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United States Government Accountability Office

GAO

Report to the Honorable Christopher S. Bond, U.S. Senate

August 2005

VA HEALTH CARE

Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care

GAO-05-429

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Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care

GAO Accountability·Integrity·Reliability

Highlights

Highlights of GAO-05-429, a report to the Honorable Christopher S. Bond, U.S. Senate

Why GAO Did This Study

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

In response, VA initiated its Capital Asset Realignment for Enhanced Services (CARES) process to identify what health care services it should provide in which locations through fiscal year 2022. CARES resulted in decisions to realign inpatient services at some VA facilities and to leave services as currently aligned at others. VA did not complete inpatient alignment decisions across VA for long-term care and mental health services and for inpatient services at some facilities because VA lacked sufficient information on demand for such care and other factors.

GAO was asked to examine key challenges VA will face in completing and implementing CARES. This report discusses three key challenges: (1) developing information to complete inpatient alignment decisions, (2) improving management of excess property, and (3) determining priorities for purchasing care to improve access. GAO's analysis is based on its prior CARES work, review of CARES documents, and interviews with VA officials.

www.gao.gov/cgi-bin/getrpt?GAO-05-429.

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

What GAO Found

VA faces a key challenge in developing sufficient information to complete inpatient service alignment decisions. VA concluded that it did not have sufficient information to complete such decisions across VA for long-term care (including nursing home care) and mental health services (including acute psychiatric care). VA also concluded that it did not have sufficient information to complete alignment decisions for inpatient services at 12 facilities. VA faces this challenge for several reasons. For example, it is unclear whether VA has adequate information on the number of veterans who will seek nursing home care and inpatient mental health services from VA on a daily basis because it concluded that its models were inadequate to forecast demand and it has not finalized revised models. VA has taken steps to address the challenge of developing the information needed such as working to develop improved models of demand for these services.

Improving the management of VA's large inventory of excess property—including 8.5 million square feet of vacant space—poses another key challenge. This challenge results from disincentives associated with administrative complexity and costs of the disposal of federal property. Like all federal agencies, VA must comply with federal requirements governing property disposal that are intended, for example, to protect subsequent users of the property from environmental hazards. Some VA managers have retained excess property because the complexity and costs of complying with these requirements were disincentives to disposal. Congress has given VA authority to use disposal proceeds for construction and renovation of VA patient facilities and disposal activities, to the extent specified in appropriations acts. VA is taking steps to address this challenge, including hiring network-level capital asset managers to facilitate disposal.

VA faces another key challenge in determining priorities for the purchase of inpatient services to improve access to care. While VA determined that purchasing inpatient services from non-VA health care providers in 25 health care markets would be a reasonable option for providing care closer to where veterans live, VA's network managers have to balance the costs and benefits of purchasing care against competing priorities. VA has taken steps to facilitate managers' development of information they need to decide among priorities, including information on the cost effectiveness of proposed contracts and their impact on other health care priorities.

To improve its management of capital assets and enhance veterans' health care by reinvesting resources now spent on excess property, VA must overcome challenges in completing and implementing decisions reached through CARES. Furthermore, institutionalizing the CARES process into its ongoing strategic planning will be crucial to VA's effectiveness as a steward of national resources and a health care provider for the nation's veterans.

VA concurred with GAO's findings and conclusions.

Contents

Abbreviations

CARES	Capital Asset Realignment for Enhanced Services
DOD	Department of Defense
GSA	General Services Administration
VA	Department of Veterans Affairs

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

August 5, 2005

The Honorable Christopher S. Bond
United States Senate

Dear Senator Bond:

The Department of Veterans Affairs (VA) operates one of the largest health care systems in the country. In fiscal year 2004, VA provided health care to nearly 4.7 million of the 7.4 million veterans who were enrolled for VA health care services. To support its mission, VA has a diverse inventory of real property—VA reported in February 2005 that its capital assets included more than 5,600 buildings and about 32,000 acres of land.[1] 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 21st century. In numerous reports and testimonies, we found that better management of VA's buildings and land could significantly reduce operating and maintenance costs and that these resources could be reinvested to enhance veterans' health care services.[2] Because of similar shortcomings in the management of capital assets across the government, we designated real property management as a high-risk area in order to highlight the need for federal agencies, including VA, to address long-standing problems with excess real property. These problems include underutilized and vacant building space and unneeded land.[3]

[1]Department of Veterans Affairs, *5-Year Capital Plan 2005-2010* (Washington, D.C.: February 2005).

[2]See Related GAO Products at the end of this report.

[3]We have reported that over 30 federal agencies, including VA, control a valuable portfolio of facilities and land that is at high risk due to vulnerabilities to waste, fraud, abuse, and mismanagement or major challenges associated with their economy, efficiency, or effectiveness. See GAO, *High-Risk Series: Federal Real Property*, GAO-03-122 (Washington, D.C.: January 2003); *High-Risk Series: An Update,* GAO-05-207 (Washington, D.C.: January 2005); and *Federal Real Property: Further Actions Needed to Address Long-standing and Complex Problems*, GAO-05-848T (Washington, D.C.: June 22, 2005).

In response to our recommendations in 1999 for improving VA's capital asset planning and budgeting,[4] VA initiated a process known as Capital Asset Realignment for Enhanced Services (CARES). CARES was designed to assess VA's buildings and land ownership in light of expected demand for VA inpatient and outpatient health care services through fiscal year 2022. Through CARES, VA sought to determine what health care services veterans would need in what locations. VA existing locations included VA's 172 medical facilities,[5] 77 health care markets,[6] and 21 health care networks.[7]

In May 2004, the Secretary of Veterans Affairs announced decisions resulting from the CARES process. This announcement included decisions to realign VA's inpatient health care services at a number of facilities to improve quality, efficiency, or accessibility and to leave inpatient services as currently aligned at other facilities.[8] Among these inpatient services were tertiary care; the acute inpatient services of medicine, surgery, and psychiatry; nursing home care; long-term psychiatric care; residential rehabilitation; domiciliary care;[9] and specialized inpatient services treatment of spinal cord injury and disorder. However, VA did not complete all its inpatient alignment decisions in the CARES process

[4]See GAO, *VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting,* GAO/HEHS-99-145 (Washington, D.C.: Aug. 13, 1999).

