



U.S. Department
of Veterans Affairs

VA Integrated Planning Handbook

May 2014



VBA



VA Defining
HEALTH CARE **EXCELLENCE**
in the 21st Century

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Chapter 1: Overview of Integrated Planning Process

1.1 Background and Purpose

1. The Department of Veterans Affairs (VA) delivers health care, benefits, and memorial services to Veterans of U.S. military service through a nationwide system of programs and facilities. The Department includes three Administrations: Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA). Each Administration has geographic subdivisions created to suit the particular needs of that Administration for service delivery.
2. VA is responsible for the effective use of a significant appropriation of public funds and an extensive complement of capital and non-capital assets. The Department is continuously working to improve the efficient use of its resources and embarked upon a VA Facility Management (VAFM) Transformation that includes improvements to processes and standards for life-cycle facility management across all three Administrations. This initiative includes the establishment of a Department-wide, uniform planning process which incorporates an Integrated Planning (IP) approach to strategic and capital planning.
3. “Many VA facilities have aging infrastructure and technology that are progressively more obsolete. Changing demographics have led to geographic mismatches between VA facilities and the Veterans they are intended to serve.” (DVA Strategic Plan Refresh FY 2011-2015, p. 51) VA has recognized that a process to correct these mismatches must start with the services that need to be delivered, and must consider capital and non-capital delivery methods.
4. This VAFM Integrated Planning Handbook is designed to be a reference guide for VA staff and contractors. It provides the focus needed to carry out the Integrated Planning process consistently across the Department. The Handbook is organized to follow the flow and steps of the process diagram below. This planning process is dynamic and feedback is encouraged. The Handbook will be revised as the process evolves. Contractors shall use this Handbook to supplement their Statement of Work.

1.2 The Integrated Planning Process

5. Executive Summary: Integrated Planning is a Department-level process coordinated by a Team with members from OCFM, VHA, VBA, NCA and OAEM. Integrated Plans are developed and refreshed on a 5-year cycle using Architect/Engineer contracts awarded by CFM using the Advance Planning Fund. The process serves as a bridge between existing VA and Administration strategic goals and objectives, and VHA’s CAMP process and the Strategic Capital Investment Planning (SCIP) process. (See diagram in 1.3 below.)
6. Focus and Scope: The focus is to develop an operational planning process that starts with strategic planning and results in operational services delivery plans for every VA market with facility master plans for every VA-owned facility in each market. Since most location-critical VA

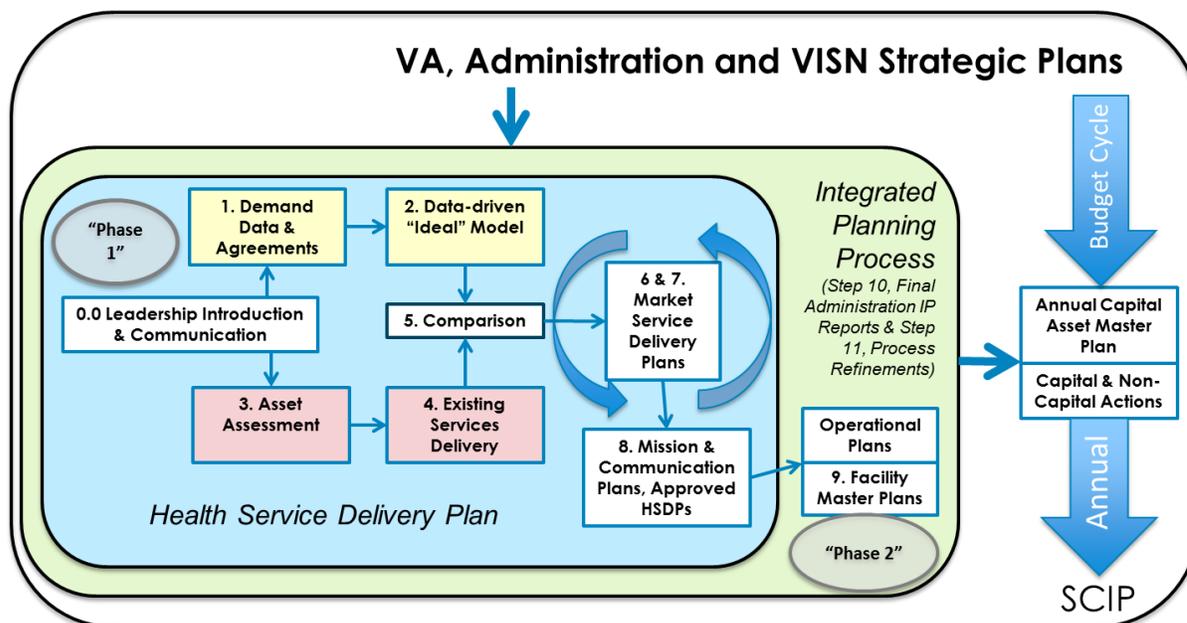
services are delivered through VHA, planning is being done in “groups of markets” corresponding to VHA VISNs.

7. Significance and Consequences: VA recognizes the “...geographic mismatches between VA facilities and the Veterans they are intended to serve.”¹ This process creates a data driven services delivery model and an asset assessment tool that are used to determine where mismatches exist and then to guide the creation of viable operational plans to address those mismatches. The process includes risk identification and stakeholder communication plans since the resulting operational plans will be used to direct resources to correct mismatches.
8. Evidence Base: “The VA delivery system has many strengths However, shifts in health care across the Nation and the evolving needs of Veterans call for a more fundamental reassessment of VA’s approach to healthcare delivery, funding, and coordination. We need to adapt our service delivery model to address these and other potential changes.”² Under health care reform this appears to be even more important. Two completed pilots have confirmed the validity of the process.
9. Current Processes and Gaps: VHA VISNs are required to prepare Strategic Plans and all Administrations are required to submit Strategic Capital Assessments as a part of SCIP; however the operational services delivery plans and facility master plans needed to turn strategies and demand into actions and projects have not been required.
10. Impact of Current Practices: The previously discussed geographic mismatches, numerous aging and obsolete buildings, and continued problems in the various construction programs are the direct results of the planning gap discussed above.
11. Objectives:
 - a. Planning processes that result in demand-driven operational non-capital and capital plans.
 - b. An agile VA infrastructure footprint fully comparable to the best in the nation.
 - c. Capital investments based on approved strategic, operational and facility master plans.
 - d. A continually updated process with local flexibility that is able to reflect the unique circumstances of the various States and markets served by VA.
12. Performance Metrics: Progress toward the goals will be measured by the Administrations and VISNs through the CAMP and SCIP processes.
13. Management Plan:
 - a. This process informs the submissions made into the new VHA Capital Asset Master Planning Process and the existing SCIP process by each Administration, and falls under the existing Capital Asset Board leadership and approval process.
 - b. Integrated planning process operating procedures are developed by a VA Facility Management (VAFM) Team consisting of representatives from all three Administrations, CFM and OAEM.
 - c. The planning contracts are managed by the three CFM Regional Offices who work closely with the Administrations and VISNs on a recurring cycle.

¹ DVA Strategic Plan Refresh FY 2011-2015, p. 51

² DVA Strategic Plan Refresh FY 2011-2015, p. 50.

1.3 Planning Process Diagram



1.4 Goals of this process

1. Goal is to facilitate the continuous planning process of the VA
2. To put in place a standardized enterprise-wide integrated planning process that integrates strategies and capital to consistently produce better requirements for submission to SCIP and for action at the local level.

1.5 Outcomes and Benefits sought

The purposes and advantages of a standardized, enterprise-wide integrated planning process include:

1. Consistently applied methods and process for planning for all three administrations
2. Creation of an integrated planning team of government stakeholders supplemented by pre-selected and capable consultants
3. Migration from Planning as a "project" to planning as a "process"
4. Standardized method for developing approaches for service delivery planning, resource allocation, personnel allocations and facility asset allocation
5. Standardized methods for developing and sequencing requirements that support CAMP and SCIP annual submissions
6. Access to a diverse consultant capability that helps blend operations and infrastructure as part of the planning process
7. Integration of market level real estate requirements and strategies for all assets for all Administrations
8. Development of VISN, region and administration market strategies for delivering services both capital & non-capital

9. Development of alternate business strategies to help guide Facility Master Planning
10. Master Plans driven by approved missions for all facilities and integrated at the VISN or Region level
11. Integration of existing VA data for enrollment, forecasting, workload, population, facility condition
12. Capital requirements driven by gaps identified in service delivery driven master planning process, not through facility condition assessments
13. An effective way to develop and evaluate requirements within declining markets by developing alternate use or re-purposing schemes for existing infrastructure

1.6 Definitions

1. **Market Area.** Market areas constitute the basic planning unit in the VA Integrated Planning process. Each VISN or other geographic identifier used by VA includes one or more market areas. While VBA and NCA use different geographic boundaries, for the purposes of this Task Order, the geographic grouping of markets adopted by VHA (VISNs) shall be used.
2. **VISN VA Integrated Planning Team (Team)** consists of executives, VISN Planner, Capital Asset Manager (CAM), staff, clinical and technical personnel and other designated persons, including VHA, VBA, NCA, CFM, VISN and local support teams and their contractors, who will participate in some or all aspects of this services planning effort. The team also may include VA-designated agency consultants who are helping to develop and document this planning process. To support VA planning efforts, VISNs are encouraged to include representatives from existing VISN planning bodies and workgroups including Patient Aligned Care Teams (PACT) and Patient Centered Care.
3. **Services** are defined to include the full complement of health, benefit, and memorial services provided to Veterans and other qualified beneficiaries by the Department of Veterans Affairs.
 - i. **Health Services** include Inpatient Hospital, Special VA Program Bed Section Care, Long-Term Care, Ambulatory Services and Procedures, Medical Diagnostics, Outpatient Mental Health VA Programs, Dental, Pharmacy, and durable medical equipment (DME) and Prosthetics provided by VHA.
 - ii. **Benefit Services** include all services provided by VBA.
 - iii. **Memorial Services** include Burial, Memorial, and Maintenance of National Shrines services provided by NCA.
4. **Guiding Principles** – Guiding Principles inform the process to enable decisions on when and where services should be offered; by what mode the services will be provided and how what resources will be needed to provide that service. The principles address the entire continuum of care by service line. These standards and guidelines inform the development of the Data Driven (ideal) model. This plan should be based upon the latest VHA programmatic and health industry standards/criteria for operational efficiency, productivity

and program activation thresholds. In the VA Integrated Planning process we refer to these essential guidelines as the Guiding Service Distribution Principles (GSDP) or simply “Guiding Principles”. These were referred to as Ideal Service Distribution Principles in the VISN 17 and 11 Integrated Planning Studies.

5. **Integrated Planning** is the combination of Services Planning and Facility Planning into one continuous and dynamic planning process. Integrated Planning develops goals and strategies consistent with organizational strategic plans and programmatic Guiding Principles, which drive non-capital and capital planning. This integrated planning methodology starts with the current and projected demand for services needed by Veterans before focusing on gaps in existing capacities.
6. **Services Planning** is the identification of specific customer needs by quantity, type, and location over a specific time period and the determination of ideal methods for delivery of those services. It includes creation of delivery scenarios which consider a variety of potential developments, assumptions, and limiting factors. Methods for delivery include facility-based, non-facility based, non-capital, or other alternatives. Services Planning takes into account existing capacities, locations, efficiencies, and other resources including those of private, local, state, and other Federal organizations. Services Planning is the bridge between Administration-specific strategic planning and actual delivery solutions, including those to be provided in VA owned or leased facilities. Services Planning includes consulting by professional health systems planners and providing technical and administrative experts to provide various types of support described herein. It includes receipt, review, and organization of various types of documents, documentation of meetings, conferences, and phone conversations and preparation of reports, diagrams, charts, tables and narratives derived from participation with the VA Planning Team.
7. **Delivery Models** refers to the various ways that services are or can be delivered. This process is intended to clearly define the existing delivery models and establish innovative models to provide services that are patient centered, data-driven, continuously improving and team-based.
8. **Non-capital solutions** include telehealth/telemedicine, home care, extended hours, sharing, contracts, and telework. VA delivers health care in a dynamic environment that increasingly requires agility. In this environment VA must consider non-capital solutions before capital solutions. VA will always have a physical presence in key geographic areas, but is moving toward health care that promotes wellness (fewer visits) versus treating diseases.
9. **Capital Assets** are health care and administrative facilities (owned, leased, and contracted), equipment (both medical and non-medical), resources devoted to the provision of care using virtual modalities, and information technology solutions for health care delivery.

10. **Leap to the Ideal (or data driven model)** is a conceptual step in the services planning process for establishing data-driven theoretical “best practice” delivery models to be compared to the existing delivery system. This step is a valuable exercise and is intended to start many conversations with the VA Planning team and the contractor. It is intended to be a purely data-driven solution that ignores current sites of care and stakeholder issues (medical schools, politics etc.). The Leap to Ideal exercise tests and re-rationalizes VA’s continuum of care based upon VA’s access policies, patient utilization, operational benchmarks (Guiding Principles), published strategic direction and the patient’s perspective and their geographic distribution. This part of the process allows for open conversations concerning “what-ifs” for accessibility, operational efficiencies, and quality management across each segment of the health care, memorial and benefits delivery system. VISN participants can critique the data-driven model and can use it to help envision new and improved ways of delivering care. VA enrollee and unique patient populations as well as VA Strategic Planning Category utilization projections are analyzed and displayed to visually demonstrate alternative solutions for service delivery. The results of these conversations lead to the next steps in the process: the development of goals and strategies for improving the continuum of care. The solutions, often evolving from a framework of primary care service areas, can be quite disruptive and organizationally sensitive, and require plans for communicating long-range and interim goals, as appropriate, to stakeholders.
11. **Asset Assessment, or Assessment of Physical Infrastructure**, is a part of the Existing Services Inventory step in the Service Delivery phase and is a technical site and building related data analysis and physical inspection process that results in a concise summary of what all VA-owned assets are, and what their current and potential value to VA mission is. Ideally it should be done by the Team that will be working on the FMP.
12. **Market Level Services Delivery Plan** is a description of how the optimum service delivery for each market can be attained as well as the end state description of services in the market. It answers both the questions of “where, what, and by what venue” and “how” the result can be achieved. For VBA and NCA the Market Service Delivery Plans are a part of their Administration’s Summary Report. For VHA, these are called **Health Service Delivery Plans** (HSDP) and include detailed market asset assessments, program distribution and workload allocations for each Market. The Health Service Delivery Planning process includes the identification of the model for delivery of those services which are determined to be non-capital and “facility based.” This includes decisions on what to do with existing facilities and locations, including current and projected operations and maintenance. The HSDP also includes proposed new, expanded, relocated, eliminated facilities along with their operational and maintenance considerations. Before Facility Planning begins the HSDP develops goals, long-term strategies for all VA-owned and leased facilities, and interim or shorter term strategies and communication plans as needed to guide the development of Facility Master Plans for VA-owned facilities.

13. **Strategy** is the development of an action plan to move from the existing condition to the end state defined as the Strategic Goal.
14. **Communications** is a byproduct of the generation and production of planning information, maps, projections, market analyses and location analysis. Sensitivity to local conditions and long-range goals will require a coordinated effort between the VA and the consultant team members in order to develop, distribute, and communicate the planning effort and its results.
15. **Agile Footprint:** An Agile Footprint requires that VHA health delivery system capital footprints be right-sized and aligned consistent with market projections, while ensuring agility to allow for rapid adaptation to policy changes, flexibility and adaptability in clinical services delivery, divestiture of unnecessary facilities and land, and responsiveness to changing Veteran demographics.
16. **Facility Planning** begins in the Health Service Delivery Planning phase with the identification of the model for delivery of those services which are determined to be “facility based.” The preparation of **Facility Master Plans (FMPs)** for VA-owned campuses or locations cannot begin until the Market’s HSDP is approved by the VISN. FMPs are the transition between strategic service delivery needs and the physical environment. FMPs identify facility gaps, and cumulate in the identification of the actions necessary to move in the strategic direction needed to provide the services required at that location. Two FMP levels of effort are defined below.
17. The **Annual Planning Cycle** is a set of activities that commences with the Department and Administrations’ strategic planning processes, continues in VHA with VISN Health Service Delivery and Capital Asset Master Plans for approval, rolls-up Administration Capital Asset investment needs for inclusion in the budget process, and, for facility needs, concludes with funding and implementation of each specific approved capital solutions through the Department’s Strategic Capital Investment Plan (SCIP).

1.7 The VISN Integrated Planning Team (IPT)

The participants in the IP process include the VHA VISN staff, VBA planning staff, NCA planning staff, contractors, OCFM Regional Planners and OCFM VACO staff. But clearly, the major nexus of highest activity will be centered in VHA VISN and its organizational mechanism to address Integrated Planning, the Integrated Planning Team, IPT.

VISN Integrated Planning Team

1. Each VISN shall establish an Integrated Project Team (IPT) that includes representatives from the appropriate VISN strategic planning body and relevant clinical and administrative services leaders from VISN facilities.

2. VISNs will use the IPT to generate the VISN Market Health Service Delivery Plans and to oversee and monitor the integration of the approved HSDP initiatives into the annual CAMP and SCIP processes.
3. The IPT should include members who have expertise in health and health service delivery planning, clinical administration, clinical delivery (including PACT), facility planning, health care design, construction engineering, biomedical engineering, information technology, virtual care technologies, financial, security, and other appropriate areas. Administrative, clinical care delivery, technical (including Biomedical Engineering and Information Technology), and acquisition disciplines are essential competencies needed to develop actionable CAMP and for subsequent execution of these plans.
4. An Integrated Project Team (IPT), with a membership covering these, and any other necessary competencies, will assess current observed performance, the projected total performance capacity of capital assets and identify viable cost-effective capital investment or non-capital options that can improve the state of veteran health and the overall access to quality health care services for Veterans in the markets served.
5. The multi-professional composition of the IPT ensures that VISNs analyze their capital asset portfolio and its performance-related lifecycle requirements from multiple clinical, business and other perspectives.
6. Representatives should ideally be staff who can see beyond “bricks and mortar” and are a mix of big-picture thinkers and people who understand how services are delivered and have ideas about how to better add value for Veterans.
7. The VISN IPT should have members from the following disciplines:
 - a. VISN Leadership: VISN Director, Deputy Director, VISN Planner/Program Development Manager, Capital Asset Manager, Public Affairs Officer, VISN Chief Medical Officer, and other VISN Clinical Leadership positions. VISNs are encouraged to include representatives from existing VISN planning bodies and workgroups including Patient Aligned Care Teams (PACT) and Patient Centered Care
 - b. System or Medical Center Leadership: Director, Chief of Staff, Associate Director for Patient Care Services and other Clinical department chiefs, Strategic Planner, Chief Engineer, Chief of Projects/Design, Facility Planner, Energy Engineers; Biomedical Engineers;
 - c. Security and Preparedness, and VHA/DOD collaboration representatives;
 - d. Other Members could include the Chief Information Officer or Senior Information Technology Representative, the Senior Contracting Officer and Virtual Care Modality Representative.
 - e. VISNs are also encouraged to invite their VHA OCAMES support engineer, their OSPA Planning Liaison, and their OCFM Regional Office Planner to participate.

1.8 Responsibilities

VA

1. CFM Regional Office:

- a. Project Management
- b. Contract administration
- c. Conduct of IP Planning Team recurring conference calls

- d. IP Process refinement and development
- e. Coordination with VISN and contractor
- f. Maintenance and upkeep of IP Process Handbook
- g. Training of VHA and OCFM staff on IP Process

2. CFM Central Office:

- a. Technical and process coordination;
- b. Building, site, environmental and historic technical coordination;
- c. IP Process refinement and development
- d. IDIQ contracts;
- e. IT support – depository of completed VISN IP Study deliverables
- g. Training of VHA and OCFM staff on IP Process
- h. Travel and Conference Compliance

VHA

1. VHA/OCAMES:

- a. IP Facility Master Plan CAMP and SCIP technical support and guidance
- b. Establishment of proposed VISN IP review schedule
- c. Training of VHA staff on IP Process

2. VHA ADUSH Policy & Planning:

- a. Strategic planning guidance
- b. IP Process refinement and development
- c. Liaison role to VISN Planners
- d. Data analysis
- e. Source of clinical productivity data

3. Selected VHA CHIEF PROGRAM OFFICERS:

- a. Developing a Program Office Strategic Plan that is aligned with the VHA Strategic Plan
- b. Identifying strategic Program Office priorities which need to be considered and included in the planning processes in the VISNs and other VHA offices
- c. Assisting the VISNs with productivity and program threshold standards as requested by the VISNs in the data-driven planning process.
- d. Coordinating Program Office initiatives and resource distribution with VISN HSDPs and CAMPs aligning Strategic Objectives, enrollee projections, and market health system delivery demands with infrastructure, equipment, IT, and virtual care delivery assets and investments across the nation

VISN

1. VISN DIRECTOR

- a. Endorsing/sanctioning the execution of the IP process within the VISN

- b. Chartering and overseeing the VISN IPT, aligning the work of the IPT with the VISN's management and committee structure in order to develop the VISN Market Health Service Delivery Plans.
- c. Approving the Health Service Delivery Plan for each market establishing the missions, programs and workloads to be used in the subsequent development of Facility Master Plans
- d. Insuring the VISN Market Health Service Delivery Plans aligns Strategic Objectives, enrollee projections, and market health system delivery demands with facilities, equipment, IT, and virtual care delivery assets and investments across the VISN
- e. Calling for frequent updates on the IP study progress at key leadership meetings on at least a monthly basis.

