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Report to the Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate

March 2005

VA HEALTH CARE

Important Steps Taken to Enhance Veterans' Care by Aligning Inpatient Services with Projected Needs

GAO-05-160

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-05-160, a report to the Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate

Why GAO Did This Study

The Department of Veterans Affairs (VA) operates one of the nation's largest health care systems. In 1999, GAO reported on VA's aged, obsolete capital assets, noting that better management of these assets could significantly reduce VA's operating costs. GAO further noted that VA could reinvest the savings to enhance veterans' health care services.

In response, VA initiated its Capital Asset Realignment for Enhanced Services (CARES) process. Through CARES, VA identified what health care services it should provide and in which locations through 2022. The CARES process included assessing alternative ways to align inpatient services by closing or adding services at existing VA medical facilities or establishing new facilities. In May 2004, VA published its CARES decisions, but did not provide a national comprehensive summary of all its decisions about the alignment of inpatient services.

GAO was asked to provide additional information about the inpatient service assessments and decisions made by VA. To provide a national, comprehensive summary, GAO summarized the locations where VA (1) identified a need to evaluate alternative ways to align inpatient health care service to improve quality, efficiency, or access and (2) made decisions to realign inpatient services or leave inpatient services as aligned, or deferred decisions pending further study.

www.gao.gov/cgi-bin/getrpt?GAO-05-160.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

What GAO Found

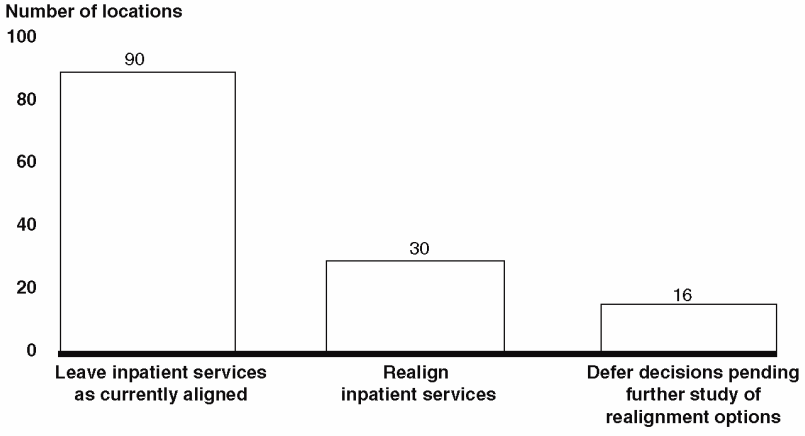
Through CARES, VA identified 136 locations for evaluation of alternative ways to align inpatient services. These locations included VA medical facilities, health care markets (geographic areas established by VA for the coordination of care), and health care networks (regional organizations of VA health care facilities established to facilitate management). Of the 136 locations, 99 were VA medical facilities with potential duplication of services at another nearby VA medical facility or low acute inpatient workload. In addition, VA identified limitations in geographic access to inpatient services in 31 markets and 6 networks, for example, when large numbers of veterans face lengthy driving times to VA facilities that provide acute or tertiary care.

VA made alignment decisions for inpatient services at 120 locations and deferred decisions for 16 locations pending further study. VA decided to realign inpatient services at 30 locations and maintain inpatient services as currently aligned at 90 locations. VA decided to close all inpatient services at 5 facilities and add them at 5 nearby VA facilities where they were not already available; close one or more, but not all, inpatient services at 12 other facilities; add inpatient services to medical facilities in 2 markets and 5 networks; and establish 1 new medical facility in a location where VA did not own an inpatient facility when it made its CARES decisions.

VA's decisions on inpatient alignment and planned studies are tangible steps forward in improving management of its capital assets and enhancing health care. Ultimately, however, accomplishing these goals will depend on VA's success in completing its studies and implementing its CARES decisions on inpatient and other health care services to better ensure that resources now spent on unneeded capital assets are redirected to health care.

VA concurred with GAO's findings.

VA's Decisions on Alignment of Inpatient Health Care Services at 136 Locations



Source: GAO analysis of VA data.

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CARES	Capital Asset Realignment for Enhanced Services
VA	Department of Veterans Affairs

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

March 2, 2005

The Honorable Christopher S. Bond
Chairman
Subcommittee on VA, HUD, and Independent Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) operates one of our nation's largest health care systems. VA provided health care to nearly 5 million veterans in fiscal year 2003 at a cost of about $26 billion.[1] Most of VA's inpatient care is provided in 172 medical facilities that it owns and maintains.[2] Many of VA's facilities were built more than 50 years ago and are no longer well suited to providing accessible, high-quality, cost-effective health care in the 21st century. For example, some facilities are not located within reasonable driving times of veterans' residences and others are structured to emphasize inpatient health care, as was the practice when these facilities were constructed, rather than outpatient health care, as is today's practice. Moreover, some facilities do not conform to modern standards because, for example, they are not configured to accommodate modern technology, lack fire sprinklers, or are not seismically sound.

In 1999, we reported that VA's aged, obsolete inventory of capital assets could be the biggest obstacle confronting VA's efforts to meet veterans' health care needs efficiently and effectively.[3] We noted that better

[1]These costs include the resources for operating VA's health care system, education and training of health care providers, administrative support, and capital investments necessary to support health care delivery.

[2]In this report, we consider medical facilities to be the capital assets owned by VA at which it provides inpatient health care services to veterans. Medical facilities include tertiary and acute hospitals, nursing homes, and other extended care assets. VA also provides outpatient care at most of these facilities and owns health care assets at other locations where it provides only outpatient care. In addition, VA has arrangements with other health care providers to provide inpatient or outpatient care to veterans in certain locations where VA does not own assets.

[3]See GAO, *Veterans' Affairs: Progress and Challenges in Transforming Health Care*, GAO/T-HEHS-99-109 (Washington D.C.: Apr. 15, 1999).

management of VA's buildings and land, which include more than 4,700 buildings and other structures and thousands of acres of land, could significantly reduce funds needed to operate current assets and that these funds could instead be used to enhance health care services for veterans.[4] The challenge of capital asset management is not unique to VA, but is part of a larger federal government challenge to effectively manage buildings and land, referred to as real property. We have designated management of federal real property as high risk because long-standing problems in this area have multibillion-dollar cost implications and can seriously jeopardize the ability of federal agencies to accomplish their missions.[5]

In response to our recommendations in 1999 for improving VA's capital asset planning and budgeting, VA initiated a process known as Capital Asset Realignment for Enhanced Services (CARES). CARES was designed to assess VA's buildings and land ownership in light of expected demand for VA inpatient and outpatient health care services through fiscal year 2022 (the CARES planning horizon). Through CARES, VA sought to determine what health care services veterans would need in what locations. These locations included VA's 172 medical facilities, 77 health care markets,[6] and 21 health care networks.[7] This process involved an examination of VA's needs for capital assets at the locations where it has

[4]See GAO, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83 (Washington, D.C.: Mar. 10, 1999); *VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting*, GAO/HEHS-99-145 (Washington D.C.: Aug. 13, 1999); and *Budget Issues: Agency Implementation of Capital Planning Principles Is Mixed*, GAO-04-138 (Washington, D.C.: Jan. 1, 2004).

[5]In January 2003, we reported that over 30 federal agencies control a valuable portfolio of facilities and land and that federal real property is a high-risk area because of such long-standing problems as excess and underutilized real property and deteriorating facilities. GAO's designation of high-risk areas is intended to help Congress focus attention on the most important issues and challenges facing the federal government. See GAO, *High-Risk Series: Federal Real Property*, GAO-03-122 (Washington D.C.: January 2003). Also see GAO, *Federal Real Property: Vacant and Underutilized Properties at GSA, VA, and USPS*, GAO-03-747 (Washington, D.C.: Aug. 19, 2003).

[6]A health care market is a geographic area having sufficient population and geographic size to (1) benefit from the coordination and planning of health care services delivered by either VA facilities or non-VA facilities and (2) support a continuum of care, including inpatient and outpatient care.

[7]VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, that are structured to manage and allocate resources to VA health care facilities. Each VA network includes from two to six markets. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

medical facilities and at possible new locations. To do so, VA first identified locations where specific factors suggested a need to evaluate options for realigning its inpatient services. VA focused on three specific factors to identify these locations. Two factors involved VA's existing medical facilities. One of these factors was potential duplication of inpatient services among two or more medical facilities that are close enough geographically to consider whether the services are needed at both facilities. A second factor was low acute inpatient workload at individual medical facilities. The third factor was geographic access limitations, which VA identified differently for different inpatient services. For most inpatient services, including acute and tertiary inpatient care, CARES addressed geographic access at the market level, primarily by identifying markets where a large number of veterans face lengthy driving times to access a VA medical facility. For two specialized inpatient services, inpatient treatment for spinal cord injury and disorder and inpatient blind rehabilitation, VA addressed geographic access at the network level based on projected demand and referral patterns. The CARES process was not designed to address another aspect of veterans' access to health care—the time that veterans wait to obtain appointments at VA medical facilities—because waiting times are related to multiple operational issues, such as staffing and resources, in addition to capital infrastructure.

On May 7, 2004, VA announced its CARES decisions on the alignment of inpatient services at locations it identified for potential service duplication, low workload, or limitations in geographic access (along with its other CARES decisions, including those regarding outpatient services) and published a report on these decisions.[8] VA announced decisions for 74 of its 77 markets.[9]

In the context of the alignment of its inpatient services, VA's report focused primarily on decisions involving medical facilities, markets, and networks where VA's inpatient health care services are to be realigned or

[8]Department of Veterans Affairs, *Secretary of Veterans Affairs: CARES Decision* (Washington, D.C.: May 7, 2004).

[9]In February 2002, VA completed a CARES pilot project that 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. At that time, VA announced its decision to, among other things, discontinue inpatient health care services at its Lakeside medical facility in Chicago, Illinois, one of eight inpatient medical facilities that VA had in these markets.

studied further. The report did not, however, provide a national, comprehensive summary of the medical facilities, markets, and networks that VA identified as needing evaluation for potential alternative alignments of inpatient services and did not include a discussion of all of the locations where it decided to leave inpatient services as currently aligned. On the basis of your request that we examine VA's inpatient service assessments and decisions, we developed (1) a national summary of the medical facilities, markets, and networks where VA identified potential service duplication, low workload, or geographic access limitations as factors that could indicate a need to evaluate alternative ways to align inpatient health care services and (2) a national summary of the medical facilities, markets, and networks where VA made decisions—to either realign inpatient services or leave inpatient services as aligned—or deferred decisions pending further study.

To summarize the number of medical facilities, markets, and networks where VA identified potential service duplication, low workload, or geographic access limitations as factors that could indicate a need to evaluate alternative ways to align inpatient health care services, we reviewed major CARES documents for information about locations where VA identified these factors. Because no one source includes all the information about these factors, we reviewed CARES planning documents, VA's *Draft National CARES Plan*, the report by an independent Commission appointed by VA that was charged with making CARES recommendations to the Secretary, and the Secretary's report of VA's CARES decisions. When identification of a medical facility as one with potential service duplication or low workload depended on the availability of acute inpatient medicine, we confirmed that the facility provided that service during the first half of fiscal year 2004, the time period immediately before VA made its CARES decisions, by examining data provided by VA.

To summarize VA's decisions about the alignment of its inpatient services, we reviewed major CARES documents to determine if VA made a decision to realign inpatient services or leave inpatient services as aligned or if VA deferred making a decision pending further study. We defined realignment of an inpatient service as (1) eliminating the service in its entirety at a facility where VA provided it, (2) adding an inpatient service to an existing VA facility where VA did not provide the service, or (3) establishing a new VA medical facility where VA did not own capital assets. The inpatient services in our review included both acute and long-term inpatient

services. Specifically, these inpatient services included tertiary care;[10] the acute inpatient services of medicine, surgery, and psychiatry; and other inpatient services. Other inpatient services included subacute and intermediate medicine; the long-term inpatient services of nursing home care, long-term psychiatry, domiciliary care,[11] and residential rehabilitation; and specialized inpatient services of blind rehabilitation and treatment for spinal cord injury and disorder. To identify VA's decisions on the alignment of inpatient services at the locations it identified for evaluation, we reviewed CARES documents and information provided by VA about the inpatient services provided at current facilities that would be affected if VA's decisions were implemented. We classified a decision as pending further study when VA determined that additional information or analysis was necessary to determine whether to add or close one or more inpatient services at that location. We compared data from CARES with other information from VA about the inpatient services available at its medical facilities and when we identified discrepancies, resolved them through discussions with VA officials. We found the data to be adequate for our purposes, and VA officials agreed that our methodology was reasonable. We did not review VA's other CARES decisions such as those for reconfiguring space to meet projected demand for services, modernization needed to provide services appropriately, disposal of assets that may no longer be needed, or the alignment of outpatient services. We conducted our work from October 2003 through March 2005 in accordance with generally accepted government auditing standards. See appendix I for a more detailed discussion of our methodology.

Results in Brief

Through its CARES process, VA identified 136 locations where potential service duplication, low workload, or limitations in geographic access to care indicated a need to evaluate alternative alignments of inpatient health care services. These locations included 99 of VA's existing medical facilities—72 medical facilities that potentially duplicated services with

[10]Tertiary care includes specialized diagnostic and treatment procedures, such as open heart surgery or neurosurgery, that are not necessarily available at all medical facilities that provide acute inpatient care. We defined realignment of tertiary care services as either eliminating all tertiary care at a facility that provided some tertiary care or adding tertiary care to an existing or new VA facility where VA did not provide any tertiary care.