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

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

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

[8]In this report, we define realignment of an inpatient service as (1) eliminating the service in its entirety at a facility where VA provided it, (2) adding an inpatient service to an existing VA facility where VA did not provide the service, or (3) establishing a new VA medical facility where VA did not own capital assets.

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

because it concluded that it lacked sufficient information to do so. VA did not complete inpatient alignment decisions across VA for long-term care (including nursing home care) and mental health services (including acute and long-term psychiatry, residential rehabilitation, and domiciliary care). VA also did not complete inpatient alignment decisions at some facilities. In his May 2004 announcement of CARES decisions, the Secretary stated that VA would improve its management of excess property by pursuing options to dispose of or lease excess property and reinvest resources now used to maintain excess property to enhance health care to veterans.[10] The Secretary also announced that VA planned to improve access to acute inpatient services—which include medicine, surgery, and psychiatry—and access to tertiary care[11] by purchasing services from non-VA providers in 25 markets. In these markets, where VA determined that a large number of veterans face lengthy driving times from their homes to the nearest VA inpatient facility, the Secretary indicated that a reasonable option for providing these services closer to where veterans live is to purchase acute inpatient and tertiary care services rather than provide these inpatient services in VA-owned facilities.

In your former capacity as Chairman of the Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate, you asked that as part of our review of the CARES process, we examine key challenges VA will encounter when completing and implementing CARES decisions.[12] This report examines three key challenges—(1) developing information needed to complete inpatient alignment decisions, (2) improving management of VA's large inventory of excess property, and (3) determining priorities for the purchase of inpatient services from non-VA providers to improve access to care.

[10]The Secretary's CARES announcement also included other decisions to better align VA's capital assets with projected needs, such as reconfiguring facility space to meet projected demand for services, modernizing facilities to provide services more appropriately, and improving the alignment of outpatient services.

[11]Tertiary care includes specialized diagnostic and treatment procedures, such as open-heart surgery or neurosurgery, that are not necessarily available at all medical facilities that provide acute inpatient care.

[12]Earlier this year, we provided a summary of locations where VA (1) identified a need to evaluate alternative ways to align inpatient health care services and (2) made decisions to realign inpatient services or leave inpatient services as aligned, or deferred decisions pending further study. See GAO, *VA Health Care: Important Steps Taken to Enhance Veterans' Care by Aligning Inpatient Services with Projected Needs,* GAO-05-160 (Washington, D.C.: Mar. 2, 2005).

To examine these challenges, we relied on our prior work on the CARES process and the conditions in VA's health care system that led to the CARES process. To track key planning issues as they emerged during the CARES process, we attended CARES-related meetings, such as those held by the CARES Commission, an independent Commission appointed by VA that was charged with making CARES recommendations to the Secretary. We also reviewed major CARES documents and interviewed CARES Commission and VA CARES program office officials. To identify what actions VA is taking to address these challenges, we reviewed VA's capital asset and CARES documents and interviewed VA officials involved in implementing the Secretary's decisions. We conducted our work from October 2003 through July 2005 in accordance with generally accepted government auditing standards.

Results in Brief

VA faces a key challenge in developing sufficient information to complete inpatient service alignment decisions. VA did not complete all its inpatient alignment decisions in the CARES process because it concluded that it lacked sufficient information to do so. VA did not complete inpatient alignment decisions across VA for long-term care (including nursing home care) and mental health services (including acute and long-term psychiatry, residential rehabilitation, and domiciliary care). VA also lacked sufficient information to complete its inpatient alignment decisions for services at 12 facilities. VA faces the challenge of developing sufficient information to complete its inpatient alignment decisions for several reasons. First, it is unclear whether VA has adequate information on the number of veterans who will seek inpatient long-term care and mental health services from VA on a daily basis. In VA's May 2004 announcement of CARES decisions, VA concluded that that its models were inadequate to forecast demand. While VA officials told us they are developing models and forecasts of demand for VA care, these revised models and forecasts are not completed. Second, VA does not know what portion of this demand it will meet because it has not made the policy determinations that would allow it to generate information concerning which veterans it will serve among those seeking nursing home care and which services it will offer. Third, VA has not finalized its strategic plan for long-term care, which would provide information for determining where VA needs to provide these services. VA also faces information challenges in completing inpatient alignment decisions for services at 12 of VA's 172 facilities. Development of this information will be challenging because VA concluded in its May 2004 announcement of CARES decisions that it does not have sufficiently precise information on the potential costs and benefits of various alignment options to make decisions for these facilities

and address related concerns of veterans and stakeholders. VA has taken several steps to address the challenge of developing sufficient information to complete its remaining inpatient alignment decisions. These steps include working to develop improved models of future demand for long-term care and mental health services, proposing policies about which veterans it will provide long-term care to, and hiring a contractor to obtain information on the costs and benefits of alternative ways to align inpatient services at 12 facilities where these decisions were not completed.

Improving the management of VA's large inventory of excess real property—including 8.5 million square feet of vacant space—poses another key challenge for VA. This challenge results from the disincentives associated with the administrative complexity and costs of disposing of federal property. Like all federal agencies, VA must comply with federal laws and regulations governing property disposal that are intended, for example, to protect subsequent users of the property from environmental hazards and to preserve historically significant sites. Federal agencies are required by law to assess and pay for any environmental cleanup that may be needed before disposing of property—an administrative process that may require years of study and result in significant costs. As valuable as these legal requirements are, their administrative complexity and the associated costs of complying with them create disincentives to the disposal of excess property. For example, some VA managers have retained excess property because the administrative complexity and costs of complying with these requirements were disincentives to disposal. Congress has given VA authority to use disposal proceeds for construction and renovation of VA patient facilities and for disposal activities, to the extent specified in appropriations acts. VA also faces difficulties in the leasing process. These include the long amount of time needed to establish leases and some local managers' lack of expertise in negotiating these leases. VA is taking steps to better manage excess property by strengthening its disposal process through such measures as establishing network-level capital asset managers, who will facilitate the disposal of excess property. VA is also taking steps to expedite its leasing process by granting authority to the capital asset managers to make some leasing decisions.

