

GAO

Report to the Chairman, Committee on  
Veterans' Affairs, House of  
Representatives

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April 2006

## VA HEALTH CARE

# Experiences in Denver and Charleston Offer Lessons for Future Partnerships with Medical Affiliates



G A O

Accountability \* Integrity \* Reliability

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Highlights of [GAO-06-472](#), a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

## Why GAO Did This Study

The Department of Veterans Affairs (VA) maintains affiliations with medical schools, including the Medical University of South Carolina (MUSC) and the University of Colorado at Denver and Health Services Center and University of Colorado Hospital (UCH), to obtain enhanced medical care for veterans. As part of their plans for new medical campuses, both UCH and MUSC proposed jointly constructing and operating new medical facilities with VA in Denver and Charleston, respectively.

This report discusses (1) how VA evaluated the joint venture proposals for Denver and Charleston and the status of these proposals, (2) the challenges these proposals pose for VA, and (3) the lessons VA can learn from its experiences in Charleston and Denver for future partnerships.

## What GAO Recommends

GAO recommends that VA establish criteria for evaluating joint venture proposals and a strategy for communicating with stakeholders when negotiating such proposals. VA agreed with GAO's conclusions and recommendations.

[www.gao.gov/cgi-bin/getrpt?GAO-06-472](http://www.gao.gov/cgi-bin/getrpt?GAO-06-472).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Mark L. Goldstein at (202) 512-2834 or [goldsteinm@gao.gov](mailto:goldsteinm@gao.gov).

# VA HEALTH CARE

## Experiences in Denver and Charleston Offer Lessons for Future Partnerships with Medical Affiliates

### What GAO Found

VA evaluated the joint venture proposals for its medical facilities in Denver and Charleston using criteria developed specifically for each location, and while VA opted to build a stand-alone facility in Denver, it is still considering a joint venture in Charleston. Because the proposals involved joint construction and service sharing on a scale beyond anything VA had experienced with its medical affiliates in the past, VA did not have criteria at the departmental level to evaluate the proposals on a consistent basis in both locations. In both locations, negotiations between VA and its medical affiliates stretched over a number of years, in part because they were hampered by limited collaboration and communication, among other things. While VA decided against a joint venture in Denver, it has made no decision on Charleston. A VA-MUSC steering group, formed last summer to study the joint venture proposal in Charleston, issued a report in December 2005 that outlined the advantages and disadvantages of different options.

The joint ventures proposed in Denver and Charleston present a number of challenges to VA, including addressing institutional differences between VA and its medical affiliates, identifying legal issues and seeking legislative remedies, and balancing funding priorities. For example, capital expenditures for a joint venture would have to be considered in the context of other VA capital priorities. Although addressing these issues will be difficult, the VA-MUSC steering group's efforts could provide insight into how to tackle them.

VA's experiences with joint venture proposals in Denver and Charleston offer several lessons for VA as it considers similar opportunities in the future. One of the most important lessons is that having criteria at the departmental level to evaluate joint venture proposals helps to improve the transparency of decisions concerning joint ventures and VA's ability to ensure that the decisions are made in a consistent manner across the country. Another key lesson is that having a strategy for communicating with stakeholders, such as employees and veterans, helps VA build understanding and trust among stakeholders. The following table identifies these and other lessons from VA's experiences in Denver and Charleston.

### Lessons Learned from VA's Experiences in Denver and Charleston

- Criteria at the departmental level help provide clarity and consistency in evaluation approach.
- A communications strategy helps avoid misinformation and confusion.
- Leadership support facilitates negotiations.
- Extensive collaboration assists negotiations.

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**Abbreviations**

CARES	Capital Asset Realignment for Enhanced Services
DOD	Department of Defense
EUL	Enhanced-Use Lease
FRA	Fitzsimons Redevelopment Authority
MUHA	Medical University Hospital Authority
MUSC	Medical University of South Carolina
PET	Positron Emission Tomography
UCH	University of Colorado Hospital
VA	Department of Veterans Affairs

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United States Government Accountability Office  
Washington, D.C. 20548

April 28, 2006

The Honorable Steve Buyer  
Chairman  
Committee on Veterans' Affairs  
House of Representatives

Dear Mr. Chairman:

For decades, the Department of Veterans Affairs (VA) has maintained partnerships, or affiliations, with university medical schools to obtain medical services for veterans and provide training and education to medical residents. These affiliations help VA fulfill its mission of providing health care to the nation's veterans. Today, VA has affiliations with 107 medical schools, including the Medical University of South Carolina (MUSC) in Charleston, South Carolina, and the University of Colorado's School of Medicine—through the University of Colorado at Denver and Health Sciences Center and the University of Colorado Hospital (UCH)—in the Denver, Colorado, area.<sup>1</sup> For example, many MUSC physicians serve as residents at VA's medical facility in Charleston, the Ralph H. Johnson VA Medical Center, and UCH physicians do the same at VA's Eastern Colorado Health System in Denver. As part of their plans for new medical campuses, UCH and MUSC proposed jointly constructing and operating new medical facilities with VA in Denver and Charleston, respectively. Although VA has a long history of partnering with its medical affiliates for training and education as well as purchasing medical services from its medical affiliates, this type of joint venture would represent a departure from VA's typical relationship with its medical affiliates.

In addition to partnering with university medical schools, VA manages a diverse inventory of real property to provide health care to veterans. However, 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 21<sup>st</sup> century. To address its aging infrastructure, VA

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<sup>1</sup>VA is affiliated with the University of Colorado's School of Medicine in Denver. The University of Colorado's School of Medicine is located at the University of Colorado at Denver and Health Sciences Center. UCH is the principal teaching hospital for the University of Colorado at Denver and the Health Sciences Center. VA negotiated with both the University of Colorado at Denver and Health Sciences Center and UCH over the joint venture proposal, although most of the correspondence was exchanged between VA and UCH.

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initiated the Capital Asset Realignment for Enhanced Services (CARES) process—the most comprehensive, long-range assessment of its health care system’s capital asset requirements ever undertaken by VA. In February 2004, the CARES Commission—an independent body charged with assessing VA’s capital assets—issued its recommendations regarding the realignment and modernization of VA’s capital assets necessary to meet the demand for veterans’ health care services through 2022. In Denver, the commission recommended VA build a replacement medical center with the Department of Defense (DOD) on the former Fitzsimons Army Base in Aurora, Colorado, which is just outside of Denver. The commission also noted widespread agreement among stakeholders that the new VA facility should be located near a new UCH facility, which was being constructed at the Fitzsimons site. In Charleston, the commission did not recommend replacing the current medical facility. However, the commission recommended that, among other things, VA promptly evaluate MUSC’s proposal to jointly construct and operate a new medical center with VA in Charleston, noting that such a joint venture arrangement could serve as a possible framework for partnerships in the future. In responding to the commission’s recommendations in May 2004, the Secretary stated that VA would build a replacement VA medical center on the Fitzsimons site with “some shared facilities with the UCH” and continue to “consider options for sharing opportunities with MUSC.”<sup>2</sup>

This report discusses (1) how VA evaluated the joint venture proposals involving its facilities in Charleston and Denver and the status of these proposals; (2) the challenges that VA faces in sharing facilities and services with its medical university affiliates in Charleston and Denver; and (3) the lessons VA can learn, if any, from its experiences in Charleston and Denver if it moves forward with other partnerships. To address these objectives, we analyzed agency documents and interviewed officials at VA, MUSC, UCH, and the University of Colorado at Denver and Health Sciences Center. We also met with local stakeholders, such as officials from the Fitzsimons Redevelopment Authority (FRA) in Aurora, the mayors of Charleston and Aurora, and representatives from the VA employee union in each location to obtain their perspectives on the joint venture proposals and to obtain information on local capital asset planning and its impact. We also discussed the CARES review process and CARES Commission recommendations with VA officials. We assessed the reliability of the information obtained from VA, MUSC, and UCH. We concluded that the

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<sup>2</sup>VA, *Secretary of Veterans Affairs CARES Decision*, May 2004.

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information was sufficiently reliable for our purposes. We also reviewed GAO's body of work on VA's management of its capital assets and on leading practices for realigning federal agency infrastructure, collaboration among organizations, and organizational transformations.<sup>3</sup> In September 2005, we also testified before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives, on the joint venture proposal involving VA's facility in Charleston and MUSC.<sup>4</sup> Although we examined the joint venture proposals for VA's Denver and Charleston facilities and the associated studies and planning documents, we did not evaluate the merits of the proposals. We conducted our work from June 2005 through February 2006 in accordance with generally accepted government auditing standards.

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## Results in Brief

Because it lacks criteria at the departmental level, VA evaluated proposals for joint ventures with local medical affiliates in Denver and Charleston using criteria developed specifically for each location, and while VA opted to build a stand-alone facility in Denver, it is still in the process of considering a joint venture in Charleston. In both locations, multiple iterations of the joint venture proposals have been considered, and negotiations between VA and its medical affiliates have stretched over a number of years, delaying decisions regarding the facilities in Denver and Charleston. For example, in Denver, VA officials at the facility and network level<sup>5</sup> and UCH officials in 1999 began informally discussing the possibility of constructing and operating a joint facility on the former Fitzsimons army base in Aurora, Colorado, which was closed as part of DOD's base realignment and closure process. Negotiations over different aspects and revisions of the joint venture proposal continued until late 2004, at which time VA decided against a joint facility with UCH. Similarly, negotiations over the joint venture proposed between VA and MUSC in Charleston began in 2002, and, to date, no decisions have been made. However, a steering group composed of VA and MUSC officials issued a report in December 2005 that outlined options for a joint venture ranging from sharing of medical services, which could occur with VA maintaining its

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<sup>3</sup>See "Related GAO Products" at the end of this report.

<sup>4</sup>See GAO, *VA Health Care: Preliminary Information on the Joint Venture Proposal for VA's Charleston Facility*, [GAO-05-1041T](#) (Washington, D.C.: Sept. 26, 2005).

<sup>5</sup>The management of VA's facilities is decentralized to 21 regional networks.

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existing building, to a large, new building with space for both VA and MUSC. Complex arrangements such as the joint venture proposals in Denver and Charleston require extensive negotiations between the potential partners. However, negotiations in both locations were hampered by limited communication and collaboration and lack of VA leadership support, among other things. For example, in Charleston, for a 2-year period after the joint venture was proposed, there was little communication between VA and MUSC, which caused negotiations to stall during this period. In Denver, top VA leadership was not fully supportive of exploring a joint venture with UCH, resulting in delays in negotiations and misunderstandings between VA and UCH.

Joint ventures proposed by VA's medical university affiliates in Denver and Charleston present several challenges to VA. These challenges include addressing institutional changes for VA and institutional differences between VA and its medical affiliates, identifying legal issues and seeking legislative remedies, and balancing funding priorities. For example, capital expenditures for a joint venture would have to be considered in the context of other VA capital priorities, and VA would have to ensure that a joint venture would allow VA to fulfill its other departmental missions, such as supporting national, state, and local emergency management. In addition, a joint venture would also require VA to depart from its traditional health care model of providing medical services in house and adopt one that includes sharing capital assets with an affiliate. Although addressing these issues will be difficult, the VA-MUSC steering group has begun to work through some of these challenges.

