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OF FOREIGN WARS OF THE UNITED STATES

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO
VA'S BUDGET REQUEST FOR FISCAL YEAR 2012

WASHINGTON, D.C.

March 2, 2011

MADAM CHAIRWOMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.1 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. The VFW works alongside the other members of the Independent Budget (IB) – AMVETS, Disabled American Veterans and Paralyzed Veterans of America – to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America's veterans. The VFW is responsible for the construction portion of the IB, so I will limit my remarks to that portion of the budget.

The Department of Veterans Affairs (VA) manages a wide portfolio of capital assets throughout the nationwide system of health-care facilities. According to the latest VA Capital Asset Plan, VA owns 5,405 buildings and almost 33,000 acres of land. It is a vast network of facilities that requires much time and attention from VA's capital asset managers. Unfortunately, VA's infrastructure is aging rapidly. Although Congress has funded a significant number of new facilities in recent years, the vast majority of existing VA medical centers and other associated buildings are on average more than 60 years old.

Aging facilities create an increased burden on VA's overall maintenance requirements. They must be maintained aggressively so that their building systems—electrical, plumbing, capital equipment, etc.—are up to date and that these facilities are able to continue to deliver health care in a clean and safe environment. Older, out-of-date facilities do not just present patient safety issues: from VA's perspective, older buildings often have inefficient layouts and inefficient use of space and energy. This means that even with modification or renovation, VA's operational costs can be higher than they would be in a more modern structure.

VA has begun a patient-centered reformation and transformation of the way it delivers care and new ways of managing its infrastructure plan based on the needs of sick and disabled veterans in the 21st century. Regardless of what the VA health-care system of the future may look like, our focus must remain on ensuring a lasting, accessible, modernized system that is dedicated to the unique needs of veterans while also providing unparalleled and timely care when and where veterans need it.

The Capital Asset Realignment for Enhanced Services (CARES) process, VA's data-driven assessment of current and future construction needs, gave VA a long-term roadmap and has helped guide its capital planning process over the past 10 years. The CARES process developed a large number of significant construction objectives that would be necessary for VA to fulfill its obligation to sick and disabled veterans. Over the past several years, the Administration and Congress have made significant inroads in funding these priorities. Since fiscal year (FY) 2004, \$5.9 billion has been allocated for these projects.

The Independent Budget veterans service organizations believe that CARES was a necessary undertaking and that VA has made slow but steady progress on many of these critical projects. In the post-CARES era, many essential construction projects are still awaiting authorization and funding, and the IBVSOs firmly believe that Congress cannot allow the construction needs that led to the CARES blueprint to be disregarded. Both strong oversight and sufficient funding are critical in this ongoing task of maintaining the best care for veterans.

Given the challenges presented by the CARES blueprint, including a backlog of partially funded construction projects, high costs of individual projects, and our concern about the timeliness of these projects—noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans' care—VA has proposed a new program, named "Strategic Capital Investment Planning" (SCIP). This initiative will address some of the infrastructure issues that have been noted in The Independent Budget.

SCIP is VA's newest approach to reevaluating its aging and underutilized infrastructure, as well as examining the lack of infrastructure in various locations around the country. The intent of SCIP, according to VA, is to scrutinize all property so that VA can best address gaps in delivery of care and services to veterans. Unlike CARES, SCIP will cover all of VA, not only Veterans Health Administration facilities; however, similar to CARES, SCIP is designed to evaluate the condition of VA infrastructure, in order to build a 10-year integrated capital plan. The goal is to improve quality of and access to VA services by modernizing facilities based on current and future needs. If SCIP is approved as VA's capital planning method, the Department plans to begin this process with the FY 2012 budget cycle.

VA has also advised the IBVSOs that SCIP is intended to address the funding shortfall of \$24.3 billion to deal with major construction and facility condition assessment backlogs, inefficient use of resources, and high maintenance costs, as well as an existing commitment of about \$4.4 billion to complete ongoing major construction projects. If approved, the goal of this new initiative must be a comprehensive plan that will improve quality by providing equitable access to services for all veterans across the VA system of care and services. As the age of VA structures increase, costs go up, often dramatically so. Accordingly, more funding is spent on older projects, leaving less for other maintenance and construction needs and increasing the overall budget for both major and minor construction. VA must adopt a plan for the future that will review and assess all current and future needs while providing priorities and transparency at the forefront.

A draft of the SCIP proposal was most recently provided to the IBVSOs in October 2010. The overview included a future-oriented view of VA capital needs beginning with the 2012 budget. According to VA, SCIP would adapt to changes in environment, provide a comprehensive

planning process for all projects, and result in one prioritized listing of capital projects VA wide. The list intends to ensure equitable access to services for veterans across the country and includes major and minor construction, nonrecurring maintenance, and leasing.

