THE FISCAL YEAR 2012 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

TOGETHER WITH

ADDITIONAL STATEMENTS SUBMITTED FOR THE RECORD

MARCH 2, 2011

Printed for the use of the Committee on Veterans' Affairs

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S. HRG. 112–95

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Available via the World Wide Web: http://www.fdsys.gov/

U.S. GOVERNMENT PRINTING OFFICE

65–905 PDF WASHINGTON : 2011

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MARCH 2, 2011

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THE FISCAL YEAR 2012 BUDGET FOR VETERANS' PROGRAMS

WEDNESDAY, MARCH 2, 2011

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

The Committee met, pursuant to notice, at 10:33 a.m., in room 418, Russell Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Rockefeller, Brown from Ohio, Sanders, Burr, Johanns, Brown from Massachusetts, and Boozman.

OPENING STATEMENT OF HON. PATTY MURRAY, CHAIRMAN, U.S. SENATOR FROM WASHINGTON

Chairman MURRAY. Good morning. This hearing will come to order. Thank you all for joining us here today.

This morning our Committee is going to begin our work on the VA's 2012 budget. I am very delighted to be here with Senator Burr, the Ranking Member. I look forward to working with you on this Committee.

Before we begin, I want to first recognize and thank Senator Akaka, who ran this Committee so well for the last 4 years. I appreciate his tremendous service. As all of us on this Committee know those 4 years were filled with a lot of major accomplishments for our Nation's veterans.

I would be really remiss if I did not mention one accomplishment that Senator Akaka led the way on, which takes on great meaning right now as the Senate and House feud over current fiscal year spending. Through Senator Akaka's efforts, VA spending for health care is now appropriated one year in advance, protecting it from an imperfect budget process that is so often affected by politics. I want to say that we are all thankful for Senator Akaka's efforts, particularly those who have been given peace of mind that because of advance appropriations the VA health care system is on track.

I am so pleased today to begin my work as Chairman of this Committee, which is about truly working for all of our Nation's veterans. Throughout my life, whether it was watching my own dad, who was a Purple Heart recipient, who raised a family of seven despite being wheelchair bound, or whether it was in college as an intern helping to care for wounded Vietnam veterans even younger than me, or in my 16 years as a Member of this Committee, I have time and time again been awed and astounded by the spirit, the determination, and the perseverance of our veterans.

I have also gained a keen, personal understanding of the consequences of sending our servicemembers into combat and of the sacred obligation we have to care for those who are injured in service.

With that in mind, I am delighted to take on this tremendous responsibility and look forward to working with all of you on the budget and on all other issues affecting veterans.

At the outset, let me say that on balance, and given that other agencies are facing budget cuts, this VA budget is a very good starting place from which to work. The President has requested an overall increase of $5.9 billion in discretionary spending over Fiscal Year 2011 levels. While health care spending is in good shape, there are some weaker points in the budget.

For example, the proposed cuts in spending for construction and non-recurring maintenance are very troubling. The budget documents lay out VA's vision for a 10-year construction plan, but what is missing in this budget is detail on how to close that gap between the funding we need to bring facilities up to date and the funding requested of the Congress.

I also want to call attention to the proposed $70 million cut for VA research funding. I am very worried that such a cut would imperil some critical projects and shove physician researchers out the door.

Topping anyone's list of problems the VA is facing is how disability benefits claims are processed. The claims backlog has gone on too long, and addressing it will be a top priority for the Committee and the Congress.

As we continue to work on this, some things do need to be acknowledged. More veterans are filing claims and more are filing increasingly complex claims. There is nothing that can be done to change that reality. That said, we need to really focus our attention on solutions, including viable IT support if we are to reach the shared goal of timely, accurate decisions on benefits claims. I expect to hear from VA, in detail, what exactly its plan is to transform this broken system.

I am also concerned that VA may not have adequately addressed the need for sufficient resources for administering the GI Bill education benefits. In light of a substantial increase in the workload and in the number of new students, the budget would reduce full-time employees, or FTE.

On the positive side, the proposed budget reflects the VA's very real commitment to end homelessness. I am encouraged to see that the Administration has increased funding for homeless programs. I am hopeful that we will continue to see significant effort to reduce the number of homeless veterans and prevent those at risk from becoming homeless.

Likewise, I am pleased that the budget reflects the Administration's continuing effort to make sure that gender-specific care for women is readily available throughout the system.

I would also note that I am as committed today as I was during my early years on the Committee to the belief that the Government can be fiscally responsible while still fulfilling its commitments to the most deserving among us, including, of course, our Nation's veterans.

This budget request includes a series of cost-saving initiatives, including better controls on contract health care, better strategies for contracting, and cutting administrative overhead, all of which I will review with an open mind.

But we must always remember that like all budgets, the VA budget is a reflection of our values, and that each of those values has a direct impact on the lives of thousands, if not millions, of our veterans.

Last week, I sat down with veterans from across my homestate and heard from the very men and women whose lives this budget will touch. I heard from a Vietnam veteran with PTSD whose son, a National Guard soldier, just recently committed suicide after returning from the battlefield with PTSD.

I heard from a female Iraq veteran who told me when she calls the VA she continually gets asked if she is calling for her husband. I heard from veterans about the claims backlog, barriers to employment, access to care, holes in the education benefit, and a lot more.

We have work to do for these veterans, and work that begins today. It begins with this budget. I look forward to working with my colleagues on this Committee.

We have a number of new Members, who I am delighted to see join us on this Committee. I will continue to work on the Budget and Appropriations Committees on which I also sit, and, of course with you, Secretary Shinseki, all your team, and the leaders from the veterans community.

With that, I will turn it over to the Ranking Member, Senator Burr.

[The prepared statement of Chairman Murray follows:]

PREPARED STATEMENT OF HON. PATTY MURRAY, CHAIRMAN,
U.S. SENATOR FROM WASHINGTON

This morning, the Committee begins work on VA's 2012 budget. Before we begin, I want to first thank Senator Akaka who led this Committee so well over the last four years. As all of us on this Committee know, those four years were filled with many major accomplishments for our Nation's veterans. But I would be remiss if I didn't mention one accomplishment that Senator Akaka led the way on that takes on great meaning right now—as the Senate and the House feud over spending for the current fiscal year. Through Senator Akaka's efforts, VA spending for health care is now appropriated a year in advance—protecting it from an imperfect budget process that is so often affected by politics. We are all thankful for Senator Akaka's work—particularly all those who have been given peace of mind that through advance appropriations the VA health care system is on track.

I am so pleased today to begin my work as Chairman of this vital Committee, on behalf of all American veterans. Throughout my life, whether it was watching my father, a purple-heart recipient, raise a family of seven despite being wheelchair bound, or whether it was in college as an intern helping to care for wounded Vietnam veterans even younger than me, or in my 16 years as a Member of this Committee, I have time and again been awed and astounded by the spirit, determination, and perseverance of our veterans.

I have also gained a keen, personal understanding of the consequences of sending our servicemembers into combat and of the sacred obligation we have to care for those injured in service. With that in mind, I am delighted to take on this tremendous responsibility and look forward to working with all of you in the time to come—on the budget and on all other issues affecting veterans.

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We have work to do for these veterans, work that begins today, work that begins with this budget. I look forward to working with my colleagues on this Committee, and on the Budget and Appropriations Committees on which I also sit, and of course, Secretary Shinseki, his team, and the leaders from the veterans' community.

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

Senator BURR. Thank you, Madam Chairman. Good morning and more importantly congratulations on your new role. As I realize and most in the room probably do, this is an historic day. Senator Murray is the first female to chair the VA Committee.

Chairman MURRAY. I'm the only female on this Committee, so I have a world on my shoulders.

Senator BURR. Affirmative action works.

Chairman MURRAY. I wrote that down.

[Laughter.]

Senator BURR. I do congratulate you on not only your leading the Committee but your fine work in the United States and for the American people.

Mr. Secretary, welcome to you and your team of professionals. More importantly, thank you for the work and the effort that you and your professional staff put into the care of our Nation's veterans.

We are grateful to the veterans' service organizations and the American Federation of Government Employees. We welcome you, as well, as part of this hearing.

I think we will run into a little glitch on votes today at 11 o'clock, but we will try to deal with them as smoothly and as quickly as we can.

Of course, we are here today to talk about the President's 2012 budget. In a time of record high debt and deficits, my priority is not only to ensure that veterans of every generation receive the care and benefits that they need and deserve, but also to analyze every area of the budget to ensure we maximize all options to spend the taxpayer's money wisely.

As President Obama states in his budget message, "Even in areas outside the freeze, we are looking for ways to save money and cut unnecessary costs."

The fiscal year 2012 Veterans Affairs budget requests an 11 percent increase over the 2010 enacted levels in discretionary spending. In examining the VA budget request, one observation I made is the growth in the budget of the staff offices in your DC central office over the last 2 years.

If this budget were to be approved, both the funding levels and the number of staff will have grown at a very high rate since 2010. The general administration budget has increased 13 percent since 2010 and the staff, or FTE's, request for 2012 reflects a 20 percent increase.

This large boost in spending led me to look closer at the FTE requests of the individual offices within general administration. Here is what I found: a 2-year staffing increase of 7 percent in the Office of the Secretary; a 2-year staffing increase of 34 percent for the Office of Public and Intergovernmental Affairs; a 2-year staffing increase of 44 percent for the Office of Congressional and Legislative Affairs.

Other examples of spending we may want to take a closer look at include: VA continuing to operate and publish a law review that has articles and book reviews; and the hiring of a speech writer for the Assistant Secretary.

How are these funding increases essential to our Nation's veterans? That is a questions we should ask. Do these additional staff directly benefit the veterans who use the VA system?

Another item I found very interesting is the $1 billion contingency fund in the Medical Services account, which would essentially provide a buffer in case poor economic conditions were to drive up the demand for VA services.

The Secretary and I talked about that earlier this week. It caught my eye because the first line of the President's Budget message says this, "America is emerging from the worst recession in generations. In 2010, an economy that had been shrinking began to grow again."

Now, what I find interesting is the seeming difference of opinion of the strength of the economy between the President and those

who forecasted the budget, and the need for a contingency fund. I have been assured by the Secretary that the contingency fund is designed for the delivery of health care, and I think as long as we stay within those parameters, we are all comfortable.

The Medical Care Collections Fund, or MCCF, is of particular interest to me. Recently, VA's Chief Business Officer informed my staff that the VA was downgrading from what it was expecting to collect in 2012 from $3.1 to $2.8 billion.

I am interested to learn more about this sudden change in the collections forecast and the actuarial model that was used to calculate it. I am also interested to know whether we are collecting everything the VA is owed under MCCF.

When my staff asked VA what percentage of available money is being collected, the Chief Business Officer could not give them a definitive answer. While VA has done an excellent job in recent years collecting what it forecasts, is there money being left on the table?

Another concern is the claims backlog which Senator Murray has raised in her opening statement and has been a continual topic of conversation. Veterans from North Carolina and across the country cannot wait so long for decisions that too often are wrong.

For years, the primary response to these problems has been to add more staff. In fact, since 2001, claims processing staff has more than doubled. But the problems of large backlogs and long delays continue. They are expected to get even worse.

Although I appreciate that the VA is now focusing on IT improvements and other initiatives rather than simply adding more staff, new ideas and good intentions are not enough. We must make sure VA has the tools and resources it needs to succeed in these efforts.

More importantly, we must make sure there is a realistic, comprehensive plan to get the backlogs under control so veterans and their families will not face delays or frustrations in accessing their VA benefits. I look forward to a productive discussion today about whether this budget would bring us closer to that reality.

In the end, we need to ask ourselves if spending money on bureaucrats, speech writers, and publishing book reviews are consistent with being good stewards of the taxpayer's money in providing benefits to veterans. More importantly, we should ask ourselves if we are fulfilling President Lincoln's promise: "To care for him who shall have borne the battle, and for his widow, and his orphan."

Mr. Secretary, welcome.

Madam Chairman, I thank you.

[The prepared statement of Senator Burr follows:]

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

Good morning, Madam Chairman. Congratulations on your new position as Chairman of this Committee. I look forward to working with you and with all of our members in improving the lives of our Nation's veterans, their families, and their survivors.

Secretary Shinseki, welcome to you and your senior leadership team. And welcome to the representatives of the Veterans Service Organizations and the American Federation of Government Employees.

We are here today to review the President's budget request for the Department of Veterans Affairs for fiscal year 2012.

In a time of record high debt and deficits, my priority is not only to ensure that veterans of every generation receive the care and benefits they need and deserve but also to analyze every area of the budget to ensure we maximize all options to spend the taxpayer's money wisely. As President Obama states in his Budget Message, "Even in areas outside the freeze, we are looking for ways to save money and cut unnecessary costs."

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The Medical Care Collections Fund—or MCCF—is of particular interest to me. Recently, VA's Chief Business Officer informed my staff VA was downgrading what it was expecting to collect in 2012 from $3.1 billion to $2.8 billion. I am interested to learn more about this sudden change in the collections forecast and the actuarial model being used.

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Another concern is the claims backlog. Veterans from North Carolina and across the country can wait far too long for decisions that too often are wrong. For years, the primary response to these problems has been to add more staff. In fact, since 2001, claims processing staff has more than doubled. But the problems of large backlogs and long delays continue. And they are expected to get even worse next year.

Although I appreciate that VA is now focusing on IT improvements and other initiatives—rather than simply adding more staff—new ideas and good intentions are not enough. We must make sure VA has the tools and resources it needs to succeed in these efforts. More importantly, we must make sure there is a realistic, comprehensive plan to get the backlog under control, so veterans and their families will not face delays or frustrations in accessing their VA benefits. I look forward to a productive discussion today about whether this budget would bring us closer to that reality.

In the end, we need to ask ourselves if spending money on bureaucrats, speech writers, and publishing book reviews are consistent with being good stewards of the taxpayer's money. More importantly, we should ask ourselves if we are fulfilling President Lincoln's promise: "To care for him who shall have borne the battle, and for his widow, and his orphan."

Thank you Madam Chairman, I yield back.

Chairman MURRAY. Thank you very much.

We will now turn to our other Senators for opening statements. Senator Brown.

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN OF OHIO. Thank you, Madam Chair, Senator Burr, and Members of the Committee.

Congratulations, Senator Murray, on your Chairmanship. I know how important that is to you. I was watching you before I was in the Senate and have worked alongside you since. Your concern and empathy while fighting for veterans is impressive.

Secretary Shinseki, welcome. All members of the panel, thank you for stopping by. Mr. Secretary, you are always patiently answering questions and advocating for veterans all the time.

We know about the President's Budget. We have talked about that among us and with the panelists separately in many cases.

I wanted to look at it in a slightly different way, which is to consider how potential cuts to other agencies and programs will affect veterans and whether these cuts will lead to a higher proportion of veterans turning to the VA for assistance.

For example, H.R. 1 in the House proposes devastating cuts to the workforce investment programs in Ohio and other places. There are 95 one-stops in Ohio and 3,000 nationwide. Many, if not all of them, will have to close their doors if the proposed $3.8 billion in cuts to workforce investment pass Congress.

Senator Murray has been very involved in that issue from her position on the Health, Education, Labor, and Pension Committee. We need to work through how those kinds of cuts would affect veteran services at the same time.

The Veterans' Workforce Investment Program is funded through WIA (Workforce Investment Act). Will those proposed cuts impact this program? It is estimated that veterans will increasingly turn to the VA, to VA's contingency fund. Will advanced appropriation requests reflect this prediction?

I am pleased to see the VA has incorporated a contingency fund for medical care for 2012 in its advance appropriations for 2013. This will help Congress and the VA to more accurately plan for the VA's future and continue to improve care and services.

Secretary Shinseki, I applaud you for taking on three of the VA's most pressing issues: the claims backlog, as Senators Murray and Burr mentioned; veteran homelessness; and expanding access to VA health care and benefits. You have done outstanding work in my State, especially in Chillicothe and southern Ohio, and I trust that your efforts will bear fruit.

Like many of my colleagues, I have concerns obviously regarding the backlog. Over the past several years, Congress has provided the resources to hire nearly 4,000 additional adjudicators to address the backlog, yet as of January 31 of this year, pending claims had increased over last year's level. And, that is not including new Agent Orange claims for the three new presumptive conditions established in 2010: ischemic heart disease; B-cell leukemia; and Parkinson's.

Not only is the backlog continuing to grow, but the accuracy of claims is approximately 80 percent and the Board of Veterans' Ap-

peals expects a 63-percent increase in case receipts over a 4-year period.

In a minute or two I will share a letter. On June 2010, a Navy veteran from Hamilton, OH, near Cincinnati, wrote my office for assistance with his VA claim. He was exposed to radiation during his service. He developed thyroid cancer.

His initial VA claim was filed in 2005. It was denied. It was not until his Notice of Disagreement was upheld that his case actually made it to the VBA. They remanded the case for dose reconstruction. It was sent to Nashville, and then sent back to the Appeals management center, and then the appeals management center sent it to the VA regional office in Cleveland, citing lack of jurisdiction.

This veteran from southern Ohio, his dose reconstruction is yet to be constructed. His claim will still have to go back to the VBA once it is determined. It has been 5 years since he started the process.

In addition, Mr. Secretary, we need to address the disparity in disability compensation, and we have not gotten any real understanding of why this is. Ohio is consistently at the bottom of benefit ratings. There is no reason that a bum knee in Lima, OH, should not be worth the same as a bum knee in San Diego, CA. I hope the panelists can discuss how this year's budget will fix that.

The last point, Madam Chair: I am concerned with the President's Budgets request for VA major and minor construction. The request is $757 million less than fiscal year 2011, approximately $1.65 billion less than the amount proposed by the VSOs' *Independent Budget*. VA has a $24 billion construction backlog. We know that. We need to pay attention to that too.

I appreciate your service. Thank you, Madam Chair.

Chairman MURRAY. Thank you very much.

Senator Johanns.

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

Senator JOHANNS. Madam Chairman, congratulations to you. It is a pleasure for me to be back on what I consider to be one of the Senate's most important Committees.

As I was thinking about my opening statement today, which I promise will be very brief, Mr. Secretary, it occurred to me that in your mission area, the Federal Government has asked you and your team to manage an enormous health care system, a very complicated one I might add; run a disability benefit programs, again, very, very complex; a home loan program; an insurance program; an education assistance program; and the largest national cemetery system in the entire Nation. You see my point. I could go on and on.

This is an area where through various decisions made by policymakers we have asked the Veterans' Administration to strap on yet another agenda item and another agenda item, which is quite easy to do over time. The challenge you and your team face is how to deliver all of these services in an efficient, prompt way while dealing with the budget constraints that we all face.

Now, I am going to offer a positive comment or two. I think you and your team probably deserve the award for the folks that are the most accessible to me. I have never had a situation where I needed to see somebody, including you, Mr. Secretary, that I had to even wait. Typically, it was my schedule that we were working around to schedule that kind of meeting, and I appreciate that.

Second, as a very new member, it was my first year here, I asked if we could do a field hearing back home in Nebraska, and that was arranged. It was an excellent hearing. We got out information that I thought was very important. Again, the response was just so positive from your office.

The challenge we face, however, is there are still many things that need to be done, and we are also mindful of the budget issues that we face.

So, in today's hearing I hope we really concentrate on what progress has been made with the resources you have been given, why those are important, and how we might think about alternatives, whether it is a different approach or whatever, that we might try to be more efficient.

I think at the end of the day, no matter which side of the table we sit on here, we want to deliver excellent service to our veterans and to families that need those services.

Sometimes those services are very extensive, as you know. We are bringing people back home that have suffered enormous injuries. Trying to do all we can to help can cost in so many ways, and the burden is on you folks to try to make that work.

Well, let me just wrap up and say as somebody who has been a mayor and a Governor and had to struggle with budgets, coming from a State where we do not borrow money—we balance the State budget without borrowing money, doing it in a way where literally we have to make cuts sometimes—we have to deal with the reality of providing services without going to the credit card.

I just think that all of us in the Federal Government need to be mindful that our credit card is getting maxed-out, and we have got to figure out how we do these things in an efficient way.

So, I am going to be looking to you and pressing you on how we can deliver these services to the these wonderful people, our veterans, and do it in the most cost-efficient way we can. Thank you.

Chairman MURRAY. Thank you very much.

Senator Sanders.

STATEMENT OF HON. BERNARD SANDERS,
U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you very much, Madam Chairman. Let me just pick up on what Senator Johanns said and applaud you, Mr. Secretary, and your staff. I talked to a lot of veterans in the State of Vermont, and we talk to veterans' organizations; yesterday, I spoke with the DAV.

I think there is a pretty widespread agreement that we are making progress, that a number of years ago the VA had a significant set of problems. We still have a long way to go; no question about it. But I do think there is an understanding that we are making some progress, and I want to thank you for your diligence and focus on issue after issue that are of concern to so many veterans.

Now, we know that in terms of health care, we are faced with a dual problem. We have older veterans, who we are absolutely going to provide the best quality care for. On the other hand, we have a lot of young people returning from Iraq and Afghanistan with a lot of serious problems. We are going to do that, and I applaud you for efforts in that area.

You have made the point when you came before this Committee that it is a national disgrace that a significant number of the people who are homeless in America are veterans. You made that point, and you pledged to us that you would address that issue, which you are doing.

I can tell you that in the State of Vermont right now we are seeing shelters going up, facilities going up, some of them quite beautiful, which are giving our veterans the kind of dignity and security that they need. I thank you for that as well.

A problem that everybody on this Committee knows has plagued the VA year after year after year is the length of time it takes to process disability claims. We have not solved it yet, but I know you are working on a number of pilots to try to address it, using technology in a way that makes a lot of sense, and I applaud you for that as well.

In Vermont, I am happy to tell you, Mr. Secretary, that we have added two new CBOCs, and I believe that the CBOC program is one of the jewels of the VA system. The fact that veterans do not have to drive long distances to a large hospital to get the primary health care they need is a huge benefit to them.

We have established one in Brattleboro, one in the southern part of our State, and one in the Newport area in the northern part of our State. I want to tell you that the veterans of the State of Vermont are very grateful for that.

We are making progress improving our main facility in White River Junction. We got some money to go in there and improve that facility, which we are grateful for, as well.

I know that you are also focusing on two of the major signature problems of our time, and that is PTSD, a very, very serious problem, and TBI. How do we address those issues?

We have thousands and thousands of veterans who are hurting from those problems, among others. When we worked on a model program in Vermont, you and I talked about that even if you had the best facilities in the world providing the best care in the world, it does not mean anything unless veterans are able to access that care.

So, how do we do better outreach? How do we make sure every veteran, especially those struggling with problems like PTSD access those facilities and that care? How do we improve outreach efforts?

So the bottom line, Mr. Secretary: I want to applaud you for what you are doing. You are doing a great job, and I look forward to continuing to work with you.

Chairman MURRAY. Thank you very much.

Senator Brown.

STATEMENT OF HON. SCOTT P. BROWN,
U.S. SENATOR FROM MASSACHUSETTS

Senator BROWN OF MASSACHUSETTS. Thank you, Madam Chair, and welcome back to the Committee. I look forward to your leadership. It is good to be back on the Committee, as well.

I want to echo what Senator Johanns said, that a lot of good is getting to a lot of challenges. I want to hear from you more than I want to hear from us.

I know we are going to be bouncing back and forth to votes, but I am very concerned about veterans finding work, the homelessness issue, and construction. For example, in Massachusetts we have the West Roxbury Hospital of the VA, which is basically the northeast region care facility. It is at the point now that they cannot even perform modern operations, cannot get the equipment in the outdated operating rooms.

So we are trying to address some of those issues, finding out what you need, what resources and help you need.

As somebody who still serves, you know, obviously I take these issues very seriously like every Member of this Committee regardless of their service.

I have found that there are some good citizen groups and nonprofit organizations that are actually working with the soldiers to process claims applications. My understanding is that part of the delay and breakdown is the fact that the applications are incomplete.

I have a group in Massachusetts that has had a hundred percent success rate when they have submitted their claims, and they have a hundred percent return, and I think that is important. Maybe having more entities like that throughout the country so when you get the claim you see that the packet is complete, versus having to send it back. The delay is what is really crushing our soldiers and their morale when it comes to getting the care and service that they need.

So, I look forward to your testimony. We will be bouncing back and forth, so no disrespect intended. Thank you.

Chairman MURRAY. Thank you very much.

With that, I want to welcome Secretary Eric Shinseki to the Committee. I really appreciate your joining us today to give us your perspective on the Department's Fiscal Year 2012 Budget. We look forward to your testimony.

Secretary Shinseki is accompanied today by Dr. Robert Petzel, Under Secretary for Health. We also have Mike Walcoff, Acting Under Secretary for Benefits; Steve L. Muro, Acting Under Secretary for Memorial Affairs; Roger W. Baker, Assistant Secretary for Information and Technology; and Todd Grams, Acting Assistant Secretary for Management.

Mr. Secretary, your prepared remarks will be, of course, in the record but we appreciate your testimony today.

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH; MICHAEL WALCOFF, ACTING UNDER SECRETARY FOR BENEFITS; STEVE L. MURO, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS; HONORABLE ROGER W. BAKER, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY; W. TODD GRAMS, ACTING ASSISTANT SECRETARY FOR MANAGEMENT

Secretary SHINSEKI. Thank you, Madam Chairman, and I add my congratulations to you as well and look forward to working with you and your leadership on this Committee. Ranking Member Burr, who has since departed, and other distinguished Members of the Senate Committee on Veterans' Affairs, thank you again. I say that genuinely.

Thank you again for this opportunity to present the President's 2012 budget and 2013 advanced appropriations request for this Department.

This Committee's support of our Nation's veterans has always been unequivocal and unwavering. That is my experience for 2 years. I wish to express my appreciation to all the Members on behalf of the professional workforce that comes to work everyday in the VA and the 8.3 million veterans who come to us for service.

Let me also acknowledge the representatives of some of our veterans' organizations in attendance today. They provide insights into veterans' needs and suggest ways in which VA can better address them. Those insights are helpful as we deliberate how to best resource our programs.

Madam Chairman, thank you for recognizing the other members of the panel. Let me just point them out so that I get faces and names aligned. Roger Baker, IT, is to my extreme left. Todd Grams, our Chief Financial Officer, is to my left. The young man to my right, Dr. Randy Petzel, is our Chief Medical Officer. Mike Walcoff, Benefits; and Steve Muro, who is the Acting Under Secretary for Memorial Affairs and the President's nominee to be the Under Secretary for the National Cemetery Administration.

Thank you, Madam Chairman, for admitting my written statement for the record.

The VA budget is large and complex and important, to be sure, because it cares for those, as several have already suggested, who safeguard our Nation so that the rest of us can do what Americans do best, and that is out think, out work, out create, out produce the rest of the world.

I say that realizing that the economy has lost some of its sparkle at the moment, but I trust the instincts, the energy, the intellect, and the ingenuity of Americans to get that back and to get us and our economy back on track.

It has been noted several times that less than 1 percent of our citizens serve in the military. But let me just tie together the two statements I just made. Those that do, these men and women who serve in uniform, enable the rest of the Nation to unleash the potential in that economic engine to do what Americans have historically done, and that is create the best economy in the world and win in this competitive area.

When those members of the military transition back to their communities to add their skills, their knowledge, and their experience to that economic engine, VA's mission is pretty clear. As Senator Burr cited, our mission goes back to President Lincoln's admonition to care for those who have borne the battle and for their spouses and orphans.

To keep that promise, VA is a large integrated health care system, the largest in the country. It is also our largest national cemetery system, repeatedly recognized as the country's top performer in customer satisfaction over the past 10 years.

The VA also manages the country's second-largest education assistance program. It guarantees nearly 1.4 million individual home loans at zero down payment with the lowest foreclosure rates in all categories of mortgage loans.

Finally, it is the country's eighth largest life insurance enterprise with a 96 percent customer satisfaction rating.

I often get asked the question, why is the VA enterprise so complex? Why is it so large? And the answer that I usually end up giving is fairly simplistic. It is because in times past those who wore the Nation's uniforms were often unable to either acquire or afford those services elsewhere on their own. In honoring their service, it was found important that they not be left unattended. For that reason we have this complex series of missions.

Our mission, to provide, or arrange for, the care of veterans who need us once the uniforms come off, again, remains rooted in President Lincoln's promise of 1865.

We deliver on the promises of Presidents and fulfill the obligations of the American people to those who have borne the battle.

Today the Nation's military remains deployed in two different operational theaters, conflicts that have been underway for most of the past decade in Afghanistan and Iraq. The burden on our magnificent all-volunteer force and their families in accomplishing those missions without failure, without fanfare, without complaint has been enormous, and they have been magnificent.

VA's requirements have grown over that time as we address long-standing issues from past wars and watch the requirements for those fighting the current conflicts grow significantly.

These numbers will continue to rise for years, maybe even decades, after the last American combatant departs Afghanistan and Iraq. That is the history of what has happened inside VA.

As a reminder of the duration of those obligations and a tribute to his life of service, let me acknowledge the passing of Mr. Frank Buckles just this past Sunday at 110 years of age.

Mr. Buckles was the last known American veteran of World War I. Our thoughts and prayers are with his family, and I have expressed them as they mourn the loss of this very special American more than 92 years after the armistice that ended the great war was signed.

This budget request is the Department's plan for meeting those obligations to all generations of our veterans effectively, accountably, and efficiently.

At present, about 8.3 million veterans depend on VA for medical care and benefits, but over 22 million veterans and another 35 million spouses and adult children see themselves as either veterans

or part of veterans' families whether or not they visit our medical centers or ever apply for benefits.

They all expect us to get things right for the veterans we do serve, and we rely on the leadership, Madam Chairman, your leadership and the leadership of this Committee and your support in helping us determine how best to serve those veterans.

To resource VA's efforts, the President's Budget request would provide $132.2 billion in 2012, $61 billion in discretionary resources, about $70.3 billion in mandatory funding.

Our discretionary budget request represents, as the Chairman pointed out, a $5.9 billion increase, which is about a 10.6 percent increase over the 2010 enacted level.

Since I appeared before this Committee last year, we have published and implemented a strategic plan to continue transforming VA into an innovative 21st-century organization, that is—and these are sort of our tag lines—a people-centric; results-driven, if you cannot measure it, you cannot declare progress; and forward-looking.

Our 2012 and 2013 budget plans are based on four goals in our strategic plan: first, continue improving the quality and accessibility of VA health care benefits and services. Second, increase veterans' satisfaction with the care and services we provide. Third, raise readiness to continue the provision of care and services in a time of crisis. Finally, improve VA's internal management systems.

Achievement of these goals mandates our constant and consistent good stewardship of the financial resources entrusted to us by this Committee and the Congress.

Every dollar counts. That is my repeated phrase. Every dollar counts always, both in the current constrained fiscal environment, but also during less stressful times. Every dollar counts.

We have designed management systems and initiatives to maximize the effectiveness and eliminate waste, including VA's Project Management Accountability System, PMAS, a new acquisition strategy to make more effective use of our IT resources.

VA's Transformation Twenty-One Total Technology, our bumper sticker for that is T4. T4 consolidates our IT requirements into 15 prime contracts and leverages economies of scale to save both time and money, enabling greater oversight and accountability.

Our Strategic Capital Investment Planning, SCIP, defines and assesses VA's large capital portfolio and enables improved efficiency of operations.

Last November we launched two online metric systems, one called LinKS (Linking Information, Knowledge, and Systems), and the other one called Aspire. Together these systems allow VA to increase our quality of health care against private-sector benchmarks transparently.

VA successfully remediated three of four long-standing material weaknesses in 2010 and earned our 12th consecutive clean audit opinion on our consolidated financial statements.

Finally, we have implemented Medicare's standard payment rates and consolidated contracting requirements to reduce cost and waste.

A recent independent study, which covered a 10-year period, found that VA's health IT investments between 1997 and 2007

amounted to $4 billion while savings from those investments came to over $7 billion. More than 86 percent of the savings resulted from the elimination of duplicate tests and reduced medical errors, contributing overall to reduced workload and lowered operating costs.

The 2012 budget continues to focus on our three key transformational priorities: expanding access; reducing and ultimately eliminating the backlog; and ending veterans' homelessness by the year 2015—three visible and urgent priorities.

A comprehensive review is underway to use VA's inventory of vacant or underutilized buildings to house homeless and at-risk veterans and their families, where practical.

Congress allocated $50 million to renovate unused VA buildings. We have identified 94 sites with the potential to add approximately 6,300 units of housing through public-private ventures using VA's enhanced use lease authority.

As we discussed, Madam Chairman, this enhanced-use lease authority is scheduled to lapse at the end of 2011, and its reauthorization is important to us and vital to our plans to increase housing for homeless veterans and families.

Today, the most flexible housing option is a HUD voucher. We work quite closely with the Department of Housing and Urban Development. Both Secretary Donovan and I endorse the importance of this joint effort to care for our homeless veterans, our only option at the moment for housing veterans with families.

As advocates for veterans and their families, VA is committed to providing the very best services. I will do everything possible to ensure that we wisely use the funds Congress appropriates for VA to improve the quality-of-life for veterans innovatively and transparently as we deliver on enduring promises of Presidents and the obligations of the American people to veterans.

Again, Madam Chairman, thank you for this opportunity to appear before this Committee and for your continued unwavering support. I look forward to your questions.

[The prepared statement of Secretary Shinseki follows:]

PREPARED STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Murray, Ranking Member Burr, Distinguished Members of the Senate Committee on Veterans' Affairs: Thank you for the opportunity to present the President's 2012 Budget and 2013 Advance Appropriations Requests for the Department of Veterans Affairs (VA). Budget requests for this Department deliver the promises of Presidents and fulfill the obligations of the American People to those who have safeguarded us in times of war and peace.

Today, the Nation's military remains deployed overseas as it has during the last 9 years of major conflict. Our requirements have grown over the past two years as we addressed longstanding issues from past wars and watched the requirements for those fighting the current conflicts grow significantly. These needs will continue long after the last American combatant departs Iraq and Afghanistan. It is our intent to continue to uphold our obligations to our Veterans when these conflicts have subsided, something that we have not always done in the past. Not upholding these obligations in the past has left at least one generation of Veterans struggling in anonymity for decades. We, who sent them, owe them better.

VA has an obligation to track, communicate to stakeholders, and take decisive action to consistently meet the requirements of our Nation's Veterans for care and services. We pay great attention to detail but there are many factors in the health care market that we cannot control. We must mitigate the risk inherent when requirements for Veterans' care and services, and costs in the healthcare market, ex-

ceed our estimates. This request is the Department's plan for managing that risk and meeting our obligations to all Veterans effectively, accountably, and efficiently.

The President's budget for 2012 requests $132 billion—$62 billion in discretionary funds and $70 billion in mandatory funding. Our discretionary budget request represents an increase of $5.9 billion, or 10.6 percent, over the 2010 enacted level.

Our plans for 2012 and 2013 pursue strategic goals we established two years ago to transform VA into an innovative, 21st century organization that is people-centric, results-driven, and forward-looking. These strategic goals seek to reverse in-effective decisionmaking, systematic inefficiency, and poor business practices in order to improve quality and accessibility to VA healthcare, benefits, and services; increase Veteran satisfaction; raise readiness to serve and protect in a time of crisis; and improve VA internal management systems to successfully perform our mission. We seek to serve as a model of governance, and this budget is shaped to provide VA both the tools and the management structure to achieve that distinction.

For almost 146 years now, VA and its predecessor institutions have had the singular mission of caring for those who have "borne the battle" and their survivors. This is our only mission, and to do that well, we operate the largest integrated healthcare system in the country; the eighth largest life insurance entity covering both active duty members as well as enrolled Veterans; a sizable education assistance program; a home mortgage enterprise which guarantees over 1.4 million Veterans' home loans with the lowest foreclosure rate in the Nation; and the largest national cemetery system, which continues to lead the country as a high performing institution.

For two years now, we have disciplined ourselves to understand that successful execution of any strategic plan, especially one for a Department as large as ours, requires good stewardship of resources entrusted to us by the Congress. Every dollar counts, both in the current constrained fiscal environment and during less stressful times. Accountability and efficiency are behaviors consistent with our philosophy of leadership and management. The responsibility of caring for America's Veterans on behalf of the American people demands unwavering commitment to effectiveness, accountability, and in the process, efficiency. In the past two years, we have established and created management systems, disciplines, processes, and initiatives that help us eliminate waste.

STEWARDSHIP OF RESOURCES

VA has made great progress instilling accountability and disciplined processes by establishing our Project Management Accountability System (PMAS). This approach has created an information technology (IT) organization that can rapidly deliver technology to transform VA. PMAS is a disciplined approach to IT project development whereby we hold ourselves and our private-sector partners accountable for cost, schedule and performance. In just one year, PMAS exceeded an 80% success rate of meeting customers' milestones.

In addition to PMAS, we adopted a new acquisition strategy to make more effective use of our IT resources. This new strategy, Transformation Twenty-One Total Technology (T4, for short), will consolidate our IT requirements into 15 prime contracts, leveraging economies of scale to save both time and money and enable greater oversight and accountability. T4 also includes significant goals for subcontractors and other protections to make sure Veteran-owned small businesses get a substantial share of the work. Seven of the 15 prime contracts are reserved for Veteran-owned small businesses, and four of the seven are reserved for service-disabled small businesses.

In developing the 2012 budget, VA used an innovative, Department-wide process to define and assess VA's capital portfolio. This process for Strategic Capital Investment Planning (SCIP) is a transformative tool enabling VA to deliver the highest quality of services by investing in the future and improving efficiency of operations. SCIP has captured the full extent of VA infrastructure and service gaps and developed both capital and non-capital solutions to address these gaps through 2021. SCIP also produced VA's first-ever Department-wide integrated and prioritized list of capital projects, which is being used to ensure that the most critical infrastructure needs are met, particularly in correcting safety, security, and seismic deficiencies, and creating consistent standards across the system.

The use of metrics to monitor and assess performance is another key strategy we employ to ensure the effective use of resources and accountability. For example, in November 2010, VA launched two online dashboards to offer transparency of the clinical performance of our healthcare system to the general public. First, VA's Linking Information Knowledge and Systems (LinKS) provides outcome measurement data in areas such as acute, intensive, and outpatient care. This allows management

to assess a specific medical facility's performance against other facilities while, at the same time, serving as a motivational tool to improve performance. The dashboard, Aspire, compiles data from VA's individual hospitals and hospital systems to measure performance against national private-sector benchmarks. Financial and performance metrics also provide the foundation for monthly performance reviews that are chaired by the Deputy Secretary. These monthly meetings play a vital role in monitoring performance throughout the Department, and are designed to ensure both operational efficiency and the achievement of key performance targets.

We also demonstrated our ongoing commitment to effective stewardship of our financial resources by obtaining our 12th consecutive unqualified (clean) audit opinion on VA's consolidated financial statements. In 2010, we were successful in remediating 3 of 4 longstanding material weaknesses, a 75 percent reduction in just one year. We also began implementation of a number of key management initiatives that will allow us to better serve Veterans by getting the most out of our available resources:

- Reducing improper payments and improving operational efficiencies in our medical fee care program will result in estimated savings of $150 million in 2011. This includes continued expansion of the Consolidated Patient Account Centers to standardize VA's billing and collection activities.
- Implementing Medicare's standard payment rates will allow VA to better plan and redirect more funding into the provision of healthcare services. The estimated savings of this change in business practices in 2011 is $275 million.
- Consolidating contracting requirements, adopting strategic sourcing and other initiatives will reduce acquisition costs by an estimated $177 million in 2011.

The effective use of information technology is critical to achieving efficient healthcare and benefits delivery systems for Veterans. To accelerate the process for adjudicating disability claims for new service-connected presumptive conditions associated with exposure to Agent Orange, we implemented a new on-line claims application and processing system.

A recent independent study, which covered a 10-year period between 1997 and 2007, found that VA's health IT investment during the period was $4 billion, while savings were more than $7 billion.[1] More than 86 percent of the savings were due to the elimination of duplicated tests and reduced medical errors. The rest of the savings came from lower operating expenses and reduced workload. VA is continuing to modernize its electronic medical records to optimally support healthcare delivery and management in a variety of settings. This effort includes migrating the current computerized patient record system into a modern, Web-based electronic health record.

Advance appropriations for VA medical care require a multi-year approach to budget planning whereby one year builds off the previous year. This provides opportunities to more effectively use resources in a constrained fiscal environment as well as to update requirements.

MULTI-YEAR PLAN FOR MEDICAL CARE BUDGET

The 2012 budget request for VA medical care of $50.9 billion is a net increase of $240 million over the 2012 advance appropriations request of $50.6 billion in the 2011 budget. This is the result of an increase of $953 million associated with potential increased reliance on the VA healthcare system due to economic employment conditions, partially offset by a rescission of $713 million which reflects the cumulative impact of the statutory freeze on pay raises for Federal employees in 2011 and 2012. The 2013 request of advance appropriations is $52.5 billion, an increase of $1.7 billion over the 2012 budget request.

The establishment of a Contingency Fund of $953 million for medical care is requested in 2012. These contingency funds would become available for obligation if the Administration determines that additional costs, due to changes in economic conditions as estimated by VA's Enrollee Health Care Projection Model, materialize in 2012. This economic impact variable was incorporated into the Model for the first time this year. Based on experience from 2010, the need for this fund will be carefully monitored in 2011 and 2012. This cautious approach recognizes the potential impact of economic conditions as estimated by the Model to ensure funds are available to care for Veterans, while acknowledging the uncertainty associated with the new methodology incorporated into the Model estimates.

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[1] *The Value From Investments In Health Information Technology at the U.S. Department of Veterans Affairs*, Colene M. Byrne, Lauren M. Mercincavage, Eric C. Pan, Adam G. Vincent, Douglas S. Johnston, and Blackford Middleton, Health Aff April 2010 29:4629–638.

Another key building block in developing the 2012 and 2013 budget request for medical care is the use of unobligated balances, or carryover, from 2011 to meet projected patient demand. This carryover of more than $1 billion, which includes savings from operational improvements, supports anticipated costs for providing medical care to Veterans in 2012 and 2013 and is factored into VA's request for appropriations. This is a vital component of our multi-year budget and any reductions in the amount of 2011 projected carryover funding would require increased appropriations in 2012 and 2013.

TRANSFORMING VA

The Department faces an increasingly challenging operating environment as a result of the changing population of Veterans and their families and the new and more complex needs and expectations for their care and services. Transforming VA into a 21st-century organization involves a commitment to many broad challenges: to stay on the cutting edge of healthcare delivery; to lay the foundation for safe, secure, and authentic health record interoperability; to deliver excellent service for Veterans who apply for disability and education benefits; and to create a modern, efficient, and customer-friendly interface that better-serves Veterans. In this journey, we are focusing on opportunities to improve our efficiency and effectiveness and the individual performance of our employees.

Our health informatics initiative is a foundational component for VA's transition from a medical model to a patient-centered model of care. The delivery of healthcare will be better tailored to the individual Veteran, yet utilize treatment regimens validated through population studies. Veterans will receive fewer unnecessary tests and procedures and more standardized care based on best practices and empirical data.

The purpose of the VA Innovation Initiative (VAi2) is to identify, fund, and test new ideas from VA employees, academia, and the private sector. The focus is on improving access, quality, performance, and cost. VA remains committed to the best system of delivering quality care and benefits to Veterans. VAi2 plays an important role by enabling the use of promising technologies in the design of cost-effective solutions. For example, TBI Toolbox pilot, located at McGuire VA Medical Center in Richmond, Virginia, will test a software tool to standardize data gathered from brain injury treatments. The strategy will allow sharing of rapidly evolving treatment guidelines at VA polytrauma centers and Department of Defense medical facilities, as well as patient progress and outcomes.

The 2012 budget continues our focus on three key transformational priorities I established when I became Secretary: Expanding access to benefits and services; reducing the claims backlog; and eliminating Veteran homelessness by 2015. These priorities address the most visible and urgent issues in VA.

EXPANDING ACCESS TO BENEFITS AND SERVICES

Expanding access to healthcare and benefits for underserved Veterans is vital to VA's success in best-serving Veterans of all eras.

The Veterans Relationship Management (VRM) initiative will provide Veterans, their families, and survivors with direct, easy, and secure access to the full range of VA programs through an efficient and responsive multi-channel program, including phone and Web services. VRM will provide VA employees with up-to-date tools to better serve VA clients, and empower clients through enhanced self-service capabilities. Expanding the self-service capabilities of the eBenefits on-line portal is one of the early successes of the VRM program in 2010, and expansion of eBenefits functionality continues through quarterly releases and programs to engage new users.

VA also saw significant progress in expanding access to Veterans. In July 2010, the Center for Women Veterans sponsored a forum to highlight enhancements in VA services and benefits for women Veterans which resulted in an information toolkit tor advocates such as Veteran Service Organizations to share with their constituencies.

