



National Trust *for*  
Historic Preservation  
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# Honoring Our Nation's Veterans: Saving Their Places of Health Care and Healing



## **ABOUT THE AUTHOR**

This report was researched and drafted by Leslie E. Barras, an attorney and consultant based in Orange, Texas, who advises and assists government agencies, businesses, and public interest groups on issues relating to environmental and historic preservation compliance and advocacy. The report was prepared with insights from the experiences of the staff of the National Trust for Historic Preservation and editorial assistance of the Trust's staff.

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## **ON THE COVER**

(clockwise, from top left)  
Former Dining Hall, Dwight D. Eisenhower VA Medical Center, Leavenworth, KS

Credit: Pioneer Group

Domiciliary Arcade, Hot Springs VA Medical Center (aka Battle Mountain Sanitarium), Hot Springs, SD

Credit: National Trust for Historic Preservation

San Francisco VA Medical Center, San Francisco, CA  
Credit: National Trust for Historic Preservation

Old Main, Clement J. Zablocki VA Medical Center (aka Milwaukee Soldiers Home), Milwaukee, WI

Credit: Matthew Gilson

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## ACRONYMS

AAB - Architectural Access Board	gsf – gross square foot
ACHP - Advisory Council on Historic Preservation	HJR - House Joint Resolution
A/E - architectural and engineering	HR - House Report
AMVETS - American Veterans	HVAC - heating, ventilation, and air conditioning
APF - Advance Planning Fund	IDIQ - indefinite delivery, indefinite quantity
BLM - Bureau of Land Management	LCA - life-cycle analysis
BOEM - Bureau of Ocean Energy Management	NAGPRA - Native American Graves Protection and Repatriation Act
BRAC - Base Realignment and Closure	NCA - National Cemetery Administration
CAI - Capital Asset Inventory	NEPA - National Environmental Policy Act
CARES - Capital Asset Realignment for Enhanced Services	NHDVS - National Home for Disabled Volunteer Soldiers
CE or CatEx - Categorical Exclusion	NHL - National Historic Landmark
CEQ - Council on Environmental Quality	NHPPA - National Historic Preservation Act
CFM - Construction and Facilities Management	NIBS - National Institute of Building Sciences
CFR - Code of Federal Regulations	NPS - National Park Service
CLC - community living center	NPV - net present value
CPRA - Civilian Property Realignment Act	NSV - National Survey of Veterans
CRMO - cultural resource manager officer	NRM - Non-Recurring Maintenance
CRS - Congressional Research Service	OAEM - Office of Asset Enterprise Management
DAD - Decide, Announce, and Defend	OALC - Office of Acquisition, Logistics, and Construction
DAV - Disabled American Veterans	OIG - Office of Inspector General
DDD - Dialogue, Decide, and Deliver	O&M - operation and maintenance
DoD - Department of Defense	OMB - Office of Management and Budget
DOE - Department of Energy	OPM - Office of Personnel Management
DOI - Department of the Interior	PEIS - Programmatic EIS
EA - Environmental Assessment	PPS - Partnership for Public Service
EIS - Environmental Impact Statement	PTSD - post-traumatic stress disorder
EMS - Environmental Management System	PVA - Paralyzed Veterans of America
EUL - enhanced-use leasing	SCIP - Strategic Capital Investment Planning
FASAB - Federal Accounting Standards Advisory Board	SHPO - State Historic Preservation Officer
FCA - Facility Condition Assessment	SFFAS - Statement of Federal Financial Accounting Standards
FEMA - Federal Emergency Management Agency	TIL - Technical Information Library
FMA - Funded Maintenance Account	URL - Uniform Resource Locator
FPO - Federal Preservation Officer	USEPA - U.S. Environmental Protection Agency
FRPC - Federal Real Property Council	VA - Department of Veterans Affairs
FRPP - Federal Real Property Profile	VBA - Veterans Benefits Administration
FY - fiscal year	VFW - Veterans of Foreign Wars of the U.S.
G-PP&E - General Property, Plant & Equipment	VHA - Veterans Health Administration
GAO - Government Accountability Office (formerly, the General Accounting Office)	VISN - Veterans Integrated Service Network
GSA - General Services Administration	VSO - veterans service organization

## TABLE OF RECOMMENDATIONS

Recommendations of <i>Honoring Our Nation's Veterans: Saving Their Places of Health Care and Healing</i>	In this report, see:
Recommendation Theme A: Expressing the Commitment of Top VA Management and Addressing Regulatory Compliance Concerns and Budgetary Barriers:	Section 4
<p><b>One:</b> The Secretary of the VA should issue a management statement that commits the VA to fulfilling its responsibilities under the National Historic Preservation Act and the VA's Sustainable Locations Program policy. The management statement should commit the VA to an accurate inventory of its historic buildings; early initiation of, and full compliance with, historic preservation and environmental review requirements; continued hiring of qualified preservation professionals and training of technical staff; and internal compliance audits.</p> <p>This action is needed because:</p> <ul style="list-style-type: none"> <li>• A statement from top VA management that affirms and supports the value of historic capital assets would help to overcome internal misconceptions about the utility of historic buildings and improve compliance with the National Historic Preservation Act.</li> <li>• The VA's capital asset inventory practices appear to promote subjective and inaccurate accounting of historic buildings.</li> <li>• Implementation and accountability in the VA's cultural resource management program is lacking.</li> </ul>	p. 48
<p><b>Two:</b> The VA's implementation of the National Historic Preservation Act and National Environmental Policy Act should be strengthened and improved in three key areas: (1) comprehensive land use planning at medical centers (including parking); (2) nationwide programs relating to disposition of buildings and medical centers; and (3) new medical center construction.</p> <p>This action is needed because:</p> <ul style="list-style-type: none"> <li>• A comprehensive blueprint for land use at each medical center, that complies with required historic property and environmental reviews and involves the public, should better serve all constituencies and stakeholders of these important community facilities and minimize conflict when individual projects in the comprehensive plans are subsequently carried out.</li> <li>• National programs affecting buildings and medical centers, including disposal and new construction, negatively impact historic properties without adequate consideration of alternatives and cumulative impacts.</li> </ul>	p. 53
<p><b>Three:</b> The management of the VA should seek congressional authorization, as needed, for flexibility in the VA's use of capital budget accounts in order to: (1) promote advance preservation planning for Minor Construction and Non-Recurring Maintenance projects; and (2) accomplish capital projects that integrate health care, historic preservation, energy conservation, other sustainability measures, and operation and maintenance demands.</p> <p>This action is needed because:</p> <ul style="list-style-type: none"> <li>• In the absence of integrated planning that addresses preservation and other factors, historic buildings will suffer from ad hoc management.</li> </ul>	p. 61
Recommendation Theme B: Encouraging and Empowering the VA's Staff to Sustain Historic Buildings:	Section 5
<p><b>Four:</b> The VA should develop instructions to help its staff implement the agency's new Sustainable Locations Program policy. Detailed guidance should be issued on how to evaluate the alternative of renovating historic buildings, including the following elements: (1) assigning monetary valuations to historic properties and lands in economic analyses; (2) quantifying sustainability considerations in these analyses (such as greenhouse gas emissions); and (3) acknowledging that historic preservation is a qualitative value that can justify selecting the renovation alternative under existing federal laws and guidance.</p> <p>This action is needed because:</p> <ul style="list-style-type: none"> <li>• The VA's economic analyses of projects do not appear to account for all factors that would promote holistic decision making about investments in capital assets.</li> <li>• Preservation of significant historic buildings is a legitimate justification, in and of itself, for renovation and modernization projects.</li> </ul>	p. 68

## TABLE OF RECOMMENDATIONS (cont.)

<b>Five:</b> The management of VA should encourage and facilitate the development of in-depth case studies of renovation and modernization of historic VA buildings. Existing guidance within the VA's Technical Information Library should be revised to provide specific and practical direction to technical staff and consultants regarding renovations and other alterations to historic buildings and landscapes.	p. 72
This action is needed because: <ul style="list-style-type: none"><li>• The VA's current repository of knowledge that guides planners, designers, and construction personnel lacks specific and practical instruction regarding the rehabilitation and reuse of historic buildings.</li></ul>	
<b>Six:</b> The management of the VA should create incentives for employees to successfully initiate and execute capital projects that integrate health care, historic preservation, energy conservation, other sustainability measures, and operation and maintenance demands. Staff should further be encouraged and supported by providing resources to access on-demand, outside historic preservation expertise through existing procurement mechanisms.	p.76
This action is needed because: <ul style="list-style-type: none"><li>• Empowering and rewarding staff to plan and implement integrated capital projects, and making external preservation assistance available, will promote more efficient solutions to all demands affecting the management of VA buildings.</li></ul>	
<b>Recommendation Theme C: Facilitating the Use of the VA's Historic Buildings by Third Parties:</b>	<b>Section 6</b>
<b>Seven:</b> The VA should explore and adopt expanded options for third parties to use historic buildings, such as the leasing authority granted to the VA by Section 111 of the National Historic Preservation Act.	p.83
This action is needed because: <ul style="list-style-type: none"><li>• The VA does not currently use all available tools provided by law that facilitate the reuse of historic buildings owned by the federal government.</li></ul>	
<b>Eight:</b> Congress should restore the VA's authority to execute a specific option for building reuse—enhanced-use leasing with third parties to provide a range of services to veterans and their communities, in addition to addressing veteran homelessness. Corrective measures should continue to be implemented in the enhanced-use leasing program to address previous concerns regarding the VA's accountability for these transactions. New measures should be instituted as well, such as a uniform requirement for Funded Maintenance Accounts to protect the condition of historic buildings that are outleased.	p.84
This action is needed because: <ul style="list-style-type: none"><li>• With appropriate management controls, expanded enhanced-use leasing authority better supports veterans and their communities and leverages existing VA capital assets.</li></ul>	
<b>Recommendation Theme D: Educating Preservation Stakeholders on Measures to Promote the VA's Stewardship of Historic Healthcare Facilities:</b>	<b>Section 7</b>
<b>Nine:</b> Preservation stakeholders should devote time to understanding the needs of veterans and, therefore, the requirements, opportunities, and constraints of the VA. Preservation stakeholders should also support the VA by convincing federal watchdog agencies (such as the Government Accountability Office and the Office of Management and Budget) that historic buildings can be valuable and sustainable assets.	p.90
This action is needed because: <ul style="list-style-type: none"><li>• To be effective partners with veterans and the VA, preservation advocates need to better understand the VA's positions and be able to articulate the valuable role historic properties can play in the agency's future.</li></ul>	
<b>Ten:</b> Preservation stakeholders should expand the public's knowledge about historic medical centers in order to promote preserving these places.	p.92
This action is needed because: <ul style="list-style-type: none"><li>• Education and promotion are instrumental to more widespread and effective advocacy efforts.</li></ul>	
<b>Eleven:</b> Preservation stakeholders should organize local campaigns in order to carry out fact-based and informed advocacy to save historic VA buildings and landscapes.	p. 94
This action is needed because: <ul style="list-style-type: none"><li>• Local, organized and vocal citizen advocacy groups increase the likelihood that positive preservation outcomes will be achieved.</li></ul>	

## EXECUTIVE SUMMARY

With more than 2,000 historic buildings and landscapes among its portfolio of 5,800 structures, the U.S. Department of Veterans Affairs (commonly referred to as the VA) is the steward of some of the Nation's most significant and prized treasures related to the medical care and recuperation of America's military men and women.

National Historic Landmarks reflecting the country's early attempts to support wounded Union Army veterans following the Civil War are the crown jewels of a vast and diverse collection of historic buildings and landscapes that reflect America's care for its veterans and the advancement of medical practice through the past two centuries.

The VA's portfolio includes everything from hospitals to residential quarters to farm buildings to cemeteries. Medical center campuses managed by the VA include magnificent structures designed by noted architects on large tracts of land in rural areas, chosen because the fresh air, sunshine, vistas, and serene landscapes were thought to be conducive to healing. Today, these elements contribute to what is called "biophilic design," which is promoted in current health-care facility planning, and which can still be found in many of the VA's historic buildings and landscapes on its active medical center campuses.

Simply put, the VA has in its care not only the men and women who were willing to make extraordinary sacrifices to help preserve our freedom, but also a remarkable collection of architecture, designed landscapes, and medical facilities built over the past two centuries to support our veterans. Unfortunately, the care provided to these historic treasures – places which have more than proven their worth as settings for the healing and nurturing of today's wounded veterans – is far from adequate and has reached crisis proportion.

### A Time for Action

The National Trust for Historic Preservation, the nation's leading nonprofit advocate for the saving and reuse of America's historic places, has a long-standing interest and involvement in the fate of historic buildings and landscapes that relate to the care of our nation's veterans. Through the years the National Trust has placed several of these sites on its annual list of America's Most Endangered Historic Places. In those places, the Trust has worked with veterans' groups, the Administration, Congress, and local preservation advocates to fight for the retention and reuse of these places. The threats vary. Some buildings sit vacant and deteriorating while others are being considered for abandonment and/or demolition to make way for newer facilities. Poor management often leads to wasted taxpayer dollars and the irreversible loss of our nation's cultural legacy.

Two threatened sites in particular – the Battle Mountain Sanitarium in Hot Springs, South Dakota, and the Milwaukee National Soldiers Home in Wisconsin – were named National Treasures by the National Trust as part of a campaign to preserve these National Historic Landmarks and to draw attention to the plight of historic VA sites across the country. In both cases, the National Trust became engaged in response to requests from veterans and local stakeholders concerned with the future of the historic campuses and the medical care that has been provided there for over a century. At Battle Mountain Sanitarium, the VA is proposing to shutter the entire campus and move medical services to a new facility 60 miles north. In Milwaukee, the VA has let several historic buildings, including the iconic Old Main – the oldest Soldiers Home building in the country – sit vacant and unmaintained for years to the point of severe deterioration.



Administration Building at the Battle Mountain Sanitarium in Hot Springs, SD, part of the VA Black Hills Health Care System proposed for closure  
Credit: National Trust for Historic Preservation

Historic preservation is not an express part of the mission of the VA. However, like all federal agencies, the VA has a legal responsibility through the National Historic Preservation Act (NHPA) and National Environmental Policy Act (NEPA) to exercise responsible stewardship for the historic properties in its care. Despite this, these laws and regulations are not being followed by the VA at many of its historic health-care facilities.

The time for action by the VA, Congress, and the Administration is now, before we lose more of our cultural heritage and the opportunity for these places to contribute to first-class medical care today. The National Trust commissioned this report in an attempt to promote a constructive dialogue between the VA and stakeholders who are interested in preserving the historic health-care buildings and places managed by the agency. By fostering improvement of the VA's cultural resources management practices, we – as a country – honor the veterans for whom these impressive buildings and landscapes were designed and built.

### Steps for Action

The report outlines four key recommendations for the improved care of the VA's historic properties:

- Top management of the VA must strongly and unequivocally commit to and support the protection of historic VA facilities – in order to comply with federal historic preservation laws and to ensure the best care possible for our nation's veterans.
- VA staff should be encouraged to support – and resources must be allocated for – the preservation of the historic buildings with which they have been entrusted. The planning process for VA facilities needs to be revised to include assessment of historic resources before years of planning for new buildings, and sometimes even Congressional authorization, make it difficult to change decisions that have become set in stone.
- Opportunities to reuse and protect the VA's historic buildings through private developers and other non-governmental parties should be expanded and actively promoted.
- Preservationists and other advocates must help the VA recognize the value of historic buildings to the mission and work of the agency and the communities in which they exist.

### What is at Risk?

Compared to other government agencies, the VA has done an exemplary job of identifying and evaluating its historic assets. Approximately 91 percent of the VA's inventory of buildings has been evaluated for eligibility for listing in the National Register of Historic Places (National Register). Despite this evaluation, however, the VA is doing an inadequate job of protecting these assets.

The VA's historic medical centers represent some of the most notable of these heritage assets. They are



"Serving Veterans Since 1907  
at the Battle Mountain  
Sanitarium Campus  
Credit: National Trust for Historic  
Preservation

categorized according to three distinct periods of building campaigns following wars. First Generation facilities (branches of the National Home for Disabled Volunteer Soldiers) were built initially to treat and care for Union Army veterans of the Civil War.

Second Generation facilities are medical centers that were built in response to the entry of the United States into World War I. These structures were built between 1918 and 1950 and a number were constructed in Colonial Revival and Georgian Colonial Revival architectural styles. In other areas, local and regional architectural styles influenced the exterior design and materials.

The Third Generation of medical centers includes hospitals and health-care buildings that were constructed in response to World War II. Unlike their predecessors, these facilities were often located in urban areas on relatively small footprints of land. Treatment at this time focused more on psychiatric care that did not require large tracts of land for active, outdoor recreation.

A number of the VA medical center complexes have been designated as historic or deemed eligible for listing in the National Register. All 11 First Generation campuses still exist. Five of these have been designated National Historic Landmarks (NHL), the nation's highest level of recognition for historic sites: Dayton, OH; Hot Springs, SD; Johnson City, TN; Leavenworth, KS; and Milwaukee, WI. In addition, the First Generation

campus in Togus, Maine has an NHL building. At least 40 of the Second Generation campuses have been listed in the National Register. And many Third Generation medical centers are now potentially eligible for listing.

Regardless of the period of construction, historic VA medical centers include multiple buildings that contribute to the overall significance of the campus as a historic district. These contributing elements include buildings for medical treatment and care and other veteran services, as well as associated infrastructure

### **How has the VA cared for its Historic Resources?**

Alarmingly, many of these historic VA buildings are currently lined up in the disposal queue.

Of the 2,008 historic buildings managed by the VA, approximately one-half of these have been categorized by the VA as "unoccupied and risk[ing] deterioration," and many are in "unsatisfactory" condition. Once these buildings land on the "unsatisfactory" list, they have little chance of being used in the future under current VA practices. Funds for repair are diverted elsewhere, the buildings are left vacant, and they continue to deteriorate.

In some cases, such as the Battle Mountain Sanitarium, the entire campus was deemed "unsatisfactory" by VA leadership, and another location was identified for the future construction or lease of an entirely new medical center. Interestingly, the VA justifies its preference for new construction, in part, on the mistaken belief that it is more appealing to staff and patients. In fact, patients are most interested in wait times for appointments, and a recent survey of some 14,000 employees found that the lowest satisfaction ratings nationwide had nothing to do with physical infrastructure (including building age), but rather issues related to human resources and managerial leadership.



Veterans in Hot Springs, SD, support the continued use of the Battle Mountain Sanitarium as a VA medical center  
Credit: Save the VA

For various reasons explained in more detail in the report, the VA is neglecting – or circumventing – its stewardship responsibilities for the historic buildings in its care. Key problem areas are the planning process for the future of the VA's building inventory; the agency's failure to comply with NEPA and NHPA (in particular Section 106, which requires agencies to consider the impacts of their programs and projects on historic properties and evaluate alternatives to avoid, minimize, or mitigate these harms, and Section 110, the requirement for federal stewardship of historic properties); and a general bias against older buildings.

As a consequence of the VA's national policy decision to realign health-care services, entire historic medical centers have been closed or are threatened with closure, jeopardizing the fate of historic buildings. Personnel responsible for the management of the VA's buildings (e.g., capital asset managers) make important decisions about the attributes of individual buildings, such as their usefulness and condition, and determine whether each building can be reused or it is no longer needed and is queued for disposal (which also subjects the building to risk of demolition by neglect). The managers often make these decisions without input from the VA's Office of Historic Preservation. This is in part because the office is quite small for an agency of its size and with such a

large portfolio of historic properties. The VA has a national preservation staff of just two: a Federal Preservation Officer and a deputy Federal Preservation Officer. These two personnel have little or no regional support or local preservation staff to provide assistance with the multiple priorities they manage. With such a small dedicated staff of professionally trained preservation professionals, and an agency culture that places little value on historic properties, it is often difficult to determine who is in charge of stewardship for the VA's historic buildings.

#### A Flawed Planning Process

These decisions appear to be made by the VA following the antiquated and exclusionary process colloquially known as "DAD" (Decide, Announce and Defend), which is in part fueled by pressure from the federal government for the agency to consolidate its building inventory. From fiscal year 2004 through fiscal year 2012, the VA disposed of 898 buildings, of which 381 were demolished and another 58 were deconstructed (physical dismantling through removal of items such as doors and hardware) in anticipation of demolition or mothballing. The current plan for fiscal year 2013 through fiscal year 2017 proposes to dispose of another 535 buildings in total, including demolishing 314 buildings and deconstructing 66.

The VA bases its decisions about facilities on factors such as the number of veterans it serves, current demand for services, and the types of health-care services it provides. Despite a substantial decline in the total population of veterans, their need for health-care services has dramatically increased. Veterans who are enrolled in VHA health care and enrollees who actually use VHA health care have increased since 2000 by 74 percent and 70 percent, respectively. In absolute numbers, almost 6 million veterans use the VHA services, up from 3.4 million in 2000. Meanwhile, the VA's budget for construction and leasing of health-care facilities has increased even more dramatically during the same period. The budget for major construction projects has skyrocketed by 717 percent since 2000.

It is not clear, from research and interviews conducted for this report, exactly how decisions on the use and treatment of historic VA properties are being made with regard to required NEPA and Section 106 compliance. Multiple efforts to reach out to the VA as part of this study were ignored. What is clear is that the VA oversees substantial construction budgets as a large real-property agency. Approximately seven new replacement medical centers are currently planned or under construction, at a total cost of \$10 billion. Most of these undertakings are contingent on closing and transferring functions from existing medical centers. Yet none of these actions appear to have been evaluated in Environmental Impact Statements under NEPA, even though they certainly have the potential to significantly impact the quality of the environment (human, natural, and cultural). Likewise, Section 106 review is sometimes treated by the VA as a perfunctory clearance by State Historic Preservation Offices, without an adequate range of alternatives, and without adequate consultation from stakeholders.

In general, the planning process for the VA's management of historic capital assets is of great concern, as it determines the short-term and long-term future of the VA's capital assets. The agency uses what it calls Strategic Capital Investment Planning (SCIP), a structured framework within which the VA identifies and prioritizes construction and maintenance activities, as well as leasing from outside organizations. Once a space need is identified, the SCIP process requires an analysis of alternatives (for example, renovating an existing building or constructing a new one). NEPA and Section 106 of NHPA also require an analysis of alternatives when a federal agency undertakes a project or program.

But the SCIP analysis and the analysis of alternatives pursuant to NEPA and NHPA do not appear to take place at the same time – a major flaw in the process which hinders the careful evaluation of historic properties for reuse. The SCIP analysis takes place well before a project is ready for execution, while NEPA and NHPA reviews take place well down the line, after a specific project has been selected by the agency, oftentimes after it has already been allocated funding by the VA and/or Congress. At this point, it is generally too late to reconsider alternatives or reverse adverse impacts and, perhaps more alarmingly, public and stakeholder voices have not been solicited or heard. By this time, NEPA and NHPA reviews focus more on mitigation, rather than avoiding or minimizing adverse effects, since the SCIP alternative was selected months, if not years, earlier. In effect, the way in which the SCIP process is carried out appears to negate the intent of the federal laws to evaluate alternatives in a meaningful way and include public participation.

## **Flawed Planning Leads to Flawed Decision-making**

This faulty planning process can be due in part to the fact that the VA often tends to see historic buildings as liabilities on the federal government's balance sheet. Many VA managers and building staff assume that older buildings simply cannot be adapted to current medical uses, even though the VA's own construction cost guides reveal that renovations are more cost-effective than new construction. In particular, they often cite ceiling heights, floor-to-floor heights, and code requirements as absolute barriers to reuse.

Yet hospital interiors can be transformed to meet both patient needs and legal requirements, such as accessibility. One example is the Henry Ford Health System in Detroit, Michigan. Founded in 1915, the historic hospital, education, and research complex and Level 1 trauma center has received numerous awards and accreditations for its excellent medical care. An essential factor in the success of the hospital is the demonstrated commitment of its leadership to devote sufficient resources to maintain the complex and its historic character. The VA's own experience, such as the gold-standard accredited VA medical center in Prescott, Arizona, as well as that of other major hospital systems like the Henry Ford Health System, clearly demonstrate that high-quality, 21st century health care can be provided in historic facilities.

### **Reversing the Trend**

Until the VA's top management annuls the bias against historic buildings in their capital asset management program, historic health-care and healing places will continue to be lost forever to demolition and other disposals. Reversing this trend—and the trend of preferring new construction over renovation and adaptive reuse—would honor not just living veterans, but all veterans, for whom these historically significant buildings and landscapes were designed and built.



National Register-listed Main Hospital at the gold-standard accredited Northern Arizona VA Health Care System  
Credit: Department of Veterans Affairs

## INTRODUCTION

The National Trust for Historic Preservation (National Trust) was charted by Congress in 1949 to further the historic preservation policy of the United States and to facilitate public participation in the preservation of our nation's heritage. In fulfilling these responsibilities, the National Trust has published reports on the cultural resource management practices of federal agencies, including the U.S. Forest Service and the Bureau of Land Management, as well as other topical reports such as the National Park Service's leasing practices for historic properties. The focus of this report is the historic building stewardship responsibilities of the Department of Veterans Affairs (VA), specifically the Veterans Health Administration (VHA), a component of the VA that is responsible for 93 percent of all the VA's buildings (VA 2013d, IV:8.2-8).<sup>1</sup>

The VA was selected for review due to concerns that have been expressed about its cultural resource management practices by multiple preservation stakeholders including the National Trust, the Advisory Council on Historic Preservation (ACHP), representatives of American Indian tribes, State Historic Preservation Officers (SHPOs) and their staffs, and local and state preservation organizations. These external stakeholders question: (1) the sufficiency of the VA's compliance with Section 106 of the National Historic Preservation Act (NHPA) and the National Environmental Policy Act (NEPA); (2) the adequacy of the number of qualified preservation professionals (on staff or on contract) to carry out the VA's responsibilities nationwide; and (3) whether the VA is carrying out the imperative of the NHPA that federal agencies exercise stewardship responsibilities for historic public assets in their control.

The commissioning of this report does not mark the first time that the National Trust has engaged with

the VA. The National Trust has taken leading roles in providing advocacy to threatened VA medical centers in Leavenworth, KS and New Orleans, LA. At the request of veterans and other local stakeholders, the National Trust is currently working to protect the Battle Mountain Sanitarium in Hot Springs, SD and the Milwaukee Soldiers Home in Milwaukee, WI. Both campuses are National Historic Landmarks that represent the earliest federally provided housing and medical care to our nation's veterans as part of the National Homes for Disabled Volunteer Soldiers. They are also National Treasures - a National Trust campaign to save endangered places of national significance, and/or places where the National Trust's on-the-ground success can have positive implications for preservation nationwide.

This report was undertaken to better understand the national implications of the VA's cultural resource management practices with the ultimate goal of affecting positive change in the agency's historic properties stewardship. The information and recommendations provided are based upon a review of relevant literature and phone interviews with 55 individuals from March through July 2013.<sup>1</sup> Interviewees included former and current employees of the VA (the latter of which agreed to speak on a non-attributed basis); veterans and representatives of veterans service organizations; the head of a national veterans homelessness organization; representatives of consulting firms that work for the VA (e.g., architectural-engineering); representatives of consulting firms that provide architectural services to private-sector and non-VA governmental hospitals and other health-care facilities; and a university-based architectural design laboratory that specializes in energy conservation in hospitals.

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<sup>1</sup>Citations to documents are provided as parenthetical references, located at the end of sentences, in the following format: (author year, volume:page) or (author year, page). See the Acronyms list for authors that are identified by acronyms. The use of [year?] in a reference indicates an inferred year of publication based upon the content of the document. Full citations for the parenthetical references are found in the References section at the end of this report.

Further, interviews were held with local elected and city management officials; SHPOs and their staff; representatives of the ACHP, General Services Administration (GSA), National Park Service (NPS), and U.S. Environmental Protection Agency (USEPA) regional offices; local and state preservation groups and individual preservation advocates; and staff of the National Trust. Interviewees outside of the National Trust were not asked to approve or endorse the observations and recommendations contained herein.

The following questions guided the research and interviews:

- Who are our nation's veterans and what are their needs, particularly in the health-care area? What services are provided by the VA to veterans, and what VHA services in particular are dependent upon specific building attributes that may or may not mesh with historic buildings?
- How many historic buildings are within the VHA's stewardship and what is their condition? How has the VHA managed its capital assets (buildings and land) in the recent past and what current factors and considerations significantly influence decision making regarding building or space needs?
- What job positions within the VA, and VHA in particular, have key decision-making responsibilities for building management?
- How is the VHA's budget structured for capital asset management funds and what dollar amounts of appropriations are available?
- What legal authorities and constraints apply to repurposing historic health-care buildings for reuse either by the VA or by third parties? Are existing authorities fully explored and used? What is the VHA's track record with respect to successful preservation?

- What VA (and VHA) programs and practices are in place to address the NHPA (particularly Section 106, which requires agencies to consider the impacts of their programs and projects on historic properties and evaluate alternatives to avoid, minimize or mitigate these harms, and Section 110, the requirement for federal stewardship of historic properties), NEPA, and related cultural and natural resource requirements? What programs and practices are in place to comply with requirements to consult with external stakeholders and to involve the public in NHPA and NEPA reviews?
- How fully are the above-mentioned programs carried out in practice? How involved are external stakeholders and how successful are they in achieving their desired outcomes?

Although this report did not focus upon the National Cemetery Administration (NCA), another component organization within the VA, a note regarding the NCA is warranted. The NCA is the second largest owner of historic properties within the VA. Research and interviews revealed that NCA planning sometimes clashes with preservation of the VHA's historic campuses. An example of this is when expansions of national cemeteries directly encroach upon VHA medical centers, causing harmful visual impacts to historic campuses and landscapes and demolishing VHA buildings, as was proposed (but averted) at the Eisenhower VA Medical Center in Leavenworth, KS.

The National Trust initiated this report in February 2013 when it wrote to the Principal Executive Director, Office of Acquisition, Logistics, and Construction (OALC) to inform the VA that the organization intended for the report to serve as a constructive opportunity to assist the federal agency in furthering the goals of the NHPA, and solicited OALC's direction and recommendation that might

be helpful to the review. Near the end of February 2013, the President of the National Trust wrote to the Secretary of the VA regarding the VA's pending proposal to realign and close the Battle Mountain Sanitarium medical center. Included in that letter was notification that this report was being initiated and an invitation for the VA's cooperation and collaboration regarding the project.

Several attempts were subsequently made by phone and email to reach the OACL, the Historic Preservation Office, and Associate Executive Director of Facilities Planning within the Office of Construction and Facilities Management (CFM). In general, the VA elected not to participate in the preparation of this report. After consultation between the primary researcher and author of this report and representatives of the National Trust, it was decided not to try to gain access to information through a comprehensive Freedom of Information Act request. As a consequence, the primary source of data and information cited in this report is VA documents available on the Internet (or supplied by interviewees and the National Trust). Without the aid and participation of the VA, inadvertent misinterpretations of VA documentation may have occurred. Any errors in this regard are not likely to substantively affect the recommendations of this report.



# 1

# Veterans, VA Services, and Veterans Service Organizations

This section summarizes information about the current population of veterans and the types of VA services available to them, followed by a description of veterans service organizations, which are key stakeholders with respect to research and advocacy on behalf of veterans, including health care and management of health-care facilities.



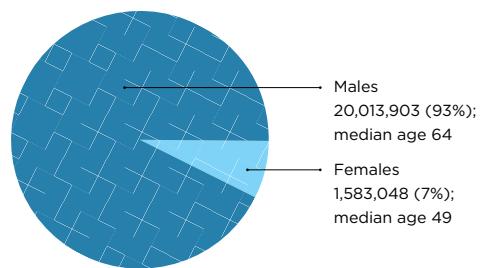
Former Dining Hall, Dwight D. Eisenhower VA Medical Center, Leavenworth, KS Credit: Pioneer Group

## VETERANS

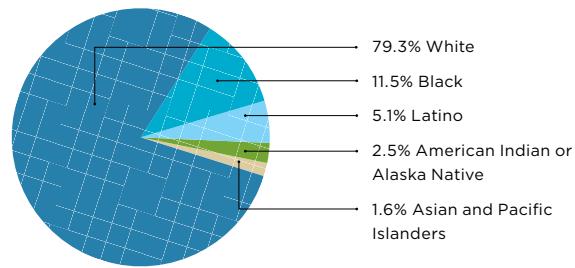
The most current official projection of the veteran population is 22,676,149 individuals as of September 2011 (VA 2013g, 2). Approximately 33.9 percent of the current veteran population has served in a combat or war zone (*Ibid.*, D:68), but such experience does not in and of itself determine whether a person is a veteran. Legally, a veteran is a person that has served his or her full obligation of active duty in the military; has

received an early discharge for a medical condition; or has been subject to a reduction in force, a hardship discharge, or has been discharged at the convenience of the military (38 U.S. Code § 101(2)). The term “veteran” does not include someone who is currently in active duty military service or someone who has been dishonorably discharged.

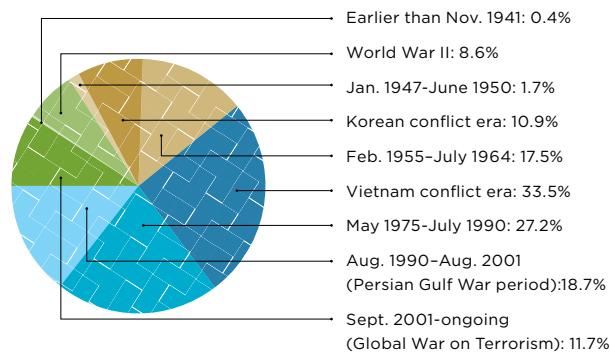
### Veterans by Gender



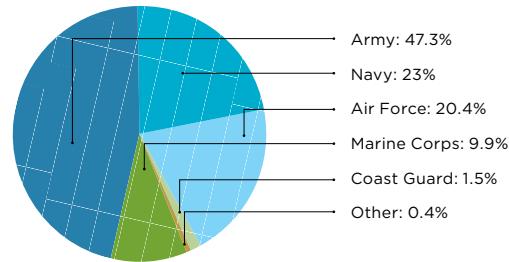
### Veterans by Race



### Veterans by Time Period of Service



### Veterans by Service of Active Duty



## VA SERVICES

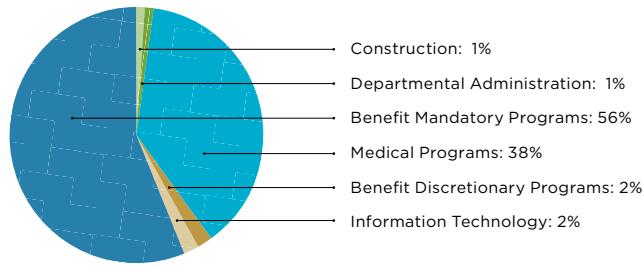
The VA is one of 15 Cabinet-level departments of the executive branch of the U.S. government. The agency has the largest civilian workforce within the executive departments, consisting of 329,937 employees (OPM 2013). With respect to its service programs for veterans, the strategic goals of the VA are to: (1) improve the quality and accessibility of health care, benefits, and memorial services while optimizing value; (2) increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services; and (3) raise readiness to provide services and protect people and assets continuously and in time of crisis (VA 2011n, 21).

The agency's fiscal year (FY) 2014 budget request to Congress totaled \$152.7 billion, allocated among the program and support areas depicted in the graph. There are three major Administrations within the VA: the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA). The VHA manages the medical programs budget and most of the VA's construction budget, the latter of which is a relatively small share of the total budget but exceeds \$1 billion. Mandatory and discretionary benefit programs are carried out by the VBA (e.g., disability compensation) and the NCA (burials and burial-related services).

