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THE U.S. DEPARTMENT OF VETERANS AFFAIRS CONSTRUCTION PROCESS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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THE U.S. DEPARTMENT OF VETERANS AFFAIRS CONSTRUCTION PROCESS

THURSDAY, NOVEMBER 1, 2007

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Brown of Florida, Snyder, Berkley, Salazar, Miller, Stearns, and Brown of South Carolina.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the Subcommittee on Health to order. I would like to thank everyone for coming this morning.

The purpose of this hearing is to learn more about the construction process within the U.S. Department of Veterans Affairs (VA). In 2004, the VA completed the Capital Asset Realignment for Enhanced Services (CARES) process. CARES was supposed to be a map to future VA facility development. It is unclear to me how closely the VA is following this map, and it is also unclear how well CARES will address the medical and demographic needs of current and future veterans of Afghanistan and Iraq.

This Subcommittee is committed to providing the highest quality of care to our Nation's veterans, and we understand that a key part of this care are the facilities in which it is provided.

We are here today to get a better understanding of the entire construction process from the concept to the opening of a facility. Understanding this process is particularly important right now.

Many of the VA hospitals and medical facilities are aging and are in need of major renovation or replacement. Many VA facilities need to be upgraded in order to meet the standards for earthquakes, fire and patient privacy. Population shifts require new facilities in new locations. The VA is in the process of planning several new hospitals in cities such as Las Vegas, Denver, and New Orleans. This process can be long and drawn out. It can take much longer than similar projects built in the private sector.

We look forward to working with the VA to ensure that our veterans receive the best possible care in medical facilities that are modern and safe while being built efficiently and cost-effectively. I look forward to hearing about the current construction process, the VA's plans and needs for future construction and how this Com-

mittee can support this effort, with the goal always being to provide the best possible healthcare for our veterans.

I now would like to recognize Mr. Miller for an opening statement.

[The prepared statement of Chairman Michaud appears on p. 28.]

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman. I appreciate you holding this hearing today.

As you have already said, access to different types of outpatient and inpatient facilities is critical in addressing the unique healthcare needs of our changing veteran population. Most of the Department of Veterans Affairs infrastructure was built more than 50 years ago. Many of these facilities continue to age and are not well suited for the 21st century healthcare that is provided now. The facilities need repair and replacement, and they are sometimes simply located too far away from the veteran's choice of living arrangements.

I have a full statement that I would like to have entered into the record, but because we do have votes coming up in a few minutes, I would like to ask unanimous consent that my statement be entered into the record.

I do want to say a special welcome this morning to our first witness, Major General David Eidsaune, who is here from Eglin Air Force Base in my district, the First Congressional District of Florida.

We are glad to have you here with us this morning, General.

I yield back.

[The prepared statement of Congressman Miller on p. 28.]

Mr. MICHAUD. Thank you very much. Without objection, your full statement will be put in the record.

Ms. Brown.

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN OF FLORIDA. Thank you. Mr. Chairman, I want to thank you for calling this hearing today. Thank you very much. I had requested this hearing, and have been pressing for it, and now we have it.

This issue is very important to me as I represent part of Orlando, Gainesville, and Jacksonville. I would say most of Florida. Some of my colleagues might disagree. Central Florida waited 25 years before the VA decided to put a VA medical center there earlier this year. Twenty-five years is too long for those men and women who have defended this country and their freedom that it holds dear. It is 25 years too long for the oldest veterans population to wait for proper care. Twenty-five years. I do not want to have to wait another 15 years for this hospital to open.

In New Orleans, it has been 2 years since Hurricane Katrina hit the Crescent City and devastated the city. The employees at the VA medical center performed heroically for the patients and in evacuating everyone safely. However, we are no closer to rebuilding that hospital now than we were 2 years ago.

I have heard good things about design-build, where the design and construction aspects are contracted for or with a single entity known as a "design-builder" or a "design-builder contract." The design-builder is usually the general contractor, but in many cases it is also the architect or the engineer. This system minimizes the project risks and reduces the delivery schedule by overlapping the design phases and construction phases of the project.

Why can't the VA use this modern device to speed up the process?

I look forward to the hearing, the testimony of the witnesses today, and I will put my complete statement in the record, Mr. Chairman.

[The prepared statement of Congresswoman Brown appears on p. 29.]

Mr. MICHAUD. Without objection.

Mr. Stearns.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Well, thank you, Mr. Chairman.

I also share similar things with my colleague from Florida, Ms. Brown. We represent the University of Florida, and we have the Gainesville Hospital up there, and so we are working together on this, and we are trying to get additional money for it and for also the new Summerfield Clinic in South Marion County, both of which are in the construction budget and are in the process. The one in Summerfield is a 95,000-square-foot facility, which is in my hometown.

I think a lot of us are concerned about a lot of the VA facilities that are aging, and in fact, I guess, a U.S. Government Accountability Office (GAO) report found that one out of every four medical care dollars goes to the maintenance and operation of the infrastructure, and we are losing millions of dollars annually on the upkeep of these facilities.

So, obviously, that is why the CARES program got started, and that is why we are interested so much in the construction.

There are, obviously, other projects throughout the United States. I think there are about 100 major construction projects in 37 States, including in the District of Columbia and in Puerto Rico. So I am very sensitive to that fact that you have this many in a priority situation. The Military Construction and Veterans Affairs Appropriations Act, 2008, would provide $1.4 billion for major construction and $650 million for minor projects. So that is the good news.

Like other Members of Congress, we have heard from our districts, and we need the facilities, and so we are particularly pleased that there is going to be additional funding for the Gainesville Hospital, and also, we want to get money for the Summerfield Clinic.

So, Mr. Chairman, I am glad we are having the hearing. I compliment you on it. I look forward to the testimony.

Thank you.

Mr. MICHAUD. Thank you very much.

Ms. Berkley.

OPENING STATEMENT HON. SHELLEY BERKLEY

Ms. BERKLEY. I thank you very much, Mr. Chairman, for holding this very important hearing, and thank you very much for being here.

I represent the Las Vegas area, and as you are well aware, we are on schedule to get a full VA medical complex that includes a VA hospital, a long-term care facility and a VA outpatient clinic, a full-service VA outpatient clinic. We have moved heaven and earth to do this. We had 147 acres transferred from the U.S. Department of the Interior to the Department of Veterans Affairs to save on costs of the land. I was at the Paiute Indian blessing of the land, which was quite an extraordinary ceremony. I was there for the groundbreaking with then Secretary Nicholson. They are moving dirt out there. Right now, it is in the middle of nowhere, but I know the growth patterns of my Congressional district and the entire State of Nevada. It is going to be in the middle of North Las Vegas in very short order.

My biggest concern—and the appropriations have already been made, and we are moving forward. My biggest concern and what keeps me up at night, quite frankly, given the fact that I have the fastest growing veterans population in the United States in the Las Vegas Valley, is that I have 300,000 veterans in the State of Nevada. Two hundred and fourteen thousand of them call my district home. They have no healthcare facilities. There is nothing to repair. There is nothing there right now, and that is why this is so critical. I have 1,600 veterans who have returned from the Iraq-Afghanistan theater of war, and they are already accessing whatever healthcare system we have in Nevada.

I need to keep this on track, and I need to have periodic—I mean other than my going over there and looking at the facilities going up, I need to know that we are moving in a positive direction. With the construction costs in Las Vegas skyrocketing beyond anybody's wildest beliefs, my concern is that this gets more costly with every passing day. The sooner we get it up, the sooner we are going to save millions and millions of taxpayers' dollars.

So anything I could do to be working with you to move this in a very rapid and a positive direction, I am there for you, but I need to get these facilities up, and I need to get them up fast.

Mr. STEARNS. Will the gentlelady yield?

Ms. BERKLEY. Of course, Mr. Stearns.

Mr. STEARNS. On this Indian blessing for the site, perhaps others might have to have that same kind of ceremony.

How long a ceremony was it?

Ms. BERKLEY. It was quite remarkable.

Mr. STEARNS. Quite remarkable.

Ms. BERKLEY. The Paiute Indians were in full regalia, and there were blessings and a lot of smoke. I do not think it was peyote, but it smelled good. It was quite an extraordinary cultural experience.

Mr. STEARNS. That is the first I have heard of something like that occurring.

So, Mr. Chairman, if you do not mind, I just indulged myself to find out a little more about it. Thank you.

Ms. BERKLEY. By the way, that is all former Paiute land.

Mr. MICHAUD. Mr. Brown.

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

Thank you, General, for coming, and I look forward to hearing your testimony and that of the other members of the panel.

I represent the First Congressional District of South Carolina. We have been working for some time now to try to develop a model that we feel would upgrade, I guess, the healthcare delivery for veterans across the Nation. It is to partner with the local, you know, State-run Medical University. We have been working on that plan for a long time, but it seems to me that we just cannot quite move to the next level.

The Medical University now is in the process of building a complete new hospital complex. What we were hoping to do is to be able to incorporate in that development the replacement for the old VA hospital now in Charleston.

We are facing a similar situation that you find in New Orleans today where the VA hospital was built on the peninsula of Charleston, which was built in a low-lying area, and we could almost sense, if we had a Katrina-type storm come through the region, that we would be out of business just like the folks in New Orleans. The Medical University is sensing that concern and is building on higher ground, and we were hoping that we would be able to replace the old VA hospital in the same time and manner as the current Medical University complex. By doing so, we would be able to unite some services between the VA and the Medical University that we currently are not doing.

Ninety-five percent of those doctors who operate in the VA hospital actually come from the Medical University, so there is already some sharing; some imaging equipment is also being shared. What we were looking for is to get the units closer together in a physical sense so we would be able to unite more services and, I think, upgrade particularly in the highly specialized areas and, I think, in the clinical care area for, I guess, mental patients and some of the prostheses and for the heart and for some of the other high-tech procedures where we could better utilize the taxpayers' dollars by uniting both of those units, but we cannot seem to move to the next level.

We have appropriated—we have not appropriated, but we authorized some $38 million last year in the authorization bill, but we cannot seem to get the connectivity with the administration to be able to move that project forward, and I certainly would like to address that as you make your statements today.

Thank you, Mr. Chairman.

Mr. MICHAUD. Mr. Salazar.

OPENING STATEMENT OF HON. JOHN T. SALAZAR

Mr. SALAZAR. Thank you, Mr. Chairman.

I just wanted to thank the General for being here.

Of course, I share the same concern as many of my colleagues here around the table. We have been working on the Fitzsimons Hospital construction in conjunction with the University of Colorado, which will be, I hope, soon a state-of-the-art facility. I want to thank you for your service as well.

So I will submit my full statement for the record, Mr. Chairman. Thank you very much for holding this hearing.

Mr. MICHAUD. Without objection.

It is my pleasure now to recognize the first panel, Major General David Eidsaune. I want to welcome you here. A lot of comments you heard this morning so far actually deal with the VA jurisdiction, but hopefully those folks from the VA heard those opening remarks and will be able to address them when they come up to do their part.

So, without further ado, Major General, I want to thank you once again for your service to this great Nation of ours. I look forward to your testimony here today.

So please begin.

STATEMENT OF MAJOR GENERAL DAVID W. EIDSAUNE, COMMANDER, AIR ARMAMENT CENTER, EGLIN AIR FORCE BASE, FL, DEPARTMENT OF THE AIR FORCE, U.S. DEPARTMENT OF DEFENSE

General EIDSAUNE. Thank you, Mr. Chairman and Members of the Subcommittee, and thank you for this opportunity to speak about the ongoing VA construction project we have at Eglin Air Force Base, and thank you for your great support of our veterans, including the many who live in the community around my base, and they are also very vibrant supporters of our mission at Eglin.

At Eglin and across the Air Force, we are continually working to expand and to improve available healthcare services for our active duty and veteran populations. This includes renovating and enlarging existing healthcare facilities as well as planning and building new facilities such as our own VA community-based outpatient clinic, which is under construction.

The VA Gulf Coast Veterans Healthcare System covers the gulf coast of Mississippi, Alabama, and the Florida Panhandle. This extensive area is covered by one VA inpatient facility in Biloxi and three outpatient clinics in Mobile, Pensacola, and Panama City.

Because the Emerald Coast of northwest Florida is one of the top 10 fastest growing areas in the United States, there is a strong need to improve access for veterans to the medical services they deserve. The VA and Eglin Air Force Base have combined forces to address this need. The resulting VA community-based outpatient clinic is currently under construction and is scheduled to open in the spring of 2008.

Eglin provided a 10-acre parcel, within walking distance of our main hospital, at no cost to the VA. The close proximity will enable a sharing arrangement for inpatient care, emergency room services, radiology, lab work, pharmacy, and specialty care, just to name a few.

In closing, this VA clinic will be a tremendous joint success for Eglin, for the VA, and for our combined patient populations. I believe this cooperative effort will serve as a model for future initiatives to support the healthcare needs of our Nation's veterans.

Thank you.

[The prepared statement of General Eidsaune appears on p. 29.]

Mr. MICHAUD. Thank you very much, Major General.

I have a couple of quick questions.

What major challenges did you face in building the community-based outpatient clinic (CBOC) at Eglin Air Force Base? Were you able to stay on schedule and on budget for this project?

General EIDSAUNE. In fact, there were no major challenges. It all went very well. We have been on schedule, on budget, and I know Congressman Miller has been out there to observe the construction, and he was very happy with that. So I would say it is a great success story so far.

Mr. MICHAUD. Great. You are to be commended.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

I think the focus of your testimony is unique now; it was not so unique 5 years ago. It was not even thought about that much, the cosharing between the VA and the U.S. Department of Defense (DoD).

When I was elected in 2001, it was interesting to me that there was a huge disconnect between the DoD and the VA. Now, I think everybody is trying to bring them together as there is a possibility of providing much better service for both DoD and VA patients.

In El Paso, the VA Medical Center and the William Beaumont Army Medical Center at Fort Bliss are colocated. VA inpatient care is provided through a VA/DoD cosharing agreement. Obviously, one was entered into in Florida because of the Community-Based Outpatient Clinic at Eglin.

Were there great problems in putting that agreement together? What do you see as the future at Eglin or at other facilities of being able to expand inpatient care for VA patients?

General EIDSAUNE. In fact, it made a lot of sense for us to have the big hospital right there at Eglin and one of the top five in the Air Force, in terms of size, to put a clinic right outside the fence and to provide primary care. If a veteran needs specialty care follow-up, they can walk right next door. We plan on putting in a golf cart shuttle system to take them back and forth through the gate, an electronic-type gate, to make it easy. So it all makes sense that we should put these two together and share arrangements.

Mr. MILLER. What type of security issues are you having to deal with, going through the fence between the two facilities?

General EIDSAUNE. What we plan to do is, for people who have appointments the next day, we will provide a list of those patients to the security forces, and when they come in the next day, they just show a picture ID and their VA patient badge, and they will be let right in to go to the hospital. For same-day appointments, we will use that gate I talked about—it will be an electronic gate—so the staff that accompanies the patient on the golf cart over there will just be able to swipe a card through the gate and get through to the hospital. So we do not see any major security concerns at all.

Mr. MILLER. Do you think that adding veterans to the mix of patients that Eglin currently has is going to provide a broader range of services than currently exists? Do you see VA patients coming in helping the physicians and the facility at the hospital expand what they do?

General EIDSAUNE. In fact, I think it will.

Part of our certification progress is we have to have a wide range of patient population, including aging patients. Well, we do not have that many on base right now in terms of the active duty. We also have a fairly good active residency program, and those residents need to see those types of patients also, so this really benefits our own hospital in terms of these VA patients coming over.

Mr. MILLER. You came in when the process was already started, but what type of stumbling blocks have you seen through the VA and the DoD working together that you have had to overcome?

General EIDSAUNE. Yes, I wish I could give you some, but it has been just a very smooth process so far. I know the folks in my hospital worked this really hard with the VA, but nothing has bubbled up to my level as being a major stumbling block in making this happen.

Mr. MILLER. I think it is important for the Subcommittee to hear that both VA and DoD have worked seamlessly in making this transition, in providing the ability for veterans to receive healthcare as close to home as possible.

As you heard this morning, there is a cry, a need for community-based outpatient clinics to be located throughout the United States. As my colleague, Ms. Berkley, and I go back and forth about who has the most veterans, she obviously has a tremendous need and has for many years been an advocate for a full service hospital in her district. Finally it has been authorized, and the process is beginning.

The veteran population has changed tremendously over the years; therefore, VA has had to modify the way that they provide healthcare. I want to say "thank you" to the DoD for being willing to partner with VA to help solve the problem. Today, once people leave active duty and become veterans or retirees within the system, they are still able to gain the healthcare that they deserve as people who have served this country, through VA and DoD collaboration.

General, thank you for coming and for representing Eglin Air Force Base, Big Blue, and certainly the DoD. It is great to have somebody from northwest Florida here today. Thank you.

General EIDSAUNE. Thank you, sir.

Mr. MICHAUD. Ms. Brown.

Mr. Brown.

Ms. Berkley.

Ms. BERKLEY. Because of your experience, what would you recommend to me? What should I be doing? What can I do to be most effective to keep this on track in Las Vegas?

General EIDSAUNE. Well, what is really important is the working level relationships between the VA and the DoD hospital there, and to make sure that is vibrant and working very well, and they just have a way of working things out.

Ms. BERKLEY. Okay. I am not sure if I understand how that helps get my facility built.

General EIDSAUNE. Well, I am not familiar with where you are going to build it. Are you close to a DoD hospital?

Ms. BERKLEY. The Michael Callahan Hospital that services Nellis Air Force Base.

The reason that we are getting this VA facility is because it is just totally inadequate for the number of enlisted that we have at Nellis and the extraordinary number of veterans. That is why we are getting our own separate hospital.

Mr. MILLER. If the gentlelady would yield for a minute, I think part of the issue is, yours is a stand-alone VA facility, and we are talking about the joint facility. So there is a difference, but I think he is right. What I have learned is the more times you visit the site, talk to the contractor, remind people that you are there, and your staff is there all the time, that is a lot. What we are looking at now is a collaborative effort, not a stand-alone facility.

Ms. BERKLEY. I think, Mr. Miller, I will bring you to my district, and we can talk to them together. I will watch you in operation.

Mr. MILLER. Let's go. I am ready.

Ms. BERKLEY. Thank you.

Mr. MICHAUD. Mr. Salazar.

Mr. SALAZAR. Thank you, Mr. Chairman.