VA faces another key challenge in determining priorities for the purchase of inpatient services from non-VA providers to improve access to care by making these services available closer to where veterans live. While VA determined that in 25 markets purchasing acute and tertiary inpatient services from non-VA providers would be a reasonable option for providing these services closer to where veterans live, VA's network

managers in these markets have to balance the costs and benefits of purchasing non-VA care against competing priorities. These managers have to determine whether, when, and to what extent they should use their resources to purchase acute and tertiary care services from non-VA providers and to what extent resources should be spent on other competing priorities, such as improving access to long-term care, mental health, and primary care services. VA's purchase of acute and tertiary care services could reduce driving times for such care for about 800,000 enrolled veterans, although only a small number of these veterans will need inpatient services in a given year. To help network managers, VA is developing guidance that requires them to develop information on the cost effectiveness of proposed contracts and on the potential impact of these contracts on other health care services in the network.

VA concurred with our findings and conclusions.

Background

VA dramatically transformed its health care delivery system over the last decade. A central goal of this transformation has been to reduce the need for, and the length of, inpatient hospital stays by providing primary care in outpatient settings and taking advantage of technological advances that reduce the need for hospitalization. VA developed a continuum of care grounded in outpatient settings; made available a broader array of services, including preventive care; and opened hundreds of community-based outpatient clinics. As a result, VA reduced the length of inpatient stays while providing health care to a growing number of veterans. From fiscal year 1996 through fiscal year 2004, VA's national acute inpatient daily census fell by nearly 40 percent while the number of veterans who received health care from VA increased by about 76 percent (2 million). As VA increased its emphasis on outpatient care rather than inpatient care, VA was left with an increasingly obsolete infrastructure, including many hospitals built or acquired more than 50 years ago in locations that are sometimes far from where veterans live.

To address its obsolete infrastructure, VA initiated its CARES process—the first comprehensive, long-range assessment of its health care system's capital asset requirements since 1981. Since its inception in 1999, VA's CARES process has reached several major milestones (see table 1).

Table 1: Milestones in VA's CARES Process

Date	Milestone	Description
February 2002	VA announced the results of a pilot CARES study.	The pilot study assessed current and future use of health care assets in the three markets of Network 12, which includes parts of five states: Illinois, Indiana, Michigan, Minnesota, and Wisconsin. It resulted in decisions to realign health care services and renovate or dispose of several buildings.
August 2003	VA's Under Secretary for Health presented the Draft National CARES Plan.	The Under Secretary's Draft National CARES Plan included recommendations about health care services and capital assets in VA's remaining 74 markets. These recommendations reflected input from managers of VA's health care networks.
February 2004	An independent CARES Commission issued recommendations.	An independent 16-member commission appointed by the Secretary of Veterans Affairs issued recommendations to the Secretary based on its review of the Draft National CARES Plan and related documents and information obtained through public hearings, site visits, public meetings, written comments from veterans and other stakeholders, and consultations with experts.
May 2004	VA's Secretary announced the CARES decisions.	The Secretary based his decisions on a review of the CARES Commission's recommendations.

Source: GAO analysis of VA data.

The remaining steps in the CARES process include completing alignment decisions for inpatient services, implementing decisions that have been completed, and institutionalizing CARES. Institutionalizing CARES will involve integrating the CARES process—a systematic, data-driven framework for evaluating VA's capital assets in light of projected demand for VA health care services—into VA's ongoing strategic planning efforts. In the announcement of CARES decisions in May 2004, the Secretary of Veterans Affairs stated that through the CARES process VA had developed more complete information about the demand for VA health care and a more comprehensive assessment of its capital assets than it ever had before. The Secretary noted that this information, along with the experience gained through conducting CARES, positioned VA to continue to expand the accuracy and scope of its planning efforts. The Secretary stressed that VA would focus on integrating the CARES process into its

annual strategic and capital planning efforts in order to ensure that VA uses the best information available when making plans to meet the health care needs of current and future veterans.[13]

VA Faces a Challenge in Developing Information Needed to Complete Decisions on the Alignment of Inpatient Services

VA faces a key challenge in developing sufficient information to complete inpatient service alignment decisions. VA did not complete all its inpatient alignment decisions in the CARES process because it concluded that it lacked sufficient information to do so. VA did not complete inpatient alignment decisions across VA for long-term care (including nursing home care) and mental health services (including acute and long-term psychiatry, residential rehabilitation, and domiciliary care). VA also lacked sufficient information to complete its inpatient alignment decisions for services at 12 facilities.

Developing Information Needed to Complete Inpatient Alignment Decisions for Long-Term Care and Mental Health Will Be Challenging

Developing information needed to complete inpatient alignment decisions for long-term care and mental health services across VA will be difficult for three reasons. First, it is unclear whether VA has adequate information on the number of veterans who will need and seek inpatient long-term care and mental health services from VA on a daily basis because VA has not finalized models for projecting future demand for these services. In VA's May 2004 announcement of CARES decision, VA concluded that its models were inadequate to forecast demand. As a result, VA did not complete its inpatient alignment decisions for these services across VA.[14] While VA officials told us that they have subsequently revised models and forecasts of demand for care from VA, these models and forecasts are not finalized.

[13]As VA implements the decisions it reached and integrates the CARES process into its ongoing strategic planning efforts, its options for studying certain alignment options may be affected by a statutory limitation on its use of health care funds. Section 8110(a)(5) of title 38, United States Code, prohibits VA from using funds appropriated for "medical care, medical and prosthetic research, and medical administration and miscellaneous operating expenses" for any studies comparing the costs of services provided by private contractors with those provided by VA, including as part of the CARES process, unless the funds are specifically made available for that purpose. VA may, however, use other funds to conduct such studies, for example, funds for construction of major projects. See GAO, *Veterans Health Administration—Appropriations for CARES Cost Comparison Studies,* B-302973 (Washington, D.C.: Oct. 6, 2004).

