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United States General Accounting Office
Washington, DC 20548

August 18, 2003

The Honorable Everett Alvarez, Jr.
Chairman, CARES Commission
Department of Veterans Affairs

Subject: *VA Health Care: Framework for Analyzing Capital Asset Realignment for Enhanced Services Decisions*

Dear Mr. Chairman:

On May 14, 2003, at your request, we briefed you on our preliminary views on the Capital Asset Realignment for Enhanced Services (CARES) process initiated by the Department of Veterans Affairs (VA). On July 29, 2003, we met with your staff to share our additional perspectives, which they indicated would be helpful to the Commission as it considers the draft National CARES Plan that VA presented on August 4, 2003. For this reason, we are providing, for your consideration, an overview of the approach that we plan to use during our continuing review of CARES.

As you know, VA operates one of the nation's largest health care systems, having provided health care services to almost 4.3 million veterans in fiscal year 2002. In 1999, we reported that better management of VA's large, aged capital assets—consisting of a real property infrastructure that includes over 4,700 buildings and structures and 15,000 acres of land—could significantly reduce funds used to operate and maintain underused, unneeded, or inefficient properties.[1] We also noted that these funds could be used to enhance health care services for veterans. Specifically, we recommended that VA develop market-based asset-restructuring plans[2] that are consistent with guidelines from the Office of Management and Budget (OMB), which provide key principles and concepts for disciplined, cost-effective management of real property.[3] In response, VA initiated the CARES process in October 2000.

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[1]See U.S. General Accounting Office, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83 (Washington, D.C.: Mar. 10, 1999), and *VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting*, GAO/HEHS-99-145 (Washington, D.C.: Aug. 13, 1999).
[2]VA subsequently defined a health care market as a geographic area having a sufficient population and geographic size to benefit from the coordination and planning of health care services and to support a full health care delivery system.
[3]Office of Management and Budget, *Capital Programming Guide*, Version 1.0 (Washington, D.C.: July 1997).

The challenge of misaligned infrastructure is not unique to VA. We identified federal real property management as a high-risk area in January 2003 because of the nationwide importance of this issue for all federal agencies.[4] We did this to draw attention to the need for broad-based transformation in this area, which, if well implemented, will better position federal agencies to achieve mission effectiveness and reduce operating costs. But VA and other agencies face common challenges, such as competing stakeholder interests in real property decisions. In VA's case, this involves achieving consensus among such stakeholders as veterans' service organizations, affiliated medical schools, employee unions, and communities. Recently, bills have been introduced in the Senate and House that would require a minimum 60-day period for congressional committees to review and consider CARES decisions before implementation.[5]

VA's draft National CARES Plan proposes a wide range of health care asset realignments and service enhancements based on analysis of VA's current capacity and accessibility to veterans and projections of the capacity necessary to meet the future health care needs of veterans. This plan includes recommendations for realigning clinical services from certain VA locations to existing VA-owned, new VA-owned, or non-VA-owned health care delivery locations and includes proposals to open some new VA delivery locations and close others. The Commission will play a critical role in

- reviewing the draft national plan and documents that support it,
- collecting information through site visits and public hearings, and
- making specific recommendations to the Secretary based on its acceptance, modification, or rejection (with supporting comments) of VA's draft recommendations.

Like the Commission, our continuing review of CARES is intended to help assure that veterans' health care needs are met effectively and efficiently. In developing our approach, we relied on our prior testimonies and reports,[6] OMB's guidelines for capital planning, VA's CARES guidelines and other documents, VA's capital investment guidelines, and Commission documents. In addition, we spoke with Commission staff and VA's CARES staff. We conducted our work from February through August 2003 in accordance with generally accepted government auditing standards.

In summary, our approach for analyzing CARES decisions will focus on a series of fundamental questions regarding whether

- appropriate alternatives were considered and
- key impacts of competing alternatives were appropriately evaluated.

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[4]See U.S. General Accounting Office, *High Risk Series: Federal Real Property*, GAO-03-122 (Washington, D.C.: January 2003) .
[5]S. 1283, H.R. 2659, and H.R. 2808, 108th Cong. (2003).
[6]See Related GAO Products at the end of this report.

As shown in the figure below, our framework examines whether choices about the development of capital asset realignment alternatives ensure consideration of alternatives that potentially provide the greatest payoffs, particularly in comparison to the status quo, that is, maintaining VA's existing real property infrastructure for the delivery of health care. It also examines the impacts of such alternatives, focusing on comparisons of their key costs and benefits in a manner consistent with OMB and CARES guidelines.

