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Report to the Ranking Minority Member, Committee on Veterans' Affairs, House of Representatives

March 2007

VA HEALTH CARE

VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions

GAO-07-408

Highlights of GAO-07-408, a report to the Ranking Minority Member, Committee on Veterans' Affairs, House of Representatives

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VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions

Why GAO Did This Study

Through its Veterans Health Administration (VHA), the Department of Veterans Affairs (VA) operates one of the largest health care systems in the country. In 1999, GAO reported that better management of VA's large inventory of aged capital assets could result in savings that could be used to enhance health care services for veterans. In response, VA initiated a process known as Capital Asset Realignment for Enhanced Services (CARES). Through CARES, VA sought to enhance veteran care by the appropriate sizing, upgrading, and locating of VA facilities.

GAO was asked to examine the CARES process. Specifically, GAO examined (1) how CARES contributes to VHA's capital planning process, (2) the extent to which the CARES process considered capital asset alignment alternatives, and (3) the extent to which VA has implemented CARES decisions and how this implementation has helped VA carry out its mission. To address these issues, we analyzed CARES documents, interviewed VA officials, and conducted six site visits, among other things.

What GAO Recommends

GAO recommends that VA develop performance measures for assessing whether CARES is achieving the intended results. VA agreed with the report's findings and recommendation.

www.gao.gov/cgi-bin/getrpt?GAO-07-408.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Mark L. Goldstein, 202-512-2834, goldsteinm@gao.gov.

What GAO Found

The CARES process provided VA with a blueprint that drives VHA's capital planning efforts. As part of the CARES process, VA adapted a model to estimate demand for health care services and to determine the capacity of its current infrastructure to meet this demand. VA continues to use this model in its capital planning process. The CARES process resulted in capital alignment decisions intended to address gaps in services or infrastructure. These decisions serve as the foundation for VA's capital planning process. According to VA officials, all capital projects must be based upon demand projections that use the planning model developed through CARES.

A range of capital asset alignment alternatives were considered throughout the CARES process, which adheres to capital planning best practices. There was relatively consistent agreement among the Draft National CARES Plan prepared by VA, the CARES Commission appointed by the VA Secretary to make alignment recommendations, and the Secretary as to which were the best alternatives to pursue. Although the Secretary tended to agree with the CARES Commission's recommendations, the extent to which he agreed varied by alignment alternative. In particular, the Secretary always agreed with the commission's recommendations to build new facilities, enter into enhanced use leases, and collaborate with the Department of Defense and universities, but was less likely to agree to the CARES Commission's recommendations to contract out or close facilities. The decisions that emerged from the CARES process will result in an overall expansion of VA's capital assets. For example, the capital alignment alternatives the Secretary chose to meet future health care demand includes building 3 new medical centers and opening 156 outpatient clinics. In contrast, VA will completely close one facility. A number of factors, including competing stakeholders interests and legal restrictions, shaped and in some cases limited VA's range of alternatives considered during the CARES process.

VA has started implementing some CARES decisions, but does not centrally track the implementation of all the CARES decisions or monitor the impact such implementation has had on its mission. VA has begun implementing 32 of the more than 100 capital projects and 32 of the 156 outpatient care centers approved by the Secretary during the CARES process. Although VA has over 100 performance measures to monitor other agency programs and activities, these measures either do not directly link to the CARES goals or VA does not use them to centrally monitor the implementation and impact of CARES decisions. Without this information, VA cannot readily assess the implementation status of CARES decisions, determine the impact such decisions are having on veterans' care, or be held accountable for achieving the intended results of CARES.

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Abbreviations

BRAC	Base Realignment and Closure
CARES	Capital Asset Realignment for Enhanced Services
CBOC	community-based outpatient clinic
DNCP	Draft National CARES Plan
DOD	Department of Defense
EUL	enhanced use lease
OAEM	Office of Asset Enterprise Management
OMB	Office of Management and Budget
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

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United States Government Accountability Office
Washington, DC 20548

March 21, 2007

The Honorable Steve Buyer
Ranking Minority Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Buyer:

The Department of Veterans Affairs (VA) operates one of the largest health care systems in the country. VA, through its Veterans Health Administration (VHA), anticipates providing health care to 5 million veterans in fiscal year 2007.[1] To support its mission, VA has a diverse inventory of real property—including over 6,500 buildings and 32,000 acres of land as of June 2006. However, many of VA's facilities were built more than 50 years ago and are not well suited to providing accessible, high-quality, cost-effective health care in the 21st century. In 1999, we reported that better management of VA's large, aged capital assets could significantly reduce funds used to operate and maintain underused, unneeded, or inefficient properties. We further noted that these funds could be used to enhance health care services for veterans.[2] Thus, we recommended that VA develop market-based plans for realigning its capital assets.[3]

In response, VA initiated a process known as Capital Asset Realignment for Enhanced Services (CARES)—the first comprehensive, long-range assessment of VA's health care system's capital asset requirements since 1981. CARES was designed to assess the appropriate function, size, and location of VA facilities in light of expected demand for VA inpatient and outpatient health care services through fiscal year 2022. Through CARES,

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[1]VA's three organizations are the Veterans Health Administration, Veterans Benefits Administration, and the National Cemetery Administration. VHA is primarily responsible for VA's health care delivery to the veterans enrolled for VA health care services and operates the majority of VA's capital assets.

[2]See GAO, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83 (Washington, D.C.: Mar. 10, 1999), and *VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting*, GAO/HEHS-99-145 (Washington, D.C.: Aug. 13, 1999).

[3]GAO/T-HEHS-99-83.

VA sought to enhance outpatient and inpatient care, as well as special programs, such as spinal cord injury, through the appropriate sizing, upgrading, and locating of VA facilities. The CARES process included nine distinct steps and required the time and expertise of many VA officials at the departmental and network levels.[4] VA has completed steps 1 through 7. The remaining two steps are implementing the CARES decisions and integrating the CARES process into VA's strategic planning efforts. The steps of the CARES process are summarized in table 1.

Table 1: Steps of the CARES Process

- Step 1: VA officials at the departmental and network level develop market areas and submarkets as the planning units for analyzing veterans' needs.
- Step 2: VA officials at the departmental level conduct market analyses of veterans' health care needs using standardized forecasts of enrollment and service needs and actuarial data.
- Step 3: VA officials at the departmental level identify planning initiatives that address apparent gaps between supply and demand in resources for each market area.
- Step 4: Network officials consider different alignment alternatives and develop specific plans for individual markets that addressed all the planning initiatives identified by VA officials at the departmental level.
- Step 5: The Under Secretary of Health uses the market plans to prepare a Draft National CARES Plan (DNCP) and the DNCP's recommendations.
- Step 6: The Secretary of Veterans Affairs appoints a commission composed of non-VA executives to make recommendations to the Secretary to accept, present alternatives to, or reject the recommendations contained in the DNCP. According to VA, the commission will help ensure objectivity and independence in the process and bring an external perspective to the recommendations contained in the DNCP.
- Step 7: The Secretary of Veterans Affairs decides whether to accept, reject, or modify the commission's recommendations regarding the DNCP.
- Step 8: Network officials may implement the Secretary's decisions.
- Step 9: VA officials at the departmental level refine and incorporate CARES planning initiatives into the annual strategic planning cycle.

Source: VA.

According to VA, the CARES process was a onetime major initiative. However, its lasting result was to provide a set of tools and processes that allow VA to continually plan for the future resources needed to provide health care to our nation's veterans. In announcing his decisions in May 2004, the Secretary stated that implementing CARES decisions will require an additional investment of approximately $1 billion per year for at least the next 5 years, with substantial infrastructure investments then continuing for the indefinite future, to modernize VA's aging

[4] VA's health care delivery system is divided into 21 health care delivery networks.

infrastructure.[5] Although CARES will require substantial investment, the Secretary noted that not proceeding with CARES would require funding to maintain or renovate obsolete facilities and would leave VA with numerous redundant, outmoded, or poorly located facilities. The Secretary further stated that through the CARES process, VA had developed more complete information about the demand for VA health care and a more comprehensive assessment of its capital assets than it ever had before. The Secretary noted that this information, along with the experience gained through conducting CARES, positioned VA to continue to expand the accuracy and scope of its planning efforts. The Secretary stressed that VA would focus on integrating the tools developed for CARES into its annual strategic and capital planning efforts in order to ensure that VA uses the best information available when making plans to meet the health care needs of current and future veterans.

Given the important role CARES plays in VA's planning efforts and decision making, you asked us to examine the CARES process. Accordingly, this report examines (1) how CARES contributes to VHA's capital planning process, (2) the extent to which the CARES process considered alignment alternatives, and (3) the extent to which VA has implemented CARES decisions and how this implementation has helped VA carry out its mission. To address these issues, we analyzed the Draft National CARES Plan (DNCP), the CARES Commission Report, the Secretary's CARES Decision document, VA's 5-Year Capital Plan, and VA's legal authorities and appropriations acts. We also conducted six site visits to a nonprobability sample of VA facilities in Big Spring, Texas, El Paso, Texas, Orlando, Florida, Pittsburgh, Pennsylvania, Walla Walla, Washington, and Los Angeles, California. We chose these locations because of the variety of capital asset alignment alternatives considered at each site and to achieve geographical dispersion. At each site, we interviewed network and local VA officials as well as local stakeholders, such as representatives from the VA employee unions, veterans service organizations, Department of Defense (DOD) affiliates, and medical university affiliates. We also toured the facilities at each location. We conducted our work from March 2006 through March 2007 in accordance with generally accepted government auditing standards. (See app. I for more information on our scope and methodology.)

[5]Since 2004, VA has requested over $3.7 billion for capital projects identified through the CARES process.

Results in Brief

The CARES process provided VA with a blueprint that drives VHA's capital planning process by developing a model for analyzing VA health care demand and making recommendations for ways to meet that demand. Specifically, as part of the CARES process, VA adapted an actuarial model to produce 20-year forecasts of the demand for services, more accurate assessments of veterans' reliance on VA services and capacity gaps, and market penetration rates. VA continues to use this model to update its workload projections, which are used to help develop the annual capital budget request. In addition, the CARES decisions serve as the foundation for VHA's capital budget process. For example, the first step in VHA's capital budget process is for officials from the network level to submit proposals that identify capital projects that will address service or infrastructure gaps identified in the CARES process to the department. According to VA officials, in order to advance through VA's capital planning process, the capital projects submitted must be based upon demand projections that use the planning model developed through CARES.

The DNCP, the CARES Commission, and the Secretary considered a range of capital asset alignment alternatives during the CARES process, and the decisions that emerged from the process will, if implemented, expand VA's capital asset portfolio. The most frequently considered alternatives included renovating or expanding existing sites, conducting additional analysis, and changing services. The consideration of a range of alignment alternatives is consistent with capital planning best practices and is an important step in ensuring appropriate alignment decisions are made. Although a wide range of alternatives were considered, there was relatively consistent agreement among the DNCP, the CARES Commission, and the Secretary as to which were the best alternatives to pursue. For example, the CARES Commission agreed with about 78 percent of the DNCP proposals, while the Secretary agreed with about 81 percent of the commission's recommendations. Although the Secretary tended to agree with the CARES Commission's recommendations, the extent to which he agreed varied by alignment alternative. In particular, the Secretary always agreed with the commission's recommendations to build new facilities, enter into enhanced use leases and collaborate with DOD and universities, but was less likely to agree to the CARES Commission's recommendations to contract out or close facilities. For example, the Secretary only agreed with about half of the commission's recommendations to contract out. The resulting capital alignment alternatives that the CARES Commission recommended and the Secretary agreed to will result in an overall increase in the number of VA facilities, if implemented. For example, the CARES decisions include building 3 new

medical centers and opening 156 community-based outpatient clinics (CBOC). As a result of the CARES process, VA will completely close only 1 facility, Gulfport, Mississippi, which was severely damaged during Hurricane Katrina. According to VA officials, rather than show that VA should downsize its capital asset portfolio, the CARES process revealed service gaps and needed infrastructure improvements. Our analysis of the alternatives considered and recommended for 6 facilities we visited indicate that a number of factors shaped and in some cases limited VA's range of alternatives considered during the CARES process. These factors included competing stakeholder's interests; facility condition and location; veterans' access to facilities; established relationships between VA and health care partners, such as DOD and university medical affiliates; and legal restrictions.

