

# Department of Veterans Affairs

## Capital Asset Realignment for Enhanced Services



**VISN 6**

**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/>>>.

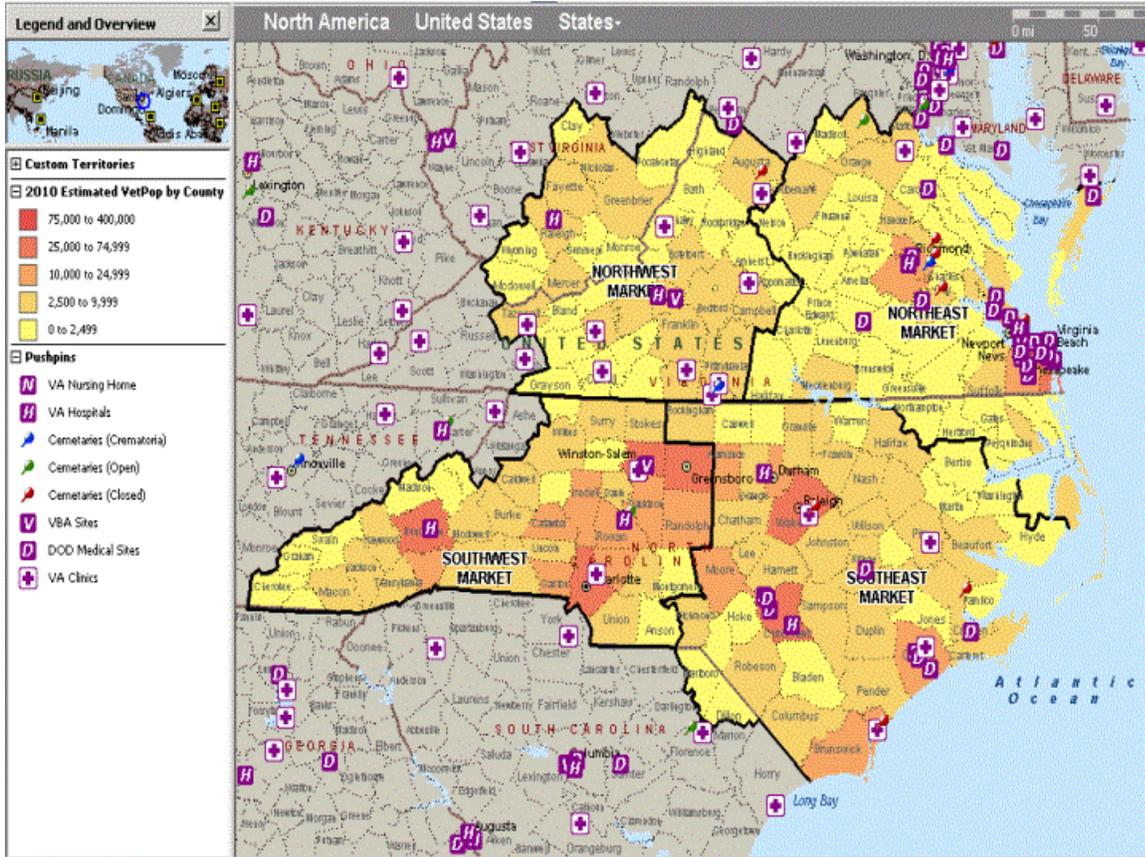
## Table of Contents – VISN 06

	<b>Page</b>
I. VISN Level Information.....	4
A. Description of the Network/Market/Facility.....	4
1. Map of VISN Markets.....	4
2. Market Definitions.....	5
3. Facility List.....	7
4. Veteran Population and Enrollment Trends.....	9
5. Planning Initiatives and Collaborative Opportunities.....	10
6. Stakeholder Information.....	16
7. Collaboration with Other VISNs.....	17
B. Resolution of VISN Level Planning Initiatives.....	18
1. Proximity Planning Initiatives.....	18
2. Special Disability Planning Initiatives.....	19
C. VISN Identified Planning Initiatives.....	21
D. VISN Level Data Summary of Post Market Plan (Workload, Space, Costs).....	23
II. Market Level Information.....	28
A. Market – Northeast.....	28
1. Description of Market.....	28
2. Resolution of Market Level Planning Initiatives: Access.....	36
3. Facility Level Information – Hampton.....	38
4. Facility Level Information – Richmond.....	43
B. Market – Northwest.....	48
1. Description of Market.....	48
2. Resolution of Market Level Planning Initiatives: Access.....	54
3. Facility Level Information – Beckley.....	55
4. Facility Level Information – Salem.....	62
C. Market – Southeast.....	67
1. Description of Market.....	67
2. Resolution of Market Level Planning Initiatives: Access.....	75
3. Facility Level Information – Durham.....	77
4. Facility Level Information – Fayetteville (NC).....	82
D. Market – Southwest.....	87
1. Description of Market.....	87
2. Resolution of Market Level Planning Initiatives: Access.....	94
3. Facility Level Information – Asheville.....	97
4. Facility Level Information – Salisbury.....	102

# I. VISN Level Information

## A. Description of the Network/Market/Facilities

### 1. Map of VISN Markets



## 2. Market Definitions

**Market Designation:** VISN 6 CARES is proposing 4 CARES markets, as follows, including the rationale for each:

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
North East Code: 6A	<b>68 Virginia Counties/ Independent Cities</b>  <b>10 North Carolina Counties</b>	The North East Market is based on the referral patterns of our Richmond and Hampton Virginia facilities with Richmond being a major tertiary facility. These facilities are also geographic partners and have a relationship of sharing services. There is one CBOC in this market supporting the Northern Virginia fringe. Unique features of this market are a high-density veteran population clustered along the coastal cities with predominantly rural areas inland. Good transportation and access routes. This market has strong VA/DoD potential. The North East market is made up of 78 counties and independent cities with an estimated FY 2002 veteran population of 363,626.	
South East Code: 6D	<b>46 North Carolina Counties</b>  <b>2 South Carolina Counties</b>	The South East Market is based on the referral patterns of our Durham and Fayetteville, North Carolina facilities with Durham being a major tertiary facility. These facilities are also geographic partners and have a relationship of sharing services. There are five CBOCs in this market The veteran population is comparatively evenly dispersed in moderately sized population areas along transportation and access routes. This market has moderate/strong VA/DoD potential. The South East market is made up of 48 counties with an estimated FY 2002 veteran population of 364,607.	

<p>North West Code: 6B</p>	<p><b>40 Virginia Counties/ Independent Cities</b></p> <p><b>11 West Virginia Counties</b></p>	<p>The North West Market is based on the referral patterns of our Salem, Virginia and Beckley, West Virginia facilities with Salem offering a greater range of services. These facilities are also geographic partners and have a relationship of sharing services. There are three CBOCs in this market two in Virginia and one in West Virginia. The market is primarily rural area covered and has adequate transportation and access routes. The North West market is made up of 51 counties and independent cities with an estimated FY 2002 veteran population of 166,373.</p>	<p>VISN 9 to include Smyth County in their planning process</p>
<p>South West Code: 6C</p>	<p><b>41 North Carolina Counties</b></p>	<p>The South West Market is based on the referral patterns of our Salisbury and Asheville, North Carolina facilities with Asheville being a tertiary facility. These facilities are also geographic partners and have a relationship of sharing services. This market has one CBOC and one SOPC to cover the two major metropolitan population centers in North Carolina. The market has one large and several moderately sized population areas dispersed along transportation and access routes. The South West market is made up of 41 counties with an estimated FY 2002 veteran population of 387,244.</p>	<p>VISN 9 to include Ashe, Watauga, &amp; Avery Counties in their planning process</p>

### 3. Facility List

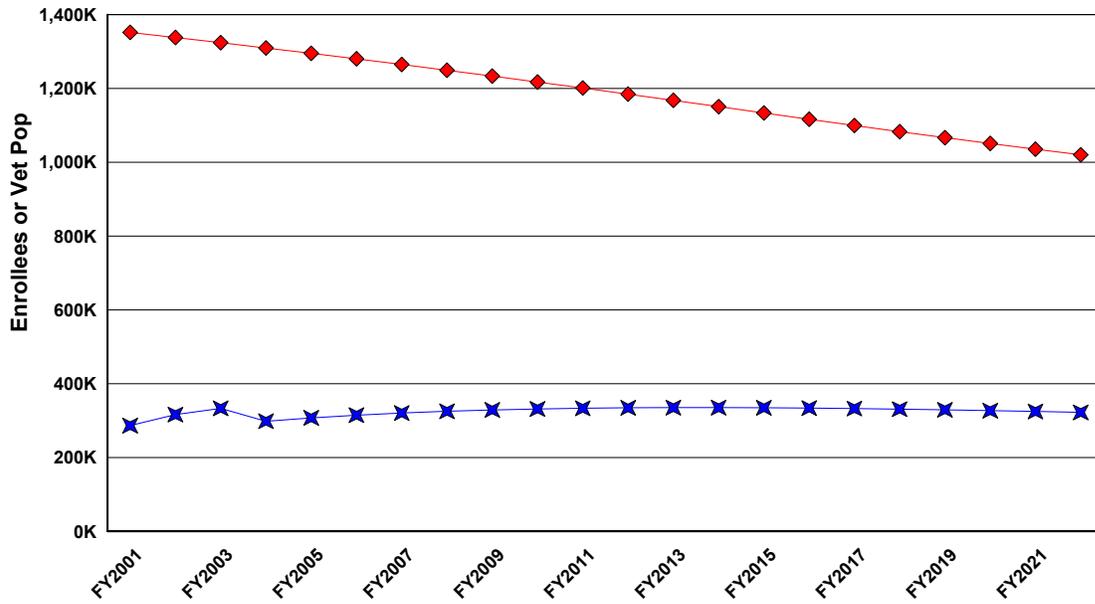
VISN : 6				
Facility	Primary	Hospital	Tertiary	Other
<b>Asheville</b>				
637 Asheville-Oteen	✓	✓	✓	-
<b>Beckley</b>				
517 Beckley	✓	✓	-	-
517GA Gassaway-Braxton County	✓	-	-	-
<b>Durham</b>				
558 Durham	✓	✓	✓	-
558GA Greenville	✓	-	-	-
558GB Raleigh	✓	-	-	-
558GC Havelock/Morehead City	✓	-	-	-
<b>Fayetteville (NC)</b>				
565 Fayetteville NC	✓	✓	-	-
565GA Jacksonville	✓	-	-	-
565GC New Hanover County (Willmington)	✓	-	-	-
<b>Hampton</b>				
590 Hampton	✓	✓	-	-
<b>Richmond</b>				
652 Richmond	✓	✓	✓	-
652GA Stafford/Fredericksburg	✓	-	-	-
<b>Salem</b>				
658 Salem	✓	✓	-	-
658GA Tazewell	✓	-	-	-
658GB Danville	✓	-	-	-
658HA Stuarts Draft	-	-	-	✓

658HB Pulaski	-	-	-	✓
658HC Lynchburg	-	-	-	✓
658HD Hillsville	-	-	-	✓
658HE Martinsville	-	-	-	✓
658HF Danville VA	-	-	-	✓
658HG Covington	-	-	-	✓
658HH Marion	-	-	-	✓
<b>Salisbury</b>				
659 W.G. (Bill) Hefner Salisbury VAMC	✓	✓	-	-
659BY Winston-Salem	✓	-	-	-
659GA Charlotte	✓	-	-	-

#### 4. Veteran Population and Enrollment Trends

--- Projected Veteran Population

--- Projected Enrollees



## 5. Planning Initiatives and Collaborative Opportunities

### a. Effective Use of Resources

Effective Use of Resources		
PI?	Issue	Rationale/Comments Re: PI
Y	Small Facility Planning Initiative	Northwest Market: Beckley, WV is projected to require fewer than 40 acute care beds by FY 2022. The VISN should review potential quality of care issues for patients in this market as well as opportunities for reassigning inpatient workload and/or enhancing volume.
N	Proximity 120 Mile Tertiary	Affected facility pairs include: Richmond, VA and Washington, DC (VISN 5) - Referral patterns and driving distances of 115 miles would create impractical commuting times to Washington DC are prohibitive
Y	Vacant Space	The following medical centers have identified strategic planning initiatives to address vacant space: Asheville, NC, Hampton, VA, Salisbury, NC, and Salem, VA. 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**

<b>Special Disabilities Program</b>		
<b>PI?</b>	<b>Other Issues</b>	<b>Rationale/Comments</b>
N	Blind Rehabilitation	Establish Visual Impairment Services Outpt Program (VISOR)
N	Spinal Cord Injury and Disorders	No recommendations

**c. Collaborative Opportunities**

<b>Collaborative Opportunities for use during development of Market Plans</b>		
<b>CO?</b>	<b>Collaborative Opportunities</b>	<b>Rationale/Comments</b>
Y	Enhanced Use	This VISN was not identified as having one of the 20 High-Potential <b>Enhanced Use Lease</b> Opportunities for VHA. The VISN should consider other potential opportunities in the development of their Market Plans, such as Durham, Hampton and Salem VAMCs. The VISN has an enhanced use project in the final stages at the Durham VAMC in the Southeast Market.
Y	VBA	No opportunities were identified within this VISN with VBA.
Y	NCA	Salem VAMC in the Northwest Market has a potential cemetery site.
Y	DOD	High potential at Hampton VAMC; also potential exists at Fayetteville VAMC and Durham VAMC to work collaboratively with the Air Force, the Navy and the Army to meet veterans' healthcare needs. There is existing collaboration with Richmond VAMC in the Northeast Market with Fort Lee (Army)

d. Other Issues

<b>Other Gaps/Issues Not Addressed By CARES Data Analysis</b>		
<b>PI?</b>	<b>Other Issues</b>	<b>Rationale/Comments</b>
	NHCU Northwest Market, VAMC Beckley, WV.	Milliman data and existing supporting documentation (CIP) supports an increase of NHCU beds in the NW market.
	Satellite OPC at Salisbury, NC	Leased Satellite OPC is in the SFO stage, with supporting documentation by Milliman data.