Its experiences in Denver and Charleston offer several lessons for VA as it considers other similar opportunities. One of the most important lessons to emerge from VA's experience with the joint venture proposals in Denver and Charleston is the need to develop criteria at the departmental level to evaluate the merits of joint venture proposals on a consistent basis. A set of criteria for evaluating decisions regarding infrastructure, including joint ventures, would enhance the transparency of these decisions and help ensure that the decisions were made in a manner that was fair to joint venture partners and other stakeholders, such as veterans and employees. The lack of departmental-level criteria forced VA to evaluate the proposals without a consistent framework that would allow VA to determine and assess the effects of each proposal on medical care cost and quality within the context of its overall mission. Another important lesson of VA's experience in Denver and Charleston is the need for a communications strategy for communicating with its medical affiliate and stakeholders.



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Such a strategy could help facilitate negotiations with the medical affiliate as well as help address concerns voiced by veterans and employees, such as the impact of the joint venture on patient care. A communication strategy would help ensure that these groups receive a message that is consistent in tone and content. The lack of such a strategy contributed to breakdowns in communications in both Denver and Charleston during key points of the negotiations and hindered progress. For example, in Charleston, there was limited communication between VA and MUSC for about 2 years; as a result, negotiations stalled. Other lessons that VA could take away from its experiences in Denver and Charleston include that negotiations are facilitated by VA leadership support for exploring the possibility of joint ventures and extensive collaboration between the potential joint venture partners.

To better position VA to consider future joint venture proposals with medical affiliates, we are recommending that the Secretary develop criteria at the departmental level for evaluating joint venture proposals on a consistent basis and a strategy for communicating with the department's affiliates and stakeholders about joint venture proposals. VA reviewed a draft of this report and agreed with the report's conclusions and recommendations.

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## Background

VA manages a large health system for veterans, providing health care services to over 5 million beneficiaries. The cost of these services in fiscal year 2005 was over \$30 billion. According to VA, its health care system now includes 157 medical centers, 862 ambulatory care and community-based outpatient clinics, and 134 nursing homes. VA health care facilities provide a broad spectrum of medical, surgical, and rehabilitative care. The management of VA's facilities is decentralized to 21 regional networks referred to as Veterans Integrated Service Networks (networks). The Charleston facility is part of Network 7, or the Southeast Network, and the Denver facility is located in Network 19, or the Rocky Mountain Network.<sup>6</sup>

To meet its mission of serving the needs of the nation's veterans, VA partners with medical universities and DOD. In 1946, VA established a program to enter into partnerships with medical universities, now referred

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<sup>6</sup>The Southeast Network includes South Carolina, Georgia, and Alabama, and the Rocky Mountain Network includes Colorado, Montana, Utah, Wyoming, and parts of Idaho, Kansas, Nebraska, Nevada, and North Dakota.

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to as academic affiliations, to provide high quality health care to America's veterans and to train new health professionals. Today, VA maintains affiliations with 107 of the nation's 126 medical schools. In addition to academic affiliation agreements, VA purchases clinical services from medical schools for the treatment of veterans.<sup>7</sup> Similarly, in 1982, the VA and DOD Health Resources Sharing and Emergency Operations Act (Sharing Act)<sup>8</sup> was enacted to provide for more efficient use of medical resources through greater interagency sharing and coordination. For example, the VA Medical Center in Louisville and the Ireland Army Community Hospital in Fort Knox, Kentucky, have engaged in sharing activities to provide services to beneficiaries that include primary care, acute care pharmacy, ambulatory, blood bank, intensive care, pathology and laboratory, audiology, podiatry, urology, internal medicine, and ophthalmology. Given the importance of these partnerships to VA's ability to meet its mission, VA's 2003-2008 strategic plan includes goals for sustaining partnerships with medical universities and sharing resources with DOD.

VA's Denver and Charleston medical facilities have long-standing affiliations with local medical universities. VA's facility in Denver is affiliated with the University of Colorado's School of Medicine—through the University of Colorado at Denver and Health Sciences Center and UCH—and VA's facility in Charleston is affiliated with MUSC. These affiliations provide both VA facilities with the majority of VA's medical residents who rotate through all VA clinical service areas. Both VA facilities also purchase a significant amount of medical services from their affiliates. Specifically, the Denver facility annually obtains \$9 million worth of services from UCH, and the Charleston VA facility buys \$13 million in services annually from MUSC. The medical services purchased are in such areas as gastroenterology, infectious disease, internal medicine, neurosurgery, anesthesia, pulmonary, and cardiovascular perfusion. In addition to these services, VA also has a medical research partnership with MUSC for a mutually supported biomedical research facility, the Thurmond Biomedical Research Center. Table 1 provides more detailed information

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<sup>7</sup>VA is authorized to enter into sharing arrangements with any health care provider or entity, such as medical universities, to secure health-care resources that otherwise might not be feasibly available, or to effectively utilize certain other health-care resources. See 38 U.S.C. § 8151-8153.

<sup>8</sup>Pub. L. 97-174, 96 Stat. 70 (1982).

about the VA facilities in Charleston and Denver and their medical affiliates.

**Table 1: Information on VA's Facilities in Charleston and Denver and MUSC's and UCH's Facilities**

	Charleston, South Carolina		Denver, Colorado	
	VA's Ralph H. Johnson Medical Center	MUSC	VA's Eastern Colorado Health System	UCH
Year built: Main hospital	1966	1955	1951	1921
Square footage	352,000	1,530,125 <sup>a</sup>	670,000	1,200,000 <sup>b</sup>
Beds	126	709	128	420
Inpatient admissions	4,510	28,591	4,750	19,622
Outpatient visits	370,917	551,914 <sup>c</sup>	481,769	546,248
Annual operating budget (in millions)	\$160	\$559	\$267	\$490

Source: GAO presentation of VA, MUSC, and UCH data.

<sup>a</sup>The MUSC medical center includes the Institute of Psychiatry (62,299 square feet), Children's Hospital (347,697), North Tower and Main Hospital (545,201), Rutledge Tower (383,752), and Charleston Memorial Hospital (191,176).

<sup>b</sup>By 2008, UCH will have approximately 1.8 million gross square footage of fully operational facilities, with about 1.5 million gross square footage dedicated to clinical and patient care services. This number does not reflect gross square footage at UCH's current facility in Denver.

<sup>c</sup>This number does not include same-day surgeries (6,802) or emergency visits (35,375).

## VA Lacks Departmental Criteria to Evaluate Joint Venture Proposals

VA evaluated the joint venture proposals for its facilities in Denver and Charleston on an ad hoc basis because it lacks criteria at the departmental level to evaluate such proposals consistently. VA has decided against a joint facility in Denver, but it is still in the process of considering such a facility in Charleston. In both locations, multiple iterations of the joint venture proposals have been considered, and negotiations between VA and its medical affiliates have stretched over a number of years. Negotiations in both locations were hampered by limited communication and collaboration, a lack of top VA leadership support for the proposals, and no single VA point of contact for the medical affiliates.

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## VA Does Not Have Criteria at the Departmental Level to Evaluate Joint Venture Proposals Consistently

VA does not have criteria at the departmental level that could be used to evaluate joint venture proposals on a consistent basis. Consequently, VA officials identified factors for considering the specific joint venture proposals in Charleston and Denver. Some of the identified factors were consistent between the two locations, and others were site-specific, but it is not clear how any of the factors weighed in VA's consideration of the proposals.

In studies and correspondence regarding the joint venture proposal in Denver, VA officials identified several factors that they believed to be important in considering the joint venture proposal. In particular, in correspondence between VA and UCH in 2002, and again in 2004, the Secretary of VA identified four major considerations—(1) maintaining VA's identity; (2) maintaining VA's governance; (3) balancing and evaluating priorities within VA's capital asset program, including the CARES process; and (4) securing funding. In 2002, a VA taskforce composed of headquarters, network, and facility officials examined the potential for a VA-UCH joint facility and identified additional factors critical to the decision-making process. These factors included maintaining VA's commitment to providing health care to meet veterans' unique needs and research programs, VA's aging infrastructure, and the gap between health care demand and capacity and funding. Another consideration that arose through the course of negotiations was VA's space requirements for a new facility and the associated acreage of land needed and available on the Fitzsimons campus. VA did not indicate how the factors identified in the studies or correspondence weighed in its decision making regarding the joint venture proposal.

Similarly, the VA-MUSC steering group identified a set of criteria to help identify and analyze the joint venture proposal for Charleston. As shown in table 2, these criteria include enhanced quality and service and financial viability. The steering group's report did not indicate how or why these criteria were chosen, provide an explanation of the individual criterion, or indicate the relative importance of the criteria. While the steering group used the criteria in identifying and evaluating options for further consideration, it is not clear how, if at all, these criteria will be used by VA leadership in making a final decision on the joint venture proposal. In meetings with VA officials about the joint venture proposal in Charleston, officials identified other considerations that could influence the decision-making process, including the condition of the existing VA facility and the need to balance investment priorities across the region and nation.

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**Table 2: Criteria Identified by the VA-MUSC Steering Group**

**Criterion**

- Enhance quality and service
- Improve access
- Financial viability
- Optimal legal authorities
- Enhance efficient infrastructure sharing
- Maximize land utilization and development
- Collaborative governance structure
- Maintain unique VA identity
- Become a regional center of excellence
- Enhance Department of Defense services
- Produce serendipitous win-wins
- Serve as a national model for collaborations