Outreach was extended directly to women when, for the first time in 25 years, VA surveyed women Veterans across the country to (1) identify in a national sample the current status, demographics, healthcare needs, and VA experiences of women Veterans; (2) determine how healthcare needs and barriers to VA healthcare differ among women Veterans of different generations; and (3) assess women Veterans' healthcare preferences in order to address VA barriers and healthcare needs. The interim report, released in summer 2010, informs policy and planning and provides a new baseline for program evaluation with regard to Veterans' perceptions of VA health services. The final report will be released in spring 2011.

The Enhancing the Veteran Experience and Access to Healthcare (EVEAH) initiative will expand healthcare for Veterans, including women and rural populations. Care alternatives will be created to meet these special population access needs, including the use of new technology. Where technology solutions safely permit, VA has already transitioned from inpatient to outpatient settings through the use of telemedicine, in-home care, and other delivery innovations.

One area of success is our expansion of telehome health-based clinical services in rural areas, which increases access, and reduces avoidable travel for patients and clinicians. In 2010, the total average daily census in telehome health was 31,155. This program will continue to expand to an estimated average daily census of 50,147 in 2012, an increase of 60 percent over 2010.

Through the Improve Veteran Mental Health (IVMH) initiative more Veterans will have access to the appropriate mental health services for which they are eligible, regardless of their geographic location. VA is leveraging the virtual environment with services such as the Veterans' Suicide Prevention Chat Line and real-time clinical video conferences.

REDUCING THE CLAIMS BACKLOG

One of VA's highest priority goals is to eliminate the disability claims backlog by 2015 and ensure all Veterans receive a quality decision (98 percent accuracy rate) in no more than 125 days. VBA is attacking the claims backlog through a focused and multi-pronged approach. At its core, our transformational approach relies on three pillars: a culture change inside VA to one that is centered on advocacy for Veterans; collaborating with stakeholders to constantly improve our claims process using best practices and ideas; and deploying powerful 21st century IT solutions to simplify and improve claims processing for timely and accurate decisions the first time.

The Veterans Benefits Management System (VBMS) initiative is the cornerstone of VA's claims transformation strategy. It integrates a business transformation strategy to address process and people with a paperless claims processing system. Combining a paperless claims processing system with improved business processes is the key to eliminating the backlog and providing Veterans with timely and quality decisions. The Virtual Regional Office, completed in May 2010, engaged employees and subject-matter experts to determine system specifications and business requirements for VBMS. The first VBMS pilot began in Providence in November 2010. Nationwide deployment of VBMS is expected to begin in 2012.

VA is encouraging Veterans to file their Agent Orange-related claims through a new on-line claims application and processing system. Vietnam Veterans are the first users of this convenient automated claims processing system, which guides them through Web-based menus to capture information and medical evidence for faster claims decisions. While the new system is currently limited to claims related to the new Agent Orange presumptive conditions of Parkinson's Disease, Ischemic Heart Disease, and Hairy Cell Leukemia's, we will expand it to include claims for other conditions.

VA also published the first set of streamlined forms capturing medical information essential to prompt evaluation of disability compensation and pension claims, and dozens more of these forms are in development for various disabilities. The content of these disability benefit questionnaires is being built into VA's own medical information system to guide in-house examinations. Veterans can provide them to private doctors as an evidence guide that will speed their claims decisions.

Another initiative to reduce the time needed to obtain private medical records utilizes a private contractor to retrieve the records from the provider, scan them into a digital format, and send them to VA through a secure transmission. This contract frees VA staff to focus on processing claims more quickly.

Additional claims transformation efforts deployed nationwide in 2010 include the Fully Developed Claims initiative to promptly rate claims submitted with all required evidence and an initiative to proactively reach out to Veterans via telephone to quickly resolve claims issues.

VA needs these innovative systems and initiatives to expedite claims processing as the number of claims continue to climb. The disability claims workload from returning war Veterans, as well as from Veterans of earlier periods, is increasing each year. Annual claims receipts increased 51 percent when comparing receipts from 2005 to 2010 (788,298 to 1,192,346). We anticipate claims receipts of nearly 1.5 million in 2011 (including new Agent Orange presumptive) and more than 1.3 million claims in 2012. The funding request in the President's budget for VBA is essential to meet the increasing workload and put VA on a path to achieve our ultimate goal of no claims over 125 days by 2015.

ELIMINATING VETERAN HOMELESSNESS

VA has an exceptionally strong track record in decreasing the number of homeless Veterans. Six years ago, there were approximately 195,000 homeless Veterans on any given night; today, there are about 75,600. VA uses a multi-faceted approach by providing safe housing; outreach; educational opportunities; mental healthcare and treatment; support services; homeless prevention services, and opportunities to return to employment. The National Call Center for Homeless has received 13,000 calls since March 2010, and 18,000 Veterans and families of Veterans have been provided permanent housing through VA and Housing and Urban Development Department programs. These Veterans were also provided with dedicated case managers and access to high-quality VA healthcare.

The Building Utilization Review and Repurpose (BURR) study is using VA's inventory of vacant/underutilized buildings to house homeless and at-risk Veterans and their families, where practical. Congress allocated $50 million to renovate unused VA buildings and VA has identified 94 sites with the potential to add approximately 6,300 units of housing through public/private ventures using VA's enhanced-use lease authority. This legislative authority is scheduled to lapse at the end of calendar year 2011. The Administration remains committed to this important program, and a proposal to address the expiration will accompany the Department's legislative package submitted through the President's Program. In addition to helping reduce homelessness, vacant building reuse is being considered for housing for OEF/OIF/OND Veterans, poly-trauma patients, assisted living, and seniors.

Homelessness is both a housing and healthcare issue, heavily burdened by depression and substance abuse. Our 2012 budget plan also supports a comprehensive approach to eliminating Veteran homelessness by making key investments in mental health programs.

The 2012 budget includes $939 million for specific programs to prevent and reduce homelessness among Veterans. This is an increase of 17.5 percent, or $140 million over the 2011 level of $799 million. This increase includes an additional $50.4 million to enhance case management for permanent housing solutions offered through the Housing Urban Development-VA Supported Housing (HUD-VASH) program. These funds are required to maintain the services that keep Veterans rescued from homelessness sheltered; get the remaining men and women off the streets whom we have not reached in the past; and, prevent additional Veterans from becoming homeless during a time of war and difficult economic conditions.

MENTAL HEALTH

The mental health of Veterans is a more important issue now than ever before, as increasing numbers of Veterans are diagnosed with mental health conditions, often coexisting with other medical problems. More than 1.2 million of the 5.2 million Veterans seen in 2009 in VA had a mental health diagnosis. This represents about a 40 percent increase since 2004.

Veterans of Iraq and Afghanistan rely on mental healthcare from VA to a greater degree than earlier groups of Veterans. Diagnosis of PTSD is on the rise as the contemporary nature of warfare increases both the chance for injuries that affect mental health and the difficulties facing Veterans upon their return home. In addition, mental health issues are often contributing factors to Veterans' homelessness.

In order to address this challenge, VA has significantly invested in our mental healthcare workforce, hiring more than 6,000 new mental healthcare workers since 2005. In 2010, VA hired more than 1,500 clinicians to conduct screenings and provide treatment as well as trained over 1,000 clinicians in evidenced-based practices. The Department has also established high standards for the provision of mental healthcare services through the recent publication of our Handbook on Uniform Mental Health Services in VA medical centers and clinics, and we have developed an integrated mental health plan with DOD to ensure better continuity of care—especially for Veterans of Iraq and Afghanistan. The 2012 budget includes $6.2 billion for mental healthcare programs, an increase of $450 million, or 8 percent over the 2011 level of $5.7 billion.

MEDICAL CARE PROGRAM

We expect to provide medical care to over 6.2 million unique patients in 2012, a 1.4 percent increase over 2011. Among this community are nearly 536,000 Veterans of Iraq and Afghanistan, an increase of over 59,000 (or 12.6 percent) above 2011.

The 2012 budget will support several new initiatives in addition to our efforts to eliminate Veteran homelessness. For example, $344 million is provided for the activation of newly constructed medical facilities. In addition, we provide $208 million

to implement provisions of the Caregivers and Veterans Omnibus Health Services Act and improve the quality of life for Veterans and their families.

The 2012 budget also includes operational improvements that will make VA more effective and efficient in this challenging fiscal and economic environment. VA is proposing $1.2 billion of operational improvements which include aligning fees that VA pays with Medicare rates, reducing and improving the administration of our fee-based care program, clinical staff realignments, reducing indirect medical and administrative support costs, and achieving significant acquisition improvements to increase our purchasing power.

Beginning in 2010, VHA embarked on a multi-year journey to enhance significantly the experience of Veterans and their families in their interactions with VA while continuing to focus on quality and safety. This journey required the VHA to develop new models of healthcare that educated and empowered patients and their families, focused not only on the technical aspects of healthcare but also designed for a more holistic, Veteran-centered system, with improved access and coordination of care. New Models of Healthcare is a portfolio of initiatives created to achieve these objectives. We are re-designing our systems around the needs of our patients and improving care coordination and virtual access through enhanced secure messaging, social networking, telehealth, and telephone access.

An essential component of this approach is transforming our primary care programs to increase our focus on health promotion, disease prevention, and chronic disease management through multidisciplinary teams. The new model of care will improve health outcomes and the care experience for our Veterans and their families. The model will standardize healthcare policies, practices and infrastructure to consistently prioritize Veterans' healthcare over any other factor without increasing cost or adversely affecting the quality of care. This important initiative will enable VA to become a national leader in transforming primary care services to a medical home model of healthcare delivery that improves patient satisfaction, clinical quality, safety and efficiencies. VA Tele-Health and the Home Care Model will develop a new generation of communication tools (i.e. social networking, micro-blogging, text messaging, and self management groups) that VA will use to disseminate and collect critical information related to health, benefits and other VA services.

VA is taking this historic step in redefining medical care for Veterans with the adoption of a modern healthcare approach called PACT, which stands for Patient Aligned Care Team. PACT is VA's adaptation of the popular contemporary team-based model of healthcare known as Patient Centered Medical Home designed to provide continuous and coordinated care throughout a patient's lifetime.

MEDICAL RESEARCH

VA's many trailblazing research accomplishments are a source of great pride to our department and the Nation. Today's committed VA researchers are focusing on Traumatic Brain Injury, Post Traumatic Stress Disorder, post-deployment health, women's health and a host of other issues key to the well-being of our Veterans. As one of the world's largest integrated healthcare systems, VA is uniquely positioned to not only conduct and fund research, but to develop solutions and implement them more quickly than other healthcare systems—turning hope into reality for Veterans and all Americans.

VA's budget request for 2012 includes $509 million for research, a decrease of $72 million below the 2010 level. In addition, VA's research program will receive approximately $1.2 billion from medical care funding and Federal and non-Federal grants. These research funds will continue support for genomic medicine, point of care research, and medical informatics and information technology. Genomic medicine, also referred to as personalized medicine, uses information on a patient's genetic make-up to tailor prevention and treatment for that individual. The Million Veteran Program invites users of the VA healthcare system nationwide to participate in a longitudinal study with the aim of better understanding the relationship between genetic characteristics, behaviors and environmental factors, and Veteran health.

To leverage data in the electronic health record, VA Informatics and Computing Infrastructure (VINCI) is creating a powerful and secure environment within the Austin Information Technology Center. This environment will allow VA researchers to access more easily a wide array of VHA databases using custom and off-the-shelf analytical tools. The Consortium for Healthcare Informatics Research (CHIR) will provide research access to patient information in VA's Computerized Patient Record System (CPRS) narrative text and laboratory reports. Together, VINCI and CHIR will allow data mining to accelerate findings and identify emerging trends. Ulti-

mately, this critical work will lead to greater effectiveness of our medical system—improving value by assisting in the prevention and cure of disease.

VETERAN BENEFITS

The 2012 budget request for the Veterans Benefits Administration is $2.0 billion, an increase of $330 million, or 19.5 percent, over the 2010 enacted level of $1.7 billion. This budget supports ongoing and new initiatives to reduce disability claims processing time, including development and implementation of further redesigned business processes. It funds an increase in FTE of 716 over 2010 to 20,321 to assist in reducing the benefits claims backlog. It also supports the administration of expanded education benefits eligibility under the Post-9/11 GI Bill, which now includes benefits for non-college degree programs, such as on-the-job training, flight training, and correspondence courses. In addition, the 2012 budget request supports the following initiatives:

Integrated Disability Evaluation System (IDES) Program

IDES simplifies the process for disabled servicemembers transitioning to Veteran status, improves the consistency of disability ratings, and improves customer satisfaction. An IDES claim is completed in an average of 309 days; 43 percent faster than in the legacy system. VA and DOD worked together to increase the number of sites for the IDES program from 21 to 27 in 2010. The six new sites are Fort Riley, Fort Benning, Fort Lewis, Fort Hood, Fort Bragg and Portsmouth Naval Hospital, and VA and DOD will continue to expand the IDES program.

IDES is being expanded to provide Vocational Rehabilitation and Employment (VR&E) services to active duty Servicemembers transitioning through the IDES. These services range from a comprehensive rehabilitation evaluation to determine abilities, skills, and interests for employment purposes as well as support services to identify and maintain employment. The budget request includes $16.2 million for 110 FTE for the VR&E program to support IDES.

Veterans Benefits Management System (VBMS)

In 2011, we will conduct two of three planned pilot programs to test VBMS, the new paperless claims processing system. Each pilot will expand on the success of the first pilot by adding additional software components. In the 2012 budget request for information technology, we will invest $148 million to complete pilot testing and initiate a national rollout.

VetSuccess on Campus

In July 2009, VA established a pilot program at the University of South Florida called VetSuccess on Campus to improve graduation rates by providing outreach and supportive services to Veterans entering colleges and universities and ensuring that their health, education and benefit needs are met. The program has since expanded to include an additional seven campuses, serving approximately 8,000 Veterans. The campus Vocational Rehabilitation Counselor (VRC) and the Vet Center Outreach Coordinator liaise with school certifying officials, perform outreach, and communicate with Veteran-students to ensure their health, education, and benefit needs are met. This will enable Veterans to stay in college to complete their degrees and enter career employment. In addition, it provides Veterans the skills necessary to gain employment after graduation, which can help prevent Veteran homelessness. The 2012 budget includes $1.1 million to expand the program to serve an additional 9,000 Veteran students on nine campuses, more than doubling the size of the current program.

NATIONAL CEMETERY ADMINISTRATION

The budget plan includes $250.9 million in operations and maintenance funding for the National Cemetery Administration (NCA). The funding will allow us to provide more than 89.8 percent of the Veteran population a burial option within 75 miles of their residences by keeping existing national cemeteries open and establishing new state Veterans cemeteries, as well as increasing outreach efforts.

VA expects to perform 115,500 interments in 2012, a 1.0 percent increase over 2011. In 2012, NCA will provide maintenance of 8,759 developed acres, 3.0 percent over the 2011 estimate, while 3,228,000 or 2.6 percent more gravesites will be given perpetual care.

The budget request will allow NCA to maintain unprecedented levels of customer satisfaction. NCA achieved the top rating in the Nation four consecutive times on the prestigious American Customer Satisfaction Index (ACSI) established by the University of Michigan. ACSI is the only national, cross-industry measure of satisfaction in the United States. On the most recent 2010 survey and over the past dec-

ade, NCA's scores bested over 100 Federal agencies and the Nation's top corporations including Ford, FedEx and Coca Cola, to name a few. Our own internal surveys confirm this exceptional level of performance. For 2010, 98% of the survey respondents rated the appearance of national cemeteries as excellent; 95% rated the quality of service as excellent.

NCA has implemented innovative approaches to cemetery operations: the use of pre-placed crypts, that preserve land and reduce operating costs; application of "water-wise" landscaping that conserves water and other resources; and installation of alternative energy products such as windmills and solar panels that supply power for facilities. NCA has also utilized biobased fuels that are homegrown and less damaging to the environment. NCA is developing an independent study of emerging burial practices throughout the world to inform its planning for the future.

Support for the Veterans Cemetery Grants Program continues in 2012 with $46 million to fund the highest priority Veterans cemetery grant requests ready for award. In addition to state cemetery grants, NCA is engaged in discussions with tribal governments regarding the construction of Veterans' cemeteries on their land and is awarding six such grants in 2011. The inclusion of tribal governments as grant recipients recognizes and empowers the authority of these groups to represent a unique group of Veterans and respond to their needs.

CAPITAL INFRASTRUCTURE

Congressional support of VA has resulted in 63 major construction projects funded in whole, or in part, since 2004. When combined with investments in our minor construction and major lease programs, this has contributed to a plant inventory which includes 5,541 owned facilities, 1,629 leased facilities, 155 million square feet of occupied space (owned and leased) and 33,718 acres of owned real property.

To best utilize resources, VA has reduced its inventory of owned vacant space by 34 percent, from 8.6 million square feet in 2001 to 5.7 million square feet in 2010. As discussed previously, we are using the Building Utilization Review and Repurpose (BURR) effort to reuse vacant space for homeless Veterans and their families. BURR also identifies other potential reuses of vacant and underutilized space and land within VA's inventory such as assisted living, senior housing, and housing for Veterans of Iraq and Afghanistan and their families. VA also houses homeless Veterans in public/private ventures through enhanced-use leasing.

Major Construction

The major construction request in 2012 is $589.6 million in new budget authority. In addition, VA has been the beneficiary of a favorable construction market and, as a result, is able to reallocate $135.6 million from previously authorized and appropriated projects to accomplish additional project work—resulting in a total of $725.2 million for the major construction program. This reflects the Department's continued commitment to provide quality healthcare and benefits through improving its infrastructure to provide for modern, safe, and secure facilities for Veterans. It includes seven ongoing medical facility projects (New Orleans, Denver, San Juan, St. Louis, Palo Alto, Bay Pines, and Seattle) and design for three new projects (Reno, West Los Angeles and San Francisco) primarily focused on safety and security corrections. One cemetery expansion will be completed to maintain and improve burial service in Honolulu, HI.

Minor Construction

In 2012, the minor construction request is $550.1 million. In support of the medical care and medical research programs, minor construction funds permit VA to realign critical services, make seismic corrections, improve patient safety, enhance access to healthcare and patient privacy, increase capacity for dental care, improve treatment of special emphasis programs, and, expand our research capability. We also use minor construction funds to improve the appearance of our national cemeteries. Further, minor construction resources will be used to comply with energy efficiency and sustainability design requirements.

Greening VA

The "greening VA" effort continues to be strong. There are 21 facilities Green Globe-certified and four LEED-certified. We have completed energy efficiency benchmarking for 99% of VA-owned facilities and obtained the Energy Star label for 30 VA sites since 2003. Electric meter installations were completed for 60% of targeted buildings and we are installing solar energy systems at 35 sites for a total capacity of 30 megawatts. VA has installed wind turbines at two sites, awarded two ground source heat pump projects, awarded five renewably fueled cogeneration projects, and completed one fuel cell project.

In 2012, we plan to invest $27 million for solar photovoltaic projects, $51 million in energy infrastructure improvements, $21 million in renewably fueled cogeneration using biomass (wood waste) or biogas (waste methane), $1 million in sustainable building, $14 million for wind projects, and $10 million for alternative fueling projects and expansion of environmental management systems.

INFORMATION TECHNOLOGY

Information Technology (IT) is integral to the delivery of efficient and effective service to Veterans. IT is not a supplementary function—it is key to the delivery of efficient, modern healthcare. The 2012 budget includes $3.161 billion to support Information Technology (IT) development, operations and maintenance expenses. The 2012 budget will fund the Department's highest IT priorities as well as information security programs, which protect privacy and provide secure IT operations across VA. Under our disciplined development program, PMAS, the delivery of customer software milestones exceeds 80% which is up from just 20% before the implementation of PMAS. The budget request will also fund systems that VA will develop and implement under the Caregivers and Veterans Omnibus Health Services Act of 2010.

In 2010, VA made the sound business decision to discontinue the Integrated Financial Accounting System (IFAS) and the data warehouse component of the Financial and Logistics Integrated Technology Enterprise (FLITE). OI&T will fund other continuing projects such as Compensation and Pension Records Interchange (CAPRI) which offers VBA Rating Veteran Service Representatives and Decision Review Officers help in building the rating decision. CAPRI does this by creating a more efficient means of requesting compensation and pension examinations and navigating existing patient records.

Veterans Relationship Management (VRM)

The 2012 IT budget for VRM is $108 million, and will support continued development of the on-line portal as well as the development of Customer Relationship Management capabilities.

Virtual Lifetime Electronic Record (VLER)

The Virtual Lifetime Electronic Record (VLER) is a Federal, inter-agency initiative to provide portability, accessibility and complete health, benefits, and administrative data for every Servicemember, Veteran, and their beneficiaries. The goal of this major initiative is to establish the interoperability and communication environment necessary to facilitate the rapid exchange of patient and beneficiary information that will yield consolidated, coherent and consistent access to electronic records between DOD, VA, and the private sector.

VLER will not create a new data record, but it will ensure availability of reliable data from the best possible source. The VLER health component of this initiative is in operation at two pilot sites with a plan to add nine more pilots this fiscal year. VLER will work closely with other major initiatives including the Veterans Benefits Management System (VBMS) and the Veterans Relationship Management (VRM). A total of $70 million in IT funds in 2012 is required to complete the effort and move to national production and deployment of initial VLER capabilities. The VLER partnership between VA and the Department of Defense will serve as a positive model for electronic health record interoperability in the country, which has been an Administration priority.

SUMMARY

VA is the second largest Federal department and has over 300,000 employees. Among the many professions represented in the vast VA workforce are physicians, nurses, counselors, claims processors, cemetery groundskeepers, statisticians, engineers, architects, computer specialists, budget analysts, police, and educators—all working with the greatest determination to best serve all generations of Veterans. In addition, VA has approximately 140,000 volunteers serving Veterans at our hospitals, Vet centers and cemeteries. There are things that they do that cannot be converted into dollar values—patience, dignity and respect for Veterans, some of whom are heavily challenged by the memories of their wars.

As advocates for Veterans and their families, VA is committed to providing the very best services. I will do everything possible to ensure that we wisely use the funds Congress appropriates for VA to improve the quality of life for Veterans and the efficiency of our operations—innovatively and transparently—as we deliver on the enduring promises of Presidents and the obligations of the American people to our Veterans.

I am honored to present the President's 2012 budget request for VA, and to represent all VA employees and the interests of those outside of VA, who share our commitment to Veterans.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Please provide a list of the medical centers that are experiencing a budget shortfall in the current fiscal year, or which experienced a shortfall in FY 2010, the amounts of those shortfalls, whether or not a request has been made to the corresponding VISN for financial relief, and the response to any such request.

Response. All Department of Veterans Affairs medical center (VAMC) requirements have been addressed within resources allocated to the Veterans Integrated Service Networks (VISN) in both fiscal year (FY) 2010 and to date in FY 2011. All VISN Directors meet with the Secretary during the year to discuss their resource needs. No VISN Directors have indicated that they will not be able to accomplish their missions without additional resources in FY 2011.

Question 2. The President's budget requests a drastic cut in the Medical and Prosthetic Research account of $72.2 million, or almost 12.5 percent. What impact will this have on VA's research program and what specific programmatic cuts are being planned? How will this impact the prioritization of research programs?

Response. VA supports research projects based on merit review, and within the FY 2012 budget, VA will support approximately 135 fewer projects from all services when compared with the FY 2010 level. While there will be fewer projects, VA will continue to emphasize research on deployment and Veteran-specific health issues. Areas of particular focus, such as Gulf War Veterans Illnesses, women Veterans and mental health, will be preserved or increased, with the reductions being realized across the board in other areas.

VA's Office of Research and Development is adopting ISO 9001 principles to increase management efficiencies in conducting clinical trials. The International Organization of Standardization (ISO) is widely considered to be the standard for efficient and effective management systems. These improvements will further reduce the cost of performing clinical trials by reducing administrative costs and streamlining processes

Question 3. Does the VERA model sufficiently accounts for a variety of anomalies in hospital operations including seasonal workload changes, historic campuses, split campuses and the associated maintenance costs?

Response. The Veterans Equitable Resource Allocation (VERA) model is designed to equitably distribute resources to the VISNs. In FY 2011, the Veterans Health Administration (VHA) is now using a standard model to further allocate funds from the VISN level to VAMCs. VISN Directors have the discretion to make appropriate adjustments to that model to reflect local realities, such as the activation of a new community-based outpatient clinic (CBOC). These adjustments are left to the VISN Director's discretion because he or she has the best knowledge of and insight into what a specific facility needs.

It should be noted that the VERA Model is designed to fund a full year of operation, so seasonal variations are accommodated within its allocations. Likewise the workload that drives VERA is measured over multiple years, so seasonal variation is also accommodated within that process.

Question 4. Projections for the Medical Care Collections Fund have historically been very inaccurate. Why is the projected increase—from FY 2011 to FY 12—so low, relative to the growth in previous years?

Response. VA recently instituted a scientifically-derived collections model including multiple variables such as projected workload, Veteran demographics, insurance status and economic conditions, to more accurately forecast collections. In FY 2010, VA experienced only a 1.4 percent increase in collections versus FY 2009 ($2.773B vs. $2.734B); based on our model output, there are a number of factors continuing to impact lower growth rates in FY 2011 and FY 2012:

- *Poor economic conditions*—Growth in national unemployment (from 7.7 percent in the First Quarter of FY 2009 to 9.8 percent at the end of the First Quarter of FY 2011) will continue to impact both first party collections (Veteran out-of-pocket costs) and third party collections (unemployment and resultant loss of health insurance coverage).
- *Hardship waivers and exemptions from copayments are increasing*—Veteran first party copayment economic hardship waivers and exemptions were at their

highest levels in FY 2010 (the most recent completed year) than in any prior year and this is expected to continue with the current economic conditions.

• *Third party "Collections to Billings" (CtB) ratios are down nationally*—CtB ratios are expected to continue a downward trend impacting third party collections. CtB decreased from 43.1 percent in January 2009 to 39.1 percent in January 2011, and was influenced by the continued shift by insurers of payment responsibility to the patient (i.e., higher deductibles, increased copayments, etc.). Section 1729 of title 38 prevents VA from billing the Veteran if the insurance company does not pay. Each one percent decrease in CtB represents a $55 million loss in revenue.

• *Priority Group migration from lower to higher status*—National Priority Group migration over the past 2 years has shown a sharp decrease in collections for Veterans in Priority Group 8 which are the primary drivers of both first and third party collections.

Question 5. Please provide a breakdown of funding to be spent on implementing the Caregivers and Veterans Omnibus Health Services Act of 2010 (PL 111–163). Please include a specific breakdown of funding to be spent on the family caregiver program, including dates by which the funds are projected to be spent.

Response. VA has identified below a general timeline with goals for implementing the family caregiver program required by title I of Public Law (PL) 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010. VA's planning and work on regulations has been ongoing since before the Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law. This work has continued throughout the time the implementation plan was under development. VA is working as quickly and responsibly as possible to deliver these enhanced benefits to eligible Veterans and their caregivers and will keep the Committee closely apprised of its progress.

Create Caregiver Support Line	February 1, 2011 (completed)
Hire All Caregiver Support Coordinators	April 2011
New State-of-the-Art Web Site	May 2011

A breakdown of funding to be spent on implementing Pub. L. 111–163 is displayed below.

Description	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate
Total Caregivers and Veterans Omnibus Health Services Act of 2010 (PL 111-163)	$132 million	$208 million	$248 million
Caregiver Support (Title I) (non-add)	$30 million	$66 million	$71 million

Question 6. Please provide a breakdown of the proposed clinical staff and resource realignment. What efficiencies does the Department anticipate achieving and how will this impact the quality of and access to patient care?

Response. As positions currently filled by professional physicians and registered nurses become vacant, VA is filling these positions with more clinically appropriate and cost effective personnel, thereby ensuring the quality of care while reducing costs. Continued access will be ensured because this transition in clinical staff mix is occurring gradually and in conjunction with an increasing emphasis on appropriate task assignments and more efficient approaches to providing care. Some examples of these approaches include reliance on telephone contacts, secure messaging, and group visits. VA expects this transition will improve the quality of care through implementation of Patient Aligned Care Teams (PACT) and features such as disease registries, population approaches toward disease prevention and chronic disease management, and focused emphasis on higher risk patients.

Question 7. How does VHA's current salary and incentive pay structure affect the willingness of top leaders to assume higher levels of responsibility, such as moving to more complex medical centers or to VISN offices? How does this structure compare with the private sector and what impact is it having on VHA's ability to recruit and retain top-level managers?

Response. The 2006 modifications to compensation for VHA medical professionals have helped the Department recruit, retain, and promote skilled individuals it otherwise would not have been able to hire or would have lost. Compensation for VHA's professionals still lags behind that of their private sector counterparts, but these modifications have helped bring more care in-house as part of the Department's efforts to reduce Fee Basis and Contract Care without compromising timeliness or quality. It's worth noting, however, that the new compensation structure has exacerbated the pay inequity between VHA's medical professionals and senior managers

that are not physicians, dentists, or nurses, whose compensation also lags behind their private sector counterparts. VHA shares this challenge recruiting and retaining these top-level managers with many other agencies across government. VHA will continue to monitor the extent to which this challenge impair our recruitment and retention of top-level managers, and will work with the Office of Personnel Management to address this issue.

Question 8. Please provide a breakdown of the operating budgets and staffing levels for each VISN office.

Response. The table below provides the operating budget and staffing levels for each VISN.

VISN	FY 2011 Operating Budget	Staffing Level (FTE)
1	$4,522,000	30.0
2	$4,027,013	22.7
3	$9,590,840	43.0
4	$11,618,654	69.0
5	$10,300,000	54.0
6	$9,916,086	52.0
7	$9,000,000	58.5
8	$17,200,000	100.8
9	$13,200,000	63.0
10	$7,300,000	51.0
11	$10,950,353	57.0
12	$7,982,147	44.0
15	$6,271,017	40.0
16	$9,514,253	57.0
17	$13,216,139	76.0
18	$10,757,900	52.0
19	$8,311,641	46.5
20	$13,243,476	55.0
21	$7,442,950	52.0
22	$7,371,021	41.5
23	$6,531,485	47.0

Question 9. Please provide an estimate of the cost avoidance of expanded use of telehealth and tele-mental health technologies.

Response. Telehealth technologies will realize cost avoidance through reduced utilization of health care resources in hospitalizations, reduced average length of stay, and decreased travel needs. This cost avoidance will allow VA more effective stewardship of health care resources and improve access for our Veterans. The actual cost avoidance is difficult to measure because in many instances it allows VA to provide more health care services within the same level of resources.

Question 10. Given the increase in beneficiary travel, is there any concern that fraudulent claims are being paid out and, if so, to what extent? What can the Department do to improve enforcement to ensure only legitimate claims are paid?

Response. As stewards of the taxpayers' funds, VA is always vigilant in monitoring the claims it receives and preventing the fraudulent use of resources. VA is implementing various initiatives to monitor and manage the Beneficiary Travel program to ensure the appropriate use and provision of Beneficiary Travel benefits. These efforts include:

- Distribution of communication material to assist Veterans in understanding their responsibilities related to this benefit.
- Regulatory changes to eliminate or clarify areas of confusion regarding travel eligibility and payment requirements.
- Identification of strong practices, including procedures and systems that effectively control this benefit. A national workgroup of subject matter experts has identified system-wide issues and potential solutions. Identified practices include a locally developed automated patient behavior and clinic utilization evaluation tool that allows stations to determine areas of local concern. This is currently being used in approximately 20 locations, and VA has scheduled a national release and training effort beginning in March 2011. VA is developing an automated tool that will standardize claims processing and payment procedures (and will include an audit capability) for national release this fiscal year. VA is gathering real cases of inappro-

priate use of Beneficiary Travel for use in a training program that will be offered in March and April 2011.

• Initiation of projects to identify national level data patterns that merit further review. This effort will allow VA to identify reimbursement transactions that are of a suspicious nature. This, in turn, will allow VA to identify various types of patterns and reimbursements within each pattern that merit further review.

• Definition and implementation of automated management systems that will improve and standardize internal controls of this benefit. VA is developing automated claims processing and audit tools to standardize procedures with an expected release date this fiscal year. VA is also in the initial stage of developing longer term solutions that are tentatively scheduled for initial development in the first quarter of FY 2012.

Question 11. What adjustment was made in the level of resources requested for CHAMPVA to account for the incorporation of family caregivers under Public Law 111–163?

Response. VA included estimates for the impact on the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) in its budget request for FY 2012 under the request for funds to support implementation of Public Law 111–163 rather than in the CHAMPVA-specific funds.

Question 12. Legislation was introduced last Congress to extend a dependant child's CHAMPVA eligibility until age 26, in congruence with the health care reform legislation. Are the resources requested for CHAMPVA sufficient to accommodate this change?

Response. VA has estimated the potential impact of changes to CHAMPVA eligibility based upon this legislation and provided this information to the Committee last Congress. The current budget estimates do not include these resources because no legislation has been enacted.

Question 13. The President's FY 2011 budget included $217.6 million to enhance primary care for women veterans. Were any of these funds obligated to fixing the deficiencies identified in GAO's report, VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes, from last March? Please provide an accounting of these expenditures.

Response. Following the Government Accountability Office's (GAO) report, "VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes," (March 2010), VA has undertaken an extensive evaluation of its facilities, identifying existing deficiencies in the environment of care, including bathrooms, privacy curtains, locks, and other areas. These deficiencies have been prioritized and tracked for correction. In FY 2011, VA has budgeted $17 million in non-recurring maintenance (NRM) projects that will be used at the facility level to correct privacy deficiencies in addition to the $241.8 million of gender-specific care (from treatment funds) and $2.89 billion for total care for women Veterans. In FY 2010, VA spent over $214 million in gender-specific care and nearly $2.6 billion in total care for women Veterans.

Question 14. The recently released 2010 Hospital Quality Report Card measured timeliness of care by presenting a table of wait times for completed appointments at each facility. Although the Report Card classifies patients as either new or established, there is no data presented on the differences in wait times between these two cohorts. Also, the data divided such wait times between primary and specialty care, but it is unclear whether there were differences in wait times across the varied types of specialty care. Further, there is no information provided on wait times for compensation and pension exams. Please provide supplementary information on wait times in terms of new and established patients, the subdivisions of specialty care, and compensation and pension exams both by contractors and VA providers, at each medical facility.

Response. The enclosed spreadsheet includes data for each VA health care system. These data include wait times for new and established patients across the top 50 subdivisions of specialty care (clinical areas), as well as compensation and pension exams. [The enclosed spreadsheet is being held in the Committee files.]

VA does not currently track and collect data on wait times from all contracted or other forms of purchased care. We are conducting a pilot program to develop greater management, control and oversight of the processes VA uses when we purchase care. This pilot is using standardized templates for "ordering" care, ensuring assessment of other VA options, and controlling and managing the care we do purchase. Specifically, we are instituting controls to track appointment dates, no-shows, and waiting times. We will also ensure we send the right clinical information prior to appointments and that we receive the appropriate clinical information after appointments. We will also track when and where Veterans receive emergent care to

monitor from the time we first receive notification from an emergency room or hospital, throughout the Veteran's hospital stay, to the Veteran's transfer to a VA facility when appropriate and all other administrative elements associated with claims payments. We are conducting this pilot in VISN 11 (Michigan), with one site in production and two others in development. VA will then expand this to VISN 18 (South West). We expect the results of the pilot to be available by the end of FY 2011.

Question 15. Last year's budget included almost $800 million for specific programs to assist homeless veterans in continued efforts to reduce homelessness. Please provide detailed analysis of how this money was utilized in each of the various programs and what impact it had on the reduction of the number of veterans who are homeless.

Response. The Department of Housing and Urban Development (HUD) recently released the Veterans Homelessness Supplemental Report to the 2009 Annual Homeless Assessment Report (AHAR), which states there are 75,609 homeless Veterans on a single night in January 2009. Our goal is to reduce the homeless population to 59,000 by June 2012. These reductions are attributable to the collective efforts of VA, the Department of Housing and Urban Development (HUD), our community partners and Congress.

The $800 million represented the 2011 estimate in the FY 2011 President's submission. In 2010, VA spent over $622 million in specific programs to assist homeless Veterans. An itemized list of the $622 million is shown below. The breakout of spending by major category is as follows: Permanent Housing and Supportive Services, $71 million; Transitional Housing, nearly $285 million; Prevention Services, $11 million; Treatment, nearly $176 million; Employment and Job Training, $61 million; and Administrative Costs, $18 million.

FY 2010 Actual

(Dollars in Thousands)

	2010
Permanent Housing/Supportive Services	
HUD-VASH case management	$71,137
Subtotal	$71,137
Transitional Housing	
Grant and Per Diem	$175,057
Health Care for Homeless Vets (HCHV)	$109,727
Subtotal	$284,784
Prevention Services	
Supportive Services Low Income Vets & Families (Exit)	$3,881
National Call Center for Homeless Veterans (NCCHV)	$2,410
Justice Outreach Homelessness Prevention Initiative	$4,803
Subtotal	$11,094
Treatment	
Domiciliary Care for Homeless Veterans	$175,979
Subtotal	$175,979
Employment/Job Training	
CWT/Vocational training	$61,205
Subtotal	$61,205
Administrative	
Other	$18,509
Subtotal	$18,509
Grand Total	$622,708

The Department of Housing and Urban Development-VA Supported Housing (HUD-VASH) program provides permanent housing and ongoing case management

treatment services for homeless Veterans who require this assistance to live independently. Cumulatively, HUD has allocated over 30,000 "Housing Choice" Section 8 vouchers to Public Housing Authorities (PHA) throughout the country for eligible homeless Veterans. In FY 2010, this program enabled 20,101 Veterans to receive permanent housing.

VA's Health Care for Homeless Veterans (HCHV) program provides "in place" residential treatment beds through contracts with community partners. It also provides VA outreach and clinical assessments to homeless Veterans who have serious psychiatric and substance use disorders. In FY 2010, HCHV supported a 12.5 percent increase in the number of Homeless Stand Downs held (217 in 2010 versus 190 in 2009). HCHV teams conducted 42,371 initial clinical assessments of Veterans nationally and established 44 new HCHV contracts providing more than 1,300 community residential treatment beds. More than 90,000 Veterans were contacted through VA's outreach efforts, resulting in 3,519 Veterans being provided community-based housing and residential care.

VA's Grant and Per Diem (GPD) program funds community-based agencies that provide transitional housing or service centers for homeless Veterans. VA awarded approximately $41 million through this program to community-based agencies ($26 million in capital funds and $15 million in per diem awards), which operationalized an additional 971 transitional housing beds nationwide; collectively, more than 17,000 Veterans were housed in these programs during FY 2010.

VA's Mental Health Residential Rehabilitation and Treatment Programs (MH RRTP) support the Domiciliary Care for Homeless Veterans (DCHV) programs, which provide homeless Veterans with 24 hour-per-day, 7 day-per-week (24/7), time-limited, residential rehabilitation and treatment services that include medical, psychiatric, substance abuse treatment, and sobriety maintenance. This program targets homeless Veterans or those at risk for homelessness. MH RRTPs improved access to residential care as evidenced by the increased bed census from 66 percent in FY 2005 to approximately 81 percent in FY 2010. This increase was achieved at the same time the average length of stay across programs decreased. With FY 2010 funding, five new 40-bed domiciliaries were authorized for a total of 200 new beds. By the end of FY 2010, VA supported 2,233 homeless domiciliary beds and provided residential, mental health and health care services to more than 8,445 Veterans.

VA offers two programs for justice involved Veterans: the Veterans Justice Outreach (VJO) and Healthcare for Reentry Veterans (HCRV). Both of these programs focus on homeless prevention efforts and link Veterans with health care services. Formally launched in 2009, VJO aims to prevent homelessness by providing outreach and linkage to VA services for Veterans at early stages of the justice system, including Veterans' courts, drug courts, and mental health courts. VJO is designed to avoid the unnecessary criminalization of mental illness and extended incarceration for Veterans by ensuring that eligible Veterans have timely access to VA mental health and substance abuse services when clinically indicated, and other services and benefits as appropriate. Using FY 2010 funds, VA hired 120 full-time VJO specialists across the country. Fifty (50) operational Veterans Courts were also established in FY 2010, and 5,849 Veterans received VJO services that year. The HCRV program is designed to address the community re-entry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems among Veterans undergoing community readjustment, and reduce the likelihood of re-incarceration. In FY 2010, 44 full-time HCRV specialists saw Veterans in 955 of the 1,319 prisons across the country. VA provided 9,622 incarcerated Veterans with reentry services in FY 2010, and since August 2007, more than 24,000 have received assistance.

VA's National Call Center for Homeless Veterans (877–4AID-VET) connects homeless Veterans, their families, and other interested parties with appropriate VA and community-based resources. This Center, co-located with VA's Suicide Prevention Hotline, began accepting calls in March 2010 and includes 30 staff members who provide 24/7 coverage. All staff are trained in crisis intervention for homelessness issues and mental health services or issues. By the end of FY 2010, VA received more than 18,000 calls from 14,000 identified Veterans; 8,500 of these individuals were provided "warm handoffs" to medical centers for engagement in treatment and housing services.

VA's new homeless prevention initiative, the Support Services for Veteran Families (SSVF) Grant Program, will establish and provide grants and technical assistance to community non-profit organizations to provide supportive services to Veterans and their families to help them maintain their current housing. This program was developed in FY 2010, and the first applications from community providers will be reviewed in March 2011.

The Substance Use Disorder (SUD) Enhancement Program is designed to provide SUD case management and services to homeless Veterans in the community. The end goal is to treat the Veteran's SUD, removing these obstacles to obtaining or maintaining housing. In FY 2010, VA funded 146 SUD specialists in the HCVH and HUD-VASH programs. These specialists are providing SUD case management and services to homeless Veterans in the community to enhance access to care and opportunities for recovery.

Question 16. In September 2010, VA's development of a new information technology procurement process for VA was halted. With the Secretary's vision for a more centralized and efficient acquisition process, what impact will the delay in replacing procurement software have on realizing this vision?

Response. In early calendar year 2010, VA undertook an extensive re-evaluation of its financial management challenges, risks and critical priorities. The re-evaluation, which included consideration of available resources, the clean audit opinions on VA's financial statements for 11 years in a row and the relative low risk with maintaining VA's legacy financial management system for the foreseeable future, resulted in a decision by the Secretary to end the FLITE Program in favor of pursuing several other lower risk and less costly financial management improvement initiatives. The Department's goal of improving financial management remains unchanged, only the path has changed. As a result other smaller, less costly, flexible and agile financial management initiatives have been undertaken to strengthen internal controls and oversight, reduce operating costs, address improper payments and improve data and analysis. These initiatives will also set the stage for a lower-risk financial management system replacement in the future. To date these actions have helped to eliminate three financial material weaknesses and significantly improved internal controls over the processing of miscellaneous obligation transactions using form 1358.

Question 17. In February 2011 the Government Accountability Office released a report critical of Virtual Lifetime Electronic Record (VLER). The report found the Departments of Defense and Veterans Affairs have failed to jointly articulate explicit plans, goals, and timeframes in creating a joint electronic health record. Please provide the Committee with itemized VLER expenditures for FY 2009, FY 2010, and FY 2011. Also, provide the Committee with the FTE allocated to the VLER project—by Department and by year—since the project was conceived. In addition, please provide the numbers of those employed through contractor support. Finally, please provide a progress report on each of the IT projects and pilots involved in fulfilling the President's vision of VLER.

Response. The Virtual Lifetime Electronic Record (VLER) program has often been so closely linked to the Electronic Health Record (EHR) modernization initiative as to become synonymous. It is important to understand that VLER is closely aligned with but unique from the EHR initiative. VLER is an interoperable and communication environment whereby health, benefits and administrative information may be electronically accessed by every Servicemember, Veteran, and/or their beneficiary. The VLER environment is structured to support the secure exchange of health, benefits and administrative information between public and private partners. Health, benefits, and administrative information resides in many DOD and VA systems, including the electronic health record system and various personnel systems. VLER ensures that regardless of the information source, policies, regulations and, procedures are put into place to secure and protect the information accessed or exchanged, and the terminologies, definitions, and terms are clearly presented.

The table below provides information on the FY 2009, FY 2010 obligations and total FY 2011 budget dollars allocated for VLER related activities and the FTEs associated with this initiative. Contracted services are firm fixed prices so there is not a specific FTE for the contracted support. Support contracts are included in the non-pay dollars in the supporting table.