VA has started implementing some CARES decisions, but does not centrally track the implementation of all the CARES decisions or monitor the impact such implementation has had on its mission. VA has begun implementing 32 of the more than 100 capital projects and 32 of the 156 CBOCs approved by the Secretary during the CARES process.[6] VA has also incorporated into its strategic planning the principles that were employed in the CARES process, such as using a model to project future health care and budgetary needs. Although VA has over 100 performance measures to monitor other agency programs and activities, these measures either do not directly link to the CARES goals or VA does not use them to monitor the implementation and impact of CARES decisions. For example, VA does not centrally track or monitor the implementation of all CARES decisions—which could be used as a performance measure for CARES. Without this information, VA cannot readily assess its progress in implementing the CARES decisions and determine the impact such decisions are having on veteran care. Moreover, the lack of CARES-specific performance measures makes it difficult for stakeholders to hold VA accountable for achieving the intended results of CARES, such as reducing funds used to operate and maintain underused facilities while enhancing services for veterans.

To allow VA to better determine the extent of implementation and impact of CARES, we are recommending that the Secretary develop performance measures to assess whether the implementation of CARES is achieving the

[6]CBOCs are VA operated, contracted, or leased health care facilities that are geographically distinct or separate from the parent VA medical facility.

intended results as well as the impact of these decisions on veterans' health care. VA and DOD reviewed a draft of this report. VA agreed with the report's findings and recommendation. VA also provided technical clarifications, which we incorporated, as appropriate. DOD did not have any comments.

Background

Over the past decade, VA's system has undergone a dramatic transformation, shifting from predominantly hospital-based care to primary reliance on outpatient care. As VA increased its emphasis on outpatient care rather than inpatient care, VA was left with an increasingly obsolete infrastructure, including many hospitals built or acquired more than 50 years ago in locations that are sometimes far from where veterans live. To address its obsolete infrastructure, VA initiated its CARES process—the first comprehensive, long-range assessment of its health care system's capital asset requirements since 1981. CARES is intended to enhance outpatient and inpatient care, as well as special programs such as spinal cord injury, blind rehabilitation, seriously mentally ill, and long-term care through the appropriate sizing, upgrading, and location of VA facilities.[7] Since its inception in 1999, the CARES process has reached several major milestones (see table 2).

[7]See appendix II for a comparison of CARES and the Department of Defense's Base Realignment and Closure process.

Table 2: Milestones in VA's CARES Process

Date	Milestone	Description
February 2002	VA announced the results of a pilot CARES study.	The pilot study assessed current and future use of health care assets in the three markets of Network 12, which includes parts of five states: Illinois, Indiana, Michigan, Minnesota, and Wisconsin. It resulted in decisions to realign health care services and renovate or dispose of several buildings consistent with VA mission and community zoning issues.
August 2003	VA's Under Secretary for Health presented the Draft National CARES Plan.	The Under Secretary's Draft National CARES Plan included recommendations about health care services and capital assets in VA's remaining 74 markets. These recommendations reflected input from managers of VA's health care networks.
February 2004	An independent CARES Commission issued recommendations.	An independent 16-member commission appointed by the Secretary of Veterans Affairs issued recommendations to the Secretary based on its review of the Draft National CARES Plan and related documents and information obtained through public hearings, site visits, public meetings, written comments from veterans and other stakeholders, and consultations with experts.
May 2004	VA's Secretary announced the CARES decisions.	The Secretary based his decisions on a review of the CARES Commission's recommendations.
January 2005	CARES follow-up studies.	VA awarded a contract for additional studies at 18 VA facilities. These studies will include evaluating outstanding health care issues, developing capital plans, as well as determining the best use for unneeded VA property consistent with VA mission and community zoning issues.

Source: GAO analysis of VA data.

The challenge of misaligned infrastructure is not unique to VA. We identified federal real property management as a high-risk area in January 2003 because of the nationwide importance of this issue for all federal agencies.[8] We did this to highlight the need for broad-based transformation in this area, which, if well implemented, will better position federal agencies to achieve mission effectiveness and reduce operating costs. But VA and other agencies face common challenges, such as competing stakeholder interests in real property decisions. In VA's case, this involves achieving consensus among such stakeholders as veterans service organizations, affiliated medical schools,[9] employee unions, and communities.

[8]GAO, *High Risk Series: Federal Real Property*, GAO-03-122, (Washington, D.C.: January 2003).

[9]VA maintains partnerships or affiliations with 107 university medical schools to obtain medical services for veterans and provide training and education to medical residents.

As noted in our high-risk work, having an effective capital planning process can help to ensure that the needs of veterans are being met. Effective planning for capital investments is a very important task because large sums of taxpayer funds are spent on capital assets and because their performance affects how well agencies are able to achieve their missions, goals, and objectives. We—as well as Congress and the Office of Management and Budget (OMB)—have all identified the need for effective capital planning. (App. III outlines a set of effective capital planning principles that we, as well as OMB, have identified.) One of these principles is for agencies to evaluate a wide range of alternatives before choosing to purchase or construct a capital asset. OMB guidance also emphasizes the importance of evaluating alternatives. Specifically, OMB guidelines state that when evaluating capital assets, a comparison of alternatives is critical for ensuring that the best alternative is selected. In its guidance, OMB challenges decision makers to consider the different ways in which various functions, most notably health care service delivery in VA's case, can be performed. In this regard, OMB labeled the development of alternatives the single most important element in that process.

CARES Process and Modeling Tools Drive VHA's Capital Planning Efforts

In developing the model for analyzing VA's health care demand and making recommendations for ways to meet that demand, the CARES process provided VA with a blueprint that drives VHA's capital planning process. Specifically, as part of the CARES process, VA adapted an actuarial model that it used to project VA budgetary needs. Modifications made for the CARES process enabled the model to produce 20-year forecasts of the demand for services. Additional modifications allowed for more accurate assessments of veterans' reliance on VA services, market penetration rates, and adjustments for capacity. Using information from the model, VA could determine current supply and identify current and future gaps in infrastructure capacity. VA continues to use this model to update its workload projections, which are used to develop the annual budget request. In addition, the CARES process serves as the foundation for VHA's capital budget process. For example, the first step in VHA's capital budget process is for networks to submit proposals that identify capital projects that will address service or infrastructure gaps identified in the CARES process to the department. Additionally, in its fiscal year 2008 budget submission, VA requested $560 million for VHA major

construction projects and $180 million for minor construction projects—all of which will be devoted to the continuation of CARES.[10]

CARES Process Has Enhanced VA's Capital Planning Process

The CARES process is the latest in a series of initiatives to improve VA's capital planning process. In 1997, VA started efforts to develop a systemwide, integrated capital planning process. According to VA, the fundamental goal of the new process was to ensure that all major capital investment proposals, including high-risk and mission-critical projects, were

- based upon sound business and economic principles;
- aligned with the overall strategic goals and objectives of VA;
- addressed the Secretary's priorities; and
- supported the President's Management Agenda, among other things.

In 2001, VA took steps to further enhance its capital planning process by creating the Office of Asset Enterprise Management (OAEM), which is responsible for developing capital asset policy, providing guidance and oversight, and ensuring a consistent and cohesive agency approach to capital asset acquisition, management, and disposal.[11] One of the objectives of creating this departmental-level office was to strengthen VA's capital planning process and ensure the coordination of planning and investment decisions throughout the department. To streamline the process for developing capital investment proposals, OAEM developed a new process that requires officials to submit and review investment proposal data in increasing levels of detail. The goal of this streamlined approach was to reduce the laborious data collection associated with developing proposals that are not funded and allow proposal developers

[10] Section 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, P.L. 109-461, 120 Stat. 3403, 3447 (2006), increases the threshold for approval for major medical facilities from $7 million to $10 million.

[11] More recently, section 811 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, P.L. 109-461, 120 Stat. 3403, 3446-3447 (2006), creates the position of Director of Construction and Facilities Management, whose responsibilities are, among other things, to develop and update short- and long-range capital investment strategies and plans of the department.

more time to provide senior management with the most accurate cost and schedule data.

Through the CARES process, VA gained the tools and information needed to plan capital investments. Despite VA's past efforts and progress, VA continued to lack current information on the condition of all VA's facilities and information on what services veterans would need—and where—in the future. As part of the CARES process, VA modified an actuarial model that it used to project VA budgetary needs. According to VA, the modifications enabled the model to produce 20-year forecasts of the demand for services and provided for more accurate assessments of veterans' reliance on VA services and capacity gaps, and market penetration rates.[12] The information provided by the model allowed VA to identify service needs and infrastructure gaps, in part, by comparing the expected location of veterans and demand for services in years 2012 through 2022 with the current location and capacity of VA health care services within each network.[13] In addition to modifying the model, facility condition assessments were conducted on all of VA's real property holdings as part of the CARES process. This provided VA information about the condition of its facilities, including infrastructure needs.

VA continues to use the tools developed through CARES as part of its capital planning process. For example, VA conducts facility condition assessments for each real property holding every 3 years on a rotating basis. In addition, VA uses the modified actuarial model to update its workload projections each year, which are used to inform the annual capital budget process.[14]

[12]We did not evaluate the reliability of the model or its projections.

[13]VA did not complete inpatient alignment decisions across VA for long-term care and mental health services and for inpatient services at some facilities because VA lacked sufficient information to do so.

[14]As a result of VA's efforts to improve its capital asset management program, VA achieved Green status on the scorecard for the federal government's real property initiative in 2006. As part of the President's Management Agenda, the Executive Branch Management Scorecard is used to track how well departments and major agencies are executing the governmentwide management initiatives. The scorecard employs a simple grading system: Green for success, Yellow for mixed results, and Red for unsatisfactory.

CARES Process Serves as the Foundation of VHA's Capital Planning Efforts

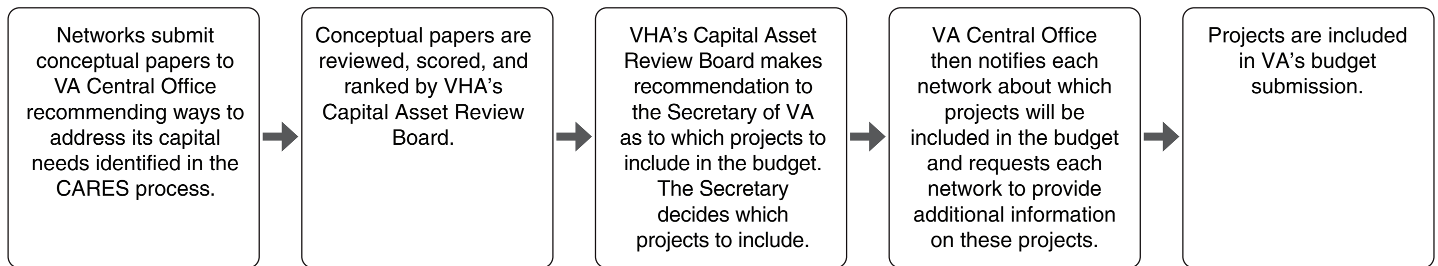
The CARES process serves as the foundation for VHA's capital planning efforts. As shown in figure 1, the first step in VHA's capital budget process is for networks to submit conceptual papers[15] that identify capital projects that will address service or infrastructure gaps identified in the CARES process and as updated through the incorporation of the CARES forecasting model into the strategic and capital planning process. The Capital Asset Review Board reviews, scores, and ranks these papers. Over 50 CARES conceptual papers and business case applications were evaluated based on criteria approved by the Secretary for the fiscal year 2008 budget process. The Capital Asset Review Board identifies the proposals that will be sent forward for additional analyses and review, and may ultimately be included as part of VA's budget request. According to VA officials, all capital projects must be based upon the CARES planning model to advance through VHA's capital planning process. On the basis of CARES-identified infrastructure needs and service gaps, VA identified more than 100 major capital projects in 37 states, the District of Columbia, and Puerto Rico.[16] In addition to these projects, the CARES planning model identified service needs and infrastructure gaps at other locations throughout the VA system.[17] These service needs and gaps could translate into other proposed major or minor capital projects in the future.

