

VHA CAPITAL ASSET MANAGEMENT

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS
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VHA CAPITAL ASSET MANAGEMENT

WEDNESDAY, MARCH 10, 1999

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

The subcommittee met, pursuant to call, at 10:07 a.m., in room 334, Cannon House Office Building, Hon. Clifford B. Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Peterson, and Rodriguez.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning, everybody. The Subcommittee on Health of Veterans' Affairs will come to order.

I want to thank all of you, of course, for being here, and a special thanks to Dan Winship, one of our witnesses, for his heroic effort getting here from Chicago.

Members of our committee will be meeting soon to adopt recommendations on the fiscal year 2000 VA budget. Given the deep flaws in the budget, I am confident the committee will work together in a bipartisan manner to fight for a very substantial increase in the fiscal year 2000 VA medical care funding.

What we have learned today, however, is that VA will continue to face severe budget problems beyond the year 2000 unless it does a better job of managing its capital assets.

Last year, as a new chairman of this committee, I was troubled by VA's funding request for major construction projects, those costing more than \$4 million. As a result, I asked the GAO to review and analyze the VA's capital asset planning process and to evaluate its construction priorities and alternatives to construction. GAO's testimony today provides the response to my questions, and, my colleagues, it is a compelling testimony.

GAO found that VA is spending one of every four medical care dollars caring for buildings. They warn that VA is likely to spend billions of dollars over the next 5 years to operate hundreds of unneeded buildings.

A second important witness, Dr. Winship, has appeared before this committee many times as Associate Chief Medical Director of the VA health care system. Today he appears as the Dean of the Stritch School of Medicine of Loyola University in Chicago, and I want to highlight a key point of his candid testimony when he says, "The VA health care system...is hampered by aging facilities not well repaired, updated and maintained over the years due to the lack of funds appropriated for that purpose, and by mandates from

headquarters in Washington to keep facilities open and their staffing levels up even though activities have drastically diminished and moved to other, more appropriate venues.”

My colleagues, it is important to note that Congress has required VA to conduct strategic, coordinated network planning in managing capital assets. Today’s testimony suggests that VA has largely ignored that directive.

These are challenging times for all of us and for the VA health care system. In making that point in a joint hearing last week, I told members of the Veterans of Foreign Wars that we need to embark on a bold new plan for the veterans’ system. With that in mind, I intend to work on legislation to reform VA’s capital asset management policies and to refocus VA’s mission, to put more emphasis on serving veterans rather than serving unneeded buildings.

GAO and Dr. Winship both prescribe tough medicine to cure a systemwide problem. Let me emphasize this morning that these needed changes cannot be realized quickly. They would not solve the fiscal year 2000 budget problem, but the necessary planning must start soon to avoid even greater problems in the future years.

So I look forward to our witnesses this morning, but, of course, before calling the panel, I would like to call upon the acting ranking member from Minnesota, my good colleague, Mr. Peterson.

OPENING STATEMENT OF HON. COLLIN C. PETERSON

Mr. PETERSON. Thank you, Mr. Chairman. And I have a statement from the ranking member, Mr. Evans, to be made part of the record.

Mr. STEARNS. Unanimous consent, so ordered.

[The statement of Hon. Lane Evans appears on p. 28.]

Mr. PETERSON. And I will be brief. I commend you for holding this hearing. I think we are focusing in on something that is a very valid concern and something that I have been struggling with out in my area. I have got a district that is huge, and people have a hard time, you know, getting to medical care. We can see in our district a lot of the money is going into capital assets, and we need to be maybe looking at providing more access for people out in outpatient kind of situations. So I think it is very valid for us to be looking into this question and looking down the road, and I think your comments about the budget, you know, from what I am hearing and seeing in some of these budget meetings that I have been going to, I think we may be heading for a train wreck with the budget, not only in the VA but in the whole situation. So it is going to be a tough budget fight, and we need, in my opinion, more resources in the VA to take care of the commitments that we have made. Clearly, if those resources are getting sucked up by capital assets where it is not really appropriate or needed, that is something we ought to be looking at.

I commend you for holding the hearing and look forward to hearing from the witnesses.

Mr. STEARNS. I thank my colleague. And as he pointed out, with veterans we have an obligation because of not only what the recruiters said when they hired them, but because these individuals were promised these benefits and they have made the highest sacrifice. So perhaps they are a little bit different than a lot of other

folks that are coming to the budget process asking for more money. So I thank you and others in a bipartisan fashion. We are here to try and make the argument and hopefully get the Speaker and others to agree with us.

If the first panel would come forward, Mr. Stephen Backhus, and Mr. Paul Reynolds of the General Accounting Office and Dr. Daniel Winship, the Dean of Loyola University, Stritch School of Medicine.

Let me start with Mr. Backhus. Why don't you go? You are right in the middle. You go ahead with your opening statement, please.

STATEMENTS OF STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY PAUL REYNOLDS, ASSISTANT DIRECTOR; AND DANIEL H. WINSHIP, M.D., DEAN, LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE, MAYWOOD, IL

Mr. BACKHUS. Thank you. Good morning, Mr. Chairman and members of the subcommittee.

I am pleased to be here today to discuss VA's management of its health care assets. Last year, I testified before this subcommittee about the progress of VA's health care system transformation and challenges it faces as its role evolves. At that time last year, I suggested that VA's asset management decisions may represent the most significant and contentious challenge that it faces. Since then, Mr. Chairman, we have taken a closer look at VA's capital asset planning and budgeting processes, as you requested. And in doing so, we visited 92 VA locations, along with headquarters and the 22 network offices. We discussed planning and budgeting issues with over 400 VA officials. We reviewed hundreds of planning documents. We reviewed industry asset management practices. So my comments this morning are based on all of these efforts as well as the results of a series of GAO reviews that have focused on ways VA could improve the efficiency and effectiveness of its health care delivery system.

In summary, I want to say that VA has made significant progress in transforming its delivery system to better serve veterans. We commend Dr. Kizer and Dr. Garthwaite for their vision and their courage which have already reaped great benefits to veterans and taxpayers.

VA's health care system is without a doubt on an unprecedented journey of change, as Dr. Kizer so often notes, a journey, I should say, though, that still appears to be in its early stages.

I wish I could tell you today that VA's capital asset planning and budgeting processes will provide the greatest benefits for veterans in years ahead with the least investment risk to taxpayers. But, unfortunately, I cannot. From my viewpoint, VA's asset planning indicates that billions of dollars might be used to operate hundreds of unneeded buildings over the next 5 years or more. Moreover, capital budgeting appears to be driven more by the availability of resources within VA's different appropriations rather than the soundness of the investments.

My written statement describes ways that VA could address these concerns, but, in general, let me highlight them here.

We are recommending that VA develop asset restructuring plans—and I will describe those momentarily—and also refine its central budgeting process for high-cost investments; and, thirdly, to use a process similar to this or its principles for a larger share of its investment decisions, meaning VA's less expensive investments.

In addition, we offer for your consideration several ways that Congress could facilitate VA's asset restructuring efforts. These include restructuring VA's appropriation into a single capital investment appropriation, authorizing new sources of investment funding, such as asset disposal proceeds or asset restructuring savings or investment returns.

In our view, VA's development of restructuring plans should be its highest asset management priority. Wise budgeting choices begin with sound planning decisions. Capital asset plans, when done properly, provide road maps that let everyone know where you are going and, most importantly, provide the opportunity for all interested parties to participate.

Today it is unclear where VA's asset planning is headed or what VA's portfolio of assets will look like when VA's journey of change is completed. Moreover, it is unknown how much of an investment will be needed to ensure that veterans are served in assets that meet industry standards. In this regard, effective management of VA's assets is not an inconsequential undertaking.

VA owns an incredibly diverse portfolio of health care assets, including over 4,700 buildings and 18,000 acres of land. Of these, over 1,800 buildings have operated already for more than 50 years, which is the period that is generally considered to be the useful life of a building. About 1,600 of its buildings have historical significance that complicates maintenance and disposal. And 1,200 of the 4,700 are used to deliver health care.

VA's plans indicate that assets will continue operating at all 181 locations where it is now over the next 5 years, essentially as it does today, a situation that we find unthinkable.

I believe the VA should restructure its assets for two reasons: first, and obviously, there is lots of money to save; but, more importantly, the savings can be used to enhance veterans' health care benefits.

We estimate that VA will spend approximately one of every four health care dollars operating and maintaining its assets. This cost of ownership could be as much as \$20 billion over the next 5 years. Those costs are paid from the same funding source, VA's medical care appropriation; thus, one less dollar spent on bricks and mortar is one more dollar that can be spent on health care services for veterans.

So how can they achieve this objective? By doing market-based assessments of veterans' needs and assets and comparing the life-cycle costs of asset ownership to alternatives for meeting veterans' needs at lower cost.

OMB encourages this approach, and State and private organizations have found that using such processes yields positive results.

VA has several appealing alternatives, including consolidating services, partnering with others, purchasing care from others, and replacing obsolete assets with modern ones. VA should explore

these alternatives in every market where it owns assets, about 106 markets nationwide.

Over the last week, we have shared our views with VA officials, and from my perspective, we appear to be in general agreement that the issues to be addressed are not whether to make major asset management changes but, rather, how plans should be developed, how budget decisions should be made, and what the VA needs to implement these plans.

In that regard, I would suggest that VA needs perhaps a little more courage, but a lot more cooperation from the stakeholders. In my view, VA should seize the opportunity to reduce the significant amount of funds used to operate and maintain needed assets and reinvest such resources to enhance veterans' health care benefits.

This concludes my statement, Mr. Chairman. Mr. Reynolds and I will be happy to answer any questions you or other members of the subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 32.]

Mr. STEARNS. Thank you.

Dr. Winship, do you have an opening statement?

STATEMENT OF DR. WINSHIP

Dr. WINSHIP. Mr. Chairman and members of the subcommittee, I am Dr. Daniel Winship, Dean of the Stritch School of Medicine of Loyola University Chicago, which is affiliated with the Hines VA Medical Center in Chicago. I am pleased to be invited to discuss the issues of consolidation, mission change, and realignment of VA medical facilities with you.

The VA health care mission has never faced greater challenges than it does right now. Repeated budget reductions for many medical centers leads to extremely difficult management decisions and reduction in service.

As health care delivery evolves rapidly, the VA is caught up, appropriately, in the shift from in-hospital to ambulatory services. This cost-effective strategy, as well as those of consolidation, appropriate mission change, and realignment, comprise a centerpiece of the bold view and plan of Dr. Kizer to modernize the VA health care enterprise.

This rationalization of the operations of the VA health care system is hampered by aging facilities, mandates from above to keep facilities open and their staffing levels up even though their activities have drastically diminished.

Efforts to develop appropriate ambulatory sites of care are inhibited by an inability to free up funds sequestered in hospital budgets. Consolidation and integration of programs and facilities are blocked by constituents and their elected representatives who fear that integration of facilities and programs will impose hardships on the veteran community by requiring some veterans to travel longer distances for services.

The medical school affiliates fear a loss of teaching and research programs for which they rely heavily on their VA partner. The idea of sharing these precious clinical, educational, and research resources between two or more medical schools is anathema, but it should not be.

This picture appears to me to be one of an increasingly dysfunctional system of health care delivery. The decline in inpatient occupancy and the closure of beds continues, but the necessary, consolidations, mission changes, and realignments needed lag unacceptably far behind.

I wish now to focus on the VA health care scene in Chicago as I see it. I will present my thoughts as "a 30,000-foot view."

Of the four VA medical centers in Chicago, two have been declared to be consolidated, and integration of their programs inches forward. All four facilities remain intact, however. They in the past represented enormous capacity for inpatient care, now much smaller. The total currently operating hospital beds for these four facilities numbers 1,262, 80 percent occupancy, a capacity which a few years ago could have almost been handled by one facility.

There are another 1,436 beds for long-term care. Three of the hospitals maintain robust general, comprehensive programmatic and staffing structure, with duplication and redundancy. All three are within a geographic area less than 15 miles across and share a common patient service area.

Nine community-based outpatient clinics are now operational, and this is a promising start.

Meanwhile VISN 12 has sustained severe budgetary reductions over the past 3 or so years. The President's straight-line budget bodes ill for this portion of the system. Mandated pay raises, increased programmatic development, in conjunction with actual dollar loss, will profoundly affect the ability of this group of four facilities to carry out their missions, especially while they are also attempting to perform the near-impossible by keeping all four viable and operational.

By any objective measure, from the 30,000-foot view, Chicago does not need four VA medical centers. I am confident it could do fine with three, perhaps even two, as recommended by the GAO last year. The VA can take a lesson from other health care systems in the rationalization of care. Savings gained by real elimination of duplication and redundancy can be applied to developing other venues for care. Replacing an archaic, decrepit, inefficient delivery system with a new, better, cost-effective one, access and quality will improve.

What do the four affiliated medical schools have at risk if my view is accepted? They will feel loss of a partnership for education, research, patients. They will encounter fears from constituencies who see the threat of change but not the future possibilities for better programs. But if they buy in, and persevere, working out Dr. Kizer's vision for the future of the VA, the result will be more appropriate venues for care, education, and research, availability of funds newly freed up to accelerate the shift to ambulatory care, and better support of the remaining streamlined facilities. The alternative is continued and increasing dysfunction and programmatic erosion.

The capable VA staff must be allowed to let go of old practices which will ultimately lead to the demise of the system and to become as nimble and efficient as they need to be.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or members of the subcommittee may have. Thank you.

[The prepared statement of Dr. Winship appears on p. 50.]

Mr. STEARNS. Well, Dr. Winship, thank you very much, and I appreciate your candid comments. I think we all agree that some of these old practices have to be stopped, and we have got to do it. But how do we do it with a bureaucracy that is in place and when you point out that a lot of the VA administrators are mandating for them to keep up even while their business is declining? And so that is our challenge.

Let me go to Mr. Backhus. Can you turn to your report on page 11? And let me just call my colleagues' attention to that. Just explain "VHA's 40 Multiple-Location Markets." We should establish for the record from you that what you are saying is that the Northeast and Midwest are expected to experience larger populations decline, and the black circles are what?

Mr. BACKHUS. Multiple markets are a reference to those geographic areas where VA has two or more large medical facilities. It could be up to as many as nine, as low as two.

Mr. STEARNS. Okay. So when I look at these black circles, all that is saying is that this is where multiple facilities are located.

Mr. BACKHUS. Correct.

Mr. STEARNS. And following up, Dr. Winship indicated that in Chicago there are four and we could downsize to three. Are you also arguing that in markets like New York and Boston and LA that what Dr. Winship is saying could be extrapolated too?

Mr. Backhus, I am asking you.

Mr. BACKHUS. I am sorry.

Mr. STEARNS. What he provided his opinion on for Chicago, I am trying to see can that be extrapolated for Boston or—

Mr. BACKHUS. Obviously, you know, we did a similar analysis last year in Chicago exclusively, and as you heard him say, we did conclude that at least one hospital there could be closed. We haven't done that kind of a detailed analysis of the other 40 that are multiple locations. We think that is what needs to be done, and our belief is, based on the number of buildings at these locations and the costs that are invested in trying to maintain these facilities, that there are quite a number that are unneeded. And the conclusion will be that several of them aren't necessary.

Mr. STEARNS. I am trying to pin you down, and maybe it is not possible. But he is saying that 25 percent of the facilities in Chicago are not needed and we would be more efficient and nimble and able to provide better service. Do you think that is possible to be true, that 25 percent in Boston and New York and LA are in the same category?

Mr. BACKHUS. Yes, absolutely.

Mr. STEARNS. So we are establishing this morning that we have 25 percent in these large cities, particularly in the Midwest and the Northeast, where 25 percent of overhead is bogging the system down, and if we had that money, we could give it to Mr. Peterson in his State and others for outpatient clinics so that the veterans wouldn't have to go across a State, and he could do a better job of providing more money.

Mr. BACKHUS. We would wind up putting facilities closer to where veterans are, more state of the art.

Mr. STEARNS. Okay.

Mr. BACKHUS. Much more efficient.

Mr. STEARNS. Dr. Winship has used the words "archaic, decrepit, and inefficient" to describe the VA's delivery system, and the indication is it is being threatened with demise if realignment isn't accomplished immediately. So I guess the situation is dire. Is there some type of timetable you are talking about? Either one of you, if you could comment on that.