[11]Domiciliary care involves coordinated rehabilitative and restorative clinical care in an inpatient setting, with the goal of helping veterans achieve and maintain the highest level of functioning and independence possible. Domiciliary care differs from other types of inpatient care in that bedside nursing is not required.

nearby VA medical facilities, 19 facilities that were expected to have low inpatient workload (primarily for acute medicine, surgery, and psychiatry) during the CARES planning horizon, and 8 other facilities that both potentially duplicated services and were expected to have low workloads. The 136 locations that VA identified also included 31 markets where VA identified limitations in geographic access to care. VA identified limitations to acute or tertiary care in markets where a large number of veterans face lengthy driving times to a VA facility. It identified limitations in access to long-term care in some locations based on information such as referral patterns, for example, when veterans were referred to a distant VA medical facility to obtain domiciliary care because that service was not available at a VA medical facility nearer to their residences. VA determined that it could not evaluate access to long-term care services on a systematic, nationwide basis because VA had not developed an adequate model for projecting demand for these services at the time CARES decisions were made. VA also identified 6 networks where projected demand and referral patterns indicated limitations in access to specialized inpatient treatment for spinal cord injury and disorder or blind rehabilitation.

VA made decisions on the alignment of inpatient health care services for 120 of the 136 locations it identified as needing evaluation of alignment alternatives; decisions for 16 locations, primarily medical facilities with service duplication or low workload, were deferred pending further study of potential realignment options. Regarding the 120 locations, VA decided to realign inpatient services for 30 locations and maintain its inpatient services as aligned for 90 locations. Of the 30 locations, 22 involved realignment of inpatient services among medical facilities that had potential service duplication or low workload. For 10 facilities, VA decided to realign inpatient services, primarily by closing all inpatient services at 5 facilities and adding services at 5 others. For 12 other medical facilities, VA decided to close some, but not all, inpatient services and refer patients to VA medical facilities that already provided these services or enter into agreements for care from non-VA providers. Of the remaining 8 locations, 3 were markets where VA identified limitations in access to acute inpatient care or a long-term inpatient service and 5 were networks where VA identified limitations in access to specialized inpatient treatment for spinal cord injury and disorder or blind rehabilitation. To improve access for veterans in these locations, VA decided to add such services at 7 existing medical facilities that had not previously offered these services and to establish a new VA medical facility where VA did not own capital assets. In addition to these decisions to realign inpatient services, for 27 of the 90 locations where VA decided to maintain its inpatient services as aligned,

VA decided to enter into agreements with non-VA providers to improve access to acute or tertiary inpatient services.

VA concurred with our findings.

Background

VA dramatically transformed its health care delivery system over the last decade. A central goal of this transformation has been to reduce the need for, and the length of, inpatient hospital stays by providing primary care in outpatient settings and taking advantage of technological advances that reduce the need for hospitalization. VA developed a continuum of care grounded in outpatient settings, made available a broader array of services including preventive care, and opened hundreds of community-based outpatient clinics. As a result, VA reduced the length of inpatient stays while providing health care to a growing number of veterans. From fiscal year 1996 through fiscal year 2003, VA's national acute inpatient daily census fell by over 40 percent while the number of veterans who received health care from VA increased by about 2 million (69 percent). As these transformations occurred, VA was left with 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. VA completed a pilot phase of the CARES process in February 2002, when it announced decisions for Network 12, which consists of parts of five states: Illinois, Indiana, Michigan, Minnesota, and Wisconsin. VA then assessed its other 20 networks. Through CARES, VA compared the sizes, locations, and available health care services of VA's existing medical facilities to projected demand for health care services through fiscal year 2022.

In conducting this comparison, VA identified three factors that indicated a need to evaluate alternative ways to align inpatient services—potential duplication of services, low acute inpatient workload, and limitations in geographic access to VA health care services.

- Duplication of inpatient services at VA inpatient medical facilities that are close to one another geographically was of concern because duplication could needlessly increase operating costs. Excess operating costs can also occur when two facilities that are close to one another geographically provide different inpatient services that could be provided in a single location. In such situations, administrative services and services that

support inpatient care, such as building maintenance, could be unnecessarily duplicated. Consolidation or closure of duplicated services in such circumstances could improve cost efficiency by eliminating the need to maintain all or part of a medical facility and reducing resources spent on inpatient services or services that support inpatient care. VA also noted that realigning inpatient services could enhance the quality or accessibility of care by placing related clinical services in the same location.

- Low acute inpatient workload was of concern for reasons associated with both the quality and cost-effectiveness of care. As VA noted, the medical literature and consumer groups have suggested that higher workload volume is generally related to better health care outcomes, particularly for surgical procedures. Although VA noted that its small facilities with lower inpatient workloads have often been leaders in the provision of quality health care, it also noted that as medical care becomes more technologically advanced, it could become more difficult and less cost-effective for such facilities to maintain and use the tools and skills necessary to provide high-quality care. In light of these concerns, VA identified medical facilities with low acute inpatient workload to evaluate the option of closing acute inpatient services.
- Limitations in veterans' geographic access to VA health care services were also of concern. VA considered options for improving access to acute and tertiary inpatient care in health care markets where large numbers of veterans face lengthy driving times to obtain those health care services from VA. VA also considered options for improving access to a long-term inpatient care service in markets where information such as referral patterns indicated limitations to access, for example, when veterans were referred to a distant VA medical facility to obtain domiciliary care because that service was not available at a VA medical facility nearer to their residences. For two specialized inpatient services—treatment for spinal cord injury and disorder and blind rehabilitation—VA used information about projected demand and referral patterns to identify networks where options for improving access to these specialized inpatient services were to be evaluated.

Three major milestones have occurred in the CARES process since August 2003. First, on August 4, 2003, VA's Under Secretary for Health released the *Draft National CARES Plan* for public review.[12] In developing this plan, VA officials, including those in the 20 networks covered by the plan,

[12]Department of Veterans Affairs, *Draft National CARES Plan* (Washington, D.C.: Aug. 4, 2003).

identified locations where changes to the existing health care delivery system could address potential duplication of services, low workload, or geographic access limitations. Network directors, working with input from local stakeholders, studied those locations and proposed plans for the alignment of health care services. After reviewing these plans, the Under Secretary for Health made recommendations concerning the alignment of health care services; these recommendations were presented in the *Draft National CARES Plan*, along with other recommendations, such as those concerning resizing of capacity and modernization of buildings that are critical to VA's missions and disposal of unneeded (excess) buildings and land.

Second, on February 12, 2004, 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*. In developing its recommendations, the CARES Commission conducted 38 public hearings, 81 site visits, and 10 public meetings; analyzed 212,000 written comments[13] from veterans and other stakeholders; reviewed VA documents supporting the *Draft National CARES Plan*; and engaged experts to evaluate key issues, such as the model used to project demand for VA health care services. The CARES Commission documented its recommendations and findings in a 609-page report to the Secretary of Veterans Affairs.[14]

Third, on May 7, 2004, VA's Secretary announced and published a report on VA's CARES decisions concerning the alignment of VA's health care services, based on his review of the CARES Commission's findings and recommendations. In general, he stated his acceptance of the Commission's report, noting that it provided a strategically sound path forward for VA's health care system. He noted that when the Commission's report provided options, he selected the option that would minimize the effect of service realignments on continuity of care for those veterans who received those services at the time VA made its CARES decisions. Moreover, he stated that implementing these decisions will require substantial capital investment—about $1 billion annually over at least the next 5 years—and that not implementing the CARES decisions would also

[13]A large number of these comments addressed a small set of VA medical facilities. For example, more than half of the comments were about a single facility in upstate New York.

[14]CARES Commission, *Capital Asset Realignment for Enhanced Services: Report to the Secretary of Veterans Affairs* (Washington, D.C.: Feb. 12, 2004).

require funding to maintain or renovate obsolete facilities and perpetuate VA's need to manage redundant, outmoded, or poorly located facilities. In anticipation of the Secretary's decision, Congress passed legislation in December 2003 that requires the Secretary to notify Congress of decisions involving reorganization, consolidation, and closure of health care services and provide a period of at least 60 days during which Congress can consider these CARES decisions before they are implemented.[15]

VA Identified 136 Locations for Evaluation of Alternative Alignments of Inpatient Services

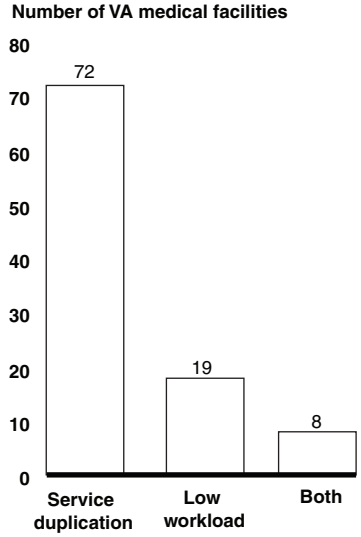
Through CARES, VA identified 136 locations where potential service duplication, low acute inpatient workload, or geographic access limitations indicated that alignment of inpatient health care services should be evaluated. These locations included 99 of VA's existing medical facilities where VA identified potential service duplication or low inpatient workload, 31 markets where VA identified a need to evaluate options for improving access to tertiary or acute inpatient care or a long-term inpatient service, and 6 networks where VA identified a need to evaluate options for improving access to specialized inpatient treatment for spinal cord injury and disorder or blind rehabilitation.

VA Identified 99 Medical Facilities with Potential Service Duplication or Low Acute Inpatient Workload

VA identified 99 of its medical facilities for evaluation of alternative ways to align inpatient services because of potential service duplication or low acute inpatient workload. Most of these facilities were identified for potential service duplication (see fig. 1).

[15]Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, Pub. L. No. 108-170, § 222, 117 Stat. 2042, 2050-2051.

Figure 1: VA Medical Facilities Identified for Evaluation of Inpatient Service Alignment Based on Potential Service Duplication, Low Acute Inpatient Workload, or Both



Source: GAO analysis of VA data.

VA identified potential service duplication when two or more inpatient medical facilities were close enough geographically to consider whether both should continue providing all the inpatient services that they provided. VA identified 80 medical facilities that potentially duplicated services. For our review, we classified these facilities as potentially duplicating tertiary care services; acute inpatient medicine services; or other services, including other types of inpatient care (such as long-term psychiatry) or services that support inpatient care (such as administration or maintenance). Some of the facilities that VA identified potentially duplicated more than one of these types of inpatient service.

For tertiary care services, we determined if the medical facilities that VA identified as potentially duplicating services were also identified by VA as tertiary care facilities within 120 miles of another VA tertiary care facility. VA selected 120 miles as a distance that would permit tertiary care facilities to develop cooperative arrangements with one another to provide tertiary care. Of the 80 medical facilities VA identified as potentially duplicating services, 28 met these criteria for potential duplication of tertiary care services (see table 1). Appendix II lists these 28 facilities and the VA medical facilities close enough geographically for VA to consider whether tertiary care services were needed at both.

Table 1: VA Medical Facilities with Potential Duplication of Tertiary Care Services

1.	Ann Arbor, Mich.
2.	Augusta, Ga.–*Downtown*
3.	Baltimore, Md.
4.	Bay Pines, Fla.
5.	Bronx, N.Y.
6.	Brooklyn, N.Y.
7.	Charleston, S.C.
8.	Cincinnati, Ohio
9.	Columbia, S.C.
10.	Dayton, Ohio
11.	Detroit, Mich.
12.	East Orange, N.J.
13.	Indianapolis, Ind.
14.	Lexington, Ky.–*Cooper*
15.	Loma Linda, Calif.
16.	Long Beach, Calif.
17.	Louisville, Ky.
18.	Manhattan, N.Y.
19.	Northport, N.Y.
20.	Palo Alto, Calif.
21.	Philadelphia, Pa.
22.	Richmond, Va.
23.	San Diego, Calif.
24.	San Francisco, Calif.
25.	Tampa, Fla.
26.	Washington, D.C.
27.	West Haven, Conn.
28.	West Los Angeles, Calif.

Source: GAO analysis of VA data.

Note: These VA medical facilities provide tertiary care services, are within 120 miles of another VA medical facility that provides tertiary care services, and were identified by VA as potentially duplicating inpatient services.

For acute inpatient medicine services, we determined if the medical facilities that VA identified as potentially duplicating services were also identified by VA as providing acute inpatient medicine services within 60 miles of another VA medical facility that provides acute inpatient medicine services.[16] VA selected 60 miles as a distance that would permit acute inpatient facilities to develop cooperative arrangements with one another to provide acute inpatient medical, surgical, or psychiatric care. Of the 80 medical facilities VA identified as potentially duplicating services, 27 potentially duplicated acute medicine services during the first half of fiscal year 2004, the time period immediately before CARES decisions were made (see table 2). Appendix III lists these 27 facilities and the VA medical facilities close enough geographically for VA to consider whether acute inpatient medicine services were needed at both. About half of these medical facilities were also identified as potentially duplicating tertiary care services.

[16]Some of these facilities also potentially duplicated acute inpatient surgery or psychiatry services.

Table 2: VA Medical Facilities with Potential Duplication of Acute Inpatient Medicine Services

1. Ann Arbor, Mich.
2. Baltimore, Md.
3. Bronx, N.Y.
4. Brooklyn, N.Y.
5. Castle Point, N.Y.
6. Cincinnati, Ohio
7. Dayton, Ohio
8. Detroit, Mich.
9. East Orange, N.J.
10. Gainesville, Fla.
11. Kansas City, Mo.
12. Lake City, Fla.
13. Leavenworth, Kans.
14. Little Rock, Ark.
15. Long Beach, Calif.
16. Manhattan, N.Y.
17. Murfreesboro, Tenn.
18. Nashville, Tenn.
19. North Little Rock, Ark.
20. Northport, N.Y.
21. Perry Point, Md.
22. Philadelphia, Pa.
23. Providence, R.I.
24. Washington, D.C.
25. West Los Angeles, Calif.
26. West Roxbury, Mass.
27. Wilmington, Del.

Source: GAO analysis of VA data.

Note: These VA medical facilities provide acute inpatient medicine services, are within 60 miles of another VA medical facility that provides acute inpatient medicine services, and were identified by VA as potentially duplicating inpatient services.