[15]CARES conceptual papers are created at the network level and provide a detailed description of the project, the problem the project will address, and other relevant information.

[16]The term "major capital projects" refers to the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $10 million. (See Section 812 of P.L.109-461, 120 Stat. 3403, 3447 (2006) and 38 U.S.C. 3108.) In contrast, a "minor capital project" refers to the construction, alteration, or acquisition of a medical facility involving a total expenditure of $10 million or less.

[17]The CARES planning model is updated annually to reflect new information such as better projections of Iraqi war veterans.

Figure 1: Major Steps of VHA's Capital Planning Process



Source: GAO analysis.

VHA's capital plan and budget only contain projects identified through the CARES planning model. According to VA, the capital plan identifies priority projects that will improve the environment of care at VA medical facilities and ensure more effective operations by redirecting resources from maintenance of vacant and underused buildings and reinvesting them in veterans' health care. The capital plan identifies 27 priority CARES projects for major construction funding for fiscal year 2008. In the accompanying fiscal year 2008 budget submission, VA requested $560 million for VHA major construction projects and $180 million for minor construction projects—all of which will be devoted to the continuation of VA's efforts to address infrastructure needs and service gaps identified through the CARES process. According to VA's fiscal year 2008 budget submission, the major construction funding provides for the construction of 3 new medical facilities, consolidation of services in Pittsburgh, and a new spinal cord injury center in Syracuse, New York, as well as various other projects, such as security upgrades, hazardous waste abatement, and design work. The minor construction funding provides for constructing, altering, extending, and improving VHA facilities where the estimated cost is $10 million or less. According to VA's capital budget, this funding will enable VA to implement the CARES proposals that can be accomplished through the minor construction program.

Range of Alignment Alternatives Considered throughout the CARES Process, and Resulting Decisions Will Result in an Expansion of VA's Capital Assets

The DNCP, the CARES Commission, and the Secretary considered a range of capital asset alignment alternatives throughout the CARES process. The most frequently considered alternatives included renovating or expanding existing sites, conducting additional analysis, and changing services. The least frequently considered alignment alternatives included closing facilities, collaborating with medical universities, expanding or using existing CBOCs, and utilizing telemedicine and telehealth.[18] Although a range of alternatives were considered, there was relatively consistent agreement among the DNCP, the CARES Commission, and the Secretary as to which were the best alternatives to pursue. For example, the CARES Commission agreed with about 78 percent of the DNCP proposals, while the Secretary agreed with about 81 percent of the commission's recommendations. Although the Secretary tended to agree with the CARES Commission's recommendations, the extent to which he agreed varied by alignment alternative. In particular, the Secretary always agreed with the commission's recommendations to build new facilities, enter into enhanced use leases, and collaborate with DOD and universities, but was less likely to agree to the CARES Commission's recommendations to contract out or close facilities. For example, the Secretary only agreed with about half of the commission's recommendations to contract out. The resulting capital alignment alternatives recommended by the CARES Commission and agreed to by the Secretary will result in an overall expansion of VA facilities. According to VA, the expansion reflects expected workload demands, service gaps, and associated infrastructure needs.

Range of Alignment Alternatives Considered for VA Facilities

Our analysis indicates that a range of alternatives for aligning capital assets was considered throughout the CARES process. Using the published reports, we categorized all instances when an alignment alternative was considered by the DNCP, CARES Commission, or the Secretary for VA facilities.[19] We identified 14 different alignment alternatives that were consistently considered during the different phases of the CARES process. The alternatives ranged from closing a facility to

[18]Telemedicine is providing health care, including medical diagnoses and patient care, from a distance through the use of telecommunications technology. Telemedicine includes speech, pathology, radiology, and patient consultation from a distance. Telehealth is the use of telecommunications technology to exchange health care information and provide health care services.

[19]Our analysis includes alignment alternatives considered for VA facilities as documented in the DNCP, CARES Commission Report, or the Secretary's Decision Report. See appendix I for more information on our methodology.

constructing a new facility (see table 3). For most of the facilities that were assessed in VA's published reports, the DNCP, CARES Commission, or the Secretary considered multiple alignment alternatives. The consideration of a range of alignment alternatives by the DNCP, CARES Commission, and the Secretary is consistent with capital planning best practices and is an important step in ensuring appropriate alignment decisions are made.[20]

Table 3: Capital Asset Alignment Alternatives Considered throughout the CARES Process

Alternative	Definition
Status quo	No changes proposed; current services are maintained
Close facility or study the feasibility of closing	Close facility or study the feasibility of closure
Change services	Services at a VA unit are changed in any way, such as converting inpatient beds to outpatient beds
Collaboration–DOD	Any collaboration between VA and DOD for medical services
Collaboration–university	Any collaboration between VA and a university or other educational institutions for medical services
Contract out	Any occasion where VA contracts in the community for medical services
Renovate/expand	Any renovation or expansion of an existing VA facility
Build new facility	New construction of any type of medical facility, such as a hospital, domiciliary,[a] or nursing home
Build new CBOC	Construction of any new CBOC of any size to address health care demands
Expand/use existing CBOC	Utilize existing CBOC or add space through construction, renovation, or leasing to existing clinics in order to address health care demands
Consolidate services	Downsizing health care services or consolidating two or more hospitals/clinics into fewer facilities
Additional analysis needed	The development of plans or policies to analyze the implementation of health care services, such as a Facility Master Plan
Enhanced use lease	VA leases underutilized or unused property to an outside entity if the agreement enhances the use of the property or results in an improvement of services to veterans in the network in which the property is located[b]
Telemedicine/telehealth	Providing health care from a distance and exchanging health care information using telecommunications technology

Source: GAO analysis.

[a]A domiciliary provides clinical care to patients who suffer from a wide range of illnesses, or areas of dysfunction, which can be medical, psychiatric, vocational, educational, or social in a safe, secure, semistructured homelike environment.

[b]Enhanced use leasing authorizes VA to lease real property under the Secretary's jurisdiction or control to a public or private entity for up to 75 years. The lease should result in a beneficial redevelopment or reuse of the VA property such as including space for a VA mission-related activity or in providing some form of consideration that can be applied to improve health care services for veterans and their families in the community where the site is located.

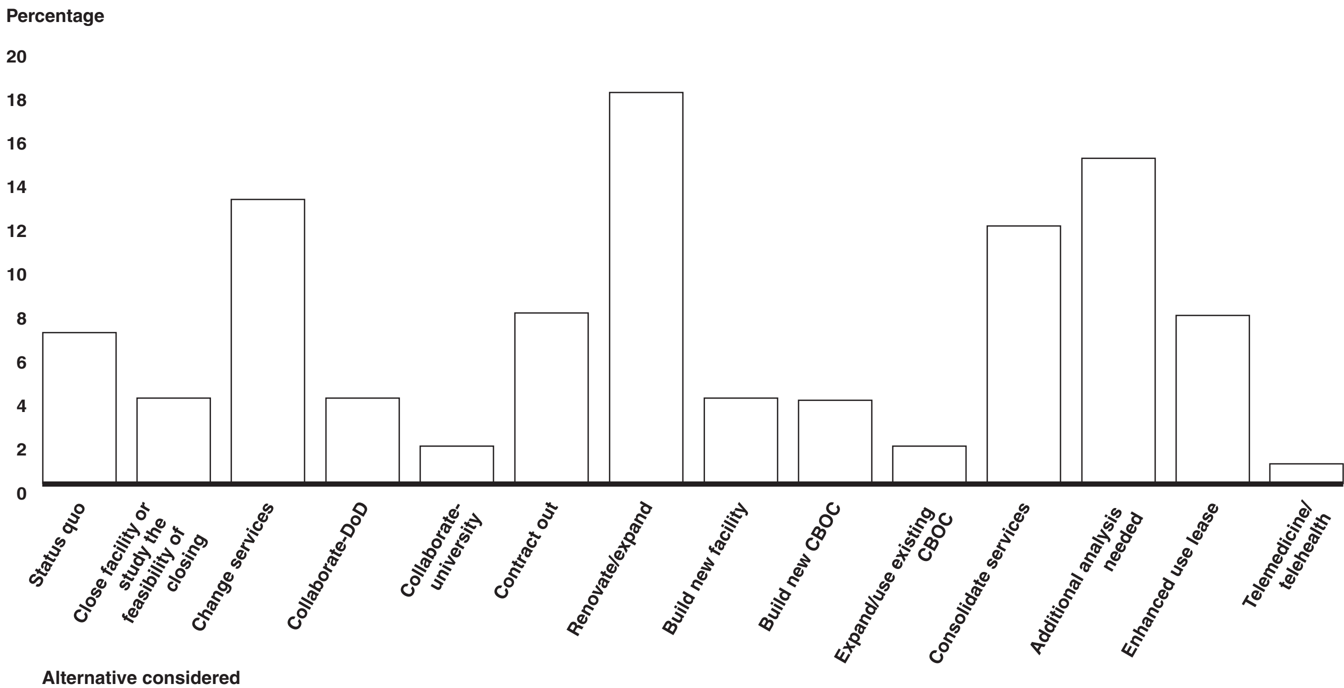
[20]See GAO-03-1103R and GAO/AIMD-99-32.

We also found that a range of alignment alternatives were considered at the six VA facilities we visited. We visited VA facilities in Big Spring and El Paso, Texas; Orlando, Florida; Pittsburgh, Pennsylvania; Los Angeles, California; and Walla Walla, Washington. We found that multiple alignment alternatives were considered for the VA facility in each location. For instance, in Pittsburgh, alternatives that were considered included maintaining the status quo, consolidation of its three separate campuses, renovation/expansion, contracting out, enhanced use leasing, and new construction. Similarly, for the VA facility in Los Angeles, alternatives considered included consolidation, collaboration, new construction, and renovation/expansion. Appendix IV provides information on the alignment alternatives considered at each facility we visited.

Although a range of capital asset alignment alternatives were considered throughout the CARES process, some alternatives were more frequently considered than others. (See fig. 2.) Our analysis indicates that the most frequently considered alternatives included renovating or expanding existing sites, conducting additional analysis, and changing services. For example, the DNCP, the CARES Commission, and the Secretary considered renovating and expanding the medical facilities in Pittsburgh to enhance veteran care. The least frequently considered alignment alternatives included closing facilities, collaborating with medical universities, expanding or using existing CBOCs, and utilizing telemedicine and telehealth. For instance, only 3.9 percent of alternatives considered involved closing facilities. According to VA officials, closure was considered for more facilities during the initial CARES planning efforts. However, the CARES projections indicated that most facilities were needed.[21] Therefore, closures were not considered as often as had been expected when CARES was initiated.

[21]We did not evaluate the reliability of the model or its projections.

Figure 2: Capital Asset Alignment Alternatives Considered during the CARES Process



Source: GAO analysis of the CARES Commission Report and Secretary's Decision document.

Note: More than one alternative may have been considered for each VA facility. We included all the alternatives considered for each facility in our analysis.

DNCP, Commission, and VA Secretary Generally Agreed on Alignment Alternatives for VA Facilities, and Decisions Will Result in an Expansion of Assets

Although a range of capital asset alignment alternatives were considered for VA facilities throughout the CARES process, there was relatively consistent agreement among the DNCP, the CARES Commission, and the Secretary as to which were the best alternatives to pursue. According to our analysis, the CARES Commission agreed with about 78 percent of the DNCP proposals, while the Secretary agreed with about 81 percent of the commission's recommendations. Thus, almost three-fourths (73.8 percent) of the DNCP proposals made it all the way through the process—that is, the CARES Commission recommended the DNCP proposal and the Secretary agreed to implement it.

