

**U.S. DEPARTMENT OF VETERANS AFFAIRS
CONSTRUCTION AUTHORIZATION**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

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**U.S. DEPARTMENT OF VETERANS AFFAIRS
CONSTRUCTION AUTHORIZATION**

WEDNESDAY, FEBRUARY 27, 2008

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

The Subcommittee met, pursuant to notice, at 10:02 a.m. in Room 334, Cannon House Office Building. Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Brown of Florida, Miller, and Brown of South Carolina.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the hearing to order. I would ask the first panel to come up.

I would like to thank everyone for coming today. Today's hearing is an opportunity for the U.S. Department of Veterans Affairs (VA), Veteran Service Organizations (VSOs) and Members of this Subcommittee to discuss legislation dealing with fiscal year 2009 VA construction.

Title 38 United States Code requires statutory authority for all VA medical facility construction projects over \$10 million and all medical facility leases more than \$600,000 per year. This hearing is a first step in this process.

I would like to note that this draft legislation is based upon the Department of Veterans Affairs fiscal year 2009 budgetary request and authorization for fiscal year 2008. I consider this draft to be a starting point. I look forward to hearing from the VA, the VSOs and Members of the Subcommittee about other construction projects that are important to them.

I will take under consideration the discussion we have here today and any input that may come up. I will then introduce legislation in the very near future.

I would now like to recognize the Ranking Member Miller for any opening statement that he may have.

[The prepared statement of Chairman Michaud appears on p. 27.]

OPENING STATEMENT OF HON. JEFF MILLER

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

I appreciate you holding this hearing. I have a statement and I would like to go ahead and read it into the record if I might. I also

apologize ahead of time. I have an Armed Services Committee hearing going on at the same time, and I have to be going in and out.

Important to delivering high quality care to our Nation's veterans is the planning for construction, as we are doing, and renovation of VA's substantial healthcare infrastructure. As you know, VA maintains an inventory of approximately 1,230 health facilities, including 153 medical centers, 135 nursing homes, 731 community-based outpatient clinics (CBOCs) and 209 Vet Centers.

VA initiated the Capital Asset Realignment for Enhanced Services (CARES) process to identify and address gaps in service and infrastructure about 8 years ago, and the CARES process is continuing to serve as the foundation for VA's capital planning priorities.

VA's construction planning, however, is not without its challenges. The rising cost of construction has been significant at best. In fact, the draft legislation we are discussing today would provide over \$670 million to account for cost increases for previously authorized construction projects.

I am extremely concerned that VA has an inability to accurately project cost estimates, and it is adversely affecting the construction process. Escalating project costs continue to require this Committee to reexamine and increase authorizations for existing projects, hindering the ability to move forward with new projects important to improving access to care and supporting future healthcare demand.

CARES identified Okaloosa County in my district in Northwest Florida as underserved for inpatient care. In fact, it is the only market area in Veterans Integrated Services Network (VISN) 16 without a medical center. However, VA has yet to act to address the inpatient care gap in this region.

There is a tremendous opportunity to collaborate with the U.S. Department of Defense (DoD) for medical services on the campus of Eglin Air Force Base (AFB) that would benefit both veterans and active-duty servicemembers in this area.

Last September, I introduced H.R. 3489, the "Northwest Florida Veterans Health Care Improvement Act." This legislation would expand partnership between Eglin AFB and the VA Gulf Coast Veterans Health Care System to provide more accessible healthcare to eligible DoD and VA patients in Northwest Florida. In collaboration with DoD, this bill would provide inpatient services and expand outpatient specialty care through the construction of a joint VA/DoD medical facility on the Eglin AFB campus.

At our November 2007 Subcommittee hearing, Major General David Eidsaune, Commander of the Air Armament Center at Eglin Air Force Base, testified about the successful partnership that the VA and DoD had developed in the region and stated that "This cooperative effort should serve as a model for future efforts to support the healthcare needs of our Nation's veterans."

Mr. Chairman, I am providing you with updated legislative language that reflects the intent of H.R. 3489, and I respectfully request that this language be included in the introduced version of the Department of Veterans Affairs Medical Facility Authorization and Lease Act of 2008 that will be considered by the full Committee.

I appreciate the opportunity to enter my statement into the record, and am available for questions at any time for you, Mr. Chairman, and I yield back.

[The prepared statement of Congressman Miller appears on p. 27.]

Mr. MICHAUD. Thank you very much, Mr. Miller, for your testimony. We definitely will consider that as we move forward dealing with important issues of construction and leases. I also would invite you to the good State of Maine. I know you are from the east coast, the southern part where it is nice and warm where we are getting a lot of snow up in Maine, and we have the dog sled races up in Northern Maine, so you are more than welcome to partake in dog sled races in Maine.

Mr. MILLER. As you well know, anytime you offer I am on my way up to your great State.

Mr. MICHAUD. Thank you. I also notice in the audience the announcer from the Maine broadcasters who is down here. I know we are getting a big snowstorm in Maine so I don't know if she got delayed and can't get out to head back to Maine. So glad to see you here as well.

On our first panel, we have Dennis Cullinan who is Director of the Veterans of Foreign Wars (VFW) of the United States who is here on behalf of *The Independent Budget*; Joe Wilson who is here from the American Legion; and Rick Weidman who is here for the Vietnam Veterans of America (VVA). We look forward to your testimony this morning, and without further ado, we will start off with Dennis.

STATEMENTS OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES, ON BEHALF OF *THE INDEPENDENT BUDGET*; JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; AND RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Chairman Michaud and Mr. Miller.

On behalf of the men and women of the Veterans of Foreign Wars and the constituent members of *The Independent Budget (IB)*, I thank you for inviting us to present our views at this most important legislative hearing. As you know, the VFW handles the construction portion of the *IB* and we will be representing the collective position of *The Independent Budget* VSOs (IBVSOs) regarding the draft bill under discussion today cited as the "Department of Veterans Affairs Medical Facility Authorization and Lease Act of 2008."

With respect to construction, the *IB*'s most fundamental objective is to produce a set of policy and budget recommendations that reflect what we believe will best meet the needs of America's veterans. In this regard, and as we have recently testified, the Administration's fiscal year 2009 budget request for major and minor construction is woefully inadequate. Despite hundreds of pages of

budgetary documents that show a need for millions of dollars of construction projects, the Administration has seen fit to have the major and minor construction accounts from the 2008 levels, failing to meet the future needs of our veterans.

The legislative proposal under discussion today demonstrates that you and this Congress are fully prepared to advance VA's construction priorities so that future generations of veterans—such as those currently serving in the deserts of Iraq and the mounts of Afghanistan—will have a first-rate VA healthcare system ready to fully meet their needs. We thank you.

It is our view that the VA construction infrastructure maintenance must be carried out in a methodically planned and orchestrated manner. One of the strengths of the VA's Capital Asset Realignment for Enhanced Services, CARES, process is that it was not just a one-time snapshot of needs. Within CARES, VA has developed a healthcare model to estimate current and future demand for healthcare services and to assess the ability of its infrastructure to meet this demand. VA uses this model throughout its capital planning process, basing all projected capital projects upon demand projections from the model.

The model, which drives many of VA healthcare decisions that VA makes, produces a 20-year forecast of the demand for services. It is a complex model that adjusts for numerous factors including demographic shifts, changing needs for healthcare as the veterans' population ages, projections for healthcare innovation and many other factors.

It is one concern of ours, however, that there have been times in the past and are currently going on, and will undoubtedly will occur in the future were things outside of the CARES process such as political exigencies and local problems that would interfere with carrying out the CARES' methodology.

We realize this is a fact of life. It is something we would ask this Committee to keep an eye on.

We applaud that the construction, renovation and maintenance projects covered in the draft bill are in keeping with this planning process. As you know, the *IB* recommendation for major construction is \$1.275 billion, and minor construction is pegged at \$621 million.

Our last observation here is that we applaud section 5 of this bill for the authorization of additional appropriations for fiscal year 2009 medical facility projects covered by this act and impacting major and minor construction projects of \$1.635 billion and \$345.9 million, respectively.

Mr. Chairman, thank you. That concludes my oral statement.

[The prepared statement of Mr. Cullinan appears on p. 28.]

Mr. MICHAUD. Thank you very much. Mr. Wilson?

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Mr. Chairman and Mr. Miller, thank you for this opportunity to present the American Legion's views on VA construction authorization within the Department of Veterans Affairs.

The average age of VA healthcare facilities is approximately 49 years old. Proper funding must be provided to update and improve VA facilities. With the enactment of Public Law 110-161, the Con-

solidated Appropriations Act for Fiscal Year 2008, VA was provided the largest increase in veterans' funding in its 77-year existence. The American Legion applauds Congress for this much needed increase.

However, there are questions, such as, whether or not construction funding adequately maintains VA's aging facilities, as well as its ongoing requirement for major and minor construction.

The fiscal year 2009 budget request was \$582 million for major construction, falling far behind the amount recommended by former Secretary Anthony Principi. From 2004 to 2007, only \$2.83 billion for CARES projects had been appropriated, an overall shortage of funding.

Mr. Chairman, veterans' healthcare is ongoing 24 hours daily, 7 days weekly, and 365 days annually. In addition, returning veterans of Operation Enduring Freedom/Operation Iraqi Freedom are returning home and seeking healthcare within the VA healthcare system.

The fiscal year 2009 budget does not begin to accommodate the needs of the Veterans Health Administration, not to mention planned projects of previous fiscal years. To date, various planned VA Construction projects, to include San Juan, Puerto Rico; Los Angeles, California; Fayetteville, Arkansas; and St. Louis, Missouri, have yet to receive adequate funding. Delays in funding cause delays in healthcare.

Mr. Chairman, when the Veterans Hospital Emergency Repair Act was passed in 2001, there was a construction backlog that continued to grow. During the CARES process, there was the de facto moratorium on construction, but the healthcare needs for this Nation's veterans didn't cease during this time, and yet still the construction backlog increased.

VA's minor construction budget includes any project with an estimated cost equal to or less than \$10 million. Maintaining the infrastructure of VA's facilities is no minor task. This is mainly due to the average age of the facilities. These structures constantly require renovations, upgrades and expansions.

From 2006 to date, the American Legion's National Field Service Staff and System Worth Saving Task Force have visited a combined total of 113 VA medical centers (VAMCs), community-based outpatient clinics, or CBOCs, and Vet Centers in all 21 Veterans Integrated Service Networks or VISNs. During these visits, many facilities reported space and infrastructure as their main challenges.

During the American Legion's 2006 site visits, our overall report ascertained that maintenance and replacement of VA's physical plant was an ongoing process and a major challenge to facility directors. It was reported that deferred maintenance and the need for entirely new facilities presented an enormous budgetary challenge.

In 2007, the National Field Service Representatives focused on VA polytrauma centers and Vet Centers, but also maintained, in thought, their connection to the entire VA Medical Center System.

During the American Legion's visit to the St. Louis VA Medical Center on May 16, 2007, it was reported that major work was required on outpatient wards. These wards were previously converted from inpatient wards but were never renovated. The outpatient

clinics were in need of modernization. The overall report of this facility included an outdated facility and lack of space.