Dr. WINSHIP. I think it is dire. And my colleagues, the deans of the medical schools who are affiliated with VA medical centers, as a group, with rare exception, believe it is dire. In fact, that group of people, who are the ones who really interact on a very regular basis and have the view a little bit from outside the VA, watching what is taking place, believe that Dr. Kizer's plan is the right plan, stating generally, that when it began that there was a window of opportunity which was a few years long, perhaps 3, perhaps 5, maybe a little longer, and that window is getting on now and is closing—and, in fact, what my colleagues are seeing and talking about a lot is that the dysfunction of their portion of the system, as I have stated about what I see in our area, is really very sizable and very troublesome. And the concern is that the VA is headed into decline from which it cannot recover, unless it can go ahead and make the changes to bring it into a very efficient system, which Dr. Kizer has talked about. So I believe it is dire.

Mr. BACKHUS. It is dire and it is urgent.

Mr. STEARNS. What does "urgent" mean?

Mr. BACKHUS. That they need to get on—

Mr. STEARNS. How soon? How soon? I mean, give me a time. He has mentioned at one point we talked about 5 to 7 years. Now Dr. Winship is saying it is down to something like 2 to 3 years before the system might be at a point that we have lost it. Am I putting words in your mouth?

Dr. WINSHIP. No. That is essentially correct.

Mr. STEARNS. Would you agree that it is 2 or 3 years?

Mr. BACKHUS. I do not think I am going to be that precise. I think it may wind up taking that long, perhaps, or—

Mr. STEARNS. To change it.

Mr. BACKHUS. Yes.

Mr. STEARNS. Yes, sir?

Mr. REYNOLDS. I believe 2 or 3 years until the kind of changes that need to take place are well underway.

Mr. BACKHUS. I would agree with that.

Mr. STEARNS. You would. You would agree with that.

We also have Mr. Reynolds, Paul Reynolds.

Mr. REYNOLDS. Correct. If I could point out that at a budget hearing before this committee a couple weeks ago, some of the witnesses were pointing out what problems the fiscal year 2000 budget was going to have for them, and essentially, as I understood their remarks, they were saying they would be facing difficult choices between a dollar spent for the assets and the operation and maintenance versus a dollar for the health care for veterans. So by that

standard, if that budget goes forward, it seems dire sooner rather than later.

Mr. STEARNS. One last question before I close. Mr. Backhus, the VA closed a hospital in California several years ago because of its vulnerability to earthquakes. Would you comment on the recent report that identified almost \$2 billion in VA seismic construction needs?

Mr. BACKHUS. Well, this is certainly significant. Obviously, facilities that need that kind of maintenance and improvement or repair to meet standards are going to move quite high on the list of projects that should be funded.

It may well not be, though, the kind of facilities where the VA needs to be in the next 10 to 15 to 20 years. I think this may force the issue at VA, or should, anyway, toward them deciding where it is they need to be in doing market kind of planning and assessments. They are going to have to make a decision whether these facilities that require the \$2 billion in seismic improvement are where they need to be and, if not, then act to close those particular facilities while they still can, while it is still safe.

Mr. STEARNS. I think that is a very important point. We funded a hospital in Puerto Rico for \$50 million to help them with their seismic construction needs, and yet I think before we allocate this money in the construction budget, we have to follow along with what you folks are saying. Is that hospital already over 50 years old? And then we would be better off either building a new one or closing it and consolidating.

Mr. BACKHUS. Correct.

Mr. STEARNS. Well, let me have my ranking member, Mr. Peterson.

Mr. PETERSON. Thank you, Mr. Chairman.

Mr. Backhus, I want to commend you and your folks for the work you did here. It looks very comprehensive and very helpful.

On page 23 of your handout, these five general categories and 20 decision criteria and so forth, has that been implemented? Is that actually—that is what they are doing in the VA? You are shaking your head, Mr. Reynolds.

Mr. REYNOLDS. Yes, that is the criteria that was used to prioritize the projects that were put into the fiscal year 2000 budget.

Mr. PETERSON. So that has already been done, and they have gone through that.

I think I am persuaded that you are on the right track here. My question is how you are—I think the constituent groups out there are going to be a big problem with a lot of what you are talking about. But, frankly, we are also going to be a big problem. Have you thought about how you are going to get around us? I mean, I guess what I am asking, have you thought about setting up like a BRAC type of a situation? Because I really think that it is going to be problematic if you get into actually trying to do what needs to be done. You are going to have everybody protecting their turf, and you know how it goes.

Mr. BACKHUS. We have talked about that at length, and I don't think we are at this point inclined to suggest that a BRAC is necessary. Not at this time.

There is a significant case, I think, that can be made, a compelling case that can be made through this market assessment and planning that can persuade members, unions, and medical schools that services can improve, efficiency can improve, there are ways to satisfy the concerns of employees who might be affected, and that medical school requirements in research and training can still be accomplished—probably better.

Mr. PETERSON. Yes. I guess I am looking at it from a little different perspective. I represent an area way out in the middle of nowhere, and Fargo, for example, which you have identified as one of these single markets, is sitting there—I think it is probably 25 percent empty or more, because they don't have the money—they have got the patients; they don't have the money to bring the patients in and serve them. So what they do is shut down the wing, and I don't know how much money we are spending, you know, maintaining that, heating it.

I can tell you the patients are out there, but they don't have the budget to do it. So I guess I don't understand in that particular situation what you would do because if you close that hospital, then people are going to have to drive 400 miles to get to the nearest hospital. You can't really realistically block off one wing of it because it is all attached. So I think you have got some problems in there where you have got too much capacity, but I don't know exactly what you do about it.

Mr. BACKHUS. There clearly are VA facilities in locations where they are the only facility, where there aren't good alternatives. We recognize that, and we note that those are limitations to what VA can do. It is not a perfect world.

Mr. PETERSON. Has anybody gone through and taken a look at this, these types of situations which really are not reconcilable and those which are that you are looking at? I guess to some extent, this information about the multiple facilities and so forth gives us some of that information where you have got a bunch of hospitals close together. Has that been quantified?

Mr. BACKHUS. This is exactly what we are suggesting needs to be done.

Mr. PETERSON. It hasn't been done yet?

Mr. BACKHUS. It hasn't been.

Mr. PETERSON. Okay. And why? Because they are afraid of the political flack they are going to get if they put that on paper, or what?

Mr. BACKHUS. Well, that has been the case in some instances in the past. That is part of the problem, for sure. But the other parts is that I think traditionally each of the locations has been—the incentives have been to keep each facility open.

Mr. PETERSON. Has it ever been looked at from a standpoint of giving these VISNs the opportunity to keep the money within their VISN if they save it on capital equipment? In other words, I would imagine part of the concern is that even if they do it, they need to do, some of the other money is going to get sucked up, and they are not going to really get it.

Has it been looked at, that they can look at their situation and if they can save capital money in their area, then they can use that

money and it is not going to go to some other place in the VA? Has that ever been looked at?

Mr. BACKHUS. I think the VA has a proposal on the table now to do just that, and we support that.

Mr. PETERSON. Is that with capital—I know they are doing some of that. Is that with capital assets?

Mr. BACKHUS. Yes.

Mr. PETERSON. And that is what they would do that it. Okay.

Mr. BACKHUS. We think that it can even go further than what they are proposing, though, in that there are opportunities to use other kinds of—or establish a revolving fund that includes even more money from different sources to allow them to establish—

Mr. PETERSON. Have efficiencies and be able to use it so they have got some incentive to do it.

Mr. BACKHUS. Exactly.

Mr. PETERSON. That is part of the process that is being established?

Mr. BACKHUS. They are proposing that.

Mr. PETERSON. But it hasn't been implemented as well.

Mr. BACKHUS. Correct.

Mr. PETERSON. And this is kind of parochial, but you had Minneapolis on the multiple list. I mean, the Minneapolis hospital is pretty much one facility, it looked like to me. Where are these other facilities? What is it? Is it a veterans' home or what?

Mr. REYNOLDS. Well, that example really shows one of the difficult things VA has to first come to grips with, which is exactly what are their target markets. That is a situation where reasonable access for medicine may be a certain distance; reasonable access for surgical services may be a little bit more distant; reasonable access for mental health services might be a little longer. And so what VA needs to do is to define their markets and what is reasonable access.

They have done that for community clinics based on hearings this committee held a couple years ago; 30 minutes, 30 miles is what they have decided with the community clinics. They really need to do that for all their other markets, for special emphasis markets, and once they have done that, then we will truly know what the markets are and then look at the inventory of assets to decide how best to meet those needs.

Mr. PETERSON. Mr. Chairman, we have to vote, but if I could just—is there—do you have the information some place? You say 1,200 of these facilities are used for actual medical care and the rest are support and whatever else. Have you got this broken down as to how many dollars of the capital budget is used for the 1,200 that are medical care, how much is for support, so we can see—I mean, it seems—these buildings that are—these other 3,700 or whatever they are must be smaller facilities and probably are not near as much of a burden as the rest.

Have you got that information so we can kind of see what dollar amounts we are talking about, not just the number of buildings?

Mr. BACKHUS. No.

Mr. PETERSON. Or how many square feet we are talking about? Is there any way to get that?

Mr. REYNOLDS. Well, the problem with the dollars and why we are estimating that it is one out of four dollars is because VA doesn't keep the information that way, so it is not readily available.

One of the things that we would like to see would be that breakdown so that exactly the kind of information you need to make decisions would be available, and hopefully VA after this hearing may start looking at their budget a little differently and trying to get a better handle on what the true costs of asset ownership are.

The square footage we have. We can provide you information on the breakdown of square footage for those buildings.

Mr. STEARNS. The gentleman from Texas—we are going to go vote, and when we come back, if the panel will be patient, we will be back shortly and reconvene. At this point we will take a break for the vote.

[Recess.]

Mr. STEARNS. The Health Subcommittee will reconvene.

The gentleman from Texas, do you have some questions?

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman.

First of all, I would just want to kind of share, I guess, some of my concerns from my area, and let me know—I have been told never to ask a question unless I know the answer. In some of these cases, I don't know the answer. But I do find myself in—I represent 13 counties, San Antonio and south, and I have a major hospital there. And then there is one 60 miles north in Kerrville, and yet when I go south, I go 13 counties south, about 200-something miles, and then I get Congressman Hinojosa, Congressman Ortiz, in Corpus that has about half a million people, has no facilities at all. Then you have Hidalgo down in the valley with no facilities at all. And I know my predecessor had been working on trying to get some clinics, and we finally, I think, made some breakthroughs in getting a clinic in Alice, TX, and a couple of others. And we have established another one in San Antonio, but it is not—it wasn't build with veterans' money. It was built with the university money there, and I think they provide some of the services.

As I hear in terms of—there is a push right now to close the Kerrville one, and, of course, you have got the two Senators and about two other Congressmen supporting that. I guess I am trying to say there is a need for services in certain areas, and it is not being met, and yet it seems like—I mean, when I see four hospitals in a facility, I think anywhere where there should be more than two, I think we need to look at it real seriously. And I was just wondering whether you might want to make some comments on that, and also on the fact that we were supposed to have been moved to allow veterans to begin to just go to a private physician and get taken care of and then a billing structure, and I know the San Antonio was a pilot study. I don't know where we are at on that or how successful that has been.

I just wanted to throw that out and get some feedback from you.

Mr. BACKHUS. Well, I don't know that I can answer your question about this particular facilities. I am not familiar in detail with those facilities. However, you are asking questions that sound like they are the kind of questions we always ask when we go out and

look at these things. Why are hospitals there? What is the workload? What is the demand? What does the future look like? What are the alternatives for health care for veterans in that area?

I will let Paul here answer in a minute, but I think that that is what obviously needs to be addressed. This is what we are suggesting here that the VA do on a market basis. For that area of the country and that market, they should—they probably can't now, but probably need to be able to be in a position rather quickly to tell you exactly what the best alternatives are for health care in that area.

Clearly, if we were to build the VA today, it wouldn't look like it does. These facilities are old, and they were built a long time ago for different needs, in a different environment, somewhat even different missions, I suppose. So it doesn't square with necessarily where veterans live today and what other health care options are available to them. That is why in our opinion there has to be a re-assessment, a restructuring, of this whole health care infrastructure by market. And you have a market there that clearly needs to be assessed and addressed.

Mr. REYNOLDS. I believe what we are trying to say is that Kerrville may be like a lot of other ones we have seen. We didn't visit Kerrville, I don't believe, but we saw places that were more thinking along the lines of the way they were built and operated over a number of years. And I guess with this market-based approach, we are saying we need to look at each market and decide what is the best way to serve veterans. And we are looking for creative solutions, and if the solution, say, in a place like Kerrville might be a smaller outpatient clinic, as they did in Martinez, CA, and then use the money for community clinics, for the primary care, that may better serve the veterans.

We feel like the market-based assessments we are calling for will let everyone know what is best in each market.

Dr. WINSHIP. Congressman Rodriguez, if I may comment, I believe that a very important concept here is to use the clinic approach for this very large underserved population, not just in South Texas but wherever the populations are, and not—pouring more money into the VA Medical Center at San Antonio, good as Jose Coronado is, is not going to result in better care for those people. It just isn't going to do it, or, similarly, Kerrville.

But to find a way to make that shift of funds, but not to build those clinics in those areas to serve just as feeders to the big tertiary centers, that is the problem that we continue to have, I think, is the concept of using those as feeders now so we can maintain the structure of the tertiary centers but, rather, develop those as almost comprehensive health care programs that have everything except what is just needed and absolutely required in a centralized area, tertiary center.

I believe that that is the conceptual approach that is going to have to be used to solve the problem you are talking about, and not building hospitals down in Harlingen or wherever, but to create a much broader network that is almost autonomous, that can do all the work that is necessary except for just a little bit of it that requires a centralized program.

Mr. RODRIGUEZ. It is also my understanding that the VA is supposed to come up with some kind of report to assess what they have been doing in reference to the cost and all that. Do you have any indications? I think it is supposed to come up in the next few weeks or so, or a month. Do you know anything in terms of their recommendations?

Mr. REYNOLDS. The cost of their asset needs?

Mr. RODRIGUEZ. Yes, I think so. I don't know what they call it, but I know it is a report in terms of cost and everything that they are doing to see how they can bring that down.

Mr. REYNOLDS. They have a number of different reporting requirements. One is commonly referred to as the Section 204 report, and that is supposed to highlight their high-priority investment projects, and that is coming available right now.

They also have a capital asset plan which they prepare, and that goes through a lot of their asset needs. It also gets into the community clinics and says where they are. It also talks about the other asset-related costs, non-recurring maintenance, minor projects. So I believe they have got a draft of that, and it will be coming up soon.

Mr. RODRIGUEZ. Let me ask you again—and I will give you the Texas experience, and let me know—you know, because I had sent some letters regarding the VERA and the distribution of resources because I was looking at the hospital in San Antonio, and I saw that even per patient there was about a \$1,000 disparity between my hospital and other hospitals in Texas. And that is per patient. So it was a pretty significant amount of resources in terms of disparity from one region in Texas to the other.

What I gathered was that it was the administration there in Texas that basically distributed the money in a different manner that allowed for that to occur, or mainly because of where the hospitals were located that caused that disparity to happen.

Is that similar in other States, or do you find that? Or have you looked at that at all?

Mr. BACKHUS. Variances within—

Mr. RODRIGUEZ. Within the State, after the resources are filtered down, I think that there is some leeway that those States have in terms of the resources. You know, after looking at the data, I found that disparity in Texas between my region and the rest of the State.

Mr. BACKHUS. Well, there is flexibility, once each of the VISNs receives their budget, to distribute that among their VISN as they see fit. That does vary from VISN to VISN. I think that is fairly common.

Mr. REYNOLDS. It is up to each of the 22 networks. About a year ago, maybe 18 months ago, we looked at that because a lot of people were saying that VERA was causing things to happen at certain locations. And when we looked into it, we found that VERA is allocating money to the 22 network directors. They then used their own approaches, and so it really was unfair to blame it all on VERA because they were not using the exact VERA model to transfer down. They were using other models.