2. VISN Planner

- a. Primary IP process coordination role
- b. Maintains IP process communications within the VISN
- c. Focal point of VA, VHA and Contractor communication with VISN
- d. Coordinates VISN IP process calendar/meeting dates, places and times
- e. Training Facility/Site coordinators on the execution of the IP process.
- f. Co-leader with VISN Public Affairs team in development of Communication Plan for IP market plan roll outs.

3. VISN CAM

- a. Coordination of Engineering Services support of IP process
- b. Coordinate submission of required infrastructure drawings to contractor
- b. Coordination of IP process with CAI, CAMP and SCIP

4. Integrated Planning Team (IPT):

- a. Primary VISN planning body vested to carry out the IP process
- b. Analysis of proposed Ideal Service Delivery Models
- c. Participation in the Compare session and contribution to strategic decisions made at that time.
- d. Development of strategies to move existing model toward Ideal care model

5. MEDICAL CENTER DIRECTORS

- a. Endorsing/sanctioning the execution of the IP process within the medical center/facility
- b. Appointing a Facility/Site Coordinator to lead/support the IP process
- c. Calling for frequent updates on the IP study progress at key leadership meetings on at least a monthly basis

6. FACILITY COORDINATORS:

- a. Communication link between VISN Planner and facility staff
- b. Insuring that contractor information requests are received and responded to in a timely manner
- c. Being the responsible person to explain the IP process to facility leadership clinical and administrative leadership and service and section chiefs.
- d. Keep their leadership advised on the progress of the IP process

e. Coordinate scheduling of IP process meetings to insure maximum facility staff participation.

7. CLINICAL SERVICE CHIEFS

- a. Participating in IP Process meetings
- b. Coordination with VACO VHA Program officials on program productivity and activation/deactivation thresholds and standards.
- c. Analysis of IP process utilization data, primary care service area alignments, and resources needed to meet projected demand.
- d. Formulation of program operating plans (method, location, staffing and space) for the planning horizon based on Ideal Service Distribution principles established by the IP Process.

CONTRACTOR

- a. Execution of Contract
- b. Coordination with OCFM Project Manager and VISN Planner
- b. Contribution of IP Process suggested changes and enhancements

NCA

- a. Designation of prime coordinator to facilitate IP Process
- b. Providing input to the IP Process on strategic memorial direction
- c. Communication with MSN sites as to their role in IP Process
- d. Recommendation of opportunities for joint ventures with VHA and VBA

VBA

- a. Designation of prime coordinator to facilitate IP Process
- b. Providing input on strategic benefits direction
- c. Communication with Regional Offices as to their role in IP Process
- d. Recommendation of opportunities for joint ventures with VHA and NCA

IT

- a. Designation of prime coordinator to facilitate IP Process
- b. Providing input on strategic IT issues.
- c. Coordination of IT planning with the administrations.

CONTRACTING

- a. Designation of prime coordinator to facilitate IP Process
- b. Providing input on strategic contracting issues.

1.9 VA Provided Data for Analysis

Administrations will provide the information detailed in this chapter to the consultants for their review and analysis as soon as possible after contract award. The VISN planner can pull most of this information from Proclarity by using the Briefing Book provided as Appendix C to this Handbook. Technical questions on using the Briefing Book should be addressed to Lori McClure (Program Analyst | Strategic Analysis Service | 10P1C | Office of the ADUSH for Policy & Planning | Phone: 757.741.2050).

1.9.1 VISION & MISSION

1. Please provide the VHA, NCA and VBA's Vision & Mission Statements, and Strategic Plan.
2. Please provide the VISN Vision & Mission Statement, and Strategic Plan.

1.9.2 POPULATION (P)

- P1. Identify the base year to be used as the basis of projections forward.
- P2. Identify the projection year(s) to be the basis of the health service planning.
- P3. **Master Mapping FIPS County State Sector** - Most current Master Map Reference file for mapping crosswalk to FIPS, County, State, Sector, Market, and VISN.
- P4. **Master Mapping SPC Crosswalk** – Most current Master Map Reference file for mapping workload to Strategic Planning Category and Strategic Planning Group.
- P5. **VISN Enrollment Projections** - Enrollment projections for the most recent base year by Age Group and Priority at the VISN, Market, Sector and County level. **Source: Briefing Book Appendix C.**
- P6. **VISN Vet Pop Projections** - VetPop projections for most recent base year by Age Group and Priority at the VISN, Market, Sector and County Level. **Source: Briefing Book Appendix C.**

1.9.3 WORKLOAD (W)

- W1. **VISN Utilization Projections by Geography** – Utilization projections for base year and twenty modeled years by Strategic Planning Group and Strategic Planning Category at the Market and Sector levels. **Source: Briefing Book Appendix C.**
- W2. **VISN Utilization Projections by Treating Facility** - Utilization projections for base year and twenty modeled years by Strategic Planning Group and Strategic Planning Category at the Treating Facility level. **Source: Briefing Book Appendix C.**
- W3. **VISN In-house vs. Fee Utilization** - Two most recent base year model's Base Year Utilization in house and fee workload broken out by Strategic Planning Group and Strategic Planning Category by VISN, Market and Sector levels. **Source: Briefing Book Appendix C.**
- W4. **Relative Value Unit (RVU) Data** – Three most recent completed fiscal years of RVU data including the total RVUs and Total by Encounter for all Specialties by medical center complexity at the national and VISN level.

- W5. **Clinic Stop Distribution Model** - Workload from the OCAMES Clinic Stop Distribution Model should include Baseline and twenty modeled years by Stop Code, Clinic Name and Strategic Planning Category (SPC) provided for the VISN, Market, and each existing facility within the VISN. *Crosswalk document (Appendix C) provides location for this data.*
- W6. **VHA Operating Room (OR) Efficiency & Staffing Data** – Three most recently completely fiscal year’s data for Operating Room & Staffing Data should be provided by VISN, Facility, and Surgical Complexity. *Crosswalk document (Appendix C) provides location for this data and instructions on pulling the data.*
- W7. **VISN Outpatient and Inpatient Pharmacy Workload** - Historic Pharmacy workload data should include the three most recently completed fiscal years broken out by total CMOP, Local Outpatient Prescriptions and Inpatient Orders at the Market, Sector (if possible), and Facility (if possible) levels. *Crosswalk document (Appendix C) provides location for this data and instructions on pulling the data.*

1.9.4 SERVICES/STAFFING

1. Provide sources that establish VHA access policies relative to primary care, emergency care, and other services. These policies can be communicated via distance to care, cost of care and/or availability of appointment.
2. Provide staffing and provider productivity benchmark standards used by the VHA & VBA.
3. Provide staffing documents and organizational charts for each VHA, VBA and NCA location identifying existing staffing by department/service, position title and position quantity.
4. Provide a list of DoD, HRSA, HHS, and/or IHS relationships, including specific partners (facility names) and description of relationship (service agreements or other).
5. Provide a list of Educational Affiliations, including specific partners (facility and institutional names) and affiliation description (service line programs, staff programs, or other educational exchanges) by facility.

Chapter 2: Communications

2.1 The Challenge

The challenge of implementing a new process is getting everyone on the same page. From the terms we use, to the choice of where a meeting is held, to who fills the room or who we choose to use as process facilitators/coordinators, many choices will impact the outcome of the Integrated Planning process. This process probably represents a substantial change for most VISN participants from their usual approach to long range planning. Educating participants on the elements of the process and their roles within that process is a fundamental and recurring part of this process.

2.2 VISN Leadership Buy-In

At a sufficient interval before contract award, the VISN Director of the selected VISN must have an executive briefing on the IP Process, its goals, steps, deliverables and most importantly the time commitment required by VISN staff to execute the process successfully. This meeting should be limited to the VISN Director and his key VISN office staff leadership staff. There must be consensus and buy-in by the VISN leadership in this process or else another VISN should be selected for the study. VISN participation in this process denotes the VISN Director's support of the Integrated Planning process. The IP Team Leadership is counting on the VISN Director and his VISN leadership teams to support the execution of this process. Plans and strategies developed by the process will be owned by the VISN and currently no higher level review (VACO) or approval of the completed Health Service Delivery Plans or Facility Master Plans is involved. These plans will tie into the annual budget cycle in VHA through the annual Capital Asset Management Process. Copies of the completed plans will be maintained in the administrations and the Office of Construction and Facilities Management.

2.3 Meetings and Reviews

In all meetings it is likely that some participants will not know what is going on and why they are there. Every meeting should begin with an overview of the process that explains the current process step and its significance. Particular emphasis should be placed on explaining the goal of the particular meeting. Nothing should be assumed about the participant's knowledge of the process; rather assume that all participants need to be briefed on the overall IP process and the current step at each meeting.

2.4 Weekly Conference Calls

The Contractor shall host weekly telephone conference calls with project participants from the Contractor's staff, and VA using VA Online Meeting (Lync). The Contractor shall publish an agenda for each of the telephone conferences at least 24 hours in advance. VA will identify participants in addition to the Contractor staff. These meetings will review progress to date, potential delays, information requirements, and other execution issues including communications.

2.5 The Leadership Introduction (Step 0)

The Leadership Introduction is envisioned as a series of meetings with VISN Administrative and Clinical Leadership utilizing standing VISN Leadership councils and board meetings. The first meeting should be with the VISN and Health System/Facility Top Management leadership (Quadrad). A key goal of this Kick Off meeting is to educate regarding the Integrated Planning process, its goals and benefits to the VISN and the staff commitments that will be required of

VISN, Health Care System and Facility staff. The timing and location of this meeting should be selected to help to insure maximum participation of executive leadership of the VISN.

Additional briefings should be scheduled with the Clinical Leadership Council/Board, the Financial Operations Council/Board and any other significant VISN Leadership Council/Board whose membership's understanding of the IP Process and support is deemed essential to the success of the process.

A key goal at this meeting will be the distribution and review of the Leadership and Health Care System Assessment Surveys. These surveys, once completed, will provide essential information for the consultant team as they prepare the Leap to the Ideal Service Distribution plan for the VISN. In order to insure good communication and reduce misunderstandings, the Stakeholder Organization Registry (Appendix E) must be completed by VA and provided to the contractor.

A key issue to emphasize is that this process involves serious operational planning in its first phase which requires the extensive involvement of the VISN designated planning team to achieve appropriate 10 year operational service delivery plans that are understood and supported by key clinical and administrative leadership. All facility master planning will be based upon the approved service delivery/operational plans developed in phase 1 that culminate in HCS and facility mission definitions. The VISN Leadership must understand that before phase 2, facility master planning, can proceed, they must endorse the Facility Mission/Strategy Templates and the Market Health Services Communication Plans resulting from phase 1 Service Delivery plans.

2.6 The Importance of Coordinators (Step 0)

Communication is a key responsibility of designated VISN, Health Care System and Facility Process Coordinators. IP communications that ultimately task Facility Coordinators to execute/monitor completion IP process tasks be emailed to the Facility Coordinators at the same time as the message is sent to the VISN Planner/CAM. Facility coordinators are responsible for insuring that contractor information requests are received and responded to in a timely manner and for being the responsible person to explain the IP process to facility executive leadership, clinical leaders and department heads. Training of these coordinators is essential to the success of the process. These coordinators must keep their leadership advised on the progress of the process and help insure meetings are scheduled to insure participation of their designated clinical and administrative leadership.

2.7 The Importance of VISN IP Clinical Work Group

The presence of a VISN Strategic Planning council or committee that has experience guiding the development of VISN clinical programs is a distinct advantage to the IP process. Using an existing VISN planning body such as this is encouraged. The availability of a core group of clinical leaders that are tapped into the heart beat of VISN clinical operations is essential for the Comparison of Ideal to Existing Session (Step 5) and the Strategies and Communication Plan Session (Step 8). If no such group currently exists, then clinical leadership across the continuum of care must be recruited/selected to form this essential core clinical decision group. This existing VISN council or commensurate clinical leaders should be in attendance at the Leadership and Communications Kick-Off Meeting.

2.8 The Importance of VISN Overview Briefing (Step 0)

The VISN Planning Staff will provide an overview briefing at the Kick-Off meeting covering the existing delivery system/continuum of care/ facility issues, workload and staffing trends,

CBOC/PACT implementation status and strategic plans. This presents the VISN the opportunity to communicate and educate the assembled contractor planning team as to the current state of their VISN and its programs.

2.9 The Importance of “Herding Cats” (All Steps)

The value of what comes out of this process will be directly proportional to what effort the VISN puts into getting the right people in the room at each planning session associated with this process. Truly, it feels like “herding cats” but it will make the difference between having a “direction” and having the right direction for the VISN. Having the right people in the room helps assure buy-in with the strategies emerging from this planning process. If no clinical leaders take part in this process, it will be no surprise when the hearts and minds of the clinical staff do not follow strategies they had no part in developing.

2.10 The Importance of Continuous Participation (All Steps)

VISN IP success depends on identifying the Clinical Leaders across the continuum of care, the “Core Group”, and ensuring their continuous participation. As stated earlier, the IP process is new and different to most clinicians and stressing the importance of commitment to this process is a key to enhancing the outcome of the process for each market/health care system/facility. Leadership endorsement of this process, and reinforcement to the clinical staff that their consistent participation and attendance at planning sessions is essential, is a key to the success of the process.

2.11 Facility Preparation for Contractor Team Site Visits (Steps 3 & 4)

Contracted AE and Health Planning consultants will make several visits to each VISN health care facility. Advance preparation for these visits is vital to insure the appropriate clinical, administrative or engineering staffs are aware of and prepared for the visit/meetings. The Facility Coordinators intervention is essential to insure that all the key facility clinical planning team members are available for these planned meeting sessions. The coordinator will also monitor the full completion and timely submission of any surveys or other informational requests made by the contract consultants. As the designated owner of the IP process at the facility, the coordinator will keep the medical center leadership informed as to when IP planning meetings will be on campus and insure management participation when requested. The consultants will be touring the campus and evaluating clinical patient care environments. The coordinator will either act as the escort or insure that a suitably briefed escort will be provided to lead the consultants about the campus. Campus engineering focused tour guides should represent the following disciplines: mechanical, civil, electrical, planning and architectural.

2.12 Existing Service Inventory (Step 4)

The successful execution of the Existing Service Inventory, Step 4, is essential for the contract consultants to fully understand the facilities current mission and what resources it has to carry out that mission. Contract consultants must meet with all owned facility department chiefs and members of the management leadership team to orient them to the purpose of the planning process. One-on-one meetings will be held with the management leadership team as well. Facility Coordinators will schedule these meetings with the department chiefs and their staff and insure that any requested staffing or workload information is provided to the visiting team as required. This is a “herding cats” experience for the Facility Coordinators, but the foundation for all the planning to be conducted with the Department chiefs will be established at these meetings so their importance cannot be overemphasized.

2.13 Development of Guiding Service Distribution Principles (GSDPs)

The contract Health Planner is responsible for taking the lead in collaboration with the VISN Planner and VISN Clinical Program leadership/subject matter experts to establish GSDPs for this VISN Integrated Planning process. The contract Health Planner team will be comprised of health planners, and appropriate clinical providers. This team will provide an initial/draft GSDP document to the VISN planning team at the initial leadership meeting and instruct them to review the key data/criteria provided in the draft and to coordinate with their VISN Clinical Chiefs. The emphasis of the GSDPs is forward looking and assumes the contract Health Planning Team will bring the latest thinking and innovation in health delivery and health promotion to the VISN study and will not simply reflect the clinical care models/practices existing within the VISN as they find it.

The Health Planners will review the latest VHA directives and manuals providing guidance on VHA service distribution principles and policy and incorporate these assumptions into the GSDP draft provided the VISN. As new policy directives impacting GSDPs are released, the Health Planners will incorporate such guidance into the planning assumptions for the study. VISN clinical leaders are encouraged to coordinate with the appropriate VHA VACO Clinical Program Subject Matter Experts to establish or review the GSDPs to guide the VISN Service Delivery planning.

2.14 Importance of a Timely Review Process

The IP process can be described as having two major phases: Part 1, the development of Market Service Delivery Plans and Part 2, the development of Facility Master Plans based on the results of Part 1. The success of both parts of the process hinges on the successful conduct of client reviews of planning materials prepared by the consultants. Both parties, the consultants and the VISN Team, must support this review schedule for it to succeed. Client review and feedback is essential to the success of the process and it is not automatic. This is another “herding cats” moment where Facility Coordinators must be anticipating the receipt of consultant deliverables, insure all appropriate departments review the materials and monitor the progress of departmental reviews/concurrence and insure feedback is provided to the consultant. Likewise, the consultants must prepare and submit deliverables to the VA on a timely basis to enable the review process to start.

2.15 The Communications Plans

The challenge of implementing a new process is getting everyone on the same page. This process represents a substantial change for most participants from their usual approach to long range planning and program change. Defining a coherent, comprehensive Communication strategy to complement and support the program changes indicated in the proposed service delivery plans is crucial to their understanding, adoption and implementation. It is important that the reasoning, rationale and justification for proposed service delivery changes be documented as they are derived in the planning process and be judiciously utilized in the development of the communication plans for internal and external stakeholders.

The Communication Plan is a contractor deliverable prepared at the conclusion of development of Market Health Service Delivery Plans. This plan will define the direction and guidance to be given to the facilities and the A/E planners so that they can develop Facility Master Plans that are consistent with the long range goals and approved facility workload allocations, allow the facility to function at the highest level possible, and limit development where necessary to support the overall long range goals. It also serves as a guiding map for all internal and external communication. This key communication plan is described in detail in Chapter 6.15.

2.16 Organizing for success

- Keep on top of scheduling and communications by using Project Management Planning tools such as MS Project
- The activities will be integrated into the existing planning management structure and cycle to the degree possible. This will insure that the right participants are involved in this process and will make the overall calendar management much more manageable.
- Use a central calendar

Chapter 3: Planning Meetings Overview

3.1 Meetings and Reviews

Outline of Meetings - The actual number of meetings necessary may vary, but the major meetings that typically should be a part of the Integrated Planning process are identified and explored in this chapter. Where possible we have suggested the number of meetings that may be necessary to achieve the purpose/goals of that meeting session/Step in the process.

3.2 Weekly Conference Call –

In addition to the formal meetings described below, the Contractor shall host a weekly telephone conference with project participants from the Contractor's staff and VA. The Contractor shall publish an agenda for each of the telephone conferences at least 24 hours in advance. VA will identify participants in addition to the Contractor staff. These meetings will review progress to date, potential delays, information requirements, and other execution issues.

3.3 VISN Director Executive Briefing -(Step 0)

Prerequisites: Coordination with VISN Planner on suitable date to meet with VISN Director and his inner leadership circle.

Frequency: Once

Location: Normally a face to face meeting at the VISN Offices.

Attendees: VISN Director, VISN Chief Medical Officer, VISN Planner, VISN CAM, Contractor representatives, OCFM Project Director, 10P1B Planning Liaison, 10N OCAMES Capital consultant.

Purpose: To provide the VISN top leadership a thorough overview of the IP Process, its goals, its challenges, its deliverables and the staff time commitments required across the VISN to successfully accomplish the process. The concept, development and application of Ideal Service Distribution Principles should be addressed. A key goal is to determine just how closely the VISN Director wants to be directly involved with each meeting with the Market meetings. Some Directors may delegate this to the VISN Planner and others may insist on attending every session themselves.

After Actions: Contractor will coordinate with OCFM Project Director on proposed any changes in the schedule driven by operational necessities that the VISN Director places upon the conduct of the IP Process.

3.4 VISN Leadership Councils/Boards Briefings -(Step 0)

Prerequisites: These meetings should follow the first meeting with the VISN Director in 3.3 above. Contractor's representative will coordinate with the VISN Planner on suitable dates to meet with appropriate VISN governing bodies, board, councils or committees.

Frequency: Once for each council or board.

Location: Normally a conference or web meeting.

Attendees: Membership of the Leadership Council or Board, VISN Planner, VISN CAM, Contractor representatives, OCFM Project Director, 10P1B Planning Liaison, 10N OCAMES Capital consultant.

Purpose: To provide the VISN governing bodies a thorough overview of the IP Process, its goals, its challenges, its deliverables and the staff time commitments required across the VISN to successfully accomplish the process. The Clinically rich boards should have extra emphasis placed on the development of the Ideal Service Distribution Principles and solicit their input on how they would like to approach the task (whether in person or virtually).

After Actions: Contractor will follow up with any Council or Board for additional information or clarification as required.