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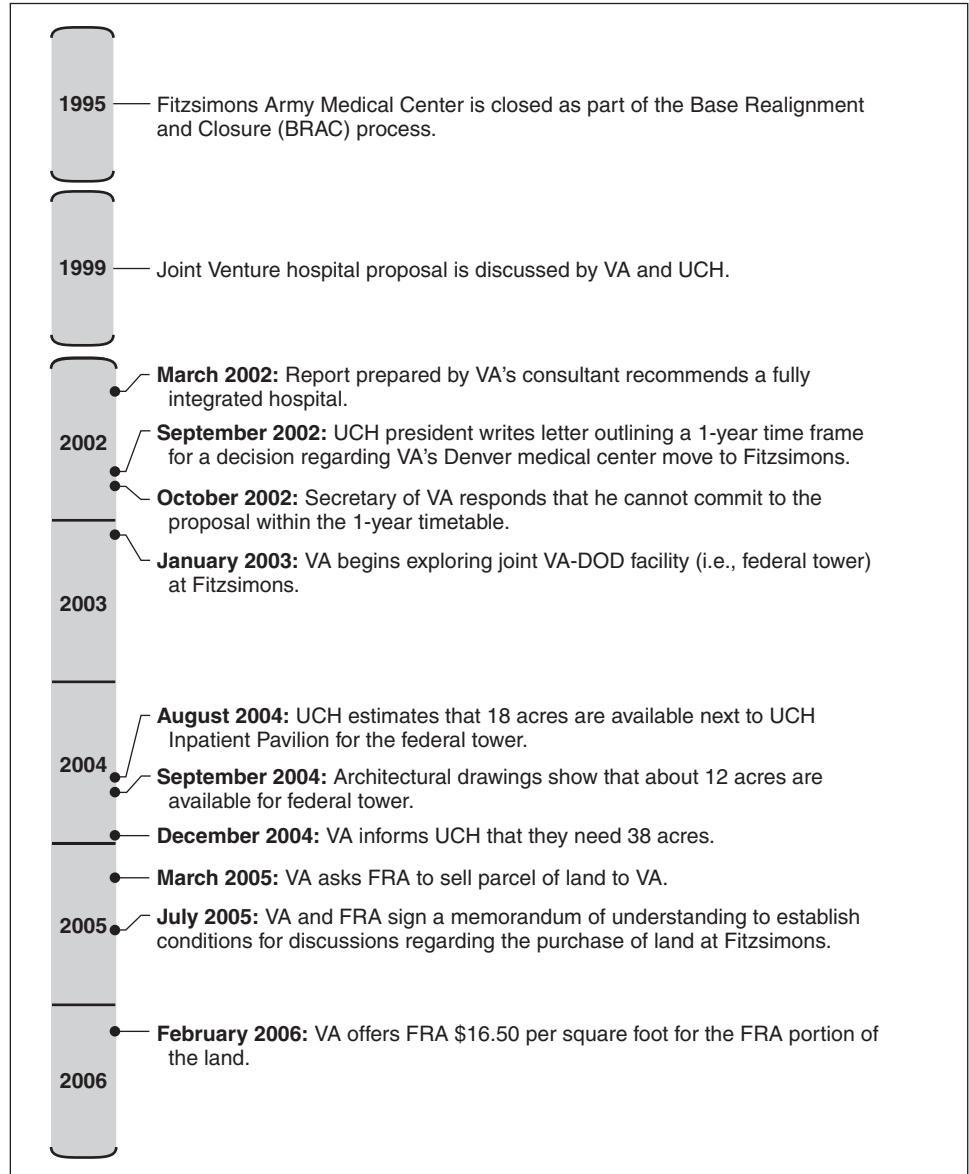
Source: Collaborative Opportunities Steering Group, Final Report, December 2005.

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**VA Decided to Construct Stand-alone Facility in Denver, but Negotiations about Location Continue**

VA has decided against a fully-integrated facility with UCH in Denver. Negotiations between VA and the University of Colorado at Denver and Health Services Center and UCH stretched over a number of years, and a number of different options were considered. The lack of leadership buy-in and miscommunication about VA's intentions regarding the future Denver facility prolonged negotiations and created an atmosphere of mistrust between the parties. Figure 1 provides a time line of key events in the negotiations between VA and UCH.

**Figure 1: Time Line of Key Events in the Negotiations between VA and UCH**



Source: GAO.

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In 1995, the University of Colorado decided to relocate its Health Sciences Center campus, including its affiliated UCH, from downtown Denver to the former Fitzsimons Army Medical Base located in nearby Aurora, Colorado, which was closed as part of DOD's base realignment and closure process. UCH determined that its facility in downtown Denver lacked the space to accommodate its patient population and that there was little room for expansion. The availability of land at the Fitzsimons site offered an opportunity for UCH to move and expand the size of its campus. When Fitzsimons closed, DOD turned a portion of the 577 acres the base occupied over to the U.S. Department of Education so that it could convey land to public educational institutions.<sup>9</sup> The University of Colorado applied for and received 227 acres from the U.S. Department of Education, and the University leased about 55 acres to UCH for its new inpatient and outpatient pavilions. The majority of the land at Fitzsimons—about 332 acres—was purchased by FRA for \$1.85 million.<sup>10</sup> FRA plans to develop a biomedical research park on this land. The remaining land at Fitzsimons is owned by the City of Aurora, a private entity, and a nonprofit organization.

In late 1999, VA officials at the facility and network level and UCH officials began to informally discuss the possibility of relocating VA's Denver medical center to the Fitzsimons campus. UCH and VA officials were concerned that UCH's move to Fitzsimons, about 6 miles from its downtown Denver location, would strain their affiliation because of the amount of time it would take doctors to travel between the facilities. The UCH president also suggested that colocating the UCH and VA medical center at Fitzsimons could achieve cost efficiencies through integrating inpatient activities, such as medical and surgical specialty labs, and sharing some patient treatment. In considering a possible joint venture, facility and network VA officials worked with UCH officials to examine options for moving VA's medical center to the Fitzsimons campus as well as sharing services and facilities with UCH. In particular, these officials jointly funded

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<sup>9</sup>VA was also offered land on the Fitzsimons campus, but declined the offer.

<sup>10</sup>FRA is a special-purpose governmental entity created in 1996 under an intergovernmental agreement between the City of Aurora and the University of Colorado Regents. FRA leads the planning, implementation, and redevelopment effort of a square mile section of the former Fitzsimons Army Medical Center dedicated to learning, patient care, basic science, and bioscience research and development in a manner that maximizes the long-term economic benefits to the Aurora community and the state of Colorado. The University of Colorado at Denver and Health Sciences Center and UCH are responsible for the redevelopment of the Fitzsimons property they received from the Department of Education.

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a study to determine the feasibility and cost of different options, including constructing free-standing facilities with limited sharing to jointly constructing and operating a new fully-integrated facility at Fitzsimons. The study, completed in 2001, concluded that a fully integrated, or joint, facility was the most cost-effective option. A second study commissioned by VA's Network 19 in 2002 also analyzed a range of options, including a joint VA-UCH facility; but this study did not recommend which option to pursue. These studies were shared with VA's central office, veteran service organizations, and the Congress, and became the basis of the joint venture proposal and negotiations.

The Secretary of VA established a task force to examine the joint venture proposal to integrate the Denver medical center and UCH on the Fitzsimons campus in July 2002. The task force was composed of VA officials at the departmental, network, and facility levels. In September 2002, the task force issued a draft report, which examined seven alternatives—ranging from maintaining the status quo to constructing a fully integrated facility with UCH. The task force's report presented advantages and disadvantages of each alternative. It did not recommend which alternative to pursue.

In September 2002, the president of UCH sent a letter to the Secretary of VA asking that VA make a decision within 1 year regarding moving the VA facility to the Fitzsimons campus. In October 2002, the Secretary responded that VA could not commit to a joint UCH-VA hospital within that time frame. The Secretary indicated that a number of important questions remained unanswered, including how the joint hospital would be governed. Furthermore, he noted that the proposal to relocate the Denver medical center to Fitzsimons had to be evaluated in the context of the CARES Commission report, which was not scheduled to be completed until the following year. The Secretary's response effectively ended discussions about constructing and operating a fully-integrated facility with UCH.

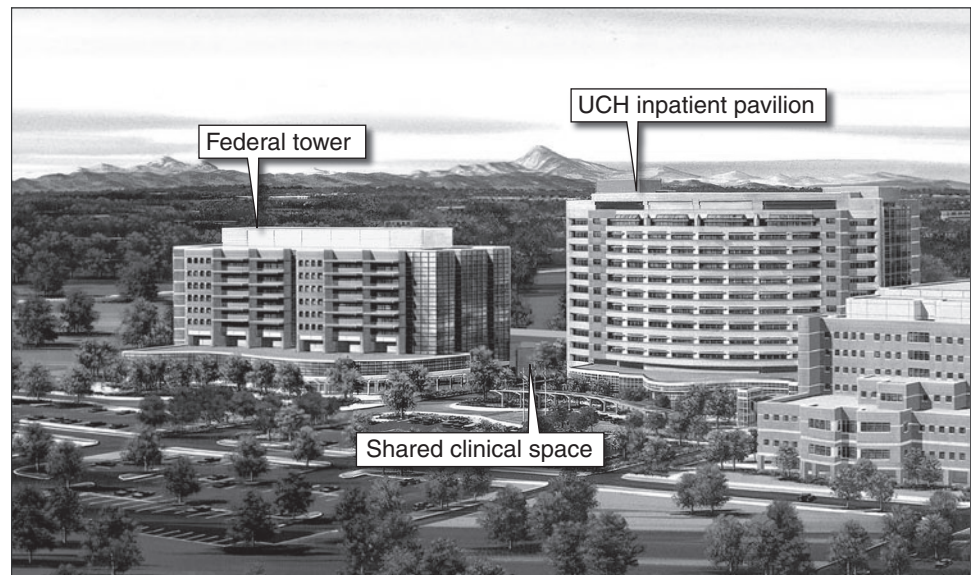
In January 2003, VA began developing a proposal for a joint VA-DOD facility on the Fitzsimons campus. Specifically, the proposed joint federal facility would house VA and DOD, and the two entities would share some medical services and equipment. The joint VA-DOD facility, which was referred to as the federal tower, would be built on UCH-leased land at Fitzsimons and would be connected to UCH's inpatient pavilion by a 2-story clinical facility. (See fig. 2.) The clinical facility would house operating rooms, imaging, and pathology laboratories, among other things, that would be shared by VA, UCH, and DOD. With this concept in hand, VA, UCH, and DOD began



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discussions about the availability of land adjacent to the UCH inpatient pavilion for the federal tower. In August 2004, the UCH president estimated that 18 acres of land was available adjacent to the UCH facility for the federal tower. However, soon thereafter, a survey of the land indicated that approximately 12 acres were available for the federal tower once easements and setbacks were taken into account.

**Figure 2: Federal Tower Proposal at Fitzsimons**



Source: University of Colorado Hospital.