Mr. RODRIGUEZ. So that after the money got down there, you know, certain areas—it was apparent to me that certain areas in

Texas were getting more than my area, in proportion to the number of veterans and the services.

Mr. REYNOLDS. Yes. What it comes down to, I guess, is each network director would have to explain what their model is, what it is based on, what is important, and how they distributed the money. So each would have their own explanation of the rationale for the distribution of the VERA money that they got for that network down to the local level.

Mr. RODRIGUEZ. Thank you.

Mr. STEARNS. I thank my colleague.

Just in conclusion, we have heard your statements, and, Mr. Backhus, the example of the Martinez, CA, hospital closure, I think provided a good prototype or a pattern or a paradigm of a win-win model for how VA can deal with unneeded facilities. Wouldn't you agree?

Mr. BACKHUS. Absolutely.

Mr. STEARNS. So as Dr. Winship said, pouring more money into some areas is not going to provide better service. So we have a bill here we are working on that, without a base closure operation, we are trying to figure out how to get the VA, the VISN directors, and others to make these important decisions. And as Mr. Peterson pointed out earlier, Members of Congress are going to fight like heck for their district.

So, would you, just in conclusion, want to amplify on what you think the type of bill coming through Congress which would either help the Administration, help the VISN directors, to get the patient care that we need and get these obsolete hospitals disposed of and the money used more efficiently?

Mr. BACKHUS. Well, the first thing is to—I don't want to sound like I am repeating myself here, but I guess to some extent I will have to. The VA needs to determine for each of the health care markets that they are operating in to produce a plan that outlines specifically where it is they think they need to be functioning over the next—

Mr. STEARNS. So Congress could mandate and say you shall provide a plan to Congress by such a date.

Mr. BACKHUS. Yes, I think that would be helpful to require market-driven plans by a certain date, and that those plans specify the expected workload in those areas, the alternatives that are available in those areas, and based on that conclude what is the most—or propose what is the most efficient and effective health care delivery system in those markets. That includes not just, obviously, their own hospitals and their own medical facilities, but those that—the care that they could purchase, partnering that they could do with other Federal agencies like the Department of Defense, or potentially leasing space from other locations, and it should emphasize, I think, ambulatory outpatient care.

Mr. STEARNS. Dr. Winship, is there anything you would suggest?

Dr. WINSHIP. Well, it is along the same line. I believe that one of the most cogent questions that has been asked in this entire hearing today was by Congressman Peterson about, well, what are you going to do with us? Because it is the issue of turf and it is the issue of protecting that turf that I think really is and has been a major barrier to making these kinds of changes.

So whatever the legislation has, if it has the rational programmatic areas that will permit agreement by the Members of Congress where they can live with that within their districts, with the goal of actually improving the health care not just of their district but of their district and the surrounding ones, and using that then as the template for creating the autonomy that is required, I believe, to achieve that nimbleness which we were talking about, to do exactly what Congressman Rodriguez is talking about in South Texas, multiplying that around the country, using a mechanism like was used at Martinez, multiplying that around the country, I think that there is some chance for success of that—in fact, likelihood of success of that. That is difficult.

Mr. STEARNS. Well, if we can set the incentives correctly so that when you shut down an unneeded hospital and you say to that Member of Congress, okay, we are shutting it down, but we are keeping the funds within your congressional district or we are keeping it within your county or city, and those funds will be used in turn to provide better care, then I think the trade-off would be to his advantage and he might be able to say back to the constituents, look, you know, we may be shutting down this hospital in Chicago, but we are taking the funds with outpatient care, we are going to renovate and increase our facility capability at the other three hospitals. And maybe that as an incentive would do it.

Dr. WINSHIP. Well, that would probably help, but with all due respect, it may well be, in order to get to South Texas for the needs that Congressman Rodriguez is talking about, perhaps taking some of the funds from Kerrville would not be allowed to do that if it has to remain in that district. I am not sure, you know, what that district looks like here.

Mr. STEARNS. I see your point.

Dr. WINSHIP. But I think the requirement is going to be that it serve the veterans primarily rather than serving a congressional district primarily.

Mr. STEARNS. Mr. Reynolds, anything you would like to add?

Mr. REYNOLDS. I think I would second the incentive notion that you just put forward. I believe that the bill should have incentives for creative solutions. There was one thing, when we looked at their investments now, most of the major investments were within the construction that has been there for several decades. Martinez is an example of what I would call a creative solution, and so, too, is northern California. And in that regard, I think what really made northern California be accepted so quickly was the plan was a good plan and a plan that could easily be demonstrated to benefit veterans of northern California by spreading the care out among Sacramento and other areas closer to where they live rather than having a large hospital built at Travis Air Force Base. Keeping the money sounds like a very good idea.

The other thing that I would put forth is as an incentive let the plans go forward as they are ready, which would—the people who are more forward thinking and are more—want to get on shouldn't be penalized by having to wait for some of those that may take longer. And so if someone gets a plan and it is a good plan and it gains rapid acceptance, they should probably be given the green light to go forward rather than waiting.

Mr. STEARNS. Well, I want to thank you for your attendance, and also, Dr. Winship, for your perseverance in coming down. Now we will have the second panel. Have a good day, gentlemen.

Mr. STEARNS. We have Dr. Garthwaite again. Nice to have you back. We have Charles Yarbrough, Chief Facilities Management Officer, and Mr. Mark Catlett, Deputy Under Secretary for Budget.

Gentlemen, we appreciate your waiting, and at this point, I guess, Dr. Garthwaite, you will open with your opening statement.

STATEMENT OF THOMAS L. GARTHWAITE, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY CHARLES V. YARBROUGH, CHIEF FACILITIES MANAGEMENT OFFICER, DEPARTMENT OF VETERANS AFFAIRS, AND D. MARK CATLETT, DEPUTY UNDER SECRETARY FOR BUDGET, DEPARTMENT OF VETERANS AFFAIRS

Dr. GARTHWAITE. Thank you, Mr. Chairman, for having the courage to take on one of the most challenging issues facing the Department of Veterans Affairs and Congress.

Just a few years ago, Kaiser Permanente health care system finished building several new hospitals and in the end occupied only one of them as soon as they finished the construction. By the time we finished our facilities in Detroit and West Palm Beach, the way health care is delivered had changed, and we had more beds than we needed.

In retrospect, the capital planning processes of Kaiser and of the VA were inadequate to deal with the rapid change and the powerful forces that are shaping health care today. Kaiser Permanente, like VA, is in the difficult position of simultaneously operating and reshaping a large health care system in the midst of profound environmental changes in biotechnology, surgical techniques, and informatics. If there is a lesson from their experience and ours, I believe it to be that whatever you do with regard to capital assets, you should build in the maximum flexibility.

In the past 3 years, we have evolved from a centralized, long-cycle capital planning process focused on large inpatient facilities to a network-initiated, shortened-cycle process emphasizing the capital needs of our rapidly evolving health care system. Like GAO, we believe that we have made progress in improving our assessment and prioritization of major projects and in tying them to our strategic plans, but we believe that capital planning in health care is a necessity without any science and that we have much to learn and much to improve.

We are learning by experience. In three geographic areas, we have undertaken comprehensive asset planning analysis. That is northern California (or Martinez), Boston, and in Chicago. We have learned from these efforts and agree with GAO that additional asset restructuring plans based on objective data and analysis are appropriate in other areas of the country. We also relearned and agree with GAO that the intense interest from veterans' groups, unions, medical schools, and elected representatives complicate our capital planning.

While we believe that we have made progress in review of major projects, the bulk of our capital investments are in the minor and

non-recurring maintenance programs. The current challenge is to make short-term operational decisions while evolving a long-term strategic vision. I am not sure if "long-term" is a term that makes any sense in health care planning; however, I use it advisedly.

Specifically, we are asking how do we ensure that we don't sink money into buildings we vacate in a few years as all these things change rather rapidly. While we cannot guarantee the future, Dr. Kizer and I see a need to subject these minor and NRM decisions to additional review and discussion.

Therefore, we will promptly institute a new process that will parallel processes we are using with success in reviewing other major decisions that we make relating to major policy decisions, to money that is distributed not through the VERA model, and to changes in the deployment of our executives.

In short, minor and NRM projects with programmatic implications will be submitted to a subcommittee of our VHA Policy Board. Enhanced guidance and criteria will be developed and will include an assessment of the future of the affected program within the network. The recommendations of the subcommittee will be forwarded to the Policy Board for review and approval.

We believe that the additional step of criteria-based review and presentation to 40 other executives will minimize the chance of investment without the clarity of strategy and will continuously teach our executives the importance and complexity of the capital asset decisionmaking process.

We have a variety of other initiatives that we are proposing or have ongoing within the Department with regards to capital assets. One of those is an initiative to improve our capital asset portfolio by increasing our flexibility and incentive to dispose of property that is no longer needed to meet our needs. This proposal would allow the VA to dispose of these properties—including land, structures, or any equipment associated with the property—by sale, transfer, or exchange, and to reinvest the bulk of the proceeds into the system. The pilot would be restricted to 30 dispositions over its 5-year life.

As previously discussed, VA's capital portfolio is large and consists of over 22,000 acres of land, 4,400 facilities, and nearly 1,200 locations. Disposal is currently a cumbersome and lengthy process, with limited benefits to VA. We propose to deposit all proceeds of disposals after deductions into a capital asset fund that will be available to be reinvested into the system's capital requirements.

Because these resources will directly benefit VA programs, I urge the committee to support this initiative.

Another initiative which has helped us to restructure our extensive capital assets to the benefit of both veterans and taxpayers is the continuing use of the Department's Enhanced-Use Leasing Program.

The Department has used this authority to consolidate operations and dispose of unneeded facilities, to collocate VBA space onto VA Medical Center grounds, to obtain child-care services, expand parking facilities for veterans and employees, and to redirect operational funds from managing golf courses into direct medical care. In doing so, these leases have achieved significant cost savings, have enhanced employee recruitment, have added substantial

private initiative to the Department's capital assets, have provided new long-term sources of revenues, and have created jobs and tax revenues for local economies.

While the program has achieved some level of success, it has limitations, namely, market demand, compatibility issues with VA and its requirements.

A final initiative that I would mention is the Department's use of Energy Savings Performance Contract Program. In short, a private contractor updates the facility with energy saving technology. The savings from utility charges are shared between VA and the contractor until the contractor's cost of the upgrades is covered. VA has completed seven projects at various medical centers, and a total of 92 medical centers have awarded contracts under this program. We intend to continue emphasizing this program as a means of upgrading energy-consuming aspects of our facilities, and I think it is a real win-win.

Mr. Chairman, our objective is to ensure that VA capital assets are utilized in ways that bring the greatest value to the Department at the lowest cost. We believe the initiatives I have discussed will help the Department in moving forward in that area.

This concludes my opening statement, and my colleagues and I welcome your questions.

[The prepared statement of Dr. Garthwaite appears on p. 54.]

Mr. STEARNS. Well, let me thank you. Let me compliment you on your presentation this morning and for talking about your central office reform in which you are going to do oversight on capital assets. We didn't see that in your original testimony, and so we appreciate your revision and making that initial step to understand how significant this is. And with that in mind, it is my understanding that in the 1999 Network Plan for Chicago there is \$22 million in planned minor construction spending with projects in each of the four hospitals in Chicago over a 3-year period. In light of Dr. Winship's testimony and the GAO, my question to you is: Do you agree with Dr. Winship, and do you intend to implement this new program you talked about for Chicago?

Dr. GARTHWAITE. I think we agree that our assets in Chicago need to be assessed and restructured, and, in fact, we agreed with the GAO report that suggested that we could operate in less than the number of facilities that we had, but suggested that we should have a comprehensive review of all assets to look at how we could restructure it to the maximum benefit of veterans in that area. So the answer, I think, to your question about do we need to rethink is yes. The assets in Chicago. We are very much supportive of that effort.

I think at least some of the capital planning issues in Chicago are related to long term nature of construction. Much of what we do in capital asset planning takes a fair amount of time to move through the pipeline, and some things were put in the beginning of the pipeline, I think, before some of these other decisions were made. I think, in fact, one of the challenges and one of the reasons I used the Kaiser Permanente example in my opening testimony is that they thought they would need more hospitals than they ended up needing when they actually built them. I think we have the same problem.

We will not just look prospectively with this committee. We will take a look at anything that we can adjust with the committee as well. That is the intent.

Mr. STEARNS. Mr. Yarbrough, you seem like you would like to participate. Any additional comments?

Mr. YARBROUGH. Not so far as the construction of the minor program is concerned. I don't have any jurisdiction there. I am aware of it and see the need to examine the assets that are used in the minor program, but I don't have any jurisdiction.

Dr. GARTHWAITE. The bind that one gets in is that we must deliver care without presupposing the result of an objective group looking at what are the proper steps to take in Chicago. One then either has to freeze and not make any changes, even though some of them have relatively short return on investment, or one has to presuppose what is going to happen and quit investing in certain areas which then raises the question as to how open and how fair the analysis that is going on really is. So it is a bit of a bind. You really need the vision of where you are headed as quickly as possible.

Mr. STEARNS. I can't put you really on the spot here. I understand. But I think what we are trying to make is a larger statement here that we had GAO and Dr. Winship who said that the demise is 2 to 3 years, and after that you are dealing with a patient that is dying and that we have got to do something pretty quick here, such as consolidation, mission changes, facility realignment, and yet we have this money being spent in hospitals that they even know intimate details on that they said is not in the best use as one of these facilities over 50 years here. I don't know.

So I guess my question—two questions are: One, do you agree with the assessment of what you heard this morning with the GAO and Dr. Winship? Do you agree with that?

Dr. GARTHWAITE. Fundamentally, yes.

Mr. STEARNS. Fundamentally. Okay. In your testimony, you mentioned the words "major policy implications" will be used for your making your decision process. Just explain to me what you mean by major policy.

Dr. GARTHWAITE. I am saying that we will use for capital assets a similar process to what we now use for policy decisionmaking, which we have a Policy Board where we lay out the options in advance of the meeting, give people adequate time to read the backup material and so forth.

Your point I think might be a valid one. If you are trying to say that if we are making policy decisions, why isn't capital policy part of the existing Policy Board process I think it is an artificial line that we have drawn between capital asset discussions and other kinds of policies. Probably it is relative, and we should not think that way anymore.

Mr. STEARNS. Amen.

Mr. Catlett, let me ask you this: In light of the testimony you have heard and this better oversight on this capital asset spending—be honest this morning—do you think we are going far enough? Do you think there is something else that you think we should be doing in this area of oversight of capital asset spending?

You should know it better than any of us. You are serving as the Under Secretary of Budget.

Mr. CATLETT. The Deputy Assistant Secretary for Budget. You are right, sir. I have been around a long time. I have seen change. I think we are moving in the right direction. I think your interest in this hearing will add impetus to that. I think it is important.

I know that your staff, at least, has been frustrated with the way we have dealt with the authorization process for major construction and leases. The indication that you have made today about changes in that process I think will be helpful, particularly focusing on the planning component. As GAO has said—whether they call it a restructuring plan or we call it a business plan, laying out how you will provide services and where the services are needed over a future period, whether that is 3 years or 5 years. I know Dr. Garthwaite is concerned that 5 years is way beyond the range of what you can foresee with the pace of change in the industry.

But, yes, a long-winded answer, I apologize for that, but I think we are moving in the right direction, and anything we can do to improve the ability for us to put a business plan on the table will be helpful. The stakeholders will object because it is change in some cases, or more importantly, that we haven't explained the change well enough to show the benefit of what we are proposing.

Mr. STEARNS. Would you suggest an aspirin or radical surgery? I mean, are we on some kind of emergency feeling of you and others here? Are we just looking for slight movement here? Are you ready for bold new strokes and something that you are going to propel this?

Dr. GARTHWAITE. I would say I think radical surgery is probably indicated; however, in medicine, we always get the consent before we do surgery, and the problem we have had with these issues is getting the consent.

Mr. STEARNS. All right. My colleague from Texas?

Mr. RODRIGUEZ. Let me know, Dr. Garthwaite, if I misquoted you or not, but I gather that—we talked about the sale of VA capital. I think you mentioned the words it would be limited benefits. But based on GAO, they indicate that we are talking about maybe \$5 billion. So I gather that what GAO has and what you assess in terms of what you might be able to sell is two different things.