**e. Market Capacity Planning Initiatives**

**Northeast Market**

<b>Category</b>	<b>Type of Gap</b>	<b>FY2001 Baseline</b>	<b>Fy 2001 Modeled ***</b>	<b>FY 2012 Gap</b>	<b>FY 2012 % Gap</b>	<b>FY 2022 Gap</b>	<b>FY 2022 % Gap</b>
Primary Care	Population Based *	169,540		<b>149,615</b>	<b>88%</b>	131,707	<b>78%</b>
	Treating Facility Based **	176,863		<b>139,362</b>	<b>79%</b>	117,549	<b>66%</b>
Specialty Care	Population Based *	194,037		<b>171,021</b>	<b>88%</b>	184,644	<b>95%</b>
	Treating Facility Based **	207,099		<b>157,403</b>	<b>76%</b>	166,353	<b>80%</b>
Mental Health	Population Based *	114,604		<b>39,756</b>	<b>35%</b>	13,084	<b>11%</b>
	Treating Facility Based **	118,922		<b>44,818</b>	<b>38%</b>	18,683	<b>16%</b>
Psychiatry	Population Based *	33751		<b>-4744</b>	<b>-14%</b>	-8636	<b>-26%</b>
	Treating Facility Based **	32407		<b>-3394.67</b>	<b>-10%</b>	-7878.03	<b>-24%</b>

**Northwest Market – None**

<b>Category</b>	<b>Type of Gap</b>	<b>FY2001 Baseline</b>	<b>Fy 2001 Modeled ***</b>	<b>FY 2012 Gap</b>	<b>FY 2012 % Gap</b>	<b>FY 2022 Gap</b>	<b>FY 2022 % Gap</b>
	None.						

## Southeast 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 *	208,100		162,710	<b>78%</b>	140,230	<b>67%</b>
	Treating Facility Based **	205,504		160,808	<b>78%</b>	137,057	<b>67%</b>
Specialty Care	Population Based *	165,562		191,931	<b>116%</b>	192,500	<b>116%</b>
	Treating Facility Based **	172,097		187,670	<b>109%</b>	185,985	<b>108%</b>
Mental Health	Population Based *	74,358		127,797	<b>172%</b>	105,208	<b>141%</b>
	Treating Facility Based **	52,947		102,089	<b>193%</b>	84,520	<b>160%</b>
Medicine	Population Based *	31516		15,916	<b>51%</b>	10,228	<b>32%</b>
	Treating Facility Based **	34665		15,935	<b>46%</b>	9,489	<b>27%</b>
Surgery	Population Based *	11676		8,344	<b>71%</b>	6,310	<b>54%</b>
	Treating Facility Based **	14774		8,526	<b>58%</b>	5,961	<b>40%</b>
Psychiatry	Population Based *	29037		13,702	<b>47%</b>	9,518	<b>33%</b>
	Treating Facility Based **	15269		11,045	<b>72%</b>	7,495	<b>49%</b>

## Southwest 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 *	176,877		131,457	74%	111,455	63%
	Treating Facility Based **	195,593		99,042	51%	76,817	39%
Specialty Care	Population Based *	126,299		160,238	127%	156,564	124%
	Treating Facility Based **	124,760		161,743	130%	155,802	125%
Mental Health	Population Based *	65,566		64,123	98%	50,332	77%
	Treating Facility Based **	70,527		73,038	104%	57,191	81%
Medicine	Population Based *	21961		15,299	70%	9,791	45%
	Treating Facility Based **	20909		15,885	76%	10,327	49%
Surgery	Population Based *	9428		6,303	67%	4,319	46%
	Treating Facility Based **	8628		5,261	61%	3,472	40%

\* – 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:

Stakeholder issues have been addressed at the VISN, market, and facility levels in a systematic fashion since the advent of the CARES process. CARES has been a standing topic on the Veterans Advisory Council, (VAC) and the Executive Veterans Advisory Council (EVAC) since July of 2002. A special EVAC meeting to address CARES was held February 25, 2003. Formal mailings (7-3-02, 7-30-02, 10-2-02, 12-10-02, 1-29-03) and e-mail correspondence have been systematically distributed to a master list of stakeholders including service organizations, affiliates, labor partners and congressional offices. This master list is supplemented at the facility level by mailings to local constituents and employees. Each facility has established a CARES Steering committee to insure development of facility level CARES plans and incorporate planning issues and stakeholder concerns. The VISN 6 web page has VISN 6 CARES updates as well as links to national CARES related websites. The Network Director and other VISN 6 Staff have conducted; 1) town hall meetings at all medical centers, 2) presentations at a number of national, state, and local Veterans Service Organization meetings 3) briefings of Washington DC congressional offices. The NW Market conducted a number of focus group meetings with stakeholders as they developed the Small Facility Planning Initiative for Beckley VAMC. VISN 6 does not have a significant number of “negative gaps” so this dampened some of the anticipated stakeholder concern. The CARES Access Application guidelines require the addition of 23 new points of access in VISN 6 to achieve a reasonable level (72-76%) of compliance with travel time guidelines. Working closely with stakeholders VISN 6 has developed recommendations for locations and timelines for these sites that reflect sensitivity to the needs of stakeholders while insuring that sites are consistent with VHA requirements for establishing Community Based Outpatient Clinics. All sites in 3 of the 4 markets (SE, SW, NE) are anticipated to score well against the criteria. Sites in the less populous and more rural NW market (Beckley/ Salem) will not score well against CBOC criteria, nonetheless , they are required to insure that the NW market meets the access guidelines.

Another issue which was raised by VSOs was the impact of CARES on the VA’s ability to perform its’ fourth mission of backup to DoD and emergency preparedness during national disasters or terrorist attacks. We have responded that the CARES process does not project any significant bed reductions so the time-tested systems for assessing bed availability by type will remain. Again, the fact that VISN 6 had only one “negative” gap and five “positive” gaps in inpatient care went a long way to alleviating their concerns.

## **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:**

Initial analysis of workload in the counties in VISN 6 determined that 4 counties on the border with VISN 9 (Ashe, Watauga, Avery NC and Smyth WV) had a majority of veterans being provided care at a VISN 9 facility, specifically Mountain Home VAMC. Travel times and distances to Mountain Home VAMC for veterans in these counties were less than those to Ashville VAMC, which would be the nearest VISN 6 Facility. Subsequently, these 4 counties are now included as part of the VISN 9 CARES Market Plan. Although included as part of the VISN 9 Market Plan both VISNs will continue to collaborate on a broad range of issues to include location of access points in and around these counties as well as shared services/ referrals between Asheville and Mountain Home VAMCs.

Collaboration with VISN 9 and VISN 4 was undertaken to review access to acute care in West Virginia. While no Acute Care Access PI was identified a proposal to evaluate a centrally located Acute Care facility in Charleston WV was considered. Analysis of this concept assumed that Acute Care services would no longer be available at Beckley, Huntington and possibly Clarksburg VAMCs and that all acute medical, surgical, and psychiatric Bed Days Of Care (BDOC) within 60 and 120 minute drive times around Charleston would be referred to the new facility. Analysis of this proposal showed that even with the very generous assumption that 100% of the projected BDOC would be going to this facility it would not support a facility of viable size. Additionally, access to Acute Care services for veterans in West Virginia would be slightly diminished by this proposal.

## **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:**

No Impact

## **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:**

The need for Nursing Home Care remains high over the planning period. The NHCU component of the VA's Long Term Care Planning model is in review for inclusion in a later cycle of the CARES process. The VISN 6 Geriatrics and Long Term Care Service Line is progressing with plans for a NHCU replacement/expansion project at the Beckley VAMC. In addition to this much needed upgrade at the Beckley facility the G&LTC Service Line is looking at alternatives to VANHCU Beds such as increasing the proportion of beds provided by the state and the community. VISN 6 already hosts state veterans homes at Fayetteville and Salem VAMCs with another scheduled to open in donated space at Salisbury VAMC in FY 2003. Richmond VAMC has also been identified as a future site for a state veterans home.

Aggressive use of alternatives to NHCU care such as Adult Day Care, HBPC, Palliative Care, Geriatric Evaluation and Management (GEM) programs adds to the progressive repertoire of services available to veterans in VISN 6.

VISN 6 does not have any designated Blind Rehabilitation Centers and anticipates that existing referral practices will remain in effect. Facilities maintain a broad array of outpatient rehabilitation services such as Visual Impairment Service Teams (VIST) and coordinators to assist veterans in accessing services.

VISN 6 has two Spinal Cord Injury Units, 100 Acute Beds at Richmond VAMC and 64 Long Term Care beds at Hampton VAMC. It is anticipated that these two facilities

will continue to handle referrals for all VISN 6 facilities as well as a number of referrals from other VISNs. While no specific recommendations have been identified for additional SCI beds in VISN 6 the CARES projections and associated space drivers show space deficiencies at Hampton VAMC and to a lesser degree at Richmond VAMC. Projects to rectify these have been recommended.

VISN 6 has included plans for growth in Outpatient Mental Health in all 4 CARES markets. Additionally the plan for the SE includes an increase in Inpatient Psychiatry Beds. The VISN will maintain its array of outpatient and residential mental health treatments programs, MHICMs, Day Treatment, PTSD individual and group clinics, PR RTP, SATP as well as the Psychiatric Intensive Care Unit at the Salisbury VAMC. Access to Mental Health services is currently available and will continue to be included in all access points such as CBOCs and SOPCs. Additionally the Mental Health Service line has been proactive in incorporating telemedicine capability in its outpatient mental health program. This extends to select CBOCs and Vet-Centers.

### **C. 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:**

##### **Proposed Satellite Outpatient Clinic(SOPC)Charlotte, NC**

The veteran population in the Charlotte metropolitan area is 121,000. This includes Mecklenburg County (Charlotte's home county) and the surrounding five counties. CARES data indicates that enrollees in this area will increase from 18,165 in FY 2001 to 31,038 in FY 2022. The entire Primary Service Area (PSA) for Salisbury VAMC has experienced burgeoning growth and Charlotte is currently the second fastest growing metropolitan area in the United States at 22%. Charlotte is currently home to a CBOC, which opened in FY 1998, but quickly reached its capacity. The Charlotte SOPC would be located within close proximity to one of the major medical centers with easy access to public transportation. The existing CBOC primary care, mental health clinic and eye clinic functions would be relocated to the new building then augmented with additional staff. Activation of the Charlotte SOPC is planned for FY 06. This proposal for the Charlotte SOPC involves construction of approximately 52,000 square feet of rentable space. The amount was determined from space data for the similarly sized, and currently existing, Winston-Salem Outpatient Clinic. At present, the SOPC is anticipated to include services such as primary care, mental health, specialty care clinics, ambulatory surgery, pharmacy, diagnostic laboratory, an imaging diagnostic center, an urgent care center, physical medicine and rehabilitation clinic, and eye, audiology and pulmonary clinics.

##### **Proposed Nursing Home Care Unit, Beckley VAMC**

The proposal for this project was developed in FY 2001 and the Capital Investment Proposal (CIP), Capital Effectiveness Analysis (CEA) and project design have been completed and were submitted in FY 2002. Details and demographics for the proposal were developed in collaboration with the consulting firm of Booz/Allen/Hamilton. Beckley VAMC is a general medicine and surgical facility and provides a wide range of services to include extended care rehabilitation through the 50 bed Extended Care Rehabilitation Services Center (ECRC). This limited 50 bed capacity together with the upward trend in the aging population growth rates, was one of the drivers for development of a Capital Effectiveness Analysis (CEA). According to the 2000 census data, approximately 200,000 veterans, mainly World War II and Korean War veterans, live in the state of West Virginia. The elderly population in West Virginia is expected to

increase from 15.3% in 1995 to 24.9% in 2025, which will put a strain on the private sector nursing homes in the area. The Long Term Care (LTC) Model developed by the VHA Office of Policy and Planning in consultation with experts from the Geriatrics and Extended Care Strategic Healthcare Group, the Agency for Health Care Policy and Research, and the University of Michigan was utilized to project required long-term care beds out to FY20. The model projects demand for nursing home care in terms of nursing home ADC. Booz Allen utilized the VA LTC Model to define the potential future LTC need. They recognized that Beckley currently enrolls a higher percentage of the veteran population than the national average and ran an iteration of the LTC model at 26 percent. The target occupancy rate for LTC is 95 percent. By FY20, it was projected that the LTC Bed Requirements at Beckley will range from 101 to 166 beds. In considering the capital investment for a new Nursing Home one can assume that a new VA-run Nursing Home would attract many veterans who are not now obtaining the required long-term care services. There is a current and projected unmet demand that is resulting in veterans not receiving the services they need in an environment specialized in meeting their specific and unique needs. Detailed evaluation of Alternatives, Cost, Benefits, and Risk Analysis was included in the process.

