Market Area Health System Optimization (MASHO) /Veteran Facility Transformation & Healthcare Enhancement (VFTHE) Blanket Purchase Agreement (BPA) Call Order 1

A. Scope

This Call Order provides the Department of Veterans Affairs (VA) with support in the completion of the VA MISSION Act requirements related to the ongoing market assessments, activities, and special studies as detailed in Task Areas 1 – 7 in the Blanket Purchase Agreement (BPA).

B. Period of Performance

The period of performance for this call order is 12 months from the date of award. Unless otherwise specified, the Contractor will have 12 months to complete each major deliverable; however, except for the continuous support deliverables such as those in task areas 6 and 7, the Contractor can execute deliverables short of 12 months and can initiate deliverables as appropriate in coordination with VA.

C. Project Description

VA has a clear need and an obligation to modernize VA facilities to provide Veterans the best possible health care outcomes and provide our VA workforce the safest and most efficient means and environment possible to deliver care. Veterans in the 21st century should not be forced to receive care in early 20th century buildings. The median age of VA's hospitals is nearly 60 years old. This is why the President requested nearly $20 billion in new VA infrastructure spending last year, and why he requested the largest ever investment in VA infrastructure in his fiscal year 2023 budget.

To identify and prioritize health care infrastructure investments that will improve Veteran access to quality VA health care, VA will execute a new collaborative approach for conducting market assessments to increase access and improve outcomes for all Veterans. The new field-driven and transparent approach to market assessments will reflect the valuable stakeholder feedback that has been received and the lessons learned. (A comprehensive Lessons Learned package will be shared as a standalone document upon award, not in advance. They are still being compiled. It will also include using new, better, and up-to-date data; deep collaboration with our networks and medical centers across the country; and early and robust engagement with stakeholders. Stakeholders include Veterans, employees, unions, Veterans Integrated Service Network (VISN) leaders, Congress, Veterans Service Organizations, and leaders in the community.

VA will create a strategy focused on building VA health system infrastructure to support Veterans with the right facilities, in the right places, to provide the right care in every part of the country.

Effective planning for Veteran care will be enhanced by Contractor support and facilitation in the several key task areas outlined below. This initial Call Order will intersect with most of these task areas:

1) Market Area Health System Optimization (MAHSO) Market Area Assessments: Conducting comprehensive market assessments that allow VA to determine how and where to best meet the needs of Veterans through VA-owned/leased infrastructure, innovative care delivery approaches (including virtual care), and partnerships with academic, Department of Defense (DoD), other federal, and community providers. This will likely include:

Development of enterprise-wide strategic analysis to assess and evaluate the current and the future state of all 95 Veteran Health Administration (VHA) Market Areas to advance strategic planning.

Delivering evidence-based advanced data analytics, VA and commercial healthcare planning expertise, and training. Support may also include supporting engagement with potential partners to identify opportunities and assess their feasibility including emerging healthcare technology and delivery processes.

Additional domains of analysis including visioning, rural healthcare, education and research, health and wellness aspirations, health equity, population migration, pandemic and Promise to Address Comprehensive Toxics (PACT) Act implications, enrollee reliance, population density distribution, population health, telehealth, and cost accounting.

2) Data Management: Data management solutions that drive effective health care planning and align with VA Data Governance requirements.

Data Repositories Maintenance and Development – Over the last four years during the first round of assessments, tools have been developed to manage and automate data related to VA facilities, health care planning, and market assessment recommendations. Further support is required for the maintenance and upgrade of these data repositories and analytics tools. Database management is essential to maintain and improve the data used across the market assessments.

Data Discovery & Findings – Providing the VA with the comprehensive market analysis data set(s) derived from authoritative or validated data sources that include data domains pertaining to People (Workforce and Veterans), Practice (Skills and Specialties) and Place (Infrastructure and Facilities) to assess market areas at a minimum by Access, Quality, and Cost standards and to clearly evaluate demand, aggregated by geography, internal and external health care capacity by market, and productivity.

3) Supporting Data Management Applications: Systems and Tools leveraging data management to best enable healthcare planning, facility planning, capital

investment planning, facility life cycle management planning, market assessments, and national strategy.

Health Systems Planning Application (Sustainment and Evolution) – Provide the expertise to integrate all data used in the market area assessment with the VHA internal facility planning to enable local planners to Assess their local Veteran population, including eligible and enrolled Veterans, as well as trends impacting Veterans associated health care, identifying projected imbalances in health care capacity, and visualizing market supply and demand.

Cost Range Model – Provide the financial expertise to develop and enhance VA tools which clearly compares the cost of care in the VA Direct Care System by Service to the cost of care for comparable Services in the Community and estimates criteria-based modernization requirements for every Veteran Administration Medical Center (VAMC) installation and includes a resource allocation element to project and distribute workload.

Conversion of Enrollee Health Care Projection Model (EHCPM) Workload for Use in VA applications – Support to convert the latest (EHCPM) workload into space conversion factors based on changes in care delivery models and the shift to outpatient Health System Planning Categories (HSPCs) from Strategic Planning Categories (SPCATs).

Interactive Mapping Tools – Provide Geospatial expertise to supplement and integrate all Geospatial Data and Analytics used in the Market Area Assessments with the VHA Geospatial Information System (GIS) Planning Portal, a geographic database of capacity, healthcare locations (internal and external) and analytical tools to enable effective distribution of capacity where it is most needed.

4) Implementation Planning: Helping VA convert high-level strategies into executable, acquisition-ready capital projects (ready for design or design-build award). As needed, this may include support for VA in executing strategic partnerships to facilitate expansion of Veteran access to care. It will include prototype facility master plans for complex VAMC campuses in dire need of modernizations and/or possible decanting of functions off campus.

5) Strategic Prioritization: A process to update approaches for prioritization based on changes in Veteran need and VA/VHA strategic direction. The process would incorporate extensive input from VISN and VAMC leaders regarding the needs of local markets and would align with VA enterprise strategies and priorities, including clinical priorities.

6) Stakeholder Management and Strategic Communications: Facilitating a Stakeholder Engagement plan through VISN and local leadership to appropriately engage with a broad range of stakeholders.

7) Program Management and Executive Support: Program management oversight, meeting management support to relevant governance bodies, communications support, legislative support, and support for the development of briefings for executive leadership.

D. Type of Call Order

This is a Firm-Fixed Price Call Order.

E. Place of Performance

The majority of work for this Call Order will take place at the Contractor's facilities or remotely. Some travel will be required within the Continental United States (CONUS). Some travel may as well be required for area outside of the Continental United States (OCONUS). See section I below regarding travel.

F. Federal Holidays

Services performed are during VA core business hours, except for the following federal holidays set by law (USC Title 5 Section 6103). Any work at the Government site shall not take place on Federal holidays or weekends unless directed by the Contracting Officer (CO). The Contractor shall observe the following 11 Federal holidays set by law (USC Title 5 Section 6103).

Under current definitions, five holidays are set by date:

New Year's Day	January 1
Independence Day	July 4
Juneteenth	June 19
Veterans Day	November 11
Christmas Day	December 25

If any of the above falls on a Saturday, then Friday shall be observed as a holiday. Similarly, if one falls on a Sunday, then Monday shall be observed as a holiday.

The other six holidays are set by a day of the week and month:

Martin Luther King's Birthday	Third Monday in January
Washington's Birthday	Third Monday in February
Memorial Day	Last Monday in May
Labor Day	First Monday in September
Columbus Day	Second Monday in October

Thanksgiving	Fourth Thursday in November

G. Call Order Award Kick-Off Meeting

The Contractor shall not commence performance on the tasks in this SOW until the CO has conducted a kick-off meeting or has advised the Contractor that a kick-off meeting is waived. It is anticipated that the kick-off meeting will be held virtually within 7 calendar days from the date of award.

