VA CAPITAL ASSET PLANNING

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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HOUSE OF REPRESENTATIVES

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VA CAPITAL ASSET PLANNING

WEDNESDAY, APRIL 5, 2000

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Smith, Doyle, Peterson, Moran, Snyder, Rodriguez, and Shows.

Ex officio present: Representative Evans.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The committee will come to order. Just a little more than a year ago, this subcommittee held a hearing aimed at setting a new direction for VA health care planning. At the hearing, the General Accounting Office produced riveting testimony warning us that VA is likely to spend billions over the next 5 years to operate hundreds of unneeded buildings. GAO reported that VA is spending one of every four medical care dollars maintaining buildings.

At that same hearing, Dr. Dan Winship, a distinguished medical school dean and former senior VA official, gave us a similar troubling perspective. He stated, "The VA health care system is hampered by aging facilities not well repaired, updated, and maintained over the years, and by mandates from headquarters in Washington to keep facilities open and their staffing levels up, even though activities have drastically diminished and moved to other more appropriate venues."

GAO later advised our Oversight and Investigations Subcommittee that VA is wasting $1 million each day that it goes without addressing those issues. VA agreed last year with GAO's assessment that it could improve veterans' care if it reduced spending on underused, obsolete buildings and reinvested the savings in modern facilities. VA committed to develop such an asset realignment process.

But where are we a year later? VA is back at square one after spending more than $1 million identifying and rejecting options for veterans' care in Chicago. More money has been set aside to contract for studies in other parts of the country. But not only are those studies on hold, even a promised policy statement to guide the planning process is still incomplete. So it is troubling that even taking the first step on the road towards improving veterans' care

rather than caring for obsolete VA buildings is moving at a snail's pace. But even more troubling, the proposed VA policy on reexamining its infrastructure may be heading down a long road towards paralysis in decision-making.

Perhaps the single most glaring flaw in VA's approach is that it seems to have lost sight of its core mission. What is missing is a clear statement that VA's planning must be guided by what best serves veterans. As GAO points out, the proposed policy has no objective criteria for decision-making. Instead, VA seems to be drifting towards a policy which is aimed at satisfying all stakeholders. Unfortunately, the many interest groups at the table do not necessarily have a common agenda. And what serves the interests of researchers, educators, or employees, for example, may not always best serve VA patients.

So it's important not only that VA accelerate the pace of its decision-making but that it act wisely. As it did last year, GAO offered VA critical but helpful advice. It is not too late for VA to act on that advice and refine its planning. I hope this hearing will aid in that effort.

Among the witnesses we will hear from this morning are the director of one of VA's networks and one of its medical center directors. These two officials have courageously guided local planning towards significant change at two VA medical facilities. It may be premature to cite these as success stories, but they suggest an exercise of leadership on this subject which so far has not been evident at the headquarters level.

I appreciate that several of our witnesses have had to juggle busy schedules to be with us for what I think will be a most important meeting and hearing. In that regard, I am delighted that a fellow Floridian, who is both a veteran and a physician, Dr. and Congressman Dave Weldon, will be testifying on a very promising proposal that he has developed that addresses some of the important issues before us today.

Before calling on my colleague from Florida, let me turn to Mr. Doyle.

Mr. DOYLE. Have an opening statement?

Mr. STEARNS. Yes. Opening statement.

OPENING STATEMENT OF HON. MICHAEL F. DOYLE

Mr. DOYLE. Thank you, Mr. Chairman. I want to thank you for convening this morning's hearing to discuss this most important matter, and I also want to welcome all of those who will be testifying before the subcommittee. I'm eager to hear your thoughts and comments on how we can improve capital asset planning within the Department of Veterans Affairs.

Without question, the current manner in which VA goes about its capital asset planning raises numerous and serious concerns. These concerns are not limited to the need for enhanced leadership and a more logical approach to decision-making, but extend to the heightened efforts that must occur in an efficient and timely fashion if we are to meet the emerging health care needs of our veterans in the best possible environments.

I think it's safe to say that we're all keenly aware of how some parts of the VA budget are more interrelated than others. And the

relationship that exists amongst capital assets planning, health care services, and construction activities is not only overlapping in nature but also multilayered and complex. In short, if you change the dynamics of one, you incontrovertibly change the tenor of the others.

Of course, we all want the VA to make adjustments to current practices that will produce budgetary and management accord throughout the system. But I must say that what I have read with regard to the CARES initiative and other proposals that will be discussed this morning indicate that the outlined approaches to finding solutions to these difficult problems are not new, improved, and worthy of pursuit, but are in fact old and rehashed, and at points, highly questionable. Specifically, the potential for an increase in the contracting-out of services, the mass closure of hospitals, and the exclusion of the thoughts and opinions of our nation's veterans do not indicate that we will be put on the right path but warn that we are destined to repeat mistakes of the past. And in my view, the greatest mistakes we have made in the past are all marked by the degree to which they deviate from the key vision and mission of the VA.

In our discussions, it is my hope that we can avoid portraying the need to take care of our health care infrastructure as being diametrically opposed to the need to provide appropriate health care services. They are and should be treated as being complementary in nature. It is also my hope that in the aftermath of decentralization, we can avoid speaking about VISNs in overly general terms. We all realize the profound differences that exist with respect to demographics, health care needs, and responsibilities.

And finally, it is my hope that we don't simply lament the facts that will be demonstrated nor rush to judgment in anointing ill-advised proposals as the panacea to all existing problems. Instead, we should be collectively and methodically gearing potential solutions toward the existing possibilities that can occur when there is support for and a coordinated plan among the different faces of the VA health care system. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague from Pennsylvania. Dr. Snyder, opening statement? Mr. Shows, gentleman from Mississippi? No?

With this, we'll turn to my good friend, Congressman Dave Weldon, a doctor, a physician from Florida. I'm delighted to welcome you, Dave, and glad to have your opening statement.

STATEMENT OF HON. DAVE WELDON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. WELDON. Thank you, Mr. Chairman. It is certainly a privilege and an honor to be able to be before you today to testify. And I would also like to thank the committee for its support of the East Central Florida pilot program. I am here today to report to you on the way this program was favorably received by the veterans in the community, how it appeared to save a substantial amount of money, and the need to continue it and expand it to other sites to allow it to be studied in more detail.

Most importantly, it serves as a possible model that would allow underserved veterans to get better access to quality medical care.

Mr. Chairman, as you alluded to in your opening statement, I appear before the committee not only as a veteran and as a physician, but as well a physician who volunteers seeing patients at the VA outpatient clinic in my congressional district. I think I also bring a valuable perspective on VA capital asset planning which I'd like to share with you.

While I want to tell you about the project taking place in my district, I want to impress on you that it has the potential for broader applications for veterans in other areas. This is about better access, better quality, and reduced costs.

What marks my district is the fact that while we have an outstanding outpatient clinic, veterans who still need hospital care must drive hours across the state to get to that VA hospital care. I'm talking about a population of veterans that number more than 60,000 that have a more than 2-hour drive to get access to their care.

To its credit, the committee has studied this complex problem associated with VA capital asset planning. I think the experience in my district offers some answers to the challenges we must address. The difficult situation we faced in my district let me to develop this legislative concept.

As many of you recall, the veterans in my district were very disappointed years ago when the Congress rejected a VA proposal to construct a hospital in East Central Florida. The VA had acknowledged the need for a hospital in the area back as far as 1983. The VA then established an interim clinic in 1997 until the completed comprehensive clinic was opened in July of 1999. Finally, after literally decades of promises, the veterans in District 15 had access to medical care, but it only took care of about 85 percent of their health care needs. The other 15 percent was the issue in question—when they needed to be hospitalized.

At the time we authorized and appropriated funding for the outpatient clinic, and I knew the clinic would do a good job to meet those needs. I put forward a proposal which was ultimately approved that would avoid the situation of having these veterans have to go these long distances for hospital care. Five million dollars was appropriated to support a pilot project that would allow veterans who were enrolled in the outpatient clinic to receive their inpatient care in local community hospitals.

Under this pilot, the veterans were given a choice of receiving care either at VA expense in the local community hospitals or being referred to the VA inpatient facility in Tampa several hours away, or West Palm, also several—West Palm Beach—also several hours away. The decision of where to receive care was left to the veteran, and the pilot program simply gave the veterans more choices of how to receive their inpatient care.

I must stress that the veterans had to be enrolled in the clinic to be allowed this option.

Between July of 1998 and October of 1999, nearly 1,000 veterans took advantage of this program. It is my understanding that the veterans who received care under the program, 90 percent reported their care as excellent or good, while nearly all of them reported that they approved of it.

What the pilot in my district has demonstrated is that we can begin to think more creatively about ways to provide for care for veterans. We have learned that a VA clinic can effectively manage the care of patients who elect to get hospital care in community facilities, and we have learned that the community can step forward and help take care of these veterans.

We have learned that patients who participate in a well designed, coordinated care program are very satisfied. And the preliminary data that I have received from the VA indicates that there has been substantial cost savings over what the cost would have been if these patients were cared for in the existing VA facilities.

It is with this background that I propose legislation to authorize a small number of pilot projects under which Veterans with Medicare or other health plan coverage who rely on nearby VA clinics for care but reside far from the nearest VA medical center could make a choice when the VA finds that they need hospital care. Veterans who are reluctant to travel hours to VA inpatient facilities could elect to receive care at a community hospital as a Medicare or other health care patient with the VA coordinating that care. The local VA clinic would coordinate the effort to ensure quality care and cost oversight. To ensure that the patient does not incur out-of-pocket costs, the VA under my proposed legislation would cover required co-payments.

The experience of the Florida pilot strongly suggests that the veterans would welcome such an option. It would have the benefit of providing for coordination of health care benefits with the result that veterans who now often pick and choose between two or more health plans would get better coordinated and most importantly less costly care.

Let us look at a Medicare-eligible veteran, for example. Under my proposal, a veteran who is enrolled for primary care at the outpatient clinic would be given a choice when needing inpatient care. The veteran could make the several hour trip across the state to receive care in a VA facility, where the VA would cover 100 percent of the costs, or the veteran could choose to go to the local community hospital, where Medicare would pick up the 80 percent of costs they would have incurred had the patient gone to the local hospital on their own, and the VA would pick up any co-payments or the other 20 percent. Under both arrangements, the veteran incurs no costs.

My bill would ensure not only a coordination of payments but coordination of the patient's care. I believe that for areas of the country that are distant from VA medical centers, linking a VA outpatient clinic with greater choices in inpatient care could serve as a model for providing better service to veterans.

I believe that as this committee considers VA capital asset issues, it will find that pilot programs employing this model may offer an innovative new mechanism to improve veterans' access to needed care. It will facilitate ready-made solutions in underserved areas and will allow for more cost-effective approaches in areas that today require unusually high maintenance of effort per patient within the VA system.

Mr. Chairman, I see that I've received the red light. Therefore, I will conclude my testimony. But before doing so I would again

like to thank you for the opportunity to testify, and I would be very happy to linger should anybody have any questions for me.

[The prepared statement of Congressman Weldon appears on p. 67.]

Mr. STEARNS. Dave, thank you. It's interesting. You bring two great qualities with your proposal. Joshua Hammond wrote a book called The Seven Cultural Forces that Define Who Americans Are, and the first thing is choice. And so, by making your proposal to include the idea that a veteran can go to the VA hospital in Tampa if he wants or she wants, but they can also go to a local hospital, brings that choice into play. So that the veterans should not feel threatened that the hospitals are going to be eliminated or anything, because this is just a choice that veterans will make. And they should have that. So I think that's one great aspect about your proposal.

The second things is, obviously you say it's more cost- efficient. Do you have any more information quantitatively to show that? Did the VISN Veterans' director give you information? Or how did you obtain information it would save cost?

Mr. WELDON. I was given the preliminary data on the project. It is still under analysis by the VA, and their official release of this is pending. But according to the information they provided to me, there was a substantial cost savings in this program over the costs of treating the veteran at existing veterans' facilities in Florida.

This in my opinion has the potential to be an example of how we could do the highly unusual, which is to provide our veterans with better quality care, closer to home, at reduced cost to the American taxpayer.

I want to stress that this is a small pilot program. The VA system is a huge, multi-billion-dollar system, and what I'm coming before you today is stressing that we need to expand it slightly and study it in more detail. It would be in my opinion an error to make sweeping judgments about multi-billion-dollar cost savings to the Veterans Administration if this were widely implemented. But it would be very foolish not to expand this and study it in more detail, considering the high level of satisfaction and the potential for cost savings.

Mr. STEARNS. Did you actually ever talk to any of the veterans?

Mr. WELDON. I personally spoke to the very first veteran who was treated under this program, and I have spoken to dozens of them since, and the level of satisfaction is extremely high.

Mr. STEARNS. Is it the fact they don't have to go to Tampa or is it the fact that they find they're better served? Or both?

Mr. WELDON. It's clearly both. But I would say it's mainly the travel issue. And I want to stress the travel issue is a huge issue for family as well. It's not just the veterans themselves being reluctant to travel, it's the spouses and children who are faced with the onerous prospect of having to visit their loved one that is 3 hours away in the hospital.

Mr. STEARNS. I remember when we talked on the floor about this idea, and I commend you for it. And to point out to my colleagues, what he has set up here in his proposal as it relates to veterans who are on Medicare, for example, is that when they go to a community hospital or they make a choice to go to the Veterans' Hos-

pital, it's their choice. But you set it up just for those folks in that category, right? Who went to a VA outpatient clinic, had been recommended for inpatient care, and are on Medicare coverage. Is that your criteria?

Mr. WELDON. Well, the original pilot which the Congress last year in the 2000 budget process authorized its continuation, under that pilot the VA assumed all the costs associated with treating veterans under 65 and over 65. What I am proposing in my new piece of legislation is something entirely new, which would be allowing something called coordination of benefits, where, for example, veterans over the age of 65 who are eligible for Medicare, yes, they would—if they were enrolled in the clinic and therefore in the pilot program, and they went to the community hospital instead of the Veterans Administration paying their entire hospital bill, the Veterans Administration would pay 20 percent and Medicare would pay the 80 percent, which they traditionally do under the Medicare plan.

This would allow a substantial expansion to include veterans who are over 65. In my opinion, it would be inappropriate for the Veterans Administration to assume all the costs of treating veterans who would normally be getting their care under the Medicare plan.

Mr. STEARNS. I thank you. The gentleman from Pennsylvania.

Mr. DOYLE. Thank you, Mr. Chairman. David, thank you for coming before the committee this morning and describing your proposal. And I think it does warrant more discussion and exploration to see where this can work.

I have a couple of questions. David, you said that the thrust of your proposal was to give veterans an option in areas where there's not a VA Hospital nearby. So this is not something—you're not proposing veterans have a choice of community hospitals over VA hospitals when there's a hospital readily available in their community? You're trying to target people who have to travel great distances?

Mr. WELDON. Absolutely. And I specify that in my bill. Now my bill is in draft form and I'm not ready to submit it yet. There are numerous details that we have to settle on. But one of the things we specifically specify in the legislative language is that expanding this pilot program to other locations, those locations would have to be underserved areas where veterans have to travel a long distance to get their health care. As you know, and all the members of the committee know, there are numerous areas like that in America.

Mr. DOYLE. I'm curious. Would any veteran be covered under your proposal, you know—for instance, higher income veterans now have to pay for some of their hospital care in the VA. So under your plan, by using another hospital, would these high-income veterans get out of their VA co-payment, too?

Mr. WELDON. I would not support that. That is an issue that we have not addressed yet in the legislation.

Mr. DOYLE. And just finally, Mr. Chairman, the one concern I do have, it seems in Florida you have a fairly unique situation where your hospital beds are pretty close to capacity. But in other areas, you know, we're just concerned. This could be a big problem if we lose a lot of veterans to the private sector because VA creates a lot

of efficiencies by creating—by providing care to a critical mass of patients.

And since many of the VA's costs are fixed, it may not cost as much to deliver care to certain veterans in the VA as it would be to pay for their care in the private sector, even their co-payments. And one of the concerns I have is that if veterans start to choose private sector providers, the VA's going to lose both its efficiency and will recognize these expenses for care it's no longer providing. Do you think under your proposal that it would be possible for VA to be able to maintain an efficient array of services while it's simultaneously paying for care in the private sector?

Mr. WELDON. Well, as I see it, the VA nationwide has two regional challenges. In the Sun Belt you have areas like mine that have underserved veterans' communities, and my proposal is really intended to address that.

In other areas, you have excess capacity. And my legislation is not intended to address that issue. Though it has the potential to enable the VA to address that issue, in the sense that the VA has always been in the onerous position where if they were dealing with a facility, an inpatient facility that was underutilized, closing it down involved telling the veterans' community in that area, we're going to take what you have and give you less or give you nothing. Under this kind of a proposal, you could literally say to those veterans, we're going to give you something new, and you're still going to get your inpatient care.

As a physician who went to medical school at a facility that was attached to a Veterans' hospital, and have worked in Army hospitals as a Medical Corps officer, I would assert that community hospitals today in America, which are now very different from what they were 50 years ago, can meet the needs of veterans at reduced costs.

Mr. DOYLE. Thank you, Mr. Chairman. Thank you, David.

Mr. STEARNS. Thank the gentleman. Gentleman from Arkansas.

OPENING STATEMENT OF HON. VIC SNYDER

Mr. SNYDER. Thank you, Mr. Chairman. Just a comment, Dave, in line with the chairman's comments about—asking you about travel versus the care. I remember about 20 years ago when I was an intern at a VA hospital, it was a Friday afternoon, I was on call for that afternoon, and we got an admit note from the emergency room. It was about three lines long. And it circulated around the hospital because basically it was, "Seeing as how it's Friday afternoon and this veteran has traveled all the distance to get here, and his appointment's not till Monday, admit VA hospital."

Mr. WELDON. Right.

Mr. SNYDER. I mean, now we don't do that kind of thing anymore. But you can put yourself in the position if you're the VA doctor and you're trying to decide, okay, the person's had a surgery, should I discharge him knowing he lives three blocks from here, and if there's any problem he can get back here, or I know he's got to drive 200 miles through a snowstorm in Minnesota or wherever it is, and what would he do in an emergency?

I think this whole thing of geography and quality of care, they really interrelate in a big way. I think that's why the VA has

moved—tried to move to a lot more outpatient and community-based services, but—thank you, Dave.

Mr. STEARNS. The gentleman from Mississippi.

OPENING STATEMENT OF HON. RONNIE SHOWS

Mr. SHOWS. Yeah. Thank you, Dave, for being here. Of course I'm real interested in veterans' health care and military retirees' health care that—in the bill we have introduced.

But on the concept here, in my area, we have—in Sonny Montgomery VA Hospital in Jackson, and my dad lives like 2 hours away from there, and it's a real problem for them to get back and forth, and they've just got an outpatient center in Hattiesburg which is not 20 minutes away from his home. So if—under your scenario he would go there, and if they referred him, then he could go to a local hospital in that area instead of having to drive to Jackson?

Mr. WELDON. Right. Right. A good example is if he developed abdominal pain and examination indicated most likely cholecystitis, a gall bladder condition, and he needed to have his gall bladder removed, your father under the proposal in my district, he would be presented the option of going to the SUNY Montgomery facility for his gall bladder operation or going to the local community hospital and having it done there.

And under that experience, the veterans were very, very favorable in terms of getting the local care in the surveys of the veterans who received the care. And the preliminary data is that there was a substantial savings to the Veterans Administration of costs using the community hospitals versus using their fixed assets.

Mr. SHOWS. And you say it saves the VAs or Veterans' Hospitals money by doing this?

Mr. WELDON. Right. It's less expensive.

Mr. SHOWS. Why is it less expensive?

Mr. WELDON. Well, I'm not prepared to answer that question. Certainly it would be something that would need to be studied in more detail, but the facts are the facts. And I think it's something that this committee needs to closely look at, because it's a legitimate issue.

Mr. SHOWS. Well, I do, too. And I agree with you, because I think they would rather be closer to home for their family's sake, and it's just like Vic was talking about a while ago, and those kind of issues, because I know if it's late at night and we get these guys and ladies in their seventies, they may get out that night, but they have to drive home, so they let them stay that night, an extra day or so so they can drive the next day.

Mr. WELDON. Right.

Mr. SHOWS. But I like your concept. Appreciate your coming.

Mr. WELDON. Thank you.

Mr. STEARNS. Maybe, Dave, the comparison would come down to is if you had to actually build a facility or hospital in that area, the cost of it, together with the delivery of the patient care, could make it more expensive than to send them to a local hospital that's in existence rather than building a new VA hospital. I mean, maybe that's one of your arguments that is part of this study.

Mr. WELDON. Well, absolutely. As I understand it, the Veterans Administration is not planning any new hospital construction at the moment.

Mr. STEARNS. Right. Right.

Mr. WELDON. But certainly in light of the data that's coming out of this pilot, it would be in my opinion inappropriate for them to build any hospitals until this is studied in more detail.

Mr. STEARNS. Well, I thank my colleague from Florida, and I appreciate his time.

Mr. WELDON. Thank you, Mr. Chairman.

Mr. STEARNS. Jerry? Mr. Moran?

OPENING STATEMENT OF HON. JERRY MORAN

Mr. MORAN. Mr. Chairman, thank you. Mr. Weldon, thank you for being with us today. I'm glad I was here to hear at least most of your testimony. I think you're onto a concept that is certainly worth exploring and certainly makes sense in many places across the country, including certainly where I come from. I represent geographically three-fourths of Kansas. There's not a VA hospital in the district. You're driving at least 3 to 5 hours to a VA hospital if you're a resident of many places of Kansas, and I've long pushed for greater community access through outreach—outpatient clinics.

And what we've discovered is that the demand for those services are tremendous, and they're underestimated by the VA. We have opened an outpatient clinic in one of our communities, and the VA estimated we'd have 1,100 patients. It turns out there's twice as many, because VA veterans are not traveling. So when the VA looks at the numbers and says that if you take these people from this part of the state and you allow them to go to an outpatient clinic, you're going to have 1,100. What they don't take into account are the folks that aren't seeing anyone.

And again, my experience is that where our hospitals, particularly in rural communities, are significantly underutilized. And it is the rule hospitals that are struggling to survive in today's Medicare world and the idea of providing additional services I think can be very cost-effective, because the facilities are there but are not being utilized. So I look forward to working with you if you're interested in this concept, and I've long said that we need to provide more options for veterans, not less. And I thank you for your testimony.

Mr. WELDON. Thank you. And as we get closer to finalizing the legislation, I'll be sure to forward a copy to you for review, and certainly I would welcome your support and the support of any members who would like to join in.

Mr. MORAN. Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentleman.

Mr. WELDON. Thank you, Mr. Chairman.

Mr. STEARNS. Dave, thank you. We'll now have our second panel. Mr. Stephen Backhus, Director of Veterans' Affairs and Military Health Care Issues, accompanied by Mr. Paul Reynolds and Mr. Walter Gembacz, both assistant directors. And gentlemen, if you would come forward and we'll have your opening statement.

STATEMENT OF STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY PAUL REYNOLDS AND WALTER GEMBACZ, ASSISTANT DIRECTORS

Mr. BACKHUS. Good morning, Mr. Chairman and members of the subcommittee. With me here today are Paul Reynolds and Walter Gembacz. Both have extensive knowledge in VA capital asset issues and were instrumental in preparing this testimony. So I feel ably assisted. We're pleased to be here.

As you know, in March 1999 we reported that the VA could enhance veterans' health care if it reduced the level of resources it spent on underused, inefficient, or obsolete buildings and reinvested the savings in providing health care more efficiently in modern facilities at existing or new locations closer to where veterans live.

In response, the VHA agreed to systematically study in a timely manner all of its medical care markets in order to develop capital asset realignment plans. Today I will discuss VHA's progress to date, several concerns we have regarding their proposed realignment process, and the potential effects on VA's capital budgeting needs.

Regrettably, VHA has been unsuccessful in designing a capital asset realignment process. In essence, it has spent the last 13 months discussing who should lead the process, how stakeholders should participate, and how decisions are made. Moreover, VHA estimates that it could take several more months before a process is operational. Such an apparent lack of urgency, given the large amount of resources that are wasted each day on bricks and mortar, in my view is clearly not in the best interest of veterans.

Our assessment of VHA's proposed process raises concerns about whether the right people are involved at the right times and in the right ways. Specifically, senior managers at headquarters may not be proactively involved at key decision points. In addition, stakeholders with vested interests appear to be involved in decision-making rather than advisory roles. And key process components are not sufficiently rigorous.

Specifically, for example, VHA's senior management should play a critical leadership role in developing evaluation criteria, generating options, and applying rigorous scoring methods to decide which option is best. However, VHA plans to give a consultant primary responsibility for these critical tasks while senior managers, in a oversight capacity, react to the consultants' work. The lack of well-defined criteria can lead to problems as it did in the Chicago realignment study.

Regarding stakeholder involvement, VHA plans to have national and local committees which possess decision-making authority, review and approve the consultants' products. We remain concerned that stakeholders' participation as decision-makers on such committees could bias the studies and ultimately the capital asset plans. For example, medical schools' reluctance to change long-standing business practices could be a factor that may inhibit asset management.

Nevertheless, we believe it's essential to involve stakeholders in an advisory role. Their valuable perspectives and understanding of the process through their participation can build confidence that realignment decisions are fair and fact-based.

While VHA possibly could satisfactorily address our concerns within the coming months, its progress to date casts doubt on its ability to do so. There is a unit within VA, though, that in our view has expertise in capital asset management decision-making: namely, VA's Capital Investment Board. Its model has been used and refined over the past 3 years, and it gives decision-makers in our view better information than they've had in the past.

Mr. Chairman, VA's slow progress creates dilemmas for VA's capital budgeting process. In the short term, VHA faces the challenge of maintaining and improving capital assets without sufficient information about future asset needs to ensure cost-effective investment decisions. By contrast, if funding for projects is delayed until capital asset plans are completed, the longer-term challenge will be how to successfully finance and implement capital realignment investments potentially totaling billions of dollars.

To successfully meet its short-term challenges, VA needs to effectively manage investment risks by evaluating proposals in relation to critical market-based risk factors, such as the availability of VA and non-VA health care alternatives.

VA's longer-term challenge of financing capital investments needed to implement asset realignment plans once developed could be mitigated through the provision of alternative financing arrangements. VA, for example, could be allowed to retain revenues generated by the sale or transfer of unneeded assets. Also because VA's realignment plans are expected to generate significant operational savings, VA could be authorized to redirect such savings for capital investments.

In conclusion, Mr. Chairman, the weaknesses we've identified in VHA's realignment process as currently proposed undermine our confidence that once implemented it will produce within a reasonable timeframe capital asset plans that are in the best interest of veterans and taxpayers. Because VHA is struggling to reach a sound realignment decision in Chicago and complete the design of a systemwide realignment process, it seems appropriate that VA consider transferring the asset planning responsibility to the Capital Investment Board. The daily costs of delayed decisions is unacceptably high.

Mr. Chairman, this concludes my statement. We will be happy to answer any questions that you or other members of the subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 73.]

Mr. STEARNS. I thank you folks. If you had to grade the Veterans Health Administration on their management dealing with this problem on an A through F grade, what would give them?

Mr. BACKHUS. Based on the way the Chicago study has gone, meaning that particular part of the process——

Mr. STEARNS. Well, just on the overall facility——

Mr. BACKHUS. Okay.

Mr. STEARNS. Overall facility realignment efforts, what would you give them?

Mr. BACKHUS. Well, probably something like a C or a D.

Mr. STEARNS. I think you're being generous.

Mr. BACKHUS. Well, I was going to say, on the Chicago part of it, an F.

Mr. STEARNS. Okay. On the Chicago part an F.

Mr. BACKHUS. An F. But you know, I think that there are some things, some parts, of this that have taken longer than any of us would have expected, and in many respects it is more difficult than what we may have thought. But the disappointment that I have a year later is very significant; it's very great. We thought and VA thought last July that this was going to take 2 more months, but now it is 8 more months later, and VA still needs many more months, so it's certainly taking significantly longer than what we expected, anyway. So a D-plus overall.

Mr. STEARNS. So in the Chicago efforts an F. In the overall you'd say about a D-plus?

Mr. BACKHUS. Yes, sir.

Mr. STEARNS. But the whole idea of what we're doing here, I mean, both the GAO and the Veterans Administration generally agree on the direction we're to go. So what went wrong in Chicago that you would give them an F rating?

Mr. BACKHUS. Well, several things. First of all, I think they learned in this case how not to do it. It's to me fairly illustrative of the need for the senior leadership in the VHA to be much more proactively involved. They need to establish at a national level, based on this experience in Chicago, very quantifiable evaluation criteria, measurable standards and linked to that criteria, and a systematic way of evaluating and scoring of results, also linked to this criteria.

In Chicago, this was all, in my judgment, vague and very subjective in nature in an attempt to try to decide things by committee that simply didn't work.

Mr. STEARNS. How do you get local acceptance of a realignment procedure? I mean, what do you do to get this local acceptance? How is it done? And I guess what role should the VA leadership play in it?

Mr. BACKHUS. There is a——

Mr. STEARNS. Maybe that's not a question that you can answer.

Mr. BACKHUS. Well, I think there is a precedent of sorts for this. As you know, VA several years ago, in Northern California had to close a facility. In this case it wasn't due to a realignment study that had been made but because there was a seismic problem. Anyway, the process that the VA embarked on successfully here was led by VA headquarters. In this case they established direct responsibility, control, and authority over how to best meet veterans' needs in Northern California. VA hired a consultant to do this but was very specific in identifying what they wanted the consultant to do. The consultant reported directly back to headquarters. The consultant also kept the stakeholders up to date.

The consultant's response went directly to the headquarters unit and VA made its decision in a short timeframe,. Everybody understood the process, there was a clear result, and VA was able to communicate to the stakeholders exactly what was involved and considered. And apparently there is a very positive final result.

So, the short answer to the question is that VHA headquarters managed this particular realignment plan.

Mr. STEARNS. Mm-hmm. In the light of the fact I think your testimony last year noted that VA has some 4,700 buildings. You noted the age of many of these buildings; some going back to 1900. And then there were some built before—50 of them built before 1900. So it's going to be a challenge for the Veterans Administration to find a way. Yet it has been done successfully. There have been examples where they've taken down a hospital that was obsolete and not being used and in turn went ahead and put a superior facility there which improved service to the veterans.

But there has to be local acceptance that this is in their best interest. Let's talk about the "stakeholders," like the veterans' organizations themselves. VSO's role should differ from other stakeholders', do you think?

Mr. BACKHUS. Potentially. I can see a distinction being made here. I view the VSOs as obviously representing the views and the needs and the desires of the veterans. They're speaking on behalf of the veterans. They are veterans. They need to be involved in this process to make sure that the needs of the veterans are put first and made the first priority.

I see a distinction, though, between them and some of the others whose principal interest may not be the veterans. It's not to say that they're not interested in helping veterans, but it may not be first and foremost among their priorities. So I do see a difference.

Mr. STEARNS. You mean first and foremost particular veterans through their VSO as opposed to all the veterans? Is that what you're saying?

Mr. REYNOLDS. The distinct—oh, I'm sorry.

Mr. STEARNS. Go ahead.

Mr. REYNOLDS. I think that he meant to say stakeholders. He's making a distinction—all the VSOs we view the same.

Mr. BACKHUS. Yes.

Mr. REYNOLDS. And the distinction is with other stakeholders. And I think what we are talking about are the medical schools, the research organizations, and the unions as examples.

Mr. STEARNS. What do you folks think of Dr. Weldon's proposal? I mean, do you think this is a viable proposal that can be beneficial and we should mount a pilot program?

Mr. BACKHUS. I don't know a lot about it. The presentation this morning was really the first time that I've heard about it. I see some advantages to testing it. There is a need to probably move somewhat cautiously with it at this point.

Clearly, some of the advantages are that if it results in better continuity of care for the patient, that's——

Mr. STEARNS. Because of the proximity, you mean?

Mr. BACKHUS. Well, it's to allow the VA to manage the outpatient and the inpatient care of a particular patient, whereas now if a patient winds up not using the VA facility somewhere in a rural area, they may or may not come back to the VA to—as a follow-up for that kind of a care.

I think what I heard envisioned here was that there would be this continued management of that patient's health needs by the VA, so there's a focus, you know. There's a quality element to this

that's very appealing. Also if it increases patient satisfaction, then I can see that as a real advantage.

The possibility also exists from this proposal that it gives additional flexibility to some of the realignment proposals that are possible. Rather than being wedded to VA facilities, you know, it opens up opportunities potentially for buying the care where you can get the price and where it's more convenient. There's good things that seem worth pursuing here. But clearly, I think caution also needs to be exercised, because it can potentially create additional demand and additional costs on Medicare and lots of other expenses that may not be obvious.

Mr. STEARNS. Unintended consequences. My last question concerns, in the light of what we just talked about there, major new construction. And last year you cited examples of costly VA mistakes in undertaking a number of construction projects such as the one in Newington, CT. Do you have any views on the VA construction plans proposed in the budget? Palo Alto and in Central Tennessee. Are there risks in any of these other pending projects mentioned in your testimony?

Mr. BACKHUS. You know, we've only had a couple of weeks to really become familiar with these proposals. And I don't think we're at the point where we can say with a kind of precision that we're real comfortable with—or most comfortable with—how we feel about any particular one. But Paul has had an opportunity to look at these over the last 2 weeks, and I think—would you mind?

Mr. REYNOLDS. Sure. I think the first thing that's important to recognize is that all investments carry risk. So what we're really talking about here I think is the degree of risk that should be associated with this large undertaking of realigning assets.

In general, talking about the projects that the VHA set forward to the Capital Investment Board, most of them are in what GAO refers to as multiple location markets. It's spending—investing capital in one location when there are other competing VA locations serving that market also. So there's a certain element of risk there.

Palo Alto is an example of one. And in fact, Palo Alto is in what we have dubbed as a megamarket. It has five different delivery locations.

Mr. STEARNS. Oh, my God.

Mr. REYNOLDS. However, in looking at the Palo Alto project, VA has done some things that I think help us to see they're managing the risk. The number one thing is that Palo Alto, as we understand it, is being set up as a geriatric/psychiatric long-term facility, and it will serve all the veterans in that network. So they've made one key decision that you would expect out of a realignment process, which is to realign care in one location.

