBOCs. It was further determined that the VISN's prior decisions to consolidate Inpatient Medicine and Surgery at the Providence and West Roxbury facilities and Inpatient Acute Spinal Cord Injury at the West Roxbury facility was not duplicative and was necessary to meet the projected workload for these areas.

It was determined that maintaining the current missions and bed allocations was the proper approach towards achieving the overall goal of CARES. The principle reasons for this decision are a) pre-CARES VISN initiated actions to adjust the missions of these facilities have already resulted in reduction of all duplication in Inpatient Medicine, Surgery and Acute SCI, b) substantial increases in projected workload for the remaining CARES categories mandates the continuation and expansion of these services at all four facilities which will utilize all current vacant space, c) projections consistently demonstrate increases in workloads that are evenly distributed throughout the Market and d) the amount of space at any facility vacated by the alternatives would be insufficient to close that facility or be sufficient to generate sufficient income to offset the costs of the alternative.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

DoD: There were no collaborative opportunities identified. Only a few small DoD facilities remain in Massachusetts. None of these facilities have excess capacity or plans for expansion of existing services that will allow for their incorporation into our market strategy.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

VBA: There were no collaborative opportunities identified.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

Enhanced Use: There were no specific PIs identified for Enhanced Use. This is because there is no existing underutilized and/or vacant space or acreage.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

The integrity of the infrastructure systems for the VA New England Healthcare System (VANEHS) was studied by the VA Office of Facility Management (OFM) in 2001. As expected the systems ranged from poor to good condition. However there were a significant number of the systems that were below par. The number of current systems deteriorating below par will increase if not accelerate as we continue to use the buildings at the growing activity level. The funds we receive to repair these systems is insufficient to stem the tide of deterioration. We must receive an influx of significant funds to bring these systems up to par and local community standards. The systems include but were not limited to site, architectural, HVAC, electrical, plumbing, structural, elevators, etc. It was a comprehensive look at the state of VISN 1's infrastructure systems. The preferred alternative is to develop a significant influx of funds to accomplish necessary capital maintenance, repair, and improvementThis Planning Initiative has the following impact on the CARES Criteria:

§ Healthcare Quality and Need- Positive impact on the quality of the services that we will be able to provide. It will also help meet the "need" since there will be less building and system downtime

§ Safety and Environment- We must develop this influx of infrastructure funds to improve the Safety and Environment of our facilities. Without the funds only emergencies will be accommodated thus increasing our exposure risk.

§ Research and Affiliations- Properly maintained buildings can provide additional opportunities to house Research and Affiliations due to efficiency and desirability of space.

§ Staffing and Community- Proper environment and facility condition increases employee satisfaction. This eliminates one layer of frustration for our workforce.

§ Optimizing Use of Resources- Without the influx of these funds we will not be able to utilize our resources effectively. Poorly maintained infrastructure leads to space closure and other downtime.

§ Support of all other VA Missions- A properly maintained infrastructure supports all the VA missions. Poorly maintained facilities detracts form all the missions.

Below is a table showing totals for the necessary work.

Station Number	Data	Total
523A4	Correction Total FY 2001	$47,940,426
	Inflated to FY 2005 (6.12%)	$51,948,028
	Inflated to FY 2012 (33.26)	$65,233,643

This CARES planning cycle is indicating a need for increased space to support our current and projected workload. We will not have the luxury of moving activities to vacant or underutilized space that is well maintained and suites the purpose. As indicated in several of our planning initiatives we will be adding additional space to support some of our future needs. If we do not receive a significant influx of infrastructure correction funds to improve the existing facilities in this VISN continued infrastructure deterioration will lead to the inability to support the projected workload. Eventually significant amounts of new construction will be required to replace the infrastructure that is beyond repair. For more detailed information see
http://vaww.va.gov/budget/capital/eu/cares_valuation_reports/WestRoxVISN1.pdf

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	29,577	15,181	38,151	23,755	509	-	-	-	-	-	37,642	$ (212,735,503)
Surgery	16,743	4,542	18,824	6,623	2,235	-	-	-	-	-	16,589	$ (99,491,476)
Intermediate/NHCU	14,636	-	14,636	-	5,562	-	-	-	-	-	9,074	$ -
Psychiatry	535	(231)	135	(631)	-	-	-	-	-	-	135	$ 8,378,350
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	4,728	-	4,728	-	-	-	-	-	-	-	4,728	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**66,218**	**19,491**	**76,474**	**29,747**	**8,306**	**-**	**-**	**-**	**-**	**-**	**68,168**	**$ (303,848,629)**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	58,302	15,258	44,303	1,259	-	-	-	-	-	-	44,303	$ 35,313,985
Specialty Care	77,733	41,030	99,632	62,929	-	-	-	-	-	-	99,632	$ (104,301,011)
Mental Health	9,910	384	9,911	385	-	-	-	-	-	-	9,911	$ -
Ancillary & Diagnostics	142,484	50,632	142,485	50,633	-	-	-	-	-	-	142,485	$ (248,504)
Total	**288,428**	**107,303**	**296,331**	**115,206**	**-**	**-**	**-**	**-**	**-**	**-**	**296,331**	**$ (69,235,530)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	92,280	48,216	117,443	73,379	44,064	5,310	17,000	22,000	-	-	88,374	(29,069)
Surgery	34,993	15,027	34,671	14,705	19,966	4,300	-	4,500	-	-	28,766	(5,905)
Intermediate Care/NHCU	12,353	-	12,353	-	12,353	-	-	-	-	-	12,353	-
Psychiatry	867	867	219	219	-	-	-	-	-	-	-	(219)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	(23,831)	23,831	-	23,831	-	-	-	-	-	23,831	-
Blind Rehab	23,831	23,831	-	-	-	-	-	-	-	-	-	-
Total	**164,324**	**64,110**	**188,517**	**88,303**	**100,214**	**9,610**	**17,000**	**26,500**	**-**	**-**	**153,324**	**(35,193)**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	43,727	18,895	33,227	8,395	24,832	-	-	-	600	-	25,432	(7,795)
Specialty Care	128,259	60,058	164,393	96,192	68,201	-	60,800	-	-	-	129,001	(35,392)
Mental Health	8,226	(2,170)	8,226	(2,170)	10,396	-	-	-	-	-	10,396	2,170
Ancillary and Diagnostics	102,589	30,356	102,589	30,356	72,233	-	7,500	-	1,000	-	80,733	(21,856)
Total	**282,801**	**107,139**	**308,435**	**132,773**	**175,662**	**-**	**68,300**	**-**	**1,600**	**-**	**245,562**	**(62,873)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	41,672	-	57,558	15,886	41,672	-	15,600	-	-	-	57,272	(286)
Administrative	180,855	63,809	205,169	88,123	117,046	-	45,000	-	-	-	162,046	(43,123)
Other	19,013	-	19,013	-	19,013	-	-	-	-	-	19,013	-
Total	**241,540**	**63,809**	**281,740**	**104,009**	**177,731**	**-**	**60,600**	**-**	**-**	**-**	**238,331**	**(43,409)**