3.5 Leadership Introduction and Communication-VBA -(Step 0)

Prerequisites: Review of VBA's services in VISN area, identification of VBA team members, distribution of questionnaires to VBA participants

Frequency: Once

Location: Normally an online meeting, VBA may also choose to attend some of the VISN meetings

Attendees: Contractor team, VBA Leadership, VISN Planner, CAM, others as required

Purpose: Review all VBA services offered; build buy-in to the process and identify possible overlaps and collaborations; discuss any assets which VBA feels the contractor's team should visit and assess

After Actions: Contractor reviews questionnaires and follows up; contractor considers needs of VBA as a part of the integrated planning process; contractor visits any assets identified during the meeting

3.6 Leadership Introduction and Communication-NCA -(Step 0)

Prerequisites: Review of NCA's services in VISN area, identification of NCA team members, distribution of questionnaires to NCA participants

Frequency: Once

Location: Normally an online meeting, NCA may also choose to attend some of the VISN meetings

Attendees: Contractor team, NCA Leadership, VISN Planner, CAM, others as required

Purpose: Review all NCA services offered; build buy-in to the process and identify possible overlaps and collaborations; discuss any assets which NCA feels the contractor's team should visit and assess

After Actions: Contractor reviews questionnaires and follows up; contractor considers needs of NCA as a part of the integrated planning process; contractor visits any assets identified during the meeting

3.7 Process Kick Off -VHA -(Step 0)

Prerequisites: The contractor will prepare an Power Point review of planning horizon VISN utilization data; the draft Guiding Service Distribution Principles; The Leadership Survey instrument; Health Care System Assessment; Market Service Delivery Planning process; approval of Facility Mission/Strategy Templates; their meeting/work plan to execute this planning process; identify their team and their roles. The VISN will provide the overview briefing of the VISN as described below.

Location: Site could be a VISN Executive Leadership Council (ELC) meeting or a specific strategic planning retreat set aside for this purpose.

Frequency: Once for large meeting and as many small separate meetings as required for individual VISN Leadership Team Members

Attendees: VISN Leadership to include VISN Director and key administrative and clinical staff that usually attend an ELC meeting. The Directors, Chiefs of Staff and other members of the executive leadership of all Health Care Systems and separate VA Medical Centers and Independent Outpatient Clinics or Health Care Centers. Membership of VISN Strategic Planning body; the VAFM Planning Team and representatives of the Contractor team; Facility Planners,

VISN CAM and staff and Facility Chief Engineers and Project Chiefs, OCFM, OSPA and OCAMS representatives.

Purpose: Process Education and Leadership Buy In

1. Introduce the process to as many of the VISN clinical and administrative leadership as possible
2. Process Overview presentation by VHACO planning representatives
3. Organizing Stakeholders – define who should participate in the process- Discuss completion of the Stakeholder Organization Registry (See Appendix E).
4. Discuss demand data (VAFM). The contractor will come prepared with a presentation that overviews the major workload trend lines for the VISN and its markets.
5. Introduce the Guiding Service Distribution Principles. Explain the productivity standards, efficiency measures and program thresholds. Discuss the idea of “franchise models”. The draft Guiding Service Distribution principles for the VISN are distributed for discussion and input. The process to revise and update the draft is explained. (VAFM/Contractor)
6. Introduce the Market Service Delivery Planning process, its impact and required approvals
7. Introduce the Mission Template approval step at the conclusion of phase 1
8. The VISN Planning Staff will provide an overview briefing covering the following topics:
 - Overview of existing delivery system and sites, workloads and issues
 - Their vision of how they see the service delivery system being improved
 - Identification of stakeholders that should be involved
 - Medically underserved areas
 - Opportunities to consolidate facilities/services, expand, phase out, etc.
 - Health professional shortages
 - Educational Affiliates
 - DoD, HHS, HIS relationships
 - State Veteran Programs
 - Challenges (upcoming big issues, activations, budget dilemmas etc.)
 - Sensitivities (political and otherwise)
9. Brainstorm: What would a better delivery system look like? The contractor will lead the VISN staff in a discussion of what an ideal delivery system might look like. Goal is to get a sense of strategic direction that the current VISN leadership endorses.
10. Introduce the Leadership Survey and Interviews. Cover how it is to be completed. Some will be conducted by mail and others will be one on one appointment with leaders.
11. Review of the Roles and Responsibilities of VISN Leadership, designated VISN process coordinators, the VAFM team, the contractor’s team and staff of the health care systems etc.
12. Designation of VISN and facility Integrated Planning Process Coordinators and their roles.
13. Designation of VISN Integrated Planning Clinical Work Group/membership and role
14. Review of process deliverables
15. Review of process timeline

After Actions: Debrief session with VISN Planner, CAM and other VISN planning team leadership to review outcome of Leadership Introductory Session. Set up one on one meetings with VISN leadership. VISN will review the draft GSDPs and disseminate it to all clinical departments for input and coordination with VACO VHA Program subject matter experts. VISN will assign Process coordinators for the VISN and each System and Facility and complete the Stakeholder Organization Registry.

3.8 Demand Data and Agreements (Guiding Principles)(Step 1)

Prerequisites: Contractor review and analysis of VHA provided staffing productivity, utilization and enrollment data, submission to the VISN of a draft Guiding Service Distribution Principles (GSDPs) document and preparation of initial Primary Care Service Areas maps for all markets.

Frequency: Organize meeting around face to face breakout sessions or set up specific web/phone meetings for clinical leadership in appropriate continuum of care clinical groupings (such as Primary Care, Mental Health Service, Medical Subspecialties, Surgical Subspecialties, Rehab Services, Ancillary Services, Acute Care, and Transitional Care) or by individual service line to establish key characteristics, productivity standards and program thresholds to finalize GSDPs

Location: Virtual/teleconference or VISN office or Health Care System convenient to major department heads traveling.

Attendees: VISN Clinical leadership from all major service lines, OSPA Liaison, Contract team, OSPA, OCFM representatives

Purpose: Lead development of the VISN Guiding Service Distribution Principles (GSDPs). Obtain clinical feedback to finalize ISDPs and secure their approval by the VISN Director for development of the Ideal Service Distribution Model.

1. Reach agreements on productivity standards and program thresholds: the Ideal Service Distribution Principles
2. Education of clinical leadership on the role of Ideal Service Distribution Principles within this study.
3. Review demand data using maps and other graphics
4. Introduce Primary Care Service Areas concept
5. Provide overview of current VISN/MSN/VBA Area demand data.
6. Obtain additional Ideas for making VA service delivery better
7. Finalize preparations to generate the Leap to Ideal model.

After Actions: The completed GSDP document is submitted to the VISN Director for review and approval. Facilitate any additional collaboration with VISN clinical leaders that may be necessary to secure an approved GSDP document. Based on finalized and agreed upon GSDP, Contractor team prepares Leap to Ideal (Data Driven) Market Service Plans

3.9 Leap to the Ideal (Step 2)

Prerequisites: Working knowledge of VISN workload and enrollment trends, knowledge of VHA Program goals and strategies and VISN goals and strategies, validated and approved VISN specific Ideal Service Distribution Principles.

Frequency: Up to contractor

Location: Contract Team site

Attendees: Contract Team only

Purpose: Conceive the future unfettered by the past

1. This data driven model will be prepared by the contract team and will be viewed as the contractor's opinion of how VISN health services could be delivered if starting with a "blank slate".
2. Prepare large scale Service Delivery Market Maps to depict the Ideal/planning horizon disposition of clinical services across the market.
3. All of the products above will be used in Step 5, "Comparison"

After Actions: Contractor presents "Ideal" at Comparison Meeting.

3.10 Assessment of Physical Infrastructure (Step 3)

Prerequisites: Accessing the required building drawings, review of CAI and associated floor plan drawings (CARES/CAI Space drawings), iDrawings if available, review of FCA

Frequency: To occur at each campus at least once.

Location: At each VA owned Facility

Attendees: Chief Engineer and Chief of Projects, Facility Planner, CAM and staff. OCAM representative

Purpose: Collect and validate infrastructure data

1. Close asset information gaps
 - Functional assessments of existing campuses and buildings
 - Assessment of highest use of an existing building compared to current use
 - Site & environmental information
2. Builds on existing data:
 - Building data and areas from Capital Asset Inventory (CAI)
 - Deficiencies from Facility Condition Assessment (FCA)
 - Historic preservation
3. Meet with OIT specialist to ascertain readiness of existing IT infrastructure to support new programmatic initiatives such as telehealth and other virtual health care modalities.
4. Roll up Building and Station Summaries into VISN summaries
5. Assemble Summaries to be used in Step 5, "Comparison"

After Actions: Contractor incorporates the Asset Assessment Spread Sheet into the existing service inventory materials.

3.11 Existing Service Inventory (Delivery Methods and Assets) (Step 4)

Prerequisites: Receipt of Leadership and Health System Assessment Questionnaire

Frequency: At least once at each campus

Location: At each facility

Attendees: Contract team especially Health Planners, CAM or staff, Facility Planner, Facility Department Chiefs, Engineering project chief or representative

Purpose: Educate Clinical Leadership to IP process and familiarize planning team to ongoing dynamics of each clinical service

1. Meet with all owned facility department chiefs and members of the management leadership team to orient them to the purpose of the planning process. One-on-one meetings will be held with the management leadership team.
2. Collect information on the mission/functioning of the services, the amount of space controlled by each department, its workloads, staffing, limitations and issues and plans for the future.
3. Assess Functional Condition of Service space and key patient care environments
 - Tour departments and talk to staff about functionality of space
 - Tour key patient care areas such as nursing units, clinics, diagnostic spaces, and public areas such as lobby and canteen etc. to assess functionality.
4. Assess Non-capital delivery
 - Extended hours
 - Purchased care
 - Telehealth

- Home-based care
 - Sharing
5. Assess Existing VHA assets and capacities
 - Clinical Inventory for each VHA facility and point of care
 - Vet Centers
 - Support locations (laundry, logistics, call-centers, central kitchens etc.)
 - Research
 6. Assess Existing VBA assets
 - Regional Offices
 - Other
 7. Assess Existing NCA assets
 - Cemeteries
 - Other

After Actions: Contractor will format existing services information in maps and tables in a way to facilitate comparisons to the Ideal service delivery model maps and tables at the Comparison Meeting.

3.12 Comparison of Ideal to Existing Meeting (Step 5)

Prerequisites: Preparation of large Market Maps (4’X6’) to display existing service distribution model and Leap to Ideal Service Delivery Model/Primary Care Area Service Delivery Plans.

Frequency: At least twice

Location: Central VISN location

Attendees: Small group Contract team, VHACO Planners, OCFM Planners, Key VISN leadership, Key Clinicians, Planners, Capital Asset Managers; VBA and NCA representatives

Please note: The Comparison meetings are the only meetings in which the Ideal (or Data-Driven) model is presented and discussed. Because of the potential for misunderstanding the purpose and use of the ideal model, Administration and VISN leadership must carefully select the participants. Ideally, this would be the VISN Director and the VISN CMO and key selected “big Picture” clinical leaders. Based on past experience, this is especially critical for VISNs with declining enrollment and workloads, and in VISNs with independent VAMCs that are not a part of a multi-campus System. A key part of the Comparison meetings is to discuss the sensitivities associated with the Ideal model and what can be said in subsequent meetings about those sensitive areas. This is the meeting where it might be decided to not pursue an idea that would make perfect sense in a perfect world. The goal is to make progress toward a services delivery driven system, not to take on battles that cannot be won or that would undermine the overall objectives. These stretch goals could be included in the Health Service Delivery Plan as Long Range Goals.

Purpose: Reconciliation of Ideal Plan to Existing Service Delivery Dynamics

1. Presentation of Existing Service Delivery System for each market
2. Presentation of Ideal Service Delivery System for each market
3. Presentation on the functional condition of each market’s physical assets
4. Comparison of:
 - Data-Driven Ideal Model to Existing Delivery System
 - Ideal Points and Modes of Care to Existing Assets—candid discussion of assets
5. Discussion of key Political and Educational forces influencing distribution of health care services in each market

6. Assessment of stakeholder responses to potential strategies/changes
7. Reach agreement on strategic directions to be developed in next steps
8. Initial revisions to the Ideal Service Plan Maps will be used as the initial Market Optimum Delivery Plan for discussion and development Step 6 that follows.

After Actions: Contractor prepares Draft Optimum Services Delivery Market plans based on marked up Ideal Plan. If the Health Care System or facility leadership were a part of the Compare session, then they should continue to analyze the decisions being integrated into the Draft Optimum Services Delivery Market Plans.

3.13 Market Goals and Program Distribution (Step 6)

Prerequisites: Initial review and edit of the Data Driven Service Delivery Plans: now the Draft Optimum Market Service Delivery Plan

Frequency: Several meetings

Location: in each Market with Market leadership

Attendees: VISN Project Manager, Market Leadership, Market Clinical Service Line Leaders, Market Planning Point of Contacts.

Purpose: Involve clinical leadership in development of future market specific plans

1. Roll out of Draft Optimum Market Service Delivery Plan/Market Maps and Continuum of Care tiles for comment and revision and buy in
2. Education of more clinical leaders to the planning process
3. Initial Market goals developed with clinical and program leadership
4. Builds on comparison of Data-Driven (Ideal) to Existing Delivery Systems (Step 5)
5. Program distribution proposed based on projected demand and other strategic considerations
6. Result is an outline of how services might be delivered for detailed analysis and feedback in next step
7. Final confirmation of borders of Primary Care Service Areas

After Actions: Contractor makes revision to Maps and finalizes the Health Service Delivery Plans/Notebooks

3.14 Market Service Delivery Plans and Allocations (Step 7)

Prerequisites: Preparation of Health Service and Resource Plan notebooks (Big Books) and Optimum Delivery Plan Maps, Market Optimum Health System narrative

Frequency: Several meeting

Location: in each Market with Market leadership

Attendees: VISN Project Manager, Market Leadership, Market Clinical Service Line Leaders, Market Planning Point of Contacts.

Purpose: Reach consensus with clinical leadership on plans for the future

1. Roll out of Market Service Delivery and Resource Plan (MSD&RP) Notebooks detailing from the PCSA basis how expected workloads will be handled in each market.
2. One on one meetings with Clinical Service Line Leaders to refine MSD&RP
3. Program locations refined based on clinical program input
4. Refinements made to delivery strategies for each Market/MSN/VBA Area
5. Initial Market Gap Analysis Initiatives reviewed

After Actions: Contractor makes revisions to the MSD&RPs

3.15 Strategies and Communication Plan (Step 8)

Prerequisites: Updates of MSD&RPs, Market Big Optimum Plan Maps, Market Optimum Health System Narrative, Recommended Market Initiatives, and Facility Mission/Strategy Templates for all facilities.

Frequency: Once if conducted centrally or as required in each Market/ Health Care System/facility.

Location: Central VISN location or at each Health Care System

Attendees: VISN and Health Care System Leadership that participated in Comparison Step/: VISN Project Manager, Market Leadership, Market Clinical Service Line Leaders, and Market Planning Point of Contacts

Purpose: Final decision on facility missions and types of master plans to be developed

1. Market strategies and futures of existing facilities reviewed with “Comparison” Team
2. Facility/ Campus Missions ratified for Existing and Long Range Strategic Direction and Facility Master Plan.
3. Approval of the Facility Mission/Strategy Template for use with Facility Master Plans.
4. For each facility, based on data & realities, VISN leadership establishes:
 - a. Long-range goals
 - b. Strategies for moving toward long-range goals (Capital and Non-Capital Initiatives)
 - c. Strategies and workload allocations to use for Facility Master Plan (FMP) and SCIP
 - d. Market Health Service Communication plans for long-range and FMP strategies
5. Non-Capital strategies defined
6. Decision on Level 1 or 2 Facility Master Plans for each campus

After Actions: Contractor prepares the Market Health Service Communication Plans in conjunction with the VISN team. Facility Master Planning cannot begin before this step is complete and communicated.

3.16 Facility Master Plan Development (Step 9)

Prerequisites: Completion of Market Health Service Communication Plans and FMP Strategy Templates; VISN approval of HSDPs

Frequency: Four meetings, varies depending on FMP Level—see FMP Chapter below

Location: At each facility, some on-line

Attendees: Contractor team, Chief Engineer, Chief Projects, Facility Planner, All Dept. Chiefs, Clinical and Management Leadership.

Purpose: Develop facility master plan to bridge from the present to the future

1. Meeting 1
 - a. Outcome: HSDP understood by facility staff; Market Initiative Department User input and Precepts Prioritized
 - b. Submission: Service Delivery Plan Summary & Market Initiatives, Site & Facility Analysis, Departmental Gap Analysis and Precepts Presentation.
2. Meeting 2
 - a. Outcome: Department User input, Concept Critiques
 - b. Submission: Site Plan Concept Drawings, Block Plans for each Concept, Phasing Plans for each Concept, Simple Total Project Cost Estimates

3. Meeting 3
 - a. Outcome: Comments on final concept for development
 - b. Submission: Concept Drawings, Block Plans for each Concept, Phasing Plans for each Concept, Total Project Cost Estimates.
 4. Meeting 4
 - a. Outcome: Approval of Final Master Plan, Market Initiative Priorities
 - b. Submission: Site Plan Concept Drawing, Block Plans, Phasing Plans, Total Project Cost Estimate, Non-Capital & Capital Priority Summary
- After Actions:** Contractor edit and finalization of deliverables and distribution

3.17 Final Meetings (Diagram Step 10)

1. VHA VISN

Prerequisites: VISN approval of Market Health Service Delivery Plans and completion of FMPS, draft version of final report

Frequency: Once

Location: VISN in person

Attendees: Contractor team, VISN Leadership, VISN Planner, CAM, Clinical Leadership, CFM Planner, others as required

Purpose: Review all Health Service Delivery Plans and FMPS in order to prioritize the necessary non-capital and capital actions and to identify specific issues that should be emphasized or played down in final report

After Actions: Contractor edits and finalizes deliverables and distributes final reports

2. VBA

Prerequisites: Completion of VBA analysis and VISN planning, draft version of final report

Frequency: Once

Location: VISN in person, or on-line

Attendees: Contractor team, VBA Leadership and Planner, VISN Planner, CAM, Clinical Leadership, CFM Planner and National Region Rep, others as required

Purpose: Review all VBA actions in order to prioritize the necessary non-capital and capital actions and to be able to finalize the final VBA report

After Actions: Contractor edits and finalizes deliverables and distributes final reports

3. NCA

Prerequisites: Completion of NCA analysis and VISN planning, draft version of final report

Frequency: Once

Location: VISN in person, or on-line

Attendees: Contractor team, NCA Leadership and Planner, VISN Planner, CAM, Clinical Leadership, CFM Planner and National Region Rep, others as required

Purpose: Review all NCA actions in order to prioritize the necessary non-capital and capital actions and to be able to finalize the final NCA report

After Actions: Contractor edits and finalizes deliverables and distributes final reports

3.18 Planning Process Refinement Meeting (Diagram Step 11)

Prerequisites: Completion of final content meeting with VISN

Frequency: Once

Location: Normally in VISN on day following final Step 10 meeting

Attendees: Contractor team and VISN Planner and CAMS, VHA, OCFM, VBA and NCA team members

Purpose: Learn from the experience and improve the IP process going forward

1. Collect lessons learned
2. Glean process improvement ideas

After Actions: VA will incorporate lessons learned into next SOW and the IP Handbook.

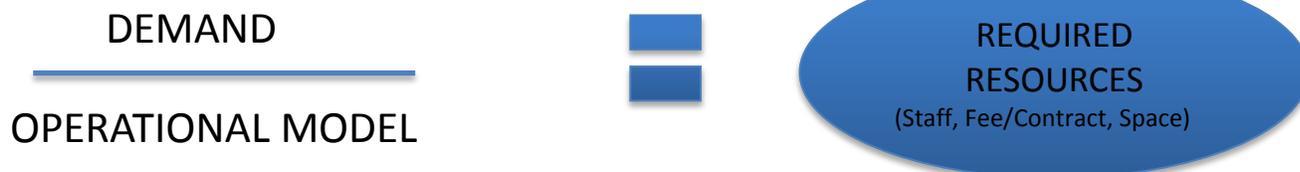
Chapter 4: Guiding Service Distribution Principles (Step 1)

4.1 The role of operational efficiency measures, productivity standards and activation thresholds in Integrated Planning Process - A key step in the Integrated Planning process is the “Leap to the Ideal” (or Data Driven Solution), wherein the contract health care planning team analyzes the target planning horizon VHA market utilization and enrollee data and then develops a Data Driven “ideal” health care delivery plan to address each Market’s enrollees’ health care needs. This plan should be based upon the latest VHA programmatic and health industry standards/criteria for operational efficiency, productivity and program activation thresholds. In the VA Integrated Planning process we refer to these essential guidelines as the Guiding Service Distribution Principles (GSDP) or simply “Guiding Principles”. The SOW refers to them as “Agreements”.

The premise of the Integrated Planning process is that VHA’s health and services delivery and related capital investment planning will be positively influenced if a data driven (ideal) Service Delivery Plan is used to help focus resource allocation for services, staff and facility planning. This vision for the future is not constrained by existing facilities locations, affiliations or politics, the weight of the status quo, but is guided by Guiding Service Distribution Principles (GSDP).