Also they assert that this is a population where the private sector alternatives are limited. And again, we can see that that is probably the case.

So, taking those things into consideration for Palo Alto, there seems to be a reasonable case made that whatever realignment decisions are made in that network, they may not impact much the investment.

As far as the others—as I said, most are in multiple location markets—we tried to think of other risk factors. One would be the

changing veteran population, whether it's declining substantially or not. A lot of them have a very large declining population projected over the next 20 years, so that adds an element of risk.

Also, the few that are in single location markets—Fargo I believe is one example that has very low workload. And that to us would be another risk factor. The larger the workload and utilization now, the greater chance we feel that the realignment would not affect the ultimate mission of that facility.

So I guess our bottom line from our quick read is that VA or someone would have to develop some risk factors and really take a closer look in order to give you a real good read on exactly which are the more risky and less risky of the projects.

Mr. STEARNS. I think you, gentlemen. Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman. Mr. Chairman, I have some statements here of some of our colleagues who have asked that they be included in the hearing record and just ask that you would have these statements——

Mr. STEARNS. By unanimous consent, so ordered.

[The statements of Representatives Evans, Rodriguez, DeLauro, and Gordon appear on pp. 54, 59, 63, and 64.]

Mr. DOYLE. And we could also leave the record open for 5 legislative days to give other members a chance to submit statements.

Mr. STEARNS. It's so ordered.

Mr. DOYLE. Thank you, Mr. Chairman. I'd like you to take a couple minutes to clarify the role you're recommending for stakeholders. Where do you draw the line between an advisory role and a participatory role?

Mr. BACKHUS. Okay. As we read the VA's current proposal—granted, it's still in draft with February date on it, and it more than likely will be revised again—there are provisions in it that establish local and national committees including various stakeholders. The charter, if you will, for those committees is to try to achieve consensus, or unanimity on the options that will be recommended for realignment.

That kind of charter, with that kind of a tasking, then suggests that these people are in fact decision-makers, recognizing that they don't have the ultimate authority to approve a project. That would still rest with the Under Secretary of Health and someone higher in VA, but all the work that the consultant does in terms of evaluating the options will ultimately be reviewed and approved by these committees. That's our reading of this.

It has been proven, I think, over the last couple of years, that to have people of such diverse interests, and vested interests in some cases, make it virtually impossible to reach consensus, and that things will come to a grinding halt if anyone here has veto power. It could be that——

Mr. DOYLE. And you read their proposal that way? That groups would have the power. If it's not unanimous, that it wouldn't move forward?

Mr. BACKHUS. Yes. The role is to reach consensus. Yes. And if that's the way this plays out, our view is that experience shows that that will be stifling to any process. So we think a more appropriate role is to engage stakeholders in an advisory capacity where they're frequently provided information as to what the criteria are,

let's say, for how things are going to be evaluated, what the appropriate options are that are going to be pursued, how the evaluation will actually be conducted in terms of scoring and a systematic process for rolling up the information at the end and making the decision so that it's transparent and clear. Because these stakeholders do offer lots of good information.

VSOs, for example, working with veterans every day, have valuable insights that they offer that need to be considered. And I think the medical schools do as well, and so do the unions and the other stakeholders. It's important that those voices be heard. But it needs to be advisory rather than decision-making so that the process can move forward. It just seems impossible to me that everybody's going to come to agreement on what the best plan is for veterans.

Mr. DOYLE. I'm curious. How do you see the proposed CARES initiative? How do you see that being different than the process that was used in the most recent Chicago process? And should we expect a different outcome?

Mr. BACKHUS. It has changed. The proposal that I just discussed is the latest CARES proposal, and it differs from Chicago. As I understand the way Chicago worked, there weren't as many stakeholders involved in the decision-making process. But what Chicago lacked and the current proposal still lacks is this clearly established quantifiable criteria and method for evaluating the proposals. Neither one contains those important ingredients, so that in the end, we have a system with rigor that's clear to everybody, that isn't too subjective and influenced by points of view. It's data-driven to the extent possible.

Mr. REYNOLDS. I think if I could offer another perspective, CARES, the way I see it designed, could end up replicating what happened in Chicago, and I think that's what we're trying avoid by addressing a little more rigor to the process. But if your question was designed to get at, if we just did CARES the way it is now, could we have another Chicago? I believe we're concerned that VA could.

Mr. DOYLE. Thank you, Mr. Chairman.

Mr. STEARNS. Thank the gentleman. The gentleman from Kansas.

Mr. MORAN. Mr. Chairman, thank you. I appreciate your report and testimony. It seems to me that you've indicated a pretty damning indictment, I think. I thought your grading was generous. I wish I would have had you in my days when I was a student. (Laughter.)

Mr. BACKHUS. I'll bet you that VA doesn't think I was generous.

Mr. MORAN. No, I understand. Let me ask just a couple of general questions. Your testimony back in March of 1999, the GAO's testimony, indicated the VA spends one of every four health care dollars on maintaining and operating buildings. Is that any different a year later?

Mr. BACKHUS. Well, you know, we had this discussion amongst ourselves here a few times, and I'm going to give you an answer that says we don't totally agree among ourselves. But some of us think that it's greater. None think that it's less. So——

Mr. MORAN. There is some indication that instead of spending one of every four dollars, we're spending more than one of every four dollars on buildings?

Mr. BACKHUS. Or that the cost of maintaining unneeded buildings is greater today than it was a year ago.

Mr. MORAN. And is that a matter of actual dollars spent, or is it an issue of relativity? That as a percentage we're spending more, or are we actually spending more dollars?

Mr. BACKHUS. Oh, relativity, I think.

Mr. REYNOLDS. You know, I think we're talking about two things here. One is about how much money—we had estimated last year $1 million a day might be spent on unneeded buildings. I think based on what VA's done in the last year, we tend to think that was an understatement, too. We were rather conservative on that. Because the Chicago study alone, while it doesn't have an outcome yet, it showed a half a million dollars of savings a day in that market alone. And then VA's good efforts in Fort Howard and Fort Lyon, which you'll hear about later today, also are showing significant savings.

So the $1 million a day we think is low. As far as the percentage of the total budget, the one out of every four dollars, I think that we recognize all the wonderful management initiatives that VA's been able to do within the construct of their assets now. They have a lot of initiatives that have saved money. They expect to save about $260 million or so in fiscal 2000. They saved a couple hundred million last year.

So I believe that those savings are somewhat reducing the amount of money that's spent maintaining and operating buildings.

Mr. MORAN. As a bottom line, things have not gotten better and perhaps either through an understatement to begin with or continual costs of maintaining these buildings, they may have gotten worse?

Mr. BACKHUS. That's correct. That's how we feel.

Mr. MORAN. That's also disturbing to me, because we spend a lot of effort as Members of Congress trying to find additional dollars within the budget, within the appropriations process, to put more specifically into VA health care. And I suppose until I was reminded of your findings, I would have thought that we're providing direct medical care for veterans in a better way by placing additional financial resources into the system.

Anything in the testimony—let me ask first, the consultant that you describe. VHA plans to give a consultant—it says "a consultant" primary responsibility. Is this one consultant for the entire system?

Mr. BACKHUS. That's the plan as we understand it, that there will be one contractor that orchestrates the studies of local markets that will take place around the country.

Mr. MORAN. Any—how far along are they in determining who the consultant will be?

Mr. BACKHUS. Well, they're still preparing the statement of work. So that hasn't taken place. As I understand it, the plan is to complete that statement of work, allow companies to prepare proposals all within the next few months and to begin contracting before the end of the fiscal year.

Mr. MORAN. I assume that you've had the opportunity and have taken the opportunity to at least read the testimony of the VA that will be presented subsequent to your presentation. Is there anything in the testimony today that stands out to you as either significant progress or movement in the right direction or particular—highlights additional problems?

Mr. BACKHUS. Well, I think that the statement acknowledges that progress hasn't quite lived up to expectations, and I agree with that. The optimism, though, that it shows about being able to conclude the process, I don't share. And we tried to express that today. So that's where we differ, I think.

Mr. MORAN. I thank you. My time has expired. Thank you, Mr. Chairman.

Mr. STEARNS. I thank you. The gentleman from Minnesota. Mr. Peterson?

Mr. PETERSON. Well, thank you, Mr. Chairman, and I apologize for getting here late, but. Mr. Reynolds, I guess, you made the statement that—and I don't know what context this is in, because I missed some of the discussion here, but that Fargo was underutilized or was—had low utilization or something like that?

Mr. REYNOLDS. Correct. Low workload, yes. Lower utilization, yes.

Mr. PETERSON. How did you come to that conclusion? By just looking at the numbers?

Mr. REYNOLDS. Basically, Yes.

Mr. PETERSON. Yeah. Well, I don't know exactly what's going on here, but I just want you to be—I guess hearing that I question your methodology of what you guys are up to. Because in Fargo, we have two wings that are closed because we won't give them the money to run those two wings, and so we've got veterans on huge waiting lists. My area is served by this hospital. And it's not because there isn't a need for this workload, it's because we won't give them the money to do it. So I'd be careful, just looking at these numbers. You know, I'm a CPA. I'm a bean counter like you guys maybe are. And sometimes, you know, figures lie and liars figure. And so, you know, I don't know exactly what all has gone into this, but I would just caution you that sometimes these facilities, it's not because there isn't the workload or isn't a demand, it's because we're not giving them the money and the resources to do what they should be doing or need to be doing.

Mr. REYNOLDS. I agree. My comments were within—the question that I was responding to was, "In looking at the projects that were put forward to the Capital Investment Board, what risk was involved in those—the risk of VA's ongoing realignment—causing some mission change or something else that would in effect put into question whether the investment was a wise investment at this point in time?" And what I was trying to do was express a couple of risk factors that we thought could be used for gauging higher risk and lower risk.

Mr. PETERSON. Well, I guess following up on that, you know, as I understand that you guys still haven't really laid out what you think the criteria ought to be. Do you have a list of specifics of what you think the evaluation criteria should—that they should do and develop and what it should be?

Mr. BACKHUS. That's a good question. I can give you an example that could clarify what it is we really intend here, what it is we're trying to say. And the one that comes to mind first is access to care.

What we're thinking is the first level of definition to be something like make care convenient to as many veterans—the greatest number of veterans possible. Defined as something like within 30 minutes of a facility or 30 miles of a facility. To specify to that extent. Then, every proposal or every option put on the table for realignment can be measured against that standard. There's sufficient data. It would be data-driven. That would result in, for example, a zip code analysis that would display for every veteran in that area exactly how close or how far they are to a facility under any particular option using that criterion.

You could weight that criterion: How important is it that access—that care be convenient to people within these standards? Is it a high priority relative to the other criteria or is it not? You can weight that. And in the end, we wind up with a process that is very data driven, very specific and very——

Mr. PETERSON. Well, I understand that. But do you have these specifics written down that you can give to us that you think they should use?

Mr. BACKHUS. No, but I——

Mr. PETERSON. I mean, like in my area, there's hardly anybody that's 30 minutes from a hospital, and there isn't going to be, unless you provide outpatient clinics all over the place, because, you know, I've got—my district is 300 miles long and it's, you know, we've got Fargo and Minneapolis-St. Cloud. So I mean it doesn't take a rocket scientist to figure out that we're not going to meet those criteria.

Mr. BACKHUS. Correct.

Mr. PETERSON. But I—what I'm wondering is, is there some kind of specifics that you have? And before my time runs out, I don't know who could answer this, but in this process, you know, I think people would feel better about this if the money—if we were going to close facilities or take the money out of spending it on capital assets, if it would actually go to veterans.

Mr. BACKHUS. Absolutely.

Mr. PETERSON. And a lot of people are afraid that if we do this it's going to just get sucked up some other place and it's not going to go to that area or somebody else is going to get it. And, you know, we've got, as I say, Fargo sitting there with two wings that we built recently that are empty, because we won't give them the money to run it, so——

Mr. BACKHUS. I couldn't agree with you more. I think, though, that when we come up and talk about this or write about it, it's often gotten lost that, we, too, have stressed that the whole point of realignment is to improve care for veterans. And that we see potentially closing facilities as a way to improve and conduct better the mission and accomplish better the mission of VA. And it means potentially putting facilities closer to where veterans live and improving access. And that's what this is all about—reinvesting resources into that.

Mr. PETERSON. Mr. Chairman, could I just follow up one—and maybe you're not the right one to ask, but I have to go to another meeting. In this plan that's being looked at, is the money that's saved within that VISN, does it stay in that VISN?

Mr. BACKHUS. Well, we have gone—we've gone on record as saying——

Mr. PETERSON. Or does it go into the whole system?

Mr. BACKHUS. We've suggested in the past that that be done. I see a lot of benefits in doing that. Whether assets are currently configured regionally in the way that they need to be is the real—the bigger question.

Mr. PETERSON. Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentleman. You know, your message basically is that the VA should close or change the mission of facilities and put these assets to best use to improve the veterans' access to care.

I just want to put onto the record that Price Waterhouse did a study which noted that the VA owns some 4,700 buildings, over 40 percent of which have operated for more than 50 years, including almost 200 built before 1900. Only 1,200 of those buildings are used to deliver care. So certainly within those statistics, there is a significant unused capacity that could be closed and those assets put to better use, and that's basically what your message is.

Mr. BACKHUS. That's right.

Mr. STEARNS. So I thank the gentleman. And I thank you for your time and your hard work. And now we'll have the third panel step forward.

Dr. Frances Murphy from the Department of Veterans Affairs, Acting Deputy Under Secretary for Policy and Management, accompanied by Terrence S. Batliner, Director, VISN 19; Dennis Smith, Director, VA Medical Health Care System; and Charles Yarbrough, Chief Facilities Management Office, Department of Veterans Affairs. Ladies and gentlemen, welcome to the Health Subcommittee. And Dr. Frances Murphy, we'd appreciate your opening statement.

STATEMENT OF FRANCES M. MURPHY, M.D., M.P.H., ACTING DEPUTY UNDER SECRETARY FOR POLICY AND MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY TERRENCE S. BATLINER, DIRECTOR, VISN 19, DENNIS SMITH, DIRECTOR, VA MARYLAND HEALTH CARE SYSTEM, AND CHARLES W. YARBROUGH, CHIEF, FACILITIES MANAGEMENT OFFICE, DEPARTMENT OF VETERANS AFFAIRS

Dr. MURPHY. Thank you, Mr. Chairman. I've submitted testimony for the record, and with your permission I'd like to make a brief opening statement and then respond to questions.

As you mentioned, with me today are Chuck Yarbrough, Terry Batliner, and Dennis Smith, all who will have comments to make later on in this session.

Before discussing capital asset budget and planning issues, it's important to recognize the notable clinical achievements and organizational changes that have occurred within VHA over the past 5 years. We've seen demonstrable improvements in our capacity to

achieve consistent, reliable, accessible, satisfying and high-quality care for veterans.

As a result of the transformation within VHA health care, we've been able to close 52 percent of our hospital beds, at the same time increasing outpatient visits from 24 million to 37 million annually. VA now has more than 1,200 sites of care, bringing health care services closer and into veterans' communities.

The transformation that is occurring in the VA health care system has outpaced our ability to make infrastructure changes. VA's infrastructure was largely built at a time when hospital bed-based care was the norm. As discussed in previous hearings before your committee, VHA is facing a challenge to realign our infrastructure to support how health care can optimally be delivered today and how it will ideally be delivered in the future.

Since our last appearance before you regarding this topic, we've improved our processes for reviewing capital asset investments to ensure that proposed investments support current requirements. We've also made progress in developing a program to review existing capital assets to identify opportunities for realignment that would enhance services to veterans.

This year VA will implement the Capital Asset Realignment for Enhanced Services (CARES) process. CARES will involve detailed studies of each VISN to systematically review current mission requirements, existing and future veterans' health care needs, veteran demographics, required service delivery options, and recommendations for capital realignment options to enhance the services to our veteran population.

CARES has emerged as one of the more challenging and complex programs that VA will undertake in the next 5 years. I think that that has remained underrecognized in the discussions today. However, through this process, VHA will position itself for optimal health care delivery in terms of both quality and access to care and hopes to realign its extensive inventory of capital assets to better support the effective and efficient delivery of health care.

As you know, the need to review and realign capital assets was discussed extensively last year. In fact, the House passed legislation that would have supported the CARES concept. However, the final Millennium Bill did not contain that provision.

VHA has been developing the CARES concept since April of 1999. Since that time, communicating the CARES program and the associated processes with VA's diverse stakeholder constituency has taken more time than anticipated. However, we feel this time has been well invested in assuring that the future efforts will have their support.

A draft CARES policy was formally shared with VA stakeholder representatives on February 17th of this year, and we've asked for their comments back by April 20th. Concurrent with this review and comment period, VHA is proceeding with the development of a statement of work for the network planning studies and development of the CARES guidebook that will assist field managers in implementing the CARES program.

VA intends to award the consultant contracts for the initial group of network planning studies by September of this year. These will include the eight megamarkets that were identified by GAO in

its testimony before this subcommittee. Although the draft CARES policy is being reviewed and revised, several networks have identified and have implemented capital realignment initiatives that will both enhance delivery of services to veterans and at the same time result in significant savings in medical care funding. My full statement describes these initiatives for you.

The diversity of approach and the potential political implications of these initiatives should give you an idea of the complexity and the challenges that VHA will face in implementing its CARES program in all 22 networks. However, although challenging, the potential benefit to veterans and veterans' health care associated with these initiatives, and from the future CARES studies, are substantial, and have the potential for significantly enhancing our service to veterans.

Mr. Chairman, our objective is to ensure that VA's capital assets support our clinical, research, and education missions and evolve quickly to keep pace with our transformed health care delivery systems.

We very much appreciate the committee's support of our efforts to review and realign our capital assets, and we particularly appreciate changes to VHA's enhanced use leasing authority that was originated in this committee last year. This new authority will give VA facilities new energy to enhance the value of the property that we hold for the benefit of the veterans that we serve. And we believe that the initiatives that will be discussed here this morning will help VA move towards meeting the challenges that we face.

That concludes my opening remarks. I'm pleased that the committee has asked Dr. Batliner and Mr. Smith to attend the hearing and to share their experience in pursuing some of these realignment initiatives. With the committee's permission, we'll briefly discuss and describe those initiatives for you this morning.

[The prepared statement of Dr. Murphy appears on p. 81.]

Mr. STEARNS. Okay. Dr. Batliner, do you have a brief statement?

Mr. BATLINER. Yes, sir.

Thank you, Mr. Chairman. I'm here to discuss Fort Lyon. Fort Lyon is a facility in rural Southeastern Colorado on 556 acres and includes over 50 buildings. For the last decade, Fort Lyon has served mainly as a long-term psychiatric facility. They did provide some acute psychiatric and medical care until 1998. In that year, acute inpatient care was discontinued due to low demand, and clinics in Pueblo and Colorado Springs were enlarged using the money made available by that change.

There is now an outpatient clinic and 216-bed nursing home at Fort Lyon. The current census in the nursing home is 174.

Changes in medicine have led to changes in the VA, mostly over the last 5 years. We hospitalize far fewer patients than we did 5 years ago. The treatment of chronic psychiatric patients, the types of patients Fort Lyon has traditionally served, has changed so that fewer of them are institutionalized for long periods. We now use an approach called assertive community treatment to keep them out of institutions. These patients are often seen by a clinician every day, but they are not institutionalized. Changes like the move to assertive community treatment in Fort Lyon have decreased the demand for institutional care.

Because of these changes, many of the buildings are underutilized there and have been for several years. On December 9th, 1998, a meeting involving private sector individuals along with local and state government officials was held to determine if anyone would be interested in leasing space at Fort Lyon. The only group that expressed interest in the use of Fort Lyon was the Department of Corrections for the state of Colorado. In September 1999, the governor of Colorado sent a letter to the secretary of VA requesting the transfer of the facility to the state DOC.

The network office subsequently developed a plan for health care improvement in southern Colorado. The plan calls for the transfer of the facility to the Colorado Department of Corrections. In the plan, we commit to three new clinical arrangements: A VA-operated clinic in La Junta, 25 miles to the west of Fort Lyon, and contract arrangements with private-sector physicians in Lamar, which is 55 miles to the east of Fort Lyon, and Alamosa. Alamosa is an underserved mountain town 200 miles west of Fort Lyon.

Our plan also proposes the establishment of a new and much smaller nursing home in Pueblo, CO. This is to care for patients that we know will be difficult to place in the private sector or in state veterans' homes. We currently believe that about 40 of the 174 nursing home patients in Fort Lyon will be difficult to place.

Now I want to make it clear that we are committed to placing each current nursing home resident in a facility that meets his or her needs and desires for as long as that veteran needs this care and at no additional cost to the veteran.

Now overhead costs are certainly a problem at Fort Lyon, but I would like the subcommittee to understand our two biggest problems in southern Colorado: First, the inability of the VA to recruit staff in Fort Lyon. We've had this problem for years. It has been extremely difficult to recruit physicians, pharmacists, physical therapists, and accountants to work at Fort Lyon.

Secondly, there is a complete lack of emergency medical services in the Fort Lyon area. Some VA patients arrive at the Fort Lyon outpatient clinic with emergent problems and must be transported to La Junta for care. That is 25 miles away, as I've said. We cannot alleviate this problem by hiring staff to serve these patients because of our inability to recruit staff to work at Fort Lyon. We therefore believe that regardless of what occurs to the entire Fort Lyon facility, we must close the outpatient clinic soon and move it to La Junta so that patients can be reasonably near emergent care when they need it. La Junta has a 78-bed hospital with 24-hour emergency services.

Now our plan was completed in October and forwarded to the secretary for review. He directed us to send it out for 30-day comment period. We did so in late November. We received approximately 30 comments. Most of the people providing comments were in favor of the plan.

Mr. Chairman, change of this type is always controversial. However, I believe that change which improves veterans' access to care, improves the quality of that care, and frees up more than $8 million per year that can be used to fund more health care must be pursued. This is $8 million that is presently spent cutting grass,

operating the sewage and water treatment equipment, maintaining aging buildings and operating a fire station. Thank you.

Mr. STEARNS. Mr. Smith, do you have an opening statement?

Mr. Dennis SMITH. Yes, I do, Mr. Chairman.

Mr. Chairman, members of the committee, the planning for the Fort Howard mission change and campus revitalization began with the establishment of a simple philosophy of keeping an open process. It was foreseen that the widespread interests would require numerous presentations to keep all stakeholders informed.

In anticipation of public interest, our public relations and community affairs office was involved in an early state, and press packages were prepared. In addition, a professional PowerPoint presentation was developed and tailored to each audience's interest.

We started by presenting our concept to headquarters in late March 1999 and obtained approval to move forward with the planning. Our position was basic—that we could no longer continue to provide inpatient care in a 57-year-old obsolete and inefficient building when excess capacity was available in other locations in my organization.

With headquarters' support, we immediately proceeded to schedule informational meetings with congressional leaders, local and state veterans' organizations, employees, unions, and the local community. Approximately 14 informal presentations were given in the first 2 months after our meeting with headquarters.

A consultant was hired in May 1999 to evaluate our workload and help develop a business plan. An advisory committee was formed to work with this consultant. Members of this committee included a wide spectrum of employees, union representatives, and veterans' service organization officials. During the planning process, informal update meetings were provided to employees, congressional stakeholders, VSO organizations, and the local community to keep everyone abreast of our progress.

The consultant's final report recommended that the Fort Howard's 85 inpatient beds be moved to other locations in our organization and that we retain our primary care outpatient clinic at the Fort Howard campus and further pursue the enhanced use continuum of care community concept which would include independent living, assisted living, and nursing home care. It is estimated that these recommendations would save the VA Maryland Health Care System over $79 million during its first 10 years, and when fully implemented, would save approximately $9.7 million a year.

By the time our business plan was submitted to headquarters in November 1999 for final approval, over 30 presentations had been given. Stakeholder feedback was not taken lightly. We have been responsive to concerns and suggestions raised in regards to the final report. For example, a concern was raised to the proposed relocation of a dementia bed unit in our Baltimore Rehabilitation and Extended Care Center. In response, we have reevaluated this move and determined that we will relocate a more general nursing home patient.

In addition, there were concerns about the allocation of hospice beds within our health care system. And as a result of that concern, we reallocated those beds in our new business plan.

VA headquarters has also been vigilant in soliciting input at a national level. In January of this year, headquarters sent copies of our consultant report to numerous stakeholders, including national headquarters for VSOs, the Maryland statewide congressional delegation, and key members of the House and Senate Committee for Veterans' Affairs for comments. The comment period ended February 25th of this year, and we did not receive any letters of nonsupport and received a number of letters of support for our proposal.

As I previously stated, during the past year, over 30 presentations have been held and given to local, state, and national stakeholders as well as to numerous community meetings for the general public and smaller interest groups. We believe that the proposed mission change and campus revitalizations has received overwhelming general acceptance and support.

I attribute much of this acceptance and support to the open philosophy that we've had and to a very sound, realistic and progressive concept. In addition, my executive officer, Mr. Alan Hackman, who is present here today, developed an enhanced use concept and approached me with his ideas to establish a continuum of care community that would be accessible to our veterans as well as their spouses during a time in their lives when assistance with some of the daily needs in life are often required. This creative approach allowed us to develop services that are not now readily available to our aging veteran population.

Mr. Chairman, I appreciate the opportunity to present this informal testimony and would like to thank you and the other members of the committee for your support.

Mr. STEARNS. I thank the gentleman. We just had a second call for a vote, so we're going to temporarily adjourn the committee and reconvene momentarily after I get back after I vote. So if you'll bear with us.

[Recess.]

Mr. STEARNS. The Health Subcommittee is reconvened. We just finished up with opening statements of the panel number three.

So I think what we have here, Dr. Murphy, is examples of how it can be done. And so what we tried to do here is somehow get measurable, objective criteria for a realignment process established—transparent criteria. And then it looks like, based upon what GAO has said, we could all come together. Wouldn't you agree on that?

Dr. MURPHY. Yes. I think actually the two examples that you've heard about this morning will ultimately be successes in our capital assets realignment program. They're much simpler than some of the complex megamarket studies that will be done, and therefore the process has been smoother. But I think the basic principles are sound, and VA has learned from these smaller projects, and we've learned from some of the approaches that were taken for the Network 12 Option Study.

Mr. STEARNS. Well, the GAO has given you a D-plus on this matter. I think they were being probably kind. At this point it looks to me like the Veterans Administration just has to have the courage to develop meaningful criteria that enable you to make these decisions. Can you give us any assurances this afternoon that VA

is equipped to make these decisions today? And I guess what I need to hear is what are you going to do differently?

Dr. MURPHY. I can't disagree with the three basic principles that the GAO outlined this morning—that is, that we have to have national leadership for the CARES process, that we have to have appropriate stakeholder involvement, and that we need to have a very specific evidence-based approach with criteria clearly outlined so that they are understandable both to the contractors who are helping us carry out the process and to the stakeholders who will be evaluating the results of the CARES studies.

So I think those are concepts that VHA can support. The CARES program is very important to VA. We understand that it will be essential for us to effectively manage our capital asset realignment program in order to be able to deliver more care, to more veterans, in the most appropriate locations. We're committed to making this process work, and we have a clear plan on how to make that happen.

Mr. STEARNS. Wouldn't you agree that the failure to give the contractor or the steering committee specific criteria by which to develop or evaluate options was a major mistake in Chicago?

Dr. MURPHY. VHA believes that the statement of work this time should include those criteria, and we will include them. We currently have asked for a data committee to put together some of the components that the contractor will need to use to be able to do that criteria-based evaluation.

Mr. STEARNS. Based on what happened in Chicago, was there anybody let go? I mean, was there any kind of disciplinary action or anything done?

Dr. MURPHY. I don't believe so.

Mr. STEARNS. I guess what we're trying to get this morning is a commitment to develop objective criteria. Are you able to develop the kind of measurable objective criteria, you feel as a result of what the GAO has said, to make the realignment decisions? I mean, do you feel you're capable now of doing it or do you need more time or——

Dr. MURPHY. We actually feel that VHA is the most capable organization to be able to do this. One of the challenges will be that there aren't other health care systems like ours. The contractors will have a difficult time, because really the Network 12 study was the first time that a contractor was asked to do such a project.

We certainly have the expertise in facility evaluation and assessments in our Facilities Management Office. We have excellent financial managers, and we have health care experts who can assess veterans' health care needs, demographics of the veteran population and structure a process that will allow us to make the assessments that are necessary. So, yes, we do make a commitment that the request for proposals will go out this summer and that the CARES process will begin at the end of the fiscal year.

Mr. STEARNS. Are you willing to work with the assistant secretary for financial management and with the GAO in developing these criteria?

Dr. MURPHY. We are already actively working with the assistant secretary for financial management through the CIB process and will use their expertise and the appropriate parts of their evalua-

tion process in designing our criteria. We would also value the input of the GAO. If they have specific recommendations on the criteria, we'll certainly consider them very seriously. We'll be using input from other stakeholders also. Our special medical advisory group, who are in Washington meeting today, have also offered to give us their perspective on some of the criteria for this process.

Mr. STEARNS. Dr. Murphy, could we have in 30 days a report back a report that talks about the measurable objective criteria you have developed? Can you give us a report and tell us what it will be? Is that feasible?

Dr. MURPHY. We'll try to make your 30-day deadline. But we'd like a bit more time.

Mr. STEARNS. How much time do you need?

Dr. MURPHY. If we could do it——

Mr. STEARNS. And based upon what has happened in Chicago and what's happening around the country and what the GAO has said, it seems like you should be able to come up with sort of an outline for us in 30 days.

Dr. MURPHY. We could give you an outline and a final version at the end of May.

Mr. STEARNS. Is there any hesitation you have with working with other offices in the VA to develop this criteria?

Dr. MURPHY. None at all.

(See p. 39.)

Mr. STEARNS. Okay. Okay. Well, we'll look forward in 30 days, a draft of the objective measurable criteria. Is that okay? Anyone else on the panel would like to say anything before we close and go to the fourth panel?

I thank the third panel, and now we'll welcome the fourth panel. Mr. Gordon Mansfield, Executive Director of the Paralyzed Veterans of America; Mr. Dennis M. Cullinan, Director, National Legislative Services of Veterans of Foreign Wars; and Jacqueline Garrick, Deputy Director, National Veterans Affairs and Rehabilitation Commission, The American Legion.

Let me welcome you folks this afternoon, and appreciate your patience in waiting for the other three panels. And at this point we'll have opening statements, and you may begin.

STATEMENTS OF GORDON H. MANSFIELD, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; AND JACQUELINE GARRICK, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF GORDON H. MANSFIELD

Mr. MANSFIELD. Thank you, Mr. Chairman and members of the subcommittee, for the opportunity to present the views of the Paralyzed Veterans of America on VA capital asset needs with regard to potential mission changes and the realignment of health care facilities. These issues hinge on the concept of how, why, and where we expend taxpayer dollars to be used in the provision of medical services for veterans.

We believe it is paramount that these dollars are expended wisely and efficiently, while ensuring—no matter what the cost or change to the infrastructure of the VA health care system—that veterans will continue to receive appropriate, timely, and quality health care service.

Because of health care realignment and lack of construction and renovation dollars, VA's infrastructure inventory and needs have changed dramatically. Most of this change, marked by the shift from inpatient to outpatient care, has occurred in the last 3 years. At some point, if that point has not already been reached, this trend will stop. Not all care can or should be provided in an outpatient setting. VA needs to maintain its core inpatient capability to maintain cohesion as a viable health care system able to provide the full range of services to veterans.

The tertiary acute care medical center, practicing medicine in the environment of academic medicine and advanced medical research, is the hallmark of the VA health care system. Downsizing that role by relegating VA medicine to a conglomeration of scattered outpatient clinics or contract providers might provide convenient access to some services but does not ensure quality health care for all. Particularly at risk are veterans who rely on the VA for specialized services, such as spinal cord injury care, that can only be provided in an inpatient setting and cannot be found anywhere outside the VA. Any realignment decision being considered or adopted must make certain that the core missions of the VA health care system, such as these specialized services, are protected and enhanced.

The VA has already begun to implement an initiative, the Capital Asset Realignment for Enhanced Services, to design potential realignment scenarios nationwide. This proposal provides considerable latitude for local steering committees to tailor the changes that are being proposed in service delivery to the local health care market and the projected needs of the veteran population.

The process also calls for active stakeholder involvement that is paramount for any realignment process being considered.

Every VA medical facility has unique characteristics influenced by its community, its range of services, and its patient population. Initially, decisions affecting potential realignment or closure of facilities should be made at this particular level. We strongly believe that this process must have central guidance and oversight to make certain that the overall mission of the VA is not eroded and that certain standards can be applied to protect core missions and the full range of services to core populations.

Protections are needed in the process to ensure that locally made decisions are not generated purely by cost reduction incentives, to the detriment of the veteran patient and the VA system as a whole. The process must utilize a wide range of criteria.

PVA has identified a number of criteria that we believe are essential for assessing any facility, whether for realignment or closure. They are included in my testimony on pages 3 and 4.

PVA also believes that the process must ensure as well that any savings or revenue generated by realignment must be protected and plowed back into enhancing services in the same area.

Stakeholder involvement is the most important component of any realignment process. Any local or national realignment plan can easily be doomed without the active participation of veterans' organizations and other stakeholders at every step of the process. The GAO last year criticized the participation of system users and service providers as having too many vested interests to be able to make tough, independent decisions. But as the name suggests, we are looking at the Veterans Health Administration, and veterans and veterans' service organizations have every right, and even a moral obligation, to make certain that the welfare and health care services for all veterans are fully protected.

The GAO last year praised the realignment process in Veterans Integrated Service Network (VISN) 12 because there was very little stakeholder involvement. From our standpoint, also in large part because many stakeholders were excluded from the process, the VISN 12 plan was a complete disaster.

One of the resulting proposals called for the elimination of all acute care at the Hines VA Medical Center. At the same time, it proposed leaving the Spinal Cord Injury Center in place at Hines. It is medically untenable to have an SCI center located without direct acute care support to provide the on-site, multi-disciplinary services SCI patients require. It is even contrary to the VA's own manuals to leave an SCI center isolated without acute care support in this fashion.