Year	FTE (Auth/Filled)	Contract support (total)	IT Budget (non-pay)	VHA Budget (non-pay)
FY09	EPMO: 0/0 IT: 1/1 VHA: 2/2	EPMO: NA IT: NA VHA: NA	NwHIN Adptor: $3.5M	$0
FY10	EPMO: 8/0 IT: 40/9 VHA: 26/5	EPMO: NA IT: NA VHA: NA	NwHIN Adaptor: $11.852M IT Infrastructure: $7.113M VLER EPMO Support: $1.85M IT PMO: $4.506M	$0

Year	FTE (Auth/Filled)	Contract support (total)	IT Budget (non-pay)	VHA Budget (non-pay)
FY11	EPMO: 8/6 IT: 46/10 VHA: 27/16	EPMO: NA IT: NA VHA: NA	NwHIN Adaptor: $31.761M Health Legacy: $23.716M Warrior Support: $20.623M IT PMO: $5M VLER EPMO Support: $2.4	$11.7M

EPMO—Executive Program Management Office (the VLER business sponsor PM office)
PMO—Program Management Office (the OI&T Product Delivery PM office)

VLER will deliver the foundational clinical encounter data capability in July 2012. This foundational capability will be enhanced to support disability adjudication within the VA and in conjunction with the Social Security Administration (SSA) in December 2012. There are four joint pilots to achieve the initial health components of VLER. The initial health data exchange joint pilot with DOD and a private healthcare partner in San Diego went into operational status December 2009; the second pilot with expanded health data element exchanges achieved at Hampton Road/Tidewater, Virginia went into operation in September 2010; the third joint pilot planned to increase points of care and health elements exchanged is on target to go into operation in March 2011 in Spokane, Washington; and the fourth joint health pilot planned for September 2011 is on target to begin shortly at Puget Sound, Washington. Following a measurement and analysis phase for all pilots planned for October 2011 through March 2012, the implementation of VLER health capability VA-wide will begin in July 2012.

Requirements, design and development of initial capability in support of the adjudication of VA disability claims has begun and is on target to provide health information exchange for use in benefits administration with initial capability by end of 2012. Additionally, a proof of concept demonstration is on target with SSA to begin in the first quarter of Fiscal Year 2012.

Question 18. The office of OI&T is carrying over $675 million from FY 2011. How does VA plan to use this carryover? Please provide a specific listing of projects and the expenditure rate for each.

Response. The carry forward funding from FY 2011 into FY 2012 is a planned $78M which will be used for Staffing and Administration. The carry forward funding from FY 2010 to FY 2011 was $675M. The complete listing of carry forward funding by program from FY 2010 to FY 2011 can be found starting on page 5B–1 of the Congressional Budget justification volume 2 of 4.

OI&T faced a substantial challenge in IT when we started in 2009, assuming control of an organization that was failing to deliver on large IT projects costing hundreds of millions of dollars. Over the last two years, the Assistant Secretary for I&T has implemented a number of strong IT disciplines; disciplines aimed at correcting the delivery problems and increasing our capacity to deliver on transformational initiatives. These disciplined approaches are largely behind our recent successful delivery of the new software system to automate payments under the GI Bill.

A side effect of those disciplines has been to eliminate spending on many programs we deemed ineffective, and slowing spending on most of our programs as we worked to ensure they were meeting their goals. The change has been dramatic. For example, under the Program Management Accountability System (PMAS), OI&T is now meeting over 80% of its software delivery milestones.

However, the main purpose has been to build a strong IT capability that can reliably deliver the IT solutions we need to transform VA. We believe we have done that. The FY 2010 carryover funds of $675M into FY 2011 will build the technology systems that will enable the transformation of VA; that will allow us break the back of the benefit claims backlog, and to implement further improvements to our medical automation systems.

Projects are now reviewed to ensure they have a plan, defined business requirements, appropriate staff, etc. and then given seed money to ensure the plan can be executed. As such, all projects are now subject to the Project Management Accountability System.

Question 19. The following questions relate to OI&T funding levels for VA's Major Transformative Initiatives:

A. *VBMS*—please provide rationale for the proposed reduction below the FY 2011 level.

Response. The proposed reduction in funding below the FY 2011 level is due to a decrease in system development activities in FY 2012. Development costs decreased by more than $50 million from FY 2011 to FY 2012 while sustainment rates

increased at a lower cost of $35 million. The majority of system capability is proceeding as scheduled for development and implementation as part of the FY 2011 funding stream. Funding for FY 2012 supports sustainment activities and the additional capacity for a national rollout of VBMS. A small amount is included for integration activities with other VBA benefit systems.

B. *GI Bill*—given that there is no funding allocated for further development of requisite software, how does VA plan to fund any needed changes due, in part, to Public Law 111–377?

Response. The new legislative requirements will be funded using FY 2011 dollars originally targeted for additional system functionality and optional tasks on the SPAWAR interagency agreement. There is no negative budget impact for FY 2011.

C. *VLER*—given the planned expansion of the program in FY 2012, why is the request for this initiative $13.5 million less that the FY 2011 level?

Response. The VLER Initiative continues on a steady course in FY 2012 with additional interoperability enhancements while meeting the planned initial operating capability and enacting the national rollout to all VA medical centers as local health information exchanges are available. These efforts will be achieved within the funding requested.

D. *Improvements in Mental Health*—please elaborate on the need for a doubling in OI&T funding for this initiative from FY 2011 to FY 12.

Response. The increase in the OI&T budget for mental health improvements from FY 2011 ($5,900,000) to FY 2012 ($12,000,000) is based on increased project development costs in the Improving Veterans Mental Health operating plan. In conjunction with OI&T, mental health has a prioritized list of projects that must be completed to develop the Mental Health Informatics Infrastructure required to fully support the implementation of the Uniform Mental Health Services Handbook through projects that increase patient safety; allow collection of population-based outcome measures; and support development of Web-based patient-centered programming. In FY 2011, the operating plan initiated projects to improve better tracking of Veterans deemed to be at high risk for suicide, enhancements in tools to track outcomes, and Web-based programming to allow Veterans to develop goals for treatment. FY 2012 will continue the development of the FY 2011 projects, and commence the following projects:

- $2.25 million—Methadone Dispense Tracking
- $1 million—Development of patient oriented Web-based educational objects to support evidence-based therapy, using My Health*e*Vet—Op
- $1 million—Promoting Resilience and Prevention
- $0.5 million—National Clozapine Coordination

E. *VRM*—the request for FY 2012 is $48.4 less than the FY 2011 level. What functionality was realized in FY 2011 to justify the reduction?

Response. A significant portion of the VRM FY 2011 budget is devoted to Voice Access Modernization. Most of this effort is scheduled to be completed in FY 2011. It is also anticipated that Identity Access Modernization (IAM) will complete a large portion of work in FY 2011, completing the remainder in FY12.

F. *Integrated Operating Model*—given the proposed increase for IOM, what metrics will VA use to gage the impact of this program on VA's corporate functions?

Response. The mission of the Integrated Operating Model (IOM) is to implement a management infrastructure that focuses on improving the integration and management across VA's departmental management functions. By improving the integration across its Acquisition, Construction and Facilities Management, Financial Management, Human Resources, and Information Technology functions, a well-managed and highly-effective VA corporate back office is better enabled to support the Administrations in enhancing direct service delivery to Veterans.

The impact of IOM is gauged through metrics related to milestone deliverables and impact on operations. Example of deliverables and impact to date include:

1. Acquisitions

   Implemented the Supplier Relationship Transformation (SRT) Initiative. The Office of Acquisition, Logistics, and Construction (OALC) developed two-way dialog with suppliers and found many suppliers to be dissatisfied with VA's order fulfillment processes. As such, OALC aimed to establish a more effective relationship with VA's suppliers. By instituting Perfect Order Fulfillment (POF), OALC enhanced the Department's relationship with its vendors to deliver the right service or product, at the right place, at the right time, with the right quality and with proper documentation. Developing more meaningful relationships with VA suppliers to achieve "Best in Class" POF improved VA's internal

capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively.

2. Financial Management

a. Implemented MyPay for all VA employees. The Office of Finance (OF) successfully implemented MyPay, an enhanced self-service employee benefit portal, for all VA employees. MyPay is an innovative, automated system that allows VA employees to electronically manage certain discretionary pay data items and allows them to view, print, and save Leave and Earning Statements (LES) and W–2s. OF's implementation of MyPay, allowed the Department to migrate from its legacy system, Employee Express, resulting in the elimination of annual fee of approximately $1,370,250. Since MyPay allows VA the ability to completely eliminate hard copy LES, there is an additional annual cost savings of approximately $1,287,000. MyPay enhances the Department's ability to manage human capital and save money that can be used for other purposes to serve Veterans.

b. Trained 2,375 VA employees through various financial management training venues in FY 2010. OF implemented an ambitious plan to train VA's financial management workforce to be better able to meet Federal appropriations, accounting, internal controls, and improper payments requirements and regulations. In one example, OF executed the August 2010 Financial Management Training Conference, which trained 1,311 employees, many of whom had never taken formal financial management training. To evaluate the effectiveness of this training, VA tested employees before and after training. The result was a 43 percent increase in average scores after training.

3. Information Technology

Implemented Program Management Accountability System (PMAS) prototype and training. VA began implementing PMAS to manage all IT development, modernization, and enhancement programs and projects in order to increase the Department's accountability for IT projects and minimize the impact of IT projects which are either behind schedule or over budget. As a part of IOM, the Office of Information and Technology (OI&T) implemented the PMAS prototype that requires (1) an incremental development approach requiring frequent delivery (every six months) of new functionality to ensure customers' mission needs are met on time and within budget and (2) a rigorous management approach, involving customers, project staff, and vendors, accountable for ensuring early identification and correction of IT program milestones. To support PMAS, OI&T also implemented PMAS training, developed and published a PMAS Guide, and finalized draft requirements for a PMAS dashboard.

4. Human Resources

Implemented Direct-Hire Authority (DHA) for Acquisition Positions. The Office of Human Resources & Administration (HRA) implemented the use of DHA to fill critical GS–1102 (contracting) series positions in the Washington, DC metropolitan area at grade level GS–12 through GS–15 or equivalent. There is a shortage of highly qualified candidates for contract specialists in the 1102 series that exists at VA in the Washington, DC area. This impeded VA from recruiting highly qualified candidates to fill critical acquisition positions in VA, thus impacting VA's acquisition operations and ultimately, Veterans. HRA worked with the Office of Acquisition, Logistics, and Construction (OALC) and Office of Personnel Management to implement this authorization and greatly enhance OALC's ability to recruit acquisition professionals.

G. *Health Informatics*—while this is a relatively new initiative, what is the expected expense over the life of this program? How does VA see this application being used in the future to cut costs within VA?

Response. Transforming Health Care Delivery through Health Informatics (Health Informatics) is a new VA Major Initiative (Initiative) that was formally launched on October 1, 2010. The purpose of the Initiative is two-fold: 1) assist with VHA's transition from a medical model of care to a patient-centered model of care; and 2) enhance collaboration between VHA and OI&T. The Initiative is the vehicle for promoting and fostering open, transparent communication between health care providers and software development teams through shared responsibility and accountability. The Health Informatics Initiative is composed of three major projects:

1. Establish a Health/IT Collaborative Supporting Rapid Product Development and Delivery. This effort restructures the working relationship between VHA and OI&T and provides an organizational foundation for reengineering existing processes and piloting VHA clinical software prototypes in a rapid, agile and iterative fashion.

2. Create a Health Management Platform to Transform Patient Care. This effort integrates informatics and health information technology (IT) in the deliv-

ery of health care. It provides a succession plan to transition the Computerized Patient Record System (CPRS) to the next generation of browser-based Electronic Health Record (EHR).

3. Build Health Informatics Capacity. This effort develops the Health Informatics workforce and enhances organizational informatics literacy through competency, career and community development.

The Health Informatics Initiative total lifecycle costs are estimated to be $41.6 million over the 3-year life of the Initiative, after which business functions will be integrated into VHA's Office of Informatics and Analytics (OIA). The funding will support the establishment of cross-cutting health informatics tools designed by health professionals to optimize performance in terms of quality, efficiency and increased job satisfaction, to encourage and facilitate increased patient and family engagement in care and decisionmaking, and support population and evidence-based care focused on preventive health care and chronic disease management.

The Initiative will develop a predominantly Web-based Electronic Health Management Platform enabling contributions from other software development sources. Additionally, it will establish a sustainable workforce capacity to support healthcare modernization and improved care delivery. The workforce capacities component will build on agency successes with continued development of curriculum, delivery of coursework and assessment of coordination strategies amongst health informaticists.

Building upon the award winning quality and cost-savings improvements of VA's Electronic Health Record CPRS, the Health Informatics Initiative has reassembled the CPRS team to take the next evolutionary step—creating Web-based, standards-compliant, extensible Health Management IT Platforms for:

- *Health Care Teams:* Modules that are health care team-driven to decrease cognitive load, effectively manage relationships between conditions, interventions and observations, acquire data (including documentation) as a by-product of workflow and ultimately support higher quality, safe patient care and clinician satisfaction;
- *Veterans:* Solutions that achieve meaningful patient use, population reach and impact, giving Veterans more responsibility and control over their own health care; and
- *Systems:* Products that look across VA's IT systems and patient populations to improve health care delivery and system performance.

According to a recent independent study,[1] reductions in unnecessary care from current VA IT systems will result in an estimated savings of $4.64 billion. Initiative products and outcomes will expand these savings by: 1) providing better team-based coordination of care to Veterans, reducing costs from complications due to poor coordination (redundant laboratory tests and medications orders, adverse drugs interactions and reactions), 2) implementing comprehensive, integrated decision support across all patient data sources to reduce diagnostic errors and associated costs as well as medication errors and over-prescription, 3) engaging patients in their own care resulting in fewer hospital admissions and clinic visits as well as more effective "self-treatment" (such as diabetes and blood pressure control), 4) providing the framework for VA population-wide epidemiological studies to enable VA researchers to identify patterns between diseases, outcomes and treatments leading to more proactive and less costly Veteran care, and 5) allowing real-time visibility into IT systems with transparency across the enterprise with regard to managing patient-health system interactions (e.g. waits and delays, flow, etc.), patient-staff relationships (e.g. handoffs) and tests and procedures.

Question 20. Please account for the decrease in overall funding in the President's request, by business line, for the Veterans Benefits Administration in the General Operating Expenses Account.

Response. The decrease in the compensation and pension budget request is due to plans by the Veterans Benefits Administration to realign $75 million in FY 2011 from personal services and from one-time items within the other services category for exploration of alternatives to FTE to address the backlog. This contractor funding is not continued in the FY 2012 request.

Also affecting the C&P decrease in FY 2012 is a reduction in funding for one-time needs (e.g., training, supplies) for the additional hires that were funded in FY 2011.

The Education budget request decreases due to the implementation of the automated long-term claims processing solution for the Post-9/11 GI Bill, which will decrease VBA's reliance on FTE. Education's FTE request decreases by 366 in FY 2012.

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[1] Byrne, et al. *The Value From Investments In Health Information Technology At The U.S. Department Of Veterans Affairs*. Health Affairs; April 2010.

Question 21. Given the increased reliance on contract services in VR&E, please comment on the FTE dedicated to management and oversight, as well as the costs associated with the contract services as envisioned in the President's budget.

Response. VR&E Service is working to decrease reliance on contract services through increased staffing. VA was able to redirect funding requested for contracts under the FY 2011 budget level to support VR&E staffing increases, and additional staffing increases are included in the FY 2012 budget request. The FY 2012 budget includes $4.4 million for contract counseling services. Nationwide, 28 contract specialists support contract oversight. VR&E Officers serve as Contracting Officer Technical Representatives (COTRs).

Question 22. To adequately staff the VR&E program, what is the target case load per caseworker and is VA currently meeting this goal at each regional office? Please provide a detailed discussion of the resources needed to meet this goal and comment on the estimated number of total FTE needed.

Response. VR&E Service is currently evaluating optimal performance in relation to workload through a work measurement study. The study is anticipated to be complete by the 3rd quarter FY 2011. Study deliverables include a model for optimal staffing projections. It should be noted that some regional offices rely on contract services to supplement staffing levels. Stations that rely on contract services would tend to have higher caseload ratios. The current nationwide average ratio is 134 Veterans per counselor.

Question 23. The President's budget increased Chapter 31 funding by $32 million from FY 2010 to FY 2011. During the same time, there was an increase of 3,645 new VR&E recipients. The FY 2012 budget calls for a $37 million increase over FY 2011, but estimates just 1,860 new users. Please explain why there is a higher budget request given that VA estimates lower utilization.

Response. Funding levels related to the payments to Chapter 31 beneficiaries are driven by several factors. Chapter 31 assists Veterans with service-connected disabilities to prepare for, find, and keep suitable jobs as well as achieve independence in daily living. The total increase in chapter 31 obligations is $36.4 million from 2010 to 2011. The Cost of Living Adjustment (COLA), an economic assumption applied to prior year average costs, is expected to increase obligations by $32.9 million. An increase in subsistence allowance trainees yields a $4.8 million increase in program costs. The average cost unrelated to the COLA decreases slightly for subsistence allowance and/or tuition, books, and supplies, which decrease obligations $1.3 million.

The increase in chapter 31 obligations is expected to be $42.6 million from 2011 to 2012. The COLA is expected to increase obligations by $35.4 million. A rise in caseload for those trainees receiving subsistence and/or tuition, books, and supplies is expected to increase obligations by $7.3 million. Average payment unrelated to the COLA will decrease slightly, lowering obligations by $78 thousand.

Question 24. Please provide the cost—for both the current and next fiscal year—of disability examination contracts to support the Integrated Disability Evaluation System. Please provide the costs to VBA and VHA separately.

Response. VHA began the acquisition process for a potential contract vehicle to supplement required disability examinations and released a Request for Proposals for disability examination services. VA has received submissions from several bidders and is currently reviewing the submissions, but no final determination or selections have been made at this time. The solicitation documents did not specify certain minimum task order amounts, and it is possible that there will be more than one award made. Since this acquisition is still in the evaluation stage, it is not possible to provide a cost estimate for VHA.

Estimated costs for VBA are $13 million in fiscal year 2011 and $20 million in fiscal year 2012. If additional IDES sites are added to the contract, the cost will increase. The current estimated cost for IDES examinations is approximately $1,000 per examination.

Question 25. VA has announced an expansion of VR&E's mission to include IDES and the "Veterans Success on Campus" programs. Please describe the role VR&E counselors would fulfill in each of these programs, their anticipated workload, and the number of FTE that will be needed to staff these programs.

Response. IDES—This initiative will provide VR&E outreach and transition services to active duty Servicemembers transitioning from military to civilian life through the IDES system. These on-base services will include one mandatory counseling appointment with a Vocational Rehabilitation Counselor, as well as services ranging from a comprehensive rehabilitation evaluation to determine abilities, skills, and interests for employment purposes to case-management services to assist Veterans to identify and maintain employment and achieve a successful transition

to a civilian career. VR&E will use 110 new FTE in the IDES process to help approximately 12,000 Servicemembers by providing the aforementioned services.

The VetSuccess on Campus (VSOC) program supports Veterans' transition from military to campus life. Veterans attending college, including those using the Post-9/11 GI Bill or other VA education benefits, are provided with a wide range of rehabilitation and personal adjustment counseling services, including referrals to VA medical facilities as needed. VSOC staff also provide assistance with general benefits issues and can assist with peer counseling and mental health referrals. The VSOC program is currently operating on 8 campuses. The budget requests supports 9 additional FTE to target 9 more campuses, providing an estimated 9,000 Veterans with on-campus benefits assistance and adjustment counseling.

Question 26. How will VA determine eligibility for VR&E services among those going through IDES?

Response. The first step in the Vocational Rehabilitation and Employment (VR&E) process is to evaluate the Servicemember's eligibility. Servicemembers must meet the following criteria: have received, or will receive, a discharge that is other than dishonorable; have a service-connected disability rating of at least 10 percent; and must complete an application for VR&E services. The basic period of eligibility in which VR&E services may be used is 12 years from the date of separation from active military service, or the date the Veteran was first notified by VA of a service-connected disability rating, which comes later.

Servicemembers going through IDES are eligible for VR&E services if they expect to receive an honorable discharge from active duty and if they obtain a memorandum rating or IDES proposed rating of 20% or more when referred to the Physical Evaluation Board (PEB). All IDES participants will receive a mandatory initial counseling session in which a VR&E counselor will work with the separating Servicemember to determine whether and how further program participation can benefit them in their transition process.

Question 27. Employee training is one of the most crucial efforts VA can put forth to improve the quality and timeliness of claims processing. What is provided in the budget for training of C&P staff? Please provide a breakdown of the types of training that will be provided.

Response. The FY 2012 budget request for VBA's Office of Employee Training and Development includes $12.9M for training of C&P personnel. This funding supports entry-level training for new claims processors, on-line training for new and experienced claims processors, nationally standardized lesson materials for local delivery to experienced claims processors, and electronic performance support systems to accelerate claims-processing decisions.

Question 28. The President's Budget request makes note of a claims transformation plan and systemwide transformation that will expand quality review procedures. Please describe these initiatives in detail.

Response. In support of the Secretary's commitment to eliminate the claims backlog and improve quality to 98% by 2015, VA has undertaken a comprehensive Transformation Plan focused on providing timely and quality service to Veterans.

Specialized quality review positions are being created in each Regional Office to focus on the improvement of quality. Employees in these positions will form part of a dedicated quality review team. The members of this team will attend training provided by the C&P Service quality assurance staff to enhance consistency between national and local quality reviews.

Additionally, logic-based tools are being developed to aid VA decisionmakers and improve consistency and accuracy. Tools to support disability evaluation calculations for hearing loss and entitlement to special monthly compensation have been implemented nationwide, and development of additional tools is underway.

Question 29. The President's Budget request states that there are an increasing number of Individual Unemployability cases. Please describe any identifiable trends in the caseload and any explanation for these trends.

Response. The number of veterans receiving Individual Unemployability (IU) benefits increased by 5.2% between 2009 and 2010. The increase was 4.2% between 2007 and 2008, and 4.4% between 2008 and 2009. VBA expects a continued increase in FY 2011 and FY 2012 as the number of Veterans receiving compensation is projected to increase. VBA completed 10.2% more claims in FY 2010 than in FY 2009 (1,076,983 vs. 977,219), and it is reasonable to conclude that this also included additional grants of compensation based on unemployability.

Question 30. Given the pending reorganization of VBA, which includes the creation of a new business line for pension and fiduciary, how will the FY 2012 budget be affected by the planned changes?

Response. The FY 2012 budget includes funding requirements for Compensation and Pension (C&P) Service. Those funds also support the fiduciary activities of the VA. Since staffing for new Pension and Fiduciary Service will come out of existing C&P Service and VBA staffing, it will not impact the FY 2012 budget

Question 31. The budget submission notes that the funding level for education benefits do not reflect the changes made by Public Law 111–252, the Post-9/11 Veterans Educational Assistance Improvements Act of 2010. However, the General Operating Expenses account for education projects a decrease of $29.1 million that is based in part on the need to incorporate changes made by the new public law. Are you satisfied that you will have sufficient FTE to support the changes made in the program and that timeliness and accuracy will not be adversely impacted?

Response. Public Law 111–377, the Veterans Educational Improvements Act of 2010, modifies certain aspects of the Post-9/11 GI Bill, with most modifications effective on August 1, 2011. The enactment of this law has impacts the development of the Long Term Solution (LTS) for processing Post-9/11 GI Bill claims and our ability to fully automate the delivery of benefits. The capability to conduct automated end-to-end processing on some supplemental claims was tentatively planned for June 2011. This capability would create a subset of claims that do not require manual intervention. Implementation of the LTS was expected to address the increased workload and improve claims processing timeliness while negating the need for temporary claims processors. Because all efforts will not be directed to implementing the changes in the new law, we now anticipate this functionality will not be available until the third quarter of FY 2012. The delay in the implementation of the enhanced functionality planned for the LTS affected the number of FTE needed to process education claims. Our budget request of 1,429 FTE reflects the need to retain 324 of the 530 temporary claims examiners through FY 2012 to maintain current claims processing efficiencies.

Question 32. VA's most recent 10-year action plan for construction notes that full implementation of Strategic Capital Investment Planning (SCIP) would require between $53 and $65 billion for capital infrastructure costs to remediate identified gaps. Please explain VA's strategy to deal with the construction backlog, including planned expenditures over the ten years.

Response. The 2012 10-year Capital Plan identified between $53B–65B in magnitude estimate costs to close Departmental gaps over 10-years. This estimate includes $4.1B needed to complete all existing partially funded major construction projects. Each year, VA determines which partially funded projects to fund based on the projects' original priority score, ability to obligate, and available funding. The total level of capital resources is reassessed each year in the annual budget process, where hard choices are made balancing between operating costs and capital needs.

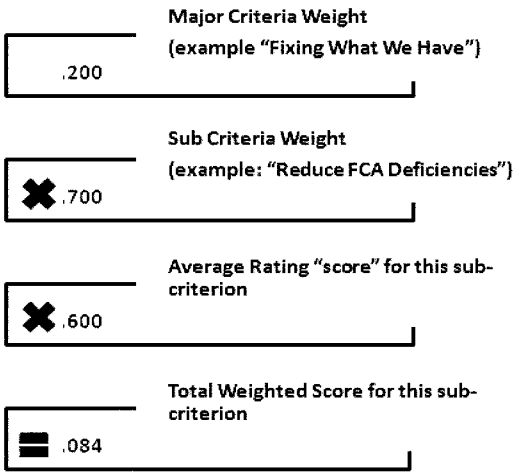
In addition, VA will continuously assess the need for projects based on space, condition, access, safety, and utilization/workload gaps and determine the best methods to resolve these gaps. Annual updates of the 10-Year Action Plan will help to track the progress of approved and in-process capital projects and their impact on gaps. The 10-Year Action Plan will inform decisions on the most critical gaps to address and the best method to address those gaps. In addition to the Department's three construction programs—major construction, minor construction, and non-recurring maintenance—it also relies on leasing and a variety of non-capital solutions to resolve gaps. Tele-health care, contract care, extending hours of operations, sharing agreements, mobile clinics, virtual call centers, telecommuting, and enhanced-use leasing (EUL) are examples of non-capital solutions that are employed to address gaps.

Question 33. Please provide the mathematical formula used to arrive at the "total score" used to prioritize funding decisions under SCIP.

Response. Capital projects are scored by the SCIP Panel, which is a sub-group of the SCIP Board and comprised of representatives from across the Department. The SCIP Panel and Board work within the VA Governance process, which provides a framework within which the SCIP process functions and culminates with the selection of capital projects for inclusion in the annual budget request. The structure of governance begins with the SCIP Board and proceeds through the Strategic Management Council/Senior Review Group (SMC/SRG) to the Veterans Affairs Executive Board (VAEB), with an increasing level of authority at each step. The SMC/SRG is chaired by the Deputy Secretary and is comprised of senior management representatives from across the VA. The final level in the VA Governance process is the VAEB, which is also a cross-Departmental group of senior management officials and chaired by the Secretary.

The decision methodology used to score projects is the Analytic Hierarchy Process (AHP). The AHP provides a structure, or "model," to determine which projects con-

tribute the most to addressing Departmental priorities. The SCIP decision model is comprised of the major criteria, sub-criteria, and their priority weights. Each project is scored on how well it addresses the each sub-criterion. The total score of a project is calculated by multiplying the project's "score" for each sub-criterion by the priority weight of the sub-criterion and then by the priority weight of the major criterion. Each sub-criterion "score" is the average of the rating (on a scale of 0 to 1) chosen by the scoring participants. A project's "Total Score" is the sum of the weighted scores for each sub-criterion.



This is simplified illustration; priority weights, ratings, and the resulting total score are fictitious. The 2012 SCIP decision criteria model consists of six major criteria and 18 sub-criteria. Each capital project was scored by SCIP Panels based on that project's contribution to each of the 18 sub-criteria. The calculation shown above would be done 18 times (once for each sub-criterion) and those 18 totals would be summed to calculate the total combined score. The scoring process is supported by the use of decision support software to record the participant's ratings and calculate the total combined scores.

More information on the 2012 decision criteria and the scoring process can be found in the FY 2012 Budget Submission, Construction and 10-Year Capital Plan, Volume 4 of 4, February 2011, which can be found at http://www.va.gov/budget/products.asp, pages 10–3, 10–5, and 8.2–1.

Question 34. As one of the largest real-property holders in the Federal Government, VA has 5.7 million vacant square feet. Knowing of the difficulties involved in disposing of unused or underutilized property, and the challenges present when attempting to repurpose a building, what is VA's strategy for right-sizing its capital asset inventory?

Response. Significant reductions in vacant space have already occurred, as the VA has reduced its inventory of owned vacant space by 34 percent, from 8.6 million square feet in 2001 to 5.7 million square feet in 2010. This 5.7 million vacant square feet accounts for less than 4% of the VA's real property inventory. VA continues to aggressively pursue reuse or disposal of assets in our inventory that are deemed unneeded. This, along with improvements in the capital planning phase contributes, to right sizing our capital inventory. VA's strategy encompasses the following elements:

1. Improving space planning for the long term—As a component of the VA's new Strategic Capital Investment Planning (SCIP) process, a detailed space analysis is performed. This analysis targets long term needs, allowing facilities to plan well in advance for the potential reuse or disposal of property. This long term planning utilizes future workload projections as a major input, ensuring that the services rendered to our Veteran's are not impacted by infrastructure challenges. By planning for potential unused space in out years, VA hopes to avoid adding vacant space to its inventory.

2. Advocating for internal and external reuse—Although reusing properties presents challenges, it is a valuable option to VA and Veterans by providing needed services, such as Homeless housing, and allowing VA to transfer the financial liability of unused property through Enhanced-Used Leasing (EUL). This legislative authority is scheduled to lapse at the end of calendar year 2011. The Administration remains committed to this important program, and a proposal to address the expiration will accompany the Department's legislative package submitted through the President's Program. VA continues to expand opportunities for reuse, including EULs, identifying collocation opportunities among VA's Administrations, sharing of space and/or services with DOD, and additional public/private partnerships. Reuse also encompasses the renovation of space to be repurposed to directly serve our Veterans, which is also stressed as part of the SCIP process.

3. Disposing of assets—The disposal of assets is often necessary when the age, condition, and campus location buildings make them poor candidates for reuse. The major challenges faced when disposing of property are historic considerations and abiding by all necessary Historic Property laws. Improvements can be made to address those challenges, such as early engagement of the VA's Historic Preservation officer in the planning phases of the SCIP process to ensure due diligence, identification of reuse opportunities, and coordination with the preservation office to ensure proper documentation is in place well before the actual disposal is planned. VA expects the end result is a more efficient and effective disposal process.

Question 35. Please provide an estimate of the cost avoidance achieved by the implementation of VA's green management program.

Response. Starting in 2008 and for approximately the next 25 years, VA's green management program projects implemented awarded through 2012 will have an estimated total avoided costs of $892.5M with an estimated annual cost avoidance of $56.1M. The cost-avoiding green projects VA plans to award in FY 2012, avoidance of $12.8 million annually, is estimated over each of the next four to 25 years. These estimates combine cost avoidance due to projects of varying lifetimes, such as renewable energy systems that last more than 25 years, air conditioning system upgrades that last an average of 15 years, and building systems retuning that provides cost savings persisting for four years. The level of cost avoidance experienced will depend primarily on how energy prices fluctuate over the lifetime of each project.

Question 36. In FY 2011, funding for the housing account was slightly over $1.4 million. However, for FY 2012, the funding is only $319,000. Please explain this decrease.

Response. The mandatory funding in the Housing Program Account includes the loan subsidy estimate for new loans, which includes loans made in the budget year (FY 2012), and the reestimate of loan subsidies for all existing loans, which includes all outstanding loans made prior to the budget year.

The FY 2011 funding of $1.4 billion represents both the loan subsidy estimate for new loans and the reestimate of loan subsidies for all existing loans. The 2012 figure represents only the loan subsidy estimate for new loans.

The two years are subject to different estimation techniques and timelines. The loan subsidy estimate for new loans is based on current economic assumptions and is included in the 2012 budget request. However, the reestimate of loan subsidies for all existing loans is not completed until after the close of a fiscal year. The reestimate will be completed in November 2011, in accordance with the OMB Circular A–11 and the Federal Credit Reform Act of 1990, and sent to Congress in the 2013 Budget Submission.

Question 37. The budget request notes that 147 Native American Direct Loans are anticipated to be made in FY 2011. However, the Agency estimates that it will make just 60 loans through this program during FY 2012. Please explain the disparity between the two numbers.

Response. The FY 2011 estimate of 147 Native American Direct loans (NADLs) reflects increased refinance loan activity due to the historically low interest rate environment of the past few years. When interest rates started dropping in FY 2009, NADL refinance activity increased as Native American Veteran borrowers took advantage of the opportunity to lower the interest rate on their home loans. VA experienced increased NADL refinance activity in FY 2009 and FY 2010, and VA expects this number to begin tapering off in FY 2011 as interest rates increase. As interest rates are expected to continue to increase, the number of NADL refinances is expected to decrease, lowering NADL activity to approximately 60 loans in FY 2012.

Question 38. The President's FY 2012 budget estimates a savings of $200 million in the area of fee care savings. Please provide details on each of the elements included within this proposal.

Response. VA has developed a plan in FY 2011 of cost savings estimates; this plan is the basis for our estimates for the FY 2012 cost savings. The elements include business process changes and the use of additional fraud, waste and abuse tools to avoid improper payments. Specifically, VA developed cost initiatives including decreased duplicate claims payments, increased use of re-pricing contracts (which allow VA lower prices for services), increased possible Medical Care Collections Fund (MCCF) collections for purchased services, and decreased interest charges applied due to delay in processing of these health care claims.

Question 39. The President's FY 2012 budget estimates a savings of $355 million by improving acquisitions in five target areas. Please list specific and separate examples where VA has identified real savings in each of these eight areas: Consolidated Contracting, Increased Competition, a return to In-House Contracting, Reverse Auction Utilities, MED PDB/EZ Save, Reduce Contracts, Property Re-utilization, and Prime Vendor.

Response. The following is a list of examples where VHA has identified real savings in the eight areas identified in the question:

1. *Consolidated Contracting*—VISN Chief Logistics Officers track previous pricing paid for supplies and services and compare those rates to current pricing to determine savings. In some cases, the vendors provide additional information on savings related to the achievement of tiered pricing discounts. The majority of savings in this category are attributable to Blanket Purchase Agreements (BPA) that provide discounted tiered pricing at the VISN or Regional level, and national contracts at the program office level.
2. *Increasing Competition*—VISN staff members determine either the amount previously paid when procuring similar services competitively or they utilize the government estimate to calculate the savings. Savings in this category primarily come from construction contracts that have been converted from sole source to competitive.
3. *Bring Contracting Back into VA*—VISNs report the dollar amount of Army Corps of Engineers fees no longer being paid.
4. *Reverse Auctioning VISN/Facility Utilities*—VISNs obtain utilities savings from the General Services Administration (GSA).
5. *MED PDB/EZ Save Methodology*—VISNs use the MED/PDB pricing data to determine the most favorable price and then calculate the difference between the old price and the new price to determine savings. This initiative is applicable to medical and surgical supplies.
6. *Reducing Unnecessary Contracts*—The contract cost avoidance is manually tracked and reported by VISN. One example is the cancellation of clinical contracts by hiring in-house staff.
7. *Re-Utilizing Excess Property*—VISNs calculate the dollar value of the avoided procurement as the contract savings.
8. *Prime Vendors Charge Us Only the Discounted Price*—VISNs manually calculate the dollar amount of price reductions and also calculate savings related to inventory reduction.

Question 40. VA plans to achieve lower unit pricing by consolidating contracting. Please explain how the Secretary's vision for the future of VA acquisitions will encourage lower unit pricing.

Response. On April 27, 2010, Secretary Shinseki approved an Executive Decision Memorandum to implement a new acquisition model for VA. Implementation of this new model enables VA to take a disciplined and collaborative approach in resolving the root causes of acquisition deficiencies; allows for the consolidation of complex, high-dollar value procurements under a single organization, thereby positioning VA to better leverage its acquisition spend. Critical to this acquisition business model is establishment of VA's Strategic Acquisition Center (SAC) within the Office of Acquisition, Logistics, and Construction (OALC), to implement strategic sourcing initiatives and handle contracting requirements exceeding field purchasing parameters. VA is pushing toward this future model with by taking actions now. For example, VA has committed 100% of its purchasing power to the new strategically sourced General Services Administration (GSA) Federal Supply Schedule Office Supply contract which offers tiered discounts and provides savings averaging 7–19% less than GSA schedule prices. Additionally, VA is identifying and developing business cases for strategic sourcing opportunities. Once fully operational, by spring of 2012, the SAC will centralize execution of these business cases that will likely lower unit prices and improve quality.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO U.S. DEPARTMENT OF VETERANS AFFAIRS

HEALTH CARE

Question 1. The budget submission proposes to realign clinical staff to get to a $150 million savings—by cutting physicians and registered nurses and replacing them with other clinical positions. What positive changes will be evident at an average facility after this change?

Response. The Team Care model supports each professional working at the "top of his/her professional skills and abilities" to provide health care that is optimally safe and cost-effective. There will be no "cuts" but, through attrition, we will replace some physicians with non-physician providers (nurse practitioners and/or physician assistants). Registered nurses will be supplemented by licensed practical nurses and other allied health support staff (pharmacists, social workers, dieticians and others) to further enhance the effectiveness of the team. This model will promote the provision of accessible, comprehensive, continuous and coordinated high quality health care while judiciously utilizing resources.

Question 2. One of the problems at the Marion, Illinois VA was a provider performing procedures for which he was not qualified or credentialed. If this realignment proceeds, what will the Department do to ensure only the right providers are giving care and that they are appropriately credentialed for those procedures?

Response. Since 2007, VHA has focused attention on the roles and responsibilities of local hospital medical staff leadership to ensure proper documentation and provider competency in the credentialing and privileging process, and has facilitated closer oversight by implementing continuous monitoring of credentials through the National Practitioner Data Bank's Continuous Query (previously known as the Proactive Disclosure Service). The new Central Office realignment will extend these efforts by bringing the Credentialing and Privileging program together with the National Center for Patient Safety, Risk Management, and the Office of Medical Legal Affairs, thereby enhancing internal communication and collaboration to ensure that only appropriately qualified clinicians are delivering care to our Nation's Veterans.

Question 3. The budget submission predicts $200 million in savings in the next two fiscal years after a variety of initiatives to cut the costs associated with buying care in communities. One of the initiatives is to decrease the average daily census at contract hospitals. How will you ensure that veterans can receive timely access to care close to their homes?

Response. Monitoring and assessing Non-VA Bed Days of Care was one of many initiatives associated with potential savings in this program. The intent of this component of the initiative was to provide broader oversight for both the inpatient care services where VA refers the Veteran as well as the emergent inpatient services that are initiated by the Veteran. It is not intended to limit access but to assure that we are purchasing inpatient care at the right time and the right location. VA is also assessing timeliness of appropriate transfers back to the VA. Each component of this initiative includes a clinical assessment to assure we have neither impacted access nor underutilized VA facilities.

Question 4. The budget submission states that most networks have implemented 90 percent of the Uniformed Mental Health Services Handbook. When does the Department anticipate all networks being 100 percent complete? Are there networks that currently are significantly below percent complete?

Response. To date, the rate of implementation of the Uniform Mental Health Services Handbook across networks is 91.68 percent. Currently, two VISNS have more than 95 percent implementation, sixteen VISNS are between 89 and 95 percent implementation, and three VISNs are between 83–89 percent implementation. While Veterans Health Administration (VHA) recognizes that 100 percent implementation of the Uniform Mental Health Services Handbook is a goal, VHA has set an internal standard of 95 percent implementation at 100 percent of VA facilities. This is a more realistic, achievable goal, as these objectives are moving targets due to staff turnover and changing needs of the Veterans we serve. Of note, implementation rates of the Uniform Services Handbook have increased steadily over time, with national implementation rates increasing 5.8 percent between August 2009 and June 2010. While some networks are below others in terms of implementation rates, the Office of Mental Health Services, the Office of Mental Health Operations, and the Improve Veterans Mental Health Initiative provide technical assistance to ensure that all networks achieve at least 95 percent implementation by second quarter, Fiscal Year 2012.

Question 5. A January 2009 VHA report found that over 49 percent of veterans returning from the Middle East and Southwest Asia who have sought VA health care were treated for symptoms associated with musculoskeletal ailments. Additionally, according to a recent VHA analysis of VA health care utilization among OEF/OIF veterans, musculoskeletal system and connective system diseases were the leading possible diagnosis, totaling more than 53 percent. Chiropractic services are available in at least one facility per VISN. However there are more than 120 facilities without a doctor of chiropractic medicine on staff and a few major metropolitan areas such as Detroit, Denver, and Chicago, without a doctor of chiropractic medicine in close proximity. What action is being taken to further accommodate the increasing number of Servicemembers in need of such care?

Response. VA currently provides chiropractic services on-station at 43 facilities, of which 7 are CBOCs. When the residence of a Veteran is geographically distant from a VA site providing on-station chiropractic care, the fee-basis program is utilized. VA continues to assess utilization and resources to further develop the chiropractic program to best serve Veterans' needs, expanding the VA chiropractic program from 24 sites in fiscal year 2005 to 43 sites in current fiscal year 2011.

Question 6. The President's budget request includes $52 million for FY 2012 and a FY 2013 advance appropriation of $57 million to fund care for American Indian/Alaska Native Veterans. How did VA arrive at these funding amounts?

Response. VA had previously received population and cost of care information from the Office of Management and Budget for the American Indian/Alaska Native (AI/AN) Veterans. The $52 million and $57 million requests were based on an estimate of the AI/AN Veterans that were Indian Health Service (IHS) users only and dual eligible users to get total potential VA cost. Based on the data provided by OMB, the following assumptions were made:

- Only IHS cost for care provided in non-IHS facilities would be shifted to VA.
- The OMB IHS cost per user was $4,386 in FY 2012 and $4,710 in FY 2013.
- 25% of dual eligible AI/AN Veterans in given year will use IHS only and 50% of the IHS cost would shift to VA.
- 50% of dual eligible AI/AN Veterans in given year will split VA/IHS care 50/50 and 25% of IHS cost will shift to VA.

Question 7. The contingency fund that is included in the budget request raises several concerns. If the models project a given level of need, why does the request not ask to be directly funded at that level?

Response. The $953 million contingency fund was requested to address the potential demand increase for medical care services due to changes in economic conditions, which was estimated for the first time in the VA's Enrollee Health Care Projection Model. Recent studies have shown that unemployment rates among Veterans are approximately double those of non-Veterans. As Veterans lose access to other health care options, such as employee health insurance, they increasingly seek VA care. However, because this economic impact was incorporated into the model for the first time, the estimated need was proposed to be funded through the contingency fund. Under this funding mechanism, the funds will only become available for obligation if the Administration determines that the estimated changes in economic conditions materialize in 2012. The contingency fund ensures the resources are available for the potential need, while monitoring the consistency between this first-time projection and latest available data.

Question 8. What guarantees are there that the dollars in the contingency fund will be released, and released on time, if the determination is made that they will be needed?

Response. Section 226 of the Administrative Provisions state that "* * * such funds shall only be available upon a determination by the Secretary of Veterans Affairs, with the concurrence of the Director of the Office of Management and Budget, that:

(a) The most recent data available for:

(1) National unemployment rates,

(2) Enrollees' utilization rates, and

(3) Obligations for Medical Services,

validates the economic conditions project in the Enrollee Health Care Projection Model, and

(b) Additional funding is required to offset the impact of such factors."

VA and the Administration will work closely together to determine if the estimated economic impact materializes and, if so, to ensure that the funds are released promptly to the VISNs and VA medical centers to meet the increased demand for health care.

CLAIMS PROCESSING

Question 9. Please describe what criteria are used in forecasting claims workload. How confident are you that the forecast for FY 2012 is correct?

Response. VBA uses historical trend analysis of VA disability claim receipts, to include information such as, but not limited to, total amount of claims received, types of claims received, regional office of jurisdiction from where claims are received, as well as an estimate of the average number of disabilities and types of disabilities claimed on an annual basis. This data is captured and stored with the centralized VBA claims corporate database. VBA also uses external information such as actual and forecasted Servicemember discharges provided by the Department of Defense in order to help in the estimation of new Veterans potentially seeking VBA services. Furthermore, VBA also uses external data from both government and private organizations such as the Centers for Disease Control and Prevention and the American Heart Association to estimate the number of potentially eligible Veterans when proposed changes to legislation and/or internal updates to regulations are introduced that impact VA disability benefits. VBA has a high degree of confidence that the workload forecast of ~1,326,000 incoming disability compensation and pension claims is valid.

Question 10. Please provide data on the status of the Agent Orange Fast Track program, including the number of claims filed and the average time to process a claim that has been filed through that system.

Response. The Fast Track Claims Processing System has been operational since October 29, 2010. The Fast Track System accepts claims for the three Agent Orange presumptive conditions of Parkinson's disease, ischemic heart disease, and B-cell leukemia. Veterans may file claims for these conditions electronically through the Fast Track web-based portal or by mail or fax to the regional offices or the Fast Track intake facility in Rocket Center, WV. Through the use of Disability Benefits Questionnaires, the system automatically generates recommended rating decisions to assist VA decisionmakers.