For other services, we determined if the medical facilities that VA identified as potentially duplicating services were ones where VA determined that it should consider whether other inpatient services and administrative or maintenance services that support inpatient care were needed at both. VA did not specify a distance criterion for identifying these

facilities as close enough geographically for it to consider whether inpatient services were needed at both. The potentially duplicated services generally included psychiatric and long-term inpatient care, administrative services, and building maintenance and groundskeeping. Of the 80 medical facilities VA identified as potentially duplicating services, 50 potentially duplicated these other inpatient, administrative, or maintenance services (see table 3). For example, in some cities VA has two inpatient medical facilities that provide different inpatient services, such as a tertiary care facility and a nursing home or one facility that provides medical and surgical care and another that provides psychiatric care. If it were possible to move all services to a single facility, potential benefits include cost savings by avoiding duplication of inpatient support services such as building maintenance at the two facilities. In addition, VA noted that placing related clinical services (such as acute medicine and acute psychiatry) in the same location has the potential to enhance the quality or accessibility of care. Appendix IV lists these 50 facilities and indicates which other VA medical facilities were close enough geographically for VA to consider whether inpatient services were needed at both.

Table 3: VA Medical Facilities with Potential Duplication of Other Inpatient Services or Services That Support Inpatient Service Delivery

1. American Lake, Wash.
2. Augusta, Ga.—*Downtown*
3. Augusta, Ga.—*Uptown*
4. Batavia, N.Y.
5. Bedford, Mass.
6. Biloxi, Miss.
7. Brockton, Mass.
8. Brooklyn, N.Y.
9. Buffalo, N.Y.
10. Canandaigua, N.Y.
11. Castle Point, N.Y.
12. Cleveland, Ohio—*Brecksville*
13. Cleveland, Ohio—*Wade Park*
14. Des Moines, Iowa
15. East Orange, N.J.
16. Fort Meade, S. Dak.
17. Fort Wayne, Ind.
18. Gainesville, Fla.
19. Gulfport, Miss.
20. Hot Springs, S. Dak.
21. Jamaica Plain, Mass.
22. Kansas City, Mo.
23. Kerrville, Tex.
24. Knoxville, Iowa
25. Lake City, Fla.
26. Leavenworth, Kans.
27. Lexington, Ky.—*Cooper*
28. Lexington, Ky.—*Leestown*
29. Livermore, Calif.
30. Lyons, N.J.
31. Marion, Ind.
32. Miami, Fla.
33. Montgomery, Ala.
34. Montrose, N.Y.
35. Palo Alto, Calif.

36. Pittsburgh, Pa.—*Heinz Center*
37. Pittsburgh, Pa.—*Highland Drive*
38. Pittsburgh, Pa.—*University Drive*
39. Portland, Oreg.
40. Roseburg, Oreg.
41. San Antonio, Tex.
42. St. Albans, N.Y.
43. Temple, Tex.
44. Topeka, Kans.
45. Tuskegee, Ala.
46. Vancouver, Wash.
47. Waco, Tex.
48. West Palm Beach, Fla.
49. West Roxbury, Mass.
50. White City, Oreg.

Source: GAO analysis of VA data.

Note: These VA medical facilities were identified by VA as close enough geographically to another VA medical facility for VA to consider whether inpatient services other than tertiary care or acute inpatient medicine were needed at both. The potentially duplicated inpatient services generally included psychiatric and long-term inpatient care; services that support inpatient care generally included administration and maintenance.

VA also evaluated the alignment of its inpatient services at its medical facilities with potential low acute inpatient workload. VA identified low acute inpatient workload based on projected need for acute inpatient beds, viability of specific services, and changes in workload at one location that could result from decisions made about other locations. VA identified low total projected acute inpatient workload when a medical facility that provides acute inpatient medicine services was projected to need fewer than 40 acute medicine, surgery, and psychiatry beds (combined) in fiscal years 2012 and 2022.[17] In addition, VA identified low acute inpatient workload at some other facilities even if the total projected number of acute medicine, surgery, and psychiatry beds was expected to exceed 40 in fiscal years 2012 or 2022. In some of these cases, VA questioned the viability of a specific acute inpatient service, for example, when projections indicated that few beds would be needed for inpatient surgery. In other cases, VA noted that low acute inpatient workload could

[17]Of the medical facilities that VA identified using these criteria, we included those that provided acute inpatient medicine services during the first half of fiscal year 2004, the time period immediately before VA made its CARES decisions.

result from decisions it made about inpatient health care at other locations, for example, when a decision to enter into an agreement for non-VA care could shift acute inpatient workload away from an existing VA medical facility. Using these criteria, 27 medical facilities were identified as having potentially low acute inpatient workload (see table 4).

Table 4: VA Medical Facilities with Potential Low Acute Inpatient Workload

1. Altoona, Pa.
2. Bath, N.Y.
3. Beckley, W.Va.
4. Big Spring, Tex.
5. Boise, Idaho
6. Butler, Pa.
7. Castle Point, N.Y.
8. Cheyenne, Wyo.
9. Chillicothe, Ohio
10. Des Moines, Iowa
11. Dublin, Ga.
12. Erie, Pa.
13. Fort Harrison, Mont.
14. Fort Wayne, Ind.
15. Grand Junction, Colo.
16. Hot Springs, S. Dak.
17. Huntington, W.Va.
18. Kerrville, Tex.
19. Marion, Ind.
20. Murfreesboro, Tenn.
21. Muskogee, Okla.
22. Poplar Bluff, Mo.
23. Prescott, Ariz.
24. Roseburg, Oreg.
25. Saginaw, Mich.
26. Spokane, Wash.
27. Walla Walla, Wash.

Source: GAO analysis of VA data.

Note: Low total projected acute inpatient workload was identified when a VA medical facility that provided acute inpatient medicine services during the first half of fiscal year 2004, the time period immediately before VA made its CARES decisions, was projected to need fewer than 40 acute medicine, surgery, and psychiatry beds (combined) in fiscal years 2012 and 2022. Other low acute inpatient workload was identified (1) when VA questioned the viability of a specific acute inpatient service, for example, because projections indicated that few beds would be needed for inpatient surgery, or (2) when low acute inpatient workload at an existing VA medical facility could result from decisions VA made about inpatient health care at other locations, even if the total projected number of acute medicine, surgery, and psychiatry beds was expected to exceed 40 in fiscal years 2012 or 2022.

Appendix V provides a complete list of VA's inpatient medical facilities and notes those at which VA identified potential service duplication, low acute inpatient workload, or both as factors that indicated that alternative ways to align inpatient services should be assessed.

VA Identified 31 Markets Where Veterans Face Limitations in Geographic Access to Acute, Tertiary, or Long-Term Inpatient Services

VA identified 31 markets where veterans face limitations in geographic access to acute, tertiary, or long-term inpatient services. VA's identification of markets where veterans face limitations in access to acute or tertiary care was based primarily on its analysis of the number of veterans who face lengthy driving times to obtain VA health care, while VA's identification of markets where veterans face limitations in access to a long-term inpatient care service was based on information such as referral patterns. Limitations in geographic access could occur in several types of situations. In some markets where a VA facility provided acute or tertiary inpatient care, too many veterans had lengthy driving times to access these services. In some markets, there were no VA facilities providing acute or tertiary inpatient care, and veterans had lengthy driving times to access that care at VA facilities in other markets. In other markets, VA had a facility, but the facility did not provide the needed service.

To identify markets where a large number of veterans face lengthy driving times from home to access acute or tertiary inpatient care at VA facilities, VA used specific standards for driving times for urban, rural, and highly rural areas (see table 5).[18] VA considered a market to have a large number of veterans facing lengthy driving times if driving time to the nearest VA facility exceeded VA's standard for more than 35 percent of those enrolled for VA health care residing in the market and exceeded VA's standard for at least 12,000 enrolled veterans.

[18]VA used a zip-code-based analysis to calculate driving times from veterans' homes to the nearest VA-owned or VA-affiliated medical facility that provides acute or tertiary care. VA-affiliated medical facilities include hospitals that are owned by non-VA providers where VA has arranged for VA staff to provide care to veterans.

Table 5: VA's Driving Time Standards for Access to Acute Inpatient Care and Tertiary Care

Type of inpatient health care	Type of county	Driving time for veterans to access health care at a VA medical facility[a]
Acute care (medicine, surgery, and psychiatry)	Urban[b]	60 minutes
	Rural[c]	90 minutes
	Highly rural[d]	120 minutes
Tertiary care	Urban[b]	240 minutes
	Rural[c]	240 minutes
	Highly rural[d]	Community standard

Source: VA, *Draft National CARES Plan.*

[a]VA used a zip-code-based analysis to calculate driving times from veterans' homes to the nearest VA-owned or VA-affiliated medical facility that provides acute or tertiary care. VA-affiliated medical facilities include hospitals that are owned by non-VA providers where VA has arranged for VA staff to provide care to veterans.

[b]Counties designated as metropolitan by the U.S. Census Bureau and counties with a population density of more than 166 people per square mile.

[c]Counties that are not designated as metropolitan by the U.S. Census Bureau and have a population density of 26 to 166 people per square mile.

[d]Counties with a population density of less than 26 people per square mile and counties designated as highly rural by the VA health care network in which the county is located.

Using these standards, VA identified 28 markets in which a large number of veterans face lengthy driving times from home to access acute or tertiary inpatient care at VA facilities (see app. VI). VA identified a need to evaluate options for improving access to acute inpatient care (medicine, surgery, and psychiatry) in 20 markets, tertiary care in 4 markets, and both acute and tertiary care in 4 markets.

In addition, VA identified 3 markets where options to improve access to a long-term care service needed evaluation by using information such as referral patterns. VA determined that it could not evaluate access to long-term care services on a systematic, nationwide basis because VA had not developed an adequate model for projecting demand for these services at the time CARES decisions were made.

- VA identified a need to assess options to improve access to domiciliary care in the Washington, D.C., market of Network 5, a market that includes the District of Columbia and parts of Maryland and Virginia. The network proposed this evaluation because VA did not provide domiciliary care and the market has a large population of homeless veterans who were referred to a different market to obtain domiciliary care.

- VA identified a need to assess options to improve access to residential rehabilitation for post-traumatic stress disorder and substance abuse in the Michigan market of Network 11, a market that includes lower Michigan and part of northwest Ohio. The CARES Commission proposed this evaluation because many veterans with these disorders who live in the Detroit, Michigan, area now travel about 125 miles to obtain inpatient residential rehabilitation through VA's medical facility in Battle Creek, Michigan.[19]
- VA identified a need to assess options to improve access to nursing home services and to ensure future access to acute inpatient care in the Nevada market of Network 22, a market that includes southern Nevada. VA did not own an inpatient medical facility in this market at the time it made its CARES decisions; instead, it collaborated with the Department of Defense to provide acute inpatient services in Las Vegas, Nevada, by having VA staff provide services to veterans in the Department of Defense hospital at Nellis Air Force Base. The network proposed an evaluation of options for improving access to nursing home care because VA did not have a nursing home in this market and the market has a large proportion of veterans who are aged 65 or older. In addition, although VA did not identify a limitation to veterans' access to acute inpatient care in this market using its driving time standards, VA identified a need to assess options to ensure future access to acute inpatient care in this market. It did so in part because of questions about whether the rapid growth in demand for inpatient services in the Nevada market could be accommodated within the existing collaborative relationship with the Department of Defense.

Appendix VI provides a list of all VA markets and indicates those in which VA identified limitations in geographic access to tertiary, acute, or long-term inpatient health care services. This appendix also summarizes descriptions of the geographic areas that each market covers.

[19]The Commission recommended that residential rehabilitation and domiciliary services be provided close to the towns or cities where veterans who receive those services typically live. The Secretary stated that VA's long-term care strategic plan would incorporate this consideration.

VA Identified Six Networks Where Options to Improve Veterans' Access to Specialized Inpatient Treatment for Spinal Cord Injury and Disorder or Blind Rehabilitation Needed Evaluation

To identify limitations in veterans' access to specialized inpatient treatment services for spinal cord injury and disorder or blind rehabilitation, VA used information about projected demand for these services and referral patterns within and across networks. VA has specialized inpatient treatment units for these two types of disability that serve veterans in areas that are larger than the markets VA defined for its other health care services. VA identified six networks where there was a need to evaluate options to improve veterans' access to these specialized services (see table 6).

Table 6: VA Networks Where VA Identified Limitations in Access to Specialized Inpatient Treatment for Spinal Cord Injury and Disorder or Blind Rehabilitation

	Type of specialized inpatient service	
Network	**Spinal cord injury and disorder**	**Blind rehabilitation**
1. Network 2 (upstate New York and parts of north central Pennsylvania)	X	
2. Network 8 (most of Florida, part of southern Georgia, Puerto Rico, the U.S. Virgin Islands of St. Thomas and St. Croix, and Arecibo)	X	
3. Network 16 (Louisiana; most of Arkansas, Mississippi, and Oklahoma; eastern Texas; and parts of three other states: Alabama, Florida, and Missouri)	X	X
4. Network 19 (Utah; most of Colorado, Montana, and Wyoming; and parts of five other states: Idaho, Kansas, Nebraska, Nevada, and North Dakota)	X	
5. Network 22 (southern California and southern Nevada)		X
6. Network 23 (Iowa and South Dakota; most of Minnesota, Nebraska, and North Dakota; and parts of five other states: Illinois, Kansas, Missouri, Wisconsin, and Wyoming)	X	

Source: GAO analysis of VA data.

Note: VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

Appendix VII provides a list of all VA networks and indicates those where VA identified limitations in access to specialized inpatient services of treatment for spinal cord injury and disorder or blind rehabilitation. This appendix also summarizes descriptions of the geographic areas that each network covers.

VA Made Decisions on Alignment of Inpatient Services for 120 Locations and Deferred Decisions for 16 Pending Completion of Studies

VA made decisions concerning the alignment of inpatient health care services for 120 of the 136 locations that it identified for potential service duplication, low acute inpatient workload, or limitations to geographic access. For the remaining 16 locations, VA deferred decisions pending further study of options that include adding or closing inpatient services. For most of its 120 decisions, VA provided reasons that were related to the feasibility of alternative ways of aligning inpatient services or the effect of possible realignments of inpatient services on such considerations as the quality or accessibility of care.