Because SCIP is a new initiative, The Independent Budget veterans service organizations encourage VA to be transparent during the process and would advise that challenges must be met when reviewing all current and future needs of its aging infrastructure. The goal must be a comprehensive plan that will improve quality by maintaining equitable access to services across the VA system. The changing health-care delivery needs of veterans, including reduced demand for inpatient beds and increasing demand for outpatient care and medical specialty services, along with limited funding available for construction of new facilities, has created a growing backlog of projects that are becoming more expensive to complete. VA has advised that SCIP is intended to address the funding shortfalls of its current capital backlog needs.

Major and Minor Construction Accounts

The Department of Veterans Affairs continues to be faced with challenges with respect to the maintenance backlog. VA regularly surveys each facility as part of the Facilities Condition Assessment (FCA) process. VA estimates the cost of repair and uses this cost estimate as a component of its Federal Real Property Report requirements. According to its latest Five-Year Capital Plan, VA has estimated the total cost of repairing all “D-rated” and “F-rated” FCA deficiencies at a cost of \$8 billion, even as it and Congress have greatly increased the amount of funding and resources devoted to this critical aspect of capital asset management. Although Congress has increased recent funding for nonrecurring maintenance (NRM), these funding levels only touch the surface of the backlog.

For years, NRM and other maintenance needs were significantly underfunded, and massive backlogs ensued (see “Increased Spending on Nonrecurring Maintenance” in this Independent Budget). Maintenance is only a small fraction of the major infrastructure issues confronting the system. The Independent Budget veterans service organizations (IBVSOs) are also concerned about the huge backlog of major medical construction projects and the political and economic reality that fully funding each of these projects and constructing them in a timely manner may not be feasible.

One of the reasons for such a large backlog of construction projects is because Congress allocated so little funding during the Capital Asset Realignment for Enhanced Services (CARES) process. The Appropriations Committees provided few resources during the initial review phase, and against our advice, preferred to wait for the result of CARES. Because of our convictions that a number of these projects needed to go forward and that they would be fully justified through any plans developed by CARES, the IBVSOs argued that a de facto moratorium on construction was unnecessary and would be harmful. The House agreed with our views as evidenced by its passage of the Veterans Hospital Emergency Repair Act, March 27, 2001; however, Congress never appropriated funding to carry out the purposes of that act, and the construction and maintenance backlogs continued to grow.

Upon completion of the CARES decision document in 2004, former VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans’ Affairs.

He noted that CARES “reflects a need for additional investment of approximately \$1 billion per year for the next five years to modernize VA’s medical infrastructure and enhance veterans’ access to care.” In a November 17, 2008, letter to the Senate Committee on Veterans’ Affairs, then-Secretary James Peake reported that VA would need at least \$6.5 billion over the following five years to meet its funding requirements for major medical facility construction projects.

As noted previously, VA has proposed a new program, Strategic Capital Investment Planning (SCIP), to address some of the construction and infrastructure issues presented in The Independent Budget. Given the President’s pledge to create a VA for the 21st century, the IBVSOs expect the Department to proceed with its SCIP plan in a transparent way, coordinate the plan through our community and other interested parties, and provide its plan to Congress for review and approval if required. However, until SCIP is fully implemented, we fear that VA’s capital programs and the significant effects on the system as a whole and veterans individually will go unchanged; ultimately risking a diminution of care and services provided by VA to sick and disabled veterans in substandard facilities.

Until the SCIP plan is approved and in place across the VA network of care, the IBVSOs will continue to argue for sufficient funding needs to maintain VA’s capital infrastructure and to ensure a safe and useful system for all veterans who need VA health care. With this in mind, the IBVSOs would like to outline the components of our Major and Minor Construction account requests of this Independent Budget.

MAJOR CONSTRUCTION

Category Recommendation

(\$ in Thousands)

Major Medical Facility Construction	\$1,850,000
NCA Construction	\$ 61,000
Advance Planning	\$45,000
Master Planning	\$15,000
Historic Preservation	\$20,000
Medical Research Infrastructure	\$150,000
Miscellaneous Accounts	\$ 60,000
TOTAL	\$2,201,000

MINOR CONSTRUCTION

Category Funding

(\$ in Thousands)

Veterans Health Administration	\$450,000
National Cemetery Administration	\$100,000
Veterans Benefits Administration	\$20,000
Staff Offices	\$15,000
TOTAL	\$585,000

Major Medical Facility Construction — This amount would allow VA to continue to address the

backlog of partially funded construction projects which includes any ongoing major construction projects already approved. Depending on the stage in the process and VA's ability to complete portions of the projects within the fiscal year, remaining funds could be used for projects identified by VA as part of SCIP.