[14]VA, however, made some inpatient long-term care and mental health alignment decisions for some locations.

Second, VA has not made the policy determinations that would allow it to generate information concerning which veterans it will serve in the future among those seeking long-term care—including nursing home care—and the nursing home care services it will offer. Completing inpatient alignment decisions for nursing home care requires having a technical forecast of how many veterans will need and seek care from VA, and requires information generated from policy decisions concerning which veterans VA will serve and which nursing home services VA will provide.[15] VA lacks this information because it has not determined criteria to be used to identify which veterans it will serve as a matter of policy, in addition to those required by law, criteria such as a veteran's level of service-connected disability or income.[16] In addition, VA lacks information on which services will be provided, such as specifying to whom it will provide nursing home care for short-stay care rehabilitation of post-acute conditions such as hip replacement and to whom it will provide long-stay support and supervision for chronic conditions such as dementia. VA officials told us that such policy decisions have not been made and, as a result, VA's long-term care model cannot provide the forecasts of workload demand that are needed to make inpatient alignment decisions.

Third, VA has not finalized its strategic plan for long-term care, which would provide information for determining where VA needs to provide these services and the types of services needed.[17] Developing adequate models for forecasting likely demand and resolving policy issues for inpatient long-term care would provide key information needed to develop a long-term care strategic plan. According to the Secretary's May 2004 summary of CARES decisions, an important element of the strategic plan for long-term care will be the goal of ensuring that veterans' access to an appropriate range of these services is equitable. This plan would help VA decide whether its current facilities and inpatient services are in the best

[15]VA estimates indicate that it does not provide nursing home services to most veterans who need them. Instead most veterans who need nursing home care rely on other payers such as Medicaid and Medicare for nursing home services. VA provided or paid for nursing home care for over 33,000 veterans daily in fiscal year 2003.

[16]The Veterans Millennium Health Care and Benefits Act requires that VA provide nursing home care to those veterans with a service-connected disability rated at 70 percent or greater, those requiring nursing home care because of a condition related to their military service who do not have a service-connected disability rating of 70 percent or greater, and those who were admitted to VA nursing homes on or before the effective date of the act. Pub. L. No. 106-117, §101(a), 113 Stat. 1545, 1547 (1999).

[17]VA approved its Mental Health Strategic Plan in November 2004.

locations to meet future demand or whether changes are needed to better align these facilities and services with demand.

Developing Information Needed to Complete Inpatient Alignment Decisions at 12 Facilities Will Be Challenging

Developing information needed to complete inpatient alignment decisions at 12 of VA's 172 facilities will be challenging because VA does not have sufficiently precise information to evaluate tradeoffs between the costs and benefits of various alignment options.[18] (See table 2 for a list of these facilities and their corresponding networks.) In some cases, these alignment decisions include inpatient long-term and mental health services. In general, VA concluded in its May 2004 announcement of CARES decisions that it does not have sufficient information to determine whether to maintain inpatient services as currently aligned at these facilities or to realign the services. For example, in the Boston area, VA provides inpatient care in 4 outdated facilities.[19] VA concluded that it did not have sufficient information about the cost-effectiveness and benefits of building a replacement hospital in the area. VA also lacked sufficient information about how to preserve veterans' access to nursing home services if such services in the Boston area are realigned.

[18]Inpatient alignment decisions were not completed at five other locations as noted in the Secretary's May 2004 CARES announcement. VA considered these inpatient alignment decisions less challenging to complete than such decisions at other locations. VA conducted studies needed for decisions at three of these locations (at facilities in Chillicothe, Ohio; Detroit, Michigan; and Tampa, Florida), had not completed a study for another location (Network 16, which is headquartered in Jackson, Mississippi) as of March 2005, and plans a study for the fifth location (Lake City, Florida).

[19]The four facilities require renovations to meet health care delivery, mechanical, privacy, and safety standards.

Table 2: Twelve VA Medical Facilities and Their Networks Where Decisions on the Alignment of Inpatient Services Are Incomplete

VA medical facility	Network
Bedford, Mass.	1
Brockton, Mass.	
Jamaica Plain, Mass.	
West Roxbury, Mass.	
Brooklyn, N.Y.	3
Manhattan, N.Y.	
Montgomery, Ala.	7
Poplar Bluff, Mo.	15
Muskogee, Okla.	16
Waco, Tex.[a]	17
Big Spring, Tex.	18
Walla Walla, Wash.	20

Source: GAO analysis of VA data.

[a]A decision to realign inpatient services at VA's medical facility in Waco could result in the addition of inpatient services at other VA medical facilities, such as the one in Temple, Texas.

Similarly, VA faces a challenge developing sufficient information about the costs and benefits of options to make alignment decisions for inpatient services at its medical facility in Waco, Texas. In October 2003, network officials estimated that in the absence of a realignment of services at the Waco facility, which is primarily a psychiatric care hospital, VA will need about $1.5 million a year to maintain unused space at the facility, and that through 2022 the facility will require an additional $61 million for nonrecurring capital costs such as renovation. Options for realigning inpatient services at the Waco facility include moving some services, such as acute inpatient psychiatry, to other locations, such as VA's medical facility in Temple, Texas.[20] VA faces a challenge weighing these options and completing its alignment decision because VA has concluded that it lacks sufficient information on the possible savings it would achieve through realignment and the likely costs of construction at the Temple facility if services are added there. VA also concluded that it lacked

[20]Another option proposed was closing the nursing home service at Waco. However, the CARES Commission did not support closing the nursing home services at the Waco facility because it was not clear to the Commission that it would be possible to contract for the type of nursing home services that VA provides at this facility.

sufficient information on access to inpatient services and continuity of care for veterans who currently receive health care services at the Waco facility. This information could help VA weigh options for the alignment of inpatient services at the Waco facility. This could also help VA address the concerns of stakeholders—including veterans' service organizations, elected officials, and employee representatives—who will be affected by changes at the Waco facility. A group of stakeholders with concerns has asked to work with VA to develop alternatives for the facility and to assist in finding ways to lease the facility's unused buildings and excess property.