Obviously, with this plan, as it was devised, the consultants gave no thought to preserving the integrity of one of the VA's core missions.

Mr. Chairman, I cite the Chicago plan as one example of how much damage can be done if a health care realignment process is carried out with an eye, only an eye, for the bottom line and not the best interests of the VA or the veterans it has been designed to serve.

As the VA begins to go down this road, all deliberation must be used to ensure that the VA does not begin to reinvent itself into something it should not be, nor was ever intended to be.

This concludes my testimony. I'll be happy to respond to questions.

[The prepared statement of Mr. Mansfield appears on p. 91.]

Mr. STEARNS. I thank the gentleman. Next?

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman. The VFW is both pleased and gratified to play a role in today's most important discussion. As an organization comprised of nearly 2 million combat theater veterans, the VFW is obviously greatly concerned with all aspects of VA's operation, emphasizing today capital asset needs, planning, and budgeting.

I would mention that the VFW is deeply troubled that the President's budget for FY 2001 would only provide $62 million for major construction projects, $114 million less than is prescribed by the Independent Budget for VA as being necessary to meet true need in this vital area.

Similarly, the President's funding recommendation for minor projects falls $29 million below the IB level of $191 million, the amount prescribed as being necessary to meet true need.

We now look to the Congress to ensure that there are adequate funds for both major and minor construction programs so that the Veterans Health Administration may address urgently needed projects in the system's antiquated infrastructure.

With respect to the department itself, VA must only restructure its capital assets to ensure the delivery of high quality and timely care to all enrolled veterans while maintaining its legislatively mandated missions.

In this regard, VA must pursue a systematic national approach to acquiring complete factual information and providing unbiased analysis to support the realignment process. And Mr. Chairman, I would just add by "unbiased" I don't mean to suggest that all stakeholders are created equally, because clearly they're not. I reflect on Mr. Backhus' comments earlier that veterans and veterans' service organization should play a very special role in this process. Who better to delineate local need than those veterans who use the system locally?

On the other hand, it's not to say that local veterans or the veterans' service organizations are best equipped for the technical detail or statistical methodologies to describe how this process should proceed. That in itself argues for the establishment of clear, objective criteria to pursue this realignment process.

With respect to any revenues that are freed up, any divestiture of resources, I certainly support my colleague to my right that all capital assets must be reinvested into veterans' programs and nowhere else.

We'll now address the Veterans Health Administration Capital Realignment for Enhanced Services program itself. The VFW is not tied to bricks and mortar, but we are insistent that the Veterans Health Administration provide quality, accessible, timely health benefits for this nation's veterans. We realize that the VHA physical infrastructure was designed for inpatient care and in many cases do not meet today's health care delivery requirements. We fully believe that a strategic realignment of these capital assets is needed to improve both access and timely service.

We encourage VA to continue forward and to refine this process, because we believe if done properly it can and will be beneficial for veterans. We insist, however, on being part of this process. The CARES draft directive is a step in the right direction, because it seems to bring balance between the network level, the corporate level, and the stakeholder involvement. If this directive is implemented as written, with special emphasis on veterans and veterans' service organization input, it should go a long way to ensure a smooth process is achieved.

Any process of this type, however, is doomed to fail if local stakeholders are not included in the planning and decision-making at the network level, and the national stakeholders are not included in the planning and decision-making at the headquarters level.

The network self-assessment survey is a good vehicle in addressing the potential realignment of facilities. However, we urge that

the addition of Potential Impact on Veterans and Potential Impact on the Families of Veterans be added to the survey.

Once again, Mr. Chairman, I thank you for this opportunity to present our views here today. That concludes my testimony.

[The prepared statement of Mr. Cullinan appears on p. 97.]

Mr. STEARNS. I thank the gentleman. Good afternoon.

STATEMENT OF JACQUELINE GARRICK

Ms. GARRICK. Mr. Chairman, good afternoon. The American Legion appreciates the opportunity to present its views on VA's capital assets, the proposed FY 2001 medical construction budget, and the mission changes and realignment of VA medical facilities.

For the American Legion, its position on the future of VA is clear and emphatic. In 1999, the National Executive Committee, representing the 2.8 million members of the American Legion, passed a resolution to oppose the systematic closing of VA medical centers. According to the resolution, the American Legion does not believe VA should close any of its existing medical centers simply as a method of generating savings. The American Legion does not believe there is one VA hospital that is not needed in some capacity and supports maintaining a viable presence at all of its existing health care facilities and enlargement of the VA health care through the GI Bill of Health.

Until all of America's veterans and their dependents can enroll in VA through various health plans and funding mechanisms, then it is premature to discuss the closure of VA facilities, which seems to be the intent of the recent VHA draft directive on CARES. According to the directive, "A CARES initiative is a capital disposal, acquisition, or realignment resulting from a facility closure or a significant mission change." It seems that CARES is becoming a means to solving VA's problems through obliteration rather than as a tool for enhancement.

The American Legion realizes there are some serious problems in the delivery of VA health care, as noted in our recently released VALUE 2000 report, which is available today. During site visits the American Legion has noted clinic appointment delays well beyond the VA benchmark of 30 days. In some networks those waiting times are upward of 200 days for an appointment. However, the American Legion cannot help but also observe that some buildings could be used for patient care so veterans might not be waiting as long to schedule clinic appointments, nor would they be waiting for an hour or more to see a provider or be sent several hours away to another facility.

Today in America many of the hospitals that we have come to know as the bastions of health care have been operating in their communities for decades. Thomas Jefferson Hospital has operated in Philadelphia since 1824. New York Hospital, originally established in 1771, has been housed in its current building since 1929. Bellevue Hospital has been at its location since the 1790s. The world-renowned Mayo Clinic has been in its original building in St. Mary's Hospital since 1889. Obviously the physical structures of these hospitals and many others around the country have needed upkeep and remodeling over the years, which is expensive, and yet no one has labeled them unneeded or has proposed closing them.

At a time when VA is taking many of the lessons learned in the private sector and applying those management principles to VA, it would seem prudent to also apply the infrastructure maintenance efforts employed in the private and not-for-profit sector.

Much of the unused VA space is newly constructed areas housed inside existing hospitals. In Chicago, the Lakeside facility has a newly constructed ICU, but only enough activating dollars for three of the seven beds. Five state-of-the-art ICU rooms sit empty. Does that mean that an aging veterans' population does not require such care? No. It is an indication that the VA system does not have enough money to care for the veterans in the most appropriate setting as possible. It means veterans at Lakeside go to Northwest at Medicare rates. In Maine, it means veterans ride for 4 hours to Boston with post-op sepsis because Togus can't afford to do the surgery there while space at Togus remains empty. In VISNs 8 and 18, it means, there is no long-term mental health.

At this point in time the American Legion does not believe that all that can be done for VA has been done. The American Legion developed the GI Bill of Health, which would bring more paying customers—veterans and their families—into VA health care through private insurance programs, TriCare, Medicare subvention, and a premium-based plan. These additional patient populations would expand the scope of VA care, making it more stable and better equipped to provide more care to more veterans. By including DOD, Medicare, Medicaid beneficiaries—and those resources in the VA health care system, then VA would be able to enhance other programs like its homeless program or compensated work therapy.

The available space at many VA facilities could be used to house, train, and treat homeless veterans, expand access to women veterans, especially if more wives were using VA, and provide the geriatric services that were just expanded.

The American Legion believes it would be infelicitous to do anything else before enacting the key components of the GI Bill of Health, and certainly it is premature to be considering the disposal of VA property.

The American Legion supports a priority ranking process for VHA construction projects. As we have testified on numerous occasions, just because no new or replacement medical centers are required, many major projects are still necessary. The American Legion believes Congress should fund at a minimum the major construction projects recommended in our FY 2001 budget testimony at $200 million level.

There is also a need for many minor construction initiatives. The American Legion does not believe that minor construction funding levels should be reduced at a time when VHA is still making the transition to primary care.

Overall, the health care industry in America is constantly changing, and new technologies and therapies enter the medical marketplace, and VA is part of that flux. It does make sense then for VA to be evaluating its capital assets, needs for technology, and enhancement of resources. Conversely, it does not make sense for VA to be closing facilities when so much more can be accomplished by expanding access to veterans and families through Medicare sub-

vention, DOD and TriCare sharing and other revenue-generating plans. Once a facility is closed and property disposed, the revenue generated is a one-time deal that cannot be undone. The American Legion sees closing VA facilities as an erosion of VA health care and the eradication of specialized care for this nation's disabled veterans.

Mr. Chairman, that concludes this statement.

[The prepared statement of Ms. Garrick appears on p. 99.]

Mr. STEARNS. Thank you. The fact that you are the fourth panel does not mean that you are the last. I mean, we in Congress and the Members of Congress take your views as extremely important in our decision process. And ultimately, your organizations have to be on board before we go forward.

Ms. Garrick, you heard the examples earlier—the success in Colorado and Baltimore. Do you think, in light of what GAO said, and in light of those two successes in Fort Lyon and Fort Howard described earlier, doesn't that make you realize that possibly we can go ahead and be successful in moving dollars that are being used inappropriately to better serve veterans in that VISN area?

Ms. GARRICK. I think when the American Legion National Executive Committee passed its resolution to oppose closings of VA hospitals, they were looking at that there's a bigger picture here that we're not paying attention to. We've been given an agenda that doesn't necessarily take into consideration that we could be looking at expanding VA by bringing in other dollars as opposed to being forced to close VA and using those dollars to reinvest it elsewhere.

Yes, the Legion has participated at the local level in both of those projects. And given—if those are our given boundaries, just like in geometry, if those are the givens that we're operating on, then those were the parameters that we had to work with and we did. But I think what the American Legion overall is seeing is that our parameters, our givens, are not necessarily the best boundaries to be working off of, and that we could be——

Mr. STEARNS. But the question is specifically to those two locations where they've been successful.

Ms. GARRICK. Mm-hmm.

Mr. STEARNS. Do you agree that they were successful?

Ms. GARRICK. Yes.

Mr. STEARNS. Okay. And knowing that they were successful and that dollars could be better used, don't you think that could be done in other parts of the country?

Ms. GARRICK. I think that if—again, it's a matter of defining those parameters.

Mr. STEARNS. Well, let's take Chicago. Do you think we could do a better job in Chicago to take the dollars that are being used there to better serve veterans?

Ms. GARRICK. When we've found—we've actually done some focus groups in Chicago, and there was an extremely strong opinion from the veterans' community not to close the hospitals in Chicago. They felt they needed those hospitals. They felt that because of the demographics of Chicago, because of the travel, that those hospitals needed to be protected. And again, the example of an ICU, where you've got seven beds that were newly constructed beds but not enough activating dollars to open all of those beds, tells me that

the problem is not in veterans who need that care; it's in the amount of revenue that the VA can generate.

If we've got patients——

Mr. STEARNS. What do you mean, the revenue that the VA can generate?

Ms. GARRICK. Well, the American Legion through its GI Bill of Health has supported Medicare subvention, more TriCare sharing, bringing in the dependents, creating a premium-based plan. There are other things that yet could be done that have not been done before we go down this road of closing hospitals.

Mr. STEARNS. Not to put you on the spot, but we have here that when you testified last May in support of the Veterans' Millennium Health Care Act, the Legion said it could support hospital closures if the reasons were compelling and not just tied to underutilization.

Ms. GARRICK. Mm-hmm.

Mr. STEARNS. What I hear you saying today is the Legion does not believe, quote, "there is one VA hospital that is not needed in some capacity." So, I mean, that's what I'm trying to come to grips with. We have the GAO audit. We've heard successfully in Colorado and Baltimore, Maryland, the closure, and we have your statement in May. And so we're trying to get everybody on board, and we don't want to go out without, of course, the American Legion. So, you know, is there apparent change here?

Ms. GARRICK. No, I don't think——

Mr. STEARNS. When you read those statements again?

Ms. GARRICK. I think, again, the systematic closing of hospitals is different from what we testified to in May, which referred more to like when they're—in California when they closed the hospital because of seismic damage. I mean, I think that is a big difference.

Mr. STEARNS. We're not talking about systematic closures. You say there isn't one VA hospital that is not needed in some capacity, you do not believe.

Ms. GARRICK. Right.

Mr. STEARNS. And yet in May you said you support hospital closures if the reasons were compelling.

Ms. GARRICK. And again, I think the example was the—is in California where the—we supported that the building was not safe, and therefore they closed it, and I think they've rebuilt an ambulatory clinic.

Mr. STEARNS. Well, we didn't replace it with a new hospital.

Ms. GARRICK. No. And I think, again, it's not so—we want to maintain the facility, not necessarily just hospitals, but that there needs to be—that VA presence must continue.

Mr. STEARNS. Well, I think we all agree that we're going to take the dollars and use them to continue the VA presence, but at a superior delivery system, modernized. I mean, all those buildings that you mention in your testimony that are older and aging, wouldn't you agree that those should be upgraded and improved if necessary?

Ms. GARRICK. Of course. And I would, having not done site visits to all of them, would assume that they have been upgraded and that they have been retrofitted to meet a more modern care delivery system.

Mr. STEARNS. Okay. Mr. Mansfield, let's see here. You cite the importance of stakeholder participation in VA's planning. Do you think medical school or employee concerns are entitled to the same weight as those of veterans' representatives?

Mr. MANSFIELD. No I don't.

Mr. STEARNS. Okay. Okay.

Mr. MANSFIELD. I think you have to go back and look at the reason we have a Veterans Administration and a Veterans Health Administration. It's for veterans. The reason for the existence of the system is the veteran patient. In fact, I'm going to start changing the PVA policy and no longer use the word "stakeholder." I'm going to use "veteran patient" when we come down here to make sure that the difference is delineated.

Mr. STEARNS. Okay. Let's see, Mr. Cullinan, the recommendation that VA develop and use objective, measurable criteria seems to offer a more open and reliable process. And you've heard us when Dr. Murphy was here earlier. What's your opinion on that?

Mr. CULLINAN. And actually having been here for this hearing, I and we as an organization are all the more convinced that that is the case, given the complexity of the process, given the politically charged nature of the process, given the inherent difficulty in resolving the differences of opinion between the various stakeholders as it were, it's all the more important that there be objective criteria, and that those objective criteria should be weighted in a certain direction. They should be weighted in the direction of serving veterans. They should be weighted in the direction of meeting local need. They should be weighted in the direction of meeting, as Mr. Mansfield just mentioned, the fundamental purpose of a Department of Veterans Affairs and a Veterans Health Administration—providing care to veterans in need.

Mr. STEARNS. I think this is probably my last year as chairman of this committee, but one of the things that I was really struggling with was try to get a consensus. Because when you look at the GAO report and you realize there are 4,700 VA buildings out there, and only 1,200 of those are being used to deliver care, and then you ask, well, what are these other 3,500 buildings being used for? And is it possible we could take those buildings and the overhead we're putting there to put it into either improving existing health care by some of the hospitals that you've mentioned, Ms. Garrick, or even new construction?

But, I mean, it's just so difficult because of the politics of it. But there's got to be a way for you folks to get the message out and not be scared of the politics that we have 3,500 buildings which are not used to deliver care that perhaps within that group of buildings we can do something to improve care. And I mean, it seems pretty apparent. Yet here we are, and we've had two successful examples in Colorado and Maryland, but we have not had a successful operation in Chicago. And so I think as an elected official, and I think my colleagues share this view, we can't help you if you won't help us. And I'm just saying, Ms. Garrick, given the testimony you had in May and the testimony you have today, we need all the organizations to come together and help us on this area and take the courage and the political capital to do it.

Now we want to make sure we don't shut any veterans' hospital down so that people are denied care, and that's self-apparent. But how we go about it is very difficult. We've had GAO's analysis. We've got confirmation of how to do it. And if we can get Dr. Murphy to come back with sound, measurable criteria and then you folks agree with it, what do we do? Because, let's face it, if you have this huge budget and you continue to add more money without restructuring it, you're not doing veterans any good, you know what I mean? We can throw more money and more money and you can come up here, you can ask for more and more money, but if I could tell you that I could operate and provide better service with just a little bit more money if you give me some latitude here to work, I think I could provide a better system.

And frankly, somewhere down the line, the VA system has to be modernized and has to be a delivery system that's par excellent. And, you know, we need your help.

Mr. MANSFIELD. Mr. Chairman?

Mr. STEARNS. Yes?

Mr. MANSFIELD. We need your help. I think the veterans' community has generally come up here and said that we want to work with you and we want to be responsible, reasonable people. In the "Independent Budget," we put down the reasons that we're asking for increased funding. And in most cases, we find that those reasons were the same reasons the VA went to OMB and asked for more money than the "Independent Budget" maybe even asked for.

So we're trying to be reasonable citizens. Going back to Chicago, I would make the point that when I say we need your help, if we're going to do this and we're going to draw a line and say we all have to step up to it, then we need the elected officials to step up to it, too. As I recollect what happened in Chicago, there was a lot of concern because the elected officials got involved in it.

Mr. STEARNS. That's a good point. Yeah. It's a good point. You know, your "Independent Budget" that I guess is a compilation from the VFW, the DAV, the PVA and the American Vets, and you came up with a larger construction budget than the president recommended.

Now I would say that we could probably fund your budget if we went back and looked at these 3,500 buildings one by one and found out they're not being used to deliver care and find out what they're doing. And we'd probably have the money to do it. And so, based on this hearing, I am hopeful that we can come out of this with criteria that everyone will agree with, and that we can get the elected officials to invest, as you point out, the political capital to accept it. And that's what they're paid to do, too.

In closing, let me say that my opening statement and my other comments reflected my concern and my frustration with the lack of progress on facility realignment, and the lack of leadership—perhaps in Congress as well—given to facility realignment in VHA headquarters.

Certainly the subject of facility realignment raises sensitive and difficult questions. And I know that including a provision in my millennium health care bill on facility realignment prompted concern from a lot of members. And so, you know, eventually that provision was taken out of the millennium health care bill.

But we have a responsibility of operating health care systems for veterans, and VA managers cannot be permitted to deal with those difficulties by completely passing the buck to government contractors. We've witnessed a costly case study in the last year in Chicago of the dismal failure of that approach.

It remains unclear, however, with so much at stake, why it takes a congressional hearing to bring focus and acknowledgement at VA that subjective decision-making is unacceptable and a rigorous, credible approach is needed. Why, in a department that claims to operate as "one VA," has the VA's clinical leadership failed to work with the VA finance office to develop tools to make businesslike decisions? Clearly, there are many questions about what has gone wrong. But the point is, to get this process straightened out and working in the best interest of veterans.

I appreciate this afternoon Dr. Murphy's commitment to address GAO's recommendation and to provide us a report in 30 days, and I ask the GAO to continue to monitor VA's progress and again remind VA that we expect to hear back with a report in 30 days.

And I thank you for waiting all this long time, and I appreciate your testimony.

The Health Subcommittee is adjourned.

[Whereupon, at 12:43 p.m., the subcommittee was adjourned.]

APPENDIX

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

JUN 7 2000

The Honorable Cliff Stearns
Chairman
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The enclosed evaluation criteria document is provided as an interim response to your request during the April 5, 2000 hearing on VA Health Care Capital Asset Planning for VHA to develop objective, measurable criteria for evaluating Capital Asset Realignment for Enhanced Services (CARES) proposals The criteria has been developed for the evaluation of CARES options during the studies VHA will initiate later this year The criteria development process has been complex, and additional enhancements are still needed. Specifically, it is imperative that the clinical target thresholds be developed and coordinated with the national data task group. Scheduling a meeting with a representative group of VA healthcare providers to accomplish that has taken more time than anticipated due to schedule conflicts, but the meeting will take place on June 7-8, 2000.

Once the criteria development is completed, the full spectrum of criteria and sub-criteria will be weighted and scored. These additional completion items will require another two weeks. The final VHA criteria will be provided to you on June 23rd. We plan to test the criteria model prior to applying it to the upcoming CARES studies.

VHA is committed to implementation of this capital realignment initiative. We have worked closely with the Department, GAO, VSOs, and the Subcommittee staff to enhance the CARES process in order to ensure the best decision-making process. Questions regarding this interim report may be directed to Mr William W. Graham on 202.273 5873.

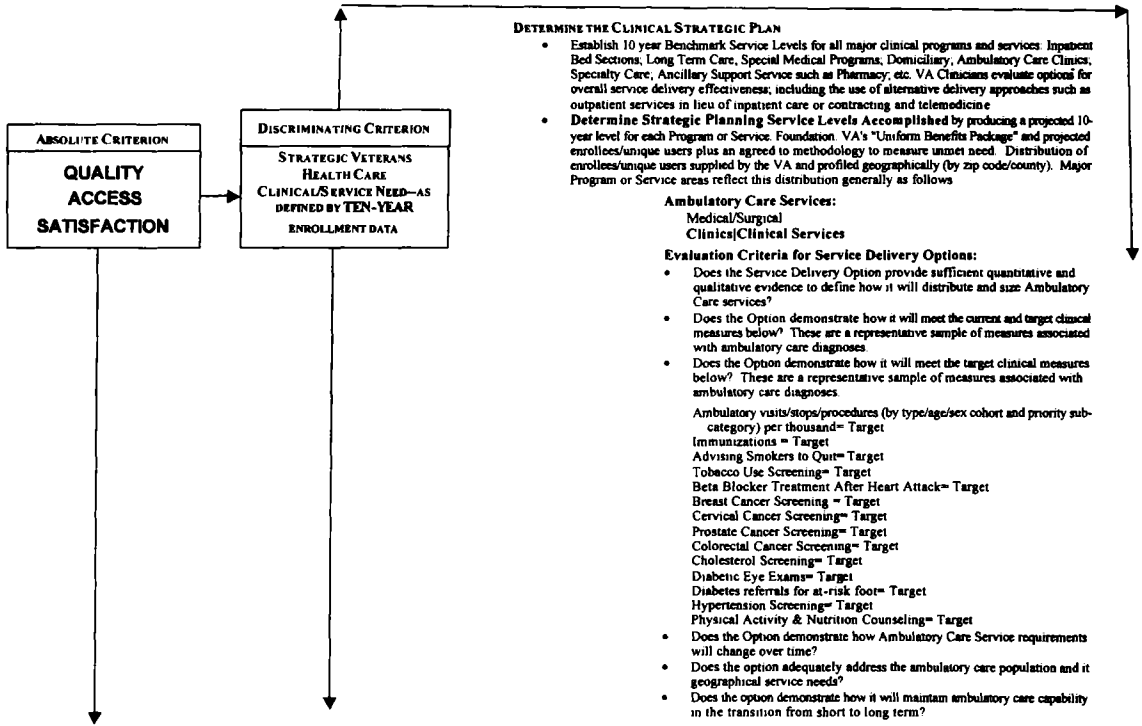
Sincerely,

Frances M. Murphy, M.D., M.P.H.
Acting Deputy Under Secretary for Health

Enclosure

CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS



DETERMINE THE CLINICAL STRATEGIC PLAN

- Establish 10 year Benchmark Service Levels for all major clinical programs and services. Inpatient Bed Sections; Long Term Care, Special Medical Programs; Domiciliary; Ambulatory Care Clinics; Specialty Care; Ancillary Support Service such as Pharmacy; etc. VA Clinicians evaluate options for overall service delivery effectiveness; including the use of alternative delivery approaches such as outpatient services in lieu of inpatient care or contracting and telemedicine
- **Determine Strategic Planning Service Levels Accomplished** by producing a projected 10-year level for each Program or Service. Foundation. VA's "Uniform Benefits Package" and projected enrollees/unique users plus an agreed to methodology to measure unmet need. Distribution of enrollees/unique users supplied by the VA and profiled geographically (by zip code/county). Major Program or Service areas reflect this distribution generally as follows

Ambulatory Care Services:

Medical/Surgical

Clinics|Clinical Services

Evaluation Criteria for Service Delivery Options:

- Does the Service Delivery Option provide sufficient quantitative and qualitative evidence to define how it will distribute and size Ambulatory Care services?
- Does the Option demonstrate how it will meet the current and target clinical measures below? These are a representative sample of measures associated with ambulatory care diagnoses.
- Does the Option demonstrate how it will meet the target clinical measures below? These are a representative sample of measures associated with ambulatory care diagnoses.

  Ambulatory visits/stops/procedures (by type/age/sex cohort and priority sub-category) per thousand= Target
  Immunizations = Target
  Advising Smokers to Quit= Target
  Tobacco Use Screening= Target
  Beta Blocker Treatment After Heart Attack= Target
  Breast Cancer Screening = Target
  Cervical Cancer Screening= Target
  Prostate Cancer Screening= Target
  Colorectal Cancer Screening= Target
  Cholesterol Screening= Target
  Diabetic Eye Exams= Target
  Diabetes referrals for at-risk foot= Target
  Hypertension Screening= Target
  Physical Activity & Nutrition Counseling= Target
- Does the Option demonstrate how Ambulatory Care Service requirements will change over time?
- Does the option adequately address the ambulatory care population and it geographical service needs?
- Does the option demonstrate how it will maintain ambulatory care capability in the transition from short to long term?

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CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS

Acute Medicine Services:

Internal Medicine/ICU/Neurology/Rehabilitation Medicine/Surgery

Beds|Clinical Services

Evaluation Criteria for Service Delivery Options:

- Does the Service Delivery Option provide sufficient quantitative and qualitative evidence to define how it will distribute and size Acute Medicine services?
- Does the Option demonstrate how Acute Medicine service requirements will change over time?
- Does the Option demonstrate how it will meet the current and target clinical measures below? These are a representative sample of measures associated with acute medicine diagnoses.
- Does the Option demonstrate how it will meet the target clinical measures below? These are a representative sample of measures associated with acute medicine diagnoses.

  Medical/Neurology/Rehabilitation Admissions/BDOC per thousand (Bed Section-admission/BDOC projections by age/sex cohort and priority sub-category)= Target

  Surgical Admissions/BDOC per thousand (Bed Section-admission/BDOC projections by age/sex cohort and priority sub-category, includes Case Volume by Category of Case) = Target

  Intermediate (sub-acute) Admissions/BDOC per thousand (Admission/BDOC projections by age/sex cohort and priority sub-category)= Target

  Surgical Procedure morbidity= Target

  LOS for Heart failure, COPD, major joint replacement= Target

  Chronic Obstructive pulmonary disease morbidity = Target

  Coronary heart disease and stroke morbidity= Targets

  Diabetes related morbidity= Target

  All cancers morbidity= Targets

  Infectious Diseases (e.g., HIV/Hepatitis) morbidity= Targets

  Chronic Kidney Disease morbidity= Target

  Arthritis, Osteoporosis and chronic back conditions morbidity= Targets
- Does the option adequately address the acute medicine population and it geographical service needs?
- Does the option demonstrate how it will maintain acute medicine capability in the transition from short to long term?

CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS

Special Emphasis Programs:

Seriously Mentally Ill/PTSD/Homeless/SCI/
Substance Abuse/Blind Rehab/TBI/
Readjustment Counseling/Gulf War/Prosthetics
Beds|Clinics|Clinical Services

Evaluation Criteria for Service Delivery Options:

- Does the Service Delivery Option provide sufficient quantitative and qualitative evidence to define how it will distribute and size Special Emphasis programs?
- Does the Option demonstrate how Special Emphasis program requirements will change over time?
- Does the Option demonstrate how it will meet the current and target clinical measures below? These are a representative sample of measures associated with special emphasis programs.
- Does the Option demonstrate how it will meet the target clinical measures below? These are a representative sample of measures associated with special emphasis programs.

  Amputee LOS efficiency-Rehab Bed Units= Target
  TBI Functional Gain-Rehab Bed Units= Target
  Stroke Functional Gain= Target
  Blind Rehab Functional Gain= Target
  SCI Inpatient Satisfaction= Target
  SCI Discharges to the community= Target
  Seriously Mentally Ill increase availability of Mental Health Intensive Case Management= Target
  Functional Improvements as measured by ASI= Target
  Independent Community Living Gain= Target
  Employment after discharge= Target
- Does the option adequately address the special emphasis program population and it geographical service needs?
- Does the option demonstrate how it will maintain special emphasis program capability in the transition from short to long term?

CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS

Extended Care Services:

Nursing Home Care/Domiciliary **Beds**

Adult Day Hospital/Home Care/Assisted Living **Clinics|Clinical Services**

Evaluation Criteria for Service Delivery Options:

- Does the Service Delivery Option provide sufficient quantitative and qualitative evidence to define how it will distribute and size Extended Care services?
- Does the Option demonstrate how Extended Care service requirements will change over time?
- Does the Option demonstrate how it will meet the current and target clinical measures below? These are a representative sample of measures associated with extended care diagnoses.
- Does the Option demonstrate how it will meet the current and target clinical measures below? These are a representative sample of measures associated with extended care diagnoses.

  Geriatric Psychiatric admissions/BDOC per thousand (Admission/BDOC projections by age/sex cohort and priority sub-category)= Target

  Nursing Home admissions/BDOC per thousand (VA/Non VA) (Admission/BDOC projections by age/sex cohort and priority sub-category)= Target

  Domiciliary admissions/BDOC per thousand (Admission/BDOC projections by age/sex cohort and priority sub-category)= Target
- Does the option adequately address the extended care population and it geographical service needs?
- Does the option demonstrate how it will maintain extended care capability in the transition from short to long term?

CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS

Mental Health Services:

Psychiatry **Beds**

Drug/Alcohol/Day Treatment/Mental Hygiene **Clinics|Clinical Services**

Evaluation Criteria for Service Delivery Options:

- Does the Service Delivery Option provide sufficient quantitative and qualitative evidence to define how it will distribute and size Mental Health services?
- Does the Option demonstrate how Mental Health service requirements will change over time?
- Does the Option demonstrate how it will meet the current and target clinical measures below? These are a representative sample of measures associated with mental health diagnoses.
- Does the Option demonstrate how it will meet the target clinical measures below? These are a representative sample of measures associated with mental health diagnoses.

  Psychiatric Admissions/BDOC per thousand (Admission/BDOC projections by age/sex cohort and priority sub-category)= Target

  Substance Abuse Admissions/BDOC per thousand (Admission/BDOC projections by age/sex cohort and priority sub-category)= Target

  Follow-Up after Hospitalization for Mental Illness= Target
- Does the option adequately address the mental health population and it geographical service needs?
- Does the option demonstrate how it will maintain mental health capability in the transition from short to long term?

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CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS

DETERMINE VETERANS SATISFACTION AND PREFERENCES

- Survey VSO and other stakeholders. Further, randomly survey enrolled veterans in each VISN Market. Survey all enrolled veterans or by Priority Level Subgroup. Determine User Satisfaction with various service delivery options. Service Delivery Options will be evaluated on how well they meet the concerns identified in the most recent customer satisfaction survey

Evaluation Criteria for Service Delivery Options:

- Does the proposal address VSO and other stakeholder concerns resulting from implementation of the service delivery option?
- What evidence does the proposal provide (e.g. focus groups, surveys, gap analysis, etc.) that the service delivery option improves customer satisfaction for Access?
- What evidence does the proposal provide (e.g. focus groups, surveys, gap analysis, etc.) that the service delivery option improves customer satisfaction for Continuity?
- What evidence does the proposal provide (e.g. focus groups, surveys, gap analysis, etc.) that the service delivery option improves customer satisfaction for Quality?
- What evidence does the proposal provide (e.g. focus groups, surveys, gap analysis, etc.) that the service delivery option improves customer satisfaction for Communication?
- What evidence does the proposal provide (e.g. focus groups, surveys, gap analysis, etc.) that the new delivery option improves customer satisfaction for other issues or areas?

IMPROVE VETERANS ACCESS TO SERVICES

- The proposal will be evaluated for impact on access across the five categories of care. Relative weights will be assigned for each of the five categories of care and then multiplied by the percentage of total customers in each category. Within each category a relative weight for driving time and the availability of the program or service will be established

Evaluation Criteria for Service Delivery Options:

Ambulatory Care Services

- Does the service delivery option meet or exceed the 30 days scheduling requirement for Primary Care appointments?
- Does the service delivery option meet or exceed the 30 days scheduling requirement for Specialty Care appointments?
- Does the service delivery option meet or exceed the 20-minute ambulatory care requirement to be seen?
- Does the service delivery option meet or exceed the 30-minute ambulatory care driving time requirement?

Acute Medicine Services

- Does the service delivery option meet or exceed the 1-hour inpatient acute care driving time requirement?
- Does the service delivery option meet or exceed the *XX* days scheduling requirement for acute medicine inpatient care services?

CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS

Special Emphasis Programs

- Does the service delivery option meet or exceed the 20-minute special emphasis program ambulatory care requirement to be seen?
- Does the service delivery option meet or exceed the 30-minute special emphasis ambulatory care driving time requirement?
- Does the service delivery option meet or exceed the 2-hour special emphasis program inpatient care driving time requirement?
- Does the service delivery option meet or exceed the *XX* days scheduling requirement for special emphasis program services?

Extended Care Services

- Does the service delivery option meet or exceed the 2-hour extended care driving time requirement?
- Does the service delivery option meet or exceed the *XX* days scheduling requirement for extended care services?

