Mr. Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars

STATEMENT OF

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA's CONSTRUCTION BUDGET FOR FISCAL YEAR 2006

WASHINGTON, D.C. FEBRUARY 16, 2005

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. and our Auxiliaries, I would express our deep appreciation for being included in today's important legislative hearing to discuss the budget for the Department of Veterans Affairs (VA). As a constituent member of the Independent Budget for VA, the VFW is responsible for the Construction portion of the VA budget so I will limit today's testimony to that area.

The Department of Veterans Affairs (VA) construction budget includes major construction, minor construction, grants for construction of state extended-care facilities, grants for state veterans' cemeteries, and the parking garage revolving fund. VA's construction budget annual appropriations for major and minor projects decreased sharply to an all-time low in FY 2003. Over the past several years, there has been political resistance to funding of any major projects before the Capital Assets Realignment for Enhanced Services (CARES) process was completed. The prospect of system-wide capital assets realignment through the CARES process continues to be used as an excuse to hold all construction projects hostage.

VA has recently completed another phase of CARES, which is a national process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of its infrastructure and programs. Through CARES, an ongoing process, VA is evaluating the demands for health-care services and identifying changes that will help meet veterans' current and future health-care needs. The CARES process included the development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the supply and identification of current and future gaps in infrastructure capacity. This resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure.

Since the publication of the FY 2005 Independent Budget, the commission has been actively evaluating the DNCP proposed by VA. The CARES Commission report was published in March 2004. The Secretary of Veterans Affairs formally accepted the CARES Commission report with the publication of the Secretary's CARES decision document in July 2004.

Initially, the DNCP market plans included flawed projections for outpatient mental health services and questionable projections for inpatient mental health services. The plans did not include any projections for long-term care other than catastrophic care. Accordingly, the commission recognized the importance of mental health services and long-term care to the veteran population and acknowledged in the CARES Commission report that VA must make modifications to its projections to include mental health services and long-term care.

Also last year, during the initial stages of the CARES process, The Independent Budget veterans service organizations (IBVSOs) suggested that further data be obtained to support various CARES recommendations that would either close or change the mission of some VA facilities. We appreciate then Secretary Principi's efforts in establishing a CARES Implementation Board and the plan to begin further feasibility studies of the 22 VA facilities identified for possible mission adjustments in the secretary's CARES decision document. However, as stakeholders, we would like to remind VA that it is imperative that veterans service organizations remain involved in all phases of this new CARES study, which will be divided into three different segments: a health-delivery study, a comprehensive capital plan, and an excess property plan identifying new land usage or disposal.

Mr. Chairman, we remain supportive of the CARES process as long as the primary emphasis is on the ?ES? portion of the acronym. We understand that the locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the upkeep of inefficient buildings, and to accommodate modern methods of health-service delivery. Accordingly, we concur with VA's plan to proceed with the feasibility study of the remaining 22 facilities contained in the Secretary's decision document.

In light of the Administration's totally inadequate budget request for VA, the IBVSOs are very concerned that Congress may not adequately fund all CARES proposed changes when CARES implementation costs are factored into the appropriations process. This will only further exacerbate the current obstacles impeding veterans' timely access to quality heath care. It is our opinion that VA should not proceed with the final implementation of CARES until sufficient funding is appropriated for the construction of new facilities and renovations of existing hospitals, as deemed appropriate and pertinent.

The VFW and IBVSOs recommend that Congress appropriate, not including funding specific to CARES, $563 million to the Major Construction account for FY 2006. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition and claims, as follows:

Construction, Major Projects Recommended Appropriation
FY 2006 Recommendation by type of service
Medical Program (VHA)
(Dollars in thousands)

Seismic Improvements $315,000
Clinical Improvements $26,250
Patient Environment $10,500
Advance Planning Fund $63,000
Asbestos Abatement $63,000
National Cemetery Administration $85,050
Recommended FY 2006 Appropriation $562,800

The VFW and IBVSOs recommend that Congress appropriate $716 million to the Minor Construction account for FY 2006. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, staff offices account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects:

Construction, Minor Projects Recommended Appropriation
FY 2006 Recommended by Type of Service
Medical Program (VHA)
(Dollars in thousands)
Inpatient Care Support $136,000
Outpatient Care and Support $105,000
Infrastructure and Physical Plant $157,000
Research Infrastructure Upgrade $52,000
Historic Preservation Grant Program $21,000
Other $26,000
Architectural Master Plans Program $100,000
VBA Regional Office Program $36,000
National Cemetery Program $36,000
VA Research Facility Improvement and Renovation $47,000
IB Recommended FY 2006 Appropriation $716,000

It is here painfully evident just how inadequate the administration's VA construction request is as compared to the VFW/IB identified need:

	Difference FY 2006 FY 2005	Admin & Admin	Difference FY 2006 2005	IB & IB	Admin
Construction Programs					
Construction, Major	455,130	607,100	151,970	562,800	-44,300
Construction, Minor	228,933	208,726	-20,207	720,000	511,274
Grants for State Extended Care Facilities	104,322	0	-104,322	150,000	150,000
Grants for Construction of State Vets cemeteries	31,744	32,000	256	37,000	5,000
Subtotal, Construction Programs	820,129	847,826	27,697	1,469,800	621,974

It is equally and most painfully clear that long-term care for veterans is to bear the brunt of the

proposed cutbacks in the budget, including the elimination of federal spending on state-run homes that provide veterans with long-term care. The program, which dates back to the Civil War, received $104 million this fiscal year. The White House plan would also trim nursing home care by $351 million, which would eliminate approximately 5,000 beds in VA-run nursing homes. These cuts, at a time when demand for VA long-term care services is increasing on the rise with a rapidly aging veteran population, are unconscionable and absolutely reprehensible.