In December 2004, in a letter to UCH, the Secretary stated that the approximate 12 acres would be insufficient to meet VA's space requirements for a new medical center. Specifically, the Secretary stated that predesign planning for the new facility revealed that VA needed approximately 1.46 million square feet to meet the specialized needs of veterans and DOD patients. To accommodate these space requirements, VA's architectural firm outlined three design options—ranging from a 6-story VA hospital on 38 acres to a 8- to 10-story VA hospital on 20 acres. Based on this analysis and other considerations, the Secretary concluded that VA needed about 38 acres on the Fitzsimons campus for the joint VA-DOD facility. This decision ended negotiations over building the federal tower on UCH-leased land and connecting it to UCH's inpatient pavilion

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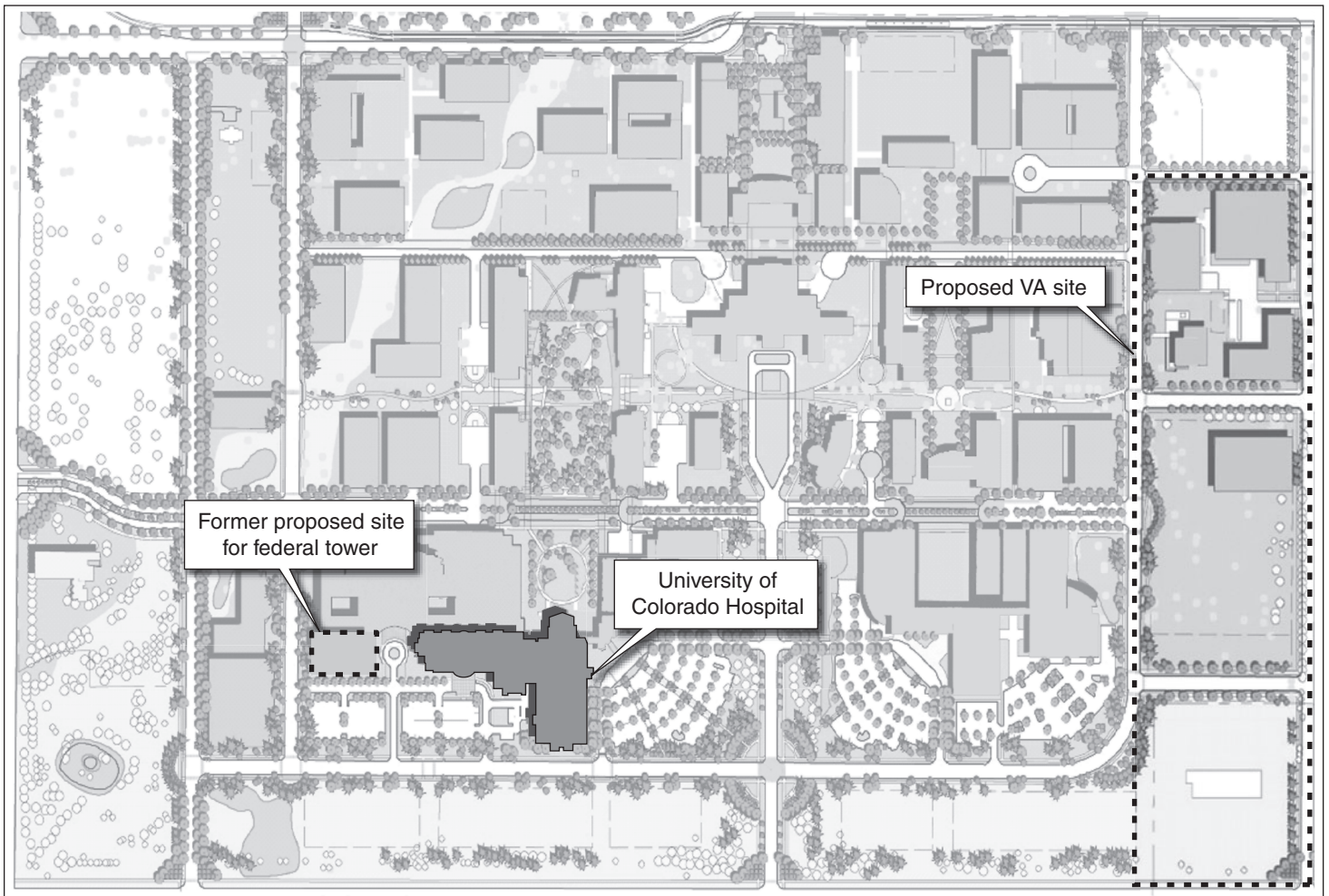
with a clinical facility. UCH subsequently decided to use the land adjacent to the inpatient pavilion for other purposes.

After land negotiations with UCH ended, VA officials began looking for a new location on the Fitzsimons site for a stand-alone VA medical center. The conference report accompanying VA's appropriation act for fiscal year 2004 directed VA to continue efforts to "co-locate the Denver VA medical center with ... [UCH] at the Fitzsimons campus."<sup>11</sup> While there is no statutory requirement to locate the VA medical center at Fitzsimons, VA considers this language in the conference report to express the will of Congress and, as a result, has gone forward with efforts to purchase property from FRA for such a purpose. In July 2005, VA signed a memorandum of understanding with FRA to set forth the conditions under which VA and FRA will proceed with discussions that may lead to the purchase and conveyance of about 40 acres located on the southeast corner of the Fitzsimons campus. (See fig. 3.) According to FRA officials, this piece of land is currently owned by FRA and three other entities. According to a VA official, in February 2006, VA offered FRA \$16.50 per square foot for the FRA-owned portion of the land. (VA is in the process of surveying the land to determine the total square footage.) The VA official responsible for the land negotiations at Fitzsimons told us that VA's offer is valid for 6 months, and that VA expects to finalize the purchase of the FRA-owned portion of the land by the end of this fiscal year. VA is currently negotiating with the other three land-holding entities about the purchase of their land. According to the VA official, he does not foresee any "show stoppers" in the negotiations with these three entities, and therefore VA expects to reach agreement with these entities in the coming months.

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<sup>11</sup>See H.R. 2673 Conf. Rep. No. 108-401, at 1040 (2003).

**Figure 3: Location of Land That VA Is Currently Pursuing at Fitzsimons in Relation to UCH facilities**



Source: VA.

**Lack of Leadership Buy-in and Miscommunication Prolonged Negotiations and Created Atmosphere of Mistrust**

Negotiations between VA and UCH on the different joint venture proposals were hampered by a lack of VA leadership buy-in and miscommunication. For instance, although VA officials at the facility and network levels worked with UCH officials in developing the joint facility proposal, the current network director told us that the Secretary was never fully supportive of this concept. Rather, according to the network director, the Secretary envisioned a stand-alone facility adjacent to the UCH complex. When VA decided to pursue a stand-alone facility, UCH officials said they

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felt as though they had been misled by VA officials, including the Secretary, about VA's interest in a joint facility. Further, in a correspondence from the UCH president to VA in 2004, the UCH president noted that a freestanding VA medical center on the Fitzsimons campus was never discussed. UCH officials also told us that at no time did UCH ever consider a freestanding facility for VA on its new campus because there would be limited opportunities for sharing capital and operating costs. In addition, there was miscommunication about the amount of land available for a federal tower and VA's space requirements. Specifically, UCH officials told VA officials that there were about 18 acres available for the federal tower; however, the survey revealed that only a little more than 12 acres were available. In addition, in December 2004, the Secretary of VA informed UCH that VA needed 1.46 million square feet for its new facility. According to UCH officials, these space requirements ran counter to estimates that were discussed with VA facility and network level officials and, according to the UCH president in 2004, would result in a facility that was about 50 percent larger than the existing VA medical center in Denver.<sup>12</sup> These events contributed to an atmosphere of mistrust between VA and UCH.

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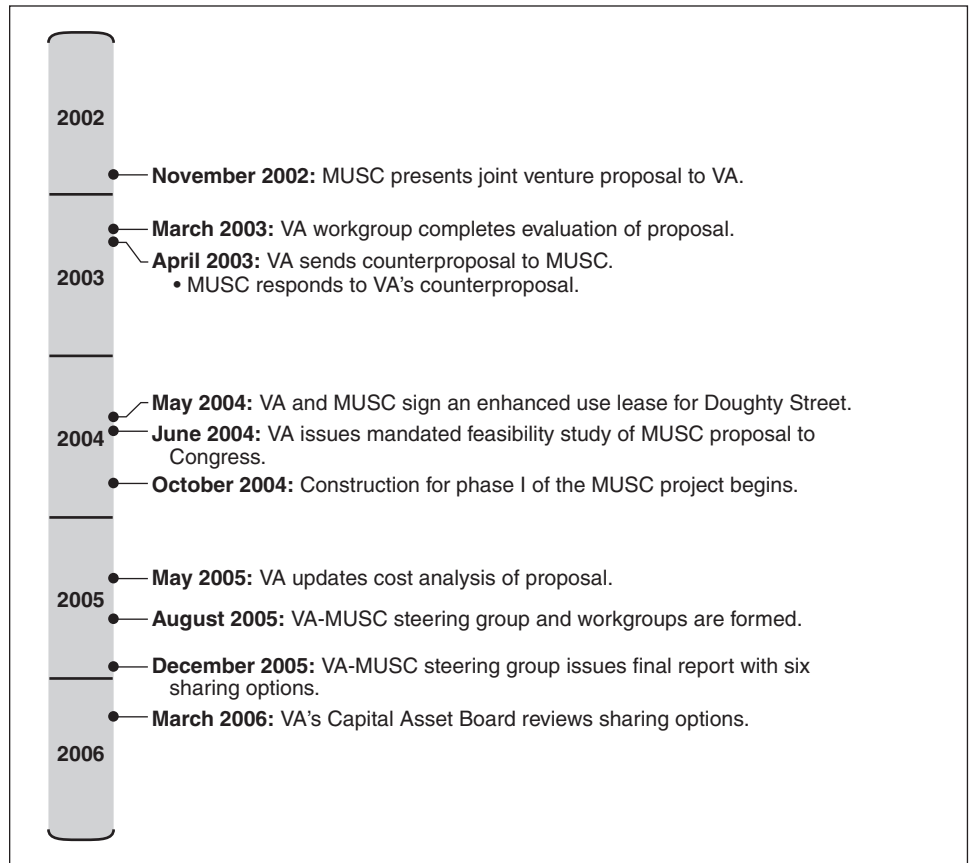
### VA and MUSC Have Identified Multiple Options for Sharing Resources and Space, but No Decision Has Been Made

VA has not made a decision regarding a joint venture with MUSC. Negotiations between VA and MUSC have stretched over a number of years and have been hampered by limited collaboration and communication among the parties. VA's Under Secretary for Health and the president of MUSC are currently considering the results of a recent report that identifies and analyzes options for sharing facilities and space in Charleston. Figure 4 provides a time line of key events in the negotiations between VA and UCH.

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<sup>12</sup>According to VA, the additional space is required to accommodate its needs—including making the majority of patient rooms private—and DOD's needs.