H. Government Furnished Property / Equipment

The Contractor shall provide all supplies, equipment, personnel, and other resources necessary to complete the work within the SOW.

I. Travel

The Contractor will be required to travel in order to complete portions of the work in this Call Order. Travel must be approved in advance and in writing by the Contracting Officer (CO) and the Contracting Officer's Representative (COR) / Alternate Contracting Officer's Representative (ACOR). Travel and will be reimbursed in accordance with Federal Travel Regulations. Please refer to FAR 31.205-46, Travel Costs. The Contractor will consult their Company, the CO, COR and/or ACOR to determine if travel requests are authorized. The contractor shall submit the request form to the COR/ ACOR a minimum of two weeks prior to departure. Travel arrangements shall not be made prior to receipt of the approved contractor travel request.

J. Key Personnel

All Key Personnel identified in the BPA Statement of Work (SOW) are Key Personnel for this call order. Please refer to section 17 of the BPA SOW for the labor categories and minimum experience and education requirements.

The Contractor shall ensure all identified personnel utilized to complete the work in this PWS are identified within the Staffing Plan. All Contractor requests for approval of personnel substitutions hereunder will be submitted in writing to the COR, or Authorized Designee, and the CO at least 30 calendar days in advance of the effective date, whenever possible, and will provide a detailed explanation of the circumstances necessitating the proposed key personnel substitute, and any other information requested by the CO necessary to verify the acceptability of the proposed substitution. New personnel will not commence work until all necessary security requirements have been fulfilled and resumes provided and accepted.

K. Security Requirements

The requirements regarding security as stated in section 17 of the BPA SOW are applicable to this Call Order.

L. Performance Standards

Performance Standards define required performance levels for specific tasks. The Government will review all services and deliverables tendered for acceptance to determine compliance with applicable performance standards. All deliverables must satisfy the requirements set forth in this SOW. If the Government determines that the Contractor has failed to meet applicable performance standards, such a determination may result in appropriate exercise of the Government's rights under FAR 52.212-4(a) with regard to nonconforming services/deliverables and commensurate past performance evaluations. The Government may also issue a Contractor Discrepancy Report (CDR) in such circumstances. When approved by the CO, the COR shall prepare a CDR and present it to the contractor's program manager. See Attachment E, Contract Discrepancy Report. The contractor shall acknowledge receipt of the CDR in writing to the CO. The CDR will state how long after receipt the contractor must take corrective action. The CDR will also specify if the contractor is required to prepare a corrective action plan to document how the contractor shall correct the unacceptable performance and avoid a recurrence. The CO shall review the contractor's corrective action plan to determine acceptability.

Any CDRs may become a part of the supporting documentation for any contractual action deemed necessary by the CO.

The general performance standards and quality levels below apply to all services and deliverables tendered for acceptance under this call order.

- Accuracy - Deliverables will be accurate in presentation, technical content, and adherence to accepted elements of style. Written documents will be in formats as specified above and shall be 99% free of grammar and spelling errors.
- Appearance - All deliverables will be neat and attractive, reflecting the role that the VA fulfills and the level at which work products will be used.
- Clarity - Deliverables will be clear and concise. Any/all diagrams shall be easy to understand and be relevant to the supporting narrative.
- Consistency to Requirements - All deliverables must satisfy the requirements of this PWS.
- File Editing - All text and diagrammatic files will be editable by the Government.
- Format - Deliverables will be submitted in media mutually agreed upon prior to submission.
- Timeliness - Deliverables will be submitted on or before the due date specified in this statement of work or submitted in accordance with a later scheduled date determined by the Government.

Any required revisions to the deliverables will be resolved in a timely manner as directed by the CO (or the applicable COR, if delegated such authority by the CO).

M. Deliverable Nomenclature
First Digit (Number) = Call Order Sequence
Second Digit (Number) = Task Order Sequence
Third Digit (Upper Case Letter) = Major Deliverable Sequence
Fourth Digit (Number) = Subordinate Deliverable Sequence
Fifth Digit (Lower Case Letter) = Sub Subordinate Deliverable Sequence
Example: 1.1.A.1.a

N. Deliverables
1.0 Overarching Reporting Requirement

For the 19 deliverables below (1.1.A through 1.7.D), the Contractor shall provide:

A. A contractor project management plan (CPMP)
B. Monthly progress reports and revisions as appropriate to the CPMP
C. Weekly highlights of key developments including research findings

Wherever the contractor is asked to “document” something, this shall mean in written or graphic printable media.

1.1 MAHSO Market Area Assessments

1.1.A: Development of Enterprise-wide Strategic Analysis

Deliverables:

1.1.A.1: Develop and document a Strategic Analysis Plan informed by the field, and aligned to the VA Strategic Plan, VA Data Strategy, VA Spatial Data Strategy, and VHA Long Range Plan that is submitted to and approved by VA Governance and provides the guidance, process, procedures, techniques, key actions, desired outcomes, measures, milestones, targets/threshold for enterprise-wide strategic analysis to be used for market area assessments focused on People (Veterans & Workforce), Practice (Skills & Services) and Place (Facilities & Infrastructure).

1.1.A.2: Define key policies and how policy analysis will be used for Market Area Assessments that is submitted to and approved by VA Governance.

1.1.A.3: Define and document the approach to assess and evaluate all Market Areas on a rolling basis and key milestones required to activate an evolved market assessment methodology and publish each market area assessment as they are completed. Include how these market area assessments will be incorporated into the VA Governance decision making and budget formulation process.

1.1.A.4: Develop key analytical questions for VA Governance approval that provide the basis for the assessment of Access, Quality, and Cost; Demand by Geography; Inventory of Capacity by VA Direct Care (DC), VA Community Care (CC), Whole of Government (WOG) Federal Health Facilities; Non-Contracted Community Care (NCC), and Academic Affiliates (AA); Capacity by Providers/Categories of Services; Effects of Capacity on Access/Quality Standards; Appointments DC/CC; Risk Assessments; Performance/Efficiency; Readiness/Training/Learning; and Partnerships.

1.1.A.5: Define and document required Data Sets/Sources/Parameters and provide an assessment of the Data Quality used for the strategic analysis and build a report that can be repeated and replicated for the purposes of assessing data quality.

1.1.A.6: Define and document evidence-based advanced data analytics and Analytic Models to be used for the strategic analysis to include the evidence-based Standards/Metrics/ Measures/Thresholds (Benchmarks) by health service categories. This includes quantitative and qualitative analytic models, such as logic, causal, and conceptual modeling that assess how a program or process is supposed to work by exploring how outcomes are associated with the process and how it is assumed to work; that identify cause and effect of Veteran centric relationships; that show how one aspect of healthcare influences other different aspects by describing how different parts of a problem interact with each other.

1.1.A.7: Define and document the domains to be used for the strategic analysis and assessments to include access, quality and cost analysis of all healthcare provided by the VA and VA Community Care; by provider; services; facility; VAMC; Market; VISN; rural healthcare; education and research; health and wellness; health equity; home health; healthcare policy; VA’s fourth mission on preparedness; population health; telehealth; Policy (current and emerging like PACT Act), etc.

1.1.A.8: Define and document data analytic techniques to be used for strategic analysis and assessment of the market areas such as regression analysis, Monte Carlo simulation, factor analysis, cohort analysis, cluster analysis, time series analysis, sentiment analysis, discrete-event simulation, social network analysis, agent-based simulation, epidemiological analysis, population health analysis, etc.

