AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. HRG. 111–176

HEARING ON VA'S CONSTRUCTION PROCESS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

JUNE 10, 2009

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.access.gpo.gov/congress/senate

U.S. GOVERNMENT PRINTING OFFICE

50–431 PDF WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

DANIEL K. AKAKA, Hawaii, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia
PATTY MURRAY, Washington
BERNARD SANDERS, (I) Vermont
SHERROD BROWN, Ohio
JIM WEBB, Virginia
JON TESTER, Montana
MARK BEGICH, Alaska
ROLAND W. BURRIS, Illinois
ARLEN SPECTER, Pennsylvania

RICHARD BURR, North Carolina, *Ranking Member*
JOHNNY ISAKSON, Georgia
ROGER F. WICKER, Mississippi
MIKE JOHANNS, Nebraska
LINDSEY O. GRAHAM, South Carolina

WILLIAM E. BREW, *Staff Director*
LUPE WISSEL, *Republican Staff Director*

C O N T E N T S

JUNE 10, 2009

SENATORS

	Page
Akaka, Hon. Daniel K., Chairman, U.S. Senator from Hawaii	1
Burr, Hon. Richard, Ranking Member, U.S. Senator from North Carolina	2
Isakson, Hon. Johnny, U.S. Senator from Georgia	9
Johanns, Hon. Mike, U.S. Senator from Nebraska	10
Burris, Hon. Roland W., U.S. Senator from Illinois	16
Begich, Hon. Mark, U.S. Senator from Alaska	24

WITNESSES

Udall, Hon. Mark, U.S. Senator from Colorado	3
Prepared statement	4
Perlmutter, Hon. Edward, House Representative from Colorado	5
Prepared statement	6
Bennet, Hon. Michael F., U.S. Senator from Colorado	8
Prepared statement	9
Orndoff, Donald H., AIA, Director, Office of Construction and Facilities Management, U.S. Department of Veterans Affairs; accompanied by Brandi Fate, Director, Office of Capital Asset Management and Planning Service, Veterans Health Administration; James M. Sullivan, Director, Office of Asset Enterprise Management; and Lisa Thomas, Ph.D., FACHE, Director, Office of Strategic Planning and Analysis, Veterans Health Administration	12
Prepared statement	13
Response to requests arising during the hearing by:	
Hon. Roland W. Burris	22
Hon. Mark Begich	27
Response to post-hearing questions submitted by:	
Hon. Daniel K. Akaka	28
Addendum—Implementation Monitoring Report on Capital Asset Realignment for Enhanced Services	35
Hon. Mike Johanns	64
Wise, David, Director of Physical Infrastructure Issues, Government Accountability Office	64
Prepared statement	66
Cullinan, Dennis, Director, National Legislative Service, Veterans of Foreign Wars of the United States	75
Prepared statement	77
Cox, J. David, R.N., National Secretary-Treasurer, American Federation of Government Employees, AFL-CIO	79
Prepared statement	81

APPENDIX

Ilem, Joy, Assistant National Legislative Director, Disabled American Veterans; prepared statement	91

HEARING ON VA'S CONSTRUCTION PROCESS

WEDNESDAY, JUNE 10, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:33 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Begich, Burris, Burr, Isakson, and Johanns.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. The Committee on Veterans' Affairs of the U.S. Senate will come to order.

Aloha. This morning we will take a look at the VA construction process, including how VA's vast infrastructure needs are managed. I also want to learn more about where we stand on the CARES effort—the now 5-year-old plan—to make sense of VA's capital assets.

VA is a large health care system with an aging infrastructure and some new and growing needs. Planners have to balance large-scale construction projects with costs in the hundreds of millions, along with smaller projects and nonrecurring maintenance. VA's infrastructure must be adapted to meet the needs of today's veterans and prepare to respond to the changes that will come.

VA has moved from a hospital-driven health care system to an integrated delivery system that emphasizes a full continuum of care. The lion's share of VA's infrastructure was designed and built decades ago under a different concept of health care delivery. Since then, VA health care has experienced a great shift from inpatient to outpatient services, and as a result, VA has a system which generally reflects yesterday's priorities, not today's.

The goal of CARES was a good one—shift resources from underused, inefficient, or obsolete buildings to support better ways of furnishing health care. However, the degree to which this has happened, as well as the extent to which this continues, remains unclear.

In terms of current projects, VA has requested over $1.9 billion for fiscal year 2010 construction programs. While this is significant, it is clear that there is an extensive backlog of major construction projects, which require far more funding with such high dollar figures dedicated to construction projects. The Committee must understand the basis for VA's decision process.

I see today's hearing as beginning a focused look at where VA is with respect to its capital infrastructure and how we might go forward. I hope that we will hear some compelling suggestions for expediting the construction process and for improving it.

I would like to now call for the statement of our Ranking Member, after which I will introduce our colleagues here for their statements.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. Aloha.

Chairman AKAKA. Aloha.

Senator BURR. Senator Udall, good to have you here. I'll be brief.

Mr. Chairman, thank you for calling this hearing. Welcome to all the witnesses of all the panels.

Mr. Chairman, you have often heard me talk about the need to transform the VA's health care system to a 21st Century delivery system and organization. In his budget, the President states that he wants the VA to be veteran-centric, results-driven, and forward-looking. Such transformation, and I quote "is determined by new times, new technologies, new demographic realities, and new commitments to today's veterans."

This transformation includes technological advances, new pharmaceutical products, and an emphasis on preventative care that greatly reduces the need for lengthy hospital stays. That's a good thing. And I've never talked to anyone who wanted to spend more time in a hospital.

This transformation also includes providing veterans greater access to care closer to where they live; dislocating families less. Something we see or have seen with increasingly regularity is VA opening new outpatient clinics across the country and some with ambulatory units attached.

The President and Secretary Shinseki have also endorsed the HCC approach—the health care centers approach—to health care delivery. HCCs have the ability to provide 90 to 95 percent of the care veterans need, including primary care, specialized care, and ambulatory surgery. One of the first HCCs was opened in Columbus, Ohio, last fall. To supplement the outpatient care provided at the HCC, VA has collaborated with inpatient providers in the community. Although more time is needed to fully evaluate the concept, one thing is clear so far, it has saved veterans living in Columbus from having to drive 144 miles to access their health care. I think that is a good thing. More HCCs are in the pipeline, including three that are in this year's budget for the State of North Carolina. I welcome those HCCs.

These state-of-the-art facilities will eliminate the need for many veterans to drive to faraway hospitals for their care and will stretch VA's construction dollars far more than it otherwise would. We all know that construction dollars are limited. There are 66 major medical facility construction projects vetted and approved by VA for the fiscal year 2010 budget. However, appropriations were requested for the design of only seven of these facilities. Fifty-nine projects will have to wait until another year.

What this suggests is that the VA and Congress must continue to think of innovative ways to meet the vast needs that exist in the system. I am pleased we have a panel of witnesses today that can help us try to chart that path forward.

One last comment before I conclude, Mr. Chairman. It concerns the over $1.4 billion allocated to the VA on the stimulus package passed last February, which included $1 billion for maintenance projects. According to the Administration's Web site, the latest numbers indicate that just over three hundredths of 1 percent of these dollars has actually been spent to date. Three hundredths of 1 percent.

We are now in the fourth month since the stimulus package was signed into law. I am anxious to hear why there has been a delay in spending money that was meant to stimulate the economy and what the plan is going forward.

Mr. Chairman, I look forward to the testimony today and to being enlightened by our good friend, Senator Udall.

Thank you, Chair.

Chairman AKAKA. Thank you very much, Senator Burr, for your opening statement.

Now, I would like to welcome two distinguished gentleman from Colorado, Senator Mark Udall and Congressman Ed Perlmutter. I understand that Senator Bennet is on his way here.

They are all supporters of a new VA standalone medical center at the former Fitzsimons Army Base in Aurora, Colorado. I can safely say that having two, and possibly three of you, certainly gives us full coverage of the Denver issue.

So, let us begin with Senator Udall. Senator Udall.

STATEMENT OF HON. MARK UDALL,
U.S. SENATOR FROM COLORADO

Senator UDALL. Thank you, Chairman Akaka, Ranking Member Burr, Senator Isakson, Senator Johanns.

I appreciate the opportunity to tell you a little bit about the history of the VA Hospital and also where we hope to go in the near and the immediate future.

We have a new, and we hope a final plan for the VA Medical Center on the Fitzsimons Campus in Aurora, Colorado. As some of you may know, the current facility is almost 60 years old. It is at full capacity, and it does not meet the needs of our veterans. Sometimes veterans, Mr. Chairman, have to wait months to see a doctor, and veterans with spinal cord injuries have to travel to other States for treatment. And that is why the development of a state-of-the-art veterans' facility at Fitzsimons was a centerpiece of the VA's Capital Construction Plan under the Capital Asset Realignment for Enhanced Services, or as it is known, the CARES Program.

Five years ago, as part of this CARES Program, Denver was identified as a city in urgent need of a new VA center. Today there is still no hospital and the need is still urgent, as you can all imagine, as thousands of young veterans returning from Iraq and Afghanistan require care for their wounds, whether physical or mental, or both. We also have an additional four hundred thousand veterans in the region who require care.

So, I am pleased to be able to say although there have been a few bumps along the road—three secretaries of the VA and numerous plans and many intervening years at Fitzsimmons—it is again one of the highest priorities for the VA.

As you know, Secretary Shinseki, who came out of retirement—I think in the wonderful State of Hawaii—listened to the concerns of our delegation, our local veterans' community, and veterans' service organizations, and his own advisors. And earlier this year he concluded that a standalone facility with comprehensive specialty care services, including a 30-bed spinal cord injury center, is essential in order to meet the needs of veterans throughout the Rocky Mountain region.

We are excited that the plan also includes constructing new health care centers in Colorado Springs, Colorado, and Billings, Montana; a number of new clinics in rural health sites; and an outpatient administrative building at the Buckley Air Force Base, which is in Colorado, as well.

Mr. Chairman, if I could turn to costs, which are always, of course, very, very important. The new estimate for the total cost is $800 million dollars with $119 requested in this year's President's 2010 budget. So far, we have authorized, Mr. Chairman, $568 million for the hospital, but this is not enough to get us all the way to the finish line. So, I look forward to working with the Committee to increase these levels.

I want to thank my colleague, Representative Perlmutter, for his hard work, and our former colleague, Senator and now Secretary Salazar, for leading the charge when it looked like the VA was going to back away from its promise to build a standalone hospital. Senator Bennet has quickly picked up where Senator Salazar left off and he is pushing hard to get the project underway.

In my notes here I am also encouraged to talk about my contribution. What I would say is I have been working on this for 10 years, and I was working on this when Senator Burr, Senator Isakson, and I were all members of the House of Representatives—all those glorious years in the past.

So, I am delighted to be here today. I am delighted to be able to, I think, see the end of the light at the end of the tunnel.

There is a groundbreaking scheduled in August, and I want to thank the Committee for giving me an opportunity to speak to you today. I ask your support so that we can finish this project in the way that our veterans deserve.

Thank you, Mr. Chairman.

[The prepared statement of Senator Udall follows:]

PREPARED STATEMENT OF HON. MARK UDALL, U.S. SENATOR FROM COLORADO

I am glad to have the chance to testify today about the new—and, we hope, final—plan for the VA Medical Center on the Fitzsimons campus in Aurora, Colorado.

As you know, the current medical center in Denver is nearly 60 years old, is at full capacity and does not meet the needs of our veterans. At the existing VA hospital in Denver, veterans sometimes have to wait months to see a doctor, and veterans with spinal-cord injuries have to travel to other states for treatment.

That's why the proposal for the development of a state-of-the-art veterans' facility at Fitzsimons was a centerpiece of the VA's capital construction plan under the Capital Asset Realignment for Enhanced Services, or CARES program.

Five years ago, as part of the CARES plan, Denver was identified as a city in urgent need of a new VA medical center. Today, there is still no new hospital, and the need is still urgent, as thousands of young veterans returning from Iraq and Afghanistan require care for their physical and mental wounds, in addition to more than 400,000 other veterans in the region who require care.

I am so pleased to be able to say that while there have been a few bumps on the road—three secretaries of Veterans Affairs, numerous plans, and many intervening years—Fitzsimons is again one of the highest priorities for the VA.

As you know, Secretary Shinseki listened to the concerns of the Colorado Congressional delegation, our local veterans' community and veterans' service organizations, and his own advisors. And earlier this year he concluded that a stand-alone full-service hospital with comprehensive specialty care services—to include a 30-bed Spinal Cord Injury Center—is essential in order to meet the needs of veterans throughout the Rocky Mountain Region.

We are excited that the plan also includes constructing new Health Care Centers in Colorado Springs, Colorado, and Billings, Montana; a number of new clinics and rural health sites; and an outpatient and administrative building at Buckley Air Force Base in Colorado.

I understand the new estimate for the hospital's total cost is $800 million, with $119 million requested in the president's fiscal year 2010 budget. As you know, Mr. Chairman, Congress has so far authorized $568 million for the hospital, but this is not enough to get us to the finish line with these updated cost estimates. I hope to work with the Committee to increase these levels.

I want to thank my colleague Representative Perlmutter and my former colleague and now Secretary Ken Salazar for leading the charge when it appeared that the VA would not make good on its promise to build a stand-alone hospital at Fitzsimons. Rep. Perlmutter has worked tirelessly to make this hospital a reality and to provide care for Colorado's veterans. Senator Bennet has quickly picked up where Senator Salazar left off and is pushing hard to get the project underway.

I have also worked hard on behalf of our veterans in Colorado. So I am delighted—after fighting for a veterans hospital for years as a member of the House—that I am testifying before you in the Senate, at a time when we can finally see a light at the end of the tunnel. I know all of us here look forward to the groundbreaking in August.

I want to thank you, Mr. Chairman, and the Members of this Committee for your support over the years, and ask that your support continue as we work to secure the funding necessary to finally complete this project.

Chairman AKAKA. Thank you for your statement, Senator Udall.

I am going to call on Representative Perlmutter for your opening statement and your statement about Denver and the hospital there.

Representative Perlmutter.

STATEMENT OF HON. EDWARD PERLMUTTER, A REPRESENTATIVE IN CONGRESS FROM COLORADO

Mr. PERLMUTTER. Thank you, Mr. Chairman, Senator Burr, and Distinguished Members. Thank you for inviting a member of the House to come testify before your Committee.

This is a great opportunity for the veterans of Colorado. We have been dealing with this project, as Senator Udall said, for at least 10 years, sort of back and forth. And the issue that we are dealing with is the need for a new state-of-the-art Veterans Administration standalone medical center at the former Fitzsimons Army Base in Aurora, Colorado.

I would like to acknowledge the work of former Senator Ken Salazar, as well as Senator Wayne Allard, both of whom were strong partners in moving this project forward. I am equally pleased that Mark Udall now is a member of your chamber and he and Senator Mike Bennet are also champions for this particular facility—one that has been long, long overdue.

Mr. Chairman, in your remarks, you talked about sort of the fits and starts within the CARES program, and this is one of those examples. But finally, I think with the concerted effort of the Congress, as well as the Administration, we can move forward and fulfill the promises that we made to these veterans a long time ago.

General Shinseki, 2½ months ago in a clear statement, said we are going to move forward with a standalone facility which will serve the Rocky Mountain West and the Western Plains veterans. So, Nebraska, Kansas, Colorado, Utah, Idaho, Montana, and Wyoming and the 700,000 veterans within that region will be served as part of this effort.

Our veterans deserve this medical facility. This is one that is worthy of their service. We found—and the CARES report is clear—that the current facility that we have simply is obsolete; it is undersized and is not meeting the needs of our veterans.

The Commission had 38 public hearings and over 200,000 public comments, and was completed and accepted by Secretary Principi 5 years ago. We are on our fourth secretary of the VA, and we hope that this time things will move forward with the groundbreaking scheduled for the end of August.

The CARES Committee Report concluded that there was a space deficit of 242,000 square feet. So, as Senator Udall said, the Congress has authorized $568 million for the project, of which $188,300,000 has been appropriated. Property has been purchased and we are ready to turn dirt. So, Senator Burr, your question about the stimulus and moving forward for jobs now to help us within this recession—this project is ready to please you.

The new medical center will provide a full range of medical, laboratory, research, and counseling services, including a new spinal cord injury unit recommended by the CARES report. Moreover, it will be a joint facility with the Department of Defense to provide care for personnel stationed at installations throughout Colorado and VISN–19. In order to accomplish this, the President's budget proposes $119 million be appropriated this year for the Fitzsimons facility.

I applaud Secretary Shinseki and President Obama for bringing closure to this long-awaited decision to move forward with this project. The veterans of Colorado very much appreciate the support of this project which it has received from this Committee. The VSOs have been involved from day one in this project and are very supportive and very determined to have this go forward, as the Chairman knows from a visit he made to Colorado a few months ago.

I thank you for the opportunity to speak to you. This is a critical project for our State, and for the Rocky Mountain West and Western Plains regions. I look forward to your questions and to your support of this project.

[The prepared statement of Mr. Perlmutter follows:]

PREPARED STATEMENT OF ED PERLMUTTER, U.S. REPRESENTATIVE, COLORADO'S SEVENTH CONGRESSIONAL DISTRICT

Chairman Akaka, Senator Burr and distinguished Members of the Committee, I would like to thank you for the opportunity to briefly testify today on an issue that has been of great concern to the Colorado veterans and veterans receiving medical care in the Veterans Integrated Service Network 19 Rocky Mountain Network. That

issue has been the need for a new state-of-the-art Veterans Administration stand-alone medical center at the former Fitzsimons Army Base in Aurora, Colorado.

But before I begin I would like to acknowledge the work of former Senator Ken Salazar on this project, he was a strong partner with me, as was former Senator Wayne Allard, in ensuring the construction of this hospital. Now, I am equally pleased that Senator Mark Udall and Senator Michael Bennet picked up where Senators Salazar and Allard left off. We are all working together with the rest of the delegation and General Shinseki to fulfill our promise to our veterans to provide them the best healthcare possible. This is the least we can do for their dedicated service to our country.

There are an estimated 426,000 veterans in Colorado, and 700,000 in VISN 19 whose major VA medical facility simply doesn't cut muster. They deserve a medical facility worthy of their service. It is our duty to give the VA the resources to make world class care available to world class soldiers. Many of them were wounded in battle, and many of them will rely on intensive medical care from the Veterans Administration for the rest of their lives.

In 1998, with the cost of healthcare and the cost to maintain older VA facilities continuing to grow, Congress established the Capital Asset Realignment for Enhanced Services Commission, or CARES Commission. The goal was to create an objective panel of experts to address the best way to consolidate existing VA facilities and potentially build new ones. After all, an independent commission is really the only venue whereby effective decisions—though sometimes politically difficult—can be made.

In 2004, following 38 public hearings and over 200,000 public comments, the CARES study was completed and accepted by then Secretary Anthony Principi. The study illustrated the need for a replacement facility for the outdated and obsolete, nearly 60 year old, Denver VA Medical Center. They concluded the existing facility had a space deficit of 242,000 square feet for inpatient and outpatient needs. Moreover, they found significant problems with patient privacy at the existing facility. These problems were—and continue to be—so bad the Commission deemed the replacement facility at Fitzsimons a high priority of the VA.

Since the 2004 CARES study, the process of seeking a final resolution to move forward with the actual construction of the new Aurora VA Medical Center has been a frustrating history of indecision and reversal of construction plans. With each succeeding VA secretary, we have seen the plans alternate between a shared facility and a stand-alone facility. Enough is enough! Congress has authorized $568,400,00 for the project, of which $188,300,000 has already been appropriated. Property has been purchased and we are ready to turn dirt.

On March 18, 2009, Secretary of Veterans Affairs Eric Shinseki met with the Colorado Congressional Delegation to announce the VA will move forward with the construction of a new stand alone VA Medical Center at the Fitzsimons site in Aurora, Colorado. The new medical center will provide a full range of medical, laboratory, research and counseling services including a new spinal cord injury unit recommended by the CARES Commission report. Moreover it will be a joint facility with DOD to provide care for personnel stationed at installations throughout Colorado and VISN 19, as stipulated in the CARES report.

In order to accomplish this, President Obama's budget proposes spending $1.19 billion in FY 2010 for construction of major projects within the VA. Of that, he has budgeted $119 million for the new Fitzsimons facility. We are anticipating a groundbreaking for construction of the new facility in August, which will create thousands of jobs and put our veterans that much closer to the care they deserve. I applaud Secretary Shinseki and President Obama for bringing closure to this long awaited decision to move forward with a project that is so critical to health care needs of the veterans served by VISN–19.

The veterans of Colorado very much appreciate the support this project has received from the Members of this Committee. They will continue to need this support as we move forward to see this vision become a reality. In order to do this, we will also need your assistance to increase the authorization level. Currently the authorization is $568,400,000. However, the VA estimates the construction will be $800 million. I look forward to working with both senators from Colorado and Members of this Committee to enact this necessary authorization.

Last, I would also like to acknowledge the very active veteran service organizations in Colorado who have played such a crucial role in fighting for this project for years. This final decision has taken well over 10 years for the Department of Veterans Affairs to reach. Also critical to this team effort were the University of Colorado Health Sciences Center, the Children's Hospital, and the city of Aurora.

I want to thank the Chairman for visiting the Fitzsimons campus site several months ago and I want to thank the Committee staff for their dedication to ensur-

ing quality healthcare for our veterans. I ask the members of the Senate VA Committee to continue their support for the stand-alone VA medical center in Aurora, Colorado in order to meet the needs of veterans in Colorado and throughout the Rocky Mountain West.

Thank you for this opportunity, and I look forward to answering any questions you may have.

Senator AKAKA. Thank you very much, Representative Perlmutter. Thank you for your statement.

Now, we will hear from Senator Bennet from Colorado.

STATEMENT OF HON. MICHAEL F. BENNET, U.S. SENATOR FROM COLORADO

Senator BENNET. Thank you, Mr. Chairman. I apologize for being late.

Mr. Chairman, Ranking Member Burr, and other Members of the Committee, thank you very much for inviting me to be a part of today's hearing.

I want to start by thanking Senator Udall for his hard work on the Denver VA Hospital, and I would also like the Committee to know that Congressman Perlmutter, in particular, has been indispensable in getting this critically important project off the ground.

When I came to the Senate just a few months ago, one of the first things I did was join Senator Udall, Congressman Perlmutter, and the rest of the Colorado delegation, many of whom had been working on getting this facility built for several years in communicating to the new Administration my support for a standalone facility in the Denver area.

Secretary Shinseki told us he supported a standalone facility, and as you know, he and President Obama have included $119 million in funding for it in their request for the upcoming fiscal year. We were particularly proud that this was the first decision that the VA made in capital construction this year. This funding will put the $800 million, 200-bed facility, which will serve 400,000 Colorado veterans, on track to open in 2013. When it does, 92 percent of Colorado veterans will be within 1 hour of VA primary care, and 81 percent of Colorado veterans will be within 2 hours of a medical center or health care center.

The new Denver facility will set the bar high. It will bring together the best resources the VA has to offer and enable more veterans to access the high quality care they need and deserve. With capacity for addressing mental health needs and spinal cord injuries, it will be a shining example of how we can do right by our veterans—one that this Committee can point to for years to come.

As the Committee considers the President's budget for fiscal year 2010, I join my colleagues and ask on behalf of Colorado's veterans that you preserve the $119 million the Administration has requested for this important project. I would also ask that when the time comes, you increase the authorization of the project to reflect its full estimated cost of $800 million. As the Congressman said, the project is currently authorized at $568 million.

I want to close by saying thank you for your consideration. Thank you for your leadership on these issues. To Congressman Perlmutter, everybody in Colorado knows and should know that his commitment to this project has been tireless over many, many years, and it is extremely gratifying to see it finally being brought

home. So, I want to thank you on behalf of all the citizens of Colorado for your tireless work on this.

Thank you, Mr. Chairman.

[The prepared statement of Senator Bennet follows:]

PREPARED STATEMENT OF HON. MICHAEL BENNET, U.S. SENATOR FROM COLORADO

Chairman Akaka, Ranking Member Burr, and other Members of the Committee, Thank you for inviting me to be a part of today's hearing. I want to start by thanking Senator Udall for his hard work on the new Denver VA hospital. And I would also like the Committee to know that Congressman Perlmutter in particular has been indispensable in getting this critically important project off the ground. My predecessor, Senator Ken Salazar, also worked hard to make this project at Fitzsimons a reality.

When I came to the Senate just a few months ago, I joined Senator Udall, Congressman Perlmutter, and the rest of the Colorado delegation—many of whom have worked on getting this facility built for several years—in communicating to the new Administration my support for a stand-alone facility in the Denver area.

Secretary Shinseki told us he supported a stand-alone facility, and he and President Obama have included $119 million in funding for it in their request for the upcoming fiscal year. This funding will put the $800 million, 200-bed facility, which will serve 400,000 Colorado veterans, on track to open in 2013. When it does, 92 percent of Colorado veterans will be within one hour of VA primary care, and 81 percent of Colorado veterans will be within two hours of a medical center or health care center.

The new Denver facility will set the bar high. It will bring together the best resources the VA has to offer and enable more veterans to access the high-quality care they need and deserve. With capacity for addressing mental health needs and spinal cord injuries, it will be a shining example of how we can do right by our veterans—one that this Committee can point to for years to come.

As the Committee considers the President's budget for FY 2010, I ask on behalf of Colorado's veterans, that you preserve the $119 million the Administration has requested for this important project. I also ask that when the time comes, you increase the authorization of the project to reflect its full estimated cost of $800 million.

Congressman Perlmutter could tell you that getting to this point hasn't been easy, but he sets a good example for us all in standing up for our veterans. Of course, it is because of the brave commitment of our veterans that we can stand here today. Their sacrifices have created the need, and the obligation we all have to fulfill that need. I'm proud of their service to Colorado and to our country.

But it also takes leadership in government to make important things happen. I know the Chairman and the Committee reflect that leadership. So does Ed Perlmutter.

Thank you, Mr. Chairman for allowing me to add to their voices.

Chairman AKAKA. Thank you very much, Senator Bennet for your statement.

Chairman AKAKA. Now I will ask for further opening statements. Senator Isakson.

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Thank you very much, Chairman Akaka. I will not make a statement, except unfortunately given the fact the HELP Committee is getting ready to start marking up the Health Care bill, I am going to have to leave. But I did want to raise a question for the panelists that hopefully they will be able to address to my office.

In Georgia, we are fortunately having a total renovation and completion of the VA Hospital on Clairmont Road. We are very grateful for that, and I am very grateful to the Committee Members who helped me get the appropriations in the Appropriations Act to do that.

However, we have run across a great problem during the course of the construction, and that is we have lost almost all of our accessible parking—or at least a significant amount of it. Clairmont Road is a very busy road that connects Interstate 85 with downtown Decatur. The VA is operating a shuttle from an offsite parking lot to get patients to the hospital, but we have a number of people that are on oxygen who are being required, even with the shuttle, to walk extensive distances to get to the shuttle to get to the hospital. We have expressed to the VA our concerns, and we have had some good attention. I am not complaining.

But, I do think when the discussion about logistics and planning for construction is done—and that is part of the purpose of this particular hearing—when there is a displacement of parking, which is oftentimes the case at a site when you do a renovation or improvement—we need to be very conscious in the planning to make parking a high consideration during that period of renovation or construction so as to minimize the amount of difficulty it causes our veterans and patients.

With that said, that is my principal question, Mr. Chairman. And I hope during the course of the discussion this morning, although I will not be here, that can be addressed and our office can get a response on the question.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Isakson.

Senator Johanns.

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Mr. Chairman and Ranking Member, thank you very much for putting this hearing together.

If I might just spend a moment talking about the Nebraska-Western Iowa Veterans' Facility that is there. And I want to alert the panelists that, of course, I have an interest in that. Having worked my way through government for many, many years as a county commissioner, a city council member, a mayor, and Governor, et cetera, I am very used to working with capital improvement processes and budgets, and I understand that there is a process that we need to go through.

But let me, if I might, cite some of the deficiencies we found in this veterans facility. There are dust, contaminants, potential infectious vectors being distributed throughout much of the hospital via the HVAC system. The hospital could not support a pandemic flu outbreak, which, of course, is on everybody's mind these days.

The system was graded F in VA assessments dating back to 1999. In the electrical system, there is not enough emergency power available to support equipment requiring emergency power. Now, in our State, like probably so many States, emergency power is absolutely necessary. Storms do come through this area and we need that power.

Plumbing and medical gas system repairs and renovations require whole hospital shutdowns. For water and oxygen, piping is 50 years old. It is corroded. It fails on a recurring basis. Moisture is pulled into wall cavities because of the faulty HVAC system. It creates a perfect breeding ground for mold in that facility.

Over 4,000 square feet of hospital space is not occupied, even though we have a deficiency in space in this hospital because there is reactor water and concrete that has yet to be removed.

Now, I could go on and on. That is the bad news of what we are dealing with here. It is not a good situation for our veterans who need care. I really appreciate the work that Colorado is doing, but if you live on the eastern side of the State of Nebraska, that is a 10-hour drive to Colorado. Now, we love to visit Colorado—except when the football team beats us—but that is a long way away. And most of our population, as you know, is in Omaha and Lincoln—on that eastern one-third of the State. So, nothing I say here stands in the way of what they are trying to do. I applaud them for their efforts.

That is the tough news. The good news about this project is the community is pulling together; the State is pulling together; and Western Iowa is pulling together to see how can we be helpful in bringing first class medical care to these veterans who have served our country so well.