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### 2014 VA Budget Request \$152.7 Billion

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### Health-Care Services and Facilities

Health-care services and facilities are provided by the VHA along a "continuum of care" (VA 2009d, 2:2-3). The continuum includes inpatient care, in which a veteran is admitted to a hospital or a separate, specialized service facility (e.g., a domiciliary, see discussion below) for one or more nights, and outpatient care (sometimes called "ambulatory care," except for emergency room visits). Currently, VHA operates 151 medical centers that feature a main hospital and inpatient beds (GAO 2012b, 30; VA 2013h, 6). Medical professionals conduct or provide examinations and procedures relating to general medical/surgery, psychiatry, long-term care (acute), rehabilitation from surgery and injuries of all types, and specialized surgical procedures such as cardiac surgery or organ transplants.

Outpatient care is comprehensive and includes surgical services, diagnostic and therapeutic services (e.g., endoscopy, physical or cancer therapy, sleep centers), medical care (e.g., heart catheterization, ear, nose, or throat offices), and eye and dental care. The VHA maintains 169 outpatient clinics in the 151 medical centers and 827 community-based outpatient clinics that are distributed in storefront locations throughout urban and rural areas (*Ibid.*). Additionally, at some locations, the VA offers overnight lodging for veterans who travel 50 miles or more to access outpatient services.<sup>2</sup>

The VA also offers substantial expertise and facilities, including domiciliaries and Vet Centers, to address behavioral health-care needs of veterans, including those that are homeless. Some of these services are provided at medical centers, while others are provided in local clinics that are not located at a medical center. Approximately 103 domiciliary residential rehabilitation sites are operated around the country (VA 2013h, 6). These are each multiple-building facilities where veterans stay in a structured and home-like environment for up to six months. Treatment is provided by a team of

<sup>2</sup>These temporary accommodations are called "hoptel" (not "hostel") lodging, which offers opportunities to repurpose historic buildings.

specialists and support personnel for basic physical-care needs, mental-health care, and addictions. Workforce preparation is also provided.

Three hundred fixed Vet Centers provide transition assistance to address the social, economic, and psychological needs of military personnel who are returning to civilian life and their families, including post-war employment, family adjustment and marital counseling, post-traumatic stress disorder, military sexual trauma, alcoholism and other substance abuse, and bereavement. In addition, there are 70 mobile Vet Centers located in rural and urban areas throughout the continental U.S., Hawaii, and Puerto Rico (VA 2012k).

The VHA also offers geriatric and extended-care services and facilities, including 135 community living centers, and provides some financial support for the care of elder veterans in their home, in medical foster homes, or in other community-based facilities.

### **Health-Care Eligibility and Use**

Veterans choose whether or not to be treated at a VHA facility. Their choice is driven by several factors, not the least of which is whether they have health-care insurance. In general, as income increases, reliance on VA decreases because the veteran has health insurance and uses non-VA facilities (GAO 1996, 5). Approximately 23 percent of veterans do not have health insurance coverage, a number that has increased since the 1990s (VA 2012o, 59). The VHA itself is not a health insurance program. Its doctors, nurses, and other personnel are federal government employees paid by direct salaries.

The Veterans' Health Care Eligibility Reform Act of 1996, which became effective October 1, 1998, requires most veterans to enroll to receive VHA health care. Following enrollment, each person is assigned to a Priority Group (from 1 to 8 currently, which relates to preferences in service delivery) that

is based upon the individual's eligibility status. At the highest-priority end of the spectrum, Priority Group 1 (representing 14.9 percent of 2011 enrollees) are veterans with service-connected disabilities rated 50 percent or more disabled (*Ibid.*, 21). The lowest-priority population is in Priority Groups 7 and 8, representing 28 percent of 2011 enrollees, which are generally veterans with non-service connected medical needs and an annual income and net worth above a VA "means test" threshold (*Ibid.*, 19).

Since enrollment figures first began to be formally compiled for health-care planning, the number of veteran-enrollees as a percentage of the overall veteran population has ranged from 14 to 35 percent (see Appendix A). The number of enrollees does not necessarily correspond with patients that use VHA facilities because veterans may not realize that they are enrolled (because individuals who have certain service-connected disabilities are automatically enrolled, for example) or, if enrolled, they may choose to use non-VA health care. In 2012, for example, only 64 percent of enrollees used VHA health care at some point (see Appendix A).

### **Planning for Veterans Health Care**

The VHA's decision to construct new buildings—or to seek opportunities to repurpose existing historic buildings—is substantially affected by planning for the projected health-care needs of veterans (e.g., the types of medical needs [such as primary or specialized care], gender-based needs, and the like). Since FY 1997, the VHA has used the Enrollee Health Care Demand Model to forecast the majority of its budget needs for medical services and facilities (GAO 1999a, 14). The model yields 20-year projections of the number of future enrollees, use of specific health-care services, and associated costs. The data is broken down by future year, enrollment priority group, veteran age, VISN, geographic market, and VHA facility.

This planning forecast draws on a broad range of data, and seeks to understand in detail demographic information about veterans, where they live, their family and work status, and their physical and medical needs. One current and future emphasis area is care for polytrauma, which is defined as “two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability” (<http://www.polytrauma.va.gov>). Another area of focus relates to planning for mental-health care, including post-traumatic stress disorder (PTSD).

Today, the VA is the largest provider of mental-health services in this country (VA 2007d).

A recent, comprehensive study of the needs of returning troops found that an estimated 110,000 to 440,000 men and women who served in these recent conflicts exhibit some degree of PTSD (*Ibid.*, 427). Sexual assault of females by co-service members or superiors during combat service (military sexual trauma) is an important risk factor contributing to PTSD among female veterans (*Ibid.*, 73).

Projected growth or decline of veteran numbers is another factor considered in the planning for projected health-care needs of veterans.

Approximately 2.2 million troops have been deployed in Iraq and Afghanistan (National Academies 2013, 1).

However, the wave of World War II veterans who are passing has exceeded the number of newly designated veterans since the September 2001 attacks; the estimated population of veterans has declined by almost 17 percent since 2000.

Despite this substantial decline in the total population of veterans, the demand among veterans for health-care services has dramatically increased. Veterans who are enrolled in VHA health care and enrollees who actually use VHA health care have increased since 2000 by 74 percent and 70 percent, respectively. In absolute numbers, almost 6 million veterans use VHA services, up from about 3.4 million in 2000. Yet, the actual enrollee-patients still comprise only about 27 percent of the entire estimated population of veterans, compared to 20.6 percent in 2000. The other 73 percent either use non-federal health-care service providers that are accessible through employer or other insurance plans or do not access health-care services.

While the demand for VHA health-care services has substantially increased, the VA's budget for construction and leasing of health-care facilities has increased much more dramatically during the same period. The Major Construction budget has increased 347 percent (with an appropriation of \$532.5 million in fiscal year 2013) and the Minor Construction budget has increased 347 percent

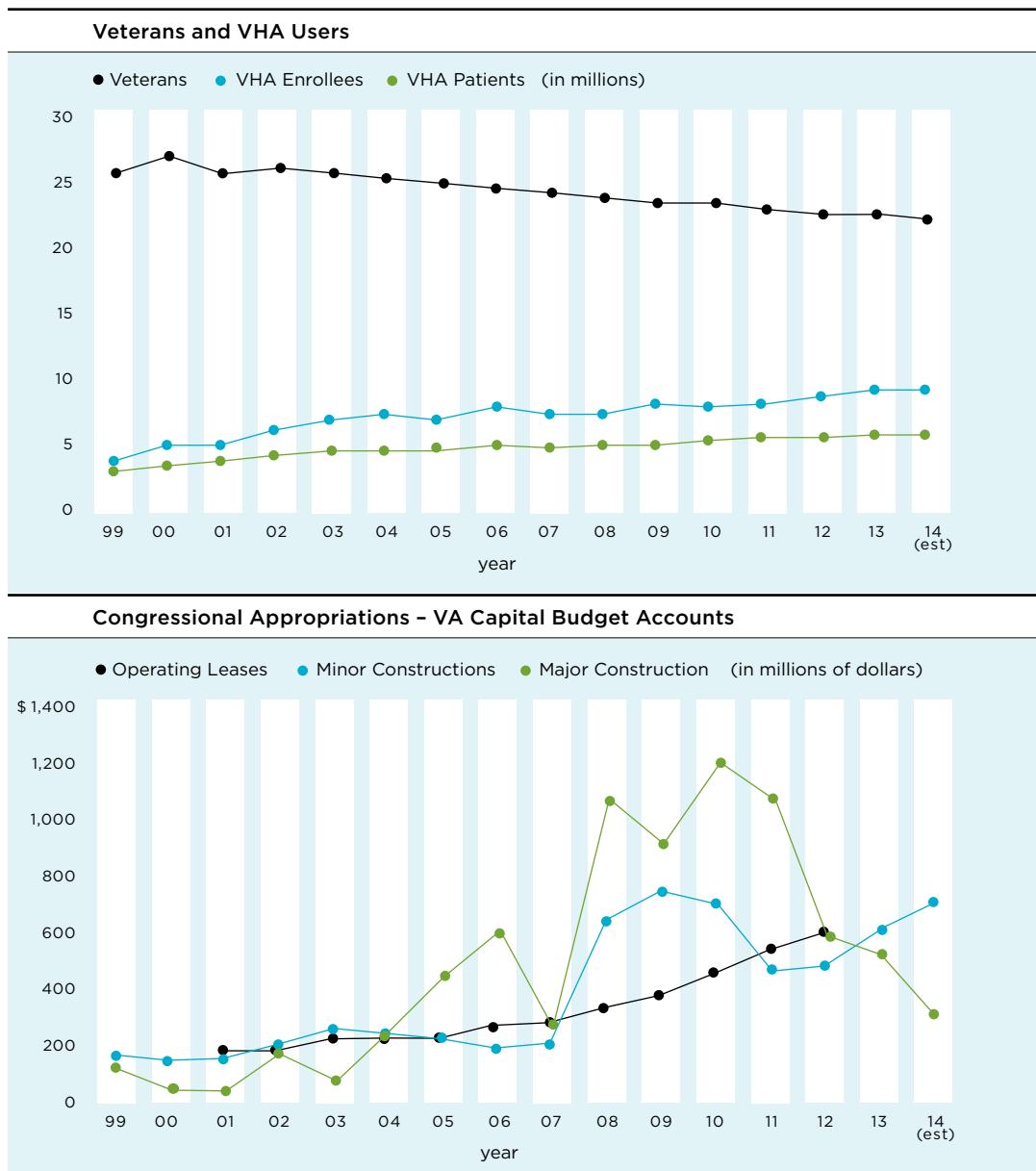
## VETERANS HOMELESSNESS

The VA is committed to eliminating homelessness among veterans, who are three times more likely to be homeless than the rest of the U.S. population. The most recent estimate, from January 2012, is that 62,619 veterans are homeless (VA 2013h, 9). African Americans, Latinos, and Native Americans comprise almost 46 percent of homeless veterans (National Academies 2013, 338), which is a sizeable percentage given that these individuals make up 19 percent of the veteran population as a whole (VA 2013g). In addition to needing shelter, homeless veterans often need treatment and care for substance abuse and mental-health disorders, primary care, and assistance in the transition to lodging.

since 2000 (with an appropriation of \$607.53 million in fiscal year 2013). Appropriations for Operating Leases, which are three-to-six times more costly than VHA construction on a square-footage basis, have risen 207 percent since 2001. The appropriation of \$608 million for these leases

in FY 2013 exceeded the individual budgets for Major and Minor Construction.<sup>3</sup>

Between the mid-1990s and August 2013, the number of VA hospitals was reduced through closure or change in use from 173 to 151 (GAO 1997a, 4; VA 2013h, 6)<sup>4</sup>. Medical care costs were also reduced by



<sup>3</sup> Construction and leasing budget accounts are explained in more detail in Section 3.

<sup>4</sup> The reduction in hospitals seems contrary to the substantial increases in the VA's construction budgets. Major and Minor Construction for new and different types of outpatient service buildings accounts for a large share of these increases, yet new replacement medical centers are being built as well despite the decline overall in hospitals.

eliminating hospital beds, even if hospitals were not closed outright—from 1980 to 1996, for example, the VA eliminated 42 percent of its hospital beds (VA 1996, 13). The impact of these initiatives is reflected in outpatient care as well. In 1995, for every veteran inpatient stay at a hospital, there were 29 visits to an outpatient clinic; by 2010, for every inpatient stay there were over 100 outpatient clinic visits (VA 2010a, 8). Community-based outpatient clinics (located separately from VA hospitals) increased in number from 12 to 827 (GAO 1997a, 14; VA 2013b, 6), many acquired through Operating Leases.

However, several considerations should give pause to the continued generalization that VA's inventory of hospitals and inpatient beds should be reduced. First is the assumption, that this country will not produce more veterans through engagements in new armed conflicts. The estimate made in 1999 that there would be 16 million veterans by 2020 is now an estimate of 19.6 million veterans by 2020, but drops substantially to 14.46 veterans by 2040 (VA 2013b, 12). Additionally, the generalization that the VA needs fewer inpatient beds is not entirely correct, based on the VA's representations to the Office of Management and Budget and Congress. Most of the VA medical centers will need additional inpatient capacity to meet the projected needs of veterans for mental health and specialty services through the year 2020 (VA 2013d, IV:8.3-4).

### **Other VA Services**

Although the VHA is responsible for the vast majority of buildings and the capital construction budget within the VA, over one-half of the VA's overall budget is devoted to the non-medical mandatory and discretionary services provided by the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA). With the exception of burials, these programs provide opportunities for co-location and repurposing of historic buildings for staff and for direct client services, including independent living.

## **VETERANS SERVICE ORGANIZATIONS**

The Office of the Secretary of the VA publishes a detailed directory of veterans service organizations (VSOS). The current directory identifies approximately 144 not-for-profit VSOS, located throughout the country, which exist to serve the interests of veterans (VA 2012b). Within the directory, these organizations are categorized into three groups: (1) congressionally chartered and other VSOS recognized by the Secretary of the VA for the purpose of preparing, presenting, and processing veteran claims for benefits (36 total); (2) other congressionally chartered VSOS that represent veteran interests but are not authorized to participate in the claims process (11 total); and (3) other VSOS that are not congressionally chartered and are not authorized to participate in the claims process (97 total).

The earliest congressionally chartered VSO is the Navy Mutual Aid Association (July 28, 1879), and the most recent is the Military Officers Association of America (November 6, 2009) (*Ibid.*, 5-3). Chartered, membership VSOS that may tend to be more well-recognized by the general public include the American Red Cross, The American Legion, Disabled American Veterans (DAV), Veterans of Foreign Wars of the United States (VFW), AMVETS (American Veterans), Paralyzed Veterans of America (PVA), Vietnam Veterans of America, and the Wounded Warrior Project. Four of these organizations—AMVETS, DAV, PVA, and VFW—co-author an “independent budget” for the VA each year for Congress to consider as the legislative body also weighs the VA's own budget submission (GAO 1996, 20). The independent budget is characterized as “created by veterans for veterans for VA” and also serves as a means to educate the public about the needs of the constituencies of these membership organizations (<http://www.independent-budget.org/>).

The combined membership of the largest two of the congressionally chartered VSOs is approximately 4.6 million—the VFW (1.6 million members) and The American Legion (3 million members). The organization of the national VSOs varies, but typically there is a governing board, staffed central headquarters, and subordinate service offices, chapters, departments, or other units, often operating at a state- or regional-level, that are staffed and also commanded by a volunteer leadership (e.g., Department Commander, Department Adjutant). The state- or regional-level units may or may not be subdivided into districts, counties, or divisions. Locally, membership participation is typically grouped around chapters, posts, or other comparable units.

VSOs perform a wide array of activities on behalf of veterans, including legislative advocacy before Congress and state legislatures, volunteering at VA facilities, providing guidance and support to veterans about VA-related issues and concerns, performing local community service for veterans and their families (e.g., transitional assistance for veterans returning to civilian life, relief funds, and health fairs), educating the public about veterans and their needs, and supporting scholarships. Representatives of VSOs also participate in 15 advisory committees that have been established by Congress, as well as another nine such committees that have been created to advise the VA on select topics and programs (VA 2012b, 6-2).

Several of the national VSOs, such as the DAV, PVA, VFW, and The American Legion, are authorized to staff offices at VA medical centers in order to advise veterans on benefits and perform related services. In fact, the VA has issued space planning criteria for their office use at VA facilities (VA 2008d). Thus, VSOs offer potential use or reuse options for the VA's historic buildings.

## 2 Historic Medical Facilities

This section provides background information on the VA's current inventory of historic medical campuses. In 2012, two branches of the National Home for Disabled Volunteer Soldiers (the First Generation facilities)—the Battle Mountain Sanitarium in Hot Springs, South Dakota, and the Milwaukee National Soldiers Home in Wisconsin—were named as National Treasures by the National Trust as part of a concerted and coordinated grassroots campaign to preserve these nationally significant landmarks.



Ward Memorial Hall, Clement J. Zablocki VA Medical Center (aka Milwaukee Soldiers Home), Milwaukee, WI Credit: National Trust for Historic Preservation

## HISTORIC MEDICAL FACILITIES

Approximately 91 percent of the VA's inventory of buildings has been evaluated for eligibility for listing in the National Register of Historic Places (National Register) (GAO 2012b, 30, fn. 95). Substantial work has been undertaken by the VA over the past decade to evaluate and nominate the VHA's historic properties to the National Register. Studies that evaluate the historic significance of the First and Second Generation facilities have been prepared, and one is reported to be pending for the Third Generation of medical centers.

As of August 2013, the VHA's National Register listings are comprised of nine branches of the National Home for Disabled Volunteer Soldiers (First Generation historic districts), five of which are National Historic Landmarks; 43 Second Generation historic districts; four archaeological sites; and nine individual buildings, mostly houses (see Appendix B). Several of the historic districts include cemeteries, and there are otherwise 68 cemeteries managed by the National Cemetery Administration that are individually listed. A National Register nomination is pending for the VHA's medical center at Fort Harrison in Helena, MT (VA [2011?o]). To date, none of the Third Generation medical centers have been listed based upon a review of the National Register database of the National Park Service.

The design of facilities to respond to the physical and mental-health needs of veterans is based on several factors, as reflected in the descriptions below of the three generations of VHA construction. These factors include the traumas of personnel serving in particular wars, the ways that troops on both sides were equipped (or insurgents, guerilla fighters, or any other type of non-militia groups were armed), and the combat zone medical services that have been available to our military personnel. Generations of veteran-care facilities are also

products of the science, equipment, and medical treatment of their time; cost and congressional appropriations; site availability; the support of local communities; and the political efficacy of elected officials.

### First Generation Facilities

#### Period of Significance 1865-1930<sup>5</sup>

As the Civil War was ending, the Superintendent of Special Relief for the U.S. Sanitary Commission issued a conceptual plan for care homes for Union Army veterans based upon the use of "the best principles of modern social science" and the desire to:

... follow no ambitious examples of the old world . . . We want to lose sight entirely of the questions of whether marble towers look better than pine barracks, while we keep our eye on the larger thought of how we can best and soonest restore these disabled men, so far as is possible, to their homes and into the working community . . . (Knapp 1865)

In order to achieve these goals, Knapp conceptualized that a sanitarium should reflect several purposes, serving as an asylum, workshop, school, farm lands, gardens, and home. Medical treatment was envisioned at the "very highest skill" that could be brought to bear on all "the arts and appliances of modern surgical and medical science." The Sanitary Commission had already conducted surveys of veterans of the Army of the Potomac and of towns throughout the North in order to plan for services and facilities.

Congress authorized 11 branches of National Home for Disabled Volunteer Soldiers (NHDVS, or National Soldiers Homes) after the Civil War in response to appeals, such as Knapp's, to serve the physical, mental, and reincorporation needs of veterans of the Grand Army of the Republic (the Union soldiers). Despite Knapp's admonition regarding "marble towers," the branches were constructed with resplendent buildings on relatively large tracts of land

<sup>5</sup>The end of this period of significance corresponds to creation of the Veterans Administration, which absorbed the National Home for Disabled Volunteer Soldiers (Julin 2007, 2). This period of significance overlaps with that of the Second Generation facilities.

(originally ranging from several hundreds acres to over 1,000 acres) in rural areas. Rural locations were consciously chosen because of favorable environmental conditions to promote healing (e.g., fresh air, sunshine, or mineral waters) and because they were relatively isolated from temptations likely to be found more readily in urban areas, such as alcohol. The National Soldiers Home campuses were huge draws for public visitation and tourism during the late 19th century and turn of the 20th century. The Milwaukee campus estimated more than 40,000 visitors in 1877, while the campus in Dayton, OH, reported over 100,000 visitors a year (Plante 2004).

The National Soldiers Homes modeled “biophilic design,” which is promoted in current health-care facility planning. The VA defines this type of design as the assembly of “buildings and constructed landscapes that foster a positive connection between people and nature in places of cultural and ecological significance” (VA 2009d, 2:2-8). Many of the First Generation hospitals feature the “pavilion style” hospital configuration that includes a linear, primary corridor to circulate supplies and people and spoke-like extensions radiating from this corridor for patient wards. The depth of the primary hospital is “thin,” which allows “light and fresh air to penetrate and create[s] garden views between the building crenellations” (Burpee 2008, 1). On the whole, some interior spaces and features may be less significant and, thus, may be more susceptible to alteration or adaptive use, while allowing the retention of the overall historic significance of the building.

Segregated facilities at the National Soldiers Homes were open to black veterans, who had comprised about 10 percent of Union Army soldiers, but the population of black veterans in the NHDVS remained relatively low (about 2.5 percent) by the late 19th century (Julin 2007, 17). The Southern Branch Home (in Hampton, VA) opened in 1870 for black veterans. However, the number of



Historic Campus Aerial, Hot Springs VA Medical Center (aka Battle Mountain Sanitarium), Hot Springs, SD  
Credit: VA Battle Mountain Museum Committee

The Battle Mountain Sanitarium in Hot Springs, SD, was established on approximately 101 acres in 1902 and opened in 1907. It is the oldest facility in the VA Medical System established solely to provide medical care, and is now identified as the Hot Springs VA Medical Center within the VA's Black Hills Health Care System. The original sandstone buildings were designed by Omaha architect Thomas Rogers Kimball in Mission/Spanish Colonial Revival-inspired style. Kimball also incorporated the elements of Romanesque Revival/Richardsonian Romanesque architecture of the spacious homes in Hot Springs that were visible from Battle Mountain. George E. Kessler of Kansas City designed the original landscape (Julin 2008). In 2011, 53 acres of Battle Mountain Sanitarium and 32 of the campus buildings were designated as a National Historic Landmark.

white veterans at this branch consistently exceeded that of their black peers (*Ibid.*, 47).

A detailed discussion of the National Soldiers Homes is found in the theme study for these First Generation facilities (Julin 2007). Appendix C to this report lists the names, locations, and current status of these 11 historic medical centers.



Old Main, Clement J. Zablocki VA Medical Center  
(aka Milwaukee Soldiers Home), Milwaukee, WI  
Credit: Matthew Gilson

In 1866, the Northwestern Branch of NHDVS was established about one mile west of Milwaukee. Local donations included 26 out of the 400 acres of land and \$95,000, showing strong local support for the facility and the "realization of the economic and social importance of the NHDVS" facilities. The visual and functional core of the campus was the Gothic Revival-style Main Building (today, "Old Main"), a five-story structure designed by Edward Townsend Mix and situated on the highest topographic point on the campus. This Old Main Building and the governor's house are the oldest remaining buildings in the U.S. constructed for the NHDVS under the direction of its Board of Managers (Julin 2007, 64). The foot of every bed featured a metal frame with a card that had each man's identifying information. However, "[t]here was no mention of his titles or his honors, for the national soldiers' home near Milwaukee is democratic in this regard. There is a brigadier general; there are some colonels and other heroes, once conspicuous, but hard luck followed them after the war, and at the home they are treated equally and ask no favors." (Burnett 1898)

## Second Generation Facilities Period of Significance 1919-1950<sup>6</sup>

The United States' formal participation in World War I was relatively brief (from April 6, 1917 until the war's end on November 11, 1918). However, the conflict had significant consequences in terms of combat trauma because it marked the largest mobilization effort in this country's history at the time (four million military troops), which meant that hundreds of thousands of returning soldiers, airmen, sailors, and Marines would need medical care.

According to the National Register Multiple Property Documentation Form for the Second Generation Hospitals, 125 facilities were built between 1918 and 1950 (Spurlock, Hudson, and Potts 2011). A list of the facilities and locations identified in this submission is provided in Appendix D. The narrative contains an extensive discussion of the two major periods of construction (Periods I and II) and four functional sub-types of these facilities (general medical and surgical hospitals, home/general medical hospitals, neuropsychiatric facilities, tuberculosis facilities).

The hospitals in Second Generation facilities reflect a plan referred to as a "podium on a platform" (Burpee 2008, 2). Instead of the thin, radial-like configuration of the First Generation facilities, Second Generation hospitals generally were built in an "H" or "E" layout when viewed from above.

The span from the front of the buildings to the back is deep, and the buildings are likely to feature at least two stories at minimum, but often more. The "podium" on top of this deep-span platform is the floor reserved for patient care and stays. The long spans meant long hallways and circulation corridors, which increased the percentage of time spent by staff and patients walking to and fro, as well as moving patients around.

<sup>6</sup>The beginning of this period of significance corresponds to the end of World War I when Congress enacted the Langley bill to fund new hospital construction for returning veterans (Spurlock, Hudson, and Potts 2011, E:9).



Historic Campus Aerial, Alexandria VA Medical Center, Pineville, LA

Credit: Photo courtesy of the State Library of Louisiana

Most of the 80 Period I hospitals (built from 1919 through the mid-1920s) were constructed on either “greenfield” sites or within the National Soldiers Home branches, or Public Health Service installations, or existing military posts (such as the Walla Walla, WA, campus that was co-located with Fort Walla Walla). The main buildings are usually two-story focal points of the campus and are situated at the end of a long, linear drive from the main entrance into the property. Patient wards and treatment buildings are typically also two stories. Exterior and interior decorative effects are fairly limited and, where they exist, are typically found in the front “entry surrounds, keystones over façade window openings, and decorative brickwork usually found on the theater/recreation buildings” (Spurlock, Hudson, and Potts 2011). The 45 Period II hospitals date from the late 1920s to 1950. Generally, main buildings grew in size to three or four stories during this period and, in some cases, included an additional floor for a central pavilion. According to the Multiple Property Documentation submittal, the majority of Period II hospital

campuses were constructed in the Colonial Revival and Georgian Colonial Revival architectural styles (red brick exterior, symmetrical fenestration, mixture of Georgian and federal elements).

However, in some areas, local and regional architectural styles influenced the exterior design and materials, including the French Colonial complex at Pineville, LA (photo previous page); the Spanish Colonial/Pueblo Revival style buildings at the Albuquerque complex (photo right); and the Spanish Colonial Revival/Mission Revival styles at American Lake, Washington.

Overall, exterior decoration is more extensively used in Period II facilities than in Period I facilities, especially in buildings that have primary public façades (such as the hospitals and recreation buildings). However, similar to buildings in the branches of the National Home for Disabled Volunteer Soldiers, retaining the integrity of the interiors of Second Generation hospitals is generally not essential to retaining their historic significance for architecture and association with events in history.



Historic Administration Building, Raymond G. Murphy VA Medical Center, Albuquerque, NM

Credit: John Phelan via Wikimedia Commons

### Third Generation Facilities

Following World War II, General Omar N. Bradley was named as administrator of the Bureau of Veterans Affairs. At least 29 of 77 proposed new hospitals (Third Generation facilities) were constructed during his two years of service between 1945 and 1947 (VA 1997a, 15). Additionally, 98 of the existing VA campuses were scheduled for expansion by construction of Third Generation buildings (U.S. Army 1946, V:527). In contrast to the previous two generations of hospital construction, new Third Generation sites were often located in urban areas on relatively small footprints of land. Psychiatric care and treatment had shifted by this time to the use of psychotropic drugs rather

than emphasizing outdoor, active recreation in rural areas, thus reducing the need for large land areas (Spurlock, Hudson, and Potts 2011, E:70). Architecturally, Third Generation hospitals are often multi-story and H-shaped, with flat roofs (*Ibid.*) (see the photo of the Louisville hospital).

In September 2010, the VA contracted with a cultural resource management consulting firm to prepare a nationwide historic context for the Third Generation facilities (VA 2011m). According to the firm's website, the study has been completed (although it has not been released publicly) and ten individual National Register nominations have been prepared for select hospitals (Goodwin n.d.).



Model (left) of a Third Generation VA hospital (1950) designed by Louis Justement, architect. Photo credit: Theodor Horydczak. Source: Library of Congress.



Third Generation facility in Louisville, KY (the Rex Robley VA Medical Center), which the VA proposes to replace. Photo credit: Department of Veterans Affairs.

# 3

## The VA's Organizational Structure and Programs for Managing Capital Assets and Cultural Resources

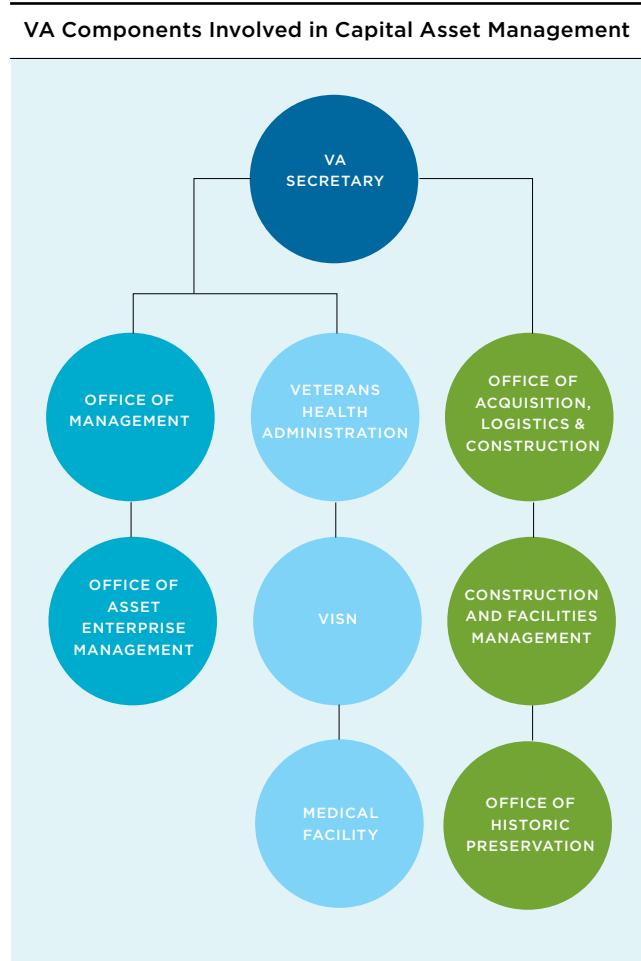
This section provides an overview of the primary VA decision makers and designated compliance officers with respect to managing capital assets (including historic buildings) and the related programs that they administer, primarily the Strategic Capital Investment Planning process. The VA's internal programs regarding implementation of the National Historic Preservation Act (NHPA) and National Environmental Policy Act (NEPA) are also addressed.

Bandstand, James H. Quillen VA Medical Center (aka Mountain Home), Johnson City, TN Credit: National Trust for Historic Preservation



## THE VA ORGANIZATION

The modified organizational chart depicts key VA components involved in capital asset management.



### Central Office

For almost 60 years, the Veterans Administration operated as an independent agency of the executive branch of the federal government. Effective March 15, 1989, however, the agency was renamed the Department of Veterans Affairs and elevated to one of 15 Cabinet-level executive departments. The Secretary of the VA is nominated by the President and is subject to Senate confirmation. He/she is

responsible for the overall direction and management of the Department and for carrying out all laws that the Department administers and to which the Department is subject.

The Deputy Secretary for Veterans Affairs oversees the Executive Director of the Office of Acquisition, Logistics, and Construction (OALC). According to the VA's cultural resources directive, the Executive Director of OALC is the Senior Policy Official with respect to the VA's compliance with cultural resource legal requirements. Located within OALC is the Office of Construction and Facilities Management (CFM), which provides services to the VA in the areas of design and historic preservation, major construction, project management of major leases, and construction standards and quality assurance.

The Office of Historic Preservation within CFM has a national preservation staff of two: a Federal Preservation Officer (FPO) (an archaeologist) and a Deputy FPO (an architect). According to interviewees, the VA's preservation staff is often actively engaged in Section 106 consultations around the country. In addition, the Office of Federal Agency Programs within the Advisory Council on Historic Preservation includes temporary employees, called "liaison" staff, who provide support in Section 106 consultations and other preservation activities (e.g., training) to certain federal agencies that fund their positions. The VA has funded a full-time liaison staff position at the Advisory Council since at least FY 2008 (AHP 2009), which allows the VA to leverage its own preservation staff.

Policy for capital asset management is primarily established by the Office of Asset Enterprise Management (OAEM), which is located in the Office of Management (the latter is headed by an Assistant Secretary who advises the Secretary's Office and the three VA Administrations). The Director of OAEM serves as the agency's Real Property Officer for the purpose of carrying out the

federal real property mandates of Executive Order 13327 (U.S. President 2004) and related directives, and also serves as the Senior Sustainability Officer for energy and natural resource conservation required under Executive Order 13514 (*Ibid.*, 2009). The OAEM also manages the VA's Strategic Capital Investment Planning process and the enhanced-use leasing program.

Each of the three VA Administrations (Veterans Health Administration, Veterans Benefits Administration, National Cemetery Administration) is responsible for carrying out capital asset policies and for annually reporting on the results of their "performance" to OAEM. The Under Secretary for Health of the VHA has overall responsibility for compliance with legal requirements relating to the construction, management, maintenance, and disposal of medical centers and other VHA facilities.

#### **Regional and Local Personnel of the VHA**

Decisions regarding building management, daily operations, and health-care delivery of the VHA are made in the 21 multi-state VISNs. Key decision makers within each VISN are primarily the VISN Director, who is responsible for overall medical, human resource, and facilities management at each medical center and related sites, and the VISN Capital Asset Manager. Their counterparts at individual medical facilities are the Medical Center Director and Medical Center Chief Engineer (or Chief Facilities Manager).

The VISN Capital Asset Managers and Medical Center Chief Engineers (or Chief Facility Managers) are chiefly responsible for VHA building and land management. Capital Asset Managers are responsible for strategic capital planning, master planning, all construction, non-recurring maintenance, leases (including enhanced-use leasing), capital asset inventories, facility condition assessments, building disposals, vehicle fleets, and energy conservation. Medical Center Chief Engineers have comparable responsibilities at the facility level.

## **CAPITAL ASSET MANAGEMENT**

This section provides contextual background to the VA's current approach to managing its buildings and lands. The current framework for this management approach—the Strategic Capital Investment Planning (SCIP) process for life-cycle management of the VA's capital assets—is then described.

#### **Background and Context**

The ways in which VA managers currently address historic and non-historic buildings seem to reflect particular influences that crystallized in the 1990s, before the Global War on Terrorism began as a result of the September 11, 2001 terrorist attacks on the U.S. Until the late 1990s, there was no systematic structure within the VA to plan for building space or to prioritize budget requests for capital projects (VA OIG 1998, i). Each annual budget request for construction funds was simply increased from that of the previous year by an inflation factor. The Central Office prepared the budget requests and controlled the construction appropriations. Medical centers did not pay for capital investments out of their own budgets, except in limited instances.