4.2 What are Guiding Principles?

These Guiding Principles inform the process to enable decisions on when and where services should be offered; by what mode the services will be provided and how what resources will be needed to provide that service. The principles address the entire continuum of care by service line.



The above formula drives the allocation of resources for planning. **Demand** is represented by veteran population size, enrollee/unique population densities and locations within the market, veteran health, and output projections for the Enrollee Health Care Projection Model. The **Operational Model** refers to the proposed clinical model of care proposed by service line; VA access standards; Service Thresholds (at what workload level is the decision made to provide a service or conversely close a service; at what workload level do you contract out in areas remote from VA services? etc.); Outcome standards/quality measures; provider productivity/staffing standards and the cost of care.

4.3 How to Develop Guiding Service Distribution Principles - The contract Health Planner is responsible for taking the lead in collaboration with the VISN Planner and VISN Clinical Program leadership/subject matter experts to establish GSDPs for this VISN Integrated Planning process. The contract Health Planner will provide the draft GSDP document to the VISN planning team at the initial leadership meeting and instruct them to review the key data/criteria provided in the draft and to coordinate with their VISN Clinical Chiefs and **most importantly with the appropriate VHA VACO Clinical Program Subject Matter Experts** to establish the required criteria to guide the Market Service Delivery planning in their VISN. Key criteria that need VISN validation should be highlighted in the draft provided to the VISN. A listing of the

criteria to be validated could also be provided that would serve as a checklist for the contractor and the VISN planner in tracking their progress in validating the criteria.

Note: In the absence of published VHA Guiding Service Distribution Principles to predict staffing needs to support VHA workload projections, consultant health planners should turn to VISN, MGMA and DOD criteria and productivity data and to their own planning expertise to provide a baseline for planning purposes. VHA VISN specific productivity data will be provided to enable the consultant planning team to customize the draft GSDP used with VISN 11 that is included as Appendix B. At the date of this revision, conversations were starting in VHA to address the need for centrally developed and published VHA Ideal Service Distribution Principles. If and when VHA GSDPs are made available, the consultants will consider and apply these standards as appropriate with the consent of the clinical leadership participating in development of GSDPs for the VISN IP Study.

4.4 Introducing GSDPs to VISN Leadership -At the initial Leadership Kickoff Meeting, the contractor will provide a draft of GSDPs for the VISN, explain their purpose and impact on the various phases of this planning process and go over the collaborative process that will be used to validate the criteria that will be used with their VISN planning process. This draft can be based upon the example GSDPs found in Appendix B.

4.5 Continuum of Care Organization- For the purposes of developing the Guiding Service Delivery Principles, the VHA Continuum of Care Service Lines have been organized into 6 clinical Groups with 31 subordinate service line breakouts:

1. General Outpatient Care
2. Medicine Specialty Care
3. Surgical Specialty Care
4. Diagnostic & Treatment
5. Mental Health
6. Extended Care and Rehabilitation

These continuum of care categories are further defined in Appendix G.

4.6 Involving the VISN Clinical Leadership - One or two subsequent meetings and/or online meetings or phone calls with the VISN Clinical leadership across the continuum of care will be scheduled to further refine and review the draft GSDP and to increase clinical understanding of the role GSDPs will play in the process and to secure buy in with the completed standards and the process. Probably the most effective approach is to schedule specific phone conferences with specific service line leaders to address program development thresholds and operational efficiency issues. At larger face to face meetings of diverse clinical leadership, the use of breakout sessions is encouraged to focus discussion and foster participation by the participants. These are extremely important sessions for the planning process and the VISN is encouraged to assure maximum participation by key clinical leaders across the spectrum of care. The more understanding, consensus and buy in achieved at this point in the process will help expedite the rest of the planning process and help insure more clinical confidence in the plans generated.

4.7 Roll Up of VHA Wide GSDPs - At the conclusion of the work in each VISN, the input received through VISN inquiries to VHACO Clinical Program Offices will be incorporated into a revised GSDP document and carried forward to serve as a starting point for succeeding VISN Integrated Planning efforts. Since the initial VISNs may not be able to get all Program Offices involved, "gaps" (planning factors that were agreed upon that did not have Program Office endorsement or input) may be present. Over time these "gaps" will be addressed in subsequent VISN Integrated Planning studies. Ultimately it is hoped that VHA

will publish an Guiding Service Distribution Principles directive that rolls up all VHA guidance on the appropriate organization and staffing models to be used in planning of health and health services for the veterans it serves.

4.8 VISN 11 Ideal Service Distribution (Guiding) Principles - VISN 11 was the second VISN to have GSDP developed. At that time they were referred to as "Ideal Principles". The contractor's analysis of background VHA guidance and their experience completing the VISN 17 ISDPs were complemented by completion of many individual phone/web conferences (30+) with clinical leaders across the continuum of care to develop the VISN 11 ideal principles. The VISN 11 ISDP excerpt found as Appendix B can be used as a starting point to develop draft GSDPs.

4.9 What are Key Characteristics? - A key characteristic is a unit of measure to describe the size or capacity of a service. In primary care this could be a provider for a clinic; a Bed for acute care; an operating room in surgery etc.) Key characteristics generate workload (encounters, bed days, surgical cases, etc.). Guiding Principles define key characteristic thresholds or minimum workload requirements for consideration of providing a service. In order to determine operational efficiency, productivity measures must be established for key characteristics. For example in the VISN 17 study it was established that key characteristic care provider productivity should meet the Median of the 2010 Medical Group Management Association (MGMA) Peer Report. For example the median productivity for a family practice/general medicine physician is 3,967 visits per year.

For non-provider key characteristics IP consultants have used the productivity throughputs outlined in the VA Space Planning Criteria. For instance, an ED Patient Treatment Space's planning capacity is 1,500 visits per year. Throughout a Guiding Principle document for VISN 17, you will see statements that say, "A _____ provider is planned to support ##### of enrollees. These numbers were established by using a an overall VISN 17 patient utilization rates for the service and dividing that use rate into the key characteristics productivity to establish the enrollee population to support that key characteristic. For example, the ED key characteristic, the Patient Treatment Space mentioned above with a throughput of 1,500 encounters per year and a patient average utilization rate of .202 encounters per enrollees per year suggests that an ED Patient Treatment Space can support 7,426 enrollees.

Some services require multiple quantities of a key characteristic to operate efficiently. For example, one would not build a single dialysis chair, but preferable build at least 8 in a single location. Whereas a single chair needs 3,763 enrollees to use the chair to its planned capacity, to use 8 chairs to their planning capacity an enrolled population of 30,104 is needed.

Chapter 5: Leap to Ideal Part A: Primary Care Service Area Development (Step 2)

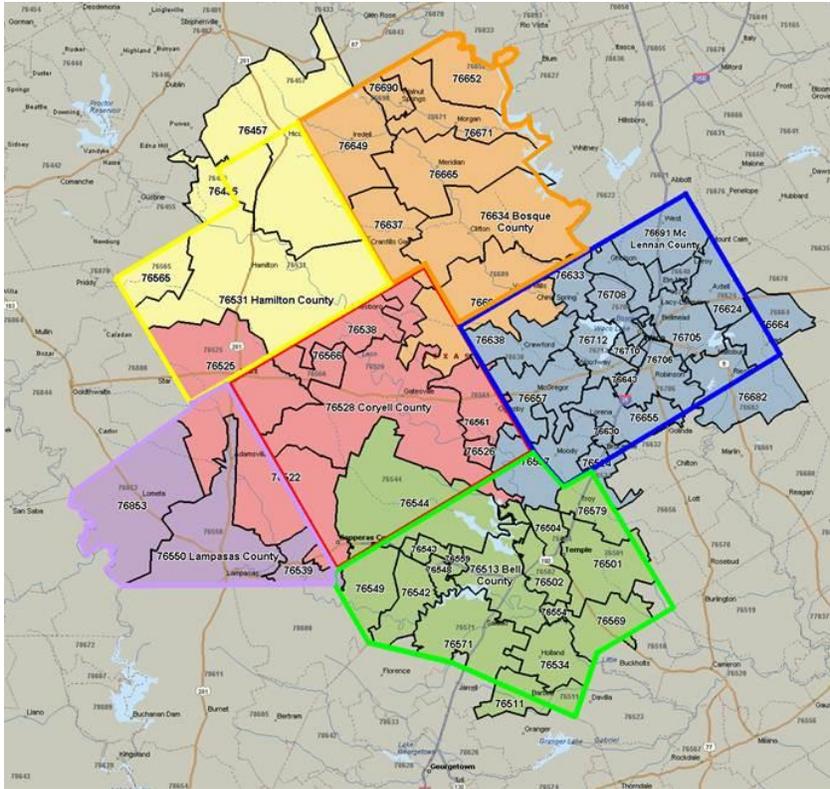
5.1 Overview - The contractor task of preparing the “Leap to the Ideal” consists of analyzing each VISN market’s enrollee geographic distribution and developing market subordinate Primary Care Service Areas (PCSAs) assuming the VA is a new entrant into the market and has no physical assets or existing service relationships with local health care providers. A “blank slate” is assumed in order to develop an Ideal distribution of services across the market. Each VISN market is to be subdivided into appropriate submarket catchment areas called Primary Care Service Areas (PCSAs). The resulting PCSAs will then each be analyzed to develop the Market Health Service Delivery Plan (the subject of Chapter 3) for each market. This chapter explains the process to use in defining market PCSAs.

5.2 Sector/County Enrollee population conversion to Zip codes

5.2.1 Data Sources: VHA will provide two data files: Base FY EOY Enrollees by Zip Code and Projected Enrollees by Market, Sector and County. (The examples below are from VISN 17 and are for illustrative purposes only.)

5.2.2 Identify which sector/county the zip codes fall within. Assign zip codes to appropriate counties/sectors. Prepare a table to display the assignments (See table 1 below).

Zip Code	Market	Sector	County	City	State	PSA Assignment
61821	(V11) Central Illinois	11-a-9-B	Champaign	Champaign	IL	Champaign
61802	(V11) Central Illinois	11-a-9-B	Champaign	Urbana	IL	Champaign
61866	(V11) Central Illinois	11-a-9-B	Champaign	Rantoul	IL	Champaign
61820	(V11) Central Illinois	11-a-9-B	Champaign	Champaign	IL	Champaign
61822	(V11) Central Illinois	11-a-9-B	Champaign	Bondville	IL	Champaign
61801	(V11) Central Illinois	11-a-9-B	Champaign	Urbana	IL	Champaign
61853	(V11) Central Illinois	11-a-9-B	Champaign	Mahomet	IL	Champaign
61953	(V11) Central Illinois	11-a-9-A	Douglas	Tuscola	IL	Champaign
61856	(V11) Central Illinois	11-a-9-A	Piatt	Monticello	IL	Champaign



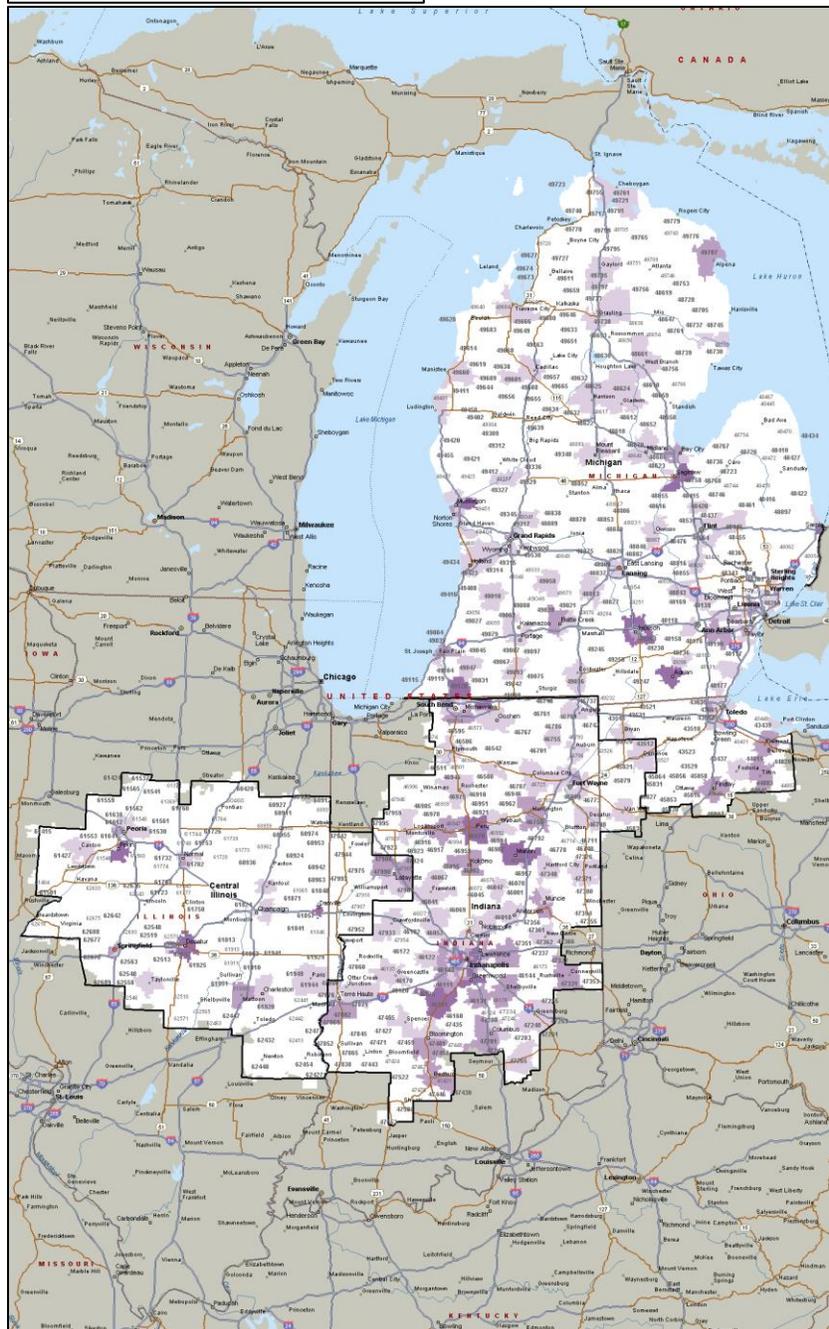
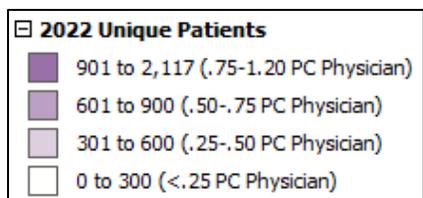
Above: How counties typically overlay the zip codes within Temple/Waco area (VISN 17 Study)

5.2.3 Prepare the planning horizon county projection of enrollee population for each zip code. Based upon the county growth rate in which the zip code is assigned in step 1, grow the zip code enrollee population at the same rate as the associated **county** growth evidenced over the planning horizon. To QC your work, compare the grown zip code enrollee population with its projected sector population.

An alternate method to distribute the projected enrollee population to the zip code would be to identify the zip codes within the sector, and distribute the projected sector enrollee projections across zip codes proportionate to the FY10 enrollee distribution in each zip code.

5.3. Map Analysis of Zip code data and development of Primary Care Service Areas

5.3.1 Map analysis of Base year and Planning horizon enrollee/unique population distribution . Utilizing Microsoft MapPoint, import the enrollee projections by zip code. Establish an appropriate map legend to segregate the varying levels of enrollee/unique population found in the zip codes by color as displayed below: Scale the color to reflect the number of Primary Care providers necessary to support the population in each zip code. Prepare maps for both the base year and target planning horizon. NOTE: Some VISNs will insist that enrollee projections be converted to UNIQUES and be displayed as such on the maps. Maps should be configured to suite the requirements of the VISN. This map will serve as the foundation for the future market service delivery maps.



VISN 11 Base Map showing the distribution of 2022 Unique population across the VISN

5.3.2 Development of Primary Care Service Delivery Points

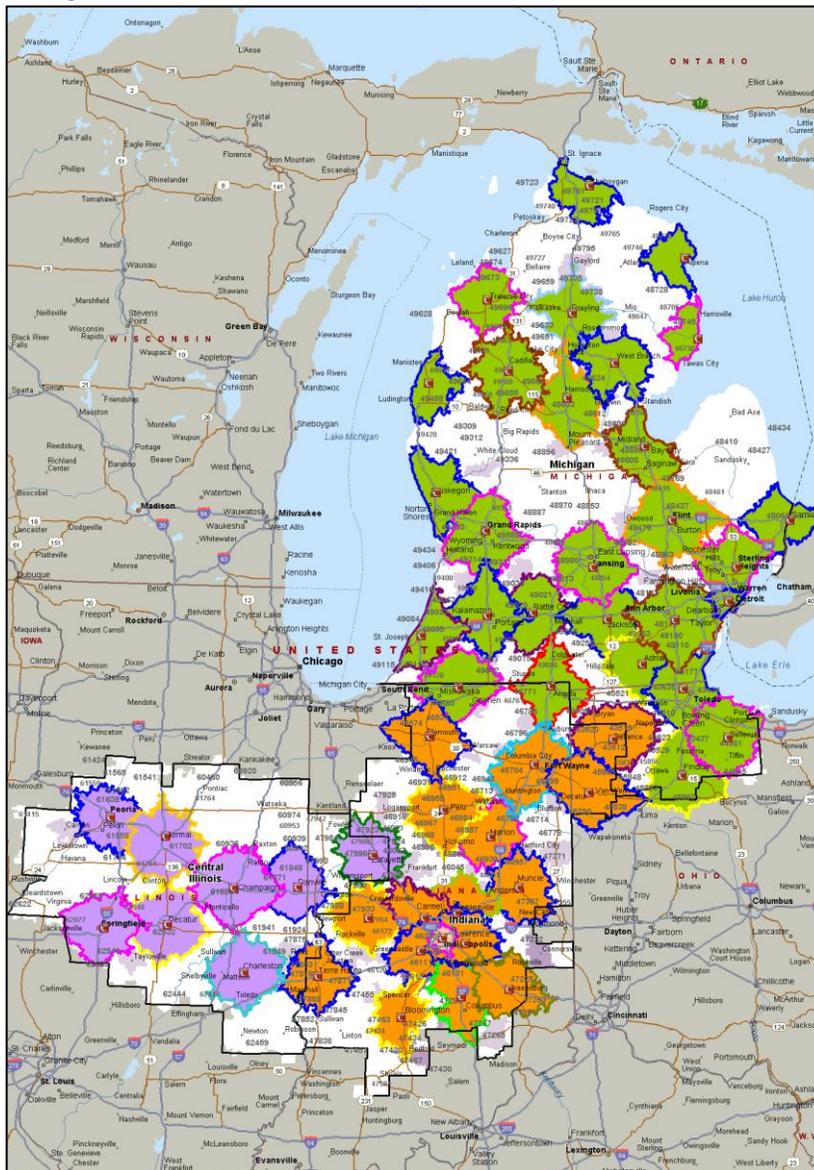
Select appropriate points to serve as the center of primary service areas.

Using the Target Planning Horizon map established in Step 3, now determine ideal Primary Care Service Delivery Points (PCSDP) by analysis of underlying map road networks to identify a major crossroads within an area of “purple zip codes” that appear to well serve those zip codes.

5.3.3 Conduct 15 and 30 minute drive time analysis

Plot 30 minute drive times radii about each PCSDP center point

Outside urban cores use the MapPoint drive time tool to plot a 30 minute drive time about each PCSDP center point. Within the urban core areas that possess a VA Medical Center, utilize a 15 minute drive time analysis to develop potential PCSDPs within the urban core. To address priority homeless veteran, the urban 15 minute drive time will be used to create an urban PCSDP to recognize public transportation utilization and 15 minute access times for urban populations. (Note: the 15 minute drive time is not a VA standard but has been used to successfully decompress busy Medical centers in dense urban settings.)



5.3.4 Download enrollee data from each Drive time area.

Export the zip code populations associated with the drive time zones. If they overlap multiple “primary care service areas” (purple cells) then a judgment will be made as to which primary care point of care the enrollee population will be assigned based upon their distance and access routes to a potential service point.

Extract whatever enrollee data is associated with the zip code. For instance, total enrollee population, enrollee diagnosis, or age demographic information about the enrollees in that zip code. This extraction will allow the establishment of a demographic profile of the enrollees within that PCSA. **This will be used later to develop the Market Service Delivery Plan for each PCSA/PCSDP.**

However, at this point only extract the total population of the zip codes because as decisions are made about the final proposed Primary Care Service Area (PCSA) definitions, the scale of the decision being made must be known. For example, resolution of zip codes in a PCSA when there are only 3 or 4 enrollees isn’t critical, but putting larger populated zip codes in the right PCSA is critical.

