

H.R. 811, VETERANS' HOSPITAL EMERGENCY REPAIR ACT

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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H.R. 811, VETERANS' HOSPITAL EMERGENCY REPAIR ACT

TUESDAY, MARCH 13, 2001

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

The committee met, pursuant to notice, at 1:33 p.m., in room 334, Cannon House Office Building, Hon. Chris Smith (chairman of the committee) presiding.

Present: Representatives Smith, Moran, Evans, Filner, Snyder, and Rodriguez.

OPENING STATEMENT OF CHAIRMAN SMITH OF NEW JERSEY

The CHAIRMAN. The hearing will come to order. Good afternoon to everyone. We welcome all of our witnesses today, and others who are in attendance and who are concerned about veterans' issues.

Today's hearing gives the committee, the VA, and veterans an opportunity to take a hard look at what is happening to a key component of VA health care: its facilities and patient care infrastructure. Then we can carefully consider what we propose to do to make things better.

As we discussed last week at our business meeting, and reported when we reported our views and estimates to the Committee on the Budget, VA health care needs more funding. One of the vital areas for which the VA needs restoration of funding is in the area of construction. The Veterans' Hospital Emergency Repair Act, H.R. 811, the bill that I introduced last week with my friend and colleague, Mr. Evans, the Ranking Member, and a number of our colleagues, is an acknowledgment that much of the VA is showing its age.

This just didn't happen, however. The flow of appropriated funds for VA construction programs, at one time in the hundreds of millions of dollars per year, slowed to barely a trickle, and last year it bottomed out, not unlike the NASDAQ. No funding was provided through the appropriations process for VA major construction in fiscal year 2001, despite Congress having authorized \$110 million for four important projects.

These were: a seismic project at the Long Beach VA Medical Center; a 120-bed gero-psychiatric unit at Palo Alto's Menlo Park campus, which included seismic reinforcement; a replacement for a 32-year-old electrical vault and wiring harness at the Miami medical center, which had been destroyed in a fire in April of last year—one of our posters notes the temporary fix now in place at Miami, high voltage exposed power lines lying on the ground with

a temporary walkway; and finally, a nursing home unit at the Beckley, WV medical center.

Also we again approved a prior-year authorization of a nursing home renovation project in Lebanon, PA. None of these projects was funded, because at least in part, the appropriators chose to wait for VA's "Capital Assets Realignment for Enhanced Services," or CARES initiative, to deliver a plan for alternative uses of unneeded VA facilities. But CARES could take 4 or 5 years just to produce a plan. Then it would take more time for projects to go forward.

The VA committee supports CARES, there is no doubt, but at best, CARES will provide us a map for future redeployment of VA capital facilities. And that is good. In fact, my colleagues may recall that the VA CARES program was developed as an adaptation of language in H.R. 2116, in the 106th Congress. CARES should eventually reach all of the major facilities, but some VA medical centers are not going to have the benefit of the results of the studies any-time soon.

I am concerned, very concerned, that CARES has already imposed a de facto moratorium on VA renovation and construction. We know that CARES will be focusing first on expensive, big city facilities, such as the multiple medical centers in Chicago and New York City, parts of Texas, Southern California, and elsewhere, but what about the VA hospitals that are off the beaten track?

It needs to be noted that CARES is designed to be a regional, but really national, mega-plan; indeed, many VA hospitals don't require a mega-plan to forecast their capital needs; some don't need a mega-anything; they need micro-help, to maintain and improve patient care facilities for veterans. I believe that veterans need these improvements, and they need them now.

As I said last week at our hearing on the budget for fiscal year 2002, the VA has a list of patient care buildings that need upkeep, restoration and modernization. The posters behind the dais show only a few illustrative examples. VA is doing some of this work by using the minor construction, minor miscellaneous, and non-recurring maintenance accounts to get the job done. Funds appropriated for small-scale maintenance and routine upkeep should not, however, be bundled and used to support major construction requirements. It's the old "zero sum game," and in the long run it poorly serves the VA and veterans.

Even with such creative juggling, the VA is falling further behind. Some of VA's 4,700 patient care buildings are outdated. Frankly, they are beginning to look a bit threadbare, and some are inefficient and very crowded. And again, we have a poster of the veterans' medical center in the West Roxbury recovery room to illustrate that point. But it's more than mere cosmetics; VA has 67 VA buildings currently in use could be damaged or collapse in the event of an earthquake, including several that suffered damage two weeks ago at the American Lake Medical Center in the State of Washington.

Let me call to my colleagues' attention a set of photographs in front of you—and I believe our witnesses will have already had copies made available to them—of just some of the damage from that so-called "mild" event. I understand that the American Lake build-

ings have been reoccupied, except for one floor of building 6, a domiciliary unit. So American Lake presumably has lost a marginal ability to provide care. I think this particular incident vividly makes our point that the CARES process is not going to address this kind of problem.

It is frustrating, and I would submit to you it's indefensible, that in recent years, OMB has reduced or squelched funding for repairs and strengthening, and has withheld funds for restoration and modernization of VA health care facilities. The Emergency Repair Act, which we are considering today, would authorize appropriations to be employed at the Secretary's discretion for some of these overdue projects.

As we advance this bill to give the Secretary needed flexibility, we are also working with members of the budget committee—two of whom I am pleased to report are members of our committee, Mr. Brown of South Carolina and Mr. Crenshaw of Florida—to be sure that the budget resolution that we approve include funds to make H.R. 811 meaningful.

H.R. 811 would provide a temporary authority to the Secretary of Veterans' Affairs, by setting aside for 2 years existing authorization requirements. It would allow the Secretary to approve repair projects based on recommendations of VA's Capital Investment Board. The bill provides strong guidance to the Secretary to give priority to projects that improve, restore, and repair patient care facilities, facilities housing VA's special programs, facilities needed by VA's women patients, and facilities that are at risk of seismic damage.

The bill limits each project to no more than \$25 million, and it requires the Secretary to report to Congress on actions taken under this authority. Also, the bill tasks the Comptroller General to observe this delegated process and report to us on how well it accomplishes our intent. The committee looks forward to the testimony we will receive this afternoon from our three panels of witnesses. At this point, I'd like to recognize my friend, Mr. Evans, for any comments he may have.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I want to thank you for holding this hearing on the Emergency Repair Act. I am an original co-sponsor of this bill, and believe it provides the opportunity for needed construction to be completed in a more timely manner. There has been too little investment in VA buildings and facilities over the last few years. A de facto moratorium has placed veterans and employees at risk, as buildings deteriorate and needed maintenance is withheld.

Under this bill, the VA would be able to expedite selection, funding, and completion of smaller major contract projects. We have prioritized facility projects to improve safety and access, and develop the capacity for programs most integral to the VA's mission: Specialized programs for our most seriously disabled veterans, long-term care, and wounded veterans.

Mr. Chairman, the need for this legislation is clear. I am pleased to recommend to my colleagues that they vote for the Repair Act, and I pledge to work with you to ensure that it goes to the floor and we enact it as quickly as possible.

Mr. Chairman, I might note that we do have a number of members on both sides that couldn't be here today. A lot of them are flying back at this hour, and some planes have been canceled. So I'd like to ask unanimous consent that the written statements be submitted into the record.

The CHAIRMAN. Without objection, so ordered.

[The statements of Hon. Corrine Brown, Silvestre Reyes, Cliff Stearns, and Tom Udall appear on pp. 46 and 47.]

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Evans. Any other member like to just be brief? Yes, Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman, and I thank you for introducing H.R. 811. We have, as you said, this impending crisis, and we all want to work with you for its enactment. I do want to mention, or enlarge on something you mentioned, Mr. Chairman, and that is the seismic problems that are within many VA hospitals.

We only have to look back at the VA Puget Sound health care system to understand the potential harm and disruption that VA staff and veterans could experience as a result of an earthquake. As you noted in the pictures, two patient care buildings were damaged on the American Lake campus and have been reoccupied, but the continued use of these buildings is not without risk to patients and employees. And the VA has, in fact, identified more than 60 projects that require seismic fortification. We must act to protect the VA patients and employees who are in harm's way.

The same is true, Mr. Chairman, for San Diego's VA medical center, which requires new exterior bracing enhancements to the existing seismic structures, and the cost of about \$35 million is, of course, more than worth it if it saves human lives. So we have to remember these bigger ticket items. I noticed, Mr. Chairman—and we may talk about this in markup—that if you raise the limit to \$30 million, for example, for the threshold, one, two, three, four, five out of the top six projects with seismic concerns can be funded. That leaves out San Diego, but if we went up to \$35 million, we'd get in San Diego also.

So we might think about that in terms of the importance of seismic repairs, and raising your limit a little bit would reach the majority of the most needed repairs.

I thank you, Mr. Chairman, for your concern for the safety of our patients, and look forward to working with you to achieve enactment.

The CHAIRMAN. I thank my friend for the statement. I just would observe that one of the nice things about the \$25 million is that it would cover, obviously, more projects, but we are looking at all possibilities by perhaps raising the amount. But that remains to be seen, and I'll gladly consult with you on that. And I would also note that nothing in this bill precludes the Veterans Administration,

Secretary Principi and his folks, from requesting additional specific funding for individual projects, as my hope is. This will compete or not compete and move on a dual track. There's nothing in this to suggest that we are, again, precluding any of that other additional authorization and appropriation, but I thank you for your comments.

Would any other member like to be heard?

If not, I would like to welcome our first panel, and as they are making their way to the witness table, just let me note that last week, all of us noticed that Secretary Principi required a large contingent—and I think they wanted to be here anyway—of VA staff to remain for the duration of the hearing after he presented his testimony. The committee was very encouraged by that action.

I especially want to commend Under Secretary Garthwaite and welcome him back, and thank him today. He was one who stayed put and listened throughout that entire testimony. And I had the good fortune of traveling with him and the Secretary, with Senator Arlen Specter, to Pennsylvania, to Brook township, and then up to Northern New Jersey, to Lyons, on Friday, and it was a very, very meaningful dialogue that we had throughout that day-long trip. So I want to thank him again for being here.

Our first panel consists of five veterans' organizations, and I'd like to just introduce each of them to the committee right now. First, Ms. Joy Ilem, who's the Assistant National Legislative Director for the Disabled American Veterans; Mr. Tom Davies, Director of Architecture for the Paralyzed Veterans; Mr. James Fischl, Director of the National Veterans' Affairs and Rehabilitation Commission of the American Legion; Mr. Dennis Cullinan, the National Legislative Director of the VFW; and Mr. Richard Jones, National Legislative Director of AMVETS.

I thank you for appearing. Without objection, your written statements will be made a part of the record, and each of you have up to 5 minutes to give your oral or read remarks. Please proceed however you wish.

STATEMENTS OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; THOMAS D. DAVIES, DIRECTOR OF ARCHITECTURE, PARALYZED VETERANS OF AMERICA; JAMES R. FISCHL, DIRECTOR OF NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DENNIS M. CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; AND RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF JOY J. ILEM

Ms. ILEM. Mr. Chairman and members of the committee, Good afternoon, I'm Joy Ilem, with the Disabled American Veterans. As an organization of more than 1 million service-connected disabled veterans, the DAV is especially concerned about maintaining a modern, effective system to meet the unique health care needs of our Nation's veterans.

Mr. Chairman, as you've recognized, the Department of Veterans Affairs has neglected its health care facilities to the point that they

have suffered physical deterioration, and have become outdated, and unsafe in some instances. As noted by the Independent Budget and outside experts, over the past several years, the VA has devoted far too little resources to the maintenance, improvement, and modernization of its facilities. This neglect erodes the very foundation of the VA health care system.

H.R. 811 establishes emergency measures to begin the rehabilitation of these facilities before they fall further into decline, and make the problems even more costly to correct. Although the bill authorizes only a 2-year construction program to improve and modernize VA facilities, it requires careful prioritization and a measured, systematic approach to obtain optimum results in the short-term, and a basis for a strategic long-term improvement plan.

The bill itself targets priorities by requiring the Secretary of Veterans' Affairs to focus on projects involving VA's special disabilities programs, patient safety, seismic protection, and privacy concerns for women veterans. In addition, the Secretary's decisions will be guided by the recommendations of the VA Capital Investment Board.

To ensure the effectiveness of this plan, the bill requires the Secretary to report his actions and results to Congress, and mandates a review of the outcomes by the General Accounting Office. H.R. 811 embodies the right balance between giving the Secretary discretion to choose the most pressing projects, and constraining his actions to ensure the overall results Congress intends. We applaud the careful, thoughtful way this legislation was crafted.

Mr. Chairman, the committee obviously did not intend that this bill and its 2-year plan to be the total answer to the major problems that have resulted from years of neglect. Neither did the committee intend that the \$55 million appropriation it authorizes to fund the construction projects in fiscal years 2002 and 2003, to do more than begin the process and correct the most urgent problems.

We believe the bill is definitely a good first step towards a longer and more comprehensive attack upon this unacceptable situation. As regrettable as this situation is, we hope its lessons will let us avoid repetition of these same mistakes in the future. We must ensure that construction and upgrading of facilities is funded and completed on a timely and ongoing basis, rather than postponed to accommodate short-term budget considerations.

As the committee has indicated, regardless of the direction of the CARES project—process—continuing maintenance on the VA system is essential, to keep it viable and safe for our veterans. As with many things, putting off until tomorrow what you should do today causes more than delay; it makes the task all the more difficult and costly in the end. This is not efficient government, and that does not serve either our Nation's veterans well, or our taxpayers.

We must ensure that VA's construction needs are adequately addressed in the annual budget process, and we look forward to working with the members of this committee to obtain the funding necessary to restore and maintain VA's health care system as a world class organization.

In closing, I want to express to you and the committee the DAV's sincere appreciation for your decisive action on this issue. That

concludes my statement. Thank you. I'll be happy to answer any questions you or members of the committee may have.

[The prepared statement of Ms. Ilem appears on p. 49.]

The CHAIRMAN. Ms. Ilem, thank you very much for your testimony. Mr. Davies.

STATEMENT OF THOMAS D. DAVIES

Mr. DAVIES. Thank you very much. Good afternoon, Chairman Smith, and Ranking Member Evans, members of the committee. My name is Tom Davies. I'm director of architecture for the Paralyzed Veterans of America. I thank you for the opportunity to give this testimony.

The PVA strongly supports the Veterans' Hospital Emergency Repair Act, for several important reasons. First, the bill represents good stewardship of VA facilities' infrastructure and reduces veterans' risk in the event of a seismic event. We believe that the VA's facilities are valuable assets, must be carefully protected, properly maintained, and effectively utilized.

Second, the measure permits combining medical upgrades with other improvements, and critical seismic fire safety projects. This is an appropriate marriage to maximize the benefits derived from the extensive disruption to patient care that is necessary for most seismic corrections. This union also yields fiscal savings by splitting the associated impact costs.

Third, the measure will help to maintain the current VA construction staffing, and the professional expertise that is required to properly manage a national system of medical care facilities. This management capacity will be critically important in the near future to oversee medical center consolidations and operational realignment that may result from current planning initiatives.

I'd also like to take this opportunity to make some comments on the general planning and construction process in the Department of Veterans Affairs. The first point I want to make is that downsizing, consolidating, or realigning the existing VA health care system will not reduce the future need for construction. Rather, operational realignments will require more construction projects in order to implement the improved delivery systems. Small, complex, ship-in-a-bottle projects that utilize existing assets typically require better project coordination and more careful design.

Second, as a matter of principle, the VA medical facility long-range planning should put a premium on future flexibility, and on incremental implementation strategies. Medical techniques and technologies, as well as veterans' demographics, will continue to change rapidly in the future. Medical facilities must, therefore, be configured in a manner that will accommodate these inevitable changes. Medical centers should not be built with extra capacity to meet current planning projections but, rather, with the capacity for future growth, when and if that becomes necessary. Construction strategies should plan for staged implementation.

The third point is that because of constantly changing planning models and rapidly evolving medical technologies, most VA facility plans have a relatively short shelf life. Historically, it takes more than 10 years to design, construct, and fund a VA facility. The current VA process must be abbreviated, and if construction funding

is delayed, design revisions must be permitted without political penalties. Currently, if a project is revised, it's place in the queue is lost. As a result, the design is effectively frozen for years, and the project may be outdated before it is even built. Predictable construction management will permit timely project development and more effective operational management.

My final point. I am an architect, and somewhat prejudiced, but I feel that good facility design is critical to quality medical care. Good planning and design is not only cost-effective, but as the advertisement says, "it's priceless." Planning and design fees are a very small percentage of total construction costs, construction cost is only a very small percentage of the medical program's operational cost. Time and money spent on planning and design are prudent expenditures and enhance rather than detract from quality patient care.

Even if major medical facilities are not expanding, an adequate construction program is necessary for both patient quality of care and for economical delivery of services.

Thank you for your attention. I would be pleased to answer any questions you may have.

[The prepared statement of Mr. Davies appears on p. 51.]

The CHAIRMAN. Thank you, Mr. Davies, very much, for your testimony, and when you say you're prejudiced, I think it's not because you flew F-100s and F-105s, but because you're an architect.

Mr. DAVIES. That's correct.

The CHAIRMAN. I think members of the committee should realize that. All of our witnesses have very good backgrounds, but I think you perhaps are especially qualified. No one on this committee is an architect, either, so we do thank you for your testimony. It's very, very helpful. And I do encourage Members—and I try to do this all the time—to get to know the witnesses, because you always have an attached biography and some background information. It does help to give us insight, so I thank you, because when you speak, I think you make some very powerful points.

I'd like to ask Mr. Fischl, Director of the National Veterans' Affairs and Rehabilitation Commission for the American Legion, if he would proceed.

STATEMENT OF JAMES R. FISCHL

Mr. FISCHL. Thank you, Mr. Chairman and members of the committee. The American Legion appreciates the opportunity to appear before you this afternoon. Mr. Chairman, our written statement has been submitted, and it details what we believe are reasons for the enactment of H.R. 811, the Veterans' Hospital Emergency Repair Act.

The legislation will allow the Secretary of Veterans' Affairs to implement several construction projects and improve patient care facilities at many VA medical centers across the Nation. The measure would appropriate \$250 million in fiscal year 2002, and \$300 million for fiscal year 2003, respectively. The American Legion believes that the amount being proposed for needed construction improvements and updates throughout the system are realistic.

We believe, and we have advocated increased funding for major and minor construction for several years. We are, however, con-

cerned with a particular provision of the bill that proposes to limit the amount of funding spent for any constructed projects to \$25 million, and we appreciate the concerns echoed by this committee previously. We believe that by imposing a cap on each project, it would severely curtail the ability to make the required improvements in several urgent projects.

Some of these projects require seismic corrections at several facilities, including, but not limited to, the VAMCs, Long Beach and San Diego. The cost for improvements for these two facilities alone will exceed the proposed \$25 million cap. The critical need for VA to make these urgent seismic improvements was never more evident than with the recent damage to two buildings at the American Lake medical center on the 28th of February. The damages to these buildings resulted in a temporary evacuation of many VA patients, and it should be a warning signal that these things can and will happen.

These affected buildings were part of VA's inventory of seismic obligations. The \$25 million cap will not even cover the \$26.6 million estimated cost to fund the planned seismic project, and perhaps the \$30 million cap would be approaching a more realistic figure. The American Legion testified several years ago before a joint session of the House and Senate Veterans' Affairs Committees that VA has 69 patient care bills totaling approximately 2,300 beds requiring seismic corrections. VA estimates that these repairs may well exceed \$300 million.

Over half of the \$250 million in major construction requested by The American Legion for 2002 is for seismic correction projects. In our judgment, although VA has shifted its healthcare mission from inpatient to primary care modalities, there is no justifiable reason to neglect VA's capital assets. VA must develop a well-substantiated annual, major priority construction listing, so that Congress can appropriate adequate funding.

The current CARES review will virtually determine the future of numerous VA facilities, but the CARES initiative is long-term, and we support the long-term initiative. But it cannot replace short-term planning. The American Legion fully supports the provisions of section III of H.R. 811 to establish major construction funding for fiscal year 2002 and fiscal year 2003 at \$250 million and \$300 million, respectively.

The American Legion would like to emphasize that minor construction, as well, has also been neglected for several years, and we continue to advocate annual funding for minor construction at \$200 million. Again, The American Legion does not support a cap for each project, since seismic correction at several West Coast facilities will exceed the \$25 million limit.

Finally, Mr. Chairman, The American Legion remains a strong advocate, and we support this emergency funding legislation for VA construction. We further submit that with adequate and sustained funding, the VA will be able to complete its projects, and without operation due to inadequate funding.

Mr. Chairman, that concludes my remarks. I'll be happy to answer any questions that the committee might have.

[The prepared statement of Mr. Fischl appears on p. 56.]

The CHAIRMAN. Mr. Fischl, thank you very much for your testimony. Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman. Good afternoon. And distinguished members of the committee. On behalf of the entire membership of the Veterans of Foreign Wars and our ladies auxiliary, I want to extend our sincere appreciation for including us in today's most important hearing.

The VFW is committed to the proposition that all veterans should enjoy ready access to timely, top-quality VA health care. Key to achieving this goal is enabling VA to sustain and appropriately enhance its physical plant. It is for this reason that we of the VFW both applaud and strongly support your bill, H.R. 811, the Veterans' Hospital Emergency Repair Act.

It is tragic that there are sections of the country where veterans must wait up to a year before they may get their first health care appointment at VA. There are areas where waiting periods for orthopedic, prosthetic, and certain specialty care services are so long that in many cases they amount to the denial of needed care.

Further, VA must update facilities and services for a rapidly growing segment of those serving the Nation in uniform today, women veterans. All necessary steps must be taken to ensure their privacy and comfort at VA facilities. The Veterans' Emergency Repair Act will allow VA to place additional emphasis on addressing the specific medical needs of women.