The good news is that in Omaha you have two medical centers—two medical schools—Creighton University, my alma mater, first class, and the University of Nebraska Medical Center. They want to join forces. They want to do everything they can to bring the best medical care to bear to help these veterans.

Now, again, I understand capital improvements processes. But these conditions are not good, and I am hoping that if we can all work together and cooperate on not only this project but other projects that have this awful list of problems, that we can solve these problems. Hopefully, we can work together to get the funding and move these projects forward.

No one would like front page stories about these conditions. They are not good.

And so, Mr. Chairman, and Ranking Member, again, I thank you so very much. This gives us a forum to debate and discuss how best to deal with these issues. The reassuring thing about this Committee and the people that come before the Committee is we share one common goal. And that is, how do we improve the conditions for our veterans? I am anxious to be a partner in that.

Thank you.

Chairman AKAKA. Thank you very much, Senator Johanns.

Now, I want to welcome our principal witness from VA, Donald Orndoff, who is the director of the Office of Construction and Facilities Management.

He is accompanied by Brandi Fate, Director of VHA's Office of Capital Asset Management and Planning Service; James Sullivan, Director of VA's Office of Asset Enterprise Management; and Dr. Lisa Thomas, Director of VHA's Office of Strategic Planning and Analysis.

I thank all of you for being here this morning. VA's full testimony will appear in the record.

STATEMENT OF MR. ORNDOFF, AIA, DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY BRANDI FATE, DIRECTOR, OFFICE OF CAPITAL ASSET MANAGEMENT AND PLANNING SERVICE, VETERANS HEALTH ADMINISTRATION; JAMES M. SULLIVAN, DIRECTOR, OFFICE OF ASSET ENTERPRISE MANAGEMENT; AND LISA THOMAS, Ph.D., FACHE, DIRECTOR, OFFICE OF STRATEGIC PLANNING AND ANALYSIS, VETERANS HEALTH ADMINISTRATION

Mr. ORNDOFF. Mr. Chairman and Members of the Committee, I am pleased to appear today to discuss the status of the Department of Veteran Affairs facility infrastructure. I will provide a brief oral statement.

Current Medical Infrastructure. VA has a real property inventory of more than 5,400 owned buildings, 1,300 leases, 33,000 acres of land, and approximately 159 million gross square feet of occupied space, both owned and leased. Our aging facilities were not designed to meet the changing demands of clinical care for the 21st Century.

Continuing our recapitalization program is critical to providing world-class health care for veterans now and into the future.

Our Current Major Construction Program. VA continues the largest capital investment program since the immediate post-World War II period. Since 2004, VA has received appropriations totaling $4.6 billion in health care projects, including 51 major construction projects. These projects include new and replacement medical centers, poly-trauma rehabilitation centers, spinal cord injury centers, ambulatory care centers, and new inpatient nursing units.

Background—CARES. In 2000, the Veterans' Health Administration embarked upon the Capital Asset Realignment and Enhanced Services program, or CARES. CARES assessed the veterans' health care needs and promoted strategic realignment of capital assets. In 2003, VA released its draft national CARES plan and created the CARES Commission for further analysis.

In May 2004, the Secretary published his CARES decisions and identified 18 sites whose complexity warranted additional study. The VA completed these studies in May 2008.

Today—Strategic Facilities Planning Process. The tools and techniques acquired through CARES are now incorporated into VA's strategic health care facilities planning process. VA no longer distinguishes between CARES and other project planning needs.

Our Goal—High Performance Medical Facilities. VA new medical facilities contribute to world-class health care for veterans today, tomorrow, and into the 21st Century. Our designed goal is to deliver high-performance buildings that are functional, cost-efficient, veteran-centric, adaptable, sustainable, energy efficient, and physically secure.

Acquisition Strategies. VA uses a range of acquisition tools that are tailored to best satisfy the unique requirements of each project. We partner with industry leaders through architect-engineer design contracts, design-bid-build contracts, design-build contracts, integrated design construct contracts, construction management contracts, and operating leases.

Our Fiscal Year 2010 Budget Requirement. VA's fiscal year 2010 budget request continues our recapitalization effort supported by Strategic Facilities Planning Process. VA requests $1.1 billion in fiscal year 2010 for major construction to replace or enhance VA medical facilities and $196 million authorization for 15 new medical facility leases. VA also requests $112 million for major construction to expand two national cemeteries.

In closing, I thank the Committee for its continued support to improve the Department's fiscal infrastructure to meet the changing needs of America's veterans. My colleagues and I stand ready to answer your questions.

[The prepared statement of Mr. Orndoff follows:]

PREPARED STATEMENT OF DONALD H. ORNDOFF, AIA, 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 status of the Department of Veterans Affairs' (VA) health care infrastructure, our strategic facilities planning process, our facility design objectives, our acquisition strategies, and our proposed Fiscal Year 2010 budget. Joining me today are Brandi Fate, Director of the Veterans Health Administration's (VHA's) Office of Capital Asset Management and Planning Service; James M. Sullivan, Director of VA's Office of Asset Enterprise Management; and Lisa Thomas, Ph.D., FACHE, Director of VHA's Office of Strategic Planning and Analysis.

CURRENT MEDICAL INFRASTRUCTURE

VA has a real property inventory of over 5,400 owned buildings, 1,300 leases, 33,000 acres of land and approximately 159 million gross square feet (owned and leased). The average age of VA facilities is well over 50 years. Our older facilities were not designed to meet the changing demands of clinical care in the 21st century. Therefore VA's continuing program of recapitalization of these aging assets is very important to providing world-class health care to veterans now and into the future.

CURRENT MAJOR CONSTRUCTION PROGRAM

The Department is currently implementing its largest capital investment program since the immediate post-World War II period. Since 2004, VA has received appropriations totaling $4.6 billion for health care projects, including 51 major construction projects for new or improved facilities across the Nation. These projects include new and replacement medical centers; poly-trauma rehabilitation centers, spinal cord injury centers; ambulatory care centers; new inpatient nursing units; and projects to improve the safety of VA facilities. Thirty-six of the 51 projects have been fully funded at a total cost of approximately $3.1 billion. The remaining 15 projects have received partial funding totaling $1.6 billion against a total estimated cost of $4.5 billion. For these larger projects, VA requests design and construction funding in increments aligned with the projected multi-year acquisition schedule.

BACKGROUND: CARES

In 2000, the Veterans Health Administration (VHA) embarked on the Capital Asset Realignment for Enhanced Services (CARES) process to provide a data driven assessment of Veterans' health care needs and to guide the strategic allocation of capital assets to support delivery of health care services over the next 20 years. The CARES program assessed Veterans' health care needs in each Veterans Integrated Service Network (VISN), identified service delivery options to meet those needs, and promoted strategic realignment of capital assets to satisfy identified needs. The goal was to improve access and quality of health care in the most cost effective manner, while mitigating impacts on staffing, communities, and on other VA missions.

VA began the CARES process in 2000 with a regional pilot, then in 2002 expanded nationally. In 2003, VA released its Draft National CARES plan and created the CARES Commission, an independent panel established to review VA's plans. The Secretary published his decisions in May 2004 and identified 18 sites whose complexity warranted additional study. VA completed these studies in May 2008.

One output of the CARES process is the development of a Five-Year Capital Plan that lists and ranks specific major construction projects.

TODAY: STRATEGIC FACILITIES PLANNING PROCESS

The lessons learned through CARES are now incorporated into VA's strategic health care and facilities planning process. VHA no longer distinguishes between CARES and non-CARES planning as the tools and techniques acquired through CARES have become part of our standard operating procedures for strategic planning within our health care system.

VA uses a multi-characteristic decision methodology in prioritizing its capital investment needs. Appropriate "joint" VA-Department of Defense (DOD) projects are evaluated to promote sharing and efficiency opportunities. Through this strategic facilities planning process, VA annually updates its Five-Year Capital Plan, which supports the development of VA's annual capital acquisition funding request.

VHA employs its Health Care Planning Model to strategically assess demographic data, anticipated workload, and actuarial projections for health care services. VHA compares this data to its capital asset inventory to identify gaps in capability. To close gaps, VHA develops investment solutions that may become capital infrastructure projects. All proposed projects undergo thorough cost effectiveness, risk, and alternatives analyses.

The Department's Capital Investment Panel (CIP) reviews, scores, and priority ranks potential projects based on criteria considered essential to providing high quality health care services. The scoring criteria include enhancement of service delivery, meeting workload projections, safeguarding assets, supporting special emphasis programs, addressing capital asset management priorities, promoting department alignment, and eliminating facility deficiencies. The CIP integrates both new and existing program requirements into a single prioritized project list.

The CIP reports its analysis to the Strategic Management Council (SMC) for review. The SMC is VA's governing body responsible for overseeing VA's capital programs and initiatives. The SMC submits its recommendations to the Secretary, who makes the final decision on which projects to include in the budget.

PROJECT DESIGN GOAL: HIGH-PERFORMANCE MEDICAL FACILITIES

New VA medical facilities will contribute to world-class health care for Veterans today, tomorrow, and well into the 21st century. Our design goal is to deliver high-performance buildings that are:

- Functional, providing cutting-edge clinical spaces that leverage the latest medical technologies to produce the highest possible health care outcomes.
- Cost efficient, incorporating evidence-based design for clinical spaces that are efficiently sized and configured to maximize clinical capability for invested capital.
- Veteran-centric, placing special emphasis on design that is Veteran and family centered. Buildings welcome patients and visitors with effective design, open circulation and waiting areas, and expected amenities.
- Adaptable, creating buildings that will serve generations of Veterans not yet born. Our buildings must be flexible to adapt and support continual changing clinical practices, advancing technology, and medical research. Buildings are designed with engineering systems organized in interstitial levels between occupied floors to enable rapid and less expensive reconfiguration of clinical spaces.
- Sustainable, setting a standard of designing our medical centers to a minimum Leadership in Environmental and Energy Design (LEED) Silver level as defined by the U.S. Green Building Council, and following all relevant Executive Orders, including the High Performance & Sustainable Buildings Guidance required under E.O. 13423.
- Energy efficient, designing new facilities to meet or exceed energy reduction targets of the Energy Policy Act of 2005 and related Executive Orders, shrinking energy use 30 percent below American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards. VA is committed to incorporating renewable energy technologies in the design of new or renovated facilities.
- Physically secure, ensuring medical facilities are designed to fully comply with stringent physical security guidelines for mission critical, high-occupancy Federal facilities. This includes hardened structures, perimeter and access control, redundancy and modularity. Water storage, emergency power, and fuel supplies are sized to enable continued health care operations for four days in the face of natural or man-made disaster.

ACQUISITION STRATEGIES

VA uses a range of acquisition tools that are tailored to best satisfy the unique requirements of each project.

For design acquisition, VA selects partners through a targeted Architect/Engineer (A/E) contract solicitation. Our selection process values past performance and experience on health care projects of similar complexity. We carefully evaluate the experience and capabilities of the key members of the proposed design team. We require our design partners to leverage the power of Building Information Modeling (BIM) as a common communication and collaboration tool. We engage peer review from separate A/E firms to assist the owner's review of proposed design solutions in meeting required design criteria and standards.

For construction acquisition, VA uses a range of contract vehicles, including:

- Design-Bid-Build, where we fully develop the project design and use best value selection process, which assesses both technical and cost proposals. We typically use this contract vehicle for large, complex medical facility projects, such as large medical clinics.
- Design-Build, where a single contractor performs both the design development and the construction. We typically use this approach for smaller, less complex projects, such as parking structures.
- Integrated Design-Construct, where we bring the general contractor on board early in the design process, initially performing construction management functions, then construction work as design packages become available. This is VA's version of CM@Risk approach that is widely used in the private sector of the construction industry. We plan to use this approach on our largest, most complex projects, such as new medical centers.
- Operating Leases, where we engage a developer to act as owner, designer, and constructor of "build to suit" leases. VA pays annual lease payments for terms up to 20 years. We typically use this strategy for smaller projects where VA does not currently own property, such as outpatient clinics.
- Construction Management, where we augment our capacity to perform the important owner role for cost analysis, schedule control, and field testing. We typically use CM support on larger, more complex projects, such as new medical centers.

VA is a leader among Federal agencies in meeting socio-economic goals for small business categories. We place special emphasis on contracting with veteran owned businesses, especially service-disabled veteran owned businesses.

MAJOR CONSTRUCTION ACQUISITION PROCESS REVIEW

In late April 2009, VA's Office of Inspector General (OIG) issued a follow-up audit report to a February 2005 IG report related to CFM major construction acquisition processes. OIG found that CFM had implemented 10 of the 12 recommendations from the original report. OIG made four new recommendations in their follow-up audit, including one implemented before the report was issued. CFM is addressing the remaining three recommendations which will require new policies, procedures, and additional oversight staff within the CFM Quality Assurance Office.

FISCAL YEAR 2010 REQUEST

VA's FY 2010 budget request continues our recapitalization effort supported by our strategic facilities planning process. VA requests $1.1 billion in FY 2010 for major construction in support of the Veterans Health Administration to replace or enhance VA medical facilities. Of this amount, $649 million provides construction funding for five ongoing projects at Denver, CO; Orlando, FL; San Juan, PR; St. Louis (Jefferson Barracks Division), MO; and Bay Pines, FL. Another $211 million will design seven new projects at Livermore, CA; Canandaigua, NY; San Diego, CA; Long Beach, CA; St. Louis (John Cochran Division), MO; Brockton, MA; and Perry Point, MD. The remainder of the major construction request will provide funds for advance planning, facility security, judgment fund and land acquisition needs.

VA requests $112 million in FY 2010 for major construction in support of the National Cemetery Administration to expand national cemeteries in Joliet, IL and Houston, TX, Also included are funds for advance planning and land acquisition.

VA requests authorization for $196 million for 15 new major medical leases. Lease projects are located at Anderson, SC; Atlanta, GA; Bakersfield, CA; Birmingham, AL; Butler, PA; Charlotte, NC; Fayetteville, NC; Huntsville, AL; Kansas City, KS; Loma Linda, CA; McAllen, TX; Monterey, CA; Montgomery, AL; Tallahassee, FL; and Winston-Salem, NC.

CONCLUSION

In closing, I thank the Committee for its continued support to improve the Department's physical infrastructure to meet the changing needs of America's Veterans. We look forward to continuing to work with the Committee on these important issues. Thank you for the opportunity to appear before the Committee today. My colleagues and I stand ready to answer your questions.

Chairman AKAKA. Thank you very much. I would like to now call on our Senator from Illinois for any opening statement he may have before we continue with the questioning.

STATEMENT OF HON. ROLAND W. BURRIS, U.S. SENATOR FROM ILLINOIS

Senator BURRIS. Not at the moment, Mr. Chairman. Thank you, sir.

Chairman AKAKA. Thank you very much.

Mr. Orndoff, accompanying you are various officials involved in the construction process. At the onset, tell me what these other individuals do specifically and how they interact with one another.

Mr. ORNDOFF. Yes, sir.

First, I'll begin with Ms. Lisa Thomas on my far left. She is in the VHA's Strategic Planning area, which basically defines our strategic requirements and ultimately identifies where areas of need are—gaps in veteran service need and capabilities. So that office basically defines, initially, the requirement that needs some type of a solution—a facility solution being potentially one of those.

Moving to my right, Ms. Brandi Fate. Her office then takes that output as input and plans projects, further defines requirements, and develops a project that would move forward. Of course, she works closely with the people at the regional level, at the VISN level, and at the local level at the medical centers to fully flush out the requirements and make sure that a project coming forward is, in fact, a valid requirement and would be one that would make—hopefully make—the priority list.

The total output of that effort is the list of projects that we have in our 5-year capital plan, which is 66 projects that were identified earlier. And all of those projects have been validated and are on the list in a priority order.

Mr. Sullivan, to my left, is from our Office of Management, the Asset Enterprise Management Office. He is the key player in working within our Office of Management and with our fiscal officer to develop the input of where we are in terms of prioritizing projects. His office takes the lead in developing the criteria that is used—creating a recommendation that comes forward ultimately approved by the Secretary.

Using that established list of criteria against the list of projects, we then basically score them and come up with a priority order. The top of the priority list, of course, then is included in the Department's budget—the annual budget that would come forward.

So, basically, Mr. Sullivan's office sort of manages the process of getting the requirements prioritized and into the budget working with the fiscal officer. So, it starts with strategic requirements, project requirements, prioritization, budgeting. And then, at the end, I catch the result of all of that and I am the execution guy—

the guy that delivers projects—the brick and mortar that we all know and love.

Chairman AKAKA. Thank you for that explanation.

You have stated in your testimony that VA no longer distinguishes between CARES and non-CARES planning. Of all the projects approved by Secretary Principi and his CARES decision, how many were undertaken? And where do we stand on those?

Mr. ORNDOFF. Yes, sir. Since fiscal year 2004, basically when CARES was initiated, we have had a total of 58 projects identified. Nine of those are complete, 20 are under construction, 13 are in design, 15 are in planning.

Many of them are projects that are continuing to work through the process, as we said, in construction. Certainly, the Denver project that was discussed earlier is one of those projects that is moving forward. Many of the projects that we have partially funded today are a result of the CARES process. All of those requirements have made the prioritization list as we continue to refresh it every year moving forward.

Any time a project is partially funded, at that point there is no longer a prioritization of that project. It is automatically above the line, if you will, and moves forward to completion. So, really, it is just project-specific as to where any particular project is in terms of scheduling and delivery, but in every case where we have a valid output from CARES they have moved forward.

Chairman AKAKA. Thank you. Let me just—before I call on Senator Burr—what were the lessons learned from CARES?

Mr. ORNDOFF. Let me turn that one to Ms. Thomas, if I may.

Chairman AKAKA. Ms. Thomas.

Ms. THOMAS. Good morning, Mr. Chairman.

As you know, CARES is a data-driven assessment of our health care system and it was used to guide the strategic allocation of our assets to support health care delivery.

Our goals under CARES were to improve access and quality in the delivery of health care to make sure that it was done in a cost-effective manner and mitigated any impacts to our staffing or our communities.

We have several very good results as a result of our CARES program. It did help us identify our priorities and improve our physical infrastructure. It also helped us increase access to services to veterans. And one of the things it did is it really improved our strategic planning and capital facilities planning process in that it led to our first ever 5-year capital plan, which now drives all of the capital requests from that point forward.

As Mr. Orndoff said in his statement, we no longer distinguish between CARES and non-CARES because we learned so many lessons as a result of CARES that we have now incorporated all of those tools and techniques into our regular standard operating procedures for strategic and facility capital planning.

We developed a 10-step health care model that replaced the 9-step CARES model that we used. It very much is similar to that model. It is a web-based portal whereby it increased our efficiency with identifying what our strategic needs are and it has greatly enhanced our ability to continue on the traditions that we learned during CARES.

Chairman AKAKA. Thank you very much.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Just one thing on CARES. Did CARES take into account the demographic shift that has happened in America in military retirees?

Ms. THOMAS. Absolutely, sir. What we built our planning upon is our Enrollee Health Care Projection Model, which identifies for us the number of enrollees that we have; where they are; the types and volume and kind of health care services that they need; and the cost of those services. And that model is updated every year.

Senator BURR. And when the CARES model originally came out, North Carolina was not projected to be the recipient of 3 HCCs or whatever the equivalent would have been under that. Yet, I am not sure whether anything would fully encapsulate the demographic shift—the decision of retirees to choose North Carolina as home. And it does put tremendous stress and strain on the delivery system when the infrastructure is not there to deliver that much care to that many veterans. We appreciate them making the decision to retire in North Carolina; we just want to make sure we have got the capacity to deal with them.

Let me move to you, Donald, if I can. Relative to my opening statement where I made the reference that less than three hundredths of 1 percent of the stimulus money had actually gone out, I hope you are going to tell me that my numbers were wrong.

Mr. ORNDOFF. Sir, I am going to, if I may, refer to our subject matter expert, Ms. Fate.

As you mentioned, the funding was targeted at maintenance and repair-type projects. And that function is managed from Ms. Fate's area. So, if I may let her respond.

Senator BURR. I would be happy to.

Ms. FATE. Thank you, Don.

Sir, the number that we have today as of our obligations is $27.5 million for the NRM stimulus funding. While that is a small percentage, it took us a while to get engaged because we changed our process to be 100 percent competitive in all of our contracting, as well as trying to engage in as many small businesses and 8(a) set-asides as we could for these contracts.

So, that took additional contract time to write these clauses, incorporating the Buy American Act and a few other requirements that were put into the contract requirements from OMB.

Senator BURR. So, is the lesson to Congress that if we are looking at divvying out stimulus money that is more immediate from a standpoint of its need, we probably should not do maintenance projects?

Ms. FATE. No, absolutely not, sir. We were ready to go with several of these projects. And, in fact, in March we had a substantial number of projects ready to go, but we wanted to be competitive to the local market so that everybody had an opportunity to get this stimulus funding. And within the next few months we anticipate awarding about at least 40 percent of the stimulus funding.

So, we are gearing up. We just had a few stumbling blocks at the very beginning, but we are projected and targeted to end fiscal year 2009 on a positive note.

Senator BURR. I appreciate that and I appreciate your diligence at making sure that communities get what, in fact, they deserve. I think the difficulty is the American people had expectations that stimulus money was going out immediately, and that is not exclusive to the VA. I think it is across the board. And I think they are shocked at the difficulty we are having pushing that money out the door, creating the jobs, having the impact that it was intended to have. I think it is absolutely vital that we know the reasons so that we can explain it to them.

Let me go on to another point. Let me go to Denver real quick.

Mr. Orndoff, it has been a long process, and I, for one, have had objections with it at certain times. Under the original footprint, taking Senator Isakson's comments to heart, what are the parking conditions at the Denver facility as currently designed?

Mr. ORNDOFF. Sir, I do not know the specific numbers, but I assure you that the full requirement is part of the solution. We have both structured parking and surface parking as part of the schematic design solution. There is no limitation or, you know, tradeoff on parking. It will meet the full requirement.

Senator BURR. The last time I looked at the plan it was the billion dollars plus plan.

Mr. ORNDOFF. Yes, sir.

Senator BURR. And it has been scaled back to $800 million. At that time the parking for the Denver facility, because of the way the footprint was designed, meant that the parking was roughly one half mile from the hospital and that every patient and visitor would have to be bused to the hospital. Do you know if that is currently still the configuration?

Mr. ORNDOFF. No, sir. It is not. The solution is that in the northern part of the site—and it is somewhat of a challenging site in that it is a relatively narrow, rectangular site, so it drives a linear facility solution to work on that site.

But the schematic design has, I think, an incredibly well thought-out design solution. I have personally been involved in reviews of all the phases of schematic design. The parking is located to the north, but it is on the site and it is connected literally by a pedestrian bridge. Some of the parking, as I mentioned, is structure, and that is actually embedded almost essentially within the facility itself at the southern part and the mid-part of the design solution.

So, there is not a long travel distance. It may be a little longer than in a perfect scenario where we had a site that was larger and a little bit more square in shape or round in shape, but I think there is certainly a lot of attention in the design process to minimize the travel impacts and to look creatively on how to do that.

Senator BURR. Any concern by you or any of your colleagues here today whether the $800 million threshold can be met?

Mr. ORNDOFF. In terms of working within that budget?

Senator BURR. Yes, sir.

Mr. ORNDOFF. That is a relatively recent estimation of the new solution. As was mentioned earlier, we changed the design solution when the Secretary made the decision to return to the standalone hospital concept. We did a re-estimation of the project based on that.

And, of course, part of the design solution is growing in other areas, as was mentioned, Colorado Springs and in Billings, Montana. So, part of the design solution is pushed out, which is why the cost has come down a little bit from the one I believe you referred to earlier, which was about a $1.1 billion solution.

That is not to say we have less service. In fact, we have the same level or arguably a higher quality of service as it is closer to veterans that are served. But, in aggregate, it is the same capability. The Denver project, specifically at $800 million, will meet the requirement. That also includes an additional project scope issue of adding renewable energies into the design solution. So, it will be——

Senator BURR. I am going to try to sneak one more question in.

Mr. ORNDOFF. Yes, sir.

Senator BURR. And I assure the Chairman if he gives me the latitude I will not have to have a second round.

There have been 36 major medical facility projects that have been fully funded since 2004. How many of those projects ended up costing more than the original projection?

Mr. ORNDOFF. Sir, I do not have the specifics on that. I could certainly get it for the record.

I think it is fair to say that all projects were delivered within, ultimately, what was the approved budget. In some cases, we had an extremely aggressive market in the construction industry. It is hard to believe with today's news, but in the not too distant past there was a very tough construction market. We had very difficult times getting competition on our projects. Incredible as it may seem to have multi-hundred million dollar projects out where in some cases we had one or two proposals on a project.

Senator BURR. Would you, for the record, provide me that number that went over budget?

Mr. ORNDOFF. Yes, sir.

Senator BURR. In addition, would you add to that how the VA tracks the accuracy of its construction budget forecast?

Mr. ORNDOFF. Yes, sir.

Senator BURR. And more importantly, how the VA tracks delays in construction, as well.

Mr. ORNDOFF. Right.

Senator BURR. I appreciate it.

Mr. ORNDOFF. And just to be clear, sir, you are talking from the original budget?

Senator BURR. Of those 36 projects since 2004, I would like to know how many were over budget. From a standpoint of the ongoing process at VA, what your method is to track the budget relative to what was forecasted.

Mr. ORNDOFF. Yes, sir.

Senator BURR. And track delays in construction.

Mr. ORNDOFF. Yes, sir. Will do.

Senator BURR. Thank you. Thank you, Mr. Chairman.

[The response to additional information requested during the hearing follows:]

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Burris.

Senator BURRIS. Thank you, Mr. Chairman.

Mr. Chairman, I would like to indicate that we will be submitting some questions for the record because I have points that may not have all the data. I was wondering if Mr. Orndoff is familiar

VA Completed CARES Major Construction Projects

($ in 000's)

Location		Project Description	Original Total Est. Cost	Current Total Est. Cost	Contract Award Date	Original Contract Completion Date	Extended Contract Completion Date	Actual Completion Date
Project Complete								
Chicago	IL	Modernize Inpatient Space	$98,500	$98,500	Sep-04	Jun-07	Dec-07	Feb-08
Columbus	OH	New Outpatient Clinic	$94,800	$94,800	Jul-05	Mar-08	Sep-08	Sep-08
Durham	NC	Renovate Patient Wards	$9,100	$9,100	Sep-07	May-09	Jun-09	Jun-09
Los Angeles	CA	Seismic Corrections - Bldgs. 500 & 501	N/A	$7,936	Canceled	Canceled	Canceled	Canceled
Minneapolis	MN	SCI & SCD Center	$20,500	$20,500	Sep-05	Feb-09	Feb-09	Oct-08
North Chicago	IL	Surgical Suite / Emergency DoD Sharing	$13,000	$10,652	Sep-04	Jun-06	Jul-06	Jul-06
Pensacola	FL	Pensacola Outpatient Clinic	$55,056	$55,056	Mar-05	Jun-07	May-08	May-08
San Diego	CA	Seismic Corrections - Bldg. 1	$48,260	$47,874	Sep-05	Jun-08	Aug-08	Apr-08
San Francisco	CA	Seismic Corrections, Bldg. 203	$41,500	$41,168	Jan-06	Aug-08	Feb-09	Feb-09
Tampa	FL	SCI Expansion	$7,100	$11,407	May-06	Dec-07	Dec-07	May-08
Tucson	AZ	Mental Health Clinic	$12,100	$13,711	Sep-09	Apr-08	Jul-08	Jul-08

Original Contract Completion Date is the Date given on the Day 1 Schedule
Extended Contract Completion Date is the Orginal Completion plus approved contract changes

with what is happening in Danville, Illinois, at that facility. Have you had any direct contact with the VA Hospital in Danville?

Mr. ORNDOFF. Direct contact? Do we have a project there? I am not sure.

Senator BURRIS. Yeah, well, what the director there is saying is that a lot of the buildings are old, and they are seeking to have this expansion program.

Mr. ORNDOFF. Yes, sir.

Senator BURRIS. And I just wondered whether any of that has been brought to your level as of yet. They have a great innovative program going on in Danville with reference to housing, where they are providing community housing for our veterans. It is not really assisted living because it is almost independent living. And they have at least two of those housing developments up and running where at least 10 veterans can be served at these homes. And that has all been approved, which I thought was a very, very innovative program for some of our aging veterans.

And, they also have these older facilities, because that is one of the best run—because I have visited several of the hospitals in Illinois, and I was very impressed with what is going on in Danville, except for the condition of the facilities. There is such a need to upgrade. Some of them are probably total reconstructions.

So, we will be submitting this information to you if you do not have it. We will certainly follow up.

Mr. ORNDOFF. Yes, sir. I would like to take that for the record and give you a full response.

[This information is held in Committee files.]

Senator BURRIS. Thank you. And to Ms. Fate, you mentioned you are working on some 8(a) programs. Now, in any of this construction, are you all looking at any type of set-aside contracts for minorities and women in your construction process? What are the requirements there?

Mr. SULLIVAN. I do know that we have a lot of our contracts focus on the set-asides, including minorities and women. I do not have the specifics, but we have our targeted socioeconomic goals. So, we can take that for the record, again, and get back with you on what those are.

Senator BURRIS. I would like to know specifically what minorities have gotten any work on contracts or any of the VA projects—minorities and women—and what is your percentage of that; and how is your process in reference to selecting those particular contractors.