**Figure 4: Time Line of Key Events in the Negotiations between VA and MUSC**



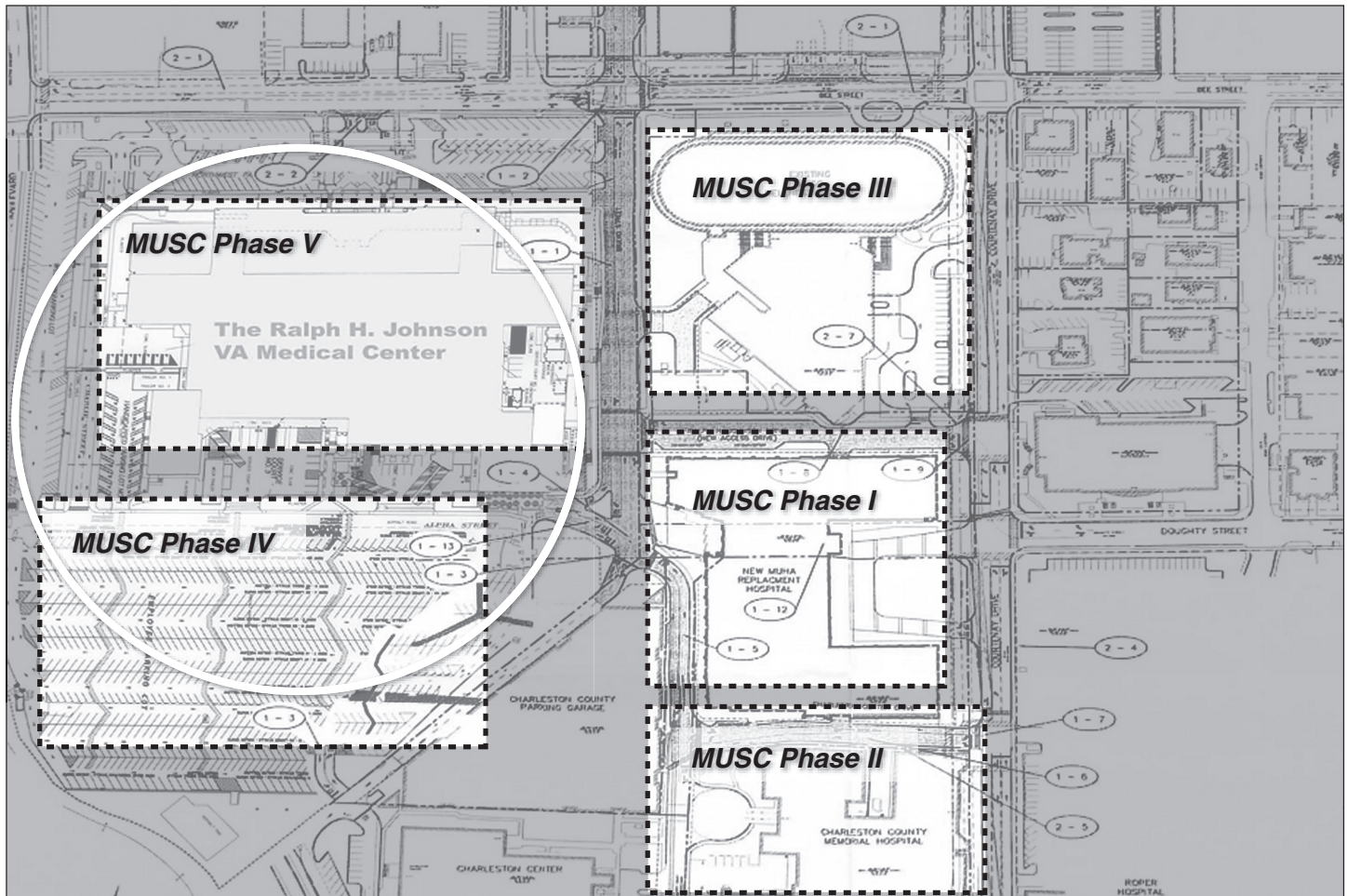
Source: GAO.

In November 2002, the president of MUSC sent a proposal to the Secretary of VA about partnering with MUSC in the construction and operation of a new medical center in phase II of MUSC's construction project. Under MUSC's proposal, VA would vacate its current facility and move to a new facility located on MUSC property. MUSC also indicated that sharing medical services would be a component of the joint venture. Although VA and MUSC currently share some services, the joint venture proposal, according to MUSC officials, would have increased the level of sharing of medical services and equipment, thereby creating cost savings for both VA and MUSC.

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To meet the needs of a growing and aging patient population, MUSC has undertaken a multiphase construction project to replace its aging medical campus. Construction on the first phase began in October 2004. Phase I includes the development of a 4-story diagnostic and treatment building and a 7-story patient hospitality tower, providing an additional 641,000 square feet in clinical and support space. Phase I also includes the construction of an atrium connecting the two buildings, a parking structure, and a central energy plant. Initial plans for phases II through V include diagnostic and treatment space and patient bed towers. According to MUSC officials, as of September 2005, there are approximately 24 months remaining for the planning of phase II. As shown in figure 5, phases IV and V would be built on VA property. In particular, phase V would be built on the site of VA's existing medical center.

Figure 5: MUSC's Construction Plan, 2002



Source: VA.

Note: The circle highlights some of VA's existing property.

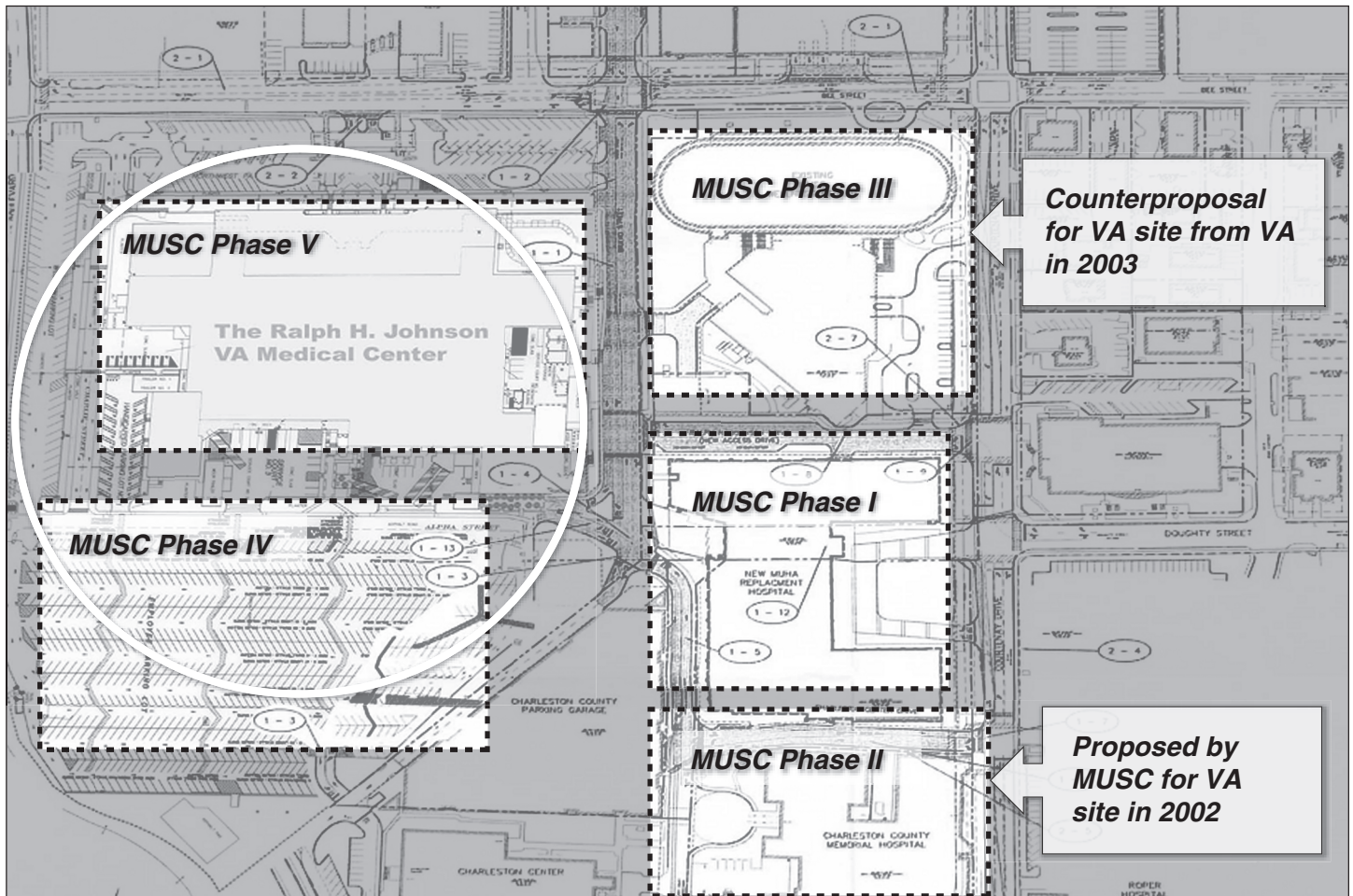
In response to MUSC's proposal, VA formed an internal workgroup composed of officials primarily from VA's Network 7 to evaluate MUSC's proposal. The workgroup analyzed the feasibility and cost-effectiveness of the proposal and issued a report in March 2003, which outlined three other options available to VA: replacing the Charleston facility at its present location, replacing the Charleston facility on land presently occupied by the Naval Hospital in Charleston, or renovating the Charleston facility. The workgroup concluded that it would be more cost-effective to renovate the current Charleston facility than to replace it with a new facility. This

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conclusion was based, in part, on the cost estimates for constructing a new medical center. In April 2003, the Secretary of VA sent a response to the president of MUSC, which stated that if VA agreed to the joint venture, it would prefer to place the new facility in phase III—which is north of phase I—to provide better street access for veterans. (See fig. 6 for MUSC’s proposal and VA’s counterproposal.) In addition, the Secretary indicated that MUSC would need to provide a financial incentive for VA to participate in the joint venture. Specifically, MUSC would need to make up the difference between the estimated life-cycle costs of renovating the Charleston facility and building a new medical center—which VA estimated to be about \$85 million—through negotiations or other means. The Secretary stated that if these conditions could not be met, VA would prefer to remain in its current facility.



Figure 6: MUSC's Proposal (2002) and VA's Counter Proposal (2003)



Source: VA.

Note: The circle highlights some of VA's existing property.

The MUSC president responded to VA's counterproposal in an April 2003 letter to the Secretary of VA. In the letter, the MUSC president stated that MUSC was proceeding with phase I of the project and that the joint venture concept could be pursued during later phases of construction. The letter did not specifically address VA's proposal to locate the new facility in phase III, or the suggestion that MUSC would need to provide some type of financial incentive for VA to participate in the joint venture. To move forward with phase I, the MUSC president stated that MUSC would like to focus on executing an enhanced-use lease (EUL) for Doughty Street.

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Although MUSC owns most of the property that will be used for phases I through III, Doughty Street is owned by VA and serves as an access road to the Charleston facility and parking lots. The planned facility for phase I would encompass Doughty Street.<sup>13</sup> (See fig. 7.) Therefore, MUSC could not proceed with phase I—as originally planned—until MUSC secured the rights to Doughty Street. To help its medical affiliate move forward with construction, VA executed an EUL agreement with MUSC in May 2004 for use of the street.<sup>14</sup> According to the terms of the EUL, MUSC will pay VA \$342,000 for initial use of the street and \$171,000 for each of the following 8 years.

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<sup>13</sup>To provide access to the current VA facility, a new street—the Ralph H. Johnson Drive—will be constructed around MUSC's new facility.

<sup>14</sup>The Secretary of VA and the Medical University Hospital Authority (MUHA), an affiliate of MUSC, entered into a 75-year EUL agreement in May 2004 for MUHA use of VA property—a 1-block segment of Doughty Street. VA's EUL authority allows VA to lease real property under the Secretary's jurisdiction or control to a private or public entity for a term of up to 75 years. EULs must result in a beneficial redevelopment/reuse of the affected VA property by the lessee that will include space for a VA mission-related activity and/or will provide consideration that can be applied to improve health care and services for veterans and their families in the community where the site is located. See 38 U.S.C. § 8161-8169.