1.1.A.9: Define and document the multivariate analytical approach to assess and evaluate all 95 Market Areas using standardized methodologies and techniques that can be repeated and replicated, and that provide an objective, numerical rating of all 95 Market Areas that provides a conclusive deterministic assessment and evaluation of each market area ranging from a high performing integrated network to a moderate performing integrated network, to a low performing integrated network.

1.1.A.10: Define and document the criteria used for the multivariate analytical approach.

1.1.A.11: Define and document the approach to incorporate sensitivity analysis to ensure there is a consensus enterprise-wide on the multivariate analytic approach to assess and evaluate each market.

1.1.A.12: Define and document screening criteria and evaluation criteria used to evaluate all opportunities and recommendations that evolve from the market area assessment.

1.1. A.13: Define distinct scenarios and assumptions to be used to assess and evaluate the future state of each market area to include the opportunities that are developed to mitigate the assessment and evaluation of the current state of each market.

1.1. A.14: Provide training to better enable the VA planning community to engage in evidence-based data analytics.

1.1.B.15: Delivering Evidence-based Advanced Data Analytics, VA and Commercial Healthcare Planning Expertise, and Training

Deliverables:

1.1.B.1: Define and deliver evidence-based advanced data analytics that can be validated by the Government Accountability Office (GAO) and Office of Inspector General (OIG) and is repeatable.

1.1.B.2: Define and document quantitative and qualitative analytic models, such as logic, causal, and conceptual modeling that assess how a program or process is supposed to work by exploring how outcomes are associated with the process and how it is assumed to work; that identify cause and effect of Veteran centric relationships; that show how one aspect of healthcare influences other different aspects by describing how different parts of a problem interact with each other.

1.1.B.3: Implement the documented approach to assess and evaluate all Market Areas on a rolling basis and key milestones required to activate an evolved market assessment methodology and publish each market area assessment as they are completed.

1.1.B.4: Document the data sets, sources and parameters used for strategic analysis and assessments; identify which data sets are authoritative and who the data stewards are of each data set.

1.1.B.5: Using first quadrennial market assessment data, develop and document an initial rating methodology (based on the six criteria domains: access, demand, quality, mission, cost effectiveness, and sustainability) to evaluate the 95 markets then rate each on a scale of high, moderate, or low risk.

1.1.C. Additional domains of analysis including visioning, rural healthcare, education and research, health and wellness aspirations, health equity, population migration, pandemic and PACT Act implications, enrollee reliance, population density distribution, population health, telehealth, and cost accounting analyses.

Deliverables:

1.1.C.1: Define and document the domains to be used for the strategic analysis and assessments to include access, quality and cost analysis all healthcare provided by the VA and VA Community Care; by provider; services; facility; VAMC; Market; VISN; rural healthcare; education and research; health and wellness; health equity; home health; healthcare policy; VA's fourth mission on preparedness; population health; telehealth; Policy (current and emerging like PACT Act) etc. (VA will provide additional population health data such as determinants of health [rurality status, veterans living w/I socioeconomic deprivation zones…].)

1.1.C.2: Define and document domains to be used for strategic analysis and assessment of **people** to include demographics and health of the Veteran population/cohorts/Priority Groups that address eligibility, enrollment, reliance, population health (Dx/CPT/Vitals), Healthcare Effectiveness Data and Information Set (HEDIS) measures, Social Determinates of Health; Citizens Health and Medical Programs of the VA (CHAMPVA) Population; Caregiver population; VA Workforce population; staffing (FTE) and skills requirements; Veteran and Staff satisfaction; etc.

1.1.C.3: Define and document domains to be used for strategic analysis and assessment of **practice** to include all inpatient and outpatient specialties, skills, and services (Clinical, Ancillary, and Administrative) provided by VA DC and CC; Productivity, Utilization, and Efficiency measures and thresholds; cost of care by service for DC and CC; balance of care by service; board certification rates; quality of care provided by service, etc.

1.1.C.4: Define and document domains to be used for strategic analysis and assessment of **place** to include all facility types; age; location; size; land; levels of care; staffed Bed types; ORs; ICUs; Exam Rooms; Enrollee Healthcare Requirements Model (EHRM); etc.

1.1.C.5: Define and document the data sets, sources, parameters for the strategic analysis and provide an assessment of the data quality of all data sets used.

1.1.C.6: Identify and document VA and commercial healthcare analytics and planning subject matter experts contributing to the strategic analysis to include input and engagement from stakeholder to include the Veterans, VAMCs, VISNs, VA Program Offices, Veteran Service Officers (VSO), Labor Unions, the Office of Management and Budget (OMB), and Congress.

1.1.C.7: Document the data sets, sources, parameters for the strategic analysis and provide an assessment of the data quality of all data sets used.

1.2) Data Management

1.2.A. Data Management Maintenance and Development

Recommended Approach

Across the four years of the original round of assessments, tools have been developed to manage and automate data related to VA facilities, health care planning, and market assessment recommendations. Further support is required for the maintenance and upgrade of these data repositories and analytics tools. Database management is essential to maintain and improve the data used across the market assessments.

Deliverables:

1.2.A.1: Host weekly status meeting with Chief Strategy Officer (CSO) to review weekly progress and discuss upcoming work.

1.2.A.2: Update and maintain the scripts, processes, and reports that validate the Corporate Data Warehouse (CDW) cubes are still available and accessible for data import into the MAHSO/VFTHE Database.

1.2.A.3: Update and maintain the MAHSO/VFTHE Database schema, data imports, and Power BI reports.

1.2.A.4: Maintain the Strategic Prioritization Application.

1.2.A.5: Update the MAHSO/VFTHE Database schema, data imports, and Power BI reports with recent fiscal year data, comparing updated data to data used in different planning stages.

1.2.A.6: Update and maintain the tools and processes that enable the synchronization of the MAHSO/VFTHE environment between the Development, Test, and Production environments.

1.2.A.7: Develop 3.0 versions of the Data Issues Log and Key Takeaways and Findings SharePoint tools and the Supplemental Data Analysis Request application.

1.2.A.8: Maintain and support the MAHSO/VFTHE Collaboration Portal SharePoint site and the Facility Hierarchy application.

1.2.A.9: Maintain and provide usability enhancements to the Automated Opportunity Listing 3.0. The AOL is a populated document of discovered opportunities to improve market conditions.

1.2.A.10: Automate with the VA ArcGIS Portal the existing maps developed for the DD&F to be refreshed along with the DD&Fs.

1.2.A.11: Maintain the interactive maps, including maps updated during reviews prior to any budget request submissions.

1.2.A.12: Perform all required tasks as defined in the VA Risk Management Framework and Authorization Requirements SOP, e.g., Plan of Action and Milestones (POAM), Annual Risk Assessment, Technical Scans, etc.

1.2.A.13: Document the MAHSO/VFTHE architecture and systems to continue support post task order.

1.2.A.14: Provide usability enhancements to the Cost Range Model as needed.

1.2.B. Data Discovery and Findings

Providing the VA with the comprehensive market analysis data set(s) derived from authoritative or validated data sources that include data domains pertaining to People (Workforce and Veterans), Practice (Skills and Specialties) and Place (Infrastructure and Facilities) to assess market areas at a minimum by Access, Quality, and Cost standards and to clearly evaluate demand, aggregated by geography, internal and external health care capacity by market, and productivity.

Deliverables:

1.2.B.1: Define and document the data sets, sources and parameters used for strategic analysis and assessments; identify which data sets are authoritative and who the data stewards are of each data set.