B. Far North Market

1. Description of Market

a. Market Definition

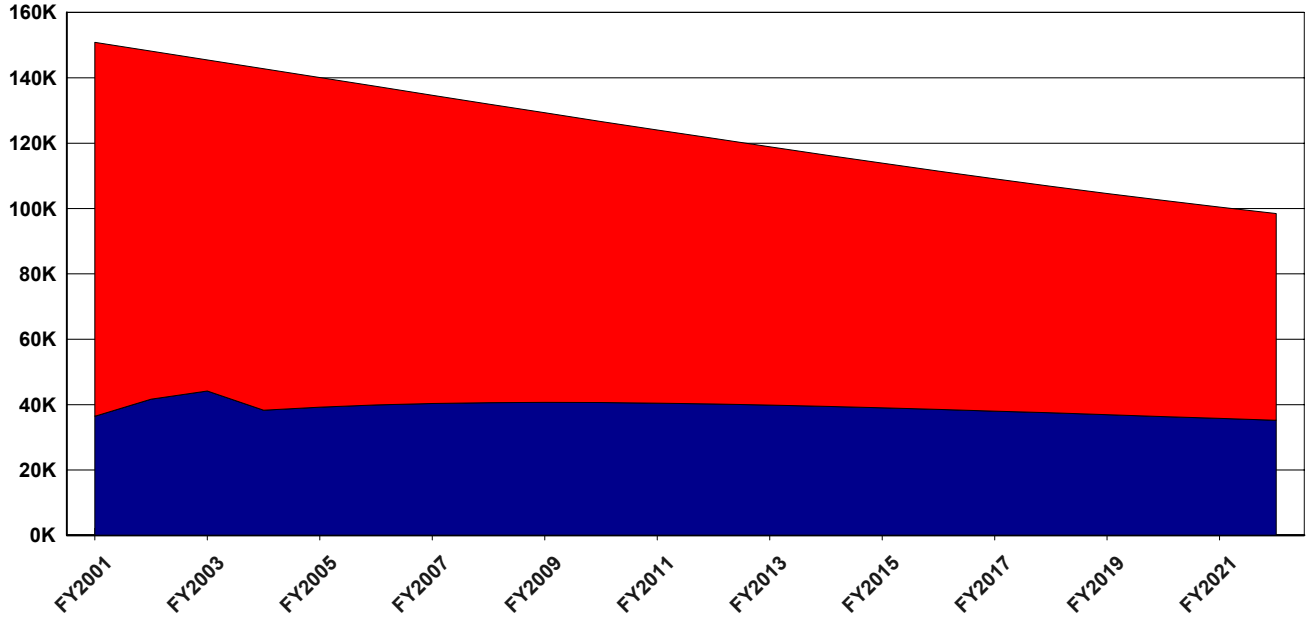
Market	Geographic Area	Rationale	Shared Counties
Far North Market **Code: 1B**	16 counties making up the state of Maine 16 Total Counties ***2010*** *projected* ***enrollees****: 57,522* **vet. pop**.: 132,593	(Maine) has vast land area and little concentration of population. The population is centered around the north-south I-95 Interstate in the eastern part of the state. There is a natural boundary (north-south mountain range) that prevents veterans from easy access to the west (New Hampshire facilities). Maine exists as a single market area. **Facilities**: Togus, ME	

b. Facility List

VISN : 1				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Togus				
402 Togus	✔	✔	-	-
402GA01 Aroostook County (Caribou)	✔	-	-	-
402GA02 Fort Kent	✔	-	-	-
402GB Calais	✔	-	-	-
402GC Rumford	✔	-	-	-
402GD Saco	✔	-	-	-
402HB Bangor	✔	-	-	-
402HC CDRP Satellite South	-	-	-	✔
402HK Machias	✔	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** -----**Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Far North Market			Februrary 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
PI	Access to Primary Care (39,556)	59% of enrollees in the Far North Market do not meet guidelines, impacting 16,218 enrollees.				
PI	Access to Hospital Care (39,556)	52% of enrollees in the Far North Market do not meet guidelines, impacting 18,987 enrollees.				
	Access to Tertiary Care (39,556)					
PI	Specialty Care Outpatient Stops	Population Based	98,303	143%	76,605	111%
		Treating Facility Based	86,799	136%	66,430	104%
PI	Primary Care Outpatient Stops	Population Based	66,813	74%	37,056	41%
		Treating Facility Based	51,867	59%	24,559	28%
PI	Medicine Inpatient Beds	Population Based	35	194%	25	140%
		Treating Facility Based	31	209%	22	151%
PI	Mental Health Outpatient Stops	Population Based	20,629	42%	2,385	5%
		Treating Facility Based	18,226	38%	1,462	3%
	Surgery Inpatient Beds	Population Based	10	88%	6	51%
		Treating Facility Based	7	92%	4	53%
	Psychiatry Inpatient Beds	Population Based	19	98%	10	52%
		Treating Facility Based	19	116%	11	64%

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

Town meetings were held throughout the market during the entire development phase of the Market Plan. VA staff met with veterans and their families, Veteran Service Organizations, and community stakeholders. Consistently through this process, our veteran stakeholders emphasized the need to provide access to healthcare services in rural areas with minimal concentration of population in addition to the most populous areas of the state. To that end, we have committed to a presence in the rural areas of Houlton, Lincoln, Dover-Foxcroft, Farmington, and South Paris in addition to the development of a new CBOC in the most populous area of the state.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

Because the Far North market consists of one VAMC, little collaboration with other facilities and/or other markets was necessary. We have collaborated with the East Market to ensure a continued referral process for selected outpatient specialties.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

The Far North Market consists of the entire State of Maine with one VA facility, the Togus VA Medical and Regional Office Center. The Market has vast land area with little concentration of population in all but the southeastern area of the Market. There is a natural boundary of a north-south mountain range that prevents veterans from easy access to the North market (i.e., New Hampshire facilities). Only 59% of veterans in this Market have access to primary care services within the CARES access guidelines, and only 52% of veterans have access to inpatient hospital care within the CARES access guidelines. Projected enrollment data revealed demand gaps in the clinical areas of Primary Care, Outpatient Specialty Care, Outpatient Mental Health Services, and Inpatient Medical Services.

Resolution of the access gap for Primary Care Services is planned to be accomplished by increasing a VA presence in the rural areas of Houlton, Lincoln, Dover-Foxcroft, Farmington, and South Paris. In addition, a new Community Based Outpatient Clinic (CBOC) is planned for Cumberland County to meet the needs of veterans who reside between an existing CBOC in Saco, and the Togus Medical Center.

Access and capacity to inpatient hospital care will be resolved by contracting for beds in York County (6 beds), Aroostook County (4 beds), Cumberland County (8 beds), Androscoggin County (5 beds), and Penobscot County (2 beds). In addition, 6 additional beds will be available at Togus upon completion of the approved Ambulatory Surgery project.

Increasing the capacity for Primary Care and Outpatient Mental Health Services will be accomplished by utilizing new VA locations in Houlton, Lincoln, Dover-Foxcroft, Farmington, and South Paris in addition to the new CBCO in Cumberland County. Mental health services already in place at Togus will also be enhanced to accommodate need. Contract mental health providers in the community will be utilized as needed.

Increasing capacity for outpatient specialty care will be accomplished by enhancing the number of specialists at Togus, continuing referrals to the East Market, and by using specialists in the community on a contractual basis. New construction of 70,000 square feet will be necessary to accomplish this goal.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

Access gaps to Primary Care Services will be resolved via the addition of a combination of a new presence in Lincoln, Dover-Foxcroft, Houlton, Farmington, and South Paris, in addition to a new CBOC in Cumberland County. The access gap to Hospital Care will be resolved via use of contract beds within community hospitals and is expected to be at a high level as we have historically experienced. This option is proposed as a result of our understanding of the needs of a highly rural population, our understanding of the benefits of VA services to this population, and our understanding of the relative scarcity of medical care in many rural areas. Diagnostic imaging studies and laboratory studies will be contracted at the local community hospital. The new CBOC in Cumberland County will serve the population located between the current Saco CBOC, and the Togus facility. A new presence in the other locations will assure access to care for patients utilizing additional providers in those areas, and/or the possibility of telemedicine technology.

The addition of Primary Care Services throughout this market is expected to improve continuity and coordination of primary care services by eliminating geographic barriers to access. The rural nature of the state combined with weather patterns that significantly impede travel for up 7 months of the year has generally created barriers to accessing follow-up care for many patients. Similarly, the availability of VA acute care beds for patients in community hospitals will facilitate the coordination of care for acute illnesses by allowing patients more timely access.

ALTERNATIVES: The alternative plan to improving access to primary care and hospital services is to utilize only community resources on a contractual basis. This option is considered problematic because of the expected costs, and because of the general lack of primary care providers throughout the state.

QUALITY: Improving access to primary care services and inpatient medical care is expected to improve the quality of health for veterans in this market by providing care in a timelier manner. Prompt attention to acute and/or chronic illness is likely to reduce the probability of complications.

SAFETY: Additional space will be required to meet the demand for primary care services throughout the market. The new proposed locations for primary care services are located in areas adjacent to community hospitals with which we can contract for ancillary services, or are close enough to the Togus facility to utilize all clinical services available at this facility.

RESEARCH: No impact.

STAFFING: Additional staffing will be required beyond the current FTEE levels. We anticipate the need for additional PCPs at Togus to support the Telemedicine technology. Mid-level providers, nursing staff and clerical support will also be needed to support this function. Improving access to inpatient medical care will require additional nursing FTEE. The plan to utilize contract beds in community hospitals will require additional support staff in the Business Office to process invoices received from the community facilities for the care provided to VA patients. This plan has been communicated to employees at the facility level by presentations at service staff meetings, and through the distribution of written materials pertaining to the CARES process.

COMMUNITY: We do not anticipate any negative impact on the healthcare industry in the private sector as a result of this plan. Availability of beds in community hospitals is not expected to be problematic.

COMMUNITY: We do not anticipate any negative impact on the healthcare industry in the private sector as a result of this plan. Availability of beds in community hospitals is not expected to be problematic.