VA Made Decisions on Alignment of Inpatient Health Care Services for 120 Locations

VA made decisions to realign inpatient services for 30 locations and to leave services as aligned at 90 locations (see table 7).

Table 7: VA's Decisions on the Alignment of Inpatient Services at 120 Locations

	Locations			
VA's decision	Medical facilities with potential service duplication or low acute inpatient workloads	Markets with limitations in geographic access to acute, tertiary, or long-term inpatient services	Networks with limitations in geographic access to specialized inpatient treatment of spinal cord injury and disorder or blind rehabilitation	Total
Realign VA inpatient services	22	3	5	**30**
Maintain VA inpatient services as aligned	63	27	0	**90**
Total	**85**	**30**	**5**	**120**

Source: GAO analysis of VA data.

VA Made Decisions to Realign Inpatient Services for 30 Locations

Of the 22 medical facilities with potential service duplication or low acute inpatient workload, VA's decisions for 10 involved realignments including the closure of all inpatient services at 5 facilities. In all but one of these closures, VA decided to add the closed services at a nearby VA medical facility when the services were not already available there (see table 8). For this closure, VA will contract for care from non-VA providers or refer veterans to a VA medical facility approximately 130 miles away.

Table 8: VA's Decisions to Close All Inpatient Services at a VA Medical Facility and Add Those Services to a Nearby VA Medical Facility When Not Already Available There

Close all inpatient services		Add inpatient services	
VA medical facility	**Services to be closed**	**VA medical facility**	**Services to be added[a]**
Cleveland, Ohio—*Brecksville*	• Acute psychiatry • Long-term psychiatry • Nursing home care • Domiciliary care	Cleveland, Ohio—*Wade Park*, about 20 miles away	• Long-term psychiatry • Nursing home care • Domiciliary care
Fort Wayne, Ind.	• Acute medicine	Not applicable (VA decided to contract for care with non-VA providers or refer veterans to its Indianapolis, Ind., medical facility, about 130 miles away)	• Not applicable
Gulfport, Miss.	• Acute psychiatry • Long-term psychiatry • Nursing home care	Biloxi, Miss., about 8 miles away	• Acute psychiatry • Long-term psychiatry
Knoxville, Iowa	• Acute psychiatry • Intermediate medicine • Nursing home care • Domiciliary care	Des Moines, Iowa (about 45 miles away)	• Acute psychiatry • Nursing home care
Pittsburgh, Pa.—*Highland Drive*	• Acute psychiatry • Long-term psychiatry • Domiciliary care Residential rehabilitation	Pittsburgh, Pa.—*University Drive*, about 5 miles away	• Acute psychiatry • Long-term psychiatry
		Pittsburgh, Pa.—*Heinz Center*, about 5 miles away	• Domiciliary care • Residential rehabilitation

Source: GAO analysis of VA data.

[a]Inpatient services already provided at the facility are not listed as added services. In each case in which VA decided to close all inpatient services at a medical facility and to add services to a nearby facility, VA decided to add all the inpatient services that it decided to close that are not already available at the nearby VA medical facility.

VA's decisions for 12 other medical facilities identified for potential service duplication or low acute inpatient workload were to close one or more inpatient services at a medical facility, but retain other inpatient services provided at that facility (see table 9). In general, VA will not add the service that will be closed at another VA facility, but instead will enter

into agreements for that care from non-VA providers or refer veterans to a VA medical facility that already provides that service. In one case, VA will add services to a nearby medical facility that did not, at the time VA made its CARES decisions, provide two inpatient services that VA decided to close. Specifically, VA decided to add acute and long-term psychiatry services to its medical facility in Castle Point, New York, which is about 30 miles from its facility in Montrose, New York.

Table 9: VA's Decisions to Close One or More, but Not All, Inpatient Services at a VA Medical Facility

Medical facility	Inpatient service or services to be closed
1. American Lake, Wash.	Acute medicine
2. Butler, Pa.	Acute medicine
3. Canandaigua, N.Y.	Acute psychiatry
4. Castle Point, N.Y.	Treatment for spinal cord injury and disorder
5. Dublin, Ga.	Surgery
6. Kerrville, Tex.	Acute medicine
7. Livermore, Calif.	Subacute medicine
8. Montrose, N.Y.	Acute and long-term psychiatry and nursing home care
9. Murfreesboro, Tenn.	Surgery
10. Muskogee, Okla.	Surgery
11. Roseburg, Oreg.	Surgery
12. Saginaw, Mich.	Acute medicine

Source: GAO analysis of VA data.

Appendix V provides a complete list of VA medical facilities and VA's decisions about the alignment of inpatient services at each.[20]

Our analysis of major CARES documents that describe VA's decisions to realign inpatient services at 22 of its medical facilities indicated that VA generally provided reasons for these decisions that involve factors such as the quality, accessibility, or costs of care. For example, at 5 of its medical facilities VA decided to realign acute psychiatry services so that they would be provided in a medical facility that also provides acute medicine services, which is consistent with VA's goal to improve the quality of care.

[20]Through CARES, VA also decided to build a replacement for its hospital in Denver, Colorado. Once the new medical facility is complete, VA will close the existing facility and transfer all inpatient care to the new facility.

When evaluating options for the alignment of health care services, CARES guidelines were consistent with guidelines from the Office of Management and Budget[21] in calling for attention to the costs and benefits of alternatives when evaluating options for the alignment of health care services. CARES guidelines are also consistent with our previous analysis and, in particular, our view of the importance of costs and benefits associated with the quality of care, access to care, cost to the government, support for VA's other strategic goals (such as medical education of health care providers and research), and economic impact on the local community.[22]

VA also made decisions to realign inpatient services in three health care markets where VA identified limitations in access to acute or long-term inpatient services (see table 10). VA had several options to address these access limitations. VA could realign inpatient services by establishing new VA medical facilities or adding services to existing VA medical facilities. As an alternative to realigning its inpatient services, VA also had the option of entering into agreements with non-VA providers. For example, it could improve access by purchasing inpatient health care services from non-VA providers, leasing space at non-VA medical facilities, or collaborating with the Department of Defense. VA decided to add inpatient services at two existing VA medical facilities and to establish a new VA medical facility to provide inpatient services in Las Vegas, Nevada.[23]

[21]Office of Management and Budget, *Capital Programming Guide*, Version 1.0 (Washington, D.C.: July 1997).

[22]See GAO, *VA Health Care: Framework for Analyzing Capital Asset Realignment for Enhanced Services Decisions*, GAO-03-1103R (Washington, D.C.: Aug. 18, 2003).

[23]At the time VA made its CARES decisions, VA collaborated with the Department of Defense to provide inpatient hospital services in Las Vegas, Nevada, by having VA staff provide services to veterans in a hospital at Nellis Air Force Base.

Table 10: VA Health Care Markets Where VA Decided to Add Acute or Long-Term Inpatient Services

	VA alignment decisions	
Markets	**Add more inpatient services to an existing facility**	**Establish a new medical facility**
1. Washington, D.C., market of Network 5 (the District of Columbia and parts of both Maryland and Virginia)	Domiciliary care at VA's Washington, D.C., medical facility	Not applicable
2. Central market of Network 8 (the central part of Florida)	Acute inpatient medicine, surgery, and psychiatry at VA's Orlando, Fla., medical facility[a]	Not applicable
3. Nevada market of Network 22 (southern Nevada)	Not applicable	Acute inpatient medicine, surgery, psychiatry, and nursing home services at a new VA medical facility in Las Vegas, Nev.[b]

Source: GAO analysis of VA data.

[a]VA decided to add an acute care hospital to its medical facility—a nursing home and domiciliary—in Orlando.

[b]VA did not have an inpatient facility in this market at the time it made its CARES decisions. It collaborated with the Department of Defense to provide acute inpatient hospital services in Las Vegas, Nev., by having VA staff provide services to veterans in a hospital at Nellis Air Force Base.

Appendix VI provides a complete list of VA's health care markets and indicates where VA identified limitations in geographic access to tertiary, acute, or long-term inpatient health care services and VA's decisions for improving veterans' access to these services.

VA also decided to add specialized centers for the inpatient treatment of spinal cord injury and disorder or blind rehabilitation to existing VA medical centers in five networks where it had identified limitations in veterans' access to these services (see table 11). VA will add inpatient centers for the treatment of spinal cord injury and disorder in three networks and inpatient centers for blind rehabilitation in two networks (see also app. VII).

Table 11: VA Health Care Networks Where VA Decided to Add Specialized Inpatient Treatment for Spinal Cord Injury and Disorder or Blind Rehabilitation

Network	Inpatient services VA decided to add to an existing facility
1. Network 2 (upstate New York and parts of north central Pennsylvania)	Inpatient Spinal Cord Injury and Disorder Center at VA's Syracuse, N.Y., medical facility
2. Network 16 (Louisiana; most of Arkansas, Mississippi, and Oklahoma; eastern Texas; and parts of three other states: Alabama, Florida, and Missouri)	Inpatient Blind Rehabilitation Center at VA's Biloxi, Miss., medical facility
3. Network 19 (Utah; most of Colorado, Montana, and Wyoming; and parts of five other states: Idaho, Kansas, Nebraska, Nevada, and North Dakota)	Inpatient Spinal Cord Injury and Disorder Center at VA's Denver, Colo., medical facility
4. Network 22 (southern California and southern Nevada)	Inpatient Blind Rehabilitation Center at VA's Long Beach, Calif., medical facility
5. Network 23 (Iowa and South Dakota; most of Minnesota, Nebraska, and North Dakota; and parts of five other states: Illinois, Kansas, Missouri, Wisconsin, and Wyoming)	Inpatient Spinal Cord Injury and Disorder Center at VA's Minneapolis, Minn., medical facility

Source: GAO analysis of VA data.

Note: VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

Appendix VII provides a complete list of VA's health care networks and indicates those where VA identified limitations in veterans' access to specialized inpatient treatment programs for spinal cord injury and disorder or blindness and VA's decisions about the alignment of these inpatient services.

VA Made Decisions to Maintain Its Inpatient Services as Currently Aligned at 90 Locations

VA decided to maintain its inpatient services as currently aligned in 90 locations—63 medical facilities identified as having potential service duplication or low acute inpatient workload and 27 markets where VA identified limitations in veterans' geographic access to tertiary or acute inpatient services. VA provided reasons for its decisions to leave services as aligned for most, but not all, of these locations. Generally the reasons VA cited in major CARES documents for leaving inpatient services as aligned at the 63 medical facilities were that realignment was not feasible

(for example, because space limitations constrain consolidation of potentially duplicative services) or would have a negative effect on the quality of care, accessibility of care, cost of care, VA's strategic missions, or the community's economy. As one example, VA decided to maintain inpatient services as aligned at its medical facility in Hot Springs, South Dakota, where acute inpatient workload is low, because there are no hospitals within 60 miles that have been accredited by the Joint Commission on Accreditation of Healthcare Organizations. As another example, VA decided to maintain inpatient services as aligned at its two medical facilities in Augusta, Georgia, because it concluded that space is insufficient to make consolidation practical.

For the 27 markets where VA decided not to realign the inpatient health care services at its existing medical facilities, VA decided instead to purchase health care services through contracts with local non-VA providers, lease space at non-VA medical facilities, or establish collaborative arrangements with the Department of Defense. Each of these markets was one where VA identified lengthy driving times to access tertiary or acute care.

VA Deferred Decisions on Alignment of Inpatient Health Care Services for 16 Locations Pending Further Study

VA deferred decisions about the alignment of inpatient health care services for 16 locations,[24] including

- 14 existing VA medical facilities that have service duplication or low acute inpatient workload (see table 12);
- 1 market where VA identified limitations in access to a long-term care service, namely, residential rehabilitation for post-traumatic stress disorder and substance abuse in the Michigan market of Network 11 (which includes lower Michigan and part of northwest Ohio); and

[24]VA also deferred, pending further study, some decisions about potential alignment options at one medical facility and one network where it had already made some decisions on inpatient services. These locations are VA's medical facility at Muskogee, Oklahoma, and Network 16, which includes Louisiana; most of Arkansas, Mississippi, and Oklahoma; eastern Texas; and parts of Alabama, Florida, and Missouri. In addition to its decision to close inpatient surgery at the facility in Muskogee, Oklahoma, VA will study further whether to add inpatient psychiatry services to that facility and whether to contract with non-VA providers to meet veterans' inpatient health care needs in the Muskogee/Tulsa region. In addition to VA's decision to add an inpatient blind rehabilitation center in Network 16, VA will study further which of its medical facilities in Network 16 would be the best location for a new inpatient center for the treatment of spinal cord injury and disorder.

- 1 network where VA identified limitations in access to specialized inpatient treatment for spinal cord injury and disorder, namely, Network 8 (which includes most of Florida, part of southern Georgia, Puerto Rico, the U.S. Virgin Islands of St. Thomas and St. Croix, and Arecibo).

Table 12: VA Medical Facilities Where Inpatient Alignment Decisions Were Deferred Pending Further Study

1.	Bedford, Mass.
2.	Big Spring, Tex.
3.	Brockton, Mass.
4.	Brooklyn, N.Y.
5.	Chillicothe, Ohio
6.	Jamaica Plain, Mass.
7.	Lake City, Fla.
8.	Manhattan, N.Y.
9.	Montgomery, Ala.
10.	Poplar Bluff, Mo.
11.	Temple, Tex.
12.	Waco, Tex.
13.	Walla Walla, Wash.
14.	West Roxbury, Mass.

Source: GAO analysis of VA data.