**D. 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)		
<b>INPATIENT CARE</b>	Baseline FY 2001 BDOC	FY 2012 BDOC	FY 2022 BDOC	In House BDOC	Other BDOC	In House BDOC	Other BDOC	<b>Net Present Value</b>
Medicine	114,508	152,933	129,263	135,329	17,608	119,642	9,624	\$ (67,824,553)
Surgery	45,836	62,751	54,326	58,806	3,948	53,367	963	\$ (846,391)
Psychiatry	151,541	163,072	147,063	153,332	10,447	142,623	4,980	\$ 19,010,030
PRRTP	205	205	205	205	-	205	-	\$ -
NHCU/Intermediate	578,105	578,105	578,105	328,691	249,414	328,691	249,414	\$ (23,802,486)
Domiciliary	55,520	55,520	55,520	55,520	-	55,520	-	\$ -
Spinal Cord Injury	40,926	40,926	40,926	40,926	-	40,926	-	\$ (11,231,513)
Blind Rehab	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>986,641</b>	<b>1,053,512</b>	<b>1,005,407</b>	<b>772,809</b>	<b>281,417</b>	<b>740,974</b>	<b>264,981</b>	<b>\$ (84,694,913)</b>

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
<b>INPATIENT CARE</b>	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	<b>Net Present Value</b>
Medicine	236,698	371,076	311,931	339,668	299,673	\$ (67,824,553)
Surgery	76,507	112,176	96,999	107,010	97,097	\$ (846,391)
Psychiatry	187,013	306,929	276,989	292,264	272,007	\$ 19,010,030
PRRTP	37,984	27,379	27,379	9,557	9,557	\$ -
NHCU/Intermediate	459,983	459,983	459,983	500,007	500,007	\$ (23,802,486)
Domiciliary	110,585	110,585	110,585	85,585	85,585	\$ -
Spinal Cord Injury	89,261	89,261	89,261	135,941	135,941	\$ (11,231,513)
Blind Rehab	-	-	-	-	-	\$ -
<b>Total</b>	<b>1,198,031</b>	<b>1,477,389</b>	<b>1,373,127</b>	<b>1,470,032</b>	<b>1,399,867</b>	<b>\$ (84,694,913)</b>

## 2. Outpatient Summary

### a. Workload

	Clinic Stop Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
<b>Outpatient CARE</b>	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	722,666	1,139,906	1,034,480	1,041,291	98,619	958,016	76,469	\$ (37,059,389)
Specialty Care	644,156	1,183,181	1,156,029	1,026,037	157,148	998,648	157,383	\$ (53,694,316)
Mental Health	309,648	531,287	470,389	472,710	58,580	436,944	33,449	\$ (9,898,551)
Ancillary& Diagnostic	836,333	1,428,777	1,434,692	1,270,539	158,242	1,273,089	161,607	\$ 16,034,697
<b>Total</b>	<b>2,512,802</b>	<b>4,283,151</b>	<b>4,095,590</b>	<b>3,810,577</b>	<b>472,589</b>	<b>3,666,697</b>	<b>428,908</b>	<b>\$ (84,617,559)</b>

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
<b>Outpatient CARE</b>	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Primary Care	326,295	593,744	540,171	587,882	544,128	\$ (37,059,389)
Specialty Care	527,927	1,261,057	1,234,358	1,234,764	1,203,916	\$ (53,694,316)
Mental Health	160,465	334,161	297,002	334,240	310,681	\$ (9,898,551)
Ancillary& Diagnostic	446,169	933,913	941,097	877,759	881,573	\$ 16,034,697
<b>Total</b>	<b>1,460,856</b>	<b>3,122,874</b>	<b>3,012,628</b>	<b>3,034,645</b>	<b>2,940,298</b>	<b>\$ (84,617,559)</b>

### 3. Non-Clinical Summary

	Space Projections (from demand)			Post CARES (from solution)		
<b>NON-CLINICAL</b>	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Research	176,436	176,436	176,436	219,297	223,384	\$ (8,386,878)
Admin	1,455,170	2,472,551	2,340,842	2,439,878	2,338,763	\$ (22,517,888)
Outleased	199,184	199,184	199,184	234,432	234,432	N/A
Other	279,907	279,907	279,907	287,581	287,581	\$ -
Vacant Space	373,034	-	-	184,380	214,044	\$ 83,613,791
<b>Total</b>	<b>2,483,731</b>	<b>3,128,078</b>	<b>2,996,369</b>	<b>3,365,568</b>	<b>3,298,204</b>	<b>\$ 52,709,025</b>

## II. Market Level Information

### A. North East Market

#### 1. Description of Market

##### a. Market Definition

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
North East Code: 6A	68 Virginia Counties/ Independent Cities  10 North Carolina Counties	The North East Market is based on the referral patterns of our Richmond and Hampton Virginia facilities with Richmond being a major tertiary facility. These facilities are also geographic partners and have a relationship of sharing services. There is one CBOC in this market supporting the Northern Virginia fringe. Unique features of this market are a high-density veteran population clustered along the coastal cities with predominantly rural areas inland. Good transportation and access routes. This market has strong VA/DoD potential. The North East market is made up of 78 counties and independent cities with an estimated FY 2002 veteran population of 363,626.	

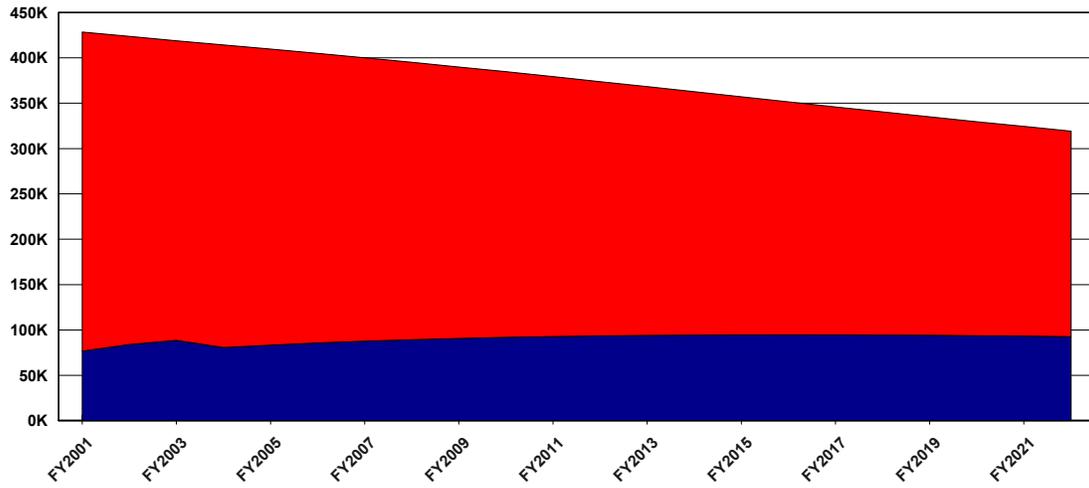
**b. Facility List**

<b>VISN : 6</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Hampton</b>				
590 Hampton	✓	✓	-	-
<b>Richmond</b>				
652 Richmond	✓	✓	✓	-
652GA Stafford/Fredericksburg	✓	-	-	-

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Northeast Market						
Market PI	Category	Type of Gap	February 2003 (New)			
			FY2012 Gap	FY2012 % Gap	FY2022 Gap	FY2022 % Gap
	Access to Primary Care					
	Access to Hospital Care					
	Access to Tertiary Care					
PI	Specialty Care Outpatient Stops	Population Based	171,023	88%	184,645	95%
		Treating Facility Based	157,405	76%	166,355	80%
PI	Primary Care Outpatient Stops	Population Based	149,615	88%	131,707	78%
		Treating Facility Based	139,362	79%	117,548	66%
PI	Mental Health Outpatient Stops	Population Based	39,757	35%	13,084	11%
		Treating Facility Based	44,819	38%	18,683	16%
PI	Psychiatry Inpatient Beds	Population Based	-15	-14%	-28	-26%
		Treating Facility Based	-11	-10%	-25	-24%
	Medicine Inpatient Beds	Population Based	17	16%	5	4%
		Treating Facility Based	18	14%	0	0%
	Surgery Inpatient Beds	Population Based	6	14%	2	4%
		Treating Facility Based	3	6%	-3	-6%

**e. Stakeholder Information**

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

**Stakeholder Narrative:**

Stakeholders in the Northeast Market have been kept involved and informed throughout the progression of the CARES process. The VISN has been involved with activities on a more global level, with regular mailings, VAC (Veterans Advisory Council) meetings, phone contacts with Congressional offices and VISN meetings with leadership of each of the VISN medical centers. At the Market level, we have been extensively involved with a wide variety of stakeholders, including veterans service organizations, veterans groups, our medical school affiliates, our staff members and volunteers, and union representatives. Information has been provided to these groups through town hall meetings, employee newsletters, e-mail notices, mailings, committee and staff meetings, strategic planning conferences and veteran council meetings. Overall, stakeholders voiced the need for additional access points to offer services to a greater number of veterans as well as access to specialty services. CARES projections support these concerns and they have been incorporated into the market plan. The Northeast Market Plan includes three additional access points (Community Based Outpatient Clinics and Satellite Outpatient Clinics) within the market (Norfolk, Charlottesville and Emporia) as well as proposed new construction and renovation at the parent facilities (Richmond and Hampton) to accommodate expanded services as well. Some stakeholders raised the concern that projected gaps seemed excessively large and that the VA may be overburdened in attempting to fill these gaps. In filling the gaps, the market sought solutions at the lowest level possible to meet established thresholds.

**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 representatives from the Northeast Market maintained communication with representatives from other markets in VISN 6 throughout the CARES process. Existing referral patterns and collaboration between facilities from other markets within VISN 6 will continue. In addition, referral patterns from outside VISN 6 for specialized programs such as SCI, Open Heart and Transplant Surgery will continue.

**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 North East Market is based on the referral patterns of the Richmond and Hampton Virginia facilities with Richmond being a major tertiary facility. These facilities are also geographic partners and have a relationship of sharing services. There is one CBOC (Fredericksburg) in this market serving the northern area of the market. Unique features of this market are a high-density veteran population clustered along the coastal cities with predominantly rural areas inland. Good transportation and access routes. This market has strong VA/DoD potential. The North East Market is made up of 78 counties and independent cities with an estimated FY 2002 veteran population of 363,626.

The Planning Initiatives identified for the North East Market are in the following CARES Planning Categories: Access – Primary Care (currently 61% of threshold)

Capacity -

Outpatient -

Specialty Care (166,355 clinic stop gap FY 2022)

Primary Care (117,548 clinic stop gap for FY 2022)

Mental Health (18,683 clinic stop gap for FY 2022)

Inpatient –

Psychiatry (25 bed reduction for FY 2022)

For the Access PI, the market proposes establishing CBOCs in Norfolk, Emporia and Charlottesville, Virginia. The placement of these new CBOCs will increase the Access threshold to 76% for FY 2022. The Capacity PIs for Primary Care and Mental Health will be addressed with the establishment of the new CBOCs. The preferred alternative for the new CBOCs is leased space with VA staff. Hampton will activate a CBOC in Norfolk in fiscal year 2005 of approximately 9500 square feet. This CBOC will expand to a Satellite Outpatient Clinic of approximately 50,000 square feet in FY2007 and remain in operation through fiscal year 2022 to meet the projected CARES demand. The Emporia and Charlottesville CBOCs would require about 7,000 sf. Basic Mental Health services will be available at all sites. With the new CBOCs, the market will meet this Capacity gap.

For the Outpatient Specialty Care Capacity PI, the preferred alternative would involve initially contracting for care and until new construction can be completed at both Hampton (70,500 sf) and Richmond (57,000 sf). The Norfolk SOPC (FY07) will include approximately 10,000 sf for specialty care. The new construction and additional leased space will allow the Market to meet this Capacity gap. The Inpatient Psychiatry Capacity bed reduction PI will be meet by

downsizing efforts currently initiated at both medical centers. Hampton will reduce by 6 beds and Richmond by 19 beds.

Stakeholders were provided information related to CARES and the Market Plan via mail, e-mail, meetings, briefings, and presentations. To date, stakeholder issues have been minimal.

The major strengths of the North East Market Plan include a commitment to Primary Care both in terms of access and capacity with the establishment of new CBOCs, the inclusion of Outpatient Mental Health Care at the CBOCs and the enhancement Specialty Care at the medical centers. A possible weakness of the plan is the proposed reduction of Inpatient Psychiatry beds. Opportunities exist for partnering with both DoD and the community. Obstacles may arise related to being able to recruit and retain adequate staffing to accommodate increases in demand.

## **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:**

The Northeast Market proposes establishing new CBOCs in Norfolk, VA, Charlottesville, VA and Emporia, VA in leased space with VA staff. The Norfolk CBOC would serve a large veteran population in the south metropolitan Hampton Roads area and some counties from North Carolina.

The Charlottesville CBOC would be located in the northwest corner of the market area and the Emporia CBOC would serve the southern area including some counties in North Carolina.

Realignment of workload should enhance the quality of care by providing a more even distribution of workload across the medical center's geographic service area. The proposed CBOCs would provide primary care and basic mental health services. The identified gap for primary care translated into new CBOCs based on the lack primary care services remote from the medical centers. These locations had been identified by the VISN 6 Primary Service Line and confirmed by the application of CBOC and CARES criteria.

CBOCs in leased space with VA staff is the preferred alternative based on cost, quality and control considerations. Community contracts were consider, but the availability of local providers, quality and control made this option less desirable. The targeted area for the Norfolk CBOC is considered medically underserved and contract physicians are not available to absorb the workload projected.

Improving access to primary care services is expected to improve the quality of health care for Northeast Market veterans by providing timely access to preventative medical services in a location close to their residence.

The VA expects that leased space will be configured to meet VA criteria regarding adequacy of space, accessibility, privacy, major building systems, applicable codes and VA standards regarding safety.

The additional clinic locations support an increase in clinical research and enhances staff exposure to research trials. The type of clinical research taking place will more than likely take place within the allocated clinical space along with providing care.

The positive impact of the expansion of veteran access points and services will only serve to strengthen Academic Affiliations and clinical education by offering residents a more diverse population than a hospital setting would afford.

Additional VA staff would be required to provide adequate staffing for these new CBOCs. Keeping the workload in-house maximizes resources and continuity of care. The contract staff alternative was considered less than optimal because contract staff would lack the training and familiarity with VA practices and policies. VA staff would also provide for greater accountability.

Activation of Hampton’s Norfolk SOPC will expand VA presence in the community and bring a portion of the health care we provide closer to the DoD facilities on the Southside of the area.

Expansion of the services has the potential to open opportunities for joint service sharing arrangements for Primary Care resources between Hampton, Portsmouth Naval, Norfolk Operating Base, and several other military installations. It is possible that the expansion to the SOPC could allow for additional space to house our One VA partners, specifically VBA, as we do at the parent facility, to allow for “one stop shopping” for our veterans.

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	61%	32,877	75%	23,355	76%	22,234
Hospital Care	85%	12,645	86%	13,079	85%	13,896
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 – Hampton

#### 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 Narrative:**

No Impact

##### **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.

##### **Small 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.

#### **DOD Narrative:**

Hampton VAMC has a number of agreements in place with DOD facilities in the Hampton Roads area. Most recently they have set up a referral process for select inpatient surgery to be sent to the Portsmouth Naval Medical Center. This agreement will continue to be refined and expanded, depending on mutual need, interest of the respective command and deployment status.

### **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.

#### **VBA Narrative:**

No Impact

### **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.

#### **NCA Narrative:**

No Impact

### **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.

#### **Enhanced Use Narrative:**

The Hampton VAMC campus, while often considered an ideal location, has somewhat limited access. The demolition and reconstruction costs of existing buildings, some of which have historic significance, limit its viability as an Enhanced Use project.