Three initiatives introduced in the 1990s, only one of which was under the VA's control, have substantially affected building management: (1) the congressionally legislated corporatization of the federal government; (2) the VHA's Vision for Change; and (3) managed care in the health-care industry. The first initiative directed that federal agencies become more business-like and "results-oriented" by requiring agencies to create a Chief Financial Officer position and prepare annual financial statements and balance sheets (see, e.g., Chief Financial Officers Act of 1990, Government Performance and Results Act of 1993). Managing "capital assets," measuring the "return on investment" of expenditures on services and infrastructure, and preparing the "business case" or "prospectus" for Congress prior to budget

approval of construction are now a routine part of the federal sector's parlance, including that of the VA's, as a result of this initiative.

The second major initiative occurred within the VA itself, specifically, the VHA. In March 1995, the Under Secretary for Health for the VHA issued the Vision for Change, a plainly written but provocative internal call to action. The transformation that followed this reorganization plan steered the VHA toward providing more primary care and established 22 (now 21) multi-state networks (the Veterans Integrated Service Networks, VISNs) within the VHA as the primary organizational units for planning, operating, and financial decisions. Establishing the VISNs and giving them decentralized decision-making authority marked the most substantial organizational change within the agency since a department-and-staff hierarchy was adopted by the Veterans Administration in 1953 (Comptroller General 1954, 11).

The third initiative that dominated the VA and health care generally in the 1990s was the rise of

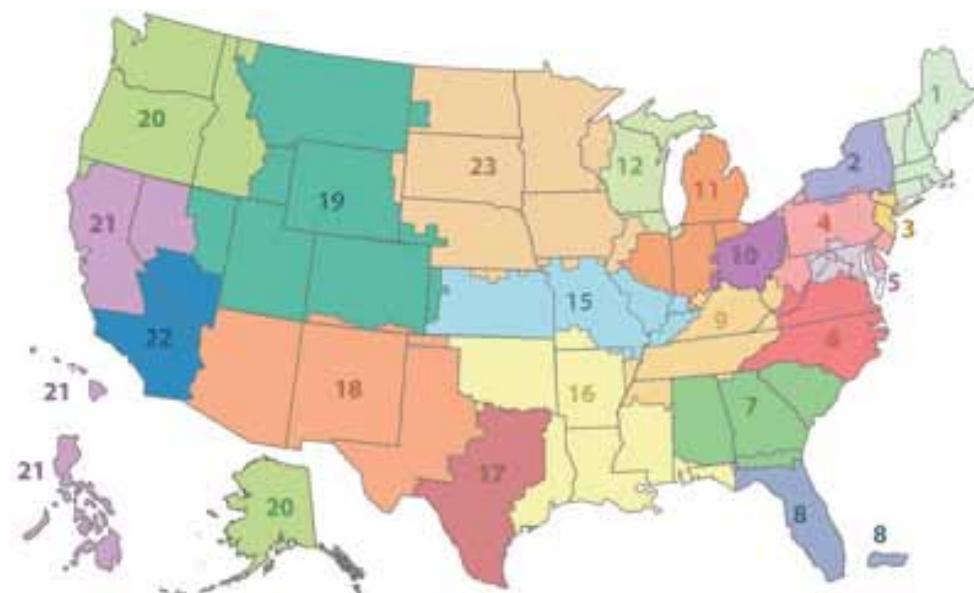
managed care. Even though the VA is not an insurance-based provider, it tries to recover revenues when it treats veterans that are insured. By 1990, 9 out of 10 veterans had other alternatives to VA standard-benefit health-care services and almost 81 percent had private health-care insurance (GAO 1996, 3). Managed care shifts the financial risks of patient care from insurers to health-care providers. In effect, the concept deemphasizes inpatient stays at hospitals and promotes providing outpatient services within existing hospitals or off site at "storefront" clinics or other outlets.

At congressional bidding, VA's health-care facilities came under intense scrutiny by the General Accounting Office—now the Government Accountability Office (GAO)—in the 1990s. This scrutiny appears to be an outcome of the previously mentioned federal financial reforms and managed care (notwithstanding that managed care did not directly apply to the VA). In a series of reports (including four in 1999 alone), the GAO criticized the VA for the number of buildings and medical centers that it operated (GAO 1996, 1997b, 1998b-c, 1999a-d).

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#### Veterans Integrated Service Networks

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The GAO observed that the average daily workload (measured in patients per day) in VA hospitals declined by about 58 percent nationwide from 1989 to 1999, and that the veteran population was projected to decline by 9 million veterans, almost 36 percent, by 2020 (GAO 1999c, 2, 4).<sup>7</sup> In testimony to Congress, the VHA Under Secretary for Health was careful to point out that the “demographic imperative” posed by this anticipated decline was conditioned on the assumption that “no major armed conflicts” would occur (VA 1999a).

The GAO urged the VA to close hospitals. When the VA resisted, the GAO recommended to the Secretary of the VA that the Great Lakes VISN director be instructed to study in detail closing one of the four Chicago hospitals (GAO 1998b, 23), which ultimately led to closure of the Lakeside hospital in the Gold Coast neighborhood. This study was designated as a pilot project for a larger initiative called Capital Asset Realignment for Enhanced Services (CARES). CARES is not dissimilar to the Base Realignment and Closure (BRAC) process undertaken by the Department of Defense to downsize or divest military installations. With a \$35 million appropriation from Congress for studies, the VA began to implement CARES in the late 1990s—the first capital asset review within the agency in years. Despite the Global War on Terrorism that commenced with the September 11 attacks, the CARES initiative continued on course. The first CARES report and recommendations on realignment and closure of medical centers, titled VA Roadmap to the Future, was issued in May 2004, just over a year after the start of the war in Iraq.

The U.S. government’s real estate inventory has continued to be a focus of the executive branch. Since the mid-2000s, major actions include, but are not limited to: an executive order on federal real property asset management (U.S. President 2004); GAO’s designation of federal real property (including

“overreliance on costly leased space”) as a “high-risk” area because of “challenges” associated with the federal government’s “economy, efficiency, or effectiveness” of managing real property (GAO 2003a); a presidential memorandum on disposing of unneeded federal real estate (U.S. President 2010), and “Freeze the Footprint” guidance issued by the Office of Management and Budget to implement presidential policy (OMB 2013b). Each of these documents places additional pressures on the VA as a building- and land-managing agency. Further, this scrutiny is not limited to the executive branch: in the 112th Congress alone, four bills were filed to “reform” federal real property management (CRS 2012).

### **Capital Assets and Their Life Cycle**

A federal “capital asset” is defined as land, buildings, structures, equipment and intellectual property (including software) with an estimated useful life of two or more years (OMB 2013a, 2). With respect to a VA building, an “asset” is a tangible item that has probable economic benefits obtained or controlled by the agency (VA 2013c, V:ch. 9, 31). Therefore, in order to seek some level of understanding about the fate of veterans historic health-care and healing places, one has to understand the “cradle-to-grave” cycle of capital asset management for buildings, which consists of the following four phases.

**Project Formulation.** This phase consists of planning to address the need for additional space, including evaluating alternatives. Depending upon the scope of the selected alternative, it can be funded from one of four VA budget accounts (which are described in the following section): Major or Minor Construction (including new construction and renovations of existing buildings), Non-Recurring Maintenance, or Operating Leases (securing the space from a third party). This phase also includes identifying an existing building that is considered as not performing and, thus, poses a “gap” in space needs.

<sup>7</sup>In reality, the subset of veterans who are VHA enrollees actually grew in number by over four million from 1996 through 2003 (see Appendix A).

**Execution.** This phase consists of the final design and construction of a capital asset project after authorization and funding by Congress.

**Steady State.** This phase refers to the use and maintenance of the building. This phase can include Non-Recurring Maintenance, which consists of activities that prevent the obsolescence of buildings and bring them up to code requirements.

**Disposal.** This phase involves the “proper and orderly retirement and liquidation” of an asset (VA 2007c, III:7-23). Methods of “disposal” include demolition, deconstruction (physical dismantlement of parts of a building), mothballing, outleasing, sharing, selling, or transferring. Since FY 2005, the VA submits a five-year building disposal plan to Congress in each annual budget submission, which is included as an appendix to the VA’s Long-Range Capital Plan. The disposal plan itemizes dispositions that have been finished, and those that are planned in the future. The plan is very specific in that it names individual buildings, the method of disposition, and the medical center location, which enables preservation (and other) stakeholders to identify the VA’s proposals that impact specific historic buildings. It appears that once the VA has assigned a building to the disposal program, the building is removed from the numerical count of usable buildings in the agency’s capital asset inventory (see explanation in Section 4).

### **Building Designations**

In their role as capital asset managers, VA personnel make extremely important decisions about attributes of individual buildings, such as their usefulness and condition. These judgments determine the subsequent fate of the building: either as an asset that is used or reused or that is a building that is no longer needed and is queued for disposal (which also subjects the building to the risk of demolition by neglect).

The number and condition of VA’s historic buildings are generally identified and accounted for in three

ways: (1) annual performance and accountability reports; (2) annual budget submissions to Congress; and (3) and internal, proprietary databases. Only the two annual documents are publicly available; however, they only present “rolled up” or cumulative information, not data about individual buildings.

The primary way that detailed information is maintained about individual VA buildings is through the VA’s internal databases that provide input to the Federal Real Property Profile (FRPP) database. The VA’s basic database is the Capital Asset Inventory (CAI), managed by the Office of Asset Enterprise Management, although other internal databases exist that combine the CAI and financial management and that automate project analyses and prioritization of projects. The FRPP database was developed pursuant to a presidential executive order on federal real property asset management (U.S. President 2004).<sup>8</sup> This digital repository is intended to capture 25 data elements for each building owned by the federal government, such as a unique identifier number, location/address, annual operating costs and recurring maintenance costs, historic status (i.e., not eligible for the National Register, National Register-eligible, National Register-listed), utilization, condition, value, and a qualitative judgment on “mission dependency” (e.g., critical to the agency’s mission or not critical).

Three particularly important building attributes that are captured in the VA’s database and the FRPP are “utilization,” “condition,” and “mission dependency.” Regarding “utilization,” a building is either used or characterized as being “useful,” “underutilized,” “excess,” or “surplus.” “Underutilized” is “an entire property or portion thereof,” with or without improvements, which is used: (1) irregularly or intermittently by the federal agency for current program purposes; or (2) for current program purposes that can be satisfied with only a portion of the property (41 C.F.R. § 102-75.50). As of

<sup>8</sup> The VA’s source databases (and those of all federal agencies) that contain the data transmitted to the FRPP and the FRPP database itself, which is managed by the GSA, are not publicly accessible (GAO 2012b, 32).

March 1, 2012, the VA had reduced the number of “vacant<sup>9</sup> and underutilized” buildings in its inventory from 1,165 in FY 2008 to 850 (GAO 2012a, 73). Many, if not most, of these buildings are likely to be historic.

Despite the number of “vacant and underutilized” buildings, the VA states that it “overutilizes” all of its buildings and leased space—meaning that there is a “performance gap” and the agency needs more space. The agency has depicted its space utilization as greater than 100 percent since at least FY 2006 (2006: 104 percent; 2007: 112 percent; 2008: 113 percent) (VA [2007?e], 35) (2009: 114 percent; 2010: 122 percent; 2011: 116 percent; and 2012: 121 percent) (VA 2013d, IV:9.3-12).

The federal agency that is responsible for a building designates it as “excess” property if the building is not needed to help fulfill the federal agency’s statutory mission (40 U.S. Code § 102(3)). The designation of “surplus” property is made only after a federal agency transfers an “excess” building to the General Services Administration (GSA) and the GSA determines that the building is not required to meet the needs or responsibilities of all federal agencies and, as a result, is eligible for disposal (*Ibid.*, § 102(10)). The VA does not formally identify buildings as “excess” in its CAI database unless and until VA is ready to turn a property over to the GSA, and instead labels buildings as “underutilized” or “not utilized” (GAO 2012a, 50). One reason for this practice may be that before a building is designated by VA as “excess,” the Secretary of the VA must determine that the property is not suitable for homeless veterans or a related use under an enhanced-use lease (38 U.S. Code § 8122(d)).

Further, once an “excess” building is transferred to the GSA for disposition as “surplus,” the VA continues to be financially responsible for the condition of the building until the GSA disposes of it, which may be months to years depending upon local market conditions. The VA also bears financial

responsibility for complying with environmental requirements (e.g., asbestos removal) and cultural resource requirements when the GSA sells or otherwise disposes of the building. From FY 2005 through FY 2007, the VHA disposed of 155 buildings, of which only six were transferred to the GSA (VA [2007?e], 79-83); in FY 2012, one building was transferred to the GSA (VA 2013d, V:10-7).

Building condition is determined through a Facility Condition Assessment (FCA), which is performed either using VA personnel or contractors. An FCA addresses the overall building condition, estimated remaining “useful life,” and 16 aspects of the building (e.g., structural, architectural, mechanical, electrical, plumbing). An individual building does not have one FCA score, but is instead rated for the condition of major subsystems (such as structural) on a scale from “A” to “F” (excepting “E”) with “A” being the highest/best condition (VA [2007?e], 28-29). Costs associated with fixing “D” and “F” conditions are also included in the FCA (*Ibid.*, 29).

“Mission dependency” is a building attribute that is entirely within the judgment of each federal agency. The VA uses three classifications: (1) “mission critical” are buildings that are 70 percent to 100 percent used; (2) “mission dependent/not critical” are buildings that are 50 percent to 70 percent used; and (3) “non mission dependent” are buildings that fall below 50 percent use (*Ibid.*, 34). (See the explanation in Section 4, however, regarding the flawed assignments of “use” in the VA’s practices.) The current baseline for assessing mission dependency was established in FY 2005 when 22 percent of the VA’s inventory was categorized as “non mission dependent,” and the target goal was to reduce this baseline to 10 percent or less (VA [2007?e], 35). The percentage of “non mission dependent” assets has remained relatively consistent since the mid-2000s (2006: 15 percent; 2007: 12 percent; 2008: 14 percent) (*Ibid.*) (2009: 12 percent; 2010: 9 percent; 2011: 10 percent; 2012: 12 percent) (VA 2013d, IV:9.3-12).

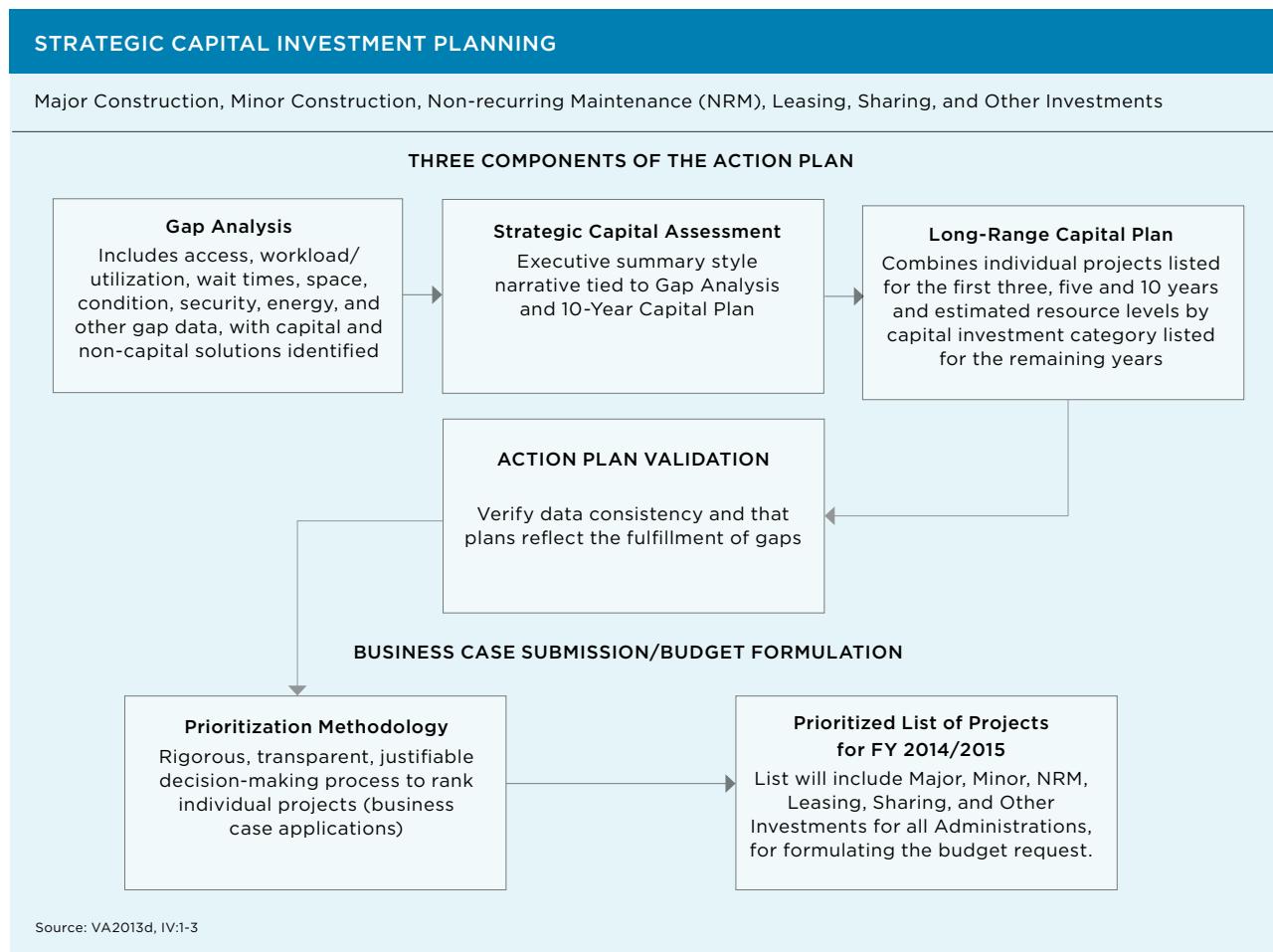
<sup>9</sup>The “vacant” condition of a building is not a formal attribute in the FRPP database.

These percentages go hand-in-hand with implementation of the VA's building disposal plan, which is designed to meet the target goal for reductions in non mission dependent buildings. Based upon the VA's statements and a review of building disposal plans, it appears that a substantial portion of the "non mission dependent" inventory is historic.

### **STRATEGIC CAPITAL INVESTMENT PLANNING (SCIP)**

The SCIP process is a structured framework within which the VA identifies and prioritizes projects involving Major and Minor Construction, Non-Recurring Maintenance, and Operating Leases.

A VA directive and handbook identify the overall roles and responsibilities for carrying out the program and contain a general outline of the annual process to implement SCIP (VA 2011c). It should be noted that the VA initiated a capital investment process in the late 1990s in response to congressional and OMB requirements that applied to all federal agencies. As it exists now, the SCIP process reflects changes that were responsive to critiques of earlier processes by the VA's Office of Inspector General and the GAO. An overview of aspects of the SCIP process that are important to understanding the VA's plans relating to the fate of historic buildings or campuses is provided as follows.



## Gap Analysis

A “need” for building space at a medical center or site is identified in the SCIP process through a gap analysis that evaluates seven measures of performance of VA services and buildings over a ten-year planning horizon. The performance measures include veteran access to primary health care; the utilization of inpatient services (measured in numbers of Bed Days of Care) and outpatient services (measured in numbers of Clinic Stops); patient wait times to primary and specialty care appointments; square footage of space; Facility Condition Assessment scores; compliance with federal energy and related conservation measures; and an “other” category that can include security, patient privacy, or parking (a parking analysis is required for parking “gaps”). Almost all of these measures are assigned a numeric performance metric, such as “Access,” the metric for which is the ability of 70 percent of VHA enrollees to be able to drive to a primary care facility in urban and suburban areas within 30 minutes and within 60 minutes in rural areas.

## Alternatives Analysis

After a space need is identified, the SCIP process requires an analysis of alternatives to fulfilling the need: (1) keep the status quo (“no action”); (2) construct a new building; (3) renovate an existing building; (3) lease the space from a third party (called an operating lease); and (4) contract with a non-VA organization or business to carry out the service or function. The alternatives analysis is also required by OMB guidance on acquiring capital assets (OMB 2013a). Most readers will also recognize that NEPA and Section 106 of the NHPA also require an analysis of alternatives when a federal agency undertakes a project or program. However, as addressed in Section 4, the SCIP analysis of alternatives and the analysis of alternatives pursuant to NEPA and the NHPA do not appear to take place at the same time. The SCIP analysis happens well before a project is ready for execution, while the NEPA and NHPA analysis appears to happen well

down the line, after a specific project has been selected by the agency. At that point, alternatives may already be foreclosed, as a practical matter, and the NEPA and NHPA reviews focus more on mitigation, rather than avoiding or minimizing adverse effects, since the SCIP alternative was selected months, if not years, earlier.

## Project Lists

The SCIP process has a decidedly “black box” feeling when one tries to understand the written guidelines on implementation and the ultimate outputs. However, lists of projects are concrete and are understood by most people. Ultimately, lists are developed in the SCIP process comprised of projects in each of the four budget accounts. The lists of VHA projects are passed up from each local level to each VISN; then each VISN produces a list of projects that is passed up to the VHA Central Office in Washington, D.C.; then the Central Office of the VA generates a consolidated and integrated list of projects that includes the three VA Administrations and the VA’s staff offices in the Central Office; and this consolidated, ten-year plan is included in budget submissions to the President and then to Congress.

Internal iterations of the lists occur, but the output at each stage or level of the VA’s internal review is always a specific itemization of projects. Further, the final list includes a disposal plan that identifies individual buildings at medical centers and the disposal method (e.g., demolish, lease, or mothball). A list of capital construction projects and planned building disposals nationwide is found in each annual budget submission in the volume dedicated to Construction and the Long-Range Capital Plan (found at <http://www.va.gov/performance/>).

## BUDGET ACCOUNTS

The financial aspect of the VA’s management of buildings is determined by how projects are categorized for budget purposes. There are four project categories relevant to capital project

budgeting and congressional appropriations, presented in order of the largest shares of the construction budget first, followed by the building lease category: (1) Minor Construction (new or renovation projects under \$10 million); (2) Non-Recurring Maintenance (projects generally under \$500,000); (3) Major Construction (new or renovation projects that exceed \$10 million); and (4) Operating Leases. The Non-Recurring Maintenance and Operating Lease accounts are housed in VHA's budget for Medical Facilities. The Medical Facilities account also covers ongoing operation and maintenance of buildings, an Advance Planning Fund for Major Construction projects (planning, design, environmental and historic preservation compliance), and real property acquisition and disposal.

The Central Office of the VA (which includes special SCIP process budget review groups) exerts substantial influence over the selection and advancement of projects that have to be individually authorized and funded by Congress (i.e., Major Construction, and Major Operating Leases with rental costs in excess of \$1 million per year). VISNs have substantial control over Minor Construction and Non-Recurring Maintenance projects, which do not receive the same level of budget submission scrutiny in the VA's Central Office as do Major Construction projects and Major Operating Leases. This aspect of the SCIP process—the decentralization of SCIP decision making for Minor Construction and Non-Recurring Maintenance—has been criticized as promoting segmentation of individual capital projects into a series of expenditures of less than \$10 million in order to avoid higher-level scrutiny (GAO 1999d, 3).

### **Minor Construction**

A Minor Construction project is currently defined as costing less than \$10 million (VA 2012p, G-3). Over the years, the annual Minor Construction budget has equaled or exceeded that of the Major Construction

budget and, for FY 2014, the requested amount substantially exceeds Major Construction (see Appendix A). Examples of projects in this category are broad and diverse: construction of new Community-Based Outpatient Clinics; new research or therapy facilities; interior space renovations of all types; parking garages or warehouses; or building or campus safety and security improvements. New construction to remedy a stated “gap” in the seismic sufficiency of an existing building (and the demolition of the existing building) is also a common type of Minor Construction project.

The VA has requested almost \$715 million in funds under this account for FY 2014, representing \$259 million in grandfathered projects, \$282 million in “ongoing” SCIP projects, \$144 million in “new SCIP initiatives,” and \$30 million in “under threshold/emergent needs” projects (VA 2013d, IV:3-1).<sup>10</sup>

Minor Construction projects are initially funded for only the design phase, not for construction (except for design-build projects, which are fully funded in the first year of the project [VA 2012p, 2]). Construction funds may or may not be subsequently authorized for the project, depending on the internal priorities developed in the SCIP process that are reflected in each year's budget submission. If funding is not obligated within two years of design approval (i.e., a legally binding agreement is finalized that commits the VA to pay for services or materials, such as architectural/engineering [A/E] design services), the project loses its funds and has to re-compete within the SCIP process (VA 2012p, 2).

### **Non-Recurring Maintenance**

Non-Recurring Maintenance (NRM) includes the following categories: (1) Maintenance and Repair of systems for heating, ventilation, air conditioning, fire alarms and sprinklers, water, wastewater, medical air, or oxygen, or for replacing roofing, exterior finishes, windows, or doors; (2) Building Service Equipment Replacement for equipment that cannot

<sup>10</sup> A grandfathered project is one that has received some appropriations in the past (i.e., is partially funded) (VA 2013d, IV:3-1). The criteria for “ongoing” projects are not defined in the FY 2014 budget submission.

be economically maintained or that is energy inefficient; (3) Building Service Equipment Additional for additions to or expansions in capacity of service (e.g., dialysis unit, inpatient lab); and (4) Minor Improvements and Associated A/E Services (usually capped at \$500,000), for changing the functional use of space, structural changes, or providing new or additional space (VA 2005b).

The VA has asked Congress for \$709.8 million during FY 2014 for 124 NRM projects (all within the VHA) (VA 2013d, IV:8.1-3), and estimates that another \$9.16 billion is needed over the next ten years for 2,738 NRM projects nationwide (*Ibid.*, IV:8.2-10). It is not clear how much, if any, of the budget request and projected needs address costs for deferred maintenance and repairs (day-to-day work that is put off) for the VA's "heritage assets," which is currently estimated at \$740 million (VA 2012I, III-99).

### **Major Construction**

As part of congressional oversight to ensure "the equitable distribution of medical facilities throughout the U.S.," the VA must secure legislative authorization of funds for the construction, alteration, or acquisition of any individual medical facility project that exceeds \$10 million in total expenditures (38 U.S.C. § 8104). The above-\$10 million expenditure level is referred to within VA as an "above-threshold" project or as "Major Construction." The range of above-threshold projects is extremely broad—from construction of an entirely new \$900 million replacement medical center, for example, to seismic corrections to buildings, replacements of operating room suites in existing hospitals, new construction for polytrauma treatment or mental-health treatment and care, or upgrading of major mechanical or electrical systems.

Additionally, an Advance Planning Fund (APF) is included within this budget and appropriation account to fund the design of Major Construction projects, prepare master plans and

historic preservation plans for campuses, and for environmental compliance programs. Three historic preservation plans have been funded via the APF (in the 2011 to 2013 timeframe) for medical centers at American Lake and Walla Walla, WA, and Tomah, WI (all Second Generation facilities). However, it is not possible from the VA's published service contract inventories for these years to precisely determine the cost of each preservation plan.

Appropriations for the APF can vary substantially from year to year. The FY 2010 APF appropriation for the VHA was \$123.56 million (VA 2011j, IV:2-68); for FY 2014, VHA has requested \$33 million in APF appropriations (VA 2013d, IV:2-7).

Major Construction projects are initially funded only for the design phase, which means that the timing and amount of subsequent construction funding is uncertain. For FY 2014, for example, only one partially funded project was included in the VHA budget submission for additional construction funding (\$149.13 million for a new mental-health building in Seattle, WA) (*Ibid.*), even though 41 Major Construction projects throughout the nation have been previously authorized and are in the planning, design, or construction stage (*Ibid.*, IV:10-61).

Historically, the Major Construction account was the VA's largest source of building or alteration funds. Appendix A reflects that it is now a decreasing amount compared to Minor Construction and Operating Leases. The decreasing trend in Major Construction funding is attributable to at least a couple of considerations. First, Congress has been very concerned with respect to the significant cost overruns for new, replacement medical centers—in the case of construction of a replacement medical center in the Denver region, the overrun is approaching 135 percent (see discussion in Section 5). Second, these projects receive more high-level scrutiny than do Minor Construction and NRM projects, the latter of which are almost entirely controlled at the VISN-level.

## **Operating Leases**

The largest expenditure in the VA's capital budget accounts is now the Operating Lease category, as reflected in Appendix A. The VA is one of the few federal agencies independently authorized by Congress to directly lease space itself rather than to secure leases through the GSA. The leasing program procures space for medical facilities, clinics, offices, administrative, and other facilities. Costs for Operating Leases involving real property are reported in the financial statement contained in each annual performance and accountability report of the VA under the category of "Other Public Funded Liabilities." The VHA accounts for almost 85 percent of the 1,595 individual leases of the VA (VA 2012I, III-52). The majority of leases are less than five years in duration, although some leases span up to 20 years.

Major Operating Leases (i.e., rental costs exceed \$1 million per year) have to be justified in a business case application that is approved by Congress. In addition to the rental costs (which includes parking spaces), leases require additional public investment, usually paid as an up-front lump sum to the lessor, for new construction to fit out the space to meet health-care, building code, and safety/security requirements. New medical supplies and equipment are additional costs. For FY 2014, the VA has sought congressional approval for the VHA to enter into 28 Major Operating Leases (VA 2013d, IV:6-3). Forty-nine Minor Operating Leases (with annual rental costs each under the \$1 million per year threshold) are also included in the budget submission (*Ibid.*, IV:8.2-15 - 8.2-18).

### **GOAL OF THE VA'S CULTURAL RESOURCE PROGRAM**

**"Timely, Efficient, Beneficial Compliance with Laws."** (VA 2011f, ¶5.a.)

According to the Federal Real Property Council, the annual operating cost per square foot for all federal buildings is only \$5.30 compared to \$15.00 for leased space (GSA 2011b, 4). The GAO has criticized the VA and other federal agencies for an "overreliance" on "costly" leases (GAO 2011b). The VA believes that short-term leases allow for its facilities to be moved more easily to respond to changes in needs of veterans and medical technology. Based on a review of the VA's annual budget submissions, it does appear that storefront space that is leased for Community-Based Outpatient Clinics, in particular, is often moved at the end of the lease term for these stated reasons.

## **CULTURAL RESOURCE MANAGEMENT**

The pivotal requirement for federal agencies to adopt and implement a program to preserve cultural resources—including historic properties—under their jurisdiction or control is found in Section 110 of the NHPA of 1966, which was added as part of the 1980 amendments to the Act (codifying many elements of Executive Order 11593, signed by President Nixon in 1971). Key aspects of a Section 110 program require that a federal agency designate a Federal Preservation Officer; identify, evaluate, and nominate historic properties to the National Register; and use, to the maximum extent feasible, historic properties available to the agency prior to acquiring, constructing, or leasing buildings to carry out the agency's responsibilities. Section 110 also requires a federal agency to implement programs to consult with other federal, state, and local agencies; Indian tribes; Native Hawaiian organizations; and the private sector in carrying out preservation-related activities (this consultation is not limited to reviews of proposed projects or programs under Section 106 of the law); and plan and take action, to the maximum extent possible, to minimize harm to National Historic Landmarks (NHLs).

## **Management System, Including Qualifications of Personnel**

The VA directive on cultural resource management and the VA's associated handbook outline the agency's program and roles and responsibilities for compliance with legal requirements relating to cultural resource management and historic preservation, and environmental requirements where they intersect with these other programs (VA 2011f).

A related document—the Cultural Resource Checklist—provides an annotated checklist for use by VA employees and contractors (VA [2011?p]). This compliance guide also addresses the VA's responsibilities pursuant to the National Environmental Policy Act (NEPA), and gives relevant examples of how projects or programs may cause direct, indirect, and cumulative effects to cultural and natural resources.

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### **VHA Positions and Cultural Resource Responsibilities**

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<b>VISN Directors</b>	<p>Designate a cultural resource management officer (CRMO), either through collateral duty or contractors, with appropriate training and authority to oversee and advise on cultural resource activities on a day-to-day basis. Provide appropriate resources to ensure that the CRMO is able to function in this capacity.</p> <p>Ensure that all subordinate personnel and contractors are aware of policies and their implications and receive training to carry out their duties.</p>
<b>Medical Center Directors</b>	<p>Ensure that center personnel with duties that may affect cultural resources (architects, engineers, maintenance staff, groundskeepers) are aware of requirements and are prepared to implement them. Where centers have historic resources, directors are “well advised” to appoint a staff cultural resource manager and ensure appropriate training, and provide appropriate resources to carry out this role.</p> <p>Ensure that all subordinate personnel and contractors are aware of policies and their implications and receive training to carry out their duties.</p> <p>Develop and regularly update lists of external stakeholders with “stated, known, or likely” interests in cultural resources of the facility. Ensure that they are “routinely advised” of plans, programs, and activities that have the potential to affect these resources and provide them opportunities to advise the VA of concerns and interests.</p>
<b>VISN Capital Asset Managers</b>	<p>Ensure that cultural resource requirements are carried out in project planning and implementation; update the Capital Asset Inventory at least yearly regarding Heritage Assets (historic buildings and structures).</p> <p>Ensure that all subordinate personnel and contractors are aware of policies and their implications and receive training to carry out their duties.</p>
<b>Project Managers (at medical centers or individual sites)</b>	<p>Ensure that potential project impacts on cultural resources are identified and addressed as early as possible in planning and in accordance with applicable regulations.</p> <p>Ensure that all subordinate personnel and contractors are aware of policies and their implications and receive training to carry out their duties.</p> <p>Contact parties with possible concerns about how cultural resources may be affected by VA activities early in planning any activity, and give them reasonable opportunities to make their views known.</p>

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The handbook that implements the VA directive on cultural resource management provides that “the appropriate Deputy Under Secretary, [VISNs] . . . Regional Offices, and Staff Offices should have systems in place to ensure that personnel carry out cultural resource responsibilities successfully” (VA 2011f, 8). Capital asset managers within the VHA are assigned key responsibilities regarding cultural resource management, as reflected in the table on the previous page (*Ibid.*, 8-9, 14, 15).

Section 110(c) of the NHPA requires that each federal agency have a qualified preservation professional on staff that fulfills the role of “Federal Preservation Officer” for that agency. In addition, officials at the VA and other federal agencies must ensure that: (1) employees or contractors “responsible for historic preservation” are qualified to perform certain tasks (NHPA of 1966, § 112(a)(1)(B); DOI. NPS 1998, 20501)<sup>11</sup>; (2) cultural resource documentation (including Section 106 documentation) meets certain professional standards (*Ibid.*, § 112(a)(1)(A)); and (3) independent findings and determinations are made when a federal agency carries out the Section 106 process with respect to proposals for projects and programs, even if contractors are engaged to prepare reports and studies (ACHP 2012, § 800.2(a)(3)). It is acceptable to hire outside consultants in order to fulfill these legal responsibilities; however, qualified staff is still needed throughout all levels of the organization to ensure the necessary oversight.

During the research for this report, the author inquired of several interviewees (including a former VA employee) whether there is a formal list of cultural resource management officers nationwide. It does not appear that such a list exists. Based upon the interviews, among the VHA field offices across the country there is one Cultural Resource Specialist position associated with the American Lake and Walla Walla, WA, Second Generation facilities,

which was filled by a historic preservation professional in 2010 for an initial three-year appointment. A Program Manager position has been established and filled at the Milwaukee National Soldiers Home.

### **Consulting Support**

The VA’s annual inventory of service contracts (contracts exceeding \$25,000) is currently available on the agency’s website for FY 2010 through FY 2012 (VA 2010i, 2011m, 2012m). Approximately \$11 million was spent on consulting services relating to VHA historic preservation projects and cultural resources management during this past three-year period. Of this total, approximately \$7.1 million was spent on architectural and engineering (A/E) services (e.g., design for building stabilization or renovation; the largest components of which were for painting and reroofing at the National Soldiers Home at Mountain Home Branch, TN, and renovation of the Dayton Protestant Chapel) and \$3.8 million on non-A/E services (e.g., historic preservation plans, other planning documents, Section 106 consultation, on-call consulting, the Third Generation national theme study, and archaeological surveys).