Mental Health Services

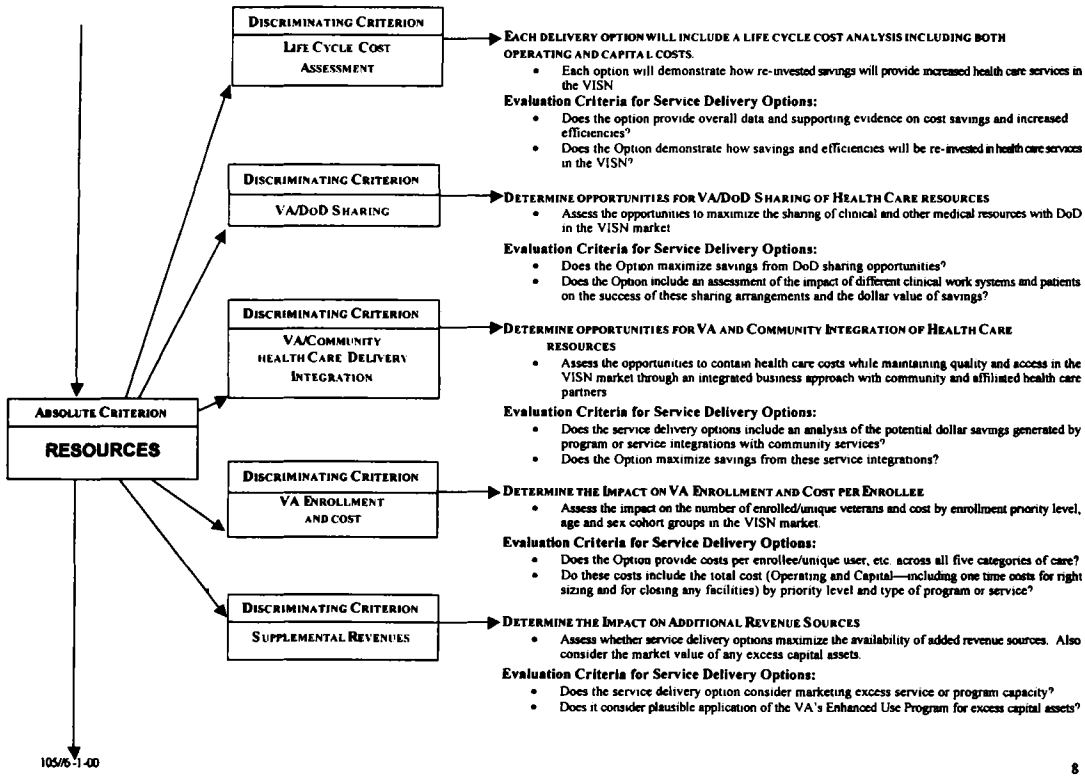
- Does the service delivery option meet or exceed the 1-hour inpatient acute care driving time requirement?
- Does the service delivery option meet or exceed the 30 days scheduling requirement for mental health outpatient care appointments?
- Does the service delivery option meet or exceed the 20-minute outpatient care requirement to be seen?
- Does the service delivery option meet or exceed the 30-minute outpatient care driving time requirement?

In addition, the following access criteria will be applied:

- Is the service delivery option geographically broad enough to effectively serve our present and future enrollees and the veteran population at large?
- Does the service delivery option directly support patient care coordinated by one clinician or a specific group of clinicians?
- Will the option maintain capacity and improve access to SCI, SMI, Homeless, Gulf War Veterans, Blind Rehabilitation, etc.?
- Does the service delivery option maintain or increase the number of enrolled Veterans/Unique Users in the VISN market?

CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS



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CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS

ABSOLUTE CRITERION

EMPLOYEE AND COMMUNITY IMPACT

DETERMINE THE IMPACT ON VA EMPLOYEES AND FAMILIES AND THE ECONOMIC BASE OF THE VISN MARKET

- Assess the impact on employees by the service delivery options, i.e., RIFs, realignments, adjustments, clinical retirements and succession planning, etc. and the impact on local communities. The service delivery options will be evaluated on the degree they mitigate adverse effects on current and proposed employees. The service delivery option will be evaluated on how completely it quantifies the adverse impact on employees (terminations, relocations, etc.). Service delivery options should include plans with detailed steps for mitigating the effect for employees that are leaving as well as the remainder of the workforce.

Evaluation Criteria for Service Delivery Options:

- Does the plan quantify impacts on current employees?
- Does the plan provide evidence that they anticipated the employee's reaction to the new service delivery option?
- Does the plan provide sufficient evidence that the new workforce can continue to function effectively?
- Does the plan provide the necessary steps to minimize the negative impact on current employees?
- Does the service delivery option clearly demonstrate an understanding of the economic, social, environmental and political impacts on the community?
- Does the service delivery option include a plan to minimize any adverse consequences on communities affected?

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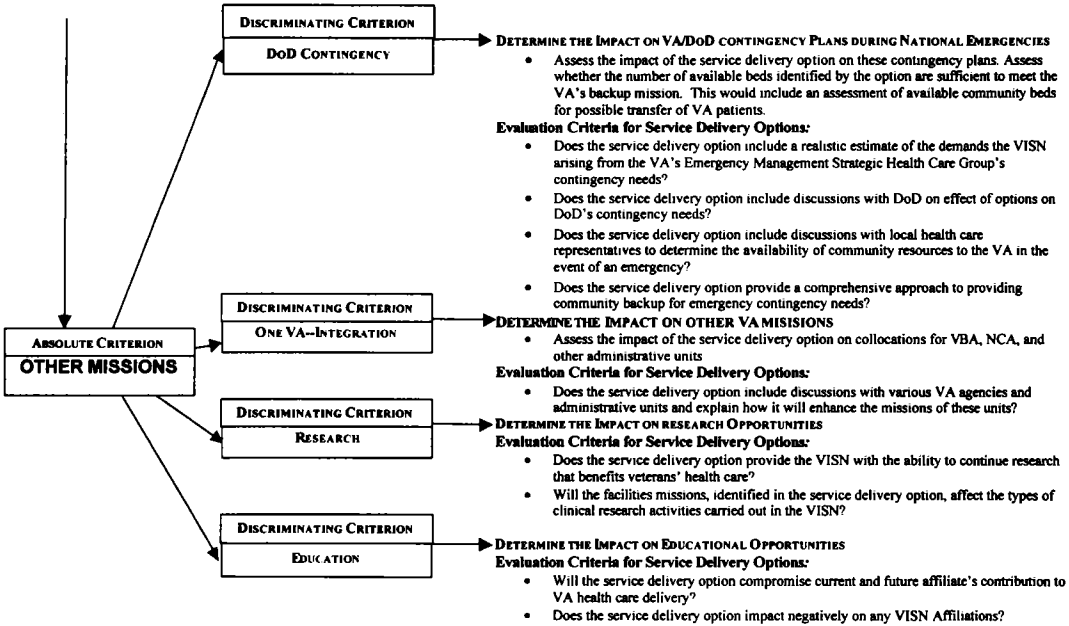
CARES EVALUATION CRITERIA

ABSOLUTE & DISCRIMINATING CRITERIA FOR EVALUATING SERVICE DELIVERY OPTIONS



Statement of Representative Luis Gutierrez
House Committee on Veterans' Affairs
Subcommittee on Health
Hearing on VA Capital Asset Planning
April 5, 2000

Thank you, Mr. Chairman. I thank the witness for joining us here today. I am pleased that the Veterans' Affairs Subcommittee on Health has convened this hearing to revisit the subject of the management of health care assets within the Department of Veterans Affairs.

As we know, last year our subcommittee held a hearing on this topic. We learned that the Veterans Health Administration could enhance veterans' health care benefits if it reduced the level of resources spent on underutilized or obsolete VA buildings and reinvested the savings in more modern facilities. I strongly believe that VA must carefully evaluate and scrutinize any proposal to shut down facilities before taking any action. Any consolidation proposals must include long-term plans for VA health care to ensure that buildings that are closed or demolished are replaced Otherwise, we will begin to see an irreversible trend of downsizing of the VA and a total shift of care to outpatient clinics.

In my home town of Chicago, the VA contracted for a study, at a cost of about one million dollars, to determine a feasible plan to improve and consolidate the delivery of health care for Chicago and suburban veterans. By adopting such a plan, the VA hoped to save money and make medical care more accessible and efficient. Unfortunately, the steering committee's recommended realignment plan was flawed. Their recommendation would separate acute inpatient medicine, surgery and neurology from chronic programs such as psychiatry and spinal cord injury and would transfer these services from four hospitals to one, located right in downtown Chicago. The study failed to consider accessibility to the main hospital for veterans, particularly the elderly and disabled. The study also failed to include a serious analysis of the impact of clinical restructuring on scientific research and medical training and education. Needless to say, it was opposed by practically every member of the Illinois Congressional delegation, both of our Senators and thousands of veterans, doctors, nurses and other VA stakeholders.

Mr. Chairman, the veterans population is aging and increasing. We must make sure we can accommodate this growing population in the future. Any realignment decisions being considered or adopted must make certain that the core missions of the VA health care system, including specialized services such as blind rehabilitation and spinal cord injury care, are protected and enhanced. Additionally, any realignment plans must put the interests of veterans above all else and any such plan must not be done just for the sake of saving money.

Finally, despite last year's $1.7 billion increase in the VA budget, many veterans must still wait months for medical visits, services are being eliminated at many of our nation's veterans hospitals and the number of doctors, nurses and medical staff at our VA hospitals are being reduced. This is unacceptable. I encourage my colleagues to support an increase of the Fiscal Year 2001 VA budget that matches last year's increase at the very least. Thank you.

Statement of Congressman Chris Smith (NJ-04)

"Assuring State-of-the-Art Medicine for Veterans Without Compromise"

April 5, 2000

It is my pleasure to be here this morning to contribute to the dialogue on a vital issue facing veterans and the Department of Veterans' Affairs how to ensure that the medical needs of former service men and women are comprehensively met while modernizing the VA health care system The issue raised by the VA's Capital Asset Realignment for Enhanced Services (CARES) process is of major significance because it involves both the financing and distribution of care critical to veterans

There has been considerable discussion of what is meant by "realigning" or "restructuring" VA's delivery of health care as part of CARES, and what is the most equitable way of doing this I am open to the VA's providing care through different and innovative ways As with medicine in general, for example, there is a major shift underway in the Veterans Health Administration (VHA) from providing care in hospitals to providing it in outpatient clinics or in the patient's home As a result of this change, state-of-the-art health care services are now being performed in more efficient settings, often on a same-day basis And while there are a number of different, and sometimes conflicting opinions about how to restructure VHA's assets in light of this change in medical practice, *the bottom line is that restructuring must not in any way incorporate any cut or decrease in the quality of services available to veterans* It is only fair that health care services provided to the men and women who have served our country so loyally be enhanced and in no way jeopardized

As we embark on re-evaluating how to distribute the VHA's resources in the most fair and efficient manner possible, it must be made clear that any savings that result from restructuring should be kept locally By making sure that savings are re-invested in the same Veterans Service Integrated Network (VISN) where they originated – or, at the very least, in the same state – we can guarantee the excellence of continuing patient care for veterans

In addition, I firmly believe that a re-evaluation of health care delivery within the VA must be done on the basis of *need* – not on the basis of cost If it is based solely on cost, then financial expediency – and not the best interests of veterans – will prevail

I know that in the case of the Veterans Clinic in Brick, New Jersey, which is in my district, the attempt to apply a cost-based evaluation to health care delivery was nearly disastrous The VA sought to reduce specialty services at the Brick Clinic in an effort to reduce costs, but this contradicted the Department's own strategy of providing care in multiple outpatient settings It made no sense to eliminate specialty services at the Brick Clinic, since veterans would have had to travel unacceptably large distances to get the care they needed Thankfully, the speciality services at the Brick Clinic were not terminated

This example illustrates the need for incorporating the views of veterans service organizations (VSOs) into the CARES process Since the VSOs work with veterans and know their needs, it is only common sense that we consider their comments on any proposal to alter the delivery of health care within the VA The VSOs should have the opportunity to provide extensive input at every step of the re-evaluation process With that in mind, I look forward to hearing the testimony of representatives from the American Legion and Veterans of Foreign Wars (VFW) this morning

I believe that every attempt must be made to meet the medical needs of veterans In the future this will require adapting to state-of-the-art medicine, which is now moving in the direction of outpatient diagnosis and care

PREPARED STATEMENT OF HON. HELEN CHENOWETH-HAGE

Chairman Stearns, I would like to thank you for holding today's hearing. I appreciate Chairman Stearns' strong commitment to removing waste in the VA healthcare system, and would like him to know that I support his efforts.

I am dismayed the Clinton/Gore Administration continues to mismanage resources intended to improve the health care of our veterans. As you recall, Mr. Chairman, the General Accounting Office (GAO) reported in a March 10, 1999 Subcommittee on Health hearing that the Department of Veterans Affairs (VA) spends one of every four dollars operating facilities and not on providing actual health care. In fact, the report projected that the VA will spend billions over the next 5 years in operating hundreds of unneeded buildings.

Despite this shocking report, thirteen months have passed and the VA still has not implemented changes. According to the GAO, the VA "has been unsuccessful over the past 13 months" in realigning the system.

Mr. Chairman, exactly how much has the Clinton/Gore Administration stolen from our veterans' to fund the bureaucratic jungle? At $1 million per day multiplied by 13 months, this Administration has cost our veterans' $461 million in wasted health care. And even worse, this Administration wants to take $350 million from the Veterans' Millennium Health Care Act and return it to the U.S. Treasury to spend on bigger government. In other words, Mr. Chairman, this Administration wants to undo the $1.7 billion in veterans' health care that Congress passed last year.

I appreciate Chairman Stearns' leadership in making the VA, and ultimately the Clinton/Gore Administration, more accountable to our veterans. This Administration must know they cannot continue to ignore their needs.

Thank you for Chairman Stearns for giving me this opportunity.

STATEMENT OF LANE EVANS
RANKING DEMOCRATIC MEMBER
HOUSE COMMITTEE ON VETERANS AFFAIRS
AT SUBCOMMITTEE ON HEALTH
HEARING ON VA CAPITAL ASSET PLANNING

Thank you Mr. Chairman and Ranking Member Gutierrez. I am pleased you have convened this hearing. There is surely no issue that will challenge the Department of Veterans Affairs (VA) Medical Care system more in the future than making the best use of its resources to meet veterans' health care needs. Last year, at about this time, the General Accounting Office (GAO) testified that the Veterans Health Administration "wastes" a million dollars a day in maintaining unused and underused assets. While that GAO study has certainly helped policymakers understand the formidable task faced in making VA's assets more productive, we should recognize this particular and oft-stated finding as, at least, an oversimplification. If we could create significant savings by razing some unused buildings, we wouldn't need to have this hearing.

Instead, we are here again today because we recognize the difficulty of planning for the best infrastructure to meet veterans' health care needs. We must ensure that VA is making the best investments today to meet veterans' needs tomorrow. Unfortunately, often these decisions are made with limited information. To bring a little more clarity to the situation, let's lay out the facts (much of it from the GAO study):

- We have an aging infrastructure. Sixty percent of VA's 4700 buildings are more than 25 years old. At this age, construction projects are necessary to maintain the safety and usefulness of buildings now fulfilling purposes for which they were never intended.
- We have lots of buildings (>75%) that are not being used to provide health care; about 30% of the buildings are used for purposes other than health care, health care support, or administration.
- Within VA's health care facilities, there is currently much unused inpatient capacity—about 62% of medicine, 56% of mental health and 17% of long term care beds are unused.
- We have an evolving health care environment. We all know about the shift from inpatient care to ambulatory care, but more care is also taking place in people's homes.

- We have a growing population of veteran users who are older and sicker than the general population. As a population, veterans who use VA are more likely to be poor, more likely to be homeless and less likely to have intact social networks which might facilitate effective home care and chronic disease management.
- VA's populations are not necessarily where VA's health facilities are—there are several large cities (such as Sacramento and Jacksonville) that lack VA medical centers. Conversely, there are some locations that have multiple VA medical centers.
- There is an increasing tendency to contract for services for veterans. VA is outsourcing much of its primary care capacity. Primary care takes place in 388 community-based outpatient clinics about half of which are not operated by VA.
- VA is beginning to outplace its inpatient capacity; VA now refers inpatient care to community hospitals in Northern California and Nebraska. We will hear Mr. Weldon speak to another pilot project that has just been completed in East Central Florida.
- VA is outsourcing more of its long-term care to community nursing homes (for more limited amounts of time) and to State Homes—many of which are at or near capacity, and in need of significant renovation as well. It is using its own nursing homes for more restorative, rehabilitative, and palliative care, rather than the traditional custodial care it once offered. VA will also refer much of its non-institutional long-care to external providers.
- Some VA programs are truly unique and cannot be found in the private-sector. VA has identified these programs, which it refers to as its "special emphasis programs". Because these programs are unique, maintaining their capacity and the online services to support them must be a paramount consideration in any restructuring scheme.

Here's what we don't know:

- No one has done a meaningful needs assessment to determine how many high-priority (Category A) veterans would use VA medical centers if they were more accessible. We also don't have a clear idea of how many veterans need services such as non-institutional long-term care, nursing home care, and long-term mental health care services. We do have a pretty good fix on the amount of care that current users have consumed in the past, which is quite a bit. However, only about 10-15% of high-priority veterans use VA medical centers,

and each opening of a Community Based Outpatient Clinic indicates that high priority veterans' demand is not satisfied.

- There has not been a thorough analysis of what services and programs veterans need from VA and how well VA is meeting these needs—particularly for long-term care services and mental health. The last survey of VA Medical System Users is now 10 years old, but even at that time—and veterans have aged since—1/3 of all veterans required help with at least one basic life activity or independent living activity. This sort of assistance is strongly associated with the need for some type of formalized care delivery, particularly if veterans lack informal support.
- Are the displaced seriously chronically mentally ill veterans the system once admitted to psychiatric long-term care beds still receiving care from VA and is VA meeting their needs as well as custodial long-term care was?
- Differences in veterans' use of and needs for health care compared to the use and need for health care in the general "mainstream" population—are some managed care principles really effective ways to deliver care to a population that is aging and has lots of chronic disabilities?
- There is no clear inventory of community resources that are on hand to meet needs VA cannot fulfill.
- What is the critical mass of veterans who must use certain VA services in order to ensure high quality? If VA programs are operating without this mass; can VA "share" services with other partners—the military, academic affiliates, or others—who may need them?

We may not have all of the information we need to answer these questions, but we should obtain as much data as reasonably possible to make these decisions. A thorough national needs assessment will give us better information to address the important planning processes VA will undertake in the near future. Based on this information, VA's Headquarters must decide what portion of the need of veterans for each service it will meet. Primary care, acute inpatient care, mental health care, special emphasis programs, including women's health care, mental health care, nursing home care and other long-term care services should all be assessed. VA's current capacity to treat veterans and its expectations about future funding should certainly play into the decisions that are made. Given these parameters developed by HQ and better information about the needs of the population, Networks can then make much more informed decisions about infrastructure needs now and in the future. But Networks must make these decisions based on the populations VA serves (or should serve) and not the facilities it currently has in place. VA's growth strategies might be better coordinated to ensure that VA retains funds to

maintain a high-quality and accessible full continuum of services. VA could make more knowledgeable investment decisions about physical plant, contracting, and other health care delivery issues as a result. I strongly reject the proposition that these types of decisions must be made by a BRAC-like Commission. Just like VA consultants, individuals who do not understand VA facilities or veterans' needs should not be making these difficult decisions.

VA has made good use of certain performance measures to create consistency in health care delivery around the system. Setting reasonable market share targets for various services could accomplish the same goals of consistency by making it clear to network directors how many veterans they are responsible for accommodating. Market share goals should be developed under the advisement of stakeholders and advisory groups such as the Federal Advisory Group on Long-term Care, the Women Veterans Advisory Group, the Advisory Group on Prosthetics and Special Disabilities, and the Advisory Group on Seriously Mentally Ill Veterans. These groups will bring special focus to special emphasis programs, for which there may not be reasonable or comparable alternatives in the private sector.

VA's performance of a national needs assessment could help VA identify the gaps in its programs so it could better assess the resources that are needed to fill them before labeling them as "excess". It would also indicate if VA had enough resources to provide all the care required.

We all know that VA cannot be all things to all people, but it should at least recognize what it can and cannot do and budget and plan accordingly. I am concerned that VA's CARES Initiative is not looking at veterans' need in a formal way. Instead, it leaves to its consultants fundamental decisions about how much demand should be met, how the system will use beds, and whether VA's patients should be treated in VA programs or outside of VA. These are decisions that must be made by the policymakers that know VA best—VA's leadership.

Without stronger guidance from VA, we will surely encounter more confusion in the future. From the perspective of this "stakeholder", we have certainly had flawed data assumptions in the strategic plans I have reviewed thus far. Often assumptions are based on "leaps of faith", and, thus, are indefensible. This was a significant underlying problem in the VISN 12 Study Options. VA built its models for determining how many beds it needed by reducing bed utilization to a standard that few providers have ever met. It assumed less use of special emphasis services and long-term care without understanding how much of the need VA currently

meets or, even suggesting how much should be met. These assumptions led to a model most agree had significant flaws—too few beds and not enough space to carry out mission-critical goals, such as medical education and research. I have similar concerns about the plan I recently reviewed for Ft. Lyon in VISN 19. The plan accommodates the veterans now being served in Ft. Lyon, but does not look at future expectations of demand for long-term care and how VA might help to satisfy this demand. At this point, it appears the Ft. Lyon VA facility is likely to be turned over to the State, but I know of no alternative plan for filling the gap the closure of Ft. Lyon will leave in addressing the network's long-term care needs.

Given the physical plant all network strategic plans must realistically accommodate, each network must decide how each of its facilities and the buildings within them contribute to market share goals. If the physical plant is not adequate to meet these goals there are options to either realign resources, construct, contract for the care, or some combination of these. Similarly, it can look for ways to consolidate or use enhanced sharing to address underutilized resources.

VA must understand what holes exist in its safety net BEFORE it undertakes its CARES initiatives, Enhanced Use, and Enhanced Sharing programs. Should it lease two floors of its acute care facility to an outside provider, when it is not meeting its veterans' needs for long-term care and mental health services? VA will indicate that Reno VA Medical Center is doing just that. Should it continue to generate new demand by launching additional Community Based Outpatient Clinics when demand for long-term care and mental health care may be going unmet? These are important questions we could better address given some serious consideration about the veterans we are attempting to serve and those we will attempt to serve in the future. Creating market share goals for many of its services will create uniform access across the system and give network directors better guidance about services it must offer. Their ability to meet these service goals can then be evaluated accordingly and it will bring more consistency and uniformity to programming—particularly for programs that are sensitive to shifts in funding—across the VA system. This will bring some logic and rationale to the difficult and important planning process VA is about to undertake.

Thank you, Mr. Chairman. This concludes my statement.

TALKING POINTS
Congressman Ciro D. Rodriguez
VA Health Subcommittee Budget
April 5, 2000

Mr Chairman,

I commend the Committee for following up on last year's hearing by holding this today. I have additional remarks which I would like to be made part of the record.

As we continue the fight for strong VA budget, we must ensure that the Construction budget is being spent wisely. Unfortunately, I am not so sure this is happening.

When you mention VA facilities in South Texas, the first thing that comes to people's mind is travel distances. While CBOCs have made some impact on delivery, much needs to be done.

Laredo and McAllen are not even in my district, but their population justifies a hospital down there.

Try explaining to veterans down there why the VA is spending $1 million per day on unused facilities and

then you will see why we need to do something now.

One specific area where I see the need for efficiency is the veterans homes construction program. While Texas is a new-comer to this area, we will be working hard at attracting future dollars under the new regulations. We must be sure that the money is going to areas that genuinely need it.

I recognize that most of the VHA budget is for staff, but the overhead for facilities is around 25%. While costs continue to rise, service has gone down.

I have included in my statement an assessment by AW Hec, Inc in Texas on one way to reduce costs and improve service by utilizing new technology. I believe we must look at these another imaginative solutions to bring service to an acceptable level.

I look forward to working with the Committee in coming up with new ways to maximize our health care dollars.

Information Provided by A.W. Hec, Inc.

The Symptoms of the Problem

? Congressional Investigators
- Found that the V A. is wasting $1,000,000 per day on unneeded facilities
- Concluded that the V A.'s proposals to fix their problems are unlikely to work
- Were critical of the V A.'s effortrs to form local committees to solve problems

? The General Accounting Office found that
- The V A. could rely heavily on those special interest -- called stake holders -- "*who may have vested interests in maintaining the status quo*"
- 25% of the V A.'s budget is for buildings, management, and maintenance
- Other problems cited

? The Under Secretary for Veterans Affairs for Health found that
- 66 6% of the budget is for STAFF only
- They need 300 new clinics
- They need a major reorganization in the structure of health care

The Analysis of the *Root Cause* of the Problem

? 50% to 60% of health care costs are non-medical

? Past attempts to curb health care costs have failed. Moreover, quality has fallen off

? The only way to lower costs and to increase care is to reduce the non-medical expenditures

The Conclusion

? In order to reduce non-medical costs, there has to be a change in the system of non-medical services. The country thus faces a stark question. Are we willing to make a change in order to lower the cost of medical services to veterans and, at the same time, increase the capacity for medical services to the veterans?

History as a Guide:

In most cases of major management failure, the current management does not have the ability to solve its own problems and operate efficiently

"This causes management to resort to temporary quick fixes to address the more pressing problems and to bolster near term performance. In place executives have no experience in

transforming a business (just improvements and changes -- adjusting). They only understand the techniques of operating a business. They add incremental changes or adjustment, not innovation." Discipline of Market Leaders

This is exactly the case with the health care system, both within and outside the V.A. Executives who operate the business are making incremental changes and adjustments when they should be working toward a major overhaul. This short-term fix-it strategy is expensive and only adds to the complexity of an already under-performing operation -- exactly the symptoms found by Congress and the Executive branch.

The Solution

? Implement the Octopus system

What is the Octopus system?

Octopus is the invention of a highly efficient medical clinic. Octopus directly addresses both cost and supply -- the underlying market forces that drive up health care costs. The Octopus system is an automatic management system that includes architectural and management changes to enhance substantially the productivity of medical personnel without incurring the high cost of conventional non-medical expenses. By the nature of its highly efficient design, Octopus addresses cost and supply by delivering more health care per patients per

? Square foot
? Medical practitioner
? Administrative person

Here is the bottom line

	105 Octopus Clinics	Current V.A. System
Number of Employees.	**2520**	**189,000**
Patients Treated Per Day	**21,000**	**21,000**
Number of Patients	**2,948,077**	**2,948,077**
Patient-visits per Year	**7,655,000**	**7,655,000**
Yearly Physical Exams	**2,406,080**	**—**
Class Openings per Year	**7,519,000**	**—**
Veteran Access Opportunities	**17,444,080**	
Budget	**(est.) $420,000,000**	**$17,000,000,000**

Octopus can deliver. The U.S. Patent Office found the Octopus system to be both novel and workable. Octopus clinics *are* the solution to the problem

STATEMENT OF THE HONORABLE ROSA L. DeLAURO
HOUSE VETERANS AFFAIRS HEALTH SUBCOMMITTEE
CAPITAL ASSET PLANNING HEARING
WEDNESDAY, APRIL 5, 2000

I would like to thank Chairman Cliff Stearns and Ranking Member Luis Gutierrez for the opportunity to testify in support of a critical veterans' hospital construction project in West Haven, Connecticut. As the daughter of a veteran, I also want to thank the subcommittee for holding this hearing on the capital investments needed to address the important health priorities of the men and women who have so bravely served our nation.

Our nation owes our veterans a tremendous debt. These courageous men and women set their own lives aside and came to the defense of their country, whether in World War I, World War II, Korea, Vietnam, or the Gulf War. It was their dedication that ensured the freedom and opportunity that are the cornerstones of our society. In times of peace, we must not take this freedom and opportunity for granted – that would be a grave mistake

The VA health services system is one of the most significant means we have of paying back the enormous debt we owe our veterans. VA hospitals have helped these men and women come to terms with and triumph over the painful physical and mental scars of war All of our veterans must be guaranteed quality health care.

I urge your support for $13.8 million to substantially upgrade and rehabilitate three in-patient nursing wards at the West Haven Campus of the VA Connecticut Healthcare System, and the consolidation of associated support services. The existing wards fail to meet current space and air quality criteria for intermediate care wards, and do not address patient privacy issues. They also pose significant safety threats to our veterans due to equipment being stored in the hospital corridors

This project would renovate the existing 119 circa-1950s in-patient beds, streamline the wards, realign support services, and address serious infrastructure problems. The project would also enable the West Haven Campus to significantly improve the access of female veterans to privacy during their stays at West Haven. Overall, it will positively impact the quality and timeliness of the care provided by the VA Medical Center. Without these improvements, VA Connecticut cannot provide our hospitalized veterans with a modern and efficient environment conducive to healing

Due to the recent focus on environmental enhancements and construction related to out-patient care, the Veterans Health Administration has not supported funding for this project – leaving these fifty-year old wards to deteriorate. All of our veterans deserve to receive the same high level of care that they sacrificed so much for. It is vital that the renovation of these inpatient nursing wards become a reality. I look forward to working with the Subcommittee on this important construction project and on all future efforts to protect the health and well-being of our veterans.

BART GORDON
6TH DISTRICT TENNESSEE
COMMERCE COMMITTEE
SCIENCE COMMITTEE
RANKING MEMBER
SUBCOMMITTEE ON SPACE

Congress of the United States
House of Representatives

2368 RAYBURN BUILDING
WASHINGTON, DC 20515-6206
(202) 225-4231
FAX: (202) 225-8897

106 SOUTH MAPLE STREET
P.O. BOX 1986
MURFREESBORO, TN 37133
(615) 896-1986
FAX: (615) 896-8218

17 SOUTH JEFFERSON STREET
P.O. BOX 1160
COOKEVILLE TN 38501
(931) 526-5907

Statement of the Honorable Bart Gordon

Subcommittee on Health

Committee on Veterans' Affairs

Hearing on Veterans' Affairs Capital Assets

April 4, 2000

Mr. Chairman and members of the Subcommittee:

I appreciate the opportunity to testify before you this morning in the hope that we can correct what has been described to me as an "oversight".

Last year, this committee developed and passed comprehensive VA authorization legislation. Unfortunately, the Conference Report did not include a provision authorizing the renovation and reconstruction of the psychiatric care facilities at the Alvin C. York Veterans Medical Center in Murfreesboro, Tennessee. The need and value of this project has already been recognized. Accordingly, I am here to request that this oversight be rectified so we can begin with the pending construction. The cost of these renovations will be approximately $18.7 million

As the son of a World War II veteran, I maintain a personal commitment to protecting the interests of those who have served our nation so selflessly. In my home of Murfreesboro, the Alvin C. York Medical Center and its employees have always strived to offer the best service they possibly can. In fact, my father worked as the hospital's groundskeeper for 27 years. I would hate to see the hospital fail in its mission because it did not receive the funding and support needed to fulfill current and future obligations.

Like you, I feel strongly that we have an obligation to provide the best possible health care to veterans who have served

email. bart.gordon@mail.house.gov Internet: http://www.house.gov/gordon/

our country. I am specifically interested in maintaining the highest level of care to veterans in my congressional district and throughout the State of Tennessee.

Alvin C. York VA Medical Center is one of only four VA hospitals in the state of Tennessee. And, these specific facilities house almost all of the veterans in need of psychiatric care in the State and to some degree the region. Alvin C. York provides quality medical care to veterans from Middle Tennessee and the surrounding area. If not for this facility, many veterans residing in the rural counties within my congressional district would likely go without the care they need.

Three years ago, the VA, HUD, and Independent Agencies Appropriations Subcommittee provided $2.3 million for the planning, design, and engineering of this construction project. Since that time, my staff and I have worked closely with the hospital, the VA regional office, and the Department here in Washington to ensure that the work was completed and the facility was ready to move forward with the construction.

Unfortunately, some changes in the scope of the project caused delays in the planning process. When this project was first conceptualized, the initial proposal was to completely rebuild the three buildings. However, in a time of fiscal responsibility, we all recognize that limited resources are available and in light of the budgetary constraints, we have changed our focus. Instead of looking to completely rebuild the existing structures at a cost of $29 million, our plan calls for the renovation of those buildings. It is estimated to cost $18.7 million to renovate the three psychiatric care buildings -- almost $11 million less than the previous proposal. Again, I am pleased to report that the planning, architectural design, and engineering has been completed and the hosptial is ready to move forward with the construction.

Last year, the Department of Veterans' Affairs budget request included funding for this project. As you know, following legislative actions by this committee the Department is required to systematically prioritize projects for their budget requests. I understand the weight that this Subcommittee places on the Department's requests and believe their endorsement and support only strengthens the argument for this project. In fact, the appropriators have already provided the funding to renovate two of three buildings. That is why it is critical that this project be authorized expeditiously. Everything is in place to begin the construction - all that is needed is an authroization.

This Committee and the Department of Veterans Affairs has

recognized the importance of quality and efficiency in a changing health care environment. This project would alleviate the severe space, functional and technical deficiencies by renovating the hospital's psychiatric nursing units in order to serve a larger veteran population. It will allow for privacy through the construction of private and semi-private rooms for patients and also provide private baths. This new privacy will allow for better accommodation of the increasing female veteran population.

The hospital's three health and behavioral psychiatric units have severe space deficiencies, as identified in the most recent VA facility development plan. Bedrooms exceed four patients per room. Little communal/recreational space exists. There is a lack of privacy, both in living quarters and in toilet/shower facilities. Nursing stations are crowded and congested due to inadequate size. In addition, the current facilities make it extremely difficult to accommodate female veterans.

As health care continues to be debated at both the national and local levels, a common concern focuses on improving the quality and accessibility of health care for rural America. We have an obligation to provide our veterans the best health care possible, whether they are living in a city or on a farm. This project will allow this hospital to not only continue its reach into the rural counties of Middle Tennessee, but also treat more of our nation's veterans in a more timely and effective manner.

In the sixteen years that I have served as the representative of the 6th district of Tennessee, this is the first time that I, or Alvin C. York Veterans Medical Center, have requested an authorization from this Subcommittee. Time has taken its toll on this invaluable facility and we must ensure its longevity. I am asking for your support so that this crucial resource to Middle Tennessee can be preserved and not left to deteriorate.

As you can see, we have made progress and are ready to begin the construction stage. I do not want this progress and hard work to be wasted. That is why I am here once again to ask that you fund the construction this year.

Thank you for this opportunity and your consideration. I would be glad to answer any questions.

Testimony of

Rep. Dave Weldon (Florida 15)

Mr. Chairman, I appear before you not only as a fellow Member but as a physician who volunteers regularly to treat veterans at the VA outpatient clinic in my district. I think I also bring a valuable perspective on VA capital asset planning which I'd like to share with you.

While I want to tell you about a project taking place in my district, I want to impress on you that it has the potential for broad application for veterans across the country. What I'd like to talk to you about briefly this morning is how the VA can provide better access to excellent quality medical care for veterans in districts like mine across the country. What marks my district is the fact that, while we have an outstanding outpatient clinic, veterans still need hospital care and must drive hours across the state to get VA hospital care. And, I'm talking about a population of veterans numbering more than 60,000 that are at least a two hour drive from a veterans medical facility.