Mr. SULLIVAN. We will take that for the record.

[This information is held in Committee files.]

Senator BURRIS. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much.

Senator Johanns.

Senator JOHANNS. I, as you know in my opening statement, went through some of the challenges we are facing in the Western Iowa-Omaha facility.

As I understand it, a feasibility study has started with that facility, and I think it has been completed. Does anybody on the panel know the status of that?

Mr. ORNDOFF. Yes, sir. Ms. Fate would like to respond.

Senator JOHANNS. Great.

Ms. FATE. Thank you, Don.

Yes, sir. We received the feasibility study and final recommendations at the beginning of May. So it is four volumes—a very thick book—very thick four books. And we are looking through that and we anticipate having a recommendation for VA, hopefully, by and within the next couple of months.

In the meantime, though, due to concerns raised by Senator Nelson of the potential patient safety concerns with the HVAC, working with GLHN—who is the contractor for the study—they garnered enough information from their analysis to provide us a very basic project just to replace the HVAC, which is $90 million. And VA is committed to ensure that that basic project at a minimum is submitted for or approved for VA in fiscal year 2010 to ensure that we are being proactive to mitigate any patient safety potential issues that might occur at that facility.

But, we want to fully vet that study to ensure that we are moving forward with the right plan—with the best plan for the veterans. We just haven't had a chance to go through all four volumes.

Senator JOHANNS. OK. Once that is done, kind of walk me through the process of what happens next, and maybe even—I know it is hard to tell me timelines—but if you could help me understand kind of where we are in the process and where we go from here.

Mr. SULLIVAN. Sure, Senator. What will happen is once the need has been verified through the study and the best way to address services is made, a resulting capital project will more than likely come forward. If it is more of a maintenance issue, in terms of HVAC and electrical, it may be handled through the nonrecurring maintenance program Ms. Fate spoke about, which was the $90–100 million dollar solution.

Should one of the options look at replacing the entire facility or moving the facility, that project then will be put through the 2011 budget formulation process where they will decide on an option and submit, if you will, a concept paper and application for that project. That project then will be evaluated against all the other projects that are coming in the 2011 process.

In 2010, as Mr. Orndoff referred to where there are 66 projects that came in for full evaluation—it was a larger number than that, which went through a full evaluation—that will go through that process as well. That happens during the summer. In about a month or two that process will move along for 2011. And as the budget formulation process continues through July and August, that listing will be submitted to the Secretary. There will be a decision made by the VA of what to submit to OMB for 2011, which usually happens in the first week of September. It goes through the OMB evaluation process sometime in December. Pass back will happen from OMB where VA will get either a list of projects approved by OMB or a funding allocation, and then that decision will then be wrapped into the President's Budget submission up to the Hill here in the first week of February.

Senator JOHANNS. OK. Let me, if I might, just to wrap up my questioning here, focus on this hoped for relationship with the med-

ical centers in Omaha and the VA. You know, I have such confidence in what Creighton and the University of Nebraska Medical Center do; and they really want to help here. They tell me every time I see the leader of those programs, "Gosh, we want to be on a team to help."

Do you see that as a positive? And just in terms of advice to the community, how does that interface with what you have just described for me?

Mr. SULLIVAN. I think the major—I will defer to Ms. Fate—the major positive in terms of working with the community would be on the services, and how those services will be delivered, and where those services will be delivered in terms of formulating the optimal solution.

So, in terms of them working with the medical center staff and the VISN staff, that would be helpful in terms of determining where those services should be and what is the best service delivery vehicle—you know, whether it be in a VA-owned building, in a renovated VA-owned building, in a shared building. So, I mean, that is on the ground. When they define those requirements, that is the best place for, I believe, that interaction to happen.

Senator JOHANNS. When you are ready for that, I hope you will reach out to Senator Nelson's office, my office, Congressman Terry's office for that matter because we—you know, in our State we just work together on these issues.

And the other thing I would say as I look through some of the challenges that we have here, they seem to be quite traumatic. Now, I think in what you are doing you are probably feeling like you do triage every day because there are old facilities out there. They do need complete replacement in many, many cases. This one dates back to the 50's. It is old. Its space requirements and its plumbing are problematic. You could probably say, you know, Mike, we've got a lot on the list like that.

But, what I want to say is this. The Medical Center, myself, others, are willing to try to put together—working with you, working under your direction—a plan that I think really would provide first-class medical care. And we are excited about Colorado and this and that, but 10 hours away for medical care is not a workable solution to this problem. We just simply need something here to try to deal with a facility that probably long ago outlived its useful life.

And the most important message I can deliver is as you are working through this, we do not want to interfere but we want to try to be a partner in what you are doing. OK?

Mr. SULLIVAN. Yes, sir.

Senator JOHANNS. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Johanns.

Senator Begich.

STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you, Mr. Chairman. I apologize. I will have to leave in a few minutes to go preside, and if these questions have already been asked I apologize.

I caught a little bit of what Senator Burr was talking about. I want to follow up on it. And I want to first say thank you for the

facility in Alaska—the new one that just opened up in the Matanuska Valley—the clinic there. It is kind of a partial clinic but it is a very good center and well received. People are very excited about it. I know you have others planned in Juno and elsewhere.

You know, after being almost 6 years as a mayor, and I am just trying to figure out how with the stimulus money you are going to achieve—and if I get these numbers wrong I apologize because I just caught part of the conversation. You have spent maybe $27–30 million and you are trying to get to 40 percent of the stimulus numbers expenditure by end of September/October 1, give or take, somewhere right in there.

Reassure me—I know this discussion occurred a little bit ago—how are you going to do that? It is a sizable amount. You have very diverse facilities all across the country. I know as a mayor what we do and how we have to do it in regards to our fees and we have to be very aggressive about it. And it means that you have to have full force focus, not just normal course of business. Give me a couple of comments on that and then I will have some additional follow up.

I do not know who wants to respond to that.

Mr. ORNDOFF. Maybe if I could just make an opening comment and I will let Ms. Fate speak to it, as well.

We have a network of acquisition professionals across VA that essentially support every local medical center and certainly every VISN. That business model is ramping up fast and understands the requirement to execute within these timelines and has the strategy to do so. As Ms. Fate was mentioning earlier, we are marshaling the troops. We had some initial startup issues, but we fully understand the requirement and the need to execute not only to obligate the funds, but also to get the output of those projects which will make our medical centers better for our veteran care.

So, we have the infrastructure in place. It was not, of course, sized to this to address this bow wave of requirements that came somewhat unexpectedly, but we are making—certainly, marshaling the troops and understand that those are the goals and objectives. And we certainly have a commitment to make that.

Let me see if Ms. Fate has additional thoughts.

Ms. FATE. Sure. Thank you, Don. Sir.

One of the tasks that was first given to us about a month ago—or 2 months ago, I'm sorry—was to ensure that NRMs—both the normal ones through the fiscal year 2009, as well as the stimulus—are the contracting's first priority. The contracting staff in the field have made it their first priority. They have been given overtime, they have been given comp time to work on the weekends and such to ensure that these obligations are on track. And they are very aggressive and pursuing obligations throughout the year.

And to ensure that by the end of this year we do not only meet the 80 percent rule for our normal Nonrecurring Maintenance (NRMs)—which is, I guess, the 20 percent rule for obligations in August and September—but it also ensures that we have the stimulus funding obligated at least by 40 percent.

But, the contracting officers have also other responsibilities that they are working—that have been delegated down to them. It used to be that projects came forward to the central office once they

passed a certain level—$500,000 or $5 million dollars. A new process started back in the January-February timeframe that has delegated a lot of those tasks to the local level so it increases the efficiencies of them getting the jobs done and oversight. And they put additional taskings for senior contracting officers so that contracting officers were not burdened with all of the tasks, but that they leveled it out so that they could be more aggressive.

So, many steps have been taken at the local level to ensure that these projects have been the primary focus to ensure obligations.

Mr. SULLIVAN. And I would just say, Senator, that each of these projects were identified and submitted to Congress. Also, every week each project is updated and reviewed with the senior contracting official to ensure that the project is staying on schedule. Or if there is an issue with the project, whether it be legal or technical, that the appropriate resource from General Counsel or the Procurement side, as Mr. Orndoff said, is brought to bear so that they are tracked and reported on weekly and sometimes twice a week.

Senator BEGICH. Let me—if I can just quickly end on this, and again, if you are repeating information, I apologize.

If I caught your word right, it is 40 percent obligated.

Mr. SULLIVAN. Yes.

Senator BEGICH. Not expended. Right? Because obligation and expenditure are two different things. So, you will have it associated with a project but not in the field necessarily working the project. Am I right?

Mr. SULLIVAN. No, obligated means an actual legal contract award. Someone is selected. They have been given notice to proceed.

Senator BEGICH. Proceed. OK.

Mr. SULLIVAN. Expenditure would be actually paying the bill after the work is completed or put in place.

Senator BEGICH. So obligation—the 40 percent obligation level will mean that contracts have been awarded. I want to repeat what you said just to make sure we are clear. Awarded. Notice to proceed has been given, whatever that timetable is. But notice to proceed to the individual contractor or contractors. Yes?

Mr. SULLIVAN. Yes.

Senator BEGICH. And then last, getting at a later time, I would be very curious, following up Senator Burris on the 8(a) components and how you utilize those. I know the Corps of Engineers utilizes 8(a)s—at least Alaska Native 8(a)s—very successfully in getting projects out and done quickly, because of weather conditions; and very efficiently and very cost effectively. I would be very interested in how you utilize 8(a)s in the competitive process, but also in a sole source process.

Again, the Corps has an incredible record—a positive record—of sole source 8(a)s because of weather conditions, especially in Alaska and how they utilize 8(a)s. So I would be very curious of how you use that and the advantage or disadvantage. If you can share that with me at a later time.

Mr. SULLIVAN. We also use what is known in VA as SDVOs—the Small Disadvantaged Veteran Owned businesses—also in that same category.

Senator BEGICH. Great. Could you give me an update in response to this question on 8(a)s: what is your percentage of hit on that. Is it 3 percent you are trying to hit?

Mr. SULLIVAN. The Agency goal?

Mr. ORNDOFF. Yeah.

Senator BEGICH. That's OK. You can just give me—I do not want to burn up time, Mr. Chairman—give me that along with the 8(a) information that would be greatly appreciated.

Mr. SULLIVAN. Yes, sir.

Senator BEGICH. Thank you, Mr. Chairman.

[This information is held in Committee files.]

Chairman AKAKA. Thank you very much, Senator Begich.

Mr. Orndoff.

Mr. ORNDOFF. Yes, sir.

Chairman AKAKA. Let me ask my last question on CARES.

Mr. ORNDOFF. Yes, sir.

Chairman AKAKA. CARES was a very data-rich, multi-layered process that involved a great deal of community input and outside review. How much community input and outside review do you seek presently?

Mr. ORNDOFF. Well, I think the main source of outside input happens at the local level—the stakeholders locally, the veteran support organizations, veteran patients. There is a process of a continual dialog in different forms that are developed to try to get input from veterans in the veteran support organization of what are the real priorities that the local medical centers should be focused on in order to provide better care for veterans.

That input very much influences the development of projects coming forward. Once it gets to the central office level here in D.C., the headquarters of VA, we look at that list in aggregate, of course, and go through a prioritization process. Yesterday, there was discussion in a hearing about more involvement of VSOs in the prioritization process, and we are going to look at how we might do that.

But, I think the real dialog happens locally. I have been personally involved and in the room giving briefings to local veteran service organizations on projects. New Orleans is a good example. It is a very spirited discussion and you get lots of good input. I think it definitely helps shape the direction we move on our facility solutions to support veterans.

Chairman AKAKA. Thank you. I have many more questions which I will submit in writing reflective of how important good construction planning is.

So, Senator Burr, do you have any? Senator Burris?

Senator BURRIS. Yes, Mr. Chairman. To Ms. Fate.

I just hope that that data I requested of you will be broken down by categories—Blacks, Hispanics, Asians, women—in terms of their ability to have received—and you can select a period of time—these projects.

Ms. FATE. Yes, sir.

Senator BURRIS. Just how many of those projects are going to minority contractors.

Ms. FATE. Yes, sir. We will break it down as far as we can.

[This information is held in Committee files.]

Senator BURRIS. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burris.

I want to thank the panel for your responses. We certainly want to continue to work with you and try to move forward with these programs.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO THE U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Would VA benefit from a BRAC-like process which would bundle a variety of recommendations for the treatment of capital assets that would have to be accepted or rejected as a package?

Response. The Department of Veterans Affairs (VA) underwent a thorough evaluation of its capital portfolio known as the Capital Asset Realignment for Enhanced Services (CARES) initiative in 2004. CARES was a comprehensive analysis that produced recommendations for the strategic realignment of capital assets and related resources to better serve the needs of Veterans. CARES was not a simple one-time solution, but the creation of a set of tools and an evolving process for annual capital and strategic planning.

The CARES strategic planning process provided a system-wide, data-driven assessment of Veterans' health care needs within geographic markets, assessed the condition of the infrastructure, and produced recommendations for the strategic realignment of capital assets and related resources to better serve the needs of Veterans. The process identified the necessary infrastructure to provide high-quality health care to Veterans where it was most needed then and in the future.

In considering the treatment of capital assets, VA evaluates the direction initially set by CARES, and uses a process to continually update VA's plan for capital investments on an annual basis, based on changing Veteran demographics, advances in health care technology, analysis from internal modeling, and stakeholder input and evaluation. VA is currently updating this process to optimize VA's resource allocations, investment choices, and response to Veterans' needs. The process will consider a wide variety of inputs, generate options, and then learn from implementation to refresh planning on an annual basis. This process will consider lessons learned from CARES and the Department of Defense's (DOD) base realignment and closure (BRAC) process, and will give us the capacity to act on recommendations for the treatment of capital assets.

Question 2. What priority in the construction planning process is given to long-term care and mental health care?

Response. At the Department level of the construction planning process, serious mental illness is addressed within the main decision criteria "special emphasis". (See response to question 13 below for VA Decision Model). Special emphasis includes the following programs: 1) Traumatic Brain Injury (TBI); 2) Post Traumatic Stress Disorder (PTSD); 3) amputation/prosthetics; 4) serious mental illness (not mental health in general); 5) blindness; 6) spinal cord injury and disorders; and 7) polytrauma. The special emphasis major criterion carries the second highest priority weight in determining how construction projects are selected. In order for a project to receive points for special emphasis, 50 percent of the total estimated square footage of the project must be attributed to one or more of the seven programs.

VA addresses long-term care and mental health services with major construction, minor construction, non-recurring maintenance (NRM), and leasing program initiatives. Service gaps and related infrastructure needs are identified at the local level and may be addressed through a fifth construction program—clinical specific initiatives (CSI)—within the Veterans Health Administration (VHA). CSI is decentralized to the Veterans integrated service networks (VISN) for weighting and funding. This option consists of five high category project profiles: polytrauma, Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), long-term care, high-tech/high-cost, and mental health, which address access issues and typically increase space at a medical center. Many of the fiscal year (FY) 2009 CSI projects included long-term care and/or mental health services.

Question 3. More and more of the newest veterans are facing significant challenges with PTSD and Traumatic Brain Injury. How is the need for treatment of those conditions factored into VA's construction planning?

Response. PTSD and TBI are two programs listed under the special emphasis major criteria, which carries the second highest priority weight in determining the prioritization of major and minor construction projects. In order for a project to receive points for special emphasis, 50 percent of the total estimated cost of the project

must be attributed to one of the seven programs mentioned previously in response to question 2.

As with long term care, one of the five categories within the CSI program is polytrauma. While not every polytrauma patient has PTSD or TBI, the polytrauma umbrella incorporates these categories. The inclusion of polytrauma as a high-profile category for the CSI program allows an even greater emphasis for construction funding for these types of needs.

Question 4. What is the current backlog in construction, and how much money would VA need to be authorized and appropriated over the next five years to complete all currently planned construction?

Response. Assuming VA's FY 2010 major construction request ($1.2 billion) is fully funded and authorized by Congress; there would be a total of 20 ongoing major projects that would require an additional $5 billion to fully fund. The list of partially funded projects may be found in the VA FY 2010 budget submission—Construction and 5-Year Capital Plan (chapter 7, pages 166–168). This estimate does not include any new projects that may be identified through VA's capital investment process beyond 2010. The estimated backlog of major construction projects consists of partially funded projects from previous years and new projects. Approximately $3 billion is required to complete the partially funded projects.

Question 5. Please explain how maintenance projects are prioritized, and describe any difference from the way in which Major Construction projects are ranked?

Response. NRM and maintenance projects are considered station level projects. Both of these types of projects are delegated to the VISN for prioritization due to a significant variance of infrastructure needs throughout VHA. The focus of these two programs is to correct, replace, and/or upgrade infrastructure systems, such as boiler plant equipment; heating, air conditioning and ventilation equipment; electrical systems. These funds are also used to modernize and create state-of-the-art inpatient units and outpatient clinics within the existing medical center's envelope.

Major construction projects focus on access for either outpatient needs and/or special focus needs, such as spinal cord injury, PTSD, TBI, polytrauma. Major construction projects are prioritized on a national level based on seven main criteria described fully in response to question 13.

Question 6. Due in part to the shift in the health care delivery model from inpatient to outpatient-focused delivery, VA last year considered a Health Care Center Facility leasing initiative. What is the status of that initiative?

Response. The Health Care Center (HCC) initiative is part of the FY 2010 budget. There are 7 major leases under HCC (Butler, PA, Charlotte, NC, Fayetteville, NC, Loma Linda, CA, Monterey, CA, Montgomery, AL, and Winston-Salem, NC) in the authorization chapter.

Question 7. Leasing is a viable way to bring a new facility on line. What is the benefit of using a lease rather than constructing a new facility?

Response. VA looks at several alternatives when determining the best course of action to provide the appropriate infrastructure needed to provide service delivery. The alternatives considered include new construction, renovation, leasing, and contracting out for care. In some cases, leasing is the best option. A lease may:

- Provide needed infrastructure faster, as in those cases where VA leases existing facilities rather than having to plan, design, and build a new facility;
- Provide greater flexibility to change course of service delivery based on medical care advancements, workload or service type needs. For example, there may be a significant change in workload, and a lease (depending on terms) allows for more flexibility to make modifications, or in extreme cases allows for termination. New construction on VA grounds does not allow such flexibility;
- Be a more cost effective alternative; and
- Be the only viable option in some areas.

In summary, leasing may be the chosen alternative based on the availability of infrastructure, flexibility of terms, and functionality, and because it may be the most cost effective option to provide the services needed.

Question 8. Please provide an update on how often VA is entering into enhanced use leases, what the results have been with such leases over the last ten years, and the extent to which VA plans to continue utilizing this process.

Response. Since the inception of its enhanced-use leasing (EUL) authority in 1991.[1] VA has executed 58 EUL projects. In the last 10 years, VA has executed 45

[1] VA's enhanced-use lease (EUL) authority was enacted in 1991 in sections 8161 through 8169 of title 38, U.S. Code. With this authority, VA may lease land or buildings under the jurisdiction

Continued

leases (an annual average of 4.5 leases). Currently, VA has 49 transitional/permanent housing projects for homeless Veterans and 40 additional projects under development. An additional 15 market-driven sites identified through VA's site review initiative are under consideration.

Results: VA obtains several types of benefits from EULs, including cost savings, cost avoidance, revenue, enhanced services, and the use of additional space and buildings. VA documented—in an FY 2008 report—the consideration resulting from our EULs; the report describes each lease and its associated benefits. We provided a copy to the Government Accountability Office (GAO) and the Office of Management and Budget (OMB) and other individuals upon request. Cumulatively, since 2006, the EUL program has generated $146.5 million in total consideration to VA. In addition, VA has been able to use EUL as a capital asset tool to obtain 15 housing developments offering services for Veterans, i.e., homeless transitional and permanent housing.

Plans to extend EUL use: The current EUL authorization will expire in December 2011. VA will seek approval to extend the authorization to continue the EUL program. An extension will allow VA to continue pursuing over 100 projects now under development and to seek new projects that expand direct benefits to Veterans and the community, improve operations, and maximize resources while lowering operational costs.

Question 9. VA uses the Design-Bid-Build contracting process predominantly with large projects. Why doesn't VA use the Design-Build process for large medical clinics, which some argue would save time and money?

Response. VA does use design build (DB) for large medical clinics. It is an excellent delivery method and VA will continue to use it in the future as appropriate.

Since the construction contractor can start some construction activities while the architect engineering firm completes the construction documents, DB may save time in the overall project schedule, but may not always reduce the cost. DB is an appropriate delivery method for projects which have a well defined scope and the nature of the work is not too technically complex. Those projects that are complex or require extensive site acquisition and/or environmental remediation work are typically not well suited for DB. Since DB involves design and construction in a single contract, full funding must be available for this type of procurement to proceed. In some markets, the construction contractor community is not supportive of DB and thus VA needs to determine if qualified contractors are interested in competing for the work.

Not withstanding the limitations listed above, VA has extensively used DB in the past, such as with the outpatient clinic at Brevard, FL, and the ambulatory care buildings at SepuAE1lveda, CA, and Martinez, CA. Also, a number of the VA CARES projects (such as those listed below) used DB:

- North Chicago—VA/Navy Operating Room & Emergency Room Renovation
- Minneapolis—Spinal Cord Injury Center
- Tucson—Mental Health Clinic
- Columbus—Outpatient Clinic
- Pensacola—VA/Navy Outpatient Clinic
- Des Moines—Extended Care Building

Question 10. What is meant by the following statement from the Department's testimony: "VA's continuing program of recapitalization of these aging assets is very important to providing world-class health care to veterans now and into the future"?

Response. VA's service to Veterans is largely provided through our facilities across the Nation. These facilities are strategic assets that enable effective mission accomplishment for the delivery of Veterans health care and benefits. VA owns and operates one of the largest inventories of land, buildings, and leasehold interests in the Federal Government, including nearly 33,000 acres of land, over 5,400 buildings, 1,300 leased facilities (comprising approximately 159 million square feet of VA-occupied space). The average age of VA facilities is over 50 years old. Therefore, modernizing or replacing these assets through recapitalization investments is in an important component to ensure we provide Veterans with high-quality health care and benefits.

---

or control of the Secretary to a public or private sector entity for a term not to exceed 75 years. The leased property may be developed for VA and/or non-VA uses that will enhance the property, provided such uses are consistent with and do not adversely affect the mission of VA. The proposed leased property must include space for an activity that contributes to VA's mission, or follow a concept that provides for using consideration from the lease to improve health care services to eligible Veterans. Benefits to VA from an EUL may include rent, cost savings, cost avoidance, revenue, services, space, and buildings.

Question 11. Please provide a detailed description of the recommendations made by the CARES Commission and of Secretary Principi's Decision document, with a current status on each of the recommendations from the Decision document.

Response. Detailed information on the status of individual CARES decisions is provided in the CARES Implementation Monitoring Report, which is appended to this document.

[The Implementation Monitoring Report on Capital Asset Realignment for Enhanced Services follows the response to Question 18.]

Question 12. Written testimony contained the assertion that the tools and techniques acquired through CARES have become part of VA's standard operating procedures for strategic planning within our health care system. What are those tools and techniques?

Response. Through the CARES process, VA adapted its actuarial model to produce 20-year forecasts of the demand for Veteran health care services. Ongoing updates allow for more accurate projections of Veteran reliance on VA services. The data from the actuarial model is used to identify gaps between current and projected demand in services within each market using the health care planning model (HCPM), implemented as part of the 2008 VHA strategic planning guidance. The 10-step HCPM planning model facilitates the planning and monitoring of strategic initiatives to address gaps in projected health care demand.

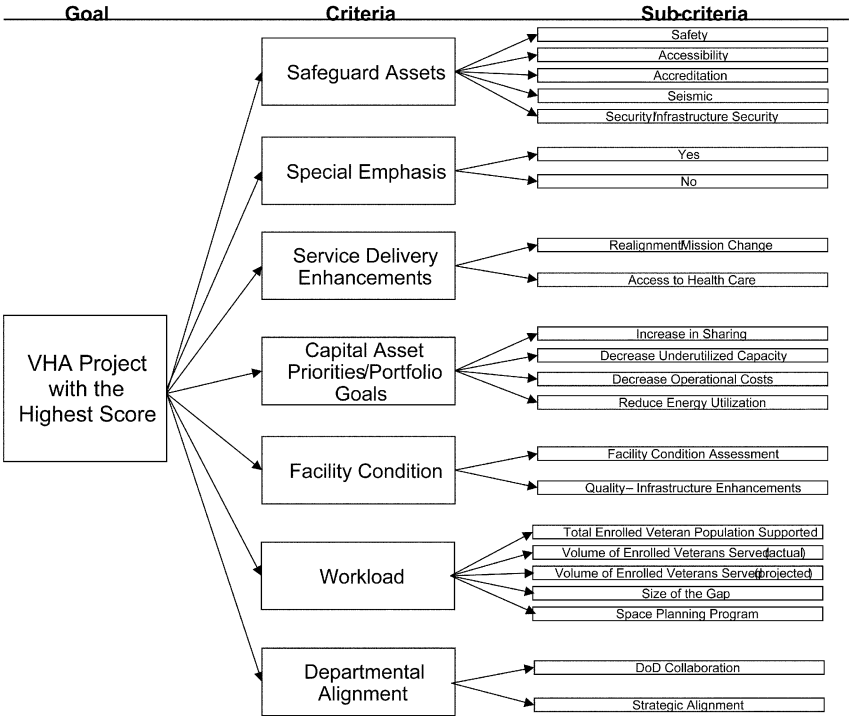
Question 13. In the Department's statement, it is noted that VA uses a "multi-characteristic decision methodology" in prioritizing its capital investment needs. Please describe with specificity what a multi-characteristic decision methodology is.

Response. The analytic hierarchy process (AHP), as depicted on the following page, is a tool VA uses to assist in evaluating and prioritizing capital needs. The AHP is a multi- attribute decision methodology that allows evaluators to consider a number of diverse criteria in reaching a decision. The AHP uses a hierarchical model comprised of a goal, criteria, and sub-criteria, and combines decisions using both quantitative and qualitative criteria. For example, the current VHA decision model (which is used to rank and prioritize construction projects) is comprised of 7 criteria and 20 additional sub-criteria.

The VA Capital Investment Panel (VACIP) (with representatives from across the Department) rates each project on how well it addresses each of the 21 scored elements based on answers provided in a standardized application form. Data requested in the applications includes quantitative data on workload, decreases in operating costs, and energy reduction, and qualitative data on realignments and the quality of infrastructure enhancements. In addition, many of the application questions require a combination of data, including metrics on the contribution to strategic goals and an explanation of those numbers. VA ranking and prioritization of construction projects are based on the VACIP's ratings, with final approval by the Secretary as part of the annual capital investment and budget process.

The VHA decision model for FY 2010 can be found on page 7.10–131 of VA's FY 2010 Budget Submission, Construction and 5 Year Capital Plan, Volume 4 of 4, May 2009.

FY 2010 VHA Capital Investment Decision Criteria



Question 14. In the last five years what "appropriate 'joint' VA/DOD projects" were evaluated to promote sharing and efficiency opportunities? Looking forward, what joint projects are being evaluated now?

Response. VA and DOD have evaluated several projects to improve collaboration and health resource sharing between the Departments (see list below). Potential projects include major construction, minor construction, and community based outpatient clinics (CBOC). VA evaluates and scores business plans for project proposals based on established criteria. One of the criteria is DOD collaboration. If a project has a DOD/VA collaborative component, it will receive a higher score and ranking overall than if it did not.

The VA/DOD Construction Planning Committee (CPC), a subcommittee of the Joint Executive Council, was created in 2003 to foster more collaborative capital efforts. The CPC is comprised of individuals with comprehensive knowledge of capital asset planning. It provides a formalized structure to facilitate cooperation and collaboration on VA/DOD capital projects. The CPC facilitates an integrated approach to construction planning initiatives that are beneficial to both Departments.

Collaborative projects over the past 5 years include:

Major construction

Biloxi, Mississippi (includes mental health services at Keesler Air Force Base)
Pensacola, Florida (outpatient clinic (OPC) at Cory Naval Air Station)
Denver, Colorado (possible DOD presence)
Anchorage, Alaska (OPC at Elmendorf Air Force Base (AFB))
North Chicago, Illinois (consolidating services with Naval Hospital Great Lakes)

Minor construction

Baltimore, Maryland (Fort Meade CBOC)
Martinsburg, West Virginia (Fort Detrick CBOC)
Honolulu, Hawaii (Guam hospital and VA CBOC)
Hilo, Hawaii (PTSD residential rehabilitation)
North Charleston, South Carolina (Goose Creek CBOC)
Eglin AFB, Florida (Eglin CBOC)

Community Based Outpatient Clinics

Charleston Naval Hospital, South Carolina (Goose Creek)
San Antonio, Texas (NE Bexar)
Fort Buchanan, Puerto Rico
Fort Meade, Maryland
South Prince Georges County, Maryland (Andrews AFB)
Fort Rucker, Alabama (Lyster Army health clinic)

The CPC serves to identify capital initiatives that may be suitable to enhance service delivery or decrease cost of asset procurement for both departments.

Potential collaborative projects being considered for the future include:

Major construction

El Paso, Texas (OPC at Fort Bliss)

Minor Construction

Panama City, Florida (CBOC)

Community Based Outpatient Clinics

Monterey, California
Colorado Springs, Colorado
Columbus, Georgia (Fort Benning)

Question 15. When VHA identifies "gaps" in capacity, does that refer to geographic gaps or gaps in ability to furnish certain types of care?