While the Secretary tended to agree with the CARES Commission's recommendations, the extent to which he agreed varied by alignment alternative. In particular, the Secretary always agreed with the commission's recommendations to build new facilities, enter into enhanced use leases, and collaborate with DOD and universities. For

example, the Secretary agreed with the commission's recommendation to build a new VA medical facility in the Orlando area and explore enhanced use leasing options at VA's West Los Angeles facility. In contrast, the Secretary was less likely to agree to the CARES Commission's recommendations to contract out or close facilities. For example, the Secretary agreed with the commission's recommendations to contract out in 8 of 14 instances. Table 4 indicates how often the Secretary agreed to the commission's recommendations, by selected alternative.

Table 4: Percentage of Secretary's Agreement with the Commission's Recommendation, by Capital Asset Alignment Alternative

Alignment alternatives	Number of times recommended by the CARES Commission	Number of times the Secretary agreed with the CARES Commission's recommendations	Percentage of times the Secretary agreed with commission recommendation
Status quo	33	26	78.8%
Close facility or study the feasibility of closing	3	1[a]	33.3%
Change services	16	13	81.3%
Collaboration-DOD	16	16	100.0%
Collaboration-university	4	4	100.0%
Contract out	14	8	57.1%
Renovate/expand	81	67	82.7%
Build new facility	13	13	100.0%
Build new CBOC or expand/use existing CBOC	67	62	92.5%
Consolidate services	56	50	89.3%
Additional analysis needed	79	74	93.7%
Enhanced use lease	27	27	100.0%

Source: GAO analysis of the CARES Commission Report and the Secretary's Decision document.

Note: More than one alternative may have been considered for each VA facility. We included all the alternatives considered for each facility in our analysis.

[a]In the 2004 Decision document, the Secretary decided to conduct feasibility studies to consider closing the Gulfport and Big Spring facilities. In 2006, the Secretary decided to close the Gulfport facility (which was damaged by Hurricane Katrina) and keep the Big Spring facility open.

Our analysis of the capital alignment alternatives recommended by the CARES Commission and agreed to by the Secretary indicates that an overall expansion of VA facilities will result. As table 4 indicates, the Secretary agreed to all of the commission's recommendations for building new facilities and nearly all of the commission's recommendations for

opening new CBOCs. As a result, VA intends to open 156 new CBOCs by 2012 and, as of February 2006, had submitted proposals to Congress to build 3 new medical centers. In contrast, Gulfport is the only VA facility that has been completely closed or planned for closure since CARES was initiated.[22] The DNCP originally proposed closing 10 facilities. However, the CARES Commission only recommended the Secretary close or consider the feasibility of closing 3 facilities—Gulfport, Walla Walla, and Big Spring. When announcing his decisions in May 2004, the Secretary stated that further study was needed to make a decision regarding the future of these three facilities.[23] In 2006, the Secretary decided to (1) completely close the Gulfport facility, which was damaged by Hurricane Katrina; (2) maintain inpatient services and expand mental health services in Big Spring; and (3) build a new outpatient clinic, but close and contract out inpatient services in Walla Walla.

In addition to the 3 facilities that the CARES Commission recommended for closure, the Secretary identified 15 other facilities that required further study in his announcement in 2004. According to the Secretary, the additional studies would help him decide whether closure, service changes, or property disposal was warranted for these facilities. The Secretary has issued decisions for 14 of these 15 facilities. None of the Secretary's decisions for these 14 facilities will result in facility closure. Table 5 describes the Secretary's decisions for all 18 facilities identified for further study.

[22]VA plans to close only inpatient services at four other VHA facilities. For more information about VA's efforts to realign its inpatient services, see GAO, *VA Health Care: Important Steps Taken to Enhance Veterans' Care by Aligning Inpatient Services with Projected Needs*, GAO-05-160 (Washington, D.C.: March 2005).

[23]The Secretary indicated that two of these studies, for Big Spring and Gulfport, would examine whether the facilities should be closed.

Table 5: Status of 18 Facilities That Required Further Study

Facility location	Secretary's decision
Big Spring, TX	Maintain inpatient services and expand mental health services, including construction of a domiciliary unit.
Boston, MA	Rejected proposal to consolidate four medical facilities into one single facility; conduct further study of options to modernize and meet the needs of veterans.
Brooklyn-Manhattan, NY	Maintain existing services at Brooklyn VA Medical Center.
Canandaigua, NY	Continue to provide inpatient and outpatient services and to build new or renovate buildings.
Gulfport, MS	Closed facility due to Hurricane Katrina.
Lexington, KY	Replace inpatient and outpatient facilities, but conduct further study of options.
Livermore, CA	Renovate or replace nursing home facilities; conduct further study of options to modernize and replace.
Louisville, KY	Build new facility to replace existing medical center.
Montgomery, AL	Continue to provide inpatient services and modernize the facility; continue to partner with Maxwell Air Force Base.
Montrose/Castle Point, NY	Conduct study of options selected to replace and/or renovate facilities at each campus.
Muskogee, OK	Maintain inpatient services and expand psychiatric services.
Perry Point, MD	Develop a capital plan to modernize campus coordinated with reuse opportunities.
Poplar Bluff, MO	Maintain inpatient services and add cardiology services.
St. Albans, NY	Replace existing facility with new nursing home, outpatient clinic, and domiciliary.
Waco, TX	All services will be maintained at Waco; VA will work to find uses for the underutilized portions of the Waco campus.
Walla Walla, WA	Build new outpatient facility for primary and specialty care and mental health services; close and contract out inpatient services.
Los Angeles, CA	To be decided.
White City, OR	Modernize rehabilitation center and clinics.

Source: GAO analysis of VA decision memos.

Although facility closure was infrequently chosen as an alignment alternative in the CARES process, the CARES Commission frequently recommended consolidating services and the use of enhanced use leasing—and the Secretary tended to agree with these recommendations. Consolidating services could position VA to close additional facilities in the future. For example, when services are consolidated from 3 to 2 campuses in Pittsburgh, VA's Highland Drive facility will become vacant and could be closed in the future. However, a VA official said that no decision has been made whether the Highland Drive facility will be demolished, leased, or sold, among other possibilities. In addition, entering into enhanced use leases could help VA reduce excess or vacant space. The CARES Commission noted that the proposals contained in the DNCP rely heavily on enhanced use leases to reduce VA's vacant space.

According to VA officials, rather than show that VA should downsize its capital asset portfolio, the CARES process revealed a greater demand for services and need for infrastructure improvements than originally expected. Although the CARES projections indicate that the overall number of veterans enrolled in VA health care will decline from fiscal year 2002 to fiscal year 2022, there are locations that are projected to experience some growth in the demand of services in the near term. For example, the number of enrollees in the Sunshine Health Care Network is expected to increase by about 7 percent from fiscal year 2001 through fiscal year 2012.[24] In addition, VA's aging infrastructure—including many hospitals built or acquired more than 50 years ago—is not well suited for modern health care delivery and does not reflect VA's increased emphasis on outpatient care. Consequently, the CARES process indicated that there was sufficient demand for services at most VA facilities, thereby validating the need to maintain or renovate these facilities as well as construct new facilities, primarily outpatient clinics, according to VA officials.

A Number of Factors Influenced the Alignment Alternatives Considered and Recommended for Six Locations Studied

Our analysis of the alternatives considered and recommended for the six facilities we visited indicate that a number of factors shape, and in some cases, limit capital asset alignment decision making. These factors include competing stakeholder interests, facility condition and location, access issues, established relationships with other health care providers, and legal restrictions. Some of these factors are similar to the challenges we have identified in our review of real property management efforts across the government.[25] The factors we identified in our site visits are summarized below.

- **Competing stakeholder interests.** Experiences from Walla Walla and Big Spring illustrate the challenges that VA can face when considering closing a facility or reducing services. In both locations, CARES workload projections indicate that the demand for services is decreasing. However, community and veteran groups as well as elected officials strongly opposed reducing services or closing facilities. Rather, they argued for preserving the status quo or increasing services. For instance, Big Spring and Walla Walla stakeholders formed community task forces to explore options for continuing VA services. According to a former Big Spring VA

[24]The Sunshine Health Care Network includes Florida (except 7 Panhandle counties), 19 rural counties in south Georgia, the U.S. Virgin Islands, and Puerto Rico.

[25]GAO-03-122.

official, approximately 2,000 members of the community attended town hall meetings to discuss the future of the Big Spring facility. According to VA officials and stakeholders, these efforts were intended to influence the Secretary's decision to maintain or increase services. Although the CARES Commission recommended closing or studying the feasibility of closing the facilities in Walla Walla and Big Spring, the Secretary ultimately decided to (1) build a new outpatient facility in Walla Walla and (2) maintain inpatient services and expand mental health services in Big Spring. According to VA, the Secretary's decisions in these two locations were based on a variety of factors, including access issues, the condition of the facilities, and potential reuse options.

- **Facility condition and location.** Experiences in Pittsburgh and Orlando illustrate how the condition of the facility and its location can influence decision making. According to a VA official, the Highland Drive facility in Pittsburgh was in poor condition and not designed for modern health care—a fact that influenced the alignment alternatives considered. The DNCP and the CARES Commission recommended consolidating services in Pittsburgh—specifically, by shifting services provided at the Highland Drive facility to the two other VA medical facilities in Pittsburgh. In Orlando, expanding the existing facility to meet growing demand was ruled out as an option because there was inadequate land available at the existing site to accommodate a larger facility.

- **Access issues.** Experiences in Walla Walla, Big Spring, and Orlando illustrate how access issues influenced the alternatives considered and recommended. VA facilities in Walla Walla and Big Spring are located in rural areas, and are at least 4 hours drive time from other VA facilities, including facilities with mental health services.[26] In addition, although the inpatient workloads at both facilities are projected to decline, demand for outpatient services is expected to remain stable or increase at these locations, according to VA. Based on our interviews with VA officials and stakeholders, maintaining access to health care services was an important factor in deciding not to completely close the Big Spring and Walla Walla facilities. Similarly, a VA official stated that a new facility was needed in Orlando to meet the CARES access proximity standard (i.e., within a 1-hour drive of acute patient care). In particular, only 45 percent of the veteran population in VA's Sunshine Health Care Network live in an area that meets this standard. Building a new facility in the Orlando area would increase the percentage of veterans living within 1 hour of acute patient care to 78 percent.

[26]VA uses drive time as a measure of access to health care services.

- **Established relationships with other health care providers.** Experiences in El Paso and Big Spring demonstrate how established relationships influenced whether collaborative opportunities were considered and recommended as an alternative. For example, according to VA officials, collaborative opportunities between the VA facility in Big Spring, Texas, and Dyess Air Force Base in Abilene, Texas, were not pursued, in part, because the two entities had no history of sharing services. Conversely, VA and DOD have a history of sharing services in El Paso, and as a result, considering further collaborative opportunities at this location was a natural outgrowth of their current relationship.

- **Legal restrictions.** Legal restrictions on the disposal of property and the use of enhanced use leasing in Los Angeles illustrate how legal restrictions can influence the capital asset alignments considered and recommended. A VA official at the West Los Angeles facility said that the value of underutilized property at the site is considerable given real estate prices in the surrounding area. As noted in the Secretary's 2004 Decision document, VA is interested in finding uses for underutilized property. However, legal restrictions have limited alternatives for the reuse or disposal of parcels of the valuable but underutilized property. In particular, a 1988 law prohibits VA from declaring as excess or taking any other action to dispose of approximately 109 acres at the 387-acre VA campus in Los Angeles.[27] While only a portion of the restricted 109 acres is underutilized, the land could provide opportunities for development. Additional legislation prohibits VA from entering into any enhanced use lease relating to the 109 acres unless the lease is specifically authorized by law.[28] These laws only apply to VA's West Los Angeles campus.