### **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

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
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	7,249	1,049	7,250	1,050	580	-	-	-	-	-	6,670	\$ (935,706)
Surgery	1,576	(957)	1,576	(957)	190	-	-	-	-	-	1,386	\$ (1,529,150)
Intermediate/NHCU	67,356	-	67,356	-	35,026	-	-	-	-	-	32,330	\$ (147,164)
Psychiatry	19,367	(7,211)	19,368	(7,210)	1,163	-	-	-	-	-	18,205	\$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	55,520	-	55,520	-	-	-	-	-	-	-	55,520	\$ -
Spinal Cord Injury	20,682	-	20,682	-	-	-	-	-	-	-	20,682	\$ (9,578,538)
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>171,750</b>	<b>(7,119)</b>	<b>171,752</b>	<b>(7,117)</b>	<b>36,959</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>134,793</b>	<b>\$ (12,190,558)</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
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	156,859	86,728	156,859	86,728	20,000	-	-	-	-	-	136,859	\$ (1,746,309)
Specialty Care	166,121	99,648	166,121	99,648	13,575	-	-	-	-	-	152,546	\$ (8,153,157)
Mental Health	104,762	32,701	104,763	32,702	2,258	-	-	-	-	-	102,505	\$ (4,445,643)
Ancillary & Diagnostics	210,993	128,503	210,993	128,503	70,000	30,000	-	-	-	-	110,993	\$ 50,865,742
<b>Total</b>	<b>638,735</b>	<b>347,579</b>	<b>638,736</b>	<b>347,580</b>	<b>105,833</b>	<b>30,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>502,903</b>	<b>\$ 36,520,633</b>

**Proposed Management of Space – FY 2012**

		Space (GSF) proposed by Market Plans in VISN									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>INPATIENT CARE</b>											
Medicine	14,541	14,541	1,482	13,059	-	-	-	-	-	13,059	(1,482)
Surgery	2,899	2,897	(3,790)	6,687	-	-	-	-	-	6,687	3,790
Intermediate Care/NHCU	65,755	65,753	(2)	65,755	-	-	-	-	-	65,755	2
Psychiatry	31,678	31,677	4,865	26,812	-	-	-	-	-	26,812	(4,865)
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	110,585	85,585	(25,000)	110,585	-	-	-	-	-	110,585	25,000
Spinal Cord Injury	-	68,000	34,680	33,320	-	68,000	-	-	-	101,320	33,320
Blind Rehab	33,320	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>258,777</b>	<b>268,453</b>	<b>12,235</b>	<b>256,218</b>	-	<b>68,000</b>	-	-	-	<b>324,218</b>	<b>55,765</b>
		Space (GSF) proposed by Market Plan									
Space (GSF) (from demand projections)		Space Driver Projection	Variance from 2001	Existing GSF	Convert Vacant	New Construction	Donated Space	Leased Space	Enhanced Use	Total Proposed Space	Space Needed/ Moved/ Vacant
	FY 2012										
<b>OUTPATIENT CARE</b>											
Primary Care	70,587	43,393	41,236	27,194	-	-	-	26,000	-	53,194	(15,236)
Specialty Care	185,939	124,747	126,440	61,192	-	70,500	-	10,000	-	141,692	(45,940)
Mental Health	56,467	32,440	32,351	24,027	10,000	-	-	10,000	-	44,027	(12,351)
Ancillary and Diagnostics	144,783	95,860	32,102	48,923	-	10,000	-	4,000	-	62,923	(18,102)
<b>Total</b>	<b>457,776</b>	<b>393,465</b>	<b>232,129</b>	<b>161,336</b>	<b>10,000</b>	<b>80,500</b>	-	<b>50,000</b>	-	<b>301,836</b>	<b>(91,629)</b>
<b>NON-CLINICAL</b>											
Research	10,600	2,512	(8,088)	10,600	-	-	-	-	-	10,600	8,088
Administrative	414,478	378,725	134,883	243,842	-	-	-	-	-	243,842	(134,883)
Other	22,760	22,760	-	22,760	-	-	-	-	-	22,760	-
<b>Total</b>	<b>447,838</b>	<b>403,997</b>	<b>126,795</b>	<b>277,202</b>	-	-	-	-	-	<b>277,202</b>	<b>(126,795)</b>

#### **4. Facility Level Information – Richmond**

##### **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 Narrative:**

No Impact

###### **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.

###### **Small 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.

#### **DOD Narrative:**

Although not identified as part of a specific VISN 6 PI Collaborative Opportunity the Richmond VAMC has been a proactive VA/DoD sharing partner and has provided leadership and key staff support to the VA/DoD sharing effort for many years. Along with Hampton, its relative proximity to a number of DoD facilities makes the NE market one of the strongest in terms of VA/DoD sharing potential. Richmond has also developed a long-standing relationship with the TRICARE Region 2 Lead Agent office exploring areas for further development and hosting educational sessions to enhance awareness of mutual needs, missions, capabilities.

### **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.

#### **VBA Narrative:**

No Impact

### **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.

#### **NCA Narrative:**

No Impact

### **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.

#### **Enhanced Use Narrative:**

No Impact

### **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

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
	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
<b>INPATIENT CARE</b>												
Medicine	36,703	4,394	36,703	4,394	735	-	-	-	-	-	35,968	\$ -
Surgery	16,624	2,022	16,624	2,022	167	-	-	-	-	-	16,457	\$ -
Intermediate/NHCU	80,806	-	80,806	-	42,020	-	-	-	-	-	38,786	\$ -
Psychiatry	9,645	3,816	9,645	3,816	1,000	-	-	-	-	-	8,645	\$ 2,829,906
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	20,244	-	20,244	-	-	-	-	-	-	-	20,244	\$ (1,652,975)
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>164,021</b>	<b>10,231</b>	<b>164,022</b>	<b>10,232</b>	<b>43,922</b>	-	-	-	-	-	<b>120,100</b>	<b>\$ 1,176,931</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
	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
<b>OUTPATIENT CARE</b>												
Primary Care	159,366	52,634	159,366	52,634	5,000	-	-	-	-	-	154,366	\$ (5,440,474)
Specialty Care	198,381	57,756	198,382	57,757	5,952	-	-	-	-	-	192,430	\$ 480,856
Mental Health	58,978	12,117	58,978	12,118	7,000	-	-	-	-	-	51,978	\$ (1,849,881)
Ancillary & Diagnostics	221,545	67,140	221,546	67,141	6,647	-	-	-	-	-	214,899	\$ (1,256,192)
<b>Total</b>	<b>638,270</b>	<b>189,647</b>	<b>638,272</b>	<b>189,649</b>	<b>24,599</b>	-	-	-	-	-	<b>613,673</b>	<b>\$ (8,065,691)</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	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/ Vacant
<b>INPATIENT CARE</b>	<b>FY 2012</b>										
Medicine	87,405	9,979	87,402	9,976	77,426	-	-	-	-	77,426	(9,976)
Surgery	27,649	4,408	27,648	4,407	23,241	-	-	-	-	23,241	(4,407)
Intermediate Care/NHCU	40,466	-	40,465	(1)	40,466	-	-	-	-	40,466	1
Psychiatry	23,534	7,524	21,094	5,084	16,010	-	-	-	-	16,010	(5,084)
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	(55,941)	67,941	12,000	55,941	-	-	-	-	67,941	-
Blind Rehab	55,941	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>234,994</b>	<b>21,910</b>	<b>244,550</b>	<b>31,466</b>	<b>213,084</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>225,084</b>	<b>(19,466)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	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/ Vacant
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>										
Primary Care	88,735	32,850	89,532	33,647	-	-	-	12,700	-	68,585	(20,947)
Specialty Care	211,674	98,573	211,673	98,572	-	57,000	-	-	-	170,101	(41,572)
Mental Health	36,419	15,675	33,786	13,042	-	-	-	5,200	-	25,944	(7,842)
Ancillary and Diagnostics	137,536	36,229	137,535	36,228	-	10,000	-	-	-	111,307	(26,228)
<b>Total</b>	<b>474,363</b>	<b>183,326</b>	<b>472,526</b>	<b>181,489</b>	<b>-</b>	<b>67,000</b>	<b>-</b>	<b>17,900</b>	<b>-</b>	<b>375,937</b>	<b>(96,589)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	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/ Vacant
<b>NON-CLINICAL</b>	<b>FY 2012</b>										
Research	56,336	-	56,618	282	-	-	-	-	-	56,336	(282)
Administrative	306,277	82,296	309,478	85,497	-	-	-	-	-	223,981	(85,497)
Other	41,944	-	41,944	-	-	-	-	-	-	41,944	-
<b>Total</b>	<b>404,557</b>	<b>82,296</b>	<b>408,040</b>	<b>85,779</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>322,261</b>	<b>(85,779)</b>

## B. North West Market

### 1. Description of Market

#### a. Market Definition

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
North West Code: 6B	<b>40 Virginia Counties/ Independent Cities</b>  <b>11 West Virginia Counties</b>	The North West Market is based on the referral patterns of our Salem, Virginia and Beckley, West Virginia facilities with Salem offering a greater range of services. These facilities are also geographic partners and have a relationship of sharing services. There are three CBOCs in this market two in Virginia and one in West Virginia. The market is primarily rural area covered and has adequate transportation and access routes. The North West market is made up of 51 counties and independent cities with an estimated FY 2002 veteran population of 166,373.	VISN 9 to include Smyth County in their planning process

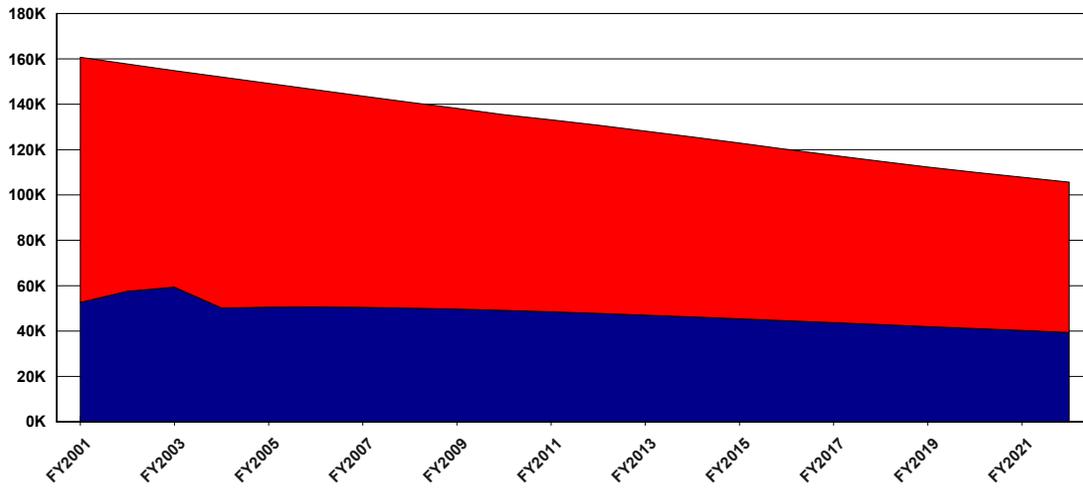
**b. Facility List**

<b>VISN : 6</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Beckley</b>				
517 Beckley	✓	✓	-	-
517GA Gassaway-Braxton County	✓	-	-	-
<b>Salem</b>				
658 Salem	✓	✓	-	-
658GA Tazewell	✓	-	-	-
658GB Danville	✓	-	-	-
658HA Stuarts Draft	-	-	-	✓
658HB Pulaski	-	-	-	✓
658HC Lynchburg	-	-	-	✓
658HD Hillsville	-	-	-	✓
658HE Martinsville	-	-	-	✓
658HF Danville VA	-	-	-	✓
658HG Covington	-	-	-	✓
658HH Marion	-	-	-	✓

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Northwest Market						
Market PI	Category	Type of Gap	February 2003 (New)			
			FY2012 Gap	FY2012 % Gap	FY2022 Gap	FY2022 % Gap
	Access to Primary Care					
	Access to Hospital Care					
	Access to Tertiary Care					
	Specialty Care Outpatient Stops	Population Based	27,308	19%	-3,087	-2%
		Treating Facility Based	32,211	23%	3,735	3%
	Primary Care Outpatient Stops	Population Based	23,707	17%	-16,169	-11%
		Treating Facility Based	18,030	12%	-19,604	-14%
	Psychiatry Inpatient Beds	Population Based	8	8%	-3	-3%
		Treating Facility Based	6	4%	-6	-5%
	Mental Health Outpatient Stops	Population Based	0	0%	0	0%
		Treating Facility Based	1,696	3%	349	1%
	Medicine Inpatient Beds	Population Based	3	3%	-20	-28%
		Treating Facility Based	4	6%	-17	-25%
	Surgery Inpatient Beds	Population Based	3	9%	-6	-22%
		Treating Facility Based	7	39%	0	0%

**e. Stakeholder Information**

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

**Stakeholder Narrative:**

The Northwest market has actively involved their stakeholders in the CARES planning process through regular meetings, mailings, presentations at employee forums and VSO meetings. The Beckley facility has also set up a Stakeholder Focus Group specifically targeted at addressing the Small Facility PI. The group includes key staff members and representatives from various Veterans Service Organizations such as American Legion, VFW and TREA( The Retired Enlisted Association)

**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 Northwest market will continue it's referral patterns within VISN 6. This is primarily referral of specialized care to the Richmond VAMC in the NE market with occassional referral of cardiac care to the SW and SE markets.

Collaboration with VISN 9 and VISN 4 was undertaken to review access to acute care in West Virginia. While no Acute Care Access PI was identified a proposal to evaluate a centrally located Acute Care facility in Charleston WV was considered. Analysis of this concept assumed that Acute Care services would no longer be available at Beckley, Huntington and possibly Clarksburg VAMCs and that all acute medical, surgical, and psychiatric Bed Days Of Care (BDOC) within 60 and 120 minute drive times around Charleston would be referred to the new facility. Analysis of this proposal showed that even with the very generous assumption that 100% of the projected BDOC would be going to this facility it would not support a facility of viable size. Additionally, access to Acute Care services for veterans in West Virginia would be slightly diminished by this proposal.

**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 Northwest market is based on the referral patterns of Salem and Beckley facilities with Salem offering a greater range of services. These facilities are geographic partners and have a relationship of shared services, there are three CBOCs in this market, two in Virginia and one in West Virginia. The market is primarily rural, is made up of 51 counties with an estimated FY 2002 Veteran Population of 166,373. It has a Small Facility PI at Beckley VAMC and an Access PI for Primary Care. Proposed resolution of the Primary Care access PI will be a CBOC in Lynchburg VA, and FEE sites in Bluefield and Lewisburg WV

## 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:

The Northwest market is geographically located in southwest Virginia and southeast West Virginia. The area is largely rural with scattered population centers Salem/Roanoke, Lynchburg, Blacksburg/Christianburg.