1.2.B.2: Define the data categories to be used to include but limited to:

a. Market Geography and Demographics (Geographic Hierarchy; VA Current Site Locations; Current Demographics; Projected Demographics; Rurality; Enrollee Demographics; Enrollment Key Drivers; Reliance Data);

b. Demand (Historical Workload Data; Community Care Workload Data; Telehealth Data; Projected Future Workload; Projections Assumptions; Referral Data).

c. Supply (Clinical FTE/Staffing; Physician Efficiency; Capacity; Staffing and Vacancies; Federally Qualified Health Center (FQHC) Listing; DoD Listing; DoD Historical Workload, Capacity, and Future Projects; Indian Health Service (IHS Listing; National Survey Results);

d. Access, Quality, Cost, and Patient Satisfaction (Appointment Wait Times; Survey of Healthcare Experience of Patients (SHEP) Patient Satisfaction; Strategic Analytics Improvement and Learning (SAIL) Value Model Data; Drive Times/Enrollee Proximity to Closest VA Site; Patient-level Costs (Inpatient); Patient-level Costs (Outpatient);

e. Supplemental Data (Acuity Data; Rural Health Projects; Academic Affiliations);

f. Facilities Data (Strategic Capital Investment Planning (SCIP) Projects; Site Plans; FCA Projects/Other Projects; Building Inventory (Leased and Owned) List; Facility Complexity Level; Active and Planned Capital Projects Facility Operating Costs; Historic Sites);

g. Community Market Data (Current and Future Market Inpatient and Outpatient Demand; Commercial Market Hospitals by Type and Bed Total; Current Commercial Market Physician Supply and Demand; Major Commercial Healthcare Changes; Commercial Hospitals Quality and Satisfaction Data; Health Service Area (HAS)/ Hospital Referral Region (HRR).

1.2.B.3: Supporting Deliverables:

a. Facilitate and document Weekly Information Management status meeting.

b. Maintain CDW Schema Validation Pipeline and Integrated Dashboard.

c. Update and maintain the MAHSO/VFTHE database schema, core data elements, and Power BI reports to facilitate annual updates to the Data, Discovery, and Findings (DDF).

d. Enhance cloud based Strategic Prioritization Application.

e. Maintain MAHSO/VFTHE Environment Synchronization functionality.

f. Migrate MAHSO SharePoint applications to a new MAHSO/VFTHE SharePoint (common application framework) site.

g. Support and maintain MAHSO/VFTHE Collaboration Tools including enhancing data tools and systems to incorporate multiple rounds of market assessments.

h. Integrate the Existing State Mapping Application into ArcGIS Enterprise Portal 4.0 with enhancements.

i. Develop interactive healthcare delivery maps as a visual tool for the market assessments.

j. Maintain the MAHSO Authority to Operate (ATO).

k. Build a MAHSO/VFTHE Transition Plan.

1.3) Supporting Data Management Applications

1.3.A. Health Systems Planning Application (HSPA) – Sustainment

A VHA internal facility planning tool to enable local planners to assess their local Veteran population, including eligible and enrolled Veterans, as well as trends impacting Veterans associated health care, Identifying projected imbalances in health care capacity, and visualizing market supply and demand.

Deliverables:

1.3.A.1: Support the annual 12-month development cycle for HSPA which begins in Q3 of each fiscal year and concludes at the end of Q2 the following fiscal year.

1.3.A.2: Within the MAHSO ATO maintain the HSPA artifacts, which will include updates to documents and artifacts within the Enterprise Mission Assurance Support Service (eMASS) that are impacted by application enhancements, as well as any activities required to satisfy the continuous monitoring requirements outlined in the Authorization Requirements Standard Operating Procedure (SOP), including application code and database scans with necessary remediation of any findings.

1.3.A.3: Develop written documentation with visual aids on the transformation steps required to update the HSPA database and application as new fiscal year Enrollee Health Care Projection Model (EHCPM) data is received from Milliman including code for any scripts that are used to facilitate new Base Year (BY) updates.

1.3.A.4: Develop additional user interface (UI) enhancements that build upon the improvements provided in HSPA 5.1.

1.3.A.5: Develop project management plan outlining key milestones for HSPA development.

1.3.A.6: Work with VA to identify required enhancements and develop plan for implementation.

1.3.A.7: Develop plan for training users on functions included in new release.

1.3.A.8: Develop transition plan capturing all technical specifications of the applications.

1.3.A.9: Develop bi-weekly status report capturing progress against key milestones.

1.3.A.10: Conduct weekly status meetings to discuss progress, risks, and issues.

1.3.A.11: Provide general maintenance of application and handle support requests.

1.3.A.12: Develop a web-based dashboard to track facility projects in SCIP, modernization efforts, and MAHSO/VFTHE recommendations.

1.3.A.13: Develop a set of VISN and national-level DD&Fs to supplement the existing market DD&Fs.

1.3.A.14: Supporting Deliverables:

a. HSPA Project Management Plan and updates.

b. HSPA Enhancement Plan and updates.

c. HSPA Training Plan and updates.

d. HSPA Transition Plan and updates.

f. HSPA Development and updates.

g. HSPA VISN and National-Level DD&Fs.

h. HSPA Dashboard.

1.3.B. Health Systems Planning Application – Evolution

To allow for enhanced alignment between the MAHSO/VFTHE database and the HSPA, continued support is required.

Deliverables:

1.3.B.1: Define and document how the strategic analysis and assessments are integrated into the VA's Health Systems Planning Application (HSPA) to enable VA planners and health systems analyst to replicate and repeat the analysis and assessments at the strategic/enterprise-level for cross comparison purposes and at operational level (VISN, Market, VAMC) in order to analyze and assess their local Veteran population, including eligible and enrolled Veterans, as well as trends impacting Veterans associated health care, identifying projected imbalances in health care capacity, and visualizing market supply and demand.

1.3.B.2: Reconcile and ensure the data, discovery & findings are accurately captured in the HSPA to ensure enterprise-wide transparency, coordination, and synchronization of the market area assessments.

1.3.C. Cost Range Model

VA tool which estimates criteria-based modernization requirements for every VAMC installation and includes a resource allocation element to project and distribute workload.

For an overview of VA's current Cost Range Model application and future aspirations see attached "VFTHE Cost Range Model Illustration."

Deliverables:

Betterments

1.3.C.1: Deliver betterments identified in Attachment D.2, VFTHE Cost Range Model Illustration.

a. Estimate healthcare delivery costs in addition to capital costs. Obtaining and implementing VA and non-VA healthcare unit costs in the CRM to be able to plan from workload, to space, to cost.

b. Support pre-planning and business case development by measuring timeline and facility life cycle variations.

c. Measure opportunity costs of not moving forward with capital investment or service delivery projects.

d. Conduct make vs. buy analyses to determine the appropriate mix of VA provided vs. Community Care based on operational costs and infrastructure capabilities.

e. Apply thresholds for service delivery planning.

f. Make recommendations to VA stakeholders who make decisions on the consolidation of care by measuring impact of pulling in workload from community.

g. Illustrate how estimates for modernization would grow based on cost escalation by parent station.

h. Illustrate how the balance between VA delivery, VA facility investment, and Community Care costs might shift over time.

i. Include projections of full costs of ownership including:

1. Initial capital investment

2. Projected lifetime operational and maintenance costs

3. Reinvestments and rehabilitation

4. Disposal and residual value

j. Process and cadence to update modernization cost estimates with VAMC Cost Guide, operational costs, Capital Asset Inventory (CAI) and Vaccine Safety Technical (VaST) data, and workload allocations.