Mr. Chairman, the issues mentioned are a microcosm of structural problems throughout the VA Medical Center System. Although not mentioned in this testimony, the American Legion maintains an account of its site visits in its annual publication of its "System Worth Savings" report.

As time progresses, the demand for VA healthcare is increasing while failure to improve the infrastructure causes unsafe conditions for veterans, as well as VA staff. The American Legion continues to insist that sufficient funding must be provided to maintain, improve, and realign VA healthcare facilities.

Mr. Chairman, Mr. Miller, the American Legion sincerely appreciates the opportunity submit testimony and looks forward to working with you and your colleagues to resolve this critical issue. Thank you.

[The prepared statement of Mr. Wilson appears on p. 29.]

Mr. MICHAUD. Thank you. Mr. Weidman?

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Mr. Chairman, on behalf of VVA National President, John Rowan, thank you for the opportunity to appear here today. Mr. Miller, thank you as well, sir.

VVA is generally in support of this legislation but believes that it is not nearly aggressive enough in fulfilling the promise of the CAREs model and the bottled-up need, if you will, for both renovation and new construction.

The physical plant is indicative of whether or not we are meeting our obligation to our Nation's veterans. We all basically posit, because it just makes common sense, that it affects the quality of healthcare, but we don't know that for a fact, and would encourage you, Mr. Chairman and Mr. Miller, to do a bipartisan call for a study of physical plant with medical outcomes, physical plant with staffing ratios of doctor/patient ratio, RN/patient ratios, et cetera, at facilities, and more importantly, as I said, medical outcomes for people who use that facility by DRG. It is something that certainly the U.S. Government Accountability Office (GAO) could accomplish in a relatively short order in just a couple of months.

Secondly, we favor all of and would suggest that you add somewhere between at least a half and probably \$1 billion to more aggressively pursue the schedule that was laid out pursuant to the CARES process.

I would be remiss if I did not note for the record that VVA never "agreed" to this CARES formula. When the people who developed this formula from Melbank turned to us and say, well, it is too complicated, you wouldn't understand, my response was "try me." I was one of only 13 George Komp Fellows at Colgate University, and they have never been forthcoming on that, but basically it is a civilian formula that does not take into account the wounds and maladies of war, does not take into account all the new veterans, does not take into account long-term care, and last but by no means least, it was developed for middle-class folks who can afford Preferred Provider Organizations and Health Maintenance Organizations, and the presentations on that, they figure an average of

one to three per person whereas at VA hospitals, we have five to seven presentations per individual who walks across the threshold.

What that means is the burden rate, if you will, of usage is much higher. In other words, many more services have to be provided on average to each veteran who shows up versus each patient in the private sector, which obviously is going to affect your overall resources in terms of staffing, which is also going to affect your overall need for a physical plant that meets the needs of those staff wherein you can provide the highest quality medical care. So we would encourage you to get GAO to do that study.

Secondly, I would like to talk about Puerto Rico for just a moment. Two billion dollars can be found for a new facility in Denver, Colorado, but they want to try and shore up a 1960s facility that is not hurricane proof even to the level of a Category 2 hurricane, and build a new bed tower, and the facilities in Puerto Rico are just simply inadequate.

The veterans who returned home from their valiant service to Puerto Rico were no less brave and no less true to their country than those who returned to Colorado. I am just using that as an example. While the Colorado hospital is needed, it is time to stop doing short shrift on Puerto Rican veterans, and that is reflected in the parking facility, and there are a number of things that we recommended in a statement that we added to this bill this year, and would encourage you to work with the Hispanic Caucus toward that end.

I am just about out of time so I want to thank you very much. I would be pleased to take any questions that you may have.

[The prepared statement of Mr. Weidman appears on p. 31.]

Mr. MICHAUD. Thank you very much. I know Mr. Miller has to leave for another Committee so I would recognize Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman, and unfortunately, I think we are all going to have to leave shortly for a vote.

One of my questions is, and I think all of you in your testimony recognize and said that there is certainly, I think you, Mr. Weidman, used the term while the legislation before us is good, it is not aggressive enough. I certainly understand that comment.

In the interim, if VA is not able to keep up at the rate that you propose, the \$1.275 billion, I think, Mr. Cullinan, that you were talking about, what suggestions do you have in the interim to provide for the needs of the veterans in the local communities?

We talk about co-sharing a lot and we talk about contracting out a lot. I will give to whoever wants to take it, and if any of the three of you want to comment, that is fine.

Mr. CULLINAN. Mr. Miller, I will speak to that briefly. I certainly don't have a perfect solution. The IBVSOs have been, and remain to be, supportive of leasing options. We are cautious, though, that leasing not supplant VA's own construction efforts. That is an area that could perhaps be pursued more vigorously.

The issue of co-locations, that is something we are trying to get a handle on. Co-locations are good in that they make services readily available to veterans. On the other hand, it sometimes seems there is almost a pattern emerging between co-locations and delays, and Fitzsimmons is an example. There is a co-location, and this is a construction project that has been playing out over too

many years. We don't know that co-location itself is the problem, but there is a pattern here.

Other than that, the construction has to be pursued, leasing, and it is absolutely necessary, they are going to have to provide services through the private sector, but that is expensive. Thank you.

Mr. WILSON. Mr. Chairman, Mr. Miller, I think there should be an actual overall assessment. Each VA medical center is unique. The American Legion has visited many medical centers and provided site visit reports on these respective VA medical centers. We found that they are very unique in nature in respect to their respective VISN, as well as their communities. For example, out in California there is the Hispanic population, while in other parts of the Nation there are other distinctive cultures, which aren't exactly relegated to ethnic background but also a way of life. This alone makes each VA medical hospital unique. Just as there was provided a model for the construction of VA medical centers, there should be an overall assessment of every facility to ascertain whether or not more funding is required at such facilities.

For example, the Sepulveda VA Medical Center is the only facility that has a Vet Center on its campus; currently there are no planned dollars for that particular structure. One could infer that the dollars were being borrowed from the VA medical center itself, or actually they lacked—they lacked funding, so that particular equipment went unrepaired.

So I would say an overall actual assessment of each VA medical center would be more effective rather than providing a model for one site or VISN to cover the entire VA Medical Center System.

Mr. WEIDMAN. Essentially, Congress put a hiatus on new construction until there was a reasonable plan about where you were going to go because folks were angry that moneys had been invested and then suddenly wards were closing and facilities were closing, wasting precious taxpayer dollars, and understandably so, the Congress said we want a plan that makes sense.

This plan is, while it doesn't go far enough because of the inadequacies of the formula itself, from my point of view, is in fact a reasonable plan that is laid before the Congress. We are not working the plan nearly fast enough, and that is the thrust of what I think we are saying to you is that with the plan VA has already laid out that was recommended by Secretary Principi, we can hike that up. There is nothing to preclude, in terms of organizational capacity to supervisor with the reorganization and separation of regular procurement of goods and services from construction procurement within the VA itself, they now have the organizational capacity to oversee many more both major as well as minor construction processes at the same time. So go to the CARES plan itself and hike it up a couple of years.

In answer to your question about contracting out, you directed VA to make sense out of the contracting out 2 years ago, and so VA took that one foot, and took three country miles, three rural country miles with it, and came up with a proposal for the very misnomered "Project Hero" that was essentially a fire sale of VA services that would have further diminished VA organizational capacity to provide quality, full wellness service as well as sickness service to our veterans.

With the VSOs united, and it is somewhat more reasonable now, but the problem, Mr. Miller, is that every time you give them a reasonable thing to go and do, and rationalize, like contracting out where it makes sense, people use that at VA as license as opposed to a mandate to do something reasonable.

So if I may suggest, sir, be very cautious in terms of directing contracting out because what may be pushed by, whether Domestic Policy Council, or by VHA, is going to be very different, Mr. Miller, than what you and the Chairman have in mind, if I may suggest.

Mr. MILLER. I appreciate it, and please do not take my comments to mean that it is something that I expect this Committee to mandate to VA. My question was, and my time is out now, but my question was in the interim while these projects are being constructed what do we do?

Mr. WEIDMAN. VVA, where it makes sense, would have no objection to contracting out if in fact there is not the capacity to do it within the VA facility, Mr. Miller.

Mr. MICHAUD. Yes, I had a couple questions on that line of thought. If I understand your testimony correctly, you all agree that the CARES process might not be perfect but at least it gives us a roadmap of where to go. It has been about 4 years now since CARES came out. A lot of things have changed since then with the Iraq and Afghanistan wars, and the economy.

What would you say about this as far as the construction? I know you say we ought to do more as far as giving more money to move this process a lot quicker. Is there anything we can do in the construction process that would help shorten the timeframe of getting these projects moving forward and hopefully do it in a cost-effective manner?

Mr. CULLINAN. Chairman Michaud, again I don't have a perfect answer. I don't seem to have any of those today. There are certain things that should be looked at. For example, right now the \$10 million limit differentiate between a major and a minor construction, perhaps that should be a little bit higher.

I know, for example, DoD, not to pick on DoD, is very good at what is called layering, splitting a project, say a \$100 million project into 10 or 11 subparts. VA can pursue a similar course as well, but perhaps it would be better to elevate the \$10 million limit. Then there is the issue of reprogramming authority.

For example, a contract goes bust, it is clear that it can't be carried out, sometimes it is difficult to get the money moved from that, at least temporarily, to fund projects into something that is viable. That is something that should be looked at.

There are a certain type of—I am trying to think of the term—single-source contracts where you hire the same company to basically do the design and research work, and do the contraction. The private sector uses that quite a bit. That is very effective. That is something VA could look at, and for now our recommendations on that.

Mr. MICHAUD. Thank you. Does anyone else have anything to add?

Mr. WILSON. It is important that VA mandate a definitive start and complete date of construction projects to ensure it is understood that outsourced contracts are temporary. It is evident some

contracts have actually become permanent in nature. It must be assured patient care remains of VA culture; a culture that veterans are accustomed to. On the other hand, when services are contracted out in the communities for an extended period of time, it removes the veteran from the comfort of VA's environment; which may impede adequate care. So I would say VA should establish and communicate a mandate to ensure such contracted projects are set for a complete date. VA should also make it concrete that contracting outside of the VA medical center environment is temporary.

Mr. WEIDMAN. Mr. Chairman, as you know in my copious free time, of which there is none, I have the privilege of serving as chairman of the Veterans Entrepreneurship Task Force, and have looked at procurement right across the board, including very carefully at VA. VA and the U.S. Department of State are actually meeting the 3 percent, but there is much more that can be done, particularly in the area of construction.

Bundling all too often happens, which freezes out all small business, and certainly service-disabled veteran-owned businesses (SDVOBs) that we know from all the studies that have been done by both Census and the Office of Advocacy at the U.S. Small Business Administration are less capitalized than their non-veteran counterparts.