Major General, as you know, out in rural communities, we face a severe problem when we try to set up CBOCs. You know, sometimes the sufficiency ratio is not very good, and so sometimes there has been some talk in this Committee about partnering with private facilities, such as other hospitals, to help run these CBOCs.

Do you have any suggestions as to how we address the issue out in small rural communities where you are not close to a military base?

General EIDSAUNE. Well, in our own hospital at Eglin, we have some sharing relationships with private hospital facilities downtown, and if our workload is too high and we cannot see patients, we will send them downtown. We have worked that out. So I would suggest the same thing, maybe working with some of the smaller medical facilities out in the rural areas in terms of sharing arrangements like that.

Mr. SALAZAR. Doing, maybe, some type of a contracting arrangement?

General EIDSAUNE. Right.

Mr. SALAZAR. I do not know. I know that Mr. Miller has the same problem—I believe it is you—and also the Chairman. So we might look at something like that in the near future because I do believe that, you know, the VA set up a CBOC out in Craig, although it is not a full facility. People have to travel, or veterans have to travel over 5 hours to get to a VA hospital from that area, and so I would really encourage us to look at something like that.

I yield back.

Mr. MICHAUD. I concur, Mr. Salazar. We definitely will. In the rural areas we have our own unique problems, and I definitely look forward to working with you as we move forward.

If there are no other questions, once again, Major General, I want to thank you very much for your testimony and for coming here today and for your enlightening the Subcommittee on how well projects can move forward if you work together in a cooperative effort. So, once again, thank you very much, and thank you for your service to this great Nation of ours.

General EIDSAUNE. Thank you, Mr. Chairman.

Mr. MICHAUD. I would like to ask the second panel to come forward.

I will also ask Congresswoman Brown if she would introduce the second panel. Ms. Brown has been a very strong advocate, to put it mildly, in making sure that we had this hearing today. As well, she feels deeply about this issue, and I appreciate her passion and her willingness to move forward as we look at the VA construction process.

So, Ms. Brown.

Ms. BROWN OF FLORIDA. Once again, Mr. Chairman, thank you for holding this hearing.

I would like to introduce the panel and really thank them. Mr. William Wakefield is the Vice President of The Haskell Company, the division leader for healthcare in Jacksonville. He has been involved in developing medical facilities for over 30 years, and he is a board certified architect. Yesterday, he was in Atlanta. He, I guess, flew to Jacksonville and flew back up here to be with us.

So I want to thank you so very, very much, and make sure you thank Mr. Haskell, too.

Mr. Bucky Clarkson, Charles Clarkson, has been involved in the real estate industry for over 25 years as an investor, developer and manager. Mr. Clarkson has also associated in the past with the Ross Company, a large national developer. He received his initial real estate experience as a real estate negotiator for the Safeway Stores in the Washington, D.C. area. He is a graduate of Princeton University and of George Washington Law School, and most importantly, he has been a very personal friend of mine for over 25 years.

Thank you very much, also, for flying up here. I talked with him yesterday morning. He got on a plane and came up here to be here today.

So thank you all very much.

Mr. MICHAUD. Once again, thank you as well.

Mr. Wakefield, would you begin?

STATEMENTS OF WILLIAM WAKEFIELD, VICE PRESIDENT, HEALTHCARE DIVISION, THE HASKELL COMPANY, JACKSONVILLE, FL; AND CHARLES A. CLARKSON, FOUNDER AND CHAIRMAN, THE CLARKSON GROUP, L.L.C., JACKSONVILLE, FL

STATEMENT OF WILLIAM WAKEFIELD

Mr. WAKEFIELD. Yes. Thank you very much for having me today on short notice. I would like to make a few comments if I can about the——

Mr. MICHAUD. Is your microphone on? Press the button.

Mr. WAKEFIELD. Thank you very much.

Again, thank you very much for having me today. I am delighted to come to talk to you today.

My principal area of focus today will be on design-build as an alternative delivery model for your consideration. I am, again, Vice President for Healthcare Facilities at the Haskell Company. Haskell is a firm that provides design and construction services to a number of markets, including healthcare providers, principally in

a design-build delivery mode. What I would like to—and I have spent most of my career also, similarly, in the design-build delivery mode.

What I would like to comment on just before we get started into questions is I would like to particularly draw your attention to a Penn State University-published study that was done in 1997, an objective study that looked at a variety of delivery models for design and construction. It studied 351 projects, and their findings are very interesting in terms of the benefits that design-build can offer to clients.

As to the unit cost in terms of the actual cost of a facility, they found that, of the 351 projects that were studied, those delivered under the design-build delivery model were the lowest cost. They also represented the lowest cost growth, if you will, and that is the cost from the initial budget to the final construction cost of the completion and occupancy of the building. There were similar results for delivery speed in terms of the shortest period of time through design and construction and for the shortest or the least scheduled growth during the process.

Finally, of course, none of that would be of much benefit if you did not have similar results in terms of quality, and again, the Penn State study indicates that quality, as ranked by the owners of the various facilities, was highest for design-build delivery projects.

There are a number of other advantages to design-build and, obviously, a number of nuances in terms of a design-build delivery versus a design-bid-build or a construction management-type delivery.

I would be delighted to entertain your questions on those as we get into the discussion. Thank you very much for the opportunity to give opening comments.

[The prepared statement of Mr. Wakefield appears on p. 34.]

Mr. MICHAUD. Thank you very much, Mr. Wakefield.

Mr. Clarkson.

STATEMENT OF CHARLES A. CLARKSON

Mr. CLARKSON. Thank you, Mr. Chairman. Thank you, Congresswoman Brown and Members of the Subcommittee.

I am pleased to share the limited amount of knowledge that I have on an extremely important topic. I just have three brief comments as I have a slightly different view than my friend Mr. Wakefield and my dear friend Congresswoman Brown.

In my experience in development, design-build definitely applies when you have what I would simply call a cookie cutter opportunity, in my experience. Making sure—and this is not always the case in design-build. Making sure that you have complete plans before you break ground is critical in terms of managing time, costs and risks. However, clearly, the positive elements of design-build that lend itself toward the encouragement of standardization are very important points.

To the extent that products can be standardized, whether for hospitals or for any other type of product, the more you can standardize, the more you get the benefits of design-build, because the more you standardize, the more you will reduce time in design—

you will reduce some cost in the design cost itself, and you also will reduce overall risk.

So, as a developer, I have chosen the alternative, mainly because our projects are high-barrier-to-entry opportunities where we have to squeeze them into downtown Savannah or into downtown Tampa or somewhere like that.

Clearly, any project that has some previously established standardized approach will really get the benefits of streamlining and cost reduction and risk management.

Thank you.

[The prepared statement of Mr. Clarkson appears on p. 39.]

Mr. MICHAUD. Thank you very much, Mr. Clarkson.

I have a couple of questions for both of you.

What difference do you see between the private development process and the VA development process? What lessons about development and construction do you feel the VA could learn from the private sector to make construction more efficient and cost-effective?

Mr. Wakefield, do you want to start off with that?

Mr. WAKEFIELD. Yes, I would be happy to. Thank you.

I do think that Mr. Clarkson's comments are valid with respect to the ability to control cost and schedule, to a large extent, through somewhat of a standardization in terms of design. Many of our clients, private-sector clients, do have standard designs for patient rooms and for other types of patient-care areas. From our perspective, of course, each is different, and therefore, each is unique.

So for a design-build firm, we deliver with a variety of design concepts, but from our owner's standpoint, the provider's standpoint, somewhat of a standardization on design is an important aspect. I do believe that the VA can benefit somewhat from that standardization. That is not to imply that a certain facility will not provide the service or the quality of service that one would wish, but to the degree that you can replicate patient rooms, for example, in inpatient facilities, the process becomes much easier, much more streamlined, and it can be more predictable in terms of time and in terms of cost.

Mr. CLARKSON. I just thought—I have not done any public projects, but I would expect an empowered decisionmaker in the private sector would be a critical difference. The public sector is not my area.

You could streamline the decision-making process and have an empowered decisionmaker to drive the project forward. There are probably a lot of things going on in the public sector. Whereas, in the private sector, we cannot afford it. Somebody has got to get it done.

Mr. MICHAUD. Great. Thank you very much.

Mr. Miller.

Mr. MILLER. I pass, and will yield my time to Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you very much.

Let me just ask; there is another problem, it seems.

Recently, I visited the Gainesville facility, and it is on-line. We have the authorization and the funding, but there is going to be a hospital built right next-door, and that hospital will probably come

up—you know, and this is private—like 2 years before our VA facility is going to come up. In that facility, you have five patients in a room, and they do not have a bathroom. Now, that does not make any sense. There has to be a way—like I said earlier, Orlando, 25 years.

How can we streamline the process? Should we think about a one-stop process? Because part of it is permits and those kinds of things, and they are all our agencies. Why can't we have kind of a one-stop facility so that you can get everybody in a room with these high-priority projects and work through the permitting process or something like that?

Mr. CLARKSON. Without knowing that project particularly, it just sounds like maybe nobody is in charge, really. Again, my gut would tell me to go back to the empowered decisionmaker who is breaking the logjam. I know there is bureaucracy at every level of industry. In any place where you have more than 300 people involved, there is a bureaucracy, and the only way you can get through it is to have an empowered decisionmaker.

Ms. BROWN OF FLORIDA. So you are suggesting something like an ombudsman——

Mr. CLARKSON. It could be. It could be.

Ms. BROWN OF FLORIDA. [continuing.] Or a building czar or something?

Mr. CLARKSON. Right. It is going to make somebody unhappy, but that happens in the private sector where the contractor is not happy or the architect is not happy, but "this is what we are going to do." That is my gut. I would suspect that nobody is in charge, so they are waiting for somebody else to tell them to do something.

Ms. BROWN OF FLORIDA. Mr. Wakefield.

Mr. WAKEFIELD. Yes. I do think that the team that is selected to implement the project can have an impact on that. Certainly, again, I believe that in a design-build arrangement, where you do have a single source that is in charge at least from the delivery side, it is an important aspect but it is not the only aspect.

We recently completed a hospital, a 100-bed hospital, in the Tulsa area for the St. John Health System 16 months from conceptual design to occupancy. So I think that the delivery speed and the cost control, and so forth, are available through an integrated design-build process, but I would reflect the comments that were made here, that the decision-making process and the permitting processes are probably the largest variables in terms of a schedule for completing a new hospital.

Ms. BROWN OF FLORIDA. So you were able to complete this hospital in 16 months.

Mr. WAKEFIELD. From beginning conceptual design to occupancy in 16 months, yes, ma'am.

Ms. BROWN OF FLORIDA. What do you think are some of the contributing factors?

Mr. WAKEFIELD. Well, I think some of the contributing factors are the streamline design—or the decision-making process on the owner's part. This is the first new, free-standing hospital that St. John Health Systems has built, but nonetheless, they organized themselves in a very efficient, committee-like organization to manage the overall process. So from our perspective, the things that

slow us down is indecision about design issues, indecision about, you know, how patient floors will be organized, and so forth.

While, again, St. John does have some standards for the design process, any new hospital is going to have a lot of custom questions and decisions to be made, St. John organized themselves very efficiently in terms of providing that guidance to us that enabled us to deliver on such a schedule.

Ms. BROWN OF FLORIDA. Mr. Chairman.

Mr. MICHAUD. Thank you very much, Ms. Brown.

Mr. Salazar.

Mr. SALAZAR. Thank you, Mr. Chairman.

I am not quite clear on the difference between design-build and whatever. Could you just explain it to a layman farmer?

Mr. WAKEFIELD. Yes, I would be happy to.

In what is often referred to as the "traditional process," an owner will hire an architect under a contract where that architect will provide design and engineering services. Once the architect's design is complete, the project would be put out for bid to contractors. Contractors would then bid on the project, and you know, the lowest qualified contractor's bid would be accepted, and that contractor would be hired also by the owner under a separate contract with the construction firm then. So the owner holds two contracts. They hold an architectural agreement with the architect, and they hold a construction agreement with the construction company.

In the design-build setting, the architect and the contractor are one in the same; they are the same entity, and the owner holds a single contract with that design-build firm.

The differences are that, in the traditional setting the owner is placed in a position of mediating, if you will, reconciling differences. When there are errors in design documents, the contractor is going to come back and look for extras as a result of that, and so forth, and that is part of the reason—and because the team is not as closely coordinated, that is part of the reason why that process does not necessarily result in as fast or as cost-effective a delivery.

In the design-build setting, under a single contract, there is a single point of accountability, so the design-builder is responsible for not only the close coordination of their work, but they are also responsible for the quality of the documents, the completeness of the documents, and so forth. So, if there were an error in the design documents, for example, that would result in additional construction costs to remedy, it would be the design-builder's responsibility, not the owner's responsibility.

Again, because it is one integrated party, they can coordinate their work much better. We can order materials. Critical lead item materials we can order before the design is completed, for example, and there are a number of techniques like that we can take advantage of as an integrated firm to increase the delivery speed.

Mr. CLARKSON. Let me just add to that.

The enemy of managing construction costs is the change order. In a very specialized project, when the contractor and the architect—the architect has had to run off sophisticated designs. Often, the contractor—certainly not the Haskell firm—looks for his profit opportunity within the change order where the architect did not

quite get it right, and he has got to make some changes. Then the contractor comes in and makes a nice adjustment in the cost.

So, to the extent that the project is more specialized and less cookie cutter, there is more risk for change orders, and therefore more risk for delays, cost controls and people yelling at one another. It also comes back to the importance of making sure those plans are not 90 percent, not 95 percent but, hopefully, 100 percent, but even with those that are 100 percent, there are still going to be some issues in terms of execution by the contractor and what the plans actually said.

So the more complicated the project, the greater the risk is. So when you have tension between the architect and the contractor, they are sort of balancing one another. Whereas, if it is a single point and the architect screwed up, it will get buried—certainly not with this firm—but the project will get built anyway, and that is the way to manage the best bottom line for the contractor.

So there is in my testimony a little bit of reference to the fox guarding the hen house. As to the architect's working for the contractor, is the quality of the resolution of that issue going to be the best resolution or is it going to be the best resolution for the contractor? So that is the advantage of the traditional.

To the extent that you standardize and you reduce the potential for confusion between the design and the execution, you are really then taking advantage of the design-build approach. So that is why I am saying it is cookie cutter. But if it is not cookie cutter, increasing standardization will reduce time issues, cost issues and risk issues. The more chance you have for a disagreement between the contractor and the design, the more you have change orders, the more you have delays, et cetera, et cetera.

There are contractors that will bid at cost, knowing they are going to make money on change orders, but again that applies to the very customized project, not a more standardized project.

As Congressman Miller and the previous witness were talking about working with the DoD and the VA, the potential for standardization between those two agencies could be huge, which again could spread the savings and risk across a much bigger area.

Mr. MICHAUD. Ms. Brown, do you have any more?

Ms. BROWN OF FLORIDA. I do have some follow-up.

If you all could just kind of walk us through the process, one of my questions is:

A lot of times, it is the lowest possible bid. We start out with that. In design-build, maybe the best thing to do is to have prequalifying first so that you go through the process, you evaluate the participants, and then after the prequalifying you select a firm. Maybe the lowest possible bid is not the best thing. Maybe qualifications and experiences have to be included in the building process.

We are getting ready to fund the largest VA budget in the history of the United States. We have a lot of projects that have been shelved, but part of the pressure that I am feeling is the veterans are saying, you know, "What are you all doing?" "Why do we have to wait so long?" I am with them. So I am trying to find out from you what some of the best ways are that we can alleviate this problem.

Mr. WAKEFIELD. The second part of my submitted testimony addresses the procurement process, and I chose to treat the delivery system as a design-build versus traditional, separate from the procurement process, because any number of procurement processes can be followed for either delivery model, and design-build is quite often selected on a qualifications-based procurement process because, again, the design-build contractor or the design-build builder is selected before final plans are done, of course, before the design is started, so the final cost is not necessarily known at the time that the design-build firm is engaged.

So, oftentimes, a process will follow a qualifications-based selection process, which is very similar to the way an architect would be hired. So you prequalify a few number of firms that you know are experienced in the field and that have the resources to deliver and that have a proven track record, and so forth. Then you look for their qualifications; also, establish what their costs will be in terms of fees, in terms of general conditions, overhead costs, and so forth, so that you know that—and design fees so you know that the fees that are controlled by the design-builder are competitive, and you can look at those across each of the design-build firms. Then as the design evolves, additional input is provided from subcontractors for the cost of the masonry work, for the cost of the mechanical system, and so forth, and those are usually taken on a competitive basis. So, again, you know that you have a competitive price for each of the relative components.

So it enables one to take advantage of a design-build delivery system while being assured that you are getting the best value for your dollar. This is a system that is followed, incidentally, especially by the State of Florida now in terms of the procurement of a number of their projects, and they similarly realize the benefits.

Mr. CLARKSON. That idea makes sense, a lot of sense, particularly if that firm has previously built a VA hospital and you know exactly what they have done. Standardization.

Ms. BROWN OF FLORIDA. Thank you very much.

Mr. MICHAUD. Once again, I would like to thank you, Mr. Clarkson and Mr. Wakefield, for your testimony this morning. I look forward to working with you, and——

Ms. BROWN OF FLORIDA. One other thing. They did not have an opportunity to put their written statements into the record. So will they have adequate time to do that?

Mr. MICHAUD. Without objection, they will be included in the record.

Ms. BROWN OF FLORIDA. Thank you.

Mr. MICHAUD. Thank you.

Now I would like to call up panel three, Christopher Needham, who represents the Veterans of Foreign Wars (VFW), as well as Shannon Middleton, who is the Deputy Director for the American Legion.

We will start off with Mr. Needham.

STATEMENTS OF CHRISTOPHER NEEDHAM, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND SHANNON L. MIDDLETON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION

STATEMENT OF CHRISTOPHER NEEDHAM

Mr. NEEDHAM. Mr. Chairman and Members of the Subcommittee, on behalf of the 2.3 million men and women of the Veterans of Foreign Wars, I am pleased to be before you today and to be presenting testimony on the VA construction budget.

For the better part of a decade, the construction process has been dominated by CARES, the Capital Asset Realignment for Enhanced Services. CARES was a systematic, data-driven methodology of assessing the VA's present/future healthcare needs based upon changing veterans demographic data.

While the review was underway, we had strong concerns about the lack of funding for VA construction projects. There was a demonstrated need for construction even while the process was ongoing. The House agreed with this when they approved the Veterans' Hospital Emergency Repair Act. Despite this obvious need, little funding was actually appropriated, with CARES being used as the excuse.