Successive years of shortfalls and major construction funding, even as the population of sick and elderly veterans is rapidly on the rise, have seriously eroded VA's ability to sustain a physical plant adequate to meet veterans' needs. That VA has had measurable success in building and staffing such effective and popular noninstitutional health care venues as community-based outpatient clinics, is certainly a tribute to good intentions, as well as managerial resourcefulness, but VA healthcare facilities continue to deteriorate, and many lack the physical configuration and state of the art technology necessary to provide modern health care services. This Nation's veterans deserve better. The additional dollars and delegation of authority to the secretary of VA, to initiate needed construction and renovation projects H.R. 811 will provide is of paramount importance to properly and compassionately serving veterans patients. We are deeply concerned that, as VA attempts to better allocate and place its physical assets through the implementation of the CARES process, this will result, or already has resulted, in a de facto moratorium on needed new construction and renovation projects.

We agree that VA must move forward in implementing a rational methodology for aligning and realigning its physical resources, but this does not mean that VA's physical assets should be frozen in place and time until that process is completed. For the sake of America's veterans in need, there are and will be projects, such as the seismic enhancements that need to be carried out at the Lake Washington VAMC, and must be carried out well before CARES is completed. And we insist that they go forward.

Mr. Chairman, on behalf of the men and women of the Veterans of Foreign Wars, I thank you for the introduction of H.R. 811. It is a thoughtfully constructed and much needed piece of veterans' legislation, and enjoys our strong support. Thank you.

[The prepared statement of Mr. Cullinan appears on p. 59.]

The CHAIRMAN. Mr. Cullinan, thank you for your suggestions, your support for the bill, and for all that the VFW does.

I'd like to ask Mr. Jones if he would now present his testimony.

STATEMENT OF RICHARD JONES

Mr. JONES. Mr. Chairman, Ranking Member Evans, members of the committee, AMVETS is pleased to testify today in full support of H.R. 811, the Veterans' Hospital Emergency Repair Act. H.R. 811 would help respond to the troubling report of VA hospitals in disrepair.

As the Independent Budget veterans' service organizations testified on March 6th, the Department of Veterans Affairs healthcare facilities system is in serious decline. Failure to provide adequate funding for renovations and modernization requirements of the system will cause continued deterioration, heightened healthcare hazards, and increased safety problems. Mr. Chairman, your action in introducing this bill sends a strong signal to the veterans' community, and in particular to those who worked hard to produce The Independent Budget. Not only are you listening, you are taking action.

Like you, we want to move the Capital Assets Realignment for Enhanced Service process along. Clearly, the practice of directing vital resources to maintaining empty, obsolete buildings short-changes direct healthcare services to veterans. As important as CARES is to improving healthcare services to veterans, there is a serious gap in the process. Frankly, the de facto funding moratorium that accompanies CARES simply does not pass the reality test. Construction, renovation, and upkeep are a necessary part of wise stewardship. Maintaining the asset base of VA's hospital care network is good business.

H.R. 811 helps fill the obvious gap between the ongoing facilities review process and the reality of VA's facility situation. The bill assures taxpayers that their investment in VA's physical plant won't be neglected. And it gives veterans assurance that access to high quality medical services will not be jeopardized as the Department moves to increase efficiency in its nationwide network of hospitals.

Without adequate upkeep of VA hospitals, veterans will face ever more serious concerns about quality of care, access to the system, and deteriorating patient satisfaction. While it is clear that the Nation's taxpayers want to restrain wasteful spending, it is also clear they won't like seeing the Nation's VA hospital system collapse from want of attention. The Nation remains grateful for the service of our brave and dedicated men and women in the Armed Services, past and present. Keeping our promise to veterans includes the promise of quality health care.

Mr. Chairman, H.R. 811 is in keeping with this promise, and AMVETS looks forward to working with the committee to achieve its passage.

This concludes my testimony. I thank you again for the privilege to present our views, and would be pleased to answer any questions.

[The prepared statement of Mr. Jones appears on p. 61.]

The CHAIRMAN. Thank you very much, Mr. Jones, and I think you know this already, all of you do, that many of us regard the Independent Budget not just as a blueprint and a viable backdrop to measure what we should or should not do, but it's also a red flag. I mean, you have signaled a number of areas that need to be rectified, and again, I find it to be a very, very useful product for the deliberations of this committee. So I, for one—and I think I speak for all of us—am very grateful for it.

Let me just ask you a few questions, then yield to my good friend and colleague. In light of the recent earthquake in Washington State, and past earthquakes in California, which have caused considerable destruction to VA facilities, what are your thoughts regarding the \$25 million limitation? I know what at least one of you feels, having just heard it, but we're looking to maximize what we can do, as I said in response to Mr. Filner earlier, just because we authorize \$250 million and then \$300 million in the second year, we're not wedded to the \$25 million as being the magic number.

But when you go to \$30 million or \$35 million—and it may be \$30 million is Aristotle's golden mean, where we should be—but then we also may get fewer repairs, and that might have a negative impact on the recommendations made by the VA on major construction projects. So what would be your thoughts, the other VSOs, if you don't mind, on that 25 million dollar cap?

Mr. CULLINAN. Mr. Chairman, I'd like to speak to that issue. You know, we of the VFW, we all here realize that to make this bill passable, there need be some sort of limit on individual spending initiatives. It's also clear to me here today that there may be a number, a small number, of construction projects that will not be accommodated by the \$25 million figure, and the \$30 million figure would work. If that's the case, it would seem advisable to us to adjust the caps or the limits to that extent.

The CHAIRMAN. Yes?

Mr. JONES. And for AMVETS, Mr. Chairman, we, too, would like to see the appropriate balance, to see something approved in the House and make its way through Congress. The inertia that has set in over the past 8 years, specifically with regard to construction, must be overcome, and so there's a need for a balance. However, if you could achieve \$35 million, that would be likely be helpful.

The CHAIRMAN. Let me ask—oh, yes?

Mr. DAVIES. I think some flexibility is critical, because one of the things that we champion is combining medical upgrades with seismic improvements. There are some seismic projects that can be done all by themselves, without a great deal of disruption, but a lot of seismic projects require taking out all the ceilings, taking out some of the air handling systems, swing space, moving clinics temporarily, et cetera.

And in a lot of instances, we think the disruption to patient care, and common sense, and fiscal prudence demands that you combine the project and do some patient privacy upgrades, or whatever,

while you're doing the seismic work. That inevitably increases the cost of the project, but we still think it's economical to do it that way.

Ms. ILEM. I would agree with those previous statements that have been made, that some flexibility in there would be appropriate, I think.

The CHAIRMAN. Let me ask on the bill, we prescribe "improvements to specialized programs to the department, including," and then we go through, "blind rehabilitation centers" right on down to "facilities for hospice," and so on. In our first draft, we had "research facilities" in there, and what would be the feeling of the panel on including that in the legislation? If you want to give it some thought and get back to us for the record, that would be fine too.

Mr. CULLINAN. Mr. Chairman, I would just speak briefly to that. And, you know, obviously, your staff have looked at this very carefully, and apparently, it was determined in the initial draft that research was not necessarily included under this rubric. On the other hand, research is such an important component in the provision of top-quality care to VA, that it could indeed be something to be included.

The CHAIRMAN. Yes.

Mr. DAVIES. Mr. Chairman, I think that the priority, in some cases, is going to set by the life safety issues, and not by the associated medical program. It may be the research wing that's the most seismically unstable and in need of the worst repair. So again, I think there has to be some flexibility in what's mated up with what, but I think the intent of the bill is to have the life safety issues drive, and the other factors follow. But we think the union is important, and sometimes the exact pairing is going to have to reflect both partners.

The CHAIRMAN. And again, this list that we promulgate here leaves the flexibility to the Secretary as well, so in your view, should life safety issues be included then, Mr. Davies? Is that what I'm hearing?

Mr. DAVIES. Sure. It's not a problem to include it.

The CHAIRMAN. Let me ask, if I could, do your organizations believe that there is a relationship between decentralization of the VA into the 22 networks and the problems that we are seeing with the maintenance of capacity in the special programs? As you know, that's an issue that I and others have been raising for quite some time. Would any of you like to touch on that? A little bit off point—

Mr. FISCHL. I'm not sure we understand the question.

The CHAIRMAN. Well, as we decentralized, and went out into the various regions, and more of the power was vested in the individual managers at the local level, we've been concerned that in spinal cord injury and a host of other specialized programs, there's been a diminution of those programs, because even in my own area, there's been an expansion, a rather significant one, of the community-based outpatient clinics, which I think is good, but it should not come at the expense of a spinal cord unit or something of that kind, or long-term care.

And as you recall, the 1996 legislation required that there be a maintenance at that level. The feeling is, among some of us at least, that perhaps there's been a downsizing there.

Mr. CULLINAN. Mr. Chairman, at the VFW, we've noted a difference from VISN to VISN, and what capabilities it maintained and what not. There was a problem a while ago with SCI beds that would seem to have been remedied for now. Long-term care capability is a very tough thing to oversee. And once again, that has to do with how the individual VISNs are meeting that particular obligation. So to the extent it's tougher to oversee, yes, it's a problem. The fact that there are apparent differences in the maintenance of, sometimes, statutorily obligated capability, that's a concern too.

Mr. FISCHL. We have been concerned about the quality of care, and that that could vary, and we think that is worth reviewing and worth watching, to make sure that it doesn't matter which VISN that you live in, that the same quality care would be available.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. May I ask each of the groups here, do you believe that the bill that I and the Chairman have introduced will help expedite funding for some of these construction projects? Or how would they help?

Mr. JONES. Well, we at AMVETS believe yes, this bill would help. It's a wake-up call in some respects. It answers a critical need, something that has been short-circuited for a number of years. The question is, how will it be received by the appropriations panel. And, of course, we're willing to work in any way possible to help that along. We would like to see this bill expedited, and we do believe that it would help in great measure to respond to the disrepair in the VA health care system.

Mr. CULLINAN. Mr. Evans, I would just add, it simply makes sense to provide the Secretary with the authority to initiate construction projects. The VA finally does have the best idea of what needs to get done and what doesn't have to get done. So by eliminating a middle step, it should definitely expedite needed construction projects.

Mr. FISCHL. And it would help to mitigate the idea that CARES will provide for everything, that—just wait for that to take care of it. And this would support the need that some things have to be done immediately, and would give the Secretary the opportunity to address those issues.

Mr. DAVIES. I think we generally support the ramping up of the construction program, because you have to recognize that construction can't be turned on and off like a water spigot. There's a long lead time involved in developing projects. There's a lot of planning involved. And they have to be implemented fairly quickly, because they have a short shelf life.

So what's important in construction is that there be predictable budgets, and a reasonable, appropriate level maintained on a year-to-year basis, rather than feast or famine kind of cycle.

Ms. ILEM. Yes. I mean, obviously, there's certainly an emergent need, and so I think that H.R. 811 would address the need, and it's definitely appropriate and well-needed.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Evans. Dr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman. Mr. Shows wanted me to tell you that he's supportive of the bill and appreciates you being with us. It's that time of the year when there's more than one committee going on at one time, and he had to go to another committee meeting.

Mr. Chairman, I appreciate you asking the question about the research facilities, and I want to pursue that, if I might, a little bit. And Mr. Davies, you might be the best person to address the question to. I got my start—I'm a family doctor—I got my start in medicine, actually, as an EMT, and then that got me a job as an orderly in a hospital in Oregon. It was a very busy emergency room. And so my job in the middle of the night was to go to the neural floor, and help lift the folks that had severe spinal cord injury, to help the nurses' aides to move them around.

And my guess is if I—and I would have some discussions about their future with these guys in the middle of the night, and most of them were men, young men—you know, if I asked them now, "Here's the deal. For the next 30 years, when you go to hospitals and clinics, the heating system is not going to work so good, and they're going to be kind of cramped, and you're not going to like the old furniture, but it means we're going to put more money into research, that maybe someday you'll have increased use of your limbs, what's going to be your choice?" I think I know what the answer's going to be.

And so I'm in agreement with the two of you that made the comment about research facilities. I think they are an important part of the VA mission, particularly when the VA Hospital was set up, essentially, to deal with war wounded, and you just can get all kinds of disabilities there that the VA has become, I think, the expert in a lot of ways, on prosthetics and these kinds of things. Hopefully, down the line, they'll be the expert in the world on seeing regeneration of neural function on some of these injuries.

But that's kind of, I guess, a lofty way of asking the question. A more practical way, Mr. Davies, a lot of research facilities are in—they're a floor or a wing or something in a hospital. I'm not sure how you can distinguish some of this. Do you have any comment on that? How are you going to do seismic repair on a hospital when the—

Mr. DAVIES. No, you have to look at the building as a whole. In a lot of cases, they're taking a tower section off hospital buildings like San Juan and Memphis. You can't help what medical services are located in that upper tower. In a lot of cases, they're inpatient services. In some cases they're research or geriatric research. And so I think that there has to be a great deal of flexibility in the way that the projects are knitted together. I think the VA will do a good job prioritizing than, by seismic zone, for example, and by some other factors. And certainly, I think the medical function should be secondary, as long as it's a worthy cause.

Dr. SNYDER. Yes. One of the categories in the bill deals with improved accommodations for people with disabilities. Well, it would be ironic if somehow this money couldn't be used to improve access

to a research wing or a research facility for people who were chosen because they had a disability. And that's what the study is addressing. So I appreciate your comments and support of that. I'm not sure what the best way is to address the issue.

Mr. Chairman, if I might, I have a statement here from the National Association of Veterans' Research and Education Foundations that I would like submitted for the record.

The CHAIRMAN. Without objection, Dr. Snyder, it's ordered.

[The provided material appears on p. 73.]

Dr. SNYDER. It's supportive of your bill, and if I understand what they've written, their suggestion would be that we add a line or a separate item K at the end of that list that says, "Improvements to research facilities," and then increase the overall amount of the bill by \$25 million in each year, and put some language in there that at least \$25 million would have to go to research facilities. I don't know if that's the best way to address it, but I would like that submitted for the record, if I might.

Mr. Davies, I was intrigued by what you said about the 10-year waiting list, and how, if someone's on a waiting list, when their number comes up and they say, "Well, you know, things have changed, we know there are new ways of doing things, we need to kind of redraw these plans," that they get bumped to the bottom of the list. Is that—

Mr. DAVIES. Certainly my experience is, once you get in the queue to be a major construction project, you don't want to change anything. If you spend 6 years in the queue, a lot of things can become outdated. Sometimes changes can make the project more expensive, but sometimes they could make the project less expensive. The need for operating rooms, for example, may have diminished over that 6-year period. But there's no incentive currently to touch that overprogrammed space, because you're going to mess up your place in line.

And I think that, again, the lengthy funding an approval process also tends to create larger projects because, if you go through the agony of getting a major, you want to get everything you can. And the second thing is, you try to knit the projects together, so they can't be taken apart. So parts can't be easily peeled off. These are things I think are not beneficial to the system. I'd rather see smaller projects. I'd rather see flexibility. I'd rather see staged implementation.

And I would certainly encourage that every project be updated before it's constructed, because the extra time that that is involved with updated planning is minimal, compared to building something wrong that's going to be operated for 30 or 40 years.

Dr. SNYDER. I've never seen any construction project that's been sitting for more than a year. When it's time to put the shovel in the dirt, you don't say, "Well, the guy wants to—we think we've found a different and a better way of doing something."

Mr. DAVIES. Yes, sir.

Dr. SNYDER. If there's any staff member that's an expert on that particular point, I'd like to hear a little bit more detail about that. Thank you all for your time today.

Mr. DAVIES. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, doctor. The chairman of our Health Subcommittee, Mr. Moran.

**OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN,
SUBCOMMITTEE ON HEALTH**

Mr. MORAN. Mr. Chairman, thank you. I have an opening statement that I'd like consent to be placed in the record I'd like to just summarize at the moment.

The CHAIRMAN. Without objection.

Mr. MORAN. I'd like to thank you and Ranking Member Evans for your efforts in regard to this legislation. I think the Veterans' Hospital Emergency Repair Act is important. I'm sure we are only scratching the surface, and it's good to see this committee working again in a bipartisan way, and placing this bill on a high priority. And I pledge to you that I'll work hard with our leadership and the leadership of Congress to make sure this legislation arrives early, and that it's addressed by the House of Representatives, hopefully before our spring break.

I think the longer we wait, the more demand there is for those dollars, the greater problems that the facilities face, and we ought to be demonstrating the importance of this issue by its timely consideration. Clearly, all of us believe that veterans deserve good, updated health care facilities, and I agree with you that this bill provides us with an interim solution to a much larger problem, maintenance of infrastructure.

I think all of us know just from common sense that if we can spend some money today to preserve what we have, it saves us money in the long run. And we need to work with our budget committee and others to make certain that this bill has a legislative history that's a real success. So I look forward to working with the organizations as we build momentum and support for this legislation. And again, I thank the chairman for his leadership, and Mr. Evans for his leadership as well, in making certain that we take this first small step today.

[The prepared statement of Congressman Moran appears on p. 47.]

The CHAIRMAN. Chairman Moran, thank you very much. Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Mr. Chairman, let me also just take this opportunity to thank you. I think that there's no doubt that we need the resources, and to beef up some of those areas that are behind, I know, from very basic things such as parking to other things. And we have a particular place where they're having difficulty getting access to it, because of the lack of parking, and some of those metropolitan areas. But let me just share one concern, I think, and I just want to maybe get some feedback overall. In terms of utilization of those resources.

At least from my perspective, I hope that it would not go into those areas that are underutilized now. I know we hear a lot of—that we have a lot of underutilized facilities where we don't even have veterans, you know. And I apologize for being here late. I'm not sure if there was some discussion, but I hope that—and maybe

you can help me in terms of how we're going to prioritize these items based on need. And I know the needs are out there, but I know that there are some facilities that don't have veterans—as many veterans—as compared to some of the others.

And also taking into consideration the flow into those States that are now seeing the influx and the growth, and where a lot of the northern people are moving. I know we have one county in Zapata that doubles in size during the summer when we get the winter—and we call them the “winter birds.” They come in for the summer from the northern States. And so I'm hoping that maybe we'll ask for some comments in that area, as to how you plan to utilize those resources.

Mr. FISCHL. Well, I think that would be up to the Secretary's discretion. I think that was the primary idea. And the Secretary would know best which—how much funds are available and where the priorities should be, so I think that's why the bill specifies that the Secretary will determine the priorities.

Mr. RODRIGUEZ. So that means that no consideration is going to be given to underutilized facilities, and maybe not to spend it in those facilities?

Mr. FISCHL. Well, that would be the Secretary's call. The Secretary would have to weigh everything. He, being the most familiar person with that, would have to weigh what should be done, and he would determine the priorities. And we are confident that, in his wisdom, he would do what's appropriate.

Mr. RODRIGUEZ. I hope so, too.

Mr. DAVIES. I think in terms of the urgency of seismic corrections, there's been a study that I've seen recently that does some prioritizing. I think that the points you make are absolutely right on in terms of a larger construction project. First of all, nobody should put money into an un-utilized building. Second of all, the money has to be put where the services demand is going to be.

But I think on an emergency basis, maybe that's not the right criteria. I think American Lake wouldn't have been a real high priority medical center, and yet that's the one that had the seismic event recently. So I think that there are complex factors that have to be considered in applying this. I have confidence that the agency can do that.

Mr. RODRIGUEZ. And by the way, so far, I'm real pleased with the Secretary—he's made some—especially going after those claims, and hopefully, we can reduce some of that time. And so far, he's doing—has the good priorities, and so hopefully, we will use that money appropriately as we move forward.

The CHAIRMAN. Thank you very much, Mr. Rodriguez, and I think it bears noting that you asked a very pertinent question about utilization. Under Secretary Garthwaite will testify, and we do have the list of 67 essential, my emphasis, essential Veterans Health Administration buildings that are considered to be at exceptional risk, and are developing plans to address these risks. So we do have the list, and it's prioritized. As soon as we get that money, they can go out the door and do its good work to fix these. But you asked a very pertinent question.

I do have one final question, if I could. Mr. Davies, this would be for you. I appreciate your mentioning the PVA statement of the

Independent Budget recommendation that the VA form a partnership with the National Trust for historic preservation, like the Army has done for its historic properties. And I note that in reading the Price Waterhouse study, those buildings greater than 100 years, 193 buildings; 75 to 99 years, 516 buildings; 50 to 74 years, 1,317; 25 years to 49, 852. There must be an enormous number of historic buildings among that. I wonder if you could just elaborate on your thoughts.

Mr. DAVIES. I think what we're hoping is that the VA will develop a comprehensive approach to the treatment of their historic facilities. They own invaluable historic assets, and these buildings represent the heritage of the country's care and concern for veterans, going back to the American Civil War. They're not just nice, old buildings, but they're buildings that represent the way the Nation has felt about veterans since the American Revolution and before.

We think these structures need to be used, and with adaptive reuse wherever possible, but we think that there are enough of them in the VA's inventory that they ought to be looked at comprehensively. There ought to be a program that addresses it in a comprehensive way rather than in a piecemeal way. Hopefully in a manager that makes for good utilization. It's a tough problem, because in the medical business, it's hard to put modern medicine in a 200-year-old building.

But historic buildings still have their place. I point locally to, for example, Johns Hopkins, which has maintained their old buildings, and yet they're certainly a state of the art hospital. You can still go in the rotunda and see what Johns Hopkins was like 150 years ago. Thank you.

The CHAIRMAN. Thank you. Yes, Mr. Cullinan.

Mr. CULLINAN. Mr. Chairman, I would certainly associate the VFW with Mr. Davies' remarks. They are more than nice, old buildings, it's a part of our history. We are concerned, however, that such a comprehensive approach not be overly stringent or somehow misapplied to totally tie VA's hands with respect to the handling of its physical properties, physical plants. That's the concern that we have.

Mr. JONES. AMVETS would just agree that history is our heritage, and that we do need to keep our eye on some of these buildings, but we also need to keep our eye on our priority, and that's service to veterans.

The CHAIRMAN. Thank you, Mr. Jones. I want to thank our panel. We are likely to have some additional questions, so I would ask if you could to return your answers within about 7 days or so we can make it part of the record. And again, I want to thank you for your testimony, and your support for the bill.

Our second panel is a VA panel. Dr. Garthwaite, and your colleagues, I will ask that you be seated at the witness table, and I'll introduce each of you. We have today our VA Under Secretary for health, Thomas Garthwaite; the Deputy Under Secretary, Dr. Frances Murphy; Deputy Assistant Secretary Mark Catlett; and Chief Facilities Management Officer Charles Yarbrough. Welcome, and we appreciate your being here this afternoon.