So the bundling freezes our folks out. There needs to be more set asides specifically for SDVOBs, service disabled veteran-owned businesses. VA now has authority under Public Law 109-461, passed by this body unanimously, and the same in the Senate, to move forward and to do set asides, not just for service disabled, but for veteran-owned businesses.

If they stop bundling, break many of those particularly minor construction projects into segments that are essentially bite size, they can be handled by small and medium-sized enterprise, then we can speed up the process, one, two. You grow the organizational capacity of those businesses to do yet more in the future, and particularly in our non-urban areas, this becomes really important, that there not be somebody—if you make it large enough, the contractor that is going to come in from the outside—Togus, Maine, as an example.

But if you break it into bite-size chunks, then in fact you grow the small businesses and medium-size enterprises that are indigenous to that area of the country, and frankly, have a more profound impact on the economy.

Let me just make a point about that. Everybody is talking about the economic stimulus package as if going out and selling consumer goods is the way to go with that. While we fought hard to get service disabled veterans included in that stimulus package, one could argue that a much more sensible approach would be rebuilding the infrastructure of the Nation, and there is no better place to start than hiking up the schedule of rebuilding the infrastructure of the system to care for those who have been injured in service to country, and I would encourage you to—we certainly, if this Committee wants to take that lead, I think all the VSOs will unite behind you and carry that message on both sides of the aisle up to the leader-

ship of the House as well as carry it on the other side of the Hill, sir.

Mr. MICHAUD. And my last question touches upon contracting out while trying to move the CARES process forward. The CARES process recommended a lot of access points, particularly in the rural areas. I don't envision the VA being able to build clinics in all of the rural areas, or it is going to take quite a lengthy amount of time for them to do that. Just very briefly, what is your feeling if there is, for instance, I will use Maine as an example, one of the access points, Holton.

There is a hospital in Holton. It is in a rural area. They have plenty of capacity for space for the VA to use to take care of our veterans, and here is an opportunity where VA is not only unique to Maine, I am sure other rural areas across this country, where it can utilize what is already built there, and provide services a lot quicker because of the facilities there. What is your thought on something like that?

Mr. CULLINAN. Chairman Michaud, on behalf of the *IB*, again the *IB* is supportive of contracting out only where absolutely necessary. Speaking on behalf of the VFW, the VFW believes that there are a number of instances, and Holton is one, where contracting out is the only viable option.

The only thing I would add to that in many areas in parts of the country it is not just a question of lack of physical infrastructure, it is a lack of healthcare providers, sometimes then you are going to have to resort to some sort of sharing, contracting out. There just aren't any other options, especially in these remote rural areas.

Thank you, sir.

Mr. WEIDMAN. Contracting out may make the only sense. I used to, when I first came home, teaching in Vermont at one of the Vermont State colleges and lived in Lamoille County, which is a big green part, which means there is no town of 2,500 or more in the middle of north-central Vermont, and so I am aware of the problems of rural healthcare. I never went to the VA. It was three hours away, and therefore, used the civilian medical system.

For us, it would make sense for us to contract it out if, in fact, there is no viable option. One of the things, however, that VA has not done well, even in many of the CBOC contracts out, is train people in the wounds and maladies of war. They haven't trained their own staff in many cases either, but the Veterans Health Initiative, and that is why in my written statement we encourage that you have a hearing on all of this, about making this a veterans' healthcare system, and how does that affect not only the physical plant but also the planning process in terms of staffing needs in the future as well as training needs.

The Veterans Health Initiative in taking of a military history and training, at least making available those curricula, which are on the Internet I might add, to any contractor is extremely important that they understand what are the particular problems of veterans. If it is just general healthcare that happens to be for veterans, we are going to be doing a disservice to those rural veterans who have served well.

An example would be mental health. Many of the CBOCs, yes, they have ostensible medical health services out there, but you start to dig into it and they are not qualified counselors who know PTSD from ABCD, and therefore, are not going to be particularly useful to those veterans who need it the most.

Mr. MICHAUD. Thank you. Mr. Brown?

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

I noted when I Chaired the Health Subcommittee, we went to Maine and looked at some of the rural healthcare delivery, and I know in South Carolina we have a lot of these community health centers, and it certainly looks like to me in some instances these are State run so that there could be some overlap there to be getting service, and we also looked at telemedicine too, which I think would certainly help fill that gap.

My question is, I represent Charleston in Congress, and we have been looking at trying to combine some services between the VA and the medical university, and I guess in the last 3 weeks, we were able to go to the Oncology Center, which has a specialty type of equipment, actually an imaging piece of equipment that takes a picture of a tumor and actually treats just the cancer cells, and that piece of equipment costs like \$3.5 million. The VA actually bought the piece of equipment in the Oncology Center at the medical university, and their doctors actually administer the treatment.

We have been trying to work at some collaborative basis with the VA and the medical university to extend that, but we have done an extensive study, and I know Mr. Wilson mentioned the Charleston plan, and this is kind of what we were hoping to develop some kind of a model of cross-sharing services. After all, we are the same taxpayer that funds both VA and the medical university too, and the needs of the veterans are becoming more specialized than ever in the history of this Nation.

So it is difficult to have that specialized service at every VA center, so it makes sense to make some combination of services.

We are stuck in some kind of a warp, I guess, in Charleston because we have good medical facilities at the VA, though it is about 50 years old, and it is sitting in a low area of the peninsula, and I know that—you mentioned, Mr. Weidman, that we just aren't proactive enough, and you mentioned the situation down in Puerto Rico. It is the same situation here.

The medical university is building a brand new facility. We could make some combination, be it the operating rooms, be it some of the recordkeeping or whatever, and put another bed in that proximity since 95 percent of the doctors are actually coming from the medical university to treat the patients at the VA center.

It would make sense, but we are caught up in some kind of a CARES process that says, you know, we want to be sure we get the maximum use of the facilities that we have, and I am certainly for that.

But I went to New Orleans and we are now doing catch-up instead of being proactive. All those veterans now have to go some place else for service because of the time lapse of being able to make another facility there.

We were hoping to do the same thing in Charleston, but apparently we are caught up in some kind of a formal or some kind of a process that is going to put us in the same posture as New Orleans, and also Puerto Rico, too, I guess, if in fact we have another Class 4 hurricane to come in our region.

I would be interested in some comments from you all, and I apologize for taking most of my time asking that question, but I just want to make that presentation.

Mr. CULLINAN. Mr. Brown, I will speak on behalf of the VFW on this one. We believe that there are instances with respect to high-tech, highly expense equipment, that the best thing to do is to engage in a sharing arrangement. There is no doubt about it. Magnetic Resonance Imaging (MRI) and other imaging devices, you are just not going to have one in every locality, and the same thing goes for certain types of service, cardiac care, for example. If you are going to do open heart surgery, you want to go somewhere where it is done all the time.

So from the perspective of providing the best possible care in the most cost-effective manner, and in the safest manner for veterans, that is the way to proceed.

The only thing I would add to that is that with respect to CARES and the planning process, we do know that there are times when it seems to be the overarching CARES process that is causing the problem with respect to sharing, and sometimes it is a local situation. It is just below the surface.

Without mentioning the location, I know of one individual whose dad had had a heart attack, and there was a VAMC located directly across from a medical center, and there was an expectance at the VAMC supposedly that the care be provided there, whereas the medical facility, it came to light, was saying, well, we should be doing this, it makes perfect sense. We do it all the time. Why not us?

Well, indeed, yes, there is an example of something where VA should simply defer to this private facility, but then we found out that actually what was going on, or a sub-story in all of this, was the fact that there was concern within VA that were they to go this route suddenly the private-sector hospital, medical facility, would be the only game in town, and the costs would go up exponentially.

So it is a complicated business. Again, I mean just to reiterate, there are clearly instances where sharing, contracting out are the best way to go for the good of the veteran, but there are these other little things percolating beneath the surface.

Thank you, sir.

Mr. WEIDMAN. VVA would very much favor that kind of cost sharing on expensive equipment and on specialty tests where there is propinquity between the two facilities.

I also might add that the co-location, when we have the opportunity, just makes sense. It depends on proactive leadership and it needs to start at the VISN level where there are opportunities developed to bring it to the attention of the under secretary. Something that VA has never done well is being proactive, and frankly, it seems to VVA that this Committee not only has the right, but the responsibility to press VA to start being proactive, and if they won't be, to give you the information or to survey members, and

that Charleston situation is an example of something that we would absolutely support 100 percent, and fight for, Mr. Brown.

But there are other opportunities I am sure around the country beyond Puerto Rico, beyond Charleston, that VA should be pursuing. If you borrow the spots analogy, it is a West Coast offense. If they give you the long ball, you go for the long ball. If they will only give you the three-yard pass, take it. But we have to be looking on the outlook for that, and VA has not done a very good job of doing that.

Mr. MICHAUD. Ms. Brown?

Ms. BROWN OF FLORIDA. Yes. I am going to be very quick, but let me just say that I can report that the VA is doing a very good job in New Orleans. I just was there about a week ago, and they have really done a good job in providing services to the veterans in the area.

I guess my question will go to—well, I want to say I am a strong opponent of design/build, because we have just funded the largest VA budget in the history of the United States, and we have a lot of projects, but if it is going to take us 10 years to build a project, it doesn't make any sense, so we need to have models that work, and if the money is there.

For example, you mentioned, Mr. Wilson, about the stimulus package. Well, what makes sense is that for every \$1 billion that we spend, it creates 715 jobs, and certainly part of that work should go to veterans that have been certified, prepared to do the work, but they are having problems. I just met with a group last week in how do they do business with VA when they—they go through the General Services Administration (GSA), they are certified, but yet they feel like they are in the system and they can't get any work.

Mr. WEIDMAN. The VA has not done a great job of doing service-disabled veterans set asides. You gave them that authority with Public Law (P.L.) 109-461. I meet and am in contact with the chief of staff of VA, and with the chief operating officer, Deputy Secretary Mansfield, literally every other week about where the heck are the regulations. They have now finally got them out of the building, part of the regulations, and they are over at the Office of Management and Budget.

However, the Black Letter Law itself, that provision of P.L. 109-461, VA can go ahead and start doing those set asides right now.

Frankly, while it is open to doing this to service-disabled veteran-owned businesses, it is not friendly to doing business with—

Ms. BROWN OF FLORIDA. Right.

Mr. WEIDMAN (continuing). Service-disabled veterans. It is almost like Washington, DC, running around Capitol Hill. Is it accessible? Yes. Is it disabled friendly? It sure in heck isn't. All my friends in wheelchairs have a hell of a time here, and it is only their determination that gets them around. We need to make the VA process of procurement and particularly in construction friendly to service-disabled vets. It may be something that you want to recommend to the Appropriations Committee is to put language in the report for the fiscal year 2009 appropriation that VA must set aside 10 percent of all construction funds for veteran-owned businesses, of which a minimum of 3 percent of every major project go to serv-

ice-disabled veteran-owned businesses. That only reiterates what is already in the law.

Ms. BROWN OF FLORIDA. I am not disagreeing with you, but all I am saying the groups that have already certified, they are ready to work. They can't get—they are given the run around. I guess we are saying the same thing.