In another area, good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs?such as seismic correction, compliance with the Americans With Disabilities Act (ADA) and Joint Commission of Accreditation of Health Care Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES? VA's construction budget continues to be inadequate.

The Independent Budget for Fiscal Year 2005 cites the recommendations of the interim report of the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). That report was made final in May 2003. To underscore the importance of this issue, we again cite the recommendations of the PTF.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64 percent of the $38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2 percent of plant replacement value for its entire facility infrastructure. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the Department of Defense adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

Mr. Chairman, the PTF also recommended that ?an important priority is to increase infrastructure funding for construction, maintenance, repair and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure.?

The PTF goes on to state, ?Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus but instead submits an annual top 20-facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within four years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program.?

The PTF articulates that VA must accomplish three key objectives:

(1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health-care delivery;

(2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and

(3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

We of the IBVSOs concur with the provisions contained in the PTF final report. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services in old and inefficient patient care settings.

Mr. Chairman and distinguished members of the Committee, Congress must ensure that there are adequate funds for the major and minor construction programs so the VHA can undertake all urgently needed projects.

I will here briefly articulate our view that in those instances where no impediment arises in providing veteran's care and services the extensive inventory of historic structures must be protected and preserved. VA's historic structures illustrate America's heritage of veterans' care, and they enhance our understanding of the lives of the soldiers and sailors who have shaped our country. Of the almost 2,000 historic structures VA owns, many are neglected and deteriorate further every year. These structures must be stabilized, protected, and preserved. As the first step in addressing this responsibility, VA must develop a comprehensive national program for its historic properties. Because most heritage structures are not suitable for modern patient care, the Capital Asset Realignment for Enhanced Services planning process did not produce a national preservation strategy. VA must undertake a separate initiative for this purpose immediately.

VA should inventory its historic structures, classify their current physical condition, and evaluate their potential for adaptive reuse by either the medical centers, local governments, nonprofit organizations, or private-sector businesses. To accomplish these objectives, we recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and also with private organizations, such as the National Trust for Historic Preservation. Such expertise should prove helpful in establishing this new program. VA must also expand its limited preservation staffing.

For its adaptive reuse program, VA needs to develop models and policies that will protect historic structures that are leased or sold. VA's legal responsibilities, for example, could be addressed through easements on property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully assisted the Department of the Army in managing its historic properties.

We recommend that specific funds should be included in the FY 2006 budget to develop a comprehensive program with detailed responsibilities for the preservation and protection of VA's inventory of historic properties.

The last issue I will address here today is the view that VA should avoid the temptation to reuse empty space inappropriately. Studies have suggested that the VA medical system has extensive empty space that can be cost-effectively reused for medical services, and that one medical

center's unused space may help address another's deficiency. Although these space inventories are accurate, the basic assumption regarding viability of space reuse is not.

Medical design is complex because of the intricate relationships that are required between functional elements and the demanding requirements of equipment that must be accommodated. For the same reasons, medical facility space is rarely interchangeable. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a second-floor space deficiency because there is no functional adjacency. Medical space has very critical inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care. In order to preserve these relationships, departmental expansions or relocations usually trigger ?domino? effects on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Medical space's permanent features, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading cannot be altered. Different medical functions have different requirements based on these characteristics. Laboratory or clinical space, for example, is not interchangeable with ward space because of the need for different column spacing and perimeter configuration. Patient wards require natural light and column grids that are compatible with room layouts. Laboratories should have long structural bays and function best without windows. In renovation, if the ?shell? space is not suited to its purpose, plans will be larger, less efficient, and more expensive.

Using renovated space rather than new construction only yields marginal cost savings. Build out of a ?gut? renovation for medical functions is approximately 85 percent of new construction cost. If the renovation plan is less efficient or the ?domino? impact costs are greater, the savings are easily lost. Remodeling projects often cost more and produce a less satisfactory result. Renovations are appropriate to achieve critical functional adjacencies, but they are rarely economical.

Early VA centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most hospitals have been consolidated into large, tall ? modern? structures. Over time, these central towers have become surrounded by radiating wings with corridors leading to secondary structures. Many medical centers are built around prototypical ?Bradley buildings.? The VA rushed to build these structures in the 1940s and 1950s for World War II veterans. Fifty years ago, these facilities were flexible and inexpensive, but today they provide a very poor chassis for the body of a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts. The Bradley hospital's central core has a few small elevator shafts that are inadequate for vertical distribution of modern services.

Much of the current vacant space is not situated in prime locations but is typically located in outlying buildings or on upper floor levels. The permanent structural characteristics of this vacant space often make it unsuitable for modern medical functions. VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved. Some space may be suitable for enhanced

use. Some should be demolished. Each medical center should develop a plan to find suitable uses for its non-historic vacant properties.

VA should develop a comprehensive plan for addressing excess space in properties that are not suitable for medical or support functions due to its permanent characteristics or location.

Mr. Chairman and distinguished members of this Committee, this concludes my statement and I will be happy to respond to any questions you may have.