At least \$2.77 million has been spent at the Milwaukee National Soldiers Home, including \$952,000 to repair the roof on Building 2 (Old Main). Other facilities that are identified in the contract descriptions of the inventories include the Walla Walla, WA, Second Generation medical center; several California facilities (Fresno, San Francisco, and Menlo Park); Tomah, WI; and Fort Meade, SD.

These services do not include the survey work conducted before FY 2010 to evaluate VHA facilities and sites for National-Register eligibility and to prepare National Register nominations. The service contract inventories for FY 2009 and earlier years are not currently posted on the VA’s website.

<sup>11</sup> Credentials for historic preservation professionals have been established by the National Park Service (DOI NPS 1983) and the federal Office of Personnel Management (OPM) has established Position Classification Standards for disciplines currently included in the field of historic preservation (see Barras 2010, II:77, n. 13).

## **Training**

The VA directive and handbook on cultural resources management assigns the VA's Historic Preservation Office with the responsibility of training personnel with cultural resource responsibilities. In a recent review of federal agency management of historic buildings, the GAO stated that the VA's Federal Preservation Officer reports that the agency "is working to improve its consultation process and has "begun to provide training on consultation requirements to VA's regional site offices" (GAO 2012b, 26).

Eighteen of these training sessions were provided to VISNs, VHA capital asset managers, planners, and engineers, and regional Offices of General Counsel from 2008 through May 2011 (VA [2012o], 6). Some interviewees for this report stated that they have recently seen VA field staff at Section 106 training sessions provided by the ACHP and the National Park Service.

## **Tribal Consultation and Related Compliance Requirements**

Two policy documents—a VA directive on consultation and visitation with American Indian and Alaskan natives and a federal tribal consultation policy—provide an overarching framework for the VA's consultation with federally recognized tribes (VA 2007a, 2011g).

The more specific guidance on consultation with tribes that may have potential interests in the VA's cultural resources management program, or specific Section 106 project consultations, is found in the cultural resource management directive and handbook. A brief review of the locations of VA medical centers indicates that several of these campuses are or may be located in geographic areas for which Indian tribes (federally recognized and state recognized) may express an interest based upon historical and prehistoric use or occupancy. Three

specific examples (of which there are several) are the medical centers at Battle Mountain Sanitarium and Fort Meade, SD (Lakota Nation); American Lake and Walla Walla, WA (Confederated Tribes of the Colville Reservation); and Pineville, LA (Caddo Nation, Choctaw Nation of Oklahoma, Coushatta Tribe of Louisiana, Jena Band of Choctaw Indians, Mississippi Band of Choctaw Indians, and Tunica-Biloxi Tribe of Louisiana).<sup>12</sup>

Notwithstanding the examples cited above, based upon publicly available resources and the interviews conducted for this report, it does not appear that the VA has developed a formal list of tribes that have ancestral, aboriginal, or other interests in lands currently occupied by the medical centers and other VA facilities. Further, there does not appear to be any comprehensive agreements or memoranda of understanding in place between VA and any tribes relating to consultation and procedures for Section 106, the Native American Graves Protection and Repatriation Act (NAGPRA), Archaeological Resources Protection Act, or any other relevant compliance program. They may exist but, if so, do not appear to be readily accessible by the public.

With respect to the VA's other compliance requirements related to Native American cultural resources, particularly under NAGPRA, the specifics of implementation is not readily found in Web-based publicly accessible resources. Some of the medical centers feature known prehistoric Native American sites, and the agency has funded archaeological surveys dating back to at least the 1980s (Cultural Resources, Inc. 2012). With the substantial amount of multi-billion dollar construction over the past two decades, it would be surprising not to have had inadvertent discoveries of sites or isolated finds. However, the locations of artifact collections were not determined during the research for this report. The National NAGPRA databases on Inventories, Summaries, and Repatriations did not contain any

<sup>12</sup>The tribes that have expressed an interest in consultation in the parish in which the Pineville Second Generation medical center is located are identified in a statewide Section 106 agreement document (FEMA et al. 2009).

reports on the VA. It may be that another agency or organization stewards such collections and maintains the repositories (such as the U.S. Army Corps of Engineers or a public university), but it is not clear from the research for this report whether this is the case.

#### **Review and Consultation under Section 106 of the National Historic Preservation Act**

In the two sentences that comprise Section 106 of the NHPA, federal agencies are directed to “take into account” the impacts of their proposed actions on historic properties and to “afford” the ACHP an opportunity to review and comment on the proposals and their consequences. Initial guidelines on implementing Section 106 were issued by the ACHP and the Department of the Interior (DOI) in 1969 and were subsequently promulgated as regulations that first became effective on January 25, 1974 (ACHP 2012b), and were amended in 1979, 1986, 1999, 2000, and 2004.

During the Section 106 review process, agencies must identify whether there is a federal “undertaking”; identify and evaluate historic properties located within an area of potential effect (the geographic area within which direct, indirect, and cumulative effects from the program or project may occur); identify effects (impacts) to historic properties from the undertaking; resolve adverse (harmful) effects (“resolve” is to avoid, minimize, or mitigate the harmful effects); and develop and sign a Memorandum of Agreement, or another type of agreement document, which identifies measures the federal agency will take to avoid, minimize, and mitigate harmful effects to historic properties. Personnel with preservation credentials must be involved in or represent the agency in making these findings and determinations.

In addition to the steps above, federal agencies or their authorized representatives must consult with consulting parties that have jurisdictional

responsibilities regarding the proposal (e.g., states, tribes, or local governments) or an interest in the proposed action (e.g., preservation advocates, veterans service organizations, environmental groups, or individuals); involve the public; and recognize that the ACHP may choose to formally comment and participate in reviewing the proposal.

The concept of “consultation” is essential in the Section 106 process and is somewhat unique in the realm of federal regulatory programs. Consultation, as envisioned by the ACHP and the DOI, is:

. . . seeking, discussing, and considering the views of other participants, and, where feasible, seeking agreement with them regarding matters arising in the section 106 process. (ACHP 2012b, § 800.16(f))

. . . the willingness to explore the possibilities for agreement—or at least for a narrowing of agreement—among the consulting parties. Even if that exploration quickly shows or confirms that further discussion would be fruitless, the attempt is fundamental to the concept of consultation. . . . Consultation is built upon the exchange of ideas, not simply providing information . . . [T]he agency should: (1) Make its interests and constraints clear at the beginning; (2) Make clear any rules, processes, or schedules applicable to the consultation; (3) Acknowledge others’ interests and seek to understand them; (4) Develop and consider a full range of options; and (5) Try to identify solutions that will leave all parties satisfied [emphases added]. (DOI, NPS 1998, 20498)

As recent case law has established in a suit against the Bureau of Land Management, a federal agency’s obligation to consult in the Section 106 process is not met by simply sending one-way communications that transmit information about a proposed project, such as emails and letters, to consulting parties (Quechan Tribe v. U.S. Department of the Interior). In short, consultation involves a give-and-take dialogue.

The Cultural Resource Checklist developed by the VA's Office of Historic Preservation explains the regulatory process of Section 106 for the benefit of VA facility managers, planners, designers, and project engineers. Templates are provided for various related communications, such as letters to SHPOs or Tribal Historic Preservation Officers when Section 106 consultation is initiated for proposed actions.

### National Environmental Policy Act Compliance

The National Environmental Policy Act (NEPA) requires federal agencies to identify and meaningfully consider alternatives to proposed federal actions and to fully consider and publicly disclose the "environmental" consequences before proceeding with agency actions. The law mandates that federal agencies share their decision making on programs and projects with stakeholders and the public by weighing the objectives to be served by a proposed action in light of the reasonably available alternatives and ways to avoid or minimize adverse impacts to the environment.

The key term—the "environment"—is not defined in the law. However, Congress identified all of the values intended to be protected and preserved by NEPA, including cultural resources (a subset of which is historic properties), in its "declaration of national environmental policy" (NEPA of 1969, § 4331(b)(4)). It should be noted that federal agencies are subject to NEPA and Section 106 of the NHPA when they propose to carry out projects and programs—each law is independent of the other and compliance with both is required.

Final NEPA regulations, adopted by the Council on Environmental Quality (CEQ), are binding on all federal agencies and establish criteria for preparing Environmental Impact Statements (EISs), environmental assessments (EAs), and categorical exclusions (CatEx's or CEs) (CEQ 2012). Historic properties that are subject to Section 106 are clearly required by the CEQ regulations to be considered in NEPA reviews, regardless of the level of document prepared, as are

resources embodying aesthetic and cultural values. Further, the criteria for determining the level of NEPA documentation associated with a proposed action include assessing direct, indirect, and cumulative impacts on cultural resources, such as historic buildings and landscapes (*Ibid.*, §§ 1508.8, 1508.27).

The VA has adopted its own NEPA-implementing regulations (VA 2012h), which have been amended once (in August 1989) to reflect the agency's elevation to a Cabinet-level Department. Part of the policy expressed within the regulations is that the VA shall "ensure that all practical means and measures are used" to achieve several objectives, including "[preservation of] historical, cultural, and natural aspects of our nation's heritage, while maintaining, where possible, an environment that supports diversity and variety and individual choice. . . ." (*Ibid.*, § 26.4(a)(2)). Each VA "element" (e.g., VHA) is directed to integrate NEPA with planning and decision making and to adopt procedures to ensure that decisions are made in this integrated fashion (*Ibid.*, §§ 26.4(b)(3), 26.5(c)). The VA has also issued "interim" NEPA guidance (VA 2010h).

### Other Initiatives Relating to Cultural Resources

A variety of other activities have been undertaken by the VA under the NHPA and related cultural resource management directives (VA [2011b]). Three historic preservation plans have been prepared for medical centers at American Lake and Walla Walla, WA, and Tomah, WI (all Second Generation facilities). A travel itinerary for the National Soldiers Home sites, called "Discover our Shared Heritage," has been developed by the VA, National Park Service, and other preservation partners. This program offers experiential enjoyment of these heritage places and promotes heritage tourism, thereby supporting local and state economies pursuant to Executive Order 13287 (Preserve America). The VHA has funded several educational and commemorative exhibits for display at medical

centers and headquarters (e.g., the Lincoln Bicentennial, Sesquicentennial of the Civil War, U.S. Colored Troops, Native American Heritage, and Historic Preservation Month).

The VA is also identified as one of many public and private partners in the “Veterans Curation Project.” Led by the U.S. Army Corps of Engineers, this program provides on-the-job training, employment, and transitional time for veterans at three laboratory locations where archaeological collections of the Corps are inventoried, characterized, rehabilitated, and curated (<http://www.veteranscurationprogram.org>).

In summary, the VA has addressed the key elements of a cultural resource management program in its internal policy and implementing instructions. It was not possible to discern the overall budget or costs associated with implementing the program from the agency’s annual budget submissions or other related documentation. The remaining sections of this report explore the perspectives of external stakeholders who were interviewed with respect to the VA’s commitment to implementing the program in all aspects and how effective the program is in practice, resulting in a series of recommendations to improve the VA’s cultural resource management program and practices and to more effectively leverage the public’s investment in the VA’s existing buildings.

## 4 Recommendation Theme A

**Expressing the Commitment of Top VA Management and Addressing Regulatory Compliance Concerns and Budgetary Barriers**



Historic buildings are included in the VA's capital asset management program. An asset is something that has been identified as providing a "probable" economic benefit. However, there is little evidence that historic health-care buildings and healing places are treated as assets within the VA's current management system. Managers signal what is and is not important to subordinate managers who, in turn, signal the same message to their staff. Based on the research conducted for this report and the interviews, it appears that VA managers do not have a preservation "will" nor an internal culture that supports stewardship of historic resources. A senior manager within the VA's Office of Construction and Facilities Management responded in writing to a request for interview for this report that "[m]any people have a tendency to think 'new is better' and often don't fully consider reuse of historic buildings. This perception is slowly changing."

This section first identifies and responds to explicit indications that the internal culture of the VA has fostered a misunderstanding about what it means to be responsible for a "historic" capital asset. It then addresses the affirmative statements that are needed from top VA management to emphasize and commit the VA to acting in a way that recognizes the value in historic preservation (Recommendation One). Recommendations Two and Three address concerns and possible barriers that exist regarding the VA's ability to carry out its work in compliance with cultural and natural resource requirements in a way that integrates multiple values important to managing capital assets, including historic buildings.

#### **Specific Misunderstandings Regarding "Historic" Status Reflect an Internal Culture that Needs Improvement in Order to Fulfill the VA's Responsibilities**

There appears to be a fundamental misunderstanding within the VA regarding what the designation of "historic" means, which particularly permeates project justifications to Congress and responses

to investigations by the Government Accountability Office. This misunderstanding thrives despite the appropriate and helpful internal historic preservation guidance prepared by the VA's Office of Historic Preservation and the VA's leadership in nominating many of its medical campuses to the National Register.

Fifteen of the 21 VISNs of the VHA identify "historic properties" as one of their top three "infrastructure challenges" (VA 2012j, IV:8.3-17 - 8.3-358). These "challenges" typically result in assigning historic buildings to the five-year disposal plan, but the VA believes that the "lengthy and cumbersome process" to remove buildings from "historic preservation status" then becomes a "significant obstacle" to try to find alternative uses or to dispose of buildings (GAO 2003b, 12). It is not clear why at least some VA leadership and staff believe that historic status has to be removed in order to be able to use a building; this perception suggests that the current cultural resource training program should be continued and expanded to correct this myth.

A pending example of another misunderstanding regarding historical significance is found in the VA's FY 2014 budget submission to Congress. VISN 23 has requested approval of a 20-year operating lease to provide residential rehabilitation treatment and multi-specialty outpatient services at a clinic in Rapid City, SD; the annual rental cost would approach \$4 million and almost \$6 million would be spent in one-time construction to prepare the building for the VA (VA 2013d, IV:6-95 - 6-100). If approved, the lease would shutter the entire Battle Mountain Sanitarium campus in Hot Springs, SD (*Ibid.*, IV:6-95). The campus is comprised of 57 buildings, sites, structures, and objects, 40 of which contribute to the National Historic Landmark (NHL) district and which are currently used as a VA medical center. The project justification for the Rapid City lease proposal rejected the alternative of renovating buildings at Battle Mountain Sanitarium on the grounds that its NHL status "significantly constrains the extent of renovation allowable and/or

feasible” and that associated water and sewer infrastructure “cannot be renovated without disturbing the existing buildings’ historic character” (*Ibid.*).

However, the very same budget submission elsewhere includes a request to Congress to approve a total of approximately \$13.77 million for 13 separate Non-Recurring Maintenance projects at Battle Mountain Sanitarium (*Ibid.*, IV:8.3-390, 3-396). These projects are primarily interior and exterior infrastructure changes (e.g., replace/update heating, ventilation, and air conditioning systems, make improvements to the exteriors of buildings, replace the campus irrigation system, fix drainage and roads). Notwithstanding the VISN’s purported justifications for moving essential veteran services to leased space 60 miles away from Hot Springs, someone has obviously determined that alterations can be successfully accomplished at the nationally significant Battle Mountain Sanitarium, consistent with the historic character of the campus.

Contrary to the VA’s budget statements, historic buildings and properties that are nationally significant are altered and/or repurposed. One recent

example is the rehabilitation of the former dining hall at the National Soldiers Home in Leavenworth, KS, a building that contributes to the historic significance of this National Historic Landmark. This project won a National Trust award in 2012 for the creative adaptive reuse as office space for the VA Central Plains Consolidated Account Center.

Another perpetuated misunderstanding reflects the need for improvements in the internal management culture regarding historic buildings: the VA’s statements that link patient and employee satisfaction with only newly constructed buildings.

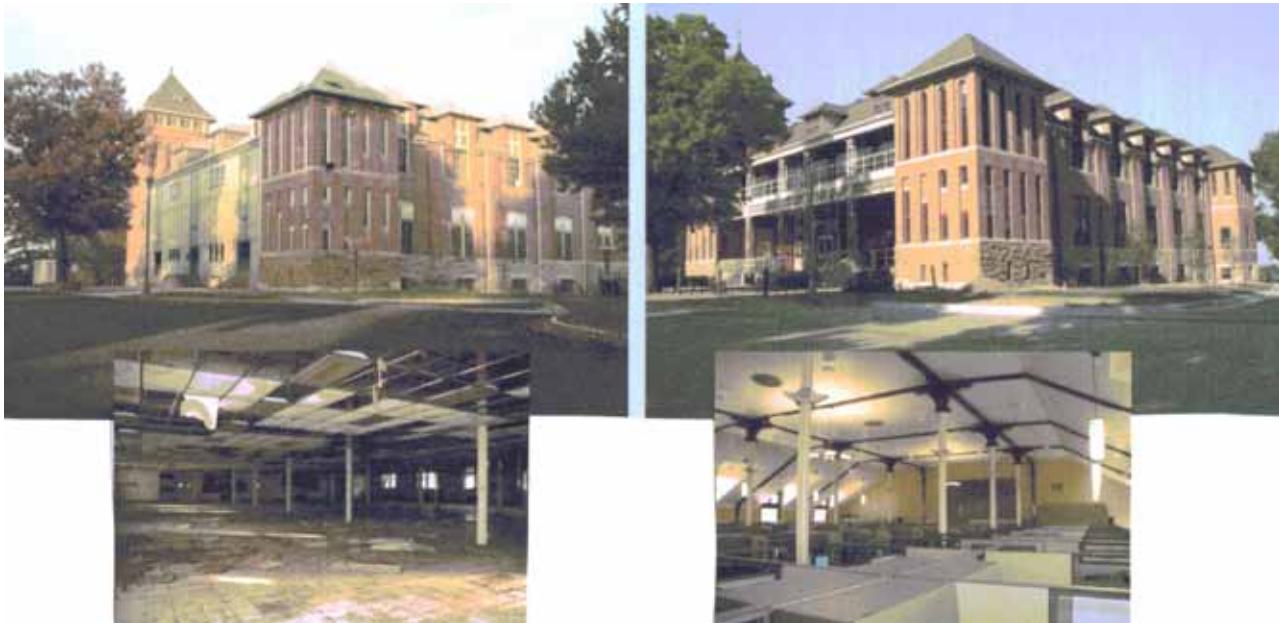
This notion is often expressed in the VA’s budget submissions for new capital construction. A budget request for a new, \$354.3 million community living center (CLC) associated with the Palo Alto, CA, health-care system, for example, rejected renovating historic buildings at the Livermore, CA, Second Generation facility on the grounds that this alternative “does [not] create a new state of the art CLC for our Veterans. This option does not provide the best option for the Veterans; therefore, it is not the preferred option” (VA 2009c, IV:2-37).

## HISTORIC HOSPITALS AND EVIDENCE-BASED DESIGN

The VA has “embraced the principles, spirit and intent” of evidence-based design (VA 2011a, 1-10).

Evidence-based design in health-care settings is an emerging field that “aims to introduce elements of construction and atmosphere proven to promote healing” as well as reduce risks of infection, inpatient falls, and other in-hospital risks (Abrams 2013; Gunderman 2013). Natural lighting (“daylighting”), sound-minimizing environments, and physical or visual access to trees and nature are all components of design that have been shown to have mood-elevating and pain- and anxiety-easing qualities.

Many of these desired qualities already exist in historic VHA facilities, such as Battle Mountain Sanitarium, which were sited and designed with many of the same goals long before the use of the buzzword “evidence-based design.” The original features of the natural and human-built environments are still essential to the healing services provided at Battle Mountain Sanitarium, based upon interviews with veterans.



The Pioneer Group, the lessee of the Eisenhower VA medical center in Leavenworth, KS, renovated the nationally significant former dining hall, Bldg. 19 (before and after). Photo credit: Pioneer Group.

#### **IS IT TRUE THAT ONLY BRIGHT, SHINY, AND NEW BUILDINGS HONOR VETERANS?**

Project justifications for new construction often state that new buildings “honor and memorialize” veterans.

(e.g., VA 2009c, IV:6-38; VA 2010g, IV:2-24; VA 2012j, IV:2-15)

This type of ipse dixit justification (“it is because I say it is”) does not appear to be based upon any feedback from veterans during routine surveys on the VHA’s performance nor on any other means of objective evaluation. There are two metrics that are important to retaining VHA health-care enrollees and satisfying patients, neither of which relates in any way to building age: (1) wait time between desired and actual appointment dates; and (2) whether a medical appointment starts on time. On both counts, the goals that the VHA set for

itself were met in FY 2012 (VA 2012l, II-65, II-67) and over a majority of inpatients gave the VHA high ratings for its services (a 9 or 10, out of a top score of 10) (*Ibid.*, II-66).

New construction projects are also routinely justified by the VA as essential to attracting and retaining staff. A recent survey of staff satisfaction gathered responses from almost 14,000 VA employees, over 60 percent of whom were female, non-supervisory personnel working in VA field offices (OPM 2011, 9-10). On the positive side, 95.5 percent of respondents felt their work is important; 73.4 percent felt that the VA succeeds in accomplishing its mission; and overall job satisfaction was rated at 70 percent (*Ibid.*, 1, 3, 6, respectively). Work setting satisfaction was measured from the standpoint of interior ambient conditions (examples provided included noise levels, temperature, lighting, and workplace cleanliness) and did not specifically inquire into the age of the building in which the employee worked; a 64 percent positive rating was reported (*Ibid.*, 1).

The areas in which employees gave the VA lower ratings have nothing to do with physical infrastructure (including building age). Employee satisfaction was substantially lower in areas relating to the VA's human resource programs (such as child-care services, the need to link performance and raises, and reward creativity and innovation) and to managerial leadership (such as the failure of managers to generate high levels of motivation and commitment in the workforce) (*Ibid.*, 2, 3, 8).

Certainly, the VA faces many challenges in carrying out its mission and fulfilling the expectations of many external stakeholders. Historic buildings that are maintained in good condition and modernized seem to be the least of the VA's challenges. By correcting many of the internal myths and misunderstandings about historic preservation, the VA could at least

minimize the internal perceptions that its historic assets are significant "problems" to be overcome.



Henry Ford Hospital, Detroit, MI  
Credit: Henry Ford Health System

#### HISTORIC HOSPITALS CAN PROVIDE QUALITY CARE

Many interviewees reported that VA staff members often frame historic preservation as a choice between "saving a vet or saving a building." This dichotomous mindset is completely unsupported by any objective measure of nationally recognized quality care, such as the accreditation and certification programs of The Joint Commission (a national, not-for-profit organization that sets the gold standard for quality in health care). Historic hospitals, such as the Henry Ford Hospital in Detroit and Bellevue Hospital in New York City, provide accredited gold-standard health care. Health care in the historic hospitals of the VA has been accredited by The Joint Commission as well. One example is the National Register-listed Second Generation hospital in Prescott, AZ, in the Northern Arizona Health Care System.

The Henry Ford Health System in Detroit, a not-for-profit private corporation founded in 1915, describes itself as "one of the nation's leading comprehensive, integrated health care systems." The organization (the core of which is a tertiary-care historic hospital, education, and research complex and Level 1 trauma center) received the Malcolm Baldrige National Quality Award in 2011. The location is accredited by The Joint Commission and has received an advanced certification from the Commission for stroke treatment and ventricular assist devices, as well as at least six special quality awards. The historic hospital is also recognized for "excellence and innovation" in "cardiology and cardiovascular surgery, neurology and neurosurgery, orthopaedics and sports medicine, organ transplants, and treatment for breast, lung, and prostate cancers." An essential factor in the success of the hospital is the demonstrated commitment of the Board of Directors and hospital managers to devote sufficient resources to maintain the complex and also to maintain its historic character. The spacing of interior columns has created a challenge in some instances of changes of use, according to the hospital's architectural consulting firm, but design solutions have allowed current medical services to be successfully accommodated in the historic buildings.

**RECOMMENDATION ONE: The Secretary of the VA should issue a management statement that commits the VA to fulfilling its responsibilities under the National Historic Preservation Act and the VA's Sustainable Locations Program policy. The management statement should commit the VA to an accurate inventory of its historic buildings; early initiation of, and full compliance with, historic preservation and environmental review requirements; continued hiring of qualified preservation professionals and training of technical staff; and internal compliance audits.**

Recommendation One sums up the observations presented in this report as a whole, and each of the other recommendations, into one definitive action: an explicit expression from the top management of the VA of their support and commitment to stewarding historic buildings and landscapes that have been entrusted to the agency. There are many examples throughout the federal government of excellence in managing historic buildings, including agencies that might not be traditionally acknowledged for preservation (NIBS 1998). Ultimately, the success of such planning is based upon one important factor: the commitment of the people involved and their lack of hesitation in borrowing “good ideas from colleagues and [being] smart enough to know when they needed help” (*Ibid.*, 7). The difficulties and challenges described below and elsewhere regarding the VA’s management of its historic capital assets are surmountable, but are not likely to be effectively handled without a strong statement of management commitment.

Two particular problem areas are subsumed within Recommendation One, which are not addressed in other recommendation sections of this report, and deserve discussion. The first relates to the VA’s inventory of historic buildings and the second relates to accountability for implementation of the VA’s cultural resource directive.

#### **The VA’s Capital Asset Inventory Practices Appear to Promote Subjective and Inaccurate Accounting of Historic Buildings**

The “Building Designation” subsection of Section 3 explains the attributes that are assigned to each building in the VA’s Capital Asset Inventory (an internal, proprietary database) that are particularly important to historic buildings (e.g., “excess,” “underutilized,” “condition,” and “mission dependency”). For interested external stakeholders, it is important to understand where the VA keeps this information and the quality of the data.

There may be more than meets the eye with respect to the VA’s designation of an individual building as “vacant,” “underutilized,” “excess,” or even in “good” condition. The VA’s deviations from executive branch guidance that defines these key terms, and subjective judgments of the VA—particularly regarding “utilization” and “condition”—may penalize historic buildings and mask their true status from veterans, Congress, preservationists, the public, and others. As a result, the ability to rely upon total numbers of “Heritage Assets” in the VA’s annual performance and accountability reports and inventory-wide statements about utilization and condition in budget submissions, in order to try to understand how well the VA stewards its historic public assets—and the accuracy of its statements about performance gaps that require new building space—is inhibited.

Recently, the Government Accountability Office (GAO) was able to gain access to building-level information in the VA's Capital Asset Inventory and the Federal Real Property Profile database managed by the General Services Administration (GSA) in order to evaluate the quality and completeness of information on federal buildings. The reason for the GAO's focus is that building management is identified as a "high risk" area of the federal government's budget (GAO 2003a).

One attribute that was evaluated by the GAO is the VA's assignment of "utilization" ratings. The method approved by the Federal Real Property Council (FRPC) for defining how space is used in a hospital, office, or warehouse is based on the ratio of occupancy of the building to its current design capacity (OMB 2004, 32). The VA instead defines "utilization" as the ratio of "ideal space" to existing space, reportedly with the approval of staff of the Office of Management and Budget (OMB) (GAO 2012b, 10).

The "ideal space" concept works against existing infrastructure if the internal culture of an agency, like the VA, regards historic buildings as liabilities rather than assets. As reported by the GAO, an "old building with an inefficient floor plan may be larger than necessary for the service it provides," but if the VA decides that changes cannot be made to the building because of its "historical designation" or because renovations are too costly (without fully evaluating the life-cycle costs), the building may be perpetually designated as "underutilized" even though it is fully occupied every business day (*Ibid.*).

In one example, the "utilization" of a VA building was reported in the VA's database as 39 percent used in 2010 and 45 percent used in 2011, even though the building had been fully occupied since 2008 (*Ibid.*). In another case, a VA building was reported to have been "utilized" 0 percent in 2010 and 59 percent in 2011, although only one room in the entire building was vacant during these periods (*Ibid.*, 10-11).

The GAO also evaluated how the VA rates the "condition" of an individual building. According to the FRPC, "condition" is based on the ratio of the cost of needed repairs to the replacement value of the building (OMB 2004, 33). In evaluating building condition, the VA, like many federal agencies, may determine that an "old" building is in bad shape and is, thus, "non mission dependent." As a result of this subjective approach, the building is not assigned any repair costs in the building inventory database, and valuable repair and maintenance funds are then used elsewhere. The VA's approach to calculating the condition index for each building in this regard works in the opposite way from the utilization index: a historic building that is in substantial use, but needs repairs, may be reported as "underutilized"—but its condition index may be reported as high as 100 percent (top condition) because repair needs are omitted from the equation.

Another substantial problem that hinders the public's understanding of the full inventory of buildings, including historic ones, is that the VA removes from the count of its usable building inventory "in-process and retiring space," which includes buildings that have been relegated to the disposal program and "other poor condition or otherwise unusable space" (VA 2013d, IV:8.3-7, 8.3-16). Thus, VA's abandoned buildings—which may still be eminently suitable for rehabilitation and reuse to fill a "space gap"—are excluded from the SCIP review, contrary to the VA's Sustainable Locations Program directive.

As a result of these practices, external stakeholders cannot know the real status of historic buildings, including their needs for regular maintenance and non-recurring maintenance. The agency's methodology is not explicit and is only revealed when an agency such as the GAO investigates; the inventory database details are not publicly accessible; and what is revealed about the agency's inventory practices and building designations renders as suspect the VA's statements about its historic buildings.

## **Implementation and Accountability in the Cultural Resource Management Program is Lacking**

The internal culture of an agency—the expressed and perceived attitudes and statements of key managers—is the top essential ingredient of a compliant and effective cultural resource program. Other important factors that support a compliant program include the credentials and training of the staff and documentation that guides internal compliance decisions, evidence of how that policy is actually carried out in practice in the field, and the measures that are in place to continually assess and correct deviations from requirements.

On paper, the VA has a comprehensive and relatively well-defined program for complying with the National Historic Preservation Act (NHPA), the National Environmental Policy Act (NEPA), and other cultural resource requirements. The VA's Historic Preservation Office has disseminated implementing guidance, including an interactive checklist and templates for different types of communications to external stakeholders, such as State Historic Preservation Officers (SHPOs). Roles and responsibilities relating to cultural resource compliance are clearly defined. Additionally, the internal guidance addresses the requirement to involve stakeholders in project planning before pinning down a specific alternative in the SCIP process. This section (titled "Consultation and Transparency" in the cultural resource management procedures handbook) is quite good, and gives clear instructions to help capital asset managers fulfill their duties to actively seek out and involve a broad range of stakeholders from the earliest stages of project planning: veterans groups, other government agencies, Indian tribes, preservation groups, environmental justice communities, individuals, and environmental groups (VA 2011f, 14-15).

Section 3 reviewed the legal requirements of federal agencies with respect to staffing or hiring outside

experts that meet professional qualification standards in order for the VA to fulfill its historic preservation responsibilities, and for ensuring that cultural resource documentation meets professional standards. The VA has had a Federal Preservation Officer (FPO) on staff at least as far back as the 1980s. However, it is not clear that the staff position was ever provided the resources or management commitment to compliance commensurate with the scope of the VA's real property inventory and substantial construction budgets. One benefit to this staff position, before the Vision for Change was implemented in the mid-1990s (and decentralized much of the capital asset management program of the VHA), was associated with the fact that the VA's team of architects and landscape architects were also located in the Central Office in Washington, D.C. As a result, the FPO could interact directly with the VA's internal planning and design team at the preliminary planning stage of a project. Adjustments could be made early in project design to site a new building in such a way to be subordinate to and not dominate a co-located historic building and materials, and rooflines could be selected or altered to maintain consistency with nearby historic structures.

The efficacy of a federal preservation program cannot solely hinge upon designation of one FPO, however. Even the most astute, dedicated, and ubiquitous FPO in any Cabinet-level agency is relatively limited in his or her reach when one considers that over 100,000 individual projects are subject to Section 106 review each year (Barras 2010, 1:3). An effective Section 110 program means that an FPO should not need to be involved in run-of-the-mill Section 106 reviews in any event. Her or his time is better spent on programmatic planning and performance assessments, tribal consultation, strategic initiatives, and helping to resolve conflicts in high-profile projects.

The judicious use of an FPO's time to assist his or her federal agency must be bolstered by the work of qualified preservation professionals in large real property-managing agencies such as the VA. As explained in Section 3, the VA's cultural resource program directive requires each of the 21 VISN Directors to designate a cultural resource management officer (CRMO) to oversee and advise on cultural resource activities on a day-to-day basis. From the interviewees, it appears that the VISN Capital Asset Managers are often assigned as CRMOs formally or informally. However, none have the academic background or experience that meet the professional qualification standards required by the NHPA, no matter how dedicated they may be to their job. Since the VISNs are the key organizational units responsible for the bulk of the VA's building stock, this report recommends that each VISN retain or hire a CRMO that fulfills the professional qualifications to perform historic preservation work.

One of the most telling indicators of whether a federal agency meets the requirements for using credentialed preservation professionals is how (and whether) it carries out Section 106 consultations for projects and programs. On this point, preservation interviewees roundly concurred that the VA's practices substantially and systematically depart from its laudable policies that are written on paper. When questioned about the VA's compliance with Section 106 of the NHPA (and NEPA), responses from government agencies that exercise jurisdiction over cultural and natural resources ranged from "extreme frustration" to "we never hear from them." According to the interviewees, repeated problems in Section 106 implementation (all of which involved VHA projects) include tardy initiation of consultation (including tribal consultation) or, in some cases, after-the-fact consultation (after a historic building has been demolished); confusion among local and regional staff and managers about what actions constitute an "undertaking"; and failure to involve consulting parties other than SHPOs.

The problems in meeting the legal requirements of Section 106 were attributed by interviewees almost exclusively to the VA's failure to use qualified preservation personnel and to also train its technical staff on the basic aspects of compliance with the NHPA. Assigning a qualified CRMO in each VISN and expanding the regulatory compliance training being given by the VA's Office of Historic Preservation would go a long way in remedying these deficiencies. Welcome recent turnarounds in individual cases, particularly with respect to the VHA's compliance with Section 106, were mentioned in the interviews, all because preservation professionals were brought in, which helped move unyielding mindsets of some VA managers. Good examples include a renovation project at the Second Generation medical center in Asheville, NC (former nurses quarters reused for administrative purposes), long-range planning at the Second Generation campus in San Francisco, and historic preservation planning at American Lake and Walla Walla, WA (the latter helped by the VA's hiring of an in-house preservation professional). An intensive consultation process that has included Milwaukee Preservation Alliance, the National Trust, and other preservation stakeholders has been underway at the Milwaukee National Soldiers Home. Several positive outcomes at this National Historic Landmark (NHL) were reported by interviewees, such as the VHA's commitment to repair and ensure the reuse of two signature historic buildings (Old Main and the Ward Theater) and the decision to locate a Fisher House (on-site lodging for veterans and their families during medical treatment) outside the boundaries of the NHL (a "win-win" according to the ACHP). The VA's hiring of a Program Manager in Milwaukee to facilitate relations with the community was also reported on positively by interviewees.

These examples illustrate that it is possible for the VHA to carry out its mission, engage in meaningful consultation, and balance preservation values with

facility needs. However, as noted by individual interviewees, and when considering the comments taken as a whole, it appears that these outcomes are episodic rather than systematic. They are too dependent upon the good intentions of individual capital asset managers; the forcefulness of Indian tribes and SHPOs; the high-visibility, grassroots organizing of preservationists; the entry of qualified preservation consultants on behalf of the VA “at the last hour”; and, in at least one case (at the San Francisco medical center), a lawsuit.