[27]Section 421(b) of the Veterans' Benefits and Services Act of 1988, P.L. 100-322, 102 Stat. 487, 552-553 (1988).

[28]VA is specifically authorized by law to enter into an enhanced use lease for the 109 acres if the lease is for child care services. See 38 U.S.C. § 8162(c).

Some CARES Decisions Implemented, but VA Does Not Use Performance Measures to Assess and Track Their Implementation and Impact

VA has started implementing some CARES decisions and integrating CARES concepts into its strategic planning process. However, VA does not use, or in some cases does not have, performance measures for CARES. These measures, if used, could help determine the extent to which the implementation of CARES is achieving the intended results and, more broadly, how it is helping the agency carry out its mission of providing health care to the nation's veterans. For example, VA does not centrally track or monitor the implementation of CARES decisions. This type of information—which could be used as a performance measure—could help VA officials and stakeholders assess VA's progress in the implementation of CARES. It would also help stakeholders hold VA accountable for results—which is especially important since VA estimates it will need at least $5 billion to implement CARES decisions.

VA Has Begun Implementing CARES Capital Decisions and Has Taken Steps to Integrate CARES into Its Strategic Planning Process

VA has begun implementing some CARES decisions. Specifically, as of February 2007, VA was in the process of implementing 32 of more than 100 major capital projects that were identified in the CARES process.[29] As table 6 shows, most of these projects are in the construction phase, although some are in the design phase. For instance, VA is in phase I of designing a new hospital in Orlando, while it is in the construction phase of consolidating three VA facilities into two in Pittsburgh. VA completed construction for one CARES-related major capital project.

[29] The major capital CARES projects that are under way were selected and prioritized through VHA's internal capital planning process as described earlier in the report.

Table 6: Status of Major CARES Capital Projects, as of February 2007

VA facility location	Project description	Status	Estimated completion date
Anchorage, AK	Outpatient clinic and regional office, phase 2 construction	Design phase 1	September 2008
Atlanta, GA	Modernize patient wards	Design phase 1	To be determined (TBD)
Biloxi, MS	Restoration of hospital/consolidation of Gulfport	Design phase 1	January 2012
Chicago, IL	Bed tower	Construction phase 2	September 2007
Cleveland, OH	Cleveland-Brecksville consolidation	Construction phase 2	February 2010
Columbus, OH	New outpatient clinic	Construction phase 2	February 2008
Denver, CO	Replacement medical center facility	Design phase 1	TBD
Des Moines, IA	Extended care building	Construction phase 2	March 2008
Durham, NC	Renovate patient ward	Design phase 1	December 2008
Fayetteville, AR	Clinical addition	Design phase 1	TBD
Gainesville, FL	Correct patient privacy deficiency	Design phase 1	August 2009
Indianapolis, IN	Seventh and eighth floor wards modernization	Construction phase 2	February 2009
Las Vegas, NV	New medical center facility	Construction phase 2	January 2011
Lee County, FL	Outpatient clinic	Design phase 1	TBD
Long Beach, CA	Seismic corrections–Buildings 7 and 10	Design phase 1	September 2009
Los Angeles, CA	Seismic corrections–Buildings 500 and 501	Design	TBD
Menlo Park, CA	Seismic corrections–geropsych replacement	Construction phase 2	December 2008
Minneapolis, MN	Spinal cord injury and spinal cord disease center	Construction phase 2	February 2009
North Chicago, IL	Joint VA and Dept. of Navy medical project	Completed	Completed
Orlando, FL	New medical center facility	Design phase 1	TBD
Palo Alto, CA	Seismic corrections–Building 2	Design phase 1	TBD
Pensacola, FL	Joint VA and Dept. of Navy outpatient clinic	Construction phase 2	September 2007
Pittsburgh, PA	Consolidation of campus	Construction phase 2	TBD
San Antonio, TX	Ward upgrades and expansion	Design	May 2010
San Diego, CA	Seismic corrections–Building 1	Construction phase 2	August 2008
San Francisco, CA	Seismic corrections–Building 203	Construction phase 2	August 2008
San Juan, PR	Seismic corrections–Building 1	Design phase 1	TBD
Syracuse, NY	Spinal cord injury center	Design	January 2010
Tampa, FL	Spinal cord injury center expansion	Construction phase 2	December 2007
Tampa, FL	Upgrade essential electrical distribution systems	Design	September 2009
Temple, TX	Blind rehabilitation and psychiatric beds	Design phase 1	TBD
Tucson, AZ	Mental health clinic	Construction phase 2	February 2008

Source: VA's Five-Year Capital Plan.

In addition to these major capital projects, VA has started efforts to develop new CBOCs. In May 2004, the Secretary decided to implement 156 new CBOCs by 2012. According to the Secretary, these CBOCs would improve access to health care for veterans. As of January 2007, 32 CBOCs have opened or been approved for opening, according to VA officials.

Although VA is moving forward with the implementation of some CARES decisions, a number of VA officials and stakeholders, including representatives from veteran service organizations and local community groups, view the implementation process as too lengthy, not transparent, and hampered by competing stakeholder interests.[30] For instance, stakeholders in Big Spring, Texas, noted that it took almost 2 years for the Secretary to decide whether to close the facility. During this period, there was a great deal of uncertainty about the future of the facility—as a result, there were problems in attracting and retaining staff at the facility, according to network and local VA officials. A VA official acknowledged that implementation of some CARES decisions, notably the further studies of the 18 facilities, have taken longer than expected and time frames have not been established for implementing decisions on those facilities.

A number of stakeholders we spoke to also indicated that the implementation of CARES decisions has been influenced by competing stakeholders' interests—thereby undermining the process. For example, several stakeholders questioned why certain projects appear to be on the fast track, while projects in other locations, such as Orlando, have not moved as quickly—even though CARES data indicate a significant need in these locations. We have previously reported that competing interests from local, state, and political stakeholders have often impeded federal agencies', including VA's, ability to make transparent capital alignment decisions.[31] As a result of competing stakeholder interests, decisions about real property often do not reflect the most cost-effective or efficient alternative that is in the interest of the agency or the government as a whole but instead reflect other priorities. In particular, this situation often arises when the federal government attempts to consolidate facilities or otherwise dispose of unneeded assets. In its report, the CARES Commission also noted that stakeholder and community pressure can act

[30] According to VA, the department complied with the open process requirements of the Federal Advisory Committee Act. For example, VA held hearings at different locations, and stakeholder comments at the hearings were recorded and transmitted to the Secretary.

[31] GAO-03-122.

as a barrier to change, and can serve to pressure VA to maintain the status quo, such as maintaining specific services or facilities.

VA has also taken steps to integrate CARES decisions into its strategic planning process. Officials from VHA's Office of Policy and Planning—the office responsible for VHA's strategic plan—told us that they used the CARES workload projections in developing the 2006-2011 Strategic Plan and incorporated CARES principles into the strategic planning process. For example, VHA incorporated the principle of enhancing access to health care services for veterans as a strategic initiative in its strategic planning process and documents.

To help advise the Secretary on integrating CARES into VA's strategic planning process, the CARES Commission recommended establishing an independent advisory body. In response, the Secretary established a permanent, senior-level CARES Implementation Board. According to the Secretary's May 2004 CARES Decision, the board was to consist of senior leadership from across the department, would work with the VA networks to implement CARES decisions, and would report directly to the Secretary. The board was charged with ensuring that CARES was integrated into strategic planning and that all CARES decisions were effectively planned, implemented, and managed. In addition, the board was responsible for overseeing the additional studies that the Secretary deemed necessary for 18 facilities. However, the board was disbanded in February 2005, less than 10 months after the Secretary announced its creation. According to VA officials, the board was disbanded because VA leadership decided to focus on the key CARES decisions that remained—namely, the 18 facilities the Secretary identified for further study.

Despite Cost and Importance of CARES, VA Does Not Use Performance Measures to Assess Implementation and Impact of CARES Decisions

As we have noted in past reports on managing for results, agencies should have performance measures for significant agency activities, such as CARES.[32] The CARES process was and continues to be a significant undertaking for VA. For example:

- CARES was a lengthy process—over 3 years elapsed between the time VA initiated CARES to when the Secretary issued his decisions. During this time, VA put a number of decisions on hold in anticipation of the CARES

[32] GAO, *The Results Act: An Evaluator's Guide to Assessing Agency Annual Performance Plans*, GAO/GGD-10.1.20 (Washington, D.C.: April 1998).

decisions. For example, according to VA officials at the West Los Angeles facility, they were planning to develop a master plan for developing and reusing its property prior to the CARES process. However, the development of the master plan was suspended until CARES decisions were made.[33] Similarly, VA did not pursue a collaborative opportunity with the University of Colorado in Denver, Colorado, in part, because VA was waiting for the CARES decisions.[34] In particular, after studying a possible joint facility between VA and the university for several years, in 2002, the President of the university asked VA to make a decision within 1 year. The Secretary responded that VA could not commit to a joint facility within that time frame because the proposal needed to be evaluated in the context of the CARES Commission's report, which was not yet released. The Secretary's response effectively ended discussions about constructing and operating a joint facility in Denver.[35]

- The CARES process was also a costly undertaking. VA did not track many of the costs associated with implementation of the CARES process, such as the staff resources spent on the process, and therefore could not estimate how much was spent on implementing the process. However, VA was able to provide us the contracts let in support of the process. The total cost of these contracts was about $18.1 million.[36]

[33]Section 707 of P.L. 105-368, the Veterans Programs Enhancement Act of 1988, 112 Stat. 3315, 3351, which was enacted in 1998, required VA to submit to Congress a report on the master plan for using VA property at the West Los Angeles campus. To date, VA has not completed the master plan.

[34]GAO, *VA Health Care: Experiences in Denver and Charleston Offer Lessons for Future Partnerships with Medical Affiliates*, GAO-06-472 (Washington, D.C.: April 2006).

[35]Section 801 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, P.L. 109-461, 120 Stat. 3403, 3442, requires the Secretary of VA to submit a report to Congress on replacing the current VA facility in Denver by June 20, 2007. The report must include, among other things, the feasibility of entering into a partnership with a federal, state, or local government agency or nonprofit organization for the construction and operation of the new facility.

[36]VA engaged in six contracts to assist the agency in implementing the CARES process. The contractors and their assigned tasks are as follows: (1) Milliman USA to develop a forecasting model on the future projected enrollment of veterans; (2) PriceWaterhouseCoopers to conduct CARES business plan studies at 18 VA facilities; (3) IBM to develop and implement financial models to determine the costs of meeting the gaps between supply and demand for capital and operating costs in the forecast years; (4) 1 of the 5 IDIQs and GTSI for servers and related equipment to store and utilize CARES data needs; (5) IDIQ (Microtech) to develop reuse plans for selected CARES business study sites; and (6) CARES Commission to independently review the Draft National CARES Plan and develop recommendations for the Secretary.

- The implementation of CARES—and the associated investment—is expected to yield a number of benefits for VA and our nation's veterans. According to the CARES Commission and the Secretary's Decision reports, implementing CARES decisions will improve access to health care, modernize VA capital assets, decrease operating costs, and decrease vacant space, among other things. For instance, the Secretary estimated that the implementation of the CARES decisions will reduce VHA's vacant space by 42.5 percent by fiscal year 2022.