Response. When VHA identifies gaps in capacity it refers to the gap between current service volume and service volumes projected in the future (5, 10, 20 years) either in a geographic market or at a particular facility. Future gaps are identified and analyzed to determine whether health care systems serving any market have the capacity to accommodate the projected gaps, or if use of purchased care will be required, or a combination thereof. These and other environmental factors, such as geographic access, are examined to ensure VA provides timely and appropriate access to health care and eliminates service disparities.

Question 16. Who develops VA's "capital asset management priorities," and what are the current priorities?

Response. Oversight and policy for VA's capital asset management priorities/portfolio goals are the responsibility of the Office of Asset Enterprise Management. Developed collaboratively with key internal stakeholders, the capital asset management priorities provide a strategic framework to meet the objectives of VA's core mission and asset management—to provide a safe and appropriate environment for the delivery of benefits to Veterans in a cost-efficient manner. The current goals are: 1) decrease operational costs; 2) decrease underused capacity; 3) decrease energy use; 4) increase intra/inter-agency and community-based sharing; 5) increase revenue opportunities; 6) safeguard assets; and 7) maximize highest and best use of assets.

In FY 2005, VA implemented the Federal Real Property Council (FRPC) tier 1 goals in addition to the established capital asset priorities/portfolio goals. The FRPC goals are: 1) percent of space use as compared to overall owned and direct-leased space (relates to decrease in underused capacity; 2) ratio of operating costs per gross square foot (relates to decrease operational costs); 3) percent condition index of owned buildings; and 4) ratio of non-mission-dependent assets to total assets. FRPC goals and VA capital goals are closely related. VA capital goals are to: 1) decrease operational costs, 2) decrease underused capacity, 3) decrease energy use,[2] 4) increase revenue opportunities, 5) safeguard assets, and 6) maximize highest and best use. As a Federal Agency, VA is adopting green and environmental design principles in accordance with the mandates of Executive Order 13243, Strengthening Federal Environmental, Energy and Transportation Management. For example, all new construction and major renovation projects are being designed to meet sustainable building principles.

[2] To support additional capital goals to decrease energy consumption, increase use of renewable energies, and reduce the Department's carbon footprint, VA developed a comprehensive green management program. Over $400 million of VA's $1.4 billion in Recovery Act funds will be obligated toward renewable energy and energy efficiency projects. VA is dedicated to building sustainable facilities with energy efficiency and renewable energy standards as well as continuing to reduce VA's overall energy consumption. It is important to note that the Department will continue to place more emphasis on both energy and "greening" and environmental projects when prioritizing projects.

Question 17. What is the timeline for the multiple internal reviews before a decision is made to include a project in the President's budget for a fiscal year?

Response. The entire review process may take up to two and half years. Approximately 12 months prior to the first submission of a major construction project to VHA Central Office, the medical facility and VISN level planning take place. VHA Central Office staff review and prioritize all major construction applications, narrowing that list down to the top 20 or 25 projects. Those top 20–25 projects are then evaluated and prioritized by the VACIP, a sub-group of the Strategic Management Council (SMC). Results from the VACIP prioritization are submitted for approval by the SMC, the VA Executive Board, and finally the Secretary, as part of the internal budget process. Decisions from the internal budget process are used to develop the list of major construction projects that will be included in the annual budget request to OMB. Negotiations with OMB result in the final list of projects to be included in the Congressional budget submission. Exact timelines vary from year to year, and emergency or "out of cycle" high priority projects may also be expedited. A schedule for a typical planning cycle as follows:

Activity	Date
1) Medical facility and VISN planning	March 2007
2) Submission of major construction applications to VHA Central Office	March 2008
3) VHA Central Office review and prioritize applications	April 2008
4) VACIP reviews and prioritizes applications	June 2008
5) Approval by Secretary via the internal budget process	July 2008
6) Submission to OMB	Sept. 2008
7) Negotiations with OMB	Nov. 2008
8) Submission of Congressional budget request	Feb. 2009

Question 18. To what extent are the potential consequences of the overall health care reform effort being integrated into VA's current planning for new medical facilities?

Response. Health care reform has not factored into the planning of our facilities. New facilities and/or expansions of existing facilities result from a capital asset analysis starting with the need for more or less space due to changing projected workload, the current condition and age of the existing facility, and the type of services that need to be provided. These are the cornerstones of all of our projects.

VA Health Care

August 2009

Implementation Monitoring Report on Capital Asset Realignment for Enhanced Services

Veterans Health Administration
Office of Assistant Deputy Under Secretary for Health
for Policy and Planning

Contents

Foreword 1

Executive Summary 1

Background 2

CARES Decision Implementation and Outcomes 3

- Community-Based Outpatient Clinics 3
- Veteran Rural Access Hospitals 5
- Improved Access/Modernization 6
- Special Disability Programs 7
- Excess Property 8
- VA/DoD Collaboration/Sharing 9
- OneVA Collaborations 10

Future 11

Appendices A-F

Foreward

This report is being published to share the results of the Capital Asset Realignment for Enhanced Services (CARES) decisions that were made in 2004 and the 17 follow-on Business Plan Studies that were completed in Fiscal Year (FY) 2008. The Department of Veterans Affairs is monitoring the implementation and impact of CARES in order to determine its effectiveness in accomplishing its intended outcomes. This report is not all-inclusive of every CARES decision, but reports on the seven most significant issues that CARES set out to improve.

Executive Summary

Health care for Veterans is a key component of the benefits and services enacted by Congress in recognition of the men and women, whose military service and sometimes sacrifice, preserve and protect America's freedom. Neither medical science nor the Veteran population is static and unchanging, and the Department of Veterans Affairs (VA) must modernize its facilities to provide quality care. VA will fail in honoring our Nation's commitment to Veterans if our medical system does not evolve to meet their needs.

In 1999, the Government Accountability Office (GAO) reported on VA's aged and obsolete capital assets, noting that better management of these assets could significantly reduce VA's operating cost. In response, VA initiated its CARES process. Through CARES, VA sought to enhance care to Veterans by appropriately upgrading and locating VA facilities. CARES focused on capital requirements at a macro level by using projections of beds and outpatient visits organized by Strategic Planning Categories such as inpatient medicine, surgery and psychiatry, and outpatient primary care, mental health and specialty care. The CARES process systematically assessed the critical components that determine the future need for capital and services.

In March 2007, GAO examined the CARES process. Specifically, GAO examined how CARES contributed to the Veterans Health Administration's (VHA's) capital planning process, the extent to which the CARES process considered capital asset alignment alternatives, and the extent to which VA has implemented CARES decisions and how this implementation has helped VA carry out its mission. GAO found that although VA has started implementing some CARES decisions, it did not centrally track the implementation of all the CARES decisions or monitor the impact such implementation had on its mission. GAO also stated that without this information, VA cannot readily assess the implementation status of CARES decisions, determine the impact of such decisions, or be held accountable for achieving the intended results of CARES.

In response to the GAO report, "VA Health Care: VA Should Better Monitor Implementation and Impact of Capital Asset Realignment Decisions," the Under Secretary for Health (USH) chartered a VA-wide work group to develop a plan for tracking the effectiveness of CARES. This report is the final product; a review of the most significant issues and recommendations identified in the CARES Decision document.

VA has made significant progress since 2004, and continues to assess the best way to adapt its health care system with more than 4,900 buildings on 15,000 plus acres of land. Since the

publication of the CARES Decision document in 2004, VA has increased access to primary care, decreased the amount of underutilized space and buildings, and increased the number of special disability programs for Veterans.

Background

Over the past decade, Veterans' health care has undergone a dramatic transformation, shifting from predominantly hospital-based care to a greater focus on outpatient care. As care was shifted to outpatient settings, VA was left with an increasingly obsolete infrastructure, including many hospitals built or acquired more than 50 years ago in locations that are sometimes far from where Veteran populations live. To address VA's aging infrastructure, VA designed the CARES process to provide a data-driven assessment of Veterans' health care needs in order to enhance health care services over a 20-year planning horizon. The multi-step process was the most comprehensive assessment ever undertaken by VA to determine the capital infrastructure needed to provide modern health care to our Nation's Veterans.

In March 2007, the GAO report, "VA Health Care: VA Should Better Monitor Implementation and Impact of Capital Asset Realignment Decisions," examined the CARES process. GAO recognized that VA started implementation of CARES decisions, but did not centrally track implementation or use performance measures to assess its impact and effectiveness. VA concurred with GAO's report, and in November 2007 the USH established a VA-wide CARES Implementation Monitoring Work Group. The work group identified existing and new output and outcome measures and established a plan to monitor the implementation and impact of CARES decisions specific to the 2004 CARES Decision document and the subsequent 17 Business Plan Studies. These decisions are being monitored and organized according to the following issues[1].

1. Improve access to care by establishing new sites of care through Community-Based Outpatient Clinics (CBOCs).
2. Establish clear definition and policy for Critical Access Hospitals (CAHs).
3. Modernize VA's infrastructure and correct seismic/life safety deficiencies.
4. Ensure inter-Veterans Integrated Service Network (VISN) collaboration in developing placement options for special disability programs (Spinal Cord Injury Programs and Blind Rehabilitation Centers).
5. Dispose of excess property or identify reuse options to maximize return on investment.
6. Identify and act on available sharing opportunities with the Department of Defense (DoD).
7. Maximize the use of VA assets to meet the service delivery goals of VA's Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA) through OneVA collaborations.

The following report represents the implementation status of CARES decisions year-to-date FY 2009. The impact measures, consistent with the monitoring plan, are reported as of the end of FY 2008.

[1] Please see Attachment 1 for a comprehensive review of the above issues, implementations, impact measures and data sources

It is also important to point out that VA is investing an estimated $4.8 billion in CARES major construction initiatives specific to the 2004 CARES Decision document and subsequent Business Plan Studies. These investments lead to a number of additional CARES-related projects that have an additional estimated cost of $4.6 billion. These CARES-related projects were not specifically mentioned in the 2004 CARES Decision document or the follow-up Business Plan Studies, but instead were identified and selected through VA's ongoing capital investment process and are reflected in VA's budget submission. All construction projects were prioritized and ranked using established VA Capital Investment Decision Methodology, which is firmly based in the principle of identifying performance gaps and selecting the optimal means (new construction, renovation, contracting out, leasing or combination of) to best deliver quality health care services to Veterans. The status of these CARES-related projects can be found in the FY 2010 Budget Submission.

CARES Decision Implementation and Outcomes

1. Community-Based Outpatient Clinics

The CARES Decision document included several positive recommendations regarding CBOCs, and VA continues to act to ensure they are met. To that end, VA revised its national criteria for establishing CBOCs to include emphasis on the importance of access to care for rural Veterans, use of travel guidelines to assess access to care, the availability of mental health services, and the flexibility for VISNs to relieve space deficits at crowded parent facilities by moving care to a nearby outpatient annex clinic. Table 1 illustrates drive time access, which provides a measure of the enrollees and patients in the categories of primary care, acute care, and tertiary care in travel time bands of minutes from the corresponding type of care.

Table 1: VA Guidelines for Health Care Access

Type of Care	Time Criteria (Minutes)	Threshold Criteria (%)
Primary Care	30 Min. - Urban 30 Min. - Rural 60 Min. - Highly Rural	70%
Acute Hospital	60 Min. - Urban 90 Min. - Rural 120 Min. - Highly Rural	65%
Tertiary Care	240 Min. - Urban 240 Min. - Rural Community Standard - Highly Rural	65%

In the 2004 CARES Decision document, VA determined that 156 new CARES Priority CBOCs would be opened by the end of FY 2012. It should be noted that as of the end of the second quarter FY 2009, VA has 768 CBOCs in its current portfolio. VA measures both the implementation and impact of activating these CBOCs on improving access.

Implementation Measure: VA's implementation measure is the total number of the 156 CARES Priority CBOCs that have been activated and serving Veterans. As of third quarter FY 2009, 54 new CBOCs have opened and 74 have been approved to open by 2011. In addition, two CBOCs planned within 30 minutes of each other were consolidated to better meet Veteran needs (Galveston site 2 consolidated with Galveston County and opened in FY 2005, and Radford consolidated with Bluefield creating Wytheville which was approved for FY 2009). One CBOC is pending approval for FY 2012.

As a result of the 2008 Strategic Planning Guidance cycle, VA developed a methodology for identifying strategic locations for CBOCs across the system. This methodology evaluated the convergence of low access (as measured by internal drive time guidelines to primary care services) and high projected demand for services. This methodology, along with an application process and an expert panel review, has become the standard approval process prior to submitting a business plan for a new CBOC. To this end, 25 CBOCs were removed from the list of 156 Priority CBOCs since it was determined that the needs of these Veterans were being met through other established CBOCs or outreach efforts.

Table 2: Summary of CBOC Implementation

CBOC Summary	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11	Total
Opened	3	5	3	15	24	4			54
Approved						60	10	4	74
Consolidated						1		1	2
Pending Approval							1		1
Removed					25				25
Total	**3**	**5**	**3**	**15**	**49**	**65**	**11**	**5**	**156**

Impact Measure: The impact of the CARES Priority CBOCS is measured by the change in market-level enrollees within primary care access guidelines from pre-activation to post-activation. Of the 54 CARES Priority CBOCs currently opened, 11 can be measured by comparing FY 2003 to FY 2007 geographic access data. Implementation of those 11 CBOCs in 9 markets increased market-level enrollees within 30 minutes of a primary care facility by 7 percent nationally [2].

Table 3: CBOC Implementation Status

VISN	Location	Market Name	Activation Year	Pre-Activation enrollees	Post-Activation Enrollees	Market Level Increase[3]
9	Logan County	North	2004	75,819	78,353	3%
16	Mena	Upper West	2004	117,490	124,980	6%
16	Columbus	Central Southern	2004	76,821	82,809	8%
7	Goose Creek	Southern Central	2005	80,431	91,739	14%
15	Hanson	East	2005	86,541	92,176	7%
16	Galveston County	Central Lower	2005	101,642	111,949	10%

[2] FY 2003 data was compared to FY 2007 to calculate percent increase in enrollees within 30 minutes of a primary care facility pre activation to 12 months post activation

[3] Percent of market-level enrollees within primary care access guidelines pre-activation to 12 months post-activation

16	Hammond	Central Southern	2005	76,821	82,809	8%
21	San Bruno	South Coast	2005	64,628	65,175	1%
7	Athens	Georgia	2006	88,285	95,472	8%
7	Bessemer	Alabama	2006	80,508	85,651	6%
16	St. Johns	Central Southern	2006	76,821	82,809	8%

In addition to the 11 CBOCs noted above, there are an additional 39 CBOCs that opened in FY 2007 and FY 2008. These CBOCs will be analyzed next year when post-activation FY 2008 geographic access data is available to calculate the impact[4].

The actions taken as a result of CARES complement existing CBOC criteria that include a focus on caring for Priority 1–6 Veterans, ensuring that VISNs have necessary funds to operate new sites, developing well conceived business plans before implementing new sites, ensuring new CBOCs will increase access to care, and other factors. A more rigorous methodology to plan sites of care is being utilized to identify markets with the highest projected demand for primary care and mental health services in combination with limited access (i.e., enrollees outside the drive-time guidelines). Further, VA continues to explore opportunities to improve management of existing CBOCs through more effective staffing, expanding hours of operation, and examining opportunities to augment services where appropriate.

2. Veteran Rural Access Hospitals

The CARES Decision document tasked VA with establishing a clear definition and policy on CAH designation prior to making decisions on the use of this designation. Recognizing that some small and rural facilities will be unable to maintain the workload necessary to perform certain surgical procedures or manage some complex illnesses effectively, VA must establish parameters to ensure high quality patient care.

In response, the Secretary appointed a work group in 2004 that developed VHA Directive 2004-061, Veterans Rural Access Hospitals (VRAHs). VRAH are VHA facilities providing acute inpatient care in rural or small urban markets where access to health care is limited. It is VHA's policy that the market area cannot support more than 40 beds and the facility is limited to not more than 25 acute medical and/or surgical beds. Such facilities must be part of a network of health care that provides an established referral system for tertiary or other specialized care not available at the rural facility. The underlying principle is that the facility must be a critical component of providing access to timely, appropriate, and cost-effective health care for the Veteran population served. The activation and operation of a VRAH will be similar to that of any other VA hospital. The designation of a facility as a VRAH does not remove or diminish that facility's responsibility in meeting appropriate VHA requirements, directives, guidance, etc. It is VHA policy to determine and monitor the scope of services to be performed at its VRAHs (specifically, those procedures that are complex in nature), and to establish parameters for how these facilities need to prepare to meet future challenges.

VHA holds VRAHs to the same external accreditation standards and internal quality measures, such as the National Surgical Quality Improvement Programs (NSQIP), credentialing and privileging requirements, utilization management, risk management, patient safety program

[4] A complete list of CARES Priority CBOCs with current status can be located in Appendix A

goals, and other VA quality, safety, and cost-effectiveness measures, as any other VHA facility.

Implementation Measure: As a result of this directive, VHA identified eight VRAHs (Altoona, Erie, Beckley, Dublin, Poplar Bluff, Cheyenne, Grand Junction and Hot Springs). VA revalidated the eight sites in 2007 and established parameters to monitor the scope of service performed at these facilities.

3. Improved Access/Modernization

The CARES Decision document identified approximately 89 areas for VA to improve VA's infrastructure and to improve inpatient care access[5]. Of these, 35 were identified to improve access to inpatient services, while the other approximately 54 projects dealt with issues of modernization.

Of the 35 areas identified to improve access to inpatient services, 15 locations improved access through existing authorities and policies to contract for care while the remaining 20 projects are major or minor construction projects. Of the 15 sites identified for contracting initiatives, 6 sites have reported access improvement through use of local contracting authorities. Most notable of these sites is the Phoenix Veterans Affairs Medical Center (VAMC) which currently has a 20-bed Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) contract while awaiting completion of a new mental health building.

Table 4: Modernization/Improved Access Summary

Modernization/Improved Access Status	
Improved Access	
Contract Care	15
Major/Minor Construction Projects	20
Subtotal	35
Modernization Projects	
Seismic/Life Safety	13
Major/Minor Construction Projects	41
Subtotal	54
Total	**89**

Of the 54 modernization projects, 13 aim to correct seismic/life safety deficiencies at six sites (San Juan, American Lake, Palo Alto, Menlo Park, San Francisco and San Diego) and are currently under construction. The remaining 41 modernization projects are being addressed through major and minor construction projects.

Impact Measure: The impact of the Improved Access and Modernization projects can be measured by comparing FY 2008 actual to planned total modernization costs. The FY 2010 Budget Submission was used to establish the actual to planned appropriations. In FY 2008, approximately 57 percent ($2.4 billion of the $4.2 billion) of the total planned amount have been appropriated on improved access and modernization projects. For example, in Pittsburg, 79 percent of $295 million planned for modernizing facilities at University Drive and Heinz campuses has been expended.

[5] A list of Improved Access and Modernization decisions is in Appendix B

4. Special Disability Programs

VA is a leader in the treatment of individuals with Spinal Cord Injury/Disorders (SCI/D) and visual impairments. VA uses an integrated network of care based on a hub and spoke model to care for SCI/D patients. Comprehensive interdisciplinary primary and specialty care is located at designated SCI Centers (hubs). Locally accessible primary care is provided at local VA facilities (spokes).

There are 10 Blind Rehabilitation Centers (BRCs) throughout the country structured to serve visually impaired Veterans in an inpatient environment. The 2004 CARES Decision document proposed expansion of both SCI/D Services and BRCs in order to sustain current services and respond to anticipated increases in demand for services.

Table 5: Special Disability Program Summary

Special Disability Program Status	SCI/D	BRC	Total
Opened	1		1
Planned	2	2	4
Expansion/Reallocation	8		8
Total	11	2	13

a. Spinal Cord Injury/Disorders

SCI/D Services mission is to support and maintain the health, independence, quality of life, and productivity of Veterans with SCI/D throughout their lives. This mission is accomplished through rehabilitation, sustaining medical and surgical care, patient and family education, psychological, and vocational care, education, and professional training. VA has the largest single network of SCI/D care in the Nation providing a full range of care to Veterans with SCI/D.

Through CARES, 11 SCI/D projects were identified to address access issues and meet the increasing need for SCI/D services. VA planned to meet these needs through expansion and relocation of beds or construction of new SCI/D Centers. Of the eleven projects planned, one SCI Center opened in Minneapolis at the end of FY 2008 and two additional centers in Denver and Syracuse are in the design phase. As a result, VA will increase services and access to care by extending the network of care from 23 regional VA SCI Centers in 15 VISNs to 26 centers in 18 VISNs.

b. Blind Rehabilitation Centers

The mission of Blind Rehabilitation Centers is to coordinate a health care service delivery system that provides a continuum of care for blinded Veterans extending from their home environment to the local VA facility and to the appropriate rehabilitation setting. These services include adjustment to blindness counseling, patient and family education, benefits analysis, comprehensive residential inpatient training, outpatient rehabilitation services, the provision of assistive technology, and research

In the CARES 2004 Decision document, VA planned construction for two new BRCs in addition to the 10 current sites (Hines, Palo Alto, West Haven, American Lake, Waco, Birmingham, West Palm Beach, San Juan, Tucson and Augusta)[6]. The VISN 22 Long Beach, California facility is currently under construction and estimated for completion in FY 2011. The

[6] A list of Special Disability Decisions can be located in Appendix C

second facility planned for Biloxi, Mississippi, in VISN 16, has been approved for construction and estimated for completion in FY 2011. Another center planned for Cleveland, Ohio (not a part of the CARES initiative) is estimated to open in FY 2011 or FY 2012. In addition to the inpatient services provided to visually impaired Veterans at the BRCs, VA has 165 Visual Impairment Service Teams (VIST) and 75 Blind Rehabilitation Outpatient Specialists (BROS) located throughout the 21 VISNs, in addition to four Visual Impairment Centers to Optimize Remaining Sight (VICTORS) located in Kansas City, Missouri; Chicago, Illinois; Northport, New York; and Lake City, Florida, providing rehabilitation and retraining in community or home settings. In FY 2008 and FY 2009, VA rolled out 55 vision and blind rehabilitation outpatient clinics at several VAMCs and existing CBOCs to complement its existing comprehensive inpatient programs.

Impact Measure: The impact of the CARES Special Disability Programs is measured by the percent of VISN-level special disability units of care per 1,000 enrollees pre-activation to 12-months post-activation. Since the 2004 CARES Decision document, one SCI/D facility was completed and operational at the end of FY 2008. This center will be analyzed next year when post-activation data is available to calculate impact.

5. Excess Property

As a result of the 2004 CARES Decision document and the 17 Business Plan Studies, 26 VHA sites in 16 VISNs were identified to reduce excess space[7]. Specific decisions for reducing excess space at these sites included the demolition of vacant buildings, the realignment of underutilized space, and use of VA's Enhanced-Use Leasing (EUL) program. The EUL authority allows VA to lease land or buildings to private and/or not-for-profit entities for uses consistent with VA's mission.

Since 2004, the majority of the identified sites have reduced underutilized space compared to overall owned space between 5 percent and 97 percent. Examples of disposals include the demolition of 15,910 square feet of vacant space in Durham, North Carolina, to meet patient care and research needs, and the 552,241 square feet EUL in Leavenworth, Kansas, for an assisted living facility. Currently, 13 disposal and EUL projects are in various phases of the planning.

Impact Measure: The impact of the CARES Excess Property decisions are measured by the percent difference of station-level underutilized space, to overall owned space, compared to the FY 2004 baseline and the annual percent difference of station-level disposed square feet, compared to prior-year station-level disposed square feet.

Table 6 Excess Property Summary

Excess Property Status	
EULs Complete	17
EULs In Progress/Pending	8
Deferred	5
Total	**30**

[7] A list of Excess Property Decisions can be located in Appendix D

6. VA/DoD Collaboration/Sharing

VA and DoD have a long history of partnering to achieve more cost-effective use of health care resources, dating back to sharing authority legislation in 1982. Since then, partnerships have evolved to include joint ventures and joint efforts to construct or share medical facilities. Joint ventures have been designed to avoid duplication of medical facilities, expand access to services for Federal beneficiaries, and to curtail Federal health expenditures through economies of scale.

In the 2004 CARES Decision document, 74 potential sharing opportunities were identified, of which 24 were characterized as highly promising[8]. Of the 24 sites in 20 different states, VA and DoD are actively collaborating at 11 sites, have 10 sites underway in the planning stage and 3 sites that have been removed due to accessibility reasons.

In 1991, VA and DoD approved the base concept for what would be the oldest and largest joint venture between VA and DoD. What was initially conceived as a small Veteran's hospital adjunct to the DoD medical center, now is a vast multi-million dollar sharing agreement spanning inpatient and outpatient services and non-medical support. In 2000, the renovation of the E-Wing of DoD's Tripler Army Medical Center and the Ambulatory Care Clinic was completed, providing Veterans access to tertiary/acute and specialty services at Tripler Army Base. In addition to the Tripler Army Base in Honolulu, VA opened a CBOC in the American Samoa in FY 2007 which treats active duty DoD personnel through the Foreign TRICARE Program. VISN 21 also has a joint dialysis unit at Travis Air Force Base with Sacramento VAMC, and plans to complete expansion of inpatient psychiatry beds by the end of FY 2009.

VISN 20 currently has two completed joint venture sites at Madigan, Washington and Fairbanks, Alaska. In FY 2004, American Lake VAMC transferred beds to Madigan allowing VA patients to be treated in all beds not just a specific ward. In FY 2007, a sharing agreement was ratified between Fort Wainwright, Alaska, and the Anchorage VAMC, allowing VA the use of space at the new Bassett Army Hospital.

In VISN 17, VA and DoD are collaborating through the North Central Bexar County Clinic which was created as a VA/DoD joint incentive. This initiative allows VA's San Antonio Health Care System to share resources with the USAir Force to operate a VA/DoD staffed primary care clinic providing services to both VA and DoD beneficiaries. VISN 17 also operates a joint sleep clinic at Darnel Army Community Hospital.

Other collaborations included a VISN 6 sharing agreement completed in FY 2007 at Camp Lejeune to support inpatient care needs at Fayetteville VAMC, expansion of space at Fort Knox CBOC to implement a Soldier Readiness Clinic and increase the number of patients seen by each physician in VISN 9, construction of a new CBOC in VISN 10 built on donated DoD land, and collocated outpatient services next to Pensacola Naval Hospital in VISN 16.

[8] A list of the promising CARES VA/DoD collaborations is located in Appendix E

Table 7: VA/DoD Collaboration Summary

VA/DoD Collaboration Status	
Active Collaborations	11
Planning Underway	10
Removed	3
Total	**24**

7. OneVA Collaborations

VA has placed a great emphasis on maximizing the use of its assets to meet the service delivery goals of VHA, VBA and NCA through OneVA Collaborations. VBA is spending significant resources on rental space for Regional Offices while NCA needs to acquire additional land to prevent premature closure of national cemeteries. Through OneVA Collaborations, VBA has identified opportunities to reduce its rental costs by seeking to collocate on VA property, while NCA has been able to use excess vacant land adjacent to VAMCs to expand cemeteries.

The 2004 CARES Decision document originally identified 15 sites for internal collaborations between VHA, VBA, and NCA[9]. Of the 15 sites, VHA has collaborated with NCA on three projects (Mountain Home, Prescott, and Roseburg) to transfer land from VHA to NCA for expansion of national cemeteries. At the Mountain Home Campus VHA transferred approximately 50 acres of land to NCA for national cemetery expansion. In Arizona, VA has transferred land to NCA for expansion of the columbarium at the Prescott National Cemetery in addition to land transferred in Oregon from VHA to expand Roseburg National Cemetery.

VBA has collaborated with VHA on three projects since the CARES Decisions, which have resulted in the collocation of VA Medical Centers and VBA Regional Offices on the same campus at Newington VAMC, Columbia VAMC, and Louisville VAMC. Of the remaining collaborations, five (three NCA and two VBA sites) are in the planning stage, and four sites have been deferred.

As opportunities arise VA will seek to improve services to Veterans by vigorously pursuing One/VA opportunities to maximize sharing of VA resources to make better use of taxpayer's funds.

Table 8: OneVA Collaboration Summary

OneVA Collaborations Status			
	NCA	**VBA**	**Total**
Completed	3	3	**6**
Planned	3	2	**5**
Deferred	3	1	**4**
Total	**9**	**6**	**15**

[9] A list of CARES OneVA Collaborations can be located in Appendix F

Future

Through the CARES process, VA has enhanced access to care in underserved areas with large numbers of Veterans outside of access guidelines and in rural and highly rural areas. VA has also enabled overcrowded facilities to better serve Veterans through implementation of outpatient centers, VA/DoD collaborations, and renovation of current facilities. Sophisticated forecasting models have provided new and more complete information about the demand for VA health care, and a comprehensive assessment of our facilities has greatly improved the depth of understanding about the condition of VA's facilities. These factors, combined with the experience of conducting the CARES process, have VA well-positioned to continue to expand the accuracy and scope of its planning efforts. The tools and lessons learned through the CARES process have been incorporated into VHA's strategic planning process and, as future decisions are implemented, established performance measures are available to measure their impact.