Mr. WEIDMAN. We are saying the same thing, and I would be—if I may talk to you off-line, Ms. Brown.

Ms. BROWN OF FLORIDA. Yes.

Mr. WEIDMAN. We have done a lot of work in pressing hard on where there are problems in VA. Some have been fixed and some have not. We brought it to the attention of the Secretary and Deputy Secretary Mansfield, to Mr. Frye and to the Chief of Staff, Thomas Bowman, repeatedly. We have a long way to go even at the VA, never mind the DoD which is still trying to figure out how to spell the word service disabled veteran-owned business.

Ms. BROWN OF FLORIDA. Thank you.

Mr. MICHAUD. Thank you very much, Ms. Brown, and I want to thank the panel for your testimony this morning, and there might be some further questions from the Subcommittee. So once again, thank you very much for coming.

We will take a recess. There is, I understand, only one vote, so it should not take long, and then we will reconvene the Subcommittee hearing. Thank you.

[Recess.]

Mr. MICHAUD. Let us get started. I want to thank the second panel for coming today as well, and we have Donald Orndoff, who is the Director of Office of Construction and Facilities Management with the Department of Veterans Affairs. So I want to thank you for coming, and if you could introduce those who are accompanying you as well.

Mr. ORNDOFF. Yes, sir. Thank you, Mr. Chairman.

To my left is Mr. Jim Sullivan. He is from the Office of Asset Enterprise Management. To my right is Mr. Robert Neary. He is the Director of Service Delivery for the Office of Construction and Facilities Management. To my far right is Mr. Joseph Williams, the Assistant Deputy Under Secretary for Health.

Mr. MICHAUD. Thank you very much. If you would begin your testimony.

STATEMENT OF DONALD H. ORNDOFF, DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT L. NEARY, JR., DIRECTOR, SERVICE DELIVERY OFFICE, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; JAMES M. SULLIVAN, DEPUTY DIRECTOR, OFFICE OF ASSET ENTERPRISE MANAGEMENT, OFFICE OF MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JOSEPH WILLIAMS, JR., RN, BSN, MPM, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. ORNDOFF. Yes, sir. Mr. Chairman and Members of the Subcommittee, I am pleased to appear today to discuss the Department of Veterans Affairs draft authorization bill related to major construction and major lease projects. I will provide a brief oral statement and request that my full statement be included in the record.

Mr. MICHAUD. Without objection.

Mr. ORNDOFF. Let me begin by briefly reviewing the status of VA's major construction program.

The average age of the 5,000 VA-owned medical facilities is over 50 years. Many of these older facilities were not designed or constructed to meet the demands of clinical care for the twenty-first century.

VA is currently implementing the largest capital investment program since the immediate post-World War II period. This program results from the VA's strategic plan and the Capital Asset Realignment Enhanced Services, or CARES program initiated systemwide in 2002 and began implementation in May 2004.

Including our fiscal year 2009 request, VA will have received appropriations totaling \$5.5 billion for CARES projects. Currently, VA has 40 active major construction projects. Thirty-three projects are fully funded, for a total cost of approximately \$2.8 billion. Seven projects have received partial funding, totaling \$560 million against a total estimated cost of \$2.3 billion.

For fiscal year 2009, VA is requesting \$471 million in new construction appropriations for medical facility projects. This request will provide additional funding to five of the partially funded projects, and begin design on three new start projects.

For fiscal year 2009, VA is seeking authorization for six major medical facility construction projects and 12 major medical facility leases.

I would like to address VA's proposed authorization bill recently submitted to the Speaker.

Section 1, authorization of fiscal year 2009 major medical facility projects: section 1 of the proposed bill would authorize the Secretary to carry out four major medical construction projects in Lee County, Florida, Palo Alto, California, San Antonio, Texas, and San Juan, Puerto Rico.

Section 2, additional authorization for facility for fiscal year 2009 major medical facility construction projects previously authorized: section 2 of the proposed bill authorizes the Secretary to carry out two major medical facility projects located in Denver, Colorado, and

New Orleans, Louisiana. Both projects were previously authorized for lesser sums under Public Law 109–461, but additional authorization is required to complete the construction projects at these locations.

Section 3, authorization of fiscal year 2009 major medical facility leases: section 3 of the proposed bill authorizes the Secretary to carry out 12 major medical facility leases in fiscal year 2009. These leases will provide an additional eight outpatient clinics, expand two current outpatient clinics, and develop a primary care annex facility and provide needed research space.

Section 4, authorization of appropriations: This section requests authorization for the appropriation of \$477,700,000 for major construction projects in fiscal year 2009, and \$1,394,200,000 for projects previously authorized for lesser sums. This section also provides \$60,114,000 for medical facilities accounts to authorize 12 major medical facility leases in fiscal year 2009.

In closing, I would like to thank the Subcommittee for its continued support of the Department's infrastructure needs. We look forward to working with the Subcommittee on these important issues. I urge you to support our proposed authorization bill so the Department can move forward on important projects to enable the highest level of care for veterans.

Again, thank you for the opportunity to appear before the Subcommittee today. My colleagues and I stand ready to answer your questions.

[The prepared statement of Mr. Orndoff appears on p. 33.]

Mr. MICHAUD. Thank you very much. I really appreciate it. A few questions.

The Department is requesting authorization for 12 leases and the Committee is aware that in October of last year, the General Services Administration recentralized leasing within the Federal Government at GSA. How will this action on the part of GSA affect VA's ability to acquire these leases?

Mr. ORNDOFF. Sir, I would like Mr. Neary to answer if I may.

Mr. MICHAUD. Yes.

Mr. NEARY. Thank you, Mr. Chairman.

It is correct that late last year the General Services Administration recentralized much of the leasing that is done within the Federal Government. However, VA retains the authority to lease medical and medically related space in support of the Health Care System. And so for these 12 leases we will be managing the execution with VA.

Mr. MICHAUD. Are these leases in VA affected by GSA's action and what is the impact on VA?

Mr. NEARY. There are many leases in VA that will be affected by GSA's actions, particularly within Veterans Benefits Administration, staff offices and others. Any non-medical lease greater than 20,000 square feet will now be required that the acquisition be by GSA for the VA. It is a very new direction, and we will be watching it closely, working closely with GSA to ensure that they are able to provide these leases in a timely manner to meet our needs.

As I say, this has happened fairly quickly, and it would be my perspective that GSA has taken on a significantly increased work-

load, and we want to make sure that they have the capacity to deliver these spaces in time to meet our needs.

Mr. MICHAUD. Thank you.

In the first panel, we heard Mr. Weidman talk about the Puerto Rico facility, that it is outdated, and a non-hurricane proof VA medical facility, and there is a report out. Has your office seen that report that Mr. Weidman was referring to, and if you have seen it, what specific steps has VA taken to correct the problem, and how long will it take to correct the conditions in Puerto Rico?

Mr. NEARY. Mr. Chairman, I am not sure if Mr. Weidman is referring to the congressionally mandated report that was required, I think, in the last session of Congress and that we responded to, but I am very familiar with Puerto Rico and the needs there, and we have a very active construction program ongoing.

We are currently under construction with a six-story bed tower that will place all the hospital beds in seismically safe space. In the emergency supplemental funding that was provided last year, a component of that went to San Juan to construct one of three pieces of our plan for San Juan. This budget that is now before the Congress includes the funding for the second piece of that, and when those two are done, which involves construction of clinical and administrative space, we will then be in a position to demolish the existing bed tower there, and retrofit the lower floors, we call it the pancake, three or four floors at the base of the existing hospital will be retrofitted to provide not only modern but seismically safe space.

So we have a plan which we believe effectively will meet the needs of veterans in Puerto Rico.

Mr. Weidman mentioned parking. There is no question about it. There is a significant parking shortage there and we are looking for ways in our plan with some of the funding that we are getting and we will get down the road to address the parking needs as well.

Mr. MICHAUD. How long do you think it will take you to deal with that?

Mr. NEARY. The bed building is under construction and it will be completed next year. We expect to award a contract for an administrative building at the end of this fiscal year in early next year. Also in 2009, we will award a construction contract for additional floors of clinical space. That will take about 24 months to construct. As I say, when those are done, the main building will be freed up to address.

So while it goes through 2013, by next year all the beds will be in new construction, and within 2 to 3 years the bulk of the administrative and clinical space will be either in new construction or in our current outpatient facility, which is only a few years old.

Mr. MICHAUD. The CARES process was decided back in May of 2005. When you look at the number of facilities, has your office done anything to actually try to speed up not only money, but try to shorten the length of time it takes to build a new facility?

Mr. ORNDOFF. Yes, sir. Basically the process that we have is a fairly rigorous racking and stacking prioritization, if you will, of the priorities, and of course working within the Department's com-

peting priorities for resources. We are moving as aggressively as we can on working down that list.

We have made a lot of progress. Once a project has in fact been budgeted and authorized and appropriated, we are moving as aggressively as we can to bring it to completion and online. We are using every innovative approach that we can to try to address that. Speed of delivery is a metric that we see foremost in our business, and understand that once the commitment has been made we need to get that project online as quickly as possible.

We have always tried to work this from the what can we get online quickly and where are the greatest needs. There is a combination of factors, of course, that go into which projects we are working first through an established process of prioritization, but I assure you that we are working as aggressively as we can on that.

Mr. MICHAUD. As you know, as time goes on it costs more to build a facility. Is there anything that we can do in Congress to help speed up the process, whether it is what Ms. Brown had mentioned this morning, as far as to speed up the construction process? What can we do to help in that manner?

Mr. ORNDOFF. Well, sir, as I said, I think we have the tools and we certainly are looking for every innovation and creative approach that we can. We are partnering very closely with industry to look at where industry is, to try to attract maximum competition on our jobs so we get the best overall pricing. We are looking at using different contracting techniques such as bringing the general contractor in very early in the process, the design process, so we can avoid some of the problems that might arise where we have design issues that turn into constructability problems and delays, so we avoid those kinds of situations.

This is a project process known as construction manager is the constructor, where the general contractor comes in early and performs construction management duties, and then follows on as the actual general contractor completing the work.

Probably the most significant thing that we are doing to address your specific issue is we are trying to improve planning and move the design process forward so we can actually get design done concurrent or prior to the appropriation of the dollars. So as soon as the dollars are appropriated, we can go immediately into the construction phase.

That would actually be a timeline that is even more aggressive than the design/build approach. The design/build approach would take the appropriated dollars and then turn it over to a firm for design and then ultimately construction. If we have the design completed ahead of appropriation, then we can go immediately into construction, which is the shortest possible timeline.

Mr. MICHAUD. So could you explain the process that you are going through right now? You have the CARES process. Is that the process that you are following as far as the top priorities under the CARES process? We are going to go one, two, three. Or do you deviate from that because things might have changed since 2004? How do you deal with that specific process as far as which ones are priorities and which ones are not?