In a fully implemented compliance management program (which consists of “Plan, Do, Check, Act”), VA management would already know of these types of problems through internal audits (“Check”) and would oversee a corrective action program to address any deficiencies (“Act”). The VA already undertakes such measures in its Environmental Management System (EMS) program on environmental compliance, which includes an annual review of the overall program by management and facility-level audits (VA 2012e). The cultural resource directive and handbook, on the other hand, is entirely missing any aspect of “Check and Act”—they do not even provide for a list of CRMOs so that people within and outside the VA can know who to contact regarding concerns affecting historic properties.

In summary, “Check and Act” measures need to be added to the VA’s cultural resource management program in order to address internal accountability. One way in which the “Check” part of this recommendation could be addressed is through the VA’s EMS program. The VA spends fairly substantial

funds to hire outside firms to audit VA facilities for environmental compliance ranging from \$58,000 to \$409,000 per VISN in FY 2012 (VA 2012m). These audits are carried out by environmental professionals, typically aided by a complex checklist. It would not significantly burden the budgets of these audits to expand their scope to include, ideally, a cultural resource professional (such as a qualified in-house VISN CRMO). Or, the audit could possibly be accomplished by the environmental team if a checklist, guidance, and training is provided.

**RECOMMENDATION TWO:** The VA's implementation of the National Historic Preservation Act and National Environmental Policy Act should be strengthened and improved in three key areas: (1) comprehensive land use planning at medical centers (including parking); (2) nationwide programs relating to disposition of buildings and medical centers; and (3) new medical center construction.

**Comprehensive Land Use Planning**

A comprehensive land use plan should be prepared for each VA medical center in order to identify the availability of building space and land and then match space needs (individual projects) to the plan. Some land-use planning is conducted (resulting in a “master plan” or “long-range development plan”) but not consistently according to interviewees. Planning for auto parking should be included since parking facilities often negatively impact historic buildings and landscapes at medical centers. The comprehensive planning process should seek the input of qualified preservation professionals (in house or contracted) to evaluate historic building reuse and renovation alternatives in a meaningful way and actively provide an opportunity for external stakeholders to participate. By taking a long-term, big-picture view and involving multiple perspectives, a blueprint can be developed that should better serve all constituencies and stakeholders of these important community facilities and minimize conflict when individual projects in the comprehensive plans are subsequently carried out.

Further, by conducting NEPA and NHPA reviews for comprehensive plans, the VA should minimize concerns that the way in which its staff develops individual projects is contrary to NEPA and the NHPA. The concern relates to the Strategic Capital Investment Planning (SCIP) process—not the process itself, but how it is implemented. As explained in Section 3, the SCIP framework emphasizes early planning and analysis of alternatives—but

the way in which these steps are carried out appears to focus only upon planning for the VA’s preferred alternative, often new construction. Through SCIP, the project is “locked” early (i.e., there is a preferred alternative, its location is selected, total costs are pinned down, and design starts) (“locked” is a word used in the VHA’s Minor Construction handbook) [VA 2012p, 1, G-5]). Implementation of SCIP in this way poses serious concerns regarding systematic “foreclosure” of an analysis of alternatives and opportunity for stakeholder participation of the types required by Section 106 of the NHPA and NEPA. These review procedures are designed to balance a federal agency’s “purposes and needs” with an emphasis on preserving natural and cultural resources.

Under Section 106 of the NHPA and implementing regulations of the Advisory Council on Historic Preservation (ACHP), a federal agency can be permissibly inclined to favor a particular alternative for a project, such as new construction, but cannot “foreclose” an opportunity for the public and other stakeholders (e.g., SHPOs, USEPA, and the ACHP) to participate meaningfully in commenting prior to the agency’s decision on the project.<sup>13</sup> Foreclosure has legal consequences.<sup>14</sup> The ACHP is authorized to formally determine that a federal agency has “foreclosed” the opportunity to comment on the undertaking by failing to comply with Section 106 prior to approving or funding a project (ACHP 2012b, § 800.9(b)).

A formal foreclosure determination of the ACHP is

<sup>13</sup> NEPA has a similar prohibition (see CEQ 2012, § 1506.1 “Limitations on actions during NEPA process”).

<sup>14</sup> Some SHPO offices reported that they have been contacted by local VHA staff to “consult” under Section 106 after a project has been completed or buildings demolished. One interviewee stated that local staff of the VHA even offered to develop Historic American Buildings Survey documentation as mitigation after a historic building had been demolished, cases that exemplify impermissible foreclosure under the NHPA.

relatively rare, averaging roughly from one to six cases per year from the late 1960s through 2008 (Barras 2010, 2:22). Nevertheless, a formal determination is significant because the Section 106 regulations of the ACHP elevate the conflict to involve the head of the federal agency (which reflects poorly upon lower managers and staff) and, as a practical matter, delays a project. A formal foreclosure determination also represents a finding that a federal agency's failure to follow the procedural aspects of Section 106 may represent a violation of the NHPA. Such a determination is afforded substantial judicial deference when individuals or organizations seek to enforce Section 106 (*Don't Tear it Down, Inc. v. GSA*).

To explain this concern further, during the development phase of a Minor Construction project, a specific scope of work is drawn up and a cost estimate is prepared based upon a specific design and location (VA 2012p, 1). The cost estimate includes "cost for any environmental and historical issues" (the meaning of which is unclear) (*Ibid.*, 2) and the construction component of the estimate includes costs for "Environmental Impact Mitigation (if necessary)" and "Mitigation for Impact on Historic Properties (if necessary)" (*Ibid.*, G-1, G-2).

The project is then queued within the VHA's Minor Construction Action Plan for prioritization and the opportunity for funding.<sup>15</sup> If funded, the project execution phase, which could be years removed from the project development phase, is the point at which the services of a final design firm and construction firm are procured and the project is built. One of the project engineer's duties during project execution is to ensure that all applicable design and construction requirements are met, including "environmental [and] historical" reviews. The meaning of this phrase is not entirely clear. If the phrase means that NHPA and NEPA compliance are to be initiated, the

alternatives analysis has already been completed and the project already designed. The only likely or possible interpretation is that any mitigation measures must be addressed at this stage. However, this interpretation would eviscerate the early planning imperatives of the NHPA and NEPA and does not comport with either law.

The VA's cultural resource compliance checklist and NEPA regulation state that environmental and historic property reviews need to be "prior to contract award for working drawings, or prior to the beginning of in-house work on such drawings" (VA [2011?p], 2:31; VA 2012h, §26.7(b)(5)). Similarly, the agency's NEPA guidance states that an "early start" to the environmental review process includes the stage "before finalizing the design for [a] Minor project" (VA 2010h, 1:11). Yet, the final design stage for Minor Construction produces the stamped documents that become the bid basis for construction. At this point, project formulation and any pro forma alternatives analysis have long been completed, without consideration of historic property or environmental impacts. And, there has been no meaningful opportunity for public involvement or consultation about the future of historic VA facilities when decisions have already been made completely outside of NEPA's or NHPA's legally mandated requirements.

One way to address these concerns regarding SCIP implementation is to ensure that historic preservation and environmental reviews and associated public involvement are initiated during development of comprehensive land use plans. However, feedback from the interviews is that these required reviews are either not being carried out, or the reviews are processed internally and external stakeholders are never notified of these important planning efforts. Even after a master plan or long-range plan is developed, individual projects still require

<sup>15</sup> A similar concern regarding foreclosure involves Major Construction projects. By the time the VA submits a funding request for a new project to Congress, at least 35 percent of the project has been designed (VA 2013d, IV:2-42). Planning and preliminary design expenditures in advance of NEPA and the NHPA are not impermissible, but the risk exists that the alternatives analysis and stakeholder involvement required by these laws have been foreclosed after the VA's preferred alternative has been substantially designed. The VA also uses these substantial design expenditures to justify its case to Congress for new Major Construction.

compliance with the NHPA and NEPA. However, by having provided an earlier opportunity for these compliance reviews, public participation, and stakeholder consensus on viable alternatives through the overall campus plan, the VA would reduce the risk of a foreclosure determination or litigation generated by public opposition.

The other reason that comprehensive land use plans should be undertaken, in compliance with the NEPA and NHPA, relates to auto transportation. Promoting employee and patient access to VA facilities by all modes of transportation is an element of the VA's new Sustainable Locations Program directive. Also, employees are entitled to receive a non-taxable subsidy for using public transportation to commute to work (VA 2011d). However, most employees and veterans currently drive to VA facilities. In addition, one interviewee reported hearing of an agency policy—which could not be verified based upon the VA's published documents—that prohibits employees from riding shuttles to on- or off-site parking lots.

Vehicular parking substantially influences the VA's evaluation of individual projects. A review of the agency's budget submissions since FY 2008 reveals that parking deficiencies are consistently identified as a "performance gap" in justifying new Major and Minor Construction or Major Operating Leases. Additionally, service contract inventories show that at least \$4.8 million and \$5.5 million were spent on valet parking services for patients at VA medical centers in FY 2011 and FY 2012, respectively (VA 2011h, 2012m).

A Google Earth view of most medical centers reflects huge swaths of areas paved for surface parking lots. Surface parking affects historic buildings and landscapes directly through demolition and indirectly through visual intrusion that may obscure architecturally significant buildings and landscapes that are focal points within campuses. Interviewees concurred that parking

considerations cause problems for existing historic buildings because planning for vehicular access is conducted on a piecemeal basis. The solution that was recommended by several interviewees is to use the master planning or long-range development plan process to holistically plan for, locate, and design consolidated and distributed parking facilities appropriately in existing historic settings. This comprehensive plan process needs to include stakeholder participation by local governments, Section 106 consulting parties, and adjacent neighborhoods. It should also be noted that the Sustainable Locations Program policy requires medical centers and sites to engage local and regional planning agencies in the Department's planning efforts (e.g., regional metropolitan transportation planning organizations and city planning and zoning departments).

#### **National Programs Affecting Buildings and Medical Centers**

The VA should ensure that it complies with the NHPA and NEPA with respect to its nationwide programs to dispose of historic buildings and realign and close medical centers. The Council on Environmental Quality (CEQ), the USEPA, and the ACHP should evaluate the record of the VA in this regard in order to assist the VA in implementing this recommendation. As needed, these agencies should also assist the VA in updating and expanding upon its implementing regulations and guidance, particularly in the areas of cumulative effects of the building disposal program and realignment and closure plans for medical centers.

In November 2004, Congress authorized the VA to dispose of real property independently of the GSA and required that the VA report disposal information in each annual budget submission (VA 2007c, IV:7-29). From FY 2004 through FY 2012, the VA disposed of 898 buildings, of which 381 were permanently lost through demolition and another 58 were deconstructed (physical dismantling through

## OTHER PUBLIC HOSPITALS ARE ADDRESSING PARKING AND INVOLVING THE PUBLIC THROUGH MASTER PLANNING

In 2012, the University of Pittsburgh Medical Center issued a draft ten-year master plan for the Pittsburgh campus, which includes the circa-1972 Shadyside Hospital (which is not a VA hospital but is used here as an example of a public hospital that is tackling these issues in a public forum). The planning effort has been driven by a number of factors, including traffic and parking challenges. Multiple external stakeholders, including surrounding neighborhoods, have been actively involved in at least 20 public meetings. Traffic and parking are a key concern of the surrounding neighborhoods. The transportation component of the plan includes traffic circulation patterns that coordinate and integrate with the City's mobility plans, and a parking plan that consolidates and removes some surface lots into a recessed multi-tier garage that connects with the hospital through a landscaped upper deck. Through the public process, the draft plan eliminated over 25 percent of the 1,350 new parking spaces initially proposed, as well as two new vehicular access points. The medical center also coordinated the draft plan with city mobility studies and the city transportation plan and commits to providing an updated evaluation of traffic circulation after the opening of the new, planned Luna site parking deck and garage.

Consulting firm: Harley Ellis Devereaux/Trans Associates

removal of items such as doors and hardware) in anticipation of demolition or mothballing (VA 2013d, IV:9.3-13). The current plan for FY 2013 through FY 2017 proposes to dispose of another 535 buildings in total, including demolishing 314 buildings and deconstructing 66 (*Ibid.*).

It is likely that many of these disposals affect historic buildings based upon the VA's statement that almost half of the agency's entire inventory of "heritage assets" are unoccupied and in unsatisfactory condition (see, e.g., VA 2012l, III-43), which renders them candidates for disposal. It may be that some of these buildings and structures are contributing to the significance of a historic medical center district, but are not of a type that supports potential reuse (e.g., utility, other infrastructure, garages), and are thus appropriate for disposal.

These losses of heritage assets may seem incremental, especially if one only looks at the losses in an

individual fiscal year. Based upon the VA's annual performance and accountability reports, however, the number of heritage assets that are historic buildings and structures declined from 1,820 at the start of FY 2003 to 1,535 in FY 2011, a reduction of approximately 16 percent (VA 2003c, 225; VA 2011, III-35). These cumulative totals suggest unexplained and unanalyzed adverse impacts to historic buildings from implementation of the nationwide disposal program.

Also, the VA's annual reports to Congress identify "disposals" of buildings through leasing to third parties (e.g., enhanced-use leases or EULs, explained in Section 6). However, it is not clear whether these disposal reports include subsequent demolitions by third parties as lessees after they have gained control of VA buildings. Leasing comprises a substantial portion of the VA's disposal actions, encompassing 413 buildings from FY 2004 through FY 2012 (VA 2013d, 9.3-13). In 2012 alone, 237 VHA



Former Ft. Howard VA Medical Center, Baltimore, MD  
Credit: National Trust for Historic Preservation

buildings (most all historic) were leased via the EUL process, with major lease activities at Fort Howard, MD (39 buildings); Perry Point, MD (buildings); Fort Harrison, MT (12 buildings); Knoxville, TN (40 buildings); and Lincoln, NE (23 buildings) (VA 2013d, V:10-7 – 10-21). Thus, there may be additional permanent losses of historic buildings nationwide through leasing activities, the cumulative effect of which is unanalyzed.

Further, even if most of the VA's historic buildings that are currently in the next five-year plan were disposed of (because they are "vacant" and in "unsatisfactory" condition), there is still a relevant concern that the cumulative impact of the nationwide disposal program has not been analyzed under NHPA and NEPA for these reasons: (1) known historic buildings that are used today may be future inventory for disposal if they are not maintained and actively considered for adaptation; and (2) the VA's stock of historic buildings continues to expand as more buildings, especially those at Third Generation facilities, have reached or will reach 50 years of age.<sup>16</sup>

In contrast, the branches of the Department of Defense (DoD)—which each have 30 to 50 times more buildings than the VA—have complied with

NHPA and NEPA prior to initiating a nationwide program to dispose of certain historic building types associated with the World War II and Cold War eras (i.e., unaccompanied personnel housing, ammunition storage and production plants, certain military family housing units). There was extensive stakeholder involvement and mitigation of the loss of these historic resources as part of DoD's compliance program, all before the nationwide program was started.

The second programmatic area that does not appear to have been addressed by the VA in NEPA or NHPA compliance is the realignment and closure of historic medical centers through the Capital Asset Realignment for Enhanced Services (CARES) initiative. Other federal agencies routinely issue programmatic EISs (PEISs) for nationwide or regional initiatives—the USEPA's EIS database identifies almost 200 PEISs that have been issued just since 2004 (USEPA 2013). Examples include the U.S. Army's global realignment and transformation (DoD. Army 2007); leasing plans for uranium (DOE 2013) and the Outer Continental Shelf (DOI. BOEM 2012); and border security (Customs and Border Protection 2011).

The most relevant comparison to the nationwide CARES initiative is the cycle of military base closures under the Base Realignment and Closure (BRAC) process that began in 1988. Programmatic EISs were prepared for BRAC actions, and then individual closures were often processed as EISs as well (DoD. Army 1991; USEPA n.d.). The rationale for processing BRAC actions as EISs included the potential for harmful economic, socioeconomic, and community impacts from closure of these major federal facilities and the level of state, regional, and local controversy about proposed closures. This reasoning also applies to the loss of VA medical centers, particularly in rural areas. The EIS process was also considered as helping local communities in their economic recovery for the loss of these installations by initiating the planning process for the

<sup>16</sup> For example, the VA's inventory of historic buildings and structures jumped from 1,535 in FY 2011 to 2,081 in FY 2012 because of updated cultural resource surveys (VA 2012l, III-43

reuse of these public assets, again, not dissimilar from the experience of communities where VA facilities are located. Realignment and closures of VA medical centers are not always linked, quid pro quo, to construction of new medical centers. The gradual cessation and/or transfer of services and resources by the VA represent another way that realignment is accomplished, almost like a “silent BRAC” designed to try to minimize the attention of the public and elected officials. This withering-on-the-vine approach appears to be the mode of disposition attempted by the VA at Battle Mountain Sanitarium in Hot Springs, SD, a situation in which interviewees uniformly reported that the slow, siphoning off of resources and functions has been underway for years. In South Dakota, the silent BRAC has not been so silent due to the “Save the VA” campaign. On the other hand, an apparent silent BRAC strategy worked in Knoxville, IA, which lost its National-Register listed medical center to Iowa City before any local groups realized they needed to organize, based on the interviews for this report.

In summary, the cumulative adverse impacts of the VA’s nationwide building disposal program and CARES seem profound and do not appear to have been evaluated programmatically under the NHPA and NEPA.

### New Medical Centers

The VA should address a concern that its practice of preparing Environmental Assessments (EAs), rather than EISs, for new medical centers and other major projects systematically excludes stakeholder participation in agency decision making and, therefore, does not comply with NEPA. Additionally, construction of new medical centers (Major Construction) is often linked to realignment and closure decisions affecting existing VA medical centers. When this is the case, the scope of the NEPA and NHPA documentation for the Major Construction project should account for both actions, but does not appear to be done. The need to address related actions and cumulative impacts in NEPA and NHPA reviews of Major



Domiciliary wing of the Battle Mountain Sanitarium in Hot Springs, SD Credit: National Trust for Historic Preservation

Construction projects appears to be currently absent in the VA’s internal guidance.

The VA’s NEPA regulations include quantitative criteria as one element of determining the level of documentation that may be required (i.e., an EIS, an EA) for a project. Acquisition of more than ten acres of land for a new medical center is identified as “normally” requiring an EIS (VA 2012h, § 26.6(a)(1)(ii)), and “[s]iting of a new full-sized medical center . . . likely require[s] an EIS based upon [the] potential for impacts” (VA 2010h, 1:2). “[P]robable significant degradation of historic or cultural resources” associated with a proposed project or program is also identified as “normally” requiring an EIS, although no further guidance or examples are given (VA 2012h, § 26.6(a)(2)(i)).

The VA oversees substantial construction budgets as a large real property-managing agency (see Appendix A). It is not clear, from the interviews and research for this report, exactly how decisions are actually being made within VA regarding the level of NEPA documentation that is appropriate for new medical center construction and, where applicable, is contingent upon closure of existing medical centers. Approximately seven new replacement medical centers are currently planned or under construction,

at a total cost exceeding \$10 billion (Denver, Las Vegas, New Orleans, Omaha, Orlando, and Louisville and Lexington, KY) (VA 2013d, V:10-54 - 10-57). Most of these undertakings are contingent upon closing and transferring functions from existing medical centers. Yet, none of these actions appear to have been evaluated in an EIS.

Indeed, in reviewing public and proprietary databases that track EISs over the past 45 years, only two EISs have been found to have been issued by VHA as a lead agency for medical center projects (ProQuest 2013; USEPA 2013).<sup>17</sup> One EIS was issued in the late 1970s for the replacement hospital in Portland, OR (Coalition for Better Veterans Care v. VA). The second EIS—still in draft stage—was issued in 2012 to settle litigation regarding the claims of neighborhood and environmental groups that the VA impermissibly segmented its NEPA documentation at the San Francisco medical center (*Planning Association for Richmond v. VA*). Based upon these results and the substantial capital construction budget of the agency, it is highly questionable whether the

systematic preparation of lesser EA documentation for what appear to be “major federal actions” comports with NEPA.

At times, EAs and EIS documents can be comparable in terms of the scope and depth of analysis. In 2010, for example, the National Trust sued the VA and the Federal Emergency Management Agency for failing to prepare an EIS for replacing the Hurricane Katrina-damaged Charity Hospital and the Third Generation VA medical center in New Orleans (which included demolition of 265 houses in a historic district). The court observed that the administrative record developed by the agencies totaled almost 5,000 documents (also noting that there was an extensive Section 106 consultation process that produced a programmatic agreement for mitigation) (NTHP v. U.S. Dept. of VA, \*10).

However, there are fundamental and important differences between these two levels of NEPA documentation with respect to the opportunity for involvement by other stakeholders in federal agency decision making on proposed programs and projects. Regulations of the CEQ, which implement NEPA and are binding on all federal agencies, require that federal agencies provide formal public notices of proposed actions and involve the public and other government agencies at the draft and final stages of EIS preparation (CEQ 2012, § 1502.19, Part 1503). Additionally, the USEPA must review all Draft and Final EISs of federal agencies and “grades” the sufficiency of the documents in terms of their completeness and adherence to regulatory requirements (Clean Air Act of 1970, as amended, § 7609(a); see also Barras 2010, 2:93-95).<sup>18</sup> These reviews are accomplished in each regional office of the USEPA, and it is not uncommon for the reviewers to flag potential concerns over cultural, as well as natural, resources.



San Francisco VA Medical Center, San Francisco, CA  
Credit: Department of Veterans Affairs

<sup>17</sup> In comparison, the GSA has issued 19 EISs since January 2004 for land transfers, master plans, new construction, and consolidation of federal agency space and functions (USEPA 2013).

<sup>18</sup> The USEPA gave an “Environmental Concerns” rating to the draft EIS for the long-range development plan for the VHA’s San Francisco medical center (USEPA 2012), stating that “[i]t is not clear that all reasonable alternatives have been evaluated for the long-term projects since no alternative selection criteria are identified in the DEIS. Additionally, we have concerns regarding construction noise impacts, and request additional information on noise, aesthetics, air quality, stormwater management, and transportation.”

In contrast, NEPA regulations regarding EAs are much less prescriptive, particularly regarding involvement of the public and other governmental agencies, and are often inconsistently applied by regional and field offices even within the same federal agency. The VA is no different in this regard, even for EAs for multi-million dollar medical centers. The VHA and other the two other VA Administrations “shall include” other agencies with jurisdictional responsibilities over potential impacts (e.g., environmental, cultural resource) of projects and other stakeholders during the preparation of environmental documents, such as EAs, “to the extent practicable” and in accordance with regulations of the CEQ (VA 2012b, § 26.9(a)). However, there does not appear to be any identifiable practice, at least on the VHA’s part, to involve the public or the USEPA in EA documentation, unlike the practices of other federal agencies such as the DoD or the Federal Highway Administration. The regional offices of the USEPA that were contacted for this study reported that, with the exception of projects in which the DoD is a co-lead agency with the VA (including the VHA), none have ever received EAs from the VHA.

One pending example illustrates the concern regarding the VA’s failure to follow even its own NEPA regulations for preparing an EIS for new medical centers. In mid-June 2012, a programmatic EA and Finding of No Significant Impact were finalized for a new medical center in Louisville, KY (TTL Associates, Inc. 2012). The current cost estimate for this Major Construction proposal is \$900 million for building space sized for at least 800,000 gross square feet with 2,400 parking spaces on a 34.5-acre green-field, suburban site. The new construction would replace an existing, more centrally located Third Generation medical center that is situated on 58 acres (see photo of the Rex Robley VA medical center in Section 2 of this report). The existing hospital has had several recent major renovations, including the

emergency department, and construction of a new eye clinic, dental suite, prosthetics department, and ambulatory surgical unit (PricewaterhouseCoopers 2005, 3/24).

The Louisville medical center replacement project has been highly controversial. The reasons include the suburban site location (at one of the most congested intersections in the region), a generational divide between veterans (younger veterans wanted the services to remain in a more urban location (Otts 2012)), and environmental impacts, such as air emissions associated with adding up to 3,000 cars per day at the suburban location. The project justification to Congress included providing services to an expanding Fort Knox (VA 2009c, IV:6-7). However, the move to a suburban location would relocate the VA further away from Fort Knox and the University of Louisville Hospital (a teaching and research affiliate).

The related actions that should have been addressed in the VA’s NEPA documentation include the realignment and possible closure of the existing medical center, widening the primary access road to the new site from three to five lanes, and expanding off-ramps at the adjacent interstate highway. Despite all of the foregoing considerations, the VA determined that the project was not a major federal action with the potential to significantly impact the quality of the environment (human, natural, or cultural).

The physical size of a project or its cost is not necessarily dispositive of the level of NEPA documentation that is required. The CEQ regulations are clear that a variety of factors, including all possible impacts (direct, indirect, and cumulative) and the level of public controversy, need to be considered. However, the VA’s current NEPA approach appears to evade its own regulations and guidance, particularly with respect to EISs for new medical centers and by excluding cultural resource impacts, cumulative impacts of past harms to historic buildings, and the effects of related actions.

**RECOMMENDATION THREE:** The management of the VA should seek congressional authorization, as needed, for flexibility in the VA's use of capital budget accounts in order to: (1) promote advance preservation planning for Minor Construction and Non-Recurring Maintenance projects; and (2) accomplish capital projects that integrate health care, historic preservation, energy conservation, other sustainability measures, and operation and maintenance demands.

The VA's budget structure may impede planning for and carrying out projects that renovate and modernize historic buildings to meet current needs for medical services and goals for building performance, including operation and maintenance (O&M) goals of the VA.

As noted in Section 3, the Advance Planning Fund (APF) is a component of the VHA's Major Construction budget account. Interviewees believe that busy capital asset managers and facility managers must be provided the resources to readily fund and use qualified preservation consultants during the SCIP process for all size projects, including master planning, developing and analyzing alternatives, and conducting Section 106 consultation. This report recommends, therefore, that the VA seek congressional authorization to move the APF to the Medical Facilities account and to acknowledge its use for Minor Construction and Non-Recurring Maintenance (NRM) projects. Following this authorization, the VA should then develop a methodology that would provide an equitable and consistent distribution of APF funds to the VISNs and medical centers.

With respect to the second element of Recommendation Three, in order to succeed in accomplishing a capital project that integrates all of the life-cycle phases of a building and promotes preservation and energy conservation values, the VA may need to secure specific congressional authority to aggregate funds from one or more, or all, of the

construction and medical facilities budget accounts.<sup>19</sup> (See also related Recommendation Six regarding empowering and incentivizing the VA's staff to promote these integrated capital projects.)

The capital asset budget accounts are each separate accounts, with distinct perceived advantages and disadvantages to VA managers and some restrictions on the use of appropriated funds. VISNs control Minor Construction and NRM funds generally. Minor Construction is preferred within the field because these projects generally do not receive the headquarters-level and congressional scrutiny required of the "above threshold" Major Construction projects. The NRM account has been funded in significant amounts by Congress; however, the funds do not have to be spent and can be re-allocated to non-NRM projects, or even to cover personnel salaries. Funds for O&M costs, including some planning costs, are handled outside of the structured SCIP process and are included in the Medical Facilities budget account.

Adjustment of the SCIP process might be needed as well in order to make integrated projects more attractive to VHA regions and sites. In particular, an integrated capital investment project that would exceed the Major Construction threshold of \$10 million (short of a new medical center) could be considered for review and approval for budget submission purposes within the VHA solely (culminating in a review by the VHA "SCIP Board"). Currently, higher-level SCIP committees (the

<sup>19</sup> Without such authorization, there is a concern that aggregating such funds could run counter to the federal Antideficiency Act, which prohibits federal agencies (under risk of monetary penalties imposed upon individual managers) from obligating or spending funds in advance of appropriations or in amounts greater than annual appropriations (Antideficiency Act of 1982 [recodified], §§ 1341(a)(1)(A), 1517(a)).

Capital Investment Panel, Strategic Management Council), comprised of executives from the entire Department of the VA, review and approve projects of \$10 million or more.

In summary, a new budget approach is needed to address the myriad of building performance requirements and expectations. In the absence of structuring the funding mechanism to facilitate such integration, historic buildings, in particular, seem relegated to decline or underutilization through piecemeal planning and ad hoc management.

# 5 Recommendation Theme B

Encouraging and Empowering the VA's Staff to Sustain Historic Buildings

Dining Hall, James H. Quillen VA Medical Center (aka Mountain Home), Johnson City, TN Credit: National Trust for Historic Preservation



The Vision for Change that transformed the VHA in the mid-1990s shifted much of the power for capital asset decision making and budgeting (especially for Minor Construction and Non-Recurring Maintenance) from the VA's Central Office to the field (VISNs and local sites). Therefore, from the standpoint of historic buildings, preservation stakeholders typically find that their point of contact is a technical person at a local site or within a VISN (or their technical consultant). The attitudes, notions, practices, and belief systems of the VHA's technical staff—and the financial and other resources available to them—play a critical role in determining the fate of historic buildings and landscapes of the VA (see, in this regard, Technical Practices and Beliefs).

Project planners, engineers, and maintenance managers are often oriented toward solving problems, and they are often creative problem solvers. However, they have to be provided a clear expression of support by top management (see Recommendation One in Section 4) and practical examples and guidelines to direct their efforts. Currently, VA buildings are assumed to be “useful” for only 50 years (VA [2007]e, 28), which is not inherently supported by considerations relating to medicine, patient satisfaction, financial prudence, the integrity of the structure or its construction materials, or energy conservation. The bias is also incompatible with the agency’s responsibilities under the NHPA and related cultural resource management requirements.

This section addresses the need to provide resources, training, and tools to local facilities and VISN capital asset managers to cultivate a view that historic buildings are useful and represent an opportunity—not a hindrance—in addressing gaps in services and needs of all types (medical, energy, and operation and maintenance). Additionally, this section encourages the use of incentives to reward innovation and demonstrated successes in repurposing and using historic buildings in cost-competitive and sustainable ways.

## **Technical Practices and Beliefs that Hinder the Management of Historic Capital Assets**

A common thread emerged during the interviews for this report. In the experience of interviewees across the country, the VHA's technical staff often claims the following three factors as absolute barriers to medical reuse of historic buildings: ceiling heights, floor-to-floor ratios, and “code requirements.” This feedback was so consistently heard that these factors seemed to warrant additional research and examination in this report. A brief exploration of these factors suggests that none pose absolute restrictions and each requires a more nuanced evaluation that incorporates preservation values and specific types of uses proposed for buildings, at a minimum. Indeed, a senior manager within the VA's Office of Construction and Facilities Management acknowledged in a written response to questions that the VA's technical guidance documents are not inherently incompatible with the rehabilitation and utilization of historic interiors, but “many are silent on the issue or perhaps misleading to some.”

### **Ceiling Heights**

Ceiling heights in older VHA buildings are said to be “too low” for modern medical needs. The VA's architectural design manual generally requires a minimum ceiling height of 9 feet, measured from the surface of the finished floor to the finished ceiling (VA 2011a, 4-14). Several medical uses do require higher ceilings (from 9 feet, 6 inches, to 10 feet), mostly because of the equipment-intensive nature of the medical function. These functions include certain therapies (e.g., vocational rehabilitation, radiation, and pools), diagnostics (e.g., cyclotrons), and operating rooms (*Ibid.*, 4-14 – 4-16). Further, the increasing use of robotics in surgery can dramatically increase space needs (Mahlum 2010).

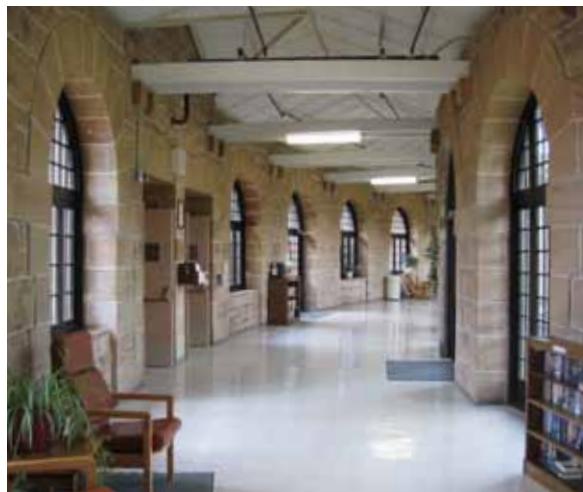
However, many different types of medical and related services are provided at VHA medical centers that do not require a higher-than-average ceiling height. These uses include psychiatric and social welfare counseling, child care, research and development, audiology and speech services, education, medical libraries, administration and staff offices, credit unions, pharmacies, staff and visitor lounges, nutrition and food service, police and security, multi-purpose recreation rooms, and veterans service organization offices. Thus, although a historic building or space may no longer be suitable or adapted to high-ceiling height functions, it may be suitable for other veteran-related uses.

### Floor-to-Floor Heights

Floor-to-floor height is another factor cited as a bar to repurposing historic health-care buildings. The VA's modular design manual for new hospitals specifies a floor-to-floor height range from 18 feet, 8 inches to 19 feet, 4 inches (VA 2006e, 4-7). These specifications accommodate a finished ceiling height of 9 feet, plus another 9 to 10 feet or more of "interstitial service zone." An interstitial service zone is where mechanical systems are located, such as heating, ventilation, and air conditioning (HVAC) ducts, telephone/data cables, electrical wiring, fire sprinkler piping, and water and wastewater piping. At the height specified in the manual for an interstitial service zone, it basically

becomes another floor itself, although it is not habitable. The rationale for dedicating an entire floor to mechanical systems is to enable personnel to conduct maintenance and repair without disrupting use of the room or floor below.

Historic hospitals were not originally designed with such generous utility service area space. It will not often be feasible to accommodate the VA's floor-to-floor height specifications without dedicating an entire floor, which is an option not likely to be feasible in a historic two- to four-story hospital. However, dedicating expansive areas to mechanical support systems may have its downsides. An experienced health-care architect who was interviewed for this report observed that large interstitial zones may be counterproductive to achieving stringent energy conservation mandates, as hospitals begin to plan to reduce energy through smaller, distributed heating and cooling systems in lieu of big overhead HVAC systems. Adding extra, dedicated floors to new hospital buildings for conventional utility systems also increases construction costs. Furthermore, engineers and architects familiar with the reuse of historic buildings are accustomed to accommodating a wide range of new mechanical systems in historic buildings, and can provide expertise to address these concerns.



Interior Hallway of Domiciliary,  
Hot Springs VA Medical Center  
(aka Battle Mountain Sanitarium),  
Hot Springs, SD

Credit: National Trust for Historic Preservation

### **“Code” or Other Legal Requirements**

A third, oft-cited, barrier to renovating VHA’s historic buildings relates to “code” or other legal requirements. The phrase “code requirements” is used in this subsection as a catch-all term for technical standards and mandates relating to buildings and/or medical services. In that regard, topics include building construction, internal air circulation, fire, safety, lighting, energy conservation, security (including Homeland Security), privacy, accessibility, environmental requirements (e.g., lead-based paint, asbestos), and high-risk locations (e.g., earthquake or hurricane zones). These mandates may be issued by organizations or governments at the level of international, national, state, or local. A discussion of the application of “code requirements” to VA facilities is beyond the purview of this report—however, they do obviously impact the use and viability of historic buildings.

As one example of the impact, federal buildings must be accessible to individuals with impaired mobility (Architectural Barriers Act of 1968; Architectural Access Board 2004). The VA’s supplemental guidelines (VA 2011b) are more stringent than those of the Architectural Access Board (AAB) in some areas. VA specifications require a slightly less-sloped surface in patient hallways than do the AAB guidelines. The more stringent VA guidelines can be a problem when applied to Second Generation hospitals because these buildings feature deep floor plates and, therefore, long hallways. Depending on the local topography, an able-bodied visitor might not see or feel a discernible change in a hallway slope. Nevertheless, a mobility-impaired patient could face a very difficult physical effort to traverse a long hallway on foot or in a wheelchair that features elevation changes of less than an inch from start to finish.

