

Construction Programs

The Department of Veterans Affairs construction budget includes major construction, minor construction, grants for construction of state extended care facilities, grants for state veterans' cemeteries, and the parking garage revolving fund.

The Historical Appropriations for VA Major and Minor Construction chart listed on the next page clearly shows that since 1993 VA's construction budget and annual appropriations for both major and minor projects continue to drop sharply to the current low level. The FY 1993 combined total was \$600 million; however, by FY 2003, the total had decreased to only about \$300 million. VA's history of low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets.

In a study completed in 1998, Price Waterhouse was asked to determine the spending level required to ensure that VHA's investment in facility assets would be adequately protected against adverse deterioration and to keep the average condition of facilities at an appropriate level. Price Waterhouse concluded that the VHA was significantly underfunding its construction spending, and based on their observations across the industry, appropriate annual spending should be between 2% and 4% of the plant replacement value (PRV) on reinvestment to replace aging facilities. Price Waterhouse considered reinvestment to be improvements funded from the major and minor construction appropriations. PRV for the VHA is approximately \$35 billion. The 2%–4% range would therefore equate to annual funding of \$700 million to \$1.4 billion

There continues to be major political resistance to fund an adequate construction budget before the Capital Asset Realignment for Enhanced Services (CARES) process has been completed. We have been supportive of the CARES process from the beginning, as long as the primary emphasis is on the "ES"—enhanced services; however, we believe that it is poor policy to defer all VA construction needs until CARES is complete.

Currently, most VA medical centers, with an average age of 54 years, are in critical need of repair. Sadly, the prospect of systemwide capital asset realignment through the CARES process has been used as an excuse to hold all construction projects hostage. These projects are essential to patient safety; moreover, they will eventually pay for themselves through future savings as a result of modernization. The ongoing reconfiguration of the system through CARES must not distract VA from its obligation to protect its current assets by postponing needed funding for the construction, maintenance, and renovations of VA facilities.

While we still believe the CARES process should proceed, we perceive a need for further data to support various recommendations that would close or change missions of certain VA long-

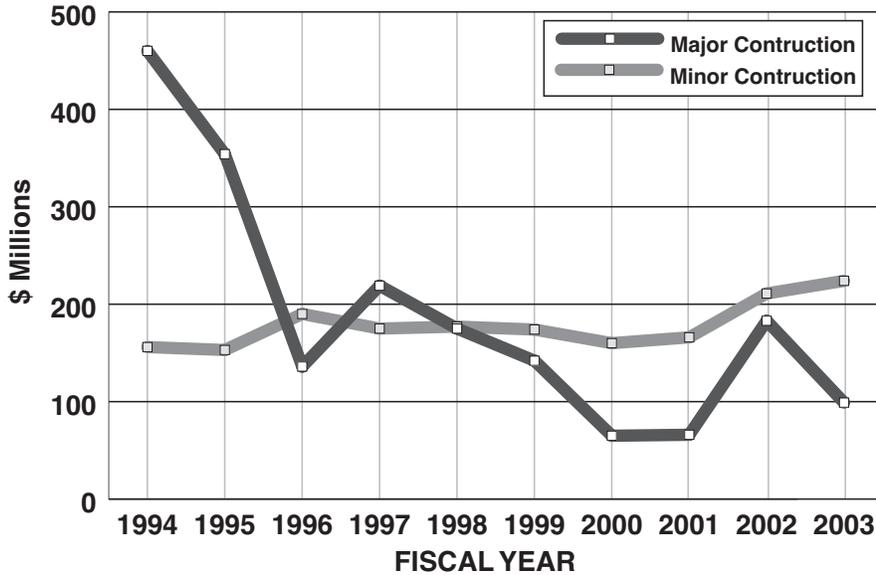
term care and small size facilities. These data should include such items as a cost analysis associated with these changes to include the costs of transferring patients and staff; the cost associated with contracting for care in the community; the cost related to shutting down and disposing of property to include asbestos removal; the cost to build or lease new facilities like community-based clinics and patient bed towers to include associated site elements to make the building functional, such as equipment, relocation, and activation costs; and updating facility infrastructures to handle additional patient workloads while maintaining privacy and safety requirements.