Note: In addition, VA chose to further study potential alignment options at its medical facility at Muskogee, Oklahoma, where it had already made one decision about inpatient services. VA decided to close inpatient surgery at Muskogee and to study the potential to add inpatient psychiatric services or to use non-VA providers to meet veterans' inpatient health care needs in the Muskogee/Tulsa region.

In general, VA indicated that it plans to study ways to align inpatient health care services at these locations because it concluded that sufficient information was not available to reach a decision by May 7, 2004. For example, VA concluded that it lacked adequate data about the feasibility and cost-effectiveness of building a single new inpatient medical facility in Boston, Massachusetts, to replace its inpatient medical facilities in Bedford, Brockton, Jamaica Plain, and West Roxbury, Massachusetts. As another example, VA concluded that further information would be needed to determine whether to add a new inpatient center for the treatment of spinal cord injury and disorder or to expand an existing center for that treatment in southern Florida. When VA announced its CARES decisions, it reported that it planned to complete most of these studies by the end of 2004 or the beginning of 2005; a VA official reported in November 2004

that VA now expects that most of the studies will be completed by the end of 2005.[25]

In addition, VA plans to develop crosscutting strategic plans for long-term care and mental health services that could result in decisions to realign inpatient services at locations where VA has decided to realign other inpatient services and at locations where no realignment decisions have been made. Although VA made some decisions about the alignment of long-term care services at facilities it had identified for potential duplication of services, the CARES process did not include a systematic analysis of VA's long-term care services (including nursing home care, long-term psychiatric care, domiciliary care, and residential rehabilitation) because VA had not developed an adequate model to project future need for these services. VA reported that it is now working on a strategic plan for long-term care that will include nursing home and long-term psychiatric care needs and will be adjusted to determine whether access to domiciliary care can be improved by realigning such services from rural to urban medical facilities. VA also reported that it plans to develop a mental health strategic plan that could suggest additional realignments of inpatient psychiatry services because it will address the collocation of acute inpatient psychiatric services with other acute inpatient services—an arrangement that VA noted can enhance the quality of acute psychiatric care—and better ensure equitable access to inpatient psychiatric services.

Concluding Observations

Through the CARES process, VA has taken important steps in assessing and making decisions on the alignment of its future inpatient health care services and capital assets in light of projected health care needs. Specifically, VA identified 136 locations where potential service duplication, low acute inpatient workload, or limitations in veterans' geographic access to VA health care indicated the need to evaluate alternatives to alignment of inpatient services that could enhance health care for veterans. In its evaluation, VA decided to realign services at 30 locations, generally citing reasons to maintain or enhance the quality of care, improve veterans' access to care, or increase the cost efficiency of

[25]VA has decided to use a contractor to complete most of these studies. It expects the contractor to begin the studies by spring of 2005. VA expects that most of the studies will require from 4 to 9 months to complete. VA also reported that one study has already been completed and that one other study will not begin for approximately 5 years because options for realignment of inpatient workload at the medical facility to be studied depend on major construction at a nearby VA medical facility.

care and decided to maintain the alignment of inpatient services at 90 locations. Among the 90 locations, VA decided to improve veterans' access to inpatient health services by entering into agreements for care from non-VA providers in the 27 locations where a large number of veterans face lengthy driving times to access VA health care and where VA decided not to add inpatient services.

VA, however, did not complete its assessment of the alignment of inpatient services at all locations identified as having potential service duplication, low acute inpatient workload, or limitations in veterans' geographic access to inpatient care. VA made no decisions on the alignment of inpatient services in 16 locations pending completion of further studies because VA believed it had insufficient information to make a decision. In addition, VA plans other studies concerning alignment of other inpatient services, such as nursing home and mental health care, that could affect the alignment of these services at other medical facilities.

VA's decisions to realign inpatient services have the potential to enhance health care services for veterans. Some veterans who will be directly affected by VA's decisions to realign inpatient services may benefit from enhanced quality or accessibility of VA health care. Moreover, cost savings associated with the closure of VA medical facilities and elimination of duplicative services can be redirected to better serve the health care needs of veterans. VA's efforts to realign its inpatient services and improve management of its capital assets are essential to meeting the health care needs of veterans in the 21st century. VA's alignment decisions and planned studies of additional alternatives for the alignment of inpatient services are tangible steps forward in this process. Ultimately, however, accomplishing these goals will depend on VA's success in completing its studies and implementing its CARES decisions on inpatient and other health care services to better ensure that resources now spent on unneeded capital assets are redirected to health care.

Agency Comments

In written comments on a draft of this report, VA concurred with our findings. VA comments are reprinted in appendix VIII.

As we agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from its date. We will then send copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. We will also make copies available to others upon

request. This report will be available at no charge on GAO's Web site at http://www.gao.gov. If you or your staff have any questions, please call me at (202) 512-7101. Another contact and key contributors are listed in appendix IX.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Appendix I: Scope and Methodology

On May 7, 2004, the Secretary of Veterans Affairs published decisions the Department of Veterans Affairs (VA) reached through its Capital Asset Realignment for Enhanced Services (CARES) process.[1] The Secretary's report included VA's CARES decisions about the alignment of inpatient services at locations it identified for potential service duplication, low acute inpatient workload, or limitations in geographic access, along with its other CARES decisions. These decisions covered 74 of VA's 77 markets in 20 of its 21 networks.[2] In the context of the alignment of its inpatient services, VA's report focused primarily on decisions involving medical facilities, markets, and networks where VA's inpatient health care services are to be realigned or studied further. The report did not, however, provide a national, comprehensive summary of the medical facilities, markets, and networks that VA identified as needing evaluation for potential alternative alignments of inpatient services and did not include a discussion of all of the locations where it decided to leave inpatient services as currently aligned.

We examined VA's inpatient service assessments and decisions to develop a national summary of the medical facilities, markets, and networks where (1) VA identified potential service duplication, low workload, or geographic access limitations as factors that could indicate a need to evaluate alternative ways to align inpatient health care services and (2) VA made decisions to either realign inpatient services or leave inpatient services as aligned, or deferred decisions pending further study. Our summary of the decisions VA made through CARES focuses on inpatient health care services that VA provides in medical facilities that it owns in the 20 networks covered by the Secretary's May 7, 2004, CARES decisions. Because no one source includes all the information about these factors, we reviewed the major CARES documents, namely, CARES planning documents such as network market plans, VA's *Draft National CARES Plan*, the report by an independent Commission appointed by VA that was charged with making CARES recommendations, and the Secretary's report of VA's CARES decisions.

[1]Department of Veterans Affairs, *Secretary of Veterans Affairs: CARES Decision* (Washington, D.C.: May 7, 2004).

[2]In February 2002, VA completed a CARES pilot project that 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. At that time, VA announced its decision to, among other things, discontinue inpatient health care services at its Lakeside medical facility in Chicago, Illinois, one of eight inpatient medical facilities that VA had in these markets.

To summarize the number of medical facilities,[3] health care markets, and health care networks where VA identified potential service duplication, low acute inpatient workload, or geographic access limitations as factors that could indicate a need to evaluate alternative ways to align inpatient health care services, we reviewed major CARES documents for information about these factors. We classified the medical facilities that VA identified as potentially duplicating inpatient services as potentially duplicating one or more of three types of inpatient services, namely, tertiary care services; acute inpatient medicine services; or other services, including other types of inpatient care (such as long-term psychiatry) or services that support inpatient care (such as administration or maintenance). When our identification of a medical facility as one with potential service duplication or low workload depended on the availability of acute inpatient medicine, we confirmed that the facility provided that service during the first half of fiscal year 2004, the time period immediately before VA made its CARES decisions, by examining data provided by VA. We resolved discrepancies in the characterization of medical facilities as potentially duplicating inpatient services or having low acute inpatient workload through discussions with VA officials.

To summarize VA's decisions about the alignment of inpatient services, we reviewed major CARES documents to determine if VA made a decision to realign inpatient services or leave inpatient services as aligned or if VA deferred making a decision pending further study. We defined realignment of an inpatient service as (1) eliminating the service in its entirety at a facility where VA provided it, (2) adding an inpatient service to an existing VA facility where VA did not provide the service, or (3) establishing a new VA medical facility where one had not existed. We did not examine the number of beds that VA decided to add or close. The inpatient services in our review included both acute and long-term inpatient services. Specifically, these inpatient services included tertiary care; the acute inpatient services of acute medicine, surgery, and psychiatry; and other inpatient services. Other inpatient services included subacute and intermediate medicine; the long-term inpatient services of nursing home

[3]In this report, we consider medical facilities to be the capital assets owned by VA at which it provides inpatient health care services to veterans. Medical facilities include tertiary and acute hospitals, nursing homes, and other extended care assets.

care, long-term psychiatry, domiciliary care,[4] and residential rehabilitation; and specialized inpatient services of treatment for spinal cord injury and disorder and blind rehabilitation. In some cases in which VA decided to close an inpatient service at one medical facility and refer patients to another VA medical facility, CARES documents did not indicate whether that inpatient service was already available at that medical facility. To determine whether VA had decided to add the inpatient service in these cases, we obtained additional information from VA. We classified a decision as pending further study when VA determined that additional information or analysis was necessary to determine whether to add or close one or more inpatient services at a location. We compared data from CARES with other information from VA about the inpatient services available at its medical facilities and when we identified discrepancies, resolved them through discussions with VA officials. To identify the reasons VA provided for its decisions about the alignment of inpatient services, we reviewed major CARES documents. We examined the stated rationale associated with each decision for references to feasibility or costs and benefits involving the quality of care, access to care, cost to the government, support for VA's other strategic goals (such as medical education and research), and economic impact on the local community. We did not evaluate the stated reasons.

We found the data to be adequate for our purposes, and VA officials agreed that our methodology was reasonable. We did not review VA's other CARES decisions such as those for reconfiguring space to meet projected demand for services, modernization needed to provide services appropriately, disposal of assets that may no longer be needed, or the alignment of outpatient services. We conducted our work from October 2003 through March 2005 in accordance with generally accepted government auditing standards.

[4]Domiciliary care involves coordinated rehabilitative and restorative clinical care in an inpatient setting, with the goal of helping veterans achieve and maintain the highest level of functioning and independence possible. Domiciliary care differs from other types of inpatient care in that bedside nursing is not required.

Appendix II: VA Medical Facilities Identified for Potential Duplication of Tertiary Care Services

VA medical facility[a]	Network[b]	VA medical facility or facilities close enough (within 120 miles) to consider whether tertiary care services were needed at both
Ann Arbor, Mich.	11	Detroit, Mich.
Augusta, Ga.—*Downtown*	7	Columbia, S.C.
Baltimore, Md.	5	Philadelphia, Pa., and Washington, D.C.
Bay Pines, Fla.	8	Tampa, Fla.
Bronx, N.Y.	3	Brooklyn, N.Y.; East Orange, N.J.; Manhattan, N.Y.; Northport, N.Y.; Philadelphia, Pa.; and West Haven, Conn.
Brooklyn, N.Y.	3	Bronx, N.Y.; East Orange, N.J.; Manhattan, N.Y.; Northport, N.Y.; Philadelphia, Pa.; and West Haven, Conn.
Charleston, S.C.	7	Columbia, S.C.
Cincinnati, Ohio	10	Dayton, Ohio; Indianapolis, Ind.; Lexington, Ky.—*Cooper*; and Louisville, Ky.
Columbia, S.C.	7	Augusta, Ga.—*Downtown* and Charleston, S.C.
Dayton, Ohio	10	Cincinnati, Ohio, and Indianapolis, Ind.
Detroit, Mich.	11	Ann Arbor, Mich.
East Orange, N.J.	3	Bronx, N.Y.; Brooklyn, N.Y.; Manhattan, N.Y.; Northport, N.Y.; Philadelphia, Pa.; and West Haven, Conn.
Indianapolis, Ind.	11	Cincinnati, Ohio; Dayton, Ohio; and Louisville, Ky.
Lexington, Ky.—*Cooper*	9	Cincinnati, Ohio, and Louisville, Ky.
Loma Linda, Calif.	22	Long Beach, Calif.; San Diego, Calif.; and West Los Angeles, Calif.
Long Beach, Calif.	22	Loma Linda, Calif.; San Diego, Calif.; and West Los Angeles, Calif.
Louisville, Ky.	9	Cincinnati, Ohio; Indianapolis, Ind.; and Lexington, Ky.—*Cooper*
Manhattan, N.Y.	3	Bronx, N.Y.; Brooklyn, N.Y.; East Orange, N.J.; Northport, N.Y.; Philadelphia, Pa.; and West Haven, Conn.
Northport, N.Y.	3	Bronx, N.Y.; Brooklyn, N.Y.; East Orange, N.J.; Manhattan, N.Y.; and West Haven, Conn.
Palo Alto, Calif.	21	San Francisco, Calif.
Philadelphia, Pa.	4	Baltimore, Md.; Bronx, N.Y.; Brooklyn, N.Y.; East Orange, N.J.; and Manhattan, N.Y.
Richmond, Va.	6	Washington, D.C.
San Diego, Calif.	22	Loma Linda, Calif., and Long Beach, Calif.
San Francisco, Calif.	21	Palo Alto, Calif.
Tampa, Fla.	8	Bay Pines, Fla.
Washington, D.C.	5	Baltimore, Md., and Richmond, Va.
West Haven, Conn.	1	Bronx, N.Y.; Brooklyn, N.Y.; East Orange, N.J.; Manhattan, N.Y.; and Northport, N.Y.
West Los Angeles, Calif.	22	Loma Linda, Calif., and Long Beach, Calif.

Source: GAO analysis of VA data.

[a]VA medical facilities that provide tertiary care services and are within 120 miles of another VA medical facility that provides tertiary care services and that VA identified as potentially duplicating inpatient services.