5.3.5 Converting PCSDP drive time radii to the final Primary Care Service Area (PCSA) boundaries

This process just takes time and requires getting into the details. The drive time borders for the PCSAs are often going to overlap. A single zip code could be in 2 or 3 PCSAs. When that is the case, one has to drill into the map and make a determination of what PCSA point of care is best supported by access patterns and the road system. One could potentially split zip codes between the multiple PCSAs (30%, 40%, 30%), but we feel that granularity is more than what is required for this effort. Primarily look at distances to points of care, and patterns of access. Significantly larger PCSAs are going to draw enrollees from more distant zip codes to their PCSAs just based on the fact that they are likely to have more services. The PCSA closer to the hub for the region is also likely to draw from more distant zip codes. After this research, the zip codes are assigned to a specific PCSA. The maps at this point are reorganized to reflect these zip code assignments.

Market	Unique Identifier	Service Area	Zip Code	Community	Total Enrollees	%	Adjusted Enrollees
North	19	Weatherford	76126	Benbrook	716	100%	716
North	11	Kaufman	75160	Terrell	724	100%	724
North	19	Weatherford	76087	Weatherford	727	100%	727
North	6	Farmers Branch	75080	Richardson	731	100%	731
North	12	McKinney	75080	Richardson	731	0%	0
North	8	Gainesville	76240	Gainesville	736	100%	736
North	9	Grand Prairie	75060	Irving	740	100%	740
North	14	North Richland Hills	76053	Hurst	747	100%	747
North	19	Weatherford	76114	River Oaks	751	0%	0
North	21	Lake Worth	76114	River Oaks	751	100%	751
North	7	Forest Hill	76016	Lindberg	756	100%	756
North	6	Farmers Branch	75061	Irving	763	100%	763
North	9	Grand Prairie	75050	Grand Prairie	766	100%	766
North	9	Grand Prairie	75211	Cockrell Hill	769	100%	769
North	6	Farmers Branch	75062	Irving	776	100%	776
North	12	McKinney	75023	Plano	781	100%	781

Primary Service Areas (PSAs) with 2022 Unique Pop					
	Adrian	2,536		Jamestown	2,072
	Alpena	1,650		Kalamazoo	5,414
	Ann Arbor	9,772		Lafayette	4,154
	Battle Creek	4,971		Lapland	1,166
	Benton Harbor	2,912		Marion	4,341
	Bettsville	3,459		Muncie	5,610
	Bloomington	4,704		Muskegon	6,212
	Cadillac	2,535		New Palestine	3,786
	Champaign	3,674		Normal	3,489
	Charleston	2,210		Oscoda	1,417
	Cheboygan	1,762		Peoria	8,212
	Clare	3,370		Peru	6,145
	Danville	4,229		Plainfield	7,331
	Decatur	3,849		Plymouth	2,260
	Defiance	2,626		Pontiac	14,763
	Detroit	27,797		Richey	1,333
	Findlay	1,198		Rural	817
	Fishers	7,593		Saginaw	9,021
	Flint	8,228		South Bend	13,481
	Fort Wayne	10,963		Springfield	4,617
	Free Soil	1,270		Taylorville	4,341
	Grand Rapids	13,901		Terre Haute	6,339
	Grayling	1,759		Toledo	10,009
	Greensburg	2,181		Traverse City	4,335
	Holt	6,803		West Branch	1,491
	Indianapolis	14,644		Whitestown	2,818
	Jackson	4,535		Yale	3,704
	Center of the PSA				

VISN 11 Primary Care Service areas Legend for PSA Map that follows.



Above: Final VISN 11 Primary Care Service area Market Map showing detail to be provided. Note the red symbols indicated existing primary care service nodes and the blue symbols representing potential future service nodes. PSA unique population displayed on previous page.

Chapter 6: Leap to the Ideal Part B: The Big Maps (Step 2)

6.1 Forecasting PCSA Workloads and Resources

The contracted health planners will analyze provided VHA utilization and enrollment data within context of the VISN Guiding Principles (program development principles developed in Chapter 4). This analysis will be done in isolation from VISN stakeholders to develop the initial Market Health Service Delivery Plans referred to in this process as the “Leap to the Ideal” or Data Driven Model. The “Plans” at this stage of the process are demographic market maps displaying all service sites, their level of care (primary, secondary or tertiary) and referral patterns for care within the market. These plans/maps will be targeted for the base year + 10 planning horizon. Complementing the market maps will be Continuum of Care breakout handouts displaying the categories of care currently provided at each site and the proposed categories of care to be provided at each Point of care/PSA.

This data driven analysis of demographic and workload data will ignore the presence of existing facilities, contractual relationships, medical schools and political influences. It will constitute a fresh look at how VHA would serve the projected demand in each market assuming it has no resources on the ground, no contractual relationships, no affiliations and is just entering the market. This Leap to the Ideal will be presented to the VISN Planning team including key clinical stakeholders at the Comparison to Existing meeting session (Step 5). Compare session changes and modifications to the Data Driven Service Delivery Plans will result in the development of the initial or Draft VISN Market Service Delivery Plans for the base year + 10 Planning Horizon which will then be further developed in Market based discussion with Market Leadership.

6.2 Data Sources: VHA will provide the data files that cover the fiscal base year with projections by year to the planning horizon target year of Base year + 10 and beyond to base year +20:

1. VISN X Projected Workload by SPC by geography to sector level
2. VISN X Workload by SPC by treating facility
3. VISN X In-house vs. Fee Utilization
4. VISN X Outpatient and Inpatient Pharmacy Workload
5. VISN X Projected Inpatient and Non-Institutional Long Term Care
6. VISN X BY11 Clinic Stop Distribution Model (by market)
7. Base year OR Efficiency RVU Reports
8. Provider Productivity Cube
9. RVUs per encounter
10. Base year VHA Productivity Benchmark Report

The VISN planner can pull most of this information from ProClarity by using the Briefing Book provided as Appendix C to this Handbook. Technical questions on using the Briefing Book should be addressed to Lori McClure (Program Analyst | Strategic Analysis Service | 10P1C | Office of the ADUSH for Policy & Planning | Phone: 757.741.2050).

6.3 Analysis of Primary Care Service Area Planning Horizon Workloads

All Market analyses and the final Health Service Delivery Plans will be driven and organized around the PCSAs and the underlying enrollee/unique populations within them that were established in Chapter 5. For each Primary Care Service Area within a market, a detailed Service Delivery Plan will be created to quantify the healthcare demand, and document the services to be provided. Delivery options for healthcare services will include:

1. Direct Care – where demand supported the decision to produce the care with VA staff and assets, it will be assigned to Direct Care. Virtual modalities and Telemedicine are included in this category.
2. Referred Care – where demand is not large enough to support the decision to produce the care at the PCSA, other VA referral partners will be identified. The workload of each referring site will be tallied in a referral summary for the site being referred to.
3. Contract Care – where direct care and referral options are not viable for all or a portion of the workload demand from a Primary Care Service Area, the workload will be assigned to Contract Care.

The level and amount of care will be driven by the volume of SPC services indicated by analysis of the number of enrollees/uniques being served in each PCSA. This analysis will be portrayed in two ways, first in Map and Continuum of Care breakout form (Sections 6.4 – 6.6) at the Compare Session and secondly in a tabular form within the “Big Books” as the detailed Market Service Delivery Plans (HSDP) are developed in Chapter 9.

6.4 Preparation of Data Driven Service Delivery Plan Maps

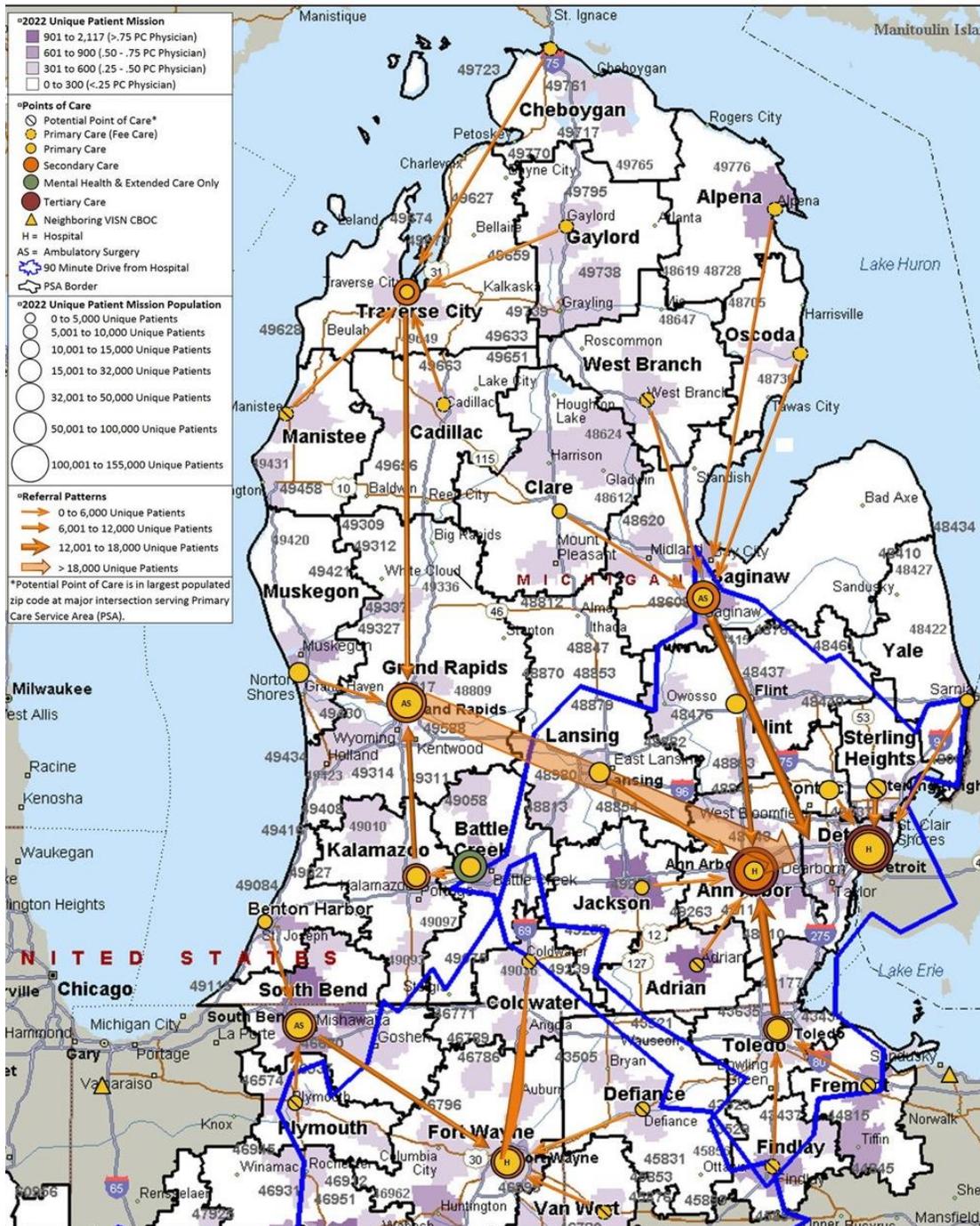
The consultants will prepare maps depicting various demographic data related to enrollment, utilization and service delivery planning, which in addition will be provided as handouts and displayed in supporting PowerPoint presentations. **However the maps described below, in addition to being provided as paper handouts, shall be prepared in large format suitable for group viewing and wall mounting. A size up to 4’ by 8’ is recommended for each market map.** These oversized printouts are referred to as the “Big Maps”.

6.5 Leap to Ideal Market Maps and Existing Service Delivery Maps

Two series of maps will be used to depict the relationship between the PCSA that were developed in Chapter 5 and the underlying Veteran enrollment statics, and the number of Primary Care providers necessary to serve that demand. The first series will depict the existing service delivery model for each market and the second will depict the Market’s Proposed Delivery Model for the planning horizon. The contractor shall develop and annotate the existing and proposed Service Delivery maps by depicting the following elements on the maps:

1. The base map will be the appropriate market area showing the underlying PSA boundaries and the existing and planning horizon enrollee or unique population distribution depended on the type of map being created
2. Annotate Points of Care by color coding the level of care of the site (Primary- gold, Secondary-orange or Tertiary-brown)
3. Annotate the relative number of enrollees/uniques served by the point of care by varying the size of the circle used to depict the point of care
4. New Points of care will be depicted by a crossed circle symbol
5. Points of care circles will be further defined by labeling them as either TC=Tertiary Care; H=Hospital or AS=Ambulatory Surgery.
6. 90 minute drive time from Hospital boundaries will be displayed on the map.
7. Referral Patterns (from primary care site to secondary and tertiary as appropriate) will be depicted by a range of colored arrows that denote the volume patients being referred by the thickness of the arrow icon chosen to depict the various volumes in the legend.

Conceptual Delivery Map - VISN 11 Points of Care & Referral Patterns - Michigan Ohio



Note: These market maps are most important and will be printed in large format and will be wall mounted to facilitate IPT review and discussion at the Compare Session.

6.6 Continuum of Care Categories for Points of Care

The Market Map described above is complemented by the production of vertical tiles/arrays of information for each Point of Care/PSA detailing (See Appendix H):

1. The PSA Name
2. PSA Population (enrollees and or uniques)
3. Population: Females, 65-84, 85+
4. Extended Service Areas (Total population with additional PSA denoted)
5. Each Continuum of Care categories proposed and the type and number of providers required by care category proposed:
 - a. Eligibility & Outreach
 - b. Primary Care
 - c. Dental
 - d. Eye Care
 - e. OP Mental Health
 - f. Acute Care – MH
 - g. Residential Treatment
 - h. OP Medical Specialties
 - i. Acute Care Medicine
 - j. Emergency Dept.
 - k. Special Procedures
 - l. OP Surgical Specialties
 - m. Acute Care Surgery
 - n. OR's (Surgical Services)
 - o. Physical Med & Rehab
 - p. Visual Impairment
 - q. Prosthetics Service
 - r. Extended Care
 - s. Community Living Center
 - t. Palliative Care
 - u. Laboratory & Pathology
 - v. Pharmacy
 - w. Audiology & Speech
 - x. Imaging
 - y. Nuclear Medicine
 - z. Radiation Therapy

Note: These arrays of PSA Proposed Continuum of Care information should also be organized and be displayed comparing the Existing Continuum of Care alongside side the Proposed Continuum of Care. The VISN 11 example below is showing the proposed services for these PSAs for 2022:

CENTRAL ILLINOIS MARKET - Champaign

PROPOSED		PROPOSED		EXISTING		PROPOSED		EXISTING		PROPOSED		EXISTING		PROPOSED	
Service Area	Champaign	Service Area	Bloomington IL	Danville VA Medical Center		Service Area	Danville	Decatur CBOC		Service Area	Decatur	Mattoon CBOC		Service Area	Mattoon
PSA	3,641	PSA	3,499	29,373 PCP Encounters (FY12)		PSA	4,255	9,074 PCP Encounters (FY12)		PSA	3,611	4,807 PCP Encounters (FY12)		PSA	2,471
Add Bloomington IL, Danville, Decatur & Mattoon				21,100 MH Couns Enctrs (FY12)				2,912 MH Couns Enctrs (FY12)				2,146 MH Couns Enctrs (FY12)			
ESA-1 17,477				1,352 FTE		850,994 BGSF		37.1 FTE		9,754 BGSF		19.0 FTE		8,436 BGSF	
Primary Care		Primary Care		Primary Care		Primary Care		Primary Care		Primary Care		Primary Care		Primary Care	
3.0 PC Provider		2.9 PC Provider		10.0 PC Provider		2.0 Physiatrist		3.9 PC Provider		3.0 PC Provider		2.2 PC Provider		2.1 PC Provider	
0.6 Women's Provider		0.5 Women's Provider		1.1 Women's Provider		5.0 Physical Therapist		0.1 Women's Provider		0.2 Dietician		0.3 MOVE Dietician		0.1 Dietician	
0.2 Dietician		0.2 Dietician		2.0 Dietician		6.0 Kinesiologist		0.5 Dietician		0.4 MOVE Dietician		0.3 Dietician		0.3 MOVE Dietician	
0.4 MOVE Dietician		0.8 Kinesiologist		2.0 MOVE Dietician		3.0 Occupational Therapist		0.5 Dietician		0.6 Women's Provider		0.3 MOVE Dietician		0.4 Women's Provider	
Eligibility & Outreach		Eligibility & Outreach		Eligibility & Outreach		Eligibility & Outreach		Eligibility & Outreach		Eligibility & Outreach		Eligibility & Outreach		Eligibility & Outreach	
OEF/OIF/OND Case Mgr		OEF/OIF/OND Case Mgr		4.0 C & P Provider		1.3 Polytrauma/TBI Therapist		1.0 OEF/OIF/OND Case Mgr		2.7 MH Counselor (PCMHI)		0.3 MH Psychiatrist		1.9 MH Counselor (PCMHI)	
C & P Provider		0.0 Chiropractor		2.0 OEF/OIF/OND Case Mgr		1.0 Chiropractor		0.8 Optometrist		1.5 MH Counselor		0.3 MH Psychiatrist		1.5 MH Counselor	
Dental		Visual Impairment		Dental		Visual Impairment		Eye Care		OP Med Specialties		OP Med Specialties		OP Med Specialties	
Dentist		0.1 VIST Coord Therapist		4.0 Dentist		0.5 VIST Coordinator		0.8 Optometrist		3.0 Dialysis Station		0.2 Tech		2.1 Dialysis Station	
Eye Care		Prosthetics Service		Eye Care		Prosthetics Service		OP Med Specialties		Emergency Dept.		Emergency Dept.		Emergency Dept.	
2.0 Optometrist		Purchasing Agent, O & P Rural Health Van		4.0 Optometrist		0.0 Amputee Clinic Tech		2.2 MH Counselor		0.3 MH Psychiatrist		0.2 Tech		0.3 MH Psychiatrist	
OP Mental Health		OP Mental Health		OP Mental Health		OP Mental Health		OP Mental Health		OP Mental Health		OP Mental Health		OP Mental Health	
MH Psychiatrist		2.1 Orthotics Lab Tech		2.2 MH Psychiatrist		3.0 Orthotics Lab Tech		3.6 Dialysis Station		2.8 HBPC FTE		0.2 Orthotics Lab Tech		3.8 HBPC FTE	
2.8 MH Counselor (PCMHI)		Amputee Point of Contact		33.5 MH Counselor		3.0 Prosthetics Agent		Emergency Dept.		Prosthetics Service		0.2 Orthotics Lab Tech		Emergency Dept.	
BHP		Level 2 Prosthetics Lab		6.0 Work Therapy Counselor		8.5 HBPC FTE		Emergency Care		2.8 MH Counselor		1.0 Clinical Pathology		Emergency Care	
MH-Spec Care		Extended Care		Physical Med & Rehab		Acute Care - MH		OP Surgical Specialties		2.8 HBPC FTE		Physical Med & Rehab		Physical Med & Rehab	
0.8 Work Therapy Counselor		Geriatric Consultation		0.8 Physical Therapist		29.0 MH Beds		0.0 SW/CM/Home Care		0.8 Physical Therapist		0.6 Physical Therapist		0.6 Physical Therapist	
1.1 PRRC Counselor		1.4 Home Based PC FTE		Extended Care		Residential Treatment		Community Living Ctr		Extended Care		Extended Care		Extended Care	
		Home Health Aide		OP Geriatric Provider		125.0 Short & Long Term Beds		Podiatrist		OP Geriatric Provider		OP Geriatric Provider		OP Geriatric Provider	
OP Med Specialties		OP Med Specialties		OP Med Specialties		OP Med Specialties		ORs (Surgical Services)		Laboratory & Pathology		Laboratory & Pathology		Laboratory & Pathology	
3.1 Dialysis Station		GEM		1.4 Home Based PC FTE		42.0 Residential Trtmt Beds		IP Surgery		0.0 Specimen Collection		1.4 Home Based PC FTE		1.0 Home Based PC FTE	
Sleep Medicine Rm		Community Living Ctr		Home Health Aide		15.0 In-House Hospice Beds		ORs (Surgical Services)		1.4 Clinical Pathology		Home Health Aide		Home Health Aide	
5.9		CNH - Long & Short Stay Beds		Community Living Ctr				Physical Med & Rehab		Pharmacy		Community Living Ctr		Community Living Ctr	
Dermatologist		Palliative Care		CNH - Long & Short Stay Beds		3.0 Cardiologist		1.0 Physical Therapist		Med Mgmt Provider		CNH - Long & Short Stay Beds		CNH - Long & Short Stay Beds	
Acute Care - Medicine		Palliative Care		Palliative Care		Palliative Care		Extended Care		0.4 Hospice Caregiver		Palliative Care		Palliative Care	
0.4 Hospice Caregiver		Home-Based		Home-Based		1.5 Gastroenterologist		OP Geriatric Provider		Home-Based Hospice Caregiver		Home-Based		Home-Based	
SPACED LEASED FOR		In-House Hospice Beds		Home-Based Hospice Caregiver		0.5 Hepatologist		Home Based PC FTE		Home Health Aide		Home-Based Hospice Caregiver		Home-Based Hospice Caregiver	
17.1 Med-Surg Beds		0.4 Hospice Caregiver		0.4 Hospice Caregiver		1.0 Neurologist		1.7 Home Based PC FTE		Home Health Aide		0.4 Hospice Caregiver		0.4 Hospice Caregiver	
16.9 Short Term CLC Beds		Laboratory & Pathology		Laboratory & Pathology		0.2 Infectious Diseases		Home Health Aide		Laboratory & Pathology		Laboratory & Pathology		Laboratory & Pathology	
OPERATED BY VA		Specimen Collection		Specimen Collection		1.0 Nephrologist		Community Living Ctr		Specimen Collection		Specimen Collection		Specimen Collection	
Emergency Dept.		Clinical Pathology		Pharmacy		2.0 Pulmonologist		CNH - Long & Short Stay Beds		Pharmacy		Pharmacy		Pharmacy	
Emergency Care		Pharmacy		Emergency Scripts		4.0 Sleep Medicine Rm		40.0 Long Term Beds		Emergency Scripts		Emergency Scripts		Emergency Scripts	
Special Procedures		OP Pharmacist		1.0 Clinical Pharmacist		Acute Care - Medicine		Palliative Care		1.0 Clinical Pharmacist		1.0 Clinical Pharmacist		1.0 Clinical Pharmacist	
0.7 Endoscopy Rm		1.0 Clinical Pharmacist		Audiology & Speech		23.0 Medical Beds		Home-Based Hospice Caregiver		Audiology & Speech		Audiology & Speech		Audiology & Speech	
OP Surgical Specialties		Audiology & Speech		Tele-Audiology		Emergency Dept		Laboratory & Pathology		Tele-Audiology		Tele-Audiology		Tele-Audiology	
Podiatrist		2.8 Audiologist w/ENT				4.0 Urgent Care Exam Rms		Specimen Collection							
Urologist		0.3 Speech Pathologist				Special Procedures		Pharmacy							
ENT Provider		Imaging (Radiology)				2.0 Endoscopy Rm		Emergency Scripts							
Ophthalmologist		1.9 General X-Ray Rooms				1.0 Cysto Suite		1.2 Clinical Pharmacist							
Orthopedist		0.9 Ultrasound Rooms				OP Surgical Specialties		Audiology & Speech							
General Surgeon		Fluoroscopy				1.8 Urologist		Tele-Audiology							
Pain Clinic Provider		1.0 CAT Rooms				0.8 Ophthalmologist		Imaging (Radiology)							
ORs (Surgical Services)		Nuclear Medicine				1.7 Orthopedist		0.6 General X-Ray Rooms							
Outpatient ORs		0.8 Nuclear Medicine Suites				2.0 Podiatrist									
IP Surgery						2.0 General Surgeon									
						0.2 Gynecologist									
						1.0 Pain Clinic Provider									