We also want to thank you for getting your statements over to us by Friday, so we could look through them and develop some insights and, hopefully, some questions. I know with some of the other committees I work on, the administration folks show up with their testimony in hand, or we get it faxed an hour before, so thank you so much for that.

Dr. Garthwaite, if you would proceed.

STATEMENT OF THOMAS L. GARTHWAITE, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY D. MARK CATLETT, ACTING ASSISTANT SECRETARY FOR MANGEMENT; FRANCES D. MURPHY, DEPUTY UNDER SECRETARY FOR HEALTH; AND CHARLES YARBROUGH, CHIEF, FACILITIES MANAGEMENT OFFICE

Dr. GARTHWAITE. Thank you. I just have a brief opening statement. Mr. Chairman, members of the committee, I am pleased to appear before the committee to express the department's support of H.R. 811. The physical infrastructure of the VA health care system is one of the largest in the Federal Government, with over 5,000 buildings, and 145 million square feet of space. While some VA facilities are relatively new, the average age of our buildings is about 50 years.

In addition to the challenges posed by the age of our buildings, aggressive shifts from inpatient to outpatient care have reduced the need for hospital beds, and dramatically increased the need for modern and efficient outpatient facilities. Our CARES initiative will better align our infrastructure to the needs of veterans, but as you noted when introducing the bill, even as the CARES process unfolds, VA facilities have safety, privacy, and other deficiencies that must be addressed.

While we have had a 30-year effort at addressing seismic deficiencies, we recently studied the capacities of susceptible VA facilities to withstand the force of an earthquake. Through the work of an independent engineering consultant, we have identified 67 essential VHA buildings that are considered to be at exceptional risk, and are developing plans to address these risks. Older buildings are also at risk of non-seismic system failures, as well, as we recently experienced when we were forced to evacuate the Miami VA following a power system failure.

H.R. 811 would provide the Department with greater flexibility in selecting major construction projects, and would result in more timely correction of deficiencies. We believe that your proposal includes processes for selection of projects that will assure the highest priority needs will be addressed. The VA thanks you, Mr. Chairman, and the members of this committee for your leadership in this and other areas, and we look forward to working with the committee to ensure that VA facilities support our continued efforts to fulfill the Nation's obligations to its veterans. Thank you.

[The prepared statement of Dr. Garthwaite appears on p. 64.]

The CHAIRMAN. Doctor, thank you very much. Would any of your colleagues like to add anything.

Dr. GARTHWAITE. No, I think we're ready for questions.

The CHAIRMAN. Thank you, doctor. Let me just ask you first, on the American Lake situation, which has captivated all of our attention, what kind of repairs, in your assessment, will be needed at American Lake, and what is the cost? And I would note that, of those essential buildings, there were a number of those buildings on that list of 67, as you know so well that could have used—

Dr. GARTHWAITE. Well, we sent out a team from Mr. Yarbrough's shop, along with some seismic experts. And the good news is, to bring the buildings in American Lake back to functionality and to put them back at the level of exceptional risk is relatively cheap. It's \$150,000. But they still remain on this exceptional-risk list at that. So to bring them back to where they could, we believe, sustain the kind of tremor or earthquake that occurred a couple weeks ago, is relatively inexpensive.

But to get them to where they could withstand a stronger earthquake with more shear forces and not collapse, is significantly more expensive. And as you note, six of the buildings out there are on that list. I would add that we are negotiating with a CARES contractor to move VISN 20 into phase II, which would accelerate the process, to look at the needs in that network, given the seismic issues there.

The CHAIRMAN. Do you have an estimation as to the cost?

Dr. GARTHWAITE. I believe—Chuck—if I'm not mistaken, if we fixed all six buildings, it's now close to \$100 million, isn't it?

Mr. YARBROUGH. About \$104 million for complete seismic and programmatic upgrade.

The CHAIRMAN. So that would be the repair plus the upgrade. Is that correct?

Dr. GARTHWAITE. That would be to take it off the exceptionally high risk category into what would be considered modern seismic standards.

The CHAIRMAN. Do you have the resources to do that, or is that something that needs to be appropriated in a special way?

Dr. GARTHWAITE. That would need to be appropriated.

Mr. YARBROUGH. \$104 million, yes.

The CHAIRMAN. Is it likely that it will be a separate line item requested by the administration for that?

Dr. GARTHWAITE. Oh, I'm sorry. Let me make it clear. Just the repairs to bring it back to the—to put it back where it was before the earthquake are relatively cheap, \$150,000, and that's something we can handle without too much difficulty. If we were to take those six buildings in American Lake and bring them to 2008 standards that are being used in California and other earthquake-prone States, would be the \$100 million, which would clearly require a separate appropriation.

The CHAIRMAN. When you say, "if," is there some discussion that it not happen?

Ms. MURPHY. Mr. Chairman?

The CHAIRMAN. Yes.

Ms. MURPHY. I've asked Dr. Galey, the—

The CHAIRMAN. Please identify yourself, just for the record, if you would.

Ms. MURPHY. I'm Dr. Frances Murphy. I've asked Dr. Galey, the network director in VISN 20, to develop a strategic plan, looking

at the continued need for these buildings, and to develop a prioritized list of the repairs that should be done. In addition, we've asked Booz-Allen, the CARES contractor, to develop a proposal for amending the contract to add VISN 20 to this year's CARES studies. That will give us a demographic needs assessment, and allow us to appropriately prioritize the six American Lake buildings among all 67 buildings that we know are exceptionally high risk. VA believes that the prioritization needs to be done before investing the \$100 million that might be necessary to repair those buildings.

The CHAIRMAN. What is the expected timeline on that?

Ms. MURPHY. That study would be done this year.

The CHAIRMAN. This year? And when would the recommendations be forthcoming?

Ms. MURPHY. At the end of a 1-year period, in 2002.

The CHAIRMAN. Okay. Is there any kind of collaboration or consultation with people who look at the potential of another earthquake hitting in that region or area, as to the emergency nature of doing the upgrades?

Ms. MURPHY. As I understand it, from the seismic predictions, an earthquake in that region is no more likely than it was a month ago, and certainly isn't predicted to be at higher risk than the California area.

The CHAIRMAN. I appreciate that.

Mr. YARBROUGH. Mr. Chairman, the seismologist, which I, don't qualify for that title, but they predict a 67 percent probability of a major 7.0-magnitude quake by the year 2020. Anytime from now till then. It could be more than one.

The CHAIRMAN. Interesting. Dr. Garthwaite, you've either been the Deputy or Under Secretary for over 6 years, and were certainly involved in many of the changes we have seen taking place in VA health care. Can you tell us why the budget dried up in the major medical and construction areas?

Dr. GARTHWAITE. I think there are several factors. First, I think the rather dramatic transformation we were undergoing from inpatient to outpatient put an emphasis on remodeling some of our inpatient wards to outpatient, and the establishment of some of the community-based outpatient clinics. So that was clearly an emphasis in the administration. There were a couple years in there where deficits were still a problem, and balancing the budget was also a high priority, both in the administration and Congress.

In addition, we wanted to begin to understand the seismic issue, so it was about, I think, 2 to 3 years ago that we commissioned a study so that we could prioritize seismic and safety issues, as well, and I think I have tried to do that. Those are the major issues that have impacted.

The CHAIRMAN. Were recommendations made, or requests, I should say, that OMB penciled out during those years?

Dr. GARTHWAITE. I think in most years, our needs list far exceeds the possibilities list, yes.

The CHAIRMAN. But there were specific projects that would have been funded, but were not, because of OMB?

Dr. GARTHWAITE. I don't know if I can put it all to OMB. I think the whole budget process—when you look at a system that's as

large as we have, and with the number of buildings that we have, there are always some needs for repair and modernization that far exceed the capacity to fund them.

The CHAIRMAN. Let me just ask you to respond, and I guess Mr. Catlett, you might be the right person to do this. Earlier in his testimony, Mr. Davies—Tom Davies from the PVA, as you know, is an architect—made the point, and I just would like to read part of his testimony. Tell me if you think it's accurate or inaccurate, where it's right or wrong.

“One pitfall of the current arrangement is the feast or famine effect inherent in the current inadequate funding levels. Because of the funding logjam, the process may take upwards of 10 years from initial planning to actual construction. The individual veterans integrated service networks, VISNs, are wary of adjusting their projects, because doing so would jeopardize their place in the queue. Projects authorized and finally funded may no longer meet the original needs for which the project was authorized. Underfunding of the construction budget also results in larger, more expensive, and less flexible projects, since there is no confidence that future construction budgets will be forthcoming, every project is made as comprehensive as possible. This is certainly an illustration of being penny wise and dollar foolish.”

Is that accurate, or is that missing the boat, Mr. Yarbrough?

Mr. YARBROUGH. Chuck Yarbrough, the chief facility management officer, Mr. Chairman. I apologize for not identifying myself earlier. The process by which a project does get through our system, and then through OMB into you, and ultimately funded, is lengthy and quite intricate. And I have to say it's much more precise and persuasive than it was several years ago, but it does take quite a bit of time to develop the projects and describe their prospectus in detail. And once that prospectus gets in your hands, and then gets appropriated, we design according to the prospectus.

Changes in the prospectus description have to come to Congress, so that people in the field, and I, for that matter, am leery of doing that—wary of doing that. I don't know if Mr. Catlett wants to embellish or not.

Mr. CATLETT. Mr. Chairman, Mark Catlett, acting assistant secretary for management. Most of that 10 years described is time—once the department has made a decision to fund a project, spent in the actual design and construction period. So the planning period is not 10 years long, as I understand it, and as I've experienced it.

And on the second point, in terms of the reluctance to make a change, that's actually something we've tried to encourage over the last several years. And the criteria we put in place have asked them to be more specific, and get down to the absolute needs, and not the desires. I think in the past, within our construction funding process, there was an implicit encouragement to try to make a project as large as possible. That has been changed with the allocation system, in place now for 4 years. And I think we have a much better effort underway by the folks in the field, who develop the projects, at requesting their highest priority needs only.

The CHAIRMAN. Let me just ask you, you're very well aware of the Price Waterhouse study, you've read it very carefully, I'm sure,

and gone over it many times. The study suggests that assets in the VA total \$35 billion. They also suggest that there needs to be between 2 to 4 percent “annual appropriation spending, plant replacement or reinvestment to replace aging facilities,” and also 2 to 4 percent per year for “nonrecurring expenses.” Now, they suggest a \$700 million to \$1.4 billion annual beef-up to maintain that infrastructure. They point out in fiscal year 2001, the major and minor construction appropriations was \$170 million.

Do you agree with the finding of this study? Is it accurate? I mean, do we really need up to \$1.4 billion per year? Is that accurate, based on your assessment, doctor?

Dr. GARTHWAITE. I'm certainly no expert, but as I've traveled around, I've been to around 80 different facilities, and I see the results of where we've modernized in terms of how that looks to our veterans coming in. I see it in terms of how it improves the efficiency and effectiveness in our outpatient clinics to have a couple of examining rooms, and allow physicians to move between them so that patients can be ready to be examined. So I think that—my sense is that we could use additional investment in infrastructure to make it more effective and efficient.

We do believe that the CARES study will commit us to those buildings and facilities that are where veterans need them, and that part of this effort will be to have a commitment to those facilities and, therefore, a commitment to making them modern and efficient, as well.

Ms. MURPHY. Price Waterhouse is a well-recognized consulting firm. Those estimates were based on private sector models, and what the investment is in similar health care corporations around the Nation. Whether that dollar figure is correct or not, I think it's clear that with our aging infrastructure, we need to be investing in renovation and upgrade.

Mr. CATLETT. Mr. Chairman, if I could be the bean counter here for a moment, which is my official title, at least for today. I generally agree with the 2 to 4 percent formula, but one thing that's hidden, is the funding within the medical care that goes towards capital improvements, and that's called “nonrecurring maintenance.” It has been sustained and increased. In the 2002 budget that we'll submit, when you add together our major, minor, and the nonrecurring maintenance, will be at the bottom edge of that estimate—of that 2 percent—that \$700 million that Price Waterhouse cited a few years ago. And that is a bump up from what we've experienced the last few years.

So I just want to make sure that—and we can certainly provide that for the record—all the funding that's invested is identified.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The VHA investment in Non-Recurring Maintenance (NRM) for FY 2002 is \$330,000,000. The FY 2002 Minor construction is \$178,900,000; together, the two total \$508,900,000.

The “Future Considerations for Construction Spending”: section (pp. 62–70) of the Price Waterhouse Review of OFM makes a number of references to benchmark levels of expenditures per annum for recurring and Non-Recurring Maintenance. The most succinct summary is found on page 63 of the Price Waterhouse Report:

“When considered together, these benchmarks imply that the VA should fund 2 percent to 4 percent of PRV (Plant Replacement Value) per annum for recurring

maintenance, and an additional 2 percent to 4 percent for Non-Recurring Maintenance for a total of 4 percent to 8 percent per annum." At the lower edge of 2 percent, the investment in NRM should be \$750 million, and another \$750 million for recurring maintenance.

The CHAIRMAN. Okay. Thank you. And let me just ask—let me go to Dr. Snyder, and then I'll continue. I've used my time. Dr. Snyder.

Dr. SNYDER. Dr. Garthwaite, I wanted to ask—you heard the discussion earlier about research.

Dr. GARTHWAITE. Yes.

Dr. SNYDER. Would it help you or hurt you to have the flexibility to have research facilities included as part of this?

Dr. GARTHWAITE. I think it would help. I think the reality is that when you're given a choice between facilities that are aging or facilities that are seismically suspect to have patients in them, or building a research facility, it puts you in a very difficult position, no matter how strongly you believe in research. You're looking at the safety issue as a very high priority. And so I think we get caught in that bind. I believe strongly in research, its importance to the VA, its importance to the patients that you talked about, its importance to our ability to attract the best doctors to the VA system.

And yet, when you're sitting there and you have a building that people say, in the next earthquake, could fall down on patients, you're hard pressed to say that you're going to prioritize the research project above that. So I think research should be included in the bill.

Dr. SNYDER. But I'm assuming that if there are 67 facilities, that a fair number of those have floors that have research going on.

Dr. GARTHWAITE. Yes, I don't know the breakout as to how much we would, in trying to correct some of these seismic deficiencies, actually also improve our research capacity. That's something we could probably break out with some effort.

Dr. SNYDER. It seems like it may actually complicate it not to include research facilities in here. I mean, Little Rock VA, it's all through the building. I don't know how you'd ever sort out and say, "Yeah, we're going to seismically stabilize this wing, and"—I don't think they're on the list, but—

Dr. GARTHWAITE. Right. Well, I think in that case we clearly would.

Dr. SNYDER. Yes. It would be helpful to have that. I wanted to add—I mean, in your written statement, Dr. Garthwaite—I think the chairman's intent is to do a better job than we have done in the past on financing of construction projects. In your written statement, you say, "The Department supports H.R. 811 to the extent that it aligns with the President's budget." Now, we've not seen the details of the President's budget, but there's no way it can be at this level of funding for construction projects. I mean, this committee works in a bipartisan way. We didn't like President Clinton's budget, we don't like President Bush's budget. I mean, we've been in agreement on that for several years.

If we pass this bill as it is, it will not align with the President's budget. If it does, I don't know if that means we cut salaries for Under Secretaries or something, because we'd have to find the

money somewhere. The bottom line is, this bill would greatly help you, and you want this money to be—I assume you don't want to have to go find somebody to cut in your current budget to fund it. Would that be a fair statement?

Dr. GARTHWAITE. Yes.

Dr. SNYDER. Thank you.

The CHAIRMAN. Chairman Moran.

Mr. MORAN. Mr. Chairman, thank you. Mr. Under Secretary, would you describe for me the consequences of the status quo, of the absence of this legislation and the funding that Dr. Snyder suggests must follow? If we don't do this, what do we see?

Dr. GARTHWAITE. I think our real challenge will be meeting the safety codes, especially with regards to the seismic issues. In California, for instance, there is a requirement mandating that all hospitals—all patient care areas in hospitals will, by 2008, meet modern seismic safety codes. It's causing a great deal of consternation and concern in the private hospital industry in California. We have always attempted to meet State codes, where they exist, for a variety of reasons. If we don't get busy at that, there's no way we're going to be able to meet that.

Now, we have prioritized both networks in California to have their CARES studies this year, so that we'll at least have that guidance as early as possible. But I think we're going to be under a lot of pressure to meet California standards, and I think one might consider that other States will be adopting similar standards in the future.

Mr. MORAN. It's my understanding—the reason the staff is whispering in my ear is because I was uncertain of something, that being your compliance with ADA. And the whispering was that you voluntarily come into compliance or agree to comply with ADA. Where are we in that regard? Where is the VA in that regard?

Dr. GARTHWAITE. I'm going to ask Chuck to comment on that one.

Mr. YARBROUGH. All of the new construction projects comply with the Americans with Disabilities Act. Everything that we construct new. Clinic or hospital. Of course, we're not building hospitals to a large extent now. When we go in to renovate, that statement's also true, but there are many, many, facilities that have been built in the 1930's, in the 1920's, and so forth, so that unless they've had a renovation project, they would not have ADA compliance.

Mr. MORAN. No effort is made by the VA to comply with ADA unless there is a renovation project?

Mr. YARBROUGH. I don't think that's quite accurate. I think there's a considerable effort at the local level, but I don't have the capability to see that, to can keep track of that. I think in many cases, NRM and minor construction does address the ADA.

Mr. MORAN. And if this legislation is passed, just in your own mind, even in an informal way, is the list of projects, desirable construction, renovation, maintenance projects, pretty well established as to who's on that list and what their priority is?

Dr. GARTHWAITE. Well, we clearly have a prioritization of the 67 seismic properties, and we also have major construction projects for 2002, and some proposed beyond that.

Mr. YARBROUGH. Yes, we've—it's not very well-known, Mr. Moran. We've been doing a progressive seismic program for 30 years. I think that was mentioned earlier. The San Fernando quake in 1971 killed 46 VA people. We've been building, I think, major projects since 1980, and 130, approximately, pieces of projects that were seismic-related. So it's been very progressive, since then. The—well, I think I'll just stop there.

Mr. MORAN. Will seismic projects, seismic-related projects, take priority over other projects if this legislation is passed?

Mr. YARBROUGH. We have the hard, empirical data that justifies the ranking of the 67 extremely high-risk buildings. I mean, there's been, as I say, years and years of cumulative data. And the latest study displays these 67. It actually involves something like a thousand buildings, and then tiered down to the 67 extremely high-risk, which are in danger of collapse or major damage in the event of an earthquake.

Mr. MORAN. At the top of the list, then, is the seismic-related projects?

Dr. GARTHWAITE. Although I think that seismic dominates the list, other types of project are also included.

Mr. YARBROUGH. Not exactly.

Dr. GARTHWAITE. Other projects would be able to compete with some of those. I think we have to work down the list of the seismic projects, at the same time being cognizant of the fact that there are other compelling needs—both safety needs, such as happened in Miami with the electrical systems, and I think other patient care needs—that we have to shuffle into that priority listing. So I wouldn't say exclusively, but I think they will immediately demand some attention. But I think there are other ones that we'll have to prioritize in there, as well.

Mr. MORAN. Mr. Under Secretary, Mr. Yarbrough, thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Chairman. Dr. Garthwaite, should we consider changing any provisions in the bill? You heard the earlier exchange about whether or not research facilities ought to be included. Is the \$25 million limit too high, too low, just about right? I mean, is the 2-year program too short? Obviously, it's not likely we'll be able to change that. And the Capital Investments Board—is that something that you think would be helpful in this process?

Dr. GARTHWAITE. I'd like to—I hadn't heard the proposal about research. I'd like to think a little more about that. But I certainly appreciate the concern about ever getting to any research funding. I think the \$25 million range is probably not unreasonable. There are a few projects you could pick up by going a little bit higher, as was mentioned earlier, I think, as well, but I think we can work with you on that.

Regarding the CIB process, I believe that's an evolving process that keeps getting better as we go through it each year. We've created that process de novo about 4 years ago, and it has evolved. We've continued to change the criteria we're using. And I think by and large it's a better process than it was 4 years ago, and we're committed to making it even better. But I do think it requires a rigorous review of proposals, it requires looking at alternatives, and

it requires prioritization based on things that are important to the veterans and the quality of care.

So I think its intent is good, and I think it's evolved in a positive direction. I think it could be very helpful in this process.

The CHAIRMAN. I want to thank you for your testimony. Secretary Catlett, if I could just ask you, AKA self-described bean counter, what assurances can you give the committee that the VA's capital assets will receive an appropriate level of capital funding and management attention?

Mr. CATLETT. Well, as Dr. Garthwaite has described, that's a moving target. We've asked for \$1 billion increase, you've indicated a need for \$2.1 billion. The most we've ever gotten is \$1.7 billion. We'll still have unfunded needs even if we get \$1.7 billion to \$2 billion. Most of that increase you identified was for more health care. So in effort of determining what to spend towards our future needs versus the immediate needs, we have a tough job. So I'm a little reluctant to give you specific assurances.

We have been, for the last several years, identifying needs beyond this level, and been requesting those. And as has been noted, the CARES process has been offered as a reference point toward having more information about our future needs before we invest significantly. And that reference is to today's level, not what we've done in the past. I'm winding around here on your question, because it is a very difficult one, and my only assurance to you is that we have raised the issue of greater capital investment over the last several years, and will continue to do so.

Ms. MURPHY. Sir, could I add one thing?

The CHAIRMAN. Yes, please.

Ms. MURPHY. Several of the previous panelists commented that they didn't believe that CARES should create an implicit moratorium against construction in the near future, and we agree with that. We've always said that we need the flexibility to exercise judgment in what construction projects need to go forward in the short-term, and that CARES was a long-term planning process. There are clearly projects that we know need to proceed, and could be done in this year or the upcoming years.