As of March 15, the Fast Track System has 17,712 cases entered—2,540 filed online by Veterans and 15,172 entered by VA employees (non-Nehmer claims received after publication of the final rule). Fast Track claims rated through March 15 total 2,294.

Average time to complete claims processed through the system is not available at this time. VA continues to work with our support contractor to refine the Fast Track System, including a more robust reporting functionality. The scheduled reporting enhancements will allow Fast Track to directly interface with the VBA corporate database, ensuring consistent data reporting across both systems.

Question 11. Please provide data on the usage of disability benefits questionnaires. To date, how many DBQs have been received by VA? Of the DBQs that have been received, how many VA medical examinations have been provided for the same condition?

Response. As of March 14, 2011, VBA has received 14,434 Disability Benefits Questionnaires (DBQs) from C&P Exams performed by VHA. VBA received an additional 2,441 DBQs from other sources. No additional analysis is currently available regarding how many VA examinations were provided in cases where a DBQ was also submitted. An in-depth case by case analysis would be required to parse out when and why a VA examination may have been subsequently requested in a case involving a DBQ received as private medical evidence.

Question 12. What measures is VA taking to prevent fraud in the use of DBQs? For example, are there controls in place to prevent VA employees or veterans from modifying the DBQs that are given to VA after being filled out by a provider? Does VA have a system in place that will recognize whether a provider is routinely giving favorable, and perhaps unwarranted, assessments of veterans?

Response. VA has a program in place to prevent fraud. Recently, VA's Office of Inspector General (OIG) conducted an evaluation of this oversight program. The Director of Compensation and Pension (C&P) Service is currently awaiting feedback from OIG about this program, which involves surveying a representative sample of submitted DBQs and validating the information with the clinician identified on the form. This validation is meant to ensure that the clinician is appropriately identified and that the submitted information has not been altered after the clinician signed the form. However, we note that the completed DBQ is merely a statement from a private physician providing relevant medical information. VA's current regulations at 38 CFR 3.326(c), regarding the validation of statements from private physicians remain applicable. However, the level of scrutiny being applied to the DBQ far exceeds the standards currently applicable to other statements from private physi-

cians. The provisions of § 3.326(c) stipulate that, provided that it is otherwise adequate for rating purposes, a statement from a private physician may be accepted for rating a claim without further examination. VA accepts private medical evidence (non-VA sources) at face value unless there is reason to question it. If questionable, the statement will either be returned to the provider for clarification or a medical opinion may be requested from VHA. VA's systemic review process to actively review DBQs for validity far exceeds the current system of validation.

Question 13. Please describe all existing claims processing pilots. What are the specifics of each pilot in terms of location, size, purpose, timeframe for completion, and other relevant elements? What are the measures of success for each pilot? Who within VA is responsible for the overall management and evaluation of each pilot and for compiling the lessons learned from the various pilots?

Response. Attached is information on the nearly four dozen pilots that have been nationally tracked. This includes 19 that have run their course and are no longer active pilots, some of them becoming permanent tools, best practices, or implemented nationally. For the remaining pilots, VA is using a project management tool to set schedules with key milestones and decision points and develop plans for potential pilot implementation and future rollout. This approach will provide a more uniform guide to defining project metrics.

In general, pilot success is measured against the overarching principles of providing greater efficiency and improving the delivery of services. This includes, but is not limited to, more timely decisions of higher quality and increased capacity to provide more claims decisions.

Responsibility for overall management, evaluation, and compilation of lessons learned lies with VBA's Office of Strategic Planning (OSP). Initiative leaders and OSP staff regularly brief VBA leadership on pilots' status, with recommendations for next steps at key junctures.

Question 14. VA does not appear to have a systemic way of incorporating current laws, including precedential case law, into the manuals relied upon or the text used in rating decisions. How can veterans expect to obtain correct decisions when adjudicators are instructed to apply incorrect laws? What actions can you take to ensure that the legal information relied upon by rating employees is correct and reflects current law?

Response. VBA's methods of incorporating current laws, including case law, into its procedures follow.

Daily, the C&P Service Policy Staff review legislative enactments, decisions by the Court of Appeals for Veterans Claims, and relevant decisions by the United States Court of Appeals for the Federal Circuit. If a new law or court decision impacts VA procedures or requires a regulatory or other change, a written assessment identifying any needed amendments is drafted within days of the decision date. The assessment document is forwarded to the appropriate C&P Service staffs for action. The assessment and the text of the court decision are immediately made available to all field offices. Regarding legislative amendments and court decisions mandating substantive policy or procedural changes, Fast Letters, which are binding on VA decisionmakers, are issued to the field offices to provide guidance in advance of amendments to the adjudication procedures manual M21–1MR or VA regulations. Simultaneously, recommendations based on the legislation or court decision are provided to the C&P Regulations or Procedures Staffs for necessary amendment. All Fast Letters, Training Letters, and assessments of court decisions are posted on the C&P Service Calendar page. The individual regional offices identify new postings affecting the adjudication process, and provide local training in accordance with the published guidance. Compliance with newly released guidance is assessed through both regional office Quality Review programs and the C&P Service's nationwide Systematic Technical Accuracy Review program.

If the Policy Staff determines that a change to the rating text is required, the decision assessment document is forwarded to C&P Service's Business Process Staff for incorporation into the Rating Board Automation (RBA) system. The C&P Service RBA business analyst submits a change request to the Hines Information Technology Center through the VBA Office of Business Process Integration for the next available VETSNET release. This may take an extended period of time, as the requirements for a release must be submitted 6 months in advance of the release. As noted above, if the text is needed immediately, the C&P service issues a Fast Letter to inform the field that until RBA2000 changes are made, they must insert approved text into the rating decision.

Question 15. How many FTE of the Compensation and Pension Service Quality Assurance program will be supported in the FY 2012 budget request?

Response. Compensation and Pension Service currently has 49 employees dedicated to quality assurance. At this time there are no plans to increase the number of employees in the National Quality Assurance Program.

Question 16. The Secretary has a commitment to eliminate the claims backlog and improve quality to 98 percent by 2015. Please explain how the level of quality of decisions is determined. How does VA intend to reach 98 percent?

Response. The Systematic Technical Accuracy Review (STAR) system is VBA's national program for measuring compensation and pension claims processing accuracy. The STAR system includes review of work in three areas: claims that usually require a rating decision, claims that generally do not require a rating decision, and fiduciary work. Audit-style case reviews are conducted after completion of all required processing actions on a claim. The review is outcome-based and includes all elements of processing that claim. STAR accuracy review results are generated for all VBA regional offices, brokering centers, the Tiger Team, which process claims from Veterans over 70 years old or pending over one year, and Pension Management Centers, and are included in the regional office directors' annual performance evaluations.

Under the STAR program, a statistically valid random sample of completed work is reviewed from each processing center. The benefit entitlement accuracy rate is the official measure of a station's quality performance. Benefit entitlement accuracy for rating claims includes: addressing all issues, compliance with Duty to Assist (38 CFR 3.159), correct decision to grant or deny, and proper award action (correct payment rates and effective dates).

In addition to STAR assessments, VBA has a number of other methods of assessing quality, including consistency assessments, site surveys, and special reviews. The results of these assessments are analyzed and used to develop both local and national training.

In support of the Secretary's commitment to eliminate the claims backlog and improve quality to 98 percent by 2015, VA has undertaken a comprehensive Claims Transformation Plan. (See attached Claims Transformation Initiatives dated March 2011.) Specialized quality review positions are being created in each regional office to focus solely on the improvement of quality. The employees selected for these positions will be part of dedicated quality review teams at each Regional Office.

During fiscal year 2011, the STAR Staff is conducting training for the employees from each regional office currently responsible for conducting local quality reviews. This training is designed to help achieve consistency between national and local quality reviews. The STAR Staff is scheduled to complete the training for employees currently assigned to these duties in May 2011.

Logic-based tools have been developed to aid VA decisionmakers by automating simple decisions to provide more accurate and consistent decisions for Veterans. Hearing loss and Special Monthly Compensation calculators have been implemented nationwide, and additional logic-based tools are currently in the works.

Through the use of sound training programs, information technology job aids, and enhancements to decision support systems, VBA decisionmakers are being provided the tools needed to make consistent, quality decisions.

Question 17. Please define the amount of money in the President's budget request that is allocated for the administration of the Integrated Disability Evaluations System for those based overseas but going through the program. Please provide the plan for this program overseas.

Response. Expansion of the Integrated Disability Evaluation System is still in the planning phase with the Department of Defense. Therefore, no specific amount of money has been allocated for this population of servicemembers.

CONSTRUCTION

Question 18. Please provide a list of priority weights for the 6 major criteria and 18 subcriteria in the Analytic Hierarchy Process used to inform the Strategic Capital Investment Plan decision plan.

Response. Priority weights for the 6 major criteria and 18 sub-criteria used to prioritize capital projects in the FY 2012 Strategic Capital Investment Planning (SCIP) cycle are provided in the table below.

FY 2012 Strategic Capital Investment Planning (SCIP)
Decision Criteria and Priority Weights

Major Criteria	Priority Weight	Sub-Criteria	Priority Weight
Improve Safety and Security	.324	Safety/Compliance (Excludes Seismic)	.338
		Security/Emergency Preparedness	.309
		Seismic	.353
Major Initiatives	.216	Major Initiatives	.596
		Supporting Initiatives	.150
		Energy Standards	.180
		DoD Collaboration	.074
Fixing What We Have	.200	Reduce Facility Condition Assessment Deficiencies	.691
		Other Self-Defined Gaps	.309
Increasing Access	.154	Client (Veteran) Access to Services	.542
		Support Structures (includes Parking)	.218
		Utilization/Workload	.131
		Customer (Internal) Access to Service	.109
Right-Sizing Inventory	.057	Space – New Construction/Renovation	.577
		Space – Repurposing	.217
		Space – Demolition	.206
Ensure Value of Investment	.048	Best Value Solution for New Facilities	.750
		Maximize Efficiencies in Existing Facilities	.250

Question 19. Please explain the 81 percent reduction in funding requested for the facility security projects account, from $42.5 million in FY 2011 to $8 million in FY12.

Response. The reduced funding requested in FY 2012 is directly related to the reduction of facility security requirements of the projects included in the FY 2012 budget.

Question 20. How is VA measuring the impact of the $24 million that funded costs associated with on-site supervision of major construction projects by 140 resident engineers?

Response. The 140 resident engineers requested in FY 2012 is the same level requested in FY 2011. VA determines the number of resident engineers (RE) needed on construction projects based on the size and complexity of the project, the amount of shift work the contractor is proposing and the number of contracts that will be on-going simultaneously. Resident engineers are evaluated based on several factors: the timeliness of responses to requests for information from the contractor, monitoring how well the contractor builds the facility in accordance with the drawings and specifications for the project, and monitoring schedule performance. Additionally, the establishment of a robust project management culture will increase project visibility and accountability for managing the capital program and decrease the risk currently assumed by having minimal government representation on complex construction projects valued in the hundreds of millions of dollars.

Question 21. VA has a variety of capital planning mechanisms. According to the FY 2012 budget request, Strategic Capital Investment Plan lays out each VISN's capital needs through a ten-year action plan; the Building Utilization and Review and Repurposing initiative identifies underutilized real estate to develop housing opportunities through the Enhanced Use Lease program; and the Real Property Cost Savings and Innovation Plan seems to include repurposing, demolition, mothballing, and a number of other initiatives. Please provide more information on each program, their synergies, and their differences. Also, please explain how each fits in to a larger national vision on capital planning, especially in the context of health care delivery.

Response. VA's Strategic Capital Investment Planning (SCIP) process is the data driven approach that systematically identifies VA service or infrastructure "gaps" and prioritizes capital investment projects in terms of their ability to close these gaps. SCIP is a forward-looking strategic plan to meet VA's current and future infrastructure needs and is inclusive of the many other on-going efforts to improve

real property utilization and meet strategic departmental objectives. Within SCIP, two of the tactical program means to close these gaps are BURR and the Real Property Cost Savings and Innovation Plan. Other tactical means include major construction, minor construction, non-recurring maintenance, leasing, and use of non-capital solutions. SCIP includes the results of many planning processes and is the collection of all activities that impact the VA real property portfolio and its performance. Projects that are identified in these planning processes must be included in the SCIP 10-year action plan on how the VISN plans to address their service or infrastructure gaps. The following is a more detailed discussion of the two tactical efforts requested in the question.

VA's Building Utilization Review and Repurposing (BURR) initiative is a targeted nationwide effort to reuse or repurpose underperforming capital assets to address strategic objectives, such as ending Veteran Homelessness and consolidating/realigning assets for direct services to the Veterans VA serves. The Department's EUL authority and the BURR initiative allow VA to match supply (available buildings and land) and demand among Veterans for housing with third-party development, financing, and supportive services. These activities affect VA's real property inventory and therefore would be part of the Strategic Capital Investment Plan (SCIP) as a means to address unused space, meet increased service demands, and provide enhanced services to Veterans.

The Real Property Cost Savings and Innovation Plan identifies cost savings expected from current and new initiatives. The expected savings from repurposing, demolition, and mothballing, reported in the Real Property Cost Savings and Innovation Plan, is a quantification of expected savings from actions planned under BURR and other disposal planning activities. Other actions, such as telework and energy conservation measures, are also part of the cost savings plan. These actions impact VA's real property portfolio and therefore would be part of the SCIP process. There are additional items in the cost savings plan that are purely operational in nature, such as commodity purchasing, that does not impact capital investments and would not be part of SCIP.

Question 22. The VA Real Property Cost Savings and Innovation Plan proposes $18.5 million in savings through several different mechanisms. Please provide the amount of savings projected for each portion of the plan.

Response. VA continues to look for innovative ways to save operational costs related to its real property inventory while maintaining a high level of service. The Cost Savings plan has a number of key initiatives that span all VA Administrations and continues to be refined as new initiatives and legislation occur. VA currently has projected the following preliminary estimates for real property cost savings for VHA.

Potential Cost Savings for VHA in FY 2012	$ in millions
Repurpose Vacant and Underutilized Assets	3
Demolition and Mothballing	3
Energy and Sustainability	10
Telework	2
Renegotiate GSA Lease Costs	0.5
Total	$18.5

Question 23. Why was renewing the enhanced use lease authority not among the Department's legislative requests?

Response. VA is developing an improved request to address the imminent expiration of its enhanced-use lease (EUL) authority that will be submitted to Congress soon.

Question 24. How much would it cost to renew the enhanced use lease authority and, separately, what cost avoidance would be realized by renewing this authority?

Response. The EUL program has been active in VA for close to 20 years. No new or additional costs are associated with the renewal of the authority. VA currently has the authority to offset its costs to administer the program with proceeds/revenue generated through EUL projects. VA's EUL authority also allows the Department to transfer the operations and maintenance costs to a third party (developer/lessee) for an extended term (up to 75 years), accounting for annual cost savings to VA that are directed to providing services to Veterans. In addition, VA generated cost revenue of $3.1 million, cost avoidance of $32.6 million, and cost savings of $ 5.8million in 2010. Since 2006, the EUL program has cumulatively generated $266.1 million in total consideration to VA. We believe that the continuation of the EUL program

would allow the Department to realize similar cost avoidance and savings in the future.

Question 25. Please provide the most recent copy of the VA Seismic Inventory Report developed in consultation with Degenkolb Engineers.

Response. See Attachment.

Degenkolb

DEPARTMENT OF VETERANS AFFAIRS
SEISMIC INVENTORY
Phase 6

VOLUME 1
Summary Report

Prepared for:
Office of Facilities Management
Department of Veterans Affairs
Washington, DC

May 1, 2006
Degenkolb Job Number: 97472.06

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DEPARTMENT OF VETERANS AFFAIRS
SEISMIC INVENTORY
PHASE 6

VOLUME I
SUMMARY REPORT

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Executive Summary

In 1994 the President issued Executive Order (EO) 12941 requiring all Federal Agencies to develop an inventory of their owned and leased buildings and to develop an estimate of the cost to mitigate unacceptable seismic risks to those buildings. The Department of Veterans Affairs (VA) selected Degenkolb Engineers as the contractor to help the VA meet this mandate. The inventory was developed during that first phase and submitted to the Federal Emergency Management Agency (FEMA) in December 1998.

This report summarizes the work completed during the sixth and final phase of the VA Seismic Inventory Program. Phase 6 is a continuation of the work initiated in Phase 1 to assist the VA in completing the inventory and developing realistic cost estimates for retrofitting its deficient buildings, and to provide guidance to the VA for the future of their seismic program, which has been in place since the early 1970's.

The VA's total building stock of 5,845 buildings comprises 5,227 buildings from the Veterans Health Administration (VHA), 610 buildings from the National Cemetery Service (NCS), and 8 buildings from the Veterans Benefit Administration (VBA). Of these buildings, 5,154 are exempt from seismic concern. There currently remain 691 non-exempt buildings in the VA Inventory.

Of the 691 non-exempt buildings, 85 have been identified as Exceptionally High Risk (EHR), with an associated estimated rehabilitation cost of $783 million, and 150 buildings have been identified as High Risk (HR), with an estimated rehabilitation cost of $664 million. Rehabilitation of the entire inventory, which comprises over 142 million square feet of space, is estimated at approximately $2.0 billion.

Report Overview

The final report for Phase 6 of the VA Seismic Inventory is divided into four separate volumes:

Volume I: Summary Report

Volume I is a summary report that contains an overview and description of the VA Seismic Inventory effort to date and significant recommendations. It also includes an updated ranked list of Exceptionally High Risk buildings, a ranked list of High Risk buildings, and the master list of studied buildings.

Volume II: VA Seismic Inventory

Volume II includes a printed version of the entire VA Seismic Inventory along with a detailed glossary that defines all of the terms used in the database. The database has been continually updated throughout the phases to reflect changes in the inventory.

Volume III: Building Evaluations

Volume III includes documentation of the fourteen detailed studies, four preliminary studies, and nine base shear comparisons performed during this effort. This documentation includes both preliminary and detailed studies for San Diego 11, and cost update information for Sacramento 728 which has been considered as a detailed study (although no architectural or mechanical site visit was performed for this building). For each detailed study, the following is included: written description of the building; list of seismic deficiencies; description of the proposed retrofit scheme; photographs of the building; sketches of the proposed retrofit scheme; two-page summary sheet; ASCE evaluation checklists; detailed cost estimate; notes and photographs from the Mechanical consultant's site visit. Included in the preliminary studies are all of the above except building photographs and Mechanical consultant's reports.

Volume IV: Calculations

Volume IV includes all of the calculations for the detailed and preliminary studies and base shear comparisons performed during this effort.

Acknowledgments

This report is part of the federal effort towards mitigating seismic hazards in federal buildings as directed by Executive Order 12941. The report has been prepared by Degenkolb Engineers for the Department of Veterans Affairs, Office of Facilities Management. The following people were involved in the preparation of this report:

James O. Malley	Degenkolb Engineers
John S. McDonald	Degenkolb Engineers
Gretchen Hall	Degenkolb Engineers
William Grogan	Degenkolb Engineers
Ross Bogen	SMP/SHG Incorporated
Richard Ford	SMP/SHG Incorporated
Alistair Roberts	Davis Langdon
Michael Darko	Mazzetti & Associates

The following engineers at Degenkolb conducted building evaluations:

Michael Alvarez
Cale Ash
Manu Garg
David Gonzalez
William Grogan
Mark Redlinger
Jeremy Woodgate

The authors would like to thank the following people at the Department of Veterans Affairs, Office of Facilities Management, for their assistance in providing much of the information presented in this report:

Krishna Banga	Project Manager
Kurt D. Knight	Director, Facilities Quality Service
Lloyd H. Siegel	Associate Chief, Strategic Management Office

We would also like to thank the numerous employees at many VA Medical Centers who generously contributed information to our effort and gave assistance to our team.

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APPENDICES

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1. INTRODUCTION

1.1 Overview

This report summarizes the work completed during the sixth phase of the VA Seismic Inventory Program, originally initiated to comply with EO 12941. Phase 6 is a continuation of the work initiated in Phase 1 to assist the VA in completing the inventory and developing realistic cost estimates for retrofitting its deficient buildings, and to provide guidance to the VA for the future of their seismic program, which has been in place since the early 1970's.

- Phase 1 was completed and fully documented in a four-volume report, *Department of Veterans Affairs Seismic Inventory*, dated December 4, 1998.
- Phase 2 was fully documented in a five-volume report, *Department of Veterans Affairs Seismic Inventory Phase II,* completed May 31, 2000.
- Phase 3 was fully documented in a four-volume report, *Department of Veterans Affairs Seismic Inventory Phase 3,*completed August 30, 2001.
- Phase 4 was fully documented in a four-volume report, *Department of Veterans Affairs Seismic Inventory Phase 4,* completed March 6, 2003.
- Phase 5 was fully documented in a four-volume report, *Department of Veterans Affairs Seismic Inventory Phase 5,* completed August 2004.

The VA's total building stock of 5,845 buildings comprises 5,227 buildings from the Veterans Health Administration (VHA), 610 buildings from the National Cemetery Service (NCS), and 8 buildings from the Veterans Benefit Administration (VBA). Of these buildings, 5,154 are exempt from seismic concern. There currently remain 691 non-exempt buildings in the VA Inventory. These buildings are identified in Appendix C.

Throughout the Phases, buildings have been evaluated in order to identify seismic deficiencies and to develop estimated mitigation costs. A total of 36 preliminary studies and 79 detailed studies of non-exempt buildings have been completed during Phases 1, 2, 3, 4, 5, and 6. 12 Base Shear Comparisons have also been completed on non-exempt buildings. (An additional 21 buildings were studied but have since been removed from the non-exempt list and therefore are not included in these statistics, which are specific to non-exempt buildings. Appendices A and B list all studied and credited buildings, respectively, exempt as well as non-exempt.) An additional 69 non-exempt buildings are 'credited', as they are similar to studied buildings, and are aggregated into the Evaluation Status tabulated below. Therefore, a total credit of 196 evaluated buildings, approximately 28 percent of the VA's 691 non-exempt building inventory, can be considered as evaluated. There exist 253 significantly small buildings in the VA non-exempt inventory (those with areas less than 5,000 sq. ft.) that may not need to be studied; therefore, the practical number of buildings remaining to be studied is 242. This information is summarized in Table 1.1.

Non-Exempt Building Evaluation Status		
Description	*Number of Buildings*	*Percent*
Non-Exempt Buildings	691	100 %
Detailed Studies	79	11 %
Preliminary Studies	36	5 %
Base Shear Comparisons	12	2%
"Credited" Studies	69	10 %
Total Studied	196	28 %
Significantly Small	253	37 %
Remain to be Studied	242	35 %

Table 1.1: Evaluation Status of Non-Exempt Buildings

For Phase 6, the VA selected a group of ten buildings for detailed evaluation and four for preliminary evaluation. In addition, eight base shear comparisons were completed. This study was extended to include three further detailed studies (including San Diego 11, previously studied in Phase 6 as Preliminary) and one base shear comparison and an updated cost estimate for Sacramento 728 (considered a detailed study, but without architectural or mechanical site visits) See Table 1.2 below.

Phase 6 Studies		
	Building	*Study Type*
1.	Fort Harrison 154	Detailed
2.	Fresno 13	Detailed
3.	Manchester 1	Detailed
4.	Martinez R-1 (was 5)	Preliminary
5.	New York 5	Detailed
6.	North Little Rock 102	Detailed
7.	Prescott 107	Detailed
8.	San Diego 11	Detailed (&Preliminary)
9.	Seattle 100 NHCU	Detailed
10.	Seattle 100 Nursing Towers	Detailed
11.	Seattle 100 Energy Plant	Preliminary
12.	St. Albans 87	Detailed
13.	Vancouver 1	Preliminary
14.	Walla Walla 69	Detailed
15.	Loma Linda 1	Base Shear Comparison
16.	Palo Alto 54	Base Shear Comparison
17.	Palo Alto MB3	Base Shear Comparison
18.	Seattle 24	Base Shear Comparison
19.	Vancouver 2	Base Shear Comparison
20.	Vancouver 3	Base Shear Comparison
21.	Vancouver 11	Base Shear Comparison

22.	Vancouver 12	Base Shear Comparison
23	American Lake 9	Detailed
24	Seattle 31	Detailed
25	Sacramento 728	Detailed (Cost Update)
26	Memphis 5	Base Shear Comparison

Table 1.2: Phase 6 Studies (contd.)

The comprehensive list of studied buildings is included in Appendix A. This list includes all of the studied buildings from Phases 1 through 6 as well as those studied through other efforts, such as the FEMA case studies and VA Project Management studies. Appendix B is the comprehensive list of "Credited" buildings, those buildings that are similar in size and building type to studied buildings. A third list, Early VA Studies, is included as Appendix I and lists those buildings that were studied only during the VA's Phase 1 and 2 evaluations in the 1970's.

The VA Owned Building database has continued to be updated during Phase 6.

1.2 Exceptionally High Risk Buildings

One of the key tasks in the ongoing Seismic Inventory effort is the identification of buildings that pose an Exceptionally High Risk (EHR) to the mission of the VA. There are currently 85 buildings on the EHR list, as identified in Table 1.5 beginning on page 1-6. This number has changed over the course of the Inventory Project and will continue to fluctuate as changes are made to the database. EHR buildings are those that meet all of the following criteria:

1. Building is located in an area of High or Very High seismicity.
2. Building is an Essential or Critical facility.
3. Building structural design did not utilize VA Seismic Design Requirements and/or the building was constructed before 1977.
4. Building is not otherwise exempt.
5. Building square footage is greater than 10,000 square feet.

The table below indicates the evaluation status of the EHR buildings at the end of Phase 6.

EHR Building Evaluation Status		
Description	*Number of Buildings*	*Percent*
Total EHR Buildings	85	100 %
Detailed Studies	44	52 %
Preliminary Studies	5	6 %
Base Shear Comparisons	3	3 %
"Credit" Studies	21	25 %
Remain to be Studied	12	14 %

Table 1.3: Evaluation Status of EHR Buildings

In addition to the 49 detailed and preliminary studied buildings indicated in Table 1.3, a further 21 buildings are similar and are considered to be 'credited'. Therefore 70 of the 85 buildings, or approximately 82 percent, can be considered to have been evaluated. There remain thirteen buildings on the EHR list that do not have either a preliminary or a detailed evaluation completed. (One of these has already been funded and has a project under way. Another five were evaluated during the early VA Phases 1 or 2; these studies are considered to have been conceptual in nature and do not constitute a formal evaluation, conforming to what has been accomplished during Phases 1 through 6.)

The following notes apply to Table 1.5:

1. During Phase 6, Seattle Building 100, the Main Hospital, was divided into its individual components in the database. This was done to allow documentation of the studies that have been done on the separate portions of the structure. Consequently, where Seattle 100 used to be listed as one building, it is now listed as five separate ones (for a total of four additional buildings to the EHR building count).
    1. Seattle 100 D & T Wing
    2. Seattle 100 Energy Plant
    3. Seattle 100 NHCU
    4. Seattle 100 Nursing Towers
    5. Seattle 100 Central Core
2. The following building was added to the EHR list during Phase 6:
    1. Vancouver 11

    While this building does not satisfy all of the requirements for EHR ranking, an exception has been made by VACO at the request of the facility to allow this building to be included in the EHR list.
3. The following building was added to the EHR list during Phase 6:
    1. Livermore stock

    This building was recently added to the Inventory database and qualifies for the EHR list.

1.3 High Risk Buildings

Evaluations of High Risk (HR) buildings, the second tier of buildings just below EHR and originally developed during Phase 3, have also continued during Phase 6. The 150 buildings currently on the HR list are identified in Table 1.6, starting on page 1-10.

The definition of HR includes buildings that are similar to EHR buildings but that are located in a slightly lower seismic hazard zone or are slightly smaller in overall area. High Risk buildings are defined as meeting either one of the following:

1. Buildings that meet the definition of EHR except are located in an area of Moderate-High seismicity,

or

2. Buildings that meet the definition of EHR except are smaller than 10,000 square feet and greater than 1,000 square feet in area

The table below indicates the evaluation status of the HR buildings at the end of Phase 6.

HR Building Evaluation Status		
Description	*Number of Buildings*	*Percent*
Total HR Buildings	150	100 %
Detailed Studies	30	20 %
Preliminary Studies	23	15 %
Base Shear Comparison	1	1 %
"Credit" Studies	21	14 %
Remain to be Studied	75	50 %

Table 1.4: Evaluation Status of HR Buildings

The following notes apply to Table 1.6:

1. Two buildings were removed from the HR list during Phase 6:
    1. North Little Rock 75 - demolished, removed from database
    2. Sacramento NCHCS 722A – construction date of 2000 makes it exempt
2. Three buildings were added to the HR list during Phase 6 as exceptions:
    1. San Francisco 7
    2. San Francisco 18
    3. Vancouver 3

    While these buildings do not satisfy all of the requirements for HR ranking, an exception has been made by VACO at the request of the respective facilities to allow these buildings to be included in the HR list.
3. Two more buildings were added to the HR list during Phase 6 as a result of the database update:
    4. Sacramento NCHCS 728
    5. Sacramento NCHCS 2880

Table 1.5: Exceptionally High Risk Ranked List

Building Data														Ranking Score										Cost		
Number	Ranking	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft.)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group[1]	Study Type[2]	S1 Spectral Ordinate[3]	S1 Spectral Ordinate[3]	Seismicity	Seismicity Category Rank[4]	Deficiency Category Score[5]	Category Rank Score[6]	Bed/Nonbed Score[7]	Size Score[8]	Total Score	Total Current Construction Cost[9]	Remarks	
RANKED BUILDINGS																										
1.	1.	San Francisco	203	Inpat Hosp/Clinic/Res	CA	Conc. shear wall	335,009	185	N04	1976	CIP-PM	D	1.638	0.962	VH	1	24.1	35	25	20	104.1	$41,500,000	d	CD+DD underway
2.	2.	West LA	500	Main Hospital	CA	Steel braced frame	937,000	391	N05	1976	CIP-PM	D	1.899	0.641	VH	2	30.1	20	25	20	95.1	$56,000,000		CD underway
3.	3.	Palo Alto	2	Psychiatry	CA	Conc. shear wall	75,300	64	N02	1960	CIP-PM	D	2.114	1.079	VH	1	35.0	35	15	10	95.0	$13,500,000	b	Under Construction
4.	4.	San Diego	1	Medical Center	CA	Steel braced frame	854,900	228	N06	1972	CIP-PM	D	1.622	0.786	VH	2	23.8	20	25	20	88.8	$47,400,000	d	Under Construction
5.	5.	Palo Alto	4	Research	CA	Conc. shear wall	90,100	0	N03	1960	CIP-PM	D	2.114	1.079	VH	1	35.0	35	5	10	85.0	$15,100,000	b	CD+DD underway
6.	6.	Long Beach	133	Nursing Home Unit	CA	Conc. shear wall	54,588	131	N01	1974	D3	D	1.787	0.760	VH	2	27.5	20	10	10	77.5	$3,721,000		CD+DD underway
7.	7.	Portland	100	Main Hospital	OR	Steel br. & mom frm	884,985	176	N09	1988	PM	D	1.046	0.343	H	2	12.3	20	25	20	77.3	$94,455,000		Added to EHR as exception, evaluated, found deficient & seismicity incr since constr'n.
8.	8.	San Juan	1	Main Hospital	PR	Steel moment frame	591,294	352	N11	1968	F	D	1.000	0.400	H	2	11.5	20	25	20	76.5	$50,000,000		Project underway; constr'n cost adjusted per VACO
9.	9.	West LA	212	Dom/Prosthetics	CA	Concrete shear wall	69,400	85	N04	1935	D5	D	1.899	0.641	VH	2	30.1	20	15	10	75.1	$8,285,186		Minor project underway
10.	10.	Seattle	100NT	Nursing Towers	WA	Steel br.& mom frm	155,000	198	N07	1985	D6	D	1.513	0.524	VH	3	21.4	10	25	15	71.4	$7,745,174		
11.	11.	Menlo Park	324	Nursing Home Care	CA	Reinf. mas. brg. wall	80,300	128	N01	1967	D3*	D	1.500	0.823	VH	2	21.1	20	10	10	71.1	$3,576,234		To be replaced (Pending Major Project approval FY05)
12.	12.	West LA	257	Brentwood Hospital	CA	Concrete shear wall	57,386	46	N03	1946	D3*	D	1.899	0.641	VH	2	30.1	20	10	10	70.1	$6,799,117		
13.	13.	Long Beach	128	Wards, Psych Admin.	CA	Conc. shear wall	90,200	33	N02	1966	D3	D	1.767	0.760	VH	2	27.5	20	10	10	67.5	$5,997,000		CD underway
14.	14.	Seattle	100DIAT	Main Hospital Diagnostic & Treatment Wing	WA	Steel br. & mom frm	250,000	18	N04	1985	D5	D	1.513	0.524	VH	2	21.4	20	10	15	66.4	$2,668,543		
15.	15.	West LA	114	Research Lab	CA	Conc. frm. w/ infill	69,921	0	N03	1950	D3*	D	1.899	0.641	VH	2	30.1	20	5	10	65.1	$25,200,000	c	CD+DD underway
16.	15.	West LA	115	Research Lab	CA	Conc. frm. w/ infill	60,314	0	N03	1950	D3	D	1.899	0.641	VH	2	30.1	20	5	10	65.1	$9,675,000		
17.	15.	West LA	205	Brentwood Hospital	CA	Concrete shear wall	53,047	0	N03	1937	D3	D	1.899	0.641	VH	2	30.1	20	5	10	65.1	$6,285,000		
18.	15.	West LA	258	Brentwood Admin.	CA	Concrete shear wall	84,715	0	N04	1946	D5*	C	1.899	0.641	VH	2	30.1	20	5	10	65.1	$7,729,268		
19.	19.	Seattle	100NHCU	NHCU	WA	Steel br.& mom frm	37,000	60	N02	1985	D6	D	1.513	0.524	VH	2	21.4	20	15	5	61.4	$1,959,400		
20.	20.	Menlo Park	323	Psychiatric	CA	Reinf. mas. brg. wall	78,434	24	N01	1967	D3	D	1.500	0.824	VH	2	21.1	20	10	10	61.1	$3,553,000		
21.	21.	White City	204	Domiciliary Bed	OR	Unreinforced masonry	19,015	51	N02	1942	D3	D	0.628	0.305	H	1	5.7	35	15	5	60.7	$4,366,000		
22.	21.	White City	205	Domiciliary Bed	OR	Unreinforced masonry	18,248	65	N02	1942	D3	D	0.628	0.305	H	1	5.7	35	15	5	60.7	$3,993,000		
23.	21.	White City	206	Domiciliary Bed	OR	Unreinforced masonry	19,016	59	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	15	5	60.7	$4,366,000		
24.	21.	White City	207	Domiciliary Bed	OR	Unreinforced masonry	19,055	61	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	15	5	60.7	$4,394,297		
25.	21.	White City	215	Domiciliary Bed	OR	Unreinforced masonry	18,240	67	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	15	5	60.7	$4,187,806		
26.	21.	White City	216	Domiciliary Bed	OR	Unreinforced masonry	18,436	57	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	15	5	60.7	$4,233,359		
27.	27.	American Lake	2	Nursing Home Care	WA	Conc.frm.w/ infill	70,000	84	N02	1923	D1	D	1.217	0.392	H	2	15.4	20	15	10	60.4	$8,960,000		
28.	27.	American Lake	16	Research/HM	WA	Concrete shear wall	20,700	0	N01	1923	D4	D	1.217	0.392	H	1	15.4	35	5	5	60.4	$2,693,000		
29.	29.	West LA	207	Brentwood Hospital	CA	Concrete shear wall	47,015	90	N03	1940	D3*	D	1.899	0.641	VH	3	30.1	10	15	5	60.1	$5,570,839		
30.	29.	West LA	208	Brentwood Hospital	CA	Concrete shear wall	47,265	0	N03	1945	D3*	D	1.899	0.641	VH	2	30.1	20	5	5	60.1	$5,599,506		
31.	31.	San Francisco	8	Research/Admin.	CA	Concrete shear wall	52,261	0	N03	1933	D3	D	1.638	0.962	VH	2	24.1	20	5	10	59.1	$15,500,000	e	
32.	32.	Roseburg	1	Main Hospital Building	OR	Conc.frm.w/ infill	123,320	39	N05	1933	D3	D	1.131	0.511	VH	2	13.8	20	10	15	58.8	$37,539,000		
33.	32.	Roseburg	2	Ment Hlth/Cont Treat	OR	Conc.frm.w/ infill	67,613	71	N03	1933	D4	P	1.131	0.511	VH	2	13.8	20	15	10	58.8	$9,405,070		

Table 1.5: Exceptionally High Risk Ranked List

Building Data														Ranking Score								Cost	
Number	Ranking	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group[1]	Study Type[2]	s, Spectral Ordinate[3]	s, Spectral Ordinate[3]	Seismicity	Deficiency Category Rank[4]	Seismicity Score[5]	Category Rank Score[6]	Bed/Nonbed Score[7]	Size Score[8]	Total Score	Total Current Construction Cost[9]	Remarks
34.	34.	San Diego	11	SCI	CA	Steel braced frame	100,929	30	N02	1988	D6	D	1.622	0.786	VH	3	23.8	10	10	15	58.8	$19,508,000	
35.	35.	Long Beach	7	Wards Psych Admin.	CA	Concrete shear wall	36,040	0	N03	1943	CIP-PM	D	1.787	0.760	VH	2	27.5	20	5	5	57.5	$62,300,000	b
36.	36.	Anchorage	3001	Domiciliary	AK	Wood, light frame	34,100	50	N01	1964	D4	D	1.504	0.562	VH	2	21.2	20	10	5	56.2	$2,433,310	
37.	37.	Menlo Park	205	Medical Research	CA	Concrete shear wall	72,300	0	N02	1929	PM	D	1.500	0.824	VH	2	21.1	20	5	10	56.1	$3,623,000	
38.	38.	White City	212	Dom.Bed/Psych/SPD	OR	Unreinforced masonry	19,178	13	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$4,403,168	
39.	38.	White City	213	Domiciliary Bed	OR	Unreinforced masonry	18,405	48	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$4,226,357	
40.	38.	White City	214	Domiciliary Bed	OR	Unreinforced masonry	18,495	34	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$4,246,567	
41.	38.	White City	217	Domiciliary Bed	OR	Unreinforced masonry	18,455	46	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$4,246,567	
42.	38.	White City	218	Domiciliary Bed	OR	Unreinforced masonry	19,070	27	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$4,378,517	
43.	38.	White City	221	Domiciliary Bed	OR	Unreinforced masonry	18,991	31	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$4,360,411	
44.	38.	White City	232	Boiler Plant	OR	Unreinforced masonry	13,419		N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$1,460,598	
45.	38.	White City	239	Domiciliary Bed	OR	Unreinforced masonry	18,240	27	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	10	5	55.7	$4,187,806	
46.	46.	American Lake	81	Main Hospital	WA	Conc. frm. w/ infill	69,996	2	N05	1947	D3	D	1.219	0.392	H	2	16.5	20	10	10	55.5	$8,944,000	
47.	47.	Fort Harrison	154	Hospital	MT	Conc.frm.w/ infill	132,381	45	N04	1953	D6	D	0.937	0.235	H	2	10.4	20	10	15	55.4	$30,438,544	
48.	48.	West LA	300	Dietetics & ADP	CA	Conc. frm. w/ infill	65,824	0	N03	1952	CIP-V2	C	1.899	0.641	VH	3	30.1	10	5	10	55.1	$7,600,000	d CD+DD underway
49.	49.	Palo Alto	51	Rehab/Research & Development Center	CA	Steel frame	23,100	0	N02	1980	DG	BSC	2.114	1.079	VH	?	35.0	10	5	5	55.0	$1,732,500	a
50.	50.	Palo Alto	54	Animal Research Facility	CA	Steel frame	18,100	0	N02	1981	D6	BSC	2.114	1.079	VH	1	35.0	35	5	5	80.0	$1,357,500	a
51.	51.	Palo Alto	MB4	Nat'l Ctr for HIV/Hepatitis Res.	CA	Steel moment frame	10,100	0	N01	1990	None		2.114	1.079	VH	?	35.0	10	5	5	55.0	$757,500	a
52.	52.	San Francisco	1	Res/Clinical/Admin.	CA	Concrete shear wall	37,765	0	N04	1933	CIP-PM	D	1.638	0.962	VH	2	24.1	20	5	5	54.1	$7,100,000	e
53.	52.	San Francisco	8	Mental Health	CA	Concrete shear wall	25,522	0	N03	1933	CIP-PM	D	1.638	0.962	VH	2	24.1	20	5	5	54.1	$4,000,000	e
54.	52.	San Francisco	12	Research	CA	Concrete shear wall	38,910	0	N02	1933	CIP-PM	D	1.638	0.962	VH	2	24.1	20	5	5	54.1	$14,100,000	b
55.	55.	Long Beach	126A	Outpatient Building	CA	Concrete shear wall	51,000	0	N03	1976	D3	D	1.787	0.760	VH	3	27.5	10	5	10	52.5	$3,279,000	
56.	56.	Portland	101	Administration/Research	OR	Steel br & mom frm	129,692	0	N06	1987	PM	D	1.046	0.343	H	2	12.3	20	5	15	52.3	$12,663,000	
57.	57.	Vancouver	11	Barnes Rehab Building (Portion 11A)	WA	Concrete shear wall	133,253	60	N04	1992	D6	BSC	1.026	0.342	H	?	12.0	10	15	15	52.0	$9,994,725	a Added to EHR as exception, significant incr. in code-designated base shear, since const.
58.	58.	Seattle	100CC	Central Core	WA	Steel br & mom frm	201,671		N01	1985	None		1.513	0.524	VH	?	21.4	10	5	15	51.4	$15,125,325	a
59.	58.	Seattle	100EP	Energy Plant	WA	Steel br & mom frm	21,648		N01	1985	D6	P	1.513	0.524	VH	2	21.4	20	5	5	51.4	$883,763	
60.	60.	White City	209	Phys Medicine & Rehab, Group Clinics, & Recreation	OR	Unreinforced masonry	19,277		N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	5	5	50.7	$4,426,039	Added to EHR list per VA email dated 5/17/06
61.	60.	White City	223	Occup & Compensated Work Therapy, Arts&Crafts	OR	Unreinforced masonry	19,356	0	N02	1942	D3*	D	0.628	0.305	H	1	5.7	35	5	5	50.7	$4,444,588	
62.	60.	White City	238	Nutrition & Food Svc	OR	Unreinforced masonry	20,000	0	N01	1942	D1	P	0.628	0.305	H	1	5.7	35	5	5	50.7	$3,513,000	

Table 1.5: Exceptionally High Risk Ranked List

Building Data													Ranking Score								Cost	
Number	Ranking	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group [1]	Study Type [2]	S1 Spectral Ordinate [3]	S1 Spectral Ordinate [3]	Seismicity	Deficiency Category Rank [4]	Seismicity Score [5]	Category Rank Score [6]	Bed/Nonbed Score [7]	Size Score [8]	Total Score	Total Current Construction Cost [9]	Remarks
63.	63.	Sepulveda	4	Clinical Care	CA	Reinf. mas. brg. wall	79,312		N03	1954	V2	C	1.702	0.731	VH	?	25.5	10	5	10	50.5	$5,948,400 a	Vacant, to be leased.
64.	63.	Sepulveda	5	Clinical Care	CA	Reinf. mas. brg. wall	57,294		N03	1954	V2	C	1.702	0.731	VH	?	25.5	10	5	10	50.5	$4,297,050 a	
65.	65.	West LA	117	Research Lab	CA	Concrete shear wall	20,873	0	N01	1930	V2	C	1.899	0.641	VH	3	30.1	10	5	5	50.1	$230,000	Minor project underway
66.	65.	West LA	206	Brentwood Hospital	CA	Concrete shear wall	47,015	0	N03	1940	D3*	D	1.899	0.641	VH	3	30.1	10	5	5	50.1	$5,570,939	
67.	65.	West LA	222	Main Out Pharmacy	CA	Concrete shear wall	26,565	0	N03	1938	D5	D	1.899	0.641	VH	3	30.1	10	5	5	50.1	$1,553,175	
68.	65.	West LA	256	Brentwood Hospital	CA	Concrete shear wall	47,575	0	N02	1946	D1	P	1.899	0.641	VH	3	30.1	10	5	5	50.1	$2,465,000	
69.	69.	Long Beach	138	Research Services	CA	Conc. shear wall	61,658	0	N02	1965	D5	D	1.787	0.760	VH	4	27.5	5	5	10	47.5	$1,013,360	
70.	70.	American Lake	3	Dietetics	WA	Conc.frm.w/ infill	22,573	0	N02	1923	D3*	D	1.217	0.392	H	2	15.4	20	5	5	45.4	$2,900,000	
71.	71.	San Francisco	13	Engineering/Research	CA	Concrete shear wall	12,906		N01	1933	V2	C	1.638	0.962	VH	3	24.1	10	5	5	44.1	$814,000	
72.	72.	Martinez/NCSC	5/R-1	Laboratory/Research	CA	Steel light frame	13,142	0	N01	1980	D6	P	1.592	0.600	VH	3	23.1	10	5	5	43.1	$1,074,849	Const. to commence August 2005
73.	73.	Seattle	13	Medical Research	WA	Reinf. mas. brg. wall	19,428	0	N02	1968	D3	D	1.513	0.524	VH	3	21.4	10	5	5	41.4	$1,118,000	
74.	73.	Seattle	16	Clinic/Administration Building	WA	Wood, light frame	21,030	0	N02	1976			1.513	0.524	VH	?	21.4	10	5	5	41.4	$1,577,250 a	
75.	75.	Menlo Park	329	Kitchen and Dining	CA	Concrete shear wall	21,300	0	N01	1969	V2	C	1.500	0.824	VH	3	21.1	10	5	5	41.1	$3,305,000 c	Funded, re-working the design to separate from renovation solicitation. Expect award in 2nd qr. of FY04.
76.	76.	Portland	T51	Radiation Lodges/Day Care	OR	Steel light frame	25,030	5	N02	1982	D4	D	1.046	0.343	H	3	12.3	10	10	5	37.3	$765,110	Added to EHR as exception: is now essential, not designed as Med Facility
77.	77.	White City	208	Domiciliary Bed	OR	Unreinforced masonry	16,586	47	N02	1942	D3	D	0.628	0.305	H	3	5.7	10	10	5	30.7	$4,079,000	
BUILDINGS NOT RANKED: PROJECT UNDERWAY (OR OTHER AS NOTED)																							
78.	**	American Lake	6	Domiciliary	WA	Conc.frm.w/ infill	19,990	0	N02	1923	D3	D	1.217	0.392	H	2	15.4	20	5	5	N/A	$2,900,000 c	Awarded for construction (FY 2003). Expected completion in 1 yr.
79.	**	American Lake	61	Mental Health	WA	Conc.frm.w/ infill	51,000	0	N03	1932	PM	D	1.217	0.392	H	2	15.4	20	5	10	N/A	$3,324,000 c	Awarded for construction (FY 2003). Expected completion in 1 yr.
80.	**	American Lake	85	Mental Hlth/GRECC	WA	Conc.frm.w/ infill	34,063	0	N03	1943	D2	D	1.217	0.392	H	2	15.4	20	5	5	N/A	$5,116,000 c	1st & 2nd flr. sels. strengthened. 3rd. Flr. & roof to be awarded for strengthening in Jan. 2004, and completed in Dec. 2004.
81.	**	Fort Harrison	2	Dormitory	MT	Unreinforced masonry	20,312	0	N02	1895	D3	D	0.937	0.235	H	1	10.4	35	5	5	N/A	$1,219,000 c	No longer patient domiciliary - primary use is night stay for patient relatives
82.	**	Fort Harrison	154A	Outpatient	MT	Conc.frm.w/ infill	24,550	0	N02	1976	PM	D	0.937	0.235	H	3	10.4	10	5	5	N/A	$281,400 c	Strengthening complete per VA email dated 5/17/06
83.	**	Menlo Park	137	Psychiatric	CA	Concrete shear wall	72,100	0	N03	1940	PM	D	1.500	0.823	VH	2	21.1	20	5	10	N/A	$2,853,000	Demolished as noted in VA email dated 5/17/06.
84.	**	Portland	6	Research	OR	Conc.frm.w/ infill	22,028	0	N02	1928	PM	D	1.046	0.343	H	2	12.3	20	5	5	N/A	$1,823,000 c	Design is complete. Construction is planned for FY2006.
85.	**	Portland	16	Admin/Research	OR	Conc.frm.w/ infill	24,089	0	N02	1928	PM	D	1.046	0.343	H	2	12.3	20	5	5	N/A	$1,985,000 c	Construction is complete.