Chapter 7: Existing Services Inventory & Physical Infrastructure Assessment (Steps 3 & 4)

7.1 Defining the Existing Health Care Delivery System

This effort includes:

- (1) Review of available VHA documentation that will prepare the team for carrying out the face to face meetings with facility staff
- (2) Meeting with relevant facility clinical and facility engineering leadership to get up to speed on the current state of and current future plans for clinical programs and the space provided for the delivery of those services
- (3) Define existing referral patterns for the continuum of care within the VISN
- (4) A physical inspection of owned assets resulting in a summary of their current use, functionality, and value to mission.
- (5) Preparation of maps and other materials that can be used to compare the existing delivery system to the ideal model

Ideally the contractor’s “Team” would be comprised of both Health Service Planners, and Architects and Engineers. This work must all be completed by the same time that the Ideal market health service delivery plans are completed by the contractor to facilitate the “Compare” meeting that is the next major milestone in the process.

7.1.1 Documentation Review - Before undertaking service planning and facility master plans, the team should review documentation about the existing delivery system. This review should include all materials provided by the VA including:

- The Health Care System Trip packs
- The latest Clinical Inventory
- Market/Sector workload demand data
- Facility existing and projected workload demand data
- Drive time access and rural population analyses
- VISN Mission and Vision Statements
- Network Plans and local planning data
- Current Health Care Planning Model (HCPM) Market Reports
- Current Strategic Capital Investment Planning (SCIP) Gaps and Projects Proposed
- Current SCIP Strategic Capital Assessment and Presentation
- Capital Asset Inventory (CA) including Facility Condition Assessments (FCA)
- Capital Functional Survey Data
- Joint Commission Statements of Condition and Plans for Improvement
- Previously completed facility master plans
- Other local facility data that may not be available before the site visits—including Physical Security Assessments
- CARES Commission Recommendations and Secretary’s CARES Decision Documents

This review of provided documents should be augmented by the execution and analysis of a Leadership Questionnaire and/or interviews. The background documentation, along with Questionnaire responses

and the frequently requested clarifications, should be reviewed and analyzed, becoming the Planning Team's understanding of how VA services are now being delivered.

A summary of the documents reviewed and questionnaires completed should be used as supporting materials and handouts for subsequent meetings

7.1.1.1 The Clinical Inventory – VHA facilities will have recently completed an extensive clinical inventory defining what services are provided at each facility. However no staffing data or workload data is associated with this inventory. Therefore, the contractor must insure that a full staffing profile for all service lines is provided by the VA to use in the development of Market Health Service Delivery Plans. This can be captured in the Leadership questionnaire and verified at face to face meetings with department chiefs.

7.1.1.2 The Leadership Questionnaire - These Questionnaires should be sent to leadership and management at each facility requesting information on services being provided and how they are being delivered to veterans. Potential changes to services for improved delivery should also documented in the questionnaires as well as physical key characteristics such as number of exam rooms and providers' offices, etc. The Questionnaires aim to be comprehensive and should request information ranging from defining the general mission at each campus to specific services provided. The gathered information helps form the basis for service planning and facility master plans. Ideally the Leadership Questionnaire should be introduced at the 1st leadership conference and its completion should be timed to allow the presentation of questionnaire results by the next meeting. Questionnaire responses should be verified during meetings with Clinical leadership during this phase of the process.

7.1.2 Meeting with Health Care System (HCS) and/or Facility Clinical Department Representatives - The contractor will meet with all owned facility department chiefs to orient them to purpose of the IP planning process, to determine the organizational alignments of the facilities and points of care, to collect information on the mission/functioning of the service, especially the current referral patterns for care, the amount of space controlled by the service, its workloads, staffing, its limitations and issues and plans for the future. These meetings will also serve as the introduction to the Facility Master Plan process which will continue after completion of the market health services delivery plans. **However, free standing Vet Centers and CMOPs require no visits by the team.**

7.1.2.1 Establishing the Current Departmental Space Inventory – The Capital Asset Inventory and the local space plans provided by the VA will be reconciled/updated based on the input of the departmental representatives. For use in the compare session, the contractor will prepare floor plan drawings that indicate what space is currently controlled by the all departments. It is intended that discrepancies in VA provided information will be transferred at the departmental meetings conducted with the chiefs and other representatives so that the facility engineering staff can correct their records as necessary.

7.2 Assessment of Physical Infrastructure - Asset assessments of existing VA-owned medical center facilities will be done by the contractor. These types of assessments are not done for leases

(CBOCs/OPCs, Vet Centers, Regional Offices, etc.) or for VBA facilities or cemeteries that are not collocated with a VHA Medical center. Some of the key A/E team members who conduct a facility asset assessment should also be a part of the team that goes on to do the Facility Master Plan.

7.2.1 Questionnaires -Questionnaires geared to these facility assessment tours should be issued requesting detailed information for each facility or site and followed by Team’s site visits to each facility for further documentation and evaluation of existing conditions.

7.2.2 CAI and FCA Reviews -The Contractor will review Capital Asset Inventory and Facility Condition Assessment information provided by VA to assist in the assessment. Problems with this data that are uncovered during the process shall be submitted to the Project Manager and VISN.

7.2.3 The Physical Inspection of Facilities - The facility/VISN will identify a Site Visit Lead (SVL) for each owned facility to work with the A/E Planning Team as a part of the Stakeholder Registry. This person will be the main point of contact for scheduling, verifying existing space and programs, and providing information. The Contractor shall make a physical inspection to assess the nature of the assets, their current use and “highest” possible use, potential reuse, and their site and building characteristics including location, compliance with VA standards and criteria, competitiveness and aesthetics, functionality, site utilities and restraints, unique functions and characteristics, and other facility information needed to complete the template tool assessment and not available from existing VA data systems. **Ideally inspections of clinical departments should be planned to occur with the departmental meetings addressed in 5.1.2 above wherever possible.**

7.2.4 Existing Service Delivery Inspection Results/Rating Tool Using VA supplied information, the results of the inspections and the VA supplied rating tool, the Contractor shall provide a summary with recommendations for each VA-owned asset indicating their value to VA service delivery, and their suitability for continued use for their present function or for one or more alternate Services. Each site, each building and each campus shall be given an overall rating as a physical asset on the supplied rating tool (see Appendix.) The rating tool is an Assessment matrix that will be completed to document the evaluation of buildings at each medical center to further the understanding of the value of the VA’s existing assets. The Contractor shall prepare an assessment of existing VA infrastructure and facilities in the VISN using a rating template tool.

The purpose of the Asset Assessment that happens early in the Health Service Delivery Planning process is to objectively determine what VA assets in the Market “are”. For example, If a building has 11 foot floor-to-floor heights, no service elevators, large areas with live loads of 40 lbs/SF, narrow wings, piece-meal medical gas systems, and obsolete HVAC systems with lots of window units, then it is not a hospital building. It may be that we are using it as a hospital building, but it is not a modern hospital building. The Asset Assessment will document what each owned building actually is today and then roll that up for each campus so that the existing assets can be compared to the ideal model. It could be that some otherwise good assets will be devalued because they are in extremely poor condition or because they are so completely dysfunctional that it makes no sense to continue to call them a useful asset.

The Asset Assessment results are used in the “Comparison” phase where an “Ideal Model” is compared to the existing delivery system. In some cases the Team will see that a hospital is needed in a city and will find that there is a hospital building in about the right place in that city—that’s the

case for San Antonio. In other cases the Team will find that a hospital is needed in a city, but a true hospital building does not exist in the city—that’s the situation in Boston. In other cases the Team will see hospital assets that are not located ideally, but when affiliations, politics and workforce planning are thrown in the mix, it makes little sense to try to move a billion dollar investment 30 miles—that’s the case in Central Texas. Here’s an example of an asset assessment summary from VISN 1:

Market with greatest demand for hospital services has no buildings meeting current hospital standards

GSF meeting hospital standards

Facility	From CAI		Rate	Risk	Total Facility Cost	By Meeting Current VA Criteria & Standards, and "Good" for (Rank may total more than Total Owned Facility GSF)					Location for US Health Care Use	Overall	Unique Issues (Brief Comments)
	Correction Cost	Replacement Cost				Core	Outpatient Clin	Prehabilitat. Clin	Office 100	Office 100			
42 - Topeka	\$ 77,708,738	\$ 475,887,124	0.16	+	845,542	155,483	28,164	127,394	28,900	0			
45 - White River Junction	\$ 48,221,828	\$ 174,482,000	0.28	+	448,830	139,828	0	127,961	0	0			
78 - Bedford	\$ 144,012,238	\$ 508,593,417	0.28	+	1,178,288	0	412,185	631,874	412,185	350,440			See Below
83 - Boston HS, Jamaica Plain	\$ 74,700,822	\$ 480,823,000	0.16	+	957,231	0	0	528,938	29,248	351,019			See Below
83M - SVAH, West Roxbury	\$ 82,707,818	\$ 225,191,000	0.37	+	891,398	0	0	327,808	0	455,820			See Below
83M - SVAH, Braintree	\$ 138,888,110	\$ 471,698,000	0.27	+	1,598,221	0	214,886	530,001	530,001	530,001			See Below
88 - Manchester	\$ 72,142,068	\$ 115,047,000	0.63	+	286,814	0	47,708	248,802	0	0			Still needed for outpatient care and long term residence
87 - VA Central Western Mass HCS	\$ 67,142,012	\$ 258,885,000	0.26	+	540,800	0	199,800	0	0	0			See Below
85 - Providence	\$ 61,081,310	\$ 198,804,000	0.31	+	450,720	0	0	327,940	7,848	79,792			See Below
89 - VAHCS, West Haven	\$ 148,919,270	\$ 502,428,000	0.30	+	1,211,802	99,000	99,000	548,010	18,000	366,800			See Below
89M - VAHCS, Newington	\$ 38,414,243	\$ 253,826,000	0.16	+	612,196	0	0	321,780	0	220,758			See Below
Stats for all selected facilities	\$ 911,747,428	\$ 3,818,886,971	0.24	+	6,070,870	363,381	1,081,454	4,502,440	1,196,412	4,198,031			
Total Owned (GSF)						458,115							
Total Annual Rate						\$ 15,987,318							

The table may be hard to read, but it shows what was discussed above—no hospital assets in the Market with the most demand for a hospital asset. It also shows that the smaller stations can prosper with NRM and Minor Construction Projects because they are trying to solve smaller problems. If, over the last 20 years, some capital investments made in the smaller markets were rolled up into a Major investment in the large Boston market, today VA probably would be better equipped overall to take care of Veterans in New England—and might also have facilities more comparable in age and condition to the best medical facilities in New England.

Consideration should be given to providing a summary of the condition of the infrastructure that supports the service line Continuum of Care/Care Categories (General Outpatient Care, Medicine Specialty Care, Surgical Specialty Care, Diagnostic & Treatment, Mental Health, and Extended Care and Rehabilitation) These condition summaries could facilitate the VISN leaderships assimilation of the impact of infrastructure status on each care category and help them make better informed decisions as to the mission of programs and facilities.

Note: All administration service sites will be located on maps including Vet Centers. **However, free standing Vet Centers and CMOPs require no visits by the team.**

Once a direction is set and the long range futures of Market facilities are worked out and workload allocations are made to each site of care, then, and only then, can the FMP process begin. This is where the Team has to address functional and condition deficiencies—but always in the context of the long range plan tempered by the realities faced today. The Asset Assessment piece is not a duplication of anything VHA does now. It is more than condition and size—it's a frank assessment of what VA real estate assets actually are—for the use of the Team.

7.2.5 Existing Service Delivery Maps -The contractor shall develop and annotate Existing Service Delivery maps showing the locations of all VA assets (owned and leased) that:

1. Color codes for what the assets are.

Red--VA-Owned

Blue—Lease

Violet--contract

2. Locate State Homes, DOD, NCA, VBA, Vet Centers, CMOPs, VISN offices etc.

7.2.6 Meet the Engineers - During the inspections, the Contractor will meet with engineering staff to identify gaps in available site and facility information and drawings. The space plans used by the facility shall be reviewed and used to assist the assessment. Space plan inaccuracies shall be corrected by the Contractor as required to complete the work. If key drawings, such as the space plans and utility site plans, do not exist, or are not available as CAD files, then the deficiencies shall be reported to the Project Manager and VISN.

7.2.7 Meet with OIT - During the inspections, the Contractor will meet with and interview VA Office of Information and Technology (OIT) specialists and include an assessment of telecommunication and OIT infrastructure indicating any bandwidth problems or other issues that would need to be addressed in order to implement telehealth and other virtual health care modalities.

Chapter 8: The Comparison (Step 5)

8.1 Purpose: The two Phase 1 process tracks of preparing the Data Driven Service Distribution Model for VISN Markets and the examination of VISN physical infrastructure and definition of the existing market service delivery model culminate in the Compare Session. Large Market Maps (4'X7' as described in Chapter 6) will be prepared to display the VISN Existing Service distribution model and Leap to Ideal/Data Driven Service Delivery Model.

8.2 Logistics – This meeting will preferably be held at a Central VISN location and be scheduled early enough to help insure full attendance by VISN/Market Clinical and Administrative Leadership selected to participate. Ideally a meeting room of adequate size to display larger format market maps be scheduled. These maps will be the focus of market centered discussions of the alignment of primary care service areas and the distribution of services across each market. The market maps will be annotated by the contractor discussion leader to reflect changes by VISN leadership. Upon completion of this session the marked up maps will be revised and then serve as the draft Optimum Market Service Delivery Plans for further discussion and refinement with the separate market leadership teams.

8.3 Participation Issues - The Comparison meetings are the only meetings in which the Data-Driven model is presented and discussed. Because of the potential for misunderstanding the purpose and use of the this model, Administration and VISN leadership must carefully select the IPT participants. Based on past experience, this is especially critical for VISNs with declining enrollment and workloads, and in VISNs with independent VAMCs that are not a part of a multi-campus System. A key part of the Comparison meetings is to discuss the sensitive issues associated with the data driven model and what can be said in subsequent meetings about those sensitive areas. This is the meeting where it might be decided to not pursue an idea that would make perfect sense in a “perfect” world. The goal is to make progress toward a services delivery driven system, not to take on battles that cannot be won or that would undermine the overall objectives. These stretch goals could be included in the Market Service Delivery Plan as Long Range Goals.

8.4 Meeting Goals: The goal of reconciling the Data Driven Market Plans to Existing Market Service Delivery Dynamics will be achieved through:

1. Presentation of Existing Service Delivery System for each market
2. Presentation of Data Driven Service Delivery System for each market
3. Presentation on the functional condition of each market’s physical assets
4. Comparison of:
 - Data-Driven Model to Existing Delivery System
 - Data Driven Service Points of Care and Modes of Care compared to Existing Sites of care and services offered at those sites—a candid discussion.
5. Discussion of key Political and Educational forces influencing distribution of health care services in each market
6. Assessment of stakeholder responses to potential strategies/changes
7. Reach agreement on strategic directions to be developed in next steps
8. Initial revisions to the Data Driven Service Plan Maps to yield initial Draft Optimum Service Delivery Plan

8.5 After Actions – The contractor will prepare Draft Optimum Market Services Delivery plans based on the marked up Data Driven Plan coming out of the Compare Session. The IPT should analyze the decisions being integrated into the Draft Optimum Services Delivery Plan. The draft

Optimum delivery plans will be reviewed and refined and finalized at the market level planning sessions that follow.

Chapter 9: Market Health Services Delivery Plans (Steps 6 & 7)

9.1. Roll out, Review, Understanding, Amendment and Buy In

Upon completion of the Comparison Session (Step 5) the IPT will proceed with detailed refinement of draft Optimum Market Service Delivery Plans. Meetings should be held in the markets with clinical and administrative leadership to:

1. Further familiarize them with the service dynamics of their markets,
2. To secure agreement on future referral patterns to secondary and tertiary care services
3. To secure agreement on future new points of care, their workloads and required staffing
4. To secure agreement on the services to be offered at each point of care
5. To secure agreement on appropriate market areas where contracting for care/ fee services are the best solution
6. To secure agreement on when it is appropriate to engage a sharing partner to fill a service gap
7. To finalize strategies to address the service gaps and opportunities surfaced by the Data Driven model analysis.
8. To prepare a defined list of initiatives (non capital and capital to address service gaps/needs of the markets.

Once these plans are fully analyzed and approved by the market leadership, they will be presented to the VISN leadership for approval.

9.2 Finalization of Primary Care Service Area Boundaries

It is crucial that draft Optimum market service delivery plan primary service area delineations be reviewed and correlated with existing points of care. Refinement of primary care service areas (PCSAs) is an iterative process and may require a couple of meetings to firm up in response to market leadership input. **Note:** If we are able to have the client understand this effort, there may be changes to these initial border definitions. For the client to own the PCSA planning concept you want to facilitate their review, understanding and have them make changes. You want all the PCSA boundaries to be understood and settled down before you begin to forecast workload and resources for these PCSAs and construct the PCSA Market Service Delivery Plan Big Books.

9.3 Finalization of Market Service Delivery Map and Distribution of Services

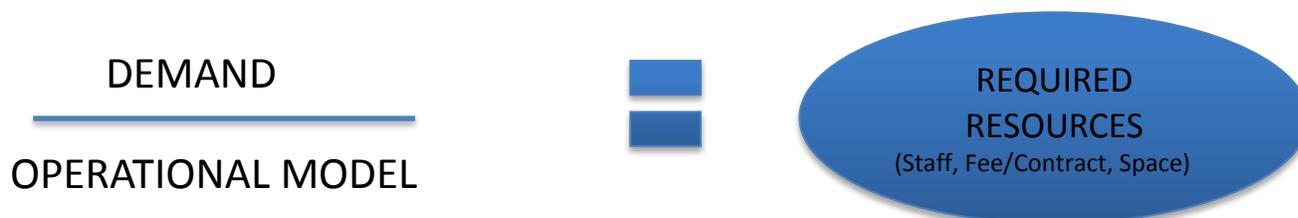
The Market Service Delivery Plan (MSDP) is comprised of the final Optimum Market Services Delivery Plan Market Map, revised Service Distribution Listing/Tiles by Point of care and the MSDP Big Books. Market clinical leadership further refines of the initial Draft Optimum Market Service Delivery Plan (Market Map and Service Distribution listing/tiles) that came out of the Compare session with VISN leadership. This stage of the process includes securing the buy in of the Market leaders that review the Service Delivery Map and Continuum of Care service distributions for each point of care. Once these two elements (the map and service distribution listings/tiles) are approved by Market leadership, this map can be referred to as the Optimum Market Service Delivery Plan. Then the second stage of this step, the development of detailed Service Delivery Plans, Resource Allocation Plans and Facility Master Planning Resource Plans can commence. These three plan components are collectively referred to as the “Big Books”.