The CHAIRMAN. You know, if you could, on that point—and I appreciate you making that point—in the strongest possible way, Dr. Garthwaite and your staff and right to Secretary Principi's level, if you could convey that to our appropriators, because they only need a short speed bump or mogul to say, "Oh, next year" or next years, "we'll get to that." And it has worked, as you pointed out, I said it in my opening, and several of our witnesses over the last several weeks have said it, to create a "de facto moratorium." They say, "Oh, let us see what CARES produces first."

And it's at the appropriations level especially, so by way of letter and, obviously, testimony, if you could convey that to them. Because I think your point is extremely well-taken, and I appreciate that. Thank you for your testimony, unless you have anything else to add, Dr. Garthwaite.

Dr. GARTHWAITE. I was just going to say, while we support the CARES project, obviously, we do believe that there are some buildings in need of some effort soon, that we cannot imagine won't be part of our future, and we need to get busy with that.

The CHAIRMAN. And I just want to make the point, you know, we put "Emergency" in the title of this bill, and we mean it. Emergency with a capital, "E," so thank you for your testimony, and I look forward to working with you in the future.

I'd like to invite our third and final panel, which is a group of VA network directors, if they could come forward, and I will introduce each of you. First, we have Jeannette Chirico-Post, M.D., Director New England VISN 1; Mr. James Farsetta, of New Jersey, New York, VISN 3; Mr. Lawrence Biro of the Pennsylvania, Delaware network, VISN 4; Ms. Patricia Crosetti of the Missouri, Kansas network, VISN 15; Dr. Robert Weibe, of the northern California network, VISN 21; and Mr. Kenneth Clark of the Southern California, Nevada network, VISN 22.

Welcome to all of you. The committee appreciates your attendance here today, and your testimony. We look forward to that. Your full statements will be made a part of the record. If you could summarize in 5 minutes or so—I'm advised that you don't have statements, unless you would like to make a comment or two. But otherwise, we will go right to some questions.

Would any of you like to say anything? If you ask a politician that, you would—let me just ask a couple of questions, then. You've heard the testimony, you've heard the panel of ESOs, you've heard, obviously, Dr. Garthwaite and his distinguished coworkers at the Veterans Administration. I wonder if you could tell us, first on the legislation itself—you heard my last question to Dr. Garthwaite, whether or not the \$250 million fiscal year 2002, \$300 million for fiscal year 2003—if I got that right—is adequate? But specifically, on the \$25 million limit, we heard some earlier conversation, if you remember, "should it be \$30 million, should it be \$20 million?"

We're very serious about making sure this becomes law and is adequately appropriated, so this isn't some exercise in making nice statements. We're going to see this through to fruition, at least that's my fondest hope. The Capital Investments Board, is that necessary? How would you use this money, if you could? I'm sure you have a wish list, and a very-necessary list. Mr. Farsetta, if you wouldn't mind beginning.

Mr. FARSETTA. I think it's a very good piece of legislation. I think it's a very essential piece of legislation. The issue about whether a \$25 million limit is adequate—I know that in some of these items, you can't have flexibility. The only suggestion I would make is, you may want to adjust that yearly based upon some inflationary factor. It may be good in 2001, but by 2005 and 2006, perhaps it isn't good.

As it relates to our own internal review process, the comment that Mr. Catlett made—I think the focus needs to be on—maybe all the T's are not crossed and all the I's are not dotted, but many of these projects relate to patient safety, and I think it's important to realize that if it doesn't happen, what are the potential implications? I think it is a moving target. I think it certainly has improved over time, but I think it needs to be sensitive to the fact that most of these projects are really patient-centered, patient-related, very highly focused on patient safety, and if they don't happen, I think there are consequences when they don't happen. And we need to be mindful of those consequences.

The CHAIRMAN. Would others like to respond to that?

Ms. CROSETTI. Yes.

The CHAIRMAN. Please identify yourself for the record, since this is being recorded.

Ms. CROSETTI. Patricia Crosetti, network 15, Kansas City. I would also like to mention something that I don't think has been mentioned yet, and that is, providing a safe environment in which our employees can work and function efficiently. I think this would help us go a long way toward that. We have very incredibly talented, dedicated employees, who have dedicated—you know, spent their entire lives taking care of our veterans, and we owe it to them to provide them a safe and efficient place in which to practice.

The CHAIRMAN. Would you agree, then, that research facilities need to be added to the list, again, life safety issues being important? Yes, Ms. Crosetti.

Ms. CROSETTI. In my network, research is so integral in our buildings, I don't have separate research buildings, so we can't touch medical care without touching research.

The CHAIRMAN. You've heard earlier—yes?

Dr. POST. Jeannette Post, network 1. If I could add to that. I don't—it's very difficult to separate a specific area of research that we might take advantage of in this bill. The only comment I want to make about, I think we need the greatest flexibility to do what we have to do, to continue to transform the organization from a hospital-centered focus to an outpatient-centered focus.

The CHAIRMAN. Let me ask you, you know, we've often heard people in the field talking about managing around the \$4 million minor-to-major statutory threshold, and splitting up projects. Is that something each of you have had to do in order to obtain at least funding for some of your projects?

Mr. CLARK. Not inappropriately. There are circumstances where projects can be split into reasonable component parts. If each part of the project is functionally independent, then it is not inappropriate to do that as a minor project. And I think—I won't speak for my colleagues, but certainly I would guess most have at one point or another, striven to try to find a way to do a project in small pieces, rather than try to apply for scarce major construction funding.

Ms. CROSETTI. I agree. If we have three inpatient wards that we need to retrofit for patient privacy, I can't do all three at once, because I have to continue to provide medical care. We're talking about renovating used buildings. We're not talking about moving out of a building, renovating it, and moving back in, in most cases. So the sequencing may be more a function of the heavy burden we're putting on our buildings and the way we're using them, than in a way to work around an appropriations limit.

The CHAIRMAN. Some of us have a concern that the CARES process may, however well-intended, in an unintentional way, become almost like the BRAC process became. And all of you may be in situations where you are fundamentally in disagreement with the finding of the analysts who produce the final product. A, if any of you have begun to deal with those people—because I know it's being done on a point by point basis, it's not just one nationwide

deal—are you confident you’ll have the ability to say, “Wait a minute, that facility is needed, or that should not be on the list.”? Have any of you had any dealings yet with any aspect of the CARES process?

Dr. POST. If I might, Congressman Smith.

The CHAIRMAN. Yes.

Dr. POST. I’ll start the response. We’re in the first round for the review through the CARES process, and it would be helpful to understand. The biggest integration that we’ve done in our network is the Boston integration between two tertiary care facilities in Massachusetts, one located at Jamaica Plain, and the other one at West Roxbury. In preparation for that, the review that was conducted through consultants, utilized criteria similar to what’s being utilized in the CARES process.

As we have moved forward with this integration—because it’s been on, now, for about 2 years—it’s been important for us to do it in an incremental fashion, to sequence it, as Mrs. Crosetti said, to live within the facility as we are doing the project. I equate the construction that we have to do in the Boston integration to the big dig in Massachusetts. And it is sequenced in such a way that one project follows another, but independent of the other one, as well.

Believe that, as CARES comes in, they will validate what we have done, and we will be at the table to have that discussion with them about what those options might be.

The CHAIRMAN. Yes.

Mr. FARSETTA. We certainly have really not begun the CARES project, other than to get some general information, but the fact of the way it’s constructed, I have every reason to believe that, whatever transpires, we will be an integral part of, and it’s hard for me to imagine that we would perhaps come to a different conclusion, or the consultant would be recommending something that we would feel is not acceptable, and they would not factor that into whatever decision is made.

This is going to be, I think, evidence-based, it’s going to be statistically-based, it’s going to be on the demographics, it’s going to be on the way the network is structured, or perhaps the way it should be structured. And I have a sense that we will be in agreement with what’s going on.

The CHAIRMAN. Will it, in your view, be more advisory or binding? I mean, I went through two BRACs in my area, Lakehurst—and you know that quite well, Jim, having just been down to the Brick Clinic, it’s right near there—that was on the radical realignment list. When we looked at the Navy’s numbers, they claimed the \$97 million it would cost would be recouped after 3 years, and then would start accruing to real gains for the Navy, it turned out to be as bogus as a three-dollar bill.

And as a matter of fact, we actually got, during that process, faxes that said, “Don’t show the cost of transporting that 200-ton”—and I say 200-ton—“machine down to Jacksonville, FL, and some of the other possible receiving sites.” I expected the Navy to be completely above board, fair, honest, transparent, and came to the view that there was a major disinformation and scam going on here. And we got it off the list. We convinced the BRAC number-

crunchers that there was a serious flaw by Bisette and the others that were crunching the numbers for the Navy.

Now, having been through that, having lost a facility when they said there would be no MILCON necessary when the West Trenton facility was closed, which was in my district, only to find out that at Patuxent River, when I was doing a tour there on the second BRAC, I said, "What's that hole in the ground over there?" "Oh, that's for the West Trenton facility, that's a MILCON." "What are you talking about? I was told it wasn't needed."

I'm concerned that the force, the inertia, of the CARES process will lead to unintended and unnecessary and disastrous closures, even though I'm hoping, going into this, that it's going to be a totally transparent process. The Navy captain who used to be the Air Boss on the Kennedy, when two of the BRAC commissioners came in, responded to very specific questions, and I was the one who asked most of those very specific questions to draw him out, and that was the end of his career. He was finished with the Navy, and that's the kind of people you want to go on to become admirals, in my view.

So it was a very discouraging process, to say the least. And now we have a MILCON there, and we've grown the base and all that, but the point is, I'm just hoping this process doesn't injure your physical plant, and that you feel emboldened to come forward if you think you've been wronged as this process goes through. Because we all want to serve the veterans, after all. I guess I went on a little too much on that one.

Let me just say, it's a concern that I have, because I've seen it in operation, and I expected honesty and got something less than that during that process. Dr. Snyder? Oh, Lane, you're back. Okay, Dr. Snyder?

Dr. SNYDER. Thank you, Mr. Chairman. When you all are looking at Chairman Smith's bill here, and looking at the amount of money that we're talking about putting into construction, if you had to rank the need that you see out there between vital and necessary, and emergency versus "oh it would be nice to have it," versus, "it's a waste of dollars, put it in something else," where do you all come down amongst those three choices in terms of infusion of cash into construction.

Mr. BIRO. Larry Biro, network four. We need money for those things that have to be done. The buildings in network four were all built before 1950 or in the 1950s, and—the core buildings—there's been some addition. We have some buildings as early as the 1930s. We have packaged up our infrastructure to about \$30 million, and it's all roads, roofs, sewers, a lot of different things.

Dr. SNYDER. It's really basic stuff.

Mr. BIRO. It's basic stuff. The other piece we packaged up was our outpatient needs, and it comes up to about 30-some million dollars, also, but it's to maintain our outpatient infrastructure. And we also have the fourth—what's in the Chairman's opening statement—project that's been authorized for three times, the Lebanon remodeling of their nursing home that has sat there without any appropriation, although, as I said—for three times, authorized for three times. So we have basic needs.

Ms. CROSETTI. We have approximately—we rolled ours up over the last 2 years. The facilities sent forward requests for \$175 million, and what they called “patching.” Air handling, water, roofs, those types of things. At the network, we have not vetted that, to the extent of, is this nice, or is this critical? And we are in the process of doing that, but even if it’s half of that, that is critical, that is still a need.

Mr. WEIBE. Robert Wiebe, VISN 21. In our network, which includes the San Francisco Bay area, we have 12 of the 67 exceptionally high-risk buildings. I’m hopeful that at least six of those could be corrected through minor projects under the \$4 million limit, but six of those will require projects above \$4 million, and several of those, I think the first four of the exceptionally high-risk buildings, are in the San Francisco Bay area. And certainly, given the risk of an earthquake, we have considerable concern about those buildings.

Mr. CLARK. I’ll comment in a manner similar to Dr. Wiebe. I’m Kenneth Clark, the network director in network 22. We have 20 buildings on the list of 67.

Dr. SNYDER. Where is network 22, sir?

Mr. CLARK. Southern California and Southern Nevada. In the first tier are the west Los Angeles project, the San Diego project, and the Long Beach project, which has been referenced earlier. All three of those are very, very large projects, \$55 million, \$26 million, and \$33 million. In the remaining projects, many of which can be done by minor projects, there’s \$25 million, and then another \$25 million to complete the list of 20.

So clearly, many of those projects can be done my minors, but the three most important projects would clearly require major projects of considerable size.

Dr. SNYDER. Ms. Crosetti, you mentioned in your—I think it was in response to the Chairman’s question about the need for a safe environment for your employees. I’ve been kind of beating the drums for research facilities today, but having toured some very modern research facilities, both in the VA and in other systems, and some very old ones, employee safety issues are certainly a part of the need to update facilities, when you’re talking about how things are vented, what the plumbing is like, how you store chemicals. Do you have any comments on that?

Ms. CROSETTI. That’s why I think it’s very difficult to separate research from health care delivery, because the researchers are also our employees, so we—you know, I don’t know how I’d separate it in my network, because it’s integral. Research is not separate. They’re separate monies, but it’s not—we don’t think of it in terms of it’s separate from medical, it is part of what we do.

Dr. SNYDER. If I might interject, and then hear your comment. I have some fear that if we don’t have the language in the bill, that there are going to be people out there saying, “We’d better make sure we don’t do anything in here on research, because it’s not going to be eligible for this money.” From your perspective, if it’s so integral, I mean they’re so integrated together, we’d be foolish not to have the language in the bill, would we not?

Mr. FARSETTA. It is—I mean, just in response to the point you just made, it is conceivable that you could put something in that

would involve renovation of research space, which may be contiguous to a patient care area, and it may receive a lower priority, because it is not patient care. But as Pat pointed out, the result of it clearly would impact patient care, and from a staff safety perspective, it certainly would be critical, whether it's sprinkling or storage or ventilation, whatever it may be.

So there may be some advantages to making sure there is no a distinction or a lower priority for something that falls outside of the realm of what's identified in the bill.

Dr. SNYDER. And then defer to the flexibility that the Chairman intends in the bill, that you all do the right things and set the priorities correctly. Yes sir?

Mr. CLARK. That would be my hope, that we would not exclude a building simply because it's a research building. In that list of 67, three of those are in network 22, and they're free-standing research buildings. In other words, they're not connected to any patient care buildings. And I would not—but they are at serious seismic risk, and need to be seismically corrected. So I would hope that we would not—the bill would not exclude those buildings simply because they're research buildings, but would include them because of their seismic condition.

Dr. SNYDER. I don't know what facility you're talking about, but I would assume, like most medical research facilities, that patients go in there sometimes to have blood drawn, or—I mean, it just depends on the kind of facility. Am I right or wrong?

Mr. CLARK. That's correct, but I think, back to Ms. Crosetti's point, the key point for me is that those buildings are occupied all during the day, and most of the night, quite frankly, by a number of research staff, and an earthquake could strike at any time, so I think the employees that are in those buildings that are seismically at risk are themselves vulnerable.

Dr. SNYDER. Let me ask one more question, Mr. Chairman. Now, separating out from the seismic—and I agree with that perspective in terms of patient safety, but you may have heard the discussion earlier about accommodation for people with disabilities. If you have one of these stand-alone research facilities that's an old building that has poor access for people with disabilities, and yet it deals with a group of, say, paralyzed veterans that are in wheelchairs, we would be a little short-sighted, would we not, not to give you all the flexibility to look at some of those buildings and say, "Wait, we've got a lot of patients that roll in this old laboratory?" I mean, the same challenge is going to be there for our patients, whether they're rolling in the research facility or rolling in the clinic; am I correct?

Mr. CLARK. Yes. I agree.

Dr. SNYDER. Thank you all.

The CHAIRMAN. Mr. Evans. Thank you, Dr. Snyder.

Mr. EVANS. Thank you, Mr. Chairman. Dr. Post, the funds are made available under this emergency legislation. Do you intend to forward a major construction proposal to continue with the integration of the Boston facility? If not, how do you intend to fund this project?

Dr. POST. As I said earlier, we have been working on the plans for the incremental improvements of the Boston merger. The plan

that exists right now is to locate all of inpatient services at the West Roxbury campus; ambulatory services at our Jamaica Plain campus; and long-term care and chronic spinal cord at our Brockton campus. The projects that we have in place will be sequenced over time, and they are in the design phase right now. The funds for those have been set aside through the network as we have made our plans in the last several years, planning for this merger in the Boston health care system.

Dr. SNYDER. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Evans. Let me ask Dr. Wiebe. You said there were six buildings. How many are inpatient care? And how much would it cost to fix the four major buildings?

Dr. WIEBE. The approximate cost of all six, I believe, is around \$80 million. Most of these buildings are direct patient care buildings, although, in a similar fashion to Mr. Clark, there is one research building. Several of the other facilities do have blends of research, outpatient care, as well as some administrative function, but there are six projects. Again, I think the total is approximately \$80 million.

The CHAIRMAN. You heard earlier, and I know you know this, and you've all seen the list, and probably tried to get some of your buildings on that list, and that are the 67 essential VHA buildings that—and I'm quoting from Dr. Garthwaite—"are considered to be at exceptional risk." Now, I always wonder about the 68th and 69th and the 70th. I mean, are there many buildings, facilities, in your VISNs that are not on that list that, based on your calculations and your sense of need, should be? What kind of universe are we talking that follows the ice breaker, if you will, the 67 buildings and facilities?

Ms. CROSETTI. Are you talking about buildings at seismic risk or buildings at—

The CHAIRMAN. Buildings at risk for the whole universe of issues. Life safety issues, seismic risk, and the like. The kind—you've seen our definition in H.R. 811—that could be included in an emergency.

Ms. CROSETTI. I think, all of my buildings. The average of my buildings is 40 years. I have six million square feet. We've taken three-quarters of a million square feet out over the last 5 years. I have 6 million square feet, most of which is—80 percent of which is over 40 years old. And we are using them in a manner for which they were not designed. They were designed for inpatient care 40 years ago. We're using them for primarily outpatient care. There's a tremendous amount of traffic in them every single day, day and night. I would be hard pressed to say that all of them couldn't use some help.

Mr. EVANS. Would anyone else like to—yes, please.

Mr. BIRO. I would agree that the 12 buildings in VISN four are in the same situation. They're old, they're not being used for what they were originally designed for, and they have a lot of usage.

Mr. EVANS. Let me ask you a question on the issue of capacity. At each of our hearings with the VSOs, with Secretary Principi, I raised—and I was not alone—concerns about that issue. All of you have the responsibility to maintain special treatment capacities and long-term care capacities, and we are concerned that that

seems to be falling. If you all could respond to this, and there's two questions.

What is your capacity for long-term care today compared to what it was on September 30th of 1998? Has it changed? How did it change? And secondly, in the area of substance abuse, what is your capacity for drug abuse programs in 1996? And how has that changed one way or the other, down or up? And I know you might want to get back to us for an elaboration on the answer, but if you could take a stab at it, each of you. Yes?

Mr. CLARK. I'll just lead it off by mentioning that in substance abuse, I can tell you that in terms of patients treated—total patients treated—my workload in that period of time is down about 10 percent. That having been said, many of those patients are now being treated in some other venue. We have over that same period of time, had a dramatic increase in, for instance, transitional housing for homeless veterans. Many of the patients, if not most of the patients in those programs, are patients suffering from some form of mental illness or substance abuse.

But in terms of patients treated, registered in a substance abuse program, it's down 10 percent. Long-term care, our nursing home bed average daily census is down, I think, about 10 percent, as I recall, offset to some extent by our community nursing home care beds. In my network, that happens to be up over that period of time, most recently by about, I think, an equal amount, about 10 percent. So those are—that's my response for network 22.

Dr. WIEBE. From network 21, in terms of long-term care beds, since 1996 our ADC has gone up. It's up about 150. And I think that reflects some beds that have been opened in the Martinez area, as well as Honolulu. I don't have the figures compared to 1998. I could submit those later for the record.

In terms of substance abuse, again, I don't have the specific figures. It is my impression that the number of patients treated in substance abuse programs has increased modestly, however, most of that has been shifted from inpatient to outpatient care. But I can get those specific numbers for you.

The CHAIRMAN. Thank you.

Mr. BIRO. In VISN four long-term care, our capacity has remained essentially the same, and actually, our authorized beds have gone up, although the average daily census has fluctuated, and actually including at this time. We've opened some additional beds in Erie, PA, and we plan to open another 30 beds in Clarksburg, West VA. Overall, for long-term care, we believe that we've at least maintained or expanded that service, although it's been very marginal, less than what I'd expected.

We have the same issue as 22 in terms of substance abuse. Our substance abuse program's off about 15 percent, and dollars spent is off about 36 percent. I'm not clear on the reason why. We do have as policy strategy in our network that we'll maintain and expand services, so it wasn't a plan to shift in any way. There is some feeling, though, that we may not be as responsive to veterans as we used to be, and that they're going to a residential setting, and from a medical model, may have had some veterans not see the program as friendly as it could be.

We also have a problem in the Philadelphia area. We don't have any residential program in Philadelphia proper. You have to go to Coatsville, which is about an hour and a half away, which presents a problem, and which we'll have to look at to see if we could have a residential program in Philadelphia, in fact, in Southern New Jersey. That is an issue, is we don't—the programs don't match up in location with the needs, and we'll have to continue to work on that.

Ms. CROSETTI. In our network, we have the same number of nursing home care unit beds as we did, because we have opened a 40-bed unit in Wichita that was closed temporarily. Our community nursing home numbers are down, but our home-based primary care is—has almost doubled, because of the rural nature of our network across Kansas and Missouri.

We think it's important to keep folks in their community as much as possible, so that is a delivery decision, as opposed to a facility decision. And our veterans are happy, because they're closer, and they're in their communities with their families, instead of half a state away in a VA nursing home. So we're trying to accommodate the families' wishes in keeping their loved ones close.

On substance abuse, we're down about 13 percent, but our seriously mentally ill is up 10 percent. Our homeless is up 55 percent. Our seriously mentally ill PTSD is at 104. Our PTSD, general, is at 106 percent of what it was in 1996, and we have just added four—we're going to be adding 40 acute psych beds in Topeka, KS, because Menninger's has closed, and we have moved the Menninger psychiatry residency from Menninger to K.U., and we're working with an affiliation there so we can maintain psychiatry services in one of our rural States.