Table 1.5: Exceptionally High Risk Ranked List

Building Data												Ranking Score										Cost	
Number	Ranking	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft.)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group [1]	Study Type [2]	S_s Spectral Ordinate [3]	S_1 Spectral Ordinate [3]	Seismicity	Deficiency Category Rank [4]	Seismicity Score [5]	Category Rank Score [6]	Bed/Nonbed Score [7]	Size Score [8]	Total Score	Total Current Construction Cost [9]	Remarks
[a]	Building has been removed from its original ranking because of ongoing activity at the station level and/or reasons stated.																						

[1] Study Group: D1, D2, D3, D4, D5, D6 - Degenkolb Phase 1, 2, 3, 4, 5, or 6, respectively; D1*, D2*, D3*, D4*, D5*, D6* - Similar to Degenkolb Phase 1, 2, 3, 4, 5, or 6, respectively; F - FEMA Case Studies; PM - VACO Project Management; CIP - Capital Investment Proposal; V2 - Evaluation during VA phase 2 in the mid-1970's and 1980's; None - Building has not been evaluated.

[2] Study Type: BSC - Base Shear Comparison (Degenkolb study); P- Preliminary (Degenkolb study); D - Detailed (Degenkolb study); BSC - Base Shear Comparison; (Degenkolb Study); C - Conceptual

[3] Based on Spectral Acceleration values with soil type B using the 1997 NEHRP Provisions maps.

[4] Deficiency Category Rank: 1 - Building is in danger of collapsing; 2 - Building may not collapse, but will be heavily damaged; 3 - Building will be damaged; 4 - Building is structurally compliant but may have non-structural deficiencies.

[5] Seismicity Score: Range between 35 (highest) and 4 (lowest) based on a non-linear ranking of relative seismic hazards; $11.5*S_s^{1.5}$.

[6] Category Rank Score: 1 - 35 points; 2 - 20 points; 3 - 10 points; 4 - 5 points. Not yet studied - 10 points.

[7] Bed/Nonbed Score: >150 beds, 25 points; 100 - 150 beds, 20 points; 50 - 100 beds, 15 points; <50 beds, 10 points; 0 beds or unknown, 5 points; Boiler Plant, 10 points.

[8] Size Score: 300,000+ square feet, 20 points; 100,000 - 300,000 square feet, 15 points; 50,000 - 100,000 square feet, 10 points; 0 - 50,000 square feet, 5 points.

[9] Current Construction Cost represents a general contractor's bid as of May 1, 2005. It **DOES NOT** include: Escalation to the construction contract award, pre-design allowance, technical services, construction contingencies, market condition allowance, or construction management fees. Also not included are alteration/renovation costs. Impact costs are included for D3, D4, D5, and D6 buildings only.

[a] This building has not yet had a detailed study. The cost is based on an assigned value of $75 per square foot, but further study should be performed in order to improve the cost estimate and to determine the deficiency category.

[b] Building has a project approved in the Capital Investment Proposal (CIP). Total construction cost is the total requested on the application and may include work other than that associated with a seismic upgrade alone. These costs do not reflect escalation beyond the date of application.

[c] Costs have not been escalated beyond award date.

[d] Costs modified per 2/23/04 est. per VACO and have not been escalated.

[e] Costs modified per 3/19/04 est. per VACO and have not been escalated.

[f] Costs modified during 2005 construction, and have not been escalated.

[g] Building has been demolished.

The number of buildings on this list should not be considered as unchanging or final. As further evaluations are completed, buildings may be removed if they are found to be at a lower risk; others may be added through acquisition of new buildings, occupancy changes, etc. The 85 buildings currently listed are those that are considered to be Exceptionally High Risk as of May 1, 2006.

Table 1.6: High Risk Ranked List

Building Data																Ranking Score										Cost	
Number	Ranking	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft.)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group [1]	Study Type [2]	S1 Spectral Ordinate [3]	S1 Spectral Ordinate [3]	Seismicity	Deficiency Category Rank [4]	Seismicity Score [5]	Category Rank Score [6]	Bed/Nonbed Score [7]	Size Score [8]	Total Score	Total Current Construction Cost [9]	Remarks
RANKED BUILDINGS																											
1.	1.	06	637	Asheville	47	Main Hospital	NC	Conc. frm. w/ infill	478,435	157	N06	1967	D2	D	0.438	0.139	MH	2	4.0	20	25	20	69.0	$29,903,000	
2.	1.	03	630A4	Brooklyn	1	Main Hospital	NY	Steel moment frame	640,889	195	N18	1950	D4	P	0.418	0.093	MH	2	4.0	20	25	20	69.0	$41,476,700	
3.	3.	15	657	St. Louis (JC)	1	Main Hospital	MO	Steel frm. w/-infill	557,779	128	N11	1953	D1	D	0.600	0.199	MH	2	5.3	20	20	20	65.3	$81,717,000	
4.	4.	20	663A4	American Lake	20	Fire Station/Transportation	WA	Conc. frm. w/ infill	5,355		N01	1924	V2	C	1.217	0.392	H	1	15.4	35	5	5	60.4	$925,000	
5.	5.	21	640	Palo Alto	40	Boiler House	CA	Concrete shear wall	6,200		N01	1960	PM	D	2.114	1.079	VH	3	35.0	10	10	5	60.0	$271,000	
6.	6.	21	662	San Francisco	9	Mental Health Clinics	CA	Concrete shear wall	7,321	15	N02	1923	D5	D	1.638	0.962	VH	2	24.1	20	10	5	59.1	$1,185,760	
7.	7.	03	561	East Orange	1	Main Hospital	NJ	Steel moment frame	775,050	219	N12	1959	None		0.423	0.094	MH	?	4.0	10	25	20	59.0	$58,128,750	Note 10
8.	7.	09	628	Nashville	1	Medical Center	TN	Conc. moment frame	623,000	177	N04	1960	D2	D	0.318	0.143	MH	3	4.0	10	25	20	59.0	$11,073,000	
9.	7.	03	630	New York	1	Main Medical Center	NY	Steel moment frame	788,410	170	N22	1954	D2	D	0.424	0.094	MH	3	4.0	10	25	20	59.0	$8,038,000	
10.	7.	03	632	Northport	200	Hospital/Amb. Care Pavilion	NY	Conc. frm. w/ infill	461,942	185	N05	1972	None		0.354	0.087	MH	?	4.0	10	25	20	59.0	$34,645,850	Note 10
11.	11.	22	691	West Los Angeles	337	Research Animal House	CA	Concrete shear wall	6,772			1962	D5	D	1.845	0.633	VH	2	28.8	20	5	5	58.8	$885,008	
12.	12.	21	662	San Francisco	3	Engineering	CA	Unreinforced masonry	9,125		N01	1933	D5	D	1.638	0.962	VH	2	24.1	20	5	5	54.1	$898,735	
13.	12.	21	662	San Francisco	5	Prosthetics/Research	CA	Concrete shear wall	5,605		N02	1933	D5*	P*	1.638	0.962	VH	2	24.1	20	5	5	54.1	$907,951	
14.	12.	21	662	San Francisco	7	Canteen/Auditorium/Chapel	CA	Concrete shear wall	36,128		N03	1933	V2		1.638	0.962	VH	2	24.1	20	5	5	54.1	$2,431,000	
15.	12.	21	662	San Francisco	10	Quarters	CA	Concrete shear wall	7,321		N02	1933	D5*	P*	1.638	0.962	VH	2	24.1	20	5	5	54.1	$1,185,760	
16.	12.	21	662	San Francisco	11	Quarters	CA	Concrete shear wall	4,562		N02	1933	D5*	P*	1.638	0.962	VH	2	24.1	20	5	5	54.1	$738,997	
17.	12.	21	662	San Francisco	18	Research/Admin.	CA	Wood, comm. & industria	9,600		N02	1934	V2	C	1.638	0.962	VH	2	24.1	20	5	5	54.1	$2,415,000	
18.	18.	19	575	Grand Junction	20	Nursing Home	CO	Steel moment frame	18,320	30	N01	1975	D5	D	0.375	0.094	MH	1	4.0	35	10	5	54.0	$1,348,331	
19.	18.	20	687	Walla Walla	68	NHCU/Admin.	WA	Unreinforced masonry	39,696	4	N03	1906	D5*	D*	0.462	0.137	MH	1	4.0	35	10	5	54.0	$9,006,986	
20.	18.	20	687	Walla Walla	69	Mental Health	WA	Unreinforced masonry	48,195	31	N03	1906	D5	D	0.462	0.137	MH	1	4.0	35	10	5	54.0	$10,880,036	
21.	21.	22	691	West Los Angeles	295	Steam Plant	CA	Concrete shear wall	5,720		N01	1947	V2	C	1.845	0.633	VH	3	28.9	10	10	5	53.8	$157,000	
22.	22.	20	663	Seattle	11	Animal Research	WA	Reinf. mas. brg. wall	6,800		N02	1961	D5	D	1.513	0.524	VH	2	21.4	20	5	5	51.4	$972,471	
23.	23.	19	575	Grand Junction	1	Main Hospital	CO	Concrete shear wall	171,220	23	N06	1948	D1	P	0.378	0.084	MH	2	4.0	20	10	15	49.0	$5,826,000	
24.	23.	01	608	Manchester	1	Main Hospital	NH	Concrete shear wall	163,124	42	N06	1949	D6	D	0.403	0.103	MH	2	4.0	20	10	15	49.0	$30,503,763	
25.	25.	16	598A0	North Little Rock	102	IRMS	AR	Unreinforced masonry	20,830		N02	1923	D6	D	0.499	0.183	MH	1	4.1	35	5	5	49.1	$3,216,623	
26.	26.	20	653	Roseburg	7	Boiler Plant	OR	Steel frm. w/-infill	3,600		N01	1933	D2	D	1.131	0.511	VH	2	13.8	20	10	5	48.8	$332,000	
27.	27.	22	691	West Los Angeles	236	Police HQ	CA	Concrete shear wall	7,018		N01	1945	D5	D	1.945	0.633	VH	3	28.8	10	5	5	48.8	$310,800	
28.	27.	22	691	West Los Angeles	259	Com Work Therapy	CA	Reinf. mas. brg. wall	9,400		N01	1945	D4	D	1.945	0.633	VH	3	28.8	10	5	5	48.8	$761,650	
29.	27.	22	691	West Los Angeles	298	Residential Treatment Center	CA	Wood, light frame	4,187			1935	V2	C	1.945	0.633	VH	3	28.8	10	5	5	48.8	$367,000	
30.	30.	19	660	Salt Lake City	37	Research	UT		2,375		N01	1985	None		1.769	0.798	VH	?	27.1	10	5	5	47.1	$178,125	Note 10
31.	31.	21	640A0	Menlo Park	114	Boiler House	CA	Concrete shear wall	6,200		N01	1929	V1	C	1.500	0.823	VH	?	21.1	10	10	5	46.1	$465,000	Note 10

Table 1.6: High Risk Ranked List

Building Data															Ranking Score										Cost	
Number	Ranking	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft.)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group [1]	Study Type [2]	S$_1$ Spectral Ordinate [3]	S$_s$ Spectral Ordinate [3]	Seismicity [3]	Deficiency Category Rank [4]	Seismicity Score [5]	Category Rank Score [6]	Bed/Nonbed Score [7]	Size Score [8]	Total Score	Total Current Construction Cost [9]	Remarks
32.	32.	22	691A4	Sepulveda	47	Animal Research	CA	Reinf. mas. brg. wall	2,797		N01	1954	None		1.702	0.731	VH	?	25.5	10	5	5	45.5	$209,775	Note 10
33.	32.	22.	691A4	Sepulveda	103 (was 109)	Animal Research Facility	CA	Reinf. mas. brg. wall	4,104		N01	1986	D5	P	1.702	0.731	VH	3	25.5	10	5	5	45.5	$141,795	Note 11
34.	34.	15	657A5	Marion	8	Mental Health	IL	Conc. frm. w/ infill	8,892		N02	1941	D2	P	1.194	0.334	H	2	15.0	20	5	5	45.0	$997,000	
35.	35.	21	662	San Francisco	21	Animal Facility	CA	Unreinforced masonry	1,900		N01	1933	None		1.638	0.962	VH	?	24.1	10	5	5	44.1	$142,500	Note 10
36.	36.	03	620	Montrose	6	Nursing Home Care Unit	NY	Conc. frm. w/ infill	43,954	68	N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	15	5	44.0	$4,570,005	
37.	36.	03	620	Montrose	14	Psychiatry	NY	Conc. frm. w/ infill	47,283	70	N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	15	5	44.0	$5,018,653	
38.	36.	03	630A5	St. Albans	85	Nursing Home Care (C wing)	NY	Steel frm. w/-infill	41,564	95	N03	1948	D6*	D*	0.408	0.092	MH	2	4.0	20	15	5	44.0	$7,584,347	
39.	36.	03	630A5	St. Albans	89	Nursing Home Care/Dorm. (A)	NY	Steel frm. w/-infill	132,243	60	N03	1948	None		0.408	0.092	MH	?	4.0	10	15	15	44.0	$9,518,225	Note 10
40.	40.	20	653	Roseburg	17	Mental Health Building	OR	Unreinforced masonry	6,480		N01	1933	D2	D	1.131	0.511	VH	2	13.8	20	5	5	43.8	$1,283,000	
41.	41.	21	612	Martinez/NCSC	R-4	Research	CA		7,920		N01	1991	None		1.592	0.800	VH	?	23.1	10	5	5	43.1	$594,000	Note 10
42.	42.	20	663	Seattle	31	Magnetic Resonance Imaging	WA	Pwd shr wall/Stl br frm	2,952	0	N01	1992	D6	D	1.513	0.524	VH	3	21.4	10	5	5	41.4	$544,000	
43.	43.	07	544	Columbia	1	USC Med School	SC	Conc. frm. w/ infill	96,096	0	N05	1932	D5	D	0.622	0.201	MH	2	5.6	20	5	10	40.6	$12,036,263	
44.	44.	18	501	Albuquerque	1	Psychiatry/Psychology	NM	Conc. frm. w/ infill	71,222		N04	1932	D1	P	0.619	0.184	MH	2	5.6	20	5	10	40.6	$9,862,000	
45.	45.	15	657A5	Marion	14	Boiler Plant	IL	Concrete shear wall	5,110		N01	1941	D2	P	1.194	0.334	H	3	15.0	10	10	5	40.0	$800,000	
46.	46.	03	630A4	Brooklyn	4A	AC Plant	NY	Steel braced frame	4,750		N01	1960	D5	D	0.418	0.093	MH	2	4.0	20	10	5	39.0	$1,283,068	
47.	46.	03	561	East Orange	8	Boiler Plant	NJ	Concrete shear wall	10,320		N01	1950	D4	D	0.423	0.094	MH	2	4.0	20	10	5	39.0	$2,210,170	
48.	46.	19	575	Grand Junction	9	Boiler Plant	CO	Concrete shear wall	2,913		N01	1949	D2	P	0.378	0.084	MH	2	4.0	20	10	5	39.0	$94,000	
49.	46.	03	561A4	Lyons	1	Lab/Rad., Clinics, Administration	NJ	Conc. frm. w/ infill	79,579		N04	1930	D2	P	0.407	0.093	MH	2	4.0	20	5	10	39.0	$9,559,000	
50.	46.	03	561A4	Lyons	7	Geriatrics, GEM	NJ	Conc. frm. w/ infill	49,500	35	N02	1930	D2	P	0.407	0.093	MH	2	4.0	20	10	5	39.0	$3,843,000	
51.	46.	03	561A4	Lyons	9	Long Term Care, EMS	NJ	Conc. frm. w/ infill	43,426	20	N02	1930	D2*	P*	0.407	0.093	MH	2	4.0	20	10	5	39.0	$3,728,924	
52.	46.	03	561A4	Lyons	53	Psychiatric	NJ	Conc. frm. w/ infill	91,303	60	N03	1940	None		0.407	0.093	MH	?	4.0	10	15	10	39.0	$6,847,725	Note 10
53.	46.	03	561A4	Lyons	57	Domiciliary	NJ	Conc. frm. w/ infill	60,500	85	N02	1946	None		0.407	0.093	MH	?	4.0	10	15	10	39.0	$4,537,500	Note 10
54.	46.	03	620	Montrose	13	Domiciliary	NY	Conc. frm. w/ infill	48,084	21	N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	10	5	39.0	$5,103,257	
55.	46.	03	620	Montrose	15	Psychiatry	NY	Conc. frm. w/ infill	45,627	37	N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	10	5	39.0	$4,842,954	
56.	46.	03	620	Montrose	20	Boiler Plant	NY	Unreinforced masonry	7,133		N01	1950	D4	D	0.397	0.093	MH	2	4.0	20	10	5	39.0	$1,900,480	
57.	46.	03	630	New York	5	Electrical Distribution Plant	NY	Conc. moment frame	10,000		N02	1969	D6	D	0.424	0.094	MH	2	4.0	20	10	5	39.0	$3,035,224	
58.	58.	16	598A0	North Little Rock	69	Boiler Plant	AR	Unreinforced masonry	4,675		N01	1936	D2	P	0.499	0.183	MH	2	4.1	20	10	5	39.1	$397,000	
59.	59.	03	630A5	St. Albans	86	Nursing Home Care (D wing)	NY	Steel frm. w/-infill	39,099	21	N03	1948	D6*	D*	0.408	0.092	MH	2	4.0	20	10	5	39.0	$7,134,549	
60.	59.	03	630A5	St. Albans	87	Nursing Home Care (B wing)	NY	Steel frm. w/-infill	35,812	40	N03	1948	D6	D	0.408	0.092	MH	2	4.0	20	10	5	39.0	$6,717,231	
61.	61.	07	534	Charleston	5MYR	Myrtle Beach Clinic	SC		4,700	0	N01	1965	None		1.388	0.399	VH	?	18.8	10	5	5	38.8	$352,500	Note 10
62.	62.	20	648A4	Vancouver	3	Boiler Plant	WA	Reinf. mas. brg. wall	5,529		N02	1954	D6	BSC	1.026	0.342	H	?	12.0	10	10	5	37.0	$414,675	Note 10
63.	63.	20	663	Seattle	8	Research	WA	Concrete shear wall	8,892	0	N02	1950	D1	P	1.513	0.524	VH	4	21.4	5	5	5	36.4	$330,000	
64.	64.	07	544	Columbia	9	Research	SC	Conc. frm. w/ infill	32,847	0	N02	1932	D1	P	0.622	0.201	MH	2	5.6	20	5	5	35.6	$2,159,000	
65.	65.	18	501	Albuquerque	10	Research	NM	Conc. frm. w/ infill	23,000		N02	1932	D4	P	0.619	0.184	MH	2	5.6	20	5	5	35.6	$1,869,360	

Table 1.6: High Risk Ranked List

Building Data														Ranking Score								Cost	
Number	Ranking	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft.)	No. of Approved Beds	Number of Stories	Date of Construction	Study Group [1]	Study Type [2]	S_s Spectral Ordinate [3]	S_1 Spectral Ordinate [3]	Seismicity	Deficiency Category Rank [4]	Seismicity Score [5]	Category Rank Score [6]	Bed/Nonbed Score [7]	Size Score [8]	Total Score	Total Current Construction Cost [9]	Remarks
66.	65.	18	501	Albuquerque	12	Research	NM	Unreinforced masonry	2,200		N01	1932	D5	D	0.619	0.184	MH	2	5.6	20	5	5	35.6	$504,180	
67.	67.	03	561	East Orange	7	Research Building	NJ	URM & Steel frm. w/-infill	25,156		N02	1950	D2	P	0.423	0.094	MH	2	4.0	20	5	5	34.0	$2,363,000	
68.	67.	21	570	Fresno	12	Mental Health Clinic	CA	Steel Frm w/ conc shear	4,984		N01	1949	D6*	D*	0.448	0.202	MH	2	4.0	20	5	5	34.0	$461,345	
69.	67.	21	570	Fresno	13	Dual/Diagnostic Clinic	CA	Steel Frm w/ conc shear	3,740		N01	1949	D6	D	0.448	0.202	MH	2	4.0	20	5	5	34.0	$345,501	
70.	67.	03	561A4	Lyons	4	Outpatient Clinics, Acute Care	NJ	Conc. frm. w/ infill	21,664		N02	1930	D2	P	0.407	0.093	MH	2	4.0	20	5	5	34.0	$1,405,000	
71.	67.	03	561A4	Lyons	8	Mental Health, BioMed., EMS	NJ	Conc. frm. w/ infill	42,923		N02	1930	D2*	P*	0.407	0.093	MH	2	4.0	20	5	5	34.0	$2,784,417	
72.	67.	03	620	Montrose	3	Outpatient/Ambulatory Care	NY	Conc. frm. w/ infill	49,500		N03	1950	D2	P	0.397	0.093	MH	2	4.0	20	5	5	34.0	$5,254,000	
73.	67.	03	620	Montrose	4	Psychiatry	NY	Conc. frm. w/ infill	42,950		N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	5	5	34.0	$4,556,358	
74.	67.	03	620	Montrose	7	Administration / Inpatient	NY	Conc. frm. w/ infill	41,638		N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	5	5	34.0	$4,419,263	
75.	67.	03	620	Montrose	8	Lab / Administration	NY	Conc. frm. w/ infill	46,436		N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	5	5	34.0	$4,928,390	
76.	67.	03	620	Montrose	11	Substance Abuse	NY	Conc. frm. w/ infill	31,128		N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	5	5	34.0	$3,304,340	
77.	67.	03	620	Montrose	12	Adm./Inpatient/Outpatient	NY	Conc. frm. w/ infill	43,048		N03	1950	D2*	P*	0.397	0.093	MH	2	4.0	20	5	5	34.0	$4,569,506	
78.	67.	03	620	Montrose	52	Domiciliary	NY	Conc. frm. w/ infill	30,260	53	N03	1960	None		0.397	0.093	MH	?	4.0	10	15	5	34.0	$2,271,750	Note 10
79.	79.	16	598A0	North Little Rock	66	Clinical Support	AR	Conc. frm. w/ infill	45,190		N03	1944	D1	P	0.499	0.183	MH	2	4.1	20	5	5	34.1	$3,844,000	
80.	80.	18	649	Prescott	107	Hospital	AZ	Concrete shear wall	99,027	35	N04	1937	D5	D	0.494	0.133	MH	3	4.0	10	10	10	34.0	$8,184,089	
81.	80.	18	649	Prescott	117	Outpatient Clinic	AZ	Stl MF & Std frm. w/-infill	12,221		N01	1975	D2	P	0.484	0.133	MH	2	4.0	20	5	5	34.0	$576,000	
82.	80.	21	612A4	Sacramento NCHCS	650	Mather Main Hospital Building	CA	Steel frm. w/-infill	132,208		N03	1967	None		0.425	0.197	MH	?	4.0	10	5	15	34.0	$13,000,000	Note 13
83.	80.	21	612A4	Sacramento NCHCS	728	Physical Med and Rehab Serv.	CA	Reinf. masonry brg wall	8,628		N01	1965	PM	D	0.425	0.197	MH	2	4.0	20	5	5	34.0	$1,236,000	Note 12
84.	80.	03	630A5	St. Albans	88	Subsistance Building	NY	Steel frm. w/-infill	79,925	50	N03	1948	None		0.408	0.092	MH	?	4.0	10	10	10	34.0	$5,994,375	Note 10
85.	80.	20	687	Walla Walla	74	Ambulatory Care	WA	Unreinforced masonry	21,500		N02	1922	D2	D	0.462	0.137	MH	2	4.0	20	5	5	34.0	$2,433,000	
86.	86.	07	544	Columbia	8	Boiler Plant/Incinerator	SC	Steel frm. w/-infill	8,110		N01	1932	D2	P	0.622	0.201	MH	3	5.6	10	10	5	30.6	$692,000	
87.	87.	18	501	Albuquerque	3	Psychiatry - RCU	NM	Concrete shear wall	46,253	26	N02	1932	V1	C	0.619	0.184	MH	?	5.6	10	10	5	30.6	$3,468,975	Note 10
88.	87.	18	501	Albuquerque	11	Research - Rehabilitation	NM	Concrete shear wall	17,300	18	N02	1932	V2	C	0.619	0.184	MH	3	5.6	10	10	5	30.6	$7,490,000	
89.	89.	15	657A0	St. Louis (JB)	70	Boiler Plant	MO	Steel frm. w/-infill	15,036		N01	1952	V2	C	0.600	0.189	MH	3	5.3	10	10	5	30.3	$315,000	
90.	89.	15	657A0	St. Louis (JB)	70A	Chiller Plant	MO	Steel frm. w/-infill	2,971		N01	1965	V2	C	0.600	0.189	MH	3	5.3	10	10	5	30.3	$33,000	
91.	80.	15	657	St. Louis (JC)	8A	Chiller Plant	MO	Steel frm. w/-infill	6,388		N01	1962	V1	C	0.600	0.189	MH	?	5.3	10	10	5	30.3	$479,100	Note 10
92.	92.	03	561	East Orange	16	Nursing Home	NJ	Steel moment frame	23,065	30	N01	1969	D2	P	0.423	0.094	MH	3	4.0	10	10	5	29.0	$779,000	
93.	92.	03	561	East Orange	18	Mental Health Building	NJ	Steel frm. w/-infill	13,900	30	N01	1969	None		0.423	0.094	MH	?	4.0	10	10	5	29.0	$1,042,500	Note 10
94.	92.	03	561A4	Lyons	2	PM&RS, Pathology	NJ	Conc. frm. w/-infill	56,015		N01	1929	None		0.407	0.093	MH	?	4.0	10	5	10	29.0	$4,201,125	Note 10
95.	92.	03	561A4	Lyons	14	Boilerhouse	NJ	Steel frm. w/-infill	4,816		N01	1930	None		0.407	0.093	MH	?	4.0	10	10	5	29.0	$361,200	Note 10
96.	92.	03	561A4	Lyons	55	Domiciliary, Psychiatric	NJ	Conc. frm. w/-infill	85,000		N03	1940	None		0.407	0.093	MH	?	4.0	10	5	10	29.0	$6,375,000	Note 10

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Building Data															Ranking Score										Cost	
Number	Ranking	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft.)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group [1]	Study Type [2]	S_s Spectral Ordinate [3]	S_1 Spectral Ordinate [3]	Seismicity	Deficiency Category Rank [4]	Seismicity Score [5]	Category Rank Score [6]	Bed/Nonbed Score [7]	Size Score [8]	Total Score	Total Current Construction Cost [9]	Remarks
97.	92.	01	608	Manchester	7	Boiler Plant/Maintenance	NH	Unreinforced masonry	13,500		N01	1949	V2	C	0.403	0.103	MH	3	4.0	10	10	5	29.0	$2,959,000	
98.	92.	03	620	Montrose	28	Domiciliary	NY	Conc. frm. w/ infill	19,360	42	N03	1950	None		0.397	0.093	MH	?	4.0	10	10	5	29.0	$1,452,000	Note 10
99.	92.	03	620	Montrose	36	Wastewater Treatment	NY	Concrete shear wall	2,840		N01	1950	None		0.397	0.093	MH	?	4.0	10	10	5	29.0	$213,000	Note 10
100.	100.	16	598A0	North Little Rock	39	Patient Dorm	AR	Unreinforced masonry	5,200	7	N01	1907	None		0.499	0.183	MH	?	4.1	10	10	5	29.1	$390,000	Note 10
101.	101.	03	632	Northport	8	Nursing Home Units	NY		48,785	32		1928	None		0.354	0.087	MH	?	4.0	10	10	5	29.0	$3,658,875	Note 10
102.	101.	03	632	Northport	11	Homeless Residence	NY	Conc. frm. w/ infill	50,399		N02	1928	None		0.354	0.087	MH	?	4.0	10	5	10	29.0	$3,779,925	Note 10
103.	101.	03	632	Northport	64	Mental Health	NY	Conc. frm. w/ infill	39,302	30	N03	1937	None		0.354	0.087	MH	?	4.0	10	10	5	29.0	$2,947,650	Note 10
104.	101.	03	632	Northport	65	Mental Hlth.	NY	Conc. frm. w/ infill	35,935	12	N03	1937	None		0.354	0.087	MH	?	4.0	10	10	5	29.0	$2,695,125	Note 10
105.	101.	18	649	Prescott	111	Boiler Plant	AZ	Steel frm. w/-infill	6,082		N01	1955	None		0.494	0.133	MH	?	4.0	10	10	5	29.0	$456,150	Note 10
106.	101.	03	630A5	St. Albans	64	Boiler Plant	NY	Steel frm. w/-infill	28,706		N01	1948	None		0.408	0.092	MH	?	4.0	10	10	5	29.0	$2,152,950	Note 10
107.	107.	07	544	Columbia	2	USC Med School	SC		18,480	0	N03	1932	V1	C	0.622	0.201	MH	?	5.6	10	5	5	25.6	$1,386,000	Note 10
108.	107.	07	544	Columbia	4	USC Med School	SC		30,832	0	N03	1932	V1	C	0.622	0.201	MH	?	5.6	10	5	5	25.6	$2,312,400	Note 10
109.	107.	07	544	Columbia	101	USC Med School	SC		48,000	0	N04	1932	None		0.622	0.201	MH	?	5.6	10	5	5	25.6	$3,600,000	Note 10
110.	107.	07	544	Columbia	28T	USC Research	SC		20,000		N02	1932	None		0.622	0.201	MH	?	5.6	10	5	5	25.6	$1,500,000	Note 10
111.	111.	18	501	Albuquerque	15	Research	NM	Unreinforced masonry	8,700		N01	1932	None		0.619	0.184	MH	?	5.6	10	5	5	25.6	$652,500	Note 10
112.	112.	15	657	St. Louis (JC)	6A	Research	MO	Steel frm. w/-infill	7,722		N03	1969	D2	P	0.600	0.189	MH	3	5.3	10	5	5	25.3	$1,348,000	
113.	113.	20	531	Boise	1	Mental Health	ID	Unreinforced masonry	3,472		N02	1863	V1	C	0.385	0.120	MH	?	4.0	10	5	5	24.0	$260,400	Note 10
114.	113.	20	531	Boise	4	Mental Health	ID	Unreinforced masonry	2,247		N02	1870	V1	C	0.385	0.120	MH	?	4.0	10	5	5	24.0	$168,525	Note 10
115.	113.	20	531	Boise	6	Eye Clinic	ID	Unreinforced masonry	4,166		N01	1863	V1	C	0.385	0.120	MH	?	4.0	10	5	5	24.0	$312,450	Note 10
116.	113.	20	531	Boise	23	Mental Health	ID	Unreinforced masonry	11,469		N01	1905	V1	C	0.385	0.120	MH	?	4.0	10	5	5	24.0	$860,175	Note 10
117.	113.	20	531	Boise	45	Research	ID	Unreinforced masonry	5,595		N01	1909	V1	C	0.385	0.120	MH	?	4.0	10	5	5	24.0	$419,625	Note 10
118.	113.	03	526	Bronx	107	Chapel/Oupat. Mental Health	NY	Steel frm. w/-infill	20,000		N03	1923	None		0.425	0.094	MH	?	4.0	10	5	5	24.0	$1,500,000	Note 10
119.	113.	03	561	East Orange	11	Research Building	NJ	Unreinforced masonry	10,969		N02	1965	None		0.423	0.094	MH	?	4.0	10	5	5	24.0	$822,675	Note 10
120.	113.	03	561	East Orange	15	Multi-Function	NJ	Steel frm. w/-infill	14,500		N01	1969	None		0.423	0.094	MH	?	4.0	10	5	5	24.0	$1,087,500	Note 10
121.	113.	03	561	East Orange	15B	MICA Building	NJ	Steel frm. w/-infill	1,874		N01	1969	None		0.423	0.094	MH	?	4.0	10	5	5	24.0	$140,550	Note 10
122.	113.	21	570	Fresno	24	UCSF Research	CA	Concrete shear wall	30,000		N03	1983	None		0.448	0.202	MH	?	4.0	10	5	5	24.0	$2,250,000	Note 10
123.	113.	03	561A4	Lyons	12	Firehouse	NJ	Unreinforced masonry	4,800		N01	1930	None		0.407	0.093	MH	?	4.0	10	5	5	24.0	$360,000	Note 10
124.	113.	03	620	Montrose	16	Outpatient	NY	Conc. frm. w/ infill	32,221		N03	1950	None		0.397	0.093	MH	?	4.0	10	5	5	24.0	$2,416,575	Note 10

Table 1.6: High Risk Ranked List

Building Data																Ranking Score									Cost	
Number	Ranking	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group [1]	Study Type [2]	a_i Spectral Ordinate [3]	s_i Spectral Ordinate [3]	Seismicity	Deficiency Category Rank [4]	Seismicity Score [5]	Category Rank Score [6]	Bad/Nonbad Score [7]	Size Score [8]	Total Score	Total Current Construction Cost [9]	Remarks
125	113	03	620	Montrose	19	Fire House/Grounds & Transp.	NY	Unreinforced masonry	9,155		N01	1950	None		0.397	0.093	MH	?	4.0	10	5	5	24.0	$695,625	Note 10
126	126	16	598A0	North Little Rock	22	Fire Station	AR	Unreinforced masonry	1,292		N01	1901	None		0.499	0.183	MH	?	4.1	10	5	5	24.1	$96,900	Note 10
127	126	16	598A0	North Little Rock	58	Research/LREERCHS R&D	AR	Conc. frm. w/ infill	43,865		N04	1931	None		0.499	0.183	MH	?	4.1	10	5	5	24.1	$3,291,375	Note 10
128	126	16	598A0	North Little Rock	76	Nutrition & Food	AR	Steel frm. w/-infill	39,430		N01	1942	None		0.499	0.183	MH	?	4.1	10	5	5	24.1	$2,957,250	Note 10
129	126	16	598A0	North Little Rock	89	RMS Psych Mental Hygiene	AR	Steel frm. w/-infill	32,000		N02	1958	D2	P	0.499	0.183	MH	3	4.1	10	5	5	24.1	$2,573,000	
130	126	16	598A0	North Little Rock	176	Animal Storage	AR	Reinf. mas. brg. wall	3,485		N01	1975	None		0.499	0.183	MH	?	4.1	10	5	5	24.1	$261,375	Note 10
131	131	16	598A0	North Little Rock	LRLease1	Day Treatment	AR		3,314		N01	1963	None		0.491	0.181	MH	?	4.0	10	5	5	24.0	$248,550	Note 10
132	131	03	632	Northport	7	Nursing Home Units	NY	Conc. frm. w/ infill	45,346		N02	1928	None		0.354	0.087	MH	?	4.0	10	5	5	24.0	$3,400,950	Note 10
133	131	03	632	Northport	9	Mental Health Units	NY	Conc. frm. w/ infill	46,809		N02	1928	None		0.354	0.087	MH	?	4.0	10	5	5	24.0	$3,510,675	Note 10
134	131	03	632	Northport	61	Research	NY	Conc. frm. w/ infill	33,690		N03	1937	None		0.354	0.087	MH	?	4.0	10	5	5	24.0	$2,526,750	Note 10
135	131	03	632	Northport	62	Research	NY	Conc. frm. w/ infill	36,787		N03	1937	None		0.354	0.087	MH	?	4.0	10	5	5	24.0	$2,759,025	Note 10
136	131	03	632	Northport	63	Mental Hlth. OPT	NY	Conc. frm. w/ infill	44,690		N03	1937	None		0.354	0.087	MH	?	4.0	10	5	5	24.0	$3,351,750	Note 10
137	131	03	632	Northport	203	Boiler Plant	NY	Conc. frm. w/ infill	6,972		N01	1972	None		0.354	0.087	MH	?	4.0	10	5	5	24.0	$522,900	Note 10
138	131	18	649	Prescott	108	Dietetics/PM&RS	AZ	Concrete shear wall	16,782		N02	1939	V1	C	0.494	0.133	MH	?	4.0	10	5	5	24.0	$1,258,650	Note 10
139	131	21	612A4	Sacramento NCHCS	88	McClellan Dental Clinic	CA	Concrete shear wall	8,900		N01	1960	C4	D	0.425	0.197	MH	3	4.0	10	5	5	24.0	$470,860	
140	131	21	612A4	Sacramento NCHCS	722	Research	CA		5,040		N01	1988	None		0.425	0.197	MH	?	4.0	10	5	5	24.0	$378,000	Note 10
141	131	03	630A5	St. Albans	90	Radiation Therapy	NY	Steel frm. w/-infill	5,822		N01	1948	None		0.408	0.092	MH	?	4.0	10	5	5	24.0	$436,650	Note 10
142	131	03	630A5	St. Albans	165	NYS Drug Treatment/J-CAP	NY		24,454		N01	1960	None		0.408	0.092	MH	?	4.0	10	5	5	24.0	$1,834,050	Note 10
143	131	03	630A5	St. Albans	166	NYS Drug Treatment/J-CAP	NY		8,638		N01	1960	None		0.408	0.092	MH	?	4.0	10	5	5	24.0	$662,850	Note 10
144	131	21	612A4	Sacramento NCHCS	2860	Mental Health	CA		5,361		N01	1953	None		0.425	0.197	MH	?	4.0	10	5	5	24.0	$402,075	Note 10
145	131	20	687	Walla Walla	7	Police	WA	Unreinforced masonry	6,780		N01	1930	V2	C	0.462	0.137	MH	3	4.0	10	5	5	24.0	$203,000	

Table 1.6: High Risk Ranked List

Building Data														Ranking Score									Cost	
Number	Ranking	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Building Type - Description	Area (sqft.)	No. of Approved Beds	Number of Stories Code	Date of Construction	Study Group[1]	Study Type[2]	S, Spectral Ordinate[3]	S, Spectral Ordinate[3]	Seismicity	Deficiency Category Rank[4]	Seismicity Score[5]	Category Rank Score[6]	Bed/Nonbed Score[7]	Size Score[8]	Total Score	Total Current Construction Cost[9]	Remarks
BUILDINGS NOT RANKED: VACANT OR CLOSED																								
146.	*	07	544	Columbia	3	USC Med School	SC		65,150	0	N04	1932	None		0.622	0.201	MH	7	5.6	10	5	10	N/A	$4,886,250	Vacant / Note 10
147.	*	03	620	Montrose	10	NHCU	NY	Conc. frm. w/ infill	54,750		N03	1950	D2	P	0.397	0.093	MH	2	4.0	20	5	10	N/A	$4,498,000	Closed
148.	*	03	630A5	St. Albans	91	Nursing Home Care (E wing)	NY	Steel frm. w/-infill	38,806		N03	1948	D5*	D*	0.408	0.092	MH	2	4.0	20	5	5	N/A	$7,081,449	Vacant
149.	*	03	630A5	St. Albans	92	Nursing Home Care (F wing)	NY	Steel frm. w/-infill	41,564		N03	1948	D5*	D*	0.408	0.092	MH	2	4.0	20	5	5	N/A	$7,584,347	Vacant
150.	*	03	630A5	St. Albans	93	Nursing Home Care (F wing)	NY	Steel frm. w/-infill	39,094		N03	1948	D5*	D*	0.408	0.092	MH	2	4.0	20	5	5	N/A	$7,133,637	Vacant

Notes:

1 Study Group: D1, D2, D3, D4, D5, D6 - Degenkolb Phase 1, 2, 3, 4, 5, or 6, respectively; D1*, D2*, D3*, D4*, D5*, D6* - Similar to Degenkolb Phase 1, 2, 3, 4, 5, or 6, respectively; F - FEMA Case Studies; PM - VACO Project Management; CIP - Capital Investment Proposal; V1, V2 - Evaluation during VA phase 1, 2 in the mid-1970's and 1980's; None - Building has not been evaluated

2 Study Type: BSC - Base Shear Comparison (Degenkolb study); P - Preliminary (Degenkolb study); D - Detailed (Degenkolb study) BSC - Base Shear Comparison (Degenkolb Study); C - Conceptual (VA Phase 1 or 2).

3 Based on Spectral Acceleration values with soil type B using the 1997 NEHRP Provisions maps.

4 Deficiency Category Rank: 1 - Building is in danger of collapsing; 2 - Building may not collapse, but will be heavily damaged; 3 - Building will be damaged; 4 - Building is structurally compliant but may have non-structural deficiencies.

5 Seismicity Score: Range between 35 (highest) and 4 (lowest) based on a non-linear ranking of relative seismic hazards; $11.5*Ss^{1.5}$

6 Category Rank Score: 1 - 35 points; 2 - 20 points; 3 - 10 points; 4 - 5 points; Not yet studied - 10 points; Conceptual study - 10 points min.

7 Bed/Nonbed Score: >150 beds, 25 points; 100 - 150 beds, 15 points; <50 beds, 10 points; 0 beds or unknown, 5 points; Boiler Plant, 10 points.

8 Size Score: 300,000+ square feet, 20 points; 100,000 - 300,000 square feet, 15 points; 50,000 - 100,000 square feet, 10 points; 0 - 50,000 square feet, 5 points.

9 Current Construction Cost represents a general contractor's bid as of May 31, 2005. It DOES NOT include: Escalation to the construction contract award, pre-design allowance, technical services, construction contingencies, market condition allowance, or construction management fees. Also not included are alteration/renovation costs. Impact costs are included for D3, D4, D5, and D6 buildings only.