We acknowledge that the VA Office of Facilities Management has assembled construction cost data for

various functional building types; however, the inclusion of the aforementioned cost could provide the rationale for reconsidering some decisions.

In additional, the assumption that Congress will adequately fund all CARES proposed changes must be questioned. The IBVSOs are concerned that when CARES implementation costs are factored into the appropriations process, Congress will not fully fund the VA system, further exacerbating the current obstacles impeding veterans' access to quality health care in a timely manner. It is our opinion that VA should not proceed with CARES changes until sufficient funding is appropriated for the construction of new facilities and renovation of existing hospitals is approved.

CHART 2. HISTORICAL APPROPRIATIONS FOR VA MAJOR AND MINOR CONSTRUCTION



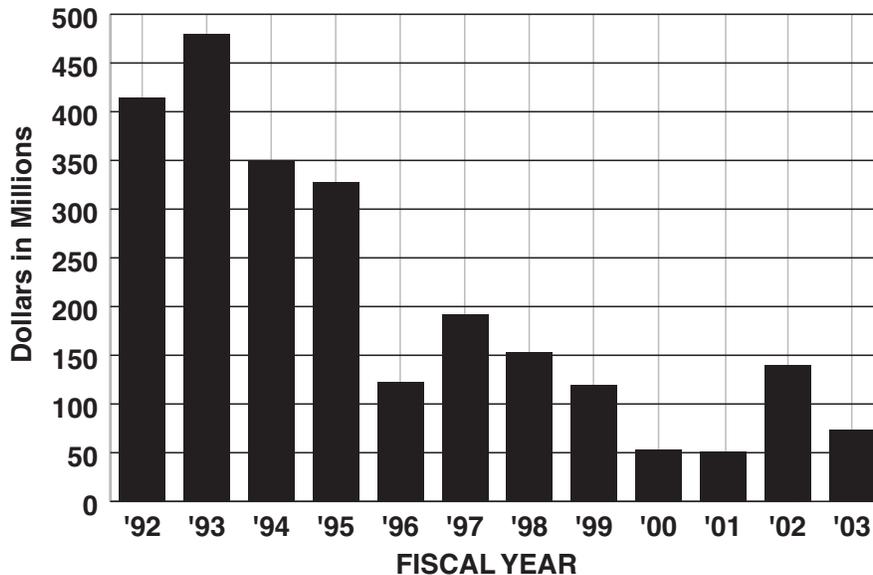
MAJOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate \$571 million to the Major Construction Account for FY 2005. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims.

Construction, Major Projects Recommended Appropriation FY 2005 IB Recommendation by Type of Service Medical Program (VHA)

Seismic Improvements	\$285,000
Clinical Improvements	25,000
Patient Environment	10,000
Research Infrastructure Upgrade and Replacement	50,000
Advance Planning Fund	60,000
Asbestos Abatement	60,000
National Cemetery Administration	81,000
IB Recommended FY 2005 Appropriation	\$571,000

CHART 3. MAJOR CONSTRUCTION BUYING POWER ADJUSTED FOR INFLATION



MINOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate \$545 million to the Minor Construction Account for FY 2005. These funds contribute to construction projects costing less than \$7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, a staff office account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects.

Construction, Minor Projects Recommended Appropriation FY 2005 Recommended by Type of Service Medical Program (VHA)

Inpatient Care Support	\$130,000
Outpatient Care and Support	100,000
Infrastructure and Physical Plant	150,000
Historic Preservation Grant Program	25,000
Other	25,000
VBA Regional Office Program	35,000
National Cemetery Program	35,000
VA Research Facility Improvement and Renovation	45,000
IB Recommendation FY 2005 Appropriation	\$545,000



CONSTRUCTION ISSUES

CORRECT SEISMIC DEFICIENCIES:

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

Annually, the VHA submits a list of Top 20 Priority Major Medical Construction Projects to Congress, which identifies the major medical construction projects that have the highest priority within VA. This list includes buildings that have been deemed at “significant” seismic risk and buildings that are at “exceptionally high risk” of catastrophic collapse or major damage. Currently, 890 of VA's 5,300 buildings have been classified as significant seismic risk, and 73 VHA buildings are at exceptionally high risk.