National Cemetery Administration — This amount would fund a number of national cemeteries from VA's priority list as well as potential projects identified by SCIP.

Advanced Planning — This amount helps develop the scope of the Major Medical Facility construction project as well as to identify proper requirements for their construction. It allows VA to conduct necessary studies and research similar to the planning process in the private sector.

Master Planning — A description of The Independent Budget request follows later in the text.

Historic Preservation — A description of The Independent Budget request follows later in the text.

Miscellaneous Accounts — These included the individual line items for such accounts as asbestos abatement, the judgment fund, and hazardous waste disposal.

Minor Construction Account — SCIP has already identified minor construction projects that update and modernize VA's aging physical plant, ensuring the health and safety of veterans and VA employees.

Medical Research Infrastructure — Funding needs to be allocated by Congress to allow for needed renovations to VA research facilities.

Medical Research Infrastructure — A description of The Independent Budget request follows later in the text.

National Cemetery Administration — This includes minor construction projects identified by SCIP to include the construction of several columbaria, installation of crypts, and landscaping and maintenance improvements.

Veterans Benefits Administration — This includes several minor construction projects identified by SCIP in addition to the leasing requirements the Veterans Benefits Administration needs. It also includes \$2 million transferred yearly for the security requirements of its Manila office.

Staff Offices — This includes minor construction projects related to staff offices, including increased space and numerous renovations for the VA Office of Inspector General.

We view these issues as the critical areas that must be addressed when developing our funding recommendations. We would also like to note that within many of these categories lies ongoing and unfunded projects as well as backlogged facility repairs and maintenance.

INADEQUATE FUNDING AND DECLINING CAPITAL ASSET VALUE:

The Department of Veterans Affairs must protect against deterioration of its infrastructure and a declining capital asset value.

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 on Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and projects that were identified by the Capital Asset Realignment for Enhanced Services (CARES) initiative, the VA construction budget continues to be inadequate. During the past decade of underfunded construction budgets, VA has not adequately recapitalized its facilities.

Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future.

VA facilities have an average age of more than 60 years, and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems. In the past, The Independent Budget veterans service organizations (IBVSOs) have cited the recommendations of the final Report of the President's Task Force to Improve Health Care Delivery for Our Nations Veterans (PTF). To underscore the importance of this issue, we again cite the recommendations of the PTF. It was noted that VA 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 of investment, VA would be recapitalizing its infrastructure every 155 years.

If maintenance and restoration were considered along with major construction, VA invests less than 2 percent of plant replacement value for its entire facility infrastructure nationwide. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain health-care infrastructure. If this rate is not improved, veterans could be receiving care in potentially more unsafe and dysfunctional settings as time goes along. Improvements in the delivery of health care to veterans require that VA adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities. The FY 2008 VA Asset Management Plan provided the most recent estimate of plant replacement value (PRV). Using the guidance of the federal government's Federal Real Property Council, VA's PRV is more than \$85 billion. The IBVSOs appreciate the Administration's efforts to increase the total capital budget, and we hope future requests will be more in line with the system's needs.

Recommendations:

Congress and the Administration must ensure that adequate funds are appropriated for VA's capital needs so that it can properly invest in its physical assets to protect their value and to ensure that it can continue to provide health care in safe and functional facilities long into the future.

INCREASED SPENDING ON NONRECURRING MAINTENANCE:

The deterioration of many VA properties requires increased spending on nonrecurring maintenance.

For years The Independent Budget veterans service organizations (IBVSOs) have stressed the importance of providing necessary funding for nonrecurring maintenance (NRM) accounts to ensure that longstanding and continual upkeep requirements at VA facilities are met. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are onetime repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors, among other routine maintenance needs. Nonrecurring maintenance is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

When NRM projects are ignored, the results can be detrimental to the value of a VA property and the quality of care they facilitate for veterans. Nonrecurring maintenance projects that are left undone inevitably require more costly and time-consuming repairs when they are eventually addressed. Furthermore, this lack of attention to basic structural maintenance issues jeopardizes the safety of staff and patients. Because delayed maintenance projects always require a more invasive response as opposed to situations in which NRM is responsibly managed, the IBVSOs believe neglecting such projects is tantamount to denying veterans timely and professional care and even placing them in danger.

Accordingly, to fully maintain its facilities, VA needs an NRM annual budget of at least \$1.7 billion.