10 This building has not yet had a detailed study. The cost is based on an assigned value of $75 per square foot, but further study should be performed in order to improve the cost estimate and to determine the deficiency category.

11 Sepulveda 109 building number was updated to 103 during the course of Phase 5.

12 Sacramento 726 had a PM study done in September 2001, but the cost estimate was reevaluated in 2005 during Phase 6. Costs are reflective of this most recent estimate.

13 Facility acquired by the VA in March 2005. Seismic retrofit cost estimate obtained directly from the facility.

The number of buildings on this list should not be considered as unchanging or final. As further evaluations are completed, buildings may be removed if they are found to be at a lower risk; others may be added through acquisition of new buildings, occupancy changes, etc. The 150 buildings currently listed are those that are considered to be High Risk as of May 1, 2006.

2. INVENTORY EVALUATIONS

2.1 Project Overview

Phase 1:
In November of 1997, Degenkolb Engineers was contracted to assist the Department of Veterans Affairs (VA) in developing a seismic inventory of their owned and leased buildings. This inventory was mandated by Executive Order (EO) and was required for all Federal Agencies by the Federal Emergency Management Agency (FEMA). The EO also required that an estimate of costs be prepared to mitigate the unacceptable risks present in the owned buildings. Phase 1 was completed on December 4, 1998 and was fully documented in a four-volume report, *Department of Veterans Affairs Seismic Inventory*.

Phase 2:
After the effort to develop the database was concluded, the VA requested that Degenkolb continue studying additional buildings. For Phase 2, the VA selected a group of 42 buildings for preliminary evaluation. When these evaluations were complete, 8 buildings from the group of 42 were chosen for detailed study. These preliminary and detailed studies were completed on May 31, 2000 and the results were published in a five-volume report, *Department of Veterans Affairs Seismic Inventory Phase II.*

Phase 3:
For Phase 3, the VA chose to concentrate on the Exceptionally High Risk (EHR) buildings. At the end of Phase 3, there were 73 buildings on the EHR list, 40 of which had had detailed or preliminary studies completed. These preliminary and detailed studies were completed on August 30, 2001 and the results were published in a four-volume report, *Department of Veterans Affairs Seismic Inventory Phase 3.*

Phase 4:
During Phase 4, the VA continued to develop cost estimates for a variety of building types. This phase involved both preliminary and detailed studies of essential, critical, and non-essential buildings. These preliminary and detailed studies were completed on March 6, 2003 and the results were published in a four-volume report, *Department of Veterans Affairs Seismic Inventory Phase 4.*

Phase 5:
During Phase 5, the VA continued to develop cost estimates for a variety of building types. This phase involved both preliminary and detailed studies of essential, critical, and non-essential buildings. These preliminary and detailed studies were completed in June 2004 and the results were published in a four-volume report, *Department of Veterans Affairs Seismic Inventory Phase 5.*

Phase 6:
Phase 6, the final phase, rounds out the studies of the VA inventory, and includes seventeen preliminary and detailed studies of Essential, Critical, and non-Essential buildings and nine more base shear comparisons. These results are published in the four-volume report, *Department of Veterans Affairs Seismic Inventory Phase 6.*

2.2 Project Resource Documents

American Society of Civil Engineers (2002). *Seismic Evaluation of Existing Buildings*, ASCE 31-02, American Society of Civil Engineers, Reston, Virginia.

Federal Emergency Management Agency, 1998, *FEMA 310: Handbook for the Seismic Evaluation of Buildings - A Prestandard*, American Society of Civil Engineers, Reston, Virginia.

Federal Emergency Management Agency, 2000, *Prestandard for the Seismic Rehabilitation of Buildings, FEMA 356*, American Society of Civil Engineers, Reston, Virginia.

Department of Veterans Affairs, 2003, *Seismic Design Requirements: H-18-8*, Office of Facilities Management Facilities Quality Office.

2.3 Site Visits

Site visits by the entire team were performed on each of the fourteen detailed evaluations performed during Phase 6 (no detailed architectural or mechanical evaluation at Sacramento 728). Each site visit included a meeting with VA staff on site and a tour of the facility. During this tour, the proposed strengthening scheme was evaluated for feasibility and the nonstructural hazards were assessed based on the ASCE 31 evaluation checklists.

2.4 Definition of Study Types

Preliminary: Preliminary studies include a broad evaluation of the building based on the evaluation procedures of ASCE 31, Tier 1 and Tier 2 only. (ASCE 31 replaces FEMA 310, which was used during Phases 1, 2, and 3.) Building drawings and soils information, when available, are gathered for preliminary building studies. With this information, nonstructural hazards are addressed as completely as possible based on the structural drawings and the known use of the building.

Each building is classified as "Compliant" or "Non-Compliant," and for each non-compliant building a Category 1, 2, or 3 ranking is assigned. A preliminary cost estimate for each non-compliant building is prepared based on the itemized list of deficiencies within the building. A summary report is prepared for each building for review by VACO.

Detailed Phases 1 and 2: Detailed evaluations include site visits by the Structural Engineer to verify that the as-built structure matches the design documents, to review the current condition of the structure, and to document nonstructural hazards. Many evaluations utilize computer models of the buildings to obtain demand/capacity ratios for individual elements. Some detailed studies utilize nonlinear analyses. Each includes a detailed strengthening scheme including figures. The building's category rank is reviewed and changed as required, if a preliminary study had previously been performed on the building.

Each scheme is reviewed with the architectural consultant as needed and a conceptual scheme for phasing and disruption is developed. A review of each building for architectural, mechanical, and electrical modifications due to the structural renovation is performed, and scopes of work are developed. Architectural, mechanical, and electrical modifications are strictly related to the alterations caused by the structural upgrade. All costs are associated with the necessity to remove or relocate equipment or elements and are not related to upgrading the architectural fabric or mechanical equipment.

Detailed cost estimates for each non-compliant building based on the detailed mitigation scheme, architectural, mechanical, and electrical modifications are produced. Note that costs for items other than structural are based on available information, chiefly the ASCE 31 checklists, and are appropriate for long-term planning. A summary report is prepared for each building.

Detailed Phases 3, 4, 5, and 6: The detailed studies completed during Phases 3, 4, 5, and 6 differ from previous detailed studies in that site visits are performed by the entire team (structural, architectural, mechanical, and electrical).

Similar to Phase 1 and 2 studies, each scheme is reviewed by the architectural consultant as needed and a conceptual scheme for phasing and disruption is developed. A review of each building for architectural, mechanical, and electrical modifications due to the structural renovation is augmented by the site visit, and written descriptions of the scopes of work are developed.

Detailed cost estimates are produced for each non-compliant building based on the detailed mitigation scheme, and the architectural, mechanical, and electrical modifications. The architectural, mechanical, and electrical modifications are strictly related to the alterations caused by the structural upgrade. All costs are associated with the necessity to remove or relocate equipment or elements and are not related to upgrading the architectural fabric or mechanical equipment. A summary report is prepared for each building.

Base Shear Comparisons Phases 5 and 6: During Phase 6, the base shear comparisons that were introduced during Phase 5 were continued. Nine buildings were selected during the current phase for base shear comparisons. A given building's base shear as prescribed by the design code used for the original design was compared to the base shear prescribed by current (2003) H-18-8 seismic design requirements. The purpose of these studies was to gauge base shear changes as seismic hazard has changed. Results of these comparisons are included in Volume III.

3. INVENTORY STATISTICS

3.1 Overview

The VA Seismic Inventory contains a wealth of information about the buildings owned by the Department of Veterans Affairs. During Phase 5, the effort was begun to coordinate the VA Seismic Inventory with its Space and Functional database. Changes were made to the VA Seismic Inventory, including: updating building areas and dates of construction for non-exempt buildings where significantly different from the S&F database; adding new buildings not previously appearing in the Seismic database; and updating VA Medical Center information. Phase 6 saw the completion of the database update.

Updated counts of several key parameters are included in Section 3.2 below. Graphs of several inventory key statistics are included in Section 3.4 below for several key groups of buildings.

3.2 Key Parameters

The following summary statistics about the buildings in the updated VA Owned Building Database illustrate the great breadth of information contained in the VA inventory:

- A total of 5,845 buildings for a total of over 142,000,000 square feet of space.
- 5,227 buildings from the Veterans Health Administration (VHA), 610 buildings from the National Cemetery Service (NCS), and 8 buildings from the Veterans Benefit Administration (VBA).
- 1,177 buildings of the entire inventory designated as critical structures, 540 buildings designated as essential structures, 1,635 buildings designated as historic structures, 270 buildings designated as both critical and historic structures, and 161 buildings designated as both essential and historic structures.
- 5,154 buildings have been identified as exempt from the program, and 691 buildings have been identified as non-exempt. Non-exempt buildings include 169 buildings designated as critical structures, 102 essential structures, and 420 non-essential structures.
- A total credit of 218 non-exempt buildings can be considered as evaluated.
- 121 buildings identified as Boiler Plants. (Appendix F)
- 191 buildings identified as Research Facilities. (Appendix G)
- 103 buildings identified as Domiciliaries. (Appendix H)
- 85 buildings, comprising approximately 7,200,000 square feet of space, identified as Exceptionally High Risk (EHR) buildings.
- 150 buildings, comprising over 8,300,000 square feet of space, identified as High Risk (HR) buildings. These represent a second tier of buildings just below the EHR buildings.

- The estimated cost of seismically rehabilitating all EHR buildings is $783 million.
- The estimated cost of seismically rehabilitating all HR buildings is $664 million. (Approximately 44% of this cost is based on a $75 per square foot cost for buildings that have not yet been evaluated and therefore have no formal cost estimate.)
- The overall estimate for rehabilitating the entire inventory is approximately $2.0 billion. The VA should consider demolition and replacement of a given structure when rehabilitation cost per square foot is high. (These costs are as recorded in the main database and include escalation to current dollars. See Section 5.5.)

3.3 Studied Building Count

A total of 36 preliminary studies, 79 detailed studies and 12 base shear comparisons have been completed on non-exempt buildings. In addition 21 exempt buildings have been studied for a total of 148 studied buildings. These buildings have similar characteristics to an additional 69 buildings, which are added to the list of studied buildings. Therefore a total credit of 217 buildings can be considered as evaluated.

The 196 non-exempt buildings that can be considered as evaluated represent approximately 28 percent of the VA's 691 non-exempt building inventory. If the 253 significantly small buildings (those with areas under 5,000 sq. ft.) are removed from the list of buildings that are considered to warrant evaluation, then approximately 45 percent of the remaining 438 buildings will be considered as evaluated.

3.4 Building Classes

3.4.1 Critical/Essential/Non-Essential

Because one of the primary missions of the VA is to provide patient care, a large number of the buildings in the VA inventory are medical facilities. After a major earthquake, many of these facilities must remain in operation or patients could be put in jeopardy.

Figure 3-1 shows the distribution of non-exempt buildings using these three categories: Critical, Essential and Non-Essential. Of the VA's non-exempt buildings, the majority are of non-essential status. Only 39 percent of the non-exempt buildings are identified as critical or essential.

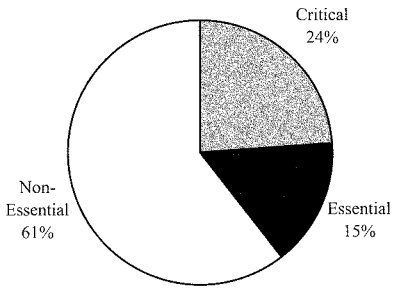

Figure 3-1: Distribution of VA Owned Non-Exempt Buildings by Essential Status

3.4.2 Exceptionally High Risk/High Risk/Critical/Essential

Buildings that are the most critical to the post-earthquake operation of the VA have been identified as Exceptionally High Risk (EHR). These buildings are described in more detail in Section 4.3. Buildings that are just below the EHR level have been designated High Risk (HR) and are described in more detail in Section 4.4.

Thirty-four percent of the total inventory of non-exempt buildings has been categorized as EHR or HR. This percentage is illustrated in Figure 3-2 below along with the remaining essential and critical buildings that are not identified as Exceptionally High Risk or High Risk.

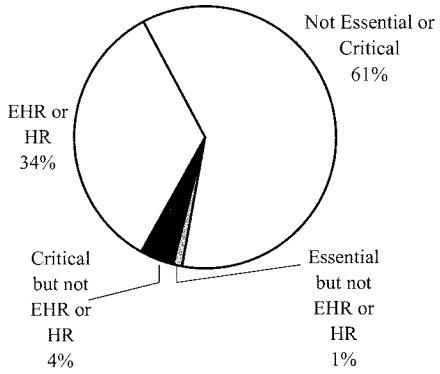

Figure 3-2: Distribution of VA Owned Buildings by EHR and HR

3.4.3 Historic/Non-Historic

The Historic Status of the buildings in the VA inventory was determined by the National Register of Historic Places and the National Park Service for the Department of Veterans Affairs.

Figure 3-3 shows the distribution of identified historic structures within the non-exempt buildings of the VA inventory. Over 40 percent of the VA's structures are considered historic. This has a large impact on the seismic safety of the inventory as a whole. Historic structures are often buildings that were constructed before the implementation of modern seismic codes. They often have historic finishes that need to be saved or duplicated, which can add a significant cost to a seismic mitigation project.

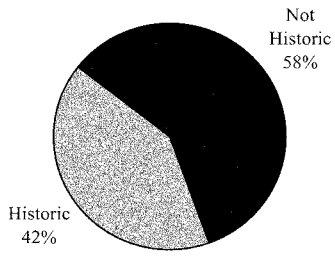

Figure 3-3: Distribution of VA Owned Buildings by Historic Status

3.5 Studied Buildings

The group of studied buildings is not entirely representative of the VA Inventory as a whole. For example, most of the non-exempt buildings that have been studied are hospitals or other critical facilities such as research buildings, as shown in Figure 3-4. Other typical types of VA structures (such as storage buildings) are not as well represented. The majority of the buildings that have been studied are large, essential structures that are critical to the mission of the VA.

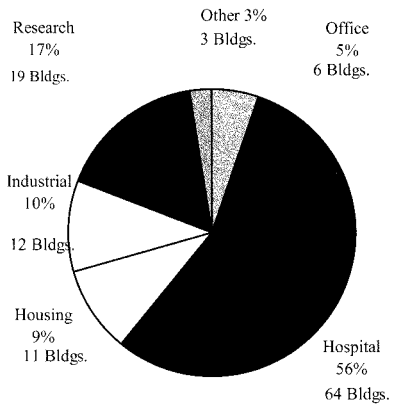

Figure 3-4: Distribution of Studied Buildings by Occupancy

The studied buildings do not equally represent the seismic hazard zones of the entire inventory. For example, Figure 3-5 indicates that most of the buildings that have been studied are in the higher seismic zones. This should be expected since these buildings are at greater risk than buildings in lower hazard zones.

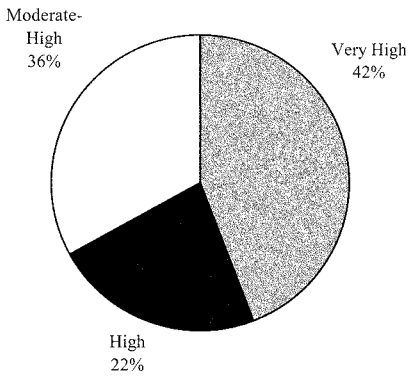

Figure 3-5: Distribution of Studied Buildings by Seismic Hazard Zone

Figure 3-5 should be compared to Figure 3-6 for the distribution of seismic hazard zone in the entire non-exempt inventory. Note, however, that buildings in the "Low" and "Moderate-Low" seismic hazard zone have been exempted from the inventory program.

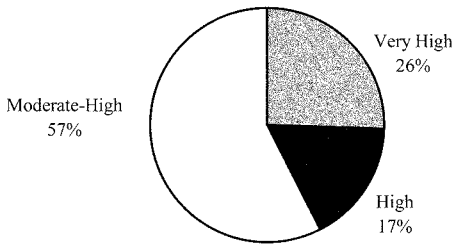

Figure 3-6: Distribution of All Buildings by Seismic Hazard Zone

4. SEISMIC ISSUES

4.1 Overview

A continuing goal of this project has been to provide guidance to the VA for the future of their seismic program. During the course of this project, several issues were raised regarding updating the occupancy categories of VA facilities, further refining the High Risk building list to exclude buildings under a given minimum floor area, and refining the category rank definition. In addition, the method by which occupancy codes have been assigned has been discussed; historically, in buildings with multiple uses the codes were assigned based on the most critical use, regardless of the percentage of floor area assigned to that function. Changing these criteria has been raised as a possibility in upcoming modifications to the database.

4.2 Essential, Non-Essential, & Critical Facilities

While developing VA-specific exemption codes for Phase 1, the issue was raised that using a two-tier classification of essential and non-essential facilities might not be sufficient for classifying all VA buildings. During Phase 3 the existing essential classification was divided into two categories by adding a "critical" designation. This critical rating has been used to classify all buildings that need to perform at the highest functionality immediately after an earthquake. These facilities include: central plant buildings, hospitals, nursing homes, psychiatric care facilities, outpatient clinics, and hazardous material facilities.

The essential classification has been used to classify buildings that can tolerate a short disruption (less than three months) in occupancy due to a limited amount of repairable seismic damage. These facilities may include: rehabilitative medical facilities, domiciles, transitional housing, research buildings, and veterinary medical units.

Non-essential (ancillary) facilities continue to classify buildings that accommodate functions not required for the post-earthquake operation of VA hospitals. These facilities are designed to a Life Safety performance criterion and may experience a significant amount of seismic damage that may result in lengthy work stoppages or the need for demolition. Included in this list are water towers, of which a number are included in VACO's "Space and Function" database and which have recently been incorporated into the current VA database.

As the VA Medical Centers have grown and evolved, there have been changes to occupancy codes necessitated by changes in programming needs at the centers. One example is at the White City Medical Center. Based on requests from the station, occupancy codes have been changed for a number of buildings to better categorize the current use of the buildings. These changes in turn have lead to changes in the "non-essential", "essential", or "critical" status of these buildings.

A detailed list of the occupancy categories is included in Appendix E.

4.3 Exceptionally High Risk Buildings and Ranking

One of the key tasks in the ongoing Seismic Inventory effort is the identification of buildings that pose an Exceptionally High Risk (EHR) to the mission of the VA. Through EO 12941, FEMA required EHR buildings to be identified. While FEMA provided guidance on how to identify these buildings, it did not provide a definition of an Exceptionally High Risk building. Consequently, the VA developed its own general definition of an EHR building to be a main hospital building in a high seismic zone that was constructed before the adoption of H-08-8 (1977). According to the VA's definition, EHR buildings must meet all of the following criteria:

1. Building is located in an area of High or Very High seismicity.
2. Building is an Essential or Critical facility.
3. Building structural design did not utilize VA Seismic Design Requirements and/or the building was constructed before 1977. (See discussion below for exceptions.)
4. Building is not otherwise exempt.
5. Building square footage is greater than 10,000 square feet.

Several exceptions have been added to the EHR list during Phases 4, 5, and 6. The first group includes Research buildings, which were not classified as Essential until 1995. Prior to this change, Research facilities were classified as ancillary buildings and were therefore not designed using H-18. Consequently, Research facilities that were constructed after 1977 but before the Essential classification have been added to the list.

A second group of exceptions includes hospitals in Portland, Seattle, and Vancouver designed after the 1977 benchmark date. The design criteria in the 1980's considered the seismic hazard in both sites to be lower than their present classification. Seismic detailing has changed dramatically since then, and the design that was carried out at the time would not meet the current H-18. Although the buildings in question do not meet the letter of the EHR definition, they meet the intent of the Exceptionally High Risk category and they have been added to the list. These buildings include:

	Medical Center	Building Number	Date of Construction
1.	Portland	100	1988
2.	Portland	T51	1982
3.	Seattle	100	1985
4.	Vancouver	11	1992

It should be noted that the EHR rankings have continually been revised throughout the lifetime of the Inventory effort, based on the findings of the seismic studies. The list should not be considered static, or complete. These changes occur through the errata process of updating individual building information in the database.

EHR buildings represent the greatest hazard of all the buildings in the VA inventory. Currently, a total of 85 buildings in the VA inventory are identified in the database as Exceptionally High Risk. A detailed list of those buildings is included in Table 1.5 in Chapter 1.

To help the VA focus their efforts on the most critical buildings, we developed a methodology to rank the EHR buildings. Again, this ranking system is not one that was prescribed by FEMA, but rather is left to the discretion of the individual agency. The criteria developed for ranking these buildings for the VA include four categories: deficiency category, seismicity, number of approved beds in the building, and building size. Each of the four pieces constituting the score has a different weight.

The original ranking score system has been modified throughout the progress of the inventory effort. The current ranking system is described as follows:

Deficiency Category	**35 points maximum**
Category 1	35 points
Category 2	20 points
Category 3	10 points
Category 4	5 points
Not yet studied	10 points

The deficiency category ranking definition is outlined in detail in Section 4.6 of this report.

Seismicity	**35 points maximum**
11.5 times $S_s^{1.5}$	Max. of 35 points, min. of 4 points

The curve fit for seismicity was used to provide a non-linear ranking of relative seismic hazard. S_s is the spectral acceleration in the short period (0.2 seconds) range for each site according to the USGS maps. By using an exponent of 1.5, the distribution of low to high is about 1:10. Using a power of 2 results in a very high spread of about 1:20. Using a linear fit results in a low spread of about 1:3 that we felt did not give enough weight to the sites in higher seismic zones.

Number of Approved Beds in the Building	**25 points maximum**
> 150 beds	25 points
100 to 150 beds	20 points
50 to 100 beds	15 points
< 50 beds	10 points
0 beds or number unknown	5 points
Boiler plant	10 points

The scoring methodology for bed buildings has been refined during this phase to give heavier weight to buildings with a large number of beds (i.e. over 150). The actual number of qualified beds in those buildings is used.

Size (square feet)	**20 points maximum**
> 300,000	20 points
100,000 to 300,000	15 points
50,000 to 100,000	10 points
< 50,000	5 points

Larger buildings were considered to be more risky than smaller buildings due to the number of occupants likely to be in the building during an earthquake. During Phase 6, this score has been recalibrated to give more weight to exceptionally large buildings (those with over 300,000 square feet of area).

The ranked EHR list presents buildings that received equal scores at the same ranking. For example, two buildings may have been tied for ranking at 12th place. These buildings would both have been ranked 12th, and no buildings would be ranked at 13th. The next ranked building would be listed as 14th.

Finally, it should be noted that the "ranking" of EHR buildings should not be mistaken as an absolute measure of merit to make decisions regarding the seismic rehabilitation of individual buildings. Rather, the list provides some relative scale to judge individual projects. The process is subjective and is based on our experience and judgement and that of the VA.

4.4 High Risk Buildings

A new category of High Risk (HR) buildings was developed during Phase 3. As part of Phase 4 these HR buildings were ranked using the identical scoring procedure for EHR buildings. This second tier category was added to identify buildings that are just below the EHR level and represent another group of VA buildings that should not be ignored. This next tier of buildings just below EHR are those that come close to meeting the EHR definition except in one key area. Thus the definition of HR includes buildings that are similar to EHR buildings but that are located in a slightly lower seismic hazard zone or are slightly smaller in overall area.

High Risk buildings are defined as meeting either one of the following:

1. Buildings that meet the definition of EHR except are located in an area of Moderate-High seismicity,

or

2. Buildings that meet the definition of EHR except are smaller than 10,000 square feet and greater than 1,000 square feet in area

Regarding the second criterion, there remains some debate about whether all essential buildings should be included. There was discussion that only buildings with "critical" occupancies should be included in HR. This issue still needs to be finalized, and is under discussion at VACO. Currently these buildings with both critical and essential occupancies are included in the HR building list.

Also, it should be noted that the other two parameters of EHR, essential status and date of construction, have not changed. It was felt that buildings that were not essential or were constructed after 1977 did not pose nearly as high a risk as the other buildings included in the HR list.

Using these definitions, there are 150 buildings in the VA inventory that are categorized as High Risk. At the present time, no decision has been made on how to approach HR buildings differently than other buildings in the inventory. We continue to recommend that the HR buildings be prioritized and evaluated in a similar approach as the EHR buildings. The complete list of High Risk Buildings is included in Chapter 1 of this report, Table 1.6.

4.5 Seismicity

Volume 1 of the Phase 1 report discusses the change in seismicity from the zone maps (FEMA 178) to the use of ground acceleration (FEMA 310, 2000 IBC). During Phase 5, further modifications to the seismicity list resulted as we updated spectral accelerations as given in the NEHRP maps. The data that was originally used in previous phases was acquired from advance copies of these maps; the most recent versions have changed in some cases. To date, this has resulted in the following changes in seismicity:

	VA Medical Center	NEW Seismicity	OLD Seismicity
1.	Calverton, NY	ML	L
2.	Cold Harbor, VA	L	ML
3.	Danville, IL	L	ML
4.	Dayton, OH	ML	L
5.	Durham, NC	ML	L
6.	Indiantown Gap, PA	L	ML
7.	Mountain Home, TN	H	L
8.	NMCA, AZ	L	ML
9.	Northport, NY	MH	ML
10	Raleigh, NC	ML	L
.			
11	Roseburg, OR	VH	H
.			
12	Seven Pines, VA	L	ML
.			

4.6 Deficiency Category Rank

The category rank definitions are written in terms of expected damage. These definitions will help technical and non-technical staff in determining which of the four categories a building should be labeled.

The damage-based definitions are as follows:

- Category 1: Building is in danger of collapsing in the Design Earthquake.
- Category 2: Building may not collapse, but will be heavily damaged in the Design Earthquake.
- Category 3: Building will be damaged in the Design Earthquake.
- Category 4: Building is structurally compliant (but may have non-structural deficiencies).

The Design Earthquake is defined as being two-thirds as large as the Maximum Considered Earthquake (MCE). The MCE is an earthquake with a 2 percent probability of exceedance in 50 years with deterministic-based maximum values near known fault sources. These definitions are consistent with those recently developed for national standards documents used in the profession.

The new definitions deal primarily with the ability of a building to withstand collapse and not whether the facility can continue to function after a major earthquake. It is our recommendation that buildings that currently do not meet a Life Safety or Collapse Prevention objective be the highest priority within the VA to rehabilitate. Buildings that are already Life Safe should not be rehabilitated to Immediate Occupancy before buildings that are not yet Life Safe are upgraded to this minimum level.

During Phase 4, these deficiency categories were retroactively applied to all the deficient buildings studied during the Phase 1, 2, and 3 efforts.

4.7 Buildings in Moderate-Low Seismicity

Throughout each of the six phases of this project we have evaluated buildings from all levels of seismicity, including moderate-low. Some of the buildings located in an area of moderate-low seismicity were found to be deficient and rehabilitation measures were recommended.

The VA's Structural Advisory Committee has modified H-18 to state that no action should be taken for those buildings in Moderate-Low seismicity; however, those buildings that have been evaluated and found to require rehabilitation are still deficient, and we recommend that they be strengthened.

5. COST ISSUES

5.1 Overview

Throughout the process of developing the VA Seismic Inventory, rehabilitation cost has always been an important issue. It should be emphasized that the main objective of Executive Order 12941 is to develop an overall cost estimate for retrofitting all federally owned seismically deficient buildings. Each federal agency was asked to develop a cost estimate for its inventory of buildings. Although the cost estimate for the entire VA inventory is as accurate as can be expected given the amount of information collected and the level of effort expended, the costs for any individual building in the VA inventory may not be very accurate. The Phase 3, 4, 5, and 6 detailed studies, however, present a fairly accurate estimate of the costs anticipated for rehabilitation. Section 4.3 below presents further details of the methods used in these more recent studies to arrive at the more realistic figures.

It is extremely important not to mistake the costs included in this database for actual project costs. The costs included in this database are associated solely with direct construction for retrofitting the building for seismic safety. These costs do not attempt to include any costs associated with upgrades of mechanical and electrical systems, upgrades to comply with ADA requirements or major interior remodels, hazardous material abatement, or any other related items, nor to improve functional changes or efficiency.

5.2 Use of Cost Estimates for Actual Projects

As noted above, it cannot be over-emphasized that the costs included in this database are not actual project costs. The costs included in this database are associated solely with retrofitting the building's deficiencies for seismic safety. Actual project costs will most probably include additional costs for any of the upgrade or improvement costs itemized in the preceding section. Overall project costs have ranged from three to seven times the associated seismic strengthening cost depending on how much architectural remodeling was done.

5.3 Impact and Phasing Costs

The intent of the "impact costs" included in the costs for EHR ranked buildings is to represent direct construction impacts, such as sequencing, additional general conditions costs, temporary screens and barricades, and out-of-hours work. The costs in this section are those that would be borne by the general contractor in order to perform the work in a manner acceptable to the staff and occupants of the building.

Developing refined and detailed information has added a higher level of detail to the cost estimates than developed in the previous phases. During the last four phases two cost categories were added. The first one, entitled "System Relocation Costs," addresses the MEP (mechanical, electrical, and plumbing) issues associated with the structural upgrades. Costs for relocation, alteration, and reinstatement of mechanical, electrical,

plumbing, and fire protection systems are included in these figures. Some of these figures were formerly included in the "Finishing Costs."

The second cost category is entitled "Phasing Costs." These costs include items that are not direct construction costs, but have been identified in the report as being required to perform the construction work. Such items include temporary reconfiguration of space in other buildings, provision of modular buildings, changes in occupancy, etc. This list is by no means exhaustive, and is provided purely as a checklist of costs that should be considered in preparing an adequate budget for the project. Further study by the VA in consultation with the staff of the facility is recommended, as these costs can be very substantial. Where adequate information was supplied by the individual medical centers to quantify these costs, they are included in the overall project cost.

5.4 Costs for Studied Buildings

Different cost-estimating criteria have been developed over the course of these studies; the costs developed during Phases 3, 4, 5, and 6 should be more reliable than those of earlier phases since they are based on more detailed information, as compared to FEMA156/157, preliminary estimates, and other detailed estimates that did not include site visits by the entire team. This discrepancy between early-phase and late-phase cost estimating methodology should be kept in mind when comparing costs. We feel that the estimates developed in Phases 3, 4, 5, and 6 are closer to what actual projects will cost because of the increased level of detail that was gained by having each team member visit the sites.

Although one of Degenkolb's goals in carrying out this study has been to provide estimates for rehabilitation of the VA's inventory, it should be noted that this should not discourage the VA from considering replacement of a facility as a more economic solution in some cases.

5.5 Reporting of Costs

As buildings have been evaluated and rehabilitation costs developed during this and previous phases, the database has been updated with these cost estimates. The costs as reported in the database are those developed at the time of the study, escalated to current dollars using a 5% per year escalation factor unless noted otherwise.

6. PROGRAM RECOMMENDATIONS

6.1 Overview

It is clear that the VA has had a very successful program over the last thirty years of seismic mitigation. Both developing the VA Seismic Inventory and the recent building studies by Degenkolb are logical extensions of this work. Throughout the course of Phase 6, we explored several issues that we recommend be addressed to continue the VA's progress toward an inventory of seismically resistant buildings. The following section outlines these recommendations.

6.2 Recommendations

1. **Strengthen all Exceptionally High Risk and High Risk buildings**: We recommend that the VA strengthen all buildings listed as Exceptionally High Risk and High Risk as soon as possible.
2. **Strengthen other deficient buildings**: We recommend that the VA strengthen all non-exempt buildings that were found by evaluation to be deficient.
3. **Continue to evaluate existing VA facilities:** We recommend that the VA continue its systematic process of evaluating all of its non-exempt buildings prioritized by Exceptionally High Risk buildings, High Risk buildings, and non-exempt facilities critical to the VA's mission.
4. **Refine the presentation of construction costs for evaluated EHR buildings.** Currently, the EHR ranked list contains information for programming costs only for those buildings evaluated during Phases 3, 4, and 5. Previous building evaluations use a nominal "programming" or "impact" cost of $6 per sq. ft., while others use the actual cost developed from project applications. This EHR Ranked list should be standardized such that all numbers displayed are consistent.
5. **Revisit and update all previous cost estimates:** We recommend all previous estimates be updated to a consistent as possible level, and that additional detailed studies be completed so that these costs can be as consistent and accurate as possible. Specifically, Architectural and Mechanical site visits, similar to those done in Phases 3, 4, and 5, should be included.
6. **Evaluate research facilities:** Research facilities were recently classified as essential. Therefore, they have not been designed per H-18. Those research buildings constructed since 1977 should be evaluated to the Immediate Occupancy performance objective.
7. **Continue to update the database:** We recommend that updated building descriptions continue to be incorporated, with continued coordination between the Space and Functional Database and the Seismic Database.
8. **Coordinate with both VISN's and Medical Centers to help ensure that the VA Directive dated April 7, 2005 is carried out:** This directive outlines the responsibilities of VACO, the VISN's and the Facility Directors. In some areas, it places more responsibility on the VISN's and Medical Centers than in the past.

VACO should assist the VISN's and Medical Centers as needed and develop program outlines where appropriate to foster implementation of the Directive.

9. **Institute a program to reduce the risk in leased buildings**: Currently, the VA does not have any program to reduce the seismic risk in its leased buildings. This responsibility has been given to the VISN's. A pilot framework program should be developed to assist VISN implementation.
10. **NIBS Facility Security Assessment Program:** The National Institute of Building Systems has recently completed a security assessment program. The inventory database should be merged with the data that the NIBS program developed.
11. **Refine non-exempt list:** We recommend formalizing the non-exempt building list to identify those buildings that may not require a seismic evaluation due to their small size or seismicity.
12. **Investigate Water Towers:** We recommend evaluating the Water Towers in the VA database to assess the effect of their expected seismic resistance on the VA mission.

APPENDIX A

Summary List of Studied Buildings

No.	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Descriptio	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Co	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.
1.	Albuquerque	1	Psychiatry/Psychology	NM	MH	Conc. frm. w/ infill shear wall	71,222	N04	1932	C	H	HR	D1	P	2	$9,862,000	$138.47
2.	Albuquerque	10	Research	NM	MH	Conc. frm. w/ infill shear wall	23,000	N02	1932	E	H	HR	D4	P	2	$1,869,360	$81.28
3.	Albuquerque	12	Research	NM	MH	Unreinforced masonry	2,200	N01	1932	E	H	HR	D5	D	2	$504,180	$229.17
4.	American Lake	2	Nursing Home Care Unit	WA	H	Conc. frm. w/ infill shear wall	70,000	N03	1923	C	H	EHR	D1	D	2	$8,960,000	$128.00
5.	American Lake	6	Domiciliary	WA	H	Conc. frm. w/ infill shear wall	19,950	N02	1923	E	H	EHR	D3	D	2	$2,900,000	$145.36
6.	American Lake	9	Auditorium	WA	H	Conc. frm. w/ infill	8,600	N02	1923		H		D6	D	3	$916,000	$106.51
7.	American Lake	18	Research/IRM	WA	H	Concrete shear wall	20,700	N01	1923	E	H	EHR	D4	D	1	$2,893,000	$139.76
8.	American Lake	61	Mental Health	WA	H	Conc. frm. w/ infill shear wall	51,000	N03	1932	C	H	EHR	PM	D	2	$3,324,000 [13]	$65.18
9.	American Lake	81	Main Hospital	WA	H	Conc. frm. w/ infill shear wall	69,996	N05	1947	C	H	EHR	D3	D	2	$8,944,000	$127.78
10.	American Lake	85	Mental Health/GRECC	WA	H	Conc. frm. w/ infill shear wall	34,063	N03	1943	E	H	EHR	D2	D	2	$4,492,000	$131.87
11.	Anchorage	3001	Domiciliary	AK	VH	Wood, light frame	34,100	N01	1964	E		EHR	D4	D	2	$2,433,310	$71.36
12.	Asheville	47	Main Hospital	NC	MH	Conc. frm. w/ infill shear wall	478,435	N08	1967	C		HR	D2	D	2	$23,427,000	$48.97
13.	Atlanta	1	Main Bld/Amb Care/Clin Add	GA	ML	Steel Frm. w/-infill shear wall	837,084	N12	1966	C			D1	P	1	$78,049,000 [15]	$93.24
14.	Augusta (Lenwood)	32	Quarters	GA	MH	Wood, light frame	3,132	N02	1931		H		D2	P	3	$68,000	$21.71
15.	Boston	1	Main Hospital	MA	ML	Conc. moment frame	695,587	N14	1952	C			D4	P	1	$60,580,190 [15]	$87.09
16.	Boston	5	Boiler Plant	MA	ML	Steel Frm. w/-infill shear wall	6,156	N01	1952	C			D4	D	2	$3,303,470 [15]	$537
17.	Brooklyn	1	Main Hospital	NY	MH	Steel moment frame	640,889	N18	1950	C		HR	D4	P	2	$41,476,700	$64.72
18.	Brooklyn	4A	AC Plant	NY	MH	Steel braced frame	4,750	N01	1966	C		HR	D5	D	2	$1,293,068	$272.22
19.	Columbia	1	USC Med School	SC	MH	Conc. frm. w/ infill shear wall	96,006	N05	1932	C	H	HR	D5	D	2	$12,036,263	$125.37
20.	Columbia	8	Boiler Plant/Incinerator	SC	MH	Steel Frm. w/-infill shear wall	8,110	N01	1932	C	H	HR	D2	P	3	$542,000	$66.83
21.	Columbia	9	Research	SC	MH	Conc. frm. w/ infill shear wall	32,847	N02	1932	E	H	HR	D1	P	2	$2,159,000	$65.73
22.	Danville	100	Boiler plant & incinerator	IL	L	Steel moment frame	5,100	N01	1964	C			D4	P	2	$1,210,570 [15]	$237.37
23.	East Orange	7	Research Building	NJ	MH	Other - describe	25,156	N02	1950	E		HR	D2	P	2	$1,851,000	$73.58
24.	East Orange	8	Boiler Plant	NJ	MH	Concrete shear wall	10,320	N01	1950	C		HR	D4	D	2	$2,210,170	$214.16
25.	East Orange	16	Nursing Home	NJ	MH	Steel moment frame	23,065	N01	1969	C		HR	D2	P	3	$610,000	$26.45
26.	Fort Harrison	2	Dormitory	MT	H	Unreinforced masonry	20,312	N02	1895	E	H	EHR	D3	D	1	$1,219,000	$60.01
27.	Fort Harrison	3	Quarters	MT	H	Wood, light frame	3,484	N02	1948		H		D2	P	3	$360,000	$103.33
28.	Fort Harrison	4	Quarters	MT	H	Unreinforced masonry	10,646	N03	1895		H		D4	D	1	$1,403,050	$131.79
29.	Fort Harrison	154	Hospital	MT	H	Conc. frm. w/ infill shear wall	132,381	N04	1963	C		EHR	D6	D	2	$30,438,544	$229.93
30.	Fort Harrison	154A	Outpatient	MT	H	Conc. frm. w/ infill shear wall	24,560	N02	1976	C		EHR	PM	D	3	$281,400 [11]	$11.46
31.	Fresno	13	Dual/Diagnostic Clinic	CA	MH	Steel Frm w/ conc shear walls	3,740	N01	1949	C		HR	D6	D	2	$345,501	$92.38
32.	Grand Junction	1	Main Hospital	CO	MH	Concrete shear wall	171,220	N06	1948	C		HR	D1	P	3	$5,826,000	$34.03
33.	Grand Junction	9	Boiler Plant	CO	MH	Concrete shear wall	2,913	N01	1949	C		HR	D2	P	2	$74,000	$25.40
34.	Grand Junction	20	Nursing Home	CO	MH	Steel moment frame	16,320	N01	1976	C		HR	D5	D	1	$1,348,331	$82.62
35.	Livermore	88	Administration	CA	VH	Conc. moment frame	18,432	N02	1978				D2	P	2	$910,000	$49.37
36.	Loma Linda	1	Main Hospital	CA	VH	Steel Frm w/ conc shear walls				C			D6	BSC			
37.	Long Beach	7	Wards, Clin. OP Pharm	CA	VH	Concrete shear wall	36,040	N03	1943	C		EHR	CIP-PM	D	2	$52,300,000 [1]	N/A
38.	Long Beach	128	Wards, Psych Admin	CA	VH	Concrete shear wall	90,200	N02	1966	C		EHR	D3	D	2	$6,997,000	$77.57
39.	Long Beach	133	Nursing Home Unit	CA	VH	Concrete shear wall	54,588	N01	1974	C		EHR	D3	D	2	$3,721,000	$68.17
40.	Long Beach	138	Research Services	CA	VH	Concrete shear wall	61,658	N02	1985	E		EHR	D5	D	4	$1,013,360	$16.44
41.	Long Beach	126A	Outpatient Building	CA	VH	Concrete shear wall	81,000	N03	1976	C		EHR	D3	D	3	$3,279,000	$40.48

No.	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Descriptio	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Co	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.
42.	Lyons	1	Lab/Rad., Clinics, Administration	NJ	MH	Conc. frm. w/ infill shear wall	79,579	N04	1930	C	H	HR	D2	P	2	$7,489,000	$94.11
43.	Lyons	4	Outpatient Clinics, Acute Care	NJ	MH	Conc. frm. w/ infill shear wall	21,664	N02	1930	C	H	HR	D2	P	2	$1,101,000	$50.82
44.	Lyons	7	Geriatrics, GEM	NJ	MH	Conc. frm. w/ infill shear wall	49,500	N02	1930	C	H	HR	D2	P	2	$3,011,000	$60.83
45.	Manchester	1	Main Hospital	NH	MH	Concrete shear wall	163,124	N06	1949	C		HR	D6	D	2	$30,503,763	$187.00
46.	Marion	8	Mental Health	IL	H	Conc. frm. w/ infill shear wall	8,892	N02	1941	C	H	HR	D2	P	2	$781,000	$87.83
47.	Marion	14	Boiler Plant	IL	H	Concrete shear wall	5,110	N01	1941	C	H	HR	D2	P	3	$627,000	$122.70
48.	Martinez/NCSC	5/R-1	Laboratory/Research	CA	VH	Steel light frame	13,142	N01	1980	E		EHR	D6	P	3	$1,074,849	$81.79
49.	Memphis	5	NHCU	TN	VH					C			D6	BSC			
50.	Menlo Park	137	Psychiatric	CA	VH	Concrete shear wall	72,100	N02	1940	C		EHR	PM	D	2	$2,853,000 [7]	$39.57
51.	Menlo Park	205	Medical Research	CA	VH	Concrete shear wall	72,300	N02	1929	E	H	EHR	PM	D	2	$3,623,000 [7]	$50.11
52.	Menlo Park	323	Psychiatric	CA	VH	Reinf. masonry bearing wall	78,434	N01	1967	C		EHR	D3	D	2	$3,533,000	$45.04
53.	Montrose	3	Outpatient/Ambulatory Care	NY	MH	Conc. frm. w/ infill shear wall	49,500	N03	1950	C	H	HR	D2	P	2	$4,116,000	$83.15
54.	Montrose	10	NHCU	NY	MH	Conc. frm. w/ infill shear wall	54,750	N03	1950	C	H	HR	D2	P	2	$3,524,000	$64.37
55.	Montrose	20	Boiler Plant	NY	MH	Unreinforced masonry	7,133	N01	1950	C	H	HR	D4	D	2	$1,900,480	$266.43
56.	Murfreesboro	8	Psychiatric Wards	TN	ML	Conc. frm. w/ infill shear wall	49,500	N03	1939	C	H		D4	P	2	$4,702,850 [16]	$95.01
57.	Nashville	1	Medical Center	TN	MH	Conc. moment frame	623,000	N04	1960	C		HR	D2	D	3	$8,675,000	$13.92
58.	New York	1	Main Medical Center	NY	MH	Steel moment frame	789,410	N22	1954	C		HR	D2	D	1	$6,297,000	$7.98
59.	New York	3	Quarters, Personnel	NY	MH	Conc. frm. w/ infill shear wall	26,590	N07	1954				D4	P	2	$3,969,050	$149.27
60.	New York	5	Electrical Distribution Plant	NY	MH	Conc. moment frame	10,900	N02	1969	C		HR	D6	D	2	$3,035,224	$278.46
61.	North Little Rock	65	Regional Office	AR	MH	Conc. frm. w/ infill shear wall	46,900	N02	1936				D2	P	2	$2,001,000	$42.67
62.	North Little Rock	66	Clinical Support	AR	MH	Conc. frm. w/ infill shear wall	45,190	N03	1944	C		HR	D1	P	4	$3,844,000	$85.06
63.	North Little Rock	69	Boiler Plant	AR	MH	Unreinforced masonry	4,875	N01	1936	C		HR	D2	P	2	$311,000	$63.79
64.	North Little Rock	89	RMS Psych Mental Hygiene	AR	MH	Steel Frm. w/-infill shear wall	32,000	N02	1958	E		HR	D2	P	3	$2,016,000	$63.00
65.	North Little Rock	102	IRMS	AR	MH	Unreinforced masonry	20,830	N02	1923	C		HR	D6	D	1	$3,216,623	$154.42
66.	Palo Alto	2	Psychiatry	CA	VH	Concrete shear wall	75,300	N02	1960	C		EHR	CIP-PM	D	1	$13,500,000 [1]	$179.28
67.	Palo Alto	4	Research	CA	VH	Concrete shear wall	90,100	N03	1960	E		EHR	CIP-PM	D	1	$15,100,000 [1]	$167.59
68.	Palo Alto	23	Therapeutic Exercise Gym.	CA	VH	Concrete shear wall	18,000	N01	1960	E			PM	D	3	$350,000 [8]	$19.44
69.	Palo Alto	40	Boiler House	CA	VH	Concrete shear wall	6,200	N01	1960	C		HR	PM	D	3	$244,000 [9]	$39.35
70.	Palo Alto	54	Animal Research Facility	CA	VH					E		EHR	D6	BSC	1		
71.	Palo Alto	MB3	Research, Union & Infection Control	CA	VH					E			D6	BSC			
72.	Portland	6	Research	OR	H	Conc. frm. w/ infill shear wall	22,028	N02	1928	E		EHR	PM	D	2	$1,823,000 [11]	$82.76
73.	Portland	16	Administration/Research	OR	H	Conc. frm. w/ infill shear wall	24,099	N02	1928	E		EHR	PM	D	2	$1,985,000 [11]	$82.37
74.	Portland	100	Main Hospital	OR	H	Steel braced frame	684,985	N09	1988	E		EHR	PM	D	2	$64,455,000	$94.10
75.	Portland	101	Administration/Research	OR	H	Steel braced frame	129,692	N06	1987	E		EHR	PM	D	2	$12,663,000	$97.64
76.	Portland	104	Research/Clinical	OR	H					E			D5	BSC			
77.	Portland	T51	Radiation Lodgers/Day Care	OR	H	Steel light frame	25,030	N02	1982	E		EHR	D4	D	3	$765,110 [13]	$30.57
78.	Prescott	107	Hospital	AZ	MH	Concrete shear wall	99,027	N04	1937	C		HR	D6	D	3	$8,184,089	$82.65
79.	Prescott	117	Outpatient Clinic	AZ	MH	Steel moment frame/braced fram	12,221	N01	1975	C		HR	D2	P	2	$451,000	$36.90
80.	Providence	1	Main Hospital	RI	ML	Conc. frm. w/ infill shear wall	290,920	N09	1948	C			D1	P	1	$18,269,000 [16]	$62.80
81.	Riverside	1001	Administration Building	CA	VH	Other - describe	9,072	N01	1977				D2	P	1	$849,000	$93.58
82.	Roseburg	1	Main Hospital Building	OR	VH	Conc. frm. w/ infill shear wall	123,320	N05	1933	C	H	EHR	D3	D	2	$37,539,000	$304.40