Mr. FARSETTA. We've decreased our capacity, or have decreased capacity in substance abuse disorder. We're down roughly 16 percent. The same can be said for the seriously mentally ill, homeless, although we are up in both PTSD SMI, and in PTSD in general, quite significantly. In long-term care we are down 150 beds, and we are down as it relates to the number of individuals in those programs—number of employees that we have in those programs.

Dr. POST. In network one, we, too, are down in both the number of beds in long-term care, as well as in substance abuse. I believe that part of my response has to speak to the complexity of providing care in both of those programs, and how we have changed from a hospital-based system to an outpatient-based system, and an attempt to keep patients at the least restrictive area to get that care.

And I think the numbers in substance abuse speak to that. Health care has changed. We no longer maintain many of those folks on an inpatient basis to treat their addiction but, rather, try to keep them in the community and partner with the community through various work programs, residential programs, and that's where some of that is.

The CHAIRMAN. If you could, each of you—and I appreciate your responses—get back to the committee within a week or so, just so that we can make this a part of the record, with an even more elaborate statement. Because my concern always remains, where is the unmet need, who's falling between the cracks? Perhaps you're doing even more than what we could have hoped for, and that mes-

sage needs to be broadcast, as well. We're going to try to, in addition to new laws and additional funding. As you know, we are trying to plus-up the President's budget, particularly on the health care area, by \$1.1 billion dollars in the discretionary programs.

But in order to really be viable in the competition for scarce dollars, we are going to have to also say how well or how poorly are we utilizing existing assets. And it seems to me if we can point to an ever-streamlined, effective delivery care system, that helps. You're walking point, and I know the committee appreciates that, so the more information you can provide us the better. Oversight and accountability is very much going to be a part—it has been, but even more so going forward—of this committee.

As you know, the VA is required by law to report to the committee on capacity in special programs not later than April 30, and I can assure you, we're going to pore over that reporting. We do have an Oversight and Investigations Subcommittee. We've just asked for additional staff from the House Administration Committee. They've indicated they're going to be positive in their consideration of our request.

We want to do the job, we want to do it well. We're all in this together, so please, get back to us on an amplification of what I think was a very good attempt by all of you to give us that information. But the more specific, the better. And again, with an emphasis on unmet need, and what you're planning for the future with regards to these kinds of programs, that would be helpful as well. Even if it's been unrealized at VA central command, in terms of previous requests, we'd like to know it, because we want to help our veterans.

Mr. Evans, do you have anything further?

Again, I want to thank you for being here, for traveling huge distances in some instances. We appreciate your testimony, we look forward to working with you going forward. The hearing is adjourned.

[Whereupon, at 3:33 p.m., the committee was adjourned.]

APPENDIX

I

107TH CONGRESS
1ST SESSION

H. R. 811

To authorize the Secretary of Veterans Affairs to carry out construction projects for the purpose of improving, renovating, and updating patient care facilities at Department of Veterans Affairs medical centers.

IN THE HOUSE OF REPRESENTATIVES

MARCH 1, 2001

Mr. SMITH of New Jersey (for himself, Mr. EVANS, Mr. MORAN of Kansas, Mr. FILNER, Mr. STUMP, Mr. REYES, Mr. BILIRAKIS, Mr. STEARNS, Mr. BAKER, Mr. SIMMONS, Mr. BROWN of South Carolina, and Mr. BUYER) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To authorize the Secretary of Veterans Affairs to carry out construction projects for the purpose of improving, renovating, and updating patient care facilities at Department of Veterans Affairs medical centers.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*
 3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Veterans' Hospital
 5 Emergency Repair Act".

1 **SEC. 2. AUTHORIZATION OF MAJOR MEDICAL FACILITY**
2 **PROJECTS FOR PATIENT CARE IMPROVE-**
3 **MENTS.**

4 (a) **IN GENERAL.**—(1) The Secretary of Veterans Af-
5 fairs is authorized to carry out major medical facility
6 projects in accordance with this section, using funds ap-
7 propriated for fiscal year 2002 or fiscal year 2003 pursu-
8 ant to section 3. The cost of any such project may not
9 exceed \$25,000,000.

10 (2) Projects carried out under this section are not
11 subject to section 8104(a)(2) of title 38, United States
12 Code.

13 (b) **PURPOSE OF PROJECTS.**—A project carried out
14 pursuant to subsection (a) may be carried out only at a
15 Department of Veterans Affairs medical center and only
16 for the purpose of improving, renovating, and updating to
17 contemporary standards patient care facilities. In selecting
18 medical centers for projects under subsection (a), the Sec-
19 retary shall select projects to improve, renovate, or update
20 facilities to achieve one or more of the following:

21 (1) Seismic protection improvements related to
22 patient safety.

23 (2) Fire safety improvements.

24 (3) Improvements to utility systems and ancil-
25 lary patient care facilities.

1 (4) Improved accommodation for persons with
2 disabilities, including barrier-free access.

3 (5) improvements to specialized programs of the
4 Department, including the following:

5 (A) Blind rehabilitation centers.

6 (B) Inpatient and residential programs for
7 seriously mentally ill veterans, including mental
8 illness research, education, and clinical centers.

9 (C) Residential and rehabilitation pro-
10 grams for veterans with substance-use dis-
11 orders.

12 (D) Physical medicine and rehabilitation
13 activities.

14 (E) Long-term care, including geriatric re-
15 search, education, and clinical centers, adult
16 day care centers, and nursing home care faci-
17 ties.

18 (F) Amputation care, including facilities
19 for prosthetics, orthotics programs, and sensory
20 aids.

21 (G) Spinal cord injury centers.

22 (H) Traumatic brain injury programs.

23 (I) Women veterans' health programs (in-
24 cluding particularly programs involving privacy
25 and accommodation for female patients).

1 (J) Facilities for hospice and palliative
2 care programs.

3 (e) REVIEW PROCESS.—(1) Before a project is sub-
4 mitted to the Secretary with a recommendation that it be
5 approved as a project to be carried out under the authority
6 of this section, the project shall be reviewed by an inde-
7 pendent board within the Department of Veterans Affairs
8 constituted by the Secretary to evaluate capital investment
9 projects. The board shall review each such project to de-
10 termine the project's relevance to the medical care mission
11 of the Department and whether the project improves, ren-
12 ovates, and updates patient care facilities of the Depart-
13 ment in accordance with this section.

14 (2) In selecting projects to be carried out under the
15 authority provided by this section, the Secretary shall con-
16 sider the recommendations of the board under paragraph
17 (1). In any case in which the Secretary selects a project
18 to be carried out under this section that was not rec-
19 ommended for such approval by the board under para-
20 graph (1), the Secretary shall include in the report of the
21 Secretary under section 4(b) notice of such selection and
22 the Secretary's reasons for not following the recommenda-
23 tion of the board with respect to that project.

1 **SEC. 3. AUTHORIZATION OF APPROPRIATIONS.**

2 (a) IN GENERAL.—There are authorized to be appro-
3 priated to the Secretary of Veterans Affairs for the Con-
4 struction, Major Projects, account for projects under sec-
5 tion 2—

6 (1) \$250,000,000 for fiscal year 2002; and

7 (2) \$300,000,000 for fiscal year 2003.

8 (b) LIMITATION.—Projects may be carried out under
9 section 2 only using funds appropriated pursuant to the
10 authorization of appropriations in subsection (a).

11 **SEC. 4. REPORTS.**

12 (a) GAO REPORT.—Not later than April 1, 2003, the
13 Comptroller General shall submit to the Committees on
14 Veterans' Affairs and on Appropriations of the Senate and
15 House of Representatives a report evaluating the advan-
16 tages and disadvantages of congressional authorization for
17 projects of the type described in section 2(b) through gen-
18 eral authorization as provided by section 2(a), rather than
19 through specific authorization as would otherwise be appli-
20 cable under section 8104(a)(2) of title 38, United States
21 Code. Such report shall include a description of the actions
22 of the Secretary of Veterans Affairs during fiscal year
23 2002 to select and carry out projects under section 2.

24 (b) SECRETARY REPORT.—Not later than 120 days
25 after the date on which the site for the final project under
26 section 2 is selected, the Secretary shall submit to the

1 committees referred to in subsection (a) a report on the
2 authorization process under section 2. The Secretary shall
3 include in the report the following:

4 (1) A listing by project of each such project se-
5 lected by the Secretary under that section, together
6 with a prospectus description of the purposes of the
7 project, the estimated cost of the project, and a
8 statement attesting to the review of the project
9 under section 2(c), and, if that project was not rec-
10 ommended by the board, the Secretary's justification
11 under section 2(d) for not following the rec-
12 ommendation of the board.

13 (2) An assessment of the utility to the Depart-
14 ment of Veterans Affairs of that authorization proc-
15 ess.

16 (3) Such recommendations as the Secretary
17 considers appropriate for future congressional policy
18 for authorizations of major and minor medical facil-
19 ity construction projects for the Department of Vet-
20 erans Affairs.

21 (4) Any other matter that the Secretary con-
22 siders to be appropriate with respect to oversight by
23 Congress of capital facilities projects of the Depart-
24 ment of Veterans Affairs.

○

PREPARED STATEMENT OF CONGRESSMAN EVANS

Good afternoon, Mr. Chairman. I want to thank you for holding this legislative hearing about the Veterans' Hospitals Emergency Repair Act. I am an original co-sponsor of the Act and believe it offers a meaningful reform that will allow needed construction to be completed in a more timely manner.

We have a serious problem on our hands. While VA is undertaking a process to review its infrastructure needs for the future, known as CARES (Capital Asset Realignment for Enhanced Services), there has been a virtual moratorium on its major construction projects starting in the late-nineties. In a system with 5,000 buildings that have an average age of 50, it is clear that there has been too little investment in infrastructure that has taken place over the last few years. The effect of this de facto moratorium likely has placed veterans and VA employees at risk as buildings age and deteriorate without necessary renovation and fortification.

From my perspective, the funding process has clearly had a dampening effect on both the quality and quantity of projects that have been routed through the agency. As major construction funds have virtually evaporated, the field has clearly gotten the message that it is not worth their time or effort to develop proposals that are unlikely to be funded—not because of their merit—but because of the availability of funds. I believe that the availability of designated funding will encourage more proposals from facilities, thereby enhancing the quality of projects from which VA may select.

The legislation we are considering today will allow VA to expedite selection, funding, and completion of "smaller" construction projects it believes are in the best interest of the system within certain guidelines developed by this committee. We have prioritized projects that will improve facilities' safety and access and develop its capacity for the programs we believe are most integral to its mission—blind rehabilitation, programs for the seriously mentally ill, substance use disorder treatment, other rehabilitation, long-term care, amputation care, spinal cord injury, traumatic brain injury, and women's health. These categories are largely consistent with the priority VA's Capital Investment Board now assigns to various construction projects it reviews. Within these priorities, it will be possible for VA to choose a range of projects that need not be held up by completion of the CARES process.

I believe it is appropriate to delegate the selection of these projects to VA as an interim approach until the system has results from its CARES process for a number of reasons. CARES will produce guidelines for restructuring system assets within market-basket areas—ultimately across the country. It is clear that some of the guidance it will produce will have significant implications for local markets, but some areas (those with only one VA medical center and high levels of acute workload) will be largely unaffected. VA also is aware of the areas (those in less populated areas whose mission has largely shifted to outpatient care and areas with more than one medical center) that may have some significant changes brought on by the CARES process. CARES may be a long-term project and projects must not be postponed indefinitely because of it.

While it is appropriate for the agency to make investments in locations that are likely to be less affected by the potential outcome of CARES, it is not appropriate to delay construction indefinitely awaiting the outcome of a process that may take a decade to complete. I am concerned that some networks, such as VISN 12, may be delaying any projects pending the outcome of the process there. I am hopeful that there will be a reasonable proposal available for the Chicago area soon, however, options for this area have been considered for almost a decade. Viable construction projects, such as replacement of the badly deteriorated blind and spinal cord injury centers at Hines, must be advanced to uphold safety standards and assure quality.

I understand that, within the guidelines of this legislation, we are giving more authority to the agency. It is my hope that Headquarters use a centrally guided and administered process, such as the Capital Investment Board, to select those projects it believes best advance the mission of the agency overall. It should *not* be a process that allocates funds to networks for use at the directors' discretion. We have seen, on too many occasions, that allocation of funds requested by the agency for special initiatives, such as waiting times or Hepatitis C, may not be used for these purposes.

Any construction planning exercise inevitably leads to the question of mission. What should VA be doing now and in the future? To be sure, the veterans' health care system has undergone many changes in the last few year—some reflect better practices from the private sector; some have redefined long-standing VA programs, such as mental health and long-term care, throughout the system, and perhaps not for the better.

To the extent that construction planning and the CARES process does not adequately "maintain the capacity" of VA's long-term care programs and services for veterans with special disabilities, I believe VA's planning outcomes will continue to face opposition from Congress and the veterans who have come to rely upon VA for its health care services. We cannot turn back the clock on these services, but we must ensure that adequate resources are available to meet veterans' needs—if not on an inpatient basis than in the community or home.

I have heard from one network director who says it is not his responsibility to "maintain capacity"—that the national effort has nothing to do with his fiefdom. Unfortunately, it is evident from the October 2000 Capacity Report that he is not alone in believing that the maintenance of capacity does not apply to him. The report shows that VISNs 3 and 21 have not maintained capacity in the number of patients they treat for spinal cord injury. VISNs 3 and 22 have significantly dropped their blind rehabilitation workloads. Only a few networks have bolstered traumatic brain injury workloads or dollars.

I am most concerned about the treatment capacity for VA's mental health patients. It's not just about dollars, which are overall *64 percent of the funds* spent for these services in fiscal year 1996. Only about a third of networks treated as many individuals with serious mental illnesses for substance use disorders in fiscal year 1999 as in fiscal year 1996. Only one of the networks represented today—VISN 21—enhanced its workload for this very vulnerable patient population over the same time. VISN 3 and 4 did bolster programs for the seriously mentally ill in need of Post-Traumatic Stress Disorder treatment.

I am also concerned about long-term care capacity. There is no question that VA has closed a number of its nursing home beds in recent years and diverted the mission of many others to subacute or rehabilitative care. VA is in the process of identifying measures that indicate its maintenance of capacity. VA long-term care programs have been considered one of its finest activities. If VA is to be responsive to its veterans needs and not just duplicate services that may already be available to them in the private sector, it must continue to make these services a priority in its infrastructure and resource utilization plans.

Mr. Chairman, there is clearly a need for your bill in beginning to facilitate addressing some of the infrastructure needs within VA. I am pleased to commend your Veterans' Hospitals Emergency Repair Act to the Full Committee and pledge to work with you to ensure its timely enactment.

PREPARED STATEMENT OF CONGRESSWOMAN BROWN

This legislation goes a long way in showing our support for VA's health care infrastructure. I hope now we can move forward in developing a health care system that truly meets the needs of our veterans.

In my home State of Florida, we built a new 120 bed Veterans Nursing Home in Orlando, and we had more veterans than beds before it even opened. We have a great need in Florida and all over this country for more health care facilities for our veterans, but we also need a fair assessment of what our veterans need and don't need. Only then can we begin to fix the problems our veterans are facing in obtaining good health care and service.

PREPARED STATEMENT OF CONGRESSMAN REYES

Mr. Secretary, it is good to see you again. I represent a district with about 80,000 veterans and they are very concerned about issues involving health care for veterans. I am pleased to be an original cosponsor and strong supporter of H.R. 811, the Veterans' Hospital Emergency Repair Act. Thank you Mr. Chairman for bringing this matter to our attention.

I understand that we will be receiving testimony today on the critical need to assure that existing VA facilities comply with relevant patient safety requirements, accommodations for persons with disabilities and structural safety in the event of tragedies such as the recent earthquake in Seattle. Prompt attention to needed emergency repairs can often prevent much more expensive renovations.

I hope that this bill will aid VA in meeting very critical needs for emergency infrastructure repair and will assist VA in meeting the needs of our aging veterans for long term care. I know of the urgent need in Texas for a State Nursing Home and hope that the monies requested in the Committee's Views and Estimates on VA's 2002 budget will be provided to meet that need.

Thank you Mr. Chairman, I look forward to today's testimony and yield back the balance of my time.

PREPARED STATEMENT OF CONGRESSMAN STEARNS

Thank you, Chairman Smith, for holding this important hearing today.

I believe we all recognize that it is essential that we redirect VA funding where it is needed—not for the upkeep of dilapidated buildings that are not being used—but to upgrade facilities that are need of repair. That is why I am pleased that our Chairman has introduced H.R. 811, the Veterans' Hospital Emergency Repair Act. I am cosponsor of this bill to authorize the Secretary of Veterans' Affairs to carry out construction projects for the purpose of improving, renovating, and updating patient care facilities at Department of Veterans Affairs Medical Centers.

We cannot wait until the cares process is completed to do something about those facilities that are in dire need of repair. A recent incident in Miami, FL where a failure in the electrical system forced the evacuation of the facility until repairs could be made is just one example of what can happen when older facilities are neglected. Coupled with the fact that many of these facilities are 50 or more years old only heightens the need to insure that they are brought up to code specifications.

I want to thank our witnesses for being here and look forward to hearing from them.

PREPARED STATEMENT OF CONGRESSMAN MORAN

Thank you Mr. Chairman and Ranking Member Evans.

H.R. 811

Compliment the bipartisan agreement that this bill is an early and high priority for America's veterans.

This is an important bill, and I hope we can move it to the floor on a fast track for passage before the Spring District Work Period begins in April.

- Veterans deserve good, updated health care facilities, and I agree with you that this bill will provide us an effective interim solution to a vexing problem in VA health care—maintenance of infrastructure.
- Members need to work with the Budget Committee, and the Leadership, to gain support for funding authority, to give real life to this authorization bill. Urge all our Members to involve themselves in this quest.

Accountability for Capacity Maintenance

Important to the Subcommittee and Full Committee to question VA's actions in carrying out the will of Congress.

We passed accountability measures in Public Law 104-262 and Public Law 106-117 dealing with *capacity to care for veterans*. VA's actions since have not improved our confidence, and the committee needs to impress upon VA the seriousness with which we hold the view that VA must sustain specialized programs, such as spinal cord and brain injury, mental health and long-term care activities.

I will raise a few questions today, and I believe so will other members of the committee. While VA has delegated much authority to its network directors, six of whom are here today, *we need to hold the Secretary and Under Secretary for Health accountable for VA's actions.*

- Veterans have earned their rights to dependable health care, in good facilities, delivered efficiently and with compassion for their needs.
- Primary care is good, and the committee endorses it, but primary care is no a substitute for effective long-term care or intensive mental health services for seriously disabled veterans.

Thank the Chairman for his leadership and compliment his assertiveness in Veterans' Affairs. Look forward to working closely with Chairman, Ranking Member Evans and Health Ranking Member Filner in advancing VA health care in the 107th Congress.

PREPARED STATEMENT OF CONGRESSMAN UDALL

Mr. Chairman, members of the committee, and distinguished veterans who are testifying on behalf of your respective organizations.

I do not have any questions for the panels, but I do want to make a brief statement. Mr. Chairman, I share many of my colleagues concerns regarding the deterioration of our VA hospitals, and the inability of the VA to update, modernize and even renovate its many patient care facilities around the country. Therefore, I am supportive of this measure in so much as it is a significant step in addressing this problem. I am hopeful that the combined authorization of \$550 million dollars in

fiscal years 2002 and 2003, and the temporary delegation of power to the Secretary to prioritize and choose the projects most in need. will help restore these VA facilities. As I have said before, we must do all we can to assure that our Veterans are well taken care of, and that the facilities that provide their medical care are first rate. We owe our Veterans too much to have it any other way.

I am supportive of this bill and commend my colleagues for introducing it. Thank you Mr. Chairman.

**STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 13, 2001**

Mr. Chairman and Members of the Committee:

I am pleased to have the opportunity to appear before you to present the views of the Disabled American Veterans (DAV) on H.R. 811, the Veterans' Hospital Emergency Repair Act. As an organization of more than one million service-connected disabled veterans, the DAV is especially concerned about maintaining a modern, effective system to meet the unique health care needs of our Nation's veterans.

This bill recognizes that the Department of Veterans Affairs (VA) has neglected its health care facilities nationwide to the point that the system's infrastructure has fallen into decay through the ravages of time and the obsolescence that comes so quickly when health care facilities are not regularly upgraded. This bill therefore truly addresses an emergency. Its purpose is to forestall the impending crises by authorizing immediate measures to begin a course to reverse the deterioration of facilities and the inevitable consequent decline in the quality of health care for veterans. The DAV fully supports H.R. 811.

As the *Independent Budget (IB)*, the bill's sponsors, and the Committee have noted, VA construction programs have fallen sharply since 1993. Making matters worse, VA's policy has been one of leaving the consequences of this neglect in place until its lengthy Capital Assets Realignment for Enhanced Services (CARES) evaluation process is completed. With the resulting adverse effects on health care quality and capacity, the loss of capital asset value, and the overall inefficiency of delay, such inaction does more than leave in place the unsatisfactory status quo, it is counterproductive inasmuch as it compounds existing problems. This neglect erodes the very foundation of the VA health care system.

The case for a reversal of course is made persuasively by the findings of the 1998 Price Waterhouse study cited by the Committee and the revealing facts and adverse trends cited by the *IB*. Such indicators as the average age of these facilities and the extremely small amount of investment in comparison with the minimum amounts that should be invested according to outside experts paint a clear and disturbing picture. Indeed, these data leave no doubt that immediate remedial action is the only prudent course.

While the bill provides for prompt reaction to an urgent predicament, it requires careful prioritization and includes a blueprint for a measured, systematic, and strategic approach designed for the best results in the short term and the long term. The bill authorizes a 2-year program in which the Secretary of Veterans Affairs will approve smaller construction projects costing not more than \$25 million at locations of his choice to restore, modernize, or improve facilities. However, the Secretary's decisions will be subject to recommendations by the VA Capital Investment Board (VACIB) and guided by congressional intent to prioritize projects in VA's special disabilities programs, patient safety, seismic protection, and privacy concerns for women veterans. For these projects, H.R. 811 authorizes \$250 million in fiscal year (FY) 2002 and \$300 million in FY 2003. The bill requires the Secretary to report his actions and results to Congress and mandates a review of the program's effectiveness by the General Accounting Office.