VA, however, does not use, or in some cases does not have, performance measures to assess the agency's progress in implementing CARES or whether CARES is achieving the intended results. Performance measures allow an agency to track its progress in achieving intended results. Performance measures can also help inform management decision making, such as the need to redirect resources or shift priorities. In addition, performance measures can be used by stakeholders, such as veterans service organizations or local communities, to hold agencies accountable for results. Performance measures for CARES should be output-based, measuring the level of activity over a period of time that was generated by CARES. An example of an output measure would be the progress VA has made in implementing CARES decisions within desired time frames. The performance measures should also be outcome-based, measuring the impact that CARES has on VA's ability to carry out its mission or on the lives of veterans. An example of an outcome measure would be the impact the implementation of CARES had on access to health care for veterans—that is, has access improved? In addition, VA's performance should be assessed using nonfinancial and financial performance measures, such as program costs or savings.[37] VA, however, lacks critical data, including the cost and timelines of implementing CARES projects and the potential savings that can be generated through alignment of resources. The CARES Commission noted these missing data in the DNCP and when developing its recommendations.

VA has over 100 performance measures that it uses to centrally monitor agency programs and activities.[38] Examples of these measures include the

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[37]GAO/GGD-10.1.20.

[38]In addition to these existing measures, under Executive Order 13327 (Federal Real Property Asset Management Initiative), VA must adopt four performance measures related to the management of its real property holdings, such as utilization and operating and maintenance costs. The executive order establishes new federal guidelines for federal real property asset management and applies to 24 executive branch departments and agencies, including VA.

percentage of used space compared to owned and leased overall space, the ratio of operating costs per gross square foot, and the percentage of patients waiting within 20 minutes to be seen. Many of these existing measures are related to the goals of CARES. However, VA does not use these existing measures to monitor the implementation and impact of CARES decisions. Thus, VA cannot readily determine whether the implementation of certain CARES decisions are achieving the intended results.

In addition, VA does not have some performance measures that could be used to monitor the implementation and impact of CARES decisions. For example, VA does not centrally monitor or track the implementation of CARES decisions, a process that could be used as a performance measure for CARES. The lack of such a measure hinders VA leadership and stakeholders from assessing the status of implementation and making necessary adjustments. Originally, VA planned to centrally track CARES decisions—and a senior VA official started to collect and assemble this information. However, this effort was abandoned because there were concerns it would duplicate efforts of officials at the network level and in individual program offices within the department. According to senior VA officials, individual networks and program offices are responsible for tracking the implementation of the CARES decisions within their area of responsibility. However, in our interviews with senior VA officials within individual program offices and at the network level, there was confusion and disagreement as to who was tracking what. For example, a senior VA official stated that VHA's Office of Policy and Planning was tracking all major CARES projects. However, officials from this office stated that this was not their responsibility; they stated it was the responsibility of the Office of Asset Enterprise Management. Officials from the Office of Asset Enterprise Management told us that they had information on the status of CARES projects that were included in the 5-year capital plan, but that they did not track the status of all CARES decisions.

VA officials from the networks responsible for the six facilities we visited told us that they were tracking the CARES decisions that affect their networks. For example, VA officials from the Sunshine Health Care Network and the Desert Pacific Health Care Network stated that they maintain a spreadsheet tracking the status of all their major construction projects, including the status of CARES decisions.[39] According to officials

[39]The Desert Pacific Health Care Network includes the southern parts of California and Nevada.

in some of the networks we visited, the department does not require them to track the implementation of CARES decisions. Rather, these officials stated that they track this information for their own purposes. In addition, several network officials stated that they suspect that the department will eventually ask for this information.

Conclusions

With the CARES process VA has made significant strides in making plans for providing medical care to meet the changes occurring in the veteran population. Under CARES, VA for the first time adopted a systematic approach to its capital asset planning based on the projected demand for future health care services. As part of the CARES process, a broad range of capital asset alternatives were considered to meet this demand, in accordance with best practices. However, factors such as competing stakeholder interests and legal restrictions constrained VA's ability to make difficult capital alignment decisions. Consequently, VA plans to close or downsize only a few of its aging and outmoded facilities, making it difficult for VA to redeploy and reduce the funds needed to maintain and operate such facilities—which was a major impetus of CARES.

VA's challenge now is to ensure that CARES becomes an ongoing and effective part of its capital asset management efforts and that CARES decisions are carried out. Although VA has taken some steps to integrate CARES into its strategic planning efforts, more action is needed. Currently, VA does not use, or in some cases does not have, performance measures to assess its progress in implementing CARES decisions and attaining the goals of CARES. Given that VA will seek billions of dollars in additional investments to implement CARES decisions, the use of performance measures is essential to ensure that these decisions are achieving their intended results. Using performance measures to monitor CARES-related decisions would also help hold VA accountable for results and increase the transparency of CARES implementation.

Recommendation for Executive Action

To provide the information necessary to monitor the implementation and impact of CARES decisions, we recommend that the Secretary use existing performance measures as well as develop new performance measures for CARES. These measures should include both output measures, such as the implementation status of all CARES decisions, and outcome measures, such as the degree to which CARES has improved access to medical services for veterans, and should be explicitly linked to the goals of CARES.

Agency Comments

We provided a draft copy of this report to VA and DOD for review and comment. VA provided written comments, which are reprinted in appendix V. VA agreed with the report's findings and recommendation. VA also provided technical clarifications, which we incorporated, as appropriate. DOD did not have any comments.

We are sending copies of this report to the Secretary of Veterans Affairs and other interested parties. We will also make copies available to others upon request. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me on (202) 512-2834 or at goldsteinm@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VI.

Sincerely yours,

Mark L. Goldstein
Director, Physical Infrastructure Issues

Appendix I: Objectives, Scope, and Methodology

Our overall objective was to determine the extent to which the Department of Veterans Affairs' (VA) Capital Asset Realignment for Enhanced Services (CARES) process has been implemented and how it has contributed to its overall mission of providing health care services to veterans. Specifically, our research examined (1) how CARES contributes to Veterans Health Administration's (VHA) capital planning process, (2) the extent to which the CARES process considered alignment alternatives, and (3) the extent to which VA has implemented CARES decisions and how this implementation has helped VA carry out its mission.

To address how the CARES process contributed to VA's capital asset management efforts, we reviewed CARES documents, including the Draft National CARES Plan (DNCP), February 2004 CARES Commission Report, and the May 2004 Secretary's CARES Decision document. We also reviewed and analyzed VA's Asset Management Plan, Five-Year Capital Plan (Fiscal Year 2007-2011), and Strategic Plan to determine the extent to which CARES is integrated into VA's capital planning efforts. We also reviewed GAO's past work on VA's management of its capital assets and leading practices for realigning federal agency infrastructure and capital decisions. We interviewed VA officials to discuss how the CARES process was incorporated into VA's capital planning efforts. We also reviewed and analyzed information from VA's budget documents to determine how CARES decisions are integrated.

To determine what CARES capital asset alignment alternatives were considered in the CARES process, we developed a spreadsheet to record all the capital asset alternatives that were considered in the DNCP, the February 2004 CARES Commission Report, and the May 2004 Secretary's CARES Decision document for each VA facility. We identified the capital asset alternatives considered by reviewing DNCP proposals, CARES Commission analysis and findings, CARES Commission recommendations, and the Secretary's CARES decisions. In addition to tracking the number of times different capital asset alternatives were considered, we developed a coding system that allowed us to determine the extent of the Secretary's concurrence with alternatives proposed in the DNCP and recommended by the CARES Commission. We also coded any additional alternatives proposed by the Secretary.

We also developed a spreadsheet to track the extent of agreements or disagreements on the CARES proposals during the different levels of the CARES process. We summarized and inputted all CARES proposals that were outlined in the CARES Commission report by network. The level of details in the proposals was broken down by VA facilities and service

levels. We identified and coded each proposal to indicate whether the commission concurred or disagreed with the CARES proposals in the DNCP, as well as any additional or alternative recommendations made by the commission. Similarly, we also coded each proposal to indicate whether the Secretary concurred or disagreed with the recommendations from the commission. We also recorded any alternative or additional CARES decisions that the Secretary decided to implement. Crosscutting recommendations were also recorded in the spreadsheet.

Both spreadsheets were pilot-tested and appropriate revisions were made to improve the instrument based on pilot results. To ensure accuracy and consistency of data entry, a second team member independently verified the information that another team member had initially entered or coded. This information was verified by comparing what was entered or coded with the information in the February 2004 CARES Commission Report and May 2004 Secretary's CARES Decision document. If the documents did not explicitly reflect what was entered in the spreadsheet, data entry corrections were made.

Furthermore, to gain in-depth information on specific alternatives that were considered in the CARES process, we conducted six site visits to a nonprobability sample of VA health care facilities in Big Spring, Texas; El Paso, Texas; Los Angeles, California; Orlando, Florida; Pittsburgh, Pennsylvania; and Walla Walla, Washington.[1] We selected these six sites based on several criteria, including collaborative agreements with the Department of Defense (DOD) and medical universities, consolidation of facilities and services, expansion of services with new facilities, sites identified for additional study by VA, and geographic dispersion. At each site, we met with VA officials from the facility and respective network to discuss the CARES process, including the alternatives that were considered and dismissed for the facility as well as the status of implementing the CARES decisions. We also obtained the perspectives of local stakeholders, including officials from veterans service organizations, VA employee unions, medical universities, DOD, and local advisory panels. We also toured the facilities at each site. In addition, we researched and analyzed relevant legislation and legal documents relating to legal issues and restrictions placed on some of the VA facilities we visited.

[1]Information obtained from these site visits is not generalizable as they are nonprobability samples. Results from nonprobability samples cannot be used to make inferences about a population because in a nonprobability sample some elements of the population being studied have no chance or an unknown chance of being selected as part of the sample.

To determine the extent VA has implemented CARES decisions and how implementation of the decisions has helped VA carry out its mission, we reviewed and analyzed the May 2004 CARES Decisions document, Asset Management Plan, VA's Five-Year Capital Plan and Strategic Plan, VA's budget submission documents, and VA's legal authorities and appropriations acts. We interviewed VA officials and VA stakeholders, such as veteran service organizations, VA employees, and collaborating organizations (i.e., DOD and medical universities) to obtain their views and perspectives on the CARES process and the implementation of CARES decisions. We synthesized information obtained from VA documents, VA officials, and VA stakeholders to determine the extent VA has implemented CARES decisions and helped the agency carry out its mission of providing high quality health care to veterans.

We conducted our work from March 2006 through March 2007 in accordance with generally accepted government auditing standards.

Appendix II: Comparison of the BRAC Process to the CARE Process

The Department of Defense's (DOD) Base Realignment and Closure (BRAC) process and VA's CARES process have a number of similarities. These similarities include the basic frameworks within which the BRAC and CARES Commissions operate, such as their independence and willingness to gather public and stakeholder views and concerns. For example, for both BRAC and CARES, independent commissions provided an objective, external analysis of alignment alternatives. In addition, both the BRAC and CARES Commissions received comments and concerns from multiple external stakeholders throughout their respective processes. For example, the BRAC Commission held numerous regional hearings throughout the nation and accepted comments and concerns in writing. Likewise, the CARES Commission also received written comments and held numerous public hearings where external stakeholders, such as individual veterans, veteran service organizations, Congress, medical school affiliates, VA employees, local government entities, and affected community groups were able to offer their perspective.

Although there are similarities between the BRAC and CARES processes, there are fundamental differences—specifically, their objectives and implementation of recommendations. The objective of the BRAC process is to reorganize DOD's base structure to more efficiently and effectively support our armed forces, increase operational readiness, and facilitate new ways of doing business through the alignment or closure of excess bases. The objective of the CARES process is to enhance outpatient and inpatient care, as well as special programs, such as spinal cord injury, through the appropriate sizing, upgrading, and locating of VA facilities. The method in which recommendations are implemented is also different in the BRAC and CARES processes. In the BRAC process, the Secretary of Defense makes recommendations to a commission that is nominated by the President. The commission reviews the recommendations and makes its recommendations to the President. The President can either reject them or accept them in their entirety. If the President accepts the recommendations, they are sent to Congress for review. If the recommendations are accepted by Congress, then implementation of the recommendations is mandatory. With the CARES process, the CARES Commission made recommendations to the Secretary of Veterans Affairs. Those recommendations were not binding and can be implemented at the Secretary's discretion. Table 7 highlights the similarities and differences of the BRAC and CARES processes.