To its credit, this Committee has studied the complex problems associated with VA capital asset planning. As GAO has noted, VA currently operates hospitals in areas which no longer have a sufficient veteran population for whom to provide care. Yet, the VA is obliged with dedicating precious health care dollars to maintaining bricks and mortar. The VA also faces demands for care in areas with a large veteran population where there is no nearby VA hospital.

I think the experience of my district offers some answers to both of these situations. The difficult situation we faced in my Congressional District led me to develop a legislative concept I would like to share with you.

As many of you may recall, veterans in my district were disappointed several years ago when Congress rejected a VA proposal to construct a hospital in East Central Florida (ECF). The VA had acknowledged the need in ECF for a VA hospital and proposed building a hospital there as early as 1983. Years of political haranguing kept the hospital a mere fantasy. Congress was on the verge of rescinding VA money allocated for this project the year I was first elected. I proposed at the time, realizing a hospital may never happen, that Congress appropriate funds for a new outpatient clinic. As a doctor, I knew that medical advances have allowed for many new treatments to be done in an outpatient setting. I felt it better to get most of the veterans' needs met rather than none, as was the current situation at that time.

The VA established an interim clinic which opened its doors in 1997 until the new, comprehensive Brevard County Outpatient Clinic opened its doors in July 1999. Finally, after literally decades of promises, the ECF area had received some VA medical care, medical care that could attend to nearly 85% of the veterans needs. But what about the remaining 15%?

At the time we authorized and appropriated funding for the outpatient clinic, I knew that the clinic would do a good job of meeting the outpatient needs. But I also believe we needed to move forward expeditiously with a plan to meet these veterans' inpatient needs. While veterans could travel for several hours to reach a VA hospital in Tampa or West Palm Beach, I believed it was important to give these veterans access to local inpatient facilities. Necessity being the mother of invention, I requested that the Congress appropriate up to $5 million to support a pilot project enabling veterans who were enrolled in the outpatient clinic to receive needed inpatient care at local hospitals.

Under this pilot, veterans were given a choice of receiving care at VA expense in a local hospital, or being referred to a VA inpatient facility in Tampa (several hours to the west) or in West Palm Beach (several hours to the south). The decision of where to receive care was left up to the veteran—the pilot program simply gave veterans more choices of how and where to receive treatment.

In order to receive care in a local community inpatient facility, the veteran had to be enrolled in the Brevard outpatient clinic for primary care. Enrolled veterans had to be referred for non-emergent, inpatient care by a VA outpatient clinic doctor. Also, the veteran could choose from any hospital with which the VA outpatient clinic had a preestablished arrangement for care.

Between July 1998 and October 1999, nearly 1,000 veterans in East Central Florida chose to receive care in local, community inpatient facilities. It is my understanding that of the veterans who chose to receive their VA care under this arrangement, 90 percent rated their care as excellent or good, while nearly all of them said that they would recommend this type of care to other veterans. It is also my understanding that the VA will soon release a report on the ECF pilot program indicating that this arrangement was not only well-received in the veterans community, but that it generated a significant cost-savings.

What the pilot in my District has demonstrated is that we can begin to think more creatively about ways to provide for the care of veterans. We have learned that a VA clinic can effectively manage the care of patients who elect to get needed hospital care in community facilities rather than driving long distances to a VA hospital. We have learned that community care can be an effective adjunct to VA-provided care. We have learned that the patients who participate in a well designed, coordinated care program are very satisfied with the arrangements and that such arrangements can have substantial cost-savings to them.

While I am advised that an independent evaluation of the east central Florida pilot is very favorable, contracting for hospital care is not the only way to build on the successes of that pilot. I think we should certainly take note, in that regard, of the numbers of veterans who rely on VA health care but are also Medicare-eligible. As this Committee has noted in the past, the VA appropriation effectively subsidizes Medicare in caring for large numbers of Medicare-eligible veterans.

The lesson I believe our pilot offers is that, in areas of the country in which VA does not operate a hospital, a VA clinic can coordinate veterans' care. Under current law, however, coordination of payments between the VA and other federal and private health care program is not permitted. This causes serious hardships for many veterans who live far from VA inpatient facilities.

It is with this background that I propose legislation to authorize a small number of pilot projects under which veterans with Medicare or other health plan coverage who rely on a nearby VA clinic for care but reside far from the nearest VA medical center could make a choice when VA finds that they need hospital care. Veterans who are reluctant to travel hours to a VA inpatient facility could elect to receive care at a community hospital as a Medicare or other health plan patient, with the VA's coordination. The local VA clinic would coordinate the effort to ensure quality care and cost oversight. To ensure that the patient does not incur out-of-pocket costs, the VA, under my bill, would cover required copayments. The experience of the Florida pilot strongly suggests that veterans would welcome such an option. It would have the benefit of providing for coordination of health care benefits, with the result that veterans who now often pick and choose between two or more health plans would get better, coordinated, and less costly care.

Let us look at a Medicare-eligible veteran for example. Under my proposal a veteran who is enrolled for primary care at the outpatient clinic would be given a choice when needing inpatient care. The veteran could make the several hour trip across the state to receive care in a VA medical facility where the VA would cover 100 percent of the costs. Or, the veteran could choose to go to a local community hospital where Medicare would pick up the 80 percent of costs they would have incurred had the patient gone to the local hospital on their own, and the VA would pick up any copayments. Under both arrangements the veteran incurs no cost.

My bill would ensure not only a coordination of payments, but coordination of the patient's care. I believe that, for areas of the country that are distant from VA medical centers, linking a VA outpatient clinic with greater choices in inpatient care could serve as a model for providing better service to veterans. I believe that as this committee considers VA capital asset issues it will find that pilot programs employing this model may offer an innovative new mechanism to improve veterans' access to needed care. It will facilitate ready-made solutions in underserved areas, and will allow for more cost-effective approaches in areas that today require unusually high maintenance of effort per patient within the VA system.

Mr. Chairman and members, we have seen significant changes in the delivery of health care over the past two decades, particularly in shifting what were once inpatient services to outpatient services. There are other changes in delivery that are taking place and I believe veterans in underserved communities are in a unique position to take advantage of these innovations, provided we move forward with legislation that permits it.

As a former Army physician who now delivers care to veterans in an underserved area, I know how important it is that we move forward with these innovative approaches to delivering care.

Mr. Chairman, I appreciate your giving me the opportunity to testify, and hope there will also be an opportunity to work with the Committee to move legislation which would enable us to test this concept. The veterans of east central Florida are excited about it, and I believe veterans in other areas would be as well.

DALLAS VETERANS MEDICAL CENTER
MENTAL HEALTH ENHANCEMENTS PROJECT

Testimony of
Congresswoman Eddie Bernice Johnson

U S. House of Representatives

Committee on Veterans Affairs
Subcommittee on Health

April 5, 2000

Mr. Chairman and distinguished Members of the Committee, I appreciate the opportunity to appear here today to discuss the Mental Health Enhancement project of the Dallas VA Medical Center (VAMC).

The Dallas VAMC has long-standing space and functional deficiencies in its 60-year-old Mental Health facilities. The Mental Health Enhancement project is the highest priority for major construction assistance for the Medical Center and Veterans Integrated Services Network (VISN) 17. The Medical Center has sought major construction assistance for over 10 years. Although this $27.6 million project consistently ranks among the VA's top 10 highest priority health care major construction projects for funding, the Office of Management and Budget (OMB) limits on the level of VA major construction funding have prevented its inclusion in the FY '96, '97, '98, '99, or 2000 budget submissions to Congress.

The House voted in 1996 and 1998 to authorize construction of these sorely needed Mental Health facilities at the Dallas VAMC. After having authorized this project for the last five years, the time has come to finally include this project in the next VA construction appropriation bill.

This project involves the construction of a 120,000 gross square foot, multi-level Mental Health addition atop an existing two level Ambulatory Care building. This project will enable new construction to aid in the consolidation of Mental Health outpatient programs with a downsized Mental Health inpatient-nursing program. These new facilities will meet all applicable VA and community standards. The following Mental Health programs are included in the scope of this project: Mental Health Clinic; Outpatient Substance Abuse; Day Treatment Center; Day Hospital; PTSD Program; Physical Medicine and Rehabilitation treatment space; 72 Inpatient Psychiatric Beds (reduces current 118 bed program by 40%); and VA Psychiatric Clinical Diagnostic Laboratory.

The following statistics compiled by the VA itself, only prove the dire need for this facility.

- More than sixty three thousand five hundred veterans came to the VA North Texas Healthcare System for their medical care during the last fiscal year. This was the third highest number of all VAs in the nation

- Nearly ten thousand of these veterans came for mental health care, accounting for 174,000 visits and 1,700 episodes of inpatient care

- The North Texas Healthcare System is the busiest health care system in the Heart of Texas Veterans Integrated Services Network (VISN 17), based on the number of veterans served for both mental health services and non-mental health services.

- The numbers of veterans seeking mental health services in the VA North Texas Healthcare System continue to rise. There was a 12 percent increase in those receiving mental health services from 1997 to 1998, and an additional 8 percent increase from 1998 to 1999

As the primary VA mental health provider in North Texas, this facility is hindered in completing its mission by the age (60 years), configuration, available space and poor condition of its mental health facilities. Building #1, the primary inpatient/outpatient Mental Health structure, was built in 1939 to support the medical and surgical inpatient needs of that era. It has been modified extensively but remains significantly inadequate to support the patient care needs of our active outpatient and inpatient mental health programs. Building #1's pervasive deficiencies (space, utilities, building systems, patient privacy, asbestos and UFAS) render it functionally obsolete. Mental Health outpatient programs are currently located in several separate, physically distant structures across the 85-acre VAMC campus The distance between various buildings works against the most ideal consolidation and effective utilization of staff among the programs. Each site is characterized by inadequate space for staff offices, group treatment rooms, and waiting rooms Our Mental Health facilities are substantially below community standards. The Joint Commission on the Accreditation of Health Care Organizations recently reinforced this disturbing fact during a July 19-23, 1999 inspection of our Mental Health facilities, we were cited for environment of care deficiencies related to patient safety and patient privacy. These conditions, if left uncorrected, could contribute to the nonaccreditation of this Medical Center in its next JCAHO inspection in just two years.

The rapid workload growth in Mental Health services has compounded the impact of space and functional deficiencies We desperately need this project to meet the need for comprehensive mental health services delivered within a facility that meets all applicable VA and community standards.

Under solid leadership, VA North Texas Healthcare System restructured the way mental health services were being delivered over the past few years This effort brought more services to the veterans through a consistent treatment team that follows the patient through all levels of care in mental health. The results are seen in greater efficiency, lower costs and higher patient satisfaction Significant improvements to each of areas and improvements to patient privacy and dignity are achievable through this construction project.

Let me end by acknowledging the path-breaking work that each of you is doing today to serve the veterans of our nation. Your efforts to protect America's veterans served by the North Texas Health Care System will continue to carry our community, state, and nation into the 21st Century. Your timely support for this project at this crucial juncture in the 2001 appropriation process would be appreciated. I thank you for your time and would appreciate your support for this needed project in Dallas community.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
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VA HEALTH CARE

VA Is Struggling to Address Asset Realignment Challenges

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

GAO/T-HEHS-00-88

Mr Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss management of health care assets owned by the Department of Veterans Affairs (VA) and operated by the Veterans Health Administration (VHA). VHA has primary responsibility for capital asset planning activities, whereas VA's Capital Investment Board has primary responsibility for capital budgeting activities, including review of VHA's capital investment proposals.

Over the next few years, VHA will spend billions of dollars operating, maintaining, and improving buildings and land at health care delivery locations nationwide. Currently, VA's health care capital assets total over 4,700 buildings and 18,000 acres of land at 181 major delivery locations.

In March 1999, we reported that VHA could enhance veterans' health care benefits if it reduced the level of resources spent on underused, inefficient, or obsolete buildings and reinvested these savings in providing health care more efficiently in modern facilities at existing locations or new locations closer to where veterans live.[1]

VHA agreed in general with our evaluation and committed at that time to taking the steps needed to realign its portfolio of health care assets. In essence, VHA agreed to implement in a timely manner a strategic planning process that would systematically study all its medical care markets in order to develop capital asset realignment plans.[2] VA's Capital Investment Board will use these plans to determine the best investment opportunities.

Last July we reported that VHA had made limited progress toward implementing a realignment process and estimated the opportunity cost of delay was as high as $1 million a day.[3] VHA's efforts had focused primarily on discussions among VHA officials, VA officials, and stakeholders, such as veterans' service organizations, regarding a conceptual framework for its asset realignment process. VHA reported at that time that its realignment process would be operational within 2 months (September 1999).[4]

In light of VHA's commitments, you asked us to (1) assess VHA's progress to date, (2) identify any concerns regarding VHA's realignment process as currently designed, and (3) consider the potential effects of VHA's actions on VA's capital budgeting process.

My comments this morning are based on

- discussions with officials responsible for VHA's asset realignment and VA's capital budgeting processes and
- reviews of documents, primarily those relating to VHA's proposed asset realignment procedures and VA's Capital Investment Board decisions concerning VHA investment proposals considered for funding in fiscal year 2001.

In summary, VHA has been unsuccessful over the past 13 months in its efforts to design a capital asset realignment process. VHA's efforts have focused on discussions of who should lead such a process, how stakeholders should participate, and how decisions are to be made. Moreover, VHA estimates, as it did 8 months ago, that it could be several months before its process is operational.

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[1] VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).

[2] A market, for the purposes of this statement, is defined as a geographic area generally within 75 miles of an existing VHA major delivery location. VHA operates assets in 106 markets.

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

[4] VA's Capital Assets Realignment Plan for Enhancing Services to Veterans, hearing before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, No. 106-20 (July 22, 1999).

Our assessment of VHA's process, as currently designed, raises concerns about whether the right people are involved at the right times and in the right ways. Specifically, senior managers at headquarters may not be proactively involved in a leadership role at key decision points. In addition, stakeholders with vested interests appear to be involved in decision-making, rather than advisory, roles. And activities supporting key components, such as options development and evaluation, are not sufficiently rigorous. As a result, VHA may not be able to produce within a reasonable time frame capital asset plans that are in the best interest of veterans.

VHA's slow progress creates dilemmas for VA's capital budgeting process. In the short term, VHA and VA's Capital Investment Board face the challenge of maintaining and improving capital assets without sufficient information about future asset needs to ensure cost-effective capital investment decisions. By contrast, if funding for projects is delayed until capital asset plans are completed, the longer-term challenge will be how to successfully finance and implement capital realignment investments potentially totaling billions of dollars. These challenges could be ameliorated, in part, if VA effectively manages short-term investment risks and the Congress provides alternative financing arrangements for future investments.

VHA IS STRUGGLING TO DESIGN ASSET REALIGNMENT PROCESS

The goal of an asset realignment process, in our view, is to produce within a reasonable time frame a capital asset plan that is in the best interest of veterans—namely one that provides better health care services for currently enrolled veterans while enabling more veterans to access VA care. The capital asset plan should conform to Office of Management and Budget guidelines.[4] If done successfully, the capital asset plan should provide a road map to guide investment decisions over the next decade.

Over the past 13 months, VHA has taken an inordinate amount of time trying to develop a method to achieve these objectives. In March 1999, VHA developed a broad conceptual framework to guide its design efforts. Over the next 3 months (July 1999), VHA developed a draft statement of work needed to conduct the market studies and an action plan for completing the studies. Three months later (October 1999), VHA developed a draft capital asset management policy statement that outlined a proposed design method as well as a revised statement of work and action plan. In February (4 months later), VHA provided a revised draft policy statement to a wide variety of stakeholders for their review.

These critical documents are currently being revised again. Over the next several months, VHA expects to (1) continue refining its capital asset realignment design method on the basis of stakeholder concerns and suggestions, (2) complete work needed to solicit and award a consulting contract, and (3) obtain senior management review and final approval of a method to employ.

During the same period, VHA has also struggled to develop a capital asset realignment plan for its Chicago market. This initiative,[5] started in July 1998, produced a draft realignment plan in September 1999. VHA has spent the last 6 months obtaining and evaluating stakeholders' concerns and advice as well as reevaluating potential options. VHA expects this experience to help shape the ultimate design of its systemwide asset realignment process.

VHA'S PROPOSED CAPITAL ASSET REALIGNMENT PROCESS RAISES CONCERNS

We identified three weaknesses in VHA's proposed method. First, senior managers at headquarters appear to be in reactive, rather than proactive, leadership roles. Second, stakeholders appear to have decision-making, rather than advisory, roles. Third, key

[4] Capital Programming Guide, Office of Management and Budget (July 1997).

[5] VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-68, Apr. 16, 1998) recommended that VHA develop and implement a plan that meets veterans' needs by operating fewer capital assets.

components, such as development of evaluation criteria, lack rigor; that is, they do not appear to be driven by quantifiable, objective data clearly linked to well-defined measurement standards.

VHA's Senior Managers
Lack Proactive Role

VHA's senior management should play a critical leadership role in the development of (1) well-defined evaluation criteria that have the measurement standards needed to guide the collection of data necessary to make capital asset realignment decisions, (2) guiding principles that consultants and others could use when developing asset realignment options for consideration, and (3) systematic procedures for scoring options in relation to each evaluation criterion

However, VHA plans to give a consultant primary responsibility for developing options and evaluation criteria as well as for conducting the evaluation of potential options. Senior managers at headquarters are to be primarily in an oversight role, reacting to the consultant's proposed evaluation criteria, methods for evaluating potential options, and choice of the best option.

We are concerned about this arrangement. The capital asset plans that result from these market studies are expected to guide VHA's future investment initiatives for the next decade Without strong leadership in the development of these plans, VHA risks not being able to timely implement meaningful capital asset realignments. A case in point is VHA's Chicago market realignment process Senior managers at headquarters were not actively involved until after stakeholders and others raised significant concerns about the recommended realignment option VHA has since convened a special review group that has spent the last 2 months assessing stakeholders' concerns and deciding how such concerns could be best resolved Now, 20 months after the study was initiated, this review group has decided to set aside the originally recommended option and consider others, including options that had not been considered before. If senior managers had been involved, such options might have been considered earlier. With senior managers continuing in a reactive role in its proposed systemwide asset realignment process, VHA risks replicating in other markets its struggle to make progress realigning assets in Chicago.

VHA's Stakeholders Have
Decision-Making Role

Last July we expressed concern that VHA's capital asset realignment process as then proposed could rely too heavily on local stakeholders who may have vested interests in maintaining the status quo Our assessment of VHA's proposed asset realignment process today suggests that stakeholders remain heavily involved in a decision-making role

VHA plans to have national and local committees, which possess decision-making authority, review the consultant's products, such as its proposed evaluation criteria and data collection methods. The committees' members include representatives of veterans' service organizations, union or labor organizations, medical school affiliates, research organizations, state veterans and health associations, and local VHA staff.

We remain concerned that stakeholders' participation as decision-makers on such committees could bias the market studies and, ultimately, the capital asset plans. VHA stakeholders are a diverse group with competing interests, who, quite naturally, could oppose some changes that they believe are not in their best interests. For example, medical schools' reluctance to change long-standing business practices has sometimes been a factor inhibiting VHA's asset management. In addition, unions sometimes are reluctant to support decisions that result in a restructuring of services because operating efficiencies can result in staffing reductions.

We believe it is essential to involve stakeholders in an advisory role in the capital asset realignment process This is because they can provide valuable perspectives on the evaluation criteria for selecting the best market study option and on procedures for

scoring realignment options in relation to the criteria. Such input could enhance stakeholder understanding of VHA's capital asset realignment process and build confidence that realignment decisions are fair and fact-based.

Realignment Decision Points Lack Rigor

From our perspective, VHA's experience with the Chicago capital asset realignment study offers three valuable lessons so far that could improve VHA's systemwide asset realignment process:

- ill-defined capital asset realignment evaluation criteria lead to unsupportable decisions;
- flawed asset realignment options result in flawed decisions; and
- an unstructured, subjective evaluation process impedes stakeholder acceptance.

It does not appear, though, that VHA has taken these lessons into account for its proposed realignment process. First, VHA's systemwide evaluation criteria, when developed, could be vaguely defined. VHA's draft statement of work for its systemwide process calls for a consultant to develop evaluation criteria, but it does not require the evaluation criteria to be defined in terms of quantifiable measurement standards that are clearly linked to each criterion. The lack of well-defined criteria can lead to problems, as it did in the Chicago realignment process. There, VHA used accessibility of health care services as a criterion without adequate measurement standards that could be quantified, such as the potential effect on veterans' travel time and the number of veterans affected. Moreover, because VHA's draft statement of work for its systemwide process does not require the consultant to develop a systematic data collection approach that directly links data to individual evaluation criteria, the consultant's data collection could be incomplete. This could significantly reduce the likelihood that VHA would select the best option available.

Second, we are concerned that VHA's systemwide realignment process may not consider the best options that are potentially available. For example, VHA's Chicago process appears to have explored flawed options because VHA's steering committee and consultant limited the options evaluated to ones that would generally rearrange services among existing assets. On the basis of its assessment of stakeholders' comments pertaining to the Chicago process, we understand that VHA is reevaluating options, including ones not originally evaluated. VHA's draft statement of work for its systemwide process calls for a consultant to develop at least three alternative asset configurations. VHA plans to rely on the consultant's judgment to develop the best options for consideration. Unless options other than incremental reconfiguration of current assets are considered, the realignment process is likely to take a narrower view than is needed to identify the most efficient and effective way to meet veterans' health care needs. For example, building or leasing a replacement facility in a location closer to where veterans live might not be evaluated.

Third, we are concerned that VHA will use an unstructured process to decide which of the available capital asset realignment options best meets the evaluation criteria. For example, in its Chicago process, VHA did not prioritize its evaluation criteria, nor did it use a systematic scoring method to reach decisions about how well each option met the evaluation criteria. Rather, its recommended realignment option was determined on the basis of the subjective consensus of a steering committee, but the draft report did not elaborate sufficiently on VHA's rationale. VHA's draft statement of work for its systemwide process calls for a consultant to develop a method for evaluating realignment options. At present, this statement of work has no requirements for the consultant to develop a systematic way to score how well each option meets the evaluation criteria, nor has anyone in VA been charged with doing this. Without a systematic method for reaching a decision about the best option, VHA's realignment decisions may be difficult to explain, support, and defend.

While VHA possibly could satisfactorily address our concerns within the coming months, its progress to date casts doubt on its ability to do so. This is because, in part, VHA may not possess the requisite financial planning skills to make the best realignment decisions. Currently, VHA is using health care professionals to make financial decisions. While

such professionals have the necessary skills to make decisions about veterans' health care needs, they may not have the business skills necessary to make the best financial decisions. For example, financial experts possess knowledge and skills for analyzing life cycle costs of assets under different scenarios as well as for determining potential payback schedules for initial capital investments for options and potential long-term returns on those investments.

Clearly, it seems desirable to bring to bear the combined expertise of financial experts and health care professionals to evaluate potential realignment options to identify those that provide the best investment return for veterans and other taxpayers. There is a unit within VA that, in our view, has worked to develop financial expertise regarding capital asset management decision-making, namely, VA's Capital Investment Board. The Board has (1) experience developing options evaluation criteria that are more clearly defined than criteria used in VHA's Chicago realignment process, (2) a systematic data collection approach that directly links data to each evaluation criteria, (3) guidance for developing options, and (4) a systematic options evaluation process. The Board currently uses a capital budgeting model for major investments that embodies the key attributes needed to address our concerns about VHA's process. Its model has been used and refined over the past 3 years, and it gives decisionmakers, in our view, better information than they had in the past.

New Business Model Could Be Considered

There appear to be two alternative business models for completing the design and implementation of a capital asset realignment process in a timely manner, besides continuing with VHA's current efforts. First, leadership of the asset management responsibilities could be transferred to another unit within VA, but outside of VHA. A second model could involve the shifting of capital asset decision responsibility outside VA.

Transferring capital asset management responsibilities to another unit within VA, such as the Capital Investment Board, could better combine VHA's health care expertise with VA's financial experts. As previously discussed, VA's Capital Investment Board appears to have a business model that could address financial management decisions involving capital asset realignment options. This approach has appeal because the Board has a full-time dedicated group that has studied industry best practices for capital asset management and has used this knowledge to develop evaluation criteria and procedures to score capital asset investment options.

Capital asset decision-making could also be moved outside of VA. This could be accomplished through the establishment of an independent commission or comparable group to develop and evaluate options for realigning capital assets. This option could be advisable if it is determined that VA lacks the desire or wherewithal to realign capital assets or that the pressures from competing stakeholders inherent in VA's environment are deemed to be insurmountable.

Regardless, VA needs to finalize its capital asset realignment process as quickly as possible because its delay is creating dilemmas for short-term and long-term capital investment decisions, as I will discuss next.

VHA'S DELAYS CREATE CAPITAL BUDGETING DILEMMAS

VHA's slow progress creates dilemmas for VA's capital budgeting process. On a short-term basis, VHA, VA's Capital Investment Board, and the Office of Management and Budget must decide what level of risk they are willing to tolerate as they continue maintaining or improving capital assets without sufficient information about VA's future asset needs to ensure cost-effective investment decisions.

Appropriately, they seem unwilling to accept much risk when making high-cost capital investment decisions—those exceeding $4 million. They have significantly limited such investments over 4 fiscal years (1998 through 2001) and could continue this de facto

moratorium for another 3 years (through 2004), given VHA's struggle to realign its assets. VA's fiscal year 2001 budget[7] for high-cost capital investments, for example, requested only $25 million for one new project after VA's Capital Investment Board considered 14 VHA high-cost investment proposals totaling $350 million.

By contrast, there appears to be a greater willingness to accept more risk for less expensive capital investment decisions—those below $4 million. We find this troublesome because there have continued to be significant investments requested for less expensive capital improvements—about $400 million for each of fiscal years 2000 and 2001. These involve improvements at many locations, such as ward renovations; outpatient space reconfigurations; and enhanced heating, ventilation, and air conditioning systems. To successfully manage investment risks, VHA needs to carefully consider its less expensive construction investments at delivery locations that could ultimately be determined to be unneeded to meet veterans' health care needs once capital asset plans are completed.

In March 1999 we reported that, until an effective capital asset planning process is in place, VHA's less expensive investment decisions should be subjected to tighter scrutiny. Toward that end, we suggested that VHA ensure that the fundamental principles underlying the Capital Investment Board's evaluation process for high-cost capital investment be rigorously implemented when making less expensive capital investment decisions.[8]

An effective risk assessment process should identify health care delivery locations where, for example, there are no alternatives for providing care. This process could involve two key components: (1) risk measurement factors and (2) data to evaluate investment proposals in relation to risk factors. Low-risk factors, for example, could include noncompetitive markets, large veteran population growth, or large growth in veterans' use of VHA services.

On a longer-term basis, VA faces a different dilemma. Today VHA's high-cost capital investment needs are not known and will remain so until its capital asset plans are completed; nonetheless, VHA believes, and we agree, that they will likely require a significant investment. VHA's investment needs may not be as daunting as they now seem because, for example, investments will be spread over the next decade and each will require many years to implement. VHA's Chicago realignment process, for example, is expected to take 10 years to be fully implemented.

Moreover, the magnitude of the new investment resources needed could be mitigated. First, VHA should realize significant returns on these capital investments—up to 100 percent or more in the form of annual operational savings. VHA's Chicago realignment option, for example, was estimated to yield annual operating cost savings of $189 million, compared with one-time capital investment needs of $92 million. In March 1999 we suggested that some or all of these savings could be used to finance future capital investment decisions. Legislative action, for example, could authorize VA to accumulate resources (that is, savings) in a Capital Asset Fund by charging VHA delivery locations for the capital investment costs used to realign assets. Locations could return to the fund some or all of the amount invested over a prescribed number of years.[9]

Second, last year VA proposed a new funding source to help finance high-priority investments faster. In its fiscal year 2000 budget submission, VA proposed a 5-year demonstration that would allow VHA to sell, transfer, or exchange up to 30 excess or underutilized properties, deposit proceeds into a new Capital Asset Fund; and use the Fund to invest in more appropriate assets. This proposal, which we supported last year, offers a way to help finance capital investments needed to realign assets for two reasons. VA has significant unused or underused buildings, and it lacks incentives to dispose of

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[7]VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).
[8]GAO/T-HEHS-99-83, Mar. 10, 1999, p. 23.

properties because funds can, by law, be spent only to construct, alter, or acquire nursing home facilities.[10]

In addition to addressing high-priority asset needs faster, such funding sources could also provide incentives for more effective capital planning and greater accountability for investment decisions. To realize such benefits, the Congress would need to expand the types of deposits that VHA could make into its proposed Capital Asset Fund or establish a separate revolving fund for this purpose

CONCLUDING OBSERVATIONS

We are concerned that VHA's slow progress in establishing an asset realignment process needlessly delays critical decisions and the opportunity to reinvest resources to enhance veterans' future health care. Furthermore, the weaknesses we identified in VHA's realignment process, as currently proposed, undermine our confidence that, once implemented, it will produce within a reasonable time frame capital asset plans that are in the best interest of veterans and taxpayers. It appears that if a capital asset realignment process is patterned after the Capital Investment Board's decision-making model, the process would be less likely to replicate VHA's Chicago experience.

Because VHA is struggling to reach a sound realignment decision in Chicago and complete the design of a systemwide realignment process, and because VA's Capital Investment Board has a model that could address many of VHA's weaknesses, it seems appropriate that VA consider transferring the asset planning responsibility to the Board. The daily cost of delayed decisions is unacceptably high

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

GAO CONTACT AND STAFF ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Stephen P Backhus at (202) 512-7101. Individuals who made key contributions to this testimony include Paul Reynolds and Walter Gembacz.

(406192)

[10]GAO/T-HEHS-99-83, Mar. 10, 1999, p.23.

Statement of

Frances M. Murphy, M. D., M. P. H.

Acting Deputy Under Secretary For Policy And Management

Veterans Health Administration

Department of Veterans Affairs

Before the

Subcommittee on Health

Committee on Veterans' Affairs

U. S. House of Representatives

April 5, 2000

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Mr. Chairman and members of the subcommittee, I am appearing before the committee this morning to discuss the Veterans Health Administration's (VHA) planning, budgeting and management of capital assets.

The discussion of our plans to most efficiently and effectively manage our capital assets must be viewed in the context of the tremendous transformation of VA health care that has occurred over the past five years. VA was a hospital-based, disease-oriented, impersonal organization of medical centers. The "New VA" is an integrated health system that provides a continuum of accessible, coordinated, patient-centered care. We have seen demonstrable improvements in our capacity to achieve consistently reliable, accessible, satisfying, high-quality care. We continue to face challenges of reducing medical errors in our health care; of meeting the needs of an aging population; of incorporating the rapid growth of scientific knowledge into daily practice; of incorporating expensive new medical and information technologies; and of realigning our infrastructure to more effectively support current health care needs.

More than at any other time in our history, VA more closely mirrors – and in many cases exceeds – the best in private sector healthcare. Indeed, this transformation underpins our quality improvements. Significant organizational changes include:

- *Closing more than 52% of all hospital care beds since July 1994.*
- *Reducing inpatient admissions by 34% from FY 1994 and FY 1999.*
- *Reducing VHA's bed days of care per 1,000 patients by more than 68% nationally – from 3,523 to 1,136 between FY 1994 and FY 1999.*
- *Increasing annual ambulatory care visits from 24 to 37 million – a 52% increase – since 1995.*

- *Providing health care to over 700,000 more veterans in FY 1999 vs FY 1994 – a 31% increase.*
- *Within Veterans Integrated Service Networks (VISNs), consolidating management and operation of 48 hospitals and/or clinics into 23 locally integrated health care systems since September 1995.*
- *Approving and/or bringing 388 new Community Based Outpatient Clinics (CBOCs) into operation since 1995. VA now has more than 1200 sites of care, bringing health services into more veteran's communities.*
- *And over this same period, increasing the rate of selected surgeries and procedures which are safely provided in the ambulatory setting to 92%*

Especially notable clinical achievements have reduced unnecessary hospitalizations, lowered mortality, and resulted in cost-savings through reductions in avoidable health care expenditures For example.

- *Rates of pneumonia and influenza vaccinations provided VA patients far exceed U S Public Health Service Healthy People 2000 goals and available benchmarks*
- *Life-saving beta-blocker medications after heart attacks are provided at VA hospitals at rates that exceed all available benchmarks.*

Similar improvements have been seen in other areas of preventive health services such as screening for cervical and breast cancer and in the treatment of prevalent diseases such as diabetes and mental illness Simultaneously, patient satisfaction has increased In fact, VHA scored 79 on the externally conducted American Customer Satisfaction Index This is significantly above the mean private sector health care score of 70 Loyalty and Customer Service scores were even higher at 90 and 87, respectively

The transformation that is occurring in how health care is provided has outpaced our ability to make infrastructure changes VA's infrastructure was built largely at a time when bed based care was the standard mode of providing health care As described above, over the past 5 years VA has significantly shifted care from inpatient to ambulatory care delivery. We have also significantly moved care closer to the patient by establishing Community Based Clinics and home care We currently face the challenge of realigning our infrastructure to optimally support how health care is being delivered today and will be delivered in the future.

As discussed below, we have capital investment planning processes in place to assure that new investments optimally support current requirements, and in the near future, we will be implementing a process to comprehensively

review existing capital assets to identify opportunities to restructure those assets in ways that will enhance our ability to serve our patients.

Capital Investment Planning Process

VA has implemented a Capital Investment Planning Process to assure that proposed capital investments support the priorities of the core mission of VA and VHA. Capital asset planning starts at the VISN level. VISN capital asset plans contain two major parts. One describes the linkage of the capital acquisition to VA/VHA/VISN mission, goals, management strategies and performance goals. The second is a baseline assessment that describes the extent that existing capital assets are helping the network to achieve goals, management strategies, operating strategies, and performance goals. The difference between current and projected performance, which cannot be met with existing assets, is the performance gap. In this section of the plan, VISNs explain options considered for closing the perceived gap, including non-capital options such as sharing and contracting. If asset acquisition is thought to be the best option, the VISN plan identifies the asset that is uniquely suited for closing existing performance gaps. In addition, in this section, the VISN plan explains why the capital asset investment is the best alternative of all the available options, including non-capital alternatives.