Upon completion of the CARES review, former VA Secretary Anthony Principi testified before this very Subcommittee in July 2004 that CARES would require $1 billion of funding each year for the next 5 years. Since then, funding has not kept pace. In fiscal year 2006, it was about $600 million. In fiscal year 2007, it was around $400 million for major construction. We sit here today, 1 month into the current fiscal year, without a budget. We are certainly very appreciative of the money the House has appropriated or has chosen to appropriate in their version of the budget, but until that money is actually allocated, nothing can be done. All of the construction projects the VA currently has cannot move forward. It simply needs on-time funding.

The need for increased funding is self-evident. The VA's facilities are very old, with an average age of over 50 years. The VA has always recapitalized at a rate well below industry standards. From 1996 to 2001, for example, the average construction budget, including major and minor construction, was $246 million. This corresponds with a 0.64 percent recapitalization rate. Basically, this means that the VA was funded on a level that would have required its hospitals to stand for 155 years.

In 1998, PricewaterhouseCoopers studied the VA's facility management programs and recommended a recapitalization rate of 4–8 percent per year, bringing them in line with the private sector. If applied to VA, this would correspond with the total major and minor construction budget of at least $1.6 billion per year, far above what the VA has historically received.

Another major issue with VA's facilities is not directly included in the medical construction account but is just as important, and that is nonrecurring maintenance, or NRM. Although not a VA facility, the deplorable conditions at Walter Reed were an example of

what could happen without proper maintenance, and it is certainly something that none of us wants to see happen at the VA.

After the news of Walter Reed broke, the VA conducted an immediate review of its facilities to identify potential NRM projects. Although the majority were cosmetic, there were a number of them that were more serious. One facility found suicide threats and problems with fixtures in a mental health unit. Another had problems with smoke barriers and fire alarms.

While we are certainly appreciative of the VA's efforts to identify these problems and with Congress' efforts to increase NRM funding in the emergency appropriations bill, it should not have come to this. These problems should have been cared for before.

Industry standards in that same PricewaterhouseCoopers review cite the need for NRM funding at 2–4 percent of the VA's plant replacement value. Further, the VA's own documents cite that same figure. Their asset management plan recommends an NRM funding level of between $800 million and $1.6 billion per year. Yet, over the previous 2 fiscal years, not including that emergency funding, only about $1 billion in total was actually appropriated. Future funding requests must be large enough so that these problems are taken care of before they develop, and if left unchecked, NRM can cause minor construction projects to cost much more money, and they can inconvenience veterans.

Providing a safe, clean and modern healthcare environment is critical to the overall delivery of care. Congress and the administration must provide the VA with all of the funding it needs to address these maintenance shortcomings but also to fully fund all current and future construction priorities. We must be proactive in our approach to do what is right for this Nation's veterans.

Mr. Chairman, thank you for the opportunity to testify. I would be happy to answer any questions you or the Members of the Subcommittee may have.

[The prepared statement of Mr. Needham appears on p. 40.]

Mr. MICHAUD. Thank you.

Ms. Middleton.

STATEMENT OF SHANNON L. MIDDLETON

Ms. MIDDLETON. Mr. Chairman and Members of the Subcommittee, thank you for allowing the American Legion to present its views on the Department of Veterans Affairs construction process.

With the rapid advancement in technology and medicine that the national healthcare system is experiencing, VA will be compelled to perpetuate the evolution of its healthcare delivery system far into the future. An important part of this evolution is ensuring that VA has adequate facilities that are safe and located in needed areas to make access to its healthcare facilities readily available for veterans.

The healthcare facilities of VA are aging: physical plants in need of replacement; substantial renovations and improvements related to fires, safety and privacy standards; as well as modernization and reconfiguration to meet the demands of the advances in medicine. The increasing demands placed on the outpatient ambulatory care service facilities of VA require substantial alterations to meet

changing space requirements. No healthcare delivery system can be expected to provide quality care if the physical setting that houses the care is allowed to deteriorate to a state which places it beyond redemption.

In March 1999, GAO published a report on VA's need to improve capital asset planning and budgeting. The report found that VA's asset plan indicated that billions of dollars would be used operating hundreds of unneeded buildings over the next 5 years or more. The report went on to state that VA did not systematically evaluate veterans' needs or asset needs on a geographic basis or compared asset life cycle costs and alternatives to identify how veterans' needs could be met at a lower cost.

VA developed a Capital Asset Realignment for Enhanced Services program, or CARES, to address the issue. The CARES decision of 2004 contained hundreds of construction requests, upgrades and alterations of current buildings that would require a substantial increase in funding for major and minor construction within VA.

During the initial stages of the CARES process, the construction budget was nearly flatlined, pending the outcome; this caused a major backup in construction projects and needed seismic repairs. Major and minor construction appropriations for VA have been consistently targeted for reduction since such funding is regrettably the most vulnerable to annual assault. For several years VA's facility directors have been forced to use nonrecurring maintenance funds to provide care.

The American Legion urges Congress to annually appropriate sufficient funds for the VA's construction program to ensure the continued provisions of quality healthcare to our Nation's veterans and the implementation of the CARES decision.

VA has a vast physical plant inventory that represents a major investment of taxpayer dollars. Despite the large number of aging facilities, construction funding has been limited. CARES construction is estimated at $6.1 billion over the next 6 years.

Sufficient funding to implement new initiatives and the proposed physical plant changes will be critical to the success of the planning initiatives. Delays in the process have a profound impact on access to healthcare for veterans.

Veterans serving in Iraq and Afghanistan have returned home with severely debilitating injuries. VA must be available to help them heal and rehabilitate, be capable of providing programs and services needed to help them live the most productive and healthy lives possible and be able to accommodate the needs of an ever-changing population of veterans. To do this, adequate funding is a must.

The American Legion believes that VA has effectively shepherded the CARES process to its current state by developing the blueprint for the delivery of VA healthcare. It is now time for Congress to do the same and adequately fund the implementation of this comprehensive and crucial undertaking.

Thank you, Mr. Chairman, again. We look forward to working with the Subcommittee to help shape the future of VA's healthcare delivery.

[The prepared statement of Ms. Middleton appears on p. 42.]

Mr. MICHAUD. I would like to thank both of you for your testimony. Just a couple of quick questions.

The CARES process, both your organizations have been very involved in that particular process. It took a lot of time and effort to come up with that final report, and I appreciate that. Since then, things have changed somewhat when you look at the war in Iraq and Afghanistan and the needs might not be there; as explained in the CARES report, they might have changed.

Do you think we ought not to start over again, but reassess the CARES process and update it before we go further with major construction? That is my first question.

Then my second question, to try to speed up the process we can put up more Federal dollars, but do you think there is an opportunity here to work with a private sector, such as, hospitals and healthcare clinics in the rural areas to help collaborate and try to get more of the facilities up in the rural areas in a timely manner by utilizing or working with the private sector?

So I will start off with Mr. Needham.

Mr. NEEDHAM. As to the first question about whether to update CARES, I mean, certainly—the war has certainly changed things. But we sort of view CARES as—one of the strengths of that was not that it was a one-time snapshot, but that it really is, in many ways, sort of a living document. They use the framework and the methodology from that to produce that annual 5-year plan from which the construction priorities are drawn.

To that end, certainly, they probably do need to pay more attention to, particularly, the mental health issue, those sorts of needs. But it is not a case of doing it over, but just sort of revising and updating.

As to the second question, in terms of collaboration, that is certainly something we are highly supportive of, particularly, I know, the challenges faced in rural healthcare. The catch is—and I think we have seen with many other facilities, collaboration sometimes introduces a problem with timeliness of construction—that the more parties that get involved, the more difficult and more drawn out the construction process can be. Not that that should keep us from doing collaboration, but that is something to keep in mind, particularly some of the concerns expressed earlier today.

Ms. MIDDLETON. I don't think I can say it better than that, but I will try to give some input.

As far as redoing CARES, I think that would just take way too much time. Reassessing changing needs, that is always important. So definitely it should be just reevaluated, just to make sure that the changing needs of the returning Operation Iraqi Freedom/Operation Enduring Freedom veterans are being addressed. That part is definitely a must because if not then, on down the road the same thing might have to happen. You might have to do the whole thing over just to make sure that these veterans are being taken care of the way that they should be.

And as far as working with the private sector to improve access to care for rural veterans, the American Legion believes that in the case of rural veterans it might be necessary to have contracting with the private sector that is more local if there is a VA medical facility too far away that the veteran can't get to.

So, yes, we would definitely be supportive of something like that.

Mr. MICHAUD. Thank you both.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

This question would go to both of you in talking about CARES, both of you referenced VA's aging infrastructure.

Give me your thought process on the need to continue to maintain some of those aging facilities versus construction of new facilities in better locations. Better locations meaning closer to the veterans, the centers of the veteran population. One of the things, we heard during the hearings that were held on CARES, a lot of people were in favor of maintaining the status quo, keeping the exact same number of buildings that were already in existence. I am wondering if that is smart, keeping the status quo, given the competition for dollars. Would your organizations support new construction over the maintenance issues that we have on existing structures today?

Mr. NEEDHAM. That is a good question. It is definitely a tough balance there. I am not sure that we have a position one way or another, other than just following the priorities has VA has laid out in terms of their five-year capital plan.

Mr. MILLER. If I could, because CARES recommended some facilities be closed, what were the positions of your organizations generally? Did you subscribe to closing some facilities?

Mr. NEEDHAM. The position we had was that we were generally supportive of CARES as long as the ultimate outcome was—the emphases on the ES portion of CARES' enhanced services, that ultimately, if veterans are having their healthcare needs and their facilities taken care of in the end, then we were supportive of the process.

Ms. MIDDLETON. I am not exactly sure how we felt about closing certain facilities, so I would definitely have to submit a response for the record in writing to that part of the question. But I would think that if the facility posed a health hazard, if there were certain structures that couldn't be repaired because there was some kind of safety issue, I would think that we would be in support of closing something like that.

As far as, would we prefer maintaining the existing facilities or constructing new ones, I think that would have to be on a case-by-case basis. If you are in an area where the veteran population is definitely growing, then the demand for healthcare would definitely grow with it. And if there is not a facility around or just a distance away, I would think that it would make sense to bring the care closer to the veteran.

Mr. NEEDHAM. If I may, one more point to that. Because of the aging infrastructure, the majority of—I don't want to say majority, but many of VA's facilities—the hospitals; they refer to them as a Bradley-type building, and it is basically the infrastructure of the older healthcare facilities, is not compatible with sort of modern healthcare delivery.

So it is not just simply a matter of being able to renovate some of these older facilities. In many cases, it really is an example where you do have to provide new construction.

Mr. MILLER. Ms. Middleton, reversing your theory, if you have a growing population, then you need to move the healthcare to where that population is, would you subscribe to the same theory if you have a declining veteran population, there may be a need to relocate or move facilities in order to better serve the greater number of veterans?

If you don't want to take that in an open hearing, I would like to know the position of both of your organizations on the CARES report in relationship to downsizing or closing facilities that were recommended. Again, everybody wants to battle for the facility that is in their district, everybody wants to make sure that we have as much available healthcare as possible. I think this Congress, and when I say "this Congress," I don't mean the 110th, the 109th; I am talking about Members that are here representing their districts. We want to provide the greatest access to healthcare possible, and in some instances that is going to be relocating facilities where some veterans are used to getting their healthcare to a newer facility to provide it. Not in all instances, but in some.

If you would, for the record, I would like to see what your positions were.

Thank you Mr. Chairman. I yield back.

[The information was provided in the answer to Question 2 in the post-hearing questions and responses for the record from the VFW and the American Legion, which appears on p. 47 and p. 49.]

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. Thank you for holding this hearing. I don't have any questions now. I'm sorry I was late getting here.

Mr. MICHAUD. Mr. Brown.

Once again, I would like to thank this panel very much.

Mr. MILLER. May I ask one question quickly?

Also, for the record, what are the positions of your organizations on VA's decision in regards to the site of the New Orleans facility? VA has made the decision to keep the facility downtown versus possibly locating it a couple of miles away. Obviously, the facility was not in the CARES process, but New Orleans has a declining veteran population with a huge medical center. There are growing populations in other parts of the Gulf Coast; therefore, I would like to get your position on the New Orleans facility as well.

[The information was provided in the answer to Question 1 in the post-hearing questions and responses for the record from the VFW and the American Legion, which appears on p. 47 and p. 49.]

Mr. MICHAUD. Once again, thank you very much. I appreciate it.

Our last panel is Donald Orndoff, who is the Director of the Office of Construction Facilities Management with the Department of Veterans Affairs; he is accompanied by Robert Neary, who is the Director of the Service Delivery Office, Office of Construction and Facilities Management; Patricia Vandenberg, who is the Assistant Deputy Under Secretary for Health for Policy and Planning; and Brandi Fate, who is the Acting Director of Capital Asset Management Planning Service in the Department of Veterans Affairs.

Mr. MICHAUD. So I would like to thank the fourth panel, and without any further ado, I will start off with Mr. Orndoff.

STATEMENT OF DONALD H. ORNDOFF, DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, ACCOMPANIED BY ROBERT NEARY, DIRECTOR, SERVICE DELIVERY OFFICE, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; PATRICIA VANDENBERG, MHA, BSN, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND BRANDI FATE, DIRECTOR, CAPITAL ASSET MANAGEMENT PLANNING SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. ORNDOFF. Mr. Chairman and Members of the Subcommittee, I am pleased to appear here today to discuss VA's healthcare construction program and, specifically, the processes we use to plan, design and construct state-of-the-art healthcare facilities. I will provide a brief oral statement and request that my full statement be included in the record.

Mr. MICHAUD. Without objection.

Mr. ORNDOFF. As Director, Office of Construction and Facilities Management, I am responsible for the execution of the VA's major construction program. Joining me today are Ms. Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning, Mr. Robert L. Neary, Jr., Director, Service Delivery Office, Office of Construction and Facilities Management, and Ms. Brandi Fate, Director, Capital Asset Management and Planning Service of Veterans Health Administration (VHA).

The Department is currently engaged in the largest building program since the immediate post-World War II period. This program represents implementation of the Capital Asset Realignment for Enhanced Services, or CARES, program, which was initiated systemwide in 2002 and produced initial results announced in May 2004. At that time, 30 major construction projects were approved and funded in whole or part.

In subsequent fiscal years, six additional projects have been submitted for funding and budget requests. The total cost of these projects approaches $5 billion. $2.83 billion, including hurricane supplemental funding, has been appropriated between fiscal year 2004 and 2007. The fiscal year 2008 budget now before the Congress requests an additional $560 million in major construction for infrastructure improvement to the veterans healthcare system.

The minor construction program is also an important part of addressing infrastructure needs of the healthcare system identified by CARES. Since fiscal year 2004, $1.08 billion has been appropriated, including hurricane supplemental funding. An additional $180 million is requested in the fiscal year 2008 budget.

VA continues to use a disciplined multi-attribute decision model to prioritize capital investment needs for budget development. Once a project is approved, the design process begins. The design consists of three phases: schematic design, design development and construction document preparation.

While the timing varies with the size and the complexity of the project, typically design takes 18 months. Once design is complete, the construction contract is executed and on-site work begins.

The Department uses standard industry practices in the design and construction of VA facilities. VA selects highly qualified architect-engineer firms with practices that focus primarily on healthcare facilities.

VA selects highly qualified construction contractors using a combination of quality assessment and price. Contractors are evaluated based on experience and past performance in construction on similar healthcare facilities. Approximately one-third of VA projects are executed using the design-build method where we award one contract to a designer-constructor team. We also engage highly capable construction management firms on VA's largest projects.

VA benefits from its reliance on the private sector architects, engineers and contractors. Selection of top firms delivers the highest quality healthcare design and construction.

VA's construction program is not without challenges. Since 2004, the rising cost of construction has had significant impact on all government and private sector organizations with construction requirements. Due to a robust economy, the demand for skilled labor and building materials continues to outpace the supply. Coupled with rising fuel prices and the impact of recent hurricanes, building programs of all types have experienced significant cost growth.

Another related challenge is attracting adequate competition for major VA projects. The large volume of construction in many markets makes it difficult to attract healthy competition to achieve best pricing. During the last 18 months, we have often seen a limited number of proposals on VA solicitations.

VA is taking a number of steps to minimize the impact to these challenges. We regularly conduct market surveys in the cities where we have upcoming work to better predict cost. We now project our future cost based on a better understanding of construction capacity and activity within individual markets. We are working closely with the contracting community to attract greater interest in performing VA work.

In closing, I would like to thank the Subcommittee for its continued support for improving the Department's physical infrastructure needs.

Mr. Chairman, my colleagues and I stand ready to answer your questions.

[The prepared statement of Mr. Orndoff appears on p. 44.]

Mr. MICHAUD. Thank you very much. I appreciate your testimony.

And we just got called for votes, and we will have three votes, so it might take about 45 minutes. I have several questions; however, I will submit them for the record, if you would kindly answer them. So you are saved by the bell, as far as I am concerned.

[The post-hearing questions and responses for the record from VA appear on p. 50.]

Mr. MICHAUD. Mr. Miller.

Mr. MILLER. I would like an update on the New Orleans project, where it is?

Mr. NEARY. As you mentioned to the previous panel, we have selected a preferred site in a downtown area of the city. But we have not completed the environmental review work, so we are currently

performing the environmental assessment of that site, as well as a site at the Oschner facility a few miles to the west.

We expect the environmental review will be completed during the month of December, and shortly after the first of the year, the Secretary would be in a position to make a final decision on the site.

We have selected the architectural team that will design the building. We are working with them now to put them under contract. And we are also continuing discussions with Louisiana State University (LSU) regarding opportunities for partnering with LSU and Tulane as we execute and go forward.

Mr. MILLER. Do you have an idea of the issue as it relates to the downtown site? I am glad to hear that there is an environmental study being done on both sites, that we are still tracking this process, because we don't need any more delays in getting a facility built.

I think when we did the field hearing down there, they were exasperated to learn that it was still 5 years out or longer before the doors would actually open once the process began. So, when do you expect a final decision from the Secretary on the site?

Mr. NEARY. Shortly after the first of the year.

Mr. MILLER. I also have some other questions for the record, but I will submit them as well. Thank you very much.

[No questions were submitted.]

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman. I would just like to hear from your sidekicks there, Mr. Orndoff, what do each of them do and how do they relate to each other?

Then you have this other group, the Capital Investment Panel. Could we kind of go down the line? How do you all—you all have four different titles, really. How do you all interrelate to make this process smooth?