Attachment 1

CARES Issues and Implementation Measures				
	Issue	**Implementation**	**Impact Measure**	**Data Source/Responsible Office**
1	Improved Access (CBOCs)	Implementation of the 156 CARES Priority CBOCs	% of market-level enrollees within primary care access guidelines pre-activation to 12-months post-activation.	VHA Service Support Center (VSSC) Planning Systems Support Group (PSSG)
2	Improved Access (Inpatient Care/Contracts)	One-time report on the extent of contracted care specific to the 2004 CARES Decisions and 17 Business Plan Studies.	N/A	Veteran Integrated Service Networks (VISNs)
3	Modernization	Annual planned to actual modernization expenditures specific to the 2004 CARES Decisions and 17 Business Plan Studies (e.g., Canandaigua, Orlando, etc.)	Percent of modernization projects completed compared to planned 2004 CARES Decisions and 17 Business Plan Studies (e.g., Canandaigua, Orlando, etc.)	Office of Construction and Facility Management (OCFM) Capital Asset Management and Planning Service (CAMPS) VSSC
4	Special Disability Programs	Implementation of programs specific to the 2004 CARES Decisions (e.g., Syracuse, Philadelphia, etc.).	percent of VISN-level special disability units of care per 1,000 enrollees pre-activation to 12-months-post-activation.	VSSC
5	Excess Property	Actions at stations specific to the 2004 CARES Decisions and 17 Business Plan Studies (e.g., Canandaigua, NY Montrose/Castle Point, NY, etc).	percent difference of station-level underutilized space to overall owned space compared to FY 2004 baseline. Annual percent difference of station-level disposed square feet compared to prior-year station-level disposed square feet. These measures will sunset one year after actions at the stations are completed.	VISNs Office of Asset Enterprise Management (OAEM)/Capital Asset Inventory (CAI)
6	VA/DoD Collaborations	Implementation of collaborations specific to the 2004 CARES Decisions (e.g., Fort Monmouth, NJ; Fort Belvoir, VA; etc.).		VISNs
7	*One*VA Collaborations	Implementation of collaborations specific to the 2004 CARES Decisions (e.g., Newington, CT; Columbia, SC; etc).		VISNs

Appendix A
Community-Based Outpatient Clinics (CBOCs

VISN	Location	State	Status	% Market-Level Enrollees within Primary Care Access Guidelines Pre-Activation to 12-Months Post-Activation
		Completed		
9	Logan County[10]	WV	Opened 2004	3%
16	Columbus	MS	Opened 2004	6%
16	Mena	AR	Opened 2004	8%
7	Goose Creek	SC	Opened 2005	14%
15	Hanson (Hopkins County)	KY	Opened 2005	7%
16	Galveston County	TX	Opened 2005	10%
16	Hammond	LA	Opened 2005	8%
21	San Bruno	CA	Opened 2005	1%
7	Athens	GA	Opened 2006	8%
7	Bessemer	AL	Opened 2006	6%
16	St. Johns	LA	Opened 2006	8%
1	Bangor Outreach - Lincoln	ME	Opened 2007	
6	Norfolk-Virginia Beach	VA	Opened 2007	
16	Conroe	TX	Opened 2007	
16	Pine Bluff	AR	Opened 2007	
17	San Antonio	TX	Opened 2007	
18	NW Tucson Urban 1	AZ	Opened 2007	
20	NW Central Washington	WA	Opened 2007	
21	American Samoa	AS	Opened 2007	
21	Lahontan Valley	NV	Opened 2007	
23	Bemidji	MN	Opened 2007	
23	Dickinson	ND	Opened 2007	
23	Jamestown	ND	Opened 2007	
23	Williston	ND	Opened 2007	
23	Spirit Lake	IA	Opened 2007	
23	Hayward	WI	Opened 2007	
1	Houlton-PT - Contract	ME	Opened 2008	
6	Hamlet	NC	Opened 2008	
6	Franklin	NC	Opened 2008	
6	Charlottesville	VA	Opened 2008	
6	Lynchburg	VA	Opened 2008	
6	Hickory	NC	Opened 2008	
7	Spartanburg	SC	Opened 2008	

10 Logan County, WV had a contracted site that predated CARES which was deactivated in July 2002. The site was included in the VISN 9 CARES Market Plan (submitted in 2003) to increase access in rural areas and subsequently included in the 156 CARES Priority CBOC sites in the Secretary's CARES document. The site was then reactivated in the 4th quarter of 2004 (June 2004).

Appendix A
Community-Based Outpatient Clinics (CBOCs

VISN	Location	State	Status	% Market-Level Enrollees within Primary Care Access Guidelines Pre-Activation to 12-Months Post-Activation
		Pending		
7	Stockbridge	GA	Opened 2008	
7	Aiken	SC	Opened 2008	
8	St. Mary's	GA	Opened 2008	
8	Marianna	FL	Opened 2008	
9	Hazard/Perry County	KY	Opened 2008	
9	Grayson County	KY	Opened 2008	
9	Scott County	IN	Opened 2008	
15	Hutchinson	KS	Opened 2008	
15	Jefferson City	MO	Opened 2008	
15	Owensboro	KY	Opened 2008	
15	Vincennes	IN	Opened 2008	
16	Eglin AFB	FL	Opened 2008	
16	Branson	MO	Opened 2008	
18	SE Tucson Urban 2	AZ	Opened 2008	
19	Cut Bank	MT	Opened 2008	
19	Lewiston	MT	Opened 2008	
23	Holdrege	NE	Opened 2008	
9	Berea	KY	Opened 2009	
9	Carroll County	KY	Opened 2009	
15	Graves County (Mayfield)	KY	Opened 2009	
19	West Valley City	UT	Opened 2009	
		Pending		
5	Ft. Detrick	MD	Approved for 2009	
5	Southern Prince George County (Andrews AFB)	MD	Approved for 2009	
6	Wytheville (Bluefield/Radford)	VA	Approved for 2009	
6	Lewisburg (Greenbrier County)	WV	Approved for 2009	
6	Lumberton	NC	Approved for 2009	
6	Rutherfordton	NC	Approved for 2009	
6	Emporia	VA	Approved for 2009	
6	Staunton (Augusta County)	VA	Approved for 2009	
7	Newnan	GA	Approved for 2009	
7	Childersburg	AL	Approved for 2009	
7	Guntersville	AL	Approved for 2009	
7	Hinesville	GA	Approved for 2009	
7	Brunswick	GA	Approved for 2009	
7	Milledgeville	GA	Approved for 2009	
7	Perry	GA	Approved for 2009	
7	Wiregrass/Enterprise (Ft. Rucker)	AL	Approved for 2009	

Appendix A
Community-Based Outpatient Clinics (CBOCs

VISN	Location	State	Status	% Market-Level Enrollees within Primary Care Access Guidelines Pre-Activation to 12-Months Post-Activation
		Pending		
7	Opelika	AL	Approved for 2009	
8	Summerfield (South Marion County)	FL	Approved for 2009	
8	Putnam County	FL	Approved for 2009	
9	Gallipolis (Gallia County)	OH	Approved for 2009	
9	Bolivar	TN	Approved for 2009	
9	Dyer County	TN	Approved for 2009	
9	Mt. Pleasant	TN	Approved for 2009	
9	Phillips County	AR	Approved for 2009	
9	Jellico (Campbell County)	TN	Approved for 2009	
9	Pigeon Forge (Sevier County)	TN	Approved for 2009	
9	Athens (McMinn County)	TN	Approved for 2009	
9	Giles County – Pulaski	TN	Approved for 2009	
9	Harriman (Roane County)	TN	Approved for 2009	
9	Hopkinsville (Christian County)	KY	Approved for 2009	
9	McMinnville (Warren County)	TN	Approved for 2009	
11	Charleston (Coles County)	IL	Approved for 2009	
11	Martinsville (Morgan County)	IN	Approved for 2009	
11	Peru (Miami County)	IN	Approved for 2009	
16	Fort Polk (Leesville)	LA	Approved for 2009	
16	Jay	OK	Approved for 2009	
16	Lake Charles	LA	Approved for 2009	
16	Natchitoches	LA	Approved for 2009	
16	Ozark	AR	Approved for 2009	
16	Searcy	AR	Approved for 2009	
16	Vinita (Craig County)	OK	Approved for 2009	
16	Bogalusa (Washington Parrish)	LA	Approved for 2009	
16	Franklin (St. Mary Parrish)	LA	Approved for 2009	
16	Altus	OK	Approved for 2009	
16	Enid	OK	Approved for 2009	
16	Stillwater	OK	Approved for 2009	
17	Brooks AFB	TX	Approved for 2009	
21	Fremont/East Bay	CA	Approved for 2009	
23	Devils Lake	ND	Approved for 2009	
23	Grand Forks	ND	Approved for 2009	
23	Wagner	SD	Approved for 2009	
23	Watertown	SD	Approved for 2009	
23	Elk River/NW Metro	MN	Approved for 2009	
23	Bellevue	NE	Approved for 2009	
23	Carroll	IA	Approved for 2009	

Appendix A
Community-Based Outpatient Clinics (CBOCs

VISN	Location	State	Status	% Market-Level Enrollees within Primary Care Access Guidelines Pre-Activation to 12-Months Post-Activation
Pending				
23	Cedar Rapids	IA	Approved for 2009	
23	Marshalltown	IA	Approved for 2009	
23	O'Neil	NE	Approved for 2009	
23	Shenandoah	IA	Approved for 2009	
23	Alexandria	MN	Approved for 2009	
1	Lewiston-Auburn	ME	Approved for 2010	
5	Ft. Meade - DoD Joint Venture	MD	Approved for 2010	
15	Washington-Sullivan (Franklin County)	MO	Approved for 2010	
16	Lake Jackson	TX	Approved for 2010	
16	Richmond	TX	Approved for 2010	
16	Conway (Faulkner County)	AR	Approved for 2010	
16	Russellville (Pope County)	AR	Approved for 2010	
18	Rio Rancho	NM	Approved for 2010	
18	East El Paso	TX	Approved for 2010	
23	Ottumwa	IA	Approved for 2010	
5	Ft. Belvoir – DoD Joint Venture	VA	Approved for 2011	
16	Katy	TX	Approved for 2011	
16	Tomball	TX	Approved for 2011	
16	McComb (Pike County)	MS	Approved for 2011	
17	Plano (Collin County/Tri County)	TX	Pending Approval	
Removed from CARES CBOC Priority List				
1	Bangor Outreach - Dover Fox	ME	Existing coverage of services	
1	Rumford Outreach - Farmington	ME	Existing coverage of services	
1	Rumford Outreach - South Paris	ME	Existing coverage of services	
5	Baltimore City - Mental Health Clinic	MD	Existing coverage of services	
5	Owings Mill (Eldersburg)	MD	Existing coverage of services	
6	Hendersonville	NC	Existing coverage of services	
6	Supply	NC	Existing coverage of services	
6	Gastonia	NC	Existing coverage of services	
6	Greensboro	NC	Existing coverage of services	
7	Maxwell AFB	AL	Existing coverage of services	

Appendix A
Community-Based Outpatient Clinics (CBOCs

VISN	Location	State	Status	% Market-Level Enrollees within Primary Care Access Guidelines Pre-Activation to 12-Months Post-Activation
Removed from CARES CBOC Priority List				
9	London	KY	Existing coverage of services	
9	Grenada	MS	Existing coverage of services	
9	Paris	TN	Existing coverage of services	
9	Pontotoc County	MS	Existing coverage of services	
9	Tunica	MS	Existing coverage of services	
9	Wynne - Cross County	AR	Existing coverage of services	
9	Davenport Clinic	VA	Existing coverage of services	
9	Davis Clinic	VA	Existing coverage of services	
9	Haysi Clinic	VA	Existing coverage of services	
9	Holston Medical Clinic	TN	Existing coverage of services	
9	Pennington Gap Clinic	VA	Existing coverage of services	
9	Thompson Clinic	VA	Existing coverage of services	
9	W. Lee County	VA	Existing coverage of services	
9	Glasgow	KY	Existing coverage of services	
23	Redwood Falls	MN	Existing coverage of services	
Consolidated				
6	Radford	VA	Consolidated-approved for 2009	
16	Galveston (Site 2)	TX	Consolidated-open 2005	

Appendix B
Improved Access and Modernization

VISN	Location	Description	Status	FY08 Actual to Planned Total Modernization Expenditures
Improved Access Projects				
Completed				
2	Canandaigua	Contract for inpatient care	Complete FY 2008	
4	Philadelphia	Consolidate inpatient services between Philadelphia and Wilmington VAMCs	Inpatient Behavioral Health Renovation construction complete	
9	Nashville and Murfreesboro	Consolidate services	Completed FY 2004	
10	Columbus	Contract for inpatient care	FY 2006	
17	San Antonio/Kerrville	Contract for inpatient care	FY 2009	$19.1M / $19.1M
17	Harlingen	Enhance access to outpatient and specialty care	FY 2008	
17	South Texas CHC (Valley Coastal Bend HCS)	Contract for inpatient care	FY 2009	
18	Tucson	Meet increasing demand for inpatient psychiatry by expanding services	Completed FY 2008	
21	Reno	Enhance telemedicine services	Completed FY 2008 and FY 2009	
21	San Francisco	Enhance telemedicine services	Complete	
Pending				
1	West Haven	Expand in-house inpatient care	Pending	
1	Providence	In-house inpatient care expansion	Pending	
3	New Jersey	Expand in-house capacity/convert vacant space	Pending	
5	Washington	Transfer domiciliary beds from Martinsburg	Pending	
7	Augusta	Convert vacant space, new construction, renovation and leasing projects	Pending	
7	Montgomery	Explore contracting under current authority	Pending	
8	Florida	Increase access through sharing	Pending	
8	Gainesville	New construction to increase inpatient capacity	Pending	
9	Chattanooga	Contract for inpatient care	Pending	

Appendix B
Improved Access and Modernization

VISN	Location	Description	Status	FY08 Actual to Planned Total Modernization Expenditures
Pending				
10	Canton	Contract for inpatient care	Pending	
11	Saginaw	Transfer care to Ann Arbor and Detroit, and contract for inpatient care	Pending	
11	Central IL	Contract for inpatient care	Pending	
17	Austin	Contract for inpatient care, affiliate with University of Texas	Pending	
18	Phoenix	Contract for inpatient care	Pending	
18	Prescott	Contract for inpatient care	Pending	
18	Phoenix	Expand inpatient psychiatry services	Pending	
18	Albuquerque	Expand inpatient psychiatry services	Pending	
19	Eastern Rockies	Contract for inpatient care	Access has improved	
19	Grand Junction	Contract for inpatient care	Access has improved	
19	Wyoming	Contract for inpatient care	Access has improved	
19	Montana	Contract for inpatient care	Access has improved	
21	Palo Alto	Expand inpatient services	Pending	
Ruled Out				
5	Washington	Transfer inpatient psychiatric beds from Perry Point	Ruled out	
9	Charleston	Contract for inpatient care	Terminated	
9	Nashville	Increase capacity through in-house expansions	Ruled out	

Appendix B
Improved Access and Modernization

VISN	Location	Description	Status	FY08 Actual to Planned Total Modernization Expenditures
Modernization Projects				
Completed				
4	Pittsburgh	Modernize facilities at University Drive and Heinz campuses	Anticipated FY 2011	$233.2 / $295M
7	Atlanta	Renovate inpatient wards	NTP 5/2009	$20.5 / $24.5M
7	Charleston	Renovate inpatient wards/ nursing home care units	FY 2006 and FY 2007	
10	Columbus	Construct Outpatient Specialty Clinic	FY 2008	$94.8 / $94.8M
21	Reno	Expand services and enhance telemedicine services	FY 2008	
22	San Diego	Correct seismic and life safety deficiencies	FY 2008	$47.9M / $47.9M
23	St. Cloud	New construction and renovations	FY 2006	
23	Minneapolis	New construction and/or renovation (lease)	FY 2009	
23	Des Moines	New construction and/or renovations	FY 2006	
23	Grand Island	LTC Unit	FY 2006	
Pending				
2	Canandaigua	Maintain current services in new/or renovated facilities	Planning	
3	Castle Point	Modernize campus	Planning	
3	Montrose	Construct multi-specialty state-of-the-art ambulatory care facility	Planning	
3	St. Albans	Construct new residential & outpatient buildings	Planning	
5	Perry Point	Construct new nursing home, modernize existing facilities	Planning	
7	Columbia	Renovate inpatient wards/ nursing home care units	Planning	
8	Gainesville	Correct Patient Privacy Deficiency	Anticipated FY 2011	$136.7M / $136.7M
8	Orlando	Construct new medical facility	Anticipated FY2012	$74.1M / $665.4M
8	San Juan	Construct new seismically safe bed tower	FY 2011 / FY 2014	$69.8M / $299.2M
8	Tampa	Polytrauma/Bed Tower	Under design	$231.5M/ $231.5
9	Lexington	Construct new admin/clinical building on campus(nursing home, domiciliary, residential rehab and outpatient facilities)	Pending	
9	Louisville	New facility	Planning	
10	Memphis	Increase capacity through in-house expansions	Pending	

Appendix B
Improved Access and Modernization

VISN	Location	Description	Status	FY08 Actual to Planned Total Modernization Expenditures
Pending				
10	Cleveland	Consolidate Cleveland VAMC Brecksville Division to Wade Park Division through major construction	Anticipated FY 2011	$102.3M / $102.3M
11	Fort Wayne	Close acute beds	Under analysis	
16	Biloxi/Gulfport	Consolidate Gulfport VAMC services to Biloxi VAMC	Under construction	$345.9M/$345.9M
17	Waco	Retain current services; reuse vacant building and land	Under development	
17	Dallas	Expand in-house services through construction and renovation	Planning	
18	Big Spring	Expand capacity for domiciliary	Pending	
19	Denver	Replace Medical Center	Under design	$168.3M / $800M
19	Fort Harrison	Correct seismic and life safety deficiencies	Planning	
20	American Lake	Correct seismic and life safety deficiencies	Anticipated FY 2010	$38.2 /$90.8M
20	Portland	Correct seismic and life safety deficiencies	Planning	
20	Roseburg	Correct seismic and life safety deficiencies	Planning	
20	Seattle	Correct seismic and life safety deficiencies	Planning	
20	Walla Walla	Construct new multi-specialty clinic	Under design	
20	White City	Correct seismic and life safety deficiencies	Planning	
20	White City	New construction and renovations	Planning	
21	Palo Alto/ Livermore	Construct new nursing home	Planning	
21	Palo Alto/ Menlo Park	Correct seismic and life safety deficiencies	Anticipated FY 2009	$32.9M / $32.9M
21	Palo Alto	Correct seismic and life safety deficiencies	Anticipated FY 2012	$54M / $54M
21	San Francisco	Correct seismic and life safety deficiencies	Anticipated FY 2009	$41.2 / $41.2M
21	Fresno	Correct seismic and life safety deficiencies	Planning	
22	Long Beach	Correct seismic and life safety deficiencies	Under construction	$107.8M/$117.8M
22	Las Vegas	New medical center campus	Anticipated FY 2011	$600.4 / $600.4M
22	West LA	Modernize acute inpatient facility for outpatient services	Planning	

Appendix B
Improved Access and Modernization

VISN	Location	Description	Status	FY08 Actual to Planned Total Modernization Expenditures
Pending				
22	West LA	New bed tower and research facility	Planning	
22	West LA	Correct seismic and life safety deficiencies	Planning	$7.9M/$162M
23	Knoxville/Des Moines	Campus realignment (new construction and/or renovations)	Planning	
Ruled Out				
9	Nashville	Increase capacity through in-house expansions	Ruled out	
16	Muskogee	Close inpatient surgery beds	Ruled out	
23	Fargo	New construction and renovations	Deferred	
23	Iowa City	New construction and renovations	Deferred	
23	Minneapolis	New construction and renovations	Ruled out	

Appendix C
Special Disability Programs

VISN	Location	Description	Status
Completed			
4	Philadelphia	Enhancements to SCI Clinic with continued referral to VISN 3	Complete
8	Tampa	New or expanded SCI presence	Complete FY 2008
23	Minneapolis	New SCI Center	Complete FY 2008
Pending			
2	Syracuse	Develop SCI/D Center	Pending construction contract
3	Bronx	Relocate SCI/D beds from Castle Point	Design Phase
7	Augusta	SCI/D expansion	Minor projects, adding beds
9	Memphis	Expand SCI/D beds	Under construction -
10	Cleveland	Expand SCI/D presence	Construction contract awarded
16	Biloxi	Blind Rehabilitation Center	Under Construction
16	Jackson	New SCI/D Center in	Pending concept approval
19	Denver	Develop SCI/D Center	Design Phase
22	Long Beach	New Blind Rehabilitation Center	Under construction
22	Long Beach	SCI LTC Services	Pending funding

Appendix D
Excess Property

VISN	Location	Description	Status	% Difference Station-Level Underutilized SF to Overall SF Compared to FY 2004 Baseline	FY08 GSF Difference Station-Level Disposed SF to Prior-Year Station-Level Disposed Square Feet
Completed					
4	Butler	EUL - Mental Health Facility	FY 2004	33%	7,626/9,808
4	Butler	EUL - Homeless Residential Program	FY 2007	33%	7,626/9,808
5	Fort Howard	EUL - Mixed use- Senior Housing	FY 2006	97%	0
6	Durham	EUL to meet parking, patient care and research needs	Building demolished FY 2008	73%	15,910
7	Charleston/MUSC	EUL - Affiliate Partnering	FY 2004	82%	0
10	Dayton	EUL - Child Care Development Center (Bldg 401)	FY 2005	13%	0/73,718
10	Dayton	EUL - Transitional Housing Facility (B 412)	FY 2005	13%	0/73,718
10	Dayton	Transitional Housing Facility (B402)	FY 2007	13%	0/73,718
12	North Chicago	EUL - Energy Center II	FY 2004	37%	0
12	Hines	EUL - Single Room Occupancy (SRO) EUL - Phase II (Bldg 53)	FY 2005	17%	1,901/145,200
12	Chicago (Lakeside)	EUL – Realignment (disposed)	FY 2005	27%	0
15	Leavenworth	EUL to renovate buildings for Veteran assisted living facility	FY 2005	68%	552,241
19	Salt Lake City	EUL - Phase II	FY 2006	16%	0
20	Portland	EUL - Crisis Triage	FY 2004	57%	0
23	Minneapolis	EUL - Credit Union	FY 2004	43%	0
23	St. Cloud	EUL - Homeless Housing	FY 2005	21%	0
23	Minneapolis	EUL - Single Room Occupancy (SRO)	FY 2005	43%	0
Pending					
2	Canandaigua, NY	EUL – Mission Homeless	Anticipated FY 2010	17%	960/0
3	St. Albans, NY	EUL – Campus Reuse	Anticipated FY 2010	19%	0
7	Augusta, GA	EUL – Mission Homeless	Anticipated FY 2010	24%	0
10	Cleveland	EUL - Brecksville VAMC (102 acres)	Anticipated FY 2009	18%	0
18	Albuquerque	EUL	Pending environmental issues	27%	0
20	White City	EUL	Under analysis	5%	0

Appendix D
Excess Property

VISN	Location	Description	Status	% Difference Station-Level Underutilized SF to Overall SF Compared to FY 2004 Baseline	FY08 GSF Difference Station-Level Disposed SF to Prior-Year Station-Level Disposed Square Feet
Pending					
21	Palo Alto / Livermore	Master Plan to dispose or reuse excess property	Under analysis	49%/65%	0
23	Knoxville/Des Moines	EUL	Anticipated FY 2011	11%/49%	0/15,600
Deferred					
8	Bay Pines	Explore EUL	Deferred	57%	0
8	Miami	Explore EUL	Deferred	48%	0
11	Danville	EUL	Deferred	21%	0
18	Phoenix	Explore EUL	Deferred	50%	0
21	San Francisco	Explore EUL to improve research and long-term care	Deferred	55%	0

Appendix E
VA/DoD Collaborations

VISN	Location	Description	Status
Completed			
9	Fort Knox	Expand space at Fort Knox CBOC	Complete FY 2004
6	Camp Lejeune	Provide shared inpatient care services	Sharing Agreement signed FY 2007
10	Columbus	Construct new Outpatient Specialty Clinic	Completed FY 2009
16	Pensacola Naval Hospital	Collocate outpatient services next to Pensacola Naval Hospital	Completed FY 2008
17	NE Bexar	Share San Antonio HCS/Air Force staffed services at North Central Bexar County Clinic	Completed FY 2007
17	Fort Hood	Operate a joint sleep clinic with Temple VAMC and Darnall Army Community Hospital	Completed FY 2007
20	Madigan	Transfer 15 inpatient beds from American Lake VAMC to Madigan Army Medical Center	Completed FY 2004
20	Fairbanks	Expand Anchorage VAMC collocated services at Ft. Wainwright	Completed FY 2007
21	Honolulu/ American Samoa	Evaluate sharing with DoD to enhance services to Veterans in American Samoa	Completed FY 2008
21	Honolulu	Provide Veterans access to tertiary/acute and specialty services at Tripler Army Base	Completed FY 2000
21	Sacramento/ Travis AFB	Expand inpatient psychiatry beds for Veterans and joint dialysis unit at Travis AFB	Joint Dialysis Unit completed FY 2007, Joint Inpatient Mental Health Unit anticipated FY 2009
Pending			
5	Fort Belvoir	Provide 60,000 SF for primary and specialty care for DC VAMC	Anticipated completion in FY 2010
5	Fort Meade/Fort Detrick	Provide outpatient services through shared CBOCs	Anticipated completion in FY 2010
8	Mac Dill AFB/Ft. Buchanan/NH Roosevelt Roads	Develop additional sharing opportunities with DoD	VA and DoD are communicating about the sites.
18	El Paso/Fort Bliss	Expand sharing agreements at William Beaumont Hospital	VA and DoD are continuing talks on integration
19	Denver	Replace VAMC on Fitzsimmons campus with some shared facilities with University of Colorado	In design

Appendix E
VA/DoD Collaborations

Pending			
20	Bremerton	Provide acute inpatient medicine, emergency room, ancillary services, and other expanded services to support Bremerton CBOC	Pending
20	Elmendorf AFB	Expand shared services with Elmendorf Air Force Base at Alaska VAMC	Construction contract awarded FY 2007
21	Honolulu/ Naval Hospital	Provide land near planned new Navy Hospital for construction of VA CBOC	Under construction
21	Palo Alto/ Monterey	Develop joint outpatient clinic at Monterey for primary and specialty care services for Veterans and specialty care for DoD	Anticipated study completion in FY 2009, Under consideration for FY 2010 funding
22	Nellis AFB	Explore sharing at Mike O'Callaghan Federal Hospital	Anticipate completion FY 2011
Deferred/Ruled Out			
8	Naval Hospital Jacksonville	Evaluate contract inpatient services for North market with University of Florida/Shands and Naval Air Station Hospital	Deferred
23	Grand Forks AFB	Share CBOC at Grand Forks AFB	Negated
23	Offutt AFB	Contract CBOC on Offutt AFB	Negated, VA CBOC opened near base

Appendix F
OneVA Collaborations

VISN	Location	Description	Status
Completed			
1	Newington	Collocate Hartford Regional Office	FY 2004
7	Columbia	Collocate Columbia Regional Office	FY 2007
9	Louisville	Explore collocating VBA Regional Office at replacement Louisville VAMC	FY 2006
9	Mountain Home	Transfer ~ 50 acres from VHA to NCA	FY 2006
18	Prescott	Transfer land at Prescott VAMC for NCA columbarium expansion	FY 2008
20	Roseburg	Transfer 44 acres from VHA to expand Roseburg National Cemetery	FY 2008
Pending			
15	Leavenworth	Provide additional land to expand Leavenworth National Cemetery	Under development
15	Jefferson Barracks	Transfer land for Jefferson Barracks National Cemetery	Approved for funding
22	Las Vegas	Collocate VBA in new Las Vegas, NV	Anticipated FY 2011
22	Los Angeles	Explore collocating Regional Office at West LA VAMC	Under analysis
22	Los Angeles	Collocate NCA columbarium on 20 acres West LA campus; Pursue further expanding NCA presence on West LA campus	In planning
Deferred			
3	Castle Point and Montrose	Explore collaboration with NCA	Deferred
8	Sarasota	Collocate with new National Cemetery	Deferred
11	Marion	Explore providing additional land to expand existing cemetery	Deferred
23	Minneapolis	Explore collocating St. Paul Regional Office at Minneapolis VAMC	Deferred

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. MIKE JOHANNS TO THE U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. When do you estimate the study will be released to the Committees on Appropriations of both chambers of Congress as required by law? I would appreciate a date certain for the release of the study.

Response. The study will be released to the Committees on Appropriations of both chambers of Congress by July 31, 2009.

Question 2. Will this study be released to the public? If so, when?

Response. The study will also be released to the general public, at the same time it has been released to the Committees on Appropriations of both chambers of Congress.

Question 3. If that study calls for corrective action, including major renovations or the construction of a new facility, how will such findings affect the ability of the Omaha VAMC to receive the necessary corrective action?

Response. If the study calls for corrective action, including major renovations or construction of a new facility, the study and the Department of Veterans Affairs' (VA) evaluation of it will guide VA in selecting the best correction strategy. The approved option from the results of the study will be included in the VA's construction project prioritization process during the budget development process.

Question 4. Will the feasibility study have any bearing on the VA's decision to prioritize the Omaha VAMC for renovation or construction?

Response. Yes the feasibility study and VA's evaluation of it will be included in the construction project prioritization process during the budget development process.

Chairman AKAKA. I would like to welcome our second panel.

First, I welcome Davis Wise, who is Director of Physical Infrastructure Issues at the GAO.