Table 7: Comparison of BRAC and CARES Processes

	BRAC	CARES
Purpose or objective	To reorganize DOD's base structure to more efficiently and effectively support our forces, increase operational readiness, and facilitate new ways of doing business.	To provide an assessment of veterans' health care needs in order to enhance health care services through the realignment of VA capital assets.
Commission membership	One chairman and 8 members	16 members.
Recommendations addressed to	President of the United States	Secretary of Veterans Affairs.
Decision to accept recommendations	The President can either accept or reject the commission's recommendations. If the President accepts the recommendations, then the President forwards the list to Congress. If the President rejects the recommendations then the BRAC Commission could give the President a revised list of recommendations.	The Secretary determines which recommendations to implement.
Decision to implement	The recommendations accepted by the President become final within 45 legislative days after the President transmits the list to Congress unless Congress enacts a joint resolution disapproving the list of recommendations.	The Secretary determines which recommendations to implement.

Source: GAO analysis of BRAC and CARES information.

Appendix III: Capital Planning Principles

Planning principle	Description
Strategic linkage	Capital planning is an integral part of an agency's strategic planning process. It provides a long-range plan for the capital asset portfolio in order to meet the goals and objectives in the agency's strategic and annual performance plans. Agency strategic and annual performance plans should identify capital assets and define how they will help the agency achieve its goals and objectives. Leading organizations also view strategic planning as the vehicle that guides decision making for all spending.
Needs assessment and gap identification	A comprehensive needs assessment identifies the resources needed to fulfill both immediate requirements and anticipated future needs based on the results-oriented goals and objectives that flow from the organization's mission. A comprehensive assessment of needs considers the capability of existing resources and makes use of an accurate and up-to-date inventory of capital assets and facilities as well as current information on asset condition. Using this information, an organization can properly determine any performance gap between current and needed capabilities.
Alternatives evaluation	Agencies should determine how best to bridge performance gaps by identifying and evaluating alternative approaches, including nonphysical capital options such as human capital. Before choosing to purchase or construct a capital asset or facility, leading organizations carefully consider a wide range of alternatives, such as contracting out, privatizing the activity, leasing, and whether existing assets can be used.
Review and approval framework with established criteria for selecting capital investments	Agencies should establish a formal process for senior management to review and approve proposed capital assets. The cost of a proposed asset, the level of risk involved in acquiring the asset, and its importance to achieving the agency mission should be considered when defining criteria for executive review. Leading organizations have processes that determine the level of review and analysis based on the size, complexity, and cost of a proposed investment or its organizationwide impact. As a part of this framework, proposed capital investments should be compared to one another to create a portfolio of major assets ranked in priority order.
Long-term capital investment plan	The long-term capital plan should be the final and principal product resulting from the agency's capital planning process. The capital plan, covering 5 years or more, should be the result of an executive review process that has determined the proper mix of existing assets and new investments needed to fulfill the agency's mission, goals, and objectives, and should reflect decision makers' priorities for the future. Leading organizations update long-term capital plans either annually or biennially. Agencies are encouraged to include certain elements in their capital plans, including a statement of the agency mission, strategic goals and objectives; a description of the agency's planning process; baseline assessments and identification of performance gaps; and a risk management plan.

Source: GAO analysis based on the Office of Management and Budget's (OMB) *Capital Programming Guide* (Version 2.0) and GAO-04-138.

Appendix IV: Information on Visited VA Facilities

Each of the six VA facilities we visited had unique features and issues concerning capital asset alignment. Several different capital asset alignment alternatives were considered at each location. While the Secretary decided on the future development of five of the six VA facilities we visited, decisions have not been made for the facility in Los Angeles, California. The following pages provide a brief summary of each VA facility we visited.

Big Spring VA Medical Center Big Spring, Texas

The Big Spring facility is part of the VA Southwest Health Care Network, which includes the states of Arizona and New Mexico and the western part of Texas. Its campus covers 31 acres and contains 13 buildings, which were constructed over a period of several years beginning in 1948. The main hospital opened in 1950. According to VA, the facility is considered to be in good condition, rating 4.4 out of 5 for critical values such as accessibility, code, functional space, and facility conditions. The Big Spring facility is a secondary care level facility offering primary care and subspecialties in medicine, surgery, and mental health, and provides nursing home care. Tertiary services, inpatient surgery, acute psychiatry, and domiciliary care are contracted from the local community or referred to other VA facilities. By 2023, inpatient medicine bed needs are projected to decline from 16 to 11, surgery beds to decline from 4 to 2, and inpatient psychiatry beds to increase from 2 to 18. Projected veteran enrollment for the New Mexico/West Texas market is projected to decrease 21 percent from 130,960 in 2003 to 103,892 in 2023. [1]

Overview of Capital Asset Alignment Issues

The Big Spring facility had three significant capital asset alignment issues that were reviewed by the CARES Commission and the Secretary. The three issues are as follows:

(1) Location of facility in rural West Texas: As part of the CARES process, the VA assessed how alignment would affect veterans' access to health care. Although there are five non-VA medical centers within 60 minutes from the Big Spring facility, some veterans would have to travel 5 hours for primary care at a VA facility if the Big Spring facility were to close, according to a VA official. In addition, a VA official states that enrollment data suggest that the location of the Big Spring facility is central to West Texas veterans in the Midland/Odessa area and Abilene.

[1] PriceWaterhouse Coopers, Stage I Report Site: Big Spring, December 2005.

(2) Stakeholder input: There was strong support from the community and local congressional delegates for keeping the Big Spring facility open. The Big Spring facility is a major employer in the community that offers above-average salaries. The community formed a task force that developed its own proposal for Big Spring, which was similar to the Secretary's final decision.

(3) Workload projections: Workload projections show a decrease in workload for Big Spring by 2022, demonstrating a need for fewer than 40 beds.[2] However, the West Texas market has capacity issues in specialty care as well as mental health gaps, which support the VA's plan to construct a domiciliary in Big Spring. Another proposal to construct a new facility in the Midland/Odessa area is not supported by projections for veteran enrollment in the area.

Capital Asset Alignment Alternatives Considered

A number of capital asset alignment alternatives were considered for the Big Spring facility during the CARES process. The following were some alternatives considered:

- status quo;
- expand inpatient and outpatient mental health services;
- close acute hospital beds and implement contracting, sharing, joint venturing, or referral to another facility;
- build a critical access hospital in the Midland/Odessa area;
- contract out inpatient care and renovate existing multispecialty clinic in Big Spring; and
- close Big Spring facility and lease space for a community-based outpatient clinic (CBOC). Lease space for inpatient care at the VA in Midland, Texas.

Secretary's Decision

In April 2006, the Secretary decided to maintain all services offered at Big Spring and look to expand inpatient care and residential mental health services.

[2] CARES Planning Initiatives. VISN 18: VA Southwest Healthcare Network.

Jonathan M. Wainwright Memorial VA Medical Center Walla Walla, Washington

The Jonathan M. Wainwright Memorial VA Medical Center is located on an 88-acre campus in the VA Northwest Network, on the site of Fort Walla Walla, which was established in 1858. The US Veterans Bureau took over the property in 1921, and the main hospital opened in 1929. Fifteen of the fort's buildings are still in use and are on the National Historic Register. Of 29 buildings, there are 7 wholly or partially vacant on the campus. According to VA, many of the buildings on campus are considered to be in poor condition and seismically unsafe. The medical center is a primary and secondary care facility, serving veterans residing in a 42,000-square-mile primary service area within the network. The facility offers outpatient services and limited inpatient medical care, including nursing home services, psychiatry, and substance abuse residential rehabilitation programs. Most emergency cases are handled by non-VA contractors in the community. Walla Walla's workload is projected to decrease 31 percent by 2022.

Overview of Capital Asset Alignment Issues

The Walla Walla facility had four significant capital asset alignment issues that were reviewed by the CARES Commission and the Secretary. The four issues are as follows:

(1) Location in rural Eastern Washington: The facility is located in a rural, sparsely populated area. Veterans would have to travel long distances—5 hours to Seattle and 4 hours to Portland—to receive VA care if the facility closed. Although options exist for contracting inpatient medicine and nursing home care in the community, no private facilities in the area provide acute psychiatric care.

(2) Facility is in poor and dilapidated condition: Many of the buildings on the campus date back to the early 1900s. The buildings are in poor condition and have lead-based paint and seismic issues. The former Network Director has estimated the cost of correcting these deficiencies at approximately $6 million per building. While there is excess space on the campus, there is low reuse or enhanced use lease (EUL) potential,

with the exception of the city of Walla Walla's interest in tapping two aquifers on the campus.[3]

(3) Underserved patient population relies on the Walla Walla VA: The facility serves a large Native-American veteran population as well as veterans who rely on mental health services. Nonetheless, veteran enrollment rates in the Walla Walla VA primary service area are projected to decrease 31 percent by 2022. The facility also has a low inpatient average daily census. In addition, low patient volume for mental health services makes it difficult for practitioners to maintain their competencies.

(4) Stakeholder input: The community and local congressional delegation have expressed a high level of interest in keeping the facility open. Congress appropriated $250,000 for the study of surplus property at the Walla Walla facility. The community organized a task force and conducted this study, which concluded that a new hospital with inpatient and outpatient services should be built.

Capital Asset Alignment Alternatives Considered

A number of capital asset alignment alternatives were considered for the Walla Walla facility during the CARES process. The following were some alternatives considered:

- Status quo.
- Construct new space for a 10-bed inpatient psychiatric unit. Space would be leased for an outpatient residential rehabilitation and substance abuse program.
- Contract all services. Vacate campus and make available for reuse.
- Replace facility with new inpatient care and outpatient care facilities on campus or in Tri-City area. Renovate the current outpatient medical and mental health facilities for ambulatory care and outpatient mental health care.

[3]Enhanced used leasing authorizes VA to lease real property under the Secretary's jurisdiction or control to a public or private entity for up to 75 years. The lease should result in a beneficial redevelopment or reuse of the VA property, such as including space for a VA mission-related activity or in providing some form of consideration that can be applied to improve health care services for veterans and their families in the community where the site is located.

- Build new state-of-the-art full-service facility.
- Replace current nursing home with new facility on site.
- Build a new outpatient clinic and close inpatient services.

Secretary's Decision

In July 2006, the Secretary decided to build a new outpatient facility for primary care, specialty care, and mental health care. Inpatient services will be provided by the community, although not necessarily on the Walla Walla VA campus.

El Paso VA Health Care Center El Paso, Texas

The El Paso VA Health Care Center opened in October 1995, replacing a smaller VA outpatient clinic. El Paso is part of the New Mexico/West Texas market in the VA Southwest Health Care Network, and the El Paso facility has the fastest-growing workload in the market. The facility is located in a four-story, 254,000-square-foot building connected to the William Beaumont Army Medical Center. The El Paso VA facility is solely an outpatient facility that provides primary and specialized care. Inpatient care for acute medical and surgical care and emergencies is provided to VA patients through a sharing agreement with the William Beaumont Army Medical Center. In 2003, the network proposed the expansion of the El Paso facility as a minor construction project. The $5.5 million dollar expansion began in December 2005 and will add space for physical therapy, behavioral health, and podiatry.

Overview of Capital Asset Alignment Issues

The El Paso facility had two significant capital asset alignment issues that were reviewed by the CARES Commission and the Secretary. The two issues are as follows:

(1) Joint VA/DOD venture at the William Beaumont Army Medical Center: The El Paso facility is connected to the William Beaumont Army Medical Center, which facilitates an expansion of the joint venture. Collaboration also presents learning opportunities for VA medical personnel.

(2) Growing workload and demand for services: The El Paso area has a growing workload for veteran care and the El Paso Health Care Center is the only VA health care center in the area. No full-service VA Medical Center exists within 250 miles of El Paso. The closest VA hospital is in Albuquerque. The increased workload supports the expansion of the El Paso Health Care Center and the addition of new parking at the facility.