Ms. VANDENBERG. In the Office of Policy and Planning. I am responsible for CARES. And so that entails the successful completion of the 18 business studies that were indicated in the 2004 decision document from the Secretary and integrating the methodology that we used in CARES into the ongoing strategic planning process.

Ms. FATE. We then take those strategic planning documents from the medical centers and the VISNs, and identify with the medical centers where there are gaps in our infrastructure and where new needs for infrastructure and/or renovations are needed throughout the country; and then those projects and admissions are sent through my office up through VHA. Then the larger ones for the major construction projects get scored by the Capital Investment Panel, which you just referred to.

Our offices are members of that panel, as well as some other administrations and offices; and we score all of those based on weights and criteria.

Mr. SNYDER. And then those plans go over to you all?

Mr. ORNDOFF. Yes, sir. Basically, the output of the Capital Investment Panel, the decision on which projects are moving forward for budgeting purposes, at that point, the Office of Construction and Facilities Management—of which I am the Director and Bob heads up our Service Delivery operations—we will take that and

begin the design process and, ultimately, the construction process and delivery of the project.

Mr. SNYDER. And then where does the Office of Management and Budget (OMB) get involved?

Mr. ORNDOFF. As we develop our budget as an output of the CIP, Capital Investment Panel, those projects, once approved by the Secretary, will be laid into the project and submitted; and then OMB would review at that point.

Mr. SNYDER. So it may or may not get the funding.

Ms. Fate, how is it that you are the Acting Director?

Ms. FATE. My predecessor retired back in January. And now about a month ago, I was officially appointed the Director of the CAMPS office.

Mr. SNYDER. So you are no longer the Acting Director?

Ms. FATE. No longer the Acting.

Mr. SNYDER. Well, we have out-of-date information here.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Well, I guess, following Dr. Snyder's questioning—I represent Charleston, South Carolina, and we have been working on a "Charleston model," they call it now, which we thought was going to be used down in New Orleans and maybe some other parts of—Orlando and then in some of the other parts of the United States. But we seem to have some kind of a bottleneck, and I am not so sure exactly where we are in the process.

I know it was identified in CARES that we would develop this model, and we have been working on that with the VISN Director and, I guess, with the Secretary too. But—we have some funding, I guess about $38 million we put in the authorization last year, but we have a problem with the administration, and I assume maybe you folks or somebody along the line, that they don't want to advance the project.

And I think you might have heard my opening statement where we actually now have designed and built the Medical University Hospital, that has already been completed, and it is adjacent to the VA hospital, within probably 100 feet. But we can't get a movement on the old VA hospital, which is over 40 years old. I guess through the process, the way the planning and all the development works, it is going to be 50 years old before we finally get to that point.

But we are in a sinkhole, just like the hospital that is in New Orleans. And we are certainly in a storm-prone region.

I am just wondering why that project is not moving. Maybe you all can give me a little address.

Mr. NEARY. Mr. Brown, as you know, we have been evaluating the needs in Charleston. And recently our Under Secretary for Health visited the Charleston facility. We are continuing to look for ways to further the partnership with the Medical University of South Carolina and see where that takes us as we move forward.

Mr. BROWN OF SOUTH CAROLINA. I just mentioned, they have already built their hospital and they have two or three other phases to go. But once all of that has been designed and carried out, it is going to be difficult to combine those resources.

I know that we got ourselves in a box down in New Orleans where we had Katrina damage. I don't want us to have the same operation down in Charleston where it is going to be maybe 3 or 4 or 5 years before those veterans now can recover, because nobody is thinking forward. And I just feel like it is a real opportunity to become proactive and try to address some of the emergency needs before they become emergencies.

The storms are going to come. We have just been blessed in Charleston. I guess Hugo was the last, back in 1989. But we know that we are vulnerable to those storms. And it looks like, to me, with a window of opportunity with the construction going on at Medical University, the VA would sense that they could be proactive in trying to address storm problems in the future by addressing them today.

And I am just kind of amazed that nobody is wanting to become proactive in that situation, particularly since we have just experienced the problem we have down in New Orleans.

Mr. NEARY. With respect to the possibility of storms, we have completed a study of the Charleston facility and identified steps that would need to be taken to further protect the facility. And it is my understanding that the medical center, the Charleston VA Medical Center, is identifying opportunities to implement some of those strategies.

We certainly have an excellent partnership with the Medical University of South Carolina now and will continue to look to foster the further development of that. And we certainly would agree with you, we wouldn't want to take steps that would cause us problems down the road in terms of meeting our future goals there.

Mr. BROWN OF SOUTH CAROLINA. I understand, Mr. Chairman, my time is gone and we need to go vote. Thank you very much for your understanding.

Mr. MICHAUD. If there are no further questions, I want to thank this panel for your testimony. And we will be submitting additional questions for the panel in writing.

So, once again, thank you very much. This hearing is closed.

[Whereupon, at 11:30 a.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee On Health

I would like to thank the members of the Subcommittee, our witnesses and all those in the audience for being here today.

The purpose of this hearing is to learn more about the construction process within the Department of Veterans Affairs (VA).

In 2004, VA completed the Capitol Asset Realignment for Enhanced Services (CARES) process. CARES was supposed to be a map for future VA facilities development.

It is unclear to me how closely VA is following this map, and it is also unclear how well CARES will address the medical and demographic needs of current and future veterans of Afghanistan and Iraq.

This Subcommittee is committed to providing the highest quality healthcare to our Nation's veterans—and we understand that a key part of this care is the facilities in which it is provided.

We are here today to get a better understanding of the entire construction process, from conception to the opening of a facility.

Understanding this process is particularly important right now. Many of the VA hospitals and medical facilities are aging and are in need of major renovation or replacement. Many VA facilities need to be upgraded in order to meet standards for Earthquakes, fires and patient privacy.

Population shifts require new facilities in new locations. VA is in the process of planning several new hospitals in cities such as Las Vegas, Denver and New Orleans.

This process can be long and drawn out. It can take much longer than similar projects built in the private sector.

We look forward to working with the VA to ensure that our veterans receive the best possible care in medical facilities that are modern and safe—while being built efficiently and cost-effectively.

I look forward to hearing about the current construction process, VA's plans and needs for future construction, and how this Committee can support this effort—with the end goal always being to provide the best possible healthcare to our veterans.

I now recognize Mr. Miller for any opening statement that he may have.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman. Access to different types of outpatient and inpatient facilities is critical in addressing the unique healthcare needs of our changing veteran population. However, most of VA's infrastructure was built more than 50 years ago. Many of these aging facilities are not well suited to 21st century healthcare, in need of repair or replacement, and sometimes simply located far from where the veterans live.

Recognizing the need to improve and update VA's patient care facilities, and address identified gaps in services, VA established the Capital Asset Realignment for Enhanced Services (CARES) process. The CARES planning model was intended to provide a blueprint for the resources needed to meet the future veteran demand for healthcare services. VA has started implementing some CARES decisions and is moving to open more than 32 of the 156 outpatient care clinics identified by CARES. Still, there are far too many instances of veterans driving several hours for primary care, and even more instances of long commutes for acute inpatient care.

VA must maintain a flexible approach to its current and future construction. At times, a solution for providing exceptional care will be obvious. At other times, VA

will need to explore potential partnerships and other agreements whereby resources and funding are not needlessly wasted and veterans and taxpayers alike get the best return.

My concern still remains for areas such as Okaloosa County in my district in Northwest Florida. While a VA outpatient clinic that will serve the basic needs of the roughly 50,000 veterans in that surrounding area is currently under construction, these same patients still have to drive over three hours to receive any sort of VA inpatient care. It has been more than three years since CARES identified this region as underserved for inpatient care. In fact, it is the only market area in the VISN, VISN 16, without a medical center.

There is a tremendous opportunity to collaborate with the Department of Defense (DoD) for inpatient medical services on the campus of Eglin Air Force Base that would benefit both veterans and active duty servicemembers in this region. The collaboration would expand VA/DoD sharing in a cost-effective manner and provide long overdue inpatient care to veterans in Northwest Florida.

It is my sincere wish that VA constantly monitor and adjust its construction efforts to best meet the geographic and healthcare needs of veterans throughout the entire nation, especially those who face the most difficulty in obtaining access to that healthcare.

I look forward to today's testimony, and would also like to give a special welcome to Major General David Eidsaune who joins us from Eglin Air Force Base in Florida's first congressional district.

Prepared Statement of Hon. Corrine Brown, a Representative in Congress from the State of Florida

Thank you, Mr. Chairman, for calling this hearing today.

This issue is very important to me as I represent part of Orlando, Florida.

Central Florida waited 25 years before the VA decided to put a VA Medical Center there earlier this year.

Twenty-five years. Too long for those men and women who have defended this country and the freedoms it holds dear.

Twenty-five years. Too long for the oldest veteran population to wait for proper care.

Twenty-five years. I do not want to have to wait for another 15 years for this hospital to open.

And New Orleans!

It has been over 2 years since Hurricane Katrina hit the Crescent City and devastated the city. The employees at the VA Medical Center there performed heroically for the patients and evacuate everyone safely. However, we are no closer to rebuilding the hospital now than we were 2 years ago.

I have heard good things about design-build—where the design and construction aspects are contracted for with a single entity known as the design-builder or design-build contractor. The design-builder is usually the general contractor, but in many cases it is also the architect or engineer.

This system minimizes the project risk and reduces the delivery schedule by overlapping the design phase and construction phase of a project.

Why can't the VA use these modern devices to speed up the process?

I look forward to hearing the testimony of the witnesses today.

Prepared Statement of Major General David W. Eidsaune, Commander, Air Armament Center, Eglin Air Force Base, FL, Department of the Air Force, U.S. Department of Defense

Executive Summary

Eglin Air Force Base (AFB) and the Veterans' Affairs (VA) Gulf Coast Veterans Healthcare System (VA GCVHS) have developed a partnership to provide more accessible healthcare to eligible Department of Defense (DoD) and Veterans' Affairs (VA) patients in the Northwest Florida region, that will be the cornerstone for future sharing activities.

Eglin Air Force Base is continually working to expand available healthcare services for our eligible patients. This has included renovating and expanding existing healthcare facilities to meet the needs of our expanding patient population as well

as planning new facilities such as the VA Community Based Outpatient Clinic (CBOC), highlighted today.

There is a clear need for additional healthcare for our veterans; the VA and Eglin AFB have combined forces to address this need. The resulting VA Community Based Outpatient Clinic (CBOC) is currently under construction and scheduled to open in the spring of 2008. It is a huge step toward meeting the needs of our veterans in northwest Florida.

The Need

The Veterans Affairs (VA) Gulf Coast Veterans' Healthcare System (VA GCVHS) covers the gulf coast of Mississippi, Alabama, and the Florida panhandle. This extensive area is covered by one VHA inpatient facility located in Biloxi, MS, and three outpatient clinics in Mobile, AL, and Pensacola and Panama City, FL. 107,979 veterans, 47% of the total veteran population for the VA Gulf Coast Veterans Healthcare System (VA GCVHS), reside in the Florida panhandle.

Because the Emerald Coast of Northwest Florida is one of the top ten fastest growing areas in the United States, there is a need to provide the VA community with the medical services they deserve. This four-county area (Walton, Santa Rosa, Holmes and Okaloosa), that will be served by the VA CBOC, is primarily rural, has a total population of 347,406 based on the 2000 U.S. census data, and a veteran population of 50,902 (based on FY 2003 Veteran Population Projections). The VA CBOC will significantly improve access to VA primary care services for veterans residing in the Northwest Florida area, eliminating the need for extended travel. Improved access and timeliness of care will further enhance the quality of healthcare services through earlier intervention.

Quick Facts

- **16,700 square foot facility**
- **Estimated cost is $5.232M**
- **Basic clinic with Primary Care, Mental Health, small Lab and Pharmacy**
- **Built on 10 acres of AF land**
- **Site allows a separate entrance for the VA**
- **Oct 2006: Groundbreaking**
- **Dec 2007: (Projected) Complete Construction**
- **Early 2008: (Projected) Complete Activation/Ribbon Cutting**

Location

The VA GCVHS requested beddown approval on Eglin AFB to improve access, prepare for continued population increases, and satisfy quality and continuity issues. This option builds upon the strong relationship locally with Department of Defense medical facilities.

On June 22, 2006, the Deputy Assistant Secretary of the Air Force for Installations signed a land-use permit that authorized the VA to use the 10-acre parcel on Eglin AFB as a CBOC building site at no cost to the VA. This arrangement saved the VA and taxpayers $1.47M by avoiding the cost of purchasing the land. The 10-acre site is adequate for both existing and future requirements. It ensures availability of land for future expansion up to 50% without incurring real estate costs. The VA CBOC's close proximity to Eglin Hospital will provide tremendous opportunities for sharing arrangements. For the past 12 months, Eglin AFB and VA GCVHS have been evaluating mutually beneficial sharing agreements for inpatient care, emergency room services, radiology, laboratory, pharmacy and specialty care. Examples of VA/DoD Sharing Agreements that already exist include the VA GCVHCS Panama City CBOC, which is located on the Navy Coastal Station in Panama City Beach, Florida and an agreement with the Pensacola Naval Hospital for inpatient and other specialty care.

Scope of Services

The clinic will offer primary care, mental health, audiology services and routine/urgent care procedures, such as suturing, simple dermatology procedures, skin testing, dressing changes, injections and immunizations. VA staff will provide Primary Care and Mental Health Services. Each team will consist of a physician, nurse and a clerk. The VA CBOC will have six teams during the initial startup year with a patient load of 1,200 for each primary care team and 800 for the psychiatrist. One additional primary care team will be added in year two and year three.

Two full-time psychiatrists will be hired for the VA CBOC to provide outpatient mental health services. The VA CBOC will feature a modest laboratory, capable of performing routine procedures. A sharing agreement will be established for prescription services. Likewise, Specialty Care workload will be accomplished through the use of a negotiated sharing agreement between VA GCVHCS and Eglin AFB.

Benefits

In addition to providing more accessible healthcare for veterans, the VA CBOC will provide backup and support for DoD during times of military conflicts and/or national emergencies.

The Family Residency Graduate Medical Education (GME) Teaching Program at Eglin is growing from 8 to 10 residents in FY 08; the Eglin 96th Medical Group's Family Practice residency program is in need of higher acuity patients in order to meet GME requirements. Sharing agreements with the VA CBOC will help meet this need. At the same time, veterans will benefit by having access to highly qualified professionals participating in the GME program.

Based on an expected increase in Active Daily Patient Load (ADPL) of 3–5 patients per day, the Eglin Hospital projects to receive $1.8 million to $2.4 million annually in reimbursement for ancillary support and inpatient services rendered. This represents a 75% increase in their current reimbursements and will help to offset the constrained Operations & Maintenance (O&M) military health care budget.

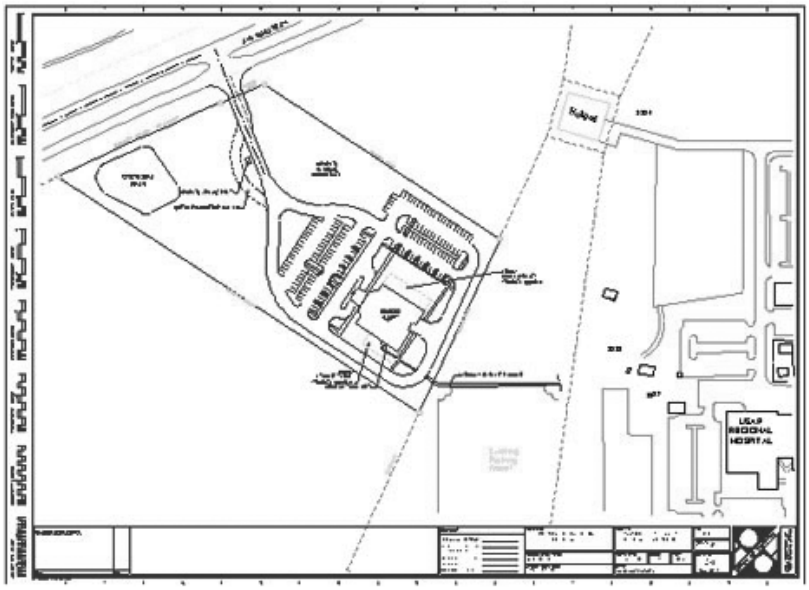
In closing, the VA Community Based Outpatient Clinic will be a joint success for Eglin AFB, the VA, and our combined patient populations. This cooperative effort should serve as a model for future efforts to support the healthcare needs of our Nation's veterans.

VA Community Based Outpatient Clinic
to be built on
Eglin, AFB

A JOINT-VENTURE PARTNERSHIP
OF THE FUTURE FOR BETTER, MORE
ACCESSABLE HEALTH CARE

Community Based Outpatient Clinic
Eglin, AFB

PROPOSED 10 Acre SITE PLAN



VA GULF COAST ONE TEAM
BILOXI MOBILE PENSACOLA PANAMA CITY

VA Outpatient Clinic at
Eglin Air Force Base

16,700 square feet

45 Staff

Primary Care

Mental Health
(Psychiatry, Psychology, Social Work)

Laboratory

Pharmacy

Construction in progress (10/1/07....