VA could use information on the costs and benefits of various alignment options not only to complete its inpatient alignment decisions for the 12 facilities, but also to address the concerns of stakeholders and others. Stakeholders—including veterans' service organizations, affiliated medical schools, employee unions, and communities—as well as decision makers and veterans are more likely to have confidence in decisions at specific VA medical facilities when VA can present sufficient information about the key costs and benefits of alternative options for the alignment of inpatient services. Costs and benefits to be considered are the impacts these alternatives would have on the quality of and access to care; the cost to the government; VA's other strategic goals, such as the medical education of health care providers and research; and the local community's economy.[21] If VA had this kind of information, it would be better positioned to make decisions and address concerns raised by veterans and stakeholders. In the past, some stakeholders have opposed proposed changes to VA's health care system that they felt were not in the best interests of their members, even when those changes could have benefited veterans.[22] For example, medical schools' reluctance to change long-standing relationships with VA medical facilities has sometimes been a major factor inhibiting VA's asset management. Similarly, unions have been reluctant to support decisions that involve restructuring services when doing so could result in staffing reductions.

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

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

VA Has Taken Steps to Develop Information Needed to Complete Inpatient Alignment Decisions

VA has taken several steps to address the challenge of developing sufficient information to complete its remaining inpatient alignment decisions. These steps include developing information for completing inpatient alignment decisions for long-term care and mental health across VA and information for completing decisions for inpatient services at the 12 facilities.

For long-term care and mental health, VA officials told us that VA has developed more adequate models to forecast the number of veterans who will need and seek these services from VA on a daily basis in the future than the models considered for use in the CARES process. However, VA officials have not finalized the long-term care and mental health models or forecasts and said that they will continue to refine these models. Regarding the policy determinations to generate information for inpatient long-term care, VA has included a proposal in its current appropriations request to revise its policy on which veterans it will provide nursing home services to and the extent to which it will provide short-stay and long-stay care beginning in fiscal year 2006. However, the proposal has not yet been made policy. VA officials told us that they are trying to address whether they can develop the information needed to incorporate into VA's nursing home model and projected demands for services before these policy issues are resolved.

VA has taken several steps to develop the information it needs to complete decisions on the alignment of inpatient services at the 12 medical facilities where alignment decisions are not complete. VA hired a contractor in January 2005 who will be responsible for developing information on the costs and benefits of specific options for aligning inpatient services at these 12 facilities. To ensure stakeholder involvement in developing this information, VA gave notice of the establishment of the Advisory Committee for CARES Business Plan Studies in October 2004, under the Federal Advisory Committee Act, which includes an advisory subcommittee for each location. These committees include both network staff and local stakeholders and will help develop information about the concerns of veterans, employees, and other stakeholders or interest groups, for example, by holding public meetings. To further assist the contractor and carry out other responsibilities, in June 2004, VA established a new headquarters office, the Office of Strategic Initiatives, which will oversee the completion of these studies.

VA Faces a Challenge in Improving Management of Excess Property

Improving the management of VA's large inventory of excess real property—including 8.5 million square feet of vacant space—poses another key challenge to VA. This challenge results, in part, from the disincentives associated with the administrative complexity and costs of disposing of federal property. In addition, the lengthy process required to establish leases, along with some local managers' lack of expertise needed to negotiate these leases, adds to VA's challenge. VA has taken steps to address some of these difficulties.

Managing excess property is challenging for VA in part because of the disincentives associated with the administrative complexity and costs involved in the disposal of federal property. Like all federal agencies that own facility space or other forms of real property,[23] VA must comply with federal requirements governing property disposal that are intended to protect subsequent users of the property from environmental hazards and preserve historically significant sites.[24] For example, federal agencies are required to assess and pay for environmental cleanup that may be needed before disposing of property[25]—a process that can require years of study and result in significant costs. Moreover, federal agencies that own buildings designated as historic structures must comply with provisions of the National Historic Preservation Act,[26] which requires agencies to manage historic properties under their control and consider the effects of their actions on historic preservation. About 30 percent of VA's buildings have been designated as historically significant. In addition, like other federal agencies, VA must generally make excess federal facilities available to other federal agencies and programs for the homeless when disposing of property. As valuable as these legal requirements are, their administrative complexity and the associated costs of complying with them create disincentives to the disposal of excess property. VA officials

[23]VA, the United States Postal Service, and GSA are the largest holders of federally owned space after the Department of Defense (DOD).

[24]VA must also comply with federal requirements governing the leasing of its property. These requirements can be administratively complex and costly. For example, VA must comply with federal environmental and historic preservation requirements before entering into leasing agreements.

[25]See 42 U.S.C. § 9620 (2000). See also GAO-03-122. Additionally, a VA official explained that the costs of an environmental study for a medical center could be considerable due to the need to assess, for example, the presence of radioactive materials left over from nuclear medicine procedures.

[26]16 U.S.C. §§ 470 *et seq.* (2000).

told us these requirements have contributed to some managers' decisions to retain excess property rather than pursue disposal.[27] In general, disposal of VA property, until November 2004, was controlled by the General Services Administration (GSA). Since 1990, VA disposed of no properties through this process and few properties through other means.

In November 2004, Congress gave VA greater discretion in managing the disposal of excess property.[28] VA had requested changes in its disposal authority to address disincentives that VA managers believed impeded their progress in disposing of excess property. The disincentives included administrative complexity and a limitation that allowed use of disposal proceeds only for nursing home construction and renovation. Changes in VA's disposal authority included permitting VA to directly manage the disposal of excess property instead of using the disposal process managed by GSA. In addition, VA was granted the authority—to the extent specified in appropriations acts—to use proceeds from disposal not only for nursing home construction and renovation but for use in construction or renovation of other VA patient facilities or to defray expenses associated with their disposal requirements.