Four exceptionally high-risk seismic correction projects—Palo Alto, San Francisco, West Los Angeles, and Long Beach—were included in VA's recent budget submission; however, none of these seismic projects were funded. These four facilities have been classified

as the most exceptionally high risk for catastrophic collapse or major damage.

The IBVSOs believe, as we have indicated in the past, that there is political resistance to fund any major construction projects before the CARES process has been completed, and this includes correcting seismic deficiencies in VHA facilities. Regardless of the recommendations of the CARES program on facility realignments, it is our contention that VA must maintain and improve its existing facilities to support the delivery of health-care services in a risk-free environment for veterans and VA employees alike.

Most seismic correction projects should include patient-care enhancements as part of their total scope.

Also, consideration must be given to enhanced service recommendations provided for CARES. Due to the lengthy and widespread disruption to ongoing hospital operations that are associated with most seismic projects, it would be prudent to make qualitative medical care upgrades at the same time.

Recommendations:

Congress should appropriate \$285 million to correct seismic deficiencies.

VA should schedule facility improvements projects and CARES recommendations concurrently with seismic corrections.



Inadequate Funding/Declining Capital Asset Value:

VA's health-care facility infrastructure is grossly undercapitalized.

Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission of Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES, VA's construction budget continues to be inadequate.

In *The Independent Budget for Fiscal Year 2004*, we cited the recommendations of the interim report of the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). That report was made final in May 2003. To underscore the importance of this issue, we will cite the recommendation of the PTF again this year.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only \$246 million annually, a recapitalization rate of 0.64% of the \$38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2% of plant replacement value for its entire facility infrastructure. A minimum of 5% to 8% investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the DOD adequately

create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

It was also recommended by the PTF that "an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure."

The PTF also indicated that "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual top 20 facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within 4 years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program."

The PTF believes that VA must accomplish three key objectives:

- (1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health-care delivery;
- (2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and

- (3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

Additionally, it was recommended by the PTF report that “an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels.” The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure.

The IBVSOs concur with the provisions contained in the PTF final report. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services in old and inefficient patient care settings.

Recommendation:

Congress must ensure that there are adequate funds for the major and minor construction programs so that the VHA can undertake all urgently needed projects and correct the system’s aging infrastructure.



Increase Spending on Nonrecurring Maintenance:

The deterioration of many VA properties calls for increased spending on nonrecurring maintenance.

The IBVSOs support the Price Waterhouse recommendation that VA spend at least 2% of the value of its buildings or \$700 million annually on upkeep. The IBVSOs believe that \$400 million should be appropriated in FY 2005 with continued increases in the following years until an appropriate level of funding that will forestall the continued deterioration of VA properties is achieved.

Recommendations:

Congress should appropriate no less than \$400 million for nonrecurring maintenance in FY 2005 to provide for adequate building maintenance.

VA should direct no less than \$400 million for nonrecurring maintenance in FY 2005. VA should also make annual increments in nonrecurring maintenance in the future until 2% of the value of its buildings is budgeted and utilized for nonrecurring maintenance.



Empty or Underutilized Space at Medical Centers:

VA should avoid the temptation to reuse empty space inappropriately.

The suggestion has been made that the VA medical system has vast quantities of empty space that can be cost effectively reused for medical services. Furthermore, it has been suggested that unused space at one medical center may help address a deficiency that exists at another. Although the space inventories may be accurate, the basic assumption regarding viability of space reuse is not.