9.4 What are BIG BOOKS?

“Big Books” document the roll up of detailed analysis of projected Strategic Planning Category workloads for each market Primary Care Service Area for the planning horizon target year (Base year + 10) and the planning decisions made on how to handle that workload (Direct Care, Referred out, or Contract/Fee). Instrumental to this analysis are the Guiding Principles that the VISN leadership endorsed earlier in the process and described in Chapter 4.

9.5 The Role of Guiding Principles

These Guiding Principles inform the process to enable decisions on how much staff is required to handle the projected workload by service line.



The above formula drives the allocation of resources. **Demand** is represented by veteran population size, enrollee/unique population densities and locations within the market, veteran health, and output projections for the Enrollee Health Care Projection Model (EHCPM). The **Operational Model** refers to the proposed clinical model of care proposed by service line. This model includes the VA access standards; Service Thresholds (at what workload level is the decision made to provide a service or conversely close a service; at what workload level do you contract out in areas remote from VA services? etc.); Outcome standards/quality measures; provider productivity/staffing standards and the cost of care.

9.6 The Service Delivery Plan

The Service Delivery Plan uses the guiding principles, specifically the ratio of workload to Key Characteristic, to enable the estimation of staffing resources needed to meet the projected service line workload in the targeted planning horizon. It documents the VISN’s plan for serving the health demand within the PCSA by stop code. For example in the example below, For the Cardiology service line, the key characteristic is “Providers” and the operative ratio is 2549 encounters per provider.

Service	Key Characteristic Workload Unit	Projected Need					Delivery Plan Assumptions				
		2010 Actual	2025 Modeled	Contract Due to Acuity	Referred In	2025 Total	Direct Care	Referred Out	Referral Location	Contract Due to Threshold	% Contract
Cardiology	* Providers	2.6	0.0	0.0	5.1	5.1	5.1	0.0		0.0	
(2549 Encounters/Provider)	Subtotal	6,641	0	0	13,126	13,126	13,100	0		26	0.2%
303 CARDIOLOGY	* Encounters	6,641	0	0	12,113	12,113	12,089	0		24	0.20%
311 PACEMAKER	* Encounters	0	0	0	1,013	1,013	1,011	0		2	0.20%
107 EKG	Encounters	6,903	0	0	7,030	7,030	7,016	0		14	0.20%

The projected workload for Cardiology above in the 2025 planning horizon target year is 13,126 encounters which yields an estimated need for 5.1 Cardiology FTEE. That staffing estimate has been entered into the “Direct Care” column under “Delivery Plan Assumptions” documenting the decision to use VA staff for this service as opposed to referring it to other VA service points or contracting out. This cardiology workload level exceeds the threshold necessary to use VA staff to meet this service need in this PCSA. This workload threshold would be defined in the Guiding Principles. Note: A Referral Plan is included in the PCSA Service Delivery Plan when a location serves more than two PSAs for a service(s).

9.7 The Resource Allocation Plan

In addition to a Service Delivery Plan for each PCSA, a Resource Allocation Plan will be developed. The workload assigned to Direct Care will be brought forward to the Resource Allocation plan where workload demand is translated into key characteristics required to provide care (quantity of providers, exam rooms, operating rooms, etc.). The key characteristic quantities are then applied to space calculating metrics to establish the required space to provide the service (department gross square feet - DGSF). The required space is tallied to establish building space requirements (building gross square feet - BGSF) to inform the Facility Master Plans. Continuing the example of Cardiology started above, the 5.1 providers will necessitate the provision of 10 exam rooms that requires an estimated 12,500 Department Gross Square Feet (DGSF) of space.

Service	Workload Unit	Direct Care (PSA+ESA)					Contracted Care			Remarks
		2025 Workload	Key Characteristic (KC)	2025 Req'd KCs	2010 Exist'g KCs	% of Need	2025 Workload	Unit Cost	Fee Based Dollars	
Cardiology	Encounters	13,100	Providers	5.1		0%	26	\$0.00	\$0.00	
			Exam Rooms	10.0		0%				
			DGSF	12,500		0%				

9.8 Resource Allocation Plans for Facility Master Plans (FMPs)

A revised Resource Allocation Plan is prepared (in addition to the base Resource Allocation Plan) for sites to be included in Facility Master Plans. The Service Plan recognizes the planning needs of the FMP, and provides a specific Resource Allocation Plan for each PCSA for Facility Master Plan development to account for interim facility strategies and the workloads and resources that will be used to address them:

Service	Workload Unit	Direct Care (PSA+ESA)					Proposed KCs	% of Need	Remarks
		2025 Workload	Key Characteristic (KC)	2025 Req'd KCs	2010 Exist'g KCs	% of Need			
Eligibility & Outreach									
Compensation & Pension									
Encounters	0	Providers	0.0		100%	0.0	100%		
		Exam Rooms	0.0		100%	0.0	100%		
		DGSF	0		100%	0.0	100%		
Integrated Disability Evaluation System									
Encounters	0	Providers	0.0		100%	0.0	100%		
		Exam Rooms	0.0		100%	0.0	100%		
		DGSF	0		100%	0.0	100%		
OEF/OIF Program									
Encounters	0	Case Managers	0.0		100%	0.0	100%		
		DGSF	0		100%	0.0	100%		
RVOEC									
Encounters	512	Counselors	0.4		0%	0.0	0%		
		Group Rooms	0.0		0%	0.0	0%		
Group Encounters	358	DGSF	0		100%	0.0	100%		
Primary Care									
Dental									
General Dentistry									
RVUs	8,155	Dentists	2.3	6.0	258%	6.0	258%		
		Hygienists	1.2	2.0	172%	3.0	258%		
		Chairs	5.0	8.0	160%	15.0	300%		
		DGSF	3,000	6,810	227%	9,000	300%		
Dental Specialties									
RVUs		Specialists	0.0		100%		100%		
		Specialty Chairs	0.0		100%		100%		
		DGSF	0	0	100%		100%		

VISN 17 Resource Allocation Plan for Facility Master Plan excerpt

9.9 Service Plan Reviews

It is important to note that draft Market Service Delivery Plans should be reviewed at the Market Health Care System level where participation by all clinical service lines can most effectively be achieved. One-on-one meetings are recommended with the Service chiefs to assure the most complete understanding and buy in of the clinical staff. **To achieve clinical buy-in of the results of Big Books, clinical stakeholders must be involved in the final review and approval of delivery decisions for their market.**

Chapter 10 Mission and Communication Plan Approval and HSDP Report (Step 8)

10.1 Health Care System Leadership Review and Sign Off

It is crucial to note that the proposed Market Service Delivery Plans should be reviewed at the Market (Health Care System/facility) level. This review must accomplish two goals, understanding of the market strategic operational directions embodied in the MSDPs and validation of those strategic directions by Market and VISN leadership. The culmination of phase 1 development of the market health service delivery plans will be a face to face meeting with Market and VISN leadership to formally approve the Market Service Delivery Plans and the Facility Mission/Strategy Templates derived from those market plans.

10.2 The Facility Mission/Strategy Template.

The Facility Mission/Strategy Template (FMST) will be prepared for each market facility and will be presented to Market (Health Care System/Facility) and VISN Leadership of approval. Approval of the FMSTs is a prerequisite to the development of the Market Health Service Communication Plan (MHSCP) and facility master plans. The purpose of the FMST template is to describe the programmatic changes that have been established within the Market Service Delivery Plans for PCSAs associated with individual facilities.

The FMST will define the mission of each facility by program and then indicate the status of each program in three modes: Existing, Long Range Goal and Strategy for FMP (facility master plan - See the example below). "Existing" refers to the current existence of the program at the facility. The "Long Range Goal" applies to the target planning horizon and may be controversial. "Strategy for FMP" applies to how the program should be handled for purposes of preparing the Facility Master Plan. The completed template is an internal planning document. The Market Health Service Communication Plan, an internal and external Communication plan, must be developed and approved by VISN and Administration leadership before information in the template can be released for FMP use. See section 10.4 below for details on the MHSCP.

Facility Mission/Strategy Template

BY20XX	BY	BY+10		BY	BY+10	
<i>PC Enrollees:</i>		11,171			10,211	
<i>SC Enrollees:</i>					51,891	
<i>ED & IP Enrollees:</i>					68,070	
<i>ESA Enrollees:</i>						
	Location/Facility 1			Location/Facility 2		
Program/Category	Existing	Long-Range Goal	Strategy for FMP	Existing	Long-Range Goal	Strategy for FMP
Primary Care	X	X	X	X	X	X
PCMH	X	X	X	X	X	X
Dental	X	X	X	X	X	X
Optometry	X	X	X	X	X	X

Audiology	X	X	X	X	X	X
Psychiatry	X	X	X	X	X	X
Sleep Studies				X	X	X
Speech				X	X	X
Dialysis						
Medical Subspecialties	X	Move to 2	Maintain	X	X	X

10.3 Designation of Level 1 and 2 FMP Sites:

Facility Master Plans will be completed for all VA-owned and designated leased facilities in the Market. Two levels of facility master plans are defined in the Handbook and the IPT Team will make the decision on which level should be applied to each facility at this point in the process and secure VISN leadership approval concurrently with approval of the Market Service Delivery Plans.

Level 2 is intended for sites where significant change and Capital Investments appear to be the most needed to support the Health services Delivery Plan. Level 2 FMPs will provide more of the planning information needed to move directly into project programming and conceptual design. A Level 2 FMP is appropriate for facilities where it is apparent that services are to be expanded or added or for campuses with extensive functional and/or condition deficiencies. A Level 1 FMP is appropriate for new campuses and for campuses with little services delivery change. In certain cases a decision may be made to not do a FMP, however every facility and lease will be a part of the Health Service Delivery Plan which will define the planned workloads, mission and departmental sizes for each location. A facility with a significant number of difficult to reuse historic structures would be a likely candidate for a Level 2 FMP.

10.4 The Market Health Service Delivery Communication Plan (MHSDCP).

Purpose

The Market Health Service Delivery Plan (MHSDCP) will be written by the contractor with input from all three Administrations at the end of the Health Service Delivery Plan phase. A template is included in the Appendix. The MHSCP:

- a. Supports the strategic goals and objectives and provides a framework for the annual organizational communication of Administration and Network plans.
- b. Defines what to say and do about the long range goals for each asset.
- c. Defines the direction and guidance to be given to the facilities and the A/E planners so that they can develop Facility Master Plans that are consistent with the long range goals and approved facility workload allocations, allow the facility to function at the highest level possible, and limit development where necessary to support the overall long range goals.
- d. Serves as a guiding map for all internal and external communication.

Situation Analysis

External:

The MHSDCP will briefly discuss external factors such as laws and Congressional, Veteran, service organization, media, or community perceptions that could be at odds with the long-range goals and missions for owned facilities. All significant stakeholders will have their interests

identified and a communication strategy to mitigate the impacts of plan implementation.

Internal:

For VACO and VHACO Leadership: The MHSCP will outline the approach to take in the annual planning cycle to explain sensitivities and any barriers to achieving the long-range facility goals that are necessary for reaching the Network Strategic Goals and Objectives. This should be a frank assessment of what should be done and what can be said about it.

For Each System/Facility: The MHSCP will outline the approach to take in the Facility Master Planning process to explain the programs and workload allocations goals that are necessary to reaching the Network Strategic Goals and Objectives. This also should be a frank assessment of what should be done and what can be said about it.

Targeted Communication Plan Products

For VACO and VHACO Leadership: The MHSCP will define the short-term and long-term missions and fates of each owned facility for use in the annual planning documents submitted and presented to Central Office leadership.

For Systems and/or Facilities: The MHSCP will:

- Define any limits on the types of development that can be planned at each site.
- Include as an attachment the approved planning workload allocations for each Strategic Planning Category for each physical point of care. This listing will be what is given to the facilities and the contractor's FMP team.
- Outline a training/education plan for making staff members aware of the critically of following the Service Delivery workload allocations and Facility Master Plans.
- Assign appropriate responsibility for linking the plans to individual job performance and the overall success of the Network.
- The MHSCP must build in effective mechanisms for input and feedback from all staff at the facility and network level.

Audiences, Media, Schedules

Each Administration and the VHA Network Office will use the elements in the completed MHSCP in their ongoing communication strategies.

10.5 The final Market HSDP report contents:

1. Table of Contents
2. Executive Summary
 - a. Summarization of the existing delivery model, ideal model, the delivery goals, and the strategic direction being taken to move toward the goals. Include non-capital solutions and collaborations with non-VA health care organizations.
 - b. Metrics & Dashboards comparing the latest SCIP submission's areas and costs to the planned course of action. Cost summaries of the two scenarios if applicable.
 - c. Any planned cross-cutting actions involving NCA and VBA
 - d. Key VA and A/E participants
3. Data-driven model maps and tables with an explanation of the assumptions and limitations
4. Existing delivery system summary maps and service and site inventory

5. Asset Assessment Tables summarizing the existing assets, and identifying geographic and asset misalignments
6. Strategic Market direction proposed through process
7. Facility Mission/Strategy Template indicating Long Term goals by Strategic Planning Category, and the presuppositions to be used in development of FMPs.
8. Market service delivery plan details for each point of care and other modality including:
 - a. Program/service distribution
 - b. Projected re-allocated planned workloads
 - c. Draft Space Calculator area (DGFSF and/or NSF) projections by Strategic Planning Category and Department for each point of care with an estimate of the total area needed for each site in Gross Square Feet (GSF) for VA-owned properties and in Rentable Area for leased properties.
 - d. MSDP Market Maps and service distribution listings/tiles
 - e. MSDP Big Books (Service Delivery, Resource, Referral and FMP Resource Plans)
 - f. Space gap analysis by facility
 - g. Summary of capital and non-capital initiatives (prioritized)
 - h. Implementation plan of projects for each facility with Phasing
9. Communication Plan to:
 - a. Support VHA strategic goals and objectives and provide a framework for the annual organizational communication of Administration and Network plans.
 - b. Define what to say and do about the long range goals for each asset.
 - c. Define the direction and guidance to be given to the facilities and the A/E planners so that they can develop Facility Master Plans that are consistent with the long range goals and approved facility workload allocations, allow the facility to function at the highest level possible, and limit development where necessary to support the overall long range goals.
 - d. Serve as a guide for all internal and external communication.

Note: VISN approval of the Market Health Service Delivery Plans completes this step, the first phase of the Integrated Planning Process

Chapter 11: Facility Master Plan Process (Step 9)

11.1 Purpose: FMPs are a key portion of the bridge from the present to the future and are intended to guide Capital Investments to where are the most needed to provide services to Veterans.

1. Together Market Health Services Delivery Plans and FMPs comprise the operational plan for the Market. Facility Master Planning cannot begin until the Market Health Services Delivery Plans are complete and approved by the VISN.
2. A FMP has two purposes: to guide capital investments and to limit capital investments. The VISN and market health services delivery plans are the basis for deciding what services should be delivered through facilities.
3. FMPs are not done for leased facilities. If the Health Services Delivery Plan calls for services to be delivered through leasing, it will also quantify those services.

11.2 Introduction: This work shall not begin until the Health Service Delivery Plan is complete and approved by the VISN.

1. The two levels of Facility Master Plans build on the Asset Assessment work done during the Health Service Delivery Planning phase, follow the same initial steps and have the same major components. Refer to the FMP Table below for a summary of the requirements for each level.
 - a. Level 1 FMP, Capital Space Management: This level is an expanded version of the Facility Capital Master Plans done internally by VHA Office of Capital Asset Management and Engineering Support and described in the VHA *Healthcare Engineering Guidebook*.
 - b. Level 2 FMP, Capital Development and Management: This level provides more of the information needed to develop requirements for significant projects.
2. In the earlier Asset Assessment step, the facility/VISN identified a Site Visit Lead (SVL) to work with the A/E Planning Team. This person will be the main point of contact for scheduling, verifying existing space and programs, and providing information.

11.3 Pre- Site Visit Call: (Approximately 2 to 3 weeks prior up to the scheduled site visit.) The A/E Team, including a Healthcare planner, will collaborate with the Site Visit Lead to:

1. Review the Health Service Delivery Plan Market Report (HSDP) with the facility. A VISN representative familiar with the approved HSDP will also be on the call. (A VHA OCAMES engineer/planner and a CFM Regional Planner will also participate to the degree that their schedules permit.)
 - a. Identify any planned new programs for the facility and review the workload, staffing and space implications for those new programs in advance of the site visit. Information on new programs must be available for the A/E Team and the facility planner prior to the site visit. If the Health Service Delivery Plan phase is not completed, it may be necessary to reschedule the site visit.

- b. Identify all existing and planned CBOCs for the Market the facility is in and review the reallocation of market level workload done during the Health Service Delivery Plan phase.
 - c. Discuss the summary of the Base Year workloads and the projected workloads for each Strategic Planning Category (SPC) for 10 and 20 years from the Base Year that are included in the HSCP.
 - d. Discuss the draft space projections for the facility that are also included in the HSDP. The space projections will be by Department in Department Gross Square Feet (DGSF) and/or Net Square Feet (NSF), and will be based on the reallocated workload projections for each department (SPC). The space projections will also include an estimate for the total facility space needs in gross square feet (GSF).
3. Review a facility a space comparison (space gap analysis) developed by the A/E team comparing the projected space needed for each department with the actual space existing for each department (as reported in the Capital Asset Inventory [CAI] data supplied to the A/E team).
4. Discuss a list of potential "areas of interest" that will be emphasized during the site visit. This will include a list of SPCs with significant (more than 10%) increases or decreases in projected workload, and departments with a projected space gap or a projected space surplus of greater than 2000 DGSF along with any other areas of interest that are identified during the initial review of the data for the Market and facility.
5. Identify program offices/departments at the facility with which the A/E wishes to conduct face to face interviews during the site visit. The A/E will coordinate with the facility planner/site visit lead the agenda as well as the logistics for the site visit including but not limited to scheduling meeting rooms, scheduling the physical walk through, scheduling face to face interviews with program offices at the facility, and scheduling the entrance and exit meetings with facility management.
6. Review the Asset Assessment that was also done during the HSDP phase. The FMP work shall build on the inspections, interviews and work done during the asset assessment. The A/E will verify that all necessary site visit documentation is available including the updated space drawings by building that show the department boundaries and the existing space (SF) assigned to each department on each floor.
7. The facility planner/site visit lead will be advised to share all of the above materials with appropriate content experts at the facility. Campus tour guides should be able to cover mechanical, civil, electrical, planning and architectural aspects of the facility. Approximately 1 week in advance of the scheduled site visit the A/E and the VISN representative will have a conference call with the SVL to coordinate and review the previously referenced data and any other issues that need to be addressed prior to the site visit. If information is not available or has not been provided, it may be necessary to reschedule the site visit until the required documentation necessary for a successful visit has been verified.

11.4 Before the Site Visit:

1. The A/E will review the materials and prepare some conceptual block planning ideas for the facility that are consistent with the Health Service Delivery Plan and the defined long range and FMP missions.
2. The A/E will also prepare materials to be used during the meetings.

11.5 During the first FMP Site Visit:

1. **General:** The site visit will typically consist of 5 days although other approaches may be used that yield equal results. Ideally the VISN representative will attend in person but they may participate remotely. Day 5 will have an exit briefing with facility management presenting the facility FMP work completed during the week.
2. **Entrance Meeting** – The A/E team will arrive at the facility on Day 1 and will conduct the entrance meeting with facility management to brief them on the agenda for the site visit and provide an overview of the Market HSDP and the process for the facility master planning effort that will take place over the next 5 days.
3. **The Physical walkthrough** – The remainder of Day 1 will be spent conducting a physical walk through of the facility to verify space information that was previously taken from the CAI during the HSDP Assessment phase and in preparation for the site visit. The facility will provide knowledgeable staff to accompany the A/E team in the walk through. The purpose of the walk through will be to verify the accuracy of the facility space information that was taken from the CAI for the Assessment and gap analysis as well as to familiarize themselves with the facility and to identify issues with departmental adjacency, fragmentation, patient flow, patient privacy and/or functionality. During the physical walk through, the team may have informal discussions with program staff in the occupied areas to gather information on the suitability, functionality, and efficiency of the space as it relates to performance of their program responsibilities. These informal discussions will not preclude subsequent face to face interviews with program offices that will take place later but may identify topics of interest for those interviews.
4. **The Face to Face interviews** – These interviews will be approximately 30-60 minutes in length for each program/department that is scheduled for an interview. Length of interview is determined by medical center based on size and complexity of the services. To maximize time some services may be combined for an interview session. If travel schedules and timing permit, face to face interviews may begin on Day 1. Day 2 and morning of day 3 will be dedicated to conducting face to face interviews with selected program offices that were previously identified and scheduled. The facility planner will attend these meetings along with the VISN planner if possible. The A/E will review the HSDP workload projections and space needs with the program office as well as gather input from the program office with regard to adequacy and capacity of the space, existence or non-existence of appropriate adjacency with other departments and functionality of the existing space. This input from the program offices will be compared with the A/E's assessment of the space that was noted during the Asset Assessment or walk through the previous days and will then be taken into consideration during the facility master plan development. In the early afternoon of day 3 a meeting will be held with medical center management to go over any issues that came up during the program office meetings that need to be discussed prior to facility master plan development.