The problems addressed by H.R. 811 are those we have specifically called to attention in the *IB*. However, the *IB* recommends for FY 2002 alone that Congress appropriate \$431 million for minor construction, \$250 million to correct seismic deficiencies, \$374 million for major construction, and \$391 million for recurring maintenance, among other things, to maintain and improve VA facilities. Thus, while H.R. 811 and its recommended \$550 million appropriation for two years are a good first start, more must be done through the regular appropriations in the annual budget for VA construction. We look forward to working with the members of this

Committee to obtain the funding necessary to restore and maintain VA's health care system as a "world class" organization.

We sincerely appreciate Chairman Smith's introduction of this most important bill along with the support of the Ranking Member, Mr. Evans, and the other distinguished cosponsors. We also appreciate the opportunity to appear before you on behalf of American's disabled veterans to present our views and support for this bill.

**STATEMENT OF
THOMAS D. DAVIES, AIA, DIRECTOR OF ARCHITECTURE
PARALYZED VETERANS OF AMERICA
BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
H.R. 811, THE "VETERANS' HOSPITAL EMERGENCY REPAIR ACT"**

MARCH 13, 2001

Chairman Smith, Ranking Democratic Member Evans, members of the Committee, the Paralyzed Veterans of America (PVA) is honored to be invited to present our views regarding H.R. 811, the "Veterans' Hospital Emergency Repair Act." PVA supports H.R. 811 and we stand ready to work for its passage and enactment.

For too many years the VA has been faced with dwindling construction budgets. The fiscal year (FY) 1993 combined construction total was \$600 million. By FY 2000, this amount had decreased to about \$200 million. VA's history of low construction budgets is an explicit indication of poor stewardship over the medical system's facility assets. Underfunding maintenance and replacement and repairs for decades has increased the urgency of today's need. This destructive cycle must be broken. H.R. 811 is a clear indication that this Committee agrees with us.

A study conducted by Price-Waterhouse in 1998 recommended that in order for the VA to protect its facility assets against deterioration and to maintain an adequate and appropriate level of building services, 2 to 4 percent of the assets' replacement value should be spent each year for facility improvements, and another 2 to 4 percent should be expended for nonrecurring maintenance. The VA's total facility assets are valued at approximately \$35 billion. Hence, according to the study, the VA should be spending \$700 million to \$1.4 billion annually, as well as a similar amount for nonrecurring maintenance.

The *Independent Budget* this year called for a sweeping initiative to begin to repair the damage done to the VA's infrastructure. This Committee listened. The introduction of H.R. 811 is an integral step forward in addressing this initiative.

With the average building 34.6 years old, the VA's building inventory has special technical problems because of its age. The most pressing technical problem is the need to undertake seismic corrections. The *Independent Budget* estimated that \$250 million would be an important first step to meet this critical objective.

As noted in the title of this measure, the physical infrastructure of the VA is indeed facing an emergency. With further inaction, a valuable and irreplaceable national asset will be lost, for without health care buildings, you do not have a health care system. Furthermore, the lives of our veterans are being put at risk. This Committee will be addressing this crisis head on by approving H.R. 811 and working to realize \$250 million in vitally needed resources.

As part of PVA's interest in finding ways to streamline and make more responsive the VA's construction program, we are interested in evaluating the effect of providing general authorization authority as compared to the specific authorization authority required by 38 U.S.C. § 8104(a)(2). One pitfall to the current arrangement is the "feast or famine" effect inherent in the current inadequate funding levels. Because of the funding logjam, the process may take upwards of ten years from initial planning to actual construction. The individual Veterans Integrated Service Networks (VISNs) are wary of

adjusting their projects because doing so would jeopardize their place in the "queue." Projects authorized, and finally funded, may no longer meet the original needs for which the project was authorized. Underfunding the construction budget also results in larger, more expensive, and less flexible projects. Since there is no confidence that future construction budgets will be forthcoming every project is made as comprehensive as possible. This is certainly an illustration of being penny wise and dollar foolish.

The entire process of initial planning, to authorization, to final construction must be streamlined. We must remove, from within the process, disincentives to proper planning and effective design. We must provide some flexibility in order to achieve the health care system needed by veterans while conserving vitally needed resources. We must bear in mind that there is always a fine line between providing the necessary flexibility, and the needed oversight.

PVA strongly supports the adoption of a more flexible general approach to medical center design that allows incremental implementation of construction projects. With this approach, long-term planning would be constantly adjusted for evolving changes in demographics and medical care delivery alternatives. Construction projects would be smaller, but more responsive to changing needs and technologies. It is essential that veterans receive 21st century health care in 21st century facilities. Adopting a more flexible approach would reduce the cost and magnitude of individual projects and provide a more uniform level of funding across the system.

H.R. 811, by beginning the process of providing \$250 million is also vital to the long-term viability of the VA health care system. No matter the end result of the Capital Asset Realignment for Enhanced Services (CARES) process, one thing is clear -- if the VA is to provide modern health care, a viable planning, design, and construction process is essential. Without H.R. 811, the VA faces a significant risk of being unable to maintain its critical competence and staffing levels in these areas. A well-designed medical facility is a physical representation of a quality health care operational plan. As Winston Churchill once noted, "we shape our buildings; thereafter they shape us."

PVA hopes that decisions made in accordance with H.R. 811 would take into account the often disruptive nature of seismic corrections and combine many of these corrections with patient care enhancements. It makes little sense to cause major disruption in hospital operations just to correct seismic deficiencies and not make needed improvements at the same time. We are heartened that this measure, by requiring that projects be undertaken for the purpose of “improving, renovating, and updating to contemporary standards patient care facilities” is cognizant of the importance of smart planning when these projects are undertaken. Doing so will save needed resources and go along way to justify disruptions. We also believe that this Committee should make clear that this legislation does not foreclose elements of new construction when such construction is needed to meet these goals.

On a related note, I would like to bring to the Committee’s attention the *Independent Budget* recommendations regarding preserving the VA’s many historic properties. The VA owns and maintains a treasure of historic properties. The *Independent Budget* has recommended that the VA form a partnership with the National Trust for Historic Preservation, along the lines of the current working relationship between the Trust and the Department of the Army. In addition, the *Independent Budget* recommends that Congress provide a \$20 million grant program to preserve and maintain VA’s historic properties as assets and not liabilities.

We support H.R. 811, and we applaud the work of Chairman Smith, and the other members of this Committee who are co-sponsors. The road ahead of us is difficult if we are to actually realize the \$250 million authorized by this measure. We are also hopeful that H.R. 811 can begin the process of improving the VA’s entire construction process. As Frederick Law Olmsted wrote about Central Park, and as we view the VA medical system, it should be “subject to the primary law of every work of art, namely, that it shall be framed upon a single noble motive, to which the design of all its parts, in some more or less subtle way, shall be confluent and helpful.”

On behalf of PVA, I again thank you for this opportunity to testify concerning H.R. 811, the "Veterans' Hospital Emergency Repair Act," and the VA construction program. I will be happy to answer any questions that you, or members of this Committee, might have.

**STATEMENT OF
JAMES R. FISCHL, DIRECTOR
NATIONAL VETERANS AFFAIRS and REHABILITATION
THE AMERICAN LEGION
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VETERANS' HOSPITAL EMERGENCY REPAIR ACT**

March 13, 2001

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to present its views on H.R. 811, the Veterans' Hospital Emergency Repair Act, which was introduced on March 1, 2001. The legislation would authorize the Secretary of Veterans Affairs to implement several construction projects to improve, renovate, and modernize patient care facilities at Department of Veterans Affairs Medical Centers (VAMCs).

Section 2 of the measure calls for the selection of designated medical centers that meet certain criteria for necessary construction improvements and updates to achieve one or more of the following:

- (1) Seismic protection improvements related to patient safety,
- (2) Fire safety improvement,
- (3) Improvements to utility systems and ancillary patient care facilities, and
- (4) Improved accommodations for persons with disabilities, including barrier-free access.

The proposal would allow the Secretary to make improvements to the Department's specialized health care treatment programs. These include blind rehabilitation centers; inpatient and residential programs for seriously mentally ill veterans, including mental illness research, education, and clinical centers; residential and rehabilitation programs for veterans with substance-abuse disorders; physical medicine and rehabilitation activities; long-term care; including geriatric research, education, and clinical centers; adult day care centers and nursing home care facilities; amputation care, including facilities for prosthetics, orthotics programs, and sensory aids; spinal cord injury centers; traumatic brain injury programs; women veterans' health programs (including programs involving privacy and accommodations for female patients); and facilities for hospice and palliative care programs.

Under section 2, subsection (c) of the bill, a review process would be initiated wherein an independent board will be established within VA and constituted by the Secretary to evaluate capital investment projects. The board would have the responsibility to review proposed projects to determine the project's relevance to the

medical care mission of the Department and whether the project improves, renovates, and updates patient care facilities in accordance with this proposal.

Section 3 of the provision would authorize appropriations to the Secretary's Construction, Major Projects, account to a tune of \$250 million for FY 2002, and \$300 million for FY 2003.

The American Legion is extremely concerned with the President's proposed VA budget for Fiscal Year 2002. This includes funding for important major and minor construction projects. Over the past several years, we have testified that VA's major and minor construction appropriation must include all infrastructure priorities. Unfortunately, over the past several years, VA has not received appropriate funding for construction priorities. Not taking care of construction priorities in a timely manner often results in additional costs. An example of this vacillation is the recent 6.8 earthquake in the Pacific Northwest.

Private consultants have been warning for years that dozens of VA patient buildings were at the highest level of risk for earthquake damage or collapse. Two of the buildings cited by a consultant are located at VAMC American Lake, near Seattle, Washington, which were severely damaged in the February 28 earthquake. The damage of course will have to be repaired, but at what cost? Will the price exceed the estimated cost of not having accomplished the necessary seismic corrections in the first place? The same situation that took place on February 28 at the American Lake VAMC, occurred in the 1989 earthquake located in the Oakland/San Francisco Bay area. VA had to replace the main patient care building at VAMC Palo Alto due to earthquake damage. The replacement cost greatly exceeded the estimated pre-earthquake repair cost. The American Legion testified two years ago before a joint hearing of the House and Senate Veterans' Affairs Committees that a mandated review determined that VA has 69 patient care buildings, totaling 2,300 beds that require seismic corrections. VA estimates that these repairs will cost nearly \$300 million.

Surely, the lack of Congress providing necessary funding to correct these seismic deficiencies is not indicative of a willingness to gamble with the safety of veterans. The American Legion, however, wonders why Congress is content to finance major repairs when a lesser upfront expenditure for corrective maintenance would be more prudent and cost-effective? Over half of the \$250 million in major construction, funding requested by The American Legion for 2002 is for seismic correction projects. The American Legion recommends that Congress provide the funding necessary to enable VA to upgrade these seismic deficiencies over a prescribed timeframe.

In our opinion, simply because the Veterans Health Administration's emphasis has shifted from inpatient care to primary care is no reason to neglect capital assets. VA must develop a well-substantiated annual major priority construction listing so that Congress can appropriate sufficient funding. The American Legion believes H.R. 811 will help to satisfy the long over due and neglected construction agenda due to a lack of funding and inappropriate direction. The current Capital Assets Realignment for

Enhanced Services (CARES) review will potentially determine the future of many VA facilities. The CARES review may eventually contradict the need to restore and renovate many patient care buildings. However, some projects are so important to facilitate patient care and staff safety issues and patient privacy that they cannot be delayed. VA and Congress have to jointly determine which facilities must move forward with enhanced construction initiatives without delay.

The American Legion fully concurs with section 3 of H.R. 811 to set major construction funding for FY 2002 and FY 2003, at \$250 million and \$300 million, respectively.

The American Legion also would like to remind this Committee that VA's minor construction program has likewise suffered significant neglect over the past several years. In our opinion, minor construction must be maintained in the range of \$200 million per year.

The American Legion does not support enacting a cap on each project selected under H.R. 801. Some urgent projects, such as seismic corrections at VAMCs Long Beach and San Diego, CA will exceed the proposed \$25 million limit. Other patient safety and patient environment projects could also exceed the proposed cap cost.

The American Legion advocates for adequate VA construction appropriations every year. Our recommendations are based on a sound realistic assessment of system wide needs. If Congress would provide sufficient funding on a regular basis, we would not today be debating the merits of an emergency funding provision. However, since VA does have many urgent construction requirements, The American Legion strongly supports the basis for this emergency bill.

Mr. Chairman, that completes my testimony.

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

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO
H.R. 811 -- "VETERANS' HOSPITAL EMERGENCY REPAIR ACT"

WASHINGTON, DC

MARCH 13, 2001

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the U.S. and our Ladies Auxiliary, I extend our sincere appreciation for including us in today's most important hearing. The VFW is committed to the proposition that all veterans should enjoy ready access to timely, top-quality VA health care.

Key to achieving this goal is enabling VA to sustain and appropriately enhance its physical plant. It is for this reason that we of the VFW both applaud and strongly support your bill, H.R. 822, the "Veterans' Hospital Emergency Repair Act."

It is tragic that there are sections of the country where veterans must wait up to a year before they may get their first health care appointment at VA. There are areas where waiting periods for orthopedic, prosthetic and certain specialty care services are so long that in many cases they amount to a denial of needed care.

Further, VA must update facilities and services for a rapidly growing segment of those serving the nation in uniform, women veterans. All necessary steps must be taken to ensure their privacy and comfort at VA facilities. The "Veterans' Emergency Repair Act," will allow VA to place additional emphasis on addressing the specific medical needs of women.

Successive years of shortfalls in major construction funding even as the population of sick and elderly veterans is rapidly on the rise have seriously eroded VA's ability to sustain a physical plant adequate to meet veterans' needs.

That VA has had measurable success in building and staffing such effective and popular non-institutional health care venues as Community Based Outpatient Clinics is certainly a tribute to good intentions as well as managerial resourcefulness. But VA health care facilities continue to deteriorate and many lack the physical configuration and state-of-the art technology necessary to provide modern health care services.

This nation's veterans deserve much better. The additional dollars and delegation of authority to the Secretary of VA to initiate needed construction and renovation projects H.R. 822 will provide is of paramount importance toward properly and compassionately serving veteran patients.

We are deeply concerned that as VA attempts to better allocate and place its physical assets through the implementation of the Capital Asset Realignment for Enhanced Services (CARES) process, this will result in a de facto moratorium on needed new construction and renovation projects.

We agree that VA must move forward in implementing a rational methodology for aligning and realigning its physical resources, but this does not mean that VA's physical assets should be frozen in place and time until the process is completed.

For the sake of America's veterans in need, there are, and will be, projects—such as the seismic enhancements that need to be carried out at the Lake Washington, VAMC—that must be carried out well before CARES is completed; and we insist that they be funded and go forward.

Mr. Chairman, on behalf of the men and women of the Veterans of Foreign Wars, I thank you for the introduction of H.R. 822, it is a thoughtfully constructed and much needed piece of veterans' legislation.

This concludes my statement and I will be happy to respond to any questions you or the members of this Committee may have.

TESTIMONY OF RICHARD JONES, AMVETS NATIONAL LEGISLATIVE DIRECTOR

MR. CHAIRMAN, RANKING MEMBER EVANS, AND MEMBERS OF THE COMMITTEE:

I am Rick Jones, National Legislative Director for AMVETS. AMVETS is pleased to testify today on H.R. 811, the Veterans' Hospital Emergency Repair Act. For the record, neither AMVETS nor I have received any federal money for grants or contracts. All AMVETS activities and services are accomplished completely free of any federal funding.

AMVETS fully supports the Veterans' Hospital Emergency Repair Act. H.R. 811 would help respond to the troubling reports of VA hospitals in disrepair.

As *The Independent Budget* veteran service organizations testified on March 6, the Department of Veterans Affairs healthcare facilities system is in serious decline. Failure to fund adequately renovations and modernization requirement of the system will cause continued deterioration, heightened healthcare hazards, and increased safety problems.

Mr. Chairman, your action in introducing this bill sends a strong signal to the veterans' community and in particular to those who worked hard to produce *The Independent Budget*. Not only are you listening; you are taking action. It tells us that you recognize the challenge ahead and are willing to move forward.

Like you, AMVETS has the greatest respect for the Department of Veterans Affairs' officials charged with facilities management. We, too, want to move the CARES (Capital Assets Realignment for Enhanced Service) process along. Clearly the practice of maintaining empty, obsolete buildings shortchanges healthcare services to veterans by directing vital resources to unproductive areas.

As important as CARES is to improving healthcare services to veterans, there is a serious gap in the process. Frankly, the *de facto* funding moratorium that accompanies CARES simply does not pass the reality test. Construction, renovation, and upkeep are a necessary part of wise stewardship. Maintaining the asset base of VA's health care network is good business. Neglecting maintenance and renovation is wasteful. It ill-serves veterans and taxpayers alike.

H.R. 811 helps fill the obvious gap between the on-going facilities' review process and the reality of VA's facility situation. The bill assures taxpayers that their investment in VA's physical plant won't be neglected. And, it gives veterans assurance that access to high quality medical services will not be jeopardized as the Department moves to increase efficiency in its nationwide network of hospitals.

Mr. Chairman, the message in H.R. 811 is timely and on-the-mark. The bill gives critical support to move essential projects forward and accomplish something urgently needed for veterans. As you say in your *Congressional Record* statement, "We can await the...conclusion of the CARES process, more comfortable in the knowledge that ... emergency maintenance construction projects will not go unnoticed, unauthorized, and unfunded."

Clearly, hospitals are an intricate part of VA's obligation to serve veterans' healthcare needs. While the task of responsible asset planning must be accomplished as quickly as the complexity of the system allows, it must not cause the system to self-destruct.

Without adequate upkeep of VA hospital facilities, veterans will face ever more serious concerns about quality of care, access to the system, and deteriorating patient satisfaction.

There is no doubt that the nation's taxpayers want to restrain wasteful spending. It is also clear they don't want to see the nations' VA hospital system collapse from want of attention.

The nation remains grateful for the service of our brave and dedicated men and women in the Armed Services, past and present. Keeping our promise to veterans includes the promise of quality health care.

Mr. Chairman, H.R. 811 is in keeping with this promise, and AMVETS is pleased to support it enthusiastically. We look forward to working with the Committee to achieve its passage.

This concludes my testimony. I thank you again for the privilege to present our views and would be pleased to answer any questions.

STATEMENT OF
THOMAS L. GARTHWAITE, M.D.
UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

March 13, 2001

Mr. Chairman and members of the committee,

I am pleased to appear before the committee to discuss the Department's views on the "Veterans Hospital Emergency Repair Act," H. R. 811.

H. R. 811 would provide the Secretary authorization to carry out construction of certain projects at VA medical centers in each of Fiscal Years (FY's) 2002 and 2003 without requiring specific authorization of individual projects. A project selected under this authority could not exceed \$25 million and would be intended to improve, renovate, or update VA health care facilities. The bill would authorize appropriations for these purposes of \$250 million for FY 2002 and \$300 million for FY 2003.

The physical infrastructure of the VA health care system is one of the largest in the Federal government with over 5,000 buildings and 145 million square feet in the inventory. While some VA facilities are relatively new, the average age of VA buildings is 50 years. In addition, most VHA facilities were designed for the delivery of inpatient hospital care. As the committee is aware, significant changes in the delivery of health care to veterans in recent years have

significantly reduced the need for hospital beds and dramatically increased the need for outpatient facilities.

During this period of change of the past few years, there has been a reluctance to commit to capital reinvestment out of the concern that VA was unsure of facilities that would clearly be needed in the future. In an effort to further define efficient options for VA health care delivery through 2010 (with a sensitivity analysis to 2020), we have embarked on a planning process called the Capital Asset Realignment for Enhanced Services (CARES) initiative. The CARES studies that are now underway will identify various options to improve access and service quality while ensuring that VA delivers services to veterans in the most efficient and effective manner. VA's motto for CARES is "The Right Care at the Right Time in the Right Place." These studies and the resulting implementation of CARES recommendations are essential for VA to make improved choices for veterans health care delivery in the future, including focusing on the core mission of providing high quality health care to veterans with disabilities or low incomes. Beginning this summer, VA will implement recommendations from the first CARES study. Although I am not at liberty to provide details on the President's FY 2002 Budget at this time, I can tell you that it supports implementation of CARES by providing funds dedicated to CARES for both Major and Minor Construction and non-recurring maintenance and repair in Medical Care. We appreciate the Congress's strong support for this important initiative.

In addition, we recognize that we must have an effective mechanism to address any deficiencies in the existing infrastructure in an ongoing, time sensitive manner. As you indicated, Mr. Chairman, in introducing H. R. 811, some VA hospitals require maintenance, repair and improvements to address immediate needs. We are particularly concerned about safety, privacy, and the need to address the requirements of special programs which are at the core of VA's obligation to veterans. As you know, we have conducted studies of the

capacities of VA facilities to withstand the forces of an earthquake in areas susceptible to such events. Through the work of an independent engineering consultant, we have identified 67 essential VHA buildings that are considered to be at exceptional risk and are developing plans to address these risks. Older buildings are at risk of building system failures as well. Several months ago, a failure in the electrical system at the Miami, Florida VA Medical Center necessitated the evacuation of the facility until temporary repairs could be made. Permanent repairs are required, and we expect to accomplish them in 2002.

VA also is committed to making needed changes to its health care system based on findings from the CARES initiative as described above. As those infrastructure modifications bring about a more appropriately structured system, we will also continue to correct deficiencies so that VA facilities are safe and appealing to veterans. All system changes will have to be made within VA's and the Administration's budget constraints.

As such, the Department supports H. R. 811 to the extent that it aligns with the President's Budget. If H. R. 811 were enacted, we believe that it could be useful to VA in improving our ability to respond to immediate needs of the system's infrastructure, as well as, implement CARES. It would provide the Department with greater flexibility in selecting major construction projects and likely would result in more timely correction of deficiencies that currently impair the health care system's ability to provide care in safe and effective facilities in locations that best meet veterans' needs. The bill also would offer the incentive to medical centers to propose smaller projects targeted to more focused requirements, such as special programs, seismic corrections, and utility systems, to name just a few.