However, hospital interiors can be transformed to meet both patient needs and legal requirements, such as accessibility. A recent renovation of the University of Washington’s Northwest Hospital & Medical

Center in Seattle provides a good example. In late 2012, the hospital created a surgical suite—the most complex of medical-service areas—from a former lecture hall that featured a severely sloped floor characteristic of such auditoriums. The engineering and construction firm used engineered, polystyrene-based foam blocks to fill the void between the sloped concrete floor and the new, overlying concrete slab at a cost of less than \$5,000 (Shong 2013). This is perhaps a dramatic example of how interiors can be adapted for complex medical uses, but it shows that creative solutions to challenges posed by older health-care buildings can be accomplished and with sensitivity to cost constraints.

Additionally, almost every “code requirement” has some flexibility in interpretation and application in order to balance values that are promoted in other “code requirements.” The AAB, for example, authorizes flexibility in applying the federal accessibility guidelines to historic federal buildings by authorizing compliance “to the maximum extent feasible” in order to prevent adverse effects to the interiors or exteriors under Section 106 of the NHPA (AAB 2004, 1:¶ F202.5, F202.3, F202.4).

The VA itself provides for waivers and exceptions of “code requirements.” The agency recently amended its regulations to enable waivers of its standards for building conditions (e.g., health, safety, and environmental) and services (e.g., quality of life, nutrition) at non-VA community residential-care centers that are approved for veteran placement, as long as the deficient condition does not “jeopardize” the health and safety of residents (VA 2013a). An appropriate application can include waiving the VA’s specification for the size of single-resident bedrooms (minimum of 100 square feet) in situations where the deficiency cannot be remedied without compromising the structural integrity of the building (*Ibid.*, 32124). This particular application of a waiver is mentioned because several interviewees recounted their experience that the VA

## BELLEVUE HOSPITAL CENTER, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Lead architect, architectural firm: Ian Bader, Pei Cobb Freed & Partners (New York City)

According to its website, Bellevue is the oldest continuously operating hospital site in the country, dating back to 1736. The architectural firm of McKim, Mead, and White was hired in 1896 to develop a master plan for the campus, which places the hospital in the era of the VA's First Generation facilities. Today, the National Register-listed historic hospital is accredited by The Joint Commission in the categories of hospital and behavioral health care.

By the early 2000s, significant additional space was needed for ambulatory care. The firm Pei Cobb Freed designed a new 210,000 square foot ambulatory-care pavilion and atrium which was constructed at a cost of \$84 million. A structural steel frame allowed the addition to be placed in a narrow area between the hospital's original facade and First Avenue and that is tied into the historic building; to maintain 12-foot floor-to-floor heights, consistent with the historic building; and to accommodate within cutbacks HVAC and other building systems. Local seismic code requirements were met for both the new addition and the historic building. The renovation also features a crescent-shaped entry atrium with a 67-by-175 foot skylight. The design and renovations received the "Lightning Design Award of Merit," "Gold Award for Engineering Excellence" (2006), and Best of Construction New York "Award of Merit" (2005). (<http://www.foundationsofamerica.com>)

often cites dimensional standards as inflexible, unalterable requirements that are used to preclude rehabilitating historic buildings, when in fact this seems not to be the case uniformly.

In sum, impediments to repurposing the VA's historic buildings exist, but may not be insurmountable technically, legally, or from a cost standpoint. Accommodation of existing standards through creative alterations to buildings, or appropriately balancing code requirements and preservation values through regulatory interpretations and waivers, may be able to support historic preservation and other goals and requirements. Successful renovation and repurposing solutions take management emphasis, staff

commitment, planning time, and a design team with multiple perspectives, including experience rehabilitating historic buildings.

The Bellevue Hospital case study illustrates a recent major expansion of a historic hospital that successfully combined preservation, modern materials and design, and code requirements, all within the project budget. The lead architect acknowledges that "intellectually, new construction is easier because one is starting with a clean slate." However, with respect to the Bellevue addition, he emphasizes that "it was unquestioned in my mind that we would not destroy the historic building. It's all about imagination and the client's value system."

**RECOMMENDATION FOUR:** The VA should develop instructions to help its staff implement the agency's new Sustainable Locations Program policy. Detailed guidance should be issued on how to evaluate the alternative of renovating historic buildings, including the following elements: (1) assigning monetary valuations to historic properties and lands in economic analyses; (2) quantifying sustainability considerations in these analyses (such as greenhouse gas emissions); and (3) acknowledging that historic preservation is a qualitative value that can justify selecting the renovation alternative under existing federal law and guidance.

The VA's Sustainable Locations Program sets a new, positive tone and direction with respect to the agency's policy toward historic medical centers and buildings. Employees are directed to "maximize" the use of existing resources and to "leverage" existing infrastructure, including "prioritizing areas that are currently well-served by water, sewer, and other relevant public infrastructure" (VA 2012f, 5), consistent with Executive Order 13514 (U.S. President 2009). In line with Section 110 of the NHPA, the directive also compels all component organizations of the VA and employees to:

Promote the preservation of historic resources and other existing buildings. Agencies should place new emphasis on examining the reuse potential of historic buildings and locating appropriate new buildings in historic districts. This reuse makes the most efficient use of already constructed buildings, supports preservation of historically significant structures, and promotes local economic development. (*Ibid.*, 6)

#### **The VA's Economic Analyses of Projects Need Updated Guidance on Historic Buildings**

Most of the VA's directives establish general policy direction for its staff, with details of implementation addressed in accompanying handbooks. The Sustainable Locations Program directive needs a Handbook to help VA planners and capital asset managers fulfill their responsibilities. The Handbook needs to address how economic analyses are conducted during the SCIP stage of project formula-

tion. As explained in Section 3, when the VA formulates or conceives of a project to acquire building space to address a performance gap, the analysis includes four alternatives, other than "no action": new construction, renovation of an existing building, leasing from others, and/or outsourcing the service. The two types of economic analyses that are conducted during SCIP are life-cycle, cost-benefit analysis (LCA)<sup>20</sup> and net present value (NPV) analysis.

Each analysis involves calculations that are intended to provide an apples-to-apples comparison of the economic consequences of alternatives, in dollar amounts. In LCA, the input (as applicable) includes direct and indirect costs for planning, acquiring land, preparing sites, constructing new buildings, renovating existing buildings, operating the building (including staffing and equipment), and ultimately disposing of the building (or space). NPV calculations quantify a dollar amount of expected future costs and benefits of each alternative (over, for example, a 20-year period) and then "discount" those costs by a set factor (percentage) to yield a current dollar ratio of benefits to costs.

The VA's annual budget submissions to Congress for approval of Major Construction projects (exceeding \$10 million), as well as some Minor Construction projects, typically present the results of these two economic analyses for the agency's "preferred" project alternative, usually new construction for its "ideal space" (see Recommendation One for the VA's

<sup>20</sup> Life-cycle analysis is also generally referred to as "life-cycle assessment" or "life-cycle costing."

concept of “ideal space”). The details of the overall methodologies and assumptions for these economic calculations were not found during the research for this report. Nevertheless, patterns can be discerned in how these cost-benefit justifications are presented, and which ones are not presented.

VA budget submissions were reviewed from FY 2009 through FY 2014. The LCA and NPV costs are not typically included for the renovation option. The common absence of economic information about the renovation option prevents comparing its costs to new construction costs. When the economic costs of the renovation option is included, it is not apparent that the VA assigns any quantitative value in the calculations to the public’s existing investment in historic buildings, the land upon which they are situated, the utility infrastructure, and medical or other equipment that will become superfluous and will not be repurposed because of new construction. The failure to present economic costs and to ensure that an apples-to-apples comparison is being made is inconsistent with the Sustainable Locations Program and OMB guidance (OMB 2013a).

The following projects (one for new Major Construction in Colorado and the other for a Major lease-build Operating Lease in North Carolina) illustrate why guidance for the technical staff might be needed to ensure that complete economic information is available to decision makers and the public. The first example relates to the replacement of the medical center in Denver, CO, a Third Generation hospital built in 1951, which has been assigned a value of \$9.3 million according to the website of the Denver Assessor’s office. In FY 2009, the VA asked Congress for \$20 million to continue funding an entirely new, freestanding medical center and 2,500-space parking garage in Aurora, six miles from the current hospital. The estimated cost for the 1.4 million gross-square-foot (gsf) hospital in this budget submission was \$769.2 million (VA 2008b, 4:2-18), increased from an initial estimate of \$328 million

(GAO 2013, 3).

Part of the stated justification for the new medical center was the “aging facility” in Denver, which is “over 50-years old, inefficient, cannot physically expand, and will not support the capacity or quality of veteran care needed for state-of-the art treatment” (VA 2008b, 4:2-15). The alternative of renovating the Third Generation hospital is identified, but dismissed as creating “higher costs, more disruption, and . . . difficulty in phasing” (Ibid., 4:2-16). On the other hand, the construction cost for the new facility was listed as \$295/gsf (2009 dollars) for a subtotal of \$418 million; land acquisition (over 30 acres), and new utility and other costs added another \$190 million; and non-recurring start-up operational costs (e.g., new equipment, supplies) added another \$141.5 million (Ibid., 4:2-18). No economic information is presented, at least in this budget submission, with respect to the public’s existing investment in the costs of utility infrastructure, building construction, and equipment associated with the Denver hospital, nor the current value of the medical center.

The VA publishes technical guides that compare, per gross square foot, the cost of new construction to renovations. With respect to the first quarter of 2013 in Denver, the VA’s cost guide is \$287/gsf for totally renovating a medical center and \$367/gsf for new medical center construction (VA 2013f). A 29 percent cost penalty for new construction is likely to be reduced for renovation items such as environmental remediation. However, the consistent cost penalty associated with new construction versus renovation in the VA’s own guides for costs across the country deserves transparent explanation and presentation in the SCIP process to provide Congress and the public with a better understanding of responsible stewardship of tax dollars and historic building management. (It should also be noted that the new Aurora facility, which is under construction, now has a price tag of more than \$800 million [VA 2013d, IV:6-133].)

The need for transparent and consistently presented project justifications, as part of implementation of

**In the VA's construction cost estimating guides, new construction is always more costly than renovations on a square-footage basis, even for Major Construction projects exceeding \$10 million.** (VA 2013c).

the new Sustainable Locations Program, is not solely limited to new Major Construction. The VA has asked Congress to approve a build-to-suit Operating Lease that would relocate outpatient services currently provided at the Fayetteville, NC, medical center (a circa-1940 Second Generation facility). In this proposal, the VA would pay a third party to acquire land elsewhere in the city and construct a new, 236,000-net-useable-square-foot building and a 1,360-space parking lot (VA 2009c, 4:6-38). The FY 2010 budget request was for \$23,487,000 for one year. However, the land acquisition and construction costs would be paid through a rental cost of \$10,507,000 each year for 20 years (over \$210 million in total) and an additional upfront cost of almost \$13 million for "special purpose" improvements for "special administrative or medical use" (*Ibid.*, 4:6-39). The justification to Congress did not present any LCA or NPV analysis for any alternative—including the +\$210 million build-to-suit lease—nor did it consider the option of renovating and expanding buildings at the Fayetteville medical center. Accordingly, there was no way to analyze whether or not this approach was the most cost-effective and viable option to address veteran needs.

It should be noted that the VA does assign an asset value to historic buildings when the agency proposes an enhanced-use lease (EUL) transaction (see Section 6 for a description of EULs). Methods for valuing

buildings in these cases include local appraisal district valuations, "comparable" values for other similar buildings in the local market, or the valuation of a commercial appraiser. In fact, the VA considers such information an "invaluable negotiation tool" (VA 2009a, II, 2G:B, 29). Additionally, VA financial policy requires assigning a "reasonable estimate" of "fair market value" when the agency secures a historic building from another federal agency for use in operations (VA 2010e, III, 6:7). The research for this report did not find any instance in which the VA has agreed to assume responsibility over another agency's historic building. Nevertheless, the VA's own financial policy is to assign a monetary value to buildings over which it assumes a stewardship role.<sup>21</sup> Yet, the economic analyses that are conducted for the public's investment in the VA's capital projects do not appear to do so.

#### **The VA's Economic Analyses of Projects Need Updated Guidance on Incorporating Sustainability Measures**

The VA should also include sustainability measures and costs in its economic analyses of projects. Based upon the budget submissions to Congress, it does not appear that the LCA and NPV analyses used in the SCIP process are truly "cradle-to-grave" tools for comparing costs and impacts of different investment strategies, particularly with respect to sustainability (e.g., quantifying environmental life-cycle impacts of historic building renovation versus new construction). The National Trust's publication, *The Greenest Building*, is entirely devoted to accounting for sustainability in economic analyses (Frey, Spataro, Dunn, and Cochrane 2011). For the commercial building sector (the one that may most closely approximate health care), the life-cycle costs for renovations scored better (i.e., is the environmentally preferred option) than did new construction with respect to quantitative

<sup>21</sup> Additionally, historic buildings that are used by a federal agency and that are not purely commemorative, such as monuments, are "multi-use heritage assets" under accounting standards applicable to the federal government (FASAB SFFAS 29, 4). Current VA financial policy states that multi-use heritage assets should be recognized and presented in the "General Property, Plant & Equipment" (G-PP&E) category of assets in the VA's annual balance sheets (VA 2010e, III:ch. 6, 11). Inclusion of multi-use heritage assets in financial statements as G-PP&E typically requires that the federal agency assign monetary values to the buildings (FASAB SFFAS 29, 5). It is not clear whether the VA's annual financial statements in performance and accountability reports actually follow these guidelines.

impacts relating to climate change, resource depletion, human health, and ecosystem quality (*Ibid.*, 62).

The DoD recently issued a quantitative methodology for incorporating emissions of carbon dioxide (a greenhouse gas that contributes to climate change) into LCA for capital projects (DoD 2013). The study demonstrates that the reuse and modernization of historic, defense-related buildings of a certain era (built before World War II) are consistently less expensive, per square foot, than new construction, and that the DoD's carbon footprint is reduced by the reuse and renovation of these existing buildings. According to the DoD, two factors result in at least a 15 percent savings in greenhouse gas emissions for the reuse and modernization alternative: (1) the "original design intelligence" of historic buildings that promote energy conservation (e.g., the siting, design, and materials of construction); and (2) the carbon dioxide emissions associated with entirely new construction (*Ibid.*, IV-6).

The methodology presented in the two studies mentioned above may need to be adjusted or developed for medical facilities specifically (although it is worth noting that one of the DoD buildings that was evaluated was a three-story historic hospital building at Fort Bliss, TX, built in 1904, which is currently used for administrative offices). However, the point is that sustainability can be quantified and incorporated into capital investment decisions, and a new Handbook on the VA's Sustainable Locations Program could instruct staff on how to do so.

#### **Preservation of Significant Historic Buildings is a Legitimate Justification for Renovation and Modernization Projects**

The last element of Recommendation Four is that a Sustainable Locations Program Handbook should acknowledge and promote the staff's ability to identify

qualitative values as project justification for retaining historic buildings with significant, character-defining features. The VA's project justifications to Congress currently fail to do so.

What does a "qualitative value" mean? One example is found in the NHPA, which compels federal agencies to steward and preserve the public's historic buildings to which they have been entrusted. Similarly, by law, the Secretary of the VA is required to "give due consideration to excellence of architecture and design" when altering, constructing, or otherwise acquiring medical facilities (38 U.S. Code § 8102(c)(2)). This mandate is not limited to new construction, but also applies to architecturally significant historic buildings and structures.

The OMB has stated, in guidance on conducting economic analyses for capital projects, that qualitative values (e.g., historic preservation, societal benefits) should be presented in the conclusions of the analyses (OMB 2013a, 15). The GAO has also noted that federal agencies can base their capital project justifications "solely on the merits of the historic structures [they] seek to preserve" (GAO 1979). Other federal agencies have adopted standard operating procedures for the economic analysis of historic properties that explicitly endorse using historic preservation as a qualitative value in selecting the renovation option to fulfill a need for additional building space or new services. The DoD, for example, states that, even if the life-cycle cost of renovating a historic building exceeds the cost of a new or replacement building, the significance of a particular historic building may warrant "special attention," justifying the retention option (DoD 2008, 12).

As part of implementing the Sustainable Locations Program directive, the VA should authorize capital asset managers to incorporate qualitative values, such as preserving historical significance of existing buildings, into the SCIP process, as well as updating the economic analysis of the renovation alternative.

**RECOMMENDATION FIVE: The management of VA should encourage and facilitate the development of in-depth case studies of renovation and modernization of historic VA buildings. Existing guidance within the VA's Technical Information Library should be revised to provide specific and practical direction to technical staff and consultants regarding renovations and other alterations to historic buildings and landscapes.**

As further empowerment of the VA's capital asset managers and other technical staff, the positive concepts expressed in the VA's Sustainable Location Program need to be translated into a practical framework for technical implementation. The VA should carry out pilot projects to develop evidence-based design solutions that are based upon renovating and modernizing historic capital assets—possibly through the VA Center for Innovation located in the Office of the Secretary of the VA—and then share outcomes through widespread dissemination.

The table below outlines criteria for evaluating the adaptive reuse of historic health-care buildings, which is based on tailoring the ten Standards for Rehabilitation of historic buildings (issued by the Secretary of the U.S. Department of the Interior) to specific technical criteria important to health-care facilities. This framework provides an example of guidance that should be applied to a VHA pilot project in order to develop specific instructions for analyzing the renovation option when the need for building space is being evaluated.

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**Framework for Considering Adapting and Reusing Historic Health Care Buildings**

**Secretary of Interior's Standards for Rehabilitation ("The Standards"):**

1. Can the proposed use or re-use be accomplished with minimal change to the existing facility?
2. Can the historic character be retained and preserved?
3. Can false or conjectural historic elements be avoided?
4. Can previous changes to a property that have become historically significant in their own right be retained?
5. Can distinctive features and craftsmanship be preserved?
6. Can deteriorated physical features be repaired rather than replaced?
7. Can the necessary restoration methods avoid damage to historic materials?
8. Can archeological resources be protected and preserved?
9. Can new additions not destroy historic materials? And, can new work be differentiated from the old?
10. Can new work be done in manner that, if removed in the future, would not impair the integrity of the asset?

**Six technical criteria specifically related to health care:**

11. Is the existing building code compliant, or can it readily be made code compliant?
12. Is the existing building, including the shell, structurally sound and capable of carrying the anticipated loading?
13. Are the existing vertical clearances (floor-to-floor heights) adequate for the required infrastructure clearances?
14. Does the existing column spacing work for the intended healthcare occupancies?
15. Is the existing building shell (exterior walls and roof) viable?
16. Is the existing building capable of meeting energy efficiency requirements?

Source: H. James Henrichs, AIA.



## OAKLAND REGIONAL HOSPITAL

(formerly the Great Lakes Rehabilitation Hospital) Southfield, MI

The Oakland Regional Hospital includes four operating rooms, inpatient hospital, inpatient rehabilitation, outpatient surgical, and diagnostic and rehabilitation. The facility is accredited by the American Osteopathic Association. The Great Lakes Rehabilitation Hospital featured a 1960s façade (not dissimilar from that of some of the VA's Third Generation hospitals), which had not been maintained. Additionally, mechanical and electrical systems within the existing building had reached the end of their useful lives.

Working within a limited budget, key components of the façade were replaced, renovated and repaired, with much of the original character retained and improved, including improvement in thermal performance. The mechanical and electrical systems were replaced and successfully integrated into the existing building, despite low floor-to-floor heights, through close coordination within the project team. Significant upgrades were completed to meet code requirements.

A project of Hobbs+Black Architects. Example and photo provided by H. James Henrichs, AIA.

This combined set of criteria can be used by qualified professionals to assess the viability of repurposing historic buildings and can serve as a set of design criteria during the planning and design phases of a given project. The framework was used successfully in the renovation of the Oakland Regional Hospital in Michigan (see insert).

Successful application of these criteria in VA (and non-VA) projects should be showcased within the VA and within the broader network of federal facilities management professionals. Summary write-ups that can be quickly disseminated in e-newsletters, such as CFM Today (a publication of the VA's Office of

Construction and Facilities Management), and comparable communications help to show others that their peers have successfully repurposed historic buildings. To maximize usefulness, a case study format should be developed that addresses key technical concerns and questions about all phases of renovation and adaptive reuse. The VA's engineering and maintenance staff should have an opportunity beforehand to identify what they need in these case studies, such as how to plan for them, the types of expertise needed in project teams, any special cost estimation considerations, and how to address code requirements and energy conservation needs.

One recent project—part of which is still pending—that could be useful for a detailed case study is located at the Charles George VA Medical Center in Oteen (Asheville), NC. The National Register-listed historic campus of the Oteen medical center is a Second Generation facility that opened in October 1920. Building 9 is a three-story masonry building with a slate roof that was historically used as a dormitory for white nurses; black nurses stayed in the adjacent Building 13. In 2010, the VA secured the services of an architectural/engineering (A/E) firm for the demolition and replacement of Building 9 with a new

building to house an oncology chemotherapy program, other pharmaceutical infusions, and a sleep study lab (a Minor Construction project). When the project proposal was submitted to the North Carolina SHPO office during the Section 106 consultation process, the SHPO's staff questioned the need for demolition and pressed the VHA to explain why the two existing buildings could not be reused for these purposes.

Ultimately, a more preservation-sensitive solution was developed through consultation between the VA



Buildings 13 and 9, Charles George VA Medical Center, Oteen, NC  
Credit: National Conference of State Historic Preservation Officers

facility staff (including the project manager), A/E firm, SHPO staff, and a cultural resource consulting team (brought in by the VA's Federal Preservation Officer). The location of the cancer center and sleep lab was moved to a site next to Building 9 and the historic garages in the back of Buildings 9 and 13 were demolished to make space for the new construction. The facility's solution, in several regards, even went beyond the original thinking in a positive way: Building 9—which was going to be demolished at a cost of at least \$500,000—is now planned for renovation as a mental-health clinic and Building 13 was rehabilitated for office space and a records center.

The outcome of the Section 106 consultation at the Oteen medical center was positive, according to the participants interviewed for this report (who are not with the VA). One individual noted that there was an inexplicable year-long time lag between the first and second consultation meetings, and then another year-long lag to complete the Section 106 Memorandum of Agreement. This case is an apt illustration of at least a two-year delay in providing veteran services because alternatives were not evaluated in a meaningful way during the SCIP project formulation phase and in consultation with external stakeholders, as required by the NHPA and NEPA.

Another measure that would promote greater sensitivity to, and understanding of, the renovation option and the location of new construction in historic settings relates to the VA's Technical Information Library (TIL)—the “Source for VA's Electronic Design and Construction Information”—which is accessed via <http://www.cfm.va.gov/til>. Typical users include VA facility planners, designers, engineers, and maintenance staff and also A/E firms, construction companies, and landscaping firms that perform services for the VA.

The TIL is a substantial body of work comprised of guidance and aids relevant to project planning, design, and construction. However, a review of the major technical documents posted on the website reveals that they either provide only a cursory reference to preservation issues—with no illuminating guidance—or they are silent. For example, the agency's Architectural Design Manual, the audience for which is primarily A/E firms, devotes a paragraph to explaining the purpose of the VA's cultural resource management handbook, with no clues as to its practical import for siting buildings, selecting materials, or using professional standards when modifying elements of historic buildings (VA 2011a, 2-5). Another paragraph in the manual references the Standards for the Treatment of Historic Properties, issued by the Secretary of the Department of Interior, for projects that affect exterior windows in historic buildings, but then directs readers to the design guide for the National Cemetery Administration (*Ibid.*, 4-6). The design guide simply refers readers to the website of the National Park Service, with no explanation (VA NCA 2010, 5-47 – 5-48).

The “A/E Quality Alert” checklist series is another example of an aid that could be modified. Minor revisions to the checklist can serve to prompt the designer or engineer to consider how new construction may pose proximity impacts to historic buildings and landscapes, and how additional consideration of material choices, siting and design features could make a new project more compatible.

The written feedback received from a senior manager within the VA's Office of Construction and Facilities Management during preparation of this report stated that the agency has hired a consultant to work on changes to some of the TIL documents (such as the space planning criteria for different types of health-care services) to incorporate considerations regarding historic preservation compatibility. This is a welcome initiative, which will hopefully be expanded to other TIL documents.

**RECOMMENDATION SIX:** The management of the VA should create incentives for employees to successfully initiate and execute capital projects that integrate health care, historic preservation, energy conservation, other sustainability measures, and operation and maintenance demands. Staff should further be encouraged and supported by providing resources to access on-demand, outside historic preservation expertise through existing procurement mechanisms.

**Empowering Staff to Plan and Implement Integrated Capital Projects**

A daily challenge is posed by the amount of electrical power used by VHA buildings and the equipment they house. Health-care facilities consume more electrical power than any other users in the building sector of industry, only surpassed by fast-food restaurants (Burpee, Loveland, Hatten, and Price 2009, 2). Federal buildings were not even required to have individual meters to monitor electricity usage until October 2012 (Energy Policy Act of 2005, 42 U.S. Code § 8253(e)(1)). By 2030, each federal agency's inventory of buildings is slated to operate in a "carbon neutral" mode (also referred to as "net zero" carbon) through reducing reliance on the combustion of coal, oil, and natural gas to generate electrical power and increasing renewable wind, solar, and geothermal power production (Energy Independence and Security Act of 2007, 42 U.S. Code § 6834(a)(3)(D)(i)(I)).

In order to achieve dramatic reductions in the use of fossil fuels to power buildings and equipment in VHA buildings, more work is needed than just relying upon site orientation, mature landscaping, durable and insulating materials of construction, and design features of historic hospitals that promote energy conservation, or upon repairing leaky windows and doors. Recent studies on buildings of all types estimate that a standard renovation of a building can produce energy savings of 20 to 30 percent; a "deep retrofit" (replacing existing systems in a building with similar ones of higher quality and performance) can reduce consumption by 50 percent or more; but a "deep renovation" (which focuses upon improvements to the building shell) can reduce energy consumption by more than 75 percent (Shnapp, Sitjà, and Laustsen 2013). Hospital retrofits are estimated as

yielding a 20 to 40 percent reduction in energy consumption (Better Bricks 2009).

Other capital asset performance requirements include the recurring cycle of medical technology upgrades, historic preservation, and meeting square-footage targets for O&M costs. A piecemeal approach is not going to meet the demands on the VA, even if it does represent the traditional—and comfortable—way of managing assets. A more holistic, proactive approach to planning is needed, and employees should be rewarded for their innovations in striving to meet multiple goals.

In order to promote changes in the internal culture, innovation has to be valued and encouraged within the agency. Among the 18th largest federal agencies, the VA's "innovation" score places it near the bottom (in the 14th position) according to the Partnership for Public Service, a not-for-profit organization (PPS 2013, 8). Importantly, a key factor identified as driving innovation in government has nothing to do with funding or physical infrastructure: it is employees' belief that they are personally empowered to effect change (*Ibid.*, 2).

Innovation should be encouraged and rewarded through financial awards and other means. The 2012 survey of Best Places To Work in the Federal Government® ranks VA relatively low in the category of providing performance-based rewards and advancement for employees (an index score of 39.1 out of 100) (PPS 2012). The score is compiled from employee surveys. Of course, financial or other incentives need to be consistent with VA's policies and procedures. Currently, an individual employee may receive up to \$10,000 in a monetary award and

groups may be awarded up to \$25,000 total, although higher amounts may be approved (VA 2011h, XV:ch. 3, 5). Within these limits, the VA could make substantial progress by actively encouraging staff innovation to develop creative solutions for integrated planning and renovations and modernization of its historic capital asset inventory.

### **Providing Staff Access to Outside Expertise**

Capital asset managers and facility managers should be provided streamlined access to experts in historic preservation planning, cost estimating, design, project execution, and inspection and repair services. The VA's Historic Preservation Office should develop language for contracting officers to use in procurement solicitations that identifies a broad scope of preservation services and specifies the professional credentials required of consultants who carry out these services.

Based upon the publicly available inventory of VA consulting contracts over the past three years (VA 2010i, 2011m, and 2012m), the VA's Historic Preservation Office has been provided budget resources to hire consultants to document the historical significance of medical centers, to develop templates and operating procedures to support the capital asset management staff, and to troubleshoot contentious and difficult Section 106 consultations. As reported by many interviewees, these specialized consultants—whose services are typically procured through indefinite-delivery, indefinite-quantity (IDIQ) contracts—have been extremely effective in helping the VA to resolve controversies around the country. A particularly effective role of outside expertise has been in the Section 106 review process by developing alternatives that are less harmful to historic properties. Several VISNs have also independently procured the assistance of cultural resource consultants and architectural firms to assist in master planning and project design.

The overwhelming feedback of interviewees is that better process and substantive outcomes happen

when the services of preservation experts are secured early in project planning and formulation. Too often, however, this expertise is only brought in after “things have gone south,” according to interviewees. Too few VISNs access experts in preservation, or they access A/E firms or individuals that do not meet the professional qualifications required by the NHPA for the work they perform.

One area of suggested improvement is to expand the services procured by the VA for multi-year IDIQ contracts with A/E firms. Once in place, these contracts allow A/E professionals to assist staff in the VA's Central Office, VISNs, and local facilities “on demand.” A typical IDIQ scope includes services relating to planning, evaluating alternatives for building space, conducting life-cycle analysis of buildings and projects, and developing cost estimates for capital projects. Rates have already been negotiated in the contract phase and individual projects are then authorized through fixed-price task orders. The potential—but not guaranteed—cumulative value of these IDIQ contracts can range from tens of millions to hundreds of millions of dollars over a five-year period. Preferences are typically expressed for veteran-owned, service-disabled veteran-owned, or small-business owned firms, and/or for regional A/E firms within certain drive-times of the medical centers to be serviced.

The federal government's procurement website (<http://www.fbo.gov>) was reviewed from 2009 to date with respect to VA solicitations for A/E services for both IDIQ and project-specific contracting opportunities. With the exception of one A/E procurement relating to the Cleveland medical center, none of the solicitations sought historic preservation and NEPA expertise as part of the team qualifications. That is not to say that such expertise was not otherwise secured. However, more frequent use of such professionals will be promoted by developing and using

standard language to describe the scope of preservation services and professional credentials sought in the procurement process.

There may not be a large or geographically distributed number of firms that qualify for technical preservation work and meet veteran preferences. Part of the needed procurement improvements in this regard should identify and prequalify such firms. Additionally, the A/E firms that are the prime contractors on IDIQ contracts can subcontract for historic preservation professionals if special expertise is needed (as has been accomplished successfully with respect to the National Soldiers Home in Milwaukee). These firms may be reluctant to add preservation subcontractors to their team, for reasons relating to administration of the subcontract or competition for services they believe they can perform. Regardless, they will certainly do so if the VA explicitly makes preservation qualifications a part of the scope of services sought.

The recommendations above regarding facilitating and streamlining the procurement of preservation expertise should also include providing on-demand access to inspection and repair services. Maintenance and potential alterations of major components of historic building subsystems (particularly structural and the exterior envelope [including the roof]) benefit from the experience of technical experts that understand historic materials and construction.

National IDIQ contracts should be procured for these types of services, such as roof inspections, that could be accessed by any VISN or medical center. In addition, the VA's Historic Preservation Office should work with each VISN's contracting officers to prequalify local or regional companies with such expertise. City historic preservation officers and the staff of SHPOs are likely to be familiar with qualified local or regional companies, and should be consulted to facilitate identifying these firms or individuals.

# 6 Recommendation Theme C

Facilitating the Use of the VA's Historic Buildings by Third Parties

Residential Duplex, Dwight D. Eisenhower VA Medical Center, Leavenworth KS Credit: Pioneer Group



Section 3 explains that “disposal” is the final stage in the life cycle of a VA building that is determined not to be “mission dependent” and/or is “vacant,” “unused,” or “underutilized.” Options to dispose of buildings (and land) include deconstruction (salvaging interior or exterior elements and then mothballing or demolishing the structure), demolition, mothballing, outleasing (leasing to a third party, including the option to transfer ownership of buildings to the lessee after the lease ends), space sharing, permitting (granting another federal agency a license for use), or executing an easement to encumber the property for a use (VA 2006b).

Through the VA’s Building Utilization Review and Repurposing process, buildings are identified for disposal through leasing and other third-party uses that are executed through “asset-related agreements.” The VA has executed a total of 538 such agreements with private and public entities for the use or reuse of buildings and campuses (VA 2013d, IV:8.2-8). This section of the report identifies ways in which stakeholders can promote the reuse of the VA’s historic buildings and recommends measures to the VA and Congress to expand the agency’s options in this regard. First, however, a brief explanation is provided regarding the laws that govern federal real property disposition and the associated incentives and disincentives that affect their use by federal agencies.

### **Legal Framework**

Generally, a federal agency cannot itself sell, transfer, or lease real property (buildings and lands) (Federal

Property and Administrative Services Act of 1949, also called the “GSA Act”).

Instead, an agency must formally declare such property as “excess” and then transfer it to the General Services Administration (GSA), where the GSA then finds another use of the “excess” property within the federal government or declares the property as “surplus” to the federal government and sells or otherwise transfers the property out of

federal ownership. The GSA recovers the costs of using its real estate professionals by charging the federal agency a percentage of the lease or sale cost (currently, 6 to 7 percent). The federal agency that originally “owned” the property remains responsible for building maintenance, energy costs, and other costs during the period before the property is sold or otherwise transferred, which may be a period of months to years. Any net proceeds from disposing of “excess” property are deposited in the U.S. Treasury as “miscellaneous receipts” or, for “surplus” property, are deposited in a separate Treasury fund (out of which disposition costs, including environmental and preservation services, can be deducted) (*Ibid.*, § 571). In both cases, the funds become available for government-wide use and are not returned to the federal agency that was originally responsible for the building.

Over the decades, mounting pressures to reduce the inventory of federal buildings have led Congress to impose clear mandates on federal agencies to develop disposal plans and also to expand the options available to shed capital assets, although disposition remains a complex and intricate process. The GSA Act now imposes a duty on all federal agencies to “continuously survey” for “excess” property; to promptly report such properties to the GSA; to transfer or dispose of “excess” property as promptly as possible in accordance with GSA requirements; to reassign property to another activity within the agency; to transfer property to other federal agencies or qualified non-federal entities and organizations; and to obtain the “excess” property of other federal agencies when space is needed (*Ibid.*, § 524).

Additionally, federal agencies are required to notify the Department of Housing and Urban Development of their “unutilized, underutilized, excess, and surplus” buildings that may or may not be suitable and available to assist the homeless for emergency shelter, shelter plus care, supportive housing, and

moderate rehabilitation/single-room occupancy (McKinney-Vento Homeless Assistance Act of 1987). Any monetary proceeds from selling or otherwise transferring a building to support the homeless under the McKinney-Vento Act cannot be kept by the VA or any other federal agency (thus creating an unfortunate disincentive that penalizes agencies for participating in this well-intentioned program).

With respect to broadening options for disposing of buildings, the VA is one of a few federal agencies authorized by Congress to directly sell, lease, or otherwise transfer capital assets. Additionally, the NHPA was amended in 1980 by adding Section 111, which provides independent authority for federal agencies to lease buildings in order to promote preservation. Some of these authorizations, such as Section 111, encourage the use of leases by allowing the federal agency that controls the building to keep any money that may be netted as a result of the transaction (as opposed to depositing funds in the U.S. Treasury for government-wide use). The following table summarizes key legal authorities currently available to the VA to directly manage the disposition of real property, including procuring services to use buildings.

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## **Authorities That Empower the VA Directly to Sell, Transfer, Share, or Lease Historic Buildings or Secure Services for the Use of Buildings**

### **VA Acquisition and Disposition of Property (38 U.S. Code):**

**§ 8103(c):** Authority to sell or exchange a site, acquired for construction of a medical facility, which is not suitable for that purpose.