**Figure 7: Construction of Phase I of MUSC's Project, July 2005**



Source: GAO.

Note: The photograph shows the initial construction for phase I of MUSC's project. Doughty Street will be encompassed by MUSC's new facility.

To facilitate negotiations on the joint venture proposal, a congressional delegation visited Charleston to meet with VA and MUSC officials to discuss the joint venture proposal on August 1, 2005. After this visit, VA and MUSC agreed to jointly examine key issues associated with the joint

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venture proposal. Specifically, VA and MUSC established the Collaborative Opportunities Steering Group (steering group). The steering group is composed of five members from VA, five members from MUSC, and a representative from DOD, which is also a stakeholder in the facility health care market.<sup>15</sup> The steering group chartered four workgroups:

- The *governance* workgroup examined ways of establishing organizational authority within a joint venture between VA and MUSC, including shared medical services.
- The *clinical service integration* workgroup identified medical services provided by VA and MUSC and opportunities to integrate or share these services.
- The *legal* workgroup reviewed federal and state authorities (or identified the lack thereof) and legal issues relating to a joint venture with shared medical services.
- The *finance* workgroup provided cost estimates and analyses relating to a joint venture with shared medical services.

The steering group and workgroups were intended to help VA and MUSC determine if the joint venture proposal would be mutually beneficial. On December 7, 2005, the steering group issued its final report to the Under Secretary for Health and to the president of MUSC. According to the report, the steering group concluded that the most advantageous options were those that provide a revenue stream for VA and provide MUSC access to new space without capital financing. Therefore, the group explored construction models that incorporated benefits to both organizations that included taking advantage of VA's access to capital financing and access to MUSC revenue streams. As shown in table 3, the report identifies six planning models, ranging from constructing a new medical facility with space for VA and MUSC, to sharing that could occur with VA maintaining its existing facility. Four of the models—A, A-1, A-2, and B—include varying levels of shared space between VA and MUSC. These four models also call for VA to overbuild the facility—that is, build it bigger than VA needs—and lease the excess space to MUSC, thus providing VA with a revenue stream to offset some of the cost of construction. The amount of excess space

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<sup>15</sup>DOD currently provides medical services to a number of its beneficiaries through the Naval Hospital in Charleston.

built and leased by VA varies among the four models. Any option pursued that involves VA building a new medical facility over-capacity for the purpose of leasing the underutilized space requires close scrutiny, since real estate leasing agreements are currently not part of its mission. In addition, such options would also require specific congressional authorization and appropriation since the costs of any of the planning models identified would exceed \$7 million, the threshold for such action.

**Table 3: Description of Planning Models Identified by Steering Group**

Model	Description
Model A	Construct a new, oversized VA medical center to replace all VA services. Excess capacity is leased to MUSC.
Model A-1	Construct a new, oversized VA medical center to replace all VA services. Excess capacity is leased to MUSC. MUSC would construct an adjacent tower.
Model A-2	Construct a new, oversized VA medical center to replace all VA services, with administrative and clinical services located in separate buildings. Excess capacity is leased to MUSC.
Model B	Construct a new, slightly oversized VA medical center to replace all VA services. Excess capacity is leased to MUSC.
Model C	Construct a new VA medical center, with no excess space available for leasing. Additional sharing between VA and MUSC consists of shared high tech equipment and contracts for services.
Model D	VA remains in its current facility, with renovations as appropriate. Additional sharing between VA and MUSC consists of shared high tech equipment and contracts for services.

Source: GAO summary of information in the Collaborative Opportunities Steering Group, Final Report, December 2005.

The steering group's December 2005 report does not recommend an option that VA should pursue. Rather, the report outlines the perceived advantages and disadvantages, as well as the costs, of each option.<sup>16</sup> (See app. I for the advantages, disadvantages, and costs of the different models.) However, the report does note that two options were rejected by steering group members. In particular, the finance workgroup rejected Model A-2—which included an oversized new VA medical center and separate buildings for administrative and clinical services—because, among other things, the construction of a separate building to house administrative services was not cost-effective. Additionally, MUSC deemed Model B—which included a replacement VA medical center with moderate excess space to lease to MUSC—not to be a viable option because it did not meet its total bed replacement needs. Although the report identifies options that provide a

<sup>16</sup>The finance workgroup did not estimate the cost of Model A-2 because it determined this option was not viable.

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revenue stream for VA, the report notes that there is not sufficient revenue or cost avoidance in any of the models for VA to achieve a 30-year payback on the construction investment. According to VA officials, the next step is for the Capital Asset Board of the Veterans Health Administration to make a recommendation regarding the options contained in the report. VA expects the Capital Asset Board's recommendations by the end of April 2006.

### Limited Collaboration and Communication Stalled Negotiations in Charleston for About 3 Years

Prior to the summer of 2005, limited collaboration and communication generally characterized the negotiations between MUSC and VA over the joint venture proposal. In particular, before August 2005, VA and MUSC had not exchanged critical information that would help facilitate negotiations. For instance, MUSC did not clearly articulate to VA how replacing the Charleston facility, rather than renovating it, would improve the quality of health care services for veterans or benefit VA. MUSC officials had generally stated that sharing services and equipment would create efficiencies and avoid duplication, which would lead to cost savings. However, MUSC had not provided any analyses to support such claims. Similarly, as required by law,<sup>17</sup> VA studied the feasibility of coordinating its health care services with MUSC, pending construction of MUSC's new medical center. This study was completed in June 2004. However, VA officials did not include MUSC officials in the development of the study, nor did they share a copy of the completed study with MUSC. VA also updated its cost analysis of the potential joint venture in the spring of 2005, but again, VA did not share the results with MUSC. Because MUSC was not included in the development of these analyses, there was no agreement between VA and MUSC on key input for the analyses, such as the specific price MUSC would charge VA for, or the nature of, the medical services that would be provided. As a result of the limited collaboration and communication, negotiations stalled—prior to August 2005, the last formal correspondence between VA and MUSC leadership on the joint venture occurred in April 2003.

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<sup>17</sup>Pub. L. 108-170, § 232, 117 Stat. 2042, 2052-2053 (2003).

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## Joint Venture Proposals in Charleston and Denver Pose Multiple Challenges

The joint venture proposals under consideration in Charleston and previously proposed in Denver raise a number of challenges for VA and its medical affiliates. These challenges—which were identified by VA, MUSC, or UCH officials as well as previous studies prepared for or by VA, MUSC, or UCH—include addressing institutional changes for VA and institutional differences between VA and its medical affiliates, identifying legal issues and seeking legislative remedies, and balancing funding priorities. Although addressing these issues will be difficult, it is not insurmountable, as evidenced by the VA-MUSC steering group’s efforts to address some of these challenges, as well as by VA’s past partnerships with some medical affiliates and DOD.

- *Addressing institutional changes and differences:* The joint ventures proposed in Charleston and Denver pose a series of institutional changes for VA and reveal a number of institutional differences between VA and its medical affiliate that would need to be reconciled. Specifically, as an in-house health care service provider with other departmental priorities, by jointly constructing and operating a hospital with a nonfederal health system, VA would deviate from its current health care model. Although VA purchases significant amounts of medical services from its medical affiliates, the relationship between VA and its affiliates has centered on providing enhanced care for veterans as well as training medical school residents and conducting medical research. According to VA, altering this historical relationship to include jointly constructing and operating facilities would introduce legal, administrative, and management complexities that might require additional authorities. In addition, according to VA and some stakeholders, a joint facility could diminish VA’s identity by deviating from a VA medical facility that treats only veterans to one with a mixed-patient population served by providers from different health systems. Hence, if maintaining VA’s identity is important to VA leadership, steps would need to be taken to protect VA’s identity in a joint facility.

Adding to the challenge of expanding affiliation relationships to include joint ventures involving major capital are inherent differences between VA and its medical affiliates—from their missions to their funding processes. For example, in addition to its mission of providing care for our nation’s veterans, VA is also responsible for supporting national, state, and local emergency management and serving as backup to DOD during war and other national emergencies. In addition, funding decisions for both VA and MUSC must go through several layers of review. VA’s major capital

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investments (over \$7 million) must be evaluated at multiple levels within VA and approved by the Office of Management and Budget and by Congress,<sup>18</sup> while such investments by MUSC must be approved by its board, and if requiring state funds, by the state legislature. These differences would need to be considered in any joint venture between VA and a medical affiliate.

- *Identifying legal issues and seeking legislative remedies:* Joint venture proposals raise many complex legal issues. The specific legal issues raised depend on the type of joint venture proposed, but many involve real estate, construction, contracting, and employment. In Charleston, the legal workgroup identified VA's and MUSC's legal authorities, or lack thereof, on numerous issues relating to each option considered. The legal workgroup concluded that VA has the legal authority to pursue any of the six planning models identified but that specific considerations would arise for each model. For example, legislative authorization and appropriation are required for any major VA construction project over \$7 million. In addition, while VA is authorized, under its EUL authority, to lease underutilized real property for up to 75 years, the authorization does not provide for building a new medical facility over-capacity for the purpose of leasing the underutilized space.<sup>19</sup>
- *Developing appropriate governance plans:* A venture involving a jointly operated facility would require the parties to agree to a plan for governing it. Any governance plan would have to maintain VA's direct authority over and accountability for the care of VA patients. In addition, if shared medical services were a component of a joint venture between the VA and an affiliate, the entities would need a mechanism to ensure that the interests of the patients served by both are protected today and in the future. For instance, VA might decide to purchase operating room services from its affiliate. If the sharing agreement were dissolved afterwards, it would be difficult for VA to resume the independent provision of these services. Therefore, a clear plan for governance would ensure that VA and its affiliate could continue to serve their patients' health care needs as well as or better than before. To address possible governance issues in Charleston, the steering group

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<sup>18</sup>38 U.S.C. § 8103-8104.

<sup>19</sup>38 U.S.C. § 8162.



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recommended instituting a joint governance council that would include a nonaffiliated third party to oversee the sharing relationship in areas other than research and educational activities. The joint governance council's decisions would be advisory in nature—and not legally binding—in order not to undermine the current authority of VA or MUSC.

- *Balancing funding priorities:* VA leadership must weigh joint venture opportunities against VA's capital assets and health care service needs throughout the nation when making funding decisions and recommendations. VA operates a nationwide health care system for veterans, including 157 medical centers and over 800 clinics. According to VA, its capital requirements are significant given the amount of real property it owns and uses and the age and condition of most of its facilities. Further, in 2004, the Secretary of VA estimated that implementing CARES will require additional investments of approximately \$1 billion per year for at least the next 5 years, with substantial infrastructure investments then continuing indefinitely. Balancing these competing capital requirements is made more difficult by the fiscal challenges facing the federal government. Given the size of the government's projected deficit, VA, like other federal agencies, could face constrained budgets in the future, making funding of even high priority capital requirements challenging.