Dr. GARTHWAITE. Right. They are talking about a theoretical maximum. We are talking about essentially a pilot program as part of our budget initiative for this year. We put forward a pilot to gain the administration's support of it.

Mr. RODRIGUEZ. Have you identified the areas of the pilot?

Dr. GARTHWAITE. We would allow people to apply from anywhere in the system.

Mr. RODRIGUEZ. So people have to apply to sell—

Dr. GARTHWAITE. They would say: We believe we have an asset which we don't require to deliver services in this area, and we would like to turn those assets to other uses to deliver services, and we would like to sell this off, we think we have a buyer, or whatever, or we would like to get it in shape to sell off and then use those assets for something different.

Mr. CATLETT. Mr. Rodriguez, could I add something?

Mr. RODRIGUEZ. Yes, sure.

Mr. CATLETT. I just want to speak to your reference to the \$4 or \$5 billion that GAO has mentioned. As Dr. Garthwaite said, that is the universe of funds that we spend on maintenance. They are not implying that there is that much savings to be had if we would do everything perfectly. There is certainly savings within that \$4 or \$5 billion, but, one of the problems with making these changes is that a large part of that savings will be reduced staff because most of the maintenance costs of our facilities, as with our direct care, is staffing. And so those are the hard choices that we have to make, and you don't make those changes quickly and overnight in terms of dealing with your partnership with your unions, your employees who have been with you for a long time. So that is another major factor in this and one of stakeholder groups that has to be understood and evaluated.

Most importantly, I just wanted to make sure—that it is understood that the \$4 or \$5 billion isn't a potential savings. That is what we spend on maintenance of our facilities now as estimated by GAO.

Mr. RODRIGUEZ. You mentioned also the leasing and that you wanted to look at enhanced leasing. Do you already have some of the power or some of the laws that are already there to allow you to do that?

Dr. GARTHWAITE. We would need help—yes. We do have legislation for enhanced-use lease. We don't for this disposal pilot project. We would need legislation.

Mr. RODRIGUEZ. You would need legislation?

Dr. GARTHWAITE. For the asset disposal part. But for the enhanced-use leasing, we are currently doing that. When is that legislation up?

Mr. YARBROUGH. December 31, 2001.

Dr. GARTHWAITE. So at the present time, we have continued authority to do that, and continue to try to use that to its maximum benefit.

Mr. RODRIGUEZ. I was told—and I am going to go back to my hometown in terms of the pilot on allowing a veteran to be able to go and reach out and see a physician and then I guess bill back. Do we have any feedback on that particular pilot program in terms of how that has been cost-effective or not? Because I have heard about it for the last year and a half. I don't even know if it is even in operation now.

Dr. GARTHWAITE. I would have to get you specific information about your specific area, but in general terms, we for years have given out fee basis cards to service-connected veterans, and they take those cards and go to their own physician, a non-VA physician and receive care, and we pay those bills.

With the restructuring of the VA, we have looked at a lot of different methods of delivering care other than VA owning the assets, and we have entered into agreements with primary care physicians to take a panel of VA patients and to be essentially their physician, doctor, health care system, for a fixed rate over a period of time.

In most cases, if we can keep the communication going well enough and select well enough and have enough selection in those areas, those have been well received. They are especially well re-

ceived because they are often much closer to home, and so the opportunity to get care much closer to home is helpful.

There are a lot of technical issues of negotiating contracts, of getting the right balance of care, finding the right providers. But I would say overall our experience has been positive from the veterans' perspective.

Mr. RODRIGUEZ. As you move in that direction—I know the military has what we call the A-76 studies that are done. Do you all have something similar to that?

Dr. GARTHWAITE. Certainly.

Mr. RODRIGUEZ. You do?

Dr. GARTHWAITE. Yes.

Mr. RODRIGUEZ. Is it more or less the same?

Dr. GARTHWAITE. Right. That is OMB Circular A-76. Exactly the same.

Mr. RODRIGUEZ. So you do it in the same approach in terms of assessing what is more cost-effective, either leasing out or sourcing out or doing it in-house, that kind of thing?

Dr. GARTHWAITE. Correct.

Mr. RODRIGUEZ. I just want to get a picture, I guess from you, in terms of the next 3 to 5 years. How do you foresee or what do you envision? Because, you know, from our perspective, I still see a great need for access to services, at least from my region, and we continue to get—you know, I mentioned certain of my counties that double in size during the winter with the winter birds coming down, snowbirds—they are not birds. These are actual people, by the way, that come down, and a lot of them are veterans and are accustomed to a certain kind of service in the North that they don't have access to in the South.

So what do you envision in terms of hopefully what direction that we would be going that we would have the VA within the next 3 to 5 years?

Dr. GARTHWAITE. I think we see continued evolution of what we have attempted to do over the last 3 years, and that is to rationalize and consolidate our referral, tertiary care, large-city facilities. And as we do that and as we extract other efficiencies and savings moving from inpatient to outpatient, better buying decisions and so forth, to take those dollars and invest those in community-based outpatient clinics, whether we own them or whether we contract for them, in areas closer to where veterans are.

We have taken some national cuts at the veterans data. Whether or not we are hitting all the pockets of veterans who are underserved by our current geographic dispersion of facilities—and I think we are hitting most of them—we have significantly decreased the average distance a veteran has to drive to get to services. We need to continue to focus in on very specific areas and continue to enhance our planning efforts, not only, as the GAO said, I believe, not only in primary care but also in mental health and other specialized services.

We also have a variety of telemedicine initiatives that we think we can take the expertise and ship it electronically close to where the veterans live.

So I think we believe that health care is local; we believe that most of it should be delivered in the community. And if we can leap

all the hurdles in the way, we will continue to move in that direction.

Mr. RODRIGUEZ. You mentioned that you would be doing some of the same things you have been doing the last 3 years. Can I ask you more or less how much you might have saved in the last 3 years or how much access you have provided?

Dr. GARTHWAITE. Well, I don't know if I can tell you how much we have saved or provided. We have approximately 300,000 additional veterans getting service than they were getting. We have done that on what would be a fixed budget, essentially, so it has a buying power that continues to diminish. I think there is a nice chart in the independent budget that shows the buying power of the VA health care funds.

We have improved customer satisfaction. We have improved surgical mortality and morbidity. We have improved survival rates in three of our common medical diagnoses and preserved or not allowed to deteriorate, kept it constant, in six others.

So we have done a variety of things that I think have been positive. One of the key pieces, we have opened a couple hundred, approximately, community-based outpatient clinic access sites which have been well received, implemented universal primary care and a variety of other things that have changed the system.

Mr. RODRIGUEZ. And we thank you for the clinics. When I first got on, I think the person who talked to me assumed that I was just from San Antonio and didn't realize I had 13 other counties going all the way to the Mexican border. He looked at me straight and said: We can assure you that every veteran is no more than—I think he said 60 miles away from the nearest facility. And I said, well, let me show you some counties that are 200-something miles away. I know that that has improved somewhat because we got a clinic that is supposed to be opening up in Alice and a couple other areas.

Dr. GARTHWAITE. Things do not often go as fast as you would like. I have used many times, in trying to make the point to people, that you can't drive 320 miles from Brownsville, TX, to San Antonio to have your blood pressure checked. It is simply not an adequate health care system, and I think that was a compelling argument for many to help with the changes.

Mr. RODRIGUEZ. Thank you.

Mr. STEARNS. Thank you. I thank my colleague.

Let me conclude with one question and perhaps get a commitment from you today, Dr. Garthwaite. You have heard the GAO and Dr. Winship talk about the facility redundancy in the VA system. In fact, 40 locations they mentioned around the country this facility redundancy exists. And he talked about Chicago in particular.

Will you commit today to do an analysis of all the other areas that are in the GAO report and provide this committee the results of this analysis at a certain date?

Dr. GARTHWAITE. Yes, I think we believe we are trying to do some of that already, and I think we just have to define exactly what you mean by analysis. What we did in the Martinez area and what we have done in Chicago and Boston has ended up being fairly expensive. There were contractors involved. There were actually

three contractors in Boston. There was a fairly large contract in Martinez. And I don't recall exactly how much we are spending in Chicago.

I would say that to learn from those, to enhance our ability to look that way at every part of every network, that is our intention and we will commit to do that.

Mr. STEARNS. So you will commit to the analysis of these other 40 locations?

Dr. GARTHWAITE. Absolutely. And we think we are already doing it, but not with the degree of precision and knowledge and expertise that we probably need to do it.

Mr. STEARNS. But you are saying you don't have the money to do the analysis that you have done before?

Dr. GARTHWAITE. The three that they are using as examples, if I committed to do that, we would have to make some significant other savings, which we are already being challenged to do, to be able to have contractors look at every one of those particular areas. So really, all I am suggesting is that it is a matter of degree and timing, but we want the answers as much as the GAO or you do.

Mr. CATLETT. Mr. Stearns?

Mr. STEARNS. Yes, sir?

Mr. CATLETT. If I could add—

Mr. STEARNS. Sure, because we are just trying to establish some training of events here and to get you folks galvanized, because the legislation that we are thinking about is—and that is the second to the last question, Dr. Garthwaite, whether you think the legislation that I have suggested is going to be credible. Go ahead.

Mr. CATLETT. I was just going to add as another suggestion we can work with your staff. Some of this funding to do this analysis is similar to activities that we have funded within the construction accounts in the past. It is a line item called advance planning funds. There is not enough there currently, I believe, to do that type of study at 37 other locations. But, again, it is an idea. If you are looking at what to do in an authorization or what to do in an appropriation recommendation, again, clearly, this is a capital asset plan, to me, which is an appropriate use of advance planning funds. It can make a difference in terms of the speed at which we can move on this type of planning activity.

Mr. STEARNS. My gut feeling is if a third party did it, it would be more credible than if it came within your office, I mean, just from perception-wise.

Mr. CATLETT. Right.

Mr. STEARNS. So the funds should be provided for you folks to do this third-party analysis, and it would be well worth the investment if we came back and found all this information and it was credible. I think your suggestion of an appropriation authorization is something we should take into consideration.

Mr. CATLETT. I am just saying a funding source may exist now, but I am sure as well there is not enough money to do 37 more of these studies, if I could count 3 being completed of the 40.

Mr. STEARNS. Maybe you could give us an idea how much money we need.

Mr. CATLETT. Yes.

Mr. STEARNS. Are you prepared to do that today?

Mr. CATLETT. No, sir. But we can soon.

Mr. STEARNS. Okay. Well, we will assume that that will be something you will give us a rough estimate for the committee here.

Mr. CATLETT. Yes, sir.

(The information follows:)

The estimate for contractor support at 37 of the 40 VA markets with more than one medical center as defined by GAO is \$35-\$40 million. This would provide the type of analysis and study of our options for the provision of health care to veterans that was provided in the northern California review done several years ago. The authority to fund these contracts within the Major Construction account is being reviewed with our General Counsel.

Mr. STEARNS. That we can give to the full committee, and I know both Mr. Stump and Mr. Evans would appreciate that, and I think they would see the argument.

I think the concluding question is: With the type of legislation that we are envisioning, do you have any suggestions on—do you think the idea is appropriate to somehow—we don't have a base closure because we are concerned about that might even make it in a different venue here. But I am open to suggestions here.

Dr. GARTHWAITE. I would like to see us rethink the approaches we have taken in the past and to look for creative new ways to line up the forces with where I think we all know we need to go. So the simple answer is I would like to think a little longer on it, but I think it is headed in the right direction, and I think that we would like to continue the discussion about seeing what can be done.

Basically, we are interested in achieving not only the plans but the actual actions that are necessary. We have had significant resistance in the past, and I think you are getting at the issue of how do we get through that resistance. We are very much in favor of that.

Mr. STEARNS. Line up the forces, Darth Vader. (Laughter.)

Well, I want to thank all of you for your time and your candidness. And, gentlemen, is there anything you would like to add?

Mr. RODRIGUEZ. No.

Mr. STEARNS. We appreciate your coming, and the committee will stand adjourned.

[Whereupon, at 12:08 p.m., the subcommittee was adjourned.]

APPENDIX

**Statement of Representative Luis Gutierrez
House Committee on Veterans' Affairs
Subcommittee on Health
Hearing on VHA Capital Asset Management
March 10, 1999**

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

As we know, the Department of Veterans Affairs (VA) is facing a crisis. The General Accounting Office (GAO) estimates that during the next few years, VA could be spending twenty-five percent of its health care budget on maintaining, operating and improving its properties and buildings. Many of these buildings are more than fifty years old. Some buildings are more than one hundred years old.

Mr. Chairman, the Department of Veterans Affairs continues to face budget constraints and must consistently stretch every dollar. We must make sure that funds spent on the maintenance of VA properties and buildings can be justified. Every dollar that goes to waste is one less dollar that can be spent on veterans health care.

However, I am concerned when I hear reports from the Government Accounting Office that many of our VA hospitals are half-empty. Sadly, there are veterans who are in desperate need of medical care but are not utilizing the hospitals. The fact is that beds are available. Unfortunately, we have a shortage of doctors, nurses and other medical personnel to treat these patients. I would urge my colleagues to keep this in mind before Congress votes to consolidate or eliminate any VA facility. The veterans population is aging and increasing. They will use the VA for health care treatment. We must make sure we can accommodate this growing population in the future.

STATEMENT OF LANE EVANS
RANKING DEMOCRATIC MEMBER

Hearing Regarding Structural Change at VA Medical Centers
And Major Medical Construction
March 10, 1999

Mr. Chairman, I commend you for holding this important hearing on capital asset management for the VA Medical Care infrastructure. Operating and maintaining VA's massive physical plant clearly consumes a major portion of the VA Health Care budget. The General Accounting Office (GAO) will tell us that in the next five years, \$20 billion will be used to maintain facilities. In FY 2000, this will consume $\frac{1}{4}$ of the proposed VA Medical Care budget. Conversely, this is a quarter of the budget that cannot be used to meet the direct health care needs of veterans. To the extent that VA can minimize these costs without compromising their direct health care missions, it is important that they do so. I know our witnesses have a great deal to share with us about VA's current efforts to manage their capital assets and initiatives underway that they hope will allow more effective asset management in the future. It is important for us to realize, however, that even if VA put these initiatives in place tomorrow, they would not be able to realize savings of the magnitude projected in the President's fiscal year 2000 budget.

Planning for VA's infrastructure is critical to the long-term viability of its health care system. Indeed we have a physical plant that is no longer "in synch" with modern health care delivery...and changes and transformations in care delivery are happening overnight. VA is both blessed and burdened with a wealth of resources that no longer serve the purpose for which they were originally intended—medical treatment. Anyone taking the time to drive around the sprawling grounds of some VA campuses can see how much labor must be devoted to maintenance. Some VA medical centers took over military facilities with hundreds of buildings—GAO reports that about 17% of its care sites have more than 46 buildings. Park-like settings that once encompassed golf courses, chapels, libraries and housing for personnel still comprise much of the physical plant. Considering comparable hospitals in the private sector, these additional grounds and buildings obviously throw VA's costs for groundskeeping, housekeeping, and utilities significantly out of alignment with other health care providers.

VA has a responsibility to convert these significant costs to the benefit of the patient wherever possible. This may involve disposing of excess property, allowing others to develop VA's resources using enhanced use leases, and converting the patient care missions at various facilities. These are hard choices for VA and VA will need our support in restructuring their resources to allow a truly "patient-centered" health care system to emerge. With that said, however, VA must put forward well-developed strategic plans for facilities, networks, and at the national level that make costs and benefits of maintaining outmoded health care structures clear to its stakeholders, including Members of Congress. We must have confidence in plans that sometimes have dramatic consequences for veterans and VA employees.

I can speak with some conviction about this matter since a hospital that has served my district well for many years is now threatened with closure. I have yet to see any credible analysis of why the network selected to investigate closing its only remaining tertiary care center, Iowa City VA Medical Center, over other alternatives for savings. I believe that the network will be at a real loss to serve its veterans with remaining VA facilities and my fears have not been alleviated by any information I have received from the network to date. For that reason, I continue to believe that this is an initiative that caters primarily to Iowa City's medical school affiliate who would continue to benefit from VA's research funding, residency training slots, and its workload in an increasingly competitive health care environment.