Scheduled to open March 2008

Eglin CBOC Timeline

- Jun 22, 06: Eglin AFB—permit for 10 acres/50 years for CBOC site Air Force
- Feb 06: Design Completed (Bullock Tice Associates)
- Sep 06: Bid/Build Contract Awarded To Environmental Safety Awareness & Construction, LLC of Fort Walton Beach, FL Over $5M including design and contingencies
- Oct 16, 06: Groundbreaking
- Dec 11, 06: Notice to Proceed- Site work/design started
- Dec 08: Contract Completion Date
- Dec 07: Current Predicted Completion Date
- Jan 08: Predicted acceptance date (punch list)
- Jan-Mar 08: Predicted activation phase
- Mar 08: Predicted Activation Date (Ribbon cutting / Occupancy)

Eglin CBOC Overview

Predicted Activation Date: March 2008

Milestones/Timeline

- Jun 06: Land Permit signed
- Feb 06: Design completed
- Sep 06: Construction contract awarded
- Oct 06: Groundbreaking
- Dec 06: Notice to Proceed- Site work started
- Dec 07: Completion date by contract
- Dec 07: Current predicted completion date
- Jan 08: Predicted acceptance date (punch list)
- Jan-Mar 08: Predicted activation phase
- Mar 08: Predicted Activation Date (Ribbon cutting/occupancy)

Planned Services

Primary Care
(CMO + 4 teams—grows to 6 teams 2nd year)
Mental Health
(Psychiatrists, 2 Psychologist, Social Work)
Small Laboratory, but no Radiology
Small Pharmacy (limited formulary—2 ADDS machines)
Dietetics
Projected Sharing with Eglin AFB Regional Hospital
Inpatient, Emergency Room, Dental, Radiology

Projected Staff: 45.5

1 Chief Medical Officer
6 Primary Care MDs
2 Psychiatrists, 2 Psychologists
1 Addiction Therapist, 1 Social Worker
2 Police
11 Other Support
1 Administrative Officer
3 RNs, 4 LPNs
2 Pharmacists, 1 Pharm Tech
5 Laboratory
0.5 Dietitian
3 Housekeeping

Building Information

- 16,700 square feet
- Construction Site 10 acres on Eglin Air Force Base Land Permit for 50 year; signed June 06
- Close Proximity to Eglin AFB Regional Hospital

Contract Background

- Design completed Feb 06 by Bullock Tice Associates
- Bid/Build Contract Awarded Sep 06 to Environmental Safety Awareness & Construction, LLC of Fort Walton Beach, FL
- Design and Construction Costs: $5.5M (including contingencies)

Prepared Statement of William Wakefield, Vice President, Healthcare Division, The Haskell Company, Jacksonville, FL

Introduction

The purpose of this summary is to provide an objective summary and comparison of the alternatives that healthcare providers may wish to consider for the design and construction of new or expanded facilities.

For this study, project delivery systems and procurement methods are discussed as separate, although related topics. A *Project Delivery System* is the process under which design and construction services are provided to complete a project. A *Procurement Method* is the process by which the Owner selects the team that will provide the services required to complete the project.

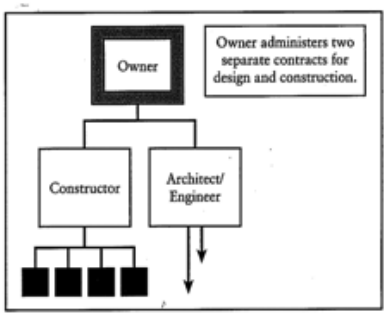
The selection of the most appropriate project delivery system must precede the selection of the procurement method. No single delivery system or procurement method is optimum for all projects and circumstances.

Project Delivery Systems

Until recently, the design and construction industry was characterized by highly contentious relationships between architects, engineers, contractors and subcontractors. In recent years partnering, alternative delivery systems and more enlightened owner-designer-contractor relationships have improved these adversarial relationships.

Design-Bid-Build

Design-Bid-Build has been the traditional project delivery system used in the United States for about 200 years. Under this system, the Owner contracts separately with a designer and a contractor. The architectural/engineering firm produces "complete" plans and specifications. Contractors provide bids to perform the work.



Advantages:

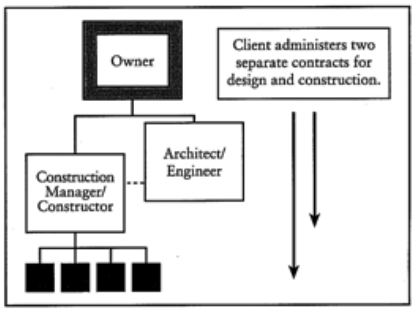
- Established and familiar system
- Established legal precedents
- A/E works directly for the Owner
- Appropriate for price competition (as opposed to value)
- Availability of insurance and bonding

Disadvantages:

- Diffuses accountability for the overall process
- Contributes to adversarial relationships and disputes
- Owner is the arbiter between design and construction
- Initial low bid does not necessarily result in low final cost or best value
- Very late knowledge of firm costs
- Slowest of the delivery systems

Construction Management at Risk (CM at Risk)

The CM at Risk delivery system evolved to take advantage of early involvement of the construction member of the project team. The Owner contracts separately for design and construction services as in the Design-Bid-Build system. However, the CM firm is selected earlier and is integrated into the design process.

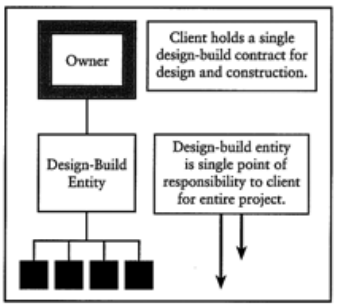


Advantages:
- Early involvement of construction
- Greater collaboration between design and construction
- Construction input during design
- Earlier knowledge of firm costs
- Improved cost control
- Faster than the Design-Bid-Build delivery system

Disadvantages:
- Same contractual relationships as Design-Bid-Build
- Diffuse accountability for the overall process
- Contributes to adversarial relationships and disputes
- Owner is the arbiter between design and construction
- Slower than the Design/Build delivery system

Design/Build

Design/Build is a project delivery system in which the Owner contracts with a single entity to perform design and construction, and perhaps additional, services. This system offers the Owner the benefits of even greater design and construction integration and singular responsibility for the outcome and the overall process.



Advantages:
- Singular responsibility
- Risk management
- Early knowledge of firm costs
- Cost savings and value
- Improved cost control
- Time savings
- Improved quality
- Reduced Administration

Disadvantages:
- Owner's unfamiliarity with the delivery system
- Greater reliance on transparency and trust
- Limited availability of insurance and bonding

Comparisons of Delivery Systems

A major research project, conducted by Penn State University in 1997, studied the outcomes for 351 projects and compared those outcomes against the delivery systems used for the projects. The measured outcomes included:

Unit Cost

A comparison of the unit cost—the cost per square foot in place—for the different systems indicated:

CM at Risk was 1.6% lower than Design-Bid-Build
Design/Build was 4.5% lower than CM at Risk
Design/Build was 6.1% lower than Design-Bid-Build

Design and Construction Cost Growth

The cost growth—from initial contract cost to final cost—for the different systems was:

Design-Bid-Build	4.83%
CM at Risk	3.37%
Design/Build	2.17%

Delivery Speed

A comparison of the delivery speed—taking into account design and construction—indicated:

Design-Bid-Build	3,250 square feet per month
CM at Risk	4,712 square feet per month
Design/Build	6,842 square feet per month

CM at Risk was 13.33% faster than Design-Bid-Build
Design/Build was 23.5% faster than CM at Risk
Design/Build was 33.5% percent faster than Design-Bid-Build

Design and Construction Schedule Growth

The schedule growth—from initial schedule to final schedule—was:

Design-Bid-Build	4.44%
CM at Risk	0%
Design/Build	0%

Quality

Measured on a scale of 1–10, with 10 being the highest, owners graded the quality of their projects at turnover and startup as follows:

Design-Bid-Build	6.00
CM at Risk	7.43
Design/Build	7.50

Summary of Comparison

A summary table of the findings of this study follows:

	Design-Bid-Build [1]	**CM at Risk** [2]	**Design/Build** [2]
Unit Cost	■	●	●
Cost Growth	■	●	●
Delivery Speed	■	●	●
Construction Speed	■	★	●
Schedule Growth	■	●	●
Turnover Quality	■	●	●
System Quality	■	●	●

● Significantly outperforms ★ No significant difference ■ Significantly underperforms

[1] Compared against other systems
[2] Compared against Design-Bid-Build

Further Discussion—Advantages of Design/Build

Undivided Responsibility

Design/Build contracting provides both architecture/engineering and construction resources under a single contract. A single entity is responsible for cost control, quality assurance, schedule adherence, and performance of the finished project. This results in clearly fixed responsibility, maximum cost control and immediate responsiveness.

The Owner can exercise his desired degree of control over design, with the added advantage of continuously knowing the cost implications of each decision. The Owner's control of the entire process is strengthened by contracting with a single firm unconditionally committed to the success of his project. It provides a comprehensive view of the project, as opposed to the one-piece-at-a-time method of multiple providers.

Time Savings

Design and construction are telescoped, bidding periods and redesign time are eliminated, and long-delivery components are identified and ordered early in the design process. Therefore, total design construction time is significantly reduced, which translates into earlier utilization of the completed facility.

Reduced Possibility of Project Delays

The integrated nature of Design/Build results in decreasing the risk of schedule erosion and project delay. Bidding periods and redesign time are eliminated. Materials and equipment procurement and construction work can begin earlier—in some cases, before the construction documents are fully completed. Since total design-construction time is reduced, Owners enjoy earlier utilization of their completed facility. The chance of late entry to market or production downtime is greatly reduced.

Early Knowledge of Costs

The Design/Build team, working closely with the Owner, accurately conceptualizes the completed project at an early stage. Continuous and concurrent estimating during the development of design results in knowledge of firm, overall cost far sooner than is possible with other approaches. This process also permits making early decisions—which have the greatest impact upon cost—in an informed, cost-based environment.

Cost Savings

Design and construction personnel, working and communicating as a team, evaluate alternative materials and methods efficiently and accurately. From the outset of the project, both design and construction expertise are brought to bear upon all components of a project, from site work through mechanical and electrical systems. Cost evaluation is continuously "fed back" into the design process and the cost implications of design decisions are known at the time—not after design is complete. Because the Design/Builder is responsible for both design and construction, cost overruns resulting from design error or faulty coordination are the responsibility of the Design/Builder, not the Owner. The Owner pays only for scope changes that he initiates.

Reduced Risk of Cost Overruns

With Design/Build, risk reduction begins at the design stage. Construction specialists are an integral part of the design team, so construction implications are addressed early. The team works together to decide the most cost-effective materials and methods of delivery before a design is finalized, which enables them to provide more accurate costs and better scheduling up front. Because the same group is responsible for both drawings and functional performance, the possibility of expensive surprises in the construction phase is virtually eliminated. Too often with design-bid-build, design impracticalities are discovered during construction, which leads to increased cost, blown schedules, and finger pointing between architect, engineer, and contractor.

Because the Design/Builder is accountable for both design and construction, the risk of cost overruns from design error or poor coordination are transferred from the Owner to the Design/Builder.

Risk Is Transferred From The Owner To The Design/Builder

Single source responsibility of Design/Build reduces risk to the Owner. The Owner no longer takes the risk of scope gaps, document misinterpretation or design errors. The Design/Builder carries singular responsibility for both the design and the construction of the project. This reduces the staff and management requirements for the Owner for those that normally manage the risk of those gaps and errors.

In the traditional design-bid-build method, multiple entities are used for the various tasks required. This separate engagement of architect/engineer, contractor, and other parties means there is no single party responsible for overseeing the entire project, and the Owner is therefore at greater risk for undesirable outcomes.

Design/Build presents less risk from a contractual perspective. There is only one contract, so Owners look to a single source for performance. This is a major advantage over the design-bid-build process, where the responsibility for any aspect of a project's outcome may be unclear due to language in the various provider contracts. Typical are phrases like, "The Owner warrants to the contractor that the drawings and specifications are complete and free from error . . ." This language places the responsibility for design solely with the Owner. If problems are encountered during construction, the contractor can blame the architect who, in turn, may point the finger right back at the contractor. This method relies on audit, inspection, and, all too frequently, the legal system to ensure final project quality. In contrast, the Design/Builder assumes all responsibility by documenting the Owner's requirements and expectations in performance terms. "The Design/Builder warrants to the Owner that it will produce documents that are complete and free from error . . ." The Design/Builder essentially guarantees high quality in the finished facility by assuming complete responsibility from design through completion and into operation.

Procurement Methods

Procurement methods are distinct from, but related to delivery systems. Not all procurement methodologies discussed below are applicable to all delivery systems. The selection of the procurement method will follow the selection of the delivery system for a particular project.

Direct Selection

Direct Selection is the process where the Owner selects a firm without considering other firms for the project or service and negotiates the terms under which services will be provided.

Direct Selection may be appropriate when the Owner has considerable positive experience with that firm, the project is so highly specialized that only one firm is qualified for the project or where an umbrella purchasing agreement is in place.

Price Bidding

Price Bidding is the process under which any reasonably qualified contractor can submit a bid for a given scope of work. A variation of this method is bidding by a small number of invited firms, who have been pre-qualified (see below). The Owner usually selects the lowest reasonable bid.

Price Bidding requires complete construction documents, which limits its application to the Design-Bid-Build delivery system.

Qualifications Based Selection (QBS)

Qualifications Based Selection is similar to the method commonly used for the selection of consultants, architects, engineers and program managers.

Pre-Qualification: Pre-qualification is the process used by an Owner to restrict the pool of firms that will be invited to propose or bid on the work. The Owner may restrict the pool in several manners, the most common of which are qualifications, relevant experience, capacity or location.

The Owner will often develop and issue a Request for Qualifications. The Owner will evaluate the submittals made by interested firms against criteria that was pre-established by the Owner. A short list of firms will be selected for further consideration, often involving interviews, proposals and reference checks.

Proposal: The proposal process usually follows a pre-qualification process. Again, the Owner would develop the Request for Proposals and evaluate the proposals against pre-established criteria.

Pre-Established Criteria: To create an objective selection process it is essential for the Owner to establish the selection criteria in advance. The criteria may include:

- Firm History
- Financial strength
- Backlog and capacity to deliver the project
- Depth of personnel in key positions
- Firm and team member experience
- Project work plan
- Ability to meet DBE and similar requirements
- Performance history
- References

Negotiation: Negotiation typically follows a Pre-Qualification, Proposal or Direct Selection process.

Qualifications Based Selection is most often used for the selection of a CM at Risk or Design/Build firm. It has the advantages of an accelerated selection process and a greater match of firms to the Owner's objectives.

Value Based Selection

Design and price proposals are solicited in a Request for Proposals, which usually stipulates program requirements, design criteria, performance specifications, site information and contract terms. The teams invited to submit proposals are often prequalified and limited to a few teams. Teams then submit design and price proposals, which are evaluated against pre-established criteria, by a selection panel or jury, and the winning team is selected.

Value Based Selection is limited to the Design/Build delivery system. While it has the advantage of providing a variety of design solutions, it can be a time and resource consuming process. Pre-qualification of firms, issuing the RFP, preparing design and price proposals, evaluation of proposals and selection of the winning firm can take many months. A jury must be appointed to evaluate the proposals and the members must agree on the application of the pre-established evaluation criteria. To offset the cost of preparing design and cost proposals, a stipend is often paid to the competing firms. For large and complex projects, stipends can exceed $100,000.

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Prepared Statement of Charles A. Clarkson, Founder and Chairman, The Clarkson Group, L.L.C., Jacksonville, FL

The recent emergence of Design-Build contracts in the U.S. building industry speaks to its many attributes. In lieu of the traditional Design-Bid-Build format, Design-Build enables fast tracking through continual designer-builder alignment and overlapping of job processes. Further, this single source of designers and contractors places the onus on one entity, thus resulting in fewer conflicts.

On the other hand, Design-Build seemingly generates an equal amount of constraints. Perhaps the greatest disadvantage with Design-Build is the loss of competition inherent to the traditional bid-process. Without this tool, owners typically lose cost-savings garnered through competitive bids. Equally disconcerting, the architect (customarily the owner's agent) pledges allegiance to the engineers and contractor. This borderless relationship essentially dismantles the owner's checks-and-balances safety net. As many laymen would say, Design-Build is essentially the "fox watching the hen house." Given the obvious advantages and disadvantages of Design-Build contracts, it becomes important to identify the circumstances by which such advantages can be put to good use.

Standardized and/or redundant projects align wonderfully with the mechanisms of Design-Build. Projects such as hangers, franchisor prototypes, highways, and industrial centers look to benefit from Design-Build arrangements. Given its predictability and knack for minimizing root causes of disputes, Design-Build proves a viable pick in this arena. Further, development of multiple standardized projects allows for future savings through the design's and methods' reusability.

Another optimal scenario for utilizing Design-Build occurs when the importance of time outweighs that of cost. As one common example, government highway projects many times look to Design-Build given their need for an accelerated completion schedule in effort to minimize commuter disruption. Further, such public projects many times have loose budgetary parameters. In these cases, Design-Build proves more effective mainly due to its ability to save time.

In more customized conditions, Design-Bid-Build tends to be the more risk-averse solution. Given the individuality of all sites (e.g. subsurface conditions, wind/rain/snow loads, topography, and zoning restrictions) coupled with the specialty design warranted by most structures, Design-Bid-Build typically proves to be the best choice. Because of such unknowns, Design-Bid-Build better blockades owners from price gauging and consultant mismanagement. In such specialized projects, many would recommend finalizing design before committing to a construction cost. Otherwise, untimely design changes will lead to rising costs though change orders.

Design-Build and Design-Bid-Build are both common to today's building circles for good reason. Each, in their own right, presents advantages beneficial to designers, builders, and owners. Given their varying components, however, it should be remembered that choosing one arrangement over the other is circumstantial. Put plainly, substantial standardization of multiple projects increases the benefits of Design-Build. Conversely, projects with more unknowns and the inability to standardize make Design-Bid-Build more attractive. Finally, given the continual advancements and standardization of both design techniques and construction methods, one should expect the applicability of Design-Build to expand.

Prepared Statement of Christopher Needham, Senior Legislative Associate, National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.3 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today with respect to the construction process of the Department of Veterans Affairs (VA).

For the better part of a decade, the VA construction process had been dominated by the Capital Asset Realignment for Enhanced Service (CARES) process. This systematic, data-driven assessment of VA's capital infrastructure aimed to plan for the current and future healthcare needs of veterans.

Throughout the CARES process, we were concerned with the under-funding of the construction budget. Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final results of CARES. This is despite the fact that many legitimate construction projects were identified by VA's hospital managers and with House passage of the "Veterans Hospital Emergency Repair Act," which authorized construction at numerous facilities. Needs were identified, but Congress never appropriated funding, with the ongoing CARES process being used as the primary excuse.

We believe that the de facto moratorium on VA major construction projects was poor public policy and that some of the extra expenses associated with construction costs today are a result of inability to begin projects in previous years. With construction, time equals money, and the longer a project takes, even in planning stages, the higher the ultimate cost will be.

In July 2004, then-VA Secretary Anthony Principi testified before this Subcommittee that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical infrastructure and enhance veterans' access to care." Yet, since then, the amount appropriated for major construction has lagged far behind. The Fiscal Year 2007 Continuing Resolution, which served as the VA Appropriation, only funded $399 million for major construction. The fiscal year 2006 appropriation was just $600 million. Today, we are a month into fiscal year 2008 and there is still no appropriation, meaning not one of the current construction priorities can move forward. We are certainly appreciative of the amount appropriated by the House, but for VA to properly manage the construction process, the department needs on-time funding.