Figure 1: GAO's Framework for Analyzing CARES Decisions

Alternatives	Compared to the status quo, have alternatives been developed that consider:
	
	• health care services, including
	  • individual services?
	  • groups of related services?
	  • all services?
	
	• health care delivery locations, including
	  • existing VA-owned locations?
	  • potential new VA-owned locations?
	  • other federally owned locations?
	  • nonfederally owned locations?
	
	• capital investments, including
	  • renovating existing assets?
	  • acquiring new assets?
	  • disposing of unneeded assets?

Impacts of alternatives	For the status quo and each alternative developed, were key costs and benefits considered regarding: • quality of care? • access to care? • cost to the government? • support for VA's other strategic goals, such as medical education and research? • economic impact on the local community?

Source: GAO.

In our view, the success of CARES depends on ensuring that the best alternatives for meeting veterans' needs within a market are recommended and a transparent public record is developed that sufficiently documents the justification supporting CARES decisions. A complete, fact-based public record can facilitate political consensus by allowing the Congress and other stakeholders to focus their deliberations on trade-offs among the benefits and costs of alternatives for realigning health care assets and enhancing care.

Ensuring That Appropriate Alternatives Are Considered

OMB guidelines state that when evaluating capital assets, a comparison of alternatives is critical for ensuring that the best alternative is selected. In its guidance, OMB challenges decision makers to consider the different ways in which various functions, most notably health care service delivery in VA's case, can be

performed. Moreover, OMB encourages the use of imagination, tempered with experience, to develop ideas that could have the greatest payoffs. In this regard, OMB labeled the development of alternatives the single most important element in that process.

OMB's guidelines also suggest that alternatives include an assessment of the continued viability of existing capital assets. VA currently owns and operates significant investments in real property at 173 health care delivery locations. For CARES purposes, VA designated 77 geographic areas as health care markets with the goal of ensuring the availability of an appropriate continuum of care for veterans in each market. Thus, in the CARES context, assessing the desirability of VA's existing assets would mean evaluating the contribution of VA's current delivery locations to their respective markets' continuum of care. A full assessment of alternatives for any market will require consideration of alternatives to the status quo for each location, including whether some existing locations might need to be supplemented or enhanced and whether it might be better to replace some existing locations with a more effective and efficient configuration of assets. VA's CARES process also targets higher priority situations that warrant special attention, including

- markets with the largest increases or decreases in predicted workload (such as the number of days of inpatient care and outpatient visits) over the next 20 years,
- markets with the largest proportions of veterans who have long travel times to existing VA health care delivery locations,
- individual health care delivery locations that are proximate to each other, and
- individual inpatient care delivery locations that are predicted to have small workloads.

Consistent with OMB and CARES guidelines, our approach will examine whether alternatives considered by VA and the Commission represent the best CARES service realignment outcomes that are potentially available for each individual health care delivery location within the CARES-designated markets. Toward that end, we plan to review whether the evidence indicates that consideration was given to realignment alternatives that reflect an appropriate range of alternatives involving health care services, delivery locations, and capital investments. In terms of the health care services offered at individual locations, alternatives range from maintaining the status quo to closing a delivery location. Intermediate alternatives could involve realigning one or more clinical services (such as vascular surgery or hemodialysis) or groups of related services (such as acute inpatient care or inpatient surgery) from one location to another. In terms of delivery locations, alternatives include maintaining existing or developing new VA-owned delivery locations, collaborating with other federal agencies such as the Department of Defense (DOD), or purchasing care from nonfederal providers such as community hospitals. In terms of capital investment decisions, alternatives include renovating existing assets, acquiring new assets, and disposing of unneeded assets.

Potentially viable alternatives would depend on the individual circumstances within CARES-designated markets, most notably, whether VA owns and operates assets at

more than one health care delivery location in a market. Of the 74 CARES markets currently under consideration,[7] 24 have a single delivery location with significant real property investments, 47 have two or more such locations, and 3 have no locations with significant real property investments. For example, the best alternatives in VA's 24 single-location markets could include the status quo, establishment of a new VA delivery location, collaborating with federal agencies, or purchasing care from private providers. In the 47 markets where VA operates multiple delivery locations, the best alternatives for delivery locations could also involve realigning individual services, groups of services, or all services to nearby VA delivery locations.