As veterans' advocates our primary concern must be creating accessible, high-quality health care settings that take veterans' special needs into consideration. Congress must have confidence that VA's decisions are based in thorough and rational analysis in order to support them. When difficult choices must be made it is also important for Congress to understand that VA has considered a variety of options.

I know that some of our witnesses will also discuss VA facilities in the Chicago area today. If VA can demonstrate that closing a facility in that area can improve quality and maintain accessibility and if VA retains the savings from restructuring within the network for its local veteran users, I do not believe it should be opposed. VA has made many forays onto this turf and none have been satisfactory to every party—indeed none ever will be. For the time being, I am satisfied that the process being used to assess VA facility use is an impartial one,

and that, at least with regard to Chicago VA, stakeholders have now had an adequate opportunity to provide input into the process. These are important criteria in implementing changes that may be necessary, but are painful nevertheless.

VA must clearly improve strategic planning at the facility level, at the network level, and in some cases, at the national level and look beyond its infrastructure to determine how best to serve its users. While I appreciate the credible and comprehensive review of the General Accounting Office, I understand that it endorsed the Office of Management and Budget's asset planning model which used current VA facilities to define veteran "markets". VA walked away from this approach to funding facilities for their operational costs. It once based allocations on historic costs of care regardless of whether providers were "efficient" or "inefficient". More recently, VA decided to allow veteran users to define where it would send health care dollars to create a more equitable allocation system that followed the veterans. I believe VA should approach construction planning in the same manner. Instead of allowing buildings to determine construction needs, VA should consider the demographics of its users in the veterans' population and site facilities in the same manner.

In some areas abiding by such a model would call for additional VA resources and in some it would likely call for fewer resources, but this manner of funding would allow a truly patient-centered system to develop. We don't have to build the system from the ground up, but it is important to understand VA's capital asset plan in the same way we understand its allocation of appropriated funding. We must understand what veterans' needs are and with that understanding design a "new system" with which to serve them. This will likely necessitate a variety of arrangements using the infrastructure now in place, new capital assets, and shared or purchased services.

Models should also recognize the true distinctions of the veterans' health care system. There are some VA programs, such as Traumatic Brain Injury, Spinal Cord Injury, and Blind Rehabilitation, that are national in scope and Headquarters should manage these programs' assets accordingly. Such programs are "scarce resources" in the system and may represent significant costs for the networks that host them. It is equitable both in terms of veterans' access and the cost borne to the host networks to plan resource distribution and asset management for these programs in VA Headquarters. Left to VISN directors who must manage within dwindling budgets and provide for competing programs that serve greater numbers of veterans these programs will remain extremely vulnerable.

As I have witnessed in monitoring the studies into closure of the Iowa City VA Medical Center, network directors must assess the ramifications of restructuring resources within their networks. Decisions about particular facilities must fit into a comprehensive strategic plan for the network—I do not believe these decisions can come from “the grassroots” if VA has a comprehensive “system” to serve its veterans.

Finally, facility directors are best suited to identify the problems within their particular facilities and make decisions about space requirements, modernization, safety, accessibility and other matters that allow their facilities to carry out the roles assigned to them in the strategic network plan.

In closing I’d also like to express a concern that I have about some of the “prototypes” for the future offered in GAO’s statement today. At what point in time does a system of care cease to be a “system”? We are talking about a number of plans today where VA’s role is primarily that of payer. As a recent VA Inspector General’s report indicates, VA’s role in monitoring the quality of care in State Homes has been something less than vigilant. Veterans in state homes and contract care settings may have little or no reason to associate that care with a “system” of care specifically devised for veterans.

I would suggest that in diminishing the capacity to deliver patient care in which VA has traditionally excelled, such as long-term care, mental health, and programs for veterans with service-connected disabilities, VA is undermining its potential to remain a viable “system” of care in the future. The Office of Management and Budget’s model suggests that government should only offer services that private sector providers are unable to deliver. At what point in time will VA, by weakening or eliminating what is unique to its system, cross that threshold?

Long ago, I bought into Dr. Kizer’s concept of “hospitals without walls”, but I still have many reservations. I welcome the opportunity to work with VA to authorize some necessary changes that will allow its managers to better manage their resources. I look forward to the testimony from our witnesses today.

United States General Accounting Office

GAO

Testimony

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

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, March 10, 1999

VA HEALTH CARE

**Capital Asset Planning and
Budgeting Needs
Improvement**

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



GAO/T-HEHS-99-83

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss management of health care assets within the Department of Veterans Affairs (VA). Over the next few years, VA could spend about 1 of every 4 health care dollars operating, maintaining, and improving buildings and land at 181 major delivery locations nationwide—in all, over 4,700 buildings and 18,000 acres of land.

Last July, you asked us to examine VA's capital asset¹ planning and budgeting processes based in part on your concerns about the aging of VA's assets, declining veteran populations in most states outside the Sunbelt, declining need for hospital beds, and limited construction budgets.²

My comments this morning are based on

- visits to 92 VA locations,
- visits to VA's headquarters and 22 regional offices,
- discussions with over 400 VA officials,
- review of hundreds of VA planning documents,
- review of industry asset management practices, and
- GAO studies completed over the past several years.³

In summary, VA's asset plans indicate that billions of dollars might be used operating hundreds of unneeded buildings over the next 5 years or more. This is because VA does 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 can be met at lower costs.

In our view, VA could enhance veterans' health care benefits if it reduced the level of resources spent on underused or inefficient buildings and used these resources, instead, to provide health care, more efficiently in existing locations or closer to where veterans live.

Over the last 2 years, VA has significantly improved its budgeting process for major capital investments. This process, however, still relies too heavily on

- inconsistent or incomplete information,
- imprecise decision criteria, and
- qualitative (rather than quantitative) measurement standards.

This results in subjective asset-management judgments, based on individual viewpoints, rather than objective decisions, based on systematic assessments of proposed investments' benefits, costs and risks.

VA's capital asset decision-making also appears to be driven more by the availability of resources within VA's different appropriations rather than the overall soundness of investments. VA, for example, sometimes decides that leasing alternatives should be used, instead of construction, to obtain needed space, because money is more readily available in the appropriation that funds leases than in the construction appropriation. As a result, VA sometimes spends millions of dollars more than would be needed to build or buy an asset.

¹Capital assets are generally defined as land, structures, equipment, and intellectual property (including software) that have a useful life of 2 years or more. This statement focuses solely on VA's land and structures, primarily buildings.

²The Chairman, Committee on Veterans' Affairs, House of Representatives, also requested this examination for the same reasons.

³See Related GAO Products listed at the end of this statement.

Furthermore, VA's reliance on construction appropriations could be reduced if VA is given legislative authority to use

- proceeds from the disposal of unneeded assets to invest in more appropriate ones, or
- some or all of operational savings or third-party collections attributable to capital investments.

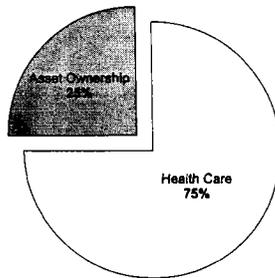
VA Has a Diverse Portfolio of Health Care Assets

Within VA, the Veterans Health Administration (VHA) has primary responsibility for health care asset management. VHA has divided its 181 delivery locations into 22 geographic regions, which have between 6 and 12 major delivery locations. Each region, referred to as a Veterans Integrated Service Network, has a director and small staff, which perform a wide range of activities, including asset planning and budgeting.

Each network director has developed a 5-year business plan.⁴ These plans indicate that assets will continue to operate at the 181 locations essentially as they do today. In so doing, VHA's cost of asset ownership could be as much as \$20 billion or more during this period, primarily for operations⁵ and maintenance costs.

Historically, VHA's medical care appropriation has funded over 95 percent of VHA's asset ownership costs; two separate construction appropriations fund the rest. In fiscal year 2000, such ownership costs could be as much as \$4 billion or more, accounting for a major slice of VHA's health care budget (see fig. 1).⁶

Figure 1: VHA's Proposed \$17 Billion Medical Care Appropriation for FY 2000



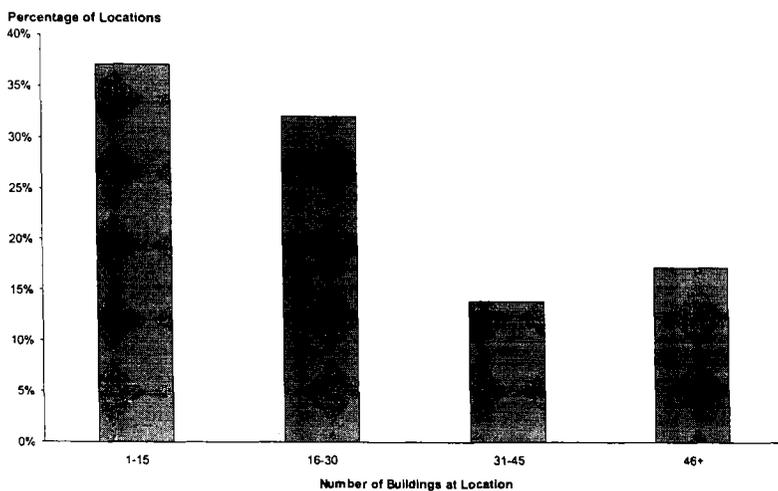
VHA operates and maintains a mix of buildings and land at its 181 medical care delivery locations. Most are campus-style, comprising over 16 buildings each, although many locations are urban-style with fewer buildings. (See fig. 2.)

⁴VHA's latest plans cover the period between 1999 and 2003.

⁵Asset-related operations include utilities and services such as security, grounds care, fire protection, waste collection, pest management, and custodial work.

⁶VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998) reports that asset operations and maintenance costs for four VA hospitals in Chicago generally represent about 25-35 percent of the hospital's operating budgets. VA officials in headquarters and regional offices who are familiar with hospitals' operating budgets generally agreed that asset costs as a percentage of budgets nationwide could be comparable to the level found in Chicago.

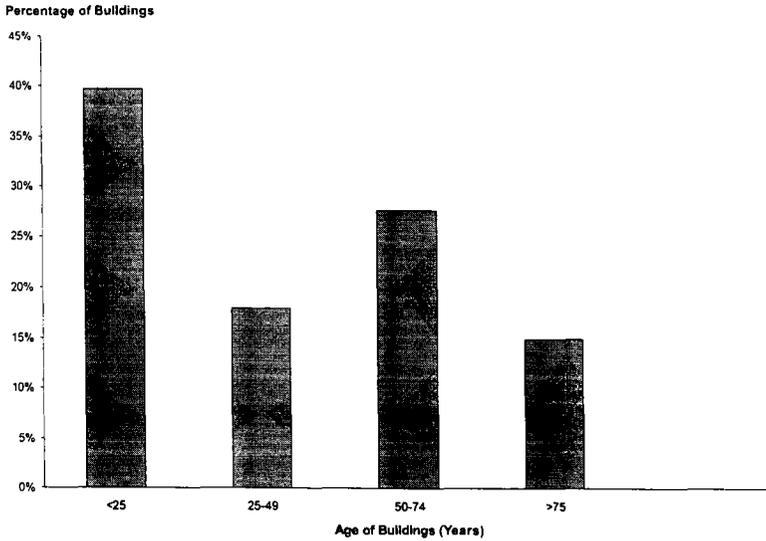
Figure 2: Number of Buildings at VHA's 181 Major Delivery Locations



VHA faces a profound asset management challenge for four primary reasons. First, VHA owns 4,700 buildings, over 40 percent of which have operated for more than 50 years, including almost 200 built before 1900 (see fig. 3). Many organizations in the facilities management environment consider 40 to 50 years to be the useful life of a building.⁷

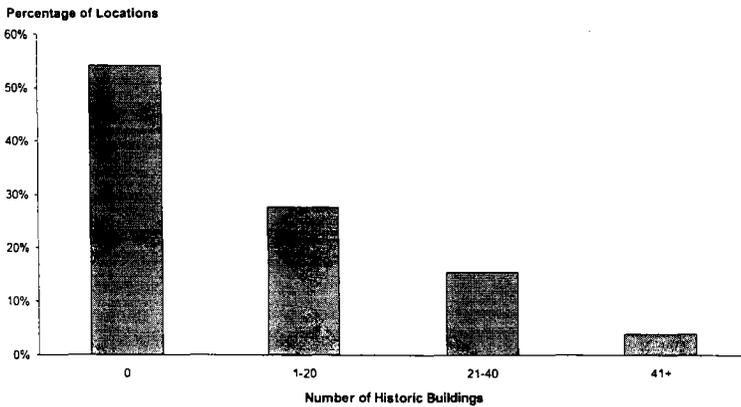
⁷Price Waterhouse, Independent Review of the Department of Veterans Affairs' Office of Facilities Management, Final Report (June 17, 1998).

Figure 3: Age of VHA Buildings



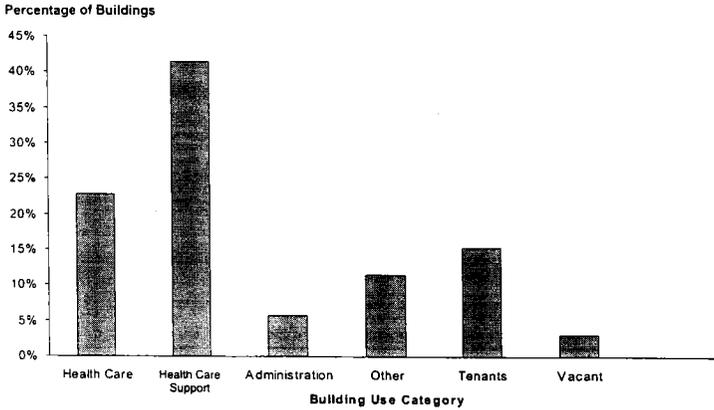
Second, over 1,600 buildings (almost one-third) have historical significance, according to VA's inventory of historical and cultural resources (see fig. 4). Historical significance is based partly on a building's age, but it also considers architectural features and history. These buildings are either formally listed or are eligible for listing on the National Register of Historic Places and all are equally protected by law. This requires VHA to comply with special procedures for maintenance and disposal. Almost half of VHA's 181 locations have historic buildings.

Figure 4: Number of VHA's Historic Buildings



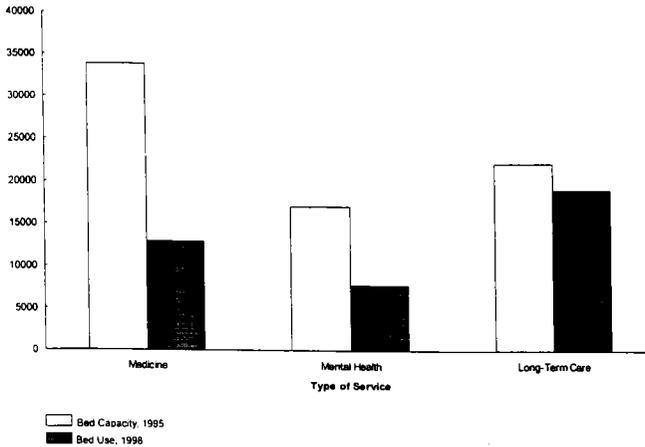
Third, VHA uses fewer than 1,200 buildings (about one-fourth) to deliver health care services to veterans (see fig. 5). The rest are used primarily to support health care activities,⁹ although many have tenants or are vacant. Of note, VA has over 5 million square feet of vacant space, which can cost as much as \$35 million a year to maintain.

Figure 5: Types of VHA Building Use



Fourth, VHA's health care buildings have significant unused inpatient capacity. For example, while VHA operated about 64,000 beds in fiscal year 1995, in 1998, veterans used fewer than 40,000 beds a day, on average. The greatest underutilization (about 21,000 fewer beds a day) occurred in acute medicine, where usage was about 38 percent of potential capacity.

Figure 6: VHA's Unused Inpatient Capacity



⁹Health care support buildings include warehouses, engineering shops, laundries, fire stations, day care centers, and boiler plants.