Beyond the former Secretary's statements and the CARES decision documents, the need for increased construction funding is evident. VA's facilities are aging, with an average age well over 50 years and VA has historically recapitalized at a rate well below industry standards. From 1996–2001, for example, the average $246 million major and minor construction appropriation corresponded with a recapitalization rate of just 0.64 percent of its approximately $40 billion plant replacement

value. This low rate means VA would rebuild its aging infrastructure every 155 years. Numerous reports and studies, including the 1998 Price Waterhouse report on VA's facility management programs, cite the need for a 4–8 percent recapitalization rate, which is consistent with a total construction budget—major and minor—of $1.6–$3.2 billion per year.

One of the strengths of the CARES process was that it was not just a one-time snapshot of the VA healthcare system and its infrastructure needs. It provided the department and its managers with the tools and a framework to evaluate future needs and a prioritization methodology to determine which projects are most critical to the department. These prioritizations help the department to determine its budget request, and the full prioritization lists are included with VA's annual budget submission as part of its 5–Year Capital Plan.

To determine the budget request, VA first assigns priority to previous year's projects that were partially funded and then adds in newly evaluated projects from the current budget year to create an ordered list. When setting the budget, VA's managers select projects from the top of this prioritization list. We believe that this apolitical methodology for determining construction priorities is an excellent process.

That process also reveals the inadequacies of the fiscal year 2008 budget request. Page 7–12 of the 5–Year Capital Plan shows that the budget request only funded six projects, all of which came from the list of projects partially funded in previous fiscal years. It included no additional money for six other partially funded construction priorities or any money for any of the top priorities identified for fiscal year 2008. Some of these projects were later funded as part of the continuing resolution that funded VA during the 2007 fiscal year, but it is troubling to us that funding was not requested in the first place.

With respect to minor construction, we were pleased to see the sizeable $326 million increase in the account as part of the fiscal year 2007 supplemental. As with the major construction account, there was little progress made on the long list of construction priorities laid out in the 5-year Capital Plan. Table 4–8 of that report details numerous projects that VA has identified and that will need funding in the future. We thank the Congress for upping the account, but we would hope that future funding needs are part of the regular appropriation, not just a supplemental.

Although not specifically related to the construction budget, I would like to place special emphasis on nonrecurring maintenance funding, part of the Medical Services budget account. When *The Washington Post* detailed the deplorable living conditions some wounded warriors faced at Walter Reed Army Medical Center, including mold, leaky plumbing and holes in walls, the reactions were swift, immediate and universal. These intolerable conditions were a national shame and we as a Nation can and must do better for those who have served this country.

The VFW absolutely agrees, but we view the problems at Walter Reed as the manifestation of a problem we have repeatedly pointed out. The unacceptable living conditions at Walter Reed were caused, in part, because of an insufficient maintenance budget. Although Walter Reed is not a VA facility, the maintenance problems are consistent with the concerns we have had with VA.

In light of the attention focused on the healthcare of veterans, VA Secretary Jim Nicholson ordered an immediate review of the Department's maintenance needs on March 7, 2007. The results, which were released on May 21, 2007, showed that the majority of VA's facilities were in good condition and that most of the deficiencies that VA's internal review identified were, in VA's words "normal wear and tear."

The VFW, however, has some concerns with the report's findings and what they represent. A March 22, 2007 article in *The Washington Post* reported that VA officials concluded that 90 percent of the problems identified were routine, but that 10 percent were deemed more critical. Among the critical problems VA identified were problems with the fire alarm and smoke barrier systems in a hospital in Amarillo. In Fayetteville, the review found problems with fixtures and other objects in patient areas that could pose a suicide threat in its mental health unit. The VA Medical Center in Saginaw found that, "[o]ld, worn out carpet may harbor residue/bacteria from patients' personal accidents." In Manchester the damaged and stained carpet is over 15 years old and was installed over asbestos floor tiles. Many other facilities had leaky pipes or roofs, discolored or defective ceiling tiles, peeling paint or holes in walls, and issues with the appearance or quality of the flooring.

We, as part of *The Independent Budget*, have identified full and proper funding of the NRM account as one of the biggest challenges facing VA. We have cited industry standards, as well as the findings of the aforementioned Price Waterhouse study that found a need for VA to spend 2–4 percent of its plant replacement value each year on NRM.

VA's Office of Asset Enterprise Management's most recent *Asset Management Plan* (accessible on the Internet at http://www.va.gov/oaem/docs/FINALAMPsigned.pdf) estimates the current plant replacement value of VA's facilities to be roughly $40 billion. Accordingly, VA's own *Asset Management Plan* recommends an appropriate level of funding ranging from $800 million to $1.6 billion on NRM.

The level of NRM funding in the past few years has fallen far below that. For fiscal year 2008, for example, the Administration recommended a paltry $573 million for NRM. Over the previous two fiscal years, only about $1 billion total was appropriated for this critical account, far below what VA itself had identified as a need.

We were pleased to see that Congress stepped up once VA identified these numerous maintenance issues, with an additional $550 million for NRM in the fiscal year 2007 supplemental appropriation. We would hope, however, that future funding requests would be sufficient enough to eliminate the need for emergency requests. These issues must be taken care of before they develop into larger problems.

We would also thank Congress for listening to our recommendations in previous years in exempting this funding from apportionment using the Veterans Equitable Resource Allocation (VERA) formula. While VERA does move the funding toward geographic areas with the highest demand for healthcare, it also tends to move funds away from facilities with the oldest capital structures—facilities that generally have the greatest maintenance needs. We would hope that future NRM goes to the facilities with the greatest demand.

Providing a safe, clean, hospitable healthcare environment is critical to the effective delivery of healthcare and accordingly Congress must provide VA with all the resources it needs to address the shortcomings already identified, but also to stay on top of any problems that arise in the future. We cannot afford to have what happened at Walter Reed happen ever again. The VFW encourages Congress and VA to be proactive and to do what is right for this nation's veterans.

Mr. Chairman, this concludes my testimony and I would be happy to answer any questions you or the members of this Subcommittee may have.

Prepared Statement of Shannon L. Middleton, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and members of the Subcommittee:

Thank you for allowing The American Legion to present its views on the Department of Veterans Affairs (VA) construction process. With the rapid advancements in technology and medicine that the national healthcare system is experiencing, VA will be compelled to perpetuate the evolution of its healthcare delivery system far into the future. An important part of this evolution is ensuring that VA has adequate facilities that are safe and located in needed areas to make access to its healthcare facilities readily available for veterans.

The healthcare delivery facilities of the Department of Veterans Affairs (VA) are increasingly aging physical plants in need of replacement; substantial renovation and improvements relating to fire, safety and privacy standards are necessary, as well as modernization and reconfiguration to meet the demands of the advances of medicine. The increasing demands placed upon the outpatient and ambulatory care facilities of VA require substantial alterations to meet changing space requirements.

No healthcare delivery system can be expected to provide quality care if the physical settings that house that care are allowed to deteriorate to a state which places them beyond redemption.

In March 1999, the then General Accounting Office (now Government Accountability Office, GAO) published a report on VA's need to improve capital asset planning and budgeting. GAO cited the fact that Veterans Health Administration's (VHA) asset challenge was due, for the most part, to four reasons. First, VHA owned 4,700 buildings, over 40 percent of which have operated for more than 50 years, including almost 200 built before 1900. Second, over 1,600 buildings (almost one-third) have historical significance. Third, VHA used fewer than 1,200 buildings (about one-fourth) to deliver healthcare services to veterans. They further noted that VA had over 5 million square feet of vacant space, which could cost as much as $35 million a year to maintain. Fourth, VHA's healthcare buildings have significant unused inpatient capacity.

Basically, the report found that VA's asset plan indicated that billions of dollars might be used operating hundreds of unneeded buildings over the next 5 years or more. The report went on to further state that VA did not systematically evaluate

veterans' or asset needs on a market (or geographic) basis or compare assets' life-cycle costs and alternatives to identify how veterans' needs could be met at lower costs.

Additionally, GAO estimated that over the next few years, VA could spend one of every four of its healthcare dollars operating, maintaining, and improving capital assets at its then 181 major delivery locations including 4,700 buildings and 18,000 acres of land nationwide. Recommendations stemming from the report included the development of asset-restructuring plans for all markets to guide future investment decisionmaking, among other initiatives.

VA's answer to GAO and Congress was the initiation and development of the Capital Asset Realignment for Enhanced Services (CARES) program. The CARES decision, released in May 2004, contained hundreds of construction requests, upgrades, and alterations of current buildings that will require a substantial increase in funding for Major and Minor Construction within VA.

During the initial stages of the CARES process, the construction budget was nearly flat-lined pending the outcome. This caused a major backup in construction projects and needed seismic repairs. Major and minor construction appropriations for VA have been consistently targeted for reduction since such funding is regrettably the most vulnerable to annual assault. For several years VA facility directors have been forced to use non-recurring maintenance funds to provide care. Sufficient funding must be provided to maintain, improve and realign VA healthcare facilities.

The American Legion urges Congress to annually appropriate sufficient funds for the VA construction program to ensure the continued provision of quality healthcare to our Nation's veterans and the implementation of the CARES decisions.

Medical Construction And Infrastructure Support

VA has a vast physical plant inventory that represents a major investment of taxpayer dollars. Despite the large number of aging facilities, construction funding has been limited. VA is seeking to maximize its use of its facilities, through the CARES decision. CARES construction is estimated at $6.1 billion over the next six years. Sufficient funding to implement new initiatives and the proposed physical plant changes will be critical to the success of the planning initiatives.

Major Construction

The CARES process identified more than 100 major construction projects in 37 states, the District of Columbia, and Puerto Rico. Construction projects are categorized as major if the estimated cost is over $7 million. Now that VA has a plan to deliver healthcare through 2022, it is up to Congress to provide adequate funds. The CARES plan calls for, among other things, the construction of new hospitals in Orlando and Las Vegas, and replacement facilities in Louisville and Denver for a total cost estimated to be well over $1 billion for these four facilities. VA has not had this type of progressive construction agenda in decades. Major construction money can be significant and proper utilization of funds must be well planned. Recently, funding for a new VAMC in Denver was approved by Congress. However, if timely completion of these projects is truly a national priority, providing adequate funding to satisfy this obligation is vital.

In addition to the cost of the proposed new facilities are the many construction issues that have been "put on hold" for the past several years due to inadequate funding, and the moratorium placed on construction spending by the CARES process. One of the most glaring shortfalls is the neglect of the buildings sorely in need of seismic correction. This is an issue of safety. The delivery of healthcare in unsafe buildings cannot be tolerated and funds must be allocated to not only construct the new facilities, but also to pay for much needed upgrades at existing facilities.

Delays in the process have a profound impact on access to healthcare for veterans. Restoration of the medical center in Biloxi, MS—which is consolidating with the medical center in Gulfport, MS—is only in Design Phase 1. The project's estimated completion date is January 2012. With the medical center in Gulfport completely closed, the medical center in Biloxi will have to provide services to even more veterans—but construction to accommodate this increase will not be completed for years to come.

The American Legion believes that VA has effectively shepherded the CARES process to its current state by developing the blueprint for the future delivery of VA healthcare—it is now time for Congress to do the same and adequately fund the implementation of this comprehensive and crucial undertaking.

Minor Construction

VA's minor construction program has also suffered significant neglect over the past several years. Maintaining the infrastructure of VA's buildings is no small task. Because many buildings are old, renovations, relocations and expansions are

quite common. When combined with the added cost of the CARES program recommendations, it is easy to see that a major increase over the previous funding level is crucial and overdue.

The American Legion has long recognized the necessity for a healthcare system that revolves around the special needs of veterans. Veterans serving in Iraq, Afghanistan and all corners of the globe are returning home with severely debilitating injuries and are now faced with new challenges they never considered before. Loss of limb(s), Traumatic Brain Injury, mental conditions, stress reactions, Post Traumatic Stress Disorder, spinal cord injury and blindness are now realities to these young heroes. VA must be there, leading the way, to help them heal and rehabilitate. VA must be capable of providing the programs and services needed to help all qualified veterans lead the most productive and healthy lives possible. VA must continue to look to the future and assess the needs of this ever-changing population. To do this, adequate funding is a must.

Thank you Mr. Chairman, again, for this opportunity to appear before this Subcommittee. We look forward to working with you to help shape the future of VA healthcare delivery.

Prepared Statement of Donald H. Orndoff, Director, Office of Construction and Facilities Management, U.S. Department of Veterans Affairs

Mr. Chairman and members of the Committee, I am pleased to appear today to discuss the VA's healthcare construction program, and specifically the processes we use to plan, design and construct state of the art healthcare facilities. In August 2007, I was honored to be appointed the Director, Office of Construction & Facilities Management (CFM). In this capacity, I am responsible for the execution of VA's major construction program. My new assignment in the VA follows over 29 years of service as an officer in the Civil Engineer Corps of the United States Navy. Joining me today are Mr. Robert Neary, Director, Service Delivery Office, CFM, Ms. Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning, and Ms. Brandi Fate, Acting Director, Capital Asset Management Planning Service. Let me begin by briefly reviewing the status of VA's construction program for healthcare.

The Department is currently engaged in the largest building program since the immediate post-World War II period. This program represents implementation of the results from the Capital Asset Realignment for Enhanced Services program or CARES which was initiated systemwide in 2002 and produced initial results announced in May 2004. At that time, 30 major construction projects were approved and funded in whole or part. In subsequent fiscal years, six additional projects have been submitted for funding in budget requests. The total cost of these projects approaches $5 billion and $2.83 billion (including Hurricane Supplemental Funding) has been appropriated between FY 2004 and FY 2007. The FY 2008 budget now before the Congress requests an additional $560 million in major construction for infrastructure improvement for the veterans health system. These projects are in various stages of design and construction. I am pleased to note that construction contracts have been awarded on 18 projects.

The minor construction program is also an important part of addressing infrastructure needs of the health system identified by CARES. Since FY 2004, $1.08 billion has been appropriated (including Hurricane Supplemental Funding) and an additional $180 million is requested in the FY 2008 budget.

VA has a real property inventory of over 5,000 owned buildings, 1,100 leases, 32,000 acres of land and approximately 158 million gross square feet (owned and leased). As the CARES process revealed, the average age of VA facilities is well over 50 years old, and many of these older facilities are not designed or constructed to meet the demands of clinical care in the 21st century. VA's management of these assets is critical to providing healthcare and services to our veterans.

Implementing an aggressive real property management program includes use of a disciplined capital investment and planning process, development of tools, processes and methods for improved inventory and analytical capability and innovative acquisition methods. VA uses internal and external benchmarks and best practices, monitoring portfolio performance on a quarterly basis. VA conducts condition evaluations, evaluating a third of VHA facilities each year. VA effectively manages its vast holding of capital assets through performance monitoring and analysis, supporting the President's Management Agenda and Federal Real Property Council efforts to decrease underutilized and vacant space, improve facility condition, decrease

operating costs and reduce non-mission dependent assets. In FY06 and FY07, VA disposed of 77 and 43 buildings, respectively. Forty-eight buildings are planned for disposal in FY08. In addition to disposals, VA also uses its authority under the Enhanced Use Program to engage the private sector and other public entities in the adaptive reuse and development of unneeded property with lease consideration flowing to VA. VA develops energy savings performance contracts designed to reduce energy consumption in federally owned facilities, reducing the demand and dependence on natural resources. Further, VA integrates energy and real property initiatives and programs. VA plans to implement energy metering, bill auditing and commodity purchasing for improved efficiency and effectiveness of both real property and energy management. VA's energy pilot is scheduled for implementation in FY08.

VA utilizes a multi-attribute decision methodology enabling a disciplined decision-making approach in prioritizing its capital investment needs and requirements. Through this methodology, VA establishes its 5 Year Capital Plan. The 5 Year Capital Plan is a living document that reflects the changes in the composition and alignment of VA's assets. The plan is the document used to describe the selection of VA's capital acquisitions and funding requests by incorporating a formal executive review process.

This process begins with Veterans Health Administration (VHA) strategic planning initiatives that identify capital needs based upon demographic data, workload, actuarial projections, cost effectiveness, risk, and alternatives. Once a potential project is identified, it is reviewed and scored based on criteria VA considers essential to providing high quality services in an efficient manner. The criteria VA utilizes in evaluating projects include service delivery enhancements, the safeguarding of assets, special emphasis programs, capital asset priorities, departmental alignment, and financial priorities. The new funding requirements are considered, along with existing CARES decisions, in determining the projects and funding levels to request as part of the VA budget submission. Appropriate projects are evaluated for joint needs with the Department of Defense and sharing opportunities.

Selected projects based on VHA strategic process are vetted through the Department's Capital Investment Panel (CIP) to ensure all projects are based upon sound business and economic principles, promote the one-VA vision, align with VA strategic goals, address the Secretary of VA's priorities, and support the President's Management Agenda. The CIP analyzes and scores these projects and submits the results to the Strategic Management Council (SMC) for consideration. The SMC is VA's governing body assigned the responsibility to oversee VA's capital programs and initiatives. The SMC reviews the projects and submits its recommendations to the Secretary, who makes the final decision on projects to include in the budget.

Identification of capital needs through the Secretary's decision occurs annually. Major capital investment needs are requested from facilities in October, prioritized through each Administration and the Departmental review process, and vetted for the Secretary's approval by the following summer. Under the current process, once a decision has been made to include a project in the Department's budget, the design process begins with the selection of the design architect. The traditional design process consists of three phases—schematic design, design development and construction document preparation. While the timing varies with the size and complexity of the project, design typically takes 18 months. Once design is complete, the construction contractor is procured and construction begins. Approximately one-third of VA projects are executed using the design build method in which a contract is awarded to an architect/engineer (A/E) and construction contractor team who take a preliminary design provided by VA and completes the design and constructs the projects.

The Department utilizes standard industry practices in the design and construction of VA facilities. The architectural and engineering firms that design facilities for VA are selected in accordance with established laws and regulations. We are pleased that highly qualified A/E firms with healthcare practices compete to be selected as VA designers. These firms are on the cutting edge of modern healthcare design for state-of-the-art medical care facilities for the private sector as well as for VA.

Construction contractors are often selected using a combination of quality factors and price. Contractors that are selected through a negotiations process are evaluated based on their experience and track record in constructing similar facilities from both a corporate perspective as well as the company's specific personnel that will be managing the VA project and the firms' proposed project management plan.