Medical facility planning is a complex task because of the intricate relationships that must be provided between functional elements and the demanding technical requirements of the sophisticated equipment that must be accommodated. For these reasons, space in medical facilities is rarely interchangeable—except at a prohibitive cost. Unoccupied rooms located on a hospital’s eighth floor, for example, cannot offset a

space deficiency in a second floor surgery because there is no functional adjacency. Medical space has very critical inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care. In order to maintain these adjacencies, departmental expansions or relocations usually trigger extensive “domino” impacts on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Some permanent features of medical space, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading, cannot be altered. Different medical functions have different technical requirements based on these permanent characteristics. Laboratory or clinical space, for example, is not interchangeable with patient ward space because of the need for different column spacing and perimeter configuration. Patient rooms need natural light and column locations that are compatible with patient room layouts. Laboratories should have long structural bays and function best without windows. If the “shell” space is not appropriate for its purpose, renovation plans will be larger and more inefficient and therefore cost more.

Using renovated space rather than new construction yields only marginal cost savings. Build out of a “gut” renovation to accommodate medical functions usually costs approximately 85% of the cost of similar new construction. If the renovation plan is less efficient, or the “domino” impact costs are greater, the small potential savings are easily lost. Renovation projects often cost more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve desirable functional adjacencies, but they are rarely economical.

Early VA medical centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most main hospitals have been consolidated into large, tall “modern” structures. Over time, these central medical towers have become surrounded by radiating wings and connecting corridors leading to secondary struc-

tures. Many current VA medical centers are built around prototypical “Bradley buildings.” These structures were rapidly constructed in the 1940s and 1950s for returning World War II veterans. Fifty years ago, these brick facilities were easily site-adapted and inexpensive to build, but today they provide a very poor chassis for a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to-floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The older hospital’s wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts by contemporary standards. The Bradley hospital’s central service core with a few small elevator shafts is inadequate for the vertical distribution of modern medical services.

In addition, much of the currently vacant space is not situated in prime locations. If the space were, it would have been previously renovated or demolished to clear the way for new additions. Unused space is typically located in outlying buildings or on upper floor levels. Its permanent characteristics often make it unsuitable for modern medical functions.

VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved and protected. Some space may be appropriate for enhanced use. Some may be appropriate for demolition. While it is tempting to focus on unused space, it should not be a major determinant in CARES realignments. Each medical center should develop a plan to find appropriate uses for its nonhistoric vacant properties.

Recommendation:

VA should develop a comprehensive plan for addressing excess space in nonhistoric properties that is not suitable for medical or support functions due to its permanent characteristics or location.



Preservation of VA's Historic Structures:

VA's extensive inventory of historic structures must be protected and preserved.

VA's historic structures provide direct physical evidence of America's proud heritage of veterans' care, and they enhance our understanding of the lives and sacrifices of the soldiers and sailors that fashioned our country. VA owns almost 2,000 historic structures. Many are suffering from neglect and deteriorate further every year. These structures must be stabilized, preserved, and protected. The first step in addressing this important legal and moral responsibility is for VA to develop a comprehensive national program for its historic properties. Because the majority of these structures are not suitable for modern patient care, the current CARES planning process will *not* produce a national strategy for the preservation of historic properties. A separate initiative must be undertaken immediately.

VA must inventory its historic structures and establish broad classifications regarding their current physical condition and their potential for adaptive reuse. This reuse may be either by VA medical centers or by local governments, nonprofit organizations, or private-sector businesses. In order to accomplish these initial objectives, we recommend that VA establish partnerships with other Federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. This expertise should prove helpful in establishing this program. In addition, VA must expand its current staffing for this new task.

In conjunction with an adaptive reuse program, VA needs to develop legal models and strict administrative policies for protecting those historic structures that are

leased or sold. VA's responsibilities, for example, could be addressed through legal easements on appropriate property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully completed a cooperative agreement assisting the Department of Army with the management of its historic properties.