Additional challenges are likely to be identified as VA continues to explore the proposed joint venture with MUSC or other possible joint ventures in the future. In particular, should VA decide to pursue a joint venture with MUSC or other medical affiliates in the future, it would likely face additional challenges during the implementation phase. For example, due to the inherent differences in the purposes for which VA's and MUSC's information management systems were designed, the systems would not be compatible. According to MUSC officials, VA's and MUSC's computerized patient record systems are different, and their billing systems are incompatible. Therefore, at least initially, the systems would not be integrated, and parallel systems would need to be implemented—which could result in added costs in terms of staff time and raise the potential for errors.

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## VA's Current Sharing Arrangements with Medical Affiliates and DOD Could Be Instructive As VA Considers Current and Future Joint Ventures

Partnerships with other health providers are not new to VA. For instance, the Mike O'Callaghan Federal Hospital, an integrated federal hospital jointly constructed by the VA and Air Force in Las Vegas, Nevada, currently serves as a model of joint operation and shared medical services.<sup>20</sup> However, joint ventures of this magnitude with DOD are limited. Further, VA has not entered into a joint venture with a medical affiliate of the magnitude proposed in Charleston or Denver. However, there are instances of significant capital ventures between VA and its affiliates involving high-priced medical equipment. For example, VA's Western New York Healthcare System in Buffalo, New York, houses a Positron Emission Tomography (PET) scanner that was purchased by its affiliate. In exchange, VA purchases scans from its affiliate for veterans and provides operational and administrative staff to support the equipment.

These past capital ventures are on a smaller scale than the joint ventures proposed in Charleston and Denver, but they could be somewhat instructive as VA considers current and future joint venture proposals and attempts to address the associated challenges. For example, in these past capital ventures, VA had to ensure that veterans received the appropriate access to equipment and services, and VA accomplished this through the terms and conditions outlined in the contract. In addition, VA had to address governance, legal, and information management challenges in establishing these capital-sharing arrangements. The difficulty of addressing such challenges, however, likely increases as the complexity and magnitude of the proposed joint venture grows.

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<sup>20</sup>The Mike O' Callaghan Federal Hospital is situated on a 49-acre site adjacent to Nellis Air Force Base, approximately 11 miles northeast of downtown Las Vegas. The facility encompasses 114 beds, with 52 designated for VA use. Activated in August 1994, the 370,000 square footage facility cost \$75 million to construct. VA contributed \$9 million for the construction of the facility.

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## VA Could Learn Several Lessons from Its Experiences with Denver and Charleston Joint Venture Proposals

Because VA may explore the possibility of entering into partnerships with other medical affiliates in the future, the lessons learned from VA's experiences in Charleston and Denver could be instructive. It is possible that more opportunities for similar joint ventures or sharing arrangements will present themselves in the coming years. In particular, our analysis of VA data on its major medical facilities indicates that 43 percent of these facilities, like the medical center in Denver, consist of buildings with an average age of over 50 years, although some have undergone extensive renovations over the years. Given the age of these facilities, many of them may need to be replaced or extensively renovated in the future. Additionally, disasters, such as Hurricane Katrina, could force unplanned renovations or replacements. As VA moves forward in making necessary renovations or replacements throughout the country, there could be opportunities for joint ventures with its medical affiliates. VA will have to determine if these opportunities are in the best interest of the federal government and our nation's veterans.

The lessons that emerged from our work in Charleston and Denver reflect how the absence of practices that we have emphasized in previous reports can hamper effective consideration of potential joint ventures. These reports examine leading practices for realigning federal agency infrastructure, collaboration among organizations, and organizational transformations.<sup>21</sup> The lessons include establishing criteria to evaluate the joint venture proposal, obtaining leadership buy-in and support for the joint venture, ensuring extensive collaboration among stakeholders, and developing a strategy for effective and ongoing communications.

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## Lack of Criteria at Departmental Level Results in Inconsistent Evaluations

One of the most important lessons from VA's experiences in Denver and Charleston is that the absence of criteria at the departmental level to evaluate joint venture proposals can result in inconsistent evaluations, misunderstandings, and delays. The joint venture proposals for VA's

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<sup>21</sup>GAO, *U.S. Postal Service: The Service's Strategy for Realigning Its Mail Processing Infrastructure Lacks Clarity, Criteria, and Accountability*, [GAO-05-261](#) (Washington, D.C.: Apr. 8, 2005); *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, [GAO-06-15](#) (Washington, D.C.: Oct. 21, 2005); *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, [GAO-03-669](#) (Washington, D.C.: July 2, 2003); and *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, [GAO-03-669](#) (Washington, D.C.: July 2, 2003).

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medical centers in Denver and Charleston presented VA with a new opportunity—that is, the proposals involved joint construction and service sharing on a scale beyond anything VA had experienced in partnering with its medical affiliates in the past. VA did not have criteria at the departmental level for evaluating and negotiating joint venture proposals, which led to inconsistent evaluations of the Denver and Charleston proposals. For instance, in Denver, VA facility and network officials worked collaboratively with UCH officials on the joint venture proposals, including jointly funding a study to assess the feasibility and cost of various options. In contrast, VA facility and network officials did not include MUSC officials in the development of the study that examined the feasibility of coordinating VA's health care services with MUSC, nor did they share a copy of the completed study with MUSC. This contributed to the negotiations between VA and MUSC stalling for over 2 years. VA officials in Denver also told us that the lack of departmental criteria hampered negotiations, and noted that on the basis of their experience a common tool or process is needed to assess joint venture proposals so that they can be evaluated consistently.

As we have emphasized in previous work on realigning federal infrastructure, a set of criteria for evaluating decisions regarding infrastructure enhances the transparency of these decisions and helps ensure that the decisions are made in a manner that is fair to all stakeholders and that is efficient and effective.<sup>22</sup> Although we recognize that every joint venture is likely to be different, criteria would establish a framework for evaluating future joint venture proposals. In addition to identifying the factors VA would consider in evaluating proposals and indicating how these factors would be measured, the criteria would help ensure that proposals are evaluated consistently—regardless of location or officials involved. The criteria would also serve to communicate VA's expectations for joint ventures. That is, they would identify what VA is looking for in potential joint ventures, such as improved medical care for veterans and reduced operating costs. By documenting and sharing these criteria with potential partners, VA would help ensure that its positions are understood from the outset and thus eliminate possible misunderstandings. The VA-MUSC steering group's efforts to identify criteria to evaluate the Charleston proposal and the studies conducted in Denver could serve as starting points for the development of criteria.

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<sup>22</sup>[GAO-05-261](#).

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## Lack of Communications Strategy Leads to Misinformation and Confusion

VA's experiences in Denver and Charleston highlighted the fact that the absence of sustained communication with potential joint venture partners and stakeholders as well as within VA can be detrimental to negotiations. Breakdowns in communication occurred in both locations during key points of the negotiations and hindered progress. For example, in Charleston, there was limited communication between VA and MUSC for about 2 years; as a result, negotiations stalled. In addition, in both locations, a primary point of contact—either a single individual or a group—was not identified to represent VA's position in negotiations with the medical universities. Rather, various VA officials at the facility, network, and departmental levels often maintained separate contacts with UCH and MUSC officials. As a result, according to MUSC and UCH officials, they received mixed signals as to VA's intentions regarding the proposals. Similarly, MUSC and UCH also contacted and communicated with different VA officials at the facility, network, and departmental levels, which also led to confusion.

In our previous work on organizational transformations, we have noted that creating an effective, ongoing communication strategy is essential to implementing significant organizational changes like the joint ventures proposed in Charleston and Denver.<sup>23</sup> Such a strategy should entail communicating information early and often to help build an understanding of the purpose of the planned change and build trust among VA and its medical affiliates as well as stakeholders, such as employees and veterans, who could have concerns over such issues as the impact of a joint venture on patient care. The strategy should also encourage communication by facilitating a two-way honest exchange with, and allow for feedback from, stakeholders. A communications strategy can also help ensure that these groups receive a message that is consistent in tone and content. Sharing a consistent message with stakeholders helps reduce the perception that others are getting the “real” story when, in fact, all are receiving the same information. The strategy should also make it clear that it is essential to have a primary point of contact with the necessary authority to negotiate effectively with partners, make timely decisions, and move quickly to implement top leadership's decisions regarding the joint venture. Good communication is central to forming the effective internal and external partnerships that are vital to the success of transforming endeavors such as joint ventures. In Charleston, the steering group has taken steps to improve

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<sup>23</sup>GAO-03-669.

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communication by establishing a plan for VA and MUSC to share information about the potential joint venture with stakeholders such as employees and veterans groups.

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## Lack of Leadership Support Can Hinder Negotiations

Another lesson that emerged from VA's experience with the joint venture proposals for Denver and Charleston is that leadership buy-in and support are critical. The proposed joint venture in Denver did not come to fruition largely because VA leadership never fully supported the concept. In particular, when the joint venture was first proposed, UCH and VA officials at the network and facility levels worked extensively together on the proposal. Top level VA management, however, was not involved in these efforts. Moreover, in response to UCH's request for a 1-year time frame for a decision regarding a joint facility, in October 2002, the VA Secretary wrote that VA "cannot now commit to a joint University-VA hospital within the one-year timetable you propose. However, I feel strongly that we should not preclude a freestanding VA medical center at Fitzsimons in the future." According to UCH officials, this decision was unexpected given the fact they had worked closely with VA facility officials on a possible joint venture. Certainly it is the VA Secretary's prerogative to extend or withhold support for different proposals, and the Secretary must determine whether the proposals are in the best interest of veterans. However, VA's experiences in Denver and Charleston indicate that without such support negotiations for joint ventures will be hampered.

Our previous work on organizational transformation indicates that support from top leadership is indispensable for fundamental change, such as a joint venture.<sup>24</sup> Top leadership's clear and personal involvement in the transformation represents stability for both the organization's employees and its external partners. Top leadership must set the direction, pace, and tone for the transformation. Likewise, when a transformation requires extensive collaboration with another organization, as would be the case with a joint venture, committed leadership at all levels is needed to overcome the many barriers to working across organizational boundaries. If VA decides to pursue a joint venture with MUSC in Charleston, or other similar projects with medical affiliates or other partners, success will hinge on the level of support the project receives from top VA management.

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<sup>24</sup>GAO-03-669.

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## Lack of Extensive Collaboration Hampers Negotiations

Another lesson that emerged from the experiences in Denver and Charleston is that a lack of, or limited, collaboration hampers negotiations. For example, in Charleston, VA and MUSC did not initially exchange or share critical information, such as the feasibility study, which contributed to the negotiations stalling from about 2003 to 2005. In addition, until the VA-MUSC steering group was formed in Charleston, there was limited collaboration between VA and its stakeholders. This heightened the stakeholders' anxiety about the proposed joint venture and led to the spread of misinformation about the proposed joint venture. In Denver, although VA officials from the facility and network level and UCH officials met frequently after UCH proposed the joint venture, VA officials with the necessary decision-making authority were not involved in these initial discussions. Consequently, when the Secretary of VA decided against a joint venture in Denver, UCH officials felt misled, which resulted in an atmosphere of mistrust between the entities.