Activation of access sites at Lewisburg WV, Bluefield WV, and Lynchburg VA will bring the access compliance from 48% in FY 2001 to 73% in FY 2012 and FY 2022 respectively. It is felt that the Lynchburg site will meet the CBOC criteria while the Bluefield and Lewisburg sites may not support a CBOC. Working with established practices in these areas in a contract/fee arrangement for Primary Care, Mental Health and possibly Specialty Care may be the most effective option.

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	48%	29,996	73%	12,888	73%	10,626
Hospital Care	75%	14,421	73%	12,888	73%	10,626
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 – Beckley

#### 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 Narrative:**

No Impact

##### **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.

##### **Small Facility Narrative:**

VISN 6 has one facility, Beckley VAMC, which has been identified as falling within the guidelines of a Small Facility.

The projection model used in the CARES process indicates that the Beckley VAMC will require fewer than 40 Acute Care beds to meet the needs of its patients in FY 2012 and FY 2022. With the issuance of the Market Planning guide VISN 6 and the Beckley CARES Committee began collating the data concerning access, quality, safety, environment, and cost. On January 27, 2003 the Small Facility workgroup submitted a draft Market Plan to the full Facility CARES Committee. That plan was then presented with the Market Planning guidance to a Stakeholder Focus Group on January 31, 2003.

The Facility CARES Committee examined stakeholder feed back and made changes to the Small Facility Market Plan (SFMP). The SFMP was then submitted to the Network CARES Team for review on February 3, 2003. Network feed back was provided on February 7, 2003. The Facility CARES Committee made changes. On February 19, 2003 a presentation was made to the Network ELC supporting a Modified Status Quo.

The plan was then again made available for comment and review by the Network CARES team. Final comment was provided on March 13, 2003 and followed by a Net Meet review. On March 27, 2003 the completed plan was presented to the Network CARES Team and Network Director.

Four options were considered.

- 1) Status Quo
- 2) Contract in the community
- 3) Transfer to another VA
- 4) Modified Status Quo.

The Modified Status Quo was selected. This option retains Acute Care capability at the Beckley VAMC with reconfiguration by bed section/type. Retaining acute inpatient capacity at Beckley while adjusting the “mix” of beds realigns resources so as to meet changes in demand, while maintaining the highest quality of care, value and access. In considering the election of Modified Status Quo considerable weight was given to the demonstrated superior performance in quality of care, value, ease of access and the overall physical condition of the facility.

Other factors examined during the process included assessing the projected capacity and cost of transferring workload to Salem VAMC and Richmond VAMC.

Comparative cost and associated impact of paying for all acute care BDOC in the local community was also evaluated as one of the options.

### **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.

#### **DOD Narrative:**

No Impact

**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.

**VBA Narrative:**

No Impact

**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.

**NCA Narrative:**

No Impact

**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.

**Enhanced Use Narrative:**

No Impact

## **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

### **VISN Identified Planning Initiatives Narrative:**

Proposed Nursing Home Care Unit, Beckley VAMC

The proposal for this project was developed in FY 2001 and the Capital Investment Proposal ( CIP) , the associated Capital Effectiveness Analysis ( CEA) and project design have been completed and were submitted in FY 2002. Details and demographics for the proposal were developed in collaboration with the consulting firm of Booz/Allen/Hamilton.

The Beckley VAMC is part of VISN 6 and provides care to 11 counties in West Virginia and one county in Virginia. The Beckley VAMC is a general medicine and surgical facility serving over 36,000 veterans and provides a wide range of services to include extended care rehabilitation. This service is provided through the Extended Care Rehabilitation Services Center (ECRC) which is comprised of 50 beds. This limited capacity together with the upward trend in the aging population growth rates, was one of the drivers for development of a Capital Effectiveness Analysis (CEA)

According to the 2000 census data, approximately 200,000 veterans, mainly World War II and Korean War veterans, live in the state of West Virginia. The elderly population in West Virginia is expected to increase from 15.3% in 1995 to 24.9% in 2025, which will put a strain on the private sector nursing homes in the area. The CEA evaluates various options for meeting this projected increase in demand and presents a path forward for the Beckley VAMC. To understand workload trends and factors that may influence future demand for care, past and current workload data was analyzed as part of a contract with Booz, Allen, and Hamilton. VA's Long Term Care (LTC) Model developed by the VHA Office of Policy and Planning in consultation with experts from the Geriatrics and Extended Care Strategic Healthcare Group, the Agency for Health Care Policy and Research, and the University of Michigan was utilized to project required long-term care beds out to FY20. The model projects demand for nursing home care in terms of nursing home ADC. The LTC model calculates the product of three variables:

- LTC Use Rates for males
- Enrollee population projected for each facility

- Market share percentage VA

This calculation can be applied to every possible combination of age, disability level, and Priority level of the enrollee population. The Model is flexible to accommodate VA policy and local conditions at any particular VAMC. Booz Allen utilized the VA LTC Model to define the low range (16 percent) of potential future LTC need. In order to define a possible higher range to cover all contingencies in our planning, Booz Allen recognized that Beckley currently enrolls a higher percentage of the veteran population than the national average and ran an iteration of the LTC model at 26 percent. The target occupancy rate for LTC is 95 percent. By FY20, Booz Allen has projected that the LTC Bed Requirements at Beckley will range from 101 to 166 beds.

In considering the capital investment for a new Nursing Home, one can posit that a new VA-run Nursing Home would attract many veterans who are not now obtaining the required long-term care services, in addition to the current population of ECRC patients. There is a current and projected unmet demand that is resulting in veterans not receiving the services they need in an environment specialized in meeting their specific and unique needs. Detailed evaluation of Alternatives, Cost, Benefits and Risk Analysis were included in the process.

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs demand projections)	(from demand projections)	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001</b>										
Medicine	3,765	(5,050)	3,766	(5,049)	38	-	-	-	-	-	3,728	\$ -
Surgery	132	(356)	133	(355)	15	-	-	-	-	-	118	\$ -
Intermediate/NHCU	24,990	-	34,990	10,000	5,949	-	-	-	-	-	29,041	\$ (64,990,978)
Psychiatry	725	(49)	725	(49)	22	-	703	-	-	-	-	\$ 4,943,945
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>29,612</b>	<b>(5,455)</b>	<b>39,614</b>	<b>4,547</b>	<b>6,024</b>	<b>-</b>	<b>703</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>32,887</b>	<b>\$ (60,047,033)</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)	Variance from 2001	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001</b>										
Primary Care	43,547	(5,242)	43,548	(5,241)	10,066	-	-	-	-	-	33,482	\$ 2,309,887
Specialty Care	38,196	(3,596)	38,197	(3,595)	3,000	-	-	-	-	-	35,197	\$ (2,785,881)
Mental Health	11,118	356	11,118	356	501	-	-	-	-	-	10,617	\$ (547,830)
Ancillary & Diagnostics	48,834	(15,975)	48,835	(15,974)	7,180	-	-	-	-	-	41,655	\$ (5,149,557)
<b>Total</b>	<b>141,695</b>	<b>(24,457)</b>	<b>141,698</b>	<b>(24,454)</b>	<b>20,747</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>120,951</b>	<b>\$ (6,173,381)</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	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/ Vacant
<b>INPATIENT CARE</b>	<b>FY 2012</b>	7,755	(3,971)	7,754	(3,972)	-	-	-	-	11,726	3,972
Medicine		241	(230)	241	(230)	-	-	-	-	471	230
Surgery		17,974	-	58,004	40,030	40,000	-	-	-	57,974	(30)
Intermediate Care/NHCU		1,139	1,139	-	-	-	-	-	-	-	-
Psychiatry		-	-	-	-	-	-	-	-	-	-
PRRTP		-	-	-	-	-	-	-	-	-	-
Domiciliary program		-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury		-	-	-	-	-	-	-	-	-	-
Blind Rehab		-	-	-	-	-	-	-	-	-	-
<b>Total</b>		<b>27,110</b>	<b>(3,061)</b>	<b>65,999</b>	<b>35,828</b>	<b>40,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>70,171</b>	<b>4,172</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	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/ Vacant
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	23,080	7,227	17,745	1,892	2,500	-	-	-	18,353	608
Primary Care		42,017	24,783	38,717	21,483	16,000	-	-	-	33,234	(5,483)
Specialty Care		7,560	5,975	7,220	5,635	-	-	-	-	6,348	(872)
Mental Health		31,254	14,813	26,659	10,218	6,000	-	-	-	22,441	(4,218)
Ancillary and Diagnostics		103,912	52,799	90,341	39,228	24,500	-	-	-	80,376	(9,965)
<b>Total</b>											
<b>NON-CLINICAL</b>	<b>FY 2012</b>	-	-	-	-	-	-	-	-	-	-
Research		136,262	52,063	162,594	78,395	-	-	-	-	84,199	(78,395)
Administrative		11,026	-	11,026	-	-	-	-	-	11,026	-
Other		147,288	52,063	173,620	78,395	-	-	-	-	95,225	(78,395)
<b>Total</b>											

#### **4. Facility Level Information – Salem**

##### **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 Narrative:**

No Impact

###### **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.

###### **Small 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.

**DOD Narrative:**

No Impact

**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.

**VBA Narrative:**

No Impact

**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.

**NCA Narrative:**

No Impact

### **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.

#### **Enhanced Use Narrative:**

Salem VAMC has vacant space and reasonable acreage. However, the market will not drive any significant benefit at this time.

### **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

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

***Proposed Management of Workload – FY 2012***

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
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	17,823	6,213	17,823	6,213	500	-	-	-	-	-	17,323	\$ 2,690,742
Surgery	7,231	2,420	7,231	2,420	73	-	-	-	-	-	7,158	\$ -
Intermediate/NHCU	80,223	-	70,223	(10,000)	38,623	-	-	-	-	-	31,600	\$ 41,335,656
Psychiatry	41,090	1,837	41,091	1,838	5,000	-	-	703	-	-	36,794	\$ (3,017,922)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>146,367</b>	<b>10,470</b>	<b>136,368</b>	<b>471</b>	<b>44,196</b>	<b>-</b>	<b>-</b>	<b>703</b>	<b>-</b>	<b>-</b>	<b>92,875</b>	<b>\$ 41,008,476</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
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	119,188	23,270	119,188	23,270	21,840	-	-	-	-	-	97,348	\$ 504,527
Specialty Care	134,215	35,805	134,215	35,806	30,000	-	-	-	-	-	104,215	\$ 2,697,570
Mental Health	57,829	1,338	57,829	1,339	4,627	-	-	-	-	-	53,202	\$ -
Ancillary & Diagnostics	144,516	36,699	144,517	36,700	20,000	-	-	-	-	-	124,517	\$ (152,507)
<b>Total</b>	<b>455,748</b>	<b>97,114</b>	<b>455,749</b>	<b>97,115</b>	<b>76,467</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>379,282</b>	<b>\$ 3,049,590</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	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
<b>INPATIENT CARE</b>	<b>FY 2012</b>	53,287	10,781	52,315	9,809	-	-	-	-	42,506	(9,809)
Medicine		13,100	1,411	13,099	1,410	-	-	-	-	11,689	(1,410)
Surgery		36,282	-	36,282	-	-	-	-	-	36,282	-
Intermediate Care/NHCU		71,087	20,484	63,654	13,051	-	-	-	-	50,603	(13,051)
Psychiatry		-	(10,605)	-	(10,605)	-	-	-	-	10,605	10,605
PRRTP		-	-	-	-	-	-	-	-	-	-
Domiciliary program		-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury		-	-	-	-	-	-	-	-	-	-
Blind Rehab		-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>173,757</b>	<b>22,072</b>	<b>165,350</b>	<b>151,685</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>151,685</b>	<b>(13,665)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	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
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	54,958	3,772	51,594	408	-	-	6,000	-	57,186	5,592
Primary Care		129,920	45,447	114,637	30,164	-	-	-	-	104,473	(10,164)
Specialty Care		44,158	7,883	44,158	7,883	-	-	-	-	36,275	(7,883)
Mental Health		86,017	14,620	79,691	8,294	-	-	-	-	71,397	(8,294)
Ancillary and Diagnostics		315,052	71,721	290,080	46,749	-	-	6,000	-	269,331	(20,749)
<b>Total</b>	<b>315,052</b>	<b>71,721</b>	<b>290,080</b>	<b>243,331</b>	<b>20,000</b>	<b>-</b>	<b>-</b>	<b>6,000</b>	<b>-</b>	<b>269,331</b>	<b>(20,749)</b>
<b>NON-CLINICAL</b>	<b>FY 2012</b>	7,071	-	4,221	(2,850)	-	-	-	-	7,071	2,850
Research		332,240	64,762	307,966	40,488	-	-	-	-	267,478	(40,488)
Administrative		46,634	-	46,634	-	-	-	-	-	46,634	-
Other		385,945	64,762	358,821	37,638	-	-	-	-	321,183	(37,638)
<b>Total</b>	<b>385,945</b>	<b>64,762</b>	<b>358,821</b>	<b>321,183</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>321,183</b>	<b>(37,638)</b>

**C. South East Market**

**1. Description of Market**

**a. Market Definition**

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
South East Code: 6D	<b>46 North Carolina Counties</b>  <b>2 South Carolina Counties</b>	The South East Market is based on the referral patterns of our Durham and Fayetteville, North Carolina facilities with Durham being a major tertiary facility. These facilities are also geographic partners and have a relationship of sharing services. There are five CBOCs in this market The veteran population is comparatively evenly dispersed in moderately sized population areas along transportation and access routes. This market has moderate/strong VA/DoD potential. The South East market is made up of 48 counties with an estimated FY 2002 veteran population of 364,607.	