VA benefits from its reliance on private sector architects, engineers and contractors. Selection of the top firms in the Nation brings to VA's construction program the highest quality of expertise in healthcare design and construction. VA is also

expanding the support received from the private sector through the use of Construction Management (CM) firms for VA's largest projects. These firms bring extensive expertise in managing large projects to support VA's major construction efforts. The first of these contracts has been implemented on the project to construct a new VA Medical Center in Las Vegas. Other projects that will benefit from the use of private sector CM are Orlando, New Orleans and Denver.

VA's construction program is not without challenges. The rising cost of construction has had a significant impact on VA since 2004. This is not a problem unique to VA, but has similarly affected all government and private sector organizations with construction requirements. Cost growth is largely attributable to the robust economy in the United States and around the world. The demand for labor and building materials continues to outpace the supply. Coupled with rising fuel prices and the impact of the hurricanes of 2004 and 2005, building programs of all types have experienced significant cost growth. As VA monitors the industry, we regularly learn of major corporate capital projects which are postponed or canceled because of the price.

Another challenge in the construction process is attracting competition for VA major projects. The large volume of construction in most markets makes it extremely difficult to attract significant competition. It has not been unusual for only one or two bidders to compete for VA work during the past 18 months and this lack of competition has diminished the likelihood of good pricing.

VA is taking a number of steps to minimize the impact of these circumstances on the construction program. VA regularly conducts market surveys in the cities where we have upcoming work in an effort to better predict the costs we will encounter, and the labor supply that will be available. In our budget estimates we now vary the escalation rates included based on the current and predicted construction activity in individual markets. We are working with the contracting community to improve their awareness of upcoming VA projects and to attract their interest in performing VA work. VA is also reviewing the planning process to identify improvements that can be made to insure that when VA commits to a budget cost, a full and compete understanding of the project requirements is known and included in the budget estimate.

In closing, I would like to thank the Committee for its continued support for improving the Department's physical infrastructure to meet the changing needs of America's veterans, and we look forward to continuing to work with the Committee on these important issues.

Again, thank you for the opportunity to appear before the Committee today and my colleagues and I would be glad to answer your questions.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
November 8, 2007

Dennis Cullinan
National Legislative Director
Veterans of Foreign Wars of the United States
200 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Cullinan:

Thank you for the testimony of Christopher Needham, Senior Legislative Associate, National Legislative Service, of the Veterans of Foreign Wars of the United States at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health hearing that took place on November 1, 2007 on "The VA Construction Process."

Please provide answers to the following questions by January 2, 2008, to Chris Austin, Executive Assistant to the Subcommittee on Health.

1. The veteran population projection for New Orleans is expected to decline by about 18% between 2001 and 2011. Given the declining veteran population, the downtown flood risk area, and travel time and distance concerns, could a replacement facility be more conveniently located outside downtown New Orleans, providing for easier accessibility and on higher ground that would be secure regardless of flooding?

2. In 1999, the Government Accountability Office (GAO) reported that VA was wasting millions of dollars annually on the upkeep of underutilized facilities that could be used to enhance veterans' healthcare. In response, VA initiated the Capital Asset Realignment for Enhanced Services (CARES) process to assess VA capital assets and establish a framework to modernize VA's healthcare facilities and use its resources more effectively to improve healthcare delivery. The Veterans of Foreign Wars (VFW) always agreed with CARES recommendations to build new facilities. However, specifically in what cases did the VFW support recommendations to downsize or close obsolete facilities?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by January 2, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Responses of the Veterans of Foreign Wars of the U.S. to Post-Hearing Questions from the November 1, 2007 Subcommittee on Health Hearing on the VA Construction Process

Question 1: The veteran population projection for New Orleans is expected to decline by about 18% between 2001 and 2011. Given the declining population, the downtown flood risk area, and travel time and distance concerns, could a replacement facility be more conveniently located outside downtown New Orleans, providing for easier accessibility and on higher ground that would be secure regardless of flooding?

Response: The VFW has traditionally deferred to the Department of Veterans Affairs (VA) with respect to their construction projections and site planning. Their efforts are based upon a rigorous model that aims to project the demand for healthcare and services for the next 25 years, taking into account the age of the veterans population, differences in healthcare needs of various localities, and many other demographic factors. VA then uses the information from this model to prioritize its construction projects, aiming to come up with an optimal solution.

In the case of the New Orleans VA facility, VA's statistics—contained in Page 6–25, Volume III of the Fiscal Year 2008 Congressional Budget Submission—cite a 1.1% growth rate in the number of veterans enrolled in the VA healthcare system in Southeast Louisiana area through 2025. This number rises likely due to the aging veteran population—older patients typically demand more services—but also because of an increasing number of veterans returning to their former homes.

As we understand it, VA's plans for the downtown medical facility are in accordance with all standards for hurricane hardening and that it lies above the 100-year flood plain. VA's plans are for all essential mechanical, electrical, and medical equipment to be contained on higher floors, allowing the facility to remain open and usable should another catastrophe occur.

Whatever choice is finally made, the VFW's paramount concern is that VA properly serve New Orleans' and Southeast Louisiana's veterans. It is critical that they have access to the same levels of first-rate healthcare and services as their fellow veterans throughout the country. This is especially true with respect to mental health issues. With the stresses and strains of having to rebuild, plus the high number of OEF/OIF veterans in the VISN who are returning from difficult overseas combats, the need is sure to grow. We urge swift action so that VA can properly care for those who are in need.

Question 2: In 1999, the Government Accountability Office (GAO) reported that VA was wasting millions of dollars annually on the upkeep of underutilized facilities that could be used to enhance veterans' healthcare. In response, VA initiated the Capital Asset Realignment for Enhanced Services (CARES) process to assess VA capital assets and establish a framework to modernize VA's healthcare facilities and use its resources more effectively to improve healthcare delivery. The Veterans of Foreign Wars (VFW) always agreed with CARES recommendations to build new facilities. However, specifically in what cases did the VFW support recommendations to downsize or close obsolete facilities?

Response: The May 2004 CARES decision document, which recommended closing or realigning a number of facilities, was not the final word on CARES construction issues. The Secretary ordered the creation of a number of CARES Business Plan

Studies to further investigate a number of these facilities to determine whether the decision document's recommendations were in the best interest of veterans. These 18 Business Plan studies are mostly complete, but the net result is that VA has earmarked only one facility—the Gulfport, MS VA Medical Center that Hurricane Katrina destroyed—for disposal.

Since that GAO issued the report referenced in the question, VA has been aggressive about properly disposing of and planning for underutilized or unused space. VA has a number of metrics to measure their progress as part of the Federal Real Property Council. By eliminating space, VA is better able to use its operations and maintenance budgets on its primary missions, delivering high-quality healthcare to this nation's veterans. Per Public Law 108–422, VA submits an annual report to Congress on its disposal plans. Page 7–51 of VA's Five-Year Capital Assets Plan is the first of several pages where VA lists buildings, sales, and realignments of its facilities. As these are in accordance with the larger CARES process and the elimination of these structures does not impair—and in many cases will allow for the expansion of—the healthcare VA provides to veterans, the VFW is supportive of these efforts.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
November 8, 2007

Steve Robertson
National Legislative Director
The American Legion
1608 K Street, N.W.
Washington, D.C. 20006

Dear Mr. Robertson:

Thank you for the testimony of Shannon L. Middleton, Deputy Director, Veterans Affairs and Rehabilitation Commission, The American Legion at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health hearing that took place on November 1, 2007 on "The VA Construction Process."

Please provide answers to the following questions by January 2, 2008, to Chris Austin, Executive Assistant to the Subcommittee on Health.

1. The veteran population projection for New Orleans is expected to decline by about 18% between 2001 and 2011. Given the declining veteran population, the downtown flood risk area, and travel time and distance concerns, could a replacement facility be more conveniently located outside downtown New Orleans, providing for easier accessibility and on higher ground that would be secure regardless of flooding?
2. In 1999, the Government Accountability Office (GAO) reported that VA was wasting millions of dollars annually on the upkeep of underutilized facilities that could be used to enhance veterans' healthcare. In response, VA initiated the Capital Asset Realignment for Enhanced Services (CARES) process to assess VA capital assets and establish a framework to modernize VA's healthcare facilities and use its resources more effectively to improve healthcare delivery. The Veterans of Foreign Wars (VFW) always agreed with CARES recommendations to build new facilities. However, specifically in what cases did the VFW support recommendations to downsize or close obsolete facilities?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by January 2, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record/Subcommittee Hearing
"The VA Construction Process"
November 1, 2007

Follow-up Answers of Deputy Director Veterans Affairs and Rehabilitation Division, The American Legion

Question 1: The veteran population projection for New Orleans is expected to decline by about 18% between 2001 and 2011. Given the declining veteran population, the downtown flood risk area, and travel time and distance concerns, could a replacement facility be more conveniently located outside downtown New Orleans, providing for easier accessibility and on higher ground that would be secure regardless of flooding?

Response: The New Orleans Veterans Affairs Medical Center (VAMC) should remain in the downtown area. The proposed location is within walking distance to the Tulane and Louisiana State University (LSU) Medical Schools, which allows staff from both medical schools to interact between campuses and the VAMC, all on behalf of patients. The close proximity also allows the medical schools to provide additional staff that is critical to the successful operation of the VAMC. In addition, the continued research, which is conducted by the medical schools, provides patients with quality medical care.

To build the new VAMC in an area that is not in the immediate proximity of the two medical schools would not be in the best interests of patients, nor the VA Medical System. The American Legion believes building the VAMC anywhere other than downtown New Orleans near the aforementioned medical schools would not allow for the hospital to provide the level of care needed to properly treat veterans.

Veterans who use the VAMC New Orleans are generally veterans who do not have medical or health insurance. Many are on fixed incomes and have no other alternatives. The VAMC's location in New Orleans will allow patients, staff and volunteers from throughout the 23-parish catchment area to access the hospital by major roadways and interstates; local and regional bus service; and rail.

Additionally, The American Legion believes veterans and the community would benefit from the construction of a joint facility with the LSU teaching hospital. The American Legion endorses such a joint facility, with the condition that the veterans will be treated in a designated medical dwelling.

Question 2: In 1999, the Government Accountability Office (GAO) reported that VA was wasting millions of dollars annually on the upkeep of underutilized facilities that could be used to enhance veterans' healthcare. In response, VA initiated the Capital Asset Realignment for Enhanced Services (CARES) process to assess VA capital assets and establish a framework to modernize VA's healthcare facilities and use its resources more effectively to improve healthcare delivery. The American Legion always agreed with CARES recommendations to build new facilities. However, specifically in what cases did The American Legion support recommendations to downsize or close obsolete facilities?

Response: Following the 1999 Government Accountability Office (GAO) report, the Department of Veterans Affairs (VA) continued to experience an unprecedented growth in the number of veterans enrolling for VA healthcare services, which in turn warranted a greater presence of its medical facilities nationwide. The American Legion continues to support allocation of funding to construct new facilities, as well as the upgrade of existing facilities, to include buildings that are old and require immediate renovations.

Enclosed, please find an American Legion report on the CARES process highlighting the key locations of concern.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
November 8, 2007

Honorable Gordon H. Mansfield
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Mansfield:

Thank you for the testimony of Donald H. Orndoff, Director, Office of Construction and Facilities Management, who was accompanied by Robert Neary, Director, Service Delivery Office, Office of Construction and Facilities Management, Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning, Veterans Health Administration, and Brandi Fate, Acting Director, Capital Asset Management Planning Service of the U.S. Department of Veterans Affairs at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health hearing that took place on November 1, 2007 on "The VA Construction Process."

Please provide answers to the following questions by January 2, 2008, to Chris Austin, Executive Assistant to the Subcommittee on Health.

1. One of the complaints that this Committee has heard many times is that the VA construction process can be slow and inefficient. What are some ways that the VA sees that this process can be improved? What can this Committee do to help the VA to improve the construction process?
2. Much of VA's medical infrastructure has become old and outdated, with the average age of VA's facilities exceeding 50 years. They are increasingly in need of either being replaced or substantially renovated to meet fire, safety, seismic considerations as well as to accommodate quality of care with the advancement in medicine. What effect has VA's aging infrastructure had on patient care? What steps has VA taken to mitigate the impact on patient care?
3. VA stated in it's testimony that the large volume of construction in most markets makes it extremely difficult to attract significant competition for VA construction projects. What requirements does the VA have for contractors to bid on VA construction projects? What can VA do to attract more competition for their construction projects? Is there anything that this Committee can do to facilitate more competition in this area?
4. In order to replace and upgrade aging infrastructure, the VA needs to embark upon an ambitious construction agenda. Can you talk in detail about the VA's plan for future construction? Does the VA feel that it will be able to upgrade and replace aging infrastructure in a timely and efficient manner?
5. Please provide an update on the status of the New Orleans Medical Center reconstruction project, to include a report on the environmental assessments underway for the downtown site and the site under consideration located 4½ miles away in Jefferson Parish and anticipated timeline for completion of the project.
6. In June 2007, VA reported to Congress on the option for Construction of Department of Veterans Affairs Medical Center in Okaloosa County, Florida. The report stated, "VISN 16 plans to establish a VA/DoD sharing agreement with the Air Force hospital to provide limited inpatient care for veteran enrollees in the Okaloosa Study Area. VA and Air Force are currently negotiating the scope and mix of these services." Has a sharing agreement been established? If so, what is the scope and mix of negotiated services? If not, what is the status of the negotiations?
7. In recent years, VA has experienced significant cost escalation in the construction of medical facilities. For example, the estimate for the construction of a new medical facility in Denver has almost doubled to $646 million. What are the causes for these increases? What steps has VA taken to prevent such escalation in the future? What is the status of a possible collaborative arrangement in Denver between VA and DoD or the University of Colorado?
8. In 2004, the Secretary agreed with the CARES Commission's recommendation that a new medical facility was needed in Orlando. However, over 3 years later, this project has not advanced. Has the site for the new Orlando facility been procured? If not, what is the cause for delay? How will this delay impact the cost of and time table for constructing a new facility?

9. How many major construction projects are currently underway? How many of these projects are behind schedule? What are the causes for these delays?
10. What effect has working under a Continuing Resolution had on your ability to move forward with major medical facility construction projects?
11. VA testified that two of the construction challenges were that the "rising cost of construction has had a significant impact on VA since 2004" and "attracting competition for VA major projects." What steps has VA taken to prevent the escalation of costs in the future? What steps has VA taken to increase competition?
12. In March 2007, the Government Accountability Office (GAO) issued a report recommending that VA develop performance measures for assessing whether CARES is achieving the intended results. Has VA developed any performance measures as recommended by GAO? If so, what performance measures have been developed?
13. On January 24, 2007, President Bush issued an Executive Order to improve energy efficiency and reduce greenhouse gas emissions of the agency, through reduction of energy intensity. How does VA incorporate energy efficiencies into its construction planning? Among the major construction projects for fiscal year 2008, how many will include the building of a new power plant? How much does the building of a new power plant add to the cost of building a VA facility? What other options are available for powering a VA without building a new plant?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by January 2, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Hon. Michael Michaud, Chairman,
Subcommittee on Health,
House Veterans' Affairs Committee
November 1, 2007

The VA Construction Process

Question 1: One of the complaints that this Committee has heard many times is that the VA construction process can be slow and inefficient. What are some ways that the VA sees that this process can be improved? What can this Committee do to help the VA to improve the construction process?

Response: The Department has taken several steps to address this issue. One reason for recent delays has been the impact on the rapid escalation affecting the construction economy and the need to address these cost increases through project design. In response to cost escalation, VA now routinely conducts cost studies of the markets where upcoming VA major construction projects are planned to ensure that the best information is available to predict anticipated costs.

Incomplete early planning can also be a cause for construction delays. Considerable effort is now underway to improve and streamline VA's construction process to increase the amount and quality of planning, project development and design work accomplished in advance of including a project in VA's budget request. This early work will enable the project to have a construction contract award made soon after the appropriation becomes available and provide less opportunity for delays to occur.

While VA is certainly not satisfied with the speed of delivery and recognizes that opportunities for improvement exist, it should be noted that during the hearing, a witness from the private sector referenced a study of construction execution done at Penn State University. The study included an examination of several VA projects and the data developed indicated that VA projects proceeded approximately one third faster that the average of over 300 public and private sector projects studied.

Question 2: Much of VA's medical infrastructure has become old and outdated, with the average age of VA's facilities exceeding 50 years. They are increasingly in need of either being replaced or substantially renovated to meet fire, safety and seismic considerations as well as to accommodate quality of care with the advancement in medicine. What effect has VA's aging infrastructure had on patient care? What steps has VA taken to mitigate the impact on patient care?

Response: Despite VA's aging infrastructure, the quality of care patients receive at VA medical centers is among the best in the Nation; VA has been recognized as a leader in healthcare delivery. As in any large healthcare system, infrastructure deficiencies directly and indirectly affect the environment for patients. VA Medical Centers are mitigating this impact by balancing operating and infrastructure needs to ensure patients are in comfortable and clean environments. Medical Centers are prioritizing their infrastructure needs and substantial funding has been allocated for Non-Recurring Maintenance (NRMs) and Minor Construction projects to allow VA to address some patient care related projects more quickly. VA is committed to maintaining a safe and clean environment for our patients.

Question 3: VA stated in its testimony that the large volume of construction in most markets makes it extremely difficult to attract significant competition for VA construction projects. What requirements does the VA have for contractors to bid on VA construction projects? What can VA do to attract more competition for their construction projects? Is there anything that this Committee can do to facilitate more competition in this area?

Response: VA contracting for construction is in keeping with law and regulation. Some aspects of Federal contracting are not attractive to construction contractors, but have been found valuable for Federal construction including the use of strict rules of competition and requiring contracts to support socioeconomic goals among others. In general, many contractors would prefer to do work in the commercial sector over the public sector. This will mostly impact VA when there is a robust commercial construction economy as there is at present.

VA can make efforts to attract more competition in several ways. One is to choose an acquisition strategy most desired by contractors. This might include selecting between design-bid-build and design-build as the contracting vehicle. In some markets, contractors will prefer one over the other. Another area has to do with the potential to award one large contract or a few smaller ones. This can attract added competition is some markets because it lowers the risk exposure and offers contracts that smaller companies can manage. We also need to make sure that contractors are aware of the upcoming work. VA has increased it communication with the contracting community throughout the design process in an effort to expand the number of contractors who are aware of the projects that will be going to the market.