CAPITAL: Leased space will be used to support new primary care locations, and the new Cumberland County CBOC.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**59%**	16,428	**73%**	10,849	**73%**	9,498
Hospital Care	**52%**	19,233	**96%**	1,607	**96%**	1,407
Tertiary Care	**80%**	8,014	**80%**	8,036	**80%**	7,036

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Togus

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

VISN PI – Infrastructure Improvements

The Togus Maine VAMC is the oldest VA facility in the country. Many buildings were built at the end of the Civil War and have undergone extensive renovations to accommodate the changing face of modern healthcare technology, however, additional infrastructure needs remain to meet regulatory standards. Additional space is needed to provide 2 exam rooms for provider.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

The DOD presence in the Far North market is minimal. The DOD facilities that do exist concentrate on basic medical care and have little or no capacity for expansion. Consequently, the potential collaboration between VHA and DOD has proven to be a viable option.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

Togus is currently co-located with the Veterans Benefits Administration (VBA) and shares many administrative functions, e.g., Human Resource Staff, Environmental Management Services, Engineering services, etc. Little opportunities exist for any additional collaboration.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

VISN PI – Infrastructure Improvements

The Togus Maine VAMC is the oldest VA facility in the country. Many buildings were built at the end of the Civil War and have undergone extensive renovations to accommodate the changing face of modern healthcare technology, however, additional infrastructure needs remain to meet regulatory standards. Additional space is needed to provide 2 exam rooms for provider.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	14,225	9,624	14,225	9,624	8,200	-	-	-	-	-	6,025	$ 24,936,983
Surgery	4,428	2,117	4,428	2,117	576	-	-	-	-	-	3,852	$ (504,783)
Intermediate/NHCU	101,363	-	101,363	-	60,818	-	-	-	-	-	40,545	$ (4,405,204)
Psychiatry	11,193	6,021	11,194	6,022	9,000	-	-	-	-	-	2,194	$ 43,195,318
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**131,209**	**17,762**	**131,210**	**17,763**	**78,594**	**-**	**-**	**-**	**-**	**-**	**52,616**	**$ 63,222,314**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	140,384	51,866	140,385	51,867	9,827	-	-	-	-	-	130,558	$ (3,651,657)
Specialty Care	150,764	86,799	150,764	86,799	47,000	-	-	-	-	-	103,764	$ 670,113
Mental Health	65,892	18,226	65,893	18,226	10,000	-	-	-	-	-	55,893	$ (3,272,757)
Ancillary & Diagnostics	130,031	35,899	130,032	35,900	52,000	-	-	-	-	-	78,032	$ (14,823,310)
Total	**487,072**	**192,790**	**487,074**	**192,792**	**118,827**	**-**	**-**	**-**	**-**	**-**	**368,247**	**$ (21,077,611)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	35,506	25,185	18,798	8,477	10,321	4,000	-	-	-	-	14,321	(4,477)
Surgery	8,090	(302)	8,089	(303)	8,392	-	-	-	-	-	8,392	303
Intermediate Care/NHCU	49,017	-	49,017	-	49,017	-	-	-	-	-	49,017	-
Psychiatry	15,777	13,077	3,554	854	2,700	-	-	-	-	-	2,700	(854)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**108,389**	**37,959**	**79,458**	**9,028**	**70,430**	**4,000**	**-**	**-**	**-**	**-**	**74,430**	**(5,028)**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	65,279	27,318	65,279	27,318	37,961	2,500	-	-	11,000	-	51,461	(13,818)
Specialty Care	204,421	157,248	154,608	107,435	47,173	-	70,000	-	-	-	117,173	(37,435)
Mental Health	33,045	16,251	32,977	16,183	16,794	-	-	-	9,750	-	26,544	(6,433)
Ancillary and Diagnostics	93,896	44,413	64,767	15,284	49,483	-	-	-	-	-	49,483	(15,284)
Total	**396,641**	**245,230**	**317,631**	**166,220**	**151,411**	**2,500**	**70,000**	**-**	**20,750**	**-**	**244,661**	**(72,970)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	560	-	-	(560)	560	-	-	-	-	-	560	560
Administrative	485,367	272,735	287,632	75,000	212,632	-	-	-	-	-	212,632	(75,000)
Other	95,623	-	95,623	-	95,623	-	-	-	-	-	95,623	-
Total	**581,550**	**272,735**	**383,255**	**74,440**	**308,815**	**-**	**-**	**-**	**-**	**-**	**308,815**	**(74,440)**

C. North Market

1. Description of Market

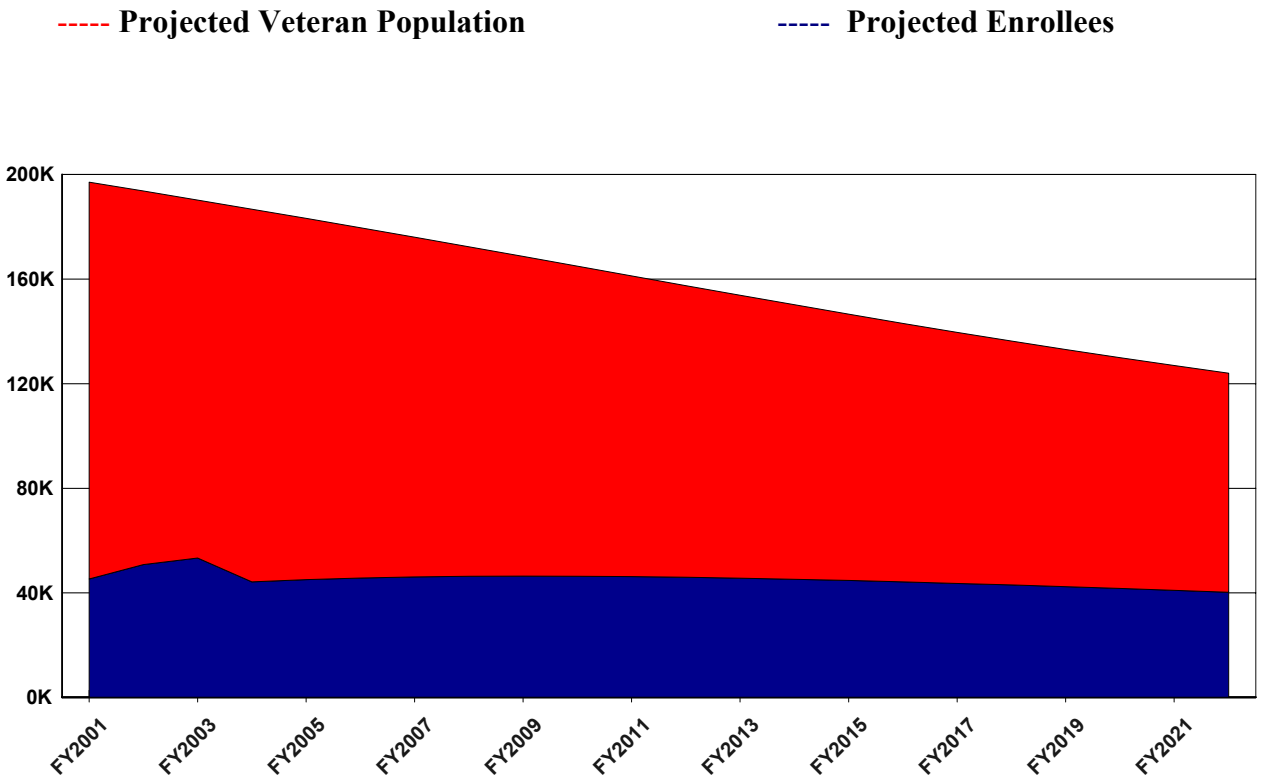
a. Market Definition

Market	Geographic Area	Rationale	Shared Counties
North Market **Code: 1C**	14 counties making up the state of Vermont and 10 counties making up the state of New Hampshire 24 Total Counties	(Vermont and New Hampshire) exists as a natural market because residents and veterans of the two states share many characteristics. Existing VA resources in the North have developed effective relationships resulting in many cooperative planning initiatives to address the unique needs of the area. A cluster of population in southern New Hampshire travels to Boston for business and work. However, surveys conducted by the VA in New Hampshire and Vermont have clearly identified that veterans in that area prefer their healthcare to be available locally. **Facilities:** White River Junction, VT; Manchester, NH	Bennington, VT **– The Bennington CBOC began as a joint CBOC with patients from both VISN 1 and VISN 2. However, VISN 1 treated over 76% of users in FY2001. It was concluded that a shared market is not necessary.** **Fairfield, CT** – The Danbury CBOC is across the river from Castle Point in VISN 2. VISN 1 treated over 86% of FY2001 users and it was also concluded that a shared market was not necessary.