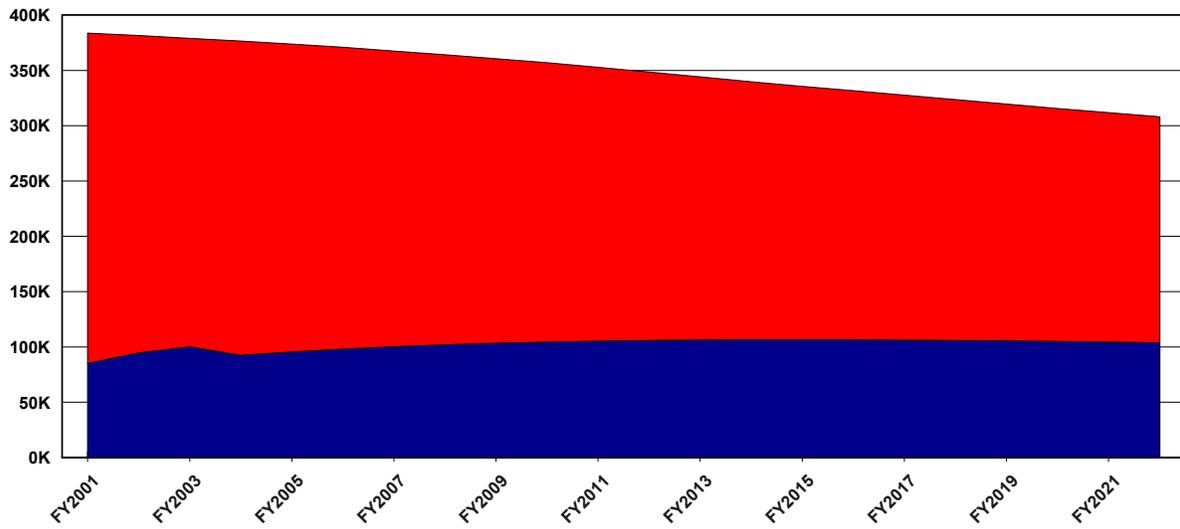
**b. Facility List**

<b>VISN : 6</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Durham</b>				
558 Durham	✓	✓	✓	-
558GA Greenville	✓	-	-	-
558GB Raleigh	✓	-	-	-
558GC Havelock/Morehead City	✓	-	-	-
<b>Fayetteville (NC)</b>				
565 Fayetteville NC	✓	✓	-	-
565GA Jacksonville	✓	-	-	-
565GC New Hanover County (Willmington)	✓	-	-	-

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Southeast Market						
Market PI	Category	Type of Gap	February 2003 (New)			
			FY2012 Gap	FY2012 % Gap	FY2022 Gap	FY2022 % Gap
	Access to Primary Care					
	Access to Hospital Care					
	Access to Tertiary Care					
PI	Specialty Care Outpatient Stops	Population Based	191,931	116%	192,501	116%
		Treating Facility Based	187,668	109%	185,984	108%
PI	Primary Care Outpatient Stops	Population Based	162,710	78%	140,230	67%
		Treating Facility Based	160,806	78%	137,057	67%
PI	Mental Health Outpatient Stops	Population Based	127,796	172%	105,208	141%
		Treating Facility Based	102,088	193%	84,520	160%
PI	Medicine Inpatient Beds	Population Based	51	51%	33	32%
		Treating Facility Based	51	46%	31	27%
PI	Psychiatry Inpatient Beds	Population Based	44	47%	31	33%
		Treating Facility Based	36	72%	24	49%
PI	Surgery Inpatient Beds	Population Based	27	71%	20	54%
		Treating Facility Based	27	58%	19	40%

**e. Stakeholder Information**

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

**Stakeholders Narrative:**

Stakeholders in the Southeast Market have been kept involved and informed throughout the progression of the CARES process. The VISN has been involved with activities on a more global level, with regular mailings, VAC (Veterans Advisory Council) meetings, phone contacts with Congressional offices and VISN meetings with leadership of each of the VISN medical centers.

At the Market level, we have been extensively involved with a wide variety of stakeholders, including veterans service organizations, veterans groups, our medical school affiliates, our staff members and volunteers, and union representatives. Information has been provided to these groups through town hall meetings, employee newsletters, e-mail notices, mailings, committee and staff meetings, strategic planning conferences and veteran council meetings.

A principal issue of the stakeholders involved was the question of whether the respective medical centers would be closed or downsized. A primary concern of the unions was whether we would experience a loss of jobs due to downsizing or contracting out of services. Their fears were allayed when they saw that the workload statistics indicated a significant and sustained increase in workload and a resultant increase versus decrease in projected jobs. The stakeholders appear to fully understand and appreciate the need for additional access points, clinics of adequate size, and construction projects to ensure VA facilities are available to support the significant veteran population and demand for health care services in the Southeast Market.

**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 Southeast Market collaborated closely with the Southwest Market within VISN 6. Proximity issues were carefully scrutinized to ensure that all CBOCs met the 30-minute requirement for separation from other VA sites. Extensive collaboration centered on the Greensboro area in the Southwest Market vis-à-vis the Burlington area in the Southeast Market. The result was location choices that would maximize 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 CBOCs and any inter-Market impact that could possibly arise from those decisions.

Clearly, there was a great deal of discussion between Durham and Fayetteville staff regarding proximity issues and placement of CBOCs. These deliberations resulted in proposed CBOC's that are well-placed for maximal benefit to patients. No collaboration was required between representatives of the Southeast Market and markets outside of VISN 6.

**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 Southeast Market in VISN 6 has Access planning initiatives for Primary Care and Acute Hospital Care, and Capacity initiatives for Primary Care, Specialty Care, Mental Health, Medicine, Psychiatry, and Surgery.

To address the Primary Care Access gap, seven new CBOCs are required. CBOC locations for Durham are in Burlington (FY04) and Rocky Mount (FY05), and those for Fayetteville are in Hamlet (FY04), Lumberton (FY05), Goldsboro (FY06), Sanford (FY08), and Supply (FY10). These additional sites will improve the percentage of enrollees within 30 minutes of a Primary Care and Mental Health site from the baseline level of 52% to 72% in FY 2012 and 73% in FY 2022.

The Acute Hospital Access gap will be resolved through use of a Sharing Agreement with the Naval Hospital Camp Lejeune, which will provide medical and surgical inpatient care for patients from Onslow, Duplin, and Jones counties. This agreement improves the percentage of enrollees within 90 minutes of an acute hospital from the baseline of 64% to 75.4% in FY 2012 and 75.6% in FY 2022.

To address the Capacity gaps, a combination of actions are needed. First, additional off site clinics using leased space are needed in Durham and Raleigh to help manage existing workload and prepare for future increases in these high population areas. Next, all new and existing CBOCs will need to be sized appropriately for the projected demand in the counties they will serve. The CBOCs in Greenville and Wilmington need to be converted to Satellite Outpatient Clinics providing Primary Care, Mental Health, and Specialty Care services, as a way of addressing the Specialty Care demand and improving access to Specialty Care and Ancillary/Diagnostic services for patients in eastern North Carolina. Finally, the remaining gap will be met by construction of Outpatient Additions at Durham (approximately 115,000 SF in size) and Fayetteville (approximately 110,000 SF in size). All of these measures are required to meet 75% of the space gaps at both Durham and Fayetteville.

The inpatient gaps in Medicine, Surgery, and Psychiatry will be met by Ward Renovation projects at both Durham and Fayetteville that will correct overcrowding in patient rooms, patient privacy issues, lack of isolation rooms

with anterooms, and lack of storage space, as well as provide sufficient bed capacity to meet projected demand. To ensure there is adequate space for inpatient programs, the outpatient projects (new and expanded CBOCs, creation of SOPCs, plus construction of Outpatient Additions) must be completed.

For both the outpatient and inpatient solutions, contract care will be required for the intervening years when bed requirements will peak and for the years prior to activation of the new CBOCs and completion of needed construction and renovation projects.

A significant strength of the Southeast Market Plan is its even distribution of access points of adequate size to ensure patients can receive needed services close to home. The new and expanded clinic sites will help decrease the need for costly construction at the parent facilities.

A potential obstacle is the time currently required within VHA to complete major projects and activate SOPC's. VHA fast-tracking of these types of initiatives is essential to meet timelines to resolve gaps. In addition, the VA regulations that limit authority for approval of leases to 10,000 SF imposes an arbitrary restriction on lease sizes for CBOCs that adversely affects the ability to size the clinic appropriately for the expected workload. (If such restrictions did not exist, some CBOCs could be larger and the demand for space at the parent facility could be decreased).

## **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:**

The Southeast Market has an access gap and planning initiative in Primary Care, with 52% of enrollees living within 30 minutes of a Primary Care site.

To improve Primary Care access, additional CBOCs are needed across the Southeast Market, with locations in Burlington, Goldsboro, Hamlet, Lumberton, Rocky Mount, Sanford, and Supply. The locations for these potential future sites were identified by looking at each county to find those where fewer than 20% of the veterans were within 30 minutes of an existing PC site, then looking at projected enrollment and veteran population levels to find areas with significant veteran population, then looking at a map for logical places to put the clinics. Potential sites were then tested to be sure they would all be at least 30 minutes from each other (and from existing VA sites and future clinics being planned in the Southwest Market), and that they would meet the major CBOC planning criteria in terms of enrollees, the number of Priority 1-6 enrollees to be served, and market penetration. Then, each site was entered into the CARES Access Data Base one at a time, until the percent of patients within the access standard reached 70%, or if not at 70%, until fewer than 11,000 veterans were still outside of the driving distance standard.

The new sites will provide both Primary Care and Mental Health services using a mixture of VA-staffed clinics in leased space and contract-model clinics, with clinical inventories similar to the existing CBOCs in Greenville, Raleigh, Jacksonville, and Wilmington. The additional sites will improve the percentage of enrollees within 30 minutes of a Primary Care site from the baseline level of 52% to 72% in FY 2012 and 73% in FY 2022.

Once established, the new clinics will provide for a more even distribution of workload across the Market's service area and will decompress significant workload and space issues at the parent facilities.

The alternative to establishment of VA CBOCs is to use Fee Basis care to allow veterans to receive Primary Care in the community. This alternative was rejected for reasons of cost, lack of continuity of care, and concerns about the ability of community providers to meet the special needs of veterans.

To improve Acute Hospital access, an existing Sharing Agreement with Naval Hospital Camp Lejeune will be used to meet acute medical and surgical hospital needs of patients enrolled at the Jacksonville CBOC (which primarily serves patients from Onslow, Duplin, and Jones Counties). This agreement provides acute hospital care until the patient is stable for transfer to the closest VA facility and has the potential for expansion to include longer lengths of stay as necessary. This agreement improves the percentage of enrollees within 90 minutes of an acute hospital from the baseline level of 64% to 75.4% in FY 2012 and 75.6% in FY 2022. If future events should require a change in this agreement, a second alternative is to establish a contract for medical and surgical inpatient care for patients followed at the Wilmington or Greenville CBOCs. Such a contract would improve the access percentage to 75.2% in FY 2012 and 76.2% in FY 2022. In both alternatives, no changes to the facility clinical inventories at Durham or Fayetteville are expected.

The only other alternative considered was construction of a new acute care hospital in the Greenville area. While population levels and utilization forecasts for the eastern half of the Southeast Market might conceivably support a small hospital, this alternative was not seriously pursued because of cost concerns.

The preferred alternative will improve access to hospital care for a large group of veterans in the southeastern portion of the market. It maintains the successful sharing agreement with the Department of Defense facility at Camp Lejeune and represents effective resource sharing between the two Departments.

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	52%	44,817	72%	29,660	73%	28,041
Hospital Care	64%	33,612	75%	26,482	76%	24,925
Tertiary Care	98%	1,867	99%	1,059	99%	1,039

**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 – Durham**

#### **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 Narrative:**

No Impact

##### **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.

##### **Small 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.

#### **DOD Narrative:**

Durham VAMC is currently in the process of establishing a CBOC in Morehead City NC. Initially extensive discussion took place between the Durham VAMC and the Navy at Cherry Point MCAS to explore the potential for a VA/DoD joint venture in the Morehead City, NC area. Plan was to treat mutual beneficiaries at this site. The Navy has decided to not participate in the project at this time. Durham VAMC is proceeding with activation of the clinic as planned.

### **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.

#### **VBA Narrative:**

No Impact

### **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.

#### **NCA Narrative:**

No Impact

### **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.

#### **Enhanced Use Narrative:**

The Durham VA Medical Center has an approved Enhanced Use Project in which a real estate development company will finance, build, operate and maintain, on the VAMC grounds a mixed-use development (approximately 650,000 square feet) consisting of a hotel, retail space, office buildings, and parking garage addition for non-VA use. In consideration to VA, the development company will design and build, and deliver to VA a 19,500 square foot primary care addition, a 34,400 square foot research facility, and 100 additional parking spaces for VA use. Although this project is in the early implementation stage and its ability to fully deliver the planned improvements is still uncertain, it may help to address some of the facility's space requirements, particularly those related to research space and parking.