Mr. SULLIVAN. If I could, Mr. Chairman. Each year the VA individually assesses its needs for capital projects through a call proc-

ess out to the field, and they rank those projects each year in terms of the priorities of VA. There is an established criteria that is used and the projects are put through that criteria, and ranked and stacked, and then we take the budget request and draw the line down basically as far as we can down that list and fund those new priorities.

The only exception to that is projects that were already prioritized and Congress has already appropriated funds. These projects are put on the side, and are funded first based on our ability to continue to spend money and put construction in place.

Mr. MICHAUD. So the initial process as far as how you rank under the CARES process, you ask the different VISNs to bring their priorities forward.

Mr. SULLIVAN. That is right.

Mr. MICHAUD. Now, under that process, it is my understanding because I know I have been trying to find out where CBOCs were in the budget. So if you have a VISN who might not have the money to move it forward even though it could be a priority, then you will never see that at Central Office, is that correct?

Mr. SULLIVAN. Not quite. The projects we are talking about here are major construction projects, those projects over \$10 million. The CBOC is different from the major construction process. It has a similar process that are for approval that is submitted with a business plan, and they are submitted in the budget each year, and Congress is notified of those CBOCs. So that is a separate process. This is just for the big, major construction.

Mr. ORNDOFF. I might add that the project identification is not resource constrained.

Mr. SULLIVAN. That is correct.

Mr. ORNDOFF. It is a requirement identified and it is not until we get to the prioritization process that we would bring in the resource constraint.

Mr. SULLIVAN. That is correct.

Mr. MICHAUD. Okay. Since you don't deal with the CBOCs, but you deal with major projects, is there a problem that VISNs might have if they don't feel that they can handle that within their budget, that it might not get to your level or is that not a problem?

Mr. SULLIVAN. You might add, Mr. Williams, to the comment.

Mr. WILLIAMS. The process for CBOC review, assessment, identification would be such that it would raise any issues with regard to access to care, and that would help drive our need and prioritization of where and what size that CBOC would be.

Typically we incorporate the plans for the CBOCs at least 2 years in advance, and if we look back at the CARES, when that started, we have a queue of CBOCs that had been identified, and as we create the business plans for these CBOCs, then we bring those forward for further assessment or approval to be activated.

Mr. MICHAUD. That is all depending on what is available for financial resources?

Mr. WILLIAMS. Mr. Chairman, we continue to assess our priorities and we assess those priorities against the needs. We look at the funding that has been provided for us to meet those needs, as we move forward to bring our projects and CBOCs online.

Mr. MICHAUD. When you look at the issue of access, I mean under the CARES process, we talk about access points, and what we are talking about is whether we are doing construction. How closely have you worked, I know it just got up and running, with the Office of Rural Health within the VA system, because now I will use the Holton example. That is supposed to be an access point. However, you really don't need to move forward with a separate building there because you can utilize existing resources with the hospital.

Under the CARES process and when you are looking at trying to move forward on construction, whether it is major or minor, are you also looking at areas of the country where you might not want to build, but you might want to collaborate with a local healthcare facility, whether it is a hospital or a federally-qualified healthcare clinic to utilize them as an access point versus building a facility?

Mr. WILLIAMS. Mr. Chairman, yes, we are, and part of that business plan or that prospective that is developed, we have to look at all viable options that are available to us, such as proximity to other services in the area, and DoD. We also review our ability to maximize the use of technology to reach some of these access points.

Now, as you are aware, on February 20, the Secretary, Dr. James Peake, made an announcement relative to the creation of Rural Health National Advisory Committee, and that Committee in itself will be an asset in that it will go out and it will assess areas of need as it relates to rural health, and come back and advise the Secretary and the Under Secretary for Health with viable options.

We look forward to the results of that Committee. Meanwhile, we rely on the medical centers, networks, headquarters, and support veteran service organizations to help us identify the opportunities that are there for us to meet or exceed our veterans' expectations.

Mr. MICHAUD. I just want to get to this line of questioning. When you do that process, are you saying, well, we get X amount of money so here are the next 20 CBOCs or access points that might be available? Are you looking at it that way or are you looking at it, well, here is the—I am not sure how many access points were in the CARES process now or how many are left to go, or are you looking at it, here, we have 500 access points nationwide. Within that 500 we know that we can't build access points in all of those, so rural health, tell me which ones we might be able to move forward next year to really collaborate with local health providers, whether it is a hospital or a federally-qualified healthcare clinic. Are you looking at it broadly or are you looking at it narrowly, this is the next line, so how can we do that versus here is a whole list, it might be near the bottom of the list, it might not be a real high priority, but you can get it up and running very quickly because you don't have to build, there is already a facility that you can work with other providers?

Mr. WILLIAMS. Mr. Chairman, as I understand it, the rural health initiative will be one component of the process that we use to assess veteran needs across the country. Where we develop a CBOC is not driven by dollars. It is driven by identified needs for our veteran population.

To that end, the business plan for a CBOC comes forward driven by the access, driven by the needs of our veterans, and based upon the facilities and the networks' determination of where their greatest need is to meet our veterans' healthcare needs.

With regards to the funding piece of it, as you know, we continue to prioritize the needs that we are presented with, and within that prioritization we make decisions about what starts when, but make no mistake, every effort is given to make sure that the highest priorities are met and addressed, and in as timely a fashion as we can address them.

Mr. MICHAUD. Thank you. My last question actually will be a parochial one in that the fiscal year 2009 budget lists Togus as a specialty care addition for a potential major construction project that was under the CARES process.

My office has been told that it would cost in the range of \$50 million. As you know, Maine remains an underserved area. How can we move this project from a potentiality to a reality? How can we do it in a timely fashion to get the services to the veterans who need them today?

Mr. SULLIVAN. Mr. Chairman, on our list of major construction projects, we don't have a Togus. Is it minor construction or is it—

Mr. MICHAUD. It is a future—

Mr. SULLIVAN. Oh, a future one?

Mr. MICHAUD. Yes.

Mr. SULLIVAN. At this point in the process, we are conducting a 2010 process, and there has been a data call that goes out to the field, get the list similar to the 2009 list together. That is currently under review and facilities are in the process of submitting their data. And as we go through the 2010 budget process, that was to come out.

Mr. MICHAUD. Okay.

Mr. SULLIVAN. I am not familiar with it. I can get you some information for the record on it.

[The following was subsequently received:]

“2009 Togus, ME, Specialty Care Addition”

This project addresses CARES projected workload and space gaps for the specialty care clinics, and permits expansion of ancillary and diagnostic services as well as administrative services to address space gaps and substandard space for these functions. The project proposes to construct a new specialty care clinic of 72,000 GSF and relocate selected specialty care functions to that space and out of Building 200/200E for the ultimate purpose of backfilling the vacated space with ancillary/diagnostic services (28,000 GSF) and administrative services (12,000 GSF) in order to resolve the existing space gaps. Additional work required to assure the viability of this project will be to increase parking and expand site utilities to support the new space and correct existing vulnerabilities.

Mr. MICHAUD. Yes. It is my understanding that it is for the potential major construction project, so I wanted to get it off that potentiality to make it a reality so I will know what the process is to do that.

Mr. SULLIVAN. The process is those projects will be rated and ranked this summer, and they will be put up against the available resources in the budget, and as I said earlier, they will draw a line and see how far it goes. I don't have any knowledge of where Togus is on that list, and they are still in the developmental stage, but

we can try and get you some information on the scope of the project.

Mr. MICHAUD. Now, when you deal with a project such as that, when you look at VISN 1, which is located in Boston, which is problematic if you want to expand or do anything in a highly metropolitan area like that, where it is a lot cheaper to deal with it in rural areas, are you also looking at that aspect as well when you deal with not only VISN 1 but other VISNs where there might be a need for an expansion to try to find the most cost-effective way to expand?

Mr. SULLIVAN. Right. If it is proposed as a major project, they look at a potential, other alternatives, do other than major construction such as leasing to see if it is viable. But the priority list is need-based. Where it is in the country per se isn't a factor, nor is the cost of construction a factor. It is based upon what is the veteran need, and we have seven bits of criteria, if you will, that they are judged against: how well does it improve the delivery of service to veterans; how much does it improve the asset, safeguarding the asset through security or safety concerns; does it have special emphasis programs for returning veterans, SCI, TBI, those types of programs in it; how well does it improve our asset portfolio goals. Those are the primary factors that the project is gauged against, if you will, and then it is prioritized based upon how well it does against those seven bits of criteria.

Mr. MICHAUD. In that criteria, you actually heard Congressman Brown talk about this morning. If there are other entities other than the VA that are actually looking at building a new medical facility, and they could do it collaboratively, is that taken into consideration as well?

Mr. SULLIVAN. Yes, especially if it is with another governmental element or DoD, those projects do get beneficial value, if you will, if they have that component in it.

Mr. MICHAUD. Another governmental entity. What if it is a private nonprofit?

Mr. SULLIVAN. I would have to check but I don't believe that is given extra value if it is a private entity.

[The following was subsequently received:]

Projects that involve a private entity do not receive extra value in the prioritization process.

Mr. MICHAUD. Okay. Thank you. Actually, I was asking all these questions giving Mr. Brown time to get back here.

I will ask one more while Mr. Brown settles in. Also the CARES process actually recommended that in VISN 1, that to try to maximize saving costs, that they actually recommended that they work with the State's veteran nursing home as well. When you look at construction or access points throughout the country, are you also looking at ways where you can collaborate, in this particular case, with the State veterans nursing home to help save on cost, but also when you look at veterans, you know, you have an opportunity to have a veterans complex versus building it someplace where there might not be a State veterans nursing home? Are you looking at those issues as well?

Mr. NEARY. Mr. Chairman, as you know, there are several instances where the VA has provided the property to a State for the

construction of a State veterans nursing home. I believe there are some instances where VA and State veterans homes collaborate in terms of providing some services.

So we obviously have close relationships with State homes, and would be glad to engage with any of them where there appear to be opportunities. There are obviously contracting rules that need to be considered, and you know, might get in the way or might not get in the way, but in each case you have to look at what kind of services you are talking about, and then move forward.

But we would be glad to look at any particular instance where a State might have an interest.

Mr. MICHAUD. Yes, this one actually—it has actually happened in Maine where I must say the new director at Togus is doing a fabulous job thinking outside the box and how he cannot only deliver services, but do it in a cost-effective manner, and actually the State veterans nursing homes, they do have a CBOC in Bangor, Maine. It is a renovated facility. It is old. It is outdated, and it is not really doing the job that it should. The State veterans nursing home is willing to actually build a brandnew building with their resources designed to what the VA needs, and it will really be cost-effective.

So those are some things that I am interested in, how can you collaborate to save resources, but also make sure veterans have the services that they need? So I do want to say I really appreciate all the work that your folks out there in the field are doing to try to deliver services to our veterans but also to do it in a manner that is cost-effective.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Well, thank you, Mr. Chairman, and I apologize for taking a little bit longer than you did to get back, but we get involved in some other things. But thank you all for being here today. You were all here, I guess, when we had the previous panel from the service organizations, and we are just looking for—as a partnership with all groups, but with certainly the VA too, to try to find as much proactive dialog as we possibly can in order to bring the highest level of service, medical service to our returning veterans as possible, and I know you were here and you have certainly been involved with the Charleston model, which I am very interested in.