b. Facility List

VISN : 1				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Manchester				
608 Manchester	✔	-	-	-
608GA Portsmouth	✔	-	-	-
608GC Wolfeboro	✔	-	-	-
608GD Conway	✔	-	-	-
608HA Tilton	✔	-	-	-
White River Junction				
405 White River Jct	✔	✔	-	-
405GA Bennington	✔	-	-	-
405HA Burlington (Appletree Bay)	✔	-	-	-
405HC Littleton/St. Johnsbury CBOC	✔	-	-	-
405HD VICC - Newport	-	-	-	✔
405HF Rutland	✔	-	-	-
405HG Wilder	-	-	-	✔

c. Veteran Population and Enrollment Trends



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
North Market			Februrary 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care (49,913)					
PI	Access to Hospital Care (49,913)	57% of enrollees in the North Market do not meet guidelines, impacting 21,463 enrollees.				
	Access to Tertiary Care (49,913)					
PI	Specialty Care Outpatient Stops	Population Based	64,204	66%	43,264	45%
		Treating Facility Based	72,548	79%	51,327	56%
PI	Medicine Inpatient Beds	Population Based	25	88%	16	55%
		Treating Facility Based	21	89%	13	55%
PI	Mental Health Outpatient Stops	Population Based	23,478	50%	4,698	10%
		Treating Facility Based	22,022	55%	6,718	17%
	Primary Care Outpatient Stops	Population Based	29,175	24%	2,190	2%
		Treating Facility Based	27,344	21%	-373	0%
	Psychiatry Inpatient Beds	Population Based	11	48%	4	18%
		Treating Facility Based	10	86%	5	38%
	Surgery Inpatient Beds	Population Based	1	4%	-3	-16%
		Treating Facility Based	1	4%	-2	-16%

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

Input was solicited from all the stakeholder groups throughout the process including a variety of stakeholder CARES briefings in a variety of settings. In addition, focus groups were held in three locations – Manchester, NH, White River Junction and Colchester, VT.

Common thread throughout the market was the desire to keep care local as much as feasible. There was agreement that contracting out in certain areas was a desirable option – particularly if it avoided the need to travel long distances. All agree that there are certain things that the VA does better than the private sector (e.g., PTSD treatment, etc.). Through the establishment of CBOCs, stakeholders' and veterans' groups can clearly see that the VA is committed to localizing veterans' health care.

The biggest difference between the White River Junction Focus Group and the Colchester Focus Group was that the northern participants were interested in local care, particularly access to specialty outpatient care and inpatient care, even if that meant contracting out services to a large degree. Although they did not want to see the VA disappear they wanted more local and convenient care.

At White River Junction, participants in the Focus Group were concerned about bed availability for veterans, quality of care with the contracts and legal responsibility for care. Participants were concerned with funding, and expressed a need for more education about services such as geriatric care and utilization of current space. Regarding Outpatient Specialty, participants were concerned with how to fund this and most liked the idea of expanding specialty care. Positive feedback on telemedicine and concerns expressed about meeting the needs of distant veterans – both groups supported this concept.

Regarding outpatient Mental Health, participants like the idea of a program modeled after VICC (Veterans Integrated Community Care), a combination of VA staff in a Community Mental Health Clinic. In White River Junction, there was more concern about contracting the VA out of business.

Specific to Manchester, although many stakeholders have, in the past, been very vocal in expressing their displeasure of the discontinuation of inpatient care at VAMC Manchester, most stakeholders now seem very accepting, and even excited about the fact that inpatient care is being offered through community facilities. Stakeholder comments now support more such arraignments across the state. Also, some stakeholders have expressed disappointment that additional CBOC capacity in NH is not being addressed under the current planning initiatives. Stakeholders express the desire to see additional CBOC's in Keene, Berlin, and Rochester. However, most stakeholders acknowledged that they understand that there are no access gaps with the existing CBOC's.

Based on positive feedback from stakeholders since development of the Planning Initiative solutions for improving access to inpatient beds, increasing the number of beds, increasing availability of local outpatient specialty and mental health care, we believe we have adequately incorporated their views. Overall, stakeholders in the North Market seem to be very comfortable with and supportive of the CARES process and the identified planning initiatives

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

No Impact.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

In addition to Access gaps, the North Market has PIs identified in three areas – Outpatient Specialty, Outpatient Mental Health, and Inpatient Medicine.

OUTPATIENT SPECIALTY
White River Junction – Specialty Care demand is expected to peak at 78,756 stops in FY 2008 up from 49,671 stops in FY 2001. The workload is then expected to gradually decrease to 62,796 in FY 2022. The increase in workload represents a space gap of 77,934 square feet at the peak year of FY 2008. WRJ plans to accommodate 20,000 square feet of the space gap by adding a third floor to Bldg. 39, WRJ's Ambulatory Care Building, and addressing the balance of the projected need via contract and to the extent feasible by expanding hours, contracting with community/affiliate and using telehealth/telemedicine. The addition of a floor to the current Ambulatory Care building will not meet the deficit in the projected square footage. Certain high volume specialties should be co-located at the Colchester CBOC by staff or contract.

Manchester – Specialty Care demand is expected to peak at 89,381 stops in FY 2010 up from 42,339 stops in FY 2001. The workload is then expected to gradually decrease to 80,542 in FY 2022. The increase in workload represents a space gap of 75,430 square feet at the peak year of FY 2010. Plan to address the space gap will be a combination of current lease expansions, contracting care in the community, and providing additional space at Manchester. A minor construction project to provide a partial third floor (18,500sf) to Bldg. 15 will assist in meeting the workload demand in the Manchester area. The plan calls for the expansion of existing leases at the Tilton CBOC and Portsmouth CBOC to provide Specialty Care -- 5,500 sq. ft. at Tilton and 6,000 sq. ft. at Portsmouth. Remaining gap will be addressed by contracting out. A 2nd alternative would be to accommodate increased demand by contracting care in the community.

OUTPATIENT MENTAL HEALTH

White River Junction–Mental Health demand is expected to peak at 35,520 stops in FY 2006 up from 23,583 stops in FY 2001. The workload is then expected to gradually decrease to 23,363 in FY 2022. The increase in workload represents a space gap of 18,344 square feet at the peak year of FY 2006. To address the gap in outpatient mental health, the plan is to provide contracted MH services to the currently unserved CBOCs in Littleton and Rutland, using existing community providers. Additional leased space (3,000 sq. ft) and VA employees will be used to enhance services at the Bennington CBOC to meet the demand. New contracted services and leased space will also be utilized in the Brattleboro/Keene area to provide services to the population centers in Southwest New Hampshire and Southeast Vermont.

Manchester–Mental Health demand is expected to peak at 33,494 stops in FY 2007 up from 16,754 stops in FY 2001. The workload is then expected to gradually decrease to 23,698 in FY 2022. The increase in workload represents a space gap of 7,687 square feet at the peak year of FY 2007. The plan to address the space gap will be a combination of current lease expansions, and contracting care in the community. We plan to expand our existing leases at the Tilton CBOC and Portsmouth CBOC to provide Mental Health Care -- 250 sq. ft. at Tilton and 500 sq. ft. at Portsmouth.

INPATIENT MEDICINE

White River Junction-To close the gap in the projected need for additional medical beds (11,075 BDOC in FY 2012, and 9,007 BDOC in 2022), the plan is to add 14 operating within existing space (not new construction. These would include 2 step-down beds. Although shown in the IBM model as 5,000 square feet of new construction, actually would be accomplished within current available space, with some renovation. In addition, to close the gap, WRJ would need to contract between 3000-4000 BDOC in the community - by a combination of fee and contract. A 2nd alternative is to accommodate all increased demand by contract

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

North Market - Currently 57% of enrollees have access to hospital care that meets identified standards. The guideline is that 65% of enrollees should have access.

White River Junction – In addition to the access gap to hospital care, there is also an identified gap in numbers of inpatient medicine beds at WRJ. To close the gap in the projected need for additional medical beds (11,075 BDOC in FY 2012, and (9,007 BDOC in 2022), plan is to add 14 operating beds at White River Junction within existing space (not new construction). These would include 2 step-down beds. However, in order for the gap to meet the 75% threshold, between 3,000 and 4,000 additional bed days of care would need to be contracted. This would be accomplished by a combination of fee and contract. As a result of implementing the additional bed initiative, the access gap will be accommodated without any additional action. Expansion of inpatient Medicine capacity at White River Junction is supported by the projected inpatient demand, not only in Medicine, but for inpatient surgical capacity as well. It would provide better access, continuity and patient satisfaction. A significant component of the gap for inpatient medicine service exists in Northwest VT. WRJ projects possible contracts with our affiliate(s) at the University of Vermont and/or DHMC. Expansion of inpatient Medicine at White River Junction and contract arrangement will enhance its mission as a referral facility for Manchester and other VISN facilities as needed. Preserving and enlarging the venues for bedside training and research are aligned with the interests of affiliates, Congressional Delegations and VSOs. Increased bed capacity will bolster WRJ response to DoD sharing and emergency preparedness/homeland security.