### **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

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
	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
<b>INPATIENT CARE</b>												
Medicine	27,167	6,678	27,168	6,679	2,600	-	-	-	-	-	24,568	\$ (6,025,773)
Surgery	21,194	7,914	21,194	7,914	1,800	-	-	-	-	-	19,394	\$ (736,546)
Intermediate/NHCU	98,457	-	98,457	-	65,967	-	-	-	-	-	32,490	\$ -
Psychiatry	10,932	3,682	10,933	3,683	700	-	-	-	-	-	10,233	\$ 9,413,166
PRRTP	-	-	-	-	-	-	-	-	-	-	-	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>157,750</b>	<b>18,274</b>	<b>157,752</b>	<b>18,276</b>	<b>71,067</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>86,685</b>	<b>\$ 2,650,847</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
	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
<b>OUTPATIENT CARE</b>												
Primary Care	210,992	120,036	213,993	123,037	29,564	-	-	-	-	-	184,429	\$ 2,721,899
Specialty Care	194,305	91,739	197,305	94,739	8,153	-	-	-	-	-	189,152	\$ (11,925,625)
Mental Health	67,558	43,768	67,558	43,768	8,559	-	-	-	-	-	58,999	\$ 9,061,054
Ancillary & Diagnostics	270,199	152,681	270,199	152,681	6,061	-	-	-	-	-	264,138	\$ (120,172)
<b>Total</b>	<b>743,053</b>	<b>408,223</b>	<b>749,055</b>	<b>414,225</b>	<b>52,337</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>696,718</b>	<b>\$ (262,844)</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in V/SN									
	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
<b>INPATIENT CARE</b>	<b>FY 2012</b>										
Medicine	74,440	67,316	27,308	40,008	-	11,000	-	-	-	51,008	(16,308)
Surgery	35,182	32,194	18,251	13,943	-	11,000	-	-	-	24,943	(7,251)
Intermediate Care/NHCU	42,872	42,871	(1)	42,872	-	-	-	-	-	42,872	1
Psychiatry	24,162	22,615	12,458	10,157	-	7,000	-	-	-	17,157	(5,458)
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>176,656</b>	<b>164,996</b>	<b>58,016</b>	<b>106,980</b>	-	<b>29,000</b>	-	-	-	<b>135,980</b>	<b>(29,016)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	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
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>										
Primary Care	155,080	138,322	89,683	48,659	-	13,000	-	48,996	-	110,635	(27,687)
Specialty Care	229,941	230,765	122,038	108,727	-	38,000	-	38,000	-	184,727	(46,038)
Mental Health	54,391	48,969	30,042	18,927	-	8,000	-	10,000	-	36,927	(12,042)
Ancillary and Diagnostics	193,300	192,821	99,386	93,435	-	44,000	-	17,000	-	154,435	(38,386)
<b>Total</b>	<b>632,712</b>	<b>610,877</b>	<b>341,149</b>	<b>269,728</b>	-	<b>103,000</b>	-	<b>113,996</b>	-	<b>486,724</b>	<b>(124,153)</b>
<b>NON-CLINICAL</b>	<b>FY 2012</b>										
Research	92,786	146,395	53,609	92,786	-	-	-	-	34,000	126,786	(19,609)
Administrative	306,732	313,571	153,271	160,300	-	-	-	-	-	160,300	(153,271)
Other	23,578	31,252	7,674	23,578	-	-	-	-	-	23,578	(7,674)
<b>Total</b>	<b>423,096</b>	<b>491,218</b>	<b>214,554</b>	<b>276,664</b>	-	-	-	-	<b>34,000</b>	<b>310,664</b>	<b>(180,554)</b>

#### **4. Facility Level Information – Fayetteville (NC)**

##### **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 Narrative:**

No Impact

###### **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.

###### **Small 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.

#### **DOD Narrative:**

Fayetteville VAMC has an existing agreement in place with Womack Army Hospital. The volume of activity and intensity of this agreement is highly variable depending on mutual need, interest of the respective command and deployment status. Recently Fayetteville is working to amend the agreement to include provision for Substance Abuse support for DoD beneficiaries. Fayetteville also has an arrangement for emergency treatment of VA patients at Camp Lejeune near Jacksonville NC.

### **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.

#### **VBA Narrative:**

No Impact

### **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.

#### **NCA Narrative:**

No Impact

### **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.

#### **Enhanced Use Narrative:**

No Impact

### **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

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

		# BDOCs proposed by Market Plans in VISN										
	# BDOCs (from demand projections)	Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value	
	FY 2012	FY 2012	from 2001									
<b>INPATIENT CARE</b>												
Medicine	23,433	23,433	9,257	8,284	-	-	-	-	-	15,149	\$ (49,541,772)	
Surgery	2,106	2,106	612	253	-	-	-	-	-	1,853	\$ -	
Intermediate/NHCU	60,246	60,246	-	34,943	-	-	-	-	-	25,303	\$ -	
Psychiatry	15,382	15,382	7,363	904	-	-	-	-	-	14,478	\$ 4,957,603	
PRRTP	-	-	-	-	-	-	-	-	-	-	\$ -	
Domiciliary	-	-	-	-	-	-	-	-	-	-	\$ -	
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	\$ -	
Blind Rehab	-	-	-	-	-	-	-	-	-	-	\$ -	
<b>Total</b>	<b>101,166</b>	<b>101,167</b>	<b>17,231</b>	<b>44,384</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>56,783</b>	<b>\$ (44,584,169)</b>	
		Clinic Stops proposed by Market Plans in VISN										
	Clinic Stops (from demand projections)	Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value	
	FY 2012	FY 2012	from 2001									
<b>OUTPATIENT CARE</b>												
Primary Care	155,319	160,320	40,772	1,000	-	-	-	-	-	159,320	\$ (19,387,728)	
Specialty Care	165,461	170,461	95,931	33,264	-	-	-	-	-	137,197	\$ (45,123,475)	
Mental Health	87,478	87,478	58,321	13,635	-	-	-	-	-	73,843	\$ (1,438,119)	
Ancillary & Diagnostics	184,408	184,408	93,243	12,135	-	-	-	-	-	172,273	\$ (12,988,647)	
<b>Total</b>	<b>592,666</b>	<b>602,667</b>	<b>288,267</b>	<b>60,034</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>542,633</b>	<b>\$ (78,937,969)</b>	

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in V/SN									
	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
FY 2012											
<b>INPATIENT CARE</b>											
Medicine	29,303	31,510	12,560	18,950	-	5,000	-	-	-	23,950	(7,560)
Surgery	946	4,632	945	3,687	-	-	-	-	-	3,687	(945)
Intermediate Care/NHCU	-	26,945	-	26,945	-	-	-	-	-	26,945	-
Psychiatry	15,623	23,454	14,158	9,296	-	8,500	-	-	-	17,796	(5,658)
PRRTP	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>45,872</b>	<b>86,541</b>	<b>27,663</b>	<b>58,878</b>	-	<b>13,500</b>	-	-	-	<b>72,378</b>	<b>(14,163)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	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
FY 2012											
<b>OUTPATIENT CARE</b>											
Primary Care	44,080	79,660	51,516	28,144	-	-	-	37,499	-	65,643	(14,017)
Specialty Care	127,434	150,917	125,465	25,452	-	50,000	-	42,000	-	117,452	(33,465)
Mental Health	35,909	42,829	32,060	10,769	-	7,000	-	15,000	-	32,769	(10,060)
Ancillary and Diagnostics	82,622	110,255	83,117	27,138	-	39,500	-	19,000	-	85,638	(24,617)
<b>Total</b>	<b>290,045</b>	<b>383,661</b>	<b>292,158</b>	<b>91,503</b>	-	<b>96,500</b>	-	<b>113,499</b>	-	<b>301,502</b>	<b>(82,159)</b>
<b>NON-CLINICAL</b>											
Research	-	-	-	-	-	-	-	-	-	-	-
Administrative	244,688	343,247	232,938	110,309	-	39,000	-	26,000	-	175,309	(167,938)
Other	-	20,699	-	20,699	-	-	-	-	-	20,699	-
<b>Total</b>	<b>244,688</b>	<b>363,946</b>	<b>232,938</b>	<b>131,008</b>	-	<b>39,000</b>	-	<b>26,000</b>	-	<b>196,008</b>	<b>(167,938)</b>

## D. South West Market

### 1. Description of Market

#### a. Market Definition

<b>Market</b>	<b>Includes</b>	<b>Rationale</b>	<b>Shared Counties</b>
South West Code: 6C	<b>41 North Carolina Counties</b>	The South West Market is based on the referral patterns of our Salisbury and Asheville, North Carolina facilities with Asheville being a tertiary facility. These facilities are also geographic partners and have a relationship of sharing services. This market has one CBOC and one SOPC to cover the two major metropolitan population centers in North Carolina. The market has one large and several moderately sized population areas dispersed along transportation and access routes. The South West market is made up of 41 counties with an estimated FY 2002 veteran population of 387,244.	VISN 9 to include Ashe, Watauga, & Avery Counties in their planning process

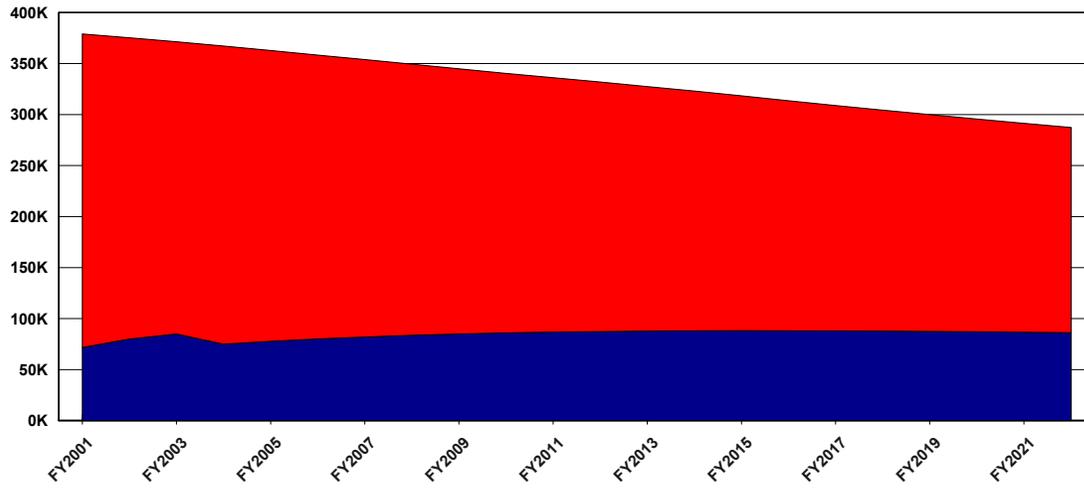
**b. Facility List**

<b>VISN : 6</b>				
<b>Facility</b>	<b>Primary</b>	<b>Hospital</b>	<b>Tertiary</b>	<b>Other</b>
<b>Asheville</b>				
637 Asheville-Oteen	✓	✓	✓	-
<b>Salisbury</b>				
659 W.G. (Bill) Hefner Salisbury VAMC	✓	✓	-	-
659BY Winston-Salem	✓	-	-	-
659GA Charlotte	✓	-	-	-

### c. Veteran Population and Enrollment Trends

----- Projected Veteran Population

----- Projected Enrollees



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Southwest Market						
Market PI	Category	Type of Gap	February 2003 (New)			
			FY2012 Gap	FY2012 % Gap	FY2022 Gap	FY2022 % Gap
	Access to Primary Care					
	Access to Hospital Care					
	Access to Tertiary Care					
PI	Specialty Care Outpatient Stops	Population Based	160,238	127%	156,565	124%
		Treating Facility Based	161,745	130%	155,804	125%
PI	Primary Care Outpatient Stops	Population Based	131,456	74%	111,456	63%
		Treating Facility Based	99,042	51%	76,818	39%
PI	Mental Health Outpatient Stops	Population Based	64,124	98%	50,335	77%
		Treating Facility Based	73,038	104%	57,193	81%
PI	Medicine Inpatient Beds	Population Based	49	70%	32	45%
		Treating Facility Based	51	76%	33	49%
PI	Surgery Inpatient Beds	Population Based	20	67%	14	46%
		Treating Facility Based	17	61%	11	40%
	Psychiatry Inpatient Beds	Population Based	0	0%	-8	-5%
		Treating Facility Based	7	3%	-7	-3%

**e. Stakeholder Information**

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

**Stakeholder Narrative:**

Stakeholders in the Southwest Market have been kept involved and informed throughout the progression of the CARES process. The VISN has been involved with activities on a more global level, with regular mailings, VAC (Veterans Advisory Council) meetings, phone contacts with Congressional offices, and VISN meetings with leadership of each of the VISN medical centers. At the Market level, we have been extensively involved with a wide variety of stakeholders, including veterans service organizations, veterans groups, our medical school affiliates, our 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, strategic planning conferences and veteran council meetings

A principal issue of the stakeholders involved the question of whether the respective medical centers would be closed or downsized. A primary concern of the unions was whether we would experience a loss of jobs due to downsizing or contracting out of services. Their fears were allayed when they saw that the workload statistics indicated a significant and sustained increase in workload and a resultant increase versus decrease in projected jobs.

Input provided by our stakeholders was considered in our planning process. This involved issues regarding VA-staffed versus contracted CBOC's, location of CBOC's, the amount of in-house versus contracted workload and the best locations for certain types of services.

**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 Southwest market collaborated closely with the Southeast market on placement of access points and determination of level of services to be offered at these sites.

The current referral patterns within the Southwest market will continue between Salisbury and Asheville VAMC. Additionally referrals to facilities in other markets , primarily Durham in the SE, will continue for patients with specialized surgery and medical needs.

Initial analysis of workload in the counties in VISN 6 in the Southwest market determined that 4 counties on the border with VISN 9 (Ashe, Watauga, Avery NC and Smyth WV) had a majority of veterans being provided care at a VISN 9 facility, specifically Mountain Home VAMC. Travel times and distances to Mountain Home VAMC for veterans in these counties were less than those to Asheville VAMC, which would be the nearest VISN 6 Facility. Subsequently, these 4 counties are now included as part of the VISN 9 CARES Market Plan.

Although included as part of the VISN 9 Market Plan both VISNs will continue to collaborate on a broad range of issues to include location of access points in and around these counties as well as shared services/ referrals between Asheville and Mountain Home VAMCs.

**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 Southwest Market in VISN 6 has a planning initiative for Access to Primary Care, and Capacity initiatives for outpatient Primary Care, outpatient Specialty Care, outpatient Mental Health, Inpatient Medicine and Inpatient Surgery.

In order to increase the Access baseline of 47% to at least 70%, six new CBOC's and one new SOPC are proposed. CBOC locations for Salisbury are in Hickory (FY04), Greensboro (FY07) and Gastonia (FY10), and those for Asheville are in Franklin (FY04), Hendersonville (FY04) and Rutherfordton (FY09). The SOPC planned for Salisbury would be located in Charlotte (FY06). The proposed activation sequence for these sites (noted in parentheses) was selected to provide needed services as quickly as possible to the most underserved areas.

The addition of the seven new sites gives the SW Market the flexibility to begin addressing the significant capacity gaps in Specialty Care (125% in FY 2022), Mental Health (81% in 2022) and Primary Care (39% by 2022). Additional services will need to be offered at both medical centers and the Winston-Salem Outpatient Clinic to fully meet the primary care outpatient care gaps. This also involves a significant increase in Specialty Care services (and space) at Salisbury VA and Asheville VA, and an increase in services (and space) at the Asheville VA for Mental Health.

Inpatient Medicine gaps (49% increase in BDOC by FY 2022) and inpatient Surgery gaps (40% increase by FY 2022) will be met via renovation projects to add additional beds at both medical centers.

A significant strength of the SW plan is the strategic placement of CBOC's and their proximity to major hubs of clinical expertise, i.e., Salisbury VA, Asheville VA, Winston-Salem OPC and Charlotte SOPC.

A potential obstacle is the time currently required within VHA to complete major projects and activate SOPC's and CBOCs. VHA fast-tracking of these types of initiatives would seem essential in order to meet timelines to resolve gaps.