VA officials acknowledge that direct management of the disposal process gives VA managers more flexibility in managing the disposal of excess buildings and land. However, they maintain that to dispose of excess property VA managers still face disincentives associated with legal requirements to address potential environmental hazards and the preservation of significant historical sites prior to disposal. In addition, VA officials acknowledge that even though VA may now use disposal proceeds for improving or disposing of other VA buildings, they believe the use of the funds for specific projects is subject to congressional approval in the appropriations process each year. VA officials also told us they believe that VA effectively derives no new funds from this authority because, in practice, funds obtained from the disposal process would be deducted each year from the amount that Congress appropriates.

Unlike most federal agencies, VA has authority to enter into leases with other organizations, called enhanced-use leases, but VA managers face

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

[28]Veterans Health Programs Improvement Act of 2004, Pub. L. No. 108-422, § 411, 118 Stat. 2379, 2388-2390.

difficulties in leasing excess property to non-VA organizations under this authority.[29] Specifically, the length of time needed to review and approve leases poses a challenge to VA in leasing excess property. For example, to establish leases, VA has had to negotiate with entities in the community that are interested in leasing VA property and obtain public comment and perform multiple rounds of review and approval by VA network and headquarters officials. The leases VA has established include, for example, partnerships for parking garages, child development centers, and senior housing. Contributing to the length of the leasing process is a requirement that VA quantify the benefits that veterans will likely derive from a lease—a task that officials say can be difficult and time consuming. For example, if VA establishes a lease for a child development center that may help in the recruitment and retention of VA staff to provide health care, VA is required to quantify the benefits to veterans of the child development center.

Another difficulty that has hindered VA's leasing activities has been that some local managers lacked the expertise needed to develop, negotiate, and finalize leases. Such expertise includes legal, real estate, marketing, and financial skills. The CARES Commission found that the lack of expertise made it difficult for VA to attract potential investors and navigate local zoning and land use requirements. Although the Commission noted that some VA networks had been successful in arranging leases for excess property, relatively few leases have been established since 1991, when VA was given authorization to lease excess property.[30]

VA has taken steps to address the difficulties associated with the disposal of excess property. For example, VA created a new position—the capital asset manager—in each of its networks to strengthen its management of excess property. These managers will be responsible for a number of tasks involving capital assets, including facilitating the disposal of excess property. The capital asset managers will also be responsible for ensuring that VA has current data on the condition and the use of its buildings and

[29]38 U.S.C. §§ 8161-8169 (2000). VA has authority to enter into leases with non-VA organizations to create partnerships in which VA contributes real property and the non-VA organization contributes financial capital and borrowing ability to redevelop or renovate real property to benefit veterans and others. Most federal agencies do not have similar authority.

[30]At the time the Commission conducted its review, VA had awarded 30 leases. As of March 2005, VA had awarded 45 leases, of which 41 are active.

land. VA officials reported that they sought capital asset manager candidates with experience in the disposal of federal real property as a means to improve VA's ability to manage its own disposal process. In addition, VA is developing an agencywide capital asset disposal policy that is designed to guide managers' efforts to reduce VA's inventory of unneeded property.

VA is also taking steps to address the difficulties it faces in developing enhanced-use leases of its excess property. To streamline VA's preparation of leasing proposals, VA recently granted authority to its capital asset managers to make some enhanced-use leasing decisions, such as conducting feasibility studies, creating enhanced-use lease business plans, and writing leases and memoranda of understanding. VA expects this will expedite its leasing process. The new capital asset managers will also be responsible for identifying leasing opportunities and negotiating leases. To facilitate leasing activities, including some that were identified in CARES, VA is making real estate, legal, marketing, financial, and other types of expertise available to network managers through a contract awarded in April 2005. According to VA officials, this expertise will help network managers develop key information, such as the potential market value of VA's excess property.[31]

[31]In addition, VA will conduct formal studies of 28 of its medical facilities to develop proposals for leasing and disposal of excess property. Studies of 3 of the 28 facilities are under way and a contract was awarded in April 2005 for the study of 22 other facilities. Studies of the 3 remaining facilities have been postponed pending future VA action at a nearby VA medical facility.

VA Faces a Challenge in Determining Priorities for the Purchase of Inpatient Services from Non-VA Providers to Improve Access to Care

VA faces another key challenge in determining priorities for the purchase of inpatient services from non-VA providers to improve access to care by making these services available closer to where veterans live. While VA determined that in 25 markets purchasing acute and tertiary inpatient services from non-VA providers would be a reasonable option for providing these services closer to where veterans live, VA's network managers, who are responsible for making such decisions, have to balance these efforts against competing priorities.[32] Improving veterans' access to inpatient acute and tertiary care through purchased care is one of many priorities that VA managers may support with their available resources.[33] As a result, VA managers have to weigh the costs and benefits of various uses of their resources to determine whether, when, and to what extent they should purchase acute and tertiary care services from non-VA providers and to what extent resources should be spent instead, for example, on improving access to long-term care, mental health, and primary care services.

VA determined that in 25 markets a large number of enrolled veterans face driving times that exceed VA standards in order to obtain inpatient acute and tertiary care services at the nearest VA-owned or VA-affiliated medical facility.[34] VA also determined that in these 25 markets the number of veterans facing lengthy driving times[35] was not sufficient to justify building a new VA facility and that a reasonable option for reducing these driving

[32]VA's network managers have many responsibilities, including allocating resources for health care services in their network.

[33]VA already purchases inpatient care in locations across the country.