Teams of professional engineers and cost estimators survey each medical facility at least once every three years as part of VA's Facilities Condition Assessment (FCA) process. These surveys assess all components of a given facility to include internal issues, such as plumbing, and external issues, such as parking and mobility barriers. Each component of a facility is given a letter grade, A through F. Areas given a grade of F no longer function or are in danger of imminent structural or system failure. VA estimates the cost of repair for each item that is rated D or F and then uses this cost estimate as a component of its Federal Real Property Report requirements. VA's latest Five-Year Capital Plan estimated the total cost of repairing all D-rated and F-rated FCA deficiencies at a staggering \$8 billion, even as VA and Congress have greatly increased the amount of funding and resources devoted to this critical aspect of capital asset management. Since that time, NRM received a one-time allocation of \$1 billion through Public Law 111-5, the "American Recovery and Reinvestment Act."

VA uses the FCA reports as part of its Federal Real Property Council metrics. The department calculates a Facility Condition Index (FCI), which is the ratio of the cost of FCA repairs compared to the cost of replacement. According to the FY 2008 Asset Management Plan, this metric has declined from 82 percent in 2006 to 68 percent in 2008. VA's strategic goal is 87 percent, and for the Department to meet that goal, it would require a sizeable investment in NRM and minor construction. Given the low level of funding NRM accounts have historically received, the IBVSOs are not surprised that basic facility maintenance remains a challenge for VA.

In addition, the IBVSOs have long-standing concerns with how this funding is apportioned once received by VA. Because NRM accounts are organized under the Medical Facilities

appropriation, it has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This formula was intended to allocate health-care dollars to those areas with the greatest demand for health care, and is not an ideal method to allocate NRM funds. When dealing with maintenance needs, this formula may prove counterproductive by moving funds away from older medical centers and reallocating the funds to newer facilities where patient demand is greater, even if the maintenance needs are not as intense. We are encouraged by actions the House and Senate Veterans' Affairs Committees have taken in recent years requiring NRM funding to be allocated outside the VERA formula, and we hope this practice will continue.

Another issue related to apportionment of funding and the budget cycle has been well documented. Prior to the passage of advance appropriations, the Government Accountability Office (GAO) had found that the bulk of NRM funding was not apportioned until September, the final month of the fiscal year. For example, the GAO reported that 60 percent of total NRM funding for FY 2006 was allocated in September of that year.

In other words, during the first 11 month of FY 2006, only 40 percent of NRM funding had been allocated even as VA knew any unobligated funds would be remitted to the Department of the Treasury by statute. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and with NRM funding year to year, those conditions, which lead to a functional mishandling of essential funds, have been changed by advance appropriations. Medical accounts are now appropriated by Congress a year in advance to allow VA the ability to plan farther in advance and reduce the impact of delayed appropriations.

Not receiving timely appropriations from Congress has curtailed the positive impacts of medical spending over the years, and Congress must now provide oversight of this process to ensure that these upfront dollars for NRM and all medical spending realize their potential benefits. Congress and VA should provide oversight to ensure this change will not result in medical center managers continuing to sit on unspent funds for longer periods of time, but that it will produce more efficient spending and better planning, thereby eliminating the previous situation in which these managers sometimes spent a large portion of their maintenance funding very late in the fiscal year.

Recommendations:

VA must dramatically increase funding for nonrecurring maintenance (NRM) in line with the industry standard of 2 percent to 4 percent of plant replacement value in order to maintain modern, safe, and efficient facilities. Congress should provide VA with additional maintenance funding in the Medical Facilities appropriation to enable the Department to begin addressing the substantial maintenance backlog of Facilities Condition Assessment-identified projects.

Congress should provide NRM funding to support maintenance and upgrades to VA's research infrastructure. Portions of the NRM account should continue to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that have the greatest maintenance needs, rather than based on other criteria unrelated to the condition of facilities. Congress must provide oversight of the NRM funding allocated through the advance appropriations process to ensure NRM funds are being spent in such a way to meet their full potential

MAINTAIN CRITICAL VA HEALTH INFRASTRUCTURE:

The Department of Veterans Affairs must execute a comprehensive, strategic health infrastructure plan that is focused on the unique needs of its veteran population. In order to reduce the growing backlog and maintenance needs of its medical facilities, Congress and the Administration must work together to secure the Department's future by designing the "VA of the 21st century."

Today 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 healthcare facility infrastructure. 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. Given these significant challenges and the shift in care in many areas, in 2008 VA developed a new approach to dealing with infrastructure, the Health Care Center Facility (HCCF) leasing program. Under the HCCF leasing program, 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 privately to VA specifications. These large clinics could provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

According to VA, inpatient needs at such sites would be managed through contracts with affiliates or local private medical centers. The Independent Budget veterans service organizations (IBVSOs) believe that the adoption of Strategic Capital Investment Planning (SCIP) and more HCCF leasing proposals illustrate a shift toward reliance on healthcare leasing or a build-to-suit strategy with reliance on community providers or academic affiliates for inpatient services, rather than VA constructing its own comprehensive medical centers. We remain watchful as to how such arrangements will be managed and what unintended consequences may await sick and disabled veterans and those who represent them.