**§ 8118(a)(1):** Authority to transfer real property at “fair market value” to another federal agency, a state or political subdivision, Indian tribes, or “any public or private entity” for fair market value. Transfers of buildings to public or private non-profit grantees that provide homeless veterans services can be cost-free or at less than fair market value. This authority expires Dec. 31, 2018.

**§ 8118(a)(4):** Authority to enter into partnerships or agreements with public or private entities “dedicated to historic preservation” to facilitate the transfer, lease, or adaptive use of historic properties (other than for enhanced-use leasing). The use of authority under (a)(1) and (a)(4) is exempt from certain provisions of the GSA Act, including competitive bidding).

**§8122(a)(1):** Authority to lease properties for up to three-year terms to public and non-profit lessees and to accept their in-kind consideration through maintenance, restoration, or protection of the property. Net proceeds cannot be retained by the VA and must be deposited as miscellaneous receipts in the Treasury.

**§8122(a)(3)(A):** Authority to transfer excess property to states for state nursing homes or domiciliary facilities.

**§8122(c):** Authority to procure laundry services and other common services from non-profit, tax-exempt educational, medical, or community institutions as possible uses for VA buildings.

**§8138:** Authority to designate VA health-care facilities (or beds in such facilities) to be used for state hospitals, nursing homes, domiciliaries, or medical care under certain conditions.

**§§8161-8169:** Authority to enter into enhanced-use leasing with public or private entities solely for the purpose of supportive housing for homeless or at-risk veterans or their families. Authority expires Dec. 31, 2023.

**§8241:** Authority to spend appropriated funds to extend, expand, alter, improve, remodel, repair VA buildings and structures to “make them suitable for use for health manpower education and training” by eligible institutions (e.g., universities, colleges, community colleges, state and local education systems).

### **VA Use or Disposition of Property—Homeless Veterans (38 U.S. Code, Part VI, Ch. 20):**

**§§2031-2033:** Authority to provide therapeutic housing and other services in VA buildings.

**§2041:** Authority to sell, lease, or donate buildings (acquired through defaults on VA mortgage-assisted loans) to public or private non-profits for shelter when in the “best interest” of homeless veterans and the federal government. Authority expired Dec. 31, 2012.

### **National Historic Preservation Act (16 U.S. Code)**

**§470h-3:** Authority to outlease or exchange historic buildings in order to ensure their preservation (also known as “Section 111” of the NHPA from the Public Law version).

### **Federal Property and Administrative Services Act (40 U.S. Code)**

(Cases in which the GSA can designate or authorize the VA to act):

**§542:** The Administrator of the GSA may authorize a federal agency in possession of surplus property to dispose of that property.

**§543:** The Administrator of the GSA may designate or authorize a federal agency to sell, exchange, lease, permit, or transfer surplus property for cash, credit, or other property, with or without warranty, on terms and conditions that the GSA considers “proper.”

**§545:** The Administrator of the GSA may authorize an executive agency’s disposal of surplus property, without public advertising for bids, for donations or through a contract broker or for a negotiated disposal and sale (under certain conditions).

**RECOMMENDATION SEVEN: The VA should explore and adopt expanded options for third parties to use historic buildings, such as the leasing authority granted to the VA by Section 111 of the National Historic Preservation Act.**

The VA's current disposal program does not appear to employ all of the legal authorities identified in the table above, particularly Section 111 of the NHPA. These options should be explored by the VA's Office of Asset Enterprise Management, with the assistance of the agency's Office of General Counsel, and specific guidance should be provided to capital asset managers so that they can be aware of how to use these potential opportunities.

Section 111 of the NHPA authorizes federal agencies to lease or exchange historic property to "any person or organization" if the agency head "determines that the lease or exchange will adequately insure the preservation of the historic property." This outleasing authority includes rentals of portions of a historic building (e.g., roof utilization for private telecommunications equipment). Rental revenue can be kept for up to two years by the lessor-agency to be used for the preservation-related needs of any of its buildings, such as roof replacements, façade and front entrance repairs, and repairs to damaged interiors (GSA 2011a, 40).

To date, the VA, like many other federal agencies, has not used this property management tool, nor issued internal guidance on how to execute and administer Section 111 leases. The U.S. Coast Guard uses Section 111 to save historic lighthouses, while the National Park Service (NPS) has issued regulations on the procurement and terms of Section 111 leases, including allowing the lease and reuse of historic properties such as farms and cabins (DOI, NPS 2013). NPS lessees are also required to dedicate a monetary reserve to improve and maintain historic buildings that are leased (ACHP 2008; DOI, NPS 2013).

The federal government's primary building repurposing agency—the GSA—did not even use Section

111 authority until the late 1990s, but it now makes "a critical difference" in the agency's ability to steward its historic properties (GSA 2011a, 43). The Public Buildings Service of the GSA has used Section 111 outleasing authority to place appropriate uses and lessees in historic buildings, while continuing to seek ultimate end users. The stunning John W. McCormack U.S. Post Office and Courthouse in Boston was leased to the Massachusetts state court system for years. Ultimately, the USEPA moved into the complex after retrofitting the interior space for offices and reusing 99 percent of the historic interior as part of its "Greening EPA" program (*Ibid.*, 40). Further, the GSA has extended the benefits of Section 111 outleasing to smaller historic buildings that are not competitive candidates for capital project funding within the agency. In these cases, the GSA combines funds from several small budget accounts to consolidate sufficient monies to restore and build-out smaller buildings for tenants (*Ibid.*, 43).

The transactions that are most suitable for Section 111 leases, according to the GSA, are those involving historic buildings that do not feature elaborate or extensive historic interiors. Historic buildings of this type tend to be more compatible with changes of use (and, thus, are more attractive to private developers and other non-governmental tenants), and interior changes are less publicly visible, which often results in a greater likelihood of community acceptance of the transaction. Undoubtedly, the VA (especially the VHA) has many such buildings. In collaboration with the GSA, the Advisory Council on Historic Preservation, and other preservation stakeholders, the VA should develop a program to use its authority under Section 111 of the NHPA to outlease historic buildings.

**RECOMMENDATION EIGHT:** Congress should restore the VA's authority to execute a specific option for building reuse—enhanced-use leasing with third parties to provide a range of services to veterans and their communities, in addition to addressing veteran homelessness. Corrective measures should continue to be implemented in the enhanced-use leasing program to address previous concerns regarding the VA's accountability for these transactions. New measures should be instituted as well, such as a uniform requirement for Funded Maintenance Accounts to protect the condition of historic buildings that are outleased.

Enhanced-use leasing (EUL, or EULs for “enhanced-use leases”) is a specific form of disposition of buildings and land that has provided substantial authority to the VA to repurpose capital assets for third-party use in providing veteran and related community services. However, this authority was curtailed by Congress in 2012. In its current form, EUL authority facilitates the extremely important goal of providing for shelter and related needs of veterans who are homeless or at risk of homelessness. In FY 2012 alone, 38 EULs added approximately 4,100 units for transitional and homeless housing facilities (VA 2013d, II:11-25). Private investment in VA buildings and property as a result of the EUL program is estimated at more than \$200 million from 1997 to 2003 (Bradley and Metzger 2003). The VA estimates that \$261.7 million in total consideration (i.e., revenue, cost avoidance, cost savings) has been generated from the program since 2006 (VA OIG 2012d, i).

The National Trust has participated in the EUL program for almost 15 years, including EUL projects at Leavenworth, KS, and Fort Howard, MD. Staff has provided feedback to the VA on Requests for Proposals, informed potential lessees about the benefits of historic rehabilitation tax credits, and participated in Section 106 consultations. Based upon this experience, the National Trust identified several factors that promote or influence the success of EULs from a preservation standpoint:

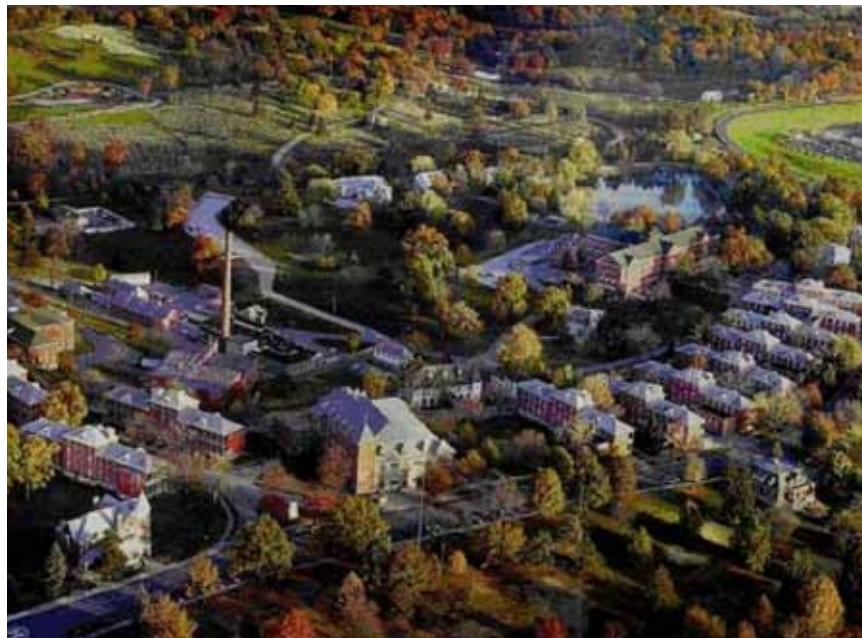
- Transactions are facilitated by including a large set of buildings rather than tackling one building at a time.
- Potential opportunities for third-party use expand when the VA maintains an operating presence at a campus.
- National searches for developers are often conducted by the VA; however, the lessees are typically local companies.
- “Slow and steady” rehabilitation of buildings by developers appears to be the norm.

**The Background and Status of the VA’s EUL Authority**

In 1991, Congress enacted enabling legislation that authorized the VA to enter into EUL transactions with third parties for the purpose of using VA buildings and land to directly serve veterans, improve the VA’s operations, or provide other community benefits. Eligible lessees include private for-profit or not-for-profit entities and non-federal governmental entities. An EUL can take many forms, from leasing an entire medical center of hundreds of acres and many historic and non-historic buildings, to leasing only a portion of a site or medical center. Buildings that have been leased through the EUL program in order to provide direct services to veterans have primarily been used for permanent housing, transitional living units, homeless shelters, and outpatient clinics.

The second phase of EUL authority (which expired December 31, 2011) authorized longer lease terms for up to 75 years. Congress also expanded the VA's flexibility to repurpose buildings: at least part of the property had to be used for activities that contributed to the VA's mission, or the VA had to show that the cash or in-kind consideration for the transaction, if applied to medical care, would demonstrably improve services to veterans in the geographic area of the VA's delivery of services. An important incentive was also authorized in this second phase: the ability of the VA to retain the net proceeds from a lease or sale (in the Capital Asset Fund, a revolving fund) after recovering transactional costs. A revolving fund allows a federal agency to deposit monetary proceeds in an account controlled by the federal agency, rather than "losing" those funds to the general U.S. Treasury, and the federal agency does not need the approval of Congress each year in the budget process to use and disburse funds from the account.

When first enacted, the EUL option was a unique tool in federal real property management, and the VA broke new ground in its real estate role. The DoD and NASA were also subsequently authorized for EULs. However, audits of each of these three agencies subsequently identified the need to improve the speed of executing EUL agreements with lessees and the completeness of lease documentation, monitoring, and cost accounting (VA OIG 2012d; GAO 2011a; NASA OIG 2012). Congress reauthorized the VA's EUL authority in August 2012 for the third phase of the program, ending December 31, 2023 (*Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012*). However, largely in response to the internal program review identified above, the VA's authority for transactions entered into on or after January 1, 2012 was substantially restricted. It appears that the anticipation of this restriction hastened the execution of many last-minute EULs: from April 1993 through October 2, 2009, the VA executed, on average, 3.5 EULs per



Campus Aerial, Dwight D. Eisenhower VA Medical Center, Leavenworth, KS  
Credit: Kansas City Star

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The National Home for Disabled Volunteer Soldiers in Leavenworth, KS (a National Historic Landmark), features 58 Georgian- and Romanesque-style buildings situated in a 214-acre, park-like setting designed by Horace W.S. Cleveland. In 2005, the VA executed an EUL agreement with The Pioneer Group of Topeka, KS, to reuse 38 buildings that the VA originally planned to demolish for a cemetery expansion. The developer has rehabilitated about half of the buildings to date, mostly for housing, and created 400 full-time jobs (Freeman 2012). Estimated investment in the total project is \$60 to \$65 million.

(Tax Credit Advisor 2006)

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year; but in 2011 alone, 40 EULs were executed (VA 2013d, V:D, 10-47 - 10-49).

The agency can now only execute EULs with lessees that provide supportive housing (transitional housing, single-room occupancy, permanent housing, congregate living housing, independent living housing, assisted living housing, and “other modalities of housing”) for homeless veterans and their families or those who are at risk of homelessness (to be codified at 38 U.S. Code § 8162(a)(2)). Additionally, the lessee must pay for the rental in cash; in-kind contributions are no longer authorized (*Ibid.*, § 8162(b)(3)(A)&(B)). Congress abolished the Capital Asset Fund, but authorized the VA to deposit any monetary proceeds from the disposition of EUL property to the Major or Minor Construction budget accounts (*Ibid.*, § 8165(a)(2)).

### **The EUL Process and VA/Lessee Roles and Responsibilities**

Proposals to outlease VHA buildings and land are formulated by individual medical centers and sites and documented in a Concept Paper, which is reviewed at the VISN level, and then by the VHA Director of the Capital Asset Management and Planning Service (VA 2009a; VA 2012l, II-111 – II-112). A Concept Paper Review Committee at the VA’s Central Office, which is described as including the VA’s Federal Preservation Officer, then reviews and makes recommendations on the viability of each EUL concept to the VA’s Chief Financial Officer (VA 2009a, 22). Authority to approve leases for “significant asset initiatives, such as campus realignments” and leases that transfer permanent ownership to a third party is vested in the Secretary of the VA and may not be delegated (*Ibid.*, 6, 18).

Information about leasing opportunities at specific VA locations is provided through the EUL website maintained by the Office of Asset Enterprise Management (OAEM), industry forums, and other forms of outreach to a wide variety of financing

institutions, developers, and housing and service advocacy groups and providers. EULs are not subject to the competitive procurement procedures of the Federal Acquisition Regulations or the VA’s own acquisition regulations. However, in practice, the VA often issues Requests for Expressions of Interest or Requests for Proposals to formally solicit and evaluate interest in potential EUL opportunities. Also, the VA can use Minor Construction funds, capped at \$10 million per project, as capital contribution to a lease (*Ibid.*, 5).

From the perspective of a private developer, the factors that influence the attractiveness and viability of an EUL project are no different than any other type of real estate transaction, including the robustness of local market conditions for the type of proposed use and whether the value of the project and anticipated cash flow are sufficient to secure financing. Features cited by the private sector as promoting EUL investments include the long lease period and the VA’s ability to accept a developer’s expenditures for repair or alteration of the building(s) as in-kind consideration instead of a monetary payment as consideration for the lease (Bradley and Metzger 2003). The federal (and, where available, state) historic rehabilitation tax credits are instrumental to the viability of using the VA’s historic buildings in an EUL transaction (Freeman 2012).

The VA is responsible for carrying out NEPA and Section 106 reviews when an EUL is initiated and during the lease term. An EUL arrangement does not necessarily mean that historic VA buildings that have been vacant or underutilized are preserved; in fact, demolitions are common in EULs. A Section 106 Programmatic Agreement or a Memorandum of Agreement is negotiated between the VA and consulting parties. These agreement documents prescribe the developer’s responsibilities for, among other matters, master planning; proposed site work and new construction; mothballing, rehabilitation, or

demolition of buildings; and hiring qualified preservation professionals to assist in carrying out the agreements, including future consultation on individual projects carried out under the EUL. Other legal requirements also apply to the lessee's project, such as accessibility for the disabled, environmental regulations, and local land use requirements. All applicable state and local taxes, fees, and assessments that would otherwise apply to a private project (regarding improvements and operations on land) are borne by the developer (Camp Lejeune Families Act of 2012, to be codified at 38 U.S. Code § 8167(a)).

The lessee also assumes responsibility for the cost of new construction, rehabilitation, alterations, operation, and maintenance. In some cases, the VA requires a Funded Maintenance Account (FMA), which is a lessee-funded monetary reserve to ensure that adequate maintenance occurs over the life of the lease, an important consideration for historic buildings. Where they exist, FMAs vary widely. They may be based on: (1) lump sums (ranging from \$250 per year for 2 buildings on 3 acres of land to \$4,100 annually for 7,196 square feet of building space); (2) square footage (from 15 cents to \$2 dollars per square foot); (3) a fixed dollar amount per residential unit (e.g., \$300 per year for each housing unit); or (4) unspecified, as "required by lender" (VA 2011i).

### **Explanation of the Recommended Improvements in the EUL Program**

Interviewees for this report generally support the EUL program and would like to see Congress restore the VA's ability to outlease buildings for a variety of veteran and community-related uses. The VA has instituted several measures in response to the internal review mentioned above that identified systematic weaknesses in the EUL program. These corrective actions include preparing a performance scorecard for each EUL project, which is reviewed by senior managers from the OAEM each quarter, and the Concept Paper Review Committee mentioned above.

These measures should be continued under a renewed full EUL authority, and additional steps should be taken as well.

The first suggested improvement in a re-expanded EUL program is for the VA to promote and fund local experts to help solicit interest and help close the transactions. The OAEM provides staff expertise from the Central Office; however, real estate deals are essentially local projects. Local experts include real estate brokers who are knowledgeable about local market conditions, established private or public developers, and economic development opportunities and initiatives (including public institutions, such as universities, and public-private partnerships). Other local experts are lawyers who specialize in private and public financing (e.g., tax increment financing and tax-exempt bonds) under state law. These types of expertise can help focus attention and resources on the most viable lease options and can facilitate timely consummation of real estate transactions that benefit historic buildings through reuse. Internal VA guidance recognizes that such expertise may be needed and should be accessed (VA 2009a, 21). It is just not clear that local help is, in fact, consistently (if ever) secured based upon the research for this report and the feedback of interviewees.

A second recommended step for the EUL program is for the VA to establish a clear and consistently applied policy regarding Funded Maintenance Accounts (FMAs). As noted above, EUL transactions executed in the past may or may not require a developer or other third-party user to establish an FMA. Even when they do, the monetization varies substantially (in total amount and in funding method used). FMAs are very important with respect to historic buildings included in EULs. Without formal maintenance agreements and access to set-aside funding, EUL buildings may languish for months, if not years, while a developer takes the "slow and steady" rehabilitation approach, waits for more

favorable market conditions or financing before even starting, or pursues other priorities.

Several preservation-minded interviewees reported that, although they favor EULs, demolition of historic buildings by neglect is a very real concern. A local government representative who was interviewed was also on alert about the potential for these leases to leave buildings in dilapidated condition. The concern relates to losing potential tax revenues and stigmatizing the surrounding area if the buildings are not maintained by the lessee (which is already a problem according to the interviewee), particularly because the VA no longer has a presence in the community. An enhanced-use lease should not perpetuate demolition by neglect of historic buildings and a consistently applied FMA policy can help to prevent, or at least minimize, the potential for these losses.

# 7

## Recommendation Theme D

Educating Preservation Stakeholders on Measures to Promote  
the VA's Stewardship of Historic Health-Care Facilities

Veterans supporting the continued use of the Battle Mountain Sanitarium in Hot Springs, SD. Credit: Save the VA



**RECOMMENDATION NINE: Preservation stakeholders should devote time to understanding the needs of veterans and, therefore, the requirements, opportunities, and constraints of the VA. Preservation stakeholders should also support the VA by convincing federal watchdog agencies (such as the Government Accountability Office and the Office of Management and Budget) that historic buildings can be valuable and sustainable assets.**

This report has attempted to provide readers who may not have VHA facilities in their own towns, or military service members or veterans in their own families or workplaces, with some background regarding the health-care needs and challenges of the women and men who have served this nation in the military and the employees of the VA who provide these needed services.

There are almost 145 veterans service organizations (VSOs) throughout the U.S. The largest are headquartered in Washington, DC, and have extensive networks of chapters (and other units of organization) at the state and local levels.

Preservation stakeholders should reach out to the membership and leadership of these VSOs in order to seek their perspective regarding the health-care needs of veterans and to build on common interests in advocating for the retention and reuse of significant historic buildings and historic medical centers. Additionally, the local affiliates of the larger VSOs have facilities that can be used for community events. Preservation stakeholders should seek opportunities to hold meetings at these facilities as a way to further connect with and support veterans.

As discussed in Section 3, the VA's management of medical centers and buildings has received extensive scrutiny since the 1990s from the GAO in particular, but also from the VA's Office of Inspector General. Additionally, the OMB has issued significant

guidance that affects the VA's retention or disposal of these assets. The audience for the investigation reports is typically a congressperson or congressional committee, not the VA directly, although the VA is provided an opportunity to comment upon the report.

Unfortunately, a common theme that is explicit in, or an undercurrent of, these reviews is that historic buildings are liabilities on the federal government's "balance sheet" and, therefore, need to be removed. Absent or less emphasized is the fact that every federal agency, VA included, has an affirmative obligation under federal law to preserve these assets for the benefit of the public and that these buildings can be positive economic assets. The GAO, for example, has characterized historic buildings and the NHPA as part of a "complex legal environment [that] has a significant impact on real property decision making and may not lead to economically rational outcomes" (GAO 2011d, 5-6). Elsewhere, the GAO has identified the consequence of "historical significance" for buildings as one imposing "special procedures" for "maintenance and disposal," rather than as an affirmative agency obligation to use and preserve such places (GAO 1999b, 6).

A second common theme of these reviews focuses on the process by which federal agencies make decisions affecting public assets. External stakeholder involvement in the fate of medical centers is consistently

identified by the GAO, for example, as hindering disposal of these historic places. Included in the group of external stakeholders cited by the GAO as complicating and “impeding” the “efficient” disposal of the VA’s real property are medical schools, unions, veterans, environmentalists, city officials, local developers, and preservationists (see, e.g., GAO 1999c, 6; GAO 2003a, 8, 39; GAO 2011d, 5; GAO 2011f, 20-21), despite the fact that NEPA and NHPA both require stakeholder involvement in such decisions.

In the middle 1990s, the VA developed a plan to establish steering committees, comprised of a broad range of stakeholders, as part of a first-ever program to decide on the fate of its medical centers in the CARES program (Capital Asset Realignment for Enhanced Services). These committees were going to be asked to be “key management entities” in CARES by helping the VA develop and evaluate data relating to facility and patient workload and to provide their views to each VISN (GAO 1999c, 6). This mode of inclusionary participation is promoted in the environmental justice movement and other grassroots organizing campaigns as “triple D” — to “Dialogue, Decide, and Deliver” (DDD).

However, the GAO criticized the VA’s inclusionary approach as inviting “protracted conflict” and “piece-meal” decision making because of the involvement of special-interest groups who would tend to “avoid difficult choices by focusing only on marginal changes to the status quo . . .” (GAO Ibid., 7-9). The GAO then recommended an “independent” planning approach, which would consist of using VA planners or outside consultants to develop and analyze data upon which the VA would make CARES decisions, followed by providing “sufficient information” to external stakeholders to “understand and support” decisions already made (Ibid., 7). As opposed to the inclusive “DDD” public process, the GAO’s proposal is rooted in an antiquated and exclusionary public relations process called “DAD” (“Decide, Announce, and Defend”).

From the perspectives of several interviewees involved

in past and current deliberations about possible realignments and closures of VHA facilities, including Battle Mountain Sanitarium, it appears that the GAO’s “DAD” approach has been followed by the VA.

Similarly, the Congressional Research Service (CRS) has identified “stakeholder conflict” as complicating federal agency disposal efforts, noting that there is no “government-wide real property guidance for addressing stakeholder conflicts” (CRS 2012, 3). Several bills have been filed in Congress that purport to “reform” public involvement in federal real property management (U.S. Senate 2013). One example is the Civilian Property Realignment Act (CPRA) of 2012, which would shorten the statute of limitations for citizen suits brought for violations of NEPA during disposal of federal property from six years to 60 days (CPRA of 2012, § 18(a)(2)).

The importance of public involvement in decisions regarding assets that are ultimately public assets, and public heritage, may not be a priority for auditors concerned with the numerical accounting required to prepare balance sheets and federal financial statements. However, the apparent resistance to public involvement noted in the examples above seems antithetical to basic concepts of fairness, rights to expression, and transparency in a democracy, not to mention current federal law.

In summary, there is a general lack of understanding among these federal watchdog agencies that historic buildings can be economically viable and contribute to the mission of the VA. Furthermore, there appears to be an absence of recognition that there is value in non-federal perspectives, experience, and knowledge in legally required processes. This report recommends that the National Trust, other preservation stakeholders, and other advocacy groups, working in collaboration with the ACHP, seek an opportunity to brief the appropriate officials of these agencies on these issues.

**RECOMMENDATION TEN: Preservation stakeholders should expand the public's knowledge about historic medical centers in order to promote public support for preserving these places.**

Representatives of the many of the SHPOs and the USEPA regional offices that were contacted during this report stated that they rarely receive comments or concerns from the public or preservation or environmental groups regarding VA proposals, unlike other agencies such as the Federal Highway Administration. One former SHPO observed during an interview for this report that one of the biggest problems in assuring public involvement is that often there is no "Friends" group for local medical centers that advocate before the VA on behalf of preserving and reusing historic buildings.

Veterans and VSOs do a commendable job of monitoring and responding to the VA and supporting local, state, and national initiatives that affect veterans. However, without active involvement of the general public in the VA's plans, there is a risk that elected officials and VA managers may tend to believe that there is no interest in the larger community. Certainly, in places where "Friends" groups have cultivated broad public engagement, such as the VA medical centers in Milwaukee, WI, Hot Springs, SD, Dayton, OH, and Canandaigua, NY, the public's voice has been extremely influential.

The National Trust, its state and local preservation partners, VSOs, and other stakeholders should collaborate with each other and with the VA to develop specific ways to increase the public's experience and awareness of VA's historic medical centers. As a start, identifying specific locations of historic districts would help. It is not a straightforward task to locate VA historic districts today because they are often subsumed within or fringed by modern VHA construction. (Appendices B through D of this report provides descriptive and location information for the First and Second Generation Facilities.) Individual websites of some of the VA medical centers tend to focus on visuals of the "new," rather

than depicting the historic core on many campuses. Further, medical centers often bear memorial names that are different from their historic names. (The national theme studies for the First and Second Generation facilities, for example, only use historic names and do not provide current street addresses.). Another practice that prevents easy identification of historic campuses is that medical centers are often identified by the VA as associated with the largest city in the service area, even though the actual campus is in a close, but separately incorporated, smaller town. As one example, the medical center in Alexandria, Louisiana, is actually in Pineville.

The National Trust has already identified some possible measures to increase public awareness of historic medical centers, including:

- Sponsoring tours ("Explore the VA" day, in which a "doors open" program is in place on campuses). A recent example is the walking tour just launched at the National Soldiers Home in Milwaukee.
- Promoting more websites, such as <http://SavetheSoldiersHome.com> and <http://www.americanveteransheritage.org/>.
- Publishing or linking to the heritage travel itinerary for the National Soldiers Homes that was developed by the VA and the National Park Service. [http://www.nps.gov/history/nr/travel/veterans\\_affairs/index.html](http://www.nps.gov/history/nr/travel/veterans_affairs/index.html).
- Sponsoring oral histories of veterans and employees to share stories of their experiences in using or working in historic medical centers.

Public awareness of and support for the VA's historic campuses and buildings could also be promoted through coining a U.S. Mint set or series commemorating the iconic National Soldiers Homes or main buildings in the Second Generation facilities, such as

the hospitals at Lebanon, PA, or Albuquerque, NM. Options for Mint products include: (1) issuance of gold and silver bullion for serious investors; and/or (2) issuance of regular numismatic gold, silver, or platinum coins or medals for hobbyists, the general public, and investors of more modest means. The Mint's total bullion sales revenue in FY 2011 was \$3.471 billion and \$2.46 billion in FY 2012; total sales revenue for numismatic coins in FY 2011 was \$721.7 million and \$481.2 million in FY 2012 (U.S. Mint 2012, 6). Mint sale proceeds could be restricted to a special dedicated account within the VA's General Post Fund (which consists of contributed/donated capital to the VA) to support planning and development for rehabilitation or adaptive reuse of the VA's historic buildings.

Congress may need to specifically authorize a new coinage program and the dedication of proceeds to the VA for uses restricted to historic preservation. Also, the novelty of new Mint products generates an initial spike in sales after the initial roll-out, which then generally subsides. An aggressive ad campaign would be helpful to promote initial and continued purchase of these commemorative products.



**RECOMMENDATION ELEVEN: Preservation stakeholders should organize local campaigns in order to carry out fact-based and informed advocacy to save historic VA buildings and landscapes.**

There are several examples of effective citizen advocacy and enforcement efforts that have resulted in the VA modifying its behavior in ways that are more favorable to historic preservation values. Years of high-profile Section 106 consultation followed Hurricane Katrina's damage to the New Orleans VA medical center. The active involvement of the ACHP and the National Trust "awakened" the VA (in the words of one interviewee) to the agency's need to implement Section 106, even though the construction of the new medical center destroyed hundreds of historic properties and many square blocks of a historic district.

A diverse, well-organized advocacy effort has considerably improved the chances to save the Milwaukee National Soldiers Home, a National Historic Landmark, and a National Treasure in the National Trust's campaign. In response to the outpouring of public concern, the VA has allocated at least \$2.77 million for repairs at the historic Milwaukee campus, including \$952,000 to repair Building 2 (Old Main) after deterioration by neglect led to a roof collapse. Further, the VA is actively studying the adaptive reuse of the historic Ward Theater at the Milwaukee campus. In addition, the possible realignment of services away from Battle Mountain Sanitarium, by closing the facility in Hot Springs, SD, and relocating services to Rapid City, has invigorated a very organized grassroots campaign

to "Save the VA," and the resulting congressional pressure has forced the VA to reconsider its proposal to close the medical center. On the west coast, a federal lawsuit was filed against the VA in 2006 by neighborhood and environmental groups regarding the VA's alleged noncompliance with NEPA and the NHPA at the San Francisco medical center. In settling the case, the VA agreed to prepare an Environmental Impact Statement (the first EIS apparently produced by the VHA in decades, issued as a draft in 2012) for a master plan and associated construction (Planning Association for Richmond v. U.S. Dept. of VA).



Veterans at public meeting regarding the proposed closure of the Battle Mountain Sanitarium in Hot Springs, SD  
Credit: William Ing



Canandaigua VA Medical Center, Canandaigua, NY  
Credit: Department of Veterans Affairs

The “We Care Committee” led successful efforts to stave off full closure of this signature medical center, which serves as a source of pride in the rural community of Canandaigua and provides hundreds of jobs and a multi-million dollar infusion into the regional economy. A leader of the advocacy group says that they inundated their elected officials in Washington “every day” to stop the closure (cited as a crucial factor in their success) and that they found every volunteer “something to do.” Local businesses pitched in by donating money and groceries to sustain the committee members. The committee also organized a media campaign, including radio talk shows and media events designed to appeal to young people. The campus subsequently realigned, but did not close, and now houses the Veterans Affairs Center for Excellence in mental health care, including the home of the only suicide/crisis hotline for veterans in the country.

## CONCLUSION

A VA official once observed that the VA’s “business is healthcare, not hospital care” (VA 1996, Preface). At the same time, the transformation of the VHA that was initiated in the mid-1990s as a result of this official’s vision included an objective that new construction would only be pursued when other alternatives, including renovations of existing buildings, were not cost effective or otherwise practicable (*Ibid.*, 45). This objective resurfaced in June 2012 when the VA issued a mandatory directive—the Sustainable Locations Program—that compels VA planners, designers, and capital asset managers to leverage the public’s existing investment in historic buildings by renovating and modernizing these buildings when the VA needs new or different building space. The economic path mandated in these high-level policies leads to a welcome view that the VA’s historic buildings and landscapes are public assets, not liabilities to be overcome through disposal.

Until the VA’s top management annuls the bias against historic buildings in their capital asset management program, historic health-care and healing places will continue to be lost forever to demolition and other disposals. Reversing this trend—and the trend of preferring new construction over renovation and adaptive reuse—would honor not just living veterans, but all veterans, for whom these historically significant buildings and landscapes were designed and built.

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References are presented by categories of authors, beginning with the VA. Because numerous sources were used to compile the table in Appendix A, titled "Veteran and VA Capital Budget Data," the references for the source data are identified by abbreviated citations at the end of Appendix A, and the full citations are included in this References section.

Internet content was retrieved from Uniform Resource Locators (URL) that were active as of September 1, 2013. A URL citation is provided below for sources, except for the following, repeatedly cited document types, which can be accessed at the following links:

- VA annual budget submissions, performance and accountability reports, and strategic plans: <http://www.va.gov/performance/>.
- VA financial policies and procedures: <http://www.va.gov/finance/policy/pubs>.
- VA directives and handbooks: <http://www.va.gov/vapubs/>.
- GAO reports: [http://www.gao.gov \("Reports & Testimonies"\)](http://www.gao.gov).
- Congressional reports, appropriations and other bills, and enacted laws: <http://thomas.loc.gov>.

See the Acronyms list for the organizations cited below that are referenced by an acronym.

Notes and explanations that accompany tables, data, and text in the original source documents are not presented below, but are integral to a complete understanding of the information presented in this report.

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## Appendix A - Veteran and VA Capital Budget Data (1992-2013)

FY	Veterans	VHA Enrollees*	VHA Patients**	Operating Leases	Non-Recurring Maintenance	Minor Construction	Major Construction
1992	27,000,000						
1993	26,800,000		2,000,000	\$66,800,000	\$200,000,000	\$125,000,000	\$467,900,000
1994	27,000,000				\$200,000,000	\$122,500,000	\$397,000,000
1995	26,198,000				\$300,000,000	\$126,900,000	\$303,200,000
1996	26,212,233		2,734,000		\$184,200,000	\$169,800,000	\$116,100,000
1997	26,212,233		2,800,000	\$87,800,000			
1998	25,195,159		3,000,000			\$175,000,000	\$177,900,000
1999	25,371,378	3,642,537	3,100,000			\$175,000,000	\$142,300,000
2000	26,549,704	5,200,000	3,427,925			\$160,000,000	\$65,140,000
2001	25,196,000	5,121,595	3,843,832	\$198,000,000		\$162,000,000	\$66,040,000
2002	25,600,000	6,175,694	4,246,084	\$206,000,000		\$210,900,000	\$183,180,000
2003	25,191,000	6,742,676	4,505,433	\$236,000,000		\$266,000,000	\$99,777,000
2004	24,793,000	7,300,000	4,667,720	\$243,000,000		\$252,144,000	\$272,690,000
2005	24,387,000	6,704,149	4,806,345	\$248,000,000	\$467,000,000	\$230,779,000	\$458,800,000
2006	23,977,000	7,900,000	4,900,800	\$280,000,000	\$384,000,000	\$198,937,000	\$607,100,000
2007	23,816,018	7,186,950	4,950,501	\$299,000,000		\$210,000,000	\$283,670,000
2008	23,442,489	7,339,531	4,999,106	\$348,000,000	\$899,000,000	\$630,535,000	\$1,069,100,000
2009	23,066,965	8,048,560	5,139,285	\$396,000,000	\$1,000,000,000	\$741,534,000	\$923,382,000
2010	23,031,892	7,804,639	5,351,873	\$468,000,000		\$703,000,000	\$1,194,000,000
2011	22,676,149	7,895,108	5,499,498	\$545,000,000	\$1,977,168,000	\$467,700,000	\$1,076,036,000
2012	22,328,279	8,762,548	5,598,829	\$608,000,000		\$482,386,000	\$589,604,000
2013	21,972,964	8,897,674	5,750,133			\$607,530,000	\$532,470,000
2014 (est.)	21,619,731	9,030,258	5,818,548			\$714,870,000	\$342,130,000

Blank cells indicate that data is not readily available based on Internet research.