[34]For acute care, VA considers driving times to be lengthy if they exceed 60 minutes in urban areas, 90 minutes in rural areas, or 120 minutes in highly rural areas. For tertiary care, VA considers driving times to be lengthy if they exceed 240 minutes for urban areas, 240 minutes in rural areas, and the community standard for highly rural areas. VA used a zip-code-based analysis to calculate driving times from veterans' homes to the nearest VA-owned or VA-affiliated medical facility that provided acute or tertiary care. VA-affiliated medical facilities include hospitals that are owned by non-VA providers where VA has arranged for VA staff to provide care to veterans.

[35]VA considered a market to have a large number of veterans facing lengthy driving times when more than 35 percent—and at least 12,000—of the veterans enrolled for VA health care in that market had driving times that exceeded VA standards.

times would be to purchase inpatient services from non-VA providers.[36] (See app. I for a list of the 25 markets and a description of the geographic areas that each market covers.) About 800,000 enrolled veterans could potentially benefit from the purchase of these inpatient services, according to our estimate using VA data for fiscal year 2001. The number of enrolled veterans potentially affected in any one of the 25 markets ranged from about 13,000 to 76,000. The number of these enrolled veterans who would actually need inpatient services in a given year would be substantially less than the total number of enrollees and would depend on a variety of factors such as age, gender, and health status.

VA's experience in Chattanooga, Tennessee, although not located in one of the 25 markets, illustrates the challenge network managers face in balancing competing priorities.[37] VA does not have an inpatient facility in Chattanooga, and most veterans in the Chattanooga area face drives of 2 or more hours to obtain inpatient care at VA's medical centers in Murfreesboro and Nashville, Tennessee. To reduce these driving times, VA contracted for acute inpatient services with a non-VA medical center in Chattanooga from September 2000 through August 2002. This arrangement did not, however, substantially improve veterans' access to inpatient care because network managers restricted referrals to the non-VA facility to veterans with relatively less severe medical conditions, such as veterans who did not require surgery or hospital stays longer than 5 days. Although network managers purchased inpatient services from non-VA providers in Chattanooga, the managers had to reconcile this effort with other needs. For example, network managers told us that the restrictions they placed on referrals to the non-VA facility were necessary to manage resources effectively as well as to ensure that patient workload at VA's Murfreesboro facility remained sufficient to support another priority—graduate medical education. As a result of the restrictions placed on the referrals, less than

[36]In some of the 25 markets, VA identified sharing agreements as another means that could be used to improve veterans' access to acute and tertiary care services. Sharing agreements are arrangements where VA buys or barters services from DOD. VA may also opt to lease inpatient facilities in some of these 25 markets and furnish VA staff to provide care in these facilities. In addition to these 25 markets, there are 3 other markets in which VA determined that a large number of enrolled veterans face lengthy driving times to access acute inpatient care at VA facilities. VA decided to build a new facility in one of these markets. In the other 2 markets VA determined that entering into sharing agreements with DOD was a reasonable option for improving access to care rather than purchasing care from non-VA providers.

[37]See GAO, *VA Health Care: Access for Chattanooga-Area Veterans Needs Improvement*, GAO-04-162 (Washington, D.C.: Jan. 30, 2004).

5 percent of Chattanooga veterans' inpatient workload was provided in Chattanooga in fiscal year 2002. VA provided most of its inpatient hospital workload for Chattanooga-area veterans in its medical facilities in Murfreesboro and Nashville.

VA is developing guidance to address the challenge VA's network managers face in determining priorities for purchasing inpatient care. This guidance specifies information that networks are to provide to headquarters when seeking approval of contracts with non-VA providers, including the inpatient services the network will purchase, the amount of resources needed to purchase these services, a timetable for when the services will be available, and the source of funding for these services. The guidance also requires network managers to provide evidence of the cost effectiveness of the proposed contract as well as a discussion of the potential impact of contracting on other health care services in the network.

Concluding Observations

Through the CARES process, VA has undertaken a critically important effort to address long-standing problems with the management of its capital assets. If it completes and successfully implements CARES decisions, VA may be able to enhance veterans' health care by reinvesting resources now spent on excess property. Achieving this will depend on VA's success in dealing with the challenges of developing sufficient information to complete inpatient alignment decisions, improving the management of excess property, and determining priorities for the purchase of inpatient services from non-VA providers to improve access to care. It is too early to know whether the steps VA is taking to address these challenges will be successful.

VA's ability to meet the goal of providing high-quality, accessible, cost-effective health care to the nation's veterans will depend largely on the extent to which VA is successful in institutionalizing the CARES process into its ongoing strategic and capital planning efforts. In the short term, institutionalizing the capacity to assess VA services and real property would provide a framework for making decisions about the alignment of long-term care and mental health services as VA develops and refines models for these services. An essential step in completing alignment decisions is finalizing the models and demand forecasts for long-term care and mental health services as well as finalizing the long-term care strategic plan. In the longer term, institutionalizing the CARES process would help ensure that VA has a systematic, data-driven framework for evaluating options for managing its real property in order to better meet the future

health care needs of veterans. Such a framework could contribute to VA's effectiveness as a steward of national resources and provider of health care services for our nation's veterans.

Agency Comments

In written comments on a draft of this report, VA concurred with our findings and conclusions and provided a technical correction and additional information on the CARES process, which we incorporated where appropriate. VA comments are reprinted in appendix II.