Further, SCIP must be clearly explained and integrated with all stakeholders involved in the process—specifically, how will it be developed and prioritized, and will the implementation of the HCCF model impact VA's specialized medical care programs, continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health profession training programs? VA noted that, in addition to any new HCCF facilities, it would maintain its VA medical centers, larger independent outpatient clinics, community-based outpatient clinics (CBOCs), and rural outreach clinics.

VA has argued that adopting the HCCF model would allow it to quickly establish new facilities that would provide 95 percent of the care and services veterans need in their catchment areas, specifically primary care, a variety of specialty care services, mental health, diagnostic testing,

and same-day ambulatory surgery. Initially, the IBVSOs have been supportive of the goals of this program. The HCCF model seems to offer a number of benefits in addressing VA 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 personal convenience.

This process could also offer the advantage of quick completion as compared to the existing major construction design-authorization-appropriation process, thus allowing more flexibility to respond to changes in patient loads and technologies and making possible net savings in operating costs and in facility maintenance.

While it offers these obvious advantages, the HCCF model raises concerns about VA's plan for providing inpatient services. VA suggests it will contract for these essential services with affiliates or community hospitals. The IBVSOs believe this program would privatize many services that we believe VA should continue to provide directly to veterans. We are also 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; maintenance of VA's specialized medical programs for spinal cord injury, blindness, amputation care, and other health challenges of seriously disabled veterans; delivery of comprehensive services; its recognized biomedical research and development programs; and, in particular, the impact on its renowned graduate medical education and health profession training programs, in conjunction with long-standing affiliations with nearly every health professions university in the nation.

Moreover, we believe the HCCF model could well challenge VA's ability to provide alternatives to maintaining directly its existing 130 nursing home care units now called "community living centers"), homelessness programs, domiciliary facilities, compensated work therapy programs, hospice and respite, 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/dysfunction centers, 10 blind rehabilitation centers, a variety of unique "centers of excellence" (in geriatrics, gerontology, mental illness, Parkinson's, and multiple sclerosis), and various critical care programs for veterans with serious and chronic mental illnesses.

In general, the IBVSOs believe the HCCF proposal could be a positive development, with good potential. But the process must be transparent to all those involved—veterans, stakeholders, community leaders, VA employees—and there must be a well-thought-out and well-communicated plan to carry out the HCCF policy. It has been proven that leasing can help to diminish 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, Vet Centers, and leased VA regional office staff expansions. However, the IBVSOs remain concerned with VA's plan for obtaining inpatient services under the HCCF model, and have many unanswered questions. There are major concerns with the pervasive contracting that would be mandated by this type of proposal.

Acknowledging all the changes taking place in health care, VA needs to look very closely at all its infrastructure plans, and needs to do a better job explaining to veterans, their representatives, and Congress what its plans are for every location, with a full exposition based on facts.

Responding to a Congressional request, VA addressed a number of specific questions related to its plan for the HCCF leasing initiative, 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; 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 and willingness to meet veterans' needs; the ramifications on the delivery of long-term care and specialized services; and whether it would be able to ensure that needed inpatient capacity would remain available indefinitely.

Based on its response, the IBVSOs believe VA has a reasonable foundation for assessing capital needs and has been forthright with the estimated total costs for ongoing major medical facility projects, and that the HCCF model can be a basis for meeting some of these needs at lower cost. We agree with VA's assertion that it needs a balanced capital assets program, of both owned and leased buildings, to ensure that demands are met under current projections. Likewise, we agree with VA that the HCCF concept could provide modern health-care facilities relatively quickly that might not otherwise be available because of the predictable constraints of VA's major construction program.

However, 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.

On the other hand, if VA plans to replace the majority or even a large fraction of all VA medical centers with Health Care Center Facilities, such a radical shift would pose a number of concerns for us. Nevertheless, the IBVSOs see this challenge as only a small part of the overall picture related to VA health infrastructure needs. The emerging HCCF plan does not address the fate of VA's 153 medical centers located throughout the nation that are on average 60 years of age or older. It does not address long-term-care needs of the aging veteran population, inpatient treatment of the chronically and seriously mentally ill, the unresolved rural health access issues, the lingering questions on improving VA's research infrastructure, or the fate of VA's academic training programs. Fully addressing these and related questions is extremely important and will have an impact on generations of sick and disabled veterans far into the future.

