

DONALD H. ORNDOFF, AIA, DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT

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SENATE VETERANS' AFFAIRS COMMITTEE

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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.