VHA's ongoing efforts to improve operating efficiency, coupled with a rapidly evolving health care market, suggest that bed use may continue declining. Declining demand for inpatient care is not unique to VHA. Community hospitals, for example, have tens of thousands of unused beds. Overall, about 26 percent of community hospitals' 873,000 beds in 1995 were unused. Like VHA, the number of unused community hospitals' beds may also increase, given the rapidly evolving health care market.⁹

VHA's Asset Planning Needs to Be Improved

The Office of Management and Budget (OMB) encourages federal agencies to develop long-term "asset plans" as part of their capital planning process and to use these plans, among other things, to justify budget requests to the Congress.

To obtain the best use of capital resources, OMB guidelines suggest that agencies should conduct market-based assessments to determine asset needs.¹⁰ These include

- assessing a target population's needs,
- evaluating the capacity of existing assets,
- identifying any performance gap (excesses or deficiencies),
- estimating assets' life-cycle costs, and
- comparing such costs to other alternatives for meeting the target population's needs.

State and private organizations have also found that using such planning processes has yielded positive results.¹¹

Currently, VHA's planning focuses on individual needs of assets at its 181 delivery locations, even though most locations operate in markets that also include other VA locations.¹² Also, VHA does not systematically assess all life-cycle costs or logical alternatives for meeting veterans' needs before deciding that capital investment is warranted.

VHA's investment planning focuses primarily on identifying asset improvements that should be done over the next 5 years. For its current planning period (1999-2003), VHA estimates high-priority improvements to cost over \$1.8 billion.¹³

If VHA followed OMB's guidance, in our view, planning would focus on assets needed to meet veterans' needs in 106 markets. These markets include

- 66 with a single VHA location and

⁹VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

¹⁰Capital Programming Guide, Version 1.0 (Washington D.C.: OMB, July 1997).

¹¹Executive Guide: Leading Practices in Capital Decision-Making (GAO/AIMD-99-32, Dec. 1998) and VA, Capital Investments: Survey of Best Practices (Washington D.C.: VA, May 1998).

¹²A market, for purposes of this statement, is defined as a geographic area with a high concentration of veterans, generally within 60 minutes of an existing VHA major delivery location.

¹³A VHA consultant advised VA in a February 12, 1999, report that an additional \$1.9 billion could be needed to seismically rehabilitate over 1,700 buildings. VHA is currently reviewing this report and expects to revise its 5-year planning as appropriate.

- 40 with multiple VHA locations (between two and nine).

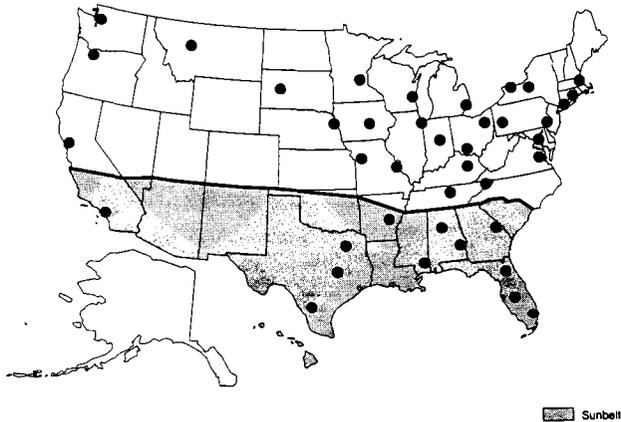
VHA's 40 multiple-location markets yield great opportunities for asset restructuring and benefit enhancements for veterans. This is because they have 115 delivery sites that

- have utilization significantly below inpatient capacity and
- compete with other VA locations to serve rapidly declining veteran populations.

Nationwide, the number of veterans (25 million) is declining and their average age (58) increasing. VHA estimates that the veteran population will number 16 million by the year 2020, a 36-percent decline from today's level.

The veteran population in some geographic areas, such as the Sunbelt,¹⁴ is expected to experience smaller declines. Other areas, such as the Northeast or Midwest, are expected to experience larger population declines. Most of VHA's multiple-location markets are in these two areas. (See fig. 7.)

Figure 7: VHA's 40 Multiple-Location Markets



We estimate that VHA spends about \$2.7 billion a year to operate and maintain 3,000 buildings and 10,000 acres in these markets. In addition, VHA plans to invest over \$1.2 billion to improve these assets over the next 5 years. This represents a drain on VHA's health care resources because most locations in these markets have delivery capacity that VHA considers functionally obsolete, including

- inpatient capacity not up to industry standards (such as patient privacy),
- substandard outpatient capacity (such as undersized examination and operating rooms), and
- safety concerns (such as seismicity).

The Chicago market, for example, has four delivery locations, comprising 126 buildings that cost over \$160 million a year to operate and maintain. Last year we

¹⁴The Sunbelt, according to available literature, is generally considered to include Alabama; Arkansas; Arizona; Florida; Georgia; Louisiana; Mississippi; New Mexico; Oklahoma; South Carolina; Texas; Southern California; and Clark County, Nevada.

reported¹⁶ that VHA could save \$20 million a year and care could be improved if veterans were served in one less location. Veterans' benefits, for example, could be enhanced if VHA used the savings to purchase primary care closer to veterans' homes.

VHA has eight other markets like Chicago that have four or more delivery locations competing to serve the same veterans; these markets have a total of 42 VHA locations. If these other markets are similar to Chicago in that veterans needs could be met with one fewer location, VHA could save \$160 million annually.

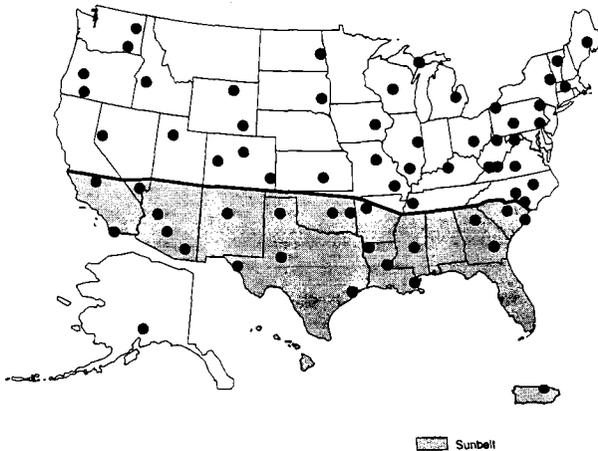
VHA has opportunities for additional savings in these markets, as well as its other 31 multiple-location markets, by

- partnering with other public or private providers,
- purchasing care from such providers, and
- replacing obsolete assets with modern ones.

For example, VHA replaced a seismically deficient building in Martinez, California, with a modern outpatient clinic about 5 years ago. This clinic, along with existing VHA inpatient locations and contract care, efficiently meets veterans' needs in that market. Moreover, VHA reported that veterans' satisfaction is high and quality of care meets performance goals.

In addition, VHA's 66 single-location markets could yield significant opportunities for restructuring and enhanced benefits for veterans. Like multiple-location markets, many are in geographic areas that have rapidly declining inpatient workloads and veteran populations. (See fig. 8.)

Figure 8: VHA's 66 Single-Location Markets



We estimate that VHA spends about \$1.4 billion to operate and maintain 1,500 buildings in the single-location markets. VHA also plans to invest over \$600 million to improve these assets and bring them up to industry standards. Opportunities to use partnering, contracting, or asset replacements, as potentially

¹⁶GAO/HEHS-98-64, Apr. 16, 1998.

lower-cost alternatives are also available, given that other public or private health care providers operate in these markets.

VHA, however, is reluctant to make these business choices. Our work has shown that VHA's environment contains a diverse group of competing stakeholders, who, quite naturally, could oppose some planned changes that they feel are not in their best interests, even when such changes benefit veterans.¹⁶

Medical schools' reluctance to change long-standing business relationships, for example, has sometimes been a major factor inhibiting VHA's asset management. For example, VHA has tried for over 2 years to integrate clinical services at two of Chicago's four locations with limited success.¹⁷ This is because such restructuring could require two medical schools to use the same location to train residents, a situation that neither supports.

Unions, too, sometimes appear reluctant to support planning decisions that result in a restructuring of services. This is because operating efficiencies often result in staffing reductions. VHA, for example, recently made a capital investment to consolidate food service at one location in New York City in order to reduce expenditures at eight other locations in that market. Two unions' objections, however, slowed VHA's restructuring, although VHA and the unions subsequently agreed on a way to complete the restructuring.

Such stakeholder pressures can lead to decisions that are not in veterans' best interests. Two years ago, a VHA consultant¹⁸ assessed nine options for restructuring two delivery locations located 7 miles apart in the Boston market. Subsequently, VHA had a second consultant¹⁹ study this situation but instructed the consultant to consider only options under which both locations remained open. Ultimately, VA decided to keep both locations open and to provide inpatient care at one facility and establish the other facility as an outpatient care site. VHA's two consultants estimate this will save \$160 million over a 5-year period after the restructuring is complete. The consultants' studies also show, however, that VHA could save as much as \$77 million more if veterans' needs are met in one facility. These funds could be used to enhance veterans' benefits, such as by providing services at new community clinics, rather than operating and maintaining unneeded buildings.

To its credit, VHA has initiated a market-based assessment in Chicago, in response to our recommendation. This assessment also includes a multiple-location market in Wisconsin. Unlike Boston, VHA placed no restrictions on options to be considered in this case. These market assessments are scheduled for completion in late spring and, if done properly, could serve as prototypes to be used in assessing VHA's other multiple- and single-location markets.

In this regard, we recommend that VHA develop asset-restructuring plans for all markets to guide its future investment decision-making, among other things. This plan should comply with OMB guidelines and incorporate best practices of industry, as well as those of VHA's 181 delivery locations.

¹⁶VA Health Care: *Lessons Learned From Medical Facility Integrations* (GAO/HEHS-97-184, July 24, 1997) and VA Health Care: *Closing a Chicago Hospital Would Save Millions and Enhance Access to Services* (GAO/HEHS-98-64, Apr. 16, 1998).

¹⁷Veterans' Health Care: *Chicago Efforts to Improve System Efficiency* (GAO/HEHS-98-118, May 29, 1998).

¹⁸Deloitte & Touche Consulting Group, *VA New England Healthcare System Tertiary Healthcare Project – Boston Area* (May 1, 1997).

¹⁹AMA Systems, Inc./McGladrey & Pullen, LLP, *Boston Integration Report* (Alexandria, Va.: AMA Systems, June 5, 1998).

VA's Capital Investment Budgeting Needs to Be Improved

VA and VHA have recently taken positive steps toward establishing an effective centralized budget development process to review and approve high-cost capital investments (\$4 million or more) under its major construction appropriation. VHA, however, continues to use a decentralized review and approval of less expensive investments, including major repairs.²⁰

VHA's decentralized decision-making is generally done without the level of systematic, rigorous assessments that the centralized process uses. In fiscal year 2000, such decisions account for over 85 percent of investment dollars.

High-Cost Capital Investments

VA uses a two-step process for prioritizing high-cost capital investments.²¹

- First, a capital investment panel²² validates that proposals use reasonable assumptions and adequate data and assigns a numerical ranking score.
- Second, a capital investment board²³ reviews the panel's results and recommends proposals to be included in VA's budget request.

The investment panel, among other things, requires that proposals answer affirmatively what are known as OMB's "Three Pesky Questions" in order for a capital investment to be considered further.²⁴ These are

- Does the investment in a major capital asset support core/priority mission functions that need to be performed by the federal government?
- Does the investment need to be undertaken by the requesting agency because no alternative private sector or governmental source can better support the function?
- Does the investment support work processes that have been simplified or otherwise redesigned to reduce costs, improve effectiveness, and make maximum use of commercial, off-the-shelf technology?

Next, the investment board scores each proposed investment on how well it addresses 20 decision criteria that are grouped into 5 general categories.²⁵ The five categories and related weights are²⁶

- improved customer service (56 percent),
- return on taxpayer investment (19 percent),
- high performing workforce (14 percent),
- risk (6 percent), and
- comparison to alternatives (5 percent).

²⁰These involve improvements or alterations, generally referred to as minor construction, and repairs beyond ordinary maintenance, generally referred to as nonrecurring maintenance.

²¹VA, VA Capital Investment Methodology Guide (Washington, D.C.: VA, May 1998).

²²The panel comprises senior staff in each of VA's major organizations: VHA, Veterans Benefits Administration, National Cemetery Administration, and staff offices.

²³The board comprises the Under Secretaries for Health, Benefits, and Cemeteries, VA's Chief Financial Officer, Information Officer, and Deputy Secretary.

²⁴OMB, Capital Programming Guide, Version 1.0 (Washington, D.C.: OMB, July 1997)

²⁵Weights are assigned to the criteria, using an analytical hierarchy process, widely known as pairwise comparison.

²⁶The 5 categories and 20 related decision criteria are listed in app. I.

VHA submitted 14 investment proposals for building improvements or alterations to VA's capital investment panel for fiscal year 2000 funding consideration. The proposals requested a total of \$286 million, ranging between \$11 million and \$28 million.

Using VA's data validation procedures, we assessed 12 proposals' assumptions and data.²⁷ In general, we found that proposal information was neither uniform nor complete. Few, for instance, identified how many veterans would benefit directly from enhanced services or contained baseline information to demonstrate the magnitude of expected benefits. This occurred primarily because

- VA's guidance is vague and sometimes confusing and
- VHA does not provide information when clearly requested.

While VA failed one proposal based on its validity assessment, we concluded that no proposal had sufficient data to answer the "pesky questions." Nine, for example, involved investments in multiple-location markets where VHA's analyses of alternatives were incomplete. These included several proposals that failed to systematically address the most logical alternatives, such as other nearby VA locations.

A recently completed capital investment demonstrates the risks that VHA faces when alternatives are not adequately considered. VHA replaced substandard inpatient and outpatient capacity at Newington, Connecticut, at a cost of \$45 million. In the midst of construction at Newington, VHA decided to consolidate inpatient care at West Haven, Connecticut, which serves the same veterans in that market.

VHA proposed to invest \$14 million of fiscal year 2000 funds to renovate substandard inpatient capacity at West Haven. VHA is currently using the Newington inpatient space to house administrative functions. VHA's decision-making essentially led it to pay inpatient medical space construction costs for office space—at a premium generally considered to be about 60 percent.

By contrast, our assessment of potential alternatives to a proposed high-cost investment in northern California demonstrates the benefits veterans could realize when market-based planning is done. VHA initially proposed construction of a \$211 million addition to the Travis Air Force Base hospital. We performed a limited market assessment and recommended that lower cost alternatives be used.²⁸

Subsequently, a VHA consultant conducted an extensive market-based assessment.²⁹ This showed that veterans' needs could best be served if VA, among other things, acquired the former McClellan Hospital at Mather Air Force Base in Sacramento, California, and used contract care in other areas closer to veterans' homes. VHA plans to spend \$81 million, savings of \$130 million over the \$211 million originally proposed.

Using VA's prioritization procedures, we reviewed and scored VHA's proposed investments. We found it difficult to systematically or objectively use VA's decision criteria. This is because criteria definitions are frequently imprecise and seldom defined quantitatively in terms of outcomes or outputs. VA, for example, uses one customer service criterion to measure "increase in customer access." This criterion, however, is defined qualitatively using such measures as "increased convenience" or "less travel time" for veterans. As a result, VA does not have reasonable assurance that it funds first those proposed investments that provide the greatest benefits for veterans at the least risk.

²⁷We did not assess two projects that received funding in fiscal year 1999.

²⁸VA Health Care, "Travis Hospital Construction Project Is Not Justified" (GAO/HEHS-96-198, Sept. 3, 1996).

²⁹Price Waterhouse LLP, The Lewin Group, Inc., and Applied Management Engineering, Inc., Assessment of Veterans' Health Care Needs in Northern California (New York: Price Waterhouse, July 15, 1997).

Also, VA's measurement standards are vaguely defined. VA, for example, requires panelists to judge whether expected benefits for each of the 20 decision criteria will have no effect, some effect, significant effect, or very significant effect. However, VA provided little or no quantitative baselines for panelists to use in making these determinations. As a result, subjective judgment must be applied when deciding, for example, whether a projected benefit should be considered to have "some effect" or "very significant effect."