Manchester – Manchester plans to expand its current inpatient care contract (or develop staff model) for non-elective inpatient acute admissions at non-VA facility. Previous experience with contracting Hospital Care in the community has shown to be very effective. The quality of care has been high. Patient satisfaction surveys have shown that patients are extremely satisfied with care received. Contracts will be written only with JCAHO Accredited Hospitals. An active patient management program and reviews by the local Quality Management assure that patient safety and an appropriate environment are met. Contracting Care with local hospitals will have a positive impact on staffing and the community. Local Hospitals will be able to make more efficient use of their current resources without competing with the VA for the same limited resources. This will allow retention of a broader range of personnel to provide services to veterans and others.

This proposal makes optimal use of existing community resources. The fact that local hospitals will be able to make more efficient us of their current resources will help to keep contract costs in check.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**75%**	12,629	**76%**	11,016	**77%**	9,245
Hospital Care	**57%**	21,722	**98%**	918	**98%**	804
Tertiary Care	**98%**	1,010	**99%**	459	**99%**	402

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Manchester

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

None.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

No collaborative opportunities were utilized in our Market Plan solutions. Only a few small DoD facilities remain in New Hampshire. None of these facilities have excess capacity or plans for expansion of existing services that will allow for their incorporation into our market strategy. Similarly there are no VBA or NCA collaborative opportunities planned which would address workload or other planning initiatives. Past reviews have shown little opportunities for enhance use. This is because there is not a large amount of existing underutilized and/or vacant space. The fact that Medical Center is located in a residential area limits the opportunities for construction of new enhanced use facilities.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

No collaborative opportunities were utilized in our Market Plan solutions. Only a few small DoD facilities remain in New Hampshire. None of these facilities have excess capacity or plans for expansion of existing services that will allow for their incorporation into our market strategy. Similarly there are no VBA or NCA collaborative opportunities planned which would address workload or other planning initiatives. Past reviews have shown little opportunities for enhance use. This is because there is not a large amount of existing underutilized and/or vacant space. The fact that Medical Center is located in a residential area limits the opportunities for construction of new enhanced use facilities.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

Manchester supports the Infrastructure Improvement imitative identified by the VISN.

The majority of the square footage associated with Manchester facility was constructed in the late 1940's. As a result most of the site utilities systems are over 50 years in age. Most of the patient care and non-patient care areas do not have air-conditioning and/or mechanical ventilation and are not incompliance with VA criteria. Those areas that do have AC are feed through a variety of package units that are beyond their life expectancy and are in need of replacement. The heating and plumbing distribution system are prone to failure resulting in increasing maintenance and repair costs. The sewer system routinely clogs up flooding the basement of the main medical complex. The building envelope requires tucking pointing and masonry repairs. Water penetrations are abundant. A large amount of the original windows remain in Building 1. Although the electrical distribution system is in fair condition replacement of lighting fixtures with energy efficient fixtures and Fire Alarm System improvements are required.

The NHCU and Primary Care buildings were added in the late 1970's and most of their building service equipment has approached its life expectancy. Their original roofs are beyond their normal life expectancy.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	2,537	1,089	2,537	1,089	2,537	-	-	-	-	-	-	$ (859,794)
Surgery	900	(479)	900	(479)	900	-	-	-	-	-	-	$ -
Intermediate/NHCU	90,231	-	90,231	-	43,311	-	-	-	-	-	46,920	$ -
Psychiatry	73	(77)	73	(77)	13	-	-	-	-	-	60	$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**93,741**	**533**	**93,741**	**533**	**46,761**	**-**	**-**	**-**	**-**	**-**	**46,980**	**$ (859,794)**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	86,445	27,328	86,445	27,328	5,187	-	-	-	-	-	81,258	$ (1,878,642)
Specialty Care	88,853	46,516	88,853	46,516	30,000	-	-	-	-	-	58,853	$ (12,044,821)
Mental Health	30,869	14,119	30,870	14,120	6,000	-	-	-	-	-	24,870	$ (1,605,774)
Ancillary & Diagnostics	87,996	34,171	87,997	34,172	50,000	-	-	-	-	-	37,997	$ (23,948,089)
Total	**294,163**	**122,134**	**294,165**	**122,136**	**91,187**	**-**	**-**	**-**	**-**	**-**	**202,978**	**$ (39,477,326)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	158	(842)	-	(1,000)	1,000	-	-	-	-	-	1,000	1,000
Surgery	-	(60,100)	-	(60,100)	60,100	-	-	-	-	-	-	-
Intermediate Care/NHCU	60,100	60,100	60,100	60,100	-	-	-	-	-	-	60,100	-
Psychiatry	98	98	97	97	-	-	-	-	-	-	-	(97)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**60,356**	**(744)**	**60,197**	**(903)**	**61,100**	**-**	**-**	**-**	**-**	**-**	**61,100**	**903**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	43,067	24,523	43,067	24,523	18,544	-	-	13,000	5,250	-	36,794	(6,273)
Specialty Care	96,681	67,480	68,858	39,657	29,201	-	18,500	-	11,500	-	59,201	(9,657)
Mental Health	16,130	5,351	13,679	2,900	10,779	-	-	-	864	-	11,643	(2,036)
Ancillary and Diagnostics	67,582	42,609	30,398	5,425	24,973	-	-	-	-	-	24,973	(5,425)
Total	**223,459**	**139,962**	**156,002**	**72,505**	**83,497**	**-**	**18,500**	**13,000**	**17,614**	**-**	**132,611**	**(23,391)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	5,280	-	2,633	(2,647)	5,280	-	-	-	-	-	5,280	2,647
Administrative	156,112	75,217	118,169	37,274	80,895	-	-	-	-	-	80,895	(37,274)
Other	19,768	-	19,768	-	19,768	-	-	-	-	-	19,768	-
Total	**181,160**	**75,217**	**140,570**	**34,627**	**105,943**	**-**	**-**	**-**	**-**	**-**	**105,943**	**(34,627)**

4. Facility Level Information – White River Junction

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

None.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

White River Junction supports the Infrastructure Improvement Initiative identified by the VISN.