We propose a \$25 million budget for FY 2005 in order to stabilize, preserve, and reuse the thousands of historic VA properties. The funds should also be used to maintain VA's artifacts and collections and to provide grants to local organizations for preservation activities related to veterans facilities. We support the proposed language in Section 8171 for the establishment of a fund and for its purpose.

The protection and preservation of VA's historic structures is an important responsibility that the Department has ignored for too long. Faced with scarce funding and competing patient care demands, VA management has delayed addressing this issue for decades. We therefore recommend that specific funding and detailed responsibilities are included in the FY 2004 budget for this purpose.

Recommendation:

Specific funds should be included in the FY 2005 budget to develop a comprehensive program for the preservation and protection of VA's inventory of historic properties.



CARES ISSUES

Establishing a Program for Medical Center Master Plans:

Each VA medical center needs to develop a detailed facility master plan.

CARES will *not* produce detailed facility master plans for each VISN medical center. Without these facility plans, the CARES recommendations cannot be efficiently implemented. Potential benefits of the lengthy and expensive CARES medical planning process will be jeopardized by hasty and ill-conceived construction planning. The construction budget should therefore include \$100 million to fund master plans for the 167 VA medical centers. In order to implement this detailed facility planning, VA must immediately establish guidelines and formats for these master plans so that work can proceed. Since VISN 12 planning was completed in the CARES pilot phase, this network would be a good starting point for the master facility planning process.

Master plans for each medical center must be developed by contracted design professionals based on programmatic and operational decisions agreed to during CARES. Medical center master plans must be internally and externally coordinated. External coordination may prove to be the more complex undertaking. For example, where current programs are relocated to from one medical center to another medical center, new construction at the second facility must be completed *before* related actions can be undertaken at the first. This requires that the proposed changes be a part of *two* facility master plans, one for the donor facility and one for the acquiring facility.

Similarly, construction priorities must be coordinated between the medical centers. Construction of an expanded SCI facility may be a high priority for the gaining facility, but the loss of an existing program may be a low priority for the donor facility. If construction funds will be expended at both facilities, it may be a practical budget policy to fund the two actions together.

Even when program changes will take place on a single campus, master plans must be developed so that a series of projects can be prioritized, coordinated, and phased. Each project is a logical step in achieving the long-range CARES objectives in an efficient and effective manner with the minimum disruption to patient care.

Master planning will allow preparation of accurate construction cost estimates that include sufficient contingency expenses for operational phasing. When complete, cost estimates prepared during master planning will either validate or challenge the original CARES strategic decisions. For example, if CARES called for use of renovated space for a relocated program and a more comprehensive examination indicates that the selected option is impractical, different options must be considered to achieve the desired results.

Master planning will also provide the mechanism for VA to address the three critical programs that were omitted for the CARES study. For long-term care, severe mental illness, and domiciliary care VA will need to accomplish both program and facility planning. Because these are significant programs, the impact of their incorporation in the planning process will be substantial.

Two other components of facility management were omitted from CARES: planning for historic structures and planning for existing vacant space on VA campuses. These must be addressed in a timely manner.

Master planning must follow immediately after CARES in order to efficiently implement necessary construction, to prepare accurate budgets, and to validate the original strategic planning decisions. VA should already have developed a master planning program as recommended in *The Independent Budget for Fiscal Year 2004*. The consequences of electing to bypass this critical step are already evident in VISN 12, where Chicago Lakeside demolition is currently scheduled to precede, rather than follow, Westside construction. Facility master planning should be funded and implemented immediately.

Recommendations:

Congress must appropriate \$100 million for medical center master plans in the FY 2005 construction budget.

The facility master plans should address the long-term care, severe mental illness, and domiciliary care programs that were inexplicably omitted from the CARES study. Facility master plans should also address historic properties and vacant space.

VA must quickly develop a format for these master plans so there is standardization throughout the

system, even though the planning work will be performed in each VISN by local contractors. The format should be tested in a pilot project.

Each VA medical center should initiate their procurement process immediately so that they are ready to proceed after CARES is completed and adopted.