The bill would require the review and recommendation of an independent board within the Department to evaluate each project before it is proposed to the Secretary for selection. VA's Capital Investment Board already serves this

important purpose, so we support this provision. This process ensures that the Secretary is afforded advice from a broad perspective of interests before decisions are made on funding. The report required of the GAO to evaluate the advantages and disadvantages of the alternate methods of congressional authorization for projects of this type will contribute to a discussion on the appropriate process to be used to consider capital reinvestment beyond the two years addressed by the bill.

The Department is committed to a set of capital programming principles that ensure that investment decisions are made wisely based on accurate data, after consideration of reasonable alternatives, and provide veterans high quality health care where they need it. This legislation does not conflict with our continued commitment to improved asset management. Our capital investment decision-making process has been evolving over several years and has been commended by many external groups including the GAO. We expect that this established process would contribute to the Secretary's selection of projects for funding under the proposed new authority of H. R. 811.

At the same time, we presume that the legislation will not alter the opportunity of VA to propose other projects through the traditional authorization process. There may be project needs which exceed the \$25 million funding limitation contained in the bill or which meet requirements other than those described in the bill. In such cases, VA would continue to propose to the committee a request for authorization on an individual basis as part of the President's annual budget.

As the Administration continues to analyze the legislation, we would like the opportunity to suggest to the Committee modifications that would improve the effectiveness of the proposed new process. One such change would address the opportunity for early planning and design. These projects require certain lead times for the design of the improvements and the preparation of appropriate

contract documents. Under current authorities, VA may begin to undertake these efforts in the previous fiscal year so that the construction contract award can be made within a reasonable time after the construction funding is available. This makes for a more timely process, and we would hope that similar authority would be available to VA for projects selected through this new process.

VA welcomes the direction that H. R. 811 takes in providing the Department additional flexibility in funding necessary improvements to its health care infrastructure. We look forward to continuing to work with the Committee to ensure that VA continues to fulfil the Nation's obligation to care for its veterans.

BLINDED VETERANS ASSOCIATION

TESTIMONY ON H.R. 811
FOR THE RECORD
TO THE

HOUSE COMMITTEE ON VETERANS'
AFFAIRS

March 13, 2001



Mr. Chairman and members of this distinguished committee, on behalf of the Blinded Veterans Association (BVA), I want to express out appreciation for the invitation to present our views at this important hearing. Unfortunately, I was unable to appear before the committee but am grateful for the opportunity to present our statement for the committee record.

BVA commends you, Mr. Chairman and Ranking Member Evans, for introducing H.R. 811, the Veterans Hospital Emergency Repair Act. This legislation recognizes the unacceptable level of deterioration of the VA's capital assets associated with the provision of health care to America's veterans. More importantly, it defines a clear approach to make the necessary renovations, repairs, and new construction projects more rapidly in order to address essential patient care and safety needs. Although the Capital Asset Realignment for Enhanced Services (CARES) project has been initiated by VA to comprehensively address their capital needs for the provision of high quality health care in the future, critical needs exist today and in the future that cannot afford to be neglected any longer. We applaud the CARES initiative for the long-term, but to hold appropriations for major construction hostage from the CARES process, will only result in further deterioration and significantly higher repair and renovation costs. Additionally, VA employees and patients will be placed at greater risk if facilities are allowed to fall into greater disrepair.

The need to move more aggressively in making renovations associated with safety was dramatically emphasized as the result of the earthquake that devastated parts of Washington State two weeks ago. Seismic corrections head the list of critical projects since VA reports 67 of its buildings are exceptionally vulnerable as they are in serious need of corrections to assure the safety of both employees and patients. Further delays in initiating these critical projects will certainly result in devastating damage to VA infrastructure as well as potentially serious injury or loss of life.

BVA is especially pleased that Section 2 of this bill authorizes major medical facility construction projects for patient care improvements. The section further places emphasis on the special disabilities programs, which we believe represent the essence of VA's mission. Of particular concern to BVA is the urgent need for a new Blind Rehabilitation Center (BRC) at the VA Hospital in Hines, Illinois. The buildings currently occupied by the BRC for the past thirty years are 72 years old and were originally designed as nurse's quarters. These buildings are not suitable for patient care and the need for a replacement building has been well documented for the past 10 years. At least two architectural studies have been completed revealing substantial problems with the buildings as both studies it was determined that the buildings would not be suitable for patient care after the year 2003. Additionally, these buildings do not meet the acceptable codes and standards for patient privacy or accessibility and are not compliant with the requirements of the Americans with Disabilities Act (ADA). The need for accessible buildings has become increasingly more important as the population of blinded veterans being treated grows older and is stricken with significant mobility and ambulatory problems. The design of these buildings also does not lend itself to an optimal therapeutic environment for the residential patients, challenging BRC management and staff to adapt over the years.

Mr. Chairman, H.R. 811 would enable Visual Impairment Service Network (VISN) 12 and the Hines facility to develop a project that would address this longstanding need. It appears at this juncture that any solution will depend on the outcome of the CARES initiative, and, given the time it will take to develop options, gain approval of an acceptable solution, and obtain the necessary funding, will certainly necessitate the BRC remaining in unacceptable buildings or relocating into temporary quarters for the duration. Renovation of the two buildings in question does not appear to be a cost-effective solution as the architectural review estimated the cost to be \$13 million--the same amount it would cost to construct a new BRC.

Many blinded veterans who have received their rehabilitation from Hines believe a new stand alone BRC should be constructed on the Hines Hospital campus, as do many retired employees of the BRC. They argue that, since Hines was the first BRC established in the VA nearly 53 years ago, it should be the premier model of state-of-the-art facilities for other BRC's throughout the country and across the world.

Another option currently under consideration within VISN 12 is the construction of a multipurpose rehabilitation building that would not only house a new BRC but a Spinal Cord Injury (SCI) program and possibly a Traumatic Brain Injury (TBI) program as well. This is made necessary by the fact that SCI and TBI also have serious needs for program space. The

perceived advantages of this proposal would be the reduced cost gained from constructing one building, rather than three. Additionally, it would provide an opportunity to establish a center of excellence at Hines, focusing on the rehabilitative needs of severely disabled veterans. Some are opposed to this concept, believing a variety of disability groups would be intermingling within the building, therefore creating serious problems. They believe that the integrity of rehabilitation lies in preserving the individual treatment models.

Mr. Chairman, we would support the construction of a multipurpose building, only if you can assure there would be adequate separate space allotted for each individual program. In other words, the design of the building must incorporate separate spaces specifically designed for the BRC program, just as if they were to receive their own separate building. Similarly, the separate space requirements for the SCI and TBI programs' specific needs would need to be met as well. They, as we, have requirements and standards for our facilities so that the rehabilitation process can commence as thoroughly, quickly, comfortably, and safely as possible.

The other concern associated with a multipurpose building is the staffing requirements of each program. Along with BVA, some fear that the Full-Time Employee Equivalent (FTEE) needs of each program would be compromised, as there would be an attempt to move staff from one program to another as a cost-savings measure therefore reducing the need for as many employees as there might otherwise be. The professionals employed in a BRC possess very specific Masters degrees in the disciplines of blind rehabilitation instruction. These employees would not be qualified to work with veterans who have spinal cord or traumatic brain injuries. Likewise, the professionals working in the SCI and TBI programs are specifically qualified for their line of work, not blind rehabilitation. Again, if these guidelines were met, BVA would support the concept of a multipurpose rehabilitation facility.

Secretary Principi proposed such a center to the Federal Advisory Committee on Prosthetics and Special Disabilities Programs nearly ten years ago during his tenure as Deputy Secretary. The importance of these programs cannot be emphasized enough, and clearly the need for appropriate space cannot be denied. Moreover, the appropriate solutions to the problems outlined above cannot wait for the outcome of the CARES initiative. H.R. 811 has the potential to provide the necessary construction funds in order to meet the needs of these programs for severely disabled veterans. Of course, we recognize that they would have to compete with other major construction projects across the system and be prioritized with respect to urgency. Clearly, patient safety must be paramount, but we hope your bill provides enough major construction funding authority to satisfy the needs of the special disabilities programs.

BVA believes section 3 of this bill authorizes sufficient appropriations to make a real difference in terms of restoring VA health care facility infrastructure to insure the safety improvements in patient care. It is clear, however, because of the sheer numbers of seismic projects classified in the urgent category, that little may be left over for other construction projects targeting patient care improvements such as the special disabilities program. Unfortunately, because of the drastic reduction the major construction budget has experienced over the past 10 years, the number and costs of these projects has increased dramatically.

We applaud the concept of establishing a cap on the major projects authorized under this legislation in an effort to insure the maximum number of projects being funded. Whether capping the project funding level at \$25 million is the correct course of action remains questionable as it may be prudent to increase the cap to \$30 million instead. The \$25 million level may be appropriate, however, if the language affords the Secretary sufficient flexibility in determining the urgency of projects, especially in regards to patient safety. Savings achieved from projects that require less than the cap could then be applied to urgent projects that might slightly exceed the established cap. We hope that by giving this discretionary authority to the Secretary, as many projects will be funded as possible.

Mr. Chairman, BVA believes that VA health care system is a national asset and should not be allowed to deteriorate any longer. Clearly, if VA is to be an excellent health care provider for veterans, it must have an infrastructure that is compatible with modern methods of health care delivery. The overarching issue, however, must be the safety of patients and employees. We cannot deny the need for and the value of the CARES initiative, but this process is not responsive to the immediate needs of the system. Your legislation is an extremely important step that will help to bridge the gap between the immediate need and the future alignment of VA's capital assets.

Finally, Mr. Chairman, I want to thank you again for this opportunity to submit out views on this important legislation for the record. You and Mr. Evans are to be commended for moving swiftly in a bi-partisan manner to address the critical need to restore the capital assets that present significant danger to our veteran patients and the dedicated professionals that take care of them. We are also very appreciative of your sensitivity to the needs of the special disabilities programs as they strive to provide high quality, comprehensive rehabilitative services to our nations most severely disabled veterans. Feel free to contact me, as I would be pleased to answer any questions you or any of the members of the committee may have.

Thomas H. Miller
Executive Director



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Statement for the Record
Submitted to the Committee on Veterans Affairs
U.S. House of Representatives
Regarding
H.R. 811, The Veterans' Hospital Emergency Repair Act
By the
National Association of Veterans' Research and Education Foundations
March 13, 2001

The National Association of Veterans' Research and Education Foundations (NAVREF), a membership organization of eighty nonprofit research and education corporations affiliated with Department of Veterans Affairs facilities across the country, appreciates the opportunity to submit a statement for the record of the March 13, 2001, Committee on Veterans Affairs hearing regarding H.R. 811, the *Veterans' Hospital Emergency Repair Act*.

NAVREF applauds the Committee on Veterans Affairs for recognizing and addressing the need for special funding to improve, renovate and upgrade VA patient care facilities. At the same time, we encourage the Committee to recognize that many VA research facilities have a similar need for improvement, upgrading and renovation. We urge the Committee to address this by broadening the authority provided in H.R. 811 to allow VA to use some of the funds to improve, renovate and upgrade research facilities located within VA medical centers. In our view, this purpose is consistent with the overall intent of H.R. 811.

As the Committee is aware, the Research and Development appropriation covers only the direct costs of research projects, primarily equipment, supplies and research technicians, and VA has no centrally directed, designated funding stream for improving, renovating and updating research facilities. When such needs occur, the facility research program must compete with other high priority medical facility needs for scarce medical care dollars. Rarely does the research program compete successfully.

NAVREF recognizes that patient care needs are VA's first priority. However, VA is also mandated to conduct research and as a result, must provide suitable facilities. Over time, VA has established a large number of research facilities. Some are new and state of the art, but many VA research laboratories have been in need of significant improvements for a number of years. In 1999, VA prepared a list of "priority sites" for VA research infrastructure improvement. (See table below.) Two years later, little progress has been made, and these sites are still in urgent need of improvements. Inadequate ventilation, electrical supply and plumbing appear frequently on the lists of needed upgrades along with space reconfiguration.

State	VA Medical Center Site	State	VA Medical Center Site	State	VA Medical Center Site
Arkansas	Little Rock	Georgia	Atlanta	Pennsylvania	Philadelphia
California	Long Beach	Iowa	Iowa City	Tennessee	Pittsburgh
	Palo Alto	Kentucky	Louisville		Texas
	Pleasant Hills	Maryland	Baltimore	Utah	San Antonio
	San Diego	Michigan	Ann Arbor		Salt Lake City
	W. Los Angeles	New Jersey	East Orange		Washington
Colorado	Denver	New York	Bronx	Wisconsin	Milwaukee
Florida	Gainesville	Ohio	Cleveland		
	Miami		Cincinnati		

In 1997, NIH conducted site visits of six VA research facilities and concluded that, "VA has had increasing difficulty in providing sufficient resources via its congressional appropriation to satisfactorily fund the infrastructure necessary to support research at the VAMCs. Although not universal, several facilities were noted to be in need of updating and other maintenance."

VA itself has had to deny funding for VA-approved projects at facilities that cannot provide the necessary infrastructure. Imagine an investigator's dismay at finally having a project approved for highly competitive VA merit review funding, only to learn that funding will be denied because the VA facility lacks the necessary infrastructure to support the project. This represents lost income to the district, lost jobs and a lost opportunity to make an advance in a condition prevalent in the veteran population.

Poorly maintained research facilities and/or lack of venting, plumbing and other systems necessary to conduct cutting edge research also make VA a less attractive partner for private sector research

sponsors as well as other federal agencies. This reduces VA's ability to leverage the R&D appropriation with private sector and non-VA federal dollars and weakens facility affiliations with universities.

NAVREF encourages the Committee to add to H.R. 811 Section 2. (b) a new item *(K) Improvements to research facilities* and to increase the authorized spending level by \$25 million. NAVREF also recommends that report language 1) direct VA to expend at least \$25 million of the amounts appropriated under this authority to improve, upgrade and renovate research facilities; and 2) instruct VA to make such improvements as may be necessary to ensure staff as well as patient safety, and to accommodate cutting edge research. Absent such report language, we are concerned that research needs will be placed at the bottom of the VA priority list and research facilities will not receive any of the funds appropriated under this authority. Also, while many of the needed improvements cannot be tied directly to patient safety, they are required for staff safety or to accommodate the technology and equipment required to conduct high tech research.

Recommendation: Revise H.R. 811 to allow VA to spend \$25 million of the funds appropriated pursuant to the *Veterans' Hospital Emergency Repair Act* to improve, renovate and update research facilities.

Thank you for your consideration. Questions or comments may be directed to NAVREF Executive Director Barbara West. Phone: 301-229-1048 Fax: 301-229-0442 Email: bwest@navref.org

**Post-Hearing Questions
Concerning the March 13, 2001 Hearing on H. R. 811**

**For
Dr. Thomas Garthwaite
Under Secretary for Health
Department of Veterans Affairs**

**From
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

1. If VA receives this authority from Congress, what process would it put in place to select projects to be funded? Would it use its current priority list for major medical construction?

Answer: The list of priority major medical construction projects, as required by 38 U.S.C. § 8107, will be the starting point for identifying projects. Additional projects will be available from those submitted by the VA Integrated Service Networks (VISNs). These additional projects are ones that were validated and scored by the VA Capital Investment Board (VACIB), but scored below the twentieth priority, or ones that may be validated this Fall in conjunction with the FY 2003 budget planning process. Selection would be based on the criteria and requirements included in H.R. 811, if passed by Congress, and would take into account the priority of the project as scored by the VACIB. Specific processes and procedures for completing selections have not yet been defined.

2. Staff have obtained a "purloined" copy of the priority major medical construction projects you will soon submit as required by Section 8107 of Title 38 U.S.C. I understand that although the "score" the CIB assigned to a project in Miami would rate it as 11th among your priorities, the agency considers this its highest priority in FY 2001. Where did the CIB rating system fail you in not identifying this project as a higher priority? Does the model need to be adjusted to give higher priorities to this type of project?

Answer: VA feels that the Miami project demonstrates the efficacy of the VA Capital Investment Board (VACIB) scoring system. For the FY 2002 budget formulation process, VA placed a high emphasis on seismic repair needs and special emphasis programs. The Miami project did not qualify in either of those categories, but scored well enough in the other categories to rank directly below those that qualified in one or both of those emphasized criteria. Only two non-seismic and non-special emphasis projects scored higher. The VACIB recognizes that the scoring methodology is a management tool to assist them in evaluating projects and prioritizing them against the many infrastructure needs of VA. While all projects are scored against the same common criteria, the Board took a further and stronger step in its deliberative process. It recognized that the Miami project is a unique emergency need and, therefore, should be placed at the top of the list of projects.

3. Last year this Committee authorized a project in Long Beach, CA, considered the agency's number 2 priority at that time. I see now that this project has fallen to number 14 on the list. What happened between last year and this year to mitigate the need you identified for this facility? Has the model significantly changed to reach this very different outcome?

Answer: The Long Beach project was submitted for budget years FY 2000, 2001, and 2002 and received high ranking scores for FY 2000 and 2001. The priority of this project was 'diminished' for FY 2002 due to an evaluation driven by the weighted factors associated with seismically-related major projects. To be considered a seismic priority, a project must meet or exceed a 70% cost factor, i.e., 70% of the project cost must be seismic-related. For the FY 2002 budget

review, the project associated with Long Beach included a seismic correction strategy whereas the majority of remaining non-compliant essential buildings were demolished, and replaced with new, but smaller structures to meet the needs of veteran care. The VA Capital Investment Board compared the cost of renovating the existing non-compliant buildings against the cost of replacement, and considered the seismic costs in the replacement strategy to be less than 70% of the total project cost. The project did not receive seismic scoring consideration, which lowered the priority rating.

4. This Committee has had quite a bit of mail from alumni of the Hines Blind Rehabilitation program who are, it appears, justifiably angry that their appeals to the VISN office for a replacement facility have gone unaddressed for about a decade. The facility, which I understand is more than 70 years old, is purportedly not up to code and will not meet CARF accreditation standards. Has there been a proposal from VISN 12? If so, what is the status of the proposal? If not, do you intend to encourage the network to submit a proposal?

Answer: In November 1998, VISN 12 conducted an in-depth analysis of the functional space and clinical workload for the Blind Rehabilitation, Spinal Cord Injury (SCI), and Traumatic Brain Injury (TBI) programs based at Hines. The goals of the project planning effort were to correct functional, space, and accessibility deficiencies in the structures that housed these programs. The network envisioned submitting two separate capital investment proposals for two major construction projects to correct the observed deficiencies. However, because of the diminishing availability of VA's capital improvement dollars, the network decided to consolidate the planning efforts for the three programs into one major construction project, instead of two separate projects. The project would construct VA's first Comprehensive Rehabilitation Center (CRC).

By combining the three rehabilitation programs into one project, rehabilitative services can be offered to patients with multiple disabilities, and provide them the opportunity to interact with others who have similar disabilities. The proposed project would be designed to allow separate functional layouts for each of these special disability programs. Moreover, the interior space would be designed to allow clinical and administrative staff to be located adjacent to the rehabilitation functions to which their specialized services are needed. In combining the three programs into one project, some advantages include a reduction in contiguous administrative space and costs for utility systems. The Network believes the biggest clinical advantage for such consolidation is the enhanced care coordination between the different rehabilitative specialties.

Presently, the network has received and is reviewing a planning submittal that combines the three programs into a proposed stand-alone facility. The network assembled a project team that consists of representatives from these programs and engineering personnel and developed a Capital Investment Proposal (CIP) for the construction of the CRC. The CIP application was received in VA Headquarters on June 16, 2001, for consideration for the FY 2003 budget request. To date, only advanced planning funds have been approved for the project planning efforts. **As you know, Network 12's health care needs and infrastructure requirements are currently being reviewed in Phase I of VA's CARES initiative. Preliminary results of this study support this project.**

The network has significant physical plant challenges in all three of these specialized rehabilitation programs and is fully aware of the need for improved clinical space for these programs. Consistent with this awareness, the network has objectively analyzed the needs of our veterans who are eligible for Special Disability Programs. With the construction of the CRC, the new environment will be conducive to the delivery of a highly effective rehabilitation program that offers a continuum of services that ensure patients will reside in the appropriate environment and receive the appropriate standard of care.

5. Your written statement says, "The Department supports H. R. 811 to the extent that it aligns with the President's Budget. It is obviously difficult for us to understand what the Budget supports since we have not seen it. Is your point

that you will support this bill within the additional \$1 billion request the Administration supports? If so, does that mean that the funds would come from some other program or that you would support the intent of the legislation, but not fund it?

Answer: The President's Budget was developed without consideration of funding to support this proposal, since H. R. 811 was introduced only as final budget decisions were being made. We do support the intent of this legislation to make appropriate improvements in the system's infrastructure. We also recognize the need to balance competing needs of the health care system and remain consistent with the goals established in the President's Budget. As H. R. 811 and the FY 2002 appropriations process move forward, we would expect further consideration of this issue between the Administration and the Congress.

6. We have heard from the Friends of VA who have questioned why restoration of research facilities is not a higher priority within H. R. 811. Can you comment on the priority construction of research facilities is now given by the Capital Investment Board?

Answer: The VA Capital Investment Board (VACIB) scoring system is focused on supporting VA priorities as identified in the VA Strategic Plan. In addition, VA coordinated the criteria with OMB and GAO and added criteria that they requested in areas of alternative analysis and risk assessment. Research projects can compete with all other projects for the limited construction funds. The VACIB, in the past, has received only one research building project for consideration, and that project scored in the middle of the projects reviewed. Other projects have had research space included within the renovation projects submitted.

**Post-Hearing Questions
Concerning the March 13, 2001 Hearing on H. R. 811**

**For
Dr. Jeannette Chirico-Post
Director, VISN 1
Department of Veterans Affairs**

**From
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

1. Dr. Post, you clearly walked into a difficult situation in VISN 1. I understand that the network still does plan to integrate the West Roxbury and Boston (Jamaica Plains) facilities. Do you plan on proposing a major construction project for the site, once this solution has been "validated" through the CARES process?