A majority of the square footage associated with the White River Junction facility was constructed in the late 1930's and 1940's. As a result, many of the utilities systems are over 60 years in age. The HVAC&R systems have difficulty supporting more recent requirements and loads. Any alterations will require upgrade of systems. Ventilation rates fall short of VA criteria in the outpatient care, SPD, Morgue, Lab and many inpatient care areas. The existing central chiller system has difficulty meeting peak summer demands due to new loads which have been added. The HVAC systems serving patient care areas are 25 to 35 years old and beyond the normal life expectancy. Several electrical deficiencies exist including the existing emergency electrical distribution system. Some building service equipment, such as the medical gas system, serving critical areas such as the OR lack emergency power. There is no separation between life safety, critical care and equipment circuits. The existing heating system is comprised of mostly original equipment, which is well beyond its useful life. The existing steam distribution systems have multiple steam trap failures blowing back into the condensate return and several underground lines which are leaking. A substantial number of control valves in the domestic water system are inoperable. Due to excessive domestic water chlorination over the last few years, sanitary drains have developed multiple leak points primarily in Bldg. #1, but has affected piping in several other buildings. The boiler plant is also operating three boilers, one is almost 50 years old and the other two are 29 years old, well beyond their useful life. Existing boiler controls are also antiquated and inefficient. Many inpatient spaces with 4-bed patient rooms require renovation to facilitate privacy. Renovation to the Nurses stations will also be needed.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	11,073	5,334	11,074	5,335	4,000	-	-	-	-	-	7,074	$ 4,989,164
Surgery	3,783	665	3,783	665	2,000	-	-	-	-	-	1,783	$ 168,055
Intermediate/NHCU	18,386	-	18,386	-	13,606	-	-	-	-	-	4,780	$ -
Psychiatry	6,910	3,300	6,911	3,301	1,000	-	-	-	-	-	5,911	$ 2,930,915
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**40,152**	**9,299**	**40,154**	**9,301**	**20,606**	**-**	**-**	**-**	**-**	**-**	**19,548**	**$ 8,088,134**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	70,133	18	70,134	18	1,000	-	-	-	-	-	69,134	$ (1,413,454)
Specialty Care	75,703	26,033	75,704	26,034	30,000	-	-	-	-	-	45,704	$ 10,255,362
Mental Health	31,485	7,904	31,486	7,905	14,000	-	-	-	-	-	17,486	$ 6,228,382
Ancillary & Diagnostics	69,753	11,974	69,753	11,974	30,000	-	-	-	-	-	39,753	$ (7,715,509)
Total	**247,074**	**45,928**	**247,077**	**45,931**	**75,000**	**-**	**-**	**-**	**-**	**-**	**172,077**	**$ 7,354,781**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	24,462	15,314	16,624	7,476	9,148	-	5,000	-	-	-	14,148	(2,476)
Surgery	5,608	1,728	4,333	453	3,880	-	-	-	-	-	3,880	(453)
Intermediate Care/NHCU	6,480	-	6,480	-	6,480	-	-	-	-	-	6,480	-
Psychiatry	11,196	3,423	9,576	1,803	7,773	-	-	-	-	-	7,773	(1,803)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**47,746**	**20,465**	**37,013**	**9,732**	**27,281**	**-**	**5,000**	**-**	**-**	**-**	**32,281**	**(4,732)**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	35,740	2,069	35,950	2,279	33,671	-	-	-	1,683	-	35,354	(596)
Specialty Care	100,603	70,530	62,614	32,541	30,073	-	20,000	-	-	-	50,073	(12,541)
Mental Health	24,565	14,690	14,513	4,638	9,875	-	-	-	3,000	-	12,875	(1,638)
Ancillary and Diagnostics	59,667	31,348	36,175	7,856	28,319	-	-	-	-	-	28,319	(7,856)
Total	**220,575**	**118,637**	**149,252**	**47,314**	**101,938**	**-**	**20,000**	**-**	**4,683**	**-**	**126,621**	**(22,631)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	32,007	-	33,410	1,403	32,007	-	-	-	-	-	32,007	(1,403)
Administrative	336,368	155,777	244,378	63,787	180,591	-	-	-	-	-	180,591	(63,787)
Other	10,758	-	10,758	-	10,758	-	-	-	-	-	10,758	-
Total	**379,133**	**155,777**	**288,546**	**65,190**	**223,356**	**-**	**-**	**-**	**-**	**-**	**223,356**	**(65,190)**

D. West Market

1. Description of Market

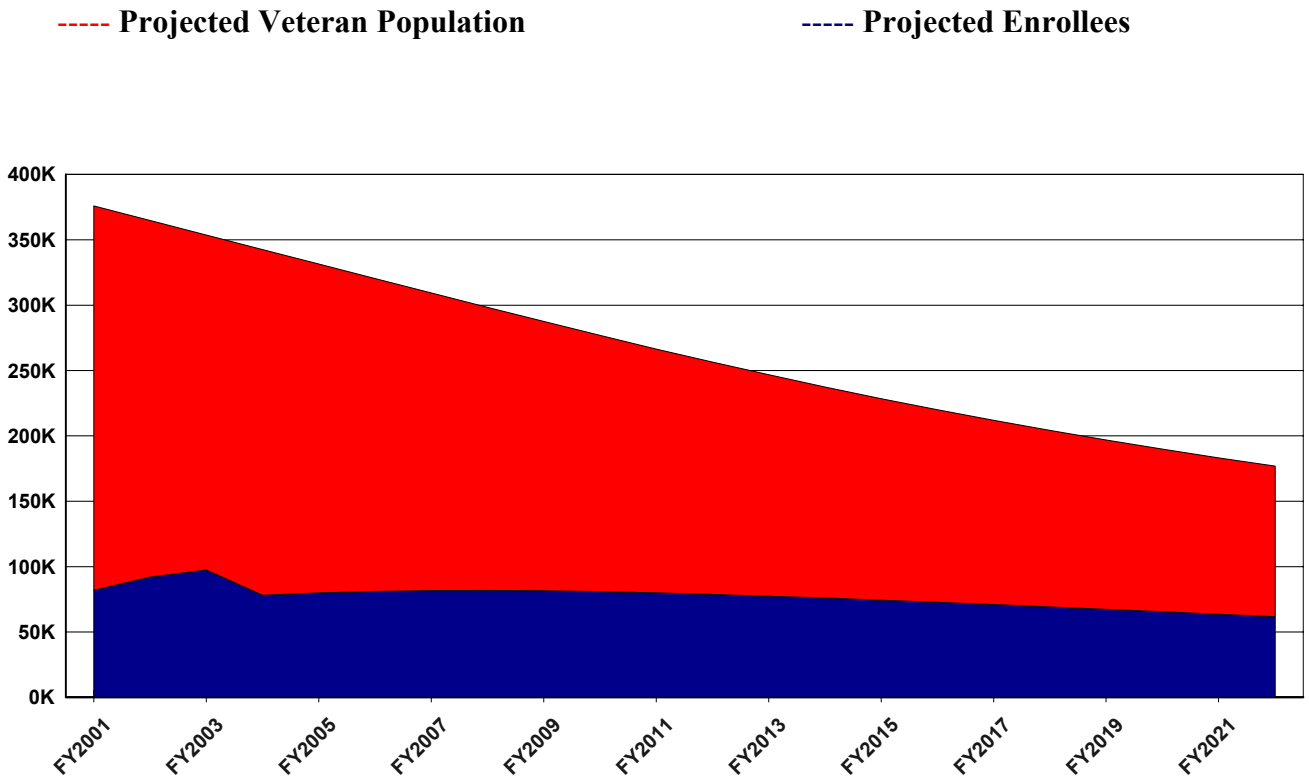
a. Market Definition

Market	Includes	Rationale	Shared Counties
West Market **Code: 1D**	4 counties in western Massachusetts and all 8 counties making up the state of Connecticut 12 Total Counties	Western Massachusetts and all of Connecticut fall together naturally because of the historical referral of western Massachusett veterans for specialty care at VA Connecticut. Veterans in western Massachusetts have expressed a preference for this referral pattern partly because of convenience, their association with CBOCs near borders and the existence of north-south highway system and the sharing of a major airport (Bradley Field). **Facilities:** West Haven, CT; Northampton, MA; Newington, CT	**Berkshire, MA** - Many patients prefer to use Albany in VISN 2 over Northampton due to distance and travel convenience. However, this represented less than 30% of users in FY2001. It was concluded that a shared market is not necessary.

b. Facility List

VISN : 1				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Newington				
689A4 Newington Campus	✔	-	-	-
Northampton				
631 Northampton	✔	-	-	-
631BY Springfield (Main St)	✔	-	-	-
631GB Springfield (State St.)	✔	-	-	-
631GC Pittsfield Veterans Community Care Center	✔	-	-	-
631GD Greenfield (Franklin County)	✔	-	-	-
West Haven				
689 West Haven	✔	✔	✔	-
689GA Waterbury VA Primary Care Center	✔	-	-	-
689GB Stamford VA Primary Care Center	✔	-	-	-
689GC Windham VA Primary Care	✔	-	-	-
689GD Winsted VA Primary Care	✔	-	-	-
689GE Danbury VA Primary Care	✔	-	-	-
689HB Norwich Screening Clinic	-	-	-	✔
689HC New London VA Primary Care Center	✔	-	-	-

c. Veteran Population and Enrollment Trends



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
West Market			Februrary 2003 (New)			
Market PI	Category	CARES Workload Category	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
	Access to Primary Care (89,339)					
	Access to Hospital Care (89,339)					
	Access to Tertiary Care (89,339)					
PI	Specialty Care Outpatient Stops	Population Based	136,630	83%	70,005	43%
		Treating Facility Based	132,407	84%	69,499	44%
PI	Medicine Inpatient Beds	Population Based	39	68%	13	23%
		Treating Facility Based	40	72%	14	26%
PI	Primary Care Outpatient Stops	Population Based	77,391	40%	8,875	5%
		Treating Facility Based	73,907	38%	8,019	4%
	Surgery Inpatient Beds	Population Based	9	29%	-3	-10%
		Treating Facility Based	9	31%	-2	-8%
	Psychiatry Inpatient Beds	Population Based	1	1%	-17	-11%
		Treating Facility Based	5	3%	-18	-11%
	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	1,282	1%	45	0%

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

Aging veterans appreciate the possibility to access specialty care and inpatient services in their own community. With some increased contracting for services in the community, this concern should be minimized. The academic affiliates and labor unions expressed concern about the potential for contracting for any services away from VA but are reasonably comfortable with the current level of postgraduate medical educational and employment opportunities presented by the current plans.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

The Eastern Blind Rehabilitation Center (EBRC) is located at the West Haven facility of the West Market. This intensive inpatient unit provides rehabilitative services to blinded veterans across markets within VISN1, as well as serves as a referral site for VISN2-5 and parts of 6. The EBRC serves this special population with 34 beds and an extensive network of VIST programs for support in the veterans' community. With the projected increases for this special population, it is anticipated that the 34 beds will be fully utilized throughout the 20 year planning cycle. As demand is extremely high in some years, additional bed space may be required at EBRC, but there is no PI in place for this currently.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

The West Market includes all of Connecticut and the western half of Massachusetts. Facilities include the tertiary care facility of West Haven, the outpatient facility at Newington, the neuropsychiatric facility at Northampton and 9 community based outpatient clinics spread evenly across the market. Projections are for significant increases in demand in primary care, outpatient specialty care and inpatient medicine. The large increase in primary care demand results in significant workload gaps of approx. 90,000 stops and space gaps of 44,000 SF; the specialty care demand results in workload gaps of <143,000 stops and space gaps of <184,00 SF; the Inpatient Medicine demands results in significant workload gaps of <17,150 BDOC and space gaps of 39,039 SF.