We would like to reiterate: Creating a VA of the 21st century must include all stakeholders' interests. The IBVSOs expect VA to establish any new infrastructure plan in a transparent way; vet that plan through our community and other interested parties; and provide its plan to Congress for review, oversight, and approval if required by law. 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, veterans' advocates, 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.

Finally, one of our community's frustrations with respect to VA's infrastructure plans is lack of consistent

and periodic updates, specific information about project plans, and even elementary communications. The

IBVSOs ask that VA improve the quality and quantity of communications with us, our larger community, enrolled veterans, concerned labor organizations, and VA's own employees, affiliates, and other stakeholders as the VA capital planning process moves forward. We believe that all of these groups must be made to understand VA's strategic plan and how it may affect them, positively and negatively.

Talking openly and discussing potential changes will help resolve the understandable angst about these complex and important questions of VA health-care infrastructure. While we agree that VA is not the sum of its buildings, and that a veteran patient's welfare must remain at the center of the Department's concern, VA must be able to maintain an adequate infrastructure around which to build and sustain "the best care anywhere."

If VA keeps faith with these principles, the IBVSOs are prepared to aid and support VA in accomplishing this important goal.

Recommendations:

VA must develop a well-thought-out health-care infrastructure and strategic plan that becomes the means for it to establish a veterans health-care system for the 21st century. Congress, the Administration, and internal and external stakeholders must work together to secure VA's future, while maintaining the integrity of the VA health-care system and all the benefits VA brings to its unique patient population.

VA's new proposal, the Strategic Capital Investment Planning (SCIP) and VA's health Care Center facility leasing proposal must be clearly explained and integrated with all stakeholders involved in the process, including how will it be developed, prioritized, and implemented, and how it will impact VA's specialized medical care programs, continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health profession training programs.

VA must improve the quality and quantity of communications with internal and external communities of interests, including the authors of this Independent Budget, concerning its plans for future infrastructure improvements through the HCCF leasing and other approaches.

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EMPTY OR UNDERUTILIZED SPACE AT MEDICAL CENTERS:

The Department of Veterans Affairs must use empty and underutilized space appropriately.

The Department of Veterans Affairs maintains approximately 1,100 buildings that are either vacant or underutilized. An underutilized building is defined as one where less than 25 percent of space is used. It costs VA from \$1 to \$3 per square foot per year to maintain a vacant building. Studies have shown that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been shown that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not. Medical facility planning is complex. It requires intricate design relationships for function, as well as the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor used as a medical surgical unit, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it. These secondary impacts greatly increase construction expense and can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot necessarily be altered. Different aspects of medical care have various requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Laboratories should have long structural bays and function best without windows. When renovating empty space, if an area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient if simply renovated. Renovating old space, rather than constructing new space, often provides only marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would cost. Factoring in domino or secondary costs, the renovation can end up costing more while producing a less satisfactory result.

Renovations are sometimes appropriate to achieve those critical functional adjacencies, but are rarely economical. As stated earlier in this analysis, the average age of VA facilities is 60 years. Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing war veteran population are simply unable to be renovated for modern needs. Most of these so called "Bradley-style" buildings were designed before the widespread use of air conditioning and the floor-to floor heights are very low. Accordingly, it is impossible to retrofit them for modern mechanical systems. Many of them also have long, narrow wings radiating from small central cores, an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services. Another important problem with this existing unused space is its location. Much of it is not in a prime location; otherwise, it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

Public Law 108-422 incentivized VA's efforts to properly dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in a Capital Asset Fund (CAF). Further, that law required VA to develop short- and long-term plans for the disposal of these facilities in an annual report to Congress. VA must continue to develop these plans, working in concert with architectural master plans and the long-range vision for all such sites.

Recommendations:

VA must develop a plan for addressing its excess space in non historic properties that is not suitable for medical or support functions because of its permanent characteristics or locations

PROGRAM FOR ARCHITECTURAL MASTER PLANS:

Each VA medical facility must develop a detailed master plan and delivery models for quality health care that are in a constant state of change as a result of factors that include advances in research, changing patient demographics, and new technology.

The Department of Veterans Affairs must design facilities with a high level of flexibility in order to accommodate new methods of patient care and new standards of care. VA must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs. VA must also provide for growth in existing programs based on projected needs through capital planning strategy.

A facility master plan is a comprehensive tool to examine and project potential new patient care programs and how they might affect the existing health-care facility design. It also provides insight with respect to growth needs, current space deficiencies, and other facility needs for existing programs and how they might be accommodated in the future with redesign, expansion, or contraction.

In many past cases VA has planned construction in a reactive manner. Projects are first funded and then placed in the facility in the most expedient manner, often not considering other future projects and facility needs. This often results in short-sighted construction that restricts rather than expands options for the future. The Independent Budget veterans service organizations believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility; \$15 million should be budgeted for this purpose.

We believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility. VA has undertaken master planning for several VA facilities, and we applaud this effort. But VA must ensure that all VA facilities develop master plan strategies to validate strategic planning decisions, prepare accurate

budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

Recommendations:

Congress must appropriate \$15 million to provide funding for each medical facility to develop a 10-year comprehensive facility master plan. The master plan should include all services currently offered at the facility and should also include any projected future programs and services as they might relate to the particular facility. Each facility master plan is to be reviewed every five years and modified accordingly based on changing needs, technologies, new programs, and new patient care delivery models.

ARCHITECT-LED DESIGN-BUILD PROJECT DELIVERY:

The Department of Veterans Affairs must evaluate use of architect-led design-build project delivery.

VA currently employs two project delivery methods: design-bid-build and design-build. Design-bid build project delivery is appropriate for all project types. Design-build is generally more effective when the project is of a low complexity level. It is critical to evaluate the complexity of the project prior to selection of a method of project delivery.

Design-bid-build is the most common method of project design and construction. In this method, an architect is engaged to design the project. At the end of the design phase, that same architect prepares a complete set of construction documents. Based on these documents, contractors are invited to submit a bid for construction of the project. A contractor is selected based on this bid and the project is constructed. With the design-bid-build process, the architect is involved in all phases of the project to insure that the design intent and quality of the project is reflected in the delivered facility. In this project delivery model, the architect is an advocate for the owner.

The design-build project delivery method attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to VA and reduce the project delivery schedule. Design build, as used by VA, is broken into two phases. During the first phase, an architect is contracted by VA to provide the initial design phases of the project, usually through the schematic design phase. After the schematic design is completed, VA contracts with a contractor to complete the remaining phases of the project.

This places the contractor as the design builder. One particular method of project delivery under the design-build model is called contractor-led design build. Under the contractor-led design-build process, the contractor is given a great deal of control over how the project is designed and completed. In

this method, as used by VA, a second architect and design professionals are hired by the contractor to complete the remaining design phases and the construction documents for the project. With the architect as a subordinate to the contractor rather than an advocate for VA, the contractor may sacrifice the quality of material and systems in order to add to his own profits at the expense of VA. In addition, much of the research and user interface may be omitted, resulting in a facility that does not best suit the needs of the patients and staff.

Use of contractor-led design-build has several inherent problems. A short-cut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents often do not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, compromising VA's design standards.

Contractor-led design-build forces VA to rely on the contractor to properly design a facility that meets its needs. In the event that the finished project is not satisfactory, VA may have no means to insist on correction of work done improperly unless the contractor agrees with VA's assessment.

This may force VA to go to some form of formal dispute resolution, such as litigation or arbitration.

An alternative method of design-build project delivery is architect-led design-build. This model places the architect as the project lead rather than the builder. This has many benefits to VA. These include ensuring the quality of the project, since the architect reports directly to VA.

A second benefit to VA is the ability to provide tight control over the project budget throughout all stages of the project by a single entity. As a result, the architect is able to access pricing options during the design process and develop the design accordingly. Another advantage of architect-led design-build is in the procurement process. Since the design and construction team is determined before the design of the project commences, the request-for-proposal process is streamlined. As a result, the project can be delivered faster than the traditional design-bid-build process. Finally, the architect-led design-build model reduces the number of project claims and disputes. It prevents the contractor from "low-balling," a process in which a contractor submits a very low bid in order to win a project and then attempts to make up the deficit by negotiating VA change orders along the way.

In addition to selecting the proper method of project delivery, there is much to learn from the design and construction process for each individual project. It is important for VA to apply these "lessons learned" to future projects.

Recommendations:

VA must establish a category system ranking design/construction project types by complexity.

This system should be used to determine if the project is a candidate for the design-build method of project management. The design-build method of project delivery should only be used on projects that have a low complexity, such as parking structures and warehouses. For health-care projects,

VA must evaluate the use of architect-led design build as the preferred method of project delivery in place of contractor-led design-build project delivery. VA must institute a program of “lessons learned.” This

would involve revisiting past projects and determining what worked, what could be improved, and what did not work. This information should be compiled and used as a guide to future projects. This document

should be updated regularly to include projects as they are completed.

INCREASE NEED FOR VA RESEARCH SPACE AND INFRASTRUCTURE IMPROVEMENTS:

The Department of Veterans Affairs needs research space renovations and improved infrastructure.

A state-of-the-art physical environment for VA research promotes excellence in science as well as teaching and patient care. Research opportunities help VA recruit and retain the best and brightest clinician scientists to care for veterans. However, many VA facilities effectively have run out of usable research space. Also, research “wet” laboratory ventilation, electrical supply, plumbing, and other projects appear frequently on internal VA lists of needed upgrades along with research space renovations and new construction, but these projects languish due to the weight VA places on direct medical care projects as opposed to research space and facility needs.