1.3.C.2: Establish Plan and cadence to integrate operational costs

1.3.C.3: Develop Approaches to automate VISN Cost Guide updates, CAI and VaST data, and workload projection updates to the model

CRM enhancements

1.3.C.4: Integrate CRM with Market Assessment

1.3.C.5: Integrate CRM with VA and non-VA healthcare delivery unit costs

1.3.C.6: Incorporate existing community care workload volumes into CRM

1.3.C.7: Develop full costs of ownership for each proposed new space in the CRM tool (e.g., operational and maintenance costs, reinvestments and rehabilitation, and disposal/residual values), and

a. Incorporate time horizon impacts
b. Individualize user flows based on the type of analysis

1.3.C.8: Expand CRM to accommodate CBA and Cost Benefit Indexing (CBI) of any suite of services at a VHA facility.

1.3.C.9: Expand the CRM platform to enable more granular CBA analysis.

1. 3.C.10: Augment CBA to receive evolved input from CRM and Health System Planning Application (HSPA) via the CRM.

CRM Data Updates and Analysis

1. 3.C.11: Update CRM with latest VAMC Cost Guide and updated workload data.

1. 3.C.12: Update CRM with latest Capital Asset Inventory (CAI) and VHA Site Tracking (VaST) System data.

1. 3.C.13: Re-run modernization estimates after new data loaded into model and incorporation into single report.

CRM Implementation Planning

1. 3.C.14: Develop process to deploy CRM application to market- and facility-level planning efforts across VISN and VAMC planning teams

a. Identify users to be prioritized for future feature development

b. Develop Training process to roll out CRM tool

c. Develop Training and communications plan

Publishing's

1. 3.C.15: Develop and document an evidenced-based cost range model used to assess the cost of care for VA direct care and community care providers, services, supplies, equipment, pharmaceuticals, facilities (VA owned and leased), and land.

1. 3.C.16: Define and document cost accounting methodologies and standards used for the cost range model.

1. 3.C.17: Provide and document a cost comparison and assessment of care provided by the VA and by the commercial sector by market.

1.3.C.18: Develop and document an assessment that compares and contrasts the cost range model with the VA's Veterans Equitable Resource Allocation (VERA) model and activity-based costing models.

1.3.D. Veterans' Health Administration Conversion of EHCPM Workload for Use in VA Space Calculator and Full Review and Update of Workload-Related Elements of VA Space Planning Criteria (PG-18-9) to Allow for Development of Future Project Space Programs Using VA Space and Equipment Planning System (SEPS)

Support is needed to convert the latest Enrollee Health Care Projection Model (EHCPM) workload into space conversion factors based on changes in care delivery models and the shift to outpatient Health System Planning Categories (HSPCs) from Strategic Planning Categories (SPCATs).

For VHA to better develop rough-order-of-magnitude capital portfolio requirements, future Veteran demand for care needs to be readily translated into physical facility requirements. The current version of EHPCM produces demand forecasts in units that have not yet been translated into physical facility needs in terms of clinical, administrative, support, and special use space. For rough-order-of-magnitude requirements development, the VA Space Calculator has been an effective high-level tool to estimate future capital portfolio budget needs, but it cannot ingest the new HSPCs. A methodological approach and the application of that approach is needed to update and re-tool the VA Space Calculator.

Similar to the high-level capital portfolio budgeting that this conversion supports for the VA Space Calculator, the VA Space and Equipment Planning System (SEPS) program also benefits from the effort. SEPS provides detailed Programs for Design (PFDs) at the room level to create Office of Management and Budget (OMB) 300 Budget Request and DD1391 programming documentation. In order to effectively build budget-ready, detailed, project-specific PFDs in SEPS, the conversion of EHCPM forecast workload aligned to every SEPS/VHA Space Planning Criteria (as detailed at https://www.cfm.va.gov/TIL/space.asp) service planning category is critical. This will entail more granular conversions of workload than the VA Space Calculator requires. While creating updated conversion factors for the Space Calculator will be the first priority due to the more immediate need for portfolio-level capital budgeting, a survey of both systems' needs for service line workload conversion is necessary to determine the full universe of conversion requirements.

Before attempting to reverse engineer Relative Value Unit (RVU) based workload into existing VA space planning criteria, survey other large healthcare systems and healthcare Architecture/Engineering (A/E) firms for best practices in translating workload demand into physical space. Large healthcare systems like Kaiser Permanente, Sutter Health, and HCA currently work from RVU-based projections to determine clinical facility needs. These systems often have a corporate capital planning group that works in conjunction with specialty healthcare A/Es like NBBJ, HDR, AECOM, etc. to develop and evolve space planning standards. After surveying and highlighting best practices that VA might adopt from these types of leading practitioners, a report recommending a way forward on VA's conversion approach, leveraging industry best practice, could be produced. This report would also recommend the scope of any new RVU-driven space planning pilots; the prioritization of service lines to

attempt conversion of first; and the timeline, level-of-effort, identification of necessary stakeholders to participate in the effort, and the data gathering, coordination, and criteria validation/adjudication process across the entire domain of VA's planning criteria.

Following from any recommendations made in the report described above, prioritization of service line conversion calculations—first by Space Calculator needs, then SEPS needs—will be undertaken. Conversion may involve clarifying interviews with service line work groups, program offices, and subject matter experts. Test run results after initial conversion will be collaboratively shared with relevant stakeholders to get feedback and improve the accuracy of model output. A second iteration will then be undertaken for pre-final validation of the conversion output. Any last adjustments will then be made for the final version of the service line workload conversion model. Lastly, many elements of VA Space Planning Criteria are dated. There is an opportunity with a review to introduce updated thresholds for whether services/procedures should be included in the planning of new projects.

Methodology – Survey of Leading Practices in RVU-based Clinical Space Planning

- Special study team, in close collaboration with VA, identifies a representative group of both leading healthcare systems and healthcare A/Es utilizing RVU-based planning.

- Conduct in depth interviews with planning representatives at each organization to identify leading practices.

- Group leading practices by type and focus and assess feasibility of adopting some or any of these practices in a new VA space planning paradigm.

- Recommend leading practices that VA could quickly adopt as well as long-term strategies to enhance RVU-based clinical planning.

- Help VA determine which project(s) would be suitable to pilot the application of new RVU-based planning criteria.

- Develop a roadmap for conversion of all criteria based on lessons learned from any initial pilots.

    - Roadmap should include process flows, key stakeholders, and integrated timeline for the conversion process.

Methodology – Update of VA Space Calculator (Following from Report Roadmap)

- Make recommendations to VA stakeholders regarding which departments should be included in the Space Calculator moving forward.

- Align the Space Calculator with the individual VA Space Planning Criteria chapters and with the Capital Asset Inventory (CAI).
- Identify all VA Space Calculator workload-driven pacing inputs.
- Initiate contact with relevant stakeholder groups to present conversion approach; agree on timeline for developing initial, secondary, and final conversion deliverables.
- Initiate conversion model update first instance, provide results, obtain feedback from stakeholder work groups.
- Update pre-final model with results from initial run, run second version of the model, provide results, obtain feedback from stakeholder work groups.
- Update final model with results from pre-final run, provide final version deliverable to stakeholder work group for approval.

Methodology – Update Workload Assumptions for VA Space Planning Criteria (Following from Report Roadmap)

Note: This work is anticipated in a subsequent Call Order.

- Identify all VA Space Planning Criteria workload-driven pacing inputs.
- Develop a work plan to begin converting service lines grouped logically to align with common stakeholder groups.
- Initiate contact with relevant stakeholder groups to present conversion approach; agree on timeline for developing initial, secondary, and final conversion deliverables.
- Initiate conversion model update first instance, provide results, obtain feedback from stakeholder work groups.
- Update pre-final model with results from initial run, run second version of the model, provide results, obtain feedback from stakeholder work groups.
- Update final model with results from pre-final run, provide final version deliverable to stakeholder work group for approval.

Deliverables:

Note: Estimated durations provided for planning purposes.