Two alternatives were examined. Because of both space gaps and infrastructure issues, one alternative considered is to contract in the community for all the excess demand over current capacity. The chosen alternative is to expand primary care, outpatient specialty care, and inpatient medicine to the extent possible within the existing space and contract in the community for the remaining demand. Through better utilization of space at Newington to free 11,000 SF and additional leased space at each of the CBOCs, the demand for primary care will be met.

No West market facility currently has vacant space to accomplish the outpatient specialty PI "in-house." The demand for outpatient specialty services requires the lease of 50,000 SF in Springfield clinic; 22,000 SF of additional space will be available in Newington in 2006 as currently out leased space becomes available. In the case of VA Connecticut facilities, both proposed increases would be contingent upon domino moves that would require moderate to major renovation projects in order to correct deficiencies noted in functional space scores. Both of these projects would maximize support services that exist within the proposed locations; although an upgrade to ancillary staff would be required.

To address the demand for inpatient services, an additional 20-bed unit, currently under construction, would augment the existing medicine beds at West Haven. This will increase "available" beds to a level that meets 50% of the workload gap by FY2012 and 100% by FY2022. The existing beds have a functional score of 2.91 and will require renovation. The unmet inpatient demand must be contracted in the community. The most recent American Hospital Association (AHA) 2003 Hospital Statistics lists Connecticut hospitals slightly under 75% utilized. Although some recent contractions of beds have occurred with the economic downturn, there has been a steady increase in the number of available beds in the state from 1998 – 2001. Currently, VA Connecticut Healthcare System has a contract with Health Net that incorporates several of the major healthcare facilities along the major traffic corridors in the West market.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact.

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**96%**	3,580	**96%**	3,148	**96%**	2,465
Hospital Care	**73%**	24,167	**72%**	22,038	**71%**	17,872
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Newington

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

None.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

Newington Campus supports the Infrastructure Improvement Initiative identified by the VISN.

The square footage associated with most of Newington Campus facility was constructed in 1931 and underwent a partial upgrading and additions in 1997. As a result, many of the utilities systems were upgraded. Areas not upgraded have HVAC&R systems that are outdated and have difficulty supporting current requirements and their intended loads. Ventilation rates in the old un-renovated spaces do not meet current VA criteria in areas such as Dental, Radiology, Nuclear Medicine, Research Labs and many inpatient care areas. The HVAC systems in un-renovated spaces are beyond the normal life expectancy and undersized. Elevator machine rooms require HVAC systems in buildings 1 and3 to keep equipment from breaking down. Fixed diagnostic equipment in radiology and nuclear medicine require replacement. The fire alarm system horn and strobe lights do not comply with ADA standards. Nurse call system has many inoperative features due to the lack of access to replacement parts. Most patient toilet areas of the Medical Center do not have a functioning emergency call system. The overhead paging system needs to be expanded thoughout the renovated and addition space to improve patient communications. The existing heating system is comprised of mostly original equipment, which is well beyond its useful life. The steam condensate return system has some areas found to be improperly piped. Existing domestic cold and hot water system is aged and is showing signs of corrosion. Some areas have been identified as having “blue water” and require re-piping and electrical modifications to transformer grounding. The boiler plant stacks and hotwells are aging and require replacement and repair. Areas such as the boiler plant and in building one on the fourth floor require sprinklers. Many of the original out buildings and connecting corridors have original single paned windows in poor condition. Windows need to be replaced with new thermal panel units. Various roofs are failing and require replacement. Original out buildings with masonry require tuckpointing of the joints and coping stones.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	407	173	407	173	407	-	-	-	-	-	-	$ -
Surgery	137	(30)	137	(30)	137	-	-	-	-	-	-	$ -
Intermediate/NHCU	-	-	-	-	-	-	-	-	-	-	-	$ -
Psychiatry	20	(32)	21	(31)	21	-	-	-	-	-	-	$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**564**	**111**	**565**	**112**	**565**	**-**	**-**	**-**	**-**	**-**	**-**	**$ -**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	70,678	21,777	70,678	21,777	2,000	-	-	-	-	-	68,678	$ 4,989,703
Specialty Care	83,679	34,962	83,679	34,962	33,681	-	-	-	-	-	49,998	$ (6,613,876)
Mental Health	28,365	198	28,366	199	-	-	-	-	-	-	28,366	$ -
Ancillary & Diagnostics	34,329	6,942	34,330	6,943	7,331	-	-	-	-	-	26,999	$ (201,127)
Total	**217,051**	**63,879**	**217,053**	**63,881**	**43,012**	**-**	**-**	**-**	**-**	**-**	**174,041**	**$ (1,825,300)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	-	-	-	-	-	-	-	-	-	-	-	-
Surgery	-	-	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	-	-	-	-	-	-	-	-	-	-	-	-
Psychiatry	-	-	-	-	-	-	-	-	-	-	-	-
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	35,339	12,791	34,339	11,791	22,548	4,000	-	-	-	-	26,548	(7,791)
Specialty Care	92,047	68,952	54,998	31,903	23,095	22,100	-	-	-	-	45,195	(9,803)
Mental Health	22,409	(1,667)	22,409	(1,667)	24,076	-	-	-	-	-	24,076	1,667
Ancillary and Diagnostics	32,957	13,250	25,919	6,212	19,707	-	-	-	-	-	19,707	(6,212)
Total	**182,752**	**93,326**	**137,665**	**48,239**	**89,426**	**26,100**	**-**	**-**	**-**	**-**	**115,526**	**(22,139)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	1,466	-	-	(1,466)	1,466	-	-	-	-	-	1,466	1,466
Administrative	211,851	107,471	158,315	53,935	104,380	-	-	-	-	-	104,380	(53,935)
Other	25,731	-	10,880	(14,851)	25,731	-	-	-	-	-	25,731	14,851
Total	**239,048**	**107,471**	**169,195**	**37,618**	**131,577**	**-**	**-**	**-**	**-**	**-**	**131,577**	**(37,618)**

4. Facility Level Information – Northhampton

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

None.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

None.

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

Improvement Initiative identified by the VISN.

The majority of this campus facility was built in the 20's with major additions to Bldg 1 and 4 in the 40's. Underground utility systems, such as, the steam distribution, sanitary and storm sewers, and water distribution system valves need replacement. Approximately 50% of the Primary and Secondary Electrical Systems need upgrading. Asbestos is present in pipe insulation and in floor tile throughout the Medical Center and needs removal during renovation work.

Building exterior surfaces need tuckpoint and waterproofing treatment. Built up roof systems are at least 20 years old, leaking and require replacement. Interior finishes will require lead abatement for any renovation work. Interior doors and hardware are in poor condition. HVAC systems do not meet existing standards. The majority of the Medical Center Air Conditioning is provided by thru-wall units rather than centralized systems. Our main chiller systems in Building 1 require replacement due to age and inadequate size. Elevators require maintenance and replacement.

Patient Wards require renovation to meet patient privacy standards for bedroom as well as toilets. Nursing stations and dayrooms are currently inadequate to meet current demands. Medical gas systems need to be expanded in Building 1 and added to other patient wards where no medical gas systems currently exist.