Capital Asset Alignment Alternatives Considered

The following capital asset alignment alternatives were considered for the El Paso facility during the CARES process:

- pursue existing joint venture with William Beaumont Army Medical Center;
- build new CBOC in East El Paso; and
- shift tertiary care from the El Paso facility to the VA facility in Albuquerque, New Mexico.

Secretary's Decision

The Secretary decided to expand the existing joint venture with the William Beaumont Army Medical Center and develop a new CBOC in El Paso, which is targeted for priority implementation by 2012.

Greater Los Angeles Healthcare System Los Angeles, California

The West Los Angeles campus is one of the VA facilities in the Greater Los Angeles Healthcare System and part of the VA Desert Pacific Health Care Network, which includes the southern parts of California and Nevada. The campus is approximately 14 miles west of downtown Los Angeles and occupies 387 acres of land, with 91 structures on the campus totaling 2,807,039 building gross square feet. It is a teaching hospital, providing a full range of patient care service through primary care, tertiary care, and a nursing home in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. Additionally, the West Los Angeles campus is affiliated with the medical schools of the University of California Los Angeles and the University of Southern California. The West Los Angeles' workload is projected to decrease 23 percent by 2023.

Overview of Capital Asset Alignment Issues

VA's West Los Angeles campus had three significant capital asset alignment issues that were reviewed by the CARES Commission and the Secretary. The three issues are as follows:

(1) Alignment/consolidation of services due to proximity: As part of the CARES process, VA medical centers within 60 miles of each other were required to evaluate whether the services could be consolidated. The West Los Angeles facility is about 27 miles apart from VA's Long Beach facility, and both offer comprehensive health care services and are affiliated with

teaching hospitals. However, certain complex services are done at the West Los Angeles campus, such as neurosurgery, interventional cardiology, and cardiac surgery. Despite the short distance between Long Beach and West Los Angeles facilities, their location in highly urban, congested settings may create extended travel times for veterans. Consolidations have already occurred, mainly in the clinical support, and administrative functions, and more are under way in geriatrics and mental health.

(2) Infrastructure and life safety issues: The West Los Angeles campus needs to correct seismic structural deficiencies for some of its old buildings. Most of the buildings on campus require major repairs and deferred maintenance, including seismic and structural upgrades. The main hospital building is considered exceptionally high risk for earthquake damage and has the potential to endanger patient and employees housed in the building. Ensuring patient safety is a high priority for VA CARES funding.

(3) Excess land use: Interest in the future use of VA's West Los Angeles campus is a major issue. Given the size of the campus (387 acres with 91 buildings), the West Los Angeles facility has excess land and vacant space. However, VA is legally restricted from taking any action in declaring 109 of the 387 acres on the West Los Angeles campus as excess or taking any other action to dispose of the property.[4] Additionally, when VA was provided EUL authority in 1991, VA was only authorized to enter into an EUL for the 109 acres on the West LA campus if the lease is specifically authorized by law. Leases relating to child care services for the 109 acres have been specifically authorized by law.[5] The West Los Angeles campus currently has nine land use agreements, including a 10-year enhanced sharing agreement (to expire in April 2015) with the Salvation Army and a 50-year revocable license with the American Red Cross, which expires in April 2039.

The network's CARES market plan proposed a majority of the vacant space be reduced through the demolition of vacant buildings. The plan called for co-locating with a Veterans Benefits Administration field office, developing a new clinical addition to accommodate outpatient mental

[4]Section 421(b) of the Veterans' Benefits and Services Act of 1988, P.L. 100-322, 102 Stat. 487, 552-553 (1988).

[5]38 U.S.C. § 8162(c).

health programs and support staff, building a state nursing home, and expanding the Los Angeles National Cemetery or other veteran-focused projects. Stakeholders, including veteran service organizations and community members, expressed strong interest in the future use of the West Los Angeles campus, particularly reserving the parklike quality of the space.

Capital Asset Alignment Alternatives Considered

A number of capital asset alignment alternatives were considered for the development of the West Los Angeles campus. The following were some alternatives that were considered for excess land use:

- use enhanced use lease authority to lease excess land;
- build a new Veterans Benefit Administration facility and columbarium for the National Cemetery Administration;
- build a replacement hospital;
- renovate and expand the existing hospital;
- develop a medical research institute;
- build affordable veteran housing;
- build a veteran memorial park; and
- build new medical office building for VA-affiliated physicians and specialists.

Secretary's Decision

In May 2004, the Secretary decided to maintain the West Los Angeles and Long Beach campuses as separate facilities, but consolidate administrative and clinical services between both facilities. The Secretary also decided to correct seismic deficiencies of the West Los Angeles buildings and conduct further studies on the options for reusing the excess land.

Orlando Outpatient Healthcare Clinic Orlando, Florida

The VA Orlando Outpatient Healthcare Clinic is part of the VA Sunshine Health Care Network, which includes Florida (except 7 Panhandle counties), 19 rural counties in southern part of Georgia, the U.S. Virgin Islands, and Puerto Rico. The clinic is located on approximately 44 acres of land, is 360,000 square feet, and includes a nursing home and

domiciliary. The facility provides care to veterans who reside in the counties surrounding Orlando. The facility currently treats over 40,000 patients per year. The Orlando facility offers numerous services, including outpatient surgery, radiology, mobile MRI, nuclear medicine, laboratory, eye clinic, prosthetics, and women health care services.

Overview of Capital Alignment Issues

VA's Orlando Outpatient Health Care Clinic had three significant capital asset alignment issues that were reviewed by the CARES Commission and the Secretary. The three issues are as follows:

(1) Large growth of veteran population: According to CARES data, the Central Market, which includes Orlando, has the largest workload gap and greatest infrastructure need of any market in the country.

(2) Lack of access to VA acute patient care: Only 45 percent of the veteran population in VA's Sunshine Network in Florida live within a 1-hour drive of acute patient care services, a condition that does not meet the CARES travel access requirement of 65 percent. Building a new facility in the Orlando area would increase the percentage of veterans living within 1-hour of acute patient care to 78 percent.

(3) Location of new facility: The existing site of the Orlando Outpatient Clinic does not have adequate land available to accommodate a larger facility.

Capital Asset Alignment Alternatives Considered

Several capital asset alignment alternatives were considered for the Orlando market during the CARES process. The following were some alternatives that were considered:

- Expand current facility at existing location.
- Build new VA hospital in Orlando area, which may also include:

  collaboration with the University of Florida or the University of Central Florida, which is contingent on the construction of a new hospital, or

  collaboration with Patrick Air Force Base, which is contingent on the construction of a new hospital.

Secretary's Decision

In May 2004, the Secretary decided to build a new VA owned and operated medical facility in Orlando. The new medical center will have 134 inpatient beds, outpatient services, a nursing home, and a domiciliary.

VA Pittsburgh Healthcare System Pittsburgh, Pennsylvania

VA Pittsburgh Healthcare System (VAPHS) is an integrated health care system, serving veterans throughout the tristate area of Western Pennsylvania, Ohio, and West Virginia.[6] VAPHS is part of the VA Stars and Stripes Health Care Network and consists of three facilities, which operate under one management in the metropolitan Pittsburgh area. The three facilities are Heinz Progressive Care Center, Highland Drive, and University Drive. Consolidation of the Highland Drive and University Drive facilities has been occurring for several years, and since 1996 the two facilities have had one administration and fully integrated service lines and support activities.

The Heinz Drive facility (formerly called Aspinwall) was originally constructed in 1925, and an additional replacement structure was constructed in 1994 on 51 acres in a residential area. It has 336 nursing home beds, primary care, and hospice care. According to VA, all patient care buildings are in excellent condition, while other buildings at the facility are older and in moderate to poor condition.

The Highland Drive facility is a 50-year-old, campus-style setting on approximately 168 acres. It has 210 psychiatry beds, including 101 patients in a homeless veteran domiciliary unit. Over the last few years, services at Highland Drive have been consolidated with University Drive, resulting in Highland Drive having the most vacant space of the three facilities of VAPHS. According to VA, the main patient care buildings are in overall good condition, while some areas are functionally and aesthetically antiquated.

University Drive is a 50-year-old facility, on almost 14 acres, located adjacent to the University of Pittsburgh, with which it has an academic affiliation. The facility has 146 medicine, surgery, neurology, and critical care beds as well as primary and specialty care outpatient clinics and ambulatory surgery. According to VA, the main building where all patient care services are delivered is in good to moderate condition. The

[6]The VA Stars and Stripes Health Care Network includes the states of Pennsylvania, Delaware, Ohio, West Virginia, New York, and New Jersey.

remaining space, which is used primarily for research activities, is in poor condition, and is not usable for patient care. Additionally, according to VA, the parking available at the facility is not adequate for the current volume of patient care activity.

Overview of Capital Alignment Issues

Pittsburgh VA had two significant capital asset realignment issues that were reviewed by the CARES Commission and the Secretary. The two issues are as follows:

(1) Facility condition: Some buildings at the Highland Drive facility are in poor condition and not designed for modern health care.

(2) Vacant space: The Highland Drive facility has a considerable amount of vacant space.

Capital Asset Alignment Alternatives Considered

Several capital asset alignment alternatives were considered for the Pittsburgh facility during the CARES process. The following were some alternatives considered:

- Status quo.
- Consolidate the three Pittsburgh facilities into two facilities, which may also include:

  closure of the Highland Drive facility,

  renovate/expand, or

  use EUL authority to lease space at Highland Drive facility.
- Contract out, which may also include:

  closure of the Highland Drive facility, or

  use EUL authority to lease space at Highland Drive facility.

Secretary's Decision

The Secretary decided to develop a master plan to guide the transition of closure of the Highland Drive facility and integration of the three facilities to two facilities. The plan will also consider disposal or reuse of the campus to enhance the department's mission.

Appendix V: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 7, 2007

Mr. Mark Goldstein
Director, Physical Infrastructure Team
U. S. Government Accountability Office
441 G Street, NW,
Washington, DC 20548

Dear Mr. Goldstein:

The Department of Veterans Affairs (VA) has reviewed your draft report, ***VA HEALTH CARE: VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions*** (GAO-07-408) and agrees with your findings and concurs with your recommendation. VA's Capital Asset Realignment for Enhanced Services (CARES) provided VA with the tools necessary to continually plan and fulfill future health care infrastructure requirements to our nation's Veterans. VA believes it is important to have measures in place to track the Department's progress in this effort.

The enclosure specifically addresses your recommendation and provides needed technical corrections as well as additional comments.

VA appreciates the opportunity to comment on your draft report.

Sincerely yours,

R. James Nicholson

Enclosure

Enclosure

Department of Veterans Affairs (VA)
Comments to
Government Accountability Office (GAO) draft report,
VA HEALTH CARE: VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions
(GAO-07-408)

GAO recommends that the Secretary use existing performance measures as well as develop new performance measures for CARES. These measures should include both output measures, such as the implementation status of all CARES decisions, and outcome measures, such as the degree to which CARES has improved access to medical services for veterans, and should be explicitly linked to the goals of CARES.

Concur –VA will, as appropriate, use existing performance measures, as well as develop new performance measures for each of the four major goals surrounding the foundation of CARES:

- maintain or improve health care;
- adjust health care delivery capacity to match veterans' needs;
- improve enrolled veterans access to medical care; and
- support VA's other missions, including Department of Defense collaboration initiatives.

The Veterans Health Administration will work with Department offices to finalize the performance measures to be used, as well as determine oversight and monitoring responsibilities.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Mark Goldstein (202) 512-2834

Staff Acknowledgments

In addition to the individual named above, Nikki Clowers and Ed Laughlin, Assistant Directors; Teresa Abruzzo; Mireya Almazan; Colin Fallon; Cindy Gilbert; Emily Hampton-Manley; Daniel Hoy; Jennifer Kim; Susan Michal-Smith; and James Musselwhite Jr. made key contributions to this report.

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