1.3.D.1: Survey of Leading Practices and Report Roadmap for RVU-based Space Planning.

a. Identification and survey of leading practitioners: ~2 months

b. Capturing and classifying leading practices that VA might adopt: ~1 month

c. Identification of pilot projects to apply leading practices identified: ~1 month

d. Roadmap with recommendations for future conversion approach system-wide ~2 months

1.3.D.2: Updated VA Space Calculator

a. Assessment of agreed upon departments to include in update: ~1 month

b. Calculator update, first instance ~2 months

c. Calculator update, second instance ~1 month

d. Calculator update, final instance ~1 month

1.3.E. Interactive Mapping Tools

Includes the VHA GIS Planning Portal, a geographic database of capacity, healthcare locations (internal and external) and analytical tools to enable effective distribution of capacity where it is most needed.

Deliverables:

1.3.E.1: Develop, implement, and document the standards for the geospatial data and the geospatial analytics used as a part of the strategic analysis and assessments and how it integrates, and will can be used with the existing VA Enterprise Geospatial Information Systems (GIS) Architecture and Interactive Mapping Tools/Applications.

1.3.E.2: Conduct and document geospatial analysis that can be replicated and repeated for geocoded data for Veteran location, Facility location by level of care and capability (DC/CC, and non-CC commercial facility); internal capacity and facility condition assessment for each VA facility); climate and environmental impact; social determinates of health; health equity; referral patterns; population health by disease pattern; etc.

1.4) Implementation Planning

1.4.A. Implementation Planning—Program Management Office

In the preceding round of assessments, an organized approach was established to outline implementation pathways for future state market strategy, recommendations, and associated initiatives. Implementation planning must take the next step in documenting the sequential order of all efforts, necessary tasks, interdependencies, timeline, and associated milestones to advance strategy to execution. Given the range of market strategy and opportunities developed, a structured, flexible approach to outline advancement of prioritized recommendations best aligns resource planning and associated budget cycles. A centralized, controlled approach to outline implementation pathways creates the necessary central leadership oversight and allow for the significant collaboration across VA offices and with facility, market and VISN leadership to ultimately execute the plan. In this MAHSO/VFTHE BPA Call Order 1, the Contractor will develop key elements of Implementation Planning, including prototypes, and use all findings and results as feedback to adjust the Implementation Planning approach developed in the preceding MAHSO BPA. In addition, the Contractor will maintain a PMO for Implementation Planning to coordinate all activities and intersections with other programs across the VA.

Deliverables:

1.4.A.1: Support the establishment of an Implementation Planning Program Management Office (PMO) in preparation for the pre-design development of capital projects that align with market assessment recommendations, including:

1.4.A.2: Structure and processes for pre-design development (requirements development).

1.4.A.3: Facilitate VA executive leadership planning sessions to develop PMO structure and associated tools (ex: business plans, staffing plans).

1.4.A.4: Formalize charter to define the scope, responsibilities, and memberships of PMO, meeting cadence, oversight/conflict resolution, and deliverables.

1.4.A.5: Create project management tools and templates.

1.4.A.6: Implementation planning structure and approach including key task structure, timelines, dependencies, and key decision points/timelines.

1.4.A.7: Review VA business case and requirements development processes and suggest improvements for VA consideration and approval.

a. Review and revise business case template, as needed.

1.4.A.8: Support the development of processes, structure, and tools for creating programmatic plans ('functional programs') from market assessment recommendations. The process must be scalable and leverage the data and learnings from market assessments. Creating a standardized approach seeks to establish a bridge from market assessment recommendations to facilities requirements planning and associated pre-design implementation planning. Key elements should include:

a. Programmatic Summary

b. Updated demand drivers and projections

c. Staffing analysis/impact

1.4.A.8: Execute a complex VAMC pilot to work with CFM, CSO, VHA facilities, VISN, and local facility staff to develop detailed requirements for a single project to test standardized approach. Effort will include review and validation of planning data

1.4.A.9: Develop and pilot in one market an economic impact assessment approach including:

a. Market Summary Statement

b. Local Economy Impact (financial and non-financial) such as:

1. Direct impact of the change (e.g., a capital investment or divestment),

2. The indirect impact (supplemental business-to-business spend as a result of the change, e.g., supply chain impacts) and

3. Other impacts (increase/decrease of spend from households to local business as a result of the change)

c. Risks

d. Timeline

1.4.A.10: Develop plans for pre-design activities (e.g., recommendation prioritization, incorporating considerations as a result of programmatic plans, staffing analysis, and economic impact assessments) that outline the following:

a. Key tasks

b. Timeline

c. Key Decision Points/Milestones

d. Dependencies

1.4.A.11: Interface with external stakeholder workgroups:

a. Align/realign requirements with partnership deals

b. Align/realign requirements with architecture/engineering/construction feasibility studies

c. Align requirements with other adjustments (i.e., emerging VA priorities)

1.4.A.12: Supporting Deliverables:

a. Develop a PMO planning structure and associated tools and templates

b. Conduct a review of VA business case and requirements development processes and suggestions for improvements

c. Develop and document processes, structure, and tools for creating programmatic plans

d. Conduct a complex VAMC Pilot to work with CFM, CSO, VHA facilities, VISN, and local facility to develop detailed requirements for a single project to test standardized approach.

e. Develop and pilot economic impact assessment approach

f. Develop and document a plan for pre-design activities

g. Engage external stakeholders and deliver a summary report

1.4.B. Master Planning

As VA has prioritized notional campus renewal investments by station; we need to deliver Feasibility Studies, Campus Master Plans, and Facility Master Plans. These deliverables overlap but are generally distinguished as such:

- Feasibility Study – Takes a comprehensive look at the VAMC and makes an assessment as whether the long-term healthcare delivery requirement can be met on campus, will require a new campus, or some combination thereof.
- Campus Master Plan – Takes a comprehensive look at the VAMC campus agnostic of specific projects to assess condition and capacity for continued and evolving healthcare delivery. This Plan would clearly assess all impacting elements such as utility distribution and capacity (including central energy plant),

environmental conditions, historic preservation needs, existing facility conditions and highest and best uses, capacity for new facility footprint, functionality, etc.

- Facility Master Plan – Takes a comprehensive look at delivering an on-site VAMC renewal once the decision has been made to remain at the existing campus. This plan is informed by the Campus Master Plan and/or Feasibility Study where one was required and executed.

Deliverables:

1.4.B.1: Deliver a Feasibility Study for Raleigh VAMC with a PRV roughly $4B. Comply with Attachment D.3, VFTHE Feasibility Study Performance Work Statement for Raleigh Durham VAMC.

1.4.B.2: Deliver a Feasibility Study for Washington, DC VAMC with a PRV roughly $4B. Comply with Attachment D.4, VFTHE Feasibility Study Performance Work Statement for Washington DC VAMC.

1.4.B.3: In conjunction with the two previous Feasibility Study deliverables for Raleigh Durham and Washington, DC VAMCs, evolve and deliver a standard process and user guide for a Phase 1 Facility Master Plan. Follow instructions in Attachment D.5, VFTHE Master Planning Statement of Work, and Attachment D.6, VFTHE Master Planning Statement of Work Deliverables. A Phase I Facility Master Plan is a high-level agnostic assessment of a medical center's current physical condition. The assessment is broken into four categories: Architectural Review, Environmental Baseline, Historical Review, Service Delivery Plan Review, and a review of approved or pending construction projects. The goal of Phase I is for the A/E to evaluate each facility's strengths, Weaknesses, Opportunities, and Threats (SWOT) as they relate to its capital inventory and strategic / service delivery plan. This initiative will serve as a pilot for Phase 1 Campus Master Planning.