Answer: The construction plan for Boston was designed as a series of phased minor construction projects due to the need to carefully sequence the construction while continuing to provide tertiary health care services. During the past 12 months, all medical and surgical inpatient services have been relocated to the West Roxbury facility. The phasing of minor projects is the most expeditious method of accomplishing the multiple projects necessary to ensure the VA Boston Healthcare System continues to meet its mission as a tertiary referral center for the veterans of New England. All projects are in VISN 1's integration plan and are ready to proceed, as soon as the Senate and House Appropriations Committees are satisfied that the recently completed Booz-Allen-Hamilton review and validation of the projects will satisfy their request for a CARES validation.

2. If funds are made available under this "emergency" legislation, do you intend to forward a major construction proposal to continue with the integration of the Boston facility? If not, how do you intend to fund the project?

Answer: Even with the opportunity of funding through the major construction process, the need to phase in the various construction projects will be key to the maintenance of continuity in the delivery of patient care services. The Network has set aside minor construction funds to accomplish the planned projects. If H. R. 811 is signed into law, we will consider requesting major construction appropriations through this process. A key deciding factor will be the time frames for approval of the projects. Currently, we are proceeding with the design of high priority projects awaiting the completion of the CARES validation process.

3. The Chairman has asked for a report on VISN 1's maintenance of capacity. In this report, please address:

a. any plans to restore programs for seriously mentally ill veterans treated for substance abuse and for post-traumatic stress disorder (PTSD)

Answer: Substance Abuse/SMI - The recently released draft of the capacity report shows VISN 1 to be at 75% of FY 1996 levels for individuals treated and 83% of dollars expended.

Recently, VISN 1 was awarded two substance abuse enhancement grants (funded through Millennium Bill funding) to improve substance abuse capacity in New England. One of these projects, based at the Bedford facility, is designed to address the treatment and housing needs of substance abusing veterans in the northern tier of the VISN. This project brings five additional FTEE to the treatment of substance abuse in this geographic region. The second project, located within the Boston Healthcare System (Brockton Division) will focus on

increasing the involvement of family members to improve the outcome of addiction treatment. It brings two additional FTEE to the Brockton campus.

We are in the process of recruiting two new PGY5 fellows in substance abuse for Boston and Connecticut for July 2001.

The Network Mental Health Care Line has developed a proposal for a domiciliary program at Togus, Maine. Evaluation of community-based residential detoxification services in both Maine and New Hampshire is underway.

A VISN 1 Substance Abuse Taskforce recently submitted a series of recommendations to enhance the provision of substance abuse treatment programs. An action plan is being developed to implement the recommendations.

PTSD/SMI - The recently released draft of the capacity report shows VISN 1 to be at 97% of FY 1996 levels for individuals treated and 97% of dollars expended.

Since FY 1998, through creative collaboration with VBA, we conducted a systematic outreach to patients who were service-connected for PTSD, but were not current users of VHA services. Our success has been remarkable.

The Network PTSD Workgroup recently conducted a review to identify any gaps or redundancies in the existing continuum of care. Recommendations regarding program changes, enhancements, or realignments needed are being discussed for proposed implementation.

Currently, there are 11 specialized outpatient PTSD programs; a 12-bed Psychiatric Residential Rehabilitation Treatment Program (PRRTP) at West Haven and a 25-bed inpatient Specialized Inpatient PTSD Unit (SIPU) at Northampton. All six states within the VISN have at least one specialized program. There are also 19 Vet Centers within VISN 1 that provide PTSD treatment.

b. PVA's claims that West Roxbury is only staffing 48% of the beds and Brockton is at 63% of its bed capacity and significant nursing vacancies at both facilities

Answer: All SCI positions are filled except for one full-time physician, one part-time physician, and multiple nursing vacancies. The VA Boston Healthcare System is actively recruiting to staff all SCI positions for both the West Roxbury and Brockton campuses as mandated by VHA Directive 2000-022, "Spinal Cord Injury Center Staffing and Beds."

c. plans for maintaining long-term care programs at the FY 98 level

Answer: The VA New England Healthcare System is committed to satisfying the needs of an aging veteran population through well planned and managed programs. In addition to providing the right care, at the right time, in the right place, at the lowest cost, we will concentrate on managing the elder population in the least restrictive environment. To this endeavor, we will develop better tools for assessing and evaluating the patient to ensure that the patient is placed at the appropriate level of care. Historically, long-term care meant institutional lifetime care. With the population aging, but staying more independent, developing home-based options will be our first priority. The home-based options will also require us to develop time-limited outcome based short-term institutional options. These options will be used when the veteran patient needs additional attention above what can be provided in the home or after acute hospitalization. The focus of these options will be to restore and rehabilitate with the ultimate goal of returning the patient to their community.

Since 1998, the VA New England Healthcare System has provided care to an ever-increasing number of veterans. The long-term care projection model forecasts a three percent increase in nursing home care and a five percent

increase in home care over the next five years. Thereafter, the demand is expected to decline. The resources available in 1998 were not adequate to meet this demand, even though VA nursing home care units continue to perform at or above the 1998 level. Emphasizing lower cost home care options will extend our capability, but we will need to rely on increased cooperation from state veterans homes and an increased appropriation to meet the demand.

**Post-Hearing Questions
Concerning the March 13, 2001 Hearing on H. R. 811**

**For
Mr. James Farsetta
Director, VISN 3
Department of Veterans Affairs**

**From
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

1. The Chairman has asked for a report on VISN 3's maintenance of capacity. In this report, please address:

- a. blind rehabilitation
- b. seriously mentally ill veterans
- c. substance abuse
- d. homeless veterans
- e. maintaining long-term care at the FY 98 level

Answer: Listed below is data on our capacity maintenance for all areas, including those mentioned (blindness, seriously mentally ill, substance abuse, and homeless). These numbers were taken from the official capacity report submitted to Congress in October 2000. It presents data contrasting the 1996 levels (from which we must maintain capacity) with the latest period available, 1999.

In blindness, we served 553 veterans in 1996 and 491 in 1999, and spent \$457,000 in 1996 and \$415,000 in 1999.

In seriously mentally ill, we served 18,329 veterans in 1996 and 17,177 in 1999, and spent \$178,291,000 in 1996 and \$171,199,000 in 1999.

In substance abuse, we served 7,028 veterans in 1996 and 5,916 in 1999, and spent \$46,056,000 in 1996 and \$39,210,000 in 1999.

In SMI Homeless Veterans (the capacity category), we served 2,153 veterans in 1996 and 1,916 in 1999, and spent \$7,797,000 in 1996 and \$11,550,000 in 1999.

**Post-Hearing Questions
Concerning the March 13, 2001 Hearing on H. R. 811**

**For
Mrs. Patricia Crosetti
Director, VISN 15
Department of Veterans Affairs**

**From
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

1. The Chairman has asked for a report on VISN 15's maintenance of capacity. In this report, please address:

a. PVA claims that St Louis has staffed only about 2/3 of the beds required and has about 1/3 of it's nursing positions vacant.

Answer: All of the required Spinal Cord Dysfunction (SCD) beds are operational. This network has increased the level of service to SCD veterans over the past five years. This is evidenced by the number of veterans treated in the program, which has grown from 416 in FY 1996 to 529 in FY 2000. The St. Louis VAMC has had nursing turnover. They are diligently recruiting nurses for the SCD Unit and all parts of the medical center. It should be noted that the city of St. Louis is ranked fourth nationally in the severity of the nursing shortage. This factors very heavily in their ability to not only recruit new nurses, but in retaining them as well. They have utilized contract nurses as an interim measure in order to maintain the capacity in the SCD Unit. To date, no veteran has been denied admission to the SCD Unit due to a shortage of nursing staff.

b. plans to restore the 13% drop in program workload and funding (50% of the resources have been diverted) for substance abuse

Answer: The decrease in the substance abuse program is more a reflection of patient classification than a diminution of services. This network, as well as many others, has moved the focus of treatment for substance abuse from a long stay inpatient modality to an intensive outpatient program. This has proven to be more effective and has been well accepted by the veterans. For those veterans requiring housing, either the HOPTEL or domiciliary are utilized. However, those costs are not captured as part of substance abuse in our present model. Additionally, the outpatient programs have been integrated as part of both our ongoing homeless and PTSD programs. Therefore, a number of veterans are captured in those programs, but receive the needed substance abuse services. It should be noted that both of those programs have grown substantially since FY 1996. In FY 2000 this network treated 128% of the number of homeless and 113% of the number of PTSD veterans served in FY 1996.

c. plans for maintaining long-term care at the FY 98 level

Answer: This network presently operates more nursing home beds than it did in FY 1998. There are no plans to close any nursing home care beds in this network. We continue to utilize the Community Nursing Home Care program to a large extent in order to provide this benefit as close to home as possible. This network has also been fortunate to establish strong working relationships with the Veterans Affairs Commissions of the States of Missouri, Kansas, and Illinois. The states of Kansas and Missouri have recently expanded the availability of long-term care through their state veterans homes. This gives us another option for providing high quality long-term care to the veterans of those states. Through use of these resources and new non-traditional modalities, such as home health care, it is our goal to meet all of the long-term care needs of the veterans of the Heartland of America.

**Post-Hearing Question
Concerning the March 13, 2001 Hearing on H. R. 811**

**For
Dr. Robert Wiebe
Director, VISN 21
Department of Veterans Affairs**

**From
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

1. The Chairman has asked for a report on VISN 21's maintenance of capacity. In this report, please address:

The Capacity Report indicates that while your network has increased its workloads in almost every specialized program, the dollars committed to these programs -- like PTSD treatment -- have dropped -- in some cases, precipitously. Will you comment on your network's ability to increase workloads while reducing costs? Do you have any concerns that the resources diverted from these programs have in any way, impaired the quality of the specialized programs in the network? For example, is there adequate follow-up after discharge from inpatient psychiatric care?

Answer: There are two major reasons for the reported reduction in expenditures associated with specialized programs in VISN 21 from FY 1996 to FY 2000. In FY 1996, the costs associated with specialized programs appear to have been significantly overstated because of inaccurate cost accounting practices in place at that time. Many of these inaccuracies were corrected in FY 1997. Consequently, there was an apparent reduction of nearly 20 percent in the combined expenditures for Seriously Mentally Ill (SMI), Substance Abuse (SA), Post-Traumatic Stress Disorder (PTSD) Programs in VISN 21 from FY 1996 to FY 1997.

Reported Combined Expenditures for SMI, SA and PTSD Programs, VISN 21

Fiscal Year	Reported Expenditures (\$000)	Change in Expenditures, Year-to-Year	Change in Expenditures, from FY96
FY96	\$187,580		
FY97	\$151,309	(19.3%)	(19.3%)
FY98	\$138,254	(8.6%)	(26.3%)
FY99	\$139,297	0.8%	(25.7%)
FY00	\$145,367	4.4%	(22.5%)

The other major and more meaningful reason for the reduction in expenditures is the concerted shift from an inpatient setting to an outpatient clinic for the treatment of selected mental health disorders, such as substance abuse. This shift and other changes in mental health programs were congruent with the principles articulated in VHA's "Vision For Change," including enhanced quality, increased access, and improved cost-effectiveness.

Mental health leaders in VISN 21 believe that the quality of mental health services in VISN 21 is outstanding, and has not been adversely impacted by programmatic or funding changes during the past five years. Although there does not appear to be a consensus opinion in the health care literature, several

published studies have demonstrated equivalent or improved results in treating patients with substance abuse disorders in an outpatient setting, compared to inpatient wards. VISN 21 has emphasized appropriate follow-up care for patients with mental health disorders treated in either an inpatient or outpatient setting. As an example, VISN 21 has consistently exceeded that national VHA target associated with the performance measure of follow-up after mental health hospitalization.

**Post-Hearing Questions
Concerning the March 13, 2001 Hearing on H. R. 811**

**For
Mr. Kenneth Clark
Director, VISN 22
Department of Veterans Affairs**

**From
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

1. This Committee authorized the Long Beach project for this fiscal year, but was surprised to learn that agency may have significantly diminished the priority it gave this project. Do you have any information that might help us understand why this project's importance diminished so significantly during the course of the year?

Answer: The Long Beach project was submitted for budget years FY 2000, 2001, and 2002 and received high ranking scores for FY 2000 and 2001. The priority of this project was 'diminished' for FY 2002 due to an evaluation driven by the weighted factors associated with seismically-related major projects. To be considered a seismic priority, a project must meet or exceed a 70% cost factor, i.e., 70% of the project cost must be seismic-related. For the FY 2002 budget review, the project associated with Long Beach included a seismic correction strategy whereas the majority of remaining non-compliant essential buildings were demolished, and replaced with new, but smaller structures to meet the needs of veteran care. The VA Capital Investment Board compared the cost of renovating the existing non-compliant buildings against the cost of replacement, and considered the seismic costs in the replacement strategy to be less than 70% of the total project cost. Although the replacement strategy is considered the best value when compared with the cost of renovating 1940 vintage structures, the project did not receive seismic scoring consideration, which lowered the priority rating.

2. The Chairman has asked for a report on VISN 22's maintenance of capacity. In this report, please address:

a. Plans to restore significant decreases in workloads in VISN 22's blind rehabilitation and substance abuse programs between fiscal year 96 and 99

Answer: Although statistics reflect decreased workload, there was an intentional strategy to offer convenience in providing care to patients. The workload figures for Network 22's substance abuse patients show significant reductions from 5,813 in FY 1997 to 4,966 in FY 2000, which supports our intent to provide care conveniently to the patient. The network has made strides in partnering with community and other agencies to achieve this goal. Substance abuse care has shifted from hospital wards to transition intensified outpatient care to communities where patients live. Assisted living programs have increased in both community nursing homes and board and care settings. Additionally, contract and grant per diem beds, primarily for our large population of homeless mentally ill patients and substance abusers, have increased.

In regard to the workload reduction in blind rehabilitation programs, we were faced with several significant staff losses at the same time in FY 1999. Working with VISN 21's Blind Rehabilitation Center and Program Director to address our needs, we referred patients to the Tucson facility, as their program offered a higher level of services, and better suited some patients' needs. We have now filled the necessary positions and staff have been appropriately trained.

**Post-Hearing Questions
Concerning the March 13, 2001 Hearing on H. R. 811**

**For
Lawrence Biro
Director, VISN 4
Department of Veterans Affairs**

**From
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives**

1. The Chairman has asked for a report on VISN 4's maintenance of capacity. In this report, please address:

a. plans to assist Philadelphia and Pittsburgh in meeting the "continuity of care" standard for seriously mentally ill veterans

Answer: Philadelphia: In the past four years much has been accomplished to reduce costs and increase quality in the Behavioral Health Service at Philadelphia VAMC. At the beginning of 1996, the Behavioral Health Service launched a lengthy reorganization process, emphasizing the VHA principles and community practice patterns that supported a shift of resources and service from inpatient to outpatient and community-based care. Our philosophy of treatment, which had emphasized outpatient treatment long before 1996, was consistent with the VHA Prescription and Journey for Change and simplified our restructuring. The NEPEC data (Rosenheck) and our own workload figures clearly demonstrate that the cost savings in Behavioral Health at this facility are real and substantial. A portion of the cost savings has been redirected to the ambulatory Behavioral Health programs, which currently treats 9,600 unique veterans, up from 7,048 in 1996.

NEPEC data for 1996 through 1999 documents that our staffing has decreased by more than 20% as workload (unique patients treated) has increased by almost 33%. NEPEC data for FY 2000 shows a decrease in the workload of specialty substance abuse services and for PTSD services. Clinic stop codes are not inclusive and have limited us from accurately capturing the dual diagnosis patient. We are treating more substance abuse now than we ever have. We are not, however, getting credit for the methodology that is being utilized. Aggressive data validation efforts are being implemented to more accurately calculate workload for our specialty services.

Philadelphia Behavioral Health will be using augmentation funds recently awarded through the Millennium Act (5 FTEE for substance abuse and 2.5 FTEE for PTSD Staff to add clinical capacity to our specialty programs (PTSD, SMI and SATU). Philadelphia is also collaborating with Coatesville to build intensive management services to better address the continuity of care needs for our specialty programs to promote better treatment engagement and retention. Finally, Philadelphia is in the process of finalizing a business plan to assess the need for a community-based residential care program. The program would have a specialty focus on dual diagnosis patients who are homeless with SMI and substance abuse disorders.

Pittsburgh: A psychosocial rehabilitation approach has been adopted with the aid of consultation and training from Boston University in a psychosocial model that includes the stages of engagement, readiness, choices and achievement, with the ultimate goal of improving functional status and the quality of life for persons with disabilities. Ms. Christine Woods, National Manager, Psychosocial Residential and Day Treatment Services, VA Headquarters, has also made a site

visit and offered recommendations for this approach to care. Services include acute inpatient care; extended inpatient care in the Psychosocial Rehabilitation Engagement Program (PREP); a transitional living unit – Psychosocial Residential Rehabilitation Treatment Program for the Seriously Mentally Ill (PRRTP-SMI); community living with Intensive Case Management; and a Day Treatment Center. Entry to these programs can be at any point and veterans can move back and forth as determined clinically.

VA Pittsburgh Healthcare System has capacity in all areas of Behavioral Health including treatment for PTSD, Substance Abuse, Homeless and SMI. Pittsburgh is adding a vocational rehabilitation specialist to work with SMI patients and to enhance vocational rehabilitation services within the homeless program. It should be noted that the number of patients treated increased for Homelessness (16 percent) from 1996 to 2000; decreased slightly for substance abuse and serious mentally ill; and remained stable for PTSD. Expenditures have decreased by approximately 35 percent from 1996 to 2000 for substance abuse, PTSD and SMI. This can be attributed to the shift from a bed model of care to an outpatient model of healthcare delivery. The Homeless Program has always been funded as an outpatient program.

A performance measure used to monitor continuity of care is "patients discharged for mental illness disorders will receive outpatient care related to mental health within 30 days of discharge." The VA Pittsburgh meets this standard at 97%, through February 2001.

b. plans for Clarksburg and Wilkes-Barre to meet the follow-up standard for substance abuse care

Answer: Clarksburg: A data review indicates that Clarksburg had an increase from 180 in FY 1999 to 293 in FY 2000. Clarksburg is monitoring veterans discharged from the substance abuse program for the following: percentage of patients reporting to referral source at the time of discharge; percentage who continued in care after 30 days; and percentage of abstinence. The facility has noted positive outcomes, as follow-up of inpatient care is extremely important for this group. Overall recovery of 30% is considered well within an expected range for substance abuse.

Wilkes-Barre: Currently, initial Addiction Severity Index (ASIs) are completed for all patients entering the SAR RTP. All of these patients are then scheduled for a six-month ASI follow-up interview. Initial ASIs and follow-up ASIs have not been completed/scheduled for patients admitted to the detox unit.

All patients entering SAR RTP will continue to be administered a full ASI and will be scheduled for a six-month follow-up ASI interview. If the veteran does not keep the follow-up appointment, the assigned clinician will make every effort to contact the veteran by phone and/or letter in order to complete the ASI telephonically or by rescheduling another appointment. If the veteran cannot be located or fails to show up for another follow-up interview, the clinician will enter an ASI in the computer indicating under G12, "Patient Unable to Respond."

An ASI will be completed for all patients admitted to the detox unit. A six-month follow-up appointment will be provided. The same outreach will be provided to detox patients as we provide to SAR RTP patients. Outpatients identified as having a substance abuse diagnosis will be administered the ASI. On the day the patient completes the initial ASI, that individual will be given a return appointment for six months to complete the follow-up ASI. More staff will need to receive training in completing the ASI in order to meet the requirement of the performance standard. Follow-up for those patients that were missed for an initial and/or six-month ASI will commence immediately.

c. plans for maintaining long-term care at the FY 98 level

Answer: Leaders and planners in VISN 4 have studied demographic trends, market penetration and actuarial forecasts. We have learned that while the total

veteran population is declining, the number of veterans that are 65 years or older is declining more slowly and the number of veterans over the age of 85 is actually increasing. These same studies have shown that a greater than expected percentage of highly service-connected veterans in VISN 4 are already using VA services and that the greatest potential for new demand is from non-service connected veterans.

We predict, therefore, that the long term care capacities that would be of greatest value to and in greatest demand by older veterans in VISN 4 are home and community-based services and transitional nursing home services. Specifically, veterans would be seeking:

- Skilled and non-skilled nursing services in their homes
- Adult Day Health Care
- In-home Primary Care
- Domiciliary Care
- Rehabilitation
- Sub-acute care and other transitional nursing home services
- Respite Care
- End of Life Care

The 1998 baseline long-term care levels established by the Millennium Act Task Force include most of these services either provided by VA or contracted. While it is clear that the purpose of the baseline is to establish a floor for the level of long-term care services provided by VA, we believe that needs of aging veterans in VISN 4 will require service levels above that floor.

The long-term care model provided by the Geriatrics and Extended Care Strategic Health Group in VA Headquarters indicates that this increased level of service will not be expressed in terms of an increased nursing home census. The model predicts a stable (or decreasing) average daily census for VISN 4 nursing home over the next ten years. We do predict, however, that more veterans will use transitional nursing home services, respite care and hospice in our nursing homes. The turnover that is characteristic of these services will result in an increase in the number of unique veterans served despite a stable census.

The significant increase in demand for long-term care services by older veterans in VISN 4 will occur in home and community-based programs (home care, domiciliary, etc.), where a nearly five-fold increase is projected during the next five years. Therefore, we have increased our domiciliary capacity this fiscal year and have included an increased provision of skilled and non-skilled home care services in our financial plan. In addition, VISN 4 facilities are expected to respond to the needs of aging veterans with plans for more home-based primary care and adult day health care.

In summary, in order to meet the needs of the aging VISN 4 veteran population, our long-term care capacity will, of necessity, exceed that of 1998 levels for several years to come. This will be evident in the number of unique veterans who are treated in our nursing homes and for whom we provide home and community-based services. We will regularly measure the provision of these long-term care services and our VISN financial plan will support that.