

- Savings from reducing vacant/underutilized space would total over \$45 million per year. [Note that the GAO report which estimated a savings of \$1 million a day was based on complete campus closures (about 19–20 campuses) and not individual building closures, so it is not comparable to this CARES study.]

- Total demolition costs would amount to \$58,796,952.

Service Consolidations (Proximity) and Campus Realignment

Actual savings due to campus realignments, consolidations, downsizing and closures will be assessed in detail during the CARES implementation process. When the proposed realignments and consolidations are approved as strategic directions, final decisions regarding relative savings and costs of the changes will be fully analyzed before the implementation plan is finalized.

Implementation of the National CARES Plan

Implementation of the National CARES Plan will extend over many years. It will be multifaceted, depending upon whether implementation requires additional capital, recurring funding, primarily policy changes and/or realignments that are possible at minimal cost. For example, converting to a Critical Access Hospital⁹ is driven more by policy than by resources, whereas meeting the requirements to upgrade the acute capital infrastructures are heavily dependent on budget. Priority mechanisms, either in place or recently revised (such as the Capital Asset Prioritization process), will advance funding proposals from the National CARES Plan on a project-by-project basis.

Extensive development of business plans, clinical service consolidation plans, contracting and other plans will require time to ensure that services are maintained to veterans during the transition period.

The National CARES Plan also proposed additional collaborations within VA—with VBA and NCA—to maximize the use of VA assets. These implementation plans will fall under the “One VA” Initiative managed by the VA. Numerous additional collaborations between VA and DoD sites will ensure the most effective use of federal health care assets and will be integrated within the VA/DoD collaborative mechanisms currently in place.

The community is an important partner in the implementation process.

Partnerships with the community, in which community resources can be used to meet VA capital requirements, are proposed in the plan. Community contracts are an effective way to meet changes in demand that warrant investments in capital. They also often bring services closer to veterans, particularly in rural areas. They are particularly encouraged in the context of the demand peak in 2012 and 2013. Innovative approaches to community partnerships will be encouraged for further development during implementation.

Cycles of Improvement

CARES was the first step in VHA’s revised strategic planning process. The planning horizon extends to 2022, and the plan is based upon enrollment and utilization forecasts. As in all strategic plans that look into the future based upon assumptions, policies, health care delivery and veteran choices, the planning system must be sufficiently flexible to adapt to a changing health care environment. The forecasts and forecasting methods will be continuously tested and improved by monitoring actual experience. In addition, alternative future scenarios may be created to ensure that investments that are planned remain viable as developments pose new challenges and opportunities. Until fully implemented, all approved CARES proposals will be updated based upon the latest forecasts of veteran enrollee workload.

Chapter 2: The CARES Planning Process

Phased Application Chosen To Facilitate Adjustments

Managing the capital assets of the nation’s largest health care system is a complicated prospect by any measure. The CARES mission was to reform this undertaking into an objective process using unprecedented levels of data sophistication, systematic evaluation, and stakeholder involvement, integrated into a comprehensive 20-year look at VA’s capital asset needs.

Anticipating that such an innovative methodology would benefit significantly from the ability to make adjustments after an initial trial, VA leaders chose a phased approach to designing and implementing CARES. Phase I was a pilot test of the process conducted by a contractor working with a single VA health care network (VISN 12); in Phase II, the refined CARES process was applied within the remaining 20 VISNs comprising the balance of the VA health care system.

The second, larger effort took place under the guidance of the National CARES Program Office (NCPO), but represented an intensely collaborative effort within the Veterans Health Administration, as well as with the other two VA Administrations, other VA support staff and many other organizations. The staff of the VISNs, in particular, played a key role in the process, and notable contributions were made by VA experts from special disability programs.

Pilot Experience Yields Local Action, Improvements to National Plan

In accordance with OMB guidelines,¹⁰ the CARES process focuses on markets—or distinct veteran population areas. The Phase I pilot identified three market areas: the Chicago area, Wisconsin and the Upper Peninsula of Michigan.

In this initial effort, the contractor¹¹ developed a data driven, predictive methodology to assess veterans’ health care needs in the test market, and then formulated various solutions that could meet those needs. Following a detailed review process, the contractor recommended options to the Secretary of Veterans Affairs. After consulting with stakeholders, the Secretary of Veterans Affairs made a decision to realign capital assets in the VISN 12 market areas.¹² The final results of CARES Phase I were announced in February 2002.

In preparing for CARES Phase II (extension of the refined methodology to all markets within VHA’s remaining 20 VISNs), VA leadership decided that VA personnel, rather than contractor staff, would coordinate and carry out the planning process. The conversion from a contracted study in one VISN, to a VA-operated planning process extended to the entire system, went well beyond the scope of the pilot. The extensive revisions of the CARES process included not only substantive data validation issues, such as updating enrollment projections, but also refining utilization projections, creating a standardized costing and workload allocation tool, assessing all space in VHA facilities and developing new projection methods for special disability programs. In effect, CARES Phase II piloted a new process that would be

¹⁰ OMB Capital Program Guide, Version 1.0 (Washington, DC: July 1997).

¹¹ Booz, Allen Hamilton.

¹² Actions included: consolidation of inpatient activities at two Chicago VA facilities; conversion of Lakeside VA Medical Center to a long-term care facility; expansion of access to VA outpatient facilities in the market.

⁹ See Chapter 8, Small Facilities.