Coordinate Planning and Design Time Frames in Order to Efficiently Manage Construction:

VA must develop realistic and compatible time frames for use in CARES, facility master planning, and individual project development.

Based on historical data, the VA project development process for design and construction takes from 8 to 10 years, measured from design initiation to building occupancy. The length of the process cannot be ignored in evaluating current CARES planning initiatives. The inherent contradiction is that a rather short, 17-year long-range planning process is coupled to a long, 10-year implementation process. The current project timeline does not include the critical new master planning step. Furthermore, many CARES-generated projects will require more complex construction phasing and private-sector real estate transactions. Therefore implementation of CARES projects will take longer than current projects—even if funding were immediately available. This reality has ramifications for CARES planning because it impacts its implementation.

The medical center master planning process will add at least one year to the current project development process. Even if master planning were initiated for every medical center immediately after CARES was adopted, building occupancy of the first CARES project would be more than a decade later. As a practical matter, the assumption must be that the majority of the CARES projects will *not* be completed by 2020, the second CARES planning target date. Very few projects will be completed by 2012, the “bump” year and the first CARES target date.

Recognition of these time frames means that CARES plans must be viewed in a different light. For example,

the higher demand for veterans’ services that are projected for 2012 (the “bump”) must be addressed by *nonconstruction* alternatives. There is simply not sufficient time to construct new facilities to meet the forecast need. VA should therefore begin to address this responsibility immediately by means of operational adjustments.

In order to efficiently manage its assets and construction, VA must develop realistic and coordinated cycles for medical planning, facility planning, and project design. Statistical data gathering, for example, should be conducted annually. Now that planning tools have been adopted for CARES, the same data should be evaluated and updated annually. This will allow VA to monitor previous planning projections. Was the CARES demand forecast for future services accurate? If not, why not? This analysis will also allow VA to conduct future long-range planning more easily, more inexpensively, and more accurately. Comprehensive medical planning (like CARES) should be conducted on a 10-year cycle but reviewed and updated annually.

Facility master planning should be conducted on the same cycle as comprehensive medical planning, but it should be updated every 3 years to reflect ongoing changes in demand for services and in philosophy of care. VA should make every effort to reduce the length of the design and construction process so that newly completed facilities reflect the most current planning data, the most advanced medical technologies, and the

newest models for patient care. Medical advances occur at much too swift a pace to be compatible with a long and inflexible design and construction process.

Recommendations:

VA must develop nonconstruction alternatives to enable it to meet the projected increased demand for veterans' health-care services in the year 2012.

VA should conduct both medical program and facility master planning on a regular cycle that is appropriate for each activity.

Congress must appropriate sufficient construction funding each year so that there is steady implementation of planning initiatives.



Uses for CARES Statistical Data in Facility Management and Budgeting:

VA and Congress should make full use of the data produced by the CARES initiative.

The CARES process has produced extensive new data that is potentially useful to Congress and VA, regardless of full acceptance or implementation of the entire study. Even if there is disagreement on the planning assumptions, one category of CARES data paints a clear picture of VA facilities as they exist today. This category is "existing space deficiencies."

CARES provides a statistical analysis of the VA system's current deficiencies in functional space that is available to support the medical services that are currently delivered. By the application of established planning algorithms, the current space requirements have been mathematically computed for every program except long-term care, severe mental illness, and domiciliary. This computation establishes an objective benchmark that is compared to existing space inventories. These inventories are available on a program-by-program basis for each medical center, for each VISN, and for the overall VA system. The mathematical difference between the benchmark and the inventory represents the deficiency. This deficiency is the current need for new facility construction in order to provide quality medical care to today's veterans. Using this CARES data, a specific medical center, for example, can be identified as the "most deficient" in the VA system. By extension, this facility is most in need of new construction. Specific medical programs can also be compared on a similar basis.

