United States Senate

WASHINGTON, DC 20510

July 1, 2019

The Honorable Robert Wilkie
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary,

We are writing to request immediate actions that would improve the ability of the Department of Veterans Affairs (VA) to plan, award and complete construction projects, non-recurring maintenance, and leases to improve and expand veterans' access to VA health care. As veterans across the country know, modern and safe facilities are a critical component of a well-functioning VA and contribute to quality of care, improved access, and the ability to hire and retain medical staff.

As you know, VA's Fiscal Year (FY) 2020 budget indicates that the VA's Strategic Capital Investment Planning (SCIP) process identified an estimated need of $61.86-$75.61 billion to address VA's major and minor construction, leases, non-recurring maintenance, and activation of facilities over the next 10 years. Unfortunately, VA has requested only a fraction of that in its budget and has acknowledged a challenge to execute its full appropriation in a given fiscal year. More must be done to bring medical space and facilities online more quickly and respond to the pent up and growing demand from veterans seeking care from VA. To that end, we stand willing to work with the Department to cut any burdensome red tape or address any statutory restrictions that delay or prevent the delivery of new or improved medical space that subsequently decreases veterans' access to health care. We also ask that you take immediate action in the following areas:

New Dedicated Infrastructure Tiger Team with Expanded Scope and Leadership Support: We are aware that VA has established an Infrastructure Tiger Team (ITT) and a Portfolio Performance Monitoring (PPM) working group which focus on execution of the increased Congressional funding for minor construction and non-recurring maintenance in FY 2018 and FY 2019. While we support the establishment of these teams, we believe a new team should be established with a different and more comprehensive infrastructure scope. The scope should include an analysis of the major delays in each part of the major and minor leasing processes, best practices developed in the field or Central Office to reduce these delays or mitigate their impact, and a plan to educate relevant field staff nationally on implementing process improvements. Currently, it can take several years between the time a medical center identifies the need for a new or expanded Community Based Outpatient Clinic (CBOC) or other sites of care and when that space comes online to serve veterans. Because of these delays, veterans may experience reduced access to care and dedicated clinical staff providing care in these locations have to operate in cramped conditions. In addition, it is not uncommon for a new CBOC to open and reach capacity within just a few years. The ability to bring new space online more quickly would be a tremendous service to both veterans and VA medical personnel, and a dedicated multi-stakeholder team with the support of VA senior leadership could greatly improve VA's efforts in this area. Focused attention to bringing space online more quickly, including space that meets the needs of a region's veterans for more than just a few years, is urgently needed.

Reverse New Site of Care Suspension Policy: We understand that in FY 2018 VA ended the requirement for Veterans Integrated Service Networks (VISN) to identify new sites of care where market-level geographic access was below drive-time guidelines. In other words, when certain access standards were previously not being met in a region, the VISN was required to submit a proposal through the SCIP process to add a new site for health care in the region. This policy ended that requirement. The VA policy memo directing the change indicated the policy shift was being driven largely by budget constraints, efforts to optimize care in communities, and a strategic emphasis on non-capital solutions. The memo goes on to state that VISNs are instructed to focus on capital investment needs other than new sites of care, and "to address access expansion needs - using community care resources, partnerships, and other non-capital initiatives - for future years." This policy is troubling for a number of reasons and we request that it be reversed or more properly justified.

Congress has provided VA with its requested funding, or more, for its capital budget for the past several years. If there are any budgetary constraints, they have not been identified to Congress and are coming from self-imposed limits put in place by VA and the Office of Management and Budget (OMB) during the internal budget development process, not by Congress. Also, the focus on using community care resources as an alternative to expanding access through capital investments is not consistent with Congressional intent or VA's own statements and policy. VA has been directed to continue to invest in expanding access and sites of care while concurrently using community care resources to compliment VA care delivery. Time and time again, Congress has shown its intent for VA to continue to improve and expand points of care through construction and leasing in parallel to its use of community care.

If VA has unmet resource needs to properly move forward to execute infrastructure requirements, Congress stands ready to work with VA to address those needs. However, there should be no Department policy directing facilities to focus on using community care in lieu of submitting substantive requests for new health care facilities or expanded space. As you have said in testimony, veterans are voting with their feet and continue to prefer to use VA care in high numbers. In your FY 2020 budget testimony you stated that from "FY 2014 through FY 2018, VA saw an increase of 226,000 unique patients for outpatient appointments (a four percent increase). Since FY 2014, the number of annual appointments for VA care is up by 3.4 million. There were over 58 million appointments in VA facilities in FY 2018—620,000 more than the prior fiscal year." As evidenced by these statistics, VA needs to move more rapidly to respond to this expanding demand and this policy appears to be sending an opposite message.

Secure a Strong FY 2021 VA Infrastructure Budget: Historically, VA has requested only a fraction of its needed infrastructure budget in its annual budget submission. This chronic underinvestment in infrastructure has contributed to the current backlog of new projects and maintenance. VA has the opportunity to reverse that trend. With budget formulation for the FY 2021 process underway at VA, we recommend that the Department advocate and secure a much larger construction budget and resist pressure from OMB to cut this funding during internal budget negotiations. By securing significant funding levels for infrastructure, VA will begin to make a down payment to address the infrastructure backlog that exists and be better positioned for the future.

Stable, Uniform, and Dedicated Infrastructure and Planning Staff at Each VAMC: Through our own observations at facilities in our states and feedback from stakeholders in the veterans community, it is clear that individual VA medical centers do not have uniform, stable, dedicated or adequate staffing in the area of long term capital infrastructure planning for the service region around each facility. While some facilities have seasoned and dedicated staff able to identify, plan, propose, and monitor the execution of infrastructure projects, many other facilities assign these duties to individuals who have other responsibilities and may lack the appropriate expertise and credentials. Given the dynamic nature of the health care sector, the

rapidly evolving needs of veterans, and the time it takes to bring facilities or new space into use for veterans, it is critical that each VA Medical Center (VAMC) be allocated, at a minimum, a full time employee whose sole function is on capital planning, coordination and execution of projects. These employees should be in addition to existing staff who focus on day to day critical tasks of engineering, facilities maintenance, and repairs. Having these staff will assist facilities, and VISNs, in preparing and executing strategic infrastructure plans rather than scrambling to catch up when space does not meet the needs of veterans and staff leaving a solution potentially years away.

As previously stated, if the Department is in need of additional resources or authorities to accomplish these changes, we stand ready to review those requests.

We appreciate your attention to this letter and look forward to your response.

Sincerely,

Jon Tester

Brian Schatz

Richard Blumenthal

Patty Murray

Sherrod Brown

Mazie K. Hirono