No.	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Descriptio	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Co	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.
83.	Roseburg	2	Mental Health/Continued Treatment	OR	VH	Conc. frm. w/ infill shear wall	67,613	N03	1933	C	H	EHR	D4	P	2	$9,405,070	$139.10
84.	Roseburg	7	Boiler Plant	OR	VH	Steel Frm. w/-infill shear wall	3,600	N01	1933	C	H	HR	D2	D	2	$260,000	$72.22
85.	Roseburg	17	Mental Health Building	OR	VH	Unreinforced masonry	6,480	N01	1933	E	H	HR	D2	P	2	$1,005,000	$155.09
86.	Sacramento NCHCS	88	McClellan Dental Clinic	CA	MH	Concrete shear wall	8,900	N01	1960	C		HR	D4	D	3	$470,860	$52.91
87.	Sacramento NCHCS	728	Education Building	CA	MH	Reinf. masonry bearing wall	8,628	N01	1965	E		HR	PM	D	2	$1,236,000 [15]	$143.25
88.	San Diego	1	Medical Center	CA	VH	Steel braced frame	854,900	N06	1972	C		EHR	CIP-PM	D	2	$47,400,000 [1]	$55.45
89.	San Diego	2	Power Plant	CA	VH	Concrete shear wall	19,232	N01	1972	C			PM	P	4	$781,000 [16]	$40.61
90.	San Diego	11	SCI	CA	VH	Steel braced frame	100,929	N02	1988	C		EHR	D6	D	3	$19,508,000 [16]	$193.28
91.	San Francisco	1	Research/Clinical/Admin.	CA	VH	Concrete shear wall	37,765	N04	1933	C	H	EHR	CIP-PM	D	2	$7,100,000 [10]	N/A
92.	San Francisco	3	Engineering	CA	VH	Unreinforced masonry	5,756	N01	1933	C	H	HR	D5	P	2	$898,735	$156.14
93.	San Francisco	6	Research/Admin.	CA	VH	Concrete shear wall	52,261	N03	1933	C	H	EHR	D3	D	2	$15,500,000	$296.59
94.	San Francisco	8	Mental Health	CA	VH	Concrete shear wall	25,522	N03	1933	C	H	EHR	CIP-PM	D	2	$4,000,000 [10]	N/A
95.	San Francisco	9	Mental Health Clinics	CA	VH	Concrete shear wall	7,321	N02	1933	C	H	HR	D5	D	2	$1,185,760	$161.97
96.	San Francisco	12	Research	CA	VH	Concrete shear wall	38,910	N02	1933	E	H	EHR	CIP-PM	D	2	$14,100,000 [10]	N/A
97.	San Francisco	203	Inpat Hospital/Clinic/Research	CA	VH	Concrete shear wall	335,009	N04	1976	C		EHR	CIP-PM	D	1	$41,500,000 [1]	N/A
98.	San Francisco	205	Boiler Plant	CA	VH	Concrete shear wall	8,207	N01	1973	C			D2	P	4	[16]	
99.	San Juan	1	Main Hospital	PR	H	Steel moment frame	591,294	N11	1968	C		EHR	F	D	2	$50,000,000 [6]	$84.56
100.	Seattle	8	Research	WA	VH	Concrete shear wall	8,892	N02	1950	E		HR	D1	P	4	$330,000 [16]	$37.11
101.	Seattle	11	Animal Research	WA	VH	Reinf. masonry bearing wall	6,800	N02	1961	E		HR	D5	D	2	$972,471	$143.01
102.	Seattle	13	Medical Research	WA	VH	Reinf. masonry bearing wall	19,428	N02	1966	E		EHR	D3	D	3	$1,118,000	$57.55
103.	Seattle	24	Mental Health	WA	VH					C			D6	BSC			
104.	Seattle	31	Magnetic Resonance Imaging	WA	VH	Pwd shr wall/Stl br frm	2,952	0	1992	C			D6	D	3	$544,000 [16]	$184.28
105.	Seattle	34	Animal Research	WA	VH	Reinf. masonry bearing wall	11,669	N01	1995	E			PM	P	4	[16]	
106.	Seattle	100D&T	Main Hosp. Diag.& Treatment Wing	WA	VH	Steel braced frame	250,000	N04	1985	C		EHR	D5	D	2	$2,868,543 [14]	$11.47
107.	Seattle	100EP	Energy Plant	WA	VH	Steel braced frame	21,648	N01	1985	C		EHR	D6	P	2	$883,763	$40.82
108.	Seattle	100NHCU	NHCU	WA	VH	Steel braced frame	37,000	N02	1985	C		EHR	D6	D	2	$1,959,400	$52.96
109.	Seattle	100NT	Nursing Towers	WA	VH	Steel braced frame	155,000	N07	1985	C		EHR	D6	D	3	$7,743,174	$49.96
110.	Sepulveda	23	Gym/Swimming Pool	CA	VH	Steel Frm. w/-infill shear wall	20,600	N01	1952	E			PM	D	4	$2,000,000 [11]	$97.09
111.	Sepulveda	99	Nursing Home	CA	VH	Reinf. masonry bearing wall	61,008	N01	1974	C			PM	D	2	$1,084,580	$17.78
112.	Sepulveda	103	Animal Research Facility	CA	VH	Reinf. masonry bearing wall	4,104	N01	1986	E		HR	D5	P	3	$141,795	$34.55
113.	Spokane	1	Hospital/Main Building	WA	ML	Concrete shear wall	159,850	N08	1950	C			D1	P	4	$5,068,000 [16]	$31.70
114.	St. Albans	87	Nursing Home Care (B wing)	NY	MH	Steel Frm. w/-infill shear wall	36,812	N03	1948	C		HR	D6	D	2	$6,717,231	$182.47
115.	St. Louis (JC)	1	Main Hospital	MO	MH	Steel Frm. w/-infill shear wall	557,779	N11	1953	C		HR	D1	D	3	$81,717,000	$146.50
116.	St. Louis (JC)	6A	Research	MO	MH	Steel Frm. w/-infill shear wall	7,722	N03	1969	E		HR	D2	P	3	$1,056,000	$136.75
117.	Tucson	2	Patient Care	AZ	ML	Conc. frm. w/ infill shear wall	142,595	N04	1928	C	H		D4	D	2	$13,363,080 [16]	$93.71
118.	Tuscaloosa	33	Nursing Home	AL	ML	Unreinforced masonry	57,610	N01	1939	C	H		D1	P	4	$2,245,000 [16]	$38.97
119.	Vancouver	1	NHCU	WA	H	Wood, light frame	63,780	N01	1985	C			D6	D	4	[16]	
120.	Vancouver	2	Laundry/Warehouse	WA	H								D6	BSC			

No.	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Descriptio	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Co	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.
121.	Vancouver	3	Boiler Plant	WA	H	Reinf. mas. brg. wall	5,529	N02	1984	C		HR	D6	BSC		$414,675	$75.00
122.	Vancouver	11	Barnes Rehab Building	WA	H	Concrete shear wall	133,263	N04	1992	E		EHR	D6	BSC		$9,994,725	$75.00
123.	Vancouver	12	Domiciliary	WA	H					E			D6	BSC			
124.	Walla Walla	69	Mental Health	WA	MH	Unreinforced masonry	48,195	N03	1906	C	H	HR	D6	D	1	$10,880,036	$225.75
125.	Walla Walla	74	Ambulatory Care	WA	MH	Unreinforced masonry	21,500	N02	1922	C		HR	D2	D	2	$1,906,000	$88.65
126.	Walla Walla	76	Boiler Plant	WA	MH	Unreinforced masonry	4,700	N01	1922	C			D2	P	3	$890,000 [16]	$189.36
127.	West Haven	5	Research/Administration	CT	ML	Steel Frm. w/-infill shear wall	49,045	N03	1916	E			D4	P	1	$3,374,170 [16]	$68.80
128.	West Los Angeles	115	Research Lab	CA	VH	Conc. frm. w/ infill shear wall	60,314	N03	1930	E	H	EHR	D3	D	2	$9,675,000	$160.41
129.	West Los Angeles	205	Brentwood Hospital	CA	VH	Concrete shear wall	53,047	N03	1937	C	H	EHR	D3	D	2	$6,285,000	$118.48
130.	West Los Angeles	212	Dom/Prosthetics	CA	VH	Concrete shear wall	69,400	N04	1938	E	H	EHR	D5	D	2	$8,289,186	$119.44
131.	West Los Angeles	218	Administration	CA	VH	Concrete shear wall	75,121	N04	1941		H		D1	P	3	$1,801,000	$23.97
132.	West Los Angeles	222	Mail Out Pharmacy	CA	VH	Concrete shear wall	26,565	N03	1938	C		EHR	D5	D	3	$1,553,175	$58.47
133.	West Los Angeles	236	Police HQ	CA	VH	Concrete shear wall	7,018	N01	1945	C		HR	D5	D	3	$310,800	$44.29
134.	West Los Angeles	256	Brentwood Hospital	CA	VH	Concrete shear wall	47,675	N02	1946	C	H	EHR	D1	P	3	$2,485,000	$52.12
135.	West Los Angeles	259	Corn Work Therapy	CA	VH	Reinf. masonry bearing wall	9,400	N01	1945	E		HR	D4	D	3	$761,650	$81.03
136.	West Los Angeles	292	Water Treatment Plant	CA	VH	Concrete shear wall	990	N01	1946	C			D5	D	3	$158,962	$160.57
137.	West Los Angeles	337	Research Animal House	CA	VH	Concrete shear wall	6,772	N01	1962	E		HR	D5	D	2	$885,008	$130.69
138.	West Los Angeles	500	Main Hospital	CA	VH	Steel braced frame	937,000	N06	1976	C		EHR	CIP-PM	D	3	$56,000,000 [2]	$59.77
139.	West Los Angeles	501	Power Plant for B500	CA	VH	Concrete shear wall	30,000	N01	1976	C			D2	P	4	[16]	
140.	White City	204	Domiciliary Bed	OR	H	Unreinforced masonry	19,015	N02	1942	E		EHR	D3	D	1	$4,366,000	$229.61
141.	White City	205	Domiciliary Bed	OR	H	Unreinforced masonry	18,248	N02	1942	E		EHR	D3	D	1	$3,993,000	$218.82
142.	White City	208	Domiciliary Bed	OR	H	Unreinforced masonry	18,596	N02	1942	E		EHR	D3	D	3	$4,079,000	$219.35
143.	White City	236	Nutrition & Food Services	OR	H	Unreinforced masonry	20,000	N01	1942	E		EHR	D1	P	1	$3,513,000	$175.65
144.	White River Junction	2	Boiler Plant / Warehouse	VT	ML	Unreinforced masonry	9,217	N01	1938	C	H		D4	P	1	$884,410 [16]	$95.95
145.	Willamette	1001	Administration Building	OR	H	Concrete shear wall	3,300	N01	1973				D2	D	1	$182,000	$55.15
146.	Wilmington	15	Research	DE	ML	Conc. frm. w/ infill shear wall	13,325	N02	1972	E			D4	P	2	$1,868,660 [16]	$125.23

These cost estimates do not represent actual project costs. The costs are associated only with mitigating the seismic deficiencies of the building. They do not include collateral costs such as improvements to the mechanical or electrical systems, ADA upgrades, hazardous material abatement, or other functional improvements. With the exception of CIP's, costs have been escalated to May 1, 2005 dollars.

[A]Study Group: D1, D2, D3, D4, D5, D6 - Degenkolb Phase 1, 2, 3, 4, 5, or 6 respectively; F - FEMA Case Studies; PM - VACO Project Management; CIP - Capital Investment Proposal.

[B]Preliminary Studies comply with Tier 1 evaluation phase of FEMA 310 "Handbook for the Seismic Evaluation of Buildings", January 1998, or ASCE 31 "Seismic Evaluation of Existing Buildings", 2002.

Detailed Studies comply with the Tier 2 procedure of FEMA 310 (or ASCE 31) and include a site visit and full nonstructural study.

Base Shear Comparison: the base shear coefficient used in the building design is compared with the current H-18-8 base shear value.

[C]Deficiency Category Rank: 1 - building is in danger of collapsing; 2 - building may not collapse, but will be heavily damaged; 3 - building will be damaged; 4- building is structurally compliant but has non-structural deficiencies; C - building is compliant.

[D]Current Construction Costs represents a general contractor's bid as of May 1, 2005. It includes Structural, Non-Structural, and Finishing costs. It DOES NOT include: Escalation to the construction contract award, pre-design allowance, technical services, construction contingencies, market condition allowance, or construction management fees. Also not included are alteration and renovation costs or impact costs.

No.	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Description	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Code	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.

[1]Reference: Project Application prepared by VAFMO. Does not include additional programming costs included in the application, cost per sq.ft. is therefore not applicable.
[2] CD Underway - latest pricing
[3]Reference: "FEMA 273/274 Guidelines Case Studies Project, Case Study No. 18", Section 3.0 Cost Studies, page 24. Ostah Engineers, Inc., October, 1998.
[4]Reference: "FEMA 273/274 Guidelines Case Studies Project", Section 3.0, page 19, Peer Review of report done by Wadlinger and Associates, Inc., December 10, 1998.
[5]Reference: "FEMA 273/374 Guidelines Case Studies Project, Case Study No. 37", Section 3.0 Cost Estimates, Flad & Associates, May 26, 1999.
[6]Project underway. Cost is current project cost.
[7]Reference: "Scoping Study for Five VISN 21 Buildings", Degenkolb Engineers, November 2, 1999.
[8]Reference: "Seismic Hazard Evaluation, Palo Alto Building 23," Degenkolb Engineers, August 8, 2000.
[9]Reference: "Seismic Hazard Evaluation, Palo Alto Building 40," Degenkolb Engineers, August 8, 2000.
[10]Reference: Project Application, June 2001. Prepared by VAFMO. Joint application for San Francisco Buildings 1, 8, and 12. Total cost has been divided among the three buildings according to application's estimated cost/GSF. Cost per square foot is not applicable because of additional programming costs included in the application.
[11]Cost from actual construction budget.
[12](not used)
[13]Building is undergoing construction document development; costs to be revised accordingly, 2004.
[14]Cost based on structural evaluation only.
[15]Costs updated during Degenkolb Phase 6 and include 30% Project Soft Costs per VA.
[16]Building is currently exempt from remedial measures per VA criteria, but action may be required in the future if the criteria are modified.

APPENDIX B

Summary List of "Credited" Buildings

No.	Cumulative No. [E]	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Description	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Code	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank [C]	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.
1.	135.	Albuquerque	13	PTC	NM	MH	Unreinforced masonry	2,200	N01	1932		H		D5*	D	2	$504,180	$229
2.	136.	Albuquerque	14	Rehabilitation Medicine	NM	MH	Unreinforced masonry	2,200	N01	1932		H		D5*	D	2	$504,180	$229
3.	137.	American Lake	3	Dietetics	WA	H	Conc. frm. w/ infill shear wall	22,573	N02	1923	E	H	EHR	D3*	D	2	$2,900,000	$128
4.	138.	Augusta (Lenwood)	29	Quarters	GA	MH	Wood, light frame	5,948	N02	1927		H		D2*	P	3	$129,139	$22
5.	139.	Augusta (Lenwood)	30	Quarters	GA	MH	Wood, light frame	5,948	N02	1927		H		D2*	P	3	$129,139	$22
6.	140.	Augusta (Lenwood)	31	Quarters	GA	MH	Wood, light frame	3,675	N02	1927		H		D2*	P	3	$79,789	$22
7.	141.	Augusta (Lenwood)	33	Quarters	GA	MH	Wood, light frame	5,948	N02	1931		H		D2*	P	3	$129,139	$22
8.	142.	Fort Harrison	5	Quarters	MT	H	Unreinforced masonry	10,646	N03	1895		H		D4*	D	1	$1,404,000	$132
9.	143.	Fresno	12	Mental Health Clinic	CA	MH	Steel Frm w/ conc shear walls	4,994	N01	1949	E		HR	D6*	D	2	$644,426	$129
10.	144.	Grand Junction	8	Administration	CO	MH	Concrete shear wall	3,612	N01	1949				D2*	P	2	$91,757	$25
11.	145.	Lyons	6	Dental, Canteen Svc.	NJ	MH	Conc. frm. w/ infill shear wall	57,142	N02	1930		H		D2*	P	2	$2,904,050	$51
12.	146.	Lyons	8	Mental Health, BioMed., EMS	NJ	MH	Conc. frm. w/ infill shear wall	42,923	N02	1930	E	H	HR	D2*	P	2	$2,181,417	$51
13.	147.	Lyons	9	Long Term Care, EMS	NJ	MH	Conc. frm. w/ infill shear wall	43,426	N02	1930	C	H	HR	D2*	P	2	$2,450,924	$56
14.	148.	Marion	13	Engineering/A&MM	IL	H	Conc. frm. w/ infill shear wall	10,159	N02	1941		H		D2*	P	2	$892,283	$88
15.	149.	Menlo Park	324	Nursing Home Care	CA	VH	Reinf. masonry bearing wall	80,300	N01	1967	C		EHR	D3*	D	2	$3,576,234	$45
16.	150.	Montrose	4	Psychiatry	NY	MH	Conc. frm. w/ infill shear wall	42,950	N03	1950	C	H	HR	D2*	P	2	$3,571,358	$83
17.	151.	Montrose	6	Nursing Home Care Unit	NY	MH	Conc. frm. w/ infill shear wall	43,054	N03	1950	C	H	HR	D2*	P	2	$3,580,005	$83
18.	152.	Montrose	7	Administration / Inpatient	NY	MH	Conc. frm. w/ infill shear wall	41,638	N03	1950	C	H	HR	D2*	P	2	$3,462,263	$83
19.	153.	Montrose	8	Lab / Administration	NY	MH	Conc. frm. w/ infill shear wall	46,438	N03	1950	C	H	HR	D2*	P	2	$3,861,390	$83
20.	204.	Montrose	9	Nursing Home Care Unit (Vacant)	NY	MH	Conc. frm. w/ infill shear wall	47,752	N03	1950		H		D2*	P	2	$5,068,651 [1]	$106
21.	154.	Montrose	11	Substance Abuse	NY	MH	Conc. frm. w/ infill shear wall	31,128	N03	1950	E	H	HR	D2*	P	2	$2,588,340	$83
22.	155.	Montrose	12	Adm./Inpatient/Outpatient	NY	MH	Conc. frm. w/ infill shear wall	43,048	N03	1950	C	H	HR	D2*	P	2	$3,579,506	$83
23.	156.	Montrose	13	Domiciliary	NY	MH	Conc. frm. w/ infill shear wall	48,084	N03	1950	E	H	HR	D2*	P	2	$3,998,257	$83
24.	157.	Montrose	14	Psychiatry	NY	MH	Conc. frm. w/ infill shear wall	47,283	N03	1950	C	H	HR	D2*	P	2	$3,931,653	$83
25.	158.	Montrose	15	Psychiatry	NY	MH	Conc. frm. w/ infill shear wall	45,627	N03	1950	C	H	HR	D2*	P	2	$3,793,954	$83
26.	205.	Murfreesboro	2	Admin., Kitchen and Dining	TN	ML	Conc. frm. w/ infill shear wall	53,885	N02	1939	E	H		D4*	P	2	$5,073,780 [1]	$94
27.	206.	Murfreesboro	9	Psychiatric Wards	TN	ML	Conc. frm. w/ infill shear wall	61,109	N02	1939	E	H		D4*	P	2	$5,684,721 [1]	$93
28.	159.	North Little Rock	68	Education/Storage	AR	MH	Conc. frm. w/ infill shear wall	45,127	N03	1944				D1*	P	4	$3,839,973	$85
29.	160.	North Little Rock	101	Eng./Social Work/MAS/Mech	AR	MH	Unreinforced masonry	23,425	N02	1923				D6*	D	1	$3,617,348	$154
30.	161.	Palo Alto	6	Administration	CA	VH	Concrete shear wall	77,400	N03	1960				PM*	D	1	$15,100,000	$195
31.	162.	San Francisco	5	Prosthetics/Research	CA	VH	Concrete shear wall	5,605	N02	1933	C	H	HR	D5*	D	3	$907,951	$162
32.	163.	San Francisco	10	Quarters	CA	VH	Concrete shear wall	7,321	N02	1933	E	H	HR	D5*	D	2	$1,185,760	$162
33.	164.	San Francisco	11	Quarters	CA	VH	Concrete shear wall	4,562	N02	1933	E	H	HR	D5*	D	2	$738,997	$162

No.	Cumulative No. [n]	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Description	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Code	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank [C]	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.
34.	165.	St. Albans	85	Nursing Home Care (C wing)	NY	MH	Steel Frm. w/-infill shear wall	41,564	N03	1948	C		HR	D6*	D	2	$7,584,347	$182
35.	166.	St. Albans	86	Nursing Home Care (D wing)	NY	MH	Steel Frm. w/-infill shear wall	39,099	N03	1948	C		HR	D6*	D	2	$7,134,549	$182
36.	167.	St. Albans	91	Nursing Home Care (E wing)	NY	MH	Steel Frm. w/-infill shear wall	38,808	N03	1948	C		HR	D6*	D	2	$7,081,449	$182
37.	168.	St. Albans	92	Nursing Home Care (F wing)	NY	MH	Steel Frm. w/-infill shear wall	41,564	N03	1948	C		HR	D6*	D	2	$7,584,347	$182
38.	169.	St. Albans	93	Nursing Home Care (F wing)	NY	MH	Steel Frm. w/-infill shear wall	39,094	N03	1948	C		HR	D6*	D	2	$7,133,637	$182
39.	170.	Walla Walla	68	NHCU/Admin.	WA	MH	Unreinforced masonry	39,899	N03	1906	C	H	HR	D6*	D	1	$9,006,986	$226
40.	171.	Walla Walla	75	Canteen	WA	MH	Unreinforced masonry	20,506	N02	1922				D2*	D	2	$1,817,881	$89
41.	172.	West Los Angeles	114	Research Lab	CA	VH	Conc. frm. w/ infill shear wall	69,921	N03	1930	E	H	EHR	D3*	D	2	$25,200,000 [2]	N/A
42.	173.	West Los Angeles	206	Brentwood Hospital	CA	VH	Concrete shear wall	47,015	N03	1940	C	H	EHR	D3*	D	3	$5,570,839	$118
43.	174.	West Los Angeles	207	Brentwood Hospital	CA	VH	Concrete shear wall	47,015	N03	1940	C	H	EHR	D3*	D	3	$5,570,839	$118
44.	175.	West Los Angeles	208	Brentwood Hospital	CA	VH	Concrete shear wall	47,265	N03	1945	C	H	EHR	D3*	D	2	$5,599,506	$118
45.	176.	West Los Angeles	210	Brentwood Hospital	CA	VH	Concrete shear wall	39,677	N03	1945		H		D3*	D	2	$4,700,819	$118
46.	177.	West Los Angeles	257	Brentwood Hospital	CA	VH	Concrete shear wall	57,386	N03	1946	C	H	EHR	D3*	D	2	$6,799,117	$118
47.	178.	West Los Angeles	258	Brentwood Admin.	CA	VH	Concrete shear wall	64,715	N04	1946	C	H	EHR	D5*	D	2	$7,729,268	$119
48.	179.	White City	200	Administration	OR	H	Unreinforced masonry	12,936	N02	1942				D3*	D	1	$2,970,589	$230
49.	180.	White City	202	Activities Building	OR	H	Unreinforced masonry	15,698	N02	1942				D3*	D	1	$3,604,732	$230
50.	181.	White City	206	Domiciliary Bed	OR	H	Unreinforced masonry	19,015	N02	1942	E		EHR	D3*	D	1	$4,366,000	$230
51.	182.	White City	207	Domiciliary Bed	OR	H	Unreinforced masonry	19,095	N02	1942	E		EHR	D3*	D	1	$4,384,297	$230
52.	183.	White City	209	Phys.Medicine & Rehab. Group Clin	OR	H	Unreinforced masonry	19,277	N02	1942	E		EHR	D3*	D	1	$4,426,099	$230
53.	184.	White City	210	Dom. Bed, Lib, info. Mgt	OR	H	Unreinforced masonry	19,070	N02	1942				D3*	D	1	$4,378,517	$230
54.	185.	White City	211	Clin. Supp., Health Mgt.	OR	H	Unreinforced masonry	23,555	N02	1942				D3*	D	1	$5,408,127	$230
55.	186.	White City	212	Dom. Bed, Psych., SPD	OR	H	Unreinforced masonry	19,178	N02	1942	C		EHR	D3*	D	1	$4,403,168	$230
56.	187.	White City	213	Domiciliary Bed	OR	H	Unreinforced masonry	18,405	N02	1942	E		EHR	D3*	D	1	$4,226,357	$230
57.	188.	White City	214	Domiciliary Bed	OR	H	Unreinforced masonry	18,495	N02	1942	E		EHR	D3*	D	1	$4,246,567	$230
58.	189.	White City	215	Domiciliary Bed	OR	H	Unreinforced masonry	18,240	N02	1942	E		EHR	D3*	D	1	$4,187,806	$230
59.	190.	White City	216	Domiciliary Bed	OR	H	Unreinforced masonry	18,439	N02	1942	E		EHR	D3*	D	1	$4,233,859	$230
60.	191.	White City	217	Domiciliary Bed	OR	H	Unreinforced masonry	18,495	N02	1942	E		EHR	D3*	D	1	$4,246,567	$230
61.	192.	White City	218	Domiciliary Bed	OR	H	Unreinforced masonry	19,070	N02	1942	E		EHR	D3*	D	1	$4,378,517	$230
62.	193.	White City	220	Theater, Canteen	OR	H	Unreinforced masonry	20,251	N02	1942				D3*	D	1	$4,650,345	$230
63.	194.	White City	221	Domiciliary Bed	OR	H	Unreinforced masonry	18,991	N02	1942	E		EHR	D3*	D	1	$4,360,411	$230
64.	195.	White City	222	Voluntary Serv, Day Treatment, & V	OR	H	Unreinforced masonry	19,045	N02	1942				D3*	D	1	$4,372,737	$230
65.	196.	White City	223	Occupational & Compensated Work	OR	H	Unreinforced masonry	19,358	N02	1942	E		EHR	D3*	D	1	$4,444,588	$230
66.	197.	White City	224	A&MMS, Social Work	OR	H	Unreinforced masonry	19,045	N02	1942				D3*	D	1	$4,372,737	$230

No.	Cumulative No. [E]	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Description	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Code	Historic Building Code	Except. High Risk Code	Study Group [A]	Preliminary or Detailed [B]	Deficiency Category Rank [C]	Total Current Construction Cost [D]	Total Current Construction Cost / sq.ft.
67.	198.	White City	232	Boiler Plant	OR	H	Unreinforced masonry	13,419	N02	1942	C		EHR	D3*	D	1	$1,480,588	$110
68.	199.	White City	239	Domiciliary Bed	OR	H	Unreinforced masonry	18,240	N02	1942	E		EHR	D3*	D	1	$4,187,806	$230
69.	200.	White City	240	Rogue Comm. College	OR	H	Unreinforced masonry	18,240	N02	1942				D3*	D	1	$4,187,806	$230
70.	201.	White City	243	Community Resources	OR	H	Unreinforced masonry	18,240	N02	1942				D3*	D	1	$4,187,806	$230
71.	202.	White City	245	Personnel Quarters	OR	H	Unreinforced masonry	26,000	N01	1942				D1*	P	1	$4,566,700	$176
72.	203.	White City	250	Personnel Quarters	OR	H	Unreinforced masonry	21,300	N02	1942				D3*	D	1	$4,890,932	$230

These cost estimates do not represent actual project costs. The costs are associated only with mitigating the seismic deficiencies of the building. They do not include collateral costs such as improvements to the mechanical or electrical systems, ADA upgrades, hazardous material abatement, or other functional improvements. With the exception of CIP's, costs have been escalated to May 1, 2005 dollars.

[A]Study Group: D1*, D2*, D3*, D4*, D5*, D6* - Similar to Degenkolb Phase 1, 2, 3, 4, 5, or 6, respectively; F - FEMA Case Studies; PM - VACO Project Management.

[B]Preliminary Studies comply with Tier 1 evaluation phase of FEMA 310 "Handbook for the Seismic Evaluation of Buildings", January 1998, or ASCE 31 "Seismic Evaluation of Existing Buildings", 2002. Detailed Studies comply with the Tier 2 procedure of FEMA 310 (or ASCE 31) and include a site visit and full nonstructural study.

[C]Deficiency Category Rank: 1 - building is in danger of collapsing; 2 - building may not collapse, but will be heavily damaged; 3 - building will be damaged; 4- building is structurally compliant but has non-structural deficiencies; C - building is compliant.

[D]Current Construction Costs represents a general contractor's bid as of May 1, 2005. It includes Structural, Non-Structural, and Finishing costs. It DOES NOT include: Escalation to the construction contract award, pre-design allowance, technical services, construction contingencies, market condition allowance, or construction management fees. Also not included are alteration and renovation costs or impact costs. Credited building costs have been determined based on costs developed for the evaluated building that is similar in size, date of construction, and model building type.

[E] Cumulative No. - Numbering follows from "Studied" List, Appendix A.

[1]Building is currently exempt from remedial measures per VA criteria, but action may be required in the future if the criteria are modified.

[2]Cost based on CIP per VACO.

APPENDIX C

Non-Exempt Buildings

No.	VISN	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	VA Occupancy Subcode	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code	Except. High Risk Code
1.	18	Albuquerque	1	Psychiatry/Psychology	NM	MH	71,222	2106	C	H	1932	Conc. frm. w/ infill	N04	HR
2.	18	Albuquerque	2	VCS - Recreation	NM	MH	20,000	6002		H	1932	Steel frm. w/-infill	N02	
3.	18	Albuquerque	3	Psychiatry - RCU	NM	MH	46,253	2106	C	H	1932	Concrete shear wall	N02	HR
4.	18	Albuquerque	8	Admin. - Engineering shop	NM	MH	4,936	1001		H	1932	Unreinforced masonry	N01	
5.	18	Albuquerque	10	Research	NM	MH	23,000	7001	E	H	1932	Conc. frm. w/ infill	N02	HR
6.	18	Albuquerque	11	Research - Rehabilitation	NM	MH	17,300	7001	E	H	1932	Concrete shear wall	N02	HR
7.	18	Albuquerque	12	Research	NM	MH	2,200	7001	E	H	1932	Unreinforced masonry	N01	HR
8.	18	Albuquerque	13	PTC	NM	MH	2,200	1002		H	1932	Unreinforced masonry	N01	
9.	18	Albuquerque	14	Rehabilitation Medicine	NM	MH	2,200	1001		H	1932	Unreinforced masonry	N01	
10.	18	Albuquerque	15	Research	NM	MH	8,700	7001	E	H	1932	Unreinforced masonry	N01	HR
11.	18	Albuquerque	18	Administrative	NM	MH	3,300	1001		H	1932	Unreinforced masonry	N01	
12.	18	Albuquerque	32	Gate House	NM	MH		6008		H	1937			
13.	18	Albuquerque	39	Education	NM	MH	9,533	2301			1978	Steel braced frame	N01	
14.	18	Albuquerque	57	Veterans groups	NM	MH	672	1004			1932	Unreinforced masonry	N01	
15.	18	Albuquerque	58	EMS, pest control	NM	MH	180	1001			1932	Unreinforced masonry	N01	
16.	18	Albuquerque	T1	Research	NM	MH	2,700	7001	E				N01	
17.	18	Albuquerque	T2	Research	NM	MH	2,700	7001	E				N01	
18.	18	Albuquerque	T62	Credit Union	NM	MH	1,800	1005					N01	
19.	20	American Lake	2	Nursing Home Care Unit	WA	H	70,000	2102	C	H	1923	Conc. frm. w/ infill	N03	EHR
20.	20	American Lake	3	Dietetics	WA	H	22,573	2109	E	H	1923	Conc. frm. w/ infill	N02	EHR
21.	20	American Lake	6	Domiciliary	WA	H	19,950	3001	E	H	1923	Conc. frm. w/ infill	N02	EHR
22.	20	American Lake	8	Administration	WA	H	15,900	1001			1923	Conc. frm. w/ infill	N02	
23.	20	American Lake	9	Auditorium	WA	H	8,600	6001		H	1923	Conc. frm. w/ infill	N02	
24.	20	American Lake	10	Quarters	WA	H	2,633	3003		H	1923		N02	
25.	20	American Lake	11	Quarters	WA	H	4,903	3003		H	1923		N02	
26.	20	American Lake	12	Quarters	WA	H	3,896	3003		H	1923		N02	
27.	20	American Lake	13	Quarters	WA	H	3,896	3003		H	1923		N02	
28.	20	American Lake	14	Quarters	WA	H	3,896	3003		H	1923		N02	
29.	20	American Lake	15	Quarters	WA	H	3,896	3003		H	1923		N02	
30.	20	American Lake	16	Social Work/Psychology	WA	H	5,825	1002		H	1923	Conc. frm. w/ infill	N02	
31.	20	American Lake	17	Engineering/Nursing Educ.	WA	H	6,365	1001		H	1923	Conc. frm. w/ infill	N02	
32.	20	American Lake	18	Research/IRM	WA	H	20,700	7001	E	H	1923	Concrete shear wall	N01	EHR
33.	20	American Lake	20	Fire Station/Transportation	WA	H	5,355	6007	C	H	1924	Conc. frm. w/ infill	N01	HR
34.	20	American Lake	61	Mental Health	WA	H	51,000	2106	C	H	1932	Conc. frm. w/ infill	N03	EHR
35.	20	American Lake	62	Exercise Hall	WA	H	13,800	8001		H	1932	Conc. frm. w/ infill	N01	
36.	20	American Lake	81	Main Hospital	WA	H	69,996	2101	C	H	1947	Conc. frm. w/ infill	N05	EHR
37.	20	American Lake	85	Mental Health/GRECC	WA	H	34,063	2107	E	H	1943	Conc. frm. w/ infill	N03	EHR
38.	20	American Lake	88	Police	WA	H	240	6007	C		1953		N01	
39.	20	American Lake	111	Chapel	WA	H	6,610	6004			1958	Conc. moment frame	N01	
40.	20	American Lake	114	Golf Course Clubhouse	WA	H	891	8001			1956		N01	
41.	20	American Lake	132	Canteen	WA	H	12,480	6002			1980	Steel frm. w/-infill	N01	
42	20	American Lake	143	Laundry	WA	H	18,145	6006			1989	Steel moment frame	N01	
43.	20	American Lake	145	Credit Union	WA	H	2,536	1005			1987		N01	
44.	20	Anchorage	3001	Domiciliary	AK	VH	34,100	3001	E		1964	Wood, light frame	N01	EHR
45.	06	Asheville	2	Apartment	NC	MH	4,472	3003		H	1927	Wood, light frame	N02	
46.	06	Asheville	3	Apartments, 2 Units	NC	MH	7,096	3003		H	1927	Wood, light frame	N02	
47.	06	Asheville	4	Apartments, 2 Units	NC	MH	7,096	3003		H	1927	Wood, light frame	N02	
48.	06	Asheville	5	Apartments, 2 Units	NC	MH	7,096	3003		H	1927	Wood, light frame	N02	
49.	06	Asheville	6	Apartments, 4 Units	NC	MH	8,140	3003		H	1929	Wood, light frame	N02	
50.	06	Asheville	7	Apartments, 4 Units	NC	MH	8,140	3003		H	1929	Wood, light frame	N02	
51.	06	Asheville	11	Laundry	NC	MH	11,950	6006			1931	Conc. frm. w/ infill	N02	
52.	06	Asheville	14	Administration & Research	NC	MH	29,830	1001			1931	Conc. frm. w/ infill	N03	
53.	06	Asheville	15	Clinics & Administration	NC	MH	52,460	1001		H	1931	Conc. moment frame	N03	
54.	06	Asheville	24	Credit Union	NC	MH	2,733	1005			1931	Unreinforced masonry	N01	
55.	06	Asheville	47	Main Hospital	NC	MH	478,435	2101	C		1967	Conc. frm. w/ infill	N06	HR
56.	07	Augusta (Lenwood)	19	Administrative	GA	MH	48,477	1001		H	1913	Unreinforced masonry	N04	
57.	07	Augusta (Lenwood)	20	Administrative	GA	MH	34,571	1001		H	1913	Unreinforced masonry	N04	
58.	07	Augusta (Lenwood)	29	Quarters	GA	MH	5,948	3003		H	1927	Wood, light frame	N02	

No.	VISN	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	VA Occupancy Subcode	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code	Except. High Risk Code
59.	07	Augusta (Lenwood)	30	Quarters	GA	MH	5,948	3003		H	1927	Wood, light frame	N02	
60.	07	Augusta (Lenwood)	31	Quarters	GA	MH	3,675	3003		H	1927	Wood, light frame	N02	
61.	07	Augusta (Lenwood)	32	Quarters	GA	MH	3,132	3003		H	1931	Wood, light frame	N02	
62.	07	Augusta (Lenwood)	33	Quarters	GA	MH	5,948	3003		H	1931	Wood, light frame	N02	
63.	07	Augusta (Lenwood)	95	Laundry	GA	MH	36,251	6006			1954	Steel frm. w/ infill	N02	
64.	NC	Beaufort	2101	Lodge/Office	SC	MH	2,481	1001		H	1934	Unreinforced masonry	N02	
65.	NC	Beaufort	3W01	Pump House	SC	MH	100	5006			1980	Wood, light frame	N01	
66.	20	Boise	1	Mental Health	ID	MH	3,472	2106	C	H	1863	Unreinforced masonry	N02	HR
67.	20	Boise	2	Well Pump	ID	MH	365	5006					N01	
68.	20	Boise	4	Mental Health	ID	MH	2,247	2106	C	H	1870	Unreinforced masonry	N02	HR
69.	20	Boise	6	Eye Clinic	ID	MH	4,166	2105	C	H	1863	Unreinforced masonry	N01	HR
70.	20	Boise	23	Mental Health	ID	MH	11,469	2106	C	H	1905	Unreinforced masonry	N01	HR
71.	20	Boise	24	AHEC and District Counsel	ID	MH	9,623	1001		H	1905	Unreinforced masonry	N01	
72.	20	Boise	45	Research	ID	MH	5,595	7001	E	H	1909	Unreinforced masonry	N01	HR
73.	20	Boise	89	Gate House	ID	MH		6008		H	1932			
74.	20	Boise	T112	Quarters	ID	MH	1,437	3003			1998		N01	
75.	20	Boise	T113	Quarters	ID	MH	1,437	3003			1998		N01	
76.	03	Bronx	16	Quarters/Offices	NY	MH	14,375	3003			1945	Steel frm. w/-infill	N03	
77.	03	Bronx	107	Chapel/Oupat. Mental Health	NY	MH	20,000	2106	C		1923	Steel frm. w/-infill	N03	HR
78.	03	Bronx	108	Gatehouse	NY	MH	240	6008						
79.	03	Brooklyn	1	Main Hospital	NY	MH	640,889	2101	C		1950	Steel moment frame	N18	HR
80.	03	Brooklyn	2	Staff & Nurse Quarters	NY	MH	21,880	3004			1950	Conc. frm. w/ infill	N03	
81.	03	Brooklyn	3	Administrative/Fiscal	NY	MH	5,240	1001			1950	Conc. frm. w/ infill	N01	
82.	03	Brooklyn	6	Chapel	NY	MH	8,352	6004			1972	Unreinforced masonry	N01	
83.	03	Brooklyn	4A	AC Plant	NY	MH	4,750	5001	C		1966	Steel braced frame	N01	HR
84.	07	Charleston	5 MYR	Myrtle Beach Clinic	SC	VH	4,700	2103	C		1965		N01	HR
85.	07	Columbia	1	USC Med School	SC	MH	96,006	2302	C	H	1932	Conc. frm. w/ infill	N05	HR
86.	07	Columbia	2	USC Med School	SC	MH	18,480	2302	C	H	1932		N03	HR
87.	07	Columbia	3	USC Med School	SC	MH	65,150	2302	C	H	1932		N04	HR
88.	07	Columbia	4	USC Med School	SC	MH	30,832	2302	C	H	1932		N03	HR
89.	07	Columbia	5	Auditorium	SC	MH	19,258	6001		H	1932	Conc. frm. w/ infill	N03	
90.	07	Columbia	6	Education	SC	MH	7,518	2301		H	1932	Conc. frm. w/ infill	N01	
91.	07	Columbia	8	Boiler Plant/Incinerator	SC	MH	8,110	5001	C	H	1932	Steel frm. w/-infill	N01	HR
92.	07	Columbia	9	Research	SC	MH	32,847	7001	E	H	1932	Conc. frm. w/ infill	N02	HR
93.	07	Columbia	10	Administration	SC	MH	22,620	1001		H	1932	Conc. frm. w/ infill	N03	
94.	07	Columbia	11	Quarters	SC	MH	4,131	3003		H	1932	Unreinforced masonry	N03	
95.	07	Columbia	12	Quarters	SC	MH	4,644	3003		H	1932	Unreinforced masonry	N03	
96.	07	Columbia	13	Quarters	SC	MH	7,417	3003		H	1932	Unreinforced masonry	N03	
97.	07	Columbia	22	Administration	SC	MH	33,749	1001		H	1932	Conc. frm. w/ infill	N03	
98.	07	Columbia	101	USC Med School	SC	MH	48,000	2302	C		1932		N04	HR
99.	07	Columbia	104	Lecture Hall	SC	MH	7,000	6001			1995		N01	
100.	07	Columbia	28T	USC Research	SC	MH	20,000	7001	E		1932		N02	HR
101.	NC	Corinth	2101	Lodge/Office	MS	MH	2,481	6002		H	1934	Unreinforced masonry	N02	
102.	NC	Corinth	3301	Flammable Storage	MS	MH	67	4008	C		1949	Unreinforced masonry	N01	
103.	NC	Corinth	3W01	Pump House	MS	MH	169	5006			1949	Unreinforced masonry	N01	
104.	NC	Cypress Hills	2001	Lodge	NY	MH	2,470	8018		H	1887	Unreinforced masonry	N01	
105.	NC	Cypress Hills	3W01	Pump Pit	NY	MH	180	5006			1947	Unreinforced masonry	N01	
106.	NC	Eagle Point	1301	Admin./Maint. Building	OR	H	375	1001			1952	Wood, light frame	N01	
107.	NC	Eagle Point	3001	Utility Building	OR	H	800	5006			1952	Wood, light frame	N01	
108.	03	East Orange	1	Main Hospital	NJ	MH	775,050	2101	C		1950	Steel moment frame	N12	HR
109.	03	East Orange	2	Multi-Function	NJ	MH	24,354	1002			1960	Steel moment frame	N03	
110.	03	East Orange	5	Administration	NJ	MH	10,080	1001			1960	Steel moment frame	N02	
111.	03	East Orange	7	Research Building	NJ	MH	25,156	7001	E		1950	Other - describe	N02	HR
112.	03	East Orange	8	Boiler Plant	NJ	MH	10,320	5001	C		1950	Concrete shear wall	N01	HR
113.	03	East Orange	11	Research Building	NJ	MH	10,969	7001	E		1965	Unreinforced masonry	N02	HR
114.	03	East Orange	13	Vacant Grounds Bldg.	NJ	MH	1,730	8018					N01	
115.	03	East Orange	15	Multi-Function	NJ	MH	14,500	2104	C		1969	Steel frm. w/-infill	N01	HR
116.	03	East Orange	16	Nursing Home	NJ	MH	23,065	2102	C		1969	Steel moment frame	N01	HR