- a. The eventual success of the facility master plans produced hinges on the acceptance of the plans by the individual department heads as well as medical center administrative and clinical leadership. It is ideal if the consultant Health Planners and architect/engineers conduct the departmental meetings and tours.
 - b. The more information that the consultant planning team can garner from direct communication with the clinical department heads and staff will help improve the planning process in at least two ways. First, the planning team will be more aware of all the local issues impacting on the delivery of care. Secondly, the more involved the clinical staff is within the master planning process the more likely that the plan will address their needs more completely and more likely that the clinical staff are to support its conclusions and plans long term.
5. Development of the Master Plan –The afternoon of Day 3 (and into the evening) will be an intensive working session led by the A/E that includes facility planners and engineering staff to start developing the Facility Master Plan. This day should be scheduled in advance so that facility planning staff, and if possible VISN planning staff, along with engineering staff can set aside the time to participate in developing a schematic block diagram of the facility as it will need to be to meet the projected demand for the projection year. This will include consideration of appropriate sized spaces to meet the projected workload, consideration of appropriate adjacencies with other departments, consideration of the condition and adequacy of the space to meet the future demand and consideration of the functionality of the space for future intended purposes. The Master plan will also consider both phasing and scheduling of the initiatives needed to meet the demand as well as all successor/predecessor relationships that must exist to make the plan feasible. The A/E will encourage the medical center engineering staff to assist in creating block drawings using AutoCAD for the closeout presentation. Day 4 will be used to develop capital initiatives and timelines to implement the plan, to identify key engineering infrastructure actions needed, to develop an approach to the “Freeze Footprint” policy, and to create deliverables for the exit briefing.
 - a. Seeing the Twin Focus, Patient and Staff: The execution of the FMP will stress a customer centered focus on two levels. First, the needs of the Veteran patient must be paramount and given highest priority. However, the other key customer in this process is the Clinical/administrative department chief and his staff. This team is the other customer that in the end must “buy” the plan or else the #1 customer, the patient, will never see the improvements in the care environment and setting. The plans will never see the light of day if not supported by the staff. So, communication with the staff is a key and bringing the staff along with the vision is crucial.
6. Exit Briefing – The A/E will conduct an exit meeting with the facility management to summarize the overall vision and key points of the master plan and present the master plan schedule to them for their review.

11.6 After first FMP visit:

1. Capital Space Plan draft: The A/E will prepare a draft proposed Level 1 plan (see Table item 6) and submit it within two weeks for review and comments.

- a. Second Scenario: The Department's capital investment process does not permit multiple project submissions to address the same problem. Because of budget limitations, approval and funding of Major Construction Projects has historically been much more difficult than the approval and funding of projects in the NRM, Minor Construction and leasing programs.
 - i. In order for planners and leadership to better understand the capital challenges VA faces, the FMPs shall include a second scenario for those facilities where a Major Construction Project is not a part of the first scenario even though it might very well be the most logical and cost-effective way of solving the problems at that campus.
 - ii. Inclusion of a second scenario is anticipated to be typical in a Level 2 FMP, but should also be included in a Level 1 FMP if it would be a better long term solution for services delivery.
- b. For the first Scenario, the grouping of capital actions into projects shall be done in a way that maximizes the scoring potential of projects that are critically important. The project sequencing (see 6.k. in the Table below) shall be developed at the same time as the projects.
- c. Historic Preservation Issues: The majority of VA facilities are known to include structures meeting the criteria for listing in the National Register of Historic Places. Federal laws and regulations (including the National Historic Preservation Act of 1966) require VA to be responsible stewards of the nation's historic properties by 1) fully considering, during planning, how mission activities may impact historic properties and 2) making productive use of historic properties. As part of the FMP process, historic properties, including archeological sites, need to be identified and initial infrastructure analysis must include alternatives for using or reusing existing historic buildings to meet VA's mission. The analysis should identify relative appropriateness of various reuse options from a preservation standard and compare adaptive use feasibility with future program space requirements. If the historic buildings cannot accommodate any current or projected VA need, a rationale needs to be provided and external tenants and uses need to be explored. While demolition of historic properties is not prohibited by law, it can only be considered after all other options have been exhausted.
- d. Environmental Issues: As a federal agency, VA must comply with the requirements of the National Environmental Policy Act (NEPA). This requires that VA consider all reasonable alternatives and impacts both during project development, as well as long-term operation. Projects may not meet criteria for Categorical Exclusion (CATEX) and require more detailed evaluation, such as Environmental Assessments (EAs) or Environmental Impact Statements (EISs). Although some impacts cannot be evaluated properly until the schematic design phase, early evaluation of alternatives and the development of realistic customer expectations are key tasks. At minimum the application packages must include a description of the anticipated NEPA compliance strategy. Please refer to the FMP table and the following link for further information <http://www.cfm.va.gov/til/spclRqmts.asp> .
- e. NCA notification of any Excess VHA land: As a part of the process, consult with NCA if any excess VHA land is identified. Include the results of the NCA discussions in the FMP.

2. The A/E will host a call to discuss comments received from the facility and VISN regarding the proposed capital space plan after the medical center has had an opportunity to review it in detail. Following review and discussion of comments/feedback, the A/E will provide additional data and /or make final adjustments to the Capital Space Plan as required to accommodate the issues that are identified by the medical center.
3. For the Level 2, Capital Development Plan facilities only:
 - a. The A/E will identify the departments included in significant planned projects and develop an agenda for a 2nd FMP site visit.
 - b. The A/E will facilitate a call with the facility and VISN to review the work to be done and to schedule a 2nd site visit to further develop the planned projects.
 - c. The 2nd site visit will follow a similar schedule as the first with an entrance briefing, department meetings, additional walk-throughs as required, and an exit briefing. It will also include additional engineering system inspection and analysis.
 - d. The A/E will develop options for each project and document the best apparent project solutions.
 - e. For Level 2 FMPs, after the initial reuse analysis, consult with the appropriate State Historic Preservation Office (and other external stakeholders, as appropriate) regarding potential FMP impacts to historic properties. The results of this discussion will then inform refinement of infrastructure alternatives in the final FMP.
 - f. Capital Development Plan draft: After the visit the A/E will prepare a draft proposed Level 2 plan (see Table item 6) and submit it within two weeks for review and comments.
 - g. The A/E will host a call to discuss comments received from the facility and VISN regarding the proposed Capital Development Plan after the medical center has had an opportunity to review it in detail. Following review and discussion of comments/feedback, the A/E will provide additional data and /or make final adjustments to the plan as required to accommodate the issues that are identified by the medical center.

11.7 Components - The content of the FMPs that will be developed and submitted are summarized in the FMP Table.

FMP TABLE			
	Facility Master Plan Components	Level 1, Capital Space Management	Level 2, Capital Development & Management
C	Cover	Facility Name & Number, Market, VISN, City & State, location on VISN map, photo of existing main building, NCA and or VBA colocation if applicable	Same plus 3D view of significant change(s)
1	Executive Summary (one page maximum)	Facility's role in Market, key actions needed, key issues, key projects	Same

FMP TABLE			
	Facility Master Plan Components	Level 1, Capital Space Management	Level 2, Capital Development & Management
2	Market	Market map showing all VA assets and points of care	Same
3	Plan Basis	Base Year of planning data, HCDP date, methodology summary, planning team (firms and key people)	Same
4	Facility Overview	Brief history, significant buildings, events and/or people	Same
5	Asset Assessment	Summary table from Service Delivery Plan phase	Same
5a	Existing Site	Existing Site Plan showing department locations	Same plus Site analysis showing constructed features, site restraints (easements, height restrictions etc.), circulation, physical security overlay, major utility routing and capacities, environmental issues, historic assets, proximity to flight paths, elevations & contours, flood zones, etc.
5b	Existing Space	Existing Space & Functional Diagrams with problem areas identified	Same plus capacity analysis of major HVAC, plumbing and electrical building systems.
6	Proposed	Brief narrative	Same plus options considered for future Business Case use
6a	Site	Site Plan showing department locations and any excess property	Same plus campus zoning site plans showing areas of planned development, areas reserved for future needs, parking areas, easements, infrastructure development, & major site utilities. 3D site drawings.
6b	Buildings	Space & Functional blocking plan diagrams	Same plus BIM conceptual blocking plans & stacking diagrams defining specific significant projects. 3D drawings

FMP TABLE			
	Facility Master Plan Components	Level 1, Capital Space Management	Level 2, Capital Development & Management
6c	Space gap	Space gap analysis with projected space less existing space per the facility's Capital Asset Inventory with explanation of limitations of analysis	Same plus parking gap analysis
6d	Space	Spreadsheet showing Departmental Space Calculator projection distribution by building	Same plus additional room-level space programs for certain departments as necessary to define significant projects
6e	Condition & function	Summary of how FCA deficiencies and functional gaps will be resolved	Same
6f	Environmental	A brief general description of the anticipated NEPA compliance strategy with a reference to VA NEPA Guidance.	Same plus Identification of potential Proposed Actions likely to be significant that are <u>not</u> described in Categorical Exclusion (CATEX) in VA NEPA regulations
6g	Historic	Documentation of reuse analysis of properties meeting the criteria for listing in the National Register of Historic Places	Same plus documentation of consultation with State Historic Core Preservation Office (and other external stakeholders, as appropriate) regarding potential impacts to historic properties
6h	Physical Security	Brief narrative indicating if a Physical Security Assessment has been completed, the date of the assessment and who did the analysis. (No sensitive findings are to be included in the FMP.)	Same plus recommendations on the Level that should be applied to campus and each building. Recommendations for achieving results when literal compliance would be impractical
6i	Engineering Infrastructure and Energy	Summary of proposed actions based on first site visit inspections and discussions.	Summary of proposed actions based on first and second site visit inspections, discussions, and analysis.

FMP TABLE			
	Facility Master Plan Components	Level 1, Capital Space Management	Level 2, Capital Development & Management
6j	Costs	Project listing with estimated costs by VA category for use by the facility in preparing projects for the Annual Planning Cycle.	Same plus recommendations on building types and systems for new construction, including whether VA Building System is recommended
6k	Phasing	Identification of critical project sequencing	Same plus MS Project file showing sequencing of significant actions
7	Meetings and Interviews	Meeting summaries with participants and highlights	Same
8	Plan Comparison	Spreadsheet comparing department areas and project costs of this plan to the existing and the last SCIP plan submitted. Second scenario with cost comparison if applicable.	Same

Chapter 12: Prioritizing VISN Actions and Final Reports (Step 10)

12.1 Primary Care Service Area Priorities

As an aid to VISN decision making about proposed actions within each market, a variety of factors shall be weighed to prioritize the value of each Primary Care Service Area within the market and within the VISN. The working assumption being that actions proposed in higher priority PCSAs should be considered for implementation before actions found within lower ranked PCSAs. The factors used in priority scoring within the VISN 17 North Market study are described below.

12.2 Priority Factors:

1. PCSA Population – 2025 Enrollee Population ranked from highest to lowest
2. Service Area Space Gap – Needed Space versus Existing Space ranked highest to lowest
3. Transitional Care Services Present – Planned presence of CLC or Dom beds scoring six point where planned and zero points where not planned
4. Remoteness of Present Enrollees – Distance of present population to primary care assets measured in minutes ranked from highest to lowest
5. Number of Unique Chronic Care Patients – Number of patients ranked from highest to lowest (data not available at the time of this study)
6. PSA penetration and income levels- Consider market penetration rates in light of the socio-economic status of the veterans in the primary care service area. Low penetration may imply low access or low reliance due to wealth and less need for VHA services.

Considerations for future scoring criteria

Future studies could consider Socio-Economic and other factors suggested by VISN leadership to refine the prioritization methodology displayed on the next page.

12.3 Example of Prioritization

Existing sites have been identified in bold text.

Vol 2 - Service Delivery Plan_Final.pdf - Adobe Reader

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Comment

Primary Care Service Area Priority Table

Rank	Total Score	Existing & Proposed Primary Service Areas	Projected Enrollees		Space Gap		Transitional Care		Distance to PC		Chronic Care	
			2025 Enrollees	Score	BGSF	Score	Y/N	Score	Minutes	Score	# of Patients	Score
North												
1	73	McKinney	10,357	18	177,763	21	Y	12	44	22		
2	71	Mesquite	19,370	23	541,631	23	Y	12	23	13		
3	67	North Richland Hills	16,191	21	474,603	22	Y	12	21	12		
4	52	Farmers Branch	14,367	20	85,064	18		0	24	14		
6	45	Lake Worth	9,555	16	49,363	14		0	25	15		
6	45	Grand Prairie	10,306	17	70,003	17		0	20	11		
8	43	Dallas Urban	4,948	9	45,041	13	Y	12	11	9		
8	43	Fort Worth OPC	18,344	22	120,581	20		0	-	1		
5	46	Fort Worth Urban	4,843	8	53,431	16	Y	12	13	10		
10	39	Polk Clinic	13,946	19	96,338	19		0	-	1		
11	38	Waxahachie	6,436	12	31,090	9		0	26	17		
11	38	Cleburne	6,288	11	33,456	10		0	26	17		
13	30	Tyler VA PC Clinic	7,935	14	50,603	15		0	-	1		
14	28	Denton CBOC	9,321	15	44,630	12		0	-	1		
14	28	Kaufman	4,261	6	-	2		0	33	20		
14	28	Athens	3,381	5	-	2		0	43	21		
17	26	Mount Pleasant	1,310	1	-	2		0	51	23		
18	25	Sherman Clinic	6,574	13	33,887	11		0	-	1		
19	24	Weatherford	4,364	7	-	2		0	25	15		
20	23	Gainesville	1,895	2	-	2		0	32	19		
21	13	Sandknop Family Practice	5,692	10	-	2		0	-	1		
22	7	Northeast Texas PC	3,013	4	-	2		0	-	1		

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12.4 FINAL ADMINISTRATION REPORTS

1. The Contractor shall prepare Administration specific summary reports for VISN, NCA and VBA. These narrative documents shall explain the overall plan to achieve service delivery models that are better aligned with Veteran needs, how gaps will be reduced, the importance of any significant investments, the approach to the “Frozen Footprint” policy, recommended guidelines, recommended recapitalization/sustainment rates, and assumptions used in planning.
2. These reports should be concise and tailored to meet the needs of the VISN, NCA and VBA, linking Market Plans to Administration strategies and goals.
 - (a) The VISN summary shall be organized the same way as the Market Health Service Delivery Plans and shall link actions proposed with the VHA Strategic Objectives explaining the Market Level Service Delivery Plan highlights and overall direction in each Market and for all significant owned facilities. The final IP summary shall include a table with prioritized cost summaries of the Capital Actions by VA funding program from the FMPs. A cost comparison of the two Scenarios shall be included allowing for the full cost to align VHA infrastructure with optimum service delivery plans to be calculated and compared to the first scenario and the status quo costs—which are represented by the current SCIP action plans.
 - (b) The NCA and VBA plan reports shall include an Executive Summary and a cost comparison of the proposed course of action with the latest SCIP submission, and shall include site plans and project listing addressing any specific FMP tasks required above.

Appendix A Stakeholder Registry



VISN ISFP
Stakeholder Organiz:

Appendix B Guiding (Ideal) Service Distribution Principles for VISNs 11 & 17



VISN 11_Ideal
Principles_140322.pd



VISN 11_Ideal
Principles-Exec Summ



Handout #1 Leap to
Ideal - 111128.pdf

Appendix C Key Data Files: Briefing Book and Crosswalk

VISN Planners/IP Planning Coordinators are expected coordinate the development of the data required for this study as outlined in Chapter 1.9. VISN Planners are expected to pull this data from VA and VHA data sources and make it available to the consultant health planners once the contract is awarded. A Proclarity Briefing Book has been prepared to assist the VISN Planner in pulling the required most of the data elements. The Crosswalk provides sources of data elements for this study. Technical questions on using the Briefing Book or crosswalk should be addressed to Lori McClure (Program Analyst | Strategic Analysis Service | 10P1C | Office of the ADUSH for Policy & Planning | Phone: 757.741.2050).

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Master Planning Data Briefing Book Final.bbk



Adobe Acrobat
Document

VISN Master Planning Key Data Files Crosswalk Final

Appendix D Asset Assessment Matrix/Rating Tool Template/Definitions



VAFM Asset
Assessment VISN XX



Asset Assessment
Building Definitions Su

Appendix E Facility Mission/Strategy Template



Facility Mission
Strategy Template.xls

Appendix F Communication Plan Template



VISN XX VAFM
Integrated Planning C

Appendix G Continuum of Care Breakdown

General Outpatient Care

- Comp and Pen
- Primary Care
- Women's Health (PC)
- Dental
- Optometry

Mental Health

- Outpatient
- Outpatient Specialty Care
- Psychosocial Rehabilitation and Recovery Center (PRRC)
- Compensated Work Therapy
- Residential Rehabilitation and Treatment Programs (RRTP)
- Acute Mental Health

Medicine Specialty Care

- Outpatient Medicine Specialty Care
- Emergency Care
- Procedural Medicine
- Inpatient Medicine

Surgical Specialty Care

- Outpatient Surgical Specialty Care
- Operating Room
- Surgical Inpatient Care

Extended Care and Rehabilitation

- Physical Medicine and Rehabilitation
- Polytrauma
- Spinal Cord Injury
- Visual Impairment
- Prosthetics
- Extended Care

Diagnostics and Treatment

- Laboratory
- Pharmacy

Primary Care
10.0 PC Provider
1.1 Women's Provider
2.0 Dietician
2.0 MOVE Dietician
Eligibility & Outreach
4.0 C & P Provider
2.0 OEF/OIF/OND Case Mgr
Dental
4.0 Dentist
Eye Care
4.0 Optometrist

OP Mental Health
2.2 MH Psychiatrist
33.5 MH Counselor
6.0 Work Therapy Counselor
Acute Care - MH
29.0 MH Beds
Residential Treatment
42.0 Residential Trtmt Beds

OP Med Specialties
3.0 Cardiologist
1.5 Gastroenterologist
0.5 Hepatologist
1.0 Neurologist
0.2 Infectious Diseases
1.0 Nephrologist
2.0 Pulmonologist
4.0 Sleep Medicine Rm
Acute Care - Medicine

Physical Med & Rehab
2.0 Physiatrist
5.0 Physical Therapist
6.0 Kinesiologist
3.0 Occupational Therapist
1.3 Polytrauma/TBI Therapist
0.5 SCI Therapist
1.0 Chiropractor
7.0 Rec Therapist
Visual Impairment
0.5 VIST Coordinator
Prosthetics Service
0.0 Amputee Clinic Tech
3.0 Orthotics Lab Tech
3.0 Prosthetics Agent
Extended Care
8.5 HBPC FTE
0.0 SW/CM/Home Care
Community Living Ctr
125.0 Short & Long Term Beds
Palliative Care
15.0 In-House Hospice Beds

Laboratory & Pathology
0.0 Specimen Collection
31.0 Clinical Pathology
2.0 Anatomical Pathology
Pharmacy
6.4 IP Pharmacist
4.4 OP Pharmacist
3.5 Med Mgmt Provider
Audiology & Speech

0.3 Dietician
0.5 MOVE Dietician
Eligibility & Outreach
OEF/OIF/OND Case Mgr

OP Mental Health
3.2 MH Counselor (PCMHI)
Acute Care - MH
15.0 MH Beds
Residential Treatment
40.0 RRTP Beds

OP Med Specialties
3.6 Dialysis Station
Emergency Dept.
Emergency Care

OP Surgical Specialties
Podiatrist
ORs (Surgical Services)
IP Surgery

Physical Med & Rehab
1.0 Physical Therapist
Extended Care
OP Geriatric Provider
1.7 Home Based PC FTE
Home Health Aide
Community Living Ctr
4.4 CNH - Long & Short Stay Beds
40.0 Long Term Beds
Palliative Care

23.0	Medical Beds	3.0	Audiologist	0.4	Home-Based Hospice Caregiver
Emergency Dept		1.8	Speech Pathologist		
4.0	Urgent Care Exam Rms	Imaging (Radiology)		Laboratory & Pathology	
Special Procedures		2.0	General X-Ray Rooms	Specimen Collection	
2.0	Endoscopy Rm	2.0	Rad/Fluoro Rooms	Pharmacy	
1.0	Cysto Suite	1.0	Ultrasound Rooms	Emergency Scripts	
		1.0	Bone Density Rooms	1.2 Clinical Pharmacist	
OP Surgical Specialties		1.0	CAT Rooms	Audiology & Speech	
1.8	Urologist	1.0	MRI Rooms	Tele-Audiology	
0.8	Ophthalmologist	Nuclear Medicine		Imaging (Radiology)	
1.7	Orthopedist	2.0	Nuclear Medicine Suites	0.6 General X-Ray Rooms	
2.0	Podiatrist				
2.0	General Surgeon				
0.2	Gynecologist				
1.0	Pain Clinic Provider				
ORs (Surgical Services)					
4.0	Outpatient ORs				