Next, we have Dennis Cullinan, Director of National Legislative Service at the Veterans of Foreign Wars.

And I also welcome J. David Cox, National Secretary-Treasurer of the American Federation of Government Employees.

Thank you so much for being here. Mr. Wise, we will please begin with your statement.

STATEMENT OF DAVID WISE, DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. WISE. Chairman Akaka, Ranking Member Burr, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs application of enhanced use leases which allows third parties to use government property in return for consideration in cash or in kind.

As GAO noted in its June 9 testimony before the House Committee on Veterans' Affairs, Subcommittee on Health, enhanced use leasing (EUL) is one of a variety of legal authorities available to help VA manage real property and reduce underutilized space. With more than 32,000 acres of land and over 6,200 buildings on about 300 sites, VA is one of the Federal Government's largest property holders.

However, many VA properties are aged and not particularly well-suited to providing care in the current VA system. As a result, VA holds a significant amount of property that is underutilized or vacant because of age, condition, location, and other factors. Maintaining this property requires VA to spend funds that could otherwise be used to provide direct care and other medical services to veterans. In a report we issued in 2008, we estimated the VA spent

$175 million in fiscal year 2007 operating underutilized or vacant space at medical facilities.

My testimony has three parts. I will discuss: (1) VA's authority to enter into EULs; (2) how VA has used its EUL authority; and (3) the relationship between VA's authorities and the amount of real property retained or sold.

My statement is based upon our report entitled "Federal Real Property: Authorities and Actions Regarding Enhanced Use Leases and Sale of Unneeded Real Property" issued February 17, 2009.

On the first point, VA may enter into EULs for underutilized or unutilized real property for up to 75 years in exchange for cash and/or in-kind consideration, such as provision of office space or construction of facilities. After covering the cost of the EUL, VA may use the remaining proceeds for a variety of purposes, including medical care, construction, facility improvement, and other EULs without further Congressional appropriation or change in law. VA's current EUL authority will terminate on December 31, 2011.

On the second point, VA has used its EUL authority to reduce the amount of underutilized and unutilized property. In its fiscal year 2010 budget submission, VA reported disposing of 50 buildings and land in fiscal year 2008 using EUL authority. VA currently has 52 EULs, including housing, health care facilities, mixed use, and other projects.

In one example in 2006, VA entered into an EUL that will use almost 300,000 square feet of vacant space at Fort Howard, Maryland, to develop a retirement community with priority placement for veterans. While many EULs result in direct services to veterans, in some instances the relationship is less clear. For example, VA is leasing property in Hillsboro, New Jersey, to a company that subleases the property to a variety of commercial interests needing warehouse or light manufacturing space, as well as the County government.

On the third point, in addition to EUL authority, VA may sell unneeded property and retain the proceeds under its Capital Asset Fund, or CAF, authority. However, to do so VA must determine that the property is not needed to carry out its function and is not suitable for providing services to the homeless. Additionally, VA's use of these proceeds is subject to further congressional appropriation or change in law.

Despite this authority to sell property, VA has not sold any real property through its CAF authority. VA has sold only one property in Chicago, and that sale occurred under its EUL authority. According to VA officials, EULs are more attractive compared to disposal and sale under CAF, in part because VA can enter into EULs with fewer restrictions and has more flexibility on how it can use the proceeds. For example, VA can use EUL proceeds for medical care but cannot after selling a property.

VA officials said that implementing an EUL can take anywhere from 9 months to 2 years. EULs may also be complex due to issues such as land due diligence, public hearings requirements, and lease drafting and negotiations. VA officials said that they are working to streamline the process.

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions you or Members of the Committee may have.

[The prepared statement of Mr. Wise follows:]

PREPARED STATEMENT OF DIRECTOR OF PHYSICAL INFRASTRUCTURE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

United States Government Accountability Office

GAO

Testimony

Before the Senate Committee on Veterans' Affairs

For Release on Delivery
Expected at 9:30 a.m. EDT
June 10, 2009

VA REAL PROPERTY

VA Emphasizes Enhanced-Use Leases to Manage Its Real Property Portfolio

Statement of David Wise, Director
Physical Infrastructure Issues

GAO
Accountability * Integrity * Reliability

GAO-09-776T

June 10, 2009

GAO
Accountability·Integrity·Reliability

Highlights

Highlights of GAO-09-776T, a testimony before the Senate Committee on Veterans' Affairs

VA REAL PROPERTY

VA Emphasizes Enhanced-Use Leases to Manage Its Real Property Portfolio

Why GAO Did This Study

The Department of Veterans Affairs (VA) is one of the largest federal land-holding agencies and operates one of the largest health care-related real estate portfolios in the nation. However, many of VA's facilities were built more than 50 years ago and are underutilized or unutilized. Congress has provided VA with certain authorities, such as enhanced-use lease (EUL) authority, enabling the agency to lease or dispose of these properties. This statement focuses on (1) VA's authority to enter into EULs, (2) how VA has used its EUL authority, and (3) the relationship between VA's authorities and the amount of real property that is retained or sold. This statement is based on GAO's February 2009 report on federal agencies' authorities and actions regarding EULs and sale of unneeded real property (GAO-09-283R). To prepare that report, GAO analyzed the authorities and actions of the 10 largest federal land-holding agencies, including VA, to enter into EULs and sell unneeded real property. GAO reviewed VA's legal authorities related to EULs, the sale of real property, and retention of proceeds from EULs and sales; collected data on VA's use of EULs; and visited a property that VA is leasing under an EUL.

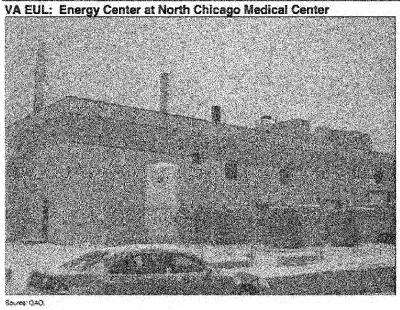
What GAO Found

VA has statutory authority to enter into enhanced-use leases (EUL), which are typically long-term agreements with public and private entities for the use of federal property in exchange for cash, in-kind consideration, or both. The agency may enter into EULs for underutilized or unutilized real property for up to 75 years and use the proceeds for a variety of purposes, including developing additional EULs, providing medical care, and constructing and improving VA medical facilities. In-kind consideration may include goods and services that benefit VA, such as provision of office, storage, or other usable space; or construction, repair, remodeling, maintenance, or other physical improvements to VA facilities.

VA has used its EUL authority to reduce the amount of its underutilized and unutilized property, and to receive financial and nonfinancial benefits. VA reported that it disposed of 50 buildings and land in fiscal year 2008 using its EUL authority. According to VA, the agency has 52 active EULs, which include housing, health care facilities, mixed-use, and other projects.

In addition to its EUL authority, VA may sell unneeded real property and retain the proceeds under its Capital Asset Fund (CAF) authority. However, VA sold no properties using this authority. According to VA officials, the agency places greater emphasis on entering into EULs, compared to real property sales, in part because VA can enter into EULs with fewer restrictions than under its CAF authority. For example, VA may enter into EULs without having to screen the property for homeless use, while property must be screened for homeless use if VA is selling property under its CAF authority. In addition, while VA has the authority to retain and spend proceeds from EULs without the need for further congressional action, proceeds retained under CAF authority are subject to further congressional action.

VA EUL: Energy Center at North Chicago Medical Center



Source: GAO

View GAO-09-776T
For more information, contact David Wise at (202) 512-2834 or wised@gao.gov.

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify today on the Department of Veterans Affairs' (VA) use of enhanced-use leases (EUL). As you know, EULs are typically long-term agreements with public and private entities for the use of federal property, resulting in cash, in-kind consideration, or both. My testimony today focuses on (1) VA's authority to enter into EULs, (2) how VA has used its EUL authority, and (3) the relationship between VA's authorities and the amount of real property that is retained or sold. This statement is based on our report issued on February 17, 2009, entitled *Federal Real Property: Authorities and Actions Regarding Enhanced Use Leases and Sale of Unneeded Real Property.*[1] To prepare that report, we analyzed the authorities and actions of the 10 largest federal land-holding agencies, including VA, to enter into EULs and sell unneeded real property. We reviewed VA's legal authorities related to EULs, the sale of real property, and retention of proceeds from EULs and sales; collected data on VA's use of EULs; and visited a property that VA is leasing under an EUL. We conducted our work in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives.

With more than 32,000 acres of land and over 6,200 buildings on approximately 300 sites, VA is among the largest federal property-holding agencies and the operator of one of the largest health care-related real estate portfolios in the nation. However, many of VA's facilities were built more than 50 years ago and are no longer well suited to providing care in the current VA system. As a result, VA has millions of square feet of property that is underutilized or vacant because of age, condition, location, or other factors. Operating and maintaining unneeded property requires VA to spend appropriations that could otherwise be used to provide direct medical care or other services. In a report we issued last year, we estimated that VA spent $175 million in fiscal year 2007 operating underutilized and vacant space at its medical facilities.[2]

[1]GAO-09-283R (Washington, D.C.: Feb. 17, 2009).

[2]GAO, *Federal Real Property: Progress Made in Reducing Unneeded Property, but VA Needs Better Information to Make Further Reductions*, GAO-08-939 (Washington, D.C.: Sept. 10, 2008).

VA Has Authority to Enter into EULs and Use the Proceeds with Few Restrictions

VA may enter into EULs and use the proceeds under several authorities. VA may enter into EULs for "underutilized" or "unutilized" real property for up to 75 years in exchange for "fair consideration," which can be in cash, in-kind consideration, or both.[3] In-kind consideration may include goods and services that benefit VA, such as the provision of office, storage, or other usable space; or construction, repairs, remodeling, maintenance, or other physical improvements to VA facilities. After covering the expenses associated with the EUL, VA may use the remaining proceeds for a variety of purposes, including developing additional EULs; providing medical care; and, at the Secretary's discretion, construction, alteration, and improvement of any VA medical facility.[4] Moreover, if the Secretary of VA determines during the term of an EUL or within 30 days after the end of the lease term that the department no longer needs the property, the Secretary is authorized to initiate an action to dispose of the property.[5] VA may deposit the proceeds from the disposal of an EUL property into its Capital Asset Fund (CAF) and use those proceeds for property transfer costs and construction, subject to further congressional action.[6] Alternatively, at the Secretary's discretion, as provided in VA's annual appropriations acts, VA may deposit the proceeds from the disposal of an EUL property into its major or minor construction accounts and use those proceeds for construction, alteration, and improvement projects for any VA medical facility without further congressional action.[7] VA's EUL and CAF authorities are listed in appendix I.

VA Has Used EULs to Reduce Its Underutilized Property

VA has used its EUL authority to reduce the amount of its underutilized and unutilized property, and to receive financial and nonfinancial benefits. In its fiscal year 2010 budget submission, VA reported that it disposed of 50 buildings and land in fiscal year 2008 using its EUL authority. According to VA, the agency has 52 active EULs, which include housing, health care facilities, mixed-use projects, golf courses, and other projects. For example,

[3]38 U.S.C. §§ 8161-8169. This authority terminates on December 31, 2011.

[4]38 U.S.C. § 8165 and P.L. No. 110-329, Division E, § 213, 122 Stat. 3574, 3711 (2008).

[5]38 U.S.C. § 8164.

[6]38 U.S.C. § 8165 and 38 U.S.C. § 8118. An appropriations act would need to be passed providing for VA to use these proceeds.

[7]P.L. No. 110-329, Division E, § 213, 122 Stat. 3574, 3711 (2008).

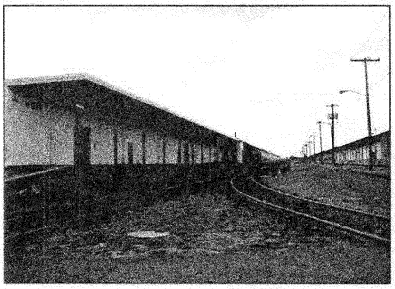
- In 2005, in Lakeside (Chicago), Illinois, VA reduced its underutilized property at the medical center by nearly 600,000 square feet by using its EUL authority with Northwestern Memorial Hospital. This EUL involved a consolidation of existing services where VA relocated inpatient beds and support services to other campus sites and leased the property to Northwestern, therefore reducing VA's underutilized property at the medical center. VA received $28 million upon execution of the lease.

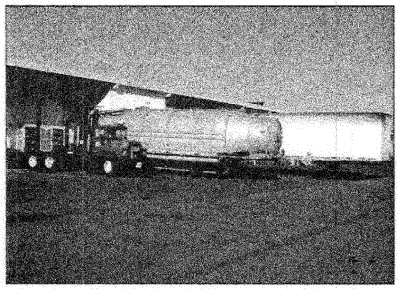
- In 2006, at Fort Howard, Maryland, VA entered into an EUL that will use about 300,000 square feet of vacant space to develop a retirement community, with priority placement for veterans. While VA has retained a portion of space on its medical campus for an outpatient clinic, it has largely reduced the vast majority of its total space at Fort Howard through the EUL. According to VA, the project will save VA over $1.5 million in construction costs and to avoid approximately $1 million in costs annually.

- In another EUL, VA is leasing property in Hillsborough, New Jersey, called Veterans Industrial Park to a company that subleases the property to a variety of commercial interests needing warehouse or light manufacturing space and to the county government. VA officials said that VA did not consider selling this property because, in 1999, when the agency entered into the EUL agreement, it did not have the authority to retain the proceeds from the sale of real property. In addition, the General Services Administration, which sells real property for federal agencies, had a similar property nearby that it had been unable to sell. Other than a small area on the property that is used for VA services to collect and distribute military clothing to homeless veterans, the property lessees are commercial renters who are not providing any direct services to VA. However, VA officials said that VA considers such EULs to be in the agency's interest because VA receives about $300,000 to $390,000 a year from rental income that it can use for its priorities.[8] (See fig. 1 for photographs of this property.)

[8]According to VA officials, VA also has a profit participation agreement for the EUL based on the lessee's net income. In 2007, VA received proceeds from the profit participation for the first time in the amount of about $32,000.

Figure 1: Veterans Industrial Park, an EUL Generating Lease Payments to VA





Source: GAO.

VA's Authorities Affect How the Agency Retains and Disposes of Real Property

In addition to its EUL authority, VA may sell unneeded real property and retain the proceeds under its CAF authority.[9] Under that authority, before VA can dispose of a property, it must determine that the property is no longer needed by the department in carrying out its functions and is not suitable for providing services to the homeless by the department or another entity. If VA sells property under its CAF authority, it may use the proceeds for property disposal costs, minor medical construction projects, or costs associated with the transfer or adaptive use of historic VA properties. Use of these proceeds is subject to further congressional action.

Despite this authority to sell property, VA has not sold any property through its CAF authority. Rather, VA sold one property—the Lakeside Medical Center in Chicago—through its EUL authority.[10] According to VA officials, VA places greater emphasis on entering into EULs, compared to

[9]38 U.S.C. §8118.

[10]The Lakeside VA Medical Center in Chicago was sold under an EUL agreement after VA determined that it was no longer needed. Sales proceeds were $50 million, which included a net present value rental return of $28 million received in 2005 for a 75-year EUL term and an additional $22 million received in 2006, with the actual closing of the sale of the property.

real property sales, in part because VA can enter into EULs with fewer restrictions than under its CAF authority. For example,

- VA may enter into EULs without having to screen the property for homeless use, while property must be screened for homeless use if VA is selling the property under its CAF authority. VA officials indicated that disposing of property under the McKinney-Vento Homeless Assistance Act can be time-consuming and cumbersome, taking an average of 2 years. Under this law, all properties that the Department of Housing and Urban Development deems suitable for use by the homeless go through a 60-day holding period, during which the property is ineligible for disposal for any other purpose. Interested representatives of the homeless submit to the Department of Health and Human Services (HHS) a written notice of their intent to apply for a property for homeless use during the 60-day holding period. After applicants have given notice of their intent to apply, they have up to 90 days to submit their application to HHS, and it has the discretion to extend the time frame if necessary. Once HHS has received an application, it has 25 days to review, accept, or decline the application. Furthermore, according to VA officials, VA may not receive compensation from agreements entered into under the McKinney-Vento Act.

- VA has greater flexibility to use proceeds from EULs compared to proceeds from the sale of property through its CAF authority. While VA has the authority to retain and spend proceeds from EULs without the need for further congressional action, proceeds retained under CAF authority are subject to further congressional action. Furthermore, VA may use EUL proceeds for purposes unrelated to real property, such as providing health care services, which are not permitted under VA's CAF authority. VA officials also said that EULs allow VA to realign its asset portfolio in a way that supports its mission by using EULs to obtain facilities, services, in-kind consideration, or revenue for VA requirements that would otherwise be unavailable or unaffordable. The officials added that local and state governments, veterans groups, private partners, and nonprofit entities and other community members potentially benefit when these properties are redeveloped to provide new services and economic opportunities to veterans and the community. VA produces an annual report that discusses and tracks the benefits of its active EULs for the past fiscal year.

Despite VA's preference for using EULs, VA officials said that implementing an EUL agreement can take a long time—anywhere from 9 months to 2 years. According to VA, each EUL is unique and involves a learning process. In addition, VA officials commented that the EUL process can be complicated. The officials noted that land due diligence requirements (such as environmental and historic reviews), public

hearings, congressional notification, lease drafting, negotiation, and other phases contribute to the length of the overall process. VA has taken actions to reduce the time it takes to implement an EUL agreement, but despite changes to streamline the EUL process, some officials stated that it is still time consuming and cumbersome.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other members of the Committee may have.

For future contacts regarding this statement, please contact David Wise at (202) 512-2834 or wised@gao.gov. Contact points for our Offices of Congressional Relations and Public Relations can be found on the last page of this statement. Mike Clements, Assistant Director; Bob Homan; Tara Jayant; Susan Michal-Smith; and Alywnne Wilbur also made key contributions to this statement.

Appendix I: VA Enhanced-Use Leasing and Capital Asset Fund Authorities

Authority	Description
Enhanced-Use Leases 38 U.S.C. §§ 8161-8169	The Secretary of Veterans Affairs (VA) is authorized to enter into leases for up to 75 years with public and private entities for underutilized and unutilized real property that is under the Secretary's jurisdiction or control. EULs shall be for "fair consideration," (i.e., cash and/or in-kind consideration, such as construction, repair, or remodeling of department facilities); providing office space, storage, or other usable space; and providing goods or services to the department. The authority to enter into EULs terminates on December 31, 2011.
Retention of Proceeds/Enhanced Use Leases 38 U.S.C. § 8165	Expenses incurred by the Secretary of VA in connection with EULs will be deducted from the proceeds of the lease and may be used to reimburse the account from which the funds were used to pay such expenses. The proceeds can be used for any expenses incurred in the development of additional EULs. Remaining funds shall be deposited into the VA Medical Care Collections Fund (see authority below for additional uses of EUL proceeds).
Retention of Proceeds/Enhanced Use Lease Property Consolidated Security, Military Construction and Veterans Affairs Appropriations Act of FY 2009, P.L. No. 110-329, Division E, § 213, 122 Stat. 3574, 3711 (2008)	At the Secretary's discretion, proceeds or revenues derived from EUL activities, including disposal, may be deposited into the "Construction, Major Projects" and "Construction Minor Projects" accounts and used for construction, alterations, and improvements of any VA medical facility.[a]
Disposal of Enhanced Use Lease Property 38 U.S.C. § 8164	If the Secretary of VA determines during the term of an EUL or within 30 days after the end of the lease term that the property is no longer needed by the department, the Secretary is authorized to initiate an action to dispose of the property.
Retention of Proceeds/Disposal of Enhanced Use Lease Property 38 U.S.C. § 8165	Funds received by VA from a disposal of an EUL property are deposited into the VA Capital Asset Fund and may be used to the extent provided for in appropriations acts for property transfer costs such as demolition, environmental remediation, maintenance, and repair; costs associated with future transfers of property under this authority; costs associated with enhancing medical care services to veterans by improving, renovating, replacing, updating or establishing patient care facilities through construction projects; and costs associated with the transfer or adaptive use of property that is under the Secretary's jurisdiction and listed on the National Register of Historic Places (see authority below for additional uses of EUL disposal proceeds).
Retention of Proceeds/Disposal of Enhanced Use Lease Property Consolidated Security, Military Construction and Veterans Affairs Appropriations Act of FY 2009, P.L. No. 110-329, Division E, § 213, 122 Stat. 3574, 3711 (2008)	At the Secretary's discretion, proceeds or revenues derived from EUL activities, including disposal, may be deposited into the "Construction, Major Projects" and "Construction Minor Projects" accounts and used for construction, alterations, and improvements of any VA medical facility.
VA Transfer Authority–Capital Asset Fund 38 U.S.C. § 8118	The Secretary of VA is authorized to transfer real property under VA's control or custody to another department or agency of the United States, to a state or political subdivision of a state, or to any public or private entity, including an Indian tribe until November 30, 2011. The property must be transferred for fair market value, unless it is transferred to a homeless provider. Property under this authority cannot be disposed of until the Secretary determines that the property is no longer needed by the department in carrying out its functions and is not suitable for use for the provision of services to homeless veterans by the department under the McKinney-Vento Act or by another entity under VA's EUL authority.

*This provision has been included in numerous appropriations acts. See the Military Construction and Veterans Affairs Appropriations Act of FY 2009, P.L. No. 110-329, Division E, § 213,122 Stat. 3574, 3711 (2008); the Consolidated Appropriations Act of FY 2008, P.L. No. 110-161, § 213, 121 Stat. 1844, 2270 (2007); the Consolidated Appropriations Act of FY 2005, P. L. No. 108-447, § 117, 118 Stat. 2809, 3293 (2004); and the Consolidated Appropriations Act of FY 2004, P.L. 108-199, § 117, 118 Stat. 3, 371 (2004).

Chairman AKAKA. Thank you very much, Mr. Wise.

Mr. Cullinan.

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

Mr. CULLINAN. Chairman Akaka, Ranking Member Burr, aloha and good morning.

On behalf of the men and women of the Veterans of Foreign Wars, I want to thank you very much for inviting us to participate in today's very important oversight hearing.

In April 1999, GAO issued a report on the challenges VA faced in transforming the health care system. At the time, VA was in the midst of reorganizing and modernizing after the passage of the Veterans' Health Care Eligibility Reform Act of 1996.

The VA then developed a 5-year plan to update and modernize the system, including introduction of system-wide managed care principles, such as the Uniform Benefits Package. In response to the enormous challenges brought about in implementing this plan, VA began the Capital Asset Realignment for Enhanced Services or CARES process. It was the first comprehensive, long-range assessment of the VA health care system's infrastructure needs since 1981.

CARES was a VA systematic dated revenue assessment of its infrastructure that evaluated the present and future demand for health care services, identifying changes that would help meet veterans' needs. The CARES process necessitated the development of actuarial models to forecast future demand for health care and the calculation of supply of care in the identification of future gaps in infrastructure capacity. Throughout the process we continuously emphasize that our support was contingent upon the primary emphasis being in ES, or Enhanced Services, of the CARES acronym.

We wanted to see that VA planned and delivered services in a more efficient manner that also properly balanced the needs of veterans, and for the most part the process did just that. The 2004 CARES decision document gave a broad and comprehensive roadmap for the future.

The strength of CARES in our view is not its being a one-time blueprint, but in the decisionmaking framework that produced it.

It created a methodology for future construction decisions. VA's construction priorities are reassessed annually all based on the basic methodology created to support the CARES decisions. These decisions are created system wide, taking into account what is best for the totality of VA health care and what its priorities should be.

We continue to have strong faith that this basic framework serves the needs of the majority of veterans. Despite its strengths there are certain challenges. While a huge number of projects are underway, a number of these are still in the planning and design phase. As such, they are subject to changes but they have also not received full funding. The Congress and this Administration must continue to provide full funding for the major construction account to reduce this backlog and also to begin funding future construction priorities.

With the twin problems of funding and speed in mind, VA has recently been exploring ways to improve the process. Last year they unveiled the HCCF leasing concept. As we understand it, an HCCF was intended to be an acute care center somewhere in size and scope between a large medical center and a CBOC. It is intended to be a leased facility—enabling a shorter time for it to be up and running—that provides outpatient care. Inpatient care would be provided on a contracted basis, typically in partnership with a local health care facility.

While supportive of more quickly providing greater health care access to veterans on a cost-effective basis, we expressed our concerns with the HCCF concept in the *Independent Budget*, or *IB*. Primarily, we are concerned that this concept—which relies heavily on widespread contracting—would be done in place of needed major construction.

Acknowledging the changes taking place in health care, VA needs to look more carefully before building facilities. Cost plus projected usage must justify full blown medical centers. Leasing is the right thing to do only if the agreements make sense. VA needs to do a better job of explaining to veterans and to Congress what their plans are for every location based on the facts. The ruinous miscommunication that plagued the Denver construction project amply demonstrates this point.

We have seen the importance of leasing facilities with certain CBOCs and Vet Centers, especially when it comes to expanding care to veterans in rural areas. CARES did an excellent job of identifying locations with gaps and care, and VA has continued to refine its statistics, especially with the improved data it is getting from DOD about OEF and OFI veterans.

Providing care to rural veterans is a major challenge for the system, and the expansion of CBOCs and other initiatives can only help. We do believe, however, that much of what will improve access for these veterans will lie outside of the construction process. VA must better use its fee-based care programs, and the recent initiatives passed by Congress, such as the mobile health care vans or the rotating satellite clinics in some areas, are helping to fix the demand problems facing veterans and VA.

Mr. Chairman, this concludes my statement. Again, I thank you and Ranking Member for inviting us to testify here today.

[The prepared statement of Mr. Cullinan follows:]

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

Mr. Chairman and Members of the Committee: On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today.

In April 1999, the Government Accountability Office (GAO) issued a report on the challenges the Department of Veterans Affairs (VA) faced in transforming the health care system. At the time, VA was in the midst of reorganizing and modernizing after passage of the Veterans Health Care Eligibility Reform Act in 1996.

With passage of that bill, VA developed a 5-year plan to update and modernize the system, including the introduction of system-wide managed care principles such as the uniform benefits package. As part of the overall plan, VA increasingly began to rely on outpatient medical care. Technological improvements, improved pharmaceutical options and management initiatives all combined to lessen the need for as many inpatient services. Additionally, the expansion of VA clinics—notably the Community Based Outpatient Clinics (CBOCs)—brought care closer to veterans.

These widespread changes represented a management challenge for VA, GAO argued: "VA's massive, aged infrastructure could be the biggest obstacle confronting VA's ongoing transformation efforts. VA's challenges in this arena are twofold: deciding how its assets should be restructured, given the dramatic shifts in VA's delivery practices, and determining how a restructuring can be financed in a timely manner."

GAO also testified before the House Veterans' Affairs Committee's Subcommittee on Health in March 1999 on VA's capital asset planning process. They concluded that, "VA could enhance veterans' health care benefits if it reduced the level of resources spent on underused or inefficient buildings and used these resources, instead, to provide health care, more efficiently in existing locations or closer to where veterans live." Further, GAO found that VA was spending about 1 in 4 Medical Care dollars on asset ownership with only about one quarter of its then–1,200 buildings being used to provide direct health care. Additionally, the Department had over 5 million square feet of unused space, which GAO claims cost VA $35 million per year to operate.

From these findings, VA began the Capital Asset Realignment for Enhanced Services (CARES) process. It was the first comprehensive, long-range assessment of the VA health care system's infrastructure needs since 1981.

CARES was VA's systematic, data-driven assessment of its infrastructure that evaluated the present and future demands for health-care services, identifying changes that would help meet veterans' needs. The CARES process necessitated the development of actuarial models to forecast future demand for health care and the calculation of the supply of care and the identification of future gaps in infrastructure capacity.

The plan was a comprehensive multi-stage process.

- February 2002—VA announced the results of the pilot program of VISN 12
- August 2003—Draft National CARES Plan submitted to the Undersecretary for Health
- February 2004—16-member independent CARES Commission submits recommendations based upon its review of the Draft Nationals CARES Plan.
- May 2004—VA Secretary announces releases final CARES Decision Document, but leaves several facilities up for further study.
- May 2008—Final Business Plan Study released, completing the CARES process.

Throughout the process, we were generally supportive. We continuously emphasized that our support was contingent on the primary emphasis being on the "ES"—enhanced services—portion of the CARES acronym. We wanted to see that VA planned and delivered services in a more efficient manner that also properly balanced the needs of veterans. And, for the most part, the process did just that.

Our main concern with the plans as they unfolded was the lack of emphasis on mental health care and long-term care. The early stages of the CARES process excluded many of these services for the most part because they lacked an adequate model to project the need for these services in the future.

The CARES Commission called for VA to develop a long-term care strategic plan, to address the needs of veterans and all care options available to them, including state veterans homes. As we discussed in the *Independent Budget*, VA's 2007 Long-Term Care Strategic Plan did not address these issues in a comprehensive manner; going forward, this must be rectified.

The 2004 CARES Decision Document gave VA a road map for the future. It called for the construction of many new medical facilities, over 100 major construction

projects to realign or renovate current facilities, and the creation of over 150 new CBOCs to expand cares into areas where the CARES process identified gaps.

Since FY 2004, 50 major construction projects have been funded for either design or actual construction. Eight of those projects are complete. Six more are expected to be completed by the end of FY 2009, and 14 others are currently under construction. So CARES has produced results.