\* Formal enrollment for VHA health care did not begin until FY 1999.

\*\*Patients are the subset of enrollees that actually use VHA medical services based upon unique patient records.

Sources for each data column (1-7) and cell are identified by abbreviated citations in the following page and are presented in full citation form in the References section of this report.

## Appendix A - Veteran and VA Capital Budget Data (1992-2013) (cont.)

<b>Veterans (data columns 1-3):</b>	<b>Minor and Major Construction (data columns 6 and 7):</b>
<p>1992 col. 1: GAO 1996, 5.</p> <p>1993 col. 1 and 3: U.S. President 2000, Foreword.</p> <p>1994 col. 1: GAO 1996, 1.</p> <p>1995 col. 1: U.S. House 1996, 115.</p> <p>1996 col. 1: VA [1997?b], vi; col. 3: VA 2002b, 11.</p> <p>1997 col. 1: VA [1998?], 178; col. 3: VA 2002b, 10.</p> <p>1998 col. 1: VA [1998?], 17; col. 3: VA 2002b, 10.</p> <p>1999 col. 1: VA 2001c, 3; col. 2: VA 2006a, 10; col. 3: VA 2002b, 10.</p> <p>2000 col. 1: VA 2003e, 2; col. 2: VA [2002?c], 1-4.</p> <p>2001 col. 1: VA [2002?c], 3-4; col. 2: VA 2001c, 3.</p> <p>2002 col. 1: Waldman Associates and REDA International 2004, 15.</p> <p>2002, 2003, 2005 col. 2: VA 2006a, 10.</p> <p>2003-2006 col. 1: VA 2008b, I:1G-1.</p> <p>2004 and 2006, col. 2:  <a href="http://www.va.gov/VETDATA/docs/QuickFacts/Utilization-slideshow.pdf">http://www.va.gov/VETDATA/docs/QuickFacts/Utilization-slideshow.pdf</a>.</p> <p>2007-2009 col. 1: VA 2012j, I:1F-1.</p> <p>2010-2014 col. 1: VA 2013d, I:1F-1.</p> <p>2007, 2008, 2010, 2011 col. 2: VA 2012a, 13.</p> <p>2009 col. 2: VA 2010g, II:1B-3.</p> <p>2012-2014 col. 2: VA 2013d, II:1B-2.</p> <p>2000-2012 col. 3:  <a href="http://www.va.gov/VETDATA/docs/Utilization/PriorityGroup_Final2.pdf">http://www.va.gov/VETDATA/docs/Utilization/PriorityGroup_Final2.pdf</a>.</p>	<p>1993-1996: VA OIG 1998, 11.</p> <p>1998: U.S. House 1997, 6.</p> <p>1999: U.S. House 1998, 6-7.</p> <p>2000: U.S. House 1999, 4.</p> <p>2001: U.S. House 2000, 9; <i>Department of [VA] Appropriations Act 2001</i>, App. A-8, A-9.</p> <p>2002: <i>Department of [VA] Appropriations Act 2002</i>, 5-6.</p> <p>2003: <i>Consolidated Appropriations Resolution [ ] 2003</i>, H.J. Res-469, 2-470.</p> <p>2004: U.S. House 2003, 366-67; <i>Consolidated Appropriations Act, 2004</i>, HR 2673-365, 2673-366.</p> <p>2005: <i>Consolidated Appropriations Act, 2005</i>, HR 4818-481, 4818-482.</p> <p>2006: <i>Military Quality of Life and Veterans Affairs Appropriations Act, 2006</i>, HR 2528-15, -16. An emergency supplemental appropriation increased the total Major Construction authorization to \$974,600,000 (<i>Emergency Supplemental Appropriations Act for Defense [ ] 2006</i>, H.R. 4939-51; see also, U.S. House 2006, 62).</p> <p>2007: U.S. House 2006, 62, 63.</p> <p>2008: <i>Consolidated Appropriations Act, 2008</i>, H.R. 2764-424, 2764-425. The total authorization for Major Construction was subsequently increased to \$1,462,477,000 (<i>Supplemental Appropriations Act, 2008</i>, H.R. 2642-4).</p> <p>2009: U.S. House 2009, 47-48.</p> <p>2010: U.S. Senate 2010, 63, 65.</p> <p>2011: U.S. House 2011a, 50, 52.</p> <p>2012: U.S. House 2011b, 368-39; <i>Consolidated Appropriations Act, 2012</i>, H.R. 2055-367, 2055-368.</p> <p>2013: <i>Consolidated [ ] Appropriations Act, 2013</i>, H.R. 933-203, 933-204.</p> <p>2014: VA 2013d, IV:1-1.</p>
<b>Operating Leases (data column 4):</b>	
<p>1993, 1997 (VHA only): VA OIG 1998, 12-13.</p> <p>2001-2012: VA <i>FY 2002 - FY 2012 Performance and Accountability Reports</i>, Notes to Consolidated Financial Statements, Other Public Funded Liabilities.</p>	
<b>Non-Recurring Maintenance (data column 5):</b>	
<p>1993-1995 (VHA only): VA OIG 1998, 14.</p> <p>1996: VA OIG 1997, 12.</p> <p>2005, 2006: VA OIG 2006, 6.</p> <p>2008: VA [2007?e], 2.</p> <p>2009: VA OIG 2010, 10 (this amount was authorized in the <i>American Recovery and Reinvestment Act of 2009</i>).</p> <p>2011: VA 2012g, II:1I-44.</p>	

**Appendix B – U.S. Department of Veterans Affairs Listings, National Register of Historic Places (August 2013) Excludes National Cemeteries, Cemetery Monumentation, and Battlefields/Fortifications**

FIRST GENERATION LISTED PROPERTIES				
<b>Listing Year</b>	<b>Resource</b>	<b>Address</b>	<b>State</b>	<b>City</b>
1992	Danville Branch, National Home for Disabled Volunteer Soldiers Historic District	1900 and 2000 E. Main St.	IL	Danville
1999	Marion Branch, National Home for Disabled Volunteer Soldiers Historic District	1700 E. 38th St.	IN	Marion
1999	Western Branch, National Home for Disabled Volunteer Soldiers	4101 S. 4th St.	KS	Leavenworth
1974	Governor's House at Togus VAMC	Off ME 17	ME	Augusta
2012	Togus VA Medical Center and National Cemetery	1 VA Center	ME	Augusta
2013	New York State Soldiers' and Sailors' Home--Bath Veterans Administration Center Historic District	76 Veterans Ave.	NY	Bath
2004	Central Branch, National Home for Disabled Volunteer Soldiers	4100 W. Third St.	OH	Dayton
2011	Battle Mountain Sanitarium, National Home For Disabled Volunteer Soldiers	500 North 5th St.	SD	Hot Springs
2011	Mountain Branch, National Home For Disabled Volunteer Soldiers	Corner of Lamont and Sidney Sts.; Mountain Home P.O.	TN	Johnson City
2005	Northwestern Branch, National Home for Disabled Volunteer Soldiers Historic District	5000 W. National Ave.	WI	Milwaukee
1993	Soldiers' Home Reef	Clement J. Zablocki Veterans Affairs Medical Center grounds	WI	Milwaukee
1984	Ward Memorial Hall	5000 W. National Ave.	WI	Milwaukee

**Appendix B – U.S. Department of Veterans Affairs Listings, National Register of Historic Places (August 2013) Excludes National Cemeteries, Cemetery Monumentation, and Battlefields/Fortifications (cont.)**

<b>SECOND GENERATION LISTED PROPERTIES</b>				
<b>Listing Year</b>	<b>Resource Name</b>	<b>Address</b>	<b>State</b>	<b>City</b>
2012	Tuskegee Veterans Administration Hospital	2400 Hospital Rd.	AL	Macon
2012	Montgomery Veterans Administration Hospital Historic District	215 Perry Hill Rd.	AL	Montgomery
2012	Tuscaloosa Veterans Administration Hospital Historic District	3701 Loop Rd., E.	AL	Tuscaloosa
1999	Fort Whipple—Department of Veterans Affairs Medical Center Historic District	500 AZ 89 N	AZ	Prescott
2012	Tucson Veterans Administration Hospital Historic District	3601 S. 6th Ave.	AZ	Tucson
1974	Fort Logan H. Roots Military Post	Scenic Hill Dr.	AR	North Little Rock
2012	Fayetteville Veterans Administration Hospital	1100 N. College Ave.	AR	Fayetteville
1972	Catholic-Protestant Chapels, Veterans Administration Center	Eisenhower Ave.	CA	Los Angeles
1972	Streetcar Depot	Pershing and Dewey Aves.	CA	Los Angeles
2009	Veterans Affairs Medical Center—San Francisco, California	4150 Clement St.	CA	San Francisco
2004	Fort Lyon	Jct. of Bent Cty. Rd. 15 and Fort Lyon Gate Rd.	CO	Las Animas
2012	Bay Pines Veterans Administration Home and Hospital Historic District	10000 Bay Pines Blvd.	FL	Bay Pines
1972	Fort Boise	About 1.5 mi. NE of State Capitol	ID	Boise
1985	Dewey House	Veterans Administration Medical Center	IL	North Chicago
2013	Marion Veterans Administration Hospital Historic District	2401 W. Main St.	IL	Marion
2012	Indianapolis Veterans Administration Hospital	2601 Cold Springs Rd.	IN	Indianapolis
2012	Knoxville Veterans Administration Hospital Historic District	1515 W. Pleasant St.	IA	Knoxville
2012	Wichita Veterans Administration Hospital	5500 E. Kellogg Ave.	KS	Wichita

**Appendix B – U.S. Department of Veterans Affairs Listings, National Register of Historic Places (August 2013) Excludes National Cemeteries, Cemetery Monumentation, and Battlefields/Fortifications (cont.)**

<b>Listing Year</b>	<b>Resource Name</b>	<b>Address</b>	<b>State</b>	<b>City</b>
1986	Fort Thomas Military Reservation District	Roughly bounded by Pearson, Alexander and Cochran Aves., River Rd., and S. Fort Thomas Ave.	KY	Fort Thomas
2012	Lexington Veterans Administration Hospital	2250 Leestown Rd.	KY	Lexington
2012	Alexandria Veterans Administration Hospital Historic District (Boundary Increase)	2495 Shreveport Hwy.	LA	Pineville
1986	Veterans Administration Medical Center	US 167/71	LA	Pineville
1975	Perry Point Mansion House and Mill	Veterans Administration Hospital grounds	MD	Perryville
2012	Northampton Veterans Administration Hospital Historic District	421 N. Main St.	MA	Northampton
2012	Bedford Veterans Administration Hospital Historic District	200 Springs Rd.	MA	Bedford
2012	Camp Custer Veterans Administration Hospital—United States Veterans Hospital No. 100	5500 Armstrong Rd.	MI	Battle Creek
2012	St. Cloud Veterans Administration Hospital Historic District	4801 Veterans Dr.	MN	St. Cloud
2002	Biloxi Veterans Administration Medical Center	400 Veterans Ave.	MS	Biloxi
1972	Jefferson Barracks Historic District	10 mi. S of St. Louis on the Mississippi River	MO	St. Louis County
2012	Lincoln Veterans Administration Hospital Historic District	600 S. 70th St.	NE	Lincoln
1978	Smyth Tower	718 Smyth Rd.	NH	Manchester
1983	Albuquerque Veterans Administration Medical Center	2100 Ridgecrest, SE	NM	Albuquerque
2012	Batavia Veterans Administration Hospital	222 Richmond Ave.	NY	Batavia
2012	Canandaigua Veterans Hospital Historic District	400 Fort Hill Ave.	NY	Canandaigua
2012	Northport Veterans Administration Hospital Historic District	79 Middleville Rd.	NY	Northport
1985	Oteen Veterans Administration Hospital Historic District	N side of US 70	NC	Ashville
2013	Roseburg Veterans Administration Hospital Historic District	913 NW Garden Valley Blvd.	OR	Roseburg
2013	Coatesville Veterans Administration Hospital Historic District	1400 Blackhorse Hill Rd.	PA	Coatesville
2013	Lebanon Veterans Administration Hospital Historic District	1700 S. Lincoln Ave.	PA	Lebanon

**Appendix B – U.S. Department of Veterans Affairs Listings, National Register of Historic Places (August 2013) Excludes National Cemeteries, Cemetery Monumentation, and Battlefields/Fortifications (cont.)**

<b>Listing Year</b>	<b>Resource Name</b>	<b>Address</b>	<b>State</b>	<b>City</b>
2012	Fayetteville Veterans Administration Hospital Historic District	2300 Ramsey St.	NC	Fayetteville
2012	Chillicothe Veterans Administration Hospital	17273 OH 104	OH	Chillicothe
2009	Veterans Hospital	William Jennings Bryan Dorn VAMC	SC	Columbia
2012	Murfreesboro VA Hospital Historic District	3400 Lebanon Pike	TN	Murfreesboro
1994	Veterans Administration Hospital Historic District	4800 Memorial Dr.	TX	Waco
2012	Roanoke Veterans Administration Hospital Historic District	1970 Roanoke Blvd.	VA	Salem
1974	Fort Walla Walla Historic District	77 Wainwright Dr.	WA	Walla Walla
1974	Officers Row, Fort Vancouver Barracks	611-1616 E Evergreen Blvd.	WA	Vancouver
2009	American Lake Veterans Hospital	9600 Veterans Dr., SW	WA	Tacoma
1981	Fort MacKenzie	N of Sheridan on WY 337	WY	Sheridan

<b>ARCHAEOLOGY SITE LISTINGS</b>				
<b>Listing Year</b>	<b>Resource Name</b>	<b>Address</b>	<b>State</b>	<b>City</b>
1982	Puvunga Indian Village Sites (Boundary Increase)	Address Restricted	CA	Long Beach
1983	Bay Pines Site (8Pi64)	Address Restricted	FL	Bay Pines
1981	Confederate Breastworks	Address Restricted	NC	Fayetteville
1983	North Carolina Arsenal Site	Address Restricted	NC	Fayetteville

**Appendix C - National Home for Disabled Volunteer Soldiers  
(First Generation Facilities)**

Original Name and Date	Current Address	Current Name	Status
Eastern Branch (Togus, Maine) -1866	Located in Togus 5 miles east of Augusta; 1 VA Center, Augusta, ME, 04330	Maine VAMC, VA Maine Healthcare System, maine.va.gov	18 surviving of the 73 NHDVS-era resources (residential quarters, cemetery, part of the road system/landscape). Determined as ineligible for NHL listing as part of the NHDVS era because of 1930s-era VA construction, although the Director's Quarters is NHL listed. May still be NR-eligible at a national level of significance for later periods.
Central Branch (Ohio) - 1867	4100 W. Third Street, Dayton, OH, 45428	Dayton VAMC, VA Healthcare System of Ohio, daytonva.gov	Listed as a National Historic Landmark. 51 buildings and structures on 266 acres (including chapel, cemetery, soldiers monument.)
Northwestern Branch ("Milwaukee Soldiers' Home") (Wood, Wisconsin) - 1867	5000 W. National Avenue, Milwaukee, WI	Clement J. Zablocki VAMC is the modern facility located to the south. milwaukee.va.gov	Listed as a National Historic Landmark. 28 surviving of 64 NHDVS-era resources. High degree of integrity of original plan (buildings, landscape, roads, cemetery). The "Old Main" Building and the Governor's House are the oldest remaining individual buildings in the U.S. of the NHDVS era (1867/88).
Southern Branch (Virginia) - 1870	100 Emancipation Drive, Hampton, VA	Hampton VAMC, hampton.va.gov	26 surviving of 68 NHDVS-era resources (Director's and other residential quarters and barracks, chapels, post office, canteen, engineering and maintenance buildings). Determined as ineligible for NHL listing as part of the NHDVS era because of demolition (new construction on 50% of campus by the mid 1980s). Six buildings, circa 1880s and 1908, were to be demolished in 2007-2008.
Western Branch (Kansas) - 1885	4101 4 <sup>th</sup> Street Trafficway, Leavenworth, KS 66048	Dwight D. Eisenhower VAMC, VA Eastern KS Health Care System, leavenworth.va.gov	Listed as a National Historic Landmark. 57 surviving of 98 NHDVS-era resources. High degree of integrity of original plan (buildings, landscape, roads, cemetery).
Pacific Branch (Sawtelle, CA) - 1888	11301 Wilshire Blvd., Los Angeles, CA 90073	West Los Angeles Medical Center, VA Greater Los Angeles Healthcare System, www.losangeles va.gov, VISN 22	Campus still present; 15 surviving of 98 NHDVS-era resources (e.g., chapel, depot, mess hall, staff quarters). The chapel and depot are NR-listed and NR-eligibility determinations made for two separate districts on the campus. The campus was determined as ineligible for NHL listing as part of the NHDVS era because of demolition and new construction.

**Appendix C - National Home for Disabled Volunteer Soldiers  
(First Generation Facilities) (cont.)**

Marion Branch (Indiana) - 1888	2401 W. Main Street, Marion, IN, 62959	Marion VAMC, marion.va.gov, VISN 15	64 surviving of 96 NHDVS-era resources (e.g., hospital, barracks, wards, fire station, greenhouse, officers' quarters, theater, gatehouse, stable, chapel). The campus was determined as ineligible for NHL listing as part of the NHDVS era because of demolition, removal of prominent architectural features on key remaining buildings, and new construction. Ten buildings were proposed for demolition in 2009.
Danville Branch (Illinois) - 1898	1900 E. Main Street, Danville, IL, 61832	VA Illiana Health Care System, danville.va.gov, VISN 11	31 surviving of 91 NHDVS-era resources (e.g., wards, library, warehouse, laundry, band stand, road system/landscape chapel). The campus was determined as ineligible for NHL listing as part of the NHDVS era because of demolition and post-1930s new construction.
Mountain Branch (Tennessee) - 1903	Corner of Lamont & Veterans Way, Johnson City, TN, 37684	James H. Quillen VAMC, mountainhome.va.gov, VISN 9	Listed as a National Historic Landmark. 57 surviving of 98 NHDVS-era resources. High degree of integrity of original plan and individual buildings (Beaux Arts-style buildings, landscape, roads, cemetery).
Battle Mountain Sanitarium (South Dakota) - 1907	500 N. 5 <sup>th</sup> Street, Hot Springs, SD, 57741	Hot Springs Campus, VA Black Hills Health Care System, blackhills.va.gov, VISN 23	Listed as a National Historic Landmark. Almost all of the 33 NHDVS-era resources survive. High degree of integrity of original plan and individual buildings (buildings, landscape, roads, cemetery).
Bath Branch (New York) - 1929	76 Veterans Avenue, Bath, NY, 14810	Bath VAMC, bath.va.gov, VISN 2	31 surviving of 63 NHDVS-era resources (e.g., quarters, engineering office, upholstery shop, Director's office, quarters, chapel, domiciliary, road system/landscape, cemetery). The campus was determined as ineligible for NHL listing as part of the NHDVS era because of its "brief history" as a First Generation facility and architecture did not reflect NHDVS design policy or management.

## Appendix D - Second Generation Facilities (Excerpt, Multiple Property Submission)

United States Department of the Interior  
National Park Service

OMB No. 1024-0018,

### National Register of Historic Places Continuation Sheet

Section No. Page 112

United States Second Generation Veterans Hospitals, Nationwide

#### Appendix Second Generation Veterans Hospitals Dating to the Period of Significance

On March 3, 1919, Congress enacted the first appropriation to purchase or lease medical facilities for veterans of World War I. This legislation, Public Law, No. 326 of the 65<sup>th</sup> Congress (40 Stat. L., 1302), placed responsibility for medical care of World War I veterans with the United States Public Health Service.<sup>349</sup> Public Act No. 47 of the 67<sup>th</sup> Congress [H.R. 6611], passed on August 9, 1921, addressed the formation of the Veterans Bureau, improvements toward the facilities utilized by the bureau, and amended the War Risk Insurance Act. An Executive Order, issued by President Warren G. Harding on April 29, 1922, referred to Section 9 of the above Act and called for the Public Health Service to transfer to the Veterans Bureau any facilities under its authority that were utilized in the care and treatment of veterans. The Executive Order also stated that any hospitals under construction by the Treasury Department were to be transferred upon completion to the Veterans Bureau.<sup>350</sup>

The following hospitals are divided by Period I and II. The designation number was originally assigned by the Public Health Service, and the Veterans Bureau continued to number their facilities chronologically until the late 1920s. Also included are the known opening and closing dates of the facilities and the original sub-type designation (if known).

#### Period I

No. Location

- 13 Alabama, Mobile (August 1, 1921–June 30, 1923) (sub-type 3)
- 14 Louisiana, Algiers (Annex to New Orleans Marine Hospital) (September 24, 1921 – December 6, 1929) (sub-type 3)
- 24 California, Palo Alto/Menlo Park (April 1, 1919 – present) (sub-type 2)
- 25 Texas, Houston (April 2, 1919 – June 25, 1919) (February 6, 1920 – June 30, 1923)
- 26 South Carolina, Greenville (April 5, 1919 – May 12, 1924) (sub-type 2)
- 27 Louisiana, Alexandria (April 7, 1919 – May 1, 1928) (sub-type 2)
- 28 New York, Dansville (May 1, 1919–September 14, 1920) (sub-type 1)
- 29 Virginia, Norfolk (Sewell's Point) (June 2, 1919 – May 24, 1922) (sub-type 3)
- 30 Illinois, Chicago (June 13, 1919 – June 30, 1923) (sub-type 3)
- 31 Texas, Corpus Christi (June 15, 1919 – September 14, 1919) (sub-type 3)
- 32 Washington, D. C. (June 24, 1919 – May 3, 1965)
- 33 Florida, Jacksonville (June 27, 1919 – October 1, 1919) (sub-type 3)
- 34 Massachusetts, East Norfolk (June 30, 1919 – May 18, 1922) (sub-type 1)
- 35 Missouri, St. Louis (July 1, 1919 – June 1, 1923) (sub-type 3)
- 36 Massachusetts, Boston (July 1, 1919 – December 1, 1922) (sub-type 3)

<sup>349</sup> Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931, 20; Adkins, 104; Weber and Schmeckeier, 156–157; Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922, 4–5.

<sup>350</sup> Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922, (Washington, DC: U.S. Government Printing Office, 1922), 601, 608–610.

## Appendix D - Second Generation Facilities (Excerpt, Multiple Property Submission) (cont.)

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United States Second Generation Veterans Hospitals, Nationwide

- 
- 37 Wisconsin, Waukesha (July 10, 1919 – September 30, 1958) (sub-type 1)  
38 New York, New York (August 15, 1919 – March 9, 1922)  
39 Pennsylvania, Hoboken (September 1, 1919 – September 11, 1920) (sub-type 3)  
40 New Jersey, Cape May (September 3, 1919 – September 28, 1921) (sub-type 1)  
41 Connecticut, New Haven (September 12, 1919 – April 30, 1927) (sub-type 2)  
42 Maryland, Perry Point (Perryville) (September 20, 1920 – present) (sub-type 1)  
44 Massachusetts, West Roxbury (December 1, 1919 – July 20, 1928) (sub-type 1)  
45 North Carolina, Biltmore (December 6, 1919 – December 1, 1922) (sub-type 3)  
46 New Mexico, Deming (December 15, 1919 – June 15, 1920) (sub-type 3)  
47 Pennsylvania, Markleton (January 7, 1920 – February 22, 1921) (sub-type 3)  
48 Georgia, Atlanta (February 1, 1920 – June 21, 1966) (sub-type 3)  
49 Pennsylvania, Philadelphia (February 18, 1920 – November 18, 1932) (sub-type 1)  
50 Arizona, Whipple Barracks (Prescott) (February 16, 1920 – present) (sub-type 2)  
51 Arizona, Tucson (March 15, 1920 – October 18, 1928) (sub-type 2)  
52 Idaho, Boise (April 19, 1920 –present day) (sub-type 3)  
53 Illinois, Dwight (June 4, 1920 – January 31, 1923) (September 20, 1923 –  
May 24, 1933) (April 15, 1935 – August 12, 1965) (sub-type 3)  
54 California, Arrowhead Springs (June 15, 1920 – June 15, 1924) (sub-type 3)  
55 New Mexico, Fort Bayard (Silver City) (June 15, 1920 – August 9, 1965) (sub-type 2)  
56 Maryland, Baltimore (Fort McHenry) (July 1, 1920 – November 1, 1923) (sub-type 3)  
57 Iowa, Knoxville (August 16, 1920 – present) (sub-type 1)  
58 Louisiana, New Orleans (September 16, 1920 – December 31, 1921) (sub-type 1)  
59 Washington, Tacoma (September 13, 1920 – January 11, 1929) (sub-type 2)  
60 North Carolina, Oteen (Asheville) (October 15, 1920 – present) (sub-type 2)  
61 New York, Fox Hills (October 15, 1920 – April 15, 1922)  
62 Georgia, Augusta (November 20, 1920 – present) (sub-type 1)  
63 Florida, Lake City (December 6, 1920 – present) (sub-type 2)  
64 California, Camp Kearney (January 2, 1921 – March 15, 1926) (sub-type 2)  
65 Minnesota, St. Paul (January 4, 1921 – April 20, 1927) (sub-type 3)  
67 Missouri, Kansas City (January 5, 1921 – July 1, 1926) (sub-type 3)  
68 Minnesota, Minneapolis (February 8, 1921 – July 2, 1928) (sub-type 3)  
69 Kentucky, Fort Thomas (February 15, 1921 – April 1, 1926)  
71 Massachusetts, Sterling Junction (March 12, 1921 – June 30, 1922) (sub-type 3)  
72 Montana, Helena (Ft William Henry Harrison) (June 6, 1921 – present) (sub-type 3)  
73 Illinois, Chicago Annex to No. 30 (aka No. 30a) (July 15, 1921 – February 29, 1924)  
(sub-type 1)  
74 Mississippi, Gulfport (July 16, 1921 – 2008) (sub-type 1)  
75 Iowa, Colfax (July 5, 1921 – February 7, 1923) (sub-type 3)  
76 Illinois, Maywood (Edward Hines, Jr. Hospital) (August 8, 1921 – present) (sub-type 3)  
77 Oregon, Portland (November 1, 1921 – December 19, 1928) (December  
19, 1928 – present) (sub-type 3)  
78 Arkansas, North Little Rock (Ft Logan H. Roots) (December 1, 1921 –  
present) (sub-type 1)  
79 Kentucky, Dawson Springs (Outwood) (February 22, 1922 – July 10, 1962) (sub-type 2)  
80 Colorado, Las Animas (Ft Lyon) (March 1, 1922 – 2001) (sub-type 2)

## Appendix D - Second Generation Facilities (Excerpt, Multiple Property Submission) (cont.)

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### National Register of Historic Places Continuation Sheet

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United States Second Generation Veterans Hospitals, Nationwide

- 
- 81 New York, Bronx (April 17, 1922 – present) (sub-type 1)
  - 83 Alabama, Mobile (same as No. 13) (August 1, 1921 – June 30, 1923)
  - 84 Louisiana, New Orleans (Algiers, same as No. 14) (September 24, 1921 – December 6, 1929)
  - 85 Washington, Walla Walla (May 10, 1922 – present) (sub-type 2)
  - 86 Wyoming, Ft. Mackenzie (May 12, 1922 – present) (sub-type 1)
  - 87 Ohio, Chillicothe (November 15, 1921 – June 16, 1924) (sub-type 3)  
Maryland, Perryville purveying depot (this appears to be associated with No. 42).<sup>351</sup>
  - 88 Tennessee, Memphis (August 14, 1922 – April 8, 1958) (sub-type 3)
  - 89 Massachusetts, Rutland (Rutland Heights) (May 15, 1923 – August 23, 1965) (sub-type 2)
  - 90 Oklahoma, Muskogee (June 14, 1923 – present) (sub-type 3)
  - 91 Alabama, Tuskegee (June 15, 1923 – present) (sub-types 1 and 2)
  - 92 Missouri, St. Louis (Jefferson Barracks Reservation) (March 16, 1923 – present) (sub-type 3)
  - 93 Texas, Legion (Kerrville) (July 1, 1923 – present) (sub-type 2)
  - 94 Washington, American Lake (Tacoma) (February 15, 1924 – present) (sub-type 1)
  - 95 Massachusetts, Northampton (April 21, 1924 – present) (sub-type 1)
  - 96 New York, Sunmount (Tupper Lake) (August 15, 1924 – August 12, 1965) (sub-type 2)
  - 97 Ohio, Chillicothe (June 1, 1924 – present) (sub-type 1)
  - 98 New York, Castle Point (September 15, 1924 – present) (sub-type 2)
  - 99 Missouri, Excelsior Springs (October 15, 1924 – July 31, 1963) (sub-type 3)
  - 100 Michigan, Camp Custer (October 15, 1924 – present) (sub-type 1)
  - 101 Minnesota, St. Cloud (September 20, 1924 – present) (sub-type 1)<sup>352</sup>
  - 102 California, Livermore (April 11, 1925 – present) (sub-type 2)
  - 103 Pennsylvania, Aspinwall (Pittsburgh) (October 10, 1925 – present) (sub-type 2)
  - 104 California, San Fernando (March 1, 1926 – closed possibly 1990s) (sub-type 2)
  - 105 Illinois, North Chicago (March 1, 1926 – present) (sub-type 1)

#### Period II

- 106 Minnesota, Minneapolis (April 9, 1927 – present)

<sup>351</sup> Ibid, 609; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, (Washington, DC: U.S. Government Printing Office, 1924), Chart No. 6; Compiled by Evaluation Division, Coordination Service, *Origin, Development, and Utilization of U.S. Veterans Hospitals* (1928 with revisions through 1933), non-paginated, located in the files of the Department of Veterans Affairs, Historic Preservation Office, Office of Construction and Facilities Management, Washington, D.C.; Robinson E. Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967): 395–409; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1929*, (Washington, DC: U.S. Government Printing Office, 1929), 108–109.

<sup>352</sup> *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 609–610; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, Chart No. 6; Compiled by Evaluation Division, Coordination Service, *Origin, Development, and Utilization of U.S. Veterans Hospitals* (1928 with revisions through 1933), non-paginated, located in the files of the Department of Veterans Affairs, Historic Preservation Office, Office of Construction and Facilities Management, Washington, D.C.; Adkins, 395–409.

## Appendix D - Second Generation Facilities (Excerpt, Multiple Property Submission) (cont.)

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### National Register of Historic Places Continuation Sheet

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United States Second Generation Veterans Hospitals, Nationwide

- 
- 107 Massachusetts, Bedford (July 17, 1928 – present) (sub-type 1)  
108 New York, Northport (April 16, 1928 – present) (sub-type 1)  
Arizona, Tucson (October 18, 1928 – present) (sub-type 2)  
North Dakota, Fargo (June 3, 1929 – present) (sub-type 3)  
Louisiana, Alexandria (December 2, 1929 – present) (sub-type 3)  
New Jersey, Lyons (October 4, 1930 – present) (sub-type 1)  
Pennsylvania, Coatesville (November 11, 1930 – present) (sub-type 1)  
Kentucky, Lexington (April 1, 1931 – present) (sub-type 3)  
Nebraska, Lincoln (April 30, 1931 – present) (sub-type 3)  
Connecticut, Newington (May 15, 1931 – present) (sub-type 3)  
Indiana, Indianapolis (January 4, 1932 – present) (sub-type 3)  
Texas, Waco (March 6, 1932 – present) (sub-type 1)  
Utah, Salt Lake City (July 15, 1932 – February 15, 1962) (sub-type 3)  
Alabama, Tuscaloosa (July 15, 1932 – present) (sub-type 3)  
New Mexico, Albuquerque (August 22, 1932 – present) (sub-type 3)  
South Carolina, Columbia (October 15, 1932 – present) (sub-type 3)  
West Virginia, Huntington (November 1, 1932 – present) (sub-type 3)  
New York, Canandaigua (February 9, 1933 – present) (sub-type 1)  
Florida, Bay Pines (March 16, 1933 – present) (sub-type 4)  
Oregon, Roseburg (May 8, 1933 – present) (sub-type 4)  
Mississippi, Biloxi (August 10, 1933 – present) (sub-type 4)  
Kansas, Wichita (November 16, 1933 – present) (sub-type 3)  
Arkansas, Fayetteville (April 2, 1934 – present) (sub-type 3)  
Iowa, Des Moines (April 2, 1934 – present) (sub-type 3)  
New York, Batavia (May 3, 1934 – present) (sub-type 3)  
Wyoming, Cheyenne (May 4, 1934 – present) (sub-type 3)  
California, Los Angeles (Wadsworth) (formerly a portion of the Sawtelle NHDVS)  
(August 4, 1934 – present)  
California, San Francisco (September 26, 1934 – present) (sub-type 3)  
Virginia, Roanoke/Salem (April 22, 1935 – present) (sub-type 1)  
Vermont, White River Junction (October 17, 1938 – present) (sub-type 3)  
Michigan, Dearborn (Allen Park) (April 15, 1939 – June 2, 1996) (sub-type 3)  
Nevada, Reno (May 22, 1939 – present) (sub-type 3)  
Tennessee, Murfreesboro (February 4, 1940 – present) (sub-type 1)  
Texas, Amarillo (April 8, 1940 – present) (sub-type 3)  
Texas, Dallas (August 22, 1940 – present) (sub-type 3)  
North Carolina, Fayetteville (October 17, 1940 – present) (sub-type 3)  
Alabama, Montgomery (November 1, 1940 – present) (sub-type 3)  
Ohio, Cleveland (Brecksville) (November 1, 1940 – present)  
(sub-type 3)  
Maryland, Fort Howard (March 17, 1941 – present) (transferred from War Dept.,  
new hospital completed January 4, 1944) (sub-type 3)  
Illinois, Marion (June 8, 1942 – present) (sub-type 3)  
Massachusetts, West Roxbury (January 20, 1944 – July 10, 1952) (October 15,  
1953 – present) (sub-type 3)

## Appendix D - Second Generation Facilities (Excerpt, Multiple Property Submission) (cont.)

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United States Second Generation Veterans Hospitals, Nationwide

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Wisconsin, Tomah (March 4, 1947 – present) (sub-type 1)  
Pennsylvania, Lebanon (September 15, 1947 – present) (sub-type 1)  
New York, Montrose (May 15, 1950 – present) (sub-type 1)<sup>353</sup>

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<sup>353</sup> Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924, Chart No. 5; Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1925, (Washington, DC: U.S. Government Printing Office, 1925), 94, 345, 355; Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1926, (Washington, DC: U.S. Government Printing Office, 1926), 77; Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931 (Washington, D.C.: U.S. Government Printing Office, 1931): 152-153; Compiled by Evaluation Division, Coordination Service, *Origin, Development, and Utilization of U.S. Veterans Hospitals* (1928 with revisions through 1933), non-paginated, located in the files of the Department of Veterans Affairs, Historic Preservation Office, Office of Construction and Facilities Management, Washington, D.C.; Adkins, 395-409; "Dedication of the New Facility at Fayetteville, N.C.," *The Medical Bulletin of the Veterans Administration* 17, no. 3 (January 1941): 322; information provided through emails by Darlene Richardson, Veterans Affairs Historian and Kelly Merrifield, Veterans Affairs Intern on January 19, 2010.



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