We are sending copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. This report will be available at no charge on GAO's Web site at http://www.gao.gov. If you or your staff have any questions, please contact me at (202) 512-7101 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care

Appendix I: 25 Markets Where VA Identified the Purchase of Inpatient Care as an Option to Improve Access

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	Type of inpatient care	
		Acute care[b]	Tertiary care[c]
1—Far North	This market includes Maine. VA owns one inpatient medical facility in this market, located in Togus, Maine.	X	
1—North	This market includes New Hampshire and Vermont. VA owns two inpatient medical facilities in this market, located in Manchester, N.H., and White River Junction, Vt.	X	
7—Alabama	This market includes most of Alabama and part of western Georgia. VA owns four inpatient medical facilities in this market, located in Birmingham, Montgomery, Tuscaloosa, and Tuskegee, Ala.	X	
7—South Carolina	This market includes most of South Carolina and part of Georgia. VA owns two inpatient medical facilities in this market, located in Charleston and Columbia, S.C.	X	
8—Gulf	This market includes part of southwestern Florida. VA owns one inpatient medical facility in this market, located in Bay Pines, Fla.	X	
8—North	This market includes most of northern Florida and part of southern Georgia. VA owns two inpatient medical facilities in this market, located in Gainesville and Lake City, Fla.	X	
10—Central	This market includes the southern central portion of Ohio. VA owns one inpatient medical facility in this market, located in Chillicothe, Ohio.	X	
10—Eastern	This market includes northeastern Ohio. VA owns two inpatient medical facilities in this market, located in Cleveland, Ohio (Brecksville and Wade Park).	X	
11—Central Illinois	This market includes the eastern central portion of Illinois and part of western Indiana. VA owns one inpatient medical facility in this market, located in Danville, Ill.	X	
16—Eastern Southern	This market includes parts of southern Alabama and western Florida. VA does not own any inpatient medical facilities in this market.	X	
17—Central	This market includes the central portion of Texas. VA owns two inpatient medical facilities in this market, located in Temple and Waco, Tex.	X	
17—Valley - Coastal Bend	This market includes southern Texas. VA does not own any inpatient medical facilities in this market.	X	
18—New Mexico - West Texas	This market includes New Mexico, western Texas, and parts of southern Colorado and western Oklahoma. VA owns three inpatient medical facilities in this market, located in Albuquerque, N. Mex., and Amarillo and Big Spring, Tex.	X	X
19—Eastern Rockies	This market includes eastern Colorado, southeastern Wyoming, and parts of both Kansas and Nebraska. VA owns two inpatient medical facilities in this market, located in Denver, Colo., and Cheyenne, Wyo.	X	
19—Montana	This market includes most of Montana and part of western North Dakota. VA owns two inpatient medical facilities in this market, located in Fort Harrison and Miles City, Mont.	X	X
20—Alaska	This market includes Alaska. VA owns one inpatient medical facility in this market, located in Anchorage, Alaska.		X

Network and market[a]	Geographic area covered by market and the VA inpatient medical facilities within it	Type of inpatient care	
		Acute care[b]	Tertiary care[c]
20—Inland North	This market includes eastern Washington, northern Idaho, northeastern Oregon, and part of northwest Montana. VA owns two inpatient medical facilities in this market, located in Spokane and Walla Walla, Wash.	X	X
20—Inland South	This market includes parts of eastern Oregon and southern Idaho. VA owns one inpatient medical facility in this market, located in Boise, Idaho.		X
20—South Cascades	This market includes western Oregon, southwestern Washington, and part of northwestern California. VA owns four inpatient medical facilities in this market, located in Portland, Roseburg, and White City, Oreg., and Vancouver, Wash.	X	
21—Sierra Nevada	This market includes northeastern California and western Nevada. VA owns one inpatient medical facility in this market, located in Reno, Nev.		X
21—South Coast	This market includes part of central California. VA owns three inpatient medical facilities in this market, located in Livermore, Menlo Park, and Palo Alto, Calif.	X	
23—Iowa	This market includes most of Iowa and parts of Illinois and Missouri. VA owns three inpatient medical facilities in this market, located in Des Moines, Iowa City, and Knoxville, Iowa.	X	
23—Minnesota	This market includes most of Minnesota and part of northwestern Wisconsin. VA owns two inpatient medical facilities in this market, located in Minneapolis and St. Cloud, Minn.	X	
23—North Dakota	This market includes most of North Dakota and parts of both Minnesota and South Dakota. VA owns one inpatient medical facility in this market, located in Fargo, N. Dak.	X	X
23—South Dakota	This market includes most of South Dakota and parts of five other states: Iowa, Minnesota, Nebraska, North Dakota, and Wyoming. VA owns three inpatient medical facilities in this market, located in Fort Meade, Hot Springs, and Sioux Falls, S. Dak.	X	

Source: GAO analysis of VA data.

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

[b]VA identified limitations in geographic access to acute inpatient care in a market when more than 35 percent, and at least 12,000 of the veterans enrolled for VA health care who reside in that market exceeded VA's driving time standards for reaching a VA health care facility of 60 minutes for urban areas, 90 minutes for rural areas, and 120 minutes for highly rural areas.

[c]VA identified limitations in geographic access to tertiary care in a market when more than 35 percent, and at least 12,000 of the veterans enrolled for VA health care who reside in that market exceeded VA's driving time standards for reaching a VA health care facility of 240 minutes for urban and rural areas or the community standard for highly rural areas.

Appendix II: Comments from the Department of Veterans Affairs

THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

July 21, 2005

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

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA HEALTH CARE: Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care,*** (GAO-05-429). VA concurs with GAO's findings and conclusions. VA appreciates GAO's efforts in examining the many aspects of challenges VA will face in completing its implementation of Capital Asset Realignment for Enhanced Services (CARES) decisions and the steps VA is taking to address these challenges. VA remains focused on continually improving the economic and technical quality of the CARES process and assuring our health care services continue to provide high quality, cost effective care long into the future.

The enclosure provides a technical correction and additional information on the CARES planning process. VA appreciates the opportunity to comment on your draft report.

Sincerely yours,

Gordon H. Mansfield

Enclosure

Appendix III: GAO Contact and Acknowledgments

GAO Contact

Cynthia A. Bascetta, (202) 512-7101 or bascettac@gao.gov

Acknowledgments

In addition to the contact named above, James C. Musselwhite, Assistant Director; Kristen Joan Anderson; Frederick Caison; Krister Friday; Clare Mamerow; and Paul Reynolds made key contributions to this report.

Related GAO Products

Federal Real Property: Further Actions Needed to Address Long-standing and Complex Problems. GAO-05-848T. Washington, D.C.: June 22, 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.

VA Health Care: Access for Chattanooga-Area Veterans Needs Improvements. GAO-04-162. Washington, D.C.: January 30, 2004.

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

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

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

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

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

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.

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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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