Our previous work on collaboration between organizations suggests several practices that VA might benefit from as it continues to consider a joint venture in Charleston as well as other such opportunities that may occur in the future.<sup>25</sup> These practices include ensuring the involvement of key stakeholders, defining and articulating a common outcome, establishing mutually reinforcing or joint strategies, identifying and addressing needs by leveraging resources, and agreeing on roles and responsibilities. The VA-MUSC steering group illustrates how some of these practices can be implemented. For example, the steering group was led by senior VA and MUSC officials and consisted of VA and MUSC staff who have knowledge in key areas (e.g., finance). In addition, the communications plan the VA-MUSC steering group established includes a presentation to use when communicating with stakeholders about the joint venture proposal.

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## Conclusions

To address future health care needs of veterans, VA's challenge is to explore new ways to fulfill its mission of providing veterans with quality health care. The prospect of jointly constructing and operating medical facilities with medical affiliates presents an opportunity for VA to consider the feasibility of expanding its relationships with university medical school affiliates to include the sharing of medical services in an integrated

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<sup>25</sup>GAO-06-15.

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hospital. This is just one of several ways VA could provide care to veterans. It is up to VA, working with its stakeholders, and Congress to determine if expanding VA's relationship with medical affiliates to include joint ventures—of the scale proposed in Denver and Charleston—is in the best interest of the federal government and the nation's veterans, as well as how such joint ventures fit within the context of the CARES framework.

VA will be in a better position to consider future joint ventures if it learns from its experiences with the joint venture proposals in Denver and Charleston. Among these lessons is the importance of leadership support and extensive collaboration. In addition, VA's experiences in Denver and Charleston indicate that having a set of criteria at the departmental level would provide a clear basis for making decisions on joint venture proposals. Although each proposal will likely be somewhat unique, and should be evaluated on its own merits and circumstances, criteria provide a framework for future evaluations and negotiations. A set of criteria at the departmental level helps ensure that proposals are evaluated in a consistent fashion across the country as well as communicates VA's expectations for joint ventures. Another important lesson is that a strategy for communicating with its medical affiliates and stakeholders, including veterans and employees, can help VA avoid the problems that hampered progress in negotiations over the Denver and Charleston joint venture proposals. A communications strategy helps build understanding and trust between VA and its medical affiliates and stakeholders as well as helps ensure that these groups receive a message that is consistent in tone and content. Establishing a set of evaluation criteria and a communications strategy are tangible steps VA could take to better position itself in considering future joint venture proposals.

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## Recommendations for Executive Action

To ensure that there is a clear basis for evaluating future joint venture proposals as well as to help ensure early and frequent communication between VA and its medical affiliates and stakeholders during negotiations, we recommend that the Secretary of VA take the following two actions:

- Identify criteria at the departmental level for evaluating joint venture proposals. In order to foster an atmosphere of collaboration, VA should share these criteria with potential joint venture partners.
- Develop a communications strategy for use in negotiating joint venture proposals.



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## Agency Comments

We provided a draft of this report to VA for its review and comment. On April 10, 2006, VA's audit liaison provided VA's comments on the draft report via e-mail. VA agreed with the report's conclusions and recommendations. We also provided UCH and MUSC officials portions of the draft report that related to their joint venture proposals. UCH and MUSC officials provided technical clarifications to these portions of the draft report, which we incorporated where appropriate.

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## Scope and Methodology

To address our objectives, we analyzed VA, UCH, and MUSC planning documents, presentations, and studies related to the joint venture proposals as well as correspondence between VA and these medical affiliates regarding the proposals. We also examined the recommendations of the CARES Commission and the Secretary's CARES Decision report, VA's 5-year capital plan (2005-2010), and federal statutes and accompanying reports. In addition, we interviewed officials from VA, DOD, MUSC, and UCH to obtain information on the history and status of the joint venture proposals as well as the challenges associated with implementing such proposals. We also interviewed local stakeholders, including officials from the Fitzsimons Redevelopment Authority in Aurora, Colorado, the mayors of Charleston and Aurora, and representatives from the VA employees' unions in each location to obtain their perspectives and to obtain information on local capital asset planning and its impact. We also toured VA and MUSC facilities in Charleston and VA and UCH facilities in the Denver area. Finally, we synthesized information obtained from VA, MUSC, and UCH officials and reviewed our past work on organizational transformation and collaboration among organizations to identify lessons learned from VA's experiences with joint venture proposals in Charleston and Denver.<sup>26</sup> Although we examined the joint venture proposals for VA's Denver and Charleston facilities and the associated studies and planning documents, we did not evaluate the merits of the proposals. We assessed the reliability of the information obtained from VA, MUSC, and UCH. We concluded that the information was sufficiently reliable for our purposes.

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<sup>26</sup>See "Related GAO Products" at the end of this report.

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We are sending copies of this report to congressional committees with responsibilities for veteran issues; the Secretary of Veterans Affairs; and the Director, Office of Management and Budget. We also will make copies available to others upon request. In addition, 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 on matters discussed in this report, please contact me on (202) 512-2834 or at [goldsteinm@gao.gov](mailto:goldsteinm@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report include Chris Bonham, Nikki Clowers, Daniel Hoy, Jennifer Kim, Edward Laughlin, Susan Michal-Smith, James Musselwhite, Jr., and Michael Tropauer.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Goldstein', with a long horizontal flourish extending to the right.

Mark L. Goldstein  
Director, Physical Infrastructure Issues

# Description of Planning Models Identified by Steering Group

**Model A:** Construct a new, oversized VA medical center to replace all VA services. Excess capacity is leased to MUSC.

Advantage	Disadvantage	Construction cost	Life cycle cost
Provides VA with \$6.7 million annually to enhance care	Requires the largest construction investment by VA	\$545.6 million + activation	\$4.3 billion
Provides VA with extra bed capacity to meet disaster needs	MUSC construction must meet VA security requirements, raising construction costs		

**Model A-1:** Construct a new, oversized VA medical center to replace all VA services. Excess capacity is leased to MUSC. MUSC would construct an adjacent tower.

Advantage	Disadvantage	Construction cost	Life cycle cost
Reduces VA's construction investment	Requires large investment by VA for construction	\$368 million + activation	\$4.2 billion
Provides MUSC with a lower construction cost	VA security and safety specifications may need to be met if buildings are connected		
Provides VA with \$4.2 million annually to enhance care	Separate construction reduces the coordination and compatibility of space		
Provides VA with extra bed capacity to meet disaster needs	Eliminates some VA lease revenue and negatively affects payback		

**Model A-2:** Construct a new, oversized VA medical center to replace all VA services, with administrative and clinical services located in separate buildings. Excess capacity is leased to MUSC.

Advantage	Disadvantage	Construction cost	Life cycle cost
Reduces VA's construction investment	Volume of administrative space is small and construction costs are similar to Model A	Not calculated	Not calculated
Builds adjacency of VA and MUSC	Some operational inefficiencies arise through lack of adjacency		
Provides VA with additional annual revenue to enhance care	MUSC construction must meet VA security requirements, raising construction costs		

**Model B:** Construct a new, slightly oversized VA medical center to replace all VA services. Excess capacity is leased to MUSC.

Advantage	Disadvantage	Construction cost	Life cycle cost
Somewhat less initial VA investment required	MUSC does not consider this model viable since it must still construct beds elsewhere	\$444.4 million + activation	\$4.2 billion
Provides VA with \$4.9 million annually to enhance care	Requires second largest investment by VA for construction		
Provides VA with extra bed capacity to meet disaster needs	MUSC construction must meet VA security requirements, raising construction costs		

**Appendix I  
Description of Planning Models Identified by  
Steering Group**

*(Continued From Previous Page)*

**Model C:** Construct a new VA medical center, with no excess space available for leasing. Additional sharing between VA and MUSC consists of shared high tech equipment and contracts for services.

<b>Advantage</b>	<b>Disadvantage</b>	<b>Construction cost</b>	<b>Life cycle cost</b>
Provides VA with state-of-the-art patient care and administrative space, including private and semiprivate patient rooms and efficient energy systems	Results in demolition of a facility currently considered to be sound	\$317.2 million+ activation	\$4.1 billion
Potentially improves adjacency of VA and MUSC	Requires a sizable construction investment by VA		
Provides VA with opportunities to address specialty care at a network level	Eliminates revenue sources that would offset construction costs through space and service sharing		
Potential for VA and MUSC to reduce the size of new facilities by planning to share some capacity through contracts	Duplicates construction of some services that could potentially be shared		
Maintains greater VA and MUSC autonomy			
Avoids further investment into VA's aging infrastructure			
Provides VA with \$4.3 million annually to enhance care			

**Model D:** VA remains in its current facility, with renovations as appropriate. Additional sharing between VA and MUSC consists of shared high tech equipment and contracts for services.

<b>Advantage</b>	<b>Disadvantage</b>	<b>Construction cost</b>	<b>Life cycle cost</b>
No up-front construction costs for VA	Existing facility is dated and will require continued investment	\$27.1 million	\$3.9 billion
Continues use of a sound facility	Replacement may be necessary at some future date		
Opportunities for increased sharing have been identified that do not necessarily require construction	Duplicates construction of services that could potentially be shared		
Provides VA with opportunities to address specialty care at a network level	Charleston area veterans may have to travel to other VA medical centers for some care		
Maintains current access	Requires that the facility be renovated to withstand disasters		
Maintains more VA and MUSC autonomy	Less bed capacity for potential disaster and DOD needs		
	Existing facility may not withstand strong hurricane or flood		

Source: Collaborative Opportunities Steering Group, Final Report, December 2005.

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# Related GAO Products

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*Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies.* [GAO-06-15](#). Washington, D.C.: October 21, 2005.

*VA Health Care: Preliminary Information on the Joint Venture Proposal for VA's Charleston Facility.* [GAO-05-1041T](#). Washington, D.C.: September 26, 2005.

*VA Health Care: Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care.* [GAO-05-429](#). Washington, D.C.: August 5, 2005.

*Federal Real Property: Further Actions Needed to Address Long-standing and Complex Problems.* [GAO-05-848T](#). Washington, D.C.: June 22, 2005.

*U.S. Postal Service: The Service's Strategy for Realigning Its Mail Processing Infrastructure Lacks Clarity, Criteria, and Accountability.* [GAO-05-261](#). Washington, D.C.: April 8, 2005.

*VA Health Care: Important Steps Taken to Enhance Veterans' Care by Aligning Inpatient Services with Projected Needs.* [GAO-05-160](#). Washington, D.C.: March 2, 2005.

*High-Risk Series: An Update.* [GAO-05-207](#). Washington, D.C.: January 2005.

*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.

*Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations.* [GAO-03-669](#). Washington, D.C.: July 2, 2003.

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

*Major Management Challenges and Program Risks: Department of Veterans Affairs.* [GAO-03-110](#). Washington, D.C.: January 2003.

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

*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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