This data identifies the current need for new space and therefore establishes the magnitude of construction that is necessary to adequately address today's veterans' needs. This data will also allow prioritization of construction funding, based on a variety of different criteria, including geographic regions or medical programs. This data is based on completely objective measurements, not based on any assumptions regarding future needs.

The CARES data category that is based on assumptions is "projected space deficiencies." These projections are based on various planning assumptions regarding veteran eligibility, population demographics, and future military actions. Actuarial data is used to project these future demands for veterans' health-care services. Because of these fundamental assumptions and unforeseeable medical advances, these space projections are based on much less solid information than existing space deficiencies. These projections must be considered, however, because VA must plan to the best of their abilities for future needs. Long-range planning is particularly critical for an efficient construction program because the implementation process is so long. Future projections can also be used to project the future need for construction and as a basis for resource allocation.

The newly collected CARES data illustrate the scope of both the system's current and future construction needs. These data can be used to establish the magni-

tude of future construction budgets and provide a rational basis to allocate these resources. Allocations, for example, could be made to address the greatest current space deficiencies. Alternatively, funding could be prioritized to offset the greatest projected space needs. Funding could also be adjusted to emphasize one medical program over another. Data of this type should have been available for decades for both management and oversight purposes.

With the new CARES data, better systemwide facility and medical management will now be possible. CARES data should therefore be periodically updated in order to verify the accuracy of the underlying assumptions and make the necessary adjustments to the facility and operational plans. Similar statistical data should be generated and maintained for the three missing programs (long-term care, severe mental illness, and domiciliary).

Recommendations:

VA should generate similar statistical data for long-term care, severe mental illness, and domiciliary.

VA should use CARES data to establish the magnitude of construction that is required to address current space deficiencies.

VA should use CARES data to identify future space deficiencies and initiate construction now to meet future needs.

VA should use the deficiencies data to establish current and future construction budgets and to allocate these resources among the various medical centers and medical programs.

VA should periodically update the CARES data as an important tool for systemwide planning and management.

What Should Follow CARES?

VA must immediately undertake certain activities in order to secure the potential benefits of CARES.

The CARES long-range planning study has been completed, and it is certainly time to initiate a major construction program to enhance VA's medical facilities. The CARES study has attempted to project the future demand for services and identify what types of patient programs will be needed. In addition, CARES has proposed a realignment of existing assets to best meet these needs. During the past few years, construction funding has been virtually frozen pending the outcome of CARES. This severe funding reduction has been detrimental to the maintenance of VA's capital assets and has allowed atrophy in the construction management program. It is now time to ramp up construction in order to meet the system's current and future needs. This expanded construction program needs to be implemented in an efficient and deliberate manner.

In order to initiate a new era of expanded medical facility construction, VA must establish a national program of facility master planning that describes, in detail, the most efficient means of implementing the medical program planning that was agreed to in the CARES study. In addition, VA needs to establish an ongoing national planning program that collects, maintains, and evaluates critical statistical data. The new planning program should monitor CARES projections and adjust the conclusions, as necessary, as future events unfold. New statistical data for the three medical programs (long-term care, severe mental health, and domiciliary) that were omitted from CARES should be added as quickly as possible.

VA must coordinate its planning, construction, and management responsibilities. Appropriate cycles for planning activities need to be established and implemented. Management mechanisms need to be estab-

lished to collect and evaluate planning data. Inaccurate planning forecasts cannot be allowed to continue uncorrected, as was the case with MEDIPP in the late 1990s. Better long-range planning also needs to be coupled with shorter design and construction time frames in order to deliver a better product in a more efficient manner.

Several aspects of the facility inventory management were not addressed in CARES. These include the historic properties that VA owns and the vacant space that exists at many medical centers. Comprehensive solutions for these management issues need to be developed, approved, and implemented.

Recommendations:

VA construction should be expanded in order to meet the system’s current and projected space needs.

VA must initiate new programs for facility master planning based on the CARES recommendations.

VA must maintain and analyze new planning data and streamline the current design and construction process.

VA must develop programs to address historic properties and vacant space.