Five years ago, the House Appropriations Committee expressed concern (House Report 109-95) that “equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department’s research facilities remain competitive.” The committee directed VA to conduct a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies.

To comply, VA initiated a comprehensive assessment of VA research infrastructure. To prompt VA to complete its long overdue assessment, House Report 111-564 accompanying the FY 2011 VA appropriations bill directed the Department to provide its final report to Congress by September 1, 2010, with details of any recent renovations or new construction.

As of publication of this Independent Budget, VA had not released the results of its review. According to an October 26, 2009, VA report to the VA National Research Advisory Committee, however, preliminary results of the review indicated, “there is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety.”

The Independent Budget veterans service organizations (IBVSOs) are concerned that a significant cause of VA’s research infrastructure neglect is that neither VA nor Congress provides

direct funding for research facilities. The VA Medical and Prosthetic Research appropriation excludes funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on their local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with other medical facility direct patient care needs (such as medical services infrastructure, capital equipment upgrades and replacements, and other medical maintenance needs) for funds provided under either the Major Medical Facility, Minor Construction, or Medical Facilities appropriations accounts.

The IBVSOs believe that correction of VA's known infrastructure deficiencies should become a higher VA and Congressional priority. Therefore, we recommend VA promptly submit to Congress the report it requested in 2006, provide construction funding sufficient to address VA's five highest priority research facility construction needs as identified in its facilities assessment report, and approve a pool of funding targeted at renovating existing research facilities to address the current and well-documented shortcomings in research infrastructure. For these funding needs we recommend \$150 million and \$50 million, respectively. Additionally, an emerging problem is that VA research facilities often are not an integral component of planning for new VA medical centers (including new medical centers in Las Vegas, Denver, and Orlando).

Modern-day biomedical research needs customized power, safety, privacy, and configuration requirements that should be fundamental to the new construction planning processes, not an expensive afterthought. The IBVSOs urge the Administration to require that research space be made an integral component of planning for every new medical center and that such space be designed by architects and engineers experienced in contemporary research facility requirements.

Recommendations:

Congress should require VA to report its findings from its research infrastructure review, now pending more than five years. Congress should authorize construction of, and appropriate \$150 million in FY 2012 to advance, the five highest priority research construction projects identified by VA in its research infrastructure review, and provide VA an additional \$50 million in maintenance funding (in the Non Recurring Maintenance account) in FY 2012 to address current shortfalls in VA's research laboratories and other research space.

PRESERVATION OF VA'S HISTORIC STRUCTURES:

The Department of Veterans Affairs must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The Department of Veterans Affairs has an extensive inventory of historic structures that highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, of those who cared for their wounds, and of those who helped to build this great nation. Of the approximately 2,000 historic structures in the VA historic building inventory, many are neglected and deteriorate year after year because of a lack of any funding for their upkeep. These structures should be stabilized, protected, and preserved because they are an integral part our nation's history.

Most of these historic facilities are not suitable for modern patient care but may be used for other purposes. For the past seven years, The Independent Budget veterans service organizations (IBVSOs) have recommended that VA conduct an inventory of these properties to classify their physical condition and study their potential for adaptive reuse. VA has moved in that direction; historic properties have been identified. Many of these buildings have been placed in an “Oldest and Most Historic” list and require immediate attention.

The cost for saving some of these buildings is not very high considering that they represent a part of American history. Once gone, they cannot be recaptured. For example, the Greek Revival Mansion at the VA Medical Center in Perry Point, Maryland, built in the 1750s can be restored and used as a facility or network training space for about \$1.2 million. The Milwaukee Ward Memorial Theater, built in 1881, could be restored as a multipurpose facility at a cost of \$6 million. These expenditures would be much less than the cost of new facilities and would preserve history simultaneously. The preservation of VA’s historic buildings also fits into the VA’s commitment to “green” architecture. Materials would be reused, reducing the amount of resources needed to manufacture and transport new materials to building sites.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly. VA’s legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. The IBVSOs encourage VA to use the tenants of Public Law 108-422, the “Veterans Health Programs Improvement Act,” in improving the plight of VA’s historic properties. This act authorizes historic preservation as one of the uses of the proceeds of the capital assets fund resulting from the sale or leases of other unneeded VA properties.

Recommendations:

VA must continue to develop a comprehensive program to preserve and protect its inventory of historic properties. VA must allocate funding for adaptive reuse of historic structures and empty or underutilized space at medical centers.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions that you or the members of the Committee may have.