In addition, weights for certain criteria seem low in relation to others. As previously mentioned, customer service has a weighting factor of 56 percent. By contrast, VA used weighting factors of 14, 6, and 5 percent for workforce, risk, and alternatives, respectively. Given VHA's planning shortcomings, it seems unusual that risk and alternatives are not afforded much higher values.

To its credit, VA is currently

- considering refinements to the decision criteria and measurement standards,
- offering seminars to improve quality of proposal information, and
- considering revisions to criteria weights.

In our view, to reduce subjectivity and thereby enhance credibility of investment decisions, VA should

- modify written guidelines to describe, in greater detail, minimum quantitative data required for each decision criterion and
- exclude, from the prioritization process, all proposals that fail to meet the information requirements.

Other Capital Investments

VA uses a decentralized approach to budget less expensive capital investments (below \$4 million), essentially empowering its 22 network directors to make prioritization decisions. Directors use varying approaches, which are considerably less rigorous than those used for larger projects. For example, VHA generally makes investment decisions without addressing systematically OMB's "three pesky questions" or expected 30-year investment returns. We find this troublesome because such decisions account for over 85 percent of VHA's total investment dollars requested for fiscal year 2000.

Over the last 3 years, VHA has significantly reduced the number of high-cost investment proposals, involving alterations or improvements, submitted for VA's centralized review and prioritization. VHA, for example, submitted 32 proposals for fiscal year 1998 funding consideration, compared with 21 and 14 for fiscal years 1999 and 2000, respectively.

This relatively small number is not attributable to a lack of assets requiring high-cost investments. VHA's planning shows that almost half of the 181 locations need capital investment of \$4 million or more, including about 50 with asset needs exceeding \$10 million. Overall, individual locations' needs range between \$4 million and \$38 million.

Instead, the decline in the number of high-cost investment proposals appears influenced by a

- desire to avoid the rigor of VA's centralized process or
- limited availability of resources for high-cost investments.

Some VHA locations, for instance, do not submit proposals to VA's centralized process because they could fail VA's validity assessment or be assigned a low priority. Others believe that there is a better chance of receiving funds through

the decentralized process if a high-cost investment is divided into several less expensive investments that can be spread over several years.

Concerns about the availability of funding appear to have merit. For fiscal year 2000, VHA has requested about \$425 million for capital investments. Of this, VHA's centralized process made decisions valued at \$48 million, and the rest are to be made using VHA's decentralized process. VA had a similar funding pattern in the 2 previous years.

In addition, this has resulted in the disturbing situation whereby VHA's decentralized process approves investments for locations that VA's centralized process has found to be or would consider to be low priority or unsound. VHA's planning, for example, shows that nine investments totaling almost \$27 million are to be considered for improvements at Fargo, North Dakota, over the next 5 years or more. VA's centralized process considered this proposed investment to be a low priority, even suggesting that lower-cost alternatives be considered.

Until effective capital asset planning is in place, it is imperative that investment decisions be based on sound economic analyses. Toward that end, we recommend that VA

- use its centralized budget process for a larger share of its investment decisions or
- ensure that the fundamental principles underlying that process are rigorously implemented when making decentralized investment decisions.

Last year, VA's Inspector General recommended that VA and VHA work together to develop policies for, among other things, the types of investments subject to capital programming, dollar thresholds, and responsibilities for considering alternatives.³⁰ VA expects to issue the revised policies within the next several weeks.

VA's Appropriations Could Be Restructured

VHA uses widely varying sources of funds to make capital investments. Sometimes, VHA's decisions appear to be based on the availability of funds under a specific appropriation rather than on the soundness of an investment. In such instances, VHA invests more money than it needs to in achieving its objectives.

VHA, for example, may use a medical care appropriation to perform nonrecurring maintenance and to lease building space. Nonrecurring maintenance involves repairs or modifications to existing buildings, including upgrades or replacements of major building systems, such as utilities, security, and health care support, or minor improvements to add space or to make other minor structural changes.

VHA also has two separate construction appropriations that may be used for

- improvements or alterations of \$4 million or more and
- improvements or alterations of less than \$4 million.

The availability of funding has varied over the last 5 years. Historically, VHA's major construction appropriation was the largest funding source. Currently, it is the smallest funding source, as funds for nonrecurring maintenance, leases, and minor construction have increased while major construction funds have declined precipitously.

VHA has discretion to decide which appropriation to use to meet most asset needs. VHA, for example, may use health care funds to lease new space or construction funds to build a building. Given the limited availability of major

³⁰VA, Office of Inspector General, *Evaluation of VA Capital Programming Practices and Initiatives*, Report No. 8R8-A19-061 (Washington, D.C.: VA, Jan. 28, 1998).

construction funds, VHA has recently decided that more costly leasing alternatives should be used to acquire needed assets, because funds are more readily available in the medical care appropriation. For example, VA's Inspector General reported last year that VHA decided to spend \$86 million (present value of life-cycle costs) to lease outpatient space in five locations, even though construction of new buildings would cost \$13 million less, an almost 20-percent savings. According to the Inspector General, VHA stated that leases were used because they could be funded using its medical care appropriation.

VHA has asked for funds for two leases in its fiscal year 2000 budget request. VA's Capital Investment Board reviewed and scored these proposed leases. In one instance, the Board instructed that alternatives such as build or buybe more seriously considered. Nonetheless, VA included both leases in its medical care budget request.

In addition, the availability of funds in the minor construction appropriation, along with the less rigorous budget process, provides an incentive to invest in a number of smaller improvements over several years rather than address needs at the same time in one potentially less costly investment. As previously mentioned, VHA plans to use this approach in Fargo as well as many other locations nationwide.

Historically, VHA has used the minor construction appropriation to fund improvements at individual locations over a period of years. VHA, for example, spent about \$19 million of minor construction appropriations at Battle Creek, Michigan, over the last 6 years. This money funded improved inpatient and outpatient capacity as well as upgraded major building systems.

Last year VA's Inspector General suggested to VHA that a new approach be considered, and VHA officials indicated that options were being discussed.²¹ To facilitate VHA's decision-making, we suggest that the Congress consider restructuring VHA's appropriations into a single capital investment appropriation.

Alternative Financing Methods Could Be Authorized

VA has proposed a new funding source, namely asset disposal revenues, to help fund high-priority investments faster. In addition, VA has other potential funding sources to achieve this objective, such as operational savings through asset restructuring and returns on capital investments. These, however, require legislative action.

In its fiscal year 2000 budget submission, VA proposes a 5-year demonstration that would allow VHA to

- sell, transfer, or exchange up to 30 excess or underutilized properties;
- deposit proceeds into a new Capital Asset Fund; and
- use the Fund to invest in more appropriate assets.²²

This proposal is compelling for two reasons:

- VA has significant unused or underused buildings, and
- VA lacks incentive to dispose of properties, because funds can, by law, be spent only to construct, alter, or acquire nursing home facilities.

VA's best opportunity, however, to accumulate resources for capital improvements could be operational savings available through asset restructuring. Legislation could authorize VHA to deposit such savings into a capital asset fund.

²¹ VA, Office of Inspector General, Evaluation of VA Capital Programming Practices and Initiatives (Jan. 28, 1998)

²² Each major project or major lease would still be subject to congressional approval.

As previously discussed, VA might save \$180 million a year, for example, if veterans' needs are met with one fewer location in the nine largest multiple-location markets. Some or all of these savings could be used to finance future capital investments.

Legislative action could authorize VA to accumulate resources in its Capital Asset Fund by charging VHA delivery locations for the costs of improving or replacing assets. VHA could use returns on capital investments, such as operational savings or third-party payments, to pay back some or all of the amount invested over a prescribed number of years.

As previously discussed, VHA's investment proposals are prioritized, in part, on their investment return potential. VHA's Tampa, Florida, proposal, for example, states that operational savings of almost \$2 million annually could be realized as a result of planned improvements. This is because Tampa will relocate related services now done on the first, second, and fifth floors, into existing contiguous space on the ground floor, which allows VHA staff to deliver health care more efficiently. A reasonable payback period could be 18 years, given the proposal's \$17.5 million cost (18 years times \$1 million).

VHA's Murfreesboro, Tennessee, proposal also states that operational savings are expected as a result of the investment. This is because veterans from two other VHA delivery locations will be referred to Murfreesboro, which, according to its proposal, has unit costs that are about half of those at the other locations. A reasonable payback period for this \$12.7 million investment, however, cannot be suggested because Murfreesboro's proposal did not quantify the magnitude of savings expected.

In addition, VHA's Dallas, Texas, proposal, states that a return of \$2 million a year could be expected from third-parties, if \$24 million is invested to improve that location. This is because Dallas expects such improvements to allow VHA to successfully compete for TRICARE patients. A reasonable payback period could be 24 years (24 years times \$1 million).

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

Concluding Observations

VHA has the opportunity to reduce significantly the amount of funds used to operate and maintain unneeded or inefficient health care delivery locations and reinvest such savings to enhance care provided to veterans. To do so, VHA needs to develop, and implement, a market-based plan for restructuring assets. Without such restructuring, it seems that VHA's resources might be increasingly shifted to operating and maintaining assets at the expense of veterans' health care needs.

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

APPENDIX I

APPENDIX I

VA's Five General Categories and Twenty Decision Criteria**One-VA Customer Service—Priority Weight .56**

- Increase in customer access
- Increase in quality of service
- Decrease in waiting time
- Increase in benefit or service provided

Return on Taxpayer Investment—Priority Weight .19

- Reduction in cost per customer
- Number of customers affected
- Increase in direct revenue
- Cost-effectiveness analysis

High-Performing Workforce—Priority Weight .14

- Improve recruitment and retention of employees
- Increase in training and development
- Increase in employee morale

Risk—Priority Weight .6

- Risk of achieving projected benefits
- Risk of achieving projected costs
- Risk of adhering to projected implementation schedule
- Risk of obsolescence

Comparison to Alternatives—Priority Weight .5

- One-VA customer service
- Return on investment
- High-performing workforce
- Risk

RELATED GAO PRODUCTS

Major Management Challenges and Program Risks Department of Veterans Affairs (GAO/OCG-99-15, Jan. 1999).

Executive Guide: Leading Practices in Capital Decision-Making (GAO/AIMD-99-32, Dec. 1998).

VA Health Care: VA's Plan for the Integration of Medical Services in Central Alabama (GAO/HEHS-98-245R, Sept. 23, 1998).

Veterans' Health Care: Challenges Facing VA's Evolving Role in Serving Veterans (GAO/T-HEHS-98-194, June 17, 1998).

VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

Budget Issues: Budgeting for Capital (GAO/T-AIMD-98-99, Mar. 6, 1998).

VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department (GAO/T-HEHS-97-97, Mar. 18, 1997).

VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997).

VA Health Care: Travis Hospital Construction Project Is Not Justified (GAO/HEHS-96-198, Sept. 3, 1996).

VA Health Care: Effects of Facility Realignment on Construction Needs Are Unknown (GAO/HEHS-96-19, Nov. 17, 1995).

VA Health Care: Need for Brevard Hospital Not Justified (GAO/HEHS-95-192, Aug. 29, 1995).

VA Health Care: Inadequate Planning in the Chesapeake Network (GAO/HEHS-95-6, Dec. 22, 1994).

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TESTIMONY
BEFORE THE SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS AFFAIRS, HOUSE OF
REPRESENTATIVES, CONCERNING

VETERANS HEALTH CARE

STATEMENT OF DANIEL H. WINSHIP, M.D.
DEAN, LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE
MAYWOOD, IL

MARCH 10, 1999

Mr. Chairman and Members of the Subcommittee:

I am Dr. Daniel Winship, Dean of the Stritch School of medicine of Loyola University Chicago. I am pleased to be invited to discuss the ongoing issues regarding consolidation, mission change and realignment of VA medical facilities in the context of the VA's capital asset needs, planning, budgeting and decision-making for FY 2000.

The Department of Veterans Affairs (VA) health care mission has never faced greater challenges than it does right now. Ever increasing budget stringencies with actual operating dollar reductions for many medical centers, especially in the northern tier of states, leads to extremely difficult management decisions, reduction in service and economies which often are forced to overreach optimal spending reductions.

As health care delivery evolves rapidly in this country, the VA is caught up, appropriately, in the shift of sites of care, from in-hospital to ambulatory, for increasing numbers of clinical activities and patient encounters. This cost-effective strategy, as well as those of consolidation, appropriate mission change and realignment comprise a centerpiece of the bold view and plan of Dr. Kenneth Kizer, Undersecretary for Health, to modernize the VA health care enterprise.

This rationalization of the operations of the VA health care system, one of the largest in the nation, is hampered by aging facilities not well repaired, updated and maintained over the years due to the lack of funds appropriated for that purpose, and by mandates from headquarters in Washington to keep facilities open and their staffing levels up even though activities have drastically diminished and moved to other, more appropriate venues.

Efforts to develop appropriate ambulatory sites of care are inhibited by an inability to free up funds sequestered in the hospital budgets even though the decline in inpatient occupancy and the closure of beds continues. Consolidation and integration of programs and facilities are blocked by constituents and their elected representatives who fear that integrations of facilities and programs will impose hardships on the veteran community by requiring some veterans to travel longer distances for services not available at the VA facility closest to them. Other constituents, the academic medical center and medical school affiliates (one of which I represent) fear disruption of established teaching and research programs for which they rely heavily on their VA partner. The idea of sharing these precious clinical, educational and research resources of the VA partner between two or more medical schools is anathema—but it should not be. Consortial relationships for purposes of carrying out the academic missions of institutions are becoming much more common, sophisticated, and productive.

The picture I paint appears to me to be that of an increasingly dysfunctional system of health care delivery. The decline in inpatient occupancy and the closure of beds continues but the necessary consolidations, mission changes and realignments which should smoothly transfer the care of veteran patients to more appropriate, and better supported, venues of care lags unacceptably far behind.

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March 10, 1999
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I wish now to focus on the VA health care scene in Chicago, as I see it. I will present my thoughts as "a 30,000-foot view", not in detail, not facility-specific, but as an overview. I am Dean of the medical school closely affiliated with the Hines VA Hospital, and we need Hines desperately for our academic programs (and Hines needs us), but I am not here to discuss that or any other specific relationship. Rather, I will suggest how, in my opinion, the troubled and dysfunctional situation in Chicago might be improved.

There are four VA medical centers in Chicago. Two of those have been declared to be consolidated, and integration of their programs inches forward. All four facilities remain intact, however. They represented an enormous capacity for mainly inpatient care in the past, a much smaller one now. The total currently operating hospital beds for those four facilities numbers 1,262, a capacity which a few years ago could have almost been handled by one facility. These beds are about 80% occupied. One of these facilities, housed in a large 22-story building, has a total of 126 operating beds. Another 1,436 beds for long term care-nursing home, domiciliary and residential care, about 83% occupied, round out the current capacity. While one of these facilities manages primarily long-term care veteran patients, with only small medical-surgical capabilities, the other three maintain a robust general, more or less comprehensive programmatic and staffing structure, with a great deal of duplication of services and substantial redundancy. All three are within a geographic area less than fifteen miles across. They share a common patient service area; the service area for two of the three are virtually identical.

Nine Community-Based Outpatient Clinics are now operational and another six are planned. All of these are linked to one or another of the Chicago VA facilities. Most are small but this is a promising start.

Meanwhile, VISN 12 and especially the Chicago hospitals, have sustained severe budgetary reductions over the past three or so years. The President's straight-line budget bodes ill for this portion of the system. Mandated pay raises, increased programmatic development in specified areas, in conjunction with actual operating dollar loss, will profoundly affect the ability of this group of four facilities to carry out their missions, especially while they are also attempting to perform the near-impossible by keeping all four viable and operational.

By any objective measure, from the 30,000 foot view, in the current and predictable future climate of health care need and practice, Chicago does not need four VA medical centers. I am confident it could do acceptably well with two, probably more optimally with three, as recommended by the GAO last year in its report to the Senate Committee on Appropriations. The VA can take a lesson from other health care systems in the rationalization of care, i.e., savings gained by real elimination of duplications and redundancies by true consolidation of services and, yes, even closure of unneeded facilities can be applied to more rapidly and completely creating ambulatory sites for care. This strategy is NOT one of closing the system. Rather, it will replace an archaic, decrepit, inefficient delivery system with a new, better, cost effective one. Quality will improve, access will improve, workload can be performed at the most reasonable and appropriate site.