It seems like that we have had a little movement on it, but not much movement, and it seemed like to me we are missing a real opportunity by not incorporating our plans to improve our services there for the veterans along with the medical university.

We already have a cooperative arrangement with the Heart Research Center, and so this is nothing new to Charleston, to work interactively with the VA and the medical university.

So could you all give me kind of an update of where we are on that project and where you think the next step might be?

Mr. WILLIAMS. Mr. Chairman, Mr. Brown, thank you for the opportunity.

As you are aware, there was a joint collaboration group that was put together several months back that was to focus on identifying opportunities for sharing between the medical center and the medical university. The medical center and the university have moved

forward, and I would agree, some small steps have been achieved. Recently collaborated approaches include new equipment, tomography equipment that has been installed. There was a ceremony in January, I believe, a ribbon cutting to support this collaboration.

We have had ongoing discussions about MRIs and various levels of negotiation with regard to that piece of equipment, but we are committed to working with the school, to move forward to address those opportunities.

We have within the past year, 18 months, have a new director in place who is engaged and works very well from what I understand with local medical school leadership, and we are fortunate to have a new network director, Mr. Larry Barrow, who understands and works hard to meet the commitment to our veterans.

I know you know that area better than anyone, and understand that although it is an old facility, you know, we continue to work hard to keep that facility in a condition that is acceptable for our veteran population. One of our biggest constraints is administrative space, and the local leadership, network leadership have been in discussions and are preparing presentations to move forward to address some of the most immediate needs.

I would say to you that we continue to observe and respect the concerns locally. We remain committed to our responsibility to work with the local leaders to help find solutions that are mutually beneficial, and are reasonable to support not only the needs of the medical center and our veterans but also to be cognizant of the needs of the community.

Thank you.

Mr. BROWN OF SOUTH CAROLINA. If I may follow up on that. I think this is the third Secretary that we have been involved with in trying to come up with this new idea, and we did an extensive study with both agencies to try to determine what would be the best areas to collaborate, and so some of those were the imaging equipment, and some of them were maybe the operating space and some other areas. Never were we ever proposing to have separate bed towers, I mean, a single bed tower. We are always having separate bed towers so the veterans would have their own identity and their own facilities there. Only we would look at collaborating with those units that there could be high cost equipment, testing equipment, operating rooms, imaging equipment, this sort of thing.

But we recognize that in order to make it a feasible operation we would have to have a closer proximity between the patient and the facilities. And so we are pretty close now as far as with a new facility that the medical university built, but to better use the land and the proposed plan for the overall medical university facility, the VA hospital where it sits is not in the same planned best use of the land facilities that both the university and the VA own.

I know that the hospital, they have done a great job in maintaining that hospital, and you walk in and it looks like, you know, state-of-the-art, but you recognize that the state-of-the-art is not only on the inside, it is actually inside the walls, and some of that infrastructure is not there to support the high-tech which we need now to service our veterans in the best accommodating way.

So we just feel like it is an opportunity lost if we don't incorporate the VA facilities with the medical university in their construction phase.

I already see as we look at the CARES package, and Mr. Chairman, you might have noticed that some of the cost has doubled even before we start making the first foundation, and that is what is going to happen in this operation here. That is the reason I mentioned earlier with the other panel about becoming proactive, you know, not reactive, and I know we are all living with what happened down in New Orleans, and what is going to happen in Puerto Rico too apparently, but sometimes we are penny-wise, a dollar foolish, and so I would hope that we could work closer.

I know Secretary Peake has certainly been apprised of this process, and so anyway, we certainly are grateful for your cooperation. I just think it is a window of opportunity. If we don't seize upon it, it is going to be something that will never happen. So I would hope, Mr. Chairman, that we could find some facilities in order to make that work.

Mr. WILLIAMS. Thank you, sir.

Mr. MICHAUD. Thank you very much, Mr. Brown. I am sure that they definitely will be a lot more proactive if we give them the resources so they can be proactive, so that is one of the things that I think is very important, and as I stated earlier, if you look at an economic stimulus package, construction is definitely the way to go. If you want projects to put people to work, the quickest, fastest way to do it is through construction, but it is also investing in an infrastructure which desperately needs it.

So hopefully we will be able to give you an opportunity to be more proactive in the future with the resources that we will be giving you.

So in closing, I do want to thank each of you, Mr. Williams, Mr. Neary, Mr. Sullivan, and Mr. Orndoff for your time this morning. We look forward to working with you, and if there is ever anything that we can do to make your life easier as far as moving these projects forward, if needs change, please don't hesitate to let us know. It is a collaborative effort. The only way that we are going to be able to help our veterans is if we work together with the VA and the VSOs to try to take care of some of the glitches that might be slowing down the process. We want to make it as smooth as possible for you so we can take care of our veterans. So once again, I want to thank each and every one of you for coming here this morning.

So if there are no further questions, we will close the hearing. Thank you.

[Whereupon, at 11:42 a.m., the Subcommittee was adjourned.]

A P P E N D I X

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

I would like to thank everyone for coming today.

Today's hearing is an opportunity for the VA, Veteran Service Organizations and Members of this Subcommittee to discuss draft legislation dealing with Fiscal Year 2009 VA construction.

Thirty-eight United States Code requires statutory authorization for all VA major medical facility construction projects over \$10 million and all major medical facility leases more than \$600,000 per year. This hearing is a first step in this important process.

I would like to note that this draft legislation is based on the Department of Veterans Affairs' Fiscal Year 2009 budget request and reauthorizations from Fiscal Year 2008. I consider this draft to be a starting point. I look forward to hearing from the VA, the VSOs and Members of the Subcommittee about other construction projects that are important to them.

I will take under consideration the discussion we have today and any input that may come up. I will then introduce legislation in the very near future.

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

Thank you, Mr. Chairman.

I appreciate your holding this hearing to discuss a draft bill that would authorize the Department of Veterans Affairs (VA) to carry out major medical facility projects and leases for fiscal year 2009.

Important to delivering high quality care to our Nation's veterans is the planning for the construction and renovation of VA's substantial health care infrastructure. VA maintains an inventory of approximately 1230 health facilities. This includes 153 Medical Centers, 135 Nursing Homes, 731 Community Based Outpatient Clinics, and 209 Vet Centers.

VA initiated the Capital Asset Realignment for Enhanced Services (CARES) process to identify and address gaps in services or infrastructure eight years ago. The CARES process continues to serve as the foundation for VA's capital planning priorities.

VA's construction planning, however, is not without challenges. The rising cost of construction has been significant. In fact, the draft legislation we are discussing today would provide over \$670 million to account for cost increases for previously authorized construction projects.

Mr. Chairman, I am extremely concerned that VA's inability to accurately project cost estimates is adversely affecting the construction process. Escalating project costs continue to require this Committee to reexamine and increase authorizations for existing projects, hindering the ability to move forward with new projects important to improving access to care and supporting future health care demand.

CARES identified Okaloosa County in my district in Northwest Florida as underserved for inpatient care. In fact, it is the only market area in the VISN, VISN 16, without a medical center. However, VA has yet to act to address the inpatient care gap in this region.

There is a tremendous opportunity to collaborate with the Department of Defense (DoD) for medical services on the campus of Eglin Air Force Base that would benefit both veterans and active duty service members in this area.

Last September, I introduced H.R. 3489, the Northwest Florida Veterans Health Care Improvement Act. This legislation would expand the partnership between Eglin Air Force Base (AFB) and the VA Gulf Coast Veterans Health Care System (VA GCVHS) to provide more accessible health care to eligible DoD and VA patients

in the Northwest Florida region. In collaboration with DoD, this bill would provide inpatient services and expand outpatient specialty care through the construction of a joint VA/DoD outpatient medical facility on the Eglin AFB campus.

At our November 2007 Subcommittee hearing, Major General David Eidsaune, Commander, Air Armament Center, Eglin Air Force Base, testified about the successful partnership VA and DoD have developed in the region and stated that “This cooperative effort should serve as a model for future efforts to support the health care needs of our nation’s veterans.”

Mr. Chairman, I am providing you with updated legislative language that reflects the intent of H.R. 3489. I respectfully request that this language be included in the introduced version of the “Department of Veterans Affairs Medical Facility Authorization and Lease Act of 2008” that will be considered by the Full Committee.

I would be pleased to answer any questions. I yield back.

Thank you, Mr. Chairman.

**Prepared Statement of Dennis M. Cullinan,
Director, National Legislative Service,
Veterans of Foreign Wars of the United States
on Behalf of *The Independent Budget***

MR. CHAIRMAN AND MEMBERS OF THIS SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the U.S. and the constituent members of the Independent Budget, I thank you for inviting us to present our views at this most important legislative hearing. The VFW handles the construction portion of the IB and we will be representing the collective position of the IBVSOs regarding the draft bill under discussion today cited as the “Department of Veterans Affairs Medical Facility Authorization and Lease Act of 2008.”

With respect to construction, the IB’s most fundamental objective is to produce a set of policy and budget recommendations that reflect what we believe will best meet the needs of America’s veterans. In this regard, and as we have recently testified, the Administration’s Fiscal Year 2009 budget request for Major and Minor construction is woefully inadequate. Despite hundreds of pages of budgetary documents that show a need for millions of dollars in construction projects, the Administration saw fit to halve the major and minor construction accounts from the FY 2008 levels, failing to meet the future needs of our veterans.

The legislative proposal under discussion today demonstrates that this Congress is ready, able and willing to correct this situation, and to advance VA’s construction priorities so that future generations of veterans—such as those currently serving in the deserts of Iraq and the mountains of Afghanistan—will have a first-rate VA health care system ready to fully meet their needs.

It is also our view that VA construction and infrastructure maintenance must be carried out in a methodically planned and orchestrated manner. One of the strengths of VA’s Capital Asset Realignment for Enhanced Services (CARES) process is that it was not just a one-time snapshot of needs. Within CARES, VA has developed a health care model to estimate current and future demand for health care services and to assess the ability of its infrastructure to meet this demand. VA uses this model throughout its capital planning process, basing all projected capital projects upon demand projections from the model.

This model, which drives many of the health-care decisions VA makes, produces 20-year forecasts of the demand for services. It is a complex model that adjusts for numerous factors including demographic shifts, changing needs for health care as the veterans’ population ages, projections for health care innovation and many other factors.

We applaud that the construction, renovation and maintenance projects covered in this draft-bill are in keeping with this planning process, and will now briefly address its specific sections.

Section 2 of this bill provides for up to \$54 million for seismic corrections at the Denver VAMC; up to \$66 million for construction of a Polytrauma Center at the VAMC in San Antonio, and up to \$225.9 million for seismic corrections at the VAMC in San Juan. The IB supports these provisions.