Ensuring That Key Impacts of Competing Alternatives Are Evaluated

OMB guidelines state that robust comparisons of costs and benefits facilitate selection among competing alternatives and that information regarding such analyses of competing alternatives should be provided in a simple, easy to understand format. Doing so involves identifying the likely consequences of specific alternatives on key impact areas and then comparing the costs and benefits of competing alternatives to determine which alternative best meets veterans' health care needs effectively and efficiently. Consistent with OMB guidelines, CARES guidelines call for impact analyses of specific costs and benefits to be considered when evaluating health care service realignment alternatives. Our approach to reviewing competing alternatives will focus on whether evidence is available for decision makers and stakeholders to understand the trade-offs among key impact areas—quality of care, access to care, cost to the government, support for VA's other strategic goals, and economic impact on the local community.

Quality of care includes continuity and coordination of care and patient safety. We will examine evidence documenting how alternatives are likely to preserve or improve the quality of care, for example, by ensuring that the volume of procedures will be sufficient to maintain the proficiency of providers, such as surgeons. Similarly, we will examine documentation indicating how outcomes could be affected if there are changes in interdependent services, such as cardiac surgery and intensive care.

Access to health care services is also a key impact area. For CARES, VA defines reasonable access in terms of travel times to its health care delivery locations. We will examine evidence to determine how the percentage of patients currently meeting VA's access goals compares to the expected percentage of patients meeting VA goals under each competing alternative and whether CARES realignments bring services closer to where veterans live. CARES also addresses access to health care in terms of capacity and projected workloads. We will examine evidence of the likely effects of realignment alternatives on ensuring that capacity will match projected demand, an important factor in ensuring reasonable access in terms of waiting times for appointments.

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[7]Three of VA's markets are not currently being considered because VA made realignment decisions for those markets during a pilot phase of the CARES process. These markets cover parts of Indiana, Illinois, Wisconsin, and Michigan.

In addition, the cost to the government, which involves one-time, recurring, and opportunity costs, is another key area in which alternatives can have varying impacts. We will examine evidence documenting how alternatives differ in their life cycle costs—the discounted present value of all one-time capital costs, continuing costs of operation and maintenance, and cost offsets available through potential revenue generation. A focus on life cycle costs is especially critical to assessing the efficiency of resource use when there is significant variation across competing alternatives in the initial one-time capital investment requirements and ongoing costs of operation and maintenance.

Another key element is support of other VA strategic goals. These strategic goals include educating health care professionals, conducting research, and serving as a primary backup to DOD in the event of a national emergency or natural disaster, and other strategic goals related to providing disability compensation and ensuring that veterans' burial needs are met. For example, we will examine evidence documenting how alternatives affect education programs, research opportunities and funding, and VA's ability to meet DOD contingency needs in the event of national emergency.

Economic impact on communities, including employees and local health care delivery systems, is the final key element we will review. For example, we will examine evidence to determine how alternatives could affect employment opportunities and the viability of other health care providers and related businesses and how VA plans to mitigate likely adverse consequences of CARES decisions.

OMB guidelines state that once the impacts on these key elements have been identified for each alternative developed, the best alternative can be identified through an explicit comparison of their relative expected costs and benefits. We will examine evidence to determine whether descriptions of such comparisons demonstrate how the recommended alternative better ensures appropriate quality of care, reasonable access to care, reasonable cost to the government, effective support for other VA strategic goals, and acceptable economic impact on communities. Because decisions will typically involve trade-offs between benefits and costs, we will focus especially on whether the priorities that influenced trade-off choices were clearly articulated. Finally, we will examine the explanations to determine if decisions in different markets were based on different priorities and if so, whether such differences were well documented.

Concluding Observations

Veterans and stakeholders such as affiliated medical schools, employee unions, communities, and the Congress will likely be more confident that CARES service realignments and enhancements represent the best alternatives for meeting veterans' health care needs if the public record provides transparent and well-supported answers to the types of questions we are using in our approach. Reaching consensus on the realignment of VA's health care capital assets as expeditiously as possible

depends on the sufficiency of the information provided in support of CARES decisions and the clarity of that documentation.

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We will send copies of this report to interested congressional committees and the Secretary of Veterans Affairs. The report will also be available at no charge on GAO's Web site at http://www.gao.gov. We will make copies available to others upon request. If you have questions, please contact me at (202) 512-7101 or Paul Reynolds at (202) 512-7109. Kristen Joan Anderson and Frederick Caison also contributed to this report.

Sincerely yours,

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

Related GAO Products

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

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

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

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

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

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

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

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

Veterans' Affairs: Progress and Challenges in Transforming Health Care. GAO/T-HEHS-99-109. Washington, D.C.: April 15, 1999.

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

Executive Guide: Leading Practices in Capital Decision-Making. GAO/AIMD-99-32. Washington, D.C.: December 1998.

VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services. GAO/HEHS-98-64. Washington, D.C.: April 16, 1998.

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