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What do the Deans of the four affiliated medical schools and their schools have at risk if my view is accepted? They will feel immediate dislocation and will feel the threat of loss of an academic partnership for education, research, patients, etc. They will encounter great fears from constituencies who see only the threat of change and will not clearly see the future possibilities for better programs. And there will be a great tendency, as there has been all along, to resist the change and erect any barriers possible to it. I recognize these feelings acutely. But if they buy in, and persevere, working out Dr. Kizer's vision for the future of the VA, the result, I am confident, will be more appropriate venues for care, education and research, new linkages which will enhance relationships, continued viability of relationships already established, availability of funds newly freed up to accelerate the shift to ambulatory care, to better support the remaining facilities to develop new programs and enhance old ones. Not easy, but it must happen. The alternative is continued and increasing dysfunction, certainly in the Chicago portion of the system and I'm sure other areas as well, continued ratcheting down of the capabilities of each of the facilities, and erosion of staff and ultimately of programs.

The VA is managed and staffed by a lot of awfully bright and competent people. They must be allowed to let go of practices which will lead to the demise of the system. Seventeen or eighteen billion dollars, whatever the final number is, will buy a lot of health care for a lot of veterans; much more if the system, through appropriate consolidation, mission change, and realignment, is freed to be as nimble and efficient as it can be.

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

**Statement of
Thomas L. Garthwaite, MD
Deputy Under Secretary for Health
Department of Veterans Affairs
Before the
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives**

March 10, 1999

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

Before discussing our efforts to plan for and manage our capital assets, it is important to recognize how our capital asset needs have been impacted by the unprecedented transformation of VA health care that has occurred during the past four years. As you know, powerful forces are rapidly transforming American health care. Prominent among these forces of change are market-based restructuring of health care which includes the rise of managed care; the explosive growth of knowledge with technological advances that are dramatically expanding the ability to treat illness and injury; unprecedented developments in information and data management; and the changing demographics and aging of America.

As has been discussed in previous hearings before the committee, in the early 90's the veterans health care system was described as having serious operational and managerial problems. Like its private sector counterparts, VA provided hospital-focused, specialist-based, and episodic treatment of illness. A number of different entities independently concluded that VA health care needed radical change if it were to have a future.

Since 1995, we have made significant progress in transitioning from a disease-oriented, hospital based, professional discipline focused health care system to a system that is patient centered, prevention oriented, community based and which has universal primary care at its foundation.

To accommodate this transformation, VHA established 22 Veterans Integrated Service Networks (VISNs) at the beginning of FY 1996. Each VISN forms a fully integrated health care system that provides a continuum of health care services to veterans who reside in a geographical area rather than a collection of individual facilities providing episodic services to veterans who come to those facilities.

VA's transformation is still in process but results have already been achieved. The following accomplishments illustrate this change:

- *More than 52% of all hospital care beds were closed between FY 1994 and FY 1998.*
- *VHA's bed days of care per 1,000 patients has declined by more than 62% nationally – from 3,530 to 1,333 from October 1995 through September 1998.*
- *Inpatient admissions have declined by 31.7% since FY 1994.*
- *Ambulatory care visits have increased by almost 10 million per year – a 35.4% increase between FY 1994 and the end of FY 1998.*
- *Management and operation of 48 hospitals and/or hospitals and clinic systems have been, or are in the process of being merged into 23 locally integrated health care systems since September 1995.*
- *271 new community based outpatient clinics (CBOCs) have been sited, or are in the process of being sited since 1995.*
- *Ambulatory surgeries increased from 35% of all surgeries performed in 1995 to about 92% in FY 1998.*

These changes and the continuing rapid changes in health care technology have significantly impacted our physical infrastructure needs. While these changes are guided by an improved strategic planning process, the rapid pace of the change has made capital asset planning especially difficult, given that capital plans can take many years to accomplish.

VA has implemented a new, and we believe improved, Departmental Capital Investment Planning Process to assure that proposed capital investments support the priorities of the core mission of VA and VHA. Capital asset planning starts at the VISN level. VISNs prepare capital asset plans utilizing the principles in the OMB "Capital Programming Guide." Proposed investments must answer three questions: 1) Does the proposal support core missions of the Department that must be performed by the government; 2) Is there no other government or private sector source that can do it better or cheaper; and 3) Have current work processes already been optimized?

The network must then identify the primary customers who would benefit from the capital investment and the specific linkages to VA and Network goals.

VISN capital asset plans contain two sections. One describes the linkage of the capital acquisition to VA/VHA/VISN mission, goals, management strategies and performance goals. The second is a Baseline Assessment that describes the extent that existing capital assets are helping the network to achieve goals, management strategies, operating strategies, and performance goals. The difference between current and projected performance, which cannot be met with existing assets, is the performance gap. In this section of the plan, VISNs explain options considered for closing the perceived gap, including non-capital options such as sharing and contracting. If asset acquisition is thought to be the best option, the network plan identifies the asset that is uniquely suited

for closing existing performance gaps. In addition, in this section, the network plan explains why the capital asset investment is the best alternative of all the available options, including non-capital alternatives.

The result of these efforts is a VISN specific Capital Asset Plan. Network Capital Asset Plans are not submitted to HQ in total. Only those proposals exceeding the established threshold (\$4.0 million for construction) are provided to VA Headquarters as part of the Network Strategic Plan submission. Analyses for capital asset expenditures not exceeding the threshold are conducted at the VISN level to facilitate their decision making. The justification includes the basis for selecting the project; a cost-effectiveness analysis; an analysis of alternative options and an analysis of the full life-cycle costs.

From the 22 Network strategic plans, a major construction project inventory is compiled. Projects are reviewed by the VA Capital Investment Board (VACIB) for budget consideration.

The VACIB was created to foster a "One VA" approach to the use of capital funds (including construction, information technology, and equipment) and to ensure all major capital investment proposals are based upon sound economic principles and are fully linked to strategic planning, budget, and performance goals. The VACIB includes senior management officials from across the Department. The VACIB reviews proposals that have high risk, national visibility or exceed dollar thresholds (\$4.0 million for construction). The Board provides an analysis to the Secretary about each proposal's viability for inclusion in the VA Capital Plan and VA budget request to OMB.

The major criteria used to select capital construction investments are prioritized and weighted by the Capital Investment Board members. The criteria for FY 2000 included:

One-VA Customer Service

Return on Taxpayer Investment

High Performing Workforce

Risk Analysis

Alternatives Analysis

Using the criteria approved by the Board, all investments including major construction projects are scored and prioritized. The VACIB recommended a list of investments to the VA Resources Board for approval. Approved major projects are submitted to OMB as part of VA's request for budget and authorization consideration.

The FY 2000 budget proposes three major construction projects to improve VHA facilities. These include a project for a new surgical suite at Kansas City, Missouri; a

spinal cord injury facility at Tampa, Florida, and the renovation of psychiatric nursing units at Murfreesboro, Tennessee. In addition, a project at the Leavenworth, Kansas VA Medical-Center will demolish 39 buildings that are no longer needed to permit the expansion of the National Cemetery at that location. I urge the committee's favorable consideration of our authorization request for these medical projects.

While we believe that we have improved our capital assets process, I would like to describe four initiatives now underway within the Department that we believe will enhance our capital asset effectiveness.

The first of these relates to improving our capital asset management program. Capital Asset Management is a business strategy that seeks to maximize the functional and financial value of capital assets through thoughtful acquisition, allocation, operation and disposition. It is an active search for ways to increase the value of an organization's assets. In recent years, private for profit, not-for profit as well as public entities have begun to pay increasing attention to the relationship between capital assets and organizational performance. The impact of capital assets on productivity and profitability has led to a significant increase in the recognition of assets as a resource.

The VA is making efforts to establish a capital asset management program that embodies a set of corporate policies and operating procedures that promote the goals of the asset management program. The functions of a program include policy development, planning, investment strategies and decision-making, portfolio management, performance measurement and administration.

The second initiative is the Department's proposal to increase the flexibility we have to dispose of property that is no longer needed to meet our needs. The Department is proposing a pilot program to significantly improve its management of capital resources by encouraging and streamlining the process of converting properties we no longer need into active assets. This proposal would allow the VA to dispose of these properties (including land, structures or any equipment associated with the property) by sale, transfer, or exchange, and to reinvest the bulk of the proceeds into the system. The pilot would be restricted to thirty dispositions over its 5-year life.

VA's capital portfolio consists of over 22,000 acres of land and 4,400 facilities at nearly 1,200 locations. Disposal is currently a cumbersome and lengthy process with limited benefits to VA. For example, to dispose of property with an estimated value over \$50,000, the asset must first be reported to Congress in an annual budget submittal. Then VA must transfer the surplus property to GSA for disposal. Before GSA can attempt to sell the asset to the private sector, they must offer it to other federal agencies, then to State, local and qualifying non-profit organizations. Disposals must also comply with the Stewart B. McKinney Homeless Assistance Act that requires that excess property be offered to homeless organizations at no cost. GSA is also authorized to offer discounts of up to 100% to public and non-profit institutions. Any proceeds realized by VA after

covering GSA's expenses of the disposal are deposited into the Nursing Home Revolving Fund. These monies can then only be used to build nursing homes -- currently not VA's highest priority need.

We propose to establish a Capital Asset Fund. All proceeds of disposals, after deductions, will be deposited into this fund to be reinvested into the system's capital requirements. Allowable deductions would include all costs of disposing of the asset such as site preparation, demolition, administrative expenses etc. This fund will have a cap of \$50 million, with excess proceeds to be transferred to the minor construction program.

The pilot would raise the threshold for reporting disposals in an annual budget document from \$50,000 to an amount equal to the cost of a major medical facility project (currently \$4 million). For disposals under this threshold a notice of intent would be provided to the local community and the congressional committees.

We also propose an innovative approach to supporting the homeless by directing 10% of the proceeds to local homeless assistance groups, which would include support for veterans. An additional 5% would be utilized to support VA-specific homeless programs. Homeless assistance groups would continue to benefit from the disposal of federal surplus property, consistent with the spirit and intent of the McKinney Act.

Because of the resources that will directly benefit VA programs, the Department will move quickly to establish procedures to implement this authority, as a part of its overall Asset Management program and I urge the Committee's support for this initiative.

A third initiative, that I would like to address, has been ongoing for a few years and has proven to be beneficial to VA. This is the Department's Enhanced-Use leasing program. This authority, which is unique among Federal agencies, is an integral part of the Department's management of its assets. The program was authorized by law in 1991.

The Department has used this authority to consolidate operations and dispose of unneeded facilities, collocate VBA office space onto VA Medical Center grounds, obtain child care services, expand parking facilities for veterans and employees, and re-direct operational funds from managing golf courses into direct medical care. In doing so, these leases have achieved significant cost savings, have enhanced employee recruitment, added substantial private investment to the Department's capital assets, provided new long-term sources of revenues, and created jobs and tax revenues for the local economies. Recently completed projects at VAMCs Portland, Oregon and Atlanta, Georgia illustrate the utility and versatility of this authority.

The VA Medical Center in Portland, entered into an Enhanced-Use lease with a local authority for the development of a "Single Room Occupancy" Facility on available property at its Vancouver Division. In return for the lease, the VAMC will have no cost access to one-half of the 120-unit facility for its use in connection with its own homeless programs. Occupancy is scheduled for this summer. The present value of the cost savings to the VAMC is estimated at \$9 million.

The Department used the Enhanced-Use leasing authority as a means to co-locate its Veterans Benefits Office with the VA's Atlanta Medical Center. Through an Enhanced-Use lease, the Department entered into innovative arrangements with a local development authority for the necessary financing and with a developer for the construction and operation of the development. Construction is now underway for the office building and the associated parking facility. When completed, the average annual VA rent over the term of the lease for office space, parking, furnishings, and associated data and telecommunication equipment, will be approximately \$11.00 per square foot as compared to the market rate of \$20.00 to \$26.00 per square foot for comparable office space alone. Finally, the Department will also obtain revenues from non-VA users in the development.

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

While the program has achieved some level of success, it has limitations; namely market demand, compatibility issues and VA mission requirements. By understanding its strengths and constraints the Department is moving toward further application of this authority as one tool in its capital asset program.

And a fourth initiative that I would like to address and which has proven to be economically beneficial to the Department is the Energy Savings Performance Contract Program. This program was authorized by the Energy Policy Act of 1992 and provides Federal Agencies unique opportunities to upgrade capital assets to achieve energy savings. VA has completed seven projects at various medical centers and a total of 92 medical centers have awarded contracts under this program. In short, a private contractor updates the facility with energy saving technology. The savings from utility charges are shared between VA and the contractor until the contractor's cost of the upgrades is covered. This program has allowed VA to address many of its energy related infrastructure needs without an investment of appropriated capital funds.

Mr. Chairman, our objective is to ensure that VA capital assets are utilized in ways that bring the greatest value to the Department at the lowest cost. We believe the initiatives that I have discussed here this morning will help in moving the Department forward in this area. This concludes my opening statement and I would be pleased to answer any questions you or the members of the committee may have.

**Post-Hearing Questions
Concerning the March 10, 1999, Hearing**

for

**The Honorable Thomas L. Garthwaite
Deputy Under Secretary for Health
Department of Veterans Affairs**

from

**The Honorable Ciro D. Rodriguez
Member, Committee on Veterans' Affairs
U.S. House of Representatives**

1. The President's budget on the one hand funds \$1.6 billion in unfunded mandates for various components, i.e., Hepatitis C, while on the other hand calls for \$1.6 billion in management efficiencies. Given the fact that significant downsizing has already occurred, where do you see these efficiencies coming from?

Answer: Savings can be derived by improved clinical processes including improved care (case) management. For example, immunizations, treatment of hypertension, team care of diabetic foot ulcers, and aggressive management of asthma have all been associated with improved outcomes which are less expensive than treating the unaltered course of these conditions (pneumonia, stroke, amputation, exacerbation of asthma leading to hospitalization). Additional savings will be sought from integrating inefficient or redundant administrative or clinical programs (e.g., in Boston, there was a 95% overlap of clinical programs in two medical centers only 7 miles apart). Modernization, automation and standardization of materiel management will produce significant savings.

2. What is the "end game" for VHA as you see it? How would you describe the Veterans Health Care System in 2003?

Answer: VA's goal for the future is to achieve maximal health care "value" for the expenditure of health care resources and to be a premiere health delivery system for veterans in the 21st century. Our concept of "value" is the composite of achieving easy access, high technical quality, good service satisfaction and optimal patient functionality at a reasonable cost.

With this requirement for demonstrating value in mind, we see VA getting better at what it now does – i.e., getting better at taking care of service-connected and poor veterans in a system that not only provides current state-of-the-art medical care, but one that also trains tomorrow's health care providers and one that researches and pioneers tomorrow's health care solutions. Finding better ways of caring for VA's population of chronically ill, older and poorer veterans will

ultimately result in better care for all Americans. In pursuing this direction, we believe that VA must adhere to five key principles:

- One, VA must continually focus on its core business of providing for the special care needs of veterans.
- Two, we must concentrate on managing care, not costs. We must especially concentrate on managing the care of complex chronic conditions. This is an immense challenge for medicine everywhere and a special opportunity for VA health care.
- Three, ensuring the provision of consistently and predictably high quality care is critical. Reducing unexplained or inappropriate variation in service utilization across the system will not only result in higher quality outcomes but also greater cost effectiveness.
- Four, better information and data management are essential to our future. In this regard, VA is no different than other health care systems in so far as future success is directly dependent on the ability to manage information – and information that is patient-centered instead of facility-based.
- Five, everyone in health care must get comfortable with continuous rapid change. There is no crystal ball that can tell us what the state of U.S. health care will be three years from now, but it is clear that the rate and pace of change in health care is accelerating.

In short, the “end game” goal is to be a health care system that demonstrates its ‘value’ by providing consistently high quality health care that results in optimal patient outcomes; that results in very high patient satisfaction with our services; that is readily accessible; and that provides care at the least possible cost to the taxpayer.

Of course, our ability to get to this end point is a complex task, requiring much hard work by VA staff throughout the country and depending greatly on the support and willingness of all stakeholders.



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