[b]VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

Appendix III: VA Medical Facilities Identified for Potential Duplication of Acute Inpatient Medicine Services

VA medical facility[a]	Network[b]	VA medical facility or facilities close enough (within 60 miles) to consider whether acute inpatient medicine services were needed at both
Ann Arbor, Mich.	11	Detroit, Mich.
Baltimore, Md.	5	Perry Point, Md., and Washington, D.C.
Bronx, N.Y.	3	Brooklyn, N.Y.; Castle Point, N.Y.; East Orange, N.J.; Manhattan, N.Y.; and Northport, N.Y.
Brooklyn, N.Y.	3	Bronx, N.Y.; East Orange, N.J.; Manhattan, N.Y.; and Northport, N.Y.
Castle Point, N.Y.	3	Bronx, N.Y.
Cincinnati, Ohio	10	Dayton, Ohio
Dayton, Ohio	10	Cincinnati, Ohio
Detroit, Mich.	11	Ann Arbor, Mich.
East Orange, N.J.	3	Bronx, N.Y.; Brooklyn, N.Y.; Manhattan, N.Y.; and Northport, N.Y.
Gainesville, Fla.	8	Lake City, Fla.
Kansas City, Mo.	15	Leavenworth, Kans.
Lake City, Fla.	8	Gainesville, Fla.
Leavenworth, Kans.	15	Kansas City, Mo.
Little Rock, Ark.	16	North Little Rock, Ark.
Long Beach, Calif.	22	West Los Angeles, Calif.
Manhattan, N.Y.	3	Bronx, N.Y.; Brooklyn, N.Y.; and East Orange, N.J.
Murfreesboro, Tenn.	9	Nashville, Tenn.
Nashville, Tenn.	9	Murfreesboro, Tenn.
North Little Rock, Ark.	16	Little Rock, Ark.
Northport, N.Y.	3	Bronx, N.Y.; Brooklyn, N.Y.; and East Orange, N.J.
Perry Point, Md.	5	Baltimore, Md., and Wilmington, Del.
Philadelphia, Pa.	4	Wilmington, Del.
Providence, R.I.	1	West Roxbury, Mass.
Washington, D.C.	5	Baltimore, Md.
West Los Angeles, Calif.	22	Long Beach, Calif.
West Roxbury, Mass.	1	Providence, R.I.
Wilmington, Del.	4	Perry Point, Md., and Philadelphia, Pa.

Source: GAO analysis of VA data.

[a]VA medical facilities that provide acute inpatient medicine services and are within 60 miles of another VA medical facility that provides acute inpatient medicine services and that VA identified as potentially duplicating inpatient services.

[b]VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

Appendix IV: VA Medical Facilities Identified for Potential Duplication of Other Inpatient Services or Support Services

VA medical facility[a]	Network[b]	VA medical facility or facilities close enough geographically to consider whether inpatient services were needed at both
American Lake, Wash.	20	White City, Oreg.
Augusta, Ga.—*Downtown*	7	Augusta, Ga.—*Uptown*
Augusta, Ga.—*Uptown*	7	Augusta, Ga.—*Downtown*
Batavia, N.Y.	2	Buffalo, N.Y., and Canandaigua, N.Y.
Bedford, Mass.	1	Brockton, Mass.; Jamaica Plain, Mass.; and West Roxbury, Mass.
Biloxi, Miss.	16	Gulfport, Miss.
Brockton, Mass.	1	Bedford, Mass.; Jamaica Plain, Mass.; and West Roxbury, Mass.
Brooklyn, N.Y.	3	St. Albans, N.Y.
Buffalo, N.Y.	2	Batavia, N.Y.
Canandaigua, N.Y.	2	Batavia, N.Y.
Castle Point, N.Y.	3	Montrose, N.Y.
Cleveland, Ohio—*Brecksville*	10	Cleveland, Ohio—*Wade Park*
Cleveland, Ohio—*Wade Park*	10	Cleveland, Ohio—*Brecksville*
Des Moines, Iowa	23	Knoxville, Iowa
East Orange, N.J.	3	Lyons, N.J.
Fort Meade, S. Dak.	23	Hot Springs, S. Dak.
Fort Wayne, Ind.	11	Marion, Ind.
Gainesville, Fla.	8	Lake City, Fla.
Gulfport, Miss.	16	Biloxi, Miss.
Hot Springs, S. Dak.	23	Fort Meade, S. Dak.
Jamaica Plain, Mass.	1	Bedford, Mass.; Brockton, Mass.; and West Roxbury, Mass.
Kansas City, Mo.	15	Leavenworth, Kans.
Kerrville, Tex.	17	San Antonio, Tex.
Knoxville, Iowa	23	Des Moines, Iowa
Lake City, Fla.	8	Gainesville, Fla.
Leavenworth, Kans.	15	Kansas City, Mo., and Topeka, Kans.
Lexington, Ky.—*Cooper*	9	Lexington, Ky.—*Leestown*
Lexington, Ky.—*Leestown*	9	Lexington, Ky.—*Cooper*
Livermore, Calif.	21	Palo Alto, Calif.
Lyons, N.J.	3	East Orange, N.J.
Marion, Ind.	11	Fort Wayne, Ind.
Miami, Fla.	8	West Palm Beach, Fla.
Montgomery, Ala.	7	Tuskegee, Ala.
Montrose, N.Y.	3	Castle Point, N.Y.
Palo Alto, Calif.	21	Livermore, Calif.

VA medical facility[a]	Network[b]	VA medical facility or facilities close enough geographically to consider whether inpatient services were needed at both
Pittsburgh, Pa.—*Heinz Center*	4	Pittsburgh, Pa.—*Highland Drive* and Pittsburgh, Pa.—*University Drive*
Pittsburgh, Pa.—*Highland Drive*	4	Pittsburgh, Pa.—*Heinz Center* and Pittsburgh, Pa.—*University Drive*
Pittsburgh, Pa.—*University Drive*	4	Pittsburgh, Pa.—*Heinz Center* and Pittsburgh, Pa.—*Highland Drive*
Portland, Oreg.	20	Vancouver, Wash.
Roseburg, Oreg.	20	White City, Oreg.
San Antonio, Tex.	17	Kerrville, Tex.
St. Albans, N.Y.	3	Brooklyn, N.Y.
Temple, Tex.	17	Waco, Tex.
Topeka, Kans.	15	Leavenworth, Kans.
Tuskegee, Ala.	7	Montgomery, Ala.
Vancouver, Wash.	20	Portland, Oreg.
Waco, Tex.	17	Temple, Tex.
West Palm Beach, Fla.	8	Miami, Fla.
West Roxbury, Mass.	1	Bedford, Mass.; Brockton, Mass.; and Jamaica Plain, Mass.
White City, Oreg.	20	American Lake, Wash., and Roseburg, Oreg.

Source: GAO analysis of VA data.

[a]VA medical facilities that VA identified as close enough geographically to another VA medical facility for VA to consider whether inpatient services other than tertiary care or acute inpatient medicine were needed at both. The potentially duplicated inpatient services generally included psychiatric and long-term inpatient care; services that support inpatient care generally included administration and maintenance.

[b]VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

Appendix V: VA's 172 Medical Facilities, Potential Service Duplication or Low Acute Inpatient Workload, and Alignment Decisions

VA medical facility[a]	Network[b]	Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
		Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
1. Albany, N.Y.	2								
2. Albuquerque, N. Mex.	18								
3. Alexandria, La.	16								
4. Altoona, Pa.	4				X				
5. Amarillo, Tex.	18								
6. American Lake, Wash.	20			X				X	
7. Anchorage, Alaska	20								
8. Ann Arbor, Mich.	11	X	X						
9. Asheville, N.C.	6								
10. Atlanta, Ga.	7								
11. Augusta, Ga.—*Downtown*	7	X		X					
12. Augusta, Ga.—*Uptown*	7			X					
13. Baltimore, Md.	5	X	X						
14. Batavia, N.Y.	2			X					
15. Bath, N.Y.	2				X				
16. Battle Creek, Mich.	11								
17. Bay Pines, Fla.	8	X							
18. Beckley, W.Va.	6				X				
19. Bedford, Mass.	1			X					X
20. Big Spring, Tex.	18					X			X
21. Biloxi, Miss.	16			X			X		

VA medical facility[a]	Network[b]	Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
		Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
22. Birmingham, Ala.	7								
23. Boise, Idaho	20					X			
24. Bonham, Tex.	17								
25. Brockton, Mass.	1			X					X
26. Bronx, N.Y.	3	X	X						
27. Brooklyn, N.Y.	3	X	X	X					X
28. Buffalo, N.Y.	2			X					
29. Butler, Pa.	4				X			X	
30. Canandaigua, N.Y.	2			X				X	
31. Castle Point, N.Y.	3		X	X	X		X	X	
32. Charleston, S.C.	7	X							
33. Cheyenne, Wyo.	19				X				
34. Chicago, Ill.—*West Side*	12[k]								
35. Chillicothe, Ohio	10					X			X
36. Cincinnati, Ohio	10	X	X						
37. Clarksburg, W.Va.	4								
38. Cleveland, Ohio—*Brecksville*	10			X				X[l]	
39. Cleveland, Ohio—*Wade Park*	10			X			X		
40. Coatesville, Pa.	4								
41. Columbia, Mo.	15								
42. Columbia, S.C.	7	X							
43. Dallas, Tex.	17								

VA medical facility[a]	Network[b]	Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
		Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
44. Danville, Ill.	11								
45. Dayton, Ohio	10	X	X						
46. Denver, Colo.[m]	19						X		
47. Des Moines, Iowa	23			X	X		X		
48. Detroit, Mich.	11	X	X						
49. Dublin, Ga.	7				X			X	
50. Durham, N.C.	6								
51. East Orange, N.J.	3	X	X	X					
52. Erie, Pa.	4				X				
53. Fargo, N. Dak.	23								
54. Fayetteville, Ark.	16								
55. Fayetteville, N.C.	6								
56. Fort Harrison, Mont.	19					X			
57. Fort Meade, S. Dak.	23			X					
58. Fort Thomas, Ky.	10								
59. Fort Wayne, Ind.	11			X	X			X[l]	
60. Fresno, Calif.	21								
61. Gainesville, Fla.	8		X	X					
62. Grand Island, Nebr.	23								
63. Grand Junction, Colo.	19				X				
64. Gulfport, Miss.	16			X				X[l]	
65. Hampton, Va.	6								
66. Hines, Ill.	12[k]								
67. Honolulu, Hawaii	21								

VA medical facility[a]	Network[b]	Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
		Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
68. Hot Springs, S. Dak.	23			X	X				
69. Houston, Tex.	16								
70. Huntington, W.Va.	9					X			
71. Indianapolis, Ind.	11	X							
72. Iowa City, Iowa	23								
73. Iron Mountain, Mich.	12[k]								
74. Jackson, Miss.	16								
75. Jamaica Plain, Mass.	1			X					X
76. Kansas City, Mo.	15		X	X					
77. Kerrville, Tex.	17			X	X			X	
78. Knoxville, Iowa	23			X				X[l]	
79. Lake City, Fla.	8		X	X					X
80. Leavenworth, Kans.	15		X	X					
81. Lebanon, Pa.	4								
82. Lexington, Ky.—*Cooper*	9	X		X					
83. Lexington, Ky.—*Leestown*	9			X					
84. Little Rock, Ark.	16		X						
85. Livermore, Calif.	21			X				X	
86. Loch Raven, Md.	5								
87. Loma Linda, Calif.	22	X							
88. Long Beach, Calif.	22	X	X				X		
89. Louisville, Ky.	9	X							

VA medical facility[a]	Network[b]	Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
		Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
90. Lyons, N.J.	3			X					
91. Madison, Wis.	12[k]								
92. Manchester, N.H.	1								
93. Manhattan, N.Y.	3	X	X						X
94. Marion, Ill.	15								
95. Marion, Ind.	11			X	X				
96. Martinez, Calif.	21								
97. Martinsburg, W.Va.	5								
98. Memphis, Tenn.	9								
99. Menlo Park, Calif.	21								
100. Miami, Fla.	8			X					
101. Miles City, Mont.	19								
102. Milwaukee, Wis.	12[k]								
103. Minneapolis, Minn.	23						X		
104. Montgomery, Ala.	7			X					X
105. Montrose, N.Y.	3			X				X	
106. Mountain Home, Tenn.	9								
107. Murfreesboro, Tenn.	9		X			X		X	
108. Muskogee, Okla.	16				X			X	X
109. Nashville, Tenn.	9		X						
110. New Orleans, La.	16								

		Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
VA medical facility[a]	Network[b]	Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
111. North Chicago, Ill.	12[k]								
112. North Little Rock, Ark.	16		X						
113. Northampton, Mass.	1								
114. Northport, N.Y.	3	X	X						
115. Oklahoma City, Okla.	16								
116. Omaha, Nebr.	23								
117. Orlando, Fla.	8						X		
118. Palo Alto, Calif.	21	X		X					
119. Perry Point, Md.	5		X						
120. Philadelphia, Pa.	4	X	X						
121. Phoenix, Ariz.	18								
122. Pittsburgh, Pa.—*Heinz Center*	4			X			X		
123. Pittsburgh, Pa.—*Highland Drive*	4			X				X[l]	
124. Pittsburgh, Pa.—*University Drive*	4			X			X		
125. Poplar Bluff, Mo.	15				X				X
126. Portland, Oreg.	20			X					
127. Prescott, Ariz.	18				X				
128. Providence, R.I.	1		X						
129. Reno, Nev.	21								
130. Richmond, Va.	6	X							

VA medical facility[a]	Network[b]	Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
		Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
131. Roseburg, Oreg.	20			X		X		X	
132. Sacramento, Calif.	21								
133. Saginaw, Mich.	11				X			X	
134. Salem, Va.	6								
135. Salisbury, N.C.	6								
136. Salt Lake City, Utah	19								
137. San Antonio, Tex.	17			X					
138. San Diego, Calif.	22	X							
139. San Francisco, Calif.	21	X							
140. San Juan, P.R.	8								
141. Seattle, Wash.	20								
142. Sepulveda, Calif.	22								
143. Sheridan, Wyo.	19								
144. Shreveport, La.	16								
145. Sioux Falls, S. Dak.	23								
146. Spokane, Wash.	20					X			
147. St. Albans, N.Y.	3			X					
148. St. Cloud, Minn.	23								
149. St. Louis, Mo.—*Jefferson Barracks*	15								

		Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
VA medical facility[a]	Network[b]	Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
150. St. Louis, Mo. —*John Cochran*	15								
151. Syracuse, N.Y.	2						X		
152. Tampa, Fla.	8	X							
153. Temple, Tex.	17			X					X
154. Togus, Maine	1								
155. Tomah, Wis.	12[k]								
156. Topeka, Kans.	15			X					
157. Tucson, Ariz.	18								
158. Tuscaloosa, Ala.	7								
159. Tuskegee, Ala.	7			X					
160. Vancouver, Wash.	20			X					
161. Waco, Tex.	17			X					X
162. Walla Walla, Wash.	20				X				X
163. Washington, D.C.	5	X	X				X		
164. West Haven, Conn.	1	X							
165. West Los Angeles, Calif.	22	X	X						
166. West Palm Beach, Fla.	8			X					
167. West Roxbury, Mass.	1		X	X					X
168. White City, Oreg.	20			X					
169. White River Junction, Vt.	1								
170. Wichita, Kans.	15								
171. Wilkes-Barre, Pa.	4								

		Potential inpatient service duplication			Low acute inpatient workload		VA's May 7, 2004, decisions to add, close, or study inpatient services		
VA medical facility[a]	Network[b]	Tertiary care[c]	Acute medicine care[d]	Other care[e]	Total projected demand[f]	Other basis[g]	Add one or more inpatient service(s)[h]	Close one or more inpatient service(s)[i]	Study ways to align inpatient services[j]
172. Wilmington, Del.	4		X						

Source: GAO analysis of VA data.