No.	VISN	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	VA Occupancy Subcode	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code	Except. High Risk Code
117.	03	East Orange	17	Administration	NJ	MH	11,300	1001			1969	Steel frm. w/-infill	N01	
118.	03	East Orange	18	Mental Health Building	NJ	MH	13,900	2106	C		1969	Steel frm. w/-infill	N01	HR
119.	03	East Orange	15A	DDTP	NJ	MH	3,031	1001			1969	Steel frm. w/-infill	N01	
120.	03	East Orange	15B	Administration	NJ	MH	1,874	2107	E		1969	Steel frm. w/-infill	N01	HR
121.	03	East Orange	5A	Administration	NJ	MH	6,100	1001			1983	Steel moment frame	N02	
122.	NC	Florence	1301	Admin./Maint./Office	SC	H	1,036	1001			1948	Unreinforced masonry	N01	
123.	NC	Fort Bliss	2101	Admin. Building	TX	MH	1,890	1001			1938	Unreinforced masonry	N01	
124.	19	Fort Harrison	2	Dormitory	MT	H	20,312	3001	E	H	1895	Unreinforced masonry	N02	EHR
125.	19	Fort Harrison	3	Quarters	MT	H	3,484	3003		H	1948	Wood, light frame	N02	
126.	19	Fort Harrison	4	Quarters	MT	H	10,646	3003		H	1895	Unreinforced masonry	N03	
127.	19	Fort Harrison	5	Quarters	MT	H	10,646	3003		H	1895	Unreinforced masonry	N03	
128.	19	Fort Harrison	11	Quarters	MT	H	3,417	3003		H	1895	Unreinforced masonry	N02	
129.	19	Fort Harrison	12	Quarters	MT	H	3,417	3003		H	1895	Unreinforced masonry	N02	
130.	19	Fort Harrison	13	Quarters	MT	H	3,417	3003		H	1895	Unreinforced masonry	N02	
131.	19	Fort Harrison	14	Quarters	MT	H	2,453	3003		H	1895	Unreinforced masonry	N02	
132.	19	Fort Harrison	17	Fitness Center	MT	H	9,984	8001		H	1895	Unreinforced masonry	N02	
133.	19	Fort Harrison	35	Quarters	MT	H	9,092	3003		H	1895	Unreinforced masonry	N02	
134.	19	Fort Harrison	41	Quarters	MT	H	2,453	3003		H	1905	Unreinforced masonry	N02	
135.	19	Fort Harrison	42	Quarters	MT	H	2,187	3003		H	1905	Unreinforced masonry	N02	
136.	19	Fort Harrison	54	Hazardous Waste Storage	MT	H	480	4008	C		1947	Reinf. masonry bearing wall	N01	
137.	19	Fort Harrison	154	Hospital	MT	H	132,381	2101	C		1963	Conc. frm. w/ infill	N04	EHR
138.	19	Fort Harrison	155	Emergency Generator	MT	H	187	5003	C		1974	Reinf. masonry bearing wall	N01	
139.	19	Fort Harrison	157	High Volt. Switchgear Building	MT	H	651	5006			1979	Reinf. masonry bearing wall	N01	
140.	19	Fort Harrison	160	Booster pump house	MT	H	226	5006			1984		N01	
141.	19	Fort Harrison	162	Dom water reservoir	MT	H		5006			1984			
142.	19	Fort Harrison	154A	Outpatient	MT	H	24,560	2104	C		1976	Conc. frm. w/ infill	N02	EHR
143.	NC	Fort Richardson	1301	Admin./Maint Building	AK	VH	1,500	1001			1990	Other - describe	N01	
144.	NC	Fort Rosecrans	1001	Admin. Building	CA	VH	1,276	1001			1960	Wood, light frame	N01	
145.	NC	Fort Rosecrans	2001	Lodge	CA	VH	2,121	3003		H	1936	Unreinforced masonry	N01	
146.	21	Fresno	3	Facility Management Ad.	CA	MH	7,622	1001			1949	Concrete shear wall	N01	
147.	21	Fresno	10	Facility Management Ad.	CA	MH	7,355	1001			1949	Concrete shear wall	N01	
148.	21	Fresno	11	Human Resource/EEO?Union	CA	MH	4,370	1001			1949	Concrete shear wall	N01	
149.	21	Fresno	12	Mental Health Clinic	CA	MH	4,994	2107	E		1949	Steel frm w/ conc	N01	HR
150.	21	Fresno	13	Dual/Diagnostic Clinic	CA	MH	3,740	2103	C		1949	Steel frm w/ conc	N01	HR
151.	21	Fresno	14	Financial Resource	CA	MH	7,584	1001			1949	Concrete shear wall	N01	
152.	21	Fresno	22	Chiller Plant	CA	MH	2,264	5006			1978		N01	
153.	21	Fresno	24	UCSF Research	CA	MH	30,000	7001	E		1983	Concrete shear wall	N03	HR
154.	NC	Golden Gate	1201	Admin./Lodge	CA	VH	2,310	1001			1940	Unreinforced masonry	N01	
155.	NC	Golden Gate	2001	Lodge	CA	VH	1,500	8001		H	1941		N01	
156.	NC	Golden Gate	3002	Utility Building	CA	VH	3,276	5006			1957	Reinf. masonry bearing wall	N01	
157.	NC	Golden Gate	4401	Chapel/Restroom	CA	VH	1,190	8004		H	1940	Unreinforced masonry	N01	
158.	NC	Golden Gate	3W01	Pump House	CA	VH	120	5006			1941	Concrete shear wall	N01	
159.	19	Grand Junction	1	Main Hospital	CO	MH	171,220	2101	C		1948	Concrete shear wall	N06	HR
160.	19	Grand Junction	3	Four Plex Quarters	CO	MH	7,276	3003			1949	Concrete shear wall	N02	
161.	19	Grand Junction	4	Administration	CO	MH	1,260	1001					N01	
162.	19	Grand Junction	5	Administration	CO	MH	6,542	1001			1949	Concrete shear wall	N01	
163.	19	Grand Junction	6	Administration	CO	MH	6,578	1001			1949	Concrete shear wall	N01	
164.	19	Grand Junction	8	Administration	CO	MH	3,612	1001			1949	Concrete shear wall	N01	
165.	19	Grand Junction	9	Boiler Plant	CO	MH	2,913	5001	C		1949	Concrete shear wall	N01	HR
166.	19	Grand Junction	13	Textile Care	CO	MH	6,599	8006			1949	Concrete shear wall	N01	
167.	19	Grand Junction	20	Nursing Home	CO	MH	16,320	2102	C		1976	Steel moment frame	N01	HR
168.	21	Honolulu	EW	E-Wing Administration	HI	MH	72,303	1001					N05	
169.	NC	Jefferson Barracks	1001	Admin. Building	MO	MH	420	1001			1974	Reinf. masonry bearing wall	N01	
170.	NC	Jefferson Barracks	3003	Employee Building	MO	MH	3,621	1001			1973	Unreinforced masonry	N01	
171.	NC	Jefferson Barracks	4401	Chapel	MO	MH	1,703	8004			1976	Steel braced frame	N01	
172.	NC	Knoxville	1301	Admin./Maint./Office	TN	MH	1,400	1001			1906	Unreinforced masonry	N02	
173.	21	Livermore	16	Director's Quarters	CA	VH	4,045	3004			1930		N01	
174.	21	Livermore	30	Resident housing	CA	VH	1,035	3004			1930		N01	

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175.	21	Livermore	88	Administration	CA	VH	18,432	1001			1978	Conc. moment frame	N02	
176.	22	Loma Linda	T13	FMS	CA	VH	660	1099			2002		N01	
177.	22	Long Beach	7	Wards, Clin. OP Pharm.	CA	VH	36,040	2104	C		1943	Concrete shear wall	N03	EHR
178.	22	Long Beach	47	House Keeping Quarters	CA	VH	25,200	3003			1944	Wood, light frame	N02	
179.	22	Long Beach	50	Offices, Training	CA	VH	13,600	1001			1943	Wood, light frame	N01	
180.	22	Long Beach	128	Wards, Psych Admin.	CA	VH	90,200	2106	C		1966	Concrete shear wall	N02	EHR
181.	22	Long Beach	133	Nursing Home Unit	CA	VH	54,588	2102	C		1974	Concrete shear wall	N01	EHR
182.	22	Long Beach	136	Recreation, Rehab.	CA	VH	1,260	8001			1965	Concrete shear wall	N01	
183.	22	Long Beach	138	Research Services	CA	VH	61,658	7001	E		1985	Concrete shear wall	N02	EHR
184.	22	Long Beach	126A	Outpatient Building	CA	VH	81,000	2104	C		1976	Concrete shear wall	N03	EHR
185.	NC	Long Island	1001	Admin. Building	NY	MH	3,640	1001			1938	Unreinforced masonry	N02	
186.	NC	Long Island	1002	Admin./Annex Building (conf. room)	NY	MH	1,036	1001			1940	Unreinforced masonry	N01	
187.	NC	Long Island	2001	Lodge	NY	MH	2,979	3003		H	1938	Unreinforced masonry	N02	
188.	NC	Long Island	3301	Flammable Storage	NY	MH	144	4008	C		1973	Unreinforced masonry	N01	
189.	NC	Long Island	3W01	Pump House No. 1	NY	MH	625	5006			1940	Unreinforced masonry	N01	
190.	NC	Long Island	3W02	Pump House No. 2	NY	MH	625	5006			1973	Unreinforced masonry	N01	
191.	NC	Long Island	3W03	Pump Vault (Underground)	NY	MH		5006						
192.	NC	Los Angeles	1001	Admin./Public Restroom	CA	VH	3,800	1001			1959	Concrete shear wall	N01	
193.	NC	Los Angeles	3003	Employee Building	CA	VH	3,468	1001			1980	Reinf. masonry bearing wall	N01	
194.	NC	Los Angeles	3301	Flammable Storage	CA	VH	150	4008	C		1930	Unreinforced masonry	N01	
195.	03	Lyons	1	Lab/Rad., Clinics, Administration	NJ	MH	79,579	2103	C	H	1930	Conc. frm. w/ infill	N04	HR
196.	03	Lyons	2	PM&RS, Pathology	NJ	MH	56,015	2102	C	H	1929	Conc. frm. w/ infill	N01	HR
197.	03	Lyons	4	Outpatient Clinics, Acute Care	NJ	MH	21,664	2101	C	H	1930	Conc. frm. w/ infill	N02	HR
198.	03	Lyons	5	Auditorium, MAS, Recreation	NJ	MH	20,225	6001		H	1930	Unreinforced masonry	N01	
199.	03	Lyons	6	Dental, Canteen Svc.	NJ	MH	57,142	6002		H	1930	Conc. frm. w/ infill	N02	
200.	03	Lyons	7	Geriatrics, GEM	NJ	MH	49,500	2102	C	H	1930	Conc. frm. w/ infill	N02	HR
201.	03	Lyons	8	Mental Health, BioMed., EMS	NJ	MH	42,923	2107	E	H	1930	Conc. frm. w/ infill	N02	HR
202.	03	Lyons	9	Long Term Care, EMS	NJ	MH	43,426	2102	C	H	1930	Conc. frm. w/ infill	N02	HR
203.	03	Lyons	10	Administrative	NJ	MH	15,900	1001		H	1930	Conc. frm. w/ infill	N02	
204.	03	Lyons	11	Administrative	NJ	MH	15,900	1001		H	1930	Conc. frm. w/ infill	N02	
205.	03	Lyons	12	Firehouse	NJ	MH	4,800	6007	C		1930	Unreinforced masonry	N01	HR
206.	03	Lyons	14	BoilerHouse	NJ	MH	4,816	5001	C		1930	Steel frm. w/-infill	N01	HR
207.	03	Lyons	15	Laundry, Engineering Shops	NJ	MH	27,000	6006			1930	Unreinforced masonry	N01	
208.	03	Lyons	16	Administrative	NJ	MH	22,000	1001		H	1930	Conc. frm. w/ infill	N03	
209.	03	Lyons	18	Quarters	NJ	MH	3,400	3003		H	1930	Unreinforced masonry	N02	
210.	03	Lyons	19	Quarters	NJ	MH	3,400	3003		H	1930	Unreinforced masonry	N02	
211.	03	Lyons	25	Quarters	NJ	MH	3,400	3003		H	1930	Unreinforced masonry	N02	
212.	03	Lyons	26	Quarters	NJ	MH	3,400	3003		H	1930	Unreinforced masonry	N02	
213.	03	Lyons	53	Psychiatric	NJ	MH	91,303	2106	C	H	1940	Conc. frm. w/ infill	N03	HR
214.	03	Lyons	54	Dietetics Office, Main Kitchen	NJ	MH	31,200	6002		H	1940	Conc. frm. w/ infill	N01	
215.	03	Lyons	55	Domiciliary, Psychiatric	NJ	MH	85,000	2106	C	H	1940	Conc. frm. w/ infill	N03	HR
216.	03	Lyons	57	Domiciliary	NJ	MH	60,500	3001	E	H	1946	Conc. frm. w/ infill	N02	HR
217.	01	Manchester	1	Main Hospital	NH	MH	163,124	2101	C		1949	Concrete shear wall	N06	HR
218.	01	Manchester	2	Quarters 2	NH	MH	2,840	3003			1949	Unreinforced masonry	N02	
219.	01	Manchester	3	A&MM/Fiscal	NH	MH	3,844	1001			1949	Unreinforced masonry	N02	
220.	01	Manchester	4	MCCR/Resident Quarters	NH	MH	3,844	3004			1949	Unreinforced masonry	N02	
221.	01	Manchester	5	HRMS/DSS	NH	MH	5,023	1001			1949	Unreinforced masonry	N01	
222.	01	Manchester	6	Facility Service	NH	MH	3,400	1001			1949	Wood, light frame	N01	
223.	01	Manchester	7	Boiler Plant/Maintenance	NH	MH	13,500	5001	C		1949	Unreinforced masonry	N01	HR
224.	01	Manchester	11	Smyth Tower- Historic Landmark	NH	MH	650	8002		H	1888	Unreinforced masonry	N03	
225.	01	Manchester	7A	Hazardous Material Storage	NH	MH	360	4009	C				N01	
226.	15	Marion	8	Mental Health	IL	H	8,892	2106	C	H	1941	Conc. frm. w/ infill	N02	HR
227.	15	Marion	13	Engineering/A&MM	IL	H	10,159	1001		H	1941	Conc. frm. w/ infill	N02	
228.	15	Marion	14	Boiler Plant	IL	H	5,110	5001	C	H	1941	Concrete shear wall	N01	HR
229.	15	Marion	37	Education/HRM/Tele	IL	H	11,795	2301			1979	Reinf. masonry bearing wall	N01	
230.	21	Martinez/NCSC	21	Mental Health/Sciences Building	CA	VH	20,200	1002			1982	Concrete shear wall	N04	
231.	21	Martinez/NCSC	AB6	Pharmacy/CBHC (office)	CA	VH	7,920	1099			1991		N01	
232.	21	Martinez/NCSC	AB7	Supply/Fiscal Services	CA	VH	12,960	1099			1991		N01	

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233.	21	Martinez/NCSC	5/R-1	Laboratory/Research	CA	VH	13,142	7001	E		1980	Steel light frame	N01	EHR
234.	21	Martinez/NCSC	R-4	Research	CA	VH	7,920	7001	E		1991		N01	HR
235.	09	Memphis	8	Education / DSS	TN	VH	3,603	2301			1902	Wood, light frame	N01	
236.	NC	Memphis	1302	Admin./Maint. Building	TN	VH	3,660	1001			1930	Unreinforced masonry	N01	
237.	NC	Memphis	3W01	Pump House	TN	VH	150	5006			1930	Unreinforced masonry	N01	
238.	21	Menlo Park	60	Quarters	CA	VH	2,900	3003		H	1929	Unreinforced masonry	N01	
239.	21	Menlo Park	114	Boiler House	CA	VH	6,200	5001	C	H	1929	Concrete shear wall	N01	HR
240.	21	Menlo Park	116	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
241.	21	Menlo Park	117	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
242.	21	Menlo Park	118	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
243.	21	Menlo Park	119	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
244.	21	Menlo Park	120	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
245.	21	Menlo Park	121	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
246.	21	Menlo Park	122	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
247.	21	Menlo Park	123	Quarters	CA	VH	1,800	3003		H	1929	Unreinforced masonry	N01	
248.	21	Menlo Park	137	Psychiatric	CA	VH	72,100	2106	C		1940	Concrete shear wall	N02	EHR
249.	21	Menlo Park	205	Medical Research	CA	VH	72,300	7001	E	H	1929	Concrete shear wall	N02	EHR
250.	21	Menlo Park	222	Quarters	CA	VH	3,400	3003		H	1929	Unreinforced masonry	N01	
251.	21	Menlo Park	301	Bone Density Research	CA	VH	14,200	8011		H	1929	Concrete shear wall	N02	
252.	21	Menlo Park	305	Quarters	CA	VH	3,400	3003		H	1929	Concrete shear wall	N01	
253.	21	Menlo Park	306	Quarters	CA	VH	3,400	3003		H	1929	Concrete shear wall	N01	
254.	21	Menlo Park	322	Chapel	CA	VH	5,200	6004			1960	Unreinforced masonry	N01	
255.	21	Menlo Park	323	Psychiatric	CA	VH	78,434	2106	C		1967	Reinf. masonry bearing wall	N01	EHR
256.	21	Menlo Park	324	Nursing Home Care	CA	VH	80,300	2102	C		1967	Reinf. masonry bearing wall	N01	EHR
257.	21	Menlo Park	329	Kitchen and Dining	CA	VH	21,300	2109	E		1969	Concrete shear wall	N01	EHR
258.	03	Montrose	1	Administration	NY	MH	57,448	1001		H	1950	Conc. frm. w/ infill	N03	
259.	03	Montrose	2	Theater	NY	MH	22,160	6001		H	1949	Steel frm. w/-infill	N01	
260.	03	Montrose	3	Outpatient/Ambulatory Care	NY	MH	49,500	2104	C	H	1950	Conc. frm. w/ infill	N03	HR
261.	03	Montrose	4	Psychiatry	NY	MH	42,950	2106	C	H	1950	Conc. frm. w/ infill	N03	HR
262.	03	Montrose	5	Kitchen & Dining Hall	NY	MH	51,455	6002		H	1950	Steel frm. w/-infill	N01	
263.	03	Montrose	6	Nursing Home Care Unit	NY	MH	43,054	2102	C	H	1950	Conc. frm. w/ infill	N03	HR
264.	03	Montrose	7	Administration / Inpatient	NY	MH	41,638	2102	C	H	1950	Conc. frm. w/ infill	N03	HR
265.	03	Montrose	8	Lab / Administration	NY	MH	46,438	2103	C	H	1950	Conc. frm. w/ infill	N03	HR
266.	03	Montrose	10	NHCU	NY	MH	54,750	2102	C	H	1950	Conc. frm. w/ infill	N03	HR
267.	03	Montrose	11	Substance Abuse	NY	MH	31,128	2110	E	H	1950	Conc. frm. w/ infill	N03	HR
268.	03	Montrose	12	Adm./Inpatient/Outpatient	NY	MH	43,048	2106	C	H	1950	Conc. frm. w/ infill	N03	HR
269.	03	Montrose	13	Domiciliary	NY	MH	48,084	3001	E	H	1950	Conc. frm. w/ infill	N03	HR
270.	03	Montrose	14	Psychiatry	NY	MH	47,283	2106	C	H	1950	Conc. frm. w/ infill	N03	HR
271.	03	Montrose	15	Psychiatry	NY	MH	45,627	2106	C	H	1950	Conc. frm. w/ infill	N03	HR
272.	03	Montrose	16	Outpatient	NY	MH	32,221	2104	C	H	1950	Conc. frm. w/ infill	N03	HR
273.	03	Montrose	18	Laundry	NY	MH	17,605	6006		H	1950	Unreinforced masonry	N01	
274.	03	Montrose	19	Fire House/Grounds & Transp.	NY	MH	9,155	6007	C	H	1950	Unreinforced masonry	N01	HR
275.	03	Montrose	20	Boiler Plant	NY	MH	7,133	5001	C	H	1950	Unreinforced masonry	N01	HR
276.	03	Montrose	25	Recreation & Canteen	NY	MH	36,640	6002		H	1950	Conc. frm. w/ infill	N02	
277.	03	Montrose	26	Pool/Gym	NY	MH	23,842	8001			1950	Steel frm. w/-infill	N01	
278.	03	Montrose	27	Chapel	NY	MH	10,758	6004		H	1950	Steel frm. w/-infill	N01	
279.	03	Montrose	28	Domiciliary	NY	MH	19,360	3001	E	H	1950	Conc. frm. w/ infill	N03	HR
280.	03	Montrose	29	Quarters	NY	MH	33,194	3003		H	1950	Conc. frm. w/ infill	N03	
281.	03	Montrose	30	Quarters	NY	MH	34,645	3003		H	1950	Conc. frm. w/ infill	N03	
282.	03	Montrose	31	Director's Quarters	NY	MH	3,664	3003		H	1950	Unreinforced masonry	N01	
283.	03	Montrose	36	Wastewater Treatment	NY	MH	2,840	5001	C		1950	Concrete shear wall	N01	HR
284.	03	Montrose	46	Boat House (Bath House)	NY	MH	2,709	8001			1941	Unreinforced masonry	N01	
285.	03	Montrose	52	Domiciliary	NY	MH	30,290	3001	E		1960	Conc. frm. w/ infill	N03	HR
286.	03	Montrose	53	Oxygen Storage Building	NY	MH	220	4007	C		1962	Unreinforced masonry	N01	
287.	03	Montrose	57	Eng.Trickling Filter	NY	MH	5,026	5006			1950	Concrete shear wall	N01	
288.	09	Mountain Home	1	James H. Quillen Med.College	TN	MH	55,928	2302		H	1905	Unreinforced masonry	N03	
289.	09	Mountain Home	4	Medical School Library	TN	MH	36,136	8002		H	1905	Unreinforced masonry	N03	
290.	09	Mountain Home	6	Fut. Enh.-Use Lease to ETSU	TN	MH	38,136	8018		H	1905	Unreinforced masonry	N03	

No.	VISN	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	VA Occupancy Subcode	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code	Except. High Risk Code
291.	09	Mountain Home	7	Fut. Enh.-Use Lease to ETSU	TN	MH	38,136	8018		H	1904	Unreinforced masonry	N03	
292.	09	Mountain Home	8	A&MM, Fiscal Svc, Impact Sp.	TN	MH	49,391	1001		H	1932	Unreinforced masonry	N03	
293.	09	Mountain Home	13	Protestant & Catholic Chapels	TN	MH	6,352	6004		H	1905	Unreinforced masonry	N01	
294.	09	Mountain Home	15	Hospitality Guest House	TN	MH	3,288	8018		H	1904		N01	
295.	09	Mountain Home	16	Single Quarters	TN	MH	3,215	3003		H	1908			
296.	09	Mountain Home	17	Carnegie Library & Conf.	TN	MH	5,380	8002		H	1904	Unreinforced masonry	N02	
297.	09	Mountain Home	19	Single Quarters	TN	MH	7,226	3003		H	1904			
298.	09	Mountain Home	20	Human Res./Admin. Space	TN	MH	6,544	1001		H	1904	Unreinforced masonry	N02	
299.	09	Mountain Home	35	Theater-To be En-Use Leased	TN	MH	16,595	6001		H	1904	Unreinforced masonry	N01	
300.	09	Mountain Home	39	Duplex Quarters	TN	MH	5,760	3003		H	1921			
301.	09	Mountain Home	41	AFGE & Res. Engr. Office	TN	MH	5,760	1001		H	1921			
302.	09	Mountain Home	42	Engineering Project Office	TN	MH	5,760	1001		H	1921			
303.	09	Mountain Home	43	MCCR, Nursing Education	TN	MH	5,760	1001		H	1921			
304.	09	Mountain Home	44	Single Quarters	TN	MH	4,389	3003		H	1905			
305.	09	Mountain Home	45	Single Quarters	TN	MH	4,389	3003		H	1905			
306.	09	Mountain Home	46	Single Quarters	TN	MH	4,389	3003		H	1905			
307.	09	Mountain Home	47	Single Quarters	TN	MH	16,989	3003		H	1905			
308.	09	Mountain Home	52	Med. School Admin. Offices	TN	MH	13,910	1001		H	1903	Unreinforced masonry	N02	
309.	09	Mountain Home	53	U.S. Post Office, Mt. Home	TN	MH	3,920	1401		H	1908	Unreinforced masonry	N01	
310.	09	Mountain Home	69	Psych., Nursing, Admin.	TN	MH	18,497	1002		H	1903	Unreinforced masonry	N03	
311.	09	Mountain Home	119	J. H. Quillen Med College	TN	MH	105,067	2302			1988			
312.	NC	Mountain Home	1301	Cemetery Service Admin.	TN	MH	4,967	1001			1978			
313.	NC	Mountain Home	3301	Flammable Storage	TN	MH	0	4008	C		0			
314.	09	Nashville	1	Medical Center	TN	MH	623,000	2101	C		1980	Conc. moment frame	N04	HR
315.	NC	Nashville	2001	Lodge	TN	MH	2,000	1001		H	1932	Unreinforced masonry	N02	
316.	03	New York	1	Main Medical Center	NY	MH	789,410	2101	C		1954	Steel moment frame	N22	HR
317.	03	New York	3	Quarters, Personnel	NY	MH	26,590	3003			1954	Conc. frm. w/ infill	N07	
318.	03	New York	5	Electrical Distribution Plant	NY	MH	10,900	5001	C		1989	Conc. moment frame	N02	HR
319.	NC	NMCP	2001	Admin. Building	HI	MH	1,500	1001			1949	Reinf. masonry bearing wall	N01	
320.	NC	NMCP	3001	Utility/Employee Building	HI	MH	1,000	5006			1949	Wood, light frame	N01	
321.	NC	NMCP	3P01	Pump House	HI	MH	100	5006			1949	Concrete shear wall	N01	
322.	16	North Little Rock	1	Engineering Admin	AR	MH	22,444	1001		H	1898			
323.	16	North Little Rock	5	Regional Counsel	AR	MH	5,381	1001		H	1896	Unreinforced masonry	N01	
324.	16	North Little Rock	6	Firemen's Dorm	AR	MH	1,593	6008		H	1896	Unreinforced masonry	N01	
325.	16	North Little Rock	11	ETCETM	AR	MH	4,791	1001		H	1896	Unreinforced masonry	N02	
326.	16	North Little Rock	16	Engineering/Transportation	AR	MH	1,345	1001		H	1896	Unreinforced masonry	N01	
327.	16	North Little Rock	22	Fire Station	AR	MH	1,292	6007	C	H	1901	Unreinforced masonry	N01	HR
328.	16	North Little Rock	26	Engineering Office	AR	MH	11,615	1001			1922	Unreinforced masonry	N01	
329.	16	North Little Rock	32	Fiscal	AR	MH	5,787	1001		H	1905	Unreinforced masonry	N02	
330.	16	North Little Rock	33	Human Resources	AR	MH	9,183	1001		H	1896	Unreinforced masonry	N01	
331.	16	North Little Rock	34	ETCETM	AR	MH	25,744	2301		H	1906	Unreinforced masonry	N02	
332.	16	North Little Rock	35	Telephone Switch	AR	MH	1,234	2902	C	H	1907	Unreinforced masonry	N01	
333.	16	North Little Rock	36	Human Resources	AR	MH	5,087	1001		H	1907	Unreinforced masonry	N01	
334.	16	North Little Rock	37	Human Resources	AR	MH	14,575	1001		H	1907	Unreinforced masonry	N01	
335.	16	North Little Rock	39	Patient Dorm	AR	MH	5,200	3001	E	H	1907	Unreinforced masonry	N01	HR
336.	16	North Little Rock	40	Quarters	AR	MH	7,788	3003		H	1907	Unreinforced masonry	N03	
337.	16	North Little Rock	41	Fiscal/A&MMS	AR	MH	14,392	1001		H	1907	Unreinforced masonry	N02	
338.	16	North Little Rock	58	Research/LREERC/HS R&D	AR	MH	43,885	7001	E		1931	Conc. frm. w/ infill	N04	HR
339.	16	North Little Rock	65	Regional Office	AR	MH	46,900	1001			1936	Conc. frm. w/ infill	N02	
340.	16	North Little Rock	66	Clinical Support	AR	MH	45,190	2103	C		1944	Conc. frm. w/ infill	N03	HR
341.	16	North Little Rock	68	Education/Storage	AR	MH	45,127	2301			1944	Conc. frm. w/ infill	N03	
342.	16	North Little Rock	69	Boiler Plant	AR	MH	4,875	5001	C		1936	Unreinforced masonry	N01	HR
343.	16	North Little Rock	76	Nutrition & Food	AR	MH	39,430	2109	E		1942	Steel frm. w/-infill	N01	HR
344.	16	North Little Rock	89	RMS Psych Mental Hygiene	AR	MH	32,000	2107	E		1956	Steel frm. w/-infill	N02	HR
345.	16	North Little Rock	90	Athletic Dressing Room	AR	MH	1,282	8001			1958	Unreinforced masonry	N01	
346.	16	North Little Rock	101	Eng./Social Work/MAS/Mech	AR	MH	23,425	1001			1923	Unreinforced masonry	N02	
347.	16	North Little Rock	102	IRMS	AR	MH	20,830	2901	C		1923	Unreinforced masonry	N02	HR
348.	16	North Little Rock	103	Conference Center	AR	MH	28,312	6001			1923	Unreinforced masonry	N02	

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349.	16	North Little Rock	104	Police Trng. Ctr.	AR	MH	7,878	6008			1923	Unreinforced masonry	N02	
350.	16	North Little Rock	105	Auditorium	AR	MH	13,099	6001			1923	Unreinforced masonry	N01	
351.	16	North Little Rock	106	EEO/Director's Suite	AR	MH	6,801	1001		H	1923	Unreinforced masonry	N01	
352.	16	North Little Rock	111	Audiology/MAS/Regional Off	AR	MH	59,454	1002			1923	Conc. frm. w/ infill	N02	
353.	16	North Little Rock	159	Laundry	AR	MH	28,426	6006			1956	Steel frm. w/-infill	N02	
354.	16	North Little Rock	168	Caddy House	AR	MH	1,547	8001			1963	Reinf. masonry bearing wall	N01	
355.	16	North Little Rock	176	Animal Storage	AR	MH	3,485	7002	E		1975	Reinf. masonry bearing wall	N01	HR
356.	16	North Little Rock	191	Firing Range	AR	MH	11,471	8001			2002		N01	
357.	16	North Little Rock	1154	Water Pumping Plant	AR	MH	703	5006			1927	Unreinforced masonry	N01	
358.	16	North Little Rock	LRLease1	Day Treatment	AR	MH	3,314	2104	C		1963		N01	HR
359.	16	North Little Rock	LRLease2	Day Treatment	AR	MH	550	2104	C		1963		N01	
360.	03	Northport	1	Offices	NY	MH	21,616	1001		H	1928			
361.	03	Northport	5	Education	NY	MH	16,239	1001		H	1928	Unreinforced masonry	N01	
362.	03	Northport	6	Clin/Adm Offices	NY	MH	40,575	1001		H	1928			
363.	03	Northport	7	Nursing Home Units	NY	MH	45,346	2102	C	H	1928	Conc. frm. w/ infill	N02	HR
364.	03	Northport	8	Nursing Home Units	NY	MH	46,785	2102	C	H	1928			HR
365.	03	Northport	9	Mental Health Units	NY	MH	46,809	2106	C	H	1928	Conc. frm. w/ infill	N02	HR
366.	03	Northport	10	Admin. Offices	NY	MH	30,094	1001		H	1928			
367.	03	Northport	11	Homeless Residence	NY	MH	50,399	3001	E	H	1928	Conc. frm. w/ infill	N02	HR
368.	03	Northport	12	Media & Library	NY	MH	31,717	8002		H	1928			
369.	03	Northport	13	Laundry	NY	MH	17,547	6006			1928			
370.	03	Northport	14	Veterans Industries	NY	MH	10,956	1004			1928			
371.	03	Northport	17	Non-Housekeeping	NY	MH	20,850	3003		H	1928			
372.	03	Northport	18	RMEC	NY	MH	21,213	8018		H	1928	Unreinforced masonry	N02	
373.	03	Northport	20	Non-Housekeeping	NY	MH	17,244	3003		H	1928	Conc. frm. w/ infill	N03	
374.	03	Northport	23	Quarters	NY	MH	6,638	8018		H	1928			
375.	03	Northport	25	Quarters	NY	MH	6,638	3003		H	1928			
376.	03	Northport	26	Quarters	NY	MH	7,078	3003		H	1928			
377.	03	Northport	27	Quarters	NY	MH	4,191	3003		H	1928			
378.	03	Northport	37	Employee Educ Svc	NY	MH	19,836	2301		H	1937			
379.	03	Northport	40	Chapel	NY	MH	3,339	6004			1949			
380.	03	Northport	61	Research	NY	MH	33,690	7001	E	H	1937	Conc. frm. w/ infill	N03	HR
381.	03	Northport	62	Research	NY	MH	36,787	7001	E	H	1937	Conc. frm. w/ infill	N03	HR
382.	03	Northport	63	Mental Hlth. OPT	NY	MH	44,690	2107	E	H	1937	Conc. frm. w/ infill	N03	HR
383.	03	Northport	64	Mental Health	NY	MH	39,302	2106	C	H	1937	Conc. frm. w/ infill	N03	HR
384.	03	Northport	65	Mental Hlth.	NY	MH	35,935	2106	C	H	1937	Conc. frm. w/ infill	N03	HR
385.	03	Northport	88	Gym	NY	MH	19,570	8001			1956			
386.	03	Northport	89	Canteen	NY	MH	13,653	6002			1958			
387.	03	Northport	200	Hospital/Amb. Care Pavilion	NY	MH	461,942	2104	C		1972	Conc. frm. w/ infill	N05	HR
388.	03	Northport	203	Boiler Plant	NY	MH	6,972	5001	C		1972	Conc. frm. w/ infill	N01	HR
389.	03	Northport	210	Sewage Treatment	NY	MH	928	5001	C		1972	Reinf. masonry bearing wall	N01	
390.	21	Palo Alto	2	Psychiatry	CA	VH	75,300	2106	C		1960	Concrete shear wall	N02	EHR
391.	21	Palo Alto	4	Research	CA	VH	90,100	7001	E		1960	Concrete shear wall	N03	EHR
392.	21	Palo Alto	6	Administration	CA	VH	77,400	1001			1960	Concrete shear wall	N03	
393.	21	Palo Alto	23	Therapeutic Exercise Gym.	CA	VH	18,000	2108	E		1960	Concrete shear wall	N01	
394.	21	Palo Alto	40	Boiler House	CA	VH	6,200	5001	C		1960	Concrete shear wall	N01	HR
395.	21	Palo Alto	51	Rehab/Research & Develop Cr	CA	VH	23,100	7003	E		1980	Steel frm w/ conc	N02	EHR
396.	21	Palo Alto	54	Animal Research Facility	CA	VH	18,100	7002	E		1981	Steel frm w/ conc	N02	EHR
397.	21	Palo Alto	MB4	Nat'l Ctr for HIV/Hepatitis Res.	CA	VH	10,100	7001	E		1990	Steel moment frame	N01	EHR
398.	21	Palo Alto	T6B	Child Care Center	CA	VH	6,700	6005			1994		N01	
399.	15	Poplar Bluff	2	Education	MO	H	4,726	2301			1950	Unreinforced masonry	N02	
400.	15	Poplar Bluff	3	Directors Quarters	MO	H	2,808	3003			1950	Unreinforced masonry	N01	
401.	15	Poplar Bluff	4	Human Resource / Hoptel	MO	H	3,300	1001			1950	Unreinforced masonry	N01	
402.	20	Portland	6	Research	OR	H	22,028	7001	E		1928	Conc. frm. w/ infill	N02	EHR
403.	20	Portland	16	Administration/Research	OR	H	24,999	7001	E		1928	Conc. frm. w/ infill	N02	EHR
404.	20	Portland	100	Main Hospital	OR	H	684,985	1001	E		1988	Steel braced frame	N09	EHR
405.	20	Portland	101	Administration/Research	OR	H	129,692	7001	E		1987	Steel braced frame	N06	EHR
406.	20	Portland	T51	Radiation Lodgers/Day Care	OR	H	25,030	6005	E		1982	Steel light frame	N02	EHR

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407.	18	Prescott	1	Quarters	AZ	MH	6,066	3003		H	1903	Unreinforced masonry	N01	
408.	18	Prescott	2	Quarters	AZ	MH	6,066	3003		H	1908	Unreinforced masonry	N01	
409.	18	Prescott	3	Quarters	AZ	MH	6,066	3003		H	1908	Unreinforced masonry	N01	
410.	18	Prescott	4	Quarters	AZ	MH	6,066	3003		H	1908	Unreinforced masonry	N01	
411.	18	Prescott	5	Quarters	AZ	MH	6,208	3003		H	1908	Unreinforced masonry	N01	
412.	18	Prescott	6	Quarters	AZ	MH	7,913	3003		H	1908	Unreinforced masonry	N01	
413.	18	Prescott	7	Quarters	AZ	MH	6,208	3003		H	1908	Unreinforced masonry	N01	
414.	18	Prescott	8	Quarters	AZ	MH	6,208	3003		H	1908	Unreinforced masonry	N01	
415.	18	Prescott	9	Quarters	AZ	MH	6,208	3003		H	1908	Unreinforced masonry	N01	
416.	18	Prescott	10	Quarters	AZ	MH	6,208	3003		H	1908	Unreinforced masonry	N01	
417.	18	Prescott	11	Administration	AZ	MH	6,208	1001		H	1908	Unreinforced masonry	N01	
418.	18	Prescott	12	Administration	AZ	MH	15,574	1001		H	1903	Unreinforced masonry	N02	
419.	18	Prescott	13	Administration	AZ	MH	16,250	1001		H	1908	Unreinforced masonry	N02	
420.	18	Prescott	14	Administration	AZ	MH	37,257	1001		H	1908	Unreinforced masonry	N02	
421.	18	Prescott	16	Canteen	AZ	MH	4,946	6002		H	1908	Unreinforced masonry	N01	
422.	18	Prescott	22	Engineering Administration	AZ	MH	4,832	1001		H	1920	Wood, light frame	N01	
423.	18	Prescott	24	Quarters	AZ	MH	2,094	3003		H	1908	Unreinforced masonry	N01	
424.	18	Prescott	25	Quarters	AZ	MH	2,094	3003		H	1908	Unreinforced masonry	N01	
425.	18	Prescott	26	Quarters	AZ	MH	2,094	3003		H	1908	Unreinforced masonry	N01	
426.	18	Prescott	27	Quarters	AZ	MH	2,094	3003		H	1908	Unreinforced masonry	N01	
427.	18	Prescott	28	Administration	AZ	MH	8,918	1001		H	1908	Unreinforced masonry	N02	
428.	18	Prescott	70	Administration	AZ	MH	20,290	1001		H	1922	Unreinforced masonry	N02	
429.	18	Prescott	76	Quarters	AZ	MH	5,510	3003		H	1922	Unreinforced masonry	N01	
430.	18	Prescott	77	Quarters	AZ	MH	5,510	3003		H	1922	Unreinforced masonry	N01	
431.	18	Prescott	78	Non-Housekeeping Quarters	AZ	MH	5,526	3003		H	1922	Unreinforced masonry	N01	
432.	18	Prescott	83	Gasoline Storage	AZ	MH		4008	C	H				
433.	18	Prescott	107	Hospital	AZ	MH	99,027	2101	C		1937	Concrete shear wall	N04	HR
434.	18	Prescott	108	Dietetics/PM&RS	AZ	MH	16,782	2109	E		1939	Concrete shear wall	N02	HR
435.	18	Prescott	111	Boiler Plant	AZ	MH	6,982	5001	C		1955	Steel frm. w/-infill	N01	HR
436.	18	Prescott	112	Laundry Distribu/CWT Shops	AZ	MH	9,493	6006			1957	Concrete shear wall	N02	
437.	18	Prescott	117	Outpatient Clinic	AZ	MH	12,221	2104	C		1975	Other - describe	N01	HR
438.	18	Prescott	152	Chapel	AZ	MH	3,000	6004			1986	Reinf. masonry bearing wall	N01	
439.	18	Prescott	154	Library	AZ	MH	3,000	8002			1986	Reinf. masonry bearing wall	N01	
440.	NC	Prescott	3W01	Pump House	AZ	MH	324	5006			1973	Concrete shear wall	N01	
441.	18	Prescott	T5	Credit Union	AZ	MH	4,597	1005			1947	Wood, light frame	N01	
442.	18	Prescott	T-5	(T-5) - Credit Union, Canteen Storage	AZ	MH		1005		H				
443.	NC	Puerto Rico	1001	Admin. Building	PR	H	2,245	1001			1985	Reinf. masonry bearing wall	N01	
444.	NC	Puerto Rico	3002	Utility Building	PR	H	2,400	5006			1981	Unreinforced masonry	N01	
445.	NC	Puerto Rico	3003	Employee Building	PR	H	1,600	1001			1981	Unreinforced masonry	N01	
446.	NC	Puerto Rico	3301	Flammable Storage Building	PR	H	120	4008	C		1981	Unreinforced masonry	N01	
447.	21	Reno	7	Laundry	NV	VH	8,227	6006			1981	Reinf. masonry bearing wall	N01	
448.	21	Reno	1A	Administration	NV	VH	29,413	1001			1937	Concrete shear wall	N03	
449.	NC	Riverside	1001	Administration Building	CA	VH	9,072	1001			1977	Other - describe	N01	
450.	NC	Riverside	3002	Utility Building	CA	VH	2,656	5006			1977	Reinf. masonry bearing wall	N01	
451.	NC	Riverside	3004	Employee Building	CA	VH	2,304	1001			1977	Reinf. masonry bearing wall	N01	
452.	NC	Riverside	3006	Flammable Storage	CA	VH	720	4008	C		1977	Reinf. masonry bearing wall	N01	
453.	NC	Riverside	4104	Amphitheater	CA	VH	1,000	8001			1977	Concrete shear wall	N01	
454.	NC	Riverside	3W01	Pump Station	CA	VH	338	5006			1977	Concrete shear wall	N01	
455.	NC	Riverside	3W02	Pump Station	CA	VH	300	5006			1980	Concrete shear wall	N01	
456.	20	Roseburg	1	Main Hospital Building	OR	VH	123,320	2101	C	H	1933	Conc. frm. w/ infill	N05	EHR
457.	20	Roseburg	2	Mental Health/Continued Treatment	OR	VH	67,613	2106	C	H	1933	Conc. frm. w/ infill	N03	EHR
458.	20	Roseburg	3	Administrative Building	OR	VH	12,394	1001		H	1933	Conc. frm. w/ infill	N03	
459.	20	Roseburg	4	Director's Quarters	OR	VH	4,292	3003		H	1933	Unreinforced masonry	N02	
460.	20	Roseburg	5	Quarters	OR	VH	6,788	3003		H	1933	Unreinforced masonry	N02	
461.	20	Roseburg	6	Quarters/AHEC	OR	VH	6,788	3003		H	1933	Unreinforced masonry	N02	
462.	20	Roseburg	7	Boiler Plant	OR	VH	3,600	5001	C	H	1933	Steel frm. w/-infill	N01	HR
463.	20	Roseburg	11	Laundry	OR	VH	11,714	6006		H	1933	Unreinforced masonry	N01	
464.	20	Roseburg	16	Canteen/Library/Chapel	OR	VH	15,