Question 4: In order to replace and upgrade aging infrastructure, the VA needs to embark upon an ambitious construction agenda. Can you talk in detail about the VA's plan for future construction? Does the VA feel that it will be able to upgrade and replace aging infrastructure in a timely and efficient manner?

Response: VA's plan for future construction funding is based on specific identified gaps in capital needs for such issues as: addressing workload gaps, correcting patient privacy issues, and reducing wait times. The majority of these capital needs are addressed through NRM, Minor and Major Construction projects. Funding for projects may be decentralized (Veteran Integrated Services Network prioritize and fund their needs based on competing clinical demands and infrastructure needs) or centralized (funding approval is based on weighted criteria).

VA can upgrade and replace aging infrastructure in a timely and efficient manner based on available funding. The timing and efficiency for upgrades for VA's aging infrastructure follows the budget submission cycle. The NRMs are a decentralized one-year program and Minor and Major Construction lag two years between the selection and submission of the projects in the budget and the project's appropriation and authorization.

Question 5: Please provide an update on the status of the New Orleans Medical Center reconstruction project, to include a report on the environmental assessments underway for the downtown site and the site under consideration located 4.5 miles away in Jefferson Parish and anticipated timeline for completion of the project.

Response: The draft environmental assessment (EA) is complete and available for public review and comment. When the public comment period is complete in February, VA will be in a position to make a final site determination. VA has indicated that of the two sites being considered, the downtown site is preferred.

VA has recently signed an memorandum of understanding (MOU) with the City of New Orleans under which the City will acquire the downtown site if it is selected, clear the site and make it available to VA.

VA continues to evaluate the opportunities for partnering with LSU and it is anticipated that early next year decisions will be made on the extent of the partnership which will guide a determination of the specific scope of VA construction. VA

design will then proceed. It is anticipated that design will be completed by July 2009, and that construction will be completed by July 2012.

Question 6: In June 2007, VA reported to Congress on the option for Construction of Department of Veterans Affairs Medical Center in Okaloosa County, Florida. The report stated, "VISN 16 plans to establish a VA/DoD sharing agreement with the Air Force hospital to provide limited inpatient care for veteran enrollees in the Okaloosa Study Area. VA and Air Force are currently negotiating the scope and mix of these services." Has a sharing agreement been established? If so, what is the scope and mix of negotiated services? If not, what is the status of the negotiations?

Response: A VA Community Based Outpatient Clinic (CBOC), located on Eglin Air Force Base in close proximity to Eglin Air Force Regional Hospital, is currently under construction with an expected completion date of February 2008 and activation in April 2008. The VA Eglin CBOC is a satellite VA Gulf Coast Veterans Healthcare System (VAGCVHCS). VAGCVHCS and 96th Medical Group (Eglin AF Regional Hospital) are nearing completion of a draft resource sharing agreement by which 96th Medical Group will provide, on a space-available basis, the following services:

- Inpatient admissions
- Emergency Room
- Some Specialty Care Referrals in Medicine, Surgery, and Ancillary Services.

The VA Eglin CBOC is a 16,700 square foot clinic with primary care and outpatient mental health services.

The target date to complete the resource sharing agreement is February 1, 2008 in order to be positioned for the planned activation date or April 2008.

Question 7: In recent years, VA has experienced significant cost escalation in the construction of medical facilities. For example, the estimate for the construction of a new medical facility in Denver has almost doubled to $646 million. What are the causes for these increases? What steps has VA taken to prevent such escalation in the future? What is the status of a possible collaborative arrangement in Denver between VA and DoD or the University of Colorado?

Response: VA is supportive of a possible collaborative arrangement. Collaborations have occurred with Buckley Air Force Base, and design plans have ensued, including Buckley's identified needs as part of VA's Denver Major project. Discussions are ongoing with the University of Colorado on possible collaborations. The construction economy in recent years has experienced rampant construction cost escalation in all market sectors nationwide. There have been significant increases in the cost of labor and building materials and this situation has been exacerbated by the rising cost of petroleum for both fuel and building products as well as the hurricanes of 2004 and 2005. This situation is not unique to VA or even healthcare in particular.

The Producer Price Index (PPI), published by Bureau of Labor & Statistics, has increased by 27 percent from December 2003 through August 2007. Commercially published, historic construction cost indexes indicate a range of approximately 23 percent to 37 percent increase for January 2003 through July 2007. The robust economy has generated an unusually high volume of work in the commercial sector resulting in non-competitive markets throughout the country.

While VA can have little impact on market forces that push construction costs higher, we can do a better job of anticipating market pricing at the time VA projects will go to bid. In that regard, VA now conducts detailed market assessments periodically in those cities where we expect to be bidding major construction projects. The information collected in these studies enables more accurate costs to be included in the budget estimates. VA is also revising the planning process in order to have earlier definition of project scope and early design completed before committing to a budget estimate. This estimate will be more accurate with this improved planning process in place.

Question 8: In 2004, the Secretary agreed with the CARES Commission's recommendation that a new medical facility was needed in Orlando. However, over 3 years later, this project has not advanced. Has the site for the new Orlando facility been procured? If not, what is the cause for delay? How will this delay impact the cost of and time table for constructing a new facility?

Response: Funding for this land acquisition of $34 million is included in the fiscal year (FY) 2008 budget. In FY 2004, $25 million was appropriated for design. The total estimated cost for the new Orlando VAMC is approximately $656 million.

On December 18, 2007 VA and Lake Nona/Tavistock Group (the property owner) reached agreement for VA to acquire 65.9 acres of land for the new VAMC Orlando through a combination of purchase and donation. A purchase option agreement securing the site for VA acquisition has been developed and signed by owner and VA senior leadership is reviewing. It is expected that the option will be signed shortly and the closing on the property will occur in the near future. In the meantime, design work has been ongoing.

Question 9: How many major construction projects are currently underway? How many of these projects are behind schedule? What are the causes for these delays?

Response: As a result of the CARES process, 36 major construction projects have been funded in whole or part between fiscal year (FY) 2004 and FY 2007. Eighteen are under construction and one is complete. With the exception of one project at Temple, TX, the remainder are in the planning and design process. Delays that have occurred related to these projects have largely been related to cost issues and specifically the rapid escalation in the construction economy and the associated need to insure that designs can be constructed within the available funds to the greatest extent possible. Other factors causing delay have been related to site acquisition issues and unanticipated planning requirements to validate the scope of projects. Attached is the medical care portion of the Department's report to the Congress on major construction delays required pursuant to P.L 109–114.

CONSTRUCTION

1. Atlanta, GA—Modernize Patient Wards

Status: Funds were appropriated in FY 2005. Procurement action was canceled after excessive price proposals were received in September 2006. The authorization for this project expired on September 30, 2006. The Department has requested reauthorization in the FY 2008 budget request. The Department cannot make a construction award until this project has been reauthorized.

2. Dallas-Fort Worth National Cemetery, Texas—Phase 2 Burial Expansion

Status: Funds were appropriated in FY 2006. Protracted negotiations with the architect/engineering design firm and completion of a Defense Contracting Audit Agency audit significantly delayed the contract award. A construction documents contract was awarded in November 2006. Design is nearing completion. Award of a construction contract is scheduled for April 2008.

3. Leavenworth National Cemetery, Kansas—Gravesite Development

Status: Funds were appropriated in FY 2000 as *One VA* project between the Veterans Health Administration (VHA) and the National Cemetery Administration (NCA). The original Congressional Budget Prospectus stated that 39 existing structures on 54 acres would be demolished and the existing VA national cemetery would be expanded onto those 54 acres. The Kansas State Historic Preservation Office remained steadfast in their desire to maintain all structures as historic. In 2005, the Office of Asset Enterprise Management finalized and executed an enhanced use lease (EUL) to make use of the buildings through a public/private venture. A contract for the master plan was awarded in February 2007 based on the reduced available acreage. Upon review and acceptance of the revised master plan, a scope change notification will be prepared defining the updated project. The revised master plan was presented to NCA in November 2007. Award for the design development is scheduled for April 2008.

4. Palo Alto, CA—Seismic Corrections Building 2

Status: Funds were appropriated in FY 2004. The procurement was canceled after excessive price proposals were received. The Congressional authorization for this project expired on September 30, 2006. The Department has requested reauthorization for the project in the FY 2008 budget request. The Department cannot make a construction award until this project has been re-authorized.

5. Syracuse, NY—Addition for Spinal Cord Injury Center (SCI)

Status: Funds were appropriated in FY 2005. After design began, it became apparent that a permanent parking loss would be created by the construction of the new addition. To offset the loss, expansion of the existing parking garage was added to the project as a first phase. Award of the construction contract for this expansion is scheduled for September 2008. The phase II portion of the project for the spinal cord injury center is under design. The in-progress cost estimate indicated a funding shortfall. Additional funds were requested in the FY 2008 budget request.

DESIGN AND CONSTRUCTION

1. Biloxi, MS—Restoration of Hospital

Status: Funds were appropriated in FY 2006. Start of design was delayed due to the impact of extensive storm damage and cleanup activity from hurricane Katrina. Discussions have been ongoing with the U.S. Air Force to explore the potential for co-location and sharing of services. Schematics, design development, and construction documents for the utility upgrades phase 2, clinical addition and blind rehab was made January 10, 2008. A construction award is scheduled for phase 1 of the utility upgrades in March 2008. A construction award for extended care is scheduled for September 2008. The mental health addition is scheduled for construction award in September 2008.

2. Columbia, MO—Operating Suite Replacement

Status: Full funding was appropriated in FY 2007. During the early design, concern about the ability to achieve the scope of work within the available funds caused a delay. Award of the design development architect engineer contract was made in July 2007. The construction document contract award was made in December 2007.

3. Great Lakes National Cemetery, Michigan—Phase 1B Development

Status: Design funds were appropriated in FY 2006. Construction funds were appropriated in FY 2007. The phase 1A portion of this project was completed in early FY 2007. The same architect engineer firm that developed the initial phase 1A design of the cemetery will be engaged to provide continuity in design for the next phase. This design contract required extensive legal review and negotiations, which delayed the contract award. The phase 1B construction documents contract was awarded in November 2006 and is scheduled for completion in January 2008. A construction award is scheduled for July 2008.

4. New Orleans, LA—Replacement Medical Center

Status: Full funding was appropriated in FY 2006 under two separate emergency supplemental appropriations—-$75M in Public Law (P.L.) 109–148 and $550M in P.L. 109–234. The project is currently undergoing an environmental analysis which, upon completion, will allow continuation of the site selection process and the actual purchase of the property. An award for schematics is scheduled for March 2008. Award of a construction documents contract is scheduled for November 2008.

5. Temple, TX—Blind Rehabilitation & Psychiatric Beds

Status: Full funding was appropriated in FY 2005. The project was placed on hold pending the completion of the Capital Asset Realignment for Enhanced Services (CARES) follow on study at the nearby Waco VA Medical Center. Because the CARES study determined that Waco would remain open; there was no longer the need for this project, which planned to move functions from Waco. This resulted in a proposed cancellation and reprogramming of this project, which was approved in the FY 2008 budget.

6. Fort Rosecrans National Cemetery, California—Phase 1 Development of Miramar Annex

Status: Design funds were appropriated in FY 2005. Construction funds were appropriated in FY 2006. VA plans to develop an annex to the Fort Rosecrans National Cemetery on 300 acres at the Miramar Marine Corps Air Station. All design contract awards are on hold pending receipt of an Environmental Impact Statement from the Department of the Navy. The Department of Navy is currently in the sign-off process on the environmental Finding of Determination. A design award is planned for July 2008, and a construction contract award is scheduled for FY 2009.

DESIGN

1. Denver, CO—Replacement Medical Center

Status: Funds were appropriated in FY 2004. Pre-design studies and environmental due diligence are ongoing. A notice to proceed was issued to the architect/engineering firm to begin schematic design. Negotiations/discussions for the remaining property acquisitions are ongoing. The award of a construction documents contract is scheduled for May 2008.

2. Fayetteville, AR—Clinical Addition

Status: Funds were appropriated in FY 2006. The master plan and space program were revised and completed in November 2006. The architect/engineer contract for schematics and design development was awarded in April 2007, and the contract for construction documents is scheduled to be awarded in February 2008.

3. Riverside National Cemetery, California—Phase 5 Development

Status: Funds were appropriated in FY 2005. Project requirements were reevaluated based on changes in gravesite use and an updated gravesite depletion date. Award of a design development contract is scheduled for FY 2009 with a construction documents contract award in FY 2010. While the project was funded in 2005, NCA decided to postpone design until 2009/2010 because the current burial inventory will not deplete until 2012.

4. San Joaquin Valley National Cemetery, California—Phase 2 Development

Status: Funds were appropriated in FY 2005. Based on changes in gravesite use, project requirements were reevaluated and the scope adjusted to meet these requirements. A series of projects are ongoing to address immediate needs for crypt installation and the site irrigation system through FY 2009. The design development contract award is being deferred indefinitely due to a recount of available burial space. The NCA determined that a new expansion project was not required at this time.

5. San Juan, PR—Seismic Corrections Building 1

Status: Funds were appropriated in FY 2005. Prior to initiating the development of schematic design, several studies were necessary to determine: 1) the exact method for retrofitting the main hospital structure to conform to seismic standards; 2) the optimal approach to packaging and sequencing contracts to provide alternative space for administration, clinical support and patient care activities; 3) size, siting and configuration of these spaces; 4) increased capacities for the utility system infrastructure; and 5) impact on parking and site traffic circulation patterns and the attendant modifications needed. Design development is approaching completion, and the award of a construction documents contract is scheduled for May 2008.

6. St. Louis, MO—Medical Facilities Improvements and National Cemetery Expansion

Status: Funds were appropriated in FY 2007. The varied and complex project scope involves the demolition of numerous buildings, replacement of the energy plant, consolidation of clinical and administrative functions through renovation and new construction, and expansion of the adjacent national cemetery to provide additional burial capacity. An architect/engineering firm was commissioned to conduct a study of these scope elements and develop a planned approach for completing the work. Upon completion of the study, the architect/engineering firm was also tasked with preparing an updated cost estimate for the project. The study results indicated that the project costs far exceeded what was originally proposed. A master plan is to be developed to guide the Department in the approach to the further execution of this project. NCA portion of this project will proceed with the design development in FY 2008. The early turnover portion of the cemetery project can be built without impacting VHA portion of this project.

Question 10: What effect has working under a Continuing Resolution had on your ability to move forward with major medical facility construction projects?

Response: The continuing resolution did not impact any major medical facility project.

Question 11: VA testified that two of the construction challenges were that the "rising cost of construction has had a significant impact on VA since 2004" and "attracting competition for VA major projects." What steps has VA taken to prevent the escalation of costs in the future? What steps has VA taken to increase competition?

Response: Over the last eighteen months, VA has undertaken in-depth market surveys in areas for which major projects are planned. These market surveys analyze the current and projected capacity of the local construction industry and depict other competing projects in the local area. General and sub contractors are contacted concerning their strategic plans on future work and their interest in pursing VA's project. Material suppliers and fabricators are made aware of VA's project while ascertaining reasonable pricing of goods and services. The surveys also look at the availability of skilled and unskilled labor, along with up to date data on the local conditions affecting cost, and current and projected construction cost escalation.

VA uses the market survey process to stimulate interest in our projects within the local contracting community. Packaging or phasing of the work may be used to attract increased competition when market data dictates. VA is also investigating alternative contracting vehicles such as GSA's Construction Manager as Constructor

(CMc) and similar negotiated types of contracts that will make our projects more attractive to qualified contractors.

Question 12: In March 2007, the Government Accountability Office (GAO) issued a report recommending that VA develop performance measures for assessing whether CARES is achieving the intended results. Has VA developed any performance measures as recommended by GAO? If so, what performance measures have been developed?

Response: VHA is establishing a Department-wide CARES Implementation Monitoring Work Group that will be responsible for finalizing performance measures and determining oversight and monitoring responsibilities in response to the Government Accountability Office (GAO) report, "VA Healthcare: VA Should Better Monitor Implementation of Capital Asset Realignment Decisions" (GAO–07–408), issued March 2007. The work group will identify new outcome performance measures for each of the four foundational goals of CARES and a plan to monitor the implementation and impact of CARES decisions. Existing and new performance measures to be considered could include: activation of CBOCs; expansion of healthcare programming; enrollees within drive time access guidelines; underutilized and vacant space; patient satisfaction; project execution/status; and support to other VA missions, including DoD collaboration initiatives. The work group is expected to hold a kickoff meeting in the winter and complete their responsibilities no later than spring 2008.

Question 13: On January 24, 2007, President Bush issued an executive order to improve energy efficiency and reduce greenhouse gas emissions of the agency, through reduction of energy intensity. How does VA incorporate energy efficiencies into its construction planning? Among the major construction projects for fiscal year 2008, how many will include the building of a new power plant? How much does the building of a new power plant add to the cost of building a VA facility? What other options are available for powering a VA without building a new plant?

Response: VA has recently completed the *Sustainable Design and Energy Reduction Manual*, which defines the goals and objectives for all VA construction projects of 30 percent energy reduction in new facilities and 20 percent for major renovations, if lifecycle cost effective. The manual includes technical options for consideration by the design teams, subject to climate and building type, which include building orientation, high performance materials, daylight harvesting and lighting controls, as well as a host of high efficiency mechanical system suggestions. Incorporating the principles of integrated design to assure discussion of synergies between systems will also improve energy performance.

Among the major projects for FY 2008, three include construction of energy plants.

The cost of an energy plant will vary with each project, depending on the amount of commercially available power, the cost of that power, and the type of VA facility being constructed. The cost for an energy plant for the FY 2008 projects is approximately $40 million each, or 5 percent to 6 percent of the total project cost.

Options available for powering a medical facility without building a new plant will depend on the site, the public utility, and the type of VA facility being constructed. Use of utility energy service contracts (UESCs), where the utility provides financing to implement energy efficiencies, along with enhanced use leasing, are being pursued. VAMCs require significant amounts of energy, which can be too great a burden for existing municipal or co-facility power infrastructure to accommodate, especially if the facility must remain operational under the 4-day survivability requirements. However, by implementing design strategies that reduce energy demand the possibility of being able to utilize existing public services is increased. The use of renewable energy alternatives, although first cost intensive, may be cost effective if the total energy reduction through the use of all strategies can offset the requirements for on-site power generation. For those locations where power generation on VA property is necessary, efficiency options include cogeneration (CHP), ground-source heat pumps, geothermal sources, wind energy, biomass, as well as other possible solutions.

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