From the 22 VISN strategic plans, a major construction project inventory is compiled. Projects are reviewed by the VA Capital Investment Board (VACIB) for budget consideration. The Board members prioritized construction investments for FY 2001 using the following criteria:

Customer Service

Return on Taxpayer Investment

High Performing Workforce

Risk Analysis

Special Emphasis Programs

Threat Mitigation

Alternatives Analysis

The VACIB provides an analysis to the Secretary about each proposal's viability for inclusion in the VA Capital Plan and VA budget request to OMB. Also, the VA Resources Board reviews projects for inclusion in VA's request for budget and authorization consideration.

For FY 2001, the Department is requesting authorization for two major construction projects to improve VHA facilities. These include a project for seismic corrections through new construction for a gero-psychiatric nursing home building at the Menlo Park Division, Palo Alto Healthcare System,

California and a project to renovate psychiatric nursing units at Murfreesboro, Tennessee. I urge the committee's favorable consideration of our authorization request for these medical projects.

While we believe that we have improved our strategic planning processes and processes for reviewing capital assets investments, I would like to describe two initiatives now underway within the Department that we believe will significantly enhance our capital asset effectiveness.

Capital Asset Realignment for Enhanced Services (CARES)

The VHA will soon implement a comprehensive capital asset management program that will involve detailed studies in each VISN to systematically review current mission requirements, existing and future veterans health care needs, recommended service delivery options, and recommendations for capital realignment options to enhance service to veterans. CARES has emerged as one of the more challenging and complex programs that VHA will undertake in the next five years. However, through this process VHA will position itself for optimal health care delivery in terms of both quality and access to care and will be able to realign its extensive inventory of capital assets to better support the effective and efficient delivery of health care.

As you know, the need to review and realign capital assets was discussed extensively last year. In fact, the House passed legislation that would have supported the CARES concept, however, the final Millennium bill did not contain this provision. VHA has been developing the CARES concept since April 1999. Since that time, communicating the CARES program and the associated processes with VHA's diverse stakeholder constituency has taken more time than I anticipated. However, this time has been well invested in assuring that this effort has their support.

The draft CARES policy was formally shared with VA stakeholder representatives on February 17, 2000. An initial 30-day comment period has been extended to April 20, 2000 to provide all stakeholders ample time to comment on this critical program. Concurrent with this review and comment period, VHA has drafted a statement of work for the network planning studies and the CARES Guidebook to assist field managers in implementing the CARES program. The initial group of seven VISN planning studies, scheduled for award later this year, will include the eight mega-market locations identified by GAO in testimony before this subcommittee in March 1999. I anticipate that the FY 2000 APF funds (made available for this purpose in VA's FY 2000 Appropriation) will be sufficient to fund these seven studies and at least two additional VISN planning studies this year.

The discussions regarding the CARES initiative within VHA, with other VA staff offices, and with stakeholder representatives outside of VA have contributed significantly to consensus support of the CARES program. This broad based support and the anticipated level of stakeholder involvement envisioned regarding the 22 VISN studies are considered essential to successfully implementing the service delivery options and capital restructuring proposals that may be identified from these studies.

Although the policy development phase has taken longer than originally anticipated, VHA has concurrently moved forward with several capital restructuring opportunities. Several networks have identified or have implemented capital realignment initiatives that would both enhance delivery of health care services to veterans and at the same time result in significant savings in medical care funding. Significant initiatives are as follows:

Ft. Lyon, Co. – The VA Rocky Mountain Network (VISN 19) has proposed a mission realignment at the Ft. Lyon Colorado facility. The proposal includes reassignment of existing outpatient and NHC functions at the Ft. Lyon facility to three CBOC's and a newer and more appropriately sized NHCU within the Southern Colorado Health Care System. These proposed changes will increase both access and quality of care for veterans in the southern Colorado area at an estimated annual savings of $8.6 million. The ensuing capital realignment proposal would transfer the Ft. Lyon facility to the State of Colorado for use as a correctional facility for geriatric and mental health inmates. VA will require authorization to affect the direct transfer of the property to the State of Colorado.

The VA Maryland Health Care System (VAMHCS) - has developed a proposal for options to enhance the use of the Ft. Howard campus to better serve veterans in the Baltimore area. VAMHCS has proposed a plan that relocates inpatient functions to other VAMHCS sites, enhances Primary Care at the Ft Howard site, and working with a private developer will create a 'continuum of care' at the Ft. Howard site. In addition to the new VA Primary Care clinic – independent living housing, assisted living housing and a private nursing home would be constructed, all at the developer's expense. VA's enhanced use leasing authority will be used to implement the proposed plan. These facilities would be operated by the developer, under VA oversight, and veterans would be given priority as well as discounts as part of the contract agreement. VAMHCS expects to save $79 million over a ten year period from this initiative.

VA Boston Healthcare System (VABHCS) – VABHCS is proposing capital realignment and integration of existing tertiary care facilities in the Boston metropolitan area. The proposed integration will downsize the leased Causeway Outpatient clinic, establish an Ambulatory care Center of Excellence at the Jamaica Plain campus , and integrate inpatient services at the West Roxbury campus. When fully implemented, the estimated annual savings and cost avoidance resulting from the integration are in excess of $50 million. The revenues and savings from the integration and subsequent capital realignment

opportunities will allow VABHCS to maintain needed services at all existing facilities as well as enhancing services to veterans by opening additional CBOCs in underserved areas.

Chicago/ VISN 12 Service Delivery Options – The Under Secretary for Health commissioned a steering committee in the fall of 1998 to undertake a detailed evaluation of the full VISN 12 healthcare delivery system. This study went beyond the initial GAO study, to facilities outside the immediate Chicago area The network-wide concept of healthcare delivery allows workload and demographic data to influence resource allocations, and ultimately, capital asset management. The report was completed in the fall of 1999, and is currently being reviewed in light of stakeholder comments When finalized, savings of up to $188 million in annual operating costs may be avoided by combining similar programs among the network of facilities

VA Sierra Nevada Health Care System (VASNHCS) – The VASNHCS is pursuing a capital realignment initiative using VA's enhanced sharing authority. The proposal consists of a use of space and shared services agreement between VASNHCS and a private hospital corporation to operate a 52 acute long term care "hospital in a hospital" on two vacant inpatient floors. The VASNHCS will realize significant annual revenues from this agreement that will be used to enhance services by opening an additional CBOC, developing rural health contracts with providers in remote areas, and expanding the use of tele-medicine and tele-radiology. Enhanced services at the existing facility will include added staff to reduce waiting times in specialty clinics, expanded clinic hours/days, and expansion of parking capacity for the existing campus.

VA Healthcare Network Upstate New York at VAMC Canandaigua - VISN 2 is pursuing a capital realignment initiative at the VAMC Canandaigua using VA's enhanced sharing authority. The proposal consists of using vacant space in two buildings on the Canandaigua campus, considered excess to the facility's needs, that will be renovated by the proposed developer for much needed affordable housing to low income veterans, especially those at risk of being homeless. It is estimated there are approximately 4700 veterans in western New York who are at risk of being homeless. This proposal allows VA to improve services to these veterans while collaterally bringing them closer to full utilization of VA health care and support activities. With minimal cost to VA, this initiative will also mitigate uncompensated operations and maintenance costs of vacant space for the facility, estimated at $ 200,000 annually.

VA Western New York Healthcare System (Batavia) – The VA Healthcare Network Upstate New York (VISN 2) is proposing to utilize VA's enhanced sharing authority in conjunction with a VA Homeless Providers Grant to enter into an agreement to provide transitional housing and a multi-resource center for "special needs" veterans. Special needs veterans include homeless, at risk of homelessness, female, recovering substance abuse, and PTSD veterans. This proposal will renovate excess space at the Batavia campus under the homeless grant program and will provide revenues to the VA through "sharing" arrangements for excess capacity services. The proposed agreement will result in cost reimbursement of annual operating and maintenance costs of $95,000 plus projected revenues of approximately $220,000 for services over the first five years of the agreement.

In conclusion, the CARES program will, through network based planning, guide VHA's future capital investment decisions to realign and allocate capital resources to better meet veterans' health care needs. To realize the full potential improvement in providing VHA health services that can result from aligning capital assets with current patient needs will require the full cooperation and support of our diverse stakeholder constituency, as well as funding for key investment initiatives identified during the process.

Enhanced-Use Leasing Program

As you are aware, this program has provided VA with the opportunity to enhance the use of our available properties with the resulting revenues supporting healthcare and other benefits services to veterans. Last year, the Millennium Act amended this unique authority in several important ways. First and foremost, all the net proceeds generated from such leases will now be re-invested to improve VA patient care. In addition, the act extended the term for Enhanced-Use leases to 75 years and allows the Department to use minor construction funds as capital contributions. Finally, the Act expanded the Department's ability to lease VA property not only in instances where the project will enhance a VA activity on the site but also when the lease results in the enhancement of services to veterans in the local community. These enhanced authorities were implemented by VA Directive issued on March 24, 2000.

Since its original enactment, VA has used this authority to improve the efficiency of operations and obtained millions of dollars in financial benefits. These projects have included consolidations, collocation, obtaining child care services, expanding parking facilities for veterans and employees, and re-direct operational funds from managing golf courses into direct medical care. In

addition to achieving significant cost savings, these projects have added substantial private investment to support the Department's capital assets, provided new long-term sources of revenues, and created jobs and tax revenues for the local economies. Recently completed projects at VAMCs Indianapolis, Indiana and Mt. Home, Tennessee demonstrate the benefits of this authority.

- The Department recently executed an Enhanced-Use lease for the development and operation of a state-of-the-art, co-generation energy plant at the James H. Quillen Veterans Affairs Medical Center (Mountain Home), Johnson City, Tennessee. In addition to providing energy services to the medical center, the energy plant will also sell energy services to the East Tennessee State University James H. Quillen Medical School and to the City of Johnson City The project will result in a 25% reduction in energy usage at the medical center, require no capital funding, provide significant operational cost savings and generate revenues. Energy savings and revenues from this project will be used to support a new CBOC thus improving customer service

- The Department also used the Enhanced-Use leasing authority as a means of obtaining skilled nursing services at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana Following a national competition, Beverly Enterprises, Inc was selected to finance, construct and operate a 94-bed, skilled nursing home care facility on the Medical Center campus for the purpose of providing skilled nursing services to the VAMC on a priority basis. Beds that are not used by VA patients will be available for use by the general public Specialty services will also be provided for Alzheimer's, Parkinson's and for other gero-psychiatric patients This lease enables VA to avoid using scarce capital resources to construct a nursing facility. It also provides for the Medical Center to obtain revenues from non-VA users and other shared service arrangements with Beverly. VA's cost per bed will be about 30% below similar costs for placing patients in local community nursing homes, with no minimum VA patient guarantee or obligation.

Other Enhanced-Use initiatives currently underway include medical and research facilities, VBA regional office collocations, assisted and specialty housing, child development centers, energy plants and parking garages

As we implement the expanded authorities provided by the Millennium Act we are taking steps to streamline the leasing process We are currently reviewing the recommendations made by a task force of principals from key offices and medical centers to expedite the approval process for Enhanced-Use leases. We expect to implement these recommendations this spring While the program has achieved some level of success, it has limitations, namely market

demand, compatibility issues and VA mission requirements. By understanding its strengths and constraints the Department is moving toward further application of this authority as one tool in its capital asset program.

Although this authority bypasses the Stewart B. McKinney Homeless Assistance Act, of which it is the Administration's policy not to bypass, VA is extremely cognizant of taking into account the needs of the homeless and provides funding for such programs as VA's:

- Loan Guaranty for Multifamily Transitional Housing for Homeless Veterans Program
- Domiciliary Care for Homeless Veterans
- VA's Compensated Work Therapy/Transitional Residence Program (CWT/TR)
- Homeless Chronically Mentally Ill Program.

Conclusion

Mr. Chairman, our objective is to ensure that VA's capital assets support our clinical, research and educational missions and evolve quickly to keep pace with our transformed health care delivery systems. These capital assets must also be utilized in ways that bring the greatest value to the Department at the lowest cost. We believe the initiatives that I have discussed here this morning will help in moving the Department forward in this area. This concludes my opening statement and I would be pleased to answer any questions you or the members of the committee may have.

STATEMENT OF

GORDON H. MANSFIELD, EXECUTIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HEALTH,

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

DEPARTMENT OF VETERANS AFFAIRS CAPITAL ASSET NEEDS

IN REGARDS TO MISSON CHANGES AND REALIGNMENT

APRIL 5, 2000

Mr Chairman and members of the Subcommittee, thank you for the opportunity to present the views of the Paralyzed Veterans of America (PVA) on the Department of Veterans Affairs (VA) capital asset needs with regard to potential mission changes and the realignment of health care facilities. These issues hinge on the concept of how, why, and where we expend taxpayer dollars in the provision of medical services for veterans We believe it is paramount that these dollars are expended wisely and efficiently, while ensuring – no matter what the cost or changes to the infrastructure of the VA health care system – that veterans will continue to receive appropriate, timely, and quality health care service

This issue gained some dubious notoriety last year with the General Accounting Office (GAO) statement that VA could or might be expending – using their words – "potentially as high as $l million per day on unneeded buildings " While the GAO further stated that it was "not possible to say with certainty what the level of savings could be," admitting that the $1 million dollar figure was more conjecture

than fact, the statement took on a life of its own as the gospel truth We believe it is important to address this issue squarely It is also important to avoid rushing into broad realignment scenarios based on the notion that VA is being wildly profligate, wasting taxpayer dollars Nor can VA solve its ongoing financial woes by merely closing and selling off facilities The GAO also stated that VA "could spend as much as" $4 billion annually for asset operations and maintenance costs It is clear that one cannot provide health care without a place to provide it in If there is a rush to alleviate some of this cost, there should also be caution to ensure that VA does not pay the same amount, or more through higher vouchering or contracting costs to cover somebody else's bricks and mortar, electricity and heating costs

Because of health care realignment and lack of construction and renovation dollars, VA's infrastructure inventory and needs have changed dramatically Most of this change, marked by the shift from inpatient to outpatient care, has occurred in the last three years At some point, if that point has not already been reached, this trend will stop Not all care can, or should be, provided in an outpatient setting VA needs to maintain its core inpatient capability to maintain cohesion as a viable health care system able to provide the full range of services to veterans The tertiary acute care medical center, practicing medicine in the environment of academic medicine and advanced medical research, is the hallmark of the VA health care system Downsizing that role by relegating VA medicine to a conglomeration of scattered outpatient clinics or contract providers might provide convenient access to some services, but does not ensure quality health care for all Particularly at risk are veterans who rely on the VA for specialized services such as spinal cord injury care, that can only be provided in an inpatient setting and cannot be found anywhere outside the VA Any realignment decision being considered or adopted must make certain that the core missions of the VA health care system, such as these specialized services, are protected and enhanced

CARES

The VA has already begun to implement an initiative, Capital Asset Realignment for Enhanced Services (CARES), to design potential realignment scenarios nationwide This proposal provides considerable latitude for local steering committees to tailor the changes that are being proposed in service delivery to the local health care market and the projected needs of the veteran population The process also calls for active stakeholder involvement that is paramount for any realignment process being considered Every VA medical facility has unique characteristics influenced by its community, range of services, and patient population Initially, decisions affecting potential realignment or closure of facilities should be made at this particular level We strongly believe that this process must have central guidance and oversight to make certain that the overall mission of the VA is not eroded, and that certain standards can be applied to protect core missions and the full range of services to core populations. Protections are needed in the process to ensure that locally made decisions are not generated purely by cost reduction incentives to the detriment of the veteran patient and the VA system as a whole The process must utilize a wide range of criteria

PVA has identified a number of criteria that we believe are essential for assessing any facility, whether for realignment or for closure. These criteria address both external and internal factors, are both qualitative and quantitative, and, taken as a whole, are designed to ensure that veterans will continue to have access to quality, timely health care. Specifically, PVA recommends, as a minimum, the use of the following criteria:

- Proximity to other VA facilities
- Relationship with other non-VA facilities
- Qualitative Factors

- Affiliations
- Political Support
- Alternatives for care
- Age and condition of facilities
- Value
- Relationship to the community
- Potential for sharing

- Quantitative Factors

  - Vacancy Rate
  - Occupancy Rate
  - Gross Utilization
  - Number of Veterans Served
  - Number of Veterans Admitted

- Availability and Protection of Core Missions and Specialized Services as Spinal Cord Dysfunction Care

The process must ensure, as well, that any savings or revenue generated by realignment must be protected and ploughed back into enhancing services in the same area

Veterans Service Organization Involvement

Stakeholder involvement is the most important component of any realignment process Any local or national realignment plan can easily be doomed without the active participation of veterans' organizations and other stakeholders at every step in the process The GAO, last year, criticized the participation of system users and service providers as having too many vested interests to be able to make tough independent decisions But, as the name suggests, we are looking at the "**VETERANS** Health Administration " Veterans, and veterans service organizations, have every right, and even a moral obligation to make certain that the welfare and health care services for all veterans are fully protected

The GAO praised last year's realignment process in Veterans Integrated Service Network (VISN) 12, in part, because there was very little stakeholder involvement From our standpoint, also in large part because many stakeholders were excluded from the process, the VISN 12 plan was a complete disaster

One of the resulting proposals called for the elimination of all acute care at the Hines VA Medical Center. At the same time, it proposed leaving the Spinal Cord Injury Center in place at Hines. It is medically untenable to have an SCI center located without direct acute care support to provide the on-site multidisciplinary services SCI patients require It is even contrary to VA's own manuals to leave an SCI center isolated without acute care support in this fashion Obviously, with this plan, as it was devised, the consultants gave no thought to preserving the integrity of one of the VA's core missions - its specialized services in SCI care. Likewise, the plan gave no thought to the statute initiated in this Subcommittee mandating that the VA maintain the capacity of its specialized services

Mr Chairman, I cite the Chicago plan as one example of how much damage can be done if a health care realignment process is carried out with only any eye for the bottom line and not the best interest of the VA or the veterans it has been designed to serve. As the VA begins to go down this road, all deliberation must be used to ensure that the VA does not begin to reinvent itself into something it should not be, nor was ever intended to be

This concludes my testimony I will be happy to respond to questions.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2000

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000.

Federal Aviation Administration – Accessibility consultation – $8000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — $240,000* (estimated amount, as of December 31, 1999).

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— $65,000 (estimated amount, as of December 31, 1999).

Fiscal Year 1999

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — $975,000* (estimated amount).

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— $240,000 (estimated amount).

Fiscal Year 1998

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — $15,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — $975,000* (estimated amount).

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— $240,000 (estimated amount).

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* This space is authorized by 38 U S.C. § 5902 These figures are estimates derived by calculating square footage and associated utilities costs. It is our belief that this space does not constitute a federal grant or contract, but is included only for the convenience of the Committee.

STATEMENT OF

DENNIS M. CULLINAN
DIRECTOR, NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

before the
SUBCOMMITTE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

CAPITAL ASSETS PLANNING AND BUDGETING

WASHINGTON, D.C. APRIL 5, 2000

MR.CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The VFW is both pleased and gratified to play a role in today's important discussion. As an organization comprised of nearly two-million combat-theater veterans, the Veterans of Foreign Wars is obviously greatly concerned with all aspects of the VA's budget, including capital assets needs, planning, and budgeting.

The VA construction budget includes Major Construction, Minor Construction, Grants for Construction of State Extended Care Facilities, Grants for State Veterans' Cemeteries, and the Parking Garage Revolving Fund.

The VFW is deeply troubled that the President's Budget for FY 2001 would only provide $62 million for Major Construction Projects, $114 million less than is prescribed by the IB as being necessary to meet true need in this vital area. Similarly, the President's funding recommendation for Minor Projects falls $29 million below the IB level of $191 million. In total, the Administration's budget for VA falls $161 million below the funding level IB has identified as being absolutely essential to properly accommodate current construction needs while preparing for the future.

Inadequate funding of the Major and Minor Construction programs has compromised VA's ability to provide high quality patient care in safe and clinically appropriate physical settings.

We note that insufficient resources and having to partially or even totally fund renovation and facility conversion projects with non-construction dollars have led to cost-cutting methods that are neither fiscally efficient nor clinically sound.

Congress must ensure that there are adequate funds for both the Major Construction and Minor Construction programs so Veterans Health Administration (VHA) may address urgently needed projects and the system's antiquated infrastructure.

VA is forced to divert scarce resources that could otherwise be spent on patient care programs to the maintenance of its large inventory of vacant buildings.

The VFW recommends that VA must restructure its capital assets to ensure the delivery of high quality and timely care to all enrolled veterans while maintaining its legislatively mandated missions. VA must also develop a systematic-national approach to acquiring complete factual information and providing unbiased analysis to support the divestiture process. All revenue resulting from the divestiture of capital assets must be reinvested in veterans' programs.

The Veterans' Integrated Service Networks (VISNs) need to undertake more extensive construction planning, and national managers must oversee this process. Again, the VFW recommends that Congress increase construction budgets to allow appropriate program consolidations, facility realignments, and other changes necessary to implement VA's changing national health-care strategy Network directors must have the authority and flexibility to alter their construction projects based on changing operational needs without fear of losing already approved constructions.

As already mentioned, the President's Minor Construction budget recommendation is inadequate to meet the needs of VA's vast and aging infrastructure. Congress should fund the Minor Construction at the IB prescribed level of $191 million to ensure that needed facility renovations and repairs are completed in a timely manner

We will now address the Veterans Healthcare Administration Capital Asset Realignment for Enhanced Services (CARES) Program. The VFW is not tied to "bricks and mortar," but we are insistent that the Veterans Health Administration provide quality, accessible, timely health care for this Nation's veterans. We realize that the VHA physical infrastructure was designed for inpatient care and, in most cases, does not meet the needs of today's health-care delivery system. We fully believe that a strategic realignment of these capital assets is needed to improve both access and timely service.

We encourage VA to continue forward with this bold process because we believe, if done properly, it can and will be beneficial for veterans. We insist, however, on being a part of that process. This draft directive is a step in the right direction because it seems to bring balance among the Network level, the corporate level, and stakeholders' involvement. If this directive is implemented as written it will go a long way to ensure that a smooth process is achieved. Any process of this type, however, is doomed to fail if local stakeholders are not included in the planning and decision-making process at the Network level, and National stakeholders are not included in the planning and decision-making process at the headquarter level.

The VFW at the National level wants to be notified earlier of any CARES initiatives. Specifically, we want to be appraised when local organizations are told. This will allow us to more effectively work with our local constituents.

The network "Self Assessment Survey" is a good vehicle in addressing potential realignment of facilities. However, we suggest the addition of "Potential Impact on Veterans" and "Potential Impact on Families of Veterans" be added to the survey.

Once again, Mr. Chairman, we thank you for this opportunity to lend our voice to today's most important discussion. This concludes my statement. I will be most happy to answer any questions you may have. Thank you.

STATEMENT OF JACQUELINE GARRICK, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS CAPITAL ASSETS

APRIL 5, 2000

Mr Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present its views on VA's capital asset needs, planning, and budget; the proposed Fiscal Year 2001 medical construction budget; and the mission changes and realignment of VA medical facilities.

VA Capital Asset Needs, Planning and budgeting

The American Legion's position on the future of VA is clear and emphatic. In 1999, the National Executive Committee passed a resolution to "Oppose the Systematic Closing of VA Medical Centers." According to the resolution, "The American Legion does not believe VA should close any of its existing medical centers simply as a method of generating savings The American Legion does not believe there is one VA hospital that is not needed in some capacity and supports maintaining a viable presence at all of its existing health care facilities and the enlargement of VA health care through the GI Bill of Health." Until all of America's veterans and their dependents can enroll in VA through various health plans and funding mechanisms, then it is premature to be discussing the closure of VA facilities, which seems to be the intent of a recent VHA draft directive on the Capital Asset Realignment for Enhanced Services (CARES) Program. According to the draft directive, "A CARES initiative is a capital disposal, acquisition, or realignment resulting from a ***facility closure*** or a significant mission change." It seems that CARES is becoming a means to solving VA's problems through obliteration rather than as a tool for enhancement.

The American Legion realizes there are some serious problems in the delivery of VA health care. During site visits to the Veterans Integrated Service Networks (VISNs), The American Legion has noted clinic appointment delays well beyond the VA benchmark of 30 days In some networks, these waiting times are upward of 200 days for an appointment. However, The American Legion can not help but observe during these visits that some buildings, which are currently vacant and idle could be used for patient care. If VA were able to operate the additional physical-plant space for the clinics and professional staff were available, then veterans might not be waiting as long to schedule clinic appointments or surgery, nor would they be waiting for an hour or more to see a provider.

Today in America, many of the hospitals that we have come to know as the bastions of healthcare have been operating in their communities for several decades as well. Thomas Jefferson University Hospital has operated in Philadelphia since 1824 In New York, the New York Hospital originally established in 1771 has been housed in its current buildings since 1929, Bellevue Hospital, which originated as a Prison, has been operating at its location since the 1790's. Mount Sinai Medical Center has been operating at its location since 1855. The world-renowned Mayo Clinic still is housed within the original Saint Mary's Hospital opened in 1889. Obviously, the physical structures of these hospitals and many others around the country have needed upkeep and remodeling over the years, which is expensive and, yet, no one has labeled them "unneeded" or has proposed closing them. At a time when VA is taking many of the lessons learned in the private sector and applying those management principles to VA, it would seem prudent to also apply the infrastructure maintenance efforts employed in the private and non-profit sector The intrinsic value of these hospitals is seen far beyond their structural and maintenance costs. Why should VA hospitals be seen in any different light?

Much of the space that is going unused by VA is newly constructed areas housed inside existing hospitals. In Chicago, the Lakeside facility has a newly constructed Intensive Care Unit

(ICU), but only enough activating dollars for three of the seven beds. Five state-of-the-art ICU rooms sit empty. Does this mean that an aging veteran's population does not require such care? No. It is an indication that the VA system does not have enough money to care for veterans in the most appropriate setting as possible. It means veterans at Lakeside are sent over a bridge to Northwestern at Medicare rates for additional ICU care. In Maine, it means veterans ride for four hours from Boston with post-operative sepsis because the Togus VA can not afford to do the surgery there, while space in Togus remains empty. In VISN 18, it means there is no long-term mental health care available in the entire network, even though there is certainly space available. The American Legion cannot help but wonder if this is what Congress had in mind when balancing the federal budget.

Since eligibility reform, VA performance data indicates that the number of veterans enrolled and using the system continues to increase. Veterans receiving care at VA went from 3,006,833 in FY 1998 to 3,610,030 in FY 1999. The demand for VA care should continue to increase as the baby-boomer generation ages. Vietnam veterans will reach their peak need for long-term care in 2030 as predicted by the 1995 White House Conference on Aging. This, then should be the strategic planning horizon for VHA as it evaluates its needs for space utilization and resource allocations.

The VA health-care system ameliorates the health status of veterans and many other citizens. It is also an American healthcare bastion that needs ballast and investment. At this point in time, The American Legion does not believe that all that can be done has been done to accomplish this goal. The American Legion developed the GI Bill of Health, which would bring more paying customers (veterans and their families) into VA healthcare through private insurance programs, TriCare, Medicare Subvention, and a premium-based plan. These additional patient populations would expand the scope of VA care, making it more stable and better equipped to provide care to more veterans. By including Department of Defense and Medicare/Medicaid beneficiaries in the VA health care system and those resources, then VA would be able to enhance other programs like its homeless program or Compensated Work Therapy operated by Psychosocial Rehabilitation. The available space at many VA facilities could then be used to house, train, and treated homeless veterans, expand access to women veterans (especially if more wives were using VA) and provide the geriatric services that were just expanded under PL 106-117. The American Legion believes it would be infelicitous to do anything else before enacting the key components of the GI Bill of Health and certainly it is premature to be considering the disposal of any VA property.

While no decisions have been made at this time to close any VA medical centers, it is unmistakable that the CARES Initiative's primary purpose is to dispose of VA property. It is hoped that section 301, Review of the Proposed Changes to Operation of Medical Facilities in the Veterans Millennium Health Care and Benefits Act will provide congressional protection of VA hospitals as part of the CARES process. The American Legion requests that as this process inevitably goes into effect that the Veterans' Service Organization (VSO) community be included in the discussion and be allowed to present testimony on these proposed changes. It is critically important, if implemented, that VSOs receive all information relative to CARES in a timely manner. The individual or individuals responsible for liaison with the VSOs should be intimately familiar with working within this environment.

The American Legion supported opening up the discussion on better utilization of VA space, through the Veterans' Millennium Health Care and Benefits Act. This measure contained elements targeted at capital asset management issues, such as improving access through facility realignment and extended enhanced use applications, it was with the understanding that these initiatives would broaden access to veterans, but not close VA hospitals. However, in the most recent CARES draft directive sent to The American Legion by VA, the initiative seems more of a "postmortem" action as the result of a facility closure or significant mission change. This, by resolution, The American Legion can not support.

Fiscal Year 2001 Medical Construction Budget

The American Legion's National Field Service makes regularly scheduled visits to VA medical facilities. These visits are intended to identify problem areas regarding the ongoing operations of the Veterans Health Administration. In the course of these visits, the field service representatives review the facilities major and minor construction needs.

Additionally, The American Legion's staff and VHA's Office of Facilities staff meet on a regular basis to review priority construction requirements. Through a combination of the field service site visits and the regular staff meetings, The American Legion identifies priority construction requirements within VHA. The American Legion draws on this process in making specific construction recommendations.

The American Legion supports a priority ranking process for VHA construction projects. As we have testified on a number of occasions, just because no new or replacement medical centers are required within VHA, many major projects are still necessary. VHA identified new major construction requirements of $260 million for FY 2001 Yet, when the President's FY 2001 budget was released on February 7, only $62 million for major construction was recommended. This low figure will exclude many worthwhile projects. The American Legion believes the Congress should fund, at a minimum, the major construction projects recommended in our FY 2001 budget testimony at a $200 million level. These include seismic projects at VAMCs Long Beach and San Diego, in addition to VAMC Palo Alto. A recent mandated review determined that VHA has 69 patient care buildings, totaling 2,300 beds that require seismic renovations. There is also a compelling need to renovate various buildings at the Brecksville Division of VAMC Cleveland, OH and to construct a new spinal cord injury unit at VAMC Augusta, GA.

There is also a need for many minor construction initiatives. It is illogical that VHA would require less minor construction funding for its accumulating needs than it received just a few years ago. VHA has an aging physical plant system. Additionally, the significant conversion from inpatient to primary care creates an ongoing requirement to improve outpatient utilization. It follows, therefore, that many VHA facilities require considerable renovations and modernization to conform to the new primary care medical model. The American Legion also recommends a minor construction budget of $200 million for FY 2001.

In the final analysis, Congress must make its own assessment of VHA's construction requirements and provide appropriate funding The American Legion does not believe that minor construction-funding levels should be reduced at a time when VHA is still making the transition to primary care. Congress should use the examples from the private sector hospitals - Thomas Jefferson University Hospital, New York Hospital, Mount Sinai Medical Center, Bellevue Hospital, and the Mayo Clinic – as a blueprint for maintaining and preserving vital health care structures.

Overall, the health care industry in America is constantly changing as new technologies and therapies enter the medical marketplace, and VA is part of that flux It does make sense then for VA to be evaluating its capital assets, needs for technology, and enhancement of resources. However, it does not make sense for VA to be closing facilities when so much more can be accomplished by expanding access to veterans families, Medicare subvention, DoD and TriCare sharing, and other revenue generating plans. Once a facility is closed, and property disposed, the revenue generated is a one-time deal that can not be undone. The American Legion sees the closing of VA facilities as the erosion of the VA health care system and the eradication of specialized care for this nation's disabled veterans.

Mr. Chairman, that concludes this statement.

Post-Hearing Questions
Concerning the April 5, 2000, Hearing

for
Dr. Frances Murphy
Acting Deputy Under Secretary for Policy and Management
Veterans Health Administration, Department of Veterans Affairs

from
The Honorable Lane Evans
Ranking Democratic Member, Veterans Affairs' Committee
U.S. House of Representatives

1. Dr. Murphy, GAO believes that VA's leadership needs to define more specific and objective criteria that will allow networks to justify the outcomes of their planning processes. Do you believe this would be helpful? If so, what types of standards might Headquarter's use?

Answer: VHA agrees with the need to develop objective and measurable criteria that can be used to evaluate the service delivery options and the associated capital realignment proposals that will result from the Capital Asset Realignment for Enhanced Services (CARES) process. As requested by the Subcommittee, VHA is committed to the development of objective, measurable evaluation criteria and a rating scale that will allow VHA to quantify the degree to which each option or recommendation satisfies the decision criteria. The evaluation and ranking methodology being considered by VHA is based upon the methodology that VA uses for evaluating and ranking the Department's major capital investment proposals by the VA Capital Investment Board (VACIB). Over the next 30 days, VA will develop the draft weighting criteria and an outline of the decision model. VHA will involve other Department Administrations and offices, and GAO, and seek advice of VA stakeholders in this process. VHA will provide a report to the subcommittee in 30 days that will identify draft evaluation criteria and will outline the process to involve stakeholders in the development of criteria weights, specific identification of quantifiable sub-criteria, identification and linkage of specific data to each of the sub-criteria, development of rating scales for evaluating the proposed options and incorporation of all of this into a methodology that will be used to evaluate CARES study recommendations. The final report and completed methodology, including specific criteria and sub-criteria with relative weights and the rating scales will be provided in 60 days.

2. Dr. Murphy, I understand that my staff requested information about the minor construction projects VA is funding for FY 2000, but VA was not able to coordinate this information in time for the hearing today. If this information is not readily available to HQ staff, how is this process being

overseen? What exactly is VA's approval process for minor construction projects?

Answer: VAHQ staff reviews and approves the VISN operating plan for minor construction projects each year. This approved list of projects is readily available to HQ staff. No project can be funded that is not on this approved operating plan. These plans, however, include an "over-subscription" of approximately 30%. This means that the list of projects on the approved operating plan exceeds available budget allocations by approximately 30%. This oversubscription allows the networks to obligate all of the minor construction funds they are allocated each year while accounting for delays during project development that are unavoidable. A list of projects that had been actually funded (obligated) from this list of approved operating plan projects was not readily available when requested by your staff. In order to provide this information it was necessary to run a query of the two data bases (i.e. the approved operating plans against the actual obligations in the Financial Management System (FMS) database). This list of funded minor construction projects in each VISN since FY 1999 is attached. Also attached is a White Paper describing the selection/approval process for VHA minor construction projects.