The strength of CARES in our view is not the one-time blueprint it created, but in the decisionmaking framework it created. It created a methodology for future construction decisions. VA's construction priorities are reassessed annually, all based on the basic methodology created to support the CARES decisions. These decisions are created system-wide, taking into account what is best for the totality of the health care system, and what its priorities should be.

VA's Capital Investment Panel (VACIP) is the organization within the department responsible for these decisions. VA's capital decision process requires the VACIP to review each project and evaluate it using VA's decision model on a yearly basis to ensure that potential projects are fully justified under current policy and demographic information. These projects are assigned a priority score and ranked, with the top projects being first in line for funding.

It is a dynamic process that depoliticizes much of the decisionmaking process. The projects selected for funding are by and large the projects that need the most immediate attention. Because it is a dynamic process, some of the projects VA has moved forward with were not part of the original CARES Decision Document, but they were identified, prioritized and funded through the methodology developed by CARES. We continue to have strong faith that this basic framework serves the needs of the majority of veterans. Despite its strengths, there are certainly some challenges.

First is that the very nature of the report required a large infusion of funding for VA's infrastructure. While a huge number of projects are underway, a number of these are still in the planning and design phase. As such, they are subject to changes, but they have also not received full funding.

This has resulted in a sizable backlog of construction projects that are only partially funded. Were the administration's construction request to move forward, VA would have a backlog in funding for major construction of nearly $4 billion. This means that to just finish up what is already in the pipeline, it would take approximately five full fiscal years of funding—based on the recent historical funding levels—just to clear the backlog.

This Congress and this Administration must continue to provide full funding to the Major Construction account to reduce this backlog, but also to begin funding future construction priorities.

Another difficulty has been the slow pace of construction. Major construction projects are huge undertakings, and in areas—such as New Orleans or Denver—where land acquisition or site planning have presented challenges, construction is slower than we would like. There are, however, many cases where there have been fewer challenges, and when the money was appropriated, construction has moved quickly.

With these twin problems of funding and speed in mind, VA has recently been exploring ways to improve the process. Last year, they unveiled the Health Care Center Facility (HCCF) leasing concept.

As we understand it, the HCCF was intended to be an acute care center somewhere in size and scope between a large Medical Center and a CBOC. It is intended to be a leased facility—enabling a shorter time for it to be up and running—that provides outpatient care. Inpatient care would be provided on a contracted basis, typically in partnership with a local health care facility.

We expressed our concerns with the HCCF concept in the *Independent Budget* (*IB*). Primarily, we are concerned that this concept—which heavily relies on widespread contracting—would be done in lieu of an investment of major construction.

Acknowledging that with the changes taking place in health care VA needs to look very carefully before building new facilities. Cost plus occupancy must justify full blown Medical Centers. But leasing is the right thing to do only if the agreements make sense.

VA needs to do a better job explaining to Veterans and the Congress what their plans are for every location based on facts. The ruinous miscommunication that plagued the Denver construction project amply demonstrates this point.

While promising, the HCCF model presents many questions that need answers before we can fully support it. Chief among these is why, given the strengths of the CARES process and the lessons VA has learned and applied from it, is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one?

We also have major concerns with the widespread contracting that would be mandated by this type of proposal. The lessons from Grand Island, NE—where the local hospital later canceled the contract, leaving veterans without local inpatient care—or from Omaha—where some veterans seeking specialized services are flown to Minneapolis—show the potential downfall of large-scale contracting.

Leasing clinical space is certainly a viable option. It does provide for quicker expansion into areas with gaps in care, and it does provide the Department with flexibility in the future.

But when it is combined with the contracting issue, and presented without information and supporting documentation that is as rigorous or comprehensive as CARES was, it will be difficult for the VFW and the veteran's community to support it.

We have seen the importance of leasing facilities with certain CBOCs and Vet Centers, especially when it comes to expanding care to veterans in rural areas. CARES did an excellent job of identifying locations with gaps in care, and VA has continued to refine its statistics, especially with the improved data it is getting from the Department of Defense about OEF/OIF veterans.

Providing care to these rural veterans is the latest challenge for the system, and the expansion of CBOCs and other initiatives can only help. We do believe, however, that much of what will improve access for these veterans will lie outside the construction process. VA must better use its fee-basis care program, and the recent initiatives passed by Congress—such as the mobile health care vans or the rotating satellite clinics in some areas—are going to fix some of the demand problems these veterans face.

We can always certainly do more, but thanks to the CARES blueprint, VA has greatly improved the ability of veterans around the country to access the care they earned by virtue of their service to this country. And with the annual adjustments and reassessments that account for changes within the veterans' population, we can assure that veterans are receiving the best possible care long into the future.

The VFW thanks you and the Committee for looking at this most important issue.

Chairman AKAKA. Thank you very much, Mr. Cullinan.

Now we will hear from Mr. Cox.

STATEMENT OF J. DAVID COX, R.N., NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Mr. COX. Chairman Akaka and Ranking Member Burr, I greatly appreciate the opportunity to discuss AFGE's concerns about the VA's health care center facility leasing program. I also want to thank the Chairman and Senator Rockefeller for their efforts last year to make the information about this program available to the public.

The leasing program was introduced by former Secretary Peake last year, and it appears that the VA considers leasing as an alternative to construction of new and replacement VA medical centers. The leasing program poses the greatest threat to the VA health care system since its creation. If Congress does not investigate and put the brakes on this program, VA medical centers as we know them today will disappear. Maybe not next year or the year after, but this unique source of health care for our veterans will become extinct by leasing's slow erosion of its core.

How can a 13-page PowerPoint presentation about enhanced leases and large outpatient facilities have a devastating effect on VA medical centers? Because the leasing program is not really about leases; it is about permanently diverting major construction dollars and patient care dollars away from standalone VA hospitals and shifting them to private hospitals. And doing it without Congressional authority. It is about starving VA medical centers of staff, beds, and maintenance in order to support health care cen-

ters—an untested model that has never been used in the public or private sector. It is about an entirely new organizational chart for the VA, one that has these outpatient facilities reporting to private hospitals instead of a VA Medical Center.

I will focus the rest of my remarks on how the leasing program is hurting the facility in my hometown that is especially near and dear to my heart—the W.G. Hefner VA Medical Center in Salisbury, North Carolina—the facility where I worked as a registered nurse for 23 years caring for America's veterans. What happened in Salisbury is a useful roadmap for how not to adapt VA health care to veterans' changing needs.

First, secrecy and exclusion do not work. When Hefner Medical Center Director, Carolyn Adams, announced last year that the acute care, intensive care, and emergency services were being cut, that veterans would be getting most of the inpatient care from private hospitals that do not specialize in veterans' conditions and are already struggling to treat growing numbers of uninsured, the news came as a complete surprise to veterans, employees, and even some Members of Congress.

The facility had recently invested in new operating rooms and intensive care units and had recruited more physicians and nurses. And veterans in Winston-Salem and Charlotte, the proposed sites for health care centers already had large outpatient clinics. Neither Ms. Adams, nor VISN–6 Network Director, Daniel Hoffman, who also played an active role in the proposed plans, included stakeholders in the planning process. When the VA contracted for a study to consider different options for the facility, the study team did not talk to a single veteran using the facility or a single employee providing care.

Second, hospitals with uncertain futures lose staff. And I would refer to that as the Walter Reed Syndrome. Upon receiving the news of proposed cuts in core inpatient services, many of the recently hired physicians and nurses left for more secure jobs.

Third, do not break promises to veterans. After the huge outcry from North Carolina veterans and labor last fall, the VA put its leasing plans on hold promising no cuts in services or staff reductions until 2013. Yet, almost immediately, hiring slowed, renovations stopped, and services were cut. Management is still talking about closing the ER and replacing it with an urgent care facility.

I would like to close by urging this Committee to investigate the impact of the leasing program on the Salisbury VA and other facilities before they are irrevocably weakened and the only remaining option for other veterans is a network of contract hospitals and providers.

As for Salisbury specifically, it is clear that Mr. Hoffman and Ms. Adams are not serving the interests of North Carolina veterans. North Carolina is home to the fourth largest veterans population in this country. Clearly, none of us—and I am surely including the Ranking Member—are interested in having one less VA Medical Center in the State of North Carolina. Yet, management insists on implementing policies that are weakening a full-service, nearly 500-bed VA Medical Center that serves as a hub in North Carolina.

Isn't it far better to plan for the future needs of North Carolina veterans by including lawmakers, veterans receiving this care, and the employees providing this care in the planning process?

Thank you, Mr. Chairman. I will be glad to take any questions.

[The prepared statement of Mr. Cox follows:]

PREPARED STATEMENT OF J. DAVID COX, R.N., NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

The American Federation of Government Employees, AFL–CIO (AFGE) thanks you for the opportunity to testify today on VA medical facility construction, specifically, recent Veterans Health Administration (VHA) plans for medical facility leasing and other contractual arrangements for providing veterans' healthcare. AFGE represents over 160,000 members of the VA workforce, more than two-thirds of whom are on the front lines caring for veterans at VA hospitals, clinics and long term care facilities.

In March 2008, the VA quietly issued a radical new approach to providing inpatient and outpatient facilities: the "Health Care Center Facility Leasing Program" (Leasing Program). Despite its far reaching impact, the VA initially provided veterans' groups with very limited information about the concept and gave no specifics as to when or where it would implemented. Lawmakers in the targeted states and unions representing VHA employees received no initial information about the new program.

The impact of the Leasing Program only became evident after the VA announced its plans to eliminate and/or downsize standalone VA medical centers in several locations, including Denver, CO, and Salisbury, NC, and instead provide services through leasing arrangements with non-VA facilities and standardized, large outpatient facilities called "Health Care Centers." The VA did not disclose its list of 22 proposed sites for enhanced leasing until October 2008; they did so only in response to requests made by Chairman Akaka and Senator Rockefeller.

When faced with strong opposition from lawmakers and stakeholders at several of the proposed sites, the VA appeared to put its leasing plans on hold. However, AFGE has recently received reports that VHA is still actively considering the leasing option for a number of locations in need of new or replacement medical centers.

At some of the sites, the first "warning sign" of the Leasing Program has been a significant reduction in inpatient and emergency room (ER) services. These cuts result in the diversion of a greater number of veterans to non-VA hospitals for inpatient care (at a higher cost to the VA). In addition, veterans with medical and mental health emergencies are forced to use overcrowded emergency rooms at non-VA hospitals that do not specialize in veterans' conditions, and often face enormous medical bills for treatment of non-service-connected conditions.

The loss or imminent loss of core inpatient services sends VA medical centers into a downward spiral:

- Physicians, nurses and other staff leave because of the facility's uncertain future and limited services;
- Due to staff shortages, more patients have to be diverted to non-VA facilities;
- Loss of services also impacts the facility's capacity to conduct diagnostic tests;
- Uncertainty also leads to deferred maintenance and postponement or cancellation of facility upgrades;
- These conditions cause more staff to leave;
- The facility's services become so limited that often, permanent outsourcing becomes the only viable option.

This scenario is all too familiar. In its 2007 study of deteriorated conditions at Walter Reed Army Medical Center, the Congressional Research Service discussed a convergence of events—a "perfect storm"—that led to that crisis: increased demand for services from returning OIF/OEF troops, privatization threats, and a base realignment decision to permanently close the facility. At the VA, the announcement of plans to permanently cut and privatize core hospital services through leasing, coupled with increased demand from returning troops and newly eligible Priority 8s, is having a similar impact.

Health Care Centers provide the perfect vehicle for the "Walter Reed-ization" of the VA because they permanently siphon off the "critical mass" of VA medical centers. The danger they present for VA's unique capacity to treat veterans cannot be overstated. The VA has evolved into a national health care leader because it relies on a single, integrated system that concentrates its resources and expertise to provide comprehensive, high quality, cost effective specialized care in tandem with in-

valuable academic affiliations and specialized research. The VA's teaching mission produces significant benefits for patient care. Similarly, "[b]ecause more than 70 percent of VA researchers are also clinicians who take care of patients, VA is uniquely positioned to move scientific discovery from investigators' laboratories to patient care" (citing 2007 testimony by Dr. Joel Kupersmith before this Committee.)

The Leasing Program utilizes an entirely different and untested delivery model—a model that has not been used by either the private or public sector to date. Currently, VA medical centers operate as the "hub" supporting small, community based outpatient clinics (CBOCs), telehealth, limited fee basis care and other "spokes." In contrast, the only "hubs" available to support the outpatient services provided by Health Care Centers are non-VA hospitals that often struggle financially to serve the general population, including large numbers of the uninsured and underinsured.

Therefore, AFGE urges the Committee to conduct an immediate investigation into the Leasing Program and its impact on VHA and the facilities facing plans for substantial changes in their delivery infrastructure: For example:

Salisbury, NC:

The Hefner VA Medical Center has a 150 acre campus and is centrally located in the state. Originally created after World War II as a large psychiatric facility, the Salisbury VA has evolved into a full service, 484 bed facility that supports several outpatient clinics, long term care and an extensive research program. The Salisbury VA is primarily affiliated with the Wake Forest University School of Medicine/Baptist Medical Center and offers residency training in eight practice areas, and in total has 78 affiliations with academic institutions.

Over the past four years, the Salisbury VA has undergone a significant transformation, including new operating rooms and intensive care units, and recruitment of additional physicians and nurses.

In September 2008, management made a surprise announcement that it was eliminating acute care, intensive care (ICU) and emergency room care (ER) services, to be replaced by leasing arrangements with community hospitals and two new Health Care Centers. The Salisbury VA would retain long-term care and outpatient services and add a mental health center of excellence. Management did not consult with or provide advance notice to veterans' groups or employees. Some members of the North Carolina Congressional delegation were also completely taken by surprise. At the time, stakeholders were not aware that Salisbury was one of the 22 proposed sites for enhanced leasing.

Management stated that this change was justified by an extensive study but would not share the results of the study with stakeholders. Once the study became available, AFGE learned that the contractor reviewed five options, including renovation or expansion of the facility, before reaching its recommendation for leasing, contracting and Health Care Centers. The contractor never met with veterans' groups or front line employees providing the care or their representatives even though it conducted a "two-day stakeholder site visit." Researchers acknowledged that this option "does not promote the inpatient veteran community or culture that veterans value."

In addition, during the same period, the VA put out a $34.5 million bid solicitation for "potential health care sources . . . to provide inpatient hospital medical and surgical services" including personnel, facilities and equipment.

Many of the recently hired physicians and nurses responded to management's announcement by leaving for more secure jobs elsewhere.

After veterans, labor and some lawmakers expressed strong opposition to the leasing plan, the VA appeared to change course. In December 2008, it issued a revised plan that "provides that no changes to the health care delivery services at the Salisbury VA Medical Center will be made until 2013, nor will there be any staff reductions." (VA Press Release dated December 11, 2008).

Despite the VA's commitment, the facility continues to implement policies that are leading to more uncertainty, service reductions and staff resignations. Specifically:

- Management is not filling physician and nurse vacancies on the acute care unit;
- One of the facility's two surgeons has been detailed to a non-patient care unit;
- Recruitment bonuses are not being used to attract new psychiatrists, even though current mental health caseloads are unreasonably large;
- Management has abandoned longstanding renovation plans for one building and converted another building recently renovated for patient care services into office space and an outpatient endoscopy clinic (even though another endoscopy unit in excellent condition is available elsewhere);
- Management has also abandoned plans to remodel the emergency room (ER) and has announced that the ER will be downgraded to an urgent care unit;
- Plans for a new outpatient clinic in Hickory have been canceled;

• There have also been early reports that the facility is facing a large deficit due to the increased use of costly contract care;
• Patient satisfaction scores have recently dropped;
• Due to inadequate nurse staffing, the Medical Unit currently has fewer than 30 beds; previously it had 42 beds;
• Management eliminated the facility's Center for Excellence for Women's Health;

If these policies remain place, the Salisbury VA's "critical mass" will be essentially depleted by 2013, and leasing with non-VA facilities may be the only remaining option.

Denver, CO:

Although this VA medical center is not on the "proposed site" list, in April 2008, the VA canceled longstanding plans for a replacement standalone facility in downtown Denver—plans that evolved through extensive analysis and consensus-building. Instead, veterans would receive care from a mix of VA and University health professionals at leased bed and research towers on the University of Colorado campus. Under the new plan, the size and scope of long term care and mental health programs would be reduced and the facility's spinal cord injury program would be bifurcated into two separate buildings.

Here too, secrecy prevailed. The VA did not consult with members of the Colorado Congressional delegation, veterans or employees prior to reaching its decision to shift major construction dollars away from the existing plan and use them to radically transform the facility. The VA contended that this untested model was the product of reliable data and projections but never made these studies available.

In response to strong opposition from lawmakers and stakeholders, the VA completely reversed itself a year after the initial announcement and reinstated plans for a new standalone, full service VA facility in Denver.

Other locations:

South Texas: Local veterans' groups have sought a standalone VA medical center in the Rio Grande Valley for many years. The VA had other plans for South Texas. Last year, it opened the South Texas Health Care Center, and announced plans for expanded contracts with local hospitals for inpatient and emergency care.

Fargo, ND: This facility is on the "proposed site" list. This month, management reported that a proposal was considered, but then rejected, to move specialty care clinics and Ambulatory Surgery offsite to a large outpatient facility resembling the Health Care Center model. Under this proposal, inpatient care would have been provided to veterans through contracts with non-VA hospitals.

Iron Mountain, MI: Last year, the VA medical center director announced plans to eliminate surgery, intensive care and emergency room services, requiring veterans to use local non-VA facilities or travel to Chicago for VA care. After pressure from Michigan lawmakers and local stakeholders, these plans were put on hold. However, management continues to incrementally erode the facility's capacity: several ICU beds have been closed and plans to downgrade the ER to urgent care are still pending. In addition, uncertainty about the future and unfair human resource policies are causing physicians to leave; the facility currently has no surgeons, requiring contracting out of all surgical procedures.

Northern Indiana: The VA Northern Indiana VA Health Care System has announced plans for Health Care Centers in Fort Wayne and South Bend. "Inpatient medical care will be provided primarily in partnership with community hospitals in Fort Wayne and South Bend." (NIHCS Web site).

Fort Worth, TX: Last year, the VA awarded a contract to build its largest outpatient clinic to date in Fort Worth. It appears to offer a similar array of services as the Leasing Program's Health Care Centers.

AFGE fully supports the VA's efforts to adapt its health care infrastructure to changing patient needs and new technologies. However, the use of secrecy, exclusion and unsupported assumptions based on shoddy research is simply bad policy. This Program may also represent bad law; it appears to be proceeding without adequate statutory authority. The VA contends that one of the Program's selling points is that "[n]o authorizing legislation [is] required to initiate [this] program." VA relies on its existing authority under 38 U.S.C. § 8153 to "make arrangements, by contract or other form of agreement" for the sharing of health-care resources between the VA and other entities.

However, the VA has not offered evidence to support a finding that it has satisfied either test under Section 8153. More specifically, the VA has failed to show that VA resources are not available to provide these services in-house or that leasing is necessary to effectively utilize other health-care resources. In addition, we question whether the VA's intention to use "information and planning" bids to lay the foun-

dation for leasing, as in the case of Salisbury, constitute a valid use of this sharing authority.

The other critical question is whether the VA has the authority to use major construction dollars for an entirely different delivery system without Congressional approval. Although Congress has granted the VA substantial discretion to build and renovate medical facilities, it has not authorized the VA to engage in large scale privatization of its health care system.

RECOMMENDATIONS

AFGE urges greater Congressional oversight of the VA's Leasing Program and other large scale initiatives to shift the bulk of veterans' health care services to non-VA providers. Leasing raises many of the same concerns about the long term impact on this world-class system as Project HERO, which uses a contractor to arrange and manage VA's contract care. (AFGE's concerns about HERO were provided to the Committee following the April 22, 2008 legislative hearing.) The most critical question of all is whether leasing and contract care are truly necessary means of filling gaps in the VA health care system, or whether these gaps are merely the result of misused health care dollars and poor staffing policies, and unnecessary privatization worsens these gaps.

If the VA is truly going to adapt to changing needs and changing times, it must stop operating in secrecy. AFGE and its members on the front lines of VA health care want to work with the VA to develop the most effective options for keeping the system viable. All stakeholders—including veterans' groups, employee representatives and academic affiliates—must be part of the planning process. Congress also needs to play an active, ongoing oversight role in all VA efforts to significantly alter its health care delivery system.

Finally, Congress should oversee research conducted to identify needed changes in the VA's delivery model in order to ensure the neutrality and reliability of these studies. Thank you for the opportunity to presents AFGE's views on this issue.

Chairman AKAKA. Thank you very much, Mr. Cox, for your statement. And since you have been mentioning North Carolina, let me call on Senator Burr for his questions.

Senator BURR. Thank you, Mr. Chairman. I explained to the Chairman that I have a mark-up in 3 minutes down at Armed Services that I need to attend and some appointments that I need to keep, and the Chairman was gracious enough to let me go first.

I am not going to ask questions. I am going to make a statement relative to specifically HCCs because they have been raised. It has been of great interest. I have spent a tremendous amount of time on them. I have worked with General Peake. I have worked with General Shinseki. I have worked with most at the VA.

What I have got here is the budget submission. I think it was referred to earlier that seven of the projects that were ranked got funding this year, and that is pretty much—that is not out of the ordinary. That is the available money to handle the maintenance requests.

Now, you heard two impassioned pleas. One from my colleague from Nebraska; one from my colleague from Georgia. The Nebraska project ranks number 16. That is clearly not one through seven. The Atlanta, Georgia, project ranks number 51. That is clearly not one through seven.

Does that lessen what they said? No, we have got veterans that in some cases are hauling oxygen across a parking lot. But let me assure you that under the process that all of us agree has to be followed because there are projects on here, 59, it is going to be—I'm sorry that we have not got the last panel up. They could tell me how many years it is going to be before they are completed, but I think we all know it is probably not going to be while I am here.

Now, where have we benefited the delivery of health care for veterans if we just queue people in this system without using the flexibility that, in fact, was the CARES recommendation. Let me read it because everybody has referred to CARES.

A finding. "Contracting for care provides VA with the flexibility to quickly add and subtract services to meet the changing veterans' needs contingent on the availability of viable alternatives in the community."

What have we screamed about, those of us from States that have a demographic shift of veterans, "Jeez, VA, Mr. Secretary, what can you do short-term to address the need that we have to deliver care to all these veterans that have moved in?" If we had a stagnant population, I'd agree. Let us do exactly what we are doing and we will get exactly the same outcome.

But, in North Carolina and in other States, we have conditions that are different than they were last year—not 10 years ago. And to be honest, Mr. Cox, when you say there is a new model—referring to the HCCs—never been used in the public or private sector, my god, what is an outpatient clinic with an ambulatory unit attached to a hospital? That is exactly what a HCC is. It is set up to take individuals out of an inpatient setting where health care can deliver a higher quality for less money because there is a higher percentage likelihood that they do not need inpatient care connected to the outpatient procedure.

But in the unlikely nature that a surgeon who does the outpatient procedure says, "something during this process led me to believe I would like to use 24 hours to observe somebody in a controlled setting, let me use the facility here versus transferring him to Asheville, or to Salisbury, or to Durham, or to Fayetteville."

Now, in the case of Fayetteville where there is a new HCC, the referral is not going to be to a community hospital when we have a VA hospital in that community. The likelihood is it is going to be to the VA facility. It doesn't lessen the need for Salisbury, or Asheville, or Durham, or Fayetteville. It begins to compliment the 21st Century delivery system that this Administration, the last Administration, and every Secretary of the Veterans Administration have strived for. And I believe it is the mission of those that have a career at the VA to make sure that our veterans have the best possible care.

If doing something different is wrong, then I am guilty because I have pushed every Secretary since I have been here in this capacity to do everything we can possibly do to meet the needs of veterans across the country. In some cases it is by contracting and using that flexibility because there is no service provided in that rural marketplace. In some cases it is to create new entities like HCCs because we can provide that care closer to where veterans live, avoid displacing them from their family, and not arguing over what the mileage reimbursement rates are. We can't keep up with the price of gasoline so we are never going to hit it in an optimal way.

But at the end of the process having the infrastructure needed, whether it is in Denver where I may have had some disagreements—not on whether we did it or not but how we did it. Not on whether Salisbury is still an integral part of the structure of North

Carolina. It is how we build out to compliment the system that we have got.

If just building standalone hospitals was the delivery of care for the 21st Century, why would every community in the United States be doing it differently? Why would they be building out these entities that provide a higher level of care?

Mr. Chairman, let me end with this. And I have overshot my time.

Health care in the 21st Century has to be about educating people how to stay well—even veterans who are susceptible to needing treatment for certain things. A hospital setting is not a place to do that. It is done through outpatient facilities. It is done through medical homes. Medical homes are not created through emergency rooms. Medical homes are established with the confidence that an individual has in a health care professional. And when that bond is established, the education begins.

I think we all know that if we want to bring down the overall cost of health care and raise the outcome, then we have got to bring prevention and wellness and disease management into the VA system, just like we do the private sector. You are not going to do that through an emergency room, though trauma facilities are important to this country's veterans and we will have them.

But do not throw something overboard that fills out and compliments the health care system just because we have got a concern that it is leased and not owned. Or we have a concern that we are duplicating an area that already has a CBOC. As a matter of fact, we just completed the Charlotte CBOC less than a year ago. And the amazing thing is on the day that I was down there to shove the first pound of dirt, we all knew that it was not big enough. When we decided to build the CBOC in Charlotte, we estimated there were 125,000 underserved veterans in the metropolitan area of Charlotte, some 45 miles to Salisbury. We could not get them to Salisbury.

If I'm not mistaken, the 290,000 square foot HCC in Charlotte, North Carolina, will not replace the CBOC; it is going to be in addition to the CBOC. And I would be bold enough to say today that 290,000 square feet plus the CBOC is not enough to meet the needs of the veterans' population that we are going to reach out to in northern South Carolina and southern North Carolina. And it is not going to have an effect on how many people end up utilizing Salisbury. It is going to mean that we are delivering care to that many more veterans. And hopefully, we are doing it in the most effective way that we can.

I want to thank all three of you for your willingness to be here today. I want to thank the Chairman for what I think is a vital hearing. And I want to thank him for his generosity of letting me go first.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Burr, for your statement.

I would like to ask all of you—the three of you—this question. And it has to do with BRAC. BRAC has its own identity. The question is would VA benefit from a BRAC-like process which would bundle a variety of recommendations into one package?

I would like to hear from each of you. Mr. Wise, would you begin?

Mr. WISE. Mr. Chairman, the subject of our report that I testified about really dealt with the issue of property management among a number of Federal agencies of which VA is one. We did not address qualitative aspects of realignment of VA resources. From the Enhanced Use Lease perspective, it is reasonable to assume that if you can reallocate resources from maintenance of unneeded or underutilized property and transfer them into providing services to veterans, this should be a plus for overall care for the veteran population.

Chairman AKAKA. Mr. Cullinan.

Mr. CULLINAN. Thank you, Mr. Chairman.

The VFW certain agrees that there are facilities out there that are not doing the job anymore—they are outdated. In fact, they bog down the system. They consume resources that could be better applied. However, at this stage we would continue to argue that the best course of action would be to go on a case-by-case basis in addressing these facilities. A key element here is to communicate to the veteran population.

In an instance where VA is going to do away with an outdated medical center, for example, what is essential then is for VA to determine what is necessary to take that facility's place with respect to appropriately providing health care services to veterans and then letting that veteran population know about it. Tell them in advance. Before it is announced that something is going to be taken away, let them know what is coming. In place of this outdated VA medical facility, we are going to provide three CBOCs or two HCCs to provide better care in a more accessible manner. And we think that would go a long way to addressing this. We are not quite at the BRAC stage yet, we hope.

Thank you.

Chairman AKAKA. Mr. Cox.

Mr. COX. Mr. Chairman, AFGE would be opposed to some process that, like BRAC, has been used for the military, or VA. We agree also that you need to look State-by-State, facility-by-facility, at the needs of those veterans. Obviously, I believe, the needs of veterans in Alaska and with the vast population is going to vary with the needs of veterans in North Carolina. I mean, what is happening in North Carolina is, yes, we are building a large health center in Charlotte at the expense of closing a full fledged VA Medical Center in Salisbury.

Those are real issues that I think have to be looked at. How do you close VA medical centers and create outpatient clinics when a medical center is a hub of the operations of any health care system?

Chairman AKAKA. Thank you. Mr. Cullinan, I know that VA's construction process is something that you have been keeping your eye on for quite a while.

Mr. CULLINAN. Yes, sir.

Chairman AKAKA. What are the biggest challenges for VA at this time? And how should those challenges be addressed?

Mr. CULLINAN. It is one of the things that we just talked about really. It has to do with VA letting veterans know what it is going

to do—I am referring to VA as if it were a sentient being—but letting the veterans know what they intend to do for them to provide proper health care services.

The other issue, of course, is what to do with facilities that have served their purpose because they are outdated, because of shifting demographics. You know, the patient loads have moved elsewhere.

Another huge issue, of course, is providing for rural veterans. I mean, that is something right now—there are parts of the country where not only is there no infrastructure, there simply are no providers. The responses to this has to do with providing satellite clinics, you know, vans, all the rest of it. But the key issue is letting veterans know what it is going on—what VA intends to do for them.

Chairman AKAKA. Thank you. Mr. Cox, VA has requested over $1.9 billion for fiscal year 2010 for its construction projects, and also faces a huge backlog of projects yet to be completed. What recommendations would you make to Congress about building versus leasing facilities?