1.5) Strategic Prioritization

1.5.A. Strategic Prioritization

Recommended Approach

This MAHSO/VFTHE BPA Call Order 1 Strategic Prioritization workstream will refine and continue the Strategic Prioritization Framework and Process previously developed in the preceding MAHSO BPA based on VA leadership feedback and will conduct the final prioritization of approved recommendations. While the Strategic Prioritization framework and an initial prioritization of opportunities occurred under the MAHSO BPA, it is anticipated that feedback will necessitate additional refinements to the methodology and cyclical (at least annual) re-prioritization. The Strategic Prioritization Application should be enhanced to incorporate updates to criteria and allow for the review of recommendations and related data, as well as provide the ability to select and prioritize

recommendations or groups of recommendations (e.g., by VA-defined prioritization criteria, by market, recommendation-type, building topology, funding programs—NRM, Minor Construction, and leasing—etc.). Once the framework and application are enhanced, it will be necessary to prioritize the recommendations from all phases of the previous MAHSO BPA assessments and subsequent opportunity development and refinement according to the updated prioritization criteria and receive approval of the prioritized recommendations from VA leadership.

While initial prioritization is a critical step towards implementation, prioritization will need to be refined and coordinated with existing VA processes and stakeholders on an ongoing basis until projects are fully executed. Ongoing prioritization will need to reflect the shifting health care, regulatory, and budget environment, and VA's ability to execute projects. VA must create a methodology to understand and execute approved recommendations within the broader landscape of Department priorities outside of MAHSO recommendations.

Deliverables:

1.5.A.1: Enhance the Strategic Decisional Framework to prioritize market assessment recommendations and strategies and subsequent opportunity development and refinement in collaboration with VA stakeholders as necessary.

1.5.A.2: Document a revised Strategic Decisional Framework in a methodology report.

1.5.A.3: Gather change requirements from VA stakeholders for the Strategic Prioritization criteria and Application.

1.5.A.4: Finalize and receive VA approval of the prioritized recommendations.

1.5.A.5: Develop a methodology to evolve the prioritization process and incorporate it into implementation planning as the health care, budgetary, and overall VA landscape evolves.

1.5.A.6: Study and recommend a process for sustainable prioritization and execution.

1.5.A.7: Physical Product Deliverables:

a. Revised Strategic Decisional Framework.

b. MAHSO/VFTHE Strategic Prioritization Recommendation Report including methodology and prioritized recommendations.

c. Sustainable Prioritization Report including process for refining prioritization process as the health care, budgetary, and overall VA landscape evolves.

d. Support for prioritization based on changes in the health care, budgetary, and overall VA landscape.

1.5.A.8: Evolve prioritization modeling tool to include automated “what if” scenario analyses.

1.5.A.9: Establish prepopulated scenarios for the basic universe of health care delivery alternatives to include a VHA limited to, outpatient MH, CBOCs including outpatient MH, foundational services, ambulatory health care, full inpatient services meeting critical volume thresholds, and all of these in conjunction with inpatient mental health, CLC’s, and RRTP’s.

1.5.A.10: “Alternative COA Development” (Infrastructure Strategy) – Develop alternative strategies balancing mission (VHA in-house care) with portfolio investment requirements. This branches off from the previous deliverable to explore other visions such as a variation of the above scenario without in-house inpatient care and both strategies with and without CLCs.

1.5.A.11: Continuing the theme of deliverable 1.5.A.10 above, build alternative scenarios based on capital investment assumptions. In other words, what in-house mission can we adequately support with total sustained annual facility funding (the full gamut of maintenance, sustainment, repair, restoration, new construction, and leasing) in increments of $5B up to the maximum we would need to sustain a facility portfolio commensurate with current VA aspirations for in-house care.

1.5.A.12: Relative to the above deliverable 1.5.A.11, identify challenges delivering modernization, new construction, and leasing to meet the upper ranges of current VA aspirations for in-house care.

1.5.A.13: Refine model annually to accommodate user requested domain, criteria, and weighting modifications

1.5.A.14: Deliver major construction and leasing prioritization feeding SCIP FY2026+ and FYDP as early as FY2026-2030

1.6) Stakeholder Management and Strategic Communications

1.6.A. External Stakeholder Response Support

VA anticipates robust collaboration with external stakeholders on Veteran Facility Transformation and Healthcare Enhancement initiatives. External stakeholders include applicable unions, veteran service organizations, media, Academic Affiliates, Community Care Network administrators, Congress, local governors, and the Administration. VA will require support to respond to questions and requests from these and other stakeholders in an accurate and timely manner. Additionally, ad-hoc analyses will be required to allow VA to effectively respond to these inquires.

Deliverables:

1.6.A.1: Develop systems/processes for tracking and VA responses to external stakeholder queries.

1.6.A.2: Develop responses to queries which may include, but are not limited to, drafting answers, and providing documentation or other information to satisfy requests.

1.6.A.3: Support analysis to enable VA to quickly respond to inquiries requiring data analysis in areas including demand, access, quality, facility condition, mission, health equity, and cost.

1.6.A.4: Generate summary tables and graphs summarizing analytical findings.

1.6.A.5: Develop presentation materials to capture findings for VA leadership and external audiences.

1.6.A.6: Physical Product Deliverables:

a. Tracking of all requests and responses provided.

b. Support the framing of VA responses to requests.

c. Analysis and corresponding presentation slides as needed

d. Develop presentation materials to capture findings to present to VA leadership.

1.6.B. Strategic Communications

VFTHE will require continued strategic communications support. Strategic communications support includes strategic messaging, communications products, legislative insight, and technical writing. This is critical as VA engages external stakeholders, builds and defends its capital investment program, and prepares to submit the next quadrennial strategic plan. Interest from stakeholders, including Congress, Veterans Service Organizations (VSOs), and other entities such as the Government Accountability Office (GAO), has increased and will continue to increase as VA pursues transformation (modernization) of its healthcare facility portfolio. Upcoming deadlines and associated actions require augmented communications support as efforts continue to educate stakeholders and secure additional capital investment funding of an order of magnitude more than VA historically receives. Clear, consistent messaging will further engage key internal and external stakeholders on MAHSO/VFTHE resulting recommendations.

Deliverables:

1.6.B.1: Manage and execute strategic communications plan to guide internal and external communications related to preceding MAHSO market assessments and healthcare facility transformation, including in the event of a critical incident requiring crisis response.

1.6.B.2: Develop and enhance strategic messaging and communications products related to preceding MAHSO market assessments and veteran facility transformation.

1.6.B.3: Collaborate with CSO and other internal VA stakeholders such as the Office of Public and Intergovernmental Affairs and the office of Congressional and Legislative Affairs.

1.6.B 4: Provide ongoing legislative insight and experienced support to shepherd potentially high-visibility initiatives to national, state, and local government officials.

1.6.B.5: Provide draft legislative relief guidance, coordination, and technical writing for VA consideration regarding future legislation based on preceding MAHSO Market Assessment outcomes. The release of VA's full criteria-based facility transformation funding requirements will bring added attention to legislative relief proposals that could be implemented

1.6.B.6: Coordinate with VA on the development of a public facing website for the veteran facility transformation requirements.

1.6.B.7: Provide strategic messaging, facilitated work sessions, facilitated leadership meetings, visioning sessions, internal and external message segmentation, and stakeholder management to support all Task Areas above.

1.6.B.8: Provide high impact technical writing and graphic support for all communications program offices.

1.6.B.9: Provide communications support to review/edit and develop answers to all taskers related to MAHSO/VFTHE at national and VISN levels to ensure consistency in messaging. Such support should be coordinated through VA stakeholders identified by CSO. Periodic meetings may also be required for communications strategy development.