3. VA has established 388 community-based outpatient clinics in recent years. How many more do you believe will open? Do you have any ideas about what types of services facility directors might be cutting to support so many new clinics?

Answer: The Strategic Plans submitted by VISNs last year identified plans for a total of 659 CBOC's by FY 2003. Depending on availability of resources in FY 2001, we may reach that level in FY 2001 or 2002. When the strategic plans are updated this year, we would expect the outyear projections for CBOC's to increase above this level. Facilities have generated resources for new CBOC's from a number of sources including, closure of unnecessary inpatient beds, reducing or streamlining administrative support processes, implementing more efficient care management strategies, pharmacy benefits management efficiencies, and from additional resources provided by the appropriations acts.

4. Since FY 1996, VA has opened many new community outpatient clinics, and at the same time it has closed a number of its women's clinics. Can you explain this trend? If not, is VA taking steps to remedy it?

Answer: One of the benefits of establishing Community Based Outpatient Clinics (CBOCs) was to provide alternative sites of service to the existing medical centers as well as make VA health care more accessible to veterans. Some of the medical centers originally designed their Women's Health Clinics to provide gender-specific specialty care e.g., gynecology exams, Pap, general reproductive health care, breast care, and sexual trauma screening for women veterans.

With the shift from specialty to primary care the trend has been to mainstream women's health as well as other specialty clinic patients into existing primary care clinics or teams. Many interpret this mainstreaming of women's health into primary care as a move to eliminate the women's clinic when, in fact, the individual needs of these women are being met in clinics of another name or type. Most of the primary care teams have designed private waiting rooms for women veterans and meet other needs women may have surrounding privacy issues. It should be noted that many primary care clinics have a specific team devoted to the delivery of primary care to women veterans exclusively and those that do not, often have at least one health care provider on the team that specializes in women's health care.

It is true that the number of separate women's health clinics has decreased from 98 in FY 1996 to 92 in FY 1998. There is however, no direct correlation between the number of women's clinics and the number of CBOC's. CBOC's were developed to improve access to all veterans, women included, who live in remote areas to eliminate the need to travel great distances to VA medical centers for a brief clinic appointment. The CBOC's were never envisioned to provide comprehensive or specialized health care services, but rather serve as primary care access points.

The women's clinics that were designed to provide comprehensive primary care to women including gender-specific health care are consistent with the direction the VA health care delivery system is moving. The Deputy Under Secretary of Health has recently charged a Women Veterans National Strategic Work Group with the responsibility of evaluating the primary health care delivery models where women are receiving care and recommend creative alternatives to ensure that women veterans receive appropriate, accessible, coordinated and compassionate health care services.

5. As you know, the House-passed version of the Veterans' Millennium Health Care Act had an enhanced services provision which shares some similarities to the CARES initiative VA has proposed. It also may have some important differences. Under the CARES initiative, will savings be retained locally? Would employees have protection if they were displaced in implementing the plan?

Answer: Under the proposed CARES initiative, operating savings resulting from implementation of a CARES proposal would be retained at the local network and used to enhance veterans' health care within that local network. Likewise, proceeds from sharing agreements or enhanced-use lease agreements would be retained at the local network. These revenues would also be used to enhance veterans' health care services in the local network.

With regards to employee protection associated with potential closures, mission changes and down-sizing of VA health care facilities resulting from CARES, VHA

has existing policies in place that would provide protection for employees that are displaced in implementing the plan. On September 12, 1995, the President issued a memorandum requiring all Executive branch agencies to develop career transition assistance programs to help their employees affected by reduction in force. The Office of Personnel Management (OPM) issued regulations establishing a new Interagency Career Transition Assistance Plan (ICTAP) requiring agencies to establish Career Transition Assistance Plans (CTAP). VA's CTAP was issued consistent with OPM's government-wide regulations and consists of three parts:

1. Providing over a dozen career transition services to assist all VA employees affected by downsizing;

2. Giving special selection priority to agency surplus and displaced employees (those who have been identified for separation by reduction in force) who apply for competitive service agency vacancies in the local commuting area;

3. Maintaining a Reemployment Priority List (RPL) to provide rehiring priority to displaced VA employees. RPL assistance is available as soon as an employee has received a RIF separation notice and for up to 2 years after separation.

ICTAP is a new system that requires agencies to select displaced employees for vacancies in other agencies when the employee applies directly for the vacancy and is determined by the agency to be well-qualified for the job.

6. Why should Capital Asset planning begin in the network? Even under a decentralized management system, shouldn't VA's leaders have an idea of how its field managers are using resources across the nation?

Answer: VHA's National Strategic Planning Guidance identifies VA's corporate goals, VHA mission goals, strategic targets, performance measures, and VHA values. Together, these define the strategic planning requirements and framework for VISN plans. Within this framework, VISNs formulate a specific plan for best meeting those goals in the context of the local health care environment and the network's individual strengths, opportunities, and weaknesses. This flexibility to allow local health care decisions is essential to the Veterans Integrated Service Network concept. Capital Asset plans are linked to specific network operating strategies and performance objectives that are identified in their network strategic plans and therefore support the corporate goals and objectives.

Capital investment decisions at the VISN reflect national goals, strategic targets and program requirements. Major capital investment proposals require submission to the Department's Capital Investment Board for evaluation and approval prior to funding. VISNs submit operating plans for the minor

construction and the non-recurring maintenance programs so that VA senior managers are aware of how these resources are being used across the nation. Selected investment decisions within the Minor and NRM programs also undergo a formal validation review by VHA headquarters staff to ensure that investment decisions are made to spend scarce capital program funds on buildings or programs that reflect the current and future priorities of VHA and the department.

7. Do you agree that VA needs to perform a thorough needs assessment and have its headquarters create guidelines for restructuring based on filling these needs? Why or why not?

Answer: As noted in the response to question #1, VHA agrees that achieving excellence in providing veterans' health care is one of the prime criteria that should be used to evaluate realignment proposals resulting from CARES studies. In order to achieve excellence in meeting those needs, we must first have a clear understanding of what those needs are. The CARES studies will assess the health care needs of veterans in each network and then identify service delivery options and capital alignments to better meet those needs. As noted above, VHA has committed to the development of objective and quantifiable evaluation criteria that are linked to specific health care data and patient outcomes. VHA senior management will weight these criteria and develop rating scales that will determine how well a particular service delivery option meets the identified evaluation criteria. The weighted decision criteria and the rating scales will be incorporated into an evaluation methodology or decision model that VHA will use to evaluate restructuring proposals. The consultants selected to perform the CARES studies will be provided with the criteria and the decision methodology and, in conjunction with the network and the Capital Asset Planning Committees to be established in each network, ensure that all service delivery option and capital realignment proposals identified in the CARES process address each of the decision criteria.

Attachment to Question 2

White Paper

Minor Capital Initiative Prioritization/Selection Methodology

April 14, 2000

The process for selecting Minor capital investment proposals for funding is decentralized to the networks. Minor capital initiatives are prioritized and selected based on the network's assessment of how well a proposed initiative supports their performance plan measures and the correlation or linkage of an investment proposal to the Network Strategic Business Plan. Each network has developed a methodology for evaluating, ranking, and selecting capital initiatives. These methodologies are unique to each network but all of the methodologies share common core evaluation criteria. Included in these criteria are : Customer Service, Return on Taxpayer Investment, Risk, Alternative Analysis, and Strategic linkage. Network organizational structures in place to perform these reviews also vary, but most networks have implemented processes involving a multiple tiered review that starts at the individual medical center completing an application, review and evaluation by a network engineering council or a similar group, and final approval by a network executive leadership council. Commencing with the project selections in the network's FY 2000 Operating Plans, a formal VHA Headquarters (VAHQ) review of selected minor capital initiatives was also implemented. This review was limited to minor inpatient category projects for FY 2000 but will be extended to all minor projects beginning in FY 2001. The VAHQ review validates network investment decisions in the context of the future mission of the affected facility or the future of the affected program.

VA Headquarters provides guidance to the networks annually in February/March for submission of capital investment proposals. Networks then issue their own call for capital investment applications, usually in March or April each year. Applications received in response to this call letter are then evaluated, ranked and prioritized as described in the previous paragraph. The network Executive Leadership Council approves selections for funding in September. The network submits their annual operating plan, along with the schedule for project awards, in October. These operating plans are subject to approval by the Assistant Secretary for Financial Management (004). Typically, projects included in the operating plans are scheduled for an actual obligation during that fiscal year. Minor Operating Plans are oversubscribed each year by approximately 30% to allow flexibility for project slippage or other delays in project development. Therefore, not all projects on an approved operating plan will actually be awarded each year but these priorities are revalidated and carried forward to the operating plan for the following year.

The funds for the minor program are allocated to the networks based on network workload and geographic cost indices. The detailed accounting and tracking of those funds are maintained at the network. The network performance monitors include the management and obligation of minor funds. These performance monitors are reviewed by the Chief Network Officer (CNO) with the network directors quarterly. Only minor projects that are on the approved operating plans may be funded. This control is ensured by the VHA headquarters budget office at the time of request for transfer of disbursing authority (TDA). No TDA can be processed to make an award unless the project is on an approved operating plan that has been approved by the Assistant Secretary for Financial Management. Obligation of minor project funds is maintained and can be tracked in the Financial Management System (FMS) database. VHA is currently in the process of developing a reporting system that will match projects in the approved operating plan database against obligations in the FMS database. This will allow VHA to generate a standard report for projects in the approved plans that have actually been obligated. These reports can be run with a manual query at this time if there is a need to have the information. The automated report query is scheduled for implementation later this fiscal year.

Post-Hearing Questions
Concerning the April 5, 2000, Hearing

for
Dr. Terrence S. Batliner
Director, VISN 19
Veterans Health Administration, Department of Veterans Affairs

from
The Honorable Lane Evans
Ranking Democratic Member, Veterans Affairs' Committee
U.S. House of Representatives

Question: Dr. Batliner, if plans go as you hope, Fort Lyon will soon be turned over to the State of Colorado. Veterans are an aging population and we just enacted the Veteran Millennium Health Care Act, which has some mandates for providing long-term care and maintaining capacity of VA's long term care system. How do you plan to fill the holes this will place in your Network's long-term care program?

Answer: The Millennium Health Care Act requires the VA to maintain long-term care capacity nationally. It allows for local adjustments to the system so long as the national capacity is maintained and veterans needs are addressed. The VA is committed to maintaining that capacity.

In Colorado, we can serve veterans better by placing them in nursing homes closer to their relatives and families. The most frequent complaint in this VISN over the past four years involves Fort Lyon. Relatives of residents there have been upset about the distance to Fort Lyon from Denver, Colorado Springs and Pueblo. They have had to drive for hours to visit their family members. This is a hardship for the families and the veterans.

If approved, we will close 216 long-term care beds in Fort Lyon and open 40 (+ or -) in Pueblo. We will work with nursing home residents displaced from Fort Lyon to find suitable placements in other VA nursing homes, state veteran homes and private sector nursing homes. This will be done at no additional cost to them. I also want to make it very clear that we will continue, into the future, to serve veterans needing long-term care through placements in VA run facilities, private sector nursing homes and state veterans homes, as prescribed by law and regulation.

There are over 20,000 long-term care beds in Colorado. We can provide much of the long-term care needed by veterans through collaboration with the private sector. Our Network data clearly indicates that the cost of a long-term care bed in

the community is significantly less than in the VA. We provide a more intensive level of care than most private sector nursing homes. Patients with dementia, serious psychiatric disorders and those patients that can benefit from physical and occupational therapy should be treated in a VA run facility. This type of patient can benefit greatly from the type of services that we offer in house. Custodial nursing home patients, however, can be treated very adequately in the private sector, at locations more convenient to their relatives and in a more cost effective manner.

The attached Project listing represents minor projects for which there were actual obligations made in FY 98, 99, or 2000.

The previously maintained Construction Management Information System (CMIS) database is no longer supported by the Office of Facilities Management for minor construction projects and an automated report showing actual obligations by project is not currently available. The VISN Support Service Center is in the process of developing an automated report menu for minor construction projects that will include an automated report for showing actual obligations. This report menu will not be operational until FY 2001.

The attached report was generated by matching projects in the approved FY 98, 99 and 2000 minor operating plan database against projects with actual obligations in the Financial Management System (FMS) database. Projects that appear in both the approved operating plan and the FMS database show up in this report (i.e. projects that were approved for funding AND had actual obligations recorded against them). Because a project may have been included in approved operating plans in multiple years (for example design development in FY 98, construction document preparation in FY 99, and construction award in FY 2000), it is possible for the project to show up in this report as multiple entries. The report has been sorted by network and arranged by project number to make it easy to identify those situations where obligations in more than one year have occurred. The obligation information reported from FMS is the cumulative obligations against that project in all years.

Minor Project Obligations from Approved Operating Plans FY 98-00

NETWORK	Plan Year	FACILITY	Proj. #	PROJECT TITLE	TARGET	Obligated
1	1998	TOGUS	402OP3281	AMBULATORY CARE/ LODGING	869,000.00	815,091.10
1	1999	TOGUS	402OP3284	AMBULATORY SURGERY	851,413.00	
1	2000	Togus	402OP3284	AMBULATORY SURGERY	893,000.00	
1	1998	WHITE RIVER	406OP3301	RENOVATE AMBULATORY CARE	2,716,000.00	3,177,077.00
1	2000	White River Junction	406DT3603	BUILDING #28 RENOVATIONS	1,187,700.00	
1	2000	White River Junction	406PP3311	UTILITY REPAIRS	2,175,750.00	
1	1999	BEDFORD	518IP3300	EXPAND B-4	334,500.00	
1	1998	BOSTON	523IP3304	WARD RENOVATION	1,867,800.00	119,039.96
1	2000	Boston HCS	523IP3334	OR Expansion B2-3	3,420,000.00	-
1	2000	Boston HCS	523IP3335	MICU, GI & Medical Stepdown, B2-1	3,765,625.00	
1	2000	Boston HCS	523IP3336	Medical Nursing Unit, B1-2N	2,012,250.00	-
1	2000	Boston HCS	523IP3337	PACU & Surgical Stepdown B1-3S	2,513,750.00	-
1	2000	Boston HCS	523IP3338	Surgical Support Space B2-3	622,500.00	-
1	2000	Boston HCS	523IP3339	Surgical Nursing Unit B1-3N	2,012,250.00	
1	2000	Boston HCS	523IP3340	Cardiac Catheterization, B1-5N	632,500.00	
1	2000	Boston HCS	523IP3344	Medical Nursing Unit B1-2S	2,012,250.00	
1	2000	Boston HCS	523IP3345	Psychiatric Nursing Unit B1-4N	2,012,250.00	
1	2000	Boston HCS	523IP3347	Primary Care & ER Modifications,B3-G	1,209,750.00	
1	1999	BOSTON	523OP3310	HUNTINGTON HOUSE-1ST,3RD,5/4TH FLS	760,000.00	89,455.00
1	2000	Boston HCS	523OP3317BR	RENOVATE B3 FOR AMB CARE(BR)	3,960,000.00	
1	2000	Boston HCS	523OP3330	Eye Clinic Consolidation, B1-5B	707,000.00	
1	2000	Boston HCS	523OP3331	Audiology & SP Consolidation, B1-5D/E	1,160,000.00	-
1	2000	Boston HCS	523OP3332	Dental Clinic Consolidation B1-2C	887,500.00	-
1	2000	Boston HCS	523OP3333	Outpatient Oncology Consolidatio, B1-1D/E	989,250.00	
1	2000	Boston HCS	523OP3342	Support Service Modifications, JP	1,245,000.00	-
1	2000	Boston HCS	523OP3349	Prosthetics Consolidation, B1-8C	608,900.00	46,004.00
1	2000	Boston HCS	523PP3309	UPGRADE HVAC SYSTEM	3,202,500.00	
1	2000	Boston HCS	523PP3343	Support Service Modifications,WR	1,245,000.00	-
1	2000	Boston HCS	523PP3346	Infrastructure Improvements, WR	1,812,500.00	16,000.00

NETWORK	Plan Year	FACILITY	Proj. #	PROJECT TITLE	TARGET	Obligated
1	2000	Boston HCS	523PP3348	Infrastructure Improvements, Jamaica Plain	1,812,500.00	29,980.00
1	1998	BROCKTON	525OP3306	CENTRALIZE MSDU (WR)	2,714,000.00	244,370.50
1	1999	BROCKTON	525OP3306	CENTRALIZE MSDU (WR)	2,464,000.00	244,370.50
1	1999	BROCKTON	525OP3317	RENOVATE B3 FOR AMB CARE, PH I	3,972,000.00	
1	1999	BROCKTON	525OP3403	MAGNETIC RESONANCE IMAGING(WR)	1,960,000.00	-
1	1998	MANCHESTER	608IP3309	SAME DAY SURGERY IMPROVEM	201,000.00	1,989,981.00
1	2000	Northampton	631IP3221	SPD improvements	1,370,760.00	
1	1998	PROVIDENCE	650OP3321	RENOVATE AMBULATORY CARE	2,683,000.00	2,727,556.51
1	2000	Providence	650OP3330	Renovate Diagnostic Service	2,396,000.00	
1	1999	WEST HAVEN	689IP3352	WARD UPGRADE G5W	310,000.00	
1	1999	WEST HAVEN	689OP3353	APU EXPANSION G-5-N	984,000.00	
2	1999	ALBANY	500IP3301	ICU/CCU RENOVATIONS	175,000.00	148,256.00
2	2000	Albany	500IP3301	RENOVATE ICU/CCU	2,012,000.00	148,256.00
2	1998	ALBANY	500OP3201	RENOVATE OUTPATIENT SURGI	1,406,703.00	1,779,726.26
2	1998	ALBANY	500OP3300	RENOVATE OUTPATIENT SURGI	192,600.00	1,868,418.52
2	1999	ALBANY	500OP3300	RENOVATE OUTPATIENT SURGICAL SUITE PHASE II	1,337,575.00	1,868,418.52
2	1998	BATH	514OP3301	AMB. CARE 2ND FL., B-78,	2,558,000.00	261,935.00
2	1998	BATH	514OP3303	AMB. CARE 2ND FL., #2	200,000.00	
2	1999	BATH	514PP3300	CENTRAL CHILLER PLANT, B-76	170,000.00	
2	1998	BUFFALO	528OP3304	OUTPATIENT CLINIC CONVERS	1,518,000.00	1,559,909.03
2	1998	BUFFALO	528OP3309	CONSOLIDATE AMBULATORY CA	117,360.00	-
2	2000	W. New York HCS	528PP3320	PHASE I HVAC	3,345,000.00	
2	1999	BUFFALO	528PP3601	HVAC SITE PREP PLAN	125,000.00	-
2	1998	CANANDAIGUA	532IP3311	RENOV 1C FOR MANAGED CARE	245,000.00	-
2	1999	CANANDAIGUA	532OP3312	RELOCATE DENTAL & CLINICAL LAB	2,634,000.00	
2	1999	CANANDAIGUA	532PP3313	HVAC, PATIENT BUILDINGS 3, 9 AND 33	300,000.00	299,245.15
2	2000	Syracuse	670OP3031	Renovate 1 South for Customer Service	1,080,000.00	
2	1999	SYRACUSE	670OP3362	PARKING GARAGE ADDITION	356,000.00	
2	1998	SYRACUSE	670OP3367	PATIENT BUSINESS AND ENTR	90,000.00	
2	1999	SYRACUSE	670OP3368	MRI SUITE	400,000.00	
2	1998	SYRACUSE	670PK4362	PARKING GARAGE ADDITION	297,000.00	
3	1998	BRONX	526IP3308	CONSOLIDATE INTENSIVE CAR	2,580,000.00	3,014,879.08
3	1999	BRONX	526IP3309	RENOVATE OP MENTAL HEALTH	2,903,000.00	
3	1999	BRONX	526IP3310	IMPROVE PATIENT PRIVACY	240,000.00	239,500.00

NETWORK	Plan Year	FACILITY	Proj. #	PROJECT TITLE	TARGET	Obligated
3	2000	Bronx	526IP3310	Improve Patient Privacy	2,819,500.00	239,600.00
3	2000	Bronx	526OT3312	Renovate Research Building	3,525,000.00	298,682.22
3	1998	BROOKLYN (CO	527IP3115	UPGRADE WARDS B-2 & B-3 (	2,497,000.00	3,215,284.39
3	1999	BROOKLYN (CO	527IP3115		3,133,872.00	3,215,284.39
3	1998	BROOKLYN (CO	527IP3305	RENOVATE WARD 13E AND 5E	1,728,000.00	1,943,689.33
3	2000	New York Harbor HCS	527IP3323	15 East Renovation	2,937,000.00	
3	1998	BROOKLYN (CO	527OP3301	AMB SURG/ SICU	2,688,000.00	2,940,393.00
3	1999	BROOKLYN (CO	527OP3321	BLDG 1. DOMINO TO NEW OPC BLDG.	250,000.00	250,000.00
3	2000	New York Harbor HCS	527OP3321	OPC Domino Bldg 1 Phase 1	2,750,000.00	250,000.00
3	1999	EAST ORANGE	561IP3300	RENOVATE 12A, SICU, OR	2,501,000.00	
3	2000	New Jersey HCS	561IP3300	RENOVATE 12A PSYCH/SICU/OR	2,809,000.00	
3	1998	EAST ORANGE	561OP3093	PRIMARY CARE/OUTPATIENT S	2,688,000.00	2,902,015.37
3	1998	EAST ORANGE	561OP3306	IMPROVE OP. ENVIRONMENT	200,000.00	2,252,579.00
3	1999	EAST ORANGE	561OP3306	IMPROVE OP. ENVIRONMENT	1,500,000.00	2,252,579.00
3	1998	EAST ORANGE	561PP3435	WARD MOD. + ENVIRON IMPRO	120,000.00	120,000.00
3	2000	New Jersey HCS	561PP3435	HVAC IMPROVEMENTS	2,020,000.00	120,000.00
3	2000	Hudson Valley HCS	620IP3311	Patient Privacy 10CD	2,750,000.00	
3	1999	MONTROSE	620IP3312	PATIENT PRIVACY 10AB	2,688,000.00	
3	2000	Hudson Valley HCS	620IP3312	Patient Privacy 10AB	3,525,000.00	
3	1998	MONTROSE	620IP3313	PATIENT PRIVACY 13AB	280,000.00	259,999.27
3	1998	NEW YORK	630IP3036	PATIENT PRIVACY,PSYCH	2,688,000.00	2,086,030.00
3	2000	New York Harbor HCS	630IP3037	PATIENT PRIVACY 17N	2,750,000.00	
3	2000	New York Harbor HCS	630OP3089	MODERNIZE CLINIC 8W	2,200,000.00	
3	1999	NEW YORK	630OP3210	MODERNIZE CLINICS,5N AND 5W	2,499,000.00	2,145,000.00
3	2000	New York Harbor HCS	630OP3215	MODERNIZE CLINICS 5W	2,210,000.00	
3	1998	NORTHPORT	632IP3313	RENOVATE UNITS 41/42	280,000.00	3,674,000.00
3	1999	NORTHPORT	632IP3313	RENOVATE UNITS 41/42	2,561,000.00	3,674,000.00
3	2000	Northport	632IP3316	Renovate Acute Med/Surg Unit	2,925,000.00	
3	1998	NORTHPORT	632OP3312	RENOVATE HOPTEL	1,200,000.00	1,200,222.72
3	2000	Northport	632OP3315	Revovate Outpatient Psych	3,650,000.00	
3	2000	Northport	632OT3311	Improve Pavilion Lower Level	2,875,000.00	
4	1998	WILMINGTON	460IP3301	CONSOLIDATE ICU (GPICU)	1,928,000.00	2,088,460.37
4	1999	WILMINGTON	460OP3203	CONSOLIDATE RMS (DOMINO)	90,000.00	81,035.89
4	2000	Wilmington	460OP3203	Consolidate RMS	878,000.00	81,035.89

NETWORK	Plan Year	FACILITY	Proj. #	PROJECT TITLE	TARGET	Obligated
4	1999	ALTOONA	503OP3301	CORRECT OUTPATIENT DEFICIENCIES	2,367,000.00	90,027.76
4	1999	BUTLER	529IP3301	MODIFY FOR BED CONVERSION, 4E	3,440,000.00	
4	2000	Butler	529IP3305	Renovate 2 East	2,940,000.00	
4	1998	BUTLER	529NH3301	MODIFY FOR BED CONVERSION	190,000.00	2,679,927.96
4	1998	BUTLER	529OP3302	CLINICAL ADDITION PH 2	3,445,000.00	3,723,000.00
4	1998	CLARKSBURG	540OP3303	OUTPATIENT SUPPORT RENOV.	250,000.00	280,765.17
4	1999	CLARKSBURG	540OP3303	OUTPATIENT SUPPORT RENOV.	3,863,000.00	280,765.17
4	2000	Clarksburg	540OP3303	OUTPATIENT SUPPORT RENOVATION PH I	1,942,500.00	280,765.17
4	1998	COATESVILLE	542IP3205	ADOL. FEMALE BATHROOMS/SH	672,000.00	86,634.64
4	2000	Coatesville	542IP3306	Renovate Ward B59	3,750,000.00	-
4	1999	ERIE	562OP3212	OUTPATIENT CLINICS 6 AND 7		1,680,618.00
4	1998	ERIE	562OP3303	AMBULATORY CARE/SURGICAL	2,751,000.00	2,112,851.36
4	2000	Erie	562OP3309	OUTPATIENT RENOVATION	3,885,000.00	319,227.00
4	1998	LEBANON	595EV3301	NEW ELEVATOR/IMPROVEMENTS	1,000,000.00	103,000.00
4	1999	LEBANON	595OP3326	CLINICAL SUPPORT FOR OUTPATIENT CLINIC	173,000.00	192,150.00
4	2000	Lebanon	595OP3326	Clinic Support for OPC	2,132,000.00	192,150.00
4	2000	Lebanon	595OP3433	AMBULATORY CARE IMPROVEMENTS	2,176,000.00	
4	1998	PHILADELPHIA	642IP3302	RENOVATE WARDS 5W/6W	310,000.00	3,225,368.78
4	1999	PHILADELPHIA	642IP3302	RENOVATE WARDS 5W/6W	3,440,000.00	3,225,368.78
4	2000	Philadelphia	642OT3303	Pedestrian Bridge	1,500,000.00	
4	2000	Pittsburgh	646IP3352	Pathology CAP Deficiencies	3,940,000.00	
4	2000	Pittsburgh	646IP3361	Correct Life Safety Deficiencies UD	3,910,000.00	-
4	1998	PITTSBURGH (	646OT3351	94 WARD IMPROVEMENTS (HD)	2,475,000.00	2,428,923.02
4	1999	PITTSBURGH (	646PP3352	PATHOLOGY CAP DEFICIENCIES	304,000.00	372,442.98
4	2000	Wilkes-Barre	693IP3307	Renovate Ward 4-West	2,200,000.00	
5	1998	BALTIMORE	512IP3500	RENOVATE WARD 23B FOR LON	175,000.00	1,722,008.80
5	1999	BALTIMORE	512IP3500	RENOVATE WARD 23B FOR LONG TERM CARE	1,609,000.00	1,722,008.80
5	1999	BALTIMORE	512OP3251	ADULT DAY HEALTHCARE CENTER	93,000.00	
5	1998	BALTIMORE	512OP3303	EXPAND PRIMARY CARE CLINI	805,000.00	1,653,772.63
5	2000	Maryland HCS	512OP3503	Admin. & Adult Day Health Bldg.	3,900,000.00	
5	2000	Maryland HCS	512OP3540	Loch Raven Imaging Center	894,000.00	158,630.08
5	1998	MARTINSBURG	613IP3061	RENOVATE BLDG 314	100,000.00	-
5	2000	Martinsburg	613IP3063	CONSTRUCT DOM POD	3,540,000.00	32,592.00
5	1998	WASHINGTON DC	688IP3314	PATIENT PRIVACY PHASE 2	275,000.00	2,731,633.00

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5	1999	WASHINGTON D	668IP3314	PATIENT PRIVACY PHASE 2	2,500,000.00	2,731,633.00
5	2000	Washington	668IP3318	PATIENT PRIVACY PHASE 3	2,220,000.00	136,862.00
5	1998	WASHINGTON DC	668OP3310	EXPAND PRIMARY CARE	2,755,000.00	2,742,973.24
5	1999	WASHINGTON D	668OP3317	RELOCATE/EXPAND DIALYSIS	160,000.00	
5	2000	Washington	668OP3317	RELOCATE/EXPAND DIALYSIS	3,260,000.00	
6	1999	BECKLEY	517PP3300	PRIMARY ENTRANCE	320,000.00	
6	1998	DURHAM	558OP3310	O.R. RENOVATION	215,000.00	3,332,871.93
6	1999	DURHAM	558OP3310	O.R. RENOVATION	3,638,000.00	3,332,871.93
6	2000	Fayetteville	565IP3302	Renovate NHCU	2,671,400.00	
6	1998	HAMPTON	590IP3208	RENOVATE PCP	170,000.00	2,453,270.00
6	1999	HAMPTON	590IP3208	RENOVATE PCP	1,878,000.00	2,453,270.00
6	2000	Hampton	590IP3225	Renovate ECRC for Geriatric Psychiatry	2,080,000.00	
6	1999	HAMPTON	590OP3221	RENOVATE 137 FOR PSYC SERVICES	300,000.00	299,675.00
6	2000	Hampton	590OP3221	Renovate Psych Building 137 Section A	3,135,500.00	299,675.00
6	2000	Asheville	637OT3309	Correct SPD Deficiencies	894,418.00	
6	1998	ASHEVILLE	637OU3201	ADULT DAY CARE/CLINICS, B	713,000.00	71,312.37
6	2000	Richmond	652OP3302	Psychiatric Day Treatment	1,846,000.00	
6	2000	Richmond	652OP3303	Expand Subspecialty Primary Care	2,080,600.00	160,000.00
6	1998	SALEM	658IP3302	B 10 PSYCH ACUTE CARE, PH	2,250,000.00	-
6	1998	SALISBURY	659OP3303	ESTABLISH PRIMARY CARE UN	1,886,000.00	2,117,601.67
7	1999	ATLANTA	508OP3212	REN SHELL SPACE FOR OUTPATIENT	2,750,000.00	2,980,436.00
7	1998	ATLANTA	508OP3305	RENOVATE AMB CARE(PHASE I	250,000.00	420,093.55
7	1999	ATLANTA	508OP3305	RENOVATE AMB CARE(PHASE II)	310,000.00	420,093.55
7	2000	Atlanta	508OP3305	RENOVATE AMB CARE (PHASE II)	3,900,000.00	420,093.55
7	1998	AUGUSTA (CON	509OP3309	PRIMARY CARE CLINIC SUPPO	77,132.00	1,737,788.08
7	1999	AUGUSTA (CON	509OP3309	PRIMARY CARE CLINIC SUPPORT DD	2,039,367.00	1,737,788.08
7	1998	BIRMINGHAM	521OP3307	COOR. PRIM. CARE & MH CAR	940,000.00	887,229.53
7	1998	BIRMINGHAM	521OP3312	SUBSPECIALTY CARE CLINICS	1,070,000.00	1,088,780.49
7	1999	BIRMINGHAM	521OP3316	GYN/FEMALE/ADMIN CLINICS	751,012.00	759,323.00
7	2000	Birmingham	521OT3315	Consolidate Business Office	1,659,212.00	173,135.00
7	1998	BIRMINGHAM	521OU3201	RENOVATE SURGERY CLINIC	100,023.00	746,185.28
7	1998	CHARLESTON	534CL3056	AMBULATORY CARE EXPANSION	343,251.00	2,765,395.76
7	1998	CHARLESTON	534IP3088	WARD RENOVATIONS PH III	142,093.00	
7	1999	CHARLESTON	534OP3302	EXPAND SPECIALTY CLINIC	717,558.00	538,132.49