## **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:**

#### **1. Health Care Quality and Need**

The SW Market has an access gap and resultant planning initiative in Primary Care. The current percentage of enrollees that meet the driving time guideline (per the FY01 baseline) is 47%. Analysis of enrollee population by county, market penetration by county and enrollee geographic trends led to the plan for one new SOPC and seven additional CBOCs. Three new CBOCs (Hickory, Greensboro and Gastonia) will be in the Salisbury PSA with three new CBOCs residing within Asheville's PSA (Hendersonville, Franklin and Rutherfordton). The SOPC will be located in Charlotte, NC. The larger health care hubs of the SW market (Salisbury and Asheville VAMCs and Winston-Salem and Charlotte SOPCs) will provide needed specialty care and support services for these outlying areas. Continuity, coordination and "one level of care" considerations will also be addressed via telemedicine capability and strong geographic partnering initiatives between the two medical centers.

#### **2. Safety and Environment**

In all likelihood, VA personnel will staff all of the newly proposed CBOCs. Location of CBOCs is accomplished with consideration of a number of factors, including adjacencies within the area, access to health care facilities and services, and veteran access. Compliance with building codes and guidelines of regulatory bodies will be strictly adhered to. Given the fact that we have an existing SOPC and CBOC in the market, we have experience with designing layouts and assuring appropriate space, privacy, adjacencies, etc.

#### **3. Research and Academic Affiliations**

The addition of six new CBOCs, and particularly the addition of the proposed Charlotte SOPC, will increase the number of sites for research opportunities and collaborations. This broader base will be advantageous to our medical school affiliates and to other research stakeholders. The increase in research access points also provides the opportunity for additional, and more broad-scoped, research initiatives. At present, there is no anticipated impact on neighboring facilities and VISNs.

The newly proposed sites will also increase the number and types of venues available for clinical education experiences. It will also increase the number of potential collaborative educational opportunities given the increased geographic access.

#### 4. Staffing and Community

##### Staffing Impact:

Activation of the seven new access points will provide opportunities for significant increase in staffing. Staffing to meet the access guideline for Primary Care will be accomplished through the VISN 6 Primary Care staffing model. Opportunities will be provided to current staff to work at the new locations, and secondarily to VISN and national VA staff, and eventually national recruitment searches. Staff are being informed, and will continue to be kept informed, regarding potential CARES initiatives via employee newsletters, town hall meetings, staff and medical center committee meetings and e-mail updates. It is anticipated that the VISN will communicate more broad reaching VISN staffing developments via appropriate communication channels.

##### Community Impact:

We are not anticipating any negative impact on health care agencies within the community. Medical center leadership will make appropriate contact with community representatives as needed and as appropriate.

#### 5. Support of All Other VA Missions

This planning initiative for Primary Care access will not have a significant impact on sharing arrangements with the Department of Defense because of the geographic distance from DoD facilities. A significant impact on NCA, VBA and overall One-VA integrations is not anticipated. Cooperation and integration with DoD contingency planning is coordinated through regional NDMS representatives and regional VA coordinators.

#### 6. Optimizing Use of Resources

Optimization of resources is accomplished for the Primary Care access P.I. through the addition of six new

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	45%	43,790	73%	23,588	74%	22,391
Hospital Care	78%	17,516	77%	20,093	77%	19,807
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 – Asheville

#### 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 Narrative:**

No Impact

##### **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.

##### **Small 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.

**DOD Narrative:**

No Impact

**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.

**VBA Narrative:**

No Impact

**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.

**NCA Narrative:**

No Impact

### **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.

#### **Enhanced Use Narrative:**

No Impact

### **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

#### **VISN Identified Planning Initiatives Narrative:**

No Impact

**b. Resolution of Capacity Planning Initiatives**

***Proposed Management of Workload – FY 2012***

# BDOCs proposed by Market Plans in VISN											
	# BDOCs demand projections)										
		Total BDOCs	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>INPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001</b>									
Medicine	23,518	11,581	23,518	11,581	2,800	-	-	-	-	20,718	\$ (11,317,063)
Surgery	12,628	5,483	12,628	5,483	1,100	-	-	-	-	11,528	\$ (296,161)
Intermediate/NHCU	58,013	-	58,013	-	13,924	-	-	-	-	44,089	\$ -
Psychiatry	12,200	1,179	12,200	1,179	500	-	-	-	-	11,700	\$ (31,231)
PRRTP	7	-	7	-	-	-	-	-	-	7	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>106,365</b>	<b>18,242</b>	<b>106,366</b>	<b>18,243</b>	<b>18,324</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>88,042</b>	<b>\$ (11,644,455)</b>
Clinic Stops proposed by Market Plans in VISN											
	Clinic Stops (from demand projections)										
		Total Stops	Variance from 2001	Contract	Joint Ventures	Transfer Out	Transfer In	In Sharing	Sell	In House	Net Present Value
<b>OUTPATIENT CARE</b>	<b>FY 2012</b>	<b>Variance from 2001</b>									
Primary Care	112,815	42,172	114,816	44,173	1,149	-	-	-	-	113,667	\$ (9,743,071)
Specialty Care	118,382	47,615	120,383	49,616	1,204	-	-	-	-	119,179	\$ (15,012,002)
Mental Health	42,080	27,961	42,081	27,962	-	-	-	-	-	42,081	\$ (3,241,833)
Ancillary & Diagnostics	155,454	54,036	155,454	54,037	6,219	-	-	-	-	149,235	\$ (3,196,222)
<b>Total</b>	<b>428,731</b>	<b>171,784</b>	<b>432,734</b>	<b>175,787</b>	<b>8,572</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>424,162</b>	<b>\$ (31,193,128)</b>

**Proposed Management of Space – FY 2012**

Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
	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/ Vacant
FY 2012											
<b>INPATIENT CARE</b>											
Medicine	63,028	35,645	28,141	27,383	-	15,000	-	-	-	42,383	(13,141)
Surgery	26,879	10,659	8,565	16,220	-	2,500	-	-	-	18,720	(6,065)
Intermediate Care/NHCU	60,460	-	(1)	60,460	-	-	-	-	-	60,460	1
Psychiatry	19,764	11,804	10,994	7,960	-	9,100	-	-	-	17,060	(1,894)
PRRTP	9,557	-	-	9,557	-	-	-	-	-	9,557	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>179,688</b>	<b>58,108</b>	<b>47,699</b>	<b>121,580</b>	-	<b>26,600</b>	-	-	-	<b>148,180</b>	<b>(21,099)</b>
Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
	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/ Vacant
FY 2012											
<b>OUTPATIENT CARE</b>											
Primary Care	55,844	15,955	16,945	39,889	-	-	-	9,500	-	49,389	(7,445)
Specialty Care	139,467	73,676	76,032	65,791	-	47,000	-	-	-	112,791	(29,032)
Mental Health	34,578	28,944	29,293	5,634	-	14,000	-	8,500	-	28,134	(6,793)
Ancillary and Diagnostics	95,511	47,140	47,139	48,371	-	28,000	-	-	-	76,371	(19,139)
<b>Total</b>	<b>325,400</b>	<b>165,715</b>	<b>169,409</b>	<b>159,685</b>	-	<b>89,000</b>	-	<b>18,000</b>	-	<b>266,685</b>	<b>(62,409)</b>
<b>NON-CLINICAL</b>											
Research	4,290	-	38	4,290	-	-	-	-	-	4,290	(38)
Administrative	249,595	108,303	103,408	141,292	-	-	-	-	-	141,292	(103,408)
Other	59,739	-	-	59,739	-	-	-	-	-	59,739	-
<b>Total</b>	<b>313,624</b>	<b>108,303</b>	<b>103,446</b>	<b>205,321</b>	-	-	-	-	-	<b>205,321</b>	<b>(103,446)</b>

#### 4. Facility Level Information – Salisbury

##### 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 Narrative:**

No Impact

###### **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.

###### **Small 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.

**DOD Narrative:**

No Impact

**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.

**VBA Narrative:**

No Impact

**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.

**NCA Narrative:**

No Impact

**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.

**Enhanced Use Narrative:**

No Impact

## **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

### **VISN Identified Planning Initiatives Narrative:**

Proposed Satellite Outpatient Clinic(SOPC)Charlotte, NC

The veteran population in the Charlotte metropolitan area is approximately 121,000. This includes Mecklenburg County (Charlotte's home county) and the surrounding counties of Cabarrus, Gaston, Iredell, Lincoln and Union. CARES data indicates that the number of enrollees in this area will increase from 18,165 in FY 2001 to 31,038 in FY 2022.

Salisbury currently operates a CBOC in Mecklenberg county, which has been in operation since 1998, and quickly reached it's capacity. The entire Primary Service Area (PSA) for Salisbury VAMC has experienced burgeoning growth in demand for primary care services. This has, of course, led to greatly increased demand for mental health, specialty care services and support services. The general population in the Charlotte region is currently estimated at 2 million. The latest projections indicate that the population will increase to 3.5 million in the year 2030. Charlotte is currently the second fastest growing metropolitan area in the United States at 22%. Only Phoenix, at 23%, has a higher growth rate. This proposal for the Charlotte SOPC involves construction of approximately 52,000 square feet of rentable space. The amount of rentable space was determined from space data for the similarly sized, and currently existing, Winston-Salem Outpatient Clinic. Gross space in the building will be approximately 74,000 square feet. At present, the SOPC is anticipated to include services such as primary care, mental health, specialty care clinics, ambulatory surgery, pharmacy, diagnostic laboratory, an imaging diagnostic center, an urgent care center, physical medicine and rehabilitation clinic, and eye, audiology and pulmonary clinics.

The Charlotte SOPC would be located within close proximity to one of the major medical centers (Presbyterian or Carolinas healthcare systems). There will be easy access to public transportation, while being located where veterans of the greater Charlotte metropolitan area are expected to obtain the majority of their health care services. The current Charlotte CBOC is slightly less than 10,000 square feet in size. It opened in FY 1998, but only has the capacity to serve

veterans who were already enrolled in primary care at the Hefner VAMC. There are similar limitations in the number of mental health patients able to be served. With a population of 2 million that is rapidly growing, an SOPC access point offering a complete range of services in Charlotte is long overdue. The current CBOC primary care, mental health clinic and eye clinic functions would be relocated to the new building. Additional staff would then augment the existing staff in accordance with VISN staffing models. It is hoped that the Charlotte SOPC can be activated in FY 06. This SOPC could also help support the proposed, and neighboring, CBOC in Gastonia, which is anticipated to become operational in FY 2010.

**b. Resolution of Capacity Planning Initiatives**

*Proposed Management of Workload – FY 2012*

# BDOCs proposed by Market Plans in VISN												
	# BDOCs (from demand projections)											
	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
<b>INPATIENT CARE</b>												
Medicine	13,276	4,304	13,276	4,304	2,071	-	-	-	-	-	11,205	\$ (2,694,981)
Surgery	1,261	(222)	1,262	(221)	350	-	-	-	-	-	912	\$ 1,715,466
Intermediate/NHCU	108,014	-	108,014	-	12,962	-	-	-	-	-	95,052	\$ -
Psychiatry	53,731	914	53,732	915	455	-	-	-	-	-	53,277	\$ (85,437)
PRRTP	198	-	198	-	-	-	-	-	-	-	198	\$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	\$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	\$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	\$ -
<b>Total</b>	<b>176,480</b>	<b>4,996</b>	<b>176,482</b>	<b>4,998</b>	<b>15,838</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>160,644</b>	<b>\$ (1,064,952)</b>
Clinic Stops proposed by Market Plans in VISN												
	Clinic Stops (from demand projections)											
	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
<b>OUTPATIENT CARE</b>												
Primary Care	181,820	56,870	171,820	46,870	10,000	-	-	-	-	-	161,820	\$ (6,278,120)
Specialty Care	168,120	114,128	158,121	104,128	62,000	-	-	-	-	-	96,121	\$ 26,127,398
Mental Health	101,484	45,077	101,485	45,077	22,000	-	-	-	-	-	79,485	\$ (7,436,299)
Ancillary & Diagnostics	192,829	76,117	192,829	76,117	-	-	-	-	-	-	192,829	\$ (11,967,748)
<b>Total</b>	<b>644,253</b>	<b>292,191</b>	<b>624,255</b>	<b>272,193</b>	<b>94,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>530,255</b>	<b>\$ 445,231</b>

**Proposed Management of Space – FY 2012**

	Space (GSF) (from demand projections)		Space Driver Projection	Variance f 2001		Space Driver Projection	Variance f 2001		Space Needed/ Moved to Vacant
	FY 2012	Variance from 2001							
<b>INPATIENT CARE</b>									
Medicine	22,367	16,727	23,306	17,666	5,640	13,000	-	18,640	(4,666)
Surgery	1,592	1,023	1,514	945	569	650	-	1,219	(295)
Intermediate Care/NHCU	169,229	-	169,228	(1)	169,229	-	-	169,229	1
Psychiatry	110,645	44,470	110,816	44,641	66,175	17,822	-	83,997	(26,819)
PRRTP	17,822	-	-	(17,822)	17,822	-	-	17,822	17,822
Domiciliary program	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>321,655</b>	<b>62,220</b>	<b>304,864</b>	<b>45,429</b>	<b>259,435</b>	<b>31,472</b>	-	<b>290,907</b>	<b>(13,957)</b>
	Space (GSF) (from demand projections)								
<b>OUTPATIENT CARE</b>									
Primary Care	73,237	13,732	85,765	26,260	59,505	-	-	81,505	(4,260)
Specialty Care	169,214	117,257	158,600	106,643	51,957	-	-	126,457	(32,143)
Mental Health	53,909	11,405	65,973	23,469	42,504	-	-	54,504	(11,469)
Ancillary and Diagnostics	135,752	96,595	154,263	115,106	39,157	-	-	124,157	(30,106)
<b>Total</b>	<b>432,111</b>	<b>238,988</b>	<b>464,601</b>	<b>271,478</b>	<b>193,123</b>	-	-	<b>386,623</b>	<b>(77,978)</b>
	Space (GSF) (from demand projections)								
<b>NON-CLINICAL</b>									
Research	5,353	-	5,223	(130)	5,353	-	-	5,353	130
Administrative	371,969	148,200	379,597	155,828	223,769	-	-	223,769	(155,828)
Other	53,527	-	53,527	-	53,527	-	-	53,527	-
<b>Total</b>	<b>430,849</b>	<b>148,200</b>	<b>438,347</b>	<b>155,698</b>	<b>282,649</b>	-	-	<b>282,649</b>	<b>(155,698)</b>