The exterior walkway structure needs the concrete slabs replaced and repaired throughout about 10% of the structure. Fencing behind Buildings 8 & 9 needs replacement.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	2,140	896	2,141	897	2,141	-	-	-	-	-	-	$ (14,170,330)
Surgery	84	(40)	84	(40)	56	-	-	-	-	-	28	$ -
Intermediate/NHCU	70,388	-	70,388	-	48,568	-	-	-	-	-	21,820	$ (2,590,779)
Psychiatry	44,341	1,405	44,341	1,405	1,000	-	-	-	-	-	43,341	$ (7,110,623)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**116,953**	**2,261**	**116,954**	**2,262**	**51,765**	**-**	**-**	**-**	**-**	**-**	**65,189**	**$ (23,871,732)**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	52,070	(571)	52,070	(570)	796	-	-	-	-	-	51,274	$ (2,043,030)
Specialty Care	54,438	40,627	54,439	40,627	7,440	-	-	-	-	-	46,999	$ (14,238,651)
Mental Health	49,694	157	49,695	157	-	-	-	-	-	-	49,695	$ (1,346,553)
Ancillary & Diagnostics	58,585	20,295	58,585	20,295	16,587	-	-	-	-	-	41,998	$ (10,946,150)
Total	**214,787**	**60,507**	**214,789**	**60,509**	**24,823**	**-**	**-**	**-**	**-**	**-**	**189,966**	**$ (28,574,384)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	5,210	1,171	-	(4,039)	4,039	-	-	-	-	-	4,039	4,039
Surgery	47	47	46	46	-	-	-	-	-	-	-	(46)
Intermediate Care/NHCU	21,339	-	21,339	-	21,339	-	-	-	-	-	21,339	-
Psychiatry	71,832	33,517	70,212	31,897	38,315	15,000	-	-	-	-	53,315	(16,897)
PRRTP	-	(15,000)	-	(15,000)	15,000	-	-	-	-	-	15,000	15,000
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**98,429**	**19,736**	**91,597**	**12,904**	**78,693**	**15,000**	**-**	**-**	**-**	**-**	**93,693**	**2,096**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	25,514	5,325	25,637	5,448	20,189	-	-	-	5,079	-	25,268	(369)
Specialty Care	84,435	72,796	77,548	65,909	11,639	-	-	-	50,000	-	61,639	(15,909)
Mental Health	38,762	1,499	38,762	1,499	37,263	-	-	-	-	-	37,263	(1,499)
Ancillary and Diagnostics	40,599	18,375	29,399	7,175	22,224	-	-	-	-	-	22,224	(7,175)
Total	**189,311**	**97,996**	**171,346**	**80,031**	**91,315**	**-**	**-**	**-**	**55,079**	**-**	**146,394**	**(24,952)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	985	-	990	5	985	-	-	-	-	-	985	(5)
Administrative	262,740	107,473	239,278	84,011	155,267	-	-	-	-	-	155,267	(84,011)
Other	60,671	-	26,150	(34,521)	60,671	-	-	-	-	-	60,671	34,521
Total	**324,396**	**107,473**	**266,418**	**49,495**	**216,923**	**-**	**-**	**-**	**-**	**-**	**216,923**	**(49,495)**

5. Facility Level Information – West Haven

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

None.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Narrative:

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Narrative:

None.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Narrative:

West Haven Campus supports the Infrastructure Improvement Initiative identified by the VISN.

Most of West Haven Campus facility (square footage) was constructed in late 1940s others existing Buildings were constructed in the late 1890s. Many of the utilities systems are over 55 years old and have long surpassed their life expectancy. Currently, the HVAC&R systems operate 24/7 using outmoded and highly inefficient component and control systems, which is making it difficult for the systems to support current load demands and put restrains on development of new hospital mission requirements. Ventilation rates do not meet current VA criteria for Clinical Labs, Research Labs and many inpatient infectious care areas. Many electrical deficiencies exist including the existing emergency electrical distribution feeders, grounding, and associated systems. Emergency exit and egress lights do not activate onto the Life Safety Branch. The fire alarm system horn and strobe lights do not comply with ADA standards. Nurse call system has many inoperative features due to the lack of access to replacement parts. There is no separation between life safety, critical care and equipment circuits in most areas of Building 1. Medical and vacuum gas systems serving patient and research spaces do not meet current codes. Upgrading to current NFPA requirements is necessary. The existing heating system is comprised of mostly original equipment, which is well beyond its useful life. The existing steam distribution header system is in poor condition. The steam condensate return system has multiple failures and several mains lines are leaking. We are experiencing numerous leaks from the plumbing piping waste and vent systems are rotting out. Existing domestic hot water system is inadequate due to improper return system and age of heat exchangers. Boiler plant controls operate three boilers. These boiler controls are antiquated, inefficient and inadequate. Boiler burners are old technology and parts are difficult to obtain. Replace with new burners, controls and associated equipment. All inpatient patient rooms do not have adequate bath facilities. Spaces require renovation to facilitate private baths. Functional inadequacies exist between primary clinical functions such ad Lab, SPD, Dietetics, Dialysis.

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	26,832	11,185	26,833	11,186	6,977	-	-	-	-	-	19,856	$ 20,340,257
Surgery	11,392	2,783	11,392	2,783	4,394	-	-	-	-	-	6,998	$ (59,465,572)
Intermediate/NHCU	100,053	-	100,053	-	90,048	-	-	-	-	-	10,005	$ (3,884,171)
Psychiatry	9,907	166	9,908	167	-	-	-	-	-	-	9,908	$ (1,366,124)
PRRTP	3,904	-	3,904	-	-	-	-	-	-	-	3,904	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	9,785	-	9,785	-	-	-	-	-	-	-	9,785	$ (3,948,259)
Total	**161,874**	**14,135**	**161,875**	**14,136**	**101,419**	**-**	**-**	**-**	**-**	**-**	**60,456**	**$ (48,323,869)**

	Clinic Stops (from demand projections)		Clinic Stops proposed by Market Plans in VISN									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	143,556	52,701	143,556	52,701	5,743	-	-	-	-	-	137,813	$ (1,853,537)
Specialty Care	152,673	56,818	152,673	56,818	12,000	-	-	-	-	-	140,673	$ 9,471,273
Mental Health	107,236	925	107,236	926	2,145	-	-	-	-	-	105,091	$ (4,906,827)
Ancillary & Diagnostics	229,966	83,645	229,966	83,645	79,967	-	-	-	-	-	149,999	$ (10,752,154)
Total	**633,429**	**194,089**	**633,431**	**194,090**	**99,855**	**-**	**-**	**-**	**-**	**-**	**533,576**	**$ (8,041,245)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)											
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Vari**							**l ed e**	**Space Needed/ Moved to Vacant**
Medicine	64,289	38,066	49,044	22,821	26,223	11,920	-	-	-	-	38,143	(10,901)
Surgery	27,857	14,541	17,285	3,969	13,316	-	-	-	-	-	13,316	(3,969)
Intermediate Care/NHCU	29,950	-	29,949	(1)	29,950	-	-	-	-	-	29,950	1
Psychiatry	20,708	8,497	20,708	8,497	12,211	7,020	-	-	-	-	19,231	(1,477)
PRRTP	5,281	-	14,281	9,000	5,281	-	-	10,000	-	-	15,281	1,000
Domiciliary program	-	(7,020)	-	(7,020)	7,020	-	-	-	-	-	7,020	7,020
Spinal Cord Injury	31,106	31,106	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	(31,106)	31,106	-	31,106	-	-	-	-	-	31,106	-
Total	**179,191**	**54,084**	**162,373**	**37,266**	**125,107**	**18,940**	**-**	**10,000**	**-**	**-**	**154,047**	**(8,326)**

	Space (GSF) (from demand projections)											
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Vari**							**l ed e**	**Space Needed/ Moved to Vacant**
Primary Care	90,957	34,142	90,957	34,142	56,815	-	-	7,340	8,010	-	72,165	(18,792)
Specialty Care	171,788	59,253	163,181	50,646	112,535	11,590	-	-	-	-	124,125	(39,056)
Mental Health	57,800	18,782	57,800	18,782	39,018	-	-	-	5,324	-	44,342	(13,458)
Ancillary and Diagnostics	144,235	69,623	95,999	21,387	74,612	-	-	-	-	-	74,612	(21,387)
Total	**464,780**	**181,800**	**407,937**	**124,957**	**282,980**	**11,590**	**-**	**7,340**	**13,334**	**-**	**315,244**	**(92,693)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Vari**							**l ed e**	**Space Needed/ Moved to Vacant**
Research	94,985	-	199,392	104,407	94,985	4,076	8,000	46,272	-	-	153,333	(46,059)
Administrative	354,699	112,933	345,336	103,570	241,766	-	-	-	-	-	241,766	(103,570)
Other	37,830	-	23,830	(14,000)	37,830	-	-	-	-	-	37,830	14,000
Total	**487,514**	**112,933**	**568,558**	**193,977**	**374,581**	**4,076**	**8,000**	**46,272**	**-**	**-**	**432,929**	**(135,629)**