Section 3 provides for the modification of funding amounts for major construction projects previously authorized. Construction for the VAMC in New Orleans is authorized at \$625 million from \$300 million and the construction project at Denver moves from \$98 million to \$769.2 million. The cost of the correction of patient privacy deficiencies at the Gainesville VAMC is updated to \$136.7 million from \$85.2 million. The construction of the new VAMC in Las Vegas is authorized at \$600.4 million from \$400.6 million. We note that this reflects the rapid escalation of con-

struction costs over time and illustrates the IB view that construction and renovation projects be authorized, funded and then carried out in a timelier manner. The construction of a new VA outpatient clinic in Lee County, Florida is authorized at \$131.8 million in place of \$65.1 million. Construction of a new VAMC is set at \$656.8 million from \$377.7 million. Last under this section, consolidation of campuses in Pittsburgh rises from \$189.205 million to \$295.6 million.

Section 4 authorizes major medical facility leases in FY 2009, Provided for: \$4.326 million for an outpatient clinic in Brandon, Florida; \$3.995 million for a clinic in Colorado Springs; \$5.826 million, Eugene, Oregon; \$5.891 million for the expansion of a clinic in Green Bay; \$3.731 million for a clinic in Greenville, SC; \$2.212 million for a clinic in Mansfield, Ohio; \$6.276 million, Mayaguez, Puerto Rico; \$5.106 million, Mesa, Arizona; \$8.636 million for interim research space in Palo Alto; \$3.168 million for a clinic expansion in Savannah; \$2.295 million for an outpatient clinic in Sun City, Arizona; and, last under this section, \$8.652 million for a primary care annex, Tampa, Florida.

Section 5 provides for the authorization of appropriations for FY 2009 Medical Facility Projects covered under this act. Provided for: \$345.9 million for projects authorized in section 2 and \$1.635 billion for the increased amounts for projects modified by section 3. Under this section, \$60.114 million is authorized for the leases provided for in section 4.

Section 6 imposes a 60-day congressional reporting requirement on the Secretary regarding compliance with section 312A of Title 38 USC and is supported by the IB VSOs. Section 7 delineates a technical correction in which we concur.

Mr. Chairman, this concludes my testimony and I will be pleased to respond to any questions you or the members of this Subcommittee may have. Thank you.

**Prepared Statement of Statement of Joseph L. Wilson, Deputy Director,
Veterans Affairs and Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on "VA Construction Authorization" within the Department of Veterans Affairs (VA).

Proper assessment and improvements to the infrastructure of the VA healthcare system is vital in ensuring America's veterans are well served. The average age of VA health care facilities is approximately 49 years old. Proper funding must be provided to update and improve VA facilities.

With the enactment of Public Law 110-161, the Consolidated Appropriations Act for FY 2008, VA was provided the largest increase in veterans' funding in its 77-year existence. The American Legion applauds Congress for this much needed increase.

However, there are questions, such as, whether or not current construction funding adequately maintains VA's aging facilities, as well as its ongoing requirement for major and minor construction.

Major Construction

When former VA Secretary Anthony Principi testified before the House Veterans' Affairs Subcommittee on Health in 2004, he stated that the Capital Asset Realignment for Enhanced Services (CARES) reflected a need for additional investments of approximately a billion dollars per year over five years to modernize VA's medical infrastructure, as well as enhance veterans' access to care. CARES became the premier plan for the correction and upgrade of VA's infrastructure.

The FY 2009 budget request was \$582 million for Major Construction, falling far below the amount recommended by former Secretary Principi. From 2004 to 2007, only \$2.83 billion for CARES projects had been appropriated, an overall shortage of funding.

Mr. Chairman, veterans' health care is ongoing, 24 hours daily, 7 days weekly, and 365 days annually. In addition, returning veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) are returning home and seeking health care within the VA health care system.

The FY 2009 budget does not begin to accommodate the needs of the VHA, not to mention planned projects of previous fiscal years. To date, four of the 10 previously planned projects, to include San Juan, Puerto Rico; Los Angeles, California; Fayetteville, Arkansas; and St. Louis, Missouri, have received no funding. Delays in funding cause delays in health care.

According to VA, the top three FY 2008 projects, Tampa, Florida; Bay Pines, Florida; and Seattle, Washington, would cost approximately \$334 million, but none re-

ceived a funding request. In addition, the 10 partially funded projects have a balance of \$1.59 billion. The aforementioned alone adds up to almost \$2 billion.

Mr. Chairman, when the Veterans Hospital Emergency Repair Act was passed in 2001, there was a construction backlog that continued to grow. During the CARES process, there was the de facto moratorium on construction, but the health care needs for this nation's veterans didn't cease during this time, and yet still, the construction backlog increased.

Minor Construction

VA's Minor Construction budget includes any project with an estimated cost equal to or less than \$10 million. Maintaining the infrastructure of VA's facilities is no minor task. This is mainly due to the average age of the facilities. These structures constantly require renovations, upgrades, and expansions. The health care delivery facilities of VA are increasingly aging and in need of substantial renovation and improvements related to fire, seismic safety and privacy standards that can be achieved with an adequate Minor Construction budget.

A System Worth Saving Site Visits

From 2006 to date, The American Legion's National Field Service Staff and System Worth Saving Task Force have visited a combined total of 113 VA Medical Centers, Community Based Outpatient Clinics, and Vet Centers in all 21 Veterans Integrated Service Networks (VISNs). During these site visits, many facilities reported space and infrastructure as their main challenges.

The American Legion receives daily calls from veterans who are concerned for their safety due to the closure of 24-hour emergency rooms in the rural areas such as Alabama and Louisiana. Within these rural areas, it was reported that the nearest VA facility was approximately one hour away.

During The American Legion's 2006 site visits, our overall report ascertained that maintenance and replacement of VA's physical plant was an ongoing process and a major challenge to facility Directors. It was also reported that deferred maintenance and the need for entirely new facilities presented an enormous budgetary challenge. The repairs in most of the facilities visited were largely successful, however, some parts of the infrastructures still posed significant risk of further deterioration. For example, it was reported that the underground main at the Albany VAMC could fail at any time and, theoretically, deprive large parts of the facility of heating.

During The American Legion's April 27, 2006 site visit to the Wilmington VA Medical Center in Delaware, building issues included a shortage of usable space to allow for expansion of needed programs to accommodate the influx of new veterans. The facility lacked construction funding for this project. With regard to funding adequacy for ongoing construction projects at Wilmington, there were no approvals for the Wilmington facility for major or minor construction for FY 2006.

The American Legion visited the Togus VA Medical Center in Augusta, Maine on January 9, 2006 to conduct a full site visit. It was reported the considerable maintenance required for the older buildings had been neglected, with management citing \$61 million in deferred maintenance. Other areas urgently requiring work included remediation of structural deficiencies, masonry restoration, roof repairs, and reconstruction/repairs to roads and parking lots.

In 2007, the National Field Service Representatives focused on VA Polytrauma Centers and Vet Centers, but also maintained, in thought, their connection to the entire VA Medical Center system. During The American Legion's visit to the St. Louis VAMC on May 16, 2007, it was reported that major work was required on outpatient wards. These wards were previously converted from inpatient wards but were never renovated. The outpatient clinics were in need of modernization. The overall report of this facility included an outdated facility and lack of space.

During The American Legion's site visit to the VA Puget Sound Health Care System in Seattle, Washington on May 7, 2007, it was reported that there was a problem with various funding, which involved the operation of each building and their function. Puget Sound reported when it comes to funding construction projects, it is like "robbing Peter to pay Paul."

The Sepulveda Vet Center visit was one of the most unique site visits, being that it is the sole Vet Center to remain on VAMC grounds. The building that houses the Sepulveda Vet Center programs lacks heating due to an inoperable furnace. The Vet Center reported that there was no budget for that expense. Although our visit didn't extend to the respective VA Medical Center, it gave rise to questions of their needs.

Mr. Chairman, the issues mentioned are a microcosm of structural problems throughout the VA Medical Center system. Although not mentioned in this testi-

mony, The American Legion maintains an account of its site visits in the annual publication of its 'System Worth Saving' report.

Conclusion

As time progresses, the demand for VA health care is increasing while failure to improve the infrastructure causes unsafe conditions for veterans, as well as VA staff. The American Legion continues to insist that sufficient funding must be provided to maintain, improve and realign VA health care facilities.

Mr. Chairman and members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues to resolve this critical issue. Thank you.

Prepared Statement of Richard F. Weidman Executive Director for Policy and Government Affairs, Vietnam Veterans of America

Good morning Chairman Michaud, Ranking Member Miller, and distinguished members of this Subcommittee. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to offer our comments the VA FY'09 Construction Authorizations.

In the last few years, the VA has spent millions of dollars on a plan to restructure the VA health care system's capital assets. After extensive study—although some of us believed it was flawed due to the absence of mental health and long-term care in its models—the report called for about \$6 billion to be invested in the system. VVA believes this indicates the magnitude of the problem of a crumbling infrastructure that was, for the most part, built in the forties and fifties.

The promises of VA's Construction Acquisition and Restoration for Enhanced Services, or CARES, program has seemed far from fulfillment in the past three or four years as the coffers of medical facilities continued to be robbed to pay for medical services operations. It must be disheartening for hardworking and dedicated employees of the VA to compare the state of many of their facilities to those in the community.

Some VA hospitals are barely maintaining accreditation because they cannot meet privacy and access standards because of overcrowding. The VA has delayed vital capital equipment purchases and non-recurring maintenance projects in order to fund gaps in veterans' health care. Yet the Administration has proposed a decrease in construction funds. This is not only not a prudent or conservative response to the clear infrastructure needs of the VA health care system, it would appear to be wildly irresponsible and far from anything that could be considered prudent business practice, much less good medicine. This practice must cease.

Dilapidated and over-crowded facilities are symbolic of the lack of consistent and concerted commitment toward meeting the obligation the federal government has to those who have served or would serve their nation, even after five years of a seemingly endless war. We can do better; we must do better.

I would be remiss if I did not note for the record that VVA never "agreed" to the civilian formula being used in the CARES process because it does not take into account the diseases, wounds, and maladies that are due to military service, depending on the branch of service, when and where one serves, and what one actually did and was exposed to (including vaccines).

VVA respectfully requests that this distinguished panel hold a future hearing on the dual subject of "caring for war wounded and ill" that would include the CARES formula, the need for VA clinicians to take a complete military history to assist in the diagnosis and treatment of veterans, and the general lack of attention to the VA's Veterans Health Initiative (VHI) 24 curricula in the wounds and maladies of war. VVA reiterates that VA must truly become a "veterans health care system" instead of a general health care system that happens to be for veterans (which is generally what we have now, with a few add-on programs). Because this shift will affect plans for physical plants to adequately meet the needs of veterans in the future, it would be a much needed and quite useful hearing that would be directly related to the matter at hand of this hearing.

Congress should restore and enhance the medical facilities budget by at least \$.5 billion for medical facilities in fiscal year 2009. It should increase VHA's portions of major and minor construction by at least \$1 billion.

The VA FY'09 request for construction funding for health care programs is \$750.0 million—\$476.6 million for major construction and \$273.4 million for minor construction.

