

Enhanced Services (CARES), and the foundational CARES Plan includes:

- Findings from an objective comparison of data on future needs versus current capabilities;
- A comprehensive assessment of the adequacy of all current VHA health care space to meet these needs;
- An investment strategy to guide the allocation of capital resources to meet those space needs;
- Exploration of alternative use of campuses to benefit veterans, such as assisted living facilities or other compatible uses, with revenues used to invest in veteran services;
- Adopting the Critical Access Hospital (CAH) model developed by the Centers for Medicare and Medicaid Services for small facilities as a guide to ensure that quality of care is maintained in the future;
- A description of consolidations of services and realignments to replace inefficient, aged campuses with modern facilities to improve quality and cost effectiveness;
- A description of internal collaborations between the three VA administrations and external collaborations with the Department of Defense (DoD) to maximize joint utilization of capital resources; and
- A description of stakeholder involvement in the CARES process.

#### *Background Includes Transformational Changes*

A brief word of background on the federal entity charged with caring for America's veterans may help to place the CARES process and this plan into perspective. This entity is the Department of Veterans Affairs (VA). Many changes in VA's health care system have come through gradual evolution, but there also have been instances of remarkable transformation. After World War II, for example, VA astounded critics by accomplishing a dramatic and highly successful expansion to meet the needs of millions of World War II veterans.

VA's health care system—in modern parlance, the Veterans Health Administration (VHA)—was transformed again in the 1990's. Having initially lagged behind the national trend of placing greater reliance on primary care and outpatient settings, VHA accomplished a reinvention of major proportions.

In just seven years—from 1995 to 2002—VA changed from an inpatient model of care characterized by a limited number of specialized facilities, to an outpatient model with more than 1,300 access sites in veterans' communities across the United States. Acute

operating beds were reduced from 52,000 to about 19,000, and the inpatient average daily census dropped about 60 percent in this period. Most telling, by 2002, the VA was treating more than 1.5 million additional veterans annually—an increase greater than 50% since the beginning of the period.<sup>1</sup>

A key element of the reorganization was dividing the VA system into strategic networks. There are currently 21 of these Veterans Integrated Service Networks, commonly referred to as "VISNs." VISNs are focal points for coordinating medical services in a population-based approach to care. In a few short years, VISNs guided VA's transformation into a system of highly efficient, ambulatory-based care, backed by a highly integrated system of tertiary care and other services.

#### *Echoes of Change: Reverberations Linger*

Reverberations can linger in the wake of such remarkable changes in the VA health care system. For example, when VA geared up to care for World War II veterans, medical staffs were augmented virtually overnight (through affiliation with the nation's medical schools). Necessary expansion of the infrastructure took much longer—with site selection, design, funding, and construction of VA facilities around the country stretching through the 1950's and 60's.

The more recent reformation of VA health care during the 1990's—creating today's efficient, primary care focused, outpatient-based system—was also followed by reverberations. While making strong progress in refining primary care modalities and expanding access through investments in community based clinics, VA had limited success in securing capital to maintain its acute care infrastructure.

Initial restructurings, such as reducing bed numbers, closing staffed wards, changing specific use of buildings, etc., were accomplished with dispatch. But further steps were problematic, since disposition of capital assets traditionally has been a difficult process in the Federal sector in general, and in the VA, in particular. In addition, vacant space may be scattered and not concentrated in specific locations amenable to closure or re-use. To some extent, the lack of concentrated space simply reflects the nature of physical plant entities, *i.e.*, vacant and underutilized buildings (many of which have historic value) cannot be moved around like most other resources.

<sup>1</sup> Source: Department of Veterans Affairs Program Statistics, April 17, 2003.

Disposing of such assets can be a complex process for any department or agency. For VA, periodic, vigorous opposition from local interest groups who object to the proposed re-use of the facility or land has complicated this difficult task.

#### *GAO Paints Challenge in Stark Terms*

In view of this background, it was not particularly surprising when, in 1999, the General Accounting Office (GAO) gave VA poor marks, for its record in divesting itself of vacant and underutilized buildings. Some details in the GAO comments were noteworthy, such as the contention that, unless VA implemented more effective capital investment planning and budgeting, it could "spend billions of dollars operating hundreds of unneeded buildings over the next 5 years or more."<sup>2</sup>

Although the GAO financial estimate were based upon complete campus closures (not closing/demolishing individual buildings at over 150 sites), which are not fully achievable, VA embraced the recommendation to strengthen capital investment planning—because the GAO's conclusion was in perfect accord with VA's own goals for the direction of its health care system. This GAO conclusion was that "VA could enhance veterans' health care benefits if it reduced the level of resources spent on underused or inefficient buildings, and used these resources instead to provide health care more efficiently in existing locations or closer to where veterans live."<sup>3</sup>

Congressional authorizing, appropriating and oversight committees had also expressed concern over the lack of a long-term capital planning process.

#### *Designing a Tool of Unprecedented Precision*

In designing the CARES process, VA explicitly followed GAO recommendations, such as working to eliminate subjective judgments, developing methods to quantify the benefits of locations and facilities, and seeking the best-defined measurement standards. The completed CARES design therefore differed from previous planning and budgeting efforts in several important respects. CARES was:

<sup>2</sup> *VA Health Care: Capital Asset Planning and Budgeting Need Improvement* (GAO/T-HEHS-99-83, Mar. 10, 1999).

<sup>3</sup> *VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting*, GAO/HEHS-99-145 (Washington, DC: Aug. 13, 1999), p. 4.