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7	2000	Charleston	534OP3302	Expand Specialty Clinics	564,558.00	536,132.49
7	2000	Charleston	534OP3310	Expand Outpatient Clinic - Myrtle Beach	254,000.00	
7	1998	CHARLESTON	534OP3811	RENOVATE PRIMARY CARE SVC	630,000.00	616,119.00
7	1998	COLUMBIA, SC	544IP3305	COMMUNITY STD UPGRADE OF	298,000.00	280,442.00
7	1999	COLUMBIA, SC	544IP3305	COMMUNITY STD UPGRADE OF SURGICAL INPATIENT B	387,000.00	280,442.00
7	1998	COLUMBIA, SC	544OP3302	AMBULATORY CARE EXPANSION	2,520,000.00	3,467,563.00
7	1999	DUBLIN	557IP3201	RENOVATE 12 NHCU	392,063.00	379,558.00
7	2000	Dublin	557IP3201	Renovate 12A NHCU	3,950,000.00	379,558.00
7	1999	MONTGOMERY	619IP3314	RENOVATE B-69 FOR LONG TERM PSYCHIATRY	330,216.00	295,401.00
7	2000	Alabama Veterans HCS	619IP3314	Renovate Bldg. 4/4A for Mental Health Programs	3,418,016.00	295,401.00
7	1998	TUSCALOOSA	679CL3301	DEMENTIA SPECIAL CARE UNI	68,714.00	1,680,810.86
7	1998	TUSCALOOSA	679OP3305	OUTPATIENT PRIMARY CARE	98,000.00	
8	1998	BAY PINES	516OP3302	PRIMARY CARE INITIATIVES	737,000.00	790,047.08
8	1998	MIAMI	546OP3101	RENOVATE LABORATORY	183,144.00	2,493,000.00
8	1999	MIAMI	546OP3101	RENOVATE LABORATORY	2,813,347.00	2,493,000.00
8	2000	Miami	546PP3102	HVAC Upgrade	2,579,000.00	263,481.75
8	1999	MIAMI	546PP3103	PATIENT AIR QUALITY	201,450.00	199,078.20
8	2000	Miami	546PP3103	Patient Air Quality	2,357,955.00	199,078.20
8	2000	N. Florida/S. Georgia HCS	573IP3311	Patient Privacy 2S & 3S (Lake City)	2,182,654.00	
8	1998	GAINESVILLE	573PP3302	UPGRADE O.R. SUITES	190,000.00	1,827,057.90
8	1999	GAINESVILLE	573PP3302	UPGRADE O.R. SUITES	1,361,000.00	1,827,057.90
8	1998	LAKE CITY	594OP3303	EXPAND OUTPATIENT CLINIC	2,612,998.00	2,729,540.23
8	1998	SAN JUAN	672IP3200	MICU RELOCATION & EXPANSI	20,000.00	
8	1998	SAN JUAN	672IP3313	UPDATE SURGICAL/LAB/SPD A	286,000.00	2,616,993.00
8	2000	San Juan	672IP3702	WARDS A4, 2D1 & 2D2	2,999,896.00	
8	1998	SAN JUAN	672OP3401	OPA BACKFILL BLDG. 1	272,465.00	267,388.00
8	2000	San Juan	672OP3401	OPA BACKFILL BLDG. 1	2,997,465.00	267,388.00
8	2000	San Juan	672OP3701	Dialysis, Fiscal, Prosthetics Relocation	2,999,257.00	
8	2000	San Juan	672OT3313	UPDATE SURGICAL/LAB/SPD ACV SYSTS	2,997,000.00	
8	1998	SAN JUAN	672PP3307	CHILLED WATER PLANT REPL.	2,591,000.00	3,299,177.00
8	1999	SAN JUAN	672PP3313	UPDATE SURGICAL/LAB/SPD ACV SYSTS	2,711,000.00	
8	1998	TAMPA	673IP3077	EXPAND SICU, MICU, CCU, P	1,100,000.00	1,755,921.24
8	1999	TAMPA	673IP3082	RENOVATE MICU	298,000.00	293,273.00
8	1999	TAMPA	673IP3084	CONSTRUCT SICU	2,261,500.00	1,675,700.00

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8	2000	Tampa	673IP3089	RENOVATE MICU	2,968,000.00	
8	1999	TAMPA	673OP3103	AMBULATORY CARE ACCESS IMPROVEMENTS ORLAND	72,081.00	56,726.50
8	2000	Tampa	673OP3103	ORL AMB CARE IMPROVE, PH-1	792,874.00	56,726.50
8	2000	Tampa	673OT3408	LAND PURCHASE/PARKING	2,734,000.00	
9	1999	HUNTINGTON	581OP3207	EXPAND ER	120,000.00	-
9	2000	Huntington	581OP3208	Expand ER	1,478,000.00	122,294.03
9	1998	HUNTINGTON	581PP3206	REPLACE HVAC, BLDG. 2	160,000.00	2,084,750.66
9	1999	HUNTINGTON	581PP3206	REPLACE HVAC, BLDG. 2	1,441,000.00	2,084,750.66
9	2000	Huntington	581PP3209	UPGRADE A/C, BLDG. 12	1,842,500.00	-
9	1998	LEXINGTON (C	596CL3062	RENOVATE PATHOLOGY	2,736,000.00	266,452.47
9	1999	LEXINGTON (C	596OP3305	ESTABLISH AMBULATORY SURG	405,000.00	3,446,189.96
9	1999	LEXINGTON (C	596OP3305	ESTABLISH AMB. SURG.,PH 1 (C)	2,849,000.00	3,446,189.96
9	2000	Lexington	596OP3305	Establish Amb. Surg., PH 1 (C)	3,670,000.00	3,446,189.96
9	1998	LEXINGTON (C	596OP3318	CONVERT 2 WEST, AMB. CARE	2,517,313.00	2,204,966.22
9	2000	Lexington	596OP3319	Consolidate Pharmacy Ops (C)	3,467,500.00	-
9	1998	LOUISVILLE	603IP3302	REMODEL CCU/MICU	132,000.00	1,769,552.24
9	1999	LOUISVILLE	603IP3302	REMODEL CCU/MICU	1,853,000.00	1,769,552.24
9	1999	LOUISVILLE	603IP3310	REMODEL 5B	120,000.00	180,000.00
9	2000	Louisville	603IP3310	REMODEL 5B	1,360,000.00	180,000.00
9	2000	Louisville	603IP3312	CREATE PUBLIC RESTROOMS	1,333,300.00	-
9	1998	LOUISVILLE	603OP3304	CONSTRUCT AMBULATORY SURG	2,379,000.00	2,748,025.96
9	1998	MEMPHIS	614OP3307	OUTPATIENT IMPROVEMENTS	232,000.00	1,939,305.67
9	1999	MEMPHIS	614OP3307	OUTPATIENT IMPROVEMENTS	2,494,000.00	1,939,305.67
9	1999	MOUNTAIN HOM	621OT3301	CONSTRUCT LAKE DRIVE ENTRANCE (DOMINO)	120,000.00	
9	2000	Murfreesboro	622OP3201	Women's Clinic	778,080.00	-
9	1999	NASHVILLE	626IP3302	WARD UPGRADE PH 3 FOR PATIENT PRIVACY	375,000.00	366,979.96
9	2000	Nashville	626IP3302	Ward Upgrade PH 3 for Patient Privacy	3,600,000.00	366,979.96
10	1998	CHILLICOTHE	539OP3300	CONNECTING CORRIDOR BLDGS	698,000.00	
10	1999	CINCINNATI	539IP3305	CRITICAL CARE ADDITION	3,525,000.00	3,629,860.00
10	1998	CINCINNATI	539OP3301	EXPAND E.R. SUITE	3,136,000.00	3,784,214.45
10	1998	CINCINNATI	539OP3302	REMODEL O.R. SUITE	250,000.00	343,588.92
10	1999	CINCINNATI	539OP3302	REMODEL O.R. SUITE, PHASE 1	400,000.00	343,588.92
10	2000	Cincinnati	539OP3302	Remodel OR Suite PH 1	1,560,000.00	343,588.92
10	2000	Cleveland	541IP3328	PATIENT PRIVACY WARDS 52/54 (W)	3,988,000.00	

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10	1998	CLEVELAND	541NH3301	NHCU UPGRADE WARD 7 1 8	2,500,000.00	138,752.00
10	1999	CLEVELAND	541OP3270	RELOCATE RADIOLOGY (B)	1,498,000.00	2,474,000.00
10	1998	CLEVELAND	541OP3380	REMODEL CLINIC SPACE	150,000.00	
10	1998	DAYTON	552IP3320	RELOCATE NHCU & DOM	210,000.00	
10	1999	DAYTON	552OP3305	PRIME CARE ADDITION	400,000.00	410,215.23
10	2000	Dayton	552OP3305	Prime Care Addition	3,998,000.00	410,215.23
10	2000	Dayton	552OT3500	Mothball 4 buildings	150,000.00	7,469.52
11	1998	ANN ARBOR	508IP3201	NHCU PATIENT PRIVACY	2,000,000.00	2,219,478.05
11	1999	ANN ARBOR	508OP3301	EXPAND DENTAL	383,125.00	
11	2000	Ann Arbor	508PP3302	Upgrade Generator Coverage and Distribution	931,500.00	
11	1998	BATTLE CREEK	515OP3301	EXPAND OUTPATIENT AND ADM	2,563,000.00	3,987,794.01
11	1999	BATTLE CREEK	515OP3303	RENOVATE 7-2	300,000.00	261,755.00
11	2000	Battle Creek	515OP3303	Renovate Building 7	3,487,000.00	261,755.00
11	1998	BATTLE CREEK	515OT3177	PURCHASE LAUNDRY/WAREHOUS	2,473,000.00	2,073,075.00
11	2000	Danville	550OP3304	Renovations for Realignment of Amb Care B98	985,376.00	
11	1999	DANVILLE	550PP3302	UPGRADE ELEC DIST SYSTEM	2,562,000.00	3,545,336.60
11	1998	ALLEN PARK	563IP3302	REMODEL NHCU AT DETROIT	150,000.00	
11	1998	INDIANAPOLIS	583OT3201	RENOVATE NUCLEAR MEDICINE	536,000.00	557,731.97
11	1999	INDIANAPOLIS	583PP3313	EXPAND COOLING TOWER/RETROFIT	1,559,000.00	
11	1999	MARION, IN	610IP3308	RENOVATE NHCU	3,428,000.00	
11	2000	Northern Indiana HCS	610OT3310	Demolish Vacant Buildings, Marion Campus	2,876,000.00	
11	1999	SAGINAW	655OT3301	RENOVATE B22 BASEMENT FOR IRM & LIBRARY	897,000.00	678,617.80
12	1998	CHICAGO (WES	537OP3202	EXPAND AMBULATORY CARE CL	3,020,303.00	3,684,858.33
12	1999	CHICAGO (WES	537OP3202	EXPAND AMBULATORY CARE CLINICS	3,440,000.00	3,684,858.33
12	1999	CHICAGO (WES	537OP3230	EXPAND AMB. SURGERY - WS	275,000.00	
12	2000	Chicago HCS	537OP3230	Expand Ambulatory Surgery	3,177,500.00	
12	1998	CHICAGO (WES	537OP3303	RENOVATE AMBULATORY CARE/	2,413,275.00	2,009,310.85
12	2000	Chicago HCS	537OP3307	Relocate Specialty Clinics	2,560,000.00	199,870.16
12	1998	CHICAGO (WES	537OP3340	UPGRADE AMBULATORY SURGER	1,920,500.00	1,885,341.87
12	2000	Hines	578IP3323	UPGRADE OPT/INPT PHARMACY	2,300,000.00	
12	1998	HINES	578OP3315	RENOVATE EMERGENCY DEPART	300,000.00	303,975.52
12	1998	HINES	578OP3317	RELOCATE PRIMARY CARE MOD	300,000.00	320,584.78
12	1999	HINES	578OP3317	CONSOLIDATE AMB. CARE MED. CLINICS	3,440,000.00	320,584.78
12	2000	Hines	578OP3317	Ambulatory Care New Elev/Lobbies	2,320,335.00	320,584.78

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12	1999	HINES	578OP3318	CONSOLIDATE AMB CARE SUB-SPEC. CLINICS	320,000.00	416,886.00
12	2000	Hines	578OP3318	Ambulatory Care Primary Clinics 3rd FL	2,761,441.00	416,886.00
12	1999	HINES	578OP3319	RELOCATE/CONSOLIDATE ICU UNITS	300,000.00	
12	2000	Hines	578OP3329	Ambulatory Care Subspecialty clinics 4th FL	2,949,500.00	
12	2000	Hines	578OT3330	Demolition of 50's Buildings	2,529,825.00	
12	1998	HINES	578OU3301	REPL AMB SURGICAL SUITE/E	3,501,000.00	3,173,109.86
12	2000	Hines	578PP3314	UPGRADE EM/STANDBY GENERATORS	3,120,000.00	
12	1998	IRON MOUNTAI	568OP3028	AMBULATORY SURGERY IMPROV	1,520,280.00	
12	1998	TOMAH	578OP3303	REM. MAIN ENTRANCE FOR AM	900,210.00	957,802.44
12	1999	MILWAUKEE	695IP3217	CONSOLIDATE ICU'S	385,000.00	375,200.00
12	1998	MILWAUKEE	695OP3205	AMBULATORY SURGERY CENTER	3,500,000.00	3,315,464.84
12	1999	MILWAUKEE	695OP3215	AMB CARE ER & RED CLINIC	3,594,875.00	3,977,300.00
12	1999	MILWAUKEE	695OP3216	AMB CARE BLUE & YELLOW CLINICS	3,594,875.00	35,000.00
13	1998	FARGO	437OP3302	AMB CARE RENOVATION	175,000.00	1,901,363.72
13	1999	FARGO	437OP3302	AMB CARE RENOVATION	1,882,000.00	1,901,363.72
13	1999	SIOUX FALLS	438IP3374	REMODEL BLDG 1	300,000.00	
13	1998	SIOUX FALLS	438IP3368	ADDITIONAL CLINIC SPACE	280,000.00	274,845.00
13	1998	SIOUX FALLS	438IP3367	REM 2N & 3N FOR NHCU	273,140.00	3,784,543.59
13	1999	SIOUX FALLS	438IP3367	REM 2N & 3N FOR NHCU	3,625,000.00	3,784,543.59
13	2000	Sioux Falls	438OP3363	Additional Clinic Space	3,635,000.00	
13	1998	FORT MEADE	568IP3204	RELOCATE CLINICS	470,000.00	480,354.06
13	1998	FORT MEADE	568IP3305	MHBS CONSOLDIATION	282,000.00	228,244.83
13	2000	Black Hills HCS	568IP3305	Consolidate MHBS	2,228,000.00	228,244.83
13	1999	FORT MEADE	568IP3405	REN. DOM /PT.PRIVACY, B-8	120,000.00	
13	1998	FORT MEADE	568OP3307	EXPAND PRIMARY CARE	2,701,000.00	2,508,810.98
13	1999	MINNEAPOLIS	618IP3320	RENOVATE PSYCHIATRIC WARDS 1J AND 1K	801,000.00	
13	1998	MINNEAPOLIS	618OP3202	CONVERT DIALYSIS SPACE TO	699,000.00	374,509.09
13	1998	MINNEAPOLIS	618OP3304	RADIATION THERAPY ENTRANC	524,000.00	468,450.00
13	1998	ST. CLOUD	656OP3314	PRIMARY CARE ADDITION TO	252,000.00	228,822.00
13	2000	St. Cloud	656OP3314	Primary Care Addition to Building 28	3,028,643.00	228,822.00
13	1999	ST. CLOUD	656OP3315	AMBULATORY CARE EXPANSION, BLDG. 1	252,000.00	64,994.00
14	2000	Central Iowa HCS	555IP3102	Consolidate Domiciliary Programs in Des Moines	972,000.00	
14	1998	DES MOINES	555OP3201	RENOVATE AMBULATORY CARE	661,255.00	773,799.04
14	1999	DES MOINES	555OP3202	EXPAND PRIMARY CARE SERVICES, BLDG 1	819,000.00	999,868.71

NETWORK	Plan Year	FACILITY	Proj. #	PROJECT TITLE	TARGET	Obligated
14	1998	DES MOINES	555OU3309	PRIMARY CARE REMODEL	2,703,223.00	2,584,637.66
14	1999	IOWA CITY	584IP3301	RENOVATE INPATIENT FACILITIES, 7TH FLOOR	350,000.00	
14	1999	LINCOLN	597IP3304	RENOVATE NHCU	390,000.00	
14	1999	OMAHA	636OP3321	OUTPATIENT CLINIC EXP - PHASE 1	1,339,744.00	1,569,590.66
14	2000	Omaha	636OP3322	OutPatient Clinic Expansion, Phase 2	2,878,000.00	
15	2000	Wichita	452IP3301	Patient Privacy Wards 3E/3W	2,742,000.00	
15	1998	WICHITA	452OT3307	CONSOLIDATE CCU'S/TELEMET	2,639,000.00	2,891,314.00
15	1998	COLUMBIA, MO	543OP3203	CONSOLIDATE CARDIOLOGY/PR	980,000.00	1,039,709.78
15	1999	COLUMBIA, MO	543OP3203	CONSOLIDATE CARDIOLOGY/PRIMARY CARE	870,000.00	1,039,709.78
15	2000	Columbia	543OT3206	VA/UMC Research Expansion	3,834,000.00	
15	1999	KANSAS CITY	589IP3312	RENOVATE 6W PRIMARY CARE WARD	1,977,000.00	345,646.44
15	2000	Kansas City	589IP3312	Renovate 6W Primary Care Ward	1,308,000.00	345,646.44
15	1999	MARION, IL	609IP3302	3RD FLOOR PATIENT PRIVACY B1	2,303,580.00	2,824,442.02
15	2000	Marion	609OP3305	Same Day Surgery Renov, Bldg 1, 1st Fl, East	951,085.00	-
15	1998	POPLAR BLUFF	647NH3301	RENOVATE NHCU	250,000.00	3,061,920.84
15	1998	ST LOUIS (CO	657OP3306	REMODEL CLINICS, 1A/B (N/	2,000,000.00	2,535,050.80
15	1999	ST LOUIS (CO	657OP3306	REMODEL CLINICS, 1A/B (N/S), JC	1,776,000.00	2,535,050.80
15	1998	ST LOUIS (CO	657PP3307	TELECOMMUNICATIONS UPGRAD	2,640,000.00	
15	1998	TOPEKA	677IP3317	PATIENT PRIVACY BLDG.1	290,000.00	2,841,363.00
15	1999	TOPEKA	677IP3317	PATIENT PRIVACY BLDG.1	2,671,000.00	2,841,363.00
15	2000	E. Kansas HCS	677IP3322	Patient Privacy Bldg 2	2,900,000.00	64,452.00
16	1998	ALEXANDRIA	502OP3402	AMBULATORY/PRIMARY CARE A	300,000.00	297,698.00
16	1999	ALEXANDRIA	502OP3402	AMBULATORY/PRIMARY CARE ADDITION, B-7	2,650,000.00	297,698.00
16	1999	BILOXI, MS	520IP3302	WARD RENOVATION PATIENT PRIVACY (B)	150,000.00	153,284.13
16	2000	Gulf Coast HCS	520IP3302	Ward Renovation Patient Privacy, Bldg 1	1,653,284.00	153,284.13
16	2000	Gulf Coast HCS	520IP3303	Ward Renovation Patient Privacy, Bldg 2	2,760,000.00	
16	1999	FAYETTEVILLE	564IP3205	ELIMINATE ICU DEFICIENCIES	80,000.00	75,548.00
16	1999	FAYETTEVILLE	564OP3213	ADD 3RD FLOOR TO PRIMARY CARE ADDITION	1,602,000.00	1,328,974.28
16	2000	Fayetteville	564OP3214	Addition for Outpatient Psychiatry	1,930,000.00	-
16	1999	HOUSTON	580OP3301	RENOVATE ER AREA	270,000.00	238,358.00
16	2000	Houston	580OP3301	Renovate ER Area	2,970,000.00	238,358.00
16	1999	JACKSON	586OP3380	PROVIDE 2ND FLOOR LIN. ACC. FOR PRIMARY CARE	1,492,000.00	1,390,786.00
16	2000	Jackson	586OT3381	Expand Atrium for Primary Care	705,000.00	
16	1998	MUSKOGEE	623OP3059	ALTERATIONS & ADDITIONS T	1,729,087.00	1,914,483.00

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16	2000	Muskogee	623OT3097	Relocate Information Resource Mgmt. to B-53	787,000.00	
16	1998	NEW ORLEANS	629AA3038	RENOVATE PATIENT WARDS, 7	1,690,000.00	1,895,324.77
16	1998	NEW ORLEANS	629IP3300	RENOVATE PATIENT WARD FOR	2,585,000.00	2,368,204.80
16	2000	New Orleans	629IP3310	Renovate 4C and 5C for MICU and CCU	3,950,000.00	-
16	1998	NEW ORLEANS	629IP3311	UPGRADE 6C FOR SICU/STU	225,000.00	1,951,312.00
16	1999	NEW ORLEANS	629IP3311	UPGRADE 6C FOR SICU/STU	2,097,000.00	1,951,312.00
16	1999	NEW ORLEANS	629IP3320	RENOVATE 7C FOR PATIENT PRIVACY	225,000.00	204,750.43
16	2000	New Orleans	629IP3320	Renovate 7C for Patient Privacy	2,205,000.00	204,750.43
16	1999	OKLAHOMA CIT	635IP3210	2ND FLOOR ADA MODIFICATION REQUIRMENTS	70,000.00	14,675.40
16	1998	OKLAHOMA CIT	635OP3301	RENOVATE FOR PRIMARY CARE	300,000.00	1,643,316.04
16	1999	OKLAHOMA CIT	635OP3301	RENOVATE FOR PRIMARY CARE	2,701,000.00	1,643,316.04
16	2000	Oklahoma City	635OT3302	SURFACE PARKING LOT	1,900,000.00	
16	1998	SHREVEPORT	667IP3058	PATIENT PRIVACY IMPROVEME	2,700,000.00	2,898,965.90
16	1999	SHREVEPORT	667IP3070	PATIENT PRIVACY 6W	160,000.00	94,900.00
16	2000	Shreveport	667IP3070	Patient Privacy Improvements 6W (Construction)	1,716,000.00	94,900.00
16	1998	SHREVEPORT	667OP3074	AMB. CARE ADD. 2ND FL.	2,700,000.00	2,886,399.81
17	1998	NORTH TEXAS	549IP3206	PATIENT PRIVACY/UFAS DEF.	800,000.00	876,728.67
17	1998	NORTH TEXAS	549IP3207	PATIENT PRIVACY/UFAS DEF.	2,400,000.00	1,081,091.91
17	1999	NORTH TEXAS	549IP3207	PATIENT PRIVACY/UFAS DEF ,PH5	2,400,000.00	1,081,091.91
17	1999	NORTH TEXAS	549IP3304	RELOCATE PM&R SERVICE AND PROSTHETICS SERVIC	300,000.00	299,970.53
17	1999	NORTH TEXAS	549IP3309	RELOCATE DAY PROCEDURE	150,000.00	
17	1998	NORTH TEXAS	549OP3208	AMBULATORY CARE RENOVATIO	200,000.00	194,985.58
17	2000	North Texas HCS	549OP3304	Rel. PM&R & Prosthetics Svc Ph.1	1,650,000.00	
17	2000	North Texas HCS	549OP3309	Upgrade Day Procedure	2,200,000.00	-
17	1998	NORTH TEXAS	549PP3209	INFRASTRUCTURE UPGRADE 6L	200,000.00	195,048.75
17	2000	South Texas HCS	671IP3219	AMB. CARE ENHANCEMENT II	3,998,000.00	
17	2000	South Texas HCS	671IP3221	MICU RELOCATION	1,980,000.00	
17	1998	SOUTH TEXAS	671OP3217	AMB CARE ENHANCEMENT PH 1	2,640,000.00	2,529,783.55
17	1998	SOUTH TEXAS	671OP3218	CARDIOLOGY ICU EXPANSION	112,000.00	1,208,863.55
17	1999	SOUTH TEXAS	671OP3218	CARDIOLOGY ICU EXPANSION	1,101,000.00	1,208,863.55
17	1998	SOUTH TEXAS	671OP3219	AMB CARE ENHANCEMENT PH 2	352,000.00	1,758,198.39
17	1999	SOUTH TEXAS	671OP3219	AMB CARE ENHANCEMENT PH 2	2,883,000.00	1,758,198.39
17	1999	SOUTH TEXAS	671OP3224	INSTALL MRI	990,000.00	1,004,203.11
17	1998	CENTRAL TEXA	674IP3502	PSYCH PATIENT PRIVACY	200,000.00	

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17	1998	CENTRAL TEXA	674OP3253	CONSOLIDATE SPECIALITY SV	237,000.00	159,313.00
17	1999	CENTRAL TEXA	674OP3253	CONSOLIDATE SPECIALITY SVCS	2,580,000.00	159,313.00
17	2000	Central Texas HCS	674OP3253	Consolidate Specialty Clinic	1,320,000.00	159,313.00
17	2000	Central Texas HCS	674OP3259	Relocate Clinics Bldg. 163	935,000.00	
17	1998	CENTRAL TEXA	674OP3320	RELOCATE AMBULATORY SURGE	1,965,000.00	2,017,447.44
18	1998	ALBUQUERQUE	501IP3310	PATIENT PRIVACY BUILDING	1,317,000.00	1,458,722.75
18	1998	ALBUQUERQUE	501IP3311	GERO-PSYCHIATRY WARD - BU	90,000.00	905,839.74
18	1999	ALBUQUERQUE	501IP3311	GERO-PSYCHIATRY WARD - BUILDING 3	1,602,000.00	905,839.74
18	2000	New Mexico HCS	501IP3311	Gero-Psychiatry Ward - Building 3	1,352,000.00	905,839.74
18	2000	New Mexico HCS	501IP3312	Critical Care Bed Expansion	1,600,000.00	110,352.25
18	1999	ALBUQUERQUE	501OP3216	INCREASE CAPACITY OF SURGERY CLINICS	75,000.00	
18	1998	AMARILLO	504OT3213	CONSTRUCT BILLING CENTER	645,000.00	
18	1999	BIG SPRING	519IP3301	IMP. PAT ENV. - 3 EAST	150,000.00	149,975.80
18	2000	West Texas HCS	519IP3301	Improve Patient Environment	1,762,500.00	149,975.80
18	1998	PHOENIX	644IP3306	RENOVATE WARD 4D	1,400,000.00	1,400,654.92
18	1999	PHOENIX	644IP3306	RENOVATE WARD 4D	1,253,000.00	1,400,654.92
18	1998	PHOENIX	644PP3202	UPGRADE MEDICAL GASES	617,000.00	1,006,703.11
18	1998	PHOENIX	644PP3206	INCREASE ELEC. DISTRIBUTI	824,000.00	735,394.83
18	1999	PRESCOTT	649IP3401	RENOVATE 1ST FLOOR B107 FOR CLINICAL DIAG. SVC'	103,200.00	
18	2000	Northern Arizona HCS	649OP3402	Renovate 2nd Floor B107 for Mental Health Clinic	1,115,000.00	
18	1998	TUCSON	678IP3307	MI/CCU & SDU EOC CORRECTI	337,594.00	853,717.35
18	1999	TUCSON	678IP3307	CONSOLIDATED INTENSIVE CARE UNIT	2,672,000.00	853,717.35
18	2000	Southern Arizona HCS	678IP3309	Correct Dementia Deficiencies	850,000.00	94,838.00
18	2000	Southern Arizona HCS	678IP3310	Renovate Ward 3 North	1,950,000.00	
18	1999	TUCSON	678OT3308	UPGRADE B6 FOR RESEARCH	250,000.00	
18	1998	BIG SPRING		AMBULATORY SURGICAL SUITE	927,000.00	
19	1998	FORT HARRISO	436OP3098	EXPAND PRIMARY CARE FACIL	583,000.00	45,688.00
19	1999	FORT HARRISO	436OT3099	SEWER PIPELINE UPGRADE	1,400,000.00	179,625.00
19	2000	Montana HCS	436PP3099	SEWER SYSTEM UPGRADE	1,675,000.00	
19	2000	Cheyenne	442IP3207	Renovate Ward for 20 Bed NHCU	880,000.00	
19	2000	Cheyenne	442OT3208	Renovate Nutrition & Food Service	825,000.00	75,000.00
19	1998	DENVER	554OP3311	DESIGN 3 FLOORS FOR E-WIN	1,290,000.00	1,835,899.01
19	1999	DENVER	554OT3312	ADDITION TO E-WING	1,995,000.00	1,522,833.00
19	2000	Salt Lake City	660OP3227	Outpatient Pharmacy Dispensing	775,000.00	

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19	2000	Salt Lake City	660OP3230	Renovate Dental/G.I.	950,000.00	
19	1998	SHERIDAN	666IP3306	PATIENT ENVIRONMENT IMPRO	715,000.00	851,902.22
19	2000	Sheridan	666OP3001	Outpatient Improvements	1,107,500.00	-
19	2000	Sheridan	666OT3002	Medical Center Centralization	1,272,000.00	-
19	1998	GRAND JUNCTION		REMODEL CLINICAL/PULMINARY LAB	1,330,000.00	
20	1998	BOISE	531OP3300	CONSOLIDATION OF PRIMARY	1,000,000.00	1,010,492.64
20	1998	BOISE	531OP3304	AMB. SURGERY IMPROVEMENTS	110,000.00	794,913.17
20	1999	BOISE	531OP3304	AMB. SURGERY IMPROVEMENTS	1,000,000.00	794,913.17
20	1999	BOISE	531OP3305	CONSOLIDATE MENTAL HEALTH CLINIC	200,000.00	191,245.34
20	2000	Boise	531OP3305	Consolidate Mental Health Clinics	2,300,000.00	191,245.34
20	2000	Boise	531OP3306	Ambulatory Surgery Addition	930,000.00	
20	1998	PORTLAND	648OP3301	PRIMARY CARE CLINIC (V)	2,682,000.00	2,813,948.42
20	1999	PORTLAND	648OP3304	PRIMARY CARE SUPPORT BLDG. (V)	252,000.00	349,441.00
20	2000	Portland	648OP3304	Primary Care Support Bldg (V)	3,849,369.00	349,441.00
20	1998	ROSEBURG	653IP3316	UPGRADE NHCU	2,688,000.00	3,906,866.62
20	1999	ROSEBURG	653OP3317	EXPAND RADIOLOGY	150,000.00	
20	2000	Roseburg HCS	653OP3318	Expand Ambulatory Care	3,850,000.00	315,007.50
20	1998	PUGET SOUND	663OP3314	OUTPATIENT MENTAL HEALTH	1,500,000.00	1,957,370.19
20	1998	PUGET SOUND	663OP3317	OUTPATIENT MENTAL HEALTH	300,000.00	2,936,499.78
20	1999	PUGET SOUND	663OP3317	OUTPATIENT MH RENOVATION PHASE 2 (A)	3,000,000.00	2,936,499.78
20	1999	SPOKANE	668IP3304	RENOVATE WARD 4	150,000.00	150,000.00
20	2000	Spokane	668IP3304	Renovate Ward 4	1,850,000.00	150,000.00
20	2000	Spokane	668IP3305	Renovate ACU Ward	1,100,000.00	
20	1998	SPOKANE	668OP3302	RENOVATE FOR COORDINATED	1,000,000.00	1,074,690.00
20	1998	SPOKANE	668OP3303	RENOVATE FOR OUTPATIENT P	105,000.00	977,318.79
20	1999	SPOKANE	668OP3303	RENOVATE FOR OUTPATIENT PSYCHIATRY	950,000.00	977,318.79
20	1999	WHITE CITY	692IP3323	RENOVATE DOM BEDS B208/1,2S	112,000.00	918,369.49
20	2000	White City	692IP3325	RENOVATE DOM BEDS B222	2,373,150.00	
21	1998	FRESNO	570IP3202	REMODEL 6-EAST FOR GERIATRIC MED	675,000.00	134,458.60
21	2000	Central California HCS	570IP3202	Remodel 6E for Geriatric Med	1,292,151.00	134,458.60
21	1998	FRESNO	570OP3086	REMODEL SURGERY OR	2,750,000.00	2,093,379.46
21	2000	Northern California HCS	612PP3307	Energy Center/ADA Upgrades, SMC	3,788,000.00	2,250,000.00
21	1998	PALO ALTO	640IP3310	PTNT PRIV B2 WARD FOR PSY	420,000.00	3,352,866.58
21	1999	PALO ALTO	640IP3310		3,580,000.00	3,352,866.58

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21	1998	PALO ALTO	640OT3247	RENOV. RESEARCH BLDG. 4	2,677,000.00	3,583,745.25
21	2000	Palo Alto HCS	640PP3301	INSTALL HVAC, BLDG. 5 PH II	2,743,732.00	223,012.00
21	2000	Sierra Nevada HCS	654OP3103	Ambulatory Care	955,764.00	
21	1998	SAN FRANCISCO	662IP3205	SURGICAL SUITE RENOVATION B203 PHI	400,000.00	3,453,047.54
21	1999	SAN FRANCISC	662OP3205	AMBULATORY SURGERY RENOVATION B-200	3,599,000.00	
21	2000	San Francisco	662OP3206	Renov. OR Suite B-200	4,000,000.00	
22	1999	LONG BEACH	600OT3303	CONSTRUCT CHILLED WATER LOOP SYSTEM	3,350,000.00	
22	1998	LONG BEACH	600PP3211	REPL/UPGR HVAC BLDG. 133	877,539.00	1,056,766.88
22	1998	LONG BEACH	600PP3302	UPGRADE HVAC, BLDG. 128	2,935,000.00	3,661,878.91
22	1999	LONG BEACH	600PP3302	UPGRADE HVAC, BLDG. 128	3,420,000.00	3,661,878.91
22	2000	Long Beach	600PP3304	UPGRADE HVAC BLDG 128, PHASE 2	2,839,000.00	
22	1999	LOMA LINDA	605IP3304	PATIENT PRIVACY WARD 2NE	900,000.00	
22	1998	LOMA LINDA	605OP3203	EXPAND EMERGENCY ROOM	725,000.00	979,754.06
22	1998	LOMA LINDA	605OP3210	RECONFIGURE FIRST FLOOR A	550,000.00	1,074,191.00
22	1999	LOMA LINDA	605OP3210	RECONFIGURE FIRST FLOOR AMB CARE	1,100,000.00	1,074,191.00
22	1998	LOMA LINDA	605OP3309	REMODEL 3NE SPECIALTY CLI	1,670,000.00	1,474,483.37
22	2000	Loma Linda	605OP3310	Outpatient Reconfiguration	3,985,000.00	
22	1998	SAN DIEGO	664OP3304	AMBULATORY SURGERY PH II	2,310,000.00	3,034,568.89
22	1999	SAN DIEGO	664OP3310	PROCEDURE CENTER	936,250.00	94,994.00
22	2000	San Diego	664OP3310	Procedure Center	2,108,000.00	94,994.00
22	1999	SAN DIEGO	664OP3311	SUBSPECIALTY CLINIC SWING SPACE	3,780,000.00	3,590,832.27
22	2000	San Diego	664OP3313	Dental /Neurology Clinics	3,788,000.00	
22	2000	San Diego	664OT3312	Relocate Loading Dock	861,000.00	97,383.00
22	2000	Southern California HCS	691IP3306WL	B500 Renovate Operation Room Suite	3,990,000.00	
22	1998	WEST LOS ANG	691IP3903	B500,RENOV.SICU, 5TH FLR.	1,504,000.00	1,420,367.20
22	1999	WEST LOS ANG	691OP3307	RELOCATE AMBULATORY MENTAL HEALTH SERVICES	373,000.00	355,534.99
22	2000	Southern California HCS	691OP3307	Relocate Ambulatory Mental Health Services	3,569,000.00	355,534.99
22	1999	WEST LOS ANG	691OP3309	CONSTRUCT COVERED WALKWAYS B500, B304, B507 &	84,000.00	83,859.23
22	2000	Southern California HCS	691OP3309	Construct Covered Walkway	799,000.00	83,859.23

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