The VA budget request for major construction would provide additional funding and VVA fully supports authorization for the following five medical facility projects:

- Denver, Colorado (\$20.0 million)—replacement medical center near the University of Colorado Fitzsimons campus;
- Lee County, Florida (\$111.4 million)—new building for an ambulatory surgery/outpatient diagnostic support center;
- Orlando, Florida (\$120.0 million)—new medical center consisting of a hospital, medical clinic, nursing home, domiciliary, and full support services;
- San Juan, Puerto Rico (\$64.4 million)—seismic corrections to the main hospital building; and
- St. Louis, Missouri (\$5.0 million)—medical facility improvements and cemetery expansion.

VVA fully supports the FY'09 VA budget for major construction funding in that would allow construction of the three new medical facility projects listed:

- Bay Pines, Florida (\$17.4 million)—inpatient and outpatient facility improvements;
- Tampa, Florida (\$21.1 million)—polytrauma expansion and bed tower upgrades; and
- Palo Alto, California (\$38.3 million)—centers for ambulatory care and polytrauma rehabilitation center.

In regard to Puerto Rico, however, we ask that this distinguished panel begin to champion the cause of correcting the shoddy infrastructure of VA facilities in Puerto Rico. VVA National President John Rowan led a fact-finding delegation to Puerto Rico in December 2006. What that delegation found was a shoddy, outdated, and non-hurricane proof VA medical center building, totally inadequate parking facilities for both staff and patients, and a cemetery that was literally “racking and stacking” remains of veterans (this last hardly qualifies as highest respect for these heroes, or the stated goal of making the national cemeteries “national shrines”).

The degraded physical plants were indicative of the degraded services provided to these veterans, who disproportionately served in the combat arms. The delay in adjudicating claims was much longer than the already too long national average. Perhaps indicative was the locked door to the “veteran’s service center” that had a “Closed until further notice” sign. There were scant services for PTSD (and seemingly only desultory interest in improving care for PTSD). Both veterans and staff were driving to the VAMC at 3 and 4 in the morning and sleeping in their cars in order to get one of the very limited parking spaces. And there was clear evidence that an additional Vet Center was vitally needed (especially in light of the scant services at the VAMC).

A report on the above was provided to the Secretary of Veterans Affairs, and VVA followed up with repeated conversations with top VA officials. VVA also discovered that our findings mirrored the findings of the Center for Minority Veterans and other VA entities. A copy of this report was also provided to the delegate from Puerto Rico and to the Hispanic caucus, with a copy to this Committee.

It is worth noting that VVA sent a one-year later follow-up delegation in December 2007 led by VVA National Secretary Barry Hagge and including VVA Regional Board of Directors Member Carol Strumkopf. They found that there were some plans in the works, but that the basic situation was little changed.

In fairness to the VA, there are plans to add a new Vet Center in Puerto Rico, to add a new bed tower, and to make some structural changes to strengthen the old VAMC building to make it a bit sturdier in the face of a major hurricane.

VVA recommends that there be an entirely new hospital designed from the outset to withstand a category 3 or 4 hurricane. Why is it that \$2 billion can be found to build an entirely new hospital in Denver but not in Puerto Rico? Were those who fought and returned home to Puerto Rico any less valiant or true to the United States than those who returned home to Colorado? VVA thinks not. Funds should be provided in FY'09 to put this vital move on the fast track.

Further, VVA has urged the Administration to acquire land for a large new national cemetery now, with a view especially to the divestment by the Department of Defense of numerous parcels of land in Puerto Rico.

VVA also strongly urges that the Congress provide funds that shall be used specifically to acquire land and build a new and large parking garage with a 6 AM to 6 PM every 15 minute shuttle service to the VAMC.

VVA believes that degraded physical plants lead to degraded medical services to the veterans who use the VA medical system. Therefore, we recommend that this committee secure a General Accountability Office (GAO) study of medical services, doctor/patient ratios, RN/patient ratios by facility to discover if there is a correlation

between poor physical facilities and the recruitment/retention of staff and the actual shape of medical services provided. Medical outcomes by DRG should also be studied to find out if new facilities improve the medical outcomes for veterans affected.

VVA fully supports the Department of Veterans Affairs Construction Authorization as written.

I thank you for affording VVA the opportunity to present our views, and thank you for what you are doing to assist veterans and their families. I will be pleased to answer any questions you may have.

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

Mr. Chairman and members of the Committee, I am pleased to appear today to discuss the Department of Veterans Affairs (VA) draft bill to request authorization for six major medical construction projects and twelve major medical facility leases, as well as addressing other issues related to VA's construction program. Joining me today are Joe Williams, Assistant Deputy Under Secretary for Health, Robert Neary, Executive-in-Charge, Office of Construction and Facilities Management, and Jim Sullivan, Deputy Director, Office of Asset Enterprise Management. Let me briefly begin by reviewing the status of VA's major construction program.

The Department is currently implementing the largest capital investment program since the immediate post-World War II period. This program represents implementation of the results from VA's strategic plan and the Capital Asset Realignment for Enhanced Services program (CARES), initiated systemwide in 2002 and yielding results in May 2004. Including this year's request, VA will have received a total of \$5.5B for CARES projects. Currently, VA has 40 active Major Construction projects. Thirty-three of the 40 projects have been funded for a total cost of approximately \$2.8 billion. The remaining seven projects have received partial funding totaling \$560 million, and have a total estimated cost of \$2.3 billion. VA is requesting \$471 million in Major Construction appropriations for FY09 for infrastructure improvements and enhancements to its medical facilities. This request will provide additional funding to five of the partially funded projects, and begin the construction process on three new starts. We are seeking authorization for six major medical facility construction projects and twelve major medical facility leases for FY09.

VA has a real property inventory of over 5,000 owned buildings, 1,100 leases, 32,000 acres of land and approximately 158 million gross square feet (owned and leased). VA has reduced in excess of 1.6 million square feet in the last two years. During the CARES process, the average age of VA facilities was calculated at well over 50 years old. Many of these older facilities are not designed or constructed to meet the demands of clinical care in the 21st century. VA's management of these assets is critical to providing healthcare and services to our veterans.

VA effectively manages its vast holding of capital assets through performance monitoring and analysis, decreasing underutilized and vacant space, improving facility conditions, decreasing operating costs, and reducing non-mission dependent assets. VA also develops energy savings performance contracts designed to reduce energy consumption in federally owned facilities, reducing the demand and dependence on natural resources.

VA utilizes a multi-characteristic decision methodology to foster a decisionmaking approach in prioritizing its capital investment needs and requirements. Through this methodology, VA establishes its Five Year Capital Plan. The plan describes the selection of VA's capital acquisitions and funding requests by incorporating a formal executive review process. The process begins with Veterans Health Administration (VHA) strategic planning initiatives that identify capital needs based upon demographic data, workload, actuarial projections, cost effectiveness, risk, and alternatives. Once a potential project is identified, it is reviewed and scored based on criteria VA considers essential to providing high quality services in an efficient manner. The new funding requirements are considered, along with existing program requirements and workload projection decisions, when determining the projects and funding levels requested as part of the VA budget submission.

Selected projects based on VHA's strategic process are then examined through the Department's Capital Investment Panel (CIP) to ensure all projects are based upon sound principles, promote the "One-VA" vision, align with VA strategic goals, address the VA Secretary's priorities, and support the President's Management Agenda. The CIP then scores and analyzes the projects on these principles and submits the results to the Strategic Management Council (SMC) for consideration. The SMC is VA's governing body responsible for overseeing VA's capital programs and initia-

tives. The SMC reviews the projects and submits its recommendations to the Secretary, who makes the final decision on which projects to include in the budget.

Major capital investment needs are requested from facilities in the fall, prioritized through each Administration and the Departmental review process, and evaluated for the Secretary's approval by the following summer. Under the current process, once a decision has been made to include a project in the Department's budget, the design process begins with the selection of the design architect. The design process consists of three phases—schematic design, design development and construction document preparation. While the timing can vary with the size and difficulty of the project, design on average takes 18 months. Once design is complete, the construction contractor is obtained and construction begins shortly thereafter. Almost one-third of VA projects are executed using the design build method in which a contract is awarded to an architect/engineer (A/E) and construction contractor team who take a preliminary design provided by VA and completes the design and then constructs the project accordingly. Although VA does not have a preference for D/B generally, we do find it preferable for some small projects, such as parking lots, clinics, and office spaces.

Mr. Chairman and members of the Committee, my further comments regard VA's proposed bill submitted to the Speaker and will relate to the four sections separately, rather than the bill as a whole.

Section 1. Authorization of Fiscal Year 2009 Major Medical Facility Projects

Section 1 of the proposed bill would authorize the Secretary to carry out four major medical construction projects in Lee County, Florida; Palo Alto, California; San Antonio, Texas; and San Juan, Puerto Rico.

Section 2. Additional Authorization for Fiscal Year 2009 Major Medical Facility Construction Projects Previously Authorized

Section 2 of the proposed bill authorizes the Secretary to carry out two major medical facility projects located in Denver, Colorado and New Orleans, Louisiana, respectively. Both projects were previously authorized for lesser sums under Public Law 109-461, but additional authorization is required to complete the construction projects at these locations.

Section 3. Authorization of Fiscal Year 2009 Major Medical Facility Leases

Section 3 of the proposed bill authorizes the Secretary to carry out twelve major medical facility leases in fiscal year 2009. These leases will provide an additional eight outpatient clinics, expand two current outpatient clinics, develop a primary care annex facility, and provide needed research space.

Section 4. Authorization of Appropriations

This section requests authorization for the appropriation of \$477,700,000 for major construction projects in fiscal year 2009 and \$1,394,200,000 for the projects previously authorized for lesser sums. This section also provides \$60,114,000 from the Medical Facilities account to authorize twelve major medical facility leases in fiscal year 2009.

In closing, I would like to thank the Committee for its continued support for improving the Department's physical infrastructure to meet the changing needs of America's veterans, and we look forward to continuing to work with the Committee on these important issues. I urge you to support our proposed authorization bill so the Department can provide the highest level of care for veterans in these high priority areas.

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

**Statement of Hon. John T. Salazar,
a Representative in Congress from the State of Colorado**

Good morning Chairman Michaud, Ranking Member Miller and distinguished members of this subcommittee.

Thank you for giving the Committee an opportunity to discuss construction authorization for 2009.

The replacement and modernization of the VA Medical Center in Denver, located on the former Fitzsimons Army Base, is critically important to the Veterans of Colorado.

The VA completed a study and secured land for the facility in 2006.

As you know, the VA, wherever possible, builds new medical facilities next to existing medical schools.

This is done to save on costs and facilitate the exchange of resources between the institutions.

This center is located adjacent to the University of Colorado Health Science Center (UCHSC).

At its completion, the Fitzsimons campus will be a healthcare hub for all of Colorado.

Construction is completed on the Children's Hospital, the University Hospital and St. Joseph's Hospital.

For every month that passes, the cost of completing these projects skyrockets.

Mr. Chairman, I thank you and the members of this committee for giving us the opportunity to discuss construction authorizations.