1.6.B.10: Provide traditional and social media monitoring to track stakeholder sentiment regarding market assessments and provide a feedback loop for strategic communications activities.

1.6.B.11: Provide communications expertise to support change management at VA national and local levels in coordination with the Change Management workstream.

1.6.B.12: Develop strategic approach to continue external stakeholder engagement efforts, to include local level outreach in advance of veteran facility transformation budget request releases.

1.6.B.13: Physical Product Deliverables:

a. Communications Plan – Provide strategic messaging, including for internal and external stakeholders; provide stakeholder management, including facilitated meetings.

b. Communications Products – Develop communications products and update and strengthen existing products, in alignment with strategic communications plan to include any follow-up inquiries from MAHSO.

c. Legislative Insight – Provide strategic legislative insight at the national, state, and local levels; develop legislative relief proposals based on previous MAHSO market assessment outcomes.

d. Technical Writing and Graphic Support – Provide technical writing and graphic support for communications products, which include reports and briefings.

e. Communications Support for Internal/External Inquiries – Provide communications support to review/edit and develop, from scratch, answers to all taskers related to MAHSO/VFTHE at the national and VISN levels to ensure consistency in messaging. Such support should be coordinated through the Office of Public and Intergovernmental Affairs (OPIA). Periodic meetings may also be required for communications strategy development.

f. Traditional and Social Media Monitoring – Provide traditional and social media monitoring related to MAHSO/VFTHE, including listening sessions

1.7) Program Management and Executive Support

1.7.A. Planning Strategy Support and Governance

National Recommended Approach

During the succeeding MAHSO BPA, VA created 12 National Planning Strategies (NPS). The National Planning Strategy (NPS) initiative was the first time VHA's program offices, the Chief Strategy Office, and the Office of Construction and Facilities Management collaborated to create planning guidelines for service lines and programs. The planning guidelines are an important milestone that should guide VA's planning efforts into the future. VA intends the impact to be an improved planning collaboration process amongst VA's internal stakeholders resulting in a more consistent experience for Veterans by reducing variation based on national planning standards.

To realize VA's intended impact, the NPSs must be integrated into ongoing planning processes. This integration must consist of creating a process to continue collaboration, continually adjust the planning guidelines as the health care landscape evolves, design and execute implementation rigor, and provide oversight of implementation.

Deliverables:

1.7.A.1: Develop and execute a strategy to integrate the NPS outputs into VA's existing planning processes.

1.7.A.2: Determine recommendations for and execution of a governance process to ensure outputs from the NPSs are adhered to in the planning process.

1.7.A.3: Identify other areas where NPSs may be useful to long term planning.

1.7.A.4: NPS Execution Plan outlining governance and how the NPSs will be used in ongoing planning.

1.7.A.5: NPS Execution Plan support.

1.7.B. Program Management

VFTHE Call Order 1 will include multiple, complex workstreams that build on the progress of work conducted under the previous MAHSO BPA contract. To ensure appropriate coordination across the project, the Contractor Project Management team will provide program management, which will include the following: Scheduling; a Quality Assurance Surveillance Plan (QASP); Project Communications; and Reporting Oversight and Support.

Deliverables:

1.7.B.1: Plan and direct the execution of the project.

1.7.B.2: Plan for and identify potential risks and address any risks as necessary.

1.7.B.3: Maintain regular communications across the Contractor team and with the government.

1.7.B.4: Develop and maintain project master schedule.

1.7.B.5: Develop regular status updates capturing progress.

1.7.B.6: Oversee compliance with administrative requirements (e.g., onboarding, security requirements, travel expense tracking, etc.).

1.7.B.7: Physical Product Deliverables:

a. Create and maintain a master schedule

b. Prepare and distribute weekly update reports

c. Prepare and submit monthly key progress update reports/Pencil Recs

1.7.C. Change Management

Change management activities must be synchronized and work in concert with all the other MAHSO project management activities.

Due to the sensitive nature of the information surrounding MAHSO/VFTHE BPA capital investment recommendations and potential impacts for VA facilities nationwide, it will be important for VA to grow the existing change management efforts to understand readiness and potential resistance (both internal and external) as well as provide a network of resources and support for stakeholders prior to the March 14, 2026, public release of the next quadrennial market studies and VA MAHSO/VFTHE Strategic Plan. This strategic plan, among other things, must define "the health care capacity to be provided at each VA medical center." Moreover, VA is responsible to provide "transformation and organizational change to achieve a high performing integrated health care network, developing the capital infrastructure planning and procurement processes required, and developing a multi-year budget process that is capable of forecasting future budget year requirements."

The MAHSO BPA and subsequent efforts have recommended modernization and improved access to care for Veterans. This is the beginning of a long process that will involve major changes for Veterans, VA staff, and external stakeholders such as Congress, Veteran Service Organizations, community providers, and future VA staff. Due to the significant changes recommended in the ACR, VA must be prepared to address resistance to these changes, especially changes that may be perceived as losses, which could potentially overshadow the many benefits of the recommendations. The long-term success of the market assessment implementation over many years requires an accelerated and coordinated suite of tools to prepare for, manage, and reinforce the change approach to move people through this change, both internally and externally.
VHA has incorporated the Prosci change management methodology in all efforts, especially those of the magnitude that the change assessments may bring. Support will be required in coordination with VHA's lead change management office, the Office of Healthcare Transformation.

Deliverables:

1.7.C.1: In collaboration with Chief Strategy Office and Office of Healthcare Transformation develop a national Prosci based Change Management Plan that identifies required activities, ties them to Awareness, Desire, Knowledge, Ability and

Reinforcement (ADKAR) and sequences them for activation. The Change Management Plan shall be geared towards national efforts and replicable for use at a VISN/Market level.

1.7.C.2: In collaboration with Chief Strategy Office and Office of Healthcare Transformation, devise a change readiness assessment strategy using stakeholder representation that is tied to the Change Management Plan key milestones and follows the ADKAR spectrum.

1.7.C.2: Conduct a Stakeholder Impact Analysis to determine current state of understanding of the market assessments and all impacted audience groups.

1.7.C.3: Develop a stakeholder channel analysis for VA to understand the communication preferences and engagement levels for each stakeholder group within each VISN to prepare the most engaging and impactful resources for each stakeholder group.

1.7.C.4: Physical Product Deliverables:

a. Change Management Plan.

b. Change Readiness Assessment Process.

c. Stakeholder Impact Analysis.

d. Stakeholder Channel Analysis.

e. Change Management execution support.

1.7.D. Executive Briefing Support

As VA leadership reviews the market strategies developed during and post MAHSO BPA, recommendations and strategies will evolve, and it will be necessary to update executive briefing materials in addition to the ACR to reflect these requested changes. In addition, briefings on MAHSO/VFTHE BPA strategy, approach, and execution will be required to progress VA strategy across a multitude of VHA and VACO program offices.

Deliverables:

1.7.D.1: Make recommendations in the revisions of executive briefing materials, including agendas and talking points for USH/NDs, Senior Advisors, other VA leaders, and SecVA.

1.7.D.2: Facilitate MAHSO/VFTHE BPA activity review sessions based on revised recommendations with USH/NDs, Senior Advisors, and SecVA.

1.7.D.3: Create and facilitate presentations on other pertinent VA leadership decisions related to the MAHSO/VFTHE BPA foundational and contextual activities in preparation for the next quadrennial round of market assessments.

1.7.D.4: Provide executive support for VFTHE Integrated Project Teams (IPT) to ensure communication of activities, decisions, and overall progress.

1.7.D.5: Physical Product Deliverables:

a. Briefing executive materials including agendas, presentations, and talking points.

b. Facilitation of executive briefing sessions

END