[a]VA medical facilities where VA owns capital assets that are used, at least in part, for inpatient health care services.

[b]VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

[c]VA medical facilities that provide tertiary care services and are within 120 miles of another VA medical facility that provides tertiary care services and that VA identified as potentially duplicating inpatient services.

[d]VA medical facilities that provide acute inpatient medicine services and are within 60 miles of another VA medical facility that provides acute inpatient medicine services and that VA identified as potentially duplicating inpatient services.

[e]VA medical facilities that VA identified as close enough geographically to another VA medical facility for VA to consider whether inpatient services other than tertiary care or acute inpatient medicine were needed at both. The potentially duplicated inpatient services generally included psychiatric and long-term inpatient care; services that support inpatient care generally included administration and maintenance.

[f]We identified low total projected acute inpatient demand when a VA medical facility that provided acute inpatient medicine services during the first half of fiscal year 2004, the time period immediately before VA made its CARES decisions, was projected to need fewer than 40 acute medicine, surgery, and psychiatry beds (combined) in fiscal years 2012 and 2022.

[g]VA identified other low acute inpatient workload, even if the total projected number of acute medicine, surgery, and psychiatry beds was expected to exceed 40 in fiscal years 2012 or 2022, when (1) it questioned the viability of a specific acute inpatient service, for example, because projections indicated that few beds would be needed for inpatient surgery or (2) low acute inpatient workload at an existing VA medical facility could result from decisions VA made about inpatient health care at other locations.

[h]VA's decision to add an inpatient service means that one or more inpatient services will be added to an existing VA medical facility that did not provide the service.

[i]VA's decision to close an inpatient service means that one or more inpatient services will be eliminated at a VA medical facility that provided the service.

[j]We defined a study as one that could result in a decision to add or close an inpatient service at a VA medical facility.

[k]VA studied its facilities in Network 12 during a pilot phase of CARES that was completed in February 2002.

[l]VA decided to close all inpatient services at this medical facility.

[m]In addition to its decision to add inpatient treatment for spinal cord injury and disorder to its medical facility in Denver, Colorado, VA also decided to build a replacement for this facility. Once the new medical facility is complete, VA will close the existing facility and transfer all inpatient care to the new facility.

Appendix VI: VA's 77 Markets, Limitations in Geographic Access to Inpatient Services, and Alignment Decisions

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
1—East	This market includes Rhode Island and eastern Massachusetts. VA owns five inpatient medical facilities in this market, located in Bedford, Brockton, Jamaica Plain, and West Roxbury, Mass., and Providence, R.I.						
1—Far North	This market includes Maine. VA owns one inpatient medical facility in this market, located in Togus, Maine.		X			X[e]	
1—North	This market includes New Hampshire and Vermont. VA owns two inpatient medical facilities in this market, located in Manchester, N.H., and White River Junction, Vt.		X			X[e]	
1—West	This market includes Connecticut and western Massachusetts. VA owns two inpatient medical facilities in this market, located in Northampton, Mass., and West Haven, Conn.						
2—Central	This market includes east central upstate New York. VA owns one inpatient medical facility in this market, located in Syracuse, N.Y.						
2—Eastern	This market includes eastern upstate New York. VA owns one inpatient medical facility in this market, located in Albany, N.Y.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
2—Finger Lakes/ Southern Tier	This market includes west central upstate New York and parts of north central Pennsylvania. VA owns two inpatient medical facilities in this market, located in Bath and Canandaigua, N.Y.						
2—Western	This market includes western upstate New York. VA owns two inpatient medical facilities in this market, located in Batavia and Buffalo, N.Y.						
3—Long Island	This market includes Long Island, New York. VA owns one inpatient medical facility in this market, located in Northport, N.Y.						
3—Metro New York	This market includes New York City and the Hudson Valley area of New York. VA owns six inpatient medical facilities in this market, located in Brooklyn, the Bronx, Castle Point, Manhattan, Montrose, and St. Albans, N.Y.						
3—New Jersey	This market includes northern New Jersey. VA owns two inpatient medical facilities in this market, located in East Orange and Lyons, N.J.						
4—Eastern	This market includes Delaware, southern New Jersey, eastern Pennsylvania, and part of New York. VA owns five inpatient medical facilities in this market, located in Coatesville, Lebanon, Philadelphia, and Wilkes-Barre, Pa., and Wilmington, Del.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
4—Western	This market includes western Pennsylvania and parts of three other states: New York, Ohio, and West Virginia. VA owns seven inpatient medical facilities in this market, located in Altoona, Butler, Erie, and Pittsburgh, Pa. (*Heinz Center*, *Highland Drive*, and *University Drive*), and Clarksburg, W.Va.						
5—Baltimore	This market includes eastern Maryland. VA owns three inpatient medical facilities in this market, located in Baltimore, Loch Raven, and Perry Point, Md.						
5—Martinsburg	This market includes western Maryland, northwestern Virginia, eastern West Virginia, and part of Pennsylvania. VA owns one inpatient medical facility in this market, located in Martinsburg, W.Va.						
5—Washington, D.C.	This market includes the District of Columbia and parts of both Maryland and Virginia. VA owns one inpatient medical facility in this market, located in Washington, D.C.			X[f]	X[f]		
6—Northeast	This market includes parts of eastern Virginia and northeastern North Carolina. VA owns two inpatient medical facilities in this market, located in Hampton and Richmond, Va.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
6—Northwest	This market includes parts of western Virginia and southeastern West Virginia. VA owns two inpatient medical facilities in this market, located in Beckley, W.Va., and Salem, Va.						
6—Southeast	This market includes most of eastern North Carolina and part of South Carolina. VA owns two inpatient medical facilities in this market, located in Durham and Fayetteville, N.C.		X			X[e]	
6—Southwest	This market includes most of western North Carolina. VA owns two inpatient medical facilities in this market, located in Asheville and Salisbury, N.C.						
7—Alabama	This market includes most of Alabama and part of western Georgia. VA owns four inpatient medical facilities in this market, located in Birmingham, Montgomery, Tuscaloosa, and Tuskegee, Ala.		X			X[e]	
7—Georgia	This market includes most of Georgia and part of South Carolina. VA owns four inpatient medical facilities in this market, located in Atlanta, Augusta (*Downtown* and *Uptown*), and Dublin, Ga.						
7—South Carolina	This market includes most of South Carolina and part of Georgia. VA owns two inpatient medical facilities in this market, located in Charleston and Columbia, S.C.		X			X[e]	

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
8—Atlantic	This market includes southeast Florida. VA owns two inpatient medical facilities in this market, located in Miami and West Palm Beach, Fla.						
8—Central	This market includes the central part of Florida. VA owns two inpatient medical facilities in this market, located in Orlando and Tampa, Fla.		X		X[g]		
8—Gulf	This market includes part of southwestern Florida. VA owns one inpatient medical facility in this market, located in Bay Pines, Fla.		X			X[e]	
8—North	This market includes most of northern Florida and part of southern Georgia. VA owns two inpatient medical facilities in this market, located in Gainesville and Lake City, Fla.		X			X[e]	
8—Puerto Rico	This market includes Puerto Rico, the U.S. Virgin Islands of St. Thomas and St. Croix, and Arecibo. VA owns one inpatient medical facility in this market, located in San Juan, P.R.						
9—Central	This market includes central Tennessee and parts of both Georgia and Kentucky. VA owns two inpatient medical facilities in this market, located in Murfreesboro and Nashville, Tenn.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
9—Eastern	This market includes eastern Tennessee and parts of three other states: Kentucky, North Carolina, and Virginia. VA owns one inpatient medical facility in this market, located in Mountain Home, Tenn.						
9—Northern	This market includes most of Kentucky and parts of three other states: Indiana, Ohio, and West Virginia. VA owns four inpatient medical facilities in this market, located in Huntington, W.Va., and Lexington (*Cooper* and *Leestown*) and Louisville, Ky.						
9—Western	This market includes eastern Arkansas, northern Mississippi, and western Tennessee. VA owns one inpatient medical facility in this market, located in Memphis, Tenn.						
10—Central	This market includes the southern central portion of Ohio. VA owns one inpatient medical facility in this market, located in Chillicothe, Ohio.		X			X[e]	
10—Eastern	This market includes northeastern Ohio. VA owns two inpatient medical facilities in this market, located in Cleveland, Ohio (*Brecksville* and *Wade Park*).		X			X[e]	

		VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
10—Western	This market includes southwestern Ohio and parts of both Indiana and Kentucky. VA owns three inpatient medical facilities in this market, located in Cincinnati and Dayton, Ohio, and Fort Thomas, Ky.						
11—Central Illinois	This market includes the eastern central portion of Illinois and part of western Indiana. VA owns one inpatient medical facility in this market, located in Danville, Ill.		X			X[e]	
11—Indiana	This market includes most of Indiana and part of Ohio. VA owns three inpatient medical facilities in this market, located in Fort Wayne, Indianapolis, and Marion, Ind.						
11—Michigan	This market includes lower Michigan and part of northwest Ohio. VA owns four inpatient medical facilities in this market, located in Ann Arbor, Battle Creek, Detroit, and Saginaw, Mich.			X[h]			X[h]
12—Central[i]	This market includes most of Wisconsin and parts of both Illinois and Minnesota. VA owns three inpatient medical facilities in this market, located in Madison, Milwaukee, and Tomah, Wis.						
12—Northern[i]	This market includes Michigan's Upper Peninsula and northeastern Wisconsin. VA owns one inpatient medical facility in this market, located in Iron Mountain, Mich.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
12—Southern[i]	This market includes parts of northeastern Illinois and northwestern Indiana. VA owns three inpatient medical facilities in this market, located in Chicago—*West Side*, Hines, and North Chicago, Ill.						
15—Central	This market includes eastern Kansas, most of western Missouri, and part of Illinois. VA owns four inpatient medical facilities in this market, located in Columbia and Kansas City, Mo., and Leavenworth and Topeka, Kans.						
15—Eastern	This market includes southern Illinois, western Kentucky, eastern Missouri, and parts of both Arkansas and Indiana. VA owns four inpatient medical facilities in this market, located in Marion, Ill., and Poplar Bluff and St. Louis (*Jefferson Barracks* and *John Cochran*), Mo.						
15—Western	This market includes most of western Kansas. VA owns one inpatient medical facility in this market, located in Wichita, Kans.						
16—Central Lower	This market includes western Louisiana, eastern Texas, and part of Arkansas. VA owns three inpatient medical facilities in this market, located in Alexandria and Shreveport, La., and Houston, Tex.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
16—Central Southern	This market includes eastern Louisiana and most of Mississippi. VA owns four inpatient medical facilities in this market, located in Biloxi, Gulfport, and Jackson, Miss., and New Orleans, La.						
16—Eastern Southern	This market includes parts of southern Alabama and western Florida. VA does not own any inpatient medical facilities in this market.		X			X[e]	
16—Upper Western	This market includes most of Arkansas and Oklahoma and parts of both Missouri and Texas. VA owns five inpatient medical facilities in this market, located in Fayetteville, Little Rock, and North Little Rock, Ark., and Muskogee and Oklahoma City, Okla.						
17—Central	This market includes the central portion of Texas. VA owns two inpatient medical facilities in this market, located in Temple and Waco, Tex.		X			X[e]	
17—North	This market includes part of north Texas and part of Oklahoma. VA owns two inpatient medical facilities in this market, located in Bonham and Dallas, Tex.						
17—Southern	This market includes south central Texas. VA owns two inpatient medical facilities in this market, located in Kerrville and San Antonio, Tex.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
17—Valley - Coastal Bend	This market includes southern Texas. VA does not own any inpatient medical facilities in this market.		X			X[e]	
18—Arizona	This market includes Arizona. VA owns three inpatient medical facilities in this market, located in Phoenix, Prescott, and Tucson, Ariz.						
18—New Mexico - West Texas	This market includes New Mexico, western Texas, and parts of southern Colorado and western Oklahoma. VA owns three inpatient medical facilities in this market, located in Albuquerque, N. Mex., and Amarillo and Big Spring, Tex.	X	X			X[e,j]	
19—Eastern Rockies	This market includes eastern Colorado, southeastern Wyoming, and parts of both Kansas and Nebraska. VA owns two inpatient medical facilities in this market, located in Denver, Colo., and Cheyenne, Wyo.		X			X[e]	
19—Grand Junction	This market includes western Colorado and southeastern Utah. VA owns one inpatient medical facility in this market, located in Grand Junction, Colo.						
19—Montana	This market includes most of Montana and part of western North Dakota. VA owns two inpatient medical facilities in this market, located in Fort Harrison and Miles City, Mont.	X	X			X[e,j]	