Mr. COX. Mr. Chairman, I would make the same recommendation I believe about homeownership. We all prefer to own our homes versus to rent homes. And when the VA builds medical centers, owns these clinics and various things of that nature, it is the VA's property. They have a pride in it. They take care of it. It is operated for veterans, and probably about 50 percent of the people that work in it are veterans. It creates that community that veterans so often seek. Many studies have shown that.

We need to be building and owning VA facilities. With leasing you lose sight of the veterans and they are just mainstreamed into a health care system that is already struggling greatly in this country. The care of veterans is very, very unique. And I also believe veterans deserve first priority when it comes to care in this country, sir.

Chairman AKAKA. Thank you for that response.

Mr. Wise, what are the pros and cons of using Enhanced Use Leases? And how does VA's use of them compare with that of other Federal agencies?

Mr. WISE. Mr. Chairman, I think from the perspective of the Veterans Administration, a plus for using enhanced use leasing is it gives the VA a bit more flexibility compared to other forms of property disposal for underutilized or unutilized property. Thus, there are some advantages from the VA's perspective in that the VA has more certainty that it will be able to retain the proceeds and ability to do more with the retention of the proceeds.

As far as comparison with other agencies, the picture is varied. Each agency is governed by a different state. The majority of the agencies we looked at do have some authority to retain proceeds, but it varies somewhat from agency to agency.

As you may know a bill that has been introduced in the House of Representatives that is intended to standarize the proceeds retention procedures for agencies.

Chairman AKAKA. I thank you for that. Let me ask my final question. I have other questions that I will submit.

For each of you, how significant of a role should community input and outside review play in the VA construction process? We have

been talking about transparency and you have mentioned this. And what are the potential pitfalls of a system that is not completely transparent?

Mr. Wise?

Mr. WISE. Mr. Chairman, from the perspective of enhanced use leasing, there are requirements and provisions that go into developing these leases that take into account certain community needs and other factors relevant to Administration enhanced use leases.

Chairman AKAKA. Mr. Cullinan?

Mr. CULLINAN. Thank you, Mr. Chairman.

We believe that local involvement is essential to the process with respect to determining true need. Who knows better what their needs are than the potential patients or customers of the VA system.

It also has to do with expectations—letting the veteran population in this case know what they can expect—what the outcome will be of a new facility, of an alteration, of a mission change in a facility.

And finally, it helps very much in the end once all of these things are done in the political process. You are not going to have the outcries and outrage that are sometimes expressed due not to a bad plan necessarily, but of the fact that it is just misunderstood. So, in terms of establishing true need and involving them in the process early on to avoiding unnecessary problems, we think it vital.

Chairman AKAKA. Thank you.

Mr. Cox?

Mr. COX. Seeking the input of the veterans, the employees who take care of the veterans, is essential to any process, as well as the community. And also, from Members of Congress.

I have to share with you, Mr. Chairman, Congressman Mel Watt read in the newspaper about the Salisbury VA Medical Center and that was the first time he was informed that a medical center in his district was being closed and turned into an outpatient clinic. He had no knowledge. And I think, certainly, involving the Members of Congress is very, very important to the process, as it does create a transparency.

Chairman AKAKA. Well, I want to thank all of our witnesses for appearing today. The VA's construction process and priorities are important to all of us. There is a lot of money at stake in these decisions, and the system needs to be transparent to the public.

VA construction projects have a great impact on so many of our veterans, and therefore, your input is very, very much appreciated.

As a follow up to this hearing, I will be asking GAO for a global review of the CARES process with a detailed analysis of all of the proposals.

Again, I want to say thank you very much for being here.

[Whereupon, at 11:16 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF JOY ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: The Disabled American Veterans (DAV) is pleased to submit testimony in conjunction with the Committee's oversight hearing to examine the Department of Veterans Affairs (VA) construction process. We appreciate the opportunity to offer our views on progress by VA in delivering on the recommendations outlined in the 2004 Capital Asset Realignment for Enhanced Services (CARES) report, and to discuss the future of VA's health care infrastructure.

As we near the end of the first decade of the 21st century, we find ourselves at a critical juncture with respect to how VA health care will be delivered and what the VA of the future will be like in terms of its health care facility infrastructure. Although admittedly this vision is yet to gain clarity, one fact is certain—our Nation's sick and disabled veterans deserve and have earned a stable, accessible VA health care system that is dedicated to their unique needs and can provide high quality, timely care where and when they need it.

CARES BEGINS

Mr. Chairman, VA initiated CARES in 1999 with a pilot program in Veterans Integrated Service Network (VISN) 12, through the auspices of a contract with the firm of Booz Allen Hamilton. In 2001, that contract was canceled and VA integrated the CARES process within its own staff and other resources. The process took years to complete and required tens of thousands of staff-hours of effort and millions of dollars in studies. At its conclusion, with issuance of the so-called "Draft National CARES Plan," the VA Secretary chartered and appointed a CARES Commission to independently evaluate and consider its outcomes and recommendations. These processes were largely conducted and reported in public.

As a general principle, the *Independent Budget* Veterans Service Organizations (IBVSOs)—DAV, AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States—concluded that CARES was a comprehensive and fully justified road map for VA's infrastructure needs, as well as a model that VA could apply periodically to assess and adjust those priorities. However, once the Draft National CARES Plan was released in 2004, an immediate backlash developed to the proposed recommendations affecting the operating missions of a number of VA facilities. Many veterans, fearful that they would lose VA health care services, and selected Members of Congress, opposed the plans for changes in their States—and in their VA facilities, irrespective of the validity of the findings or the value of the plan as a whole. Local political pressure became intense, and in many cases the proposed CARES recommendations were scuttled. In one respect, it became clear that veterans and their Members of Congress were passionate and committed in keeping targeted VA facilities intact. Unfortunately, this passionate defense of the status quo stymied the CARES implementation phase, and caused VA to become much more reserved about sharing information about any strategic infrastructure planning.

CARES STALLED

Upon completion of the Draft National CARES Plan in 2004, then-VA Secretary Anthony Principi testified before the House Veterans' Affairs Subcommittee on Health. His testimony noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical infrastructure and enhance veterans' access to care." VA reports that through fiscal year (FY) 2009, Congress has appropriated $4.9 billion for construction projects since FY 2004.

On May 20, 2008, while not declaring CARES officially "dead," then-VA Secretary James Peake spoke at the National Press Club and indicated, in answer to a question, that VA would be looking at factors beyond CARES to determine its future capital infrastructure planning needs. On July 18, 2008, Secretary Peake wrote to two Members of Congress that the planned Denver, Colorado, replacement VA medical center was ". . . not affordable . . ." as a traditional government-owned, VA-operated facility of the size, scope and price that had been designed.

For nearly a decade, the IBVSOs have argued that the VA must be protected from deterioration of its health infrastructure, and the consequent decline in VA's capital asset value. Year after year, we have urged Congress and the Administration to ensure that appropriated funding is adequate in VA's capital budget so that VA can properly invest in its physical assets, protect their value, and ensure health care in safe and functional facilities long into the future. Likewise, we have stressed that VA's facilities have an average age of more than 55 years; therefore, it is essential that funding be routinely dedicated to renovate, repair, and replace VA's aging structures, capital, and plant equipment systems as needed.

CAPITAL FUNDS DEFICIT WORSENED UNDER CARES

Mr. Chairman, unfortunately, the past decade of deferred and underfunded construction budgets has meant that VA has not adequately recapitalized its facilities, now leaving the health care system with a large backlog of major construction projects totaling between $6.5 billion to $10 billion, with an accompanying urgency to deal with this growing dilemma.

One of the reasons VA's construction backlog is so large and growing today is because both VA and Congress, by agreement with the two prior Administrations, allocated little to no capital construction funding during the pendency of the CARES process, over a six-year period. Agreeing with VA, the Appropriations Committees in both chambers provided few resources during the initial review phase, preferring to wait for CARES results, a decision the IBVSOs repeatedly opposed. We argued that a de facto moratorium on construction was unnecessary because a number of these projects obviously warranted funding, and would almost certainly be validated through the CARES review process. The House agreed with our views as evidenced by its passage of H.R. 811, the "Veterans Hospital Emergency Repair Act." That bill passed unanimously on March 27, 2001, about two years into the CARES process. Let me quote, in part, what the bill's sponsor, then Chairman Christopher H. Smith, had to say in introducing H.R. 811 over eight years ago:

> Mr. Speaker, for the past several years, we have noted that the President's annual budget for VA health care has requested little or no funding for major medical facility construction projects for America's veterans. As we indicated last year in our report to the Committee on the Budget on the Administration's budget request for fiscal year 2001, VA has engaged in an effort through market-based research by independent organizations to determine whether present VA facility infrastructures are meeting needs in the most appropriate manner, and whether services to veterans can be enhanced with alternative approaches. This process, called "Capital Assets Realignment for Enhanced Services," or "CARES," has commenced within the Department of Veterans Affairs, but will require several years before bearing fruit. In the interim, Mr. Speaker, some VA hospitals need additional maintenance, repair and improvements to address immediate dangers and hazards, to promote safety and to sustain a reasonable standard of care for the Nation's veterans. Recent reports by outside consultants and VA have revealed that dozens of VA health care buildings are still seriously at risk from seismic damage. The buildings at American Lake [Washington] damaged in yesterday's earthquake were among those identified as being at the highest levels of risk.
>
> Also, Mr. Speaker, a report by VA identified $57 million in improvements were needed to address women's health care; another report, by the Price Waterhouse firm, concluded that VA should be spending from 2 percent to 4 percent of its "plant replacement value" (PRV) on upkeep and replacement of its health care facilities. This PRV value in VA is about $35 billion; thus, using the Price Waterhouse index on maintenance and replacement, VA should be spending from $700 million to $1.4 billion each year. In fact, in fiscal year 2001, VA will spend only $170.2 million for these purposes.
>
> While Congress authorized a number of major medical construction projects in the past three fiscal years, these have received no funding through the appropriations process. I understand that some of the more recent deferrals of major VA construction funding were intended to permit

> the CARES process to proceed in an orderly fashion, avoiding unnecessary spending on VA hospital facilities that might, in the future, not be needed for veterans. I agree with this general policy, especially for those larger hospital projects, ones that ordinarily would be considered under our regular annual construction authorization authority. We need to resist wasteful spending, especially when overall funds are so precious. But I believe that I have a better plan.

To our regret, the Senate never considered the proposed bill, Congress did not appropriate supportive funding, and the construction and maintenance backlog continued to grow unabated for the next several years. Incidentally, the needed infrastructure improvements for women veterans (for privacy, restroom accommodations, etc.) mentioned by Representative Smith, were largely never made. The VA projects that the number of women veterans turning to VA for care will likely double in the next 2–4 years; therefore, it is essential that these infrastructure needs are addressed now.

Another area of concern is VA research capital infrastructure. Over the past decade, minimal funding has been appropriated or allocated to maintain, upgrade or replace aging VA research facilities. Many VA facilities have run out of adequate research space. Plumbing, ventilation, electrical equipment and other required maintenance needs have been deferred. In some urgent cases, VA medical center directors have been forced to divert medical care appropriations to research projects to avoid dangerous or hazardous situations.

The 2003 Draft National CARES Plan (DNCP) included $142 million for renovation of existing research space and to cover build-out costs for leased research facilities. However, these capital improvement costs were omitted from the VA Secretary's final report on CARES, the so-called "CARES Decision Memorandum." According to Friends of VA Medical Care and Health Research (FOVA), over the past decade, only $50 million has been spent on VA research construction or renovation in VA's nationwide research system. Additionally, FOVA noted in its fiscal year 2010 budget proposal, endorsed by DAV, that VA was congressionally-directed to conduct a comprehensive review of its research facilities and report to Congress on the deficiencies found, with recommended corrections. During FY 2008, the VA Office of Research and Development initiated a three-year examination of all VA research infrastructure to assess physical condition, capacity for current research, as well as program growth and sustainability of the space to conduct research. We urge the Committee to consider this report when completed, and for Congress to address VA's research facilities improvement needs as part of a separate VA research infrastructure appropriation. VA's Medical and Prosthetic Research program is a national asset to VA and veterans—it helps to ensure the highest standard of care for veterans enrolled in VA health care, and elevates health care practices and standards in all of America's health care. That program cannot continue its record of achievement without adequate maintenance of the capital infrastructure in which it functions.

CARES PROJECTION MODEL

One of the strengths of the CARES process was that it was not just a one-time snapshot of needs. As part of the process, VA developed a health care projection 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 projection model throughout its capital planning process, basing all projected capital projects upon the results of the demand model.

VA's model, also relied on for VA health care budget, policy and planning decisions, produces 20-year forecasts in demand for VA health services. It is a complex and sophisticated model that adjusts for numerous factors, including demographic shifts, morbidity and mortality, changing needs for health care based on aging of the veteran population, projections to account for health care innovations, and many other relevant factors.

In a November 2007 House Veterans' Affairs hearing before the Subcommittee on Health, VA's testimony summed up the process:

> Once a potential project is identified, it is reviewed and scored based on criteria VA considers essential to providing high quality services in an efficient manner. The criteria VA utilizes in evaluating projects include service delivery enhancements, the safeguarding of assets, special emphasis programs, capital asset priorities, departmental alignment, and financial priorities. VA considers these new funding requirements along with existing CARES decisions in determining the projects and funding levels to request

as part of the VA budget submission. Appropriate projects are evaluated for joint needs with the Department of Defense and sharing opportunities.

VA uses these evaluation criteria to prioritize its projects each year, releasing these results in its annual five-year capital plan. The most recent one, covering fiscal years 2009—2013, is part of the Congressional budget submission in "Volume III: Construction Activities." This plan is central to VA's funding requests and clearly lists the Department's highest construction priorities for the current year, as well as for the immediate future.

VA MOVING IN NEW DIRECTION

Mr. Chairman, over the past several years, VA began to discuss with the veterans service organization community, its desire to address its health infrastructure needs in a new way. VA acknowledged its challenges with aging infrastructure; changing health care delivery needs, including reduced demand for inpatient beds and increasing demands for outpatient care and medical specialty services; limited funding available for construction of new facilities; frequent delays in constructing and renovating space needed to increase access, and particularly the timeliness of construction projects. VA has noted, and we concur, that a decade or more is required from the time VA initially proposes a major medical facility construction project, until the doors actually open for veterans to receive care in that facility. VA indicated to us a necessity to consider alternative means to address the growing capital infrastructure backlog and the significant challenge of funding it.

Given these significant challenges, VA has broached the idea of a new model for health care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF proposal, in lieu of the traditional approach to major medical facility construction, VA would obtain by long-term lease, a number of large outpatient clinics built to VA specifications. These large clinics would provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

VA noted, that in addition to its new HCCF facilities, it would maintain its VA medical centers (VAMCs), larger independent outpatient clinics, community-based outpatient clinics (CBOCs) and rural outreach clinics. VA has argued that the HCCF model would allow VA to quickly establish new facilities that will provide 95 percent of the care and services veterans will need in their catchment areas, specifically primary care, and a variety of specialty services, mental health, diagnostic testing and same-day ambulatory surgery. According to VA, veterans' inpatient hospital services needed by these HCCFs would be provided through additional leases, VA staffed units, or other contracts or fee-for-service options with academic affiliates or in available community hospitals.

We concur with VA that the HCCF model seems to offer a number of benefits in addressing its capital infrastructure problems including more modern facilities that meet current life-safety codes; better geographic placements; increased patient safety; reductions in veterans' travel costs and increased convenience; flexibility to respond to changes in patient loads and technologies; overall savings in operating costs and in facility maintenance and reduced overhead in maintaining outdated medical centers.

CHALLENGES TO HCCF MODEL

Nevertheless Mr. Chairman, while it offers some obvious advantages, the HCCF model also portends obvious challenges. Outside the CBOC environment, contract management in complex leased health care facilities is an untested practice in VA. Congress has spent years overseeing efforts to improve VA's contracting performance across a range of activities, including obtaining contract health care for eligible veterans. Also, we are deeply concerned about the overall impact of this new model on the future of VA's system of care, including the potential unintended consequences on continuity of high-quality care, delivery of comprehensive services, VA's electronic health record (EHR), its recognized biomedical research and development programs, and particularly the impact on VA's renowned graduate medical education and health professions training programs, in conjunction with longstanding affiliations with nearly every health professions university in the Nation. Additionally, we question VA's ability to provide alternatives for maintaining its existing 130 nursing home care units, homeless programs, domiciliaries, compensated work therapy programs, hospice, adult day health care units, the Health Services Research and Development Program, and a number of other highly specialized services including 24 spinal cord injury centers, 10 blind rehabilitation centers, a variety of unique "centers of excellence" (in geriatrics, gerontology, mental illness, Parkinson's, and multiple sclerosis), and critical care programs for veterans with serious

and chronic mental illnesses. We question if VA has seriously considered the probable impact on these programs in developing the HCCF concept.

In general, the HCCF proposal seems to be a positive development, with good potential. Leasing has the advantage of avoiding long and costly in-house construction delays and can be adaptable, especially when compared to costs for renovating existing VA major medical facilities. Leasing options have been particularly valuable for VA as evidenced by the success of the leased space arrangements for many VA community-based outpatient clinics and Vet Centers. However, VA has virtually no experience managing as a tenant in a building owned by others, for the delivery of complex, subspecialty VA health care services.

INPATIENT SERVICES: A MAJOR CONCERN

The IBVSOs are also concerned with VA's plan for obtaining inpatient services under the HCCF model. VA says it will contract for these essential inpatient services with VA affiliates or community hospitals. First and foremost, we fear this approach could negatively impact safety, quality and continuity of care, and permanently privatize many services we believe VA should continue to provide. We have testified on this topic numerous times, and the IBVSOs have expressed objections to privatization and widespread contracting for care in the "Contract Care Coordination" and "Community Based Outpatient Clinics" sections of the *Fiscal Year 2010 Independent Budget*. We call the Committee's attention to those specific concerns.

Mr. Chairman, in November 2008, VA responded to yours and Senator Rockefeller's request for more information on VA's plans for the newly proposed HCCF leasing initiative. To summarize that response, VA advised it originally identified 22 sites that could potentially be considered appropriate for adoption of the HCCF concept. Following additional analysis, that number was reduced to eight potential sites for review, including Butler, Pennsylvania; Lexington, Kentucky; Monterey and Loma Linda, California; Montgomery, Alabama; and Charlotte, Fayetteville and Winston-Salem, North Carolina.

VA also addressed a number of other specific questions in the November 2008 letter, including whether studies had been carried out to determine the effectiveness of the current approach; the full extent of the current construction backlog of projects, and its projected cost over the next five years to complete; the extent to which national veterans organizations were involved in the development of the HCCF proposal; the engagement of community health care providers related to capacity to meet veterans' needs; the ramifications on the delivery of long-term care and inpatient specialty care; and whether VA would be able to ensure that needed inpatient capacity will remain available.

I will comment on some of the key responses from VA related to these noted questions. Initially, it appears VA has a reasonable foundation for assessing capital needs and has been forthright with the estimated total costs for ongoing major medical facility projects. For this year, VA estimated $2.3 billion in funding needs for existing and ongoing projects. The Department estimated that the total funding requirement for major medical facility projects over the next five years would be in excess of $6.5 billion. Additionally, if the new HCCF initiative is fully implemented, VA indicated it would need approximately $385 million more to execute seven of the eight new HCCF leases.

We agree with VA's assertion that it needs a balanced program of capital assets, both owned and leased buildings, to ensure demands are met under the current and projected workload. Likewise, we agree with VA that the HCCF concept could provide modern health care facilities that would not otherwise be available due to the predictable constraints of VA's major construction program.

VA indicated in its letter that the eight sites proposed for the HCCF initiative were chosen to ensure there would be little impact on VA specialty inpatient services or on delivery of long-term care. However, VA made a statement with respect to the HCCF model for the proposed sites that is somewhat confounding (VA's response to question 5), as follows: "By focusing the outpatient needs through HCCF's, major construction funding could then shift to the remaining capital needs." What is not clear to us is the extent to which VA plans to deploy the HCCF model. In areas where existing CBOCs need to be replaced or expanded with additional services due to the need to increase capacity, the HCCF model would seem appropriate and beneficial to veterans. On the other hand, if VA plans to replace the majority or even a large fraction of all VAMCs with HCCFs, such a radical shift would pose a number of concerns for DAV.

Mr. Chairman, before the HCCF concept is permitted to go forward on a larger scale, and with a major private sector component as described by VA, we believe VA must address and resolve a number of challenges. Among these questions are:

• Facility governance, especially with respect to the large numbers of non-VA employees who would be treating veterans;
• VA directives and rule changes that govern health care delivery and ensure safety and uniformity of the quality of care;
• VA space planning criteria and design guides' use in non-VA facilities;
• VA's critical research activities, most of which improve the lives not only of veterans but of all Americans;
• VA's electronic health record, which many observers, including the President, have rightly lauded as the EHR standard that other health care systems should aim to achieve; and
• Continuity of care within the mix of public/private facilities, as well as for those VA-enrolled veterans who relocate to other areas from the HCCF environment.

Fully addressing these and related questions are important, but we see this challenge as only a small part of the overall picture related to VA health infrastructure needs in the 21st century. The emerging HCCF plan does not address the fate of VA's 153 medical centers located throughout the Nation that are on average 55 years of age or older. It does not address long-term care needs of the aging veteran population, treatment of the chronically and seriously mentally ill, the unresolved rural health access issues, or the lingering questions on improving VA's research infrastructure.

HISTORY AS A LESSON FOR THE FUTURE

Today's VA largely was built during and immediately following World War II, to become an exalted place of care for over 500,000 injured war veterans. Some of those wounded remained hospitalized in VA for the remainder of their lives. VA's spinal cord injury, blind rehabilitation and prosthetics and sensory aids programs got their genesis or major expansions from World War II veterans' needs. In 1946, Congress established the Department of Medicine and Surgery (DM&S), now the Veterans Health Administration, and gave DM&S many independent powers that other Federal agencies lacked, in order to care for those wounded heroes. DM&S Memorandum No. 2 formed the VA-medical school affiliation relationships, to guarantee the young and energetic physicians-in-training of that age would turn their full attention to wounded and ill veterans. In conjunction with new affiliations, VA made a collective decision to locate its new post-war VA hospitals nearby or alongside existing medical schools' academic health centers for the potential symbiotic effect and to help ensure a high-quality physician workforce remained available to sick and disabled veterans. VA's biomedical research and development programs and its remarkable academic training programs we see in practice today emerged out of these seminal decisions and have become instrumental in both aiding VA with stronger academic credentials, advancing evidence-based treatments, and promoting a higher standard of care for wounded and sick veterans. Even with the advent of primary care and VA's other transformations during the past decade, this cooperative VA-academic system of care is still largely intact more than 60 years after World War II.

Mr. Chairman, as Congress considers the future of VA's infrastructure, and VA's future overall, it is good to remember our history, and to learn from it. Today, the Nation confronts two wars that, when concluded, will have likely produced over two million new veterans. While early in the process, we know from VA that already more than 400,000 of them have contacted VA for health care, for conditions ranging from post-deployment mental health conditions to minor musculoskeletal problems to severe brain injury with multiple amputations. No less than earlier generations and probably more so, these veterans will need VA to be sustained for them. The question that confronts the Committee today is—what that VA system is going to be, what it will offer, and how it will be managed and sustained. We in the veterans service organization community cannot plan the future VA, and we would not expect your Committee to do so independently. Given the President's pledge to create the VA of the 21st century; however, we do expect that VA should be mandated to establish its plan in a transparent way, vet that plan through our community and other interested parties, and provide its plan to Congress. We hope that all our communities (both inside and outside VA) share our concerns and want to help VA mold a strategic capital plan that all can accept and help collectively to accomplish. However, until this process materializes, we fear that VA's capital programs and the significant effects on the system as a whole and on veterans individually, will go unchanged, ultimately risking disaster for VA and for America's sick and disabled veterans.

AVOIDING THE OBVIOUS

As we grapple with the issue of health care and insurance reform in America, we must make every effort to protect the VA system for future generations of sick and disabled veterans. A well thought-out capital and strategic plan is urgently needed, and the tough decisions must be made, not avoided as in the response to the seemingly aborted CARES process. We are pleased the current Administration has committed to building the VA of the 21st century. However, we are not sure what this may mean, nor do we have the value of a VA comprehensive infrastructure plan. Regardless of the direction VA takes, we must insist there is consideration of all the elements we have described throughout our testimony. Critical elements in VA make up what are considered by all accounts the "best care anywhere" in the United States. We want to ensure VA's infrastructure plan maintains the integrity of the VA health care system, and all the benefits VA brings to its enrolled population. We want to ensure care is not fragmented and that high quality, safe health care remains the bulwark of VA's programs.

CARES: AN UNFULFILLED VISION

Mr. Chairman, hitting its apex in 2004, we at DAV believe CARES provided a solid foundation for, and a valuable assessment of, what VA had in its health care infrastructure portfolio and where VA needed to go, but we ask today, what substantive action has been taken since the release of the CARES report to overhaul the system to make way for the 21st century? Currently VA is planning construction of five major VA medical centers, in Orlando, Florida; Denver, Colorado; Las Vegas, Nevada; Louisville, Kentucky; and, New Orleans, Louisiana. None of the decisions to build these facilities was affected by the CARES process in any way but the most marginal sense. However, the decisions were unquestionably affected by the political process. While VA is addressing these political demands, it is still ignoring similar deficits at facilities such as in Togus, Maine; Sheridan, Wyoming; Wichita, Kansas; East Orange, New Jersey; Hines, Illinois; Mountain Home, Tennessee; Battle Creek, Michigan; and more than 100 other older VA medical centers, some of which are in, or are reaching, dire need for infusion of major infrastructure funding.

VA: AT RISK

At this juncture, we believe VA soon may be in a very precarious situation. Operations Iraqi and Enduring Freedom continue. Each day we see growth in future health care, rehabilitation and post-deployment mental health needs in our newest generation of war veterans, and record demand for VA care by previous generations of disabled veterans. As a Nation, we must be good stewards of taxpayer dollars, yet we must also fulfill the commitment of the Nation to care for those who have suffered illness or injury as a result of military service and combat deployment. Concurrently, the American economy is unstable, Social Security, Medicare and Medicaid are seen by many to be unsustainable if not changed, and the new Administration and Congress are trying to formulate a plan to ensure access to basic health care services for every U.S. resident, and simultaneously reform the private insurance system. Changes coming from those trends, and that work, will undoubtedly affect the viability of VA in the future, but it is impossible to know the depth of that impact or its nature. Unfortunately, from what we do know, VA is largely uninvolved in the health care reform debate, and therefore, VA may be negatively impacted by those larger reforms. In our opinion, the VA, as a cabinet agency, cannot be permitted to sit on the sideline of health care reform, but must be proactive and fully engaged in the debate.

ADVOCATES WANT A 21ST CENTURY VA

As advocates for veterans, we do not accept VA's contention that replacing outdated VA facilities is ". . . not affordable." VA's infrastructure needs have been deferred, neglected and delayed for far too long, to the advantage of other consumers of Federal dollars; therefore, without question facility replacements and updating are going to be costly, and both Congress and the Administration are confronted with that reality. The FY 2008 VA Asset Management Plan provides the most recent estimate of VA's needs. Using the guidance of the Federal Government's Federal Real Property Council, the value of VA's infrastructure is just over $85 billion. Accordingly, using industry standards as a yardstick, VA's capital budget should be between $4.25 billion and $6.8 billion annually in order to maintain its infrastructure at that value. VA's capital budget request for FY 2009—which includes major and minor construction, maintenance, leases, and equipment—was $3.6 billion.

The IBVSOs greatly appreciate that Congress provided funding above that level this year by an increase over the Administration's request of $750 million in Major and Minor Construction alone. That higher amount brought the total capital budget for FY 2009 in line with industry standards. We strongly urge that these targets continue to be met and we would hope that future VA requests use standard guidelines as a starting point without requiring Congress to add additional funding. We also are mindful that Congress included nearly $1 billion in the recent economic stimulus package that will fund VA infrastructure improvements and represents a significant re-payment to VA of capital funds it should have received years ago while CARES was underway.

DESIGN THE FUTURE

Congress and the Administration must work together to secure VA's future to design a VA of the 21st century. It will take the joint cooperation of Congress and the Administration to support this reform, while setting aside resistance to change, even dramatic change, when change is demanded and supported by valid data. Accordingly, we urge the Administration and Congress to live up to the President's words by making a steady, stable investment in VA's capital infrastructure to bring the system up to match the 21st century needs of veterans.

COMMUNICATIONS WILL BE KEY TO SUCCESS

Finally, one of our community's pent-up frustrations with respect to VA's infrastructure is lack of information and communication. Communications have been sorely lacking for the past several years, and VA has seemingly resisted keeping us informed of its planning. In the spirit of the President's very first executive order, on the transparency of government, we ask VA do a better job of communicating with our community, enrolled veterans, labor organizations and VA's own employees, local government and their affected communities, and other stakeholders, as the VA capital and strategic planning processes move forward. It is imperative that all of these groups understand VA's "big picture" and how it may affect them. Talking openly and discussing potential changes will help resolve the understandable angst about this complex and important question of VA health care infrastructure. While we agree that VA is not its buildings, and that the patient should be at the center of VA care and concern, VA must be able to maintain an adequate infrastructure around which to build and sustain its patient care system. The time to act is now—our Nation's veterans deserve no less than our best effort.

Thank you, Mr. Chairman and Members of the Committee for allowing DAV to share our views on this critical topic.

○