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
19—Western Rockies	This market includes most of Utah and parts of three other states: Idaho, Nevada, and Wyoming. VA owns one inpatient medical facility in this market, located in Salt Lake City, Utah.						
19—Wyoming	This market includes most of northern Wyoming. VA owns one inpatient medical facility in Sheridan, Wyo.						
20—Alaska	This market includes Alaska. VA owns one inpatient medical facility in this market, located in Anchorage, Alaska.	X				X[j]	
20—Inland North	This market includes eastern Washington, northern Idaho, northeastern Oregon, and part of northwest Montana. VA owns two inpatient medical facilities in this market, located in Spokane and Walla Walla, Wash.	X	X			X[e,j]	
20—Inland South	This market includes parts of eastern Oregon and southern Idaho. VA owns one inpatient medical facility in this market, located in Boise, Idaho.	X				X[j]	
20—South Cascades	This market includes western Oregon, southwestern Washington, and part of northwestern California. VA owns four inpatient medical facilities in this market, located in Portland, Roseburg, and White City, Oreg., and Vancouver, Wash.		X			X[e]	

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
20—Western Washington	This market includes most of western Washington. VA owns two inpatient medical facilities in this market, located in American Lake and Seattle, Wash.						
21—North Coast	This market includes northern coastal California. VA owns two inpatient medical facilities in this market, located in Martinez and San Francisco, Calif.						
21—North Valley	This market includes north central California. VA owns one inpatient medical facility in this market, located in Sacramento, Calif.						
21—Pacific Islands	This market includes Hawaii and other Pacific Islands such as Guam, the Philippines, and American Samoa. VA owns one inpatient medical facility in this market, located in Honolulu, Hawaii.	X				X[i]	
21—Sierra Nevada	This market includes northeastern California and western Nevada. VA owns one inpatient medical facility in this market, located in Reno, Nev.	X				X[i]	
21—South Coast	This market includes part of central California. VA owns three inpatient medical facilities in this market, located in Livermore, Menlo Park, and Palo Alto, Calif.		X			X[e]	
21—South Valley	This market includes part of central California. VA owns one inpatient medical facility in this market, located in Fresno, Calif.						

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
22—California	This market includes southern California. VA owns five inpatient medical facilities in this market, located in Loma Linda, Long Beach, San Diego, Sepulveda, and West Los Angeles, Calif.						
22—Nevada	This market includes southern Nevada. VA does not own any inpatient medical facilities in this market.		X[k]	X[l]	X[g,l]		
23—Iowa	This market includes most of Iowa and parts of both Illinois and Missouri. VA owns three inpatient medical facilities in this market, located in Des Moines, Iowa City, and Knoxville, Iowa.		X			X[e]	
23—Minnesota	This market includes most of Minnesota and part of northwestern Wisconsin. VA owns two inpatient medical facilities in this market, located in Minneapolis and St. Cloud, Minn.		X			X[e]	
23—Nebraska	This market includes most of Nebraska and parts of three other states: Iowa, Kansas, and Missouri. VA owns two inpatient medical facilities in this market, located in Grand Island and Omaha, Nebr.						
23—North Dakota	This market includes most of North Dakota and parts of both Minnesota and South Dakota. VA owns one inpatient medical facility in this market, located in Fargo, N. Dak.	X	X			X[e,j]	

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	VA identification of limitations in geographic access to inpatient care			VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care		
		Tertiary care[b]	Acute care[c]	Long-term care	Add one or more VA inpatient service(s)	Enter agreement with non-VA providers[d]	Study options for care
23—South Dakota	This market includes most of South Dakota and parts of five other states: Iowa, Minnesota, Nebraska, North Dakota, and Wyoming. VA owns three inpatient medical facilities in this market, located in Fort Meade, Hot Springs, and Sioux Falls, S. Dak.		X			X[e]	

Source: GAO analysis of VA data.

Notes: Markets with three blank cells under the heading "VA identification of limitations in geographic access to inpatient care" were not identified by VA as having limitations in geographic access to tertiary, acute, or long-term care and will therefore have blank entries in the cells under the heading "VA's May 7, 2004, decisions for improving access to tertiary, acute, or long-term inpatient care." VA's May 7, 2004, decisions did not address another aspect of veterans' access to health care—the time that veterans wait to obtain appointments at VA medical facilities—because waiting times are related to multiple operational issues, such as staffing and resources, in addition to capital infrastructure.

[a]VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23. VA defines a health care market as a geographic area having a sufficient population and geographic size to benefit from the coordination and planning of health care services and to support a full health care delivery system. Each VA network includes from 2 to 6 markets; nationwide, VA has 77 markets.

[b]VA identified limitations in geographic access to tertiary care in a market when more than 35 percent and at least 12,000 of the veterans enrolled for VA health care who reside in that market exceeded VA's driving time standards for reaching a VA health care facility of 240 minutes for urban and rural areas or the community standard for highly rural areas. Urban areas included counties designated as metropolitan by the U.S. Census Bureau and counties with a population density of more than 166 people per square mile. Rural areas included counties that are not designated as metropolitan and have a population density of 26 to 166 people per square mile. Highly rural counties included counties with a population density of less than 26 people per square mile and counties designated as highly rural by the VA health care network in which the county is located.

[c]VA identified limitations in geographic access to acute inpatient care in a market when more than 35 percent, and at least 12,000, of the veterans enrolled for VA health care who reside in that market exceeded VA's driving time standards for reaching a VA health care facility of 60 minutes for urban areas, 90 minutes for rural areas, and 120 minutes for highly rural areas. Urban areas included counties designated as metropolitan by the U.S. Census Bureau and counties with a population density of more than 166 people per square mile. Rural areas included counties that are not designated as metropolitan and have a population density of 26 to 166 people per square mile. Highly rural counties included counties with a population density of less than 26 people per square mile and counties designated as highly rural by the VA health care network in which the county is located.

[d]Options for VA to enter into an agreement with non-VA providers include contracting with non-VA providers, leasing space at non-VA medical facilities, or collaborating with the Department of Defense.

[e]Acute inpatient care.

[f]Domiciliary care.

[g]Inpatient medicine, surgery, and psychiatry to be provided in a new VA-owned hospital.

[h]Residential rehabilitation for post-traumatic stress disorder and substance abuse in the Detroit area.

[i]VA studied its markets in Network 12 during a pilot phase of CARES that was completed in February 2002.

[j]Tertiary care.

[k]At the time VA made its CARES decisions, VA collaborated with the Department of Defense to provide acute inpatient health care services in Las Vegas, Nev., by having VA staff provide services to veterans in a hospital at a local Air Force base. Through CARES, VA identified the Nevada market as needing evaluation of options for improving access to acute inpatient services based on its concern that this collaborative arrangement would not provide sufficient capacity to meet veterans' needs throughout the CARES planning horizon.

[l]Nursing home care.

Appendix VII: VA's 21 Networks, Limitations in Geographic Access to Specialized Inpatient Services, and Alignment Decisions

		Type of specialized inpatient care		VA's May 7, 2004, decisions for improving access to specialized inpatient treatment of spinal cord injury and disorder or blind rehabilitation	
Network[a]	Description of geographic area	Spinal cord injury and disorder	Blind rehabilitation	Add inpatient VA service	Study options for care
1	This network includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.				
2	This network includes upstate New York and parts of north central Pennsylvania.	X		X[b]	
3	This network includes parts of New York (the Hudson Valley, Long Island, and New York City) and northern New Jersey.				
4	This network includes Delaware; most of Pennsylvania; southern New Jersey; and parts of three other states: New York, Ohio, and West Virginia.				
5	This network includes the District of Columbia, Maryland, northern Virginia, eastern West Virginia, and part of Pennsylvania.				
6	This network includes most of North Carolina and Virginia, southeastern West Virginia, and part of South Carolina.				
7	This network includes most of Alabama, Georgia, and South Carolina.				
8	This network includes most of Florida, part of southern Georgia, Puerto Rico, the U.S. Virgin Islands of St. Thomas and St. Croix, and Arecibo.	X			X
9	This network includes Tennessee; most of Kentucky; eastern Arkansas; northern Mississippi; and parts of six other states: Georgia, Indiana, North Carolina, Ohio, Virginia, and West Virginia.				
10	This network includes most of Ohio and parts of both Indiana and Kentucky.				
11	This network includes the eastern central portion of Illinois, most of Indiana, lower Michigan, and part of Ohio.				
12	This network includes Michigan's Upper Peninsula, most of Wisconsin, northern Illinois, and parts of both Indiana and Minnesota.				

		Type of specialized inpatient care		VA's May 7, 2004, decisions for improving access to specialized inpatient treatment of spinal cord injury and disorder or blind rehabilitation	
Network[a]	Description of geographic area	Spinal cord injury and disorder	Blind rehabilitation	Add inpatient VA service	Study options for care
15	This network includes most of Kansas and Missouri; southern Illinois; and parts of three other states: Arkansas, Indiana, and Kentucky.				
16	This network includes Louisiana; most of Arkansas, Mississippi, and Oklahoma; eastern Texas; and parts of three other states: Alabama, Florida, and Missouri.	X	X	X[c]	X
17	This network includes central Texas and part of Oklahoma.				
18	This network includes Arizona, New Mexico, western Texas, and parts of southern Colorado and western Oklahoma.				
19	This network includes Utah; most of Colorado, Montana, and Wyoming; and parts of five other states: Idaho, Kansas, Nebraska, Nevada, and North Dakota.	X		X[b]	
20	This network includes Alaska, Oregon, and Washington; most of Idaho; and parts of both California and Montana.				
21	This network includes Hawaii; northern California; western Nevada; and Pacific Islands such as Guam, the Philippines, and American Samoa.				
22	This network includes southern California and southern Nevada.		X	X[c]	
23	This network includes Iowa and South Dakota; most of Minnesota, Nebraska, and North Dakota; and parts of five other states: Illinois, Kansas, Missouri, Wisconsin, and Wyoming.	X		X[b]	

Source: GAO analysis of VA data.

[a]VA health care facilities are organized into 21 regional networks, known as Veterans Integrated Service Networks, which are to coordinate the activities of and allocate resources to VA health care facilities. VA had 22 networks until January 2002, when it merged Networks 13 and 14 to form a new network, Network 23.

[b]Inpatient treatment for spinal cord injury and disorder.

[c]Inpatient blind rehabilitation.

Appendix VIII: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

February 28, 2005

Ms. Cynthia A. Bascetta
Director
Health Care Team
U. S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed your draft report, ***VA HEALTH CARE: Important Steps Taken to Enhance Veterans' Care by Aligning Inpatient Services With Projected Needs*** (GAO-05-160) and concurs with the information as presented. It is consistent with the information VA and GAO discussed and shared during the course of your review.

Neither medical science nor the veteran population is static and unchanging, and VA needs to modernize its facilities to provide quality care. To honor our Nation's commitment to veterans, our medical system must evolve with the times. While the practice of VA medicine has evolved, VA's medical infrastructure has not kept up.

VA's Capital Asset Realignment for Enhanced Services (CARES) process was initiated in 1999 to provide VA, veterans, the Congress, and the American people with a 20-year plan to provide the infrastructure VA will need to provide 21st Century veterans with 21st Century medical care. VA is currently in the process of implementing CARES decisions and has initiated 28 major construction projects utilizing funds provided in FY 2004 and 2005. CARES is not a simple one-time solution, but the creation of a set of tools and a process for annual capital and strategic planning.

VA looks forward to working with its stakeholders to include the Congress and the United States Government Accountability Office as we partner to fulfill this commonly held vision. I appreciate the opportunity to comment on your draft report.

Sincerely yours,

for
R. James Nicholson

Appendix IX: GAO Contact and Acknowledgments

GAO Contact

James C. Musselwhite, (202) 512-7259

Acknowledgments

In addition to the person named above, key contributors to this report were Kristen Joan Anderson, Frederick Caison, Steven R. Gregory, Janet Overton, and Paul Reynolds.

Related GAO Products

Budget Issues: Agency Implementation of Capital Planning Principles Is Mixed. GAO-04-138. Washington, D.C.: January 16, 2004.

Federal Real Property: Vacant and Underutilized Properties at GSA, VA, and USPS. GAO-03-747. Washington, D.C.: August 19, 2003.

VA Health Care: Framework for Analyzing Capital Asset Realignment for Enhanced Services Decisions. GAO-03-1103R. Washington, D.C.: August 18, 2003.

Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs. GAO-03-756T. Washington, D.C.: May 8, 2003.

VA Health Care: Improved Planning Needed for Management of Excess Real Property. GAO-03-326. Washington, D.C.: January 29, 2003.

High-Risk Series: Federal Real Property. GAO-03-122. Washington, D.C.: January 2003.

Major Management Challenges and Program Risks: Department of Veterans Affairs. GAO-03-110. Washington, D.C.: January 2003.

VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress. GAO-01-953. Washington, D.C.: August 31, 2001.

VA Health Care: Community-Based Clinics Improve Primary Care Access. GAO-01-678T. Washington, D.C.: May 2, 2001.

VA Health Care: VA Is Struggling to Address Asset Realignment Challenges. GAO/T-HEHS-00-88. Washington, D.C.: April 5, 2000.

VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting. GAO/HEHS-99-145. Washington, D.C.: August 13, 1999.

VA Health Care: Challenges Facing VA in Developing an Asset Realignment Process. GAO/T-HEHS-99-173. Washington, D.C.: July 22, 1999.

VA Health Care: Capital Asset Planning and Budgeting Need Improvement. GAO/T-HEHS-99-83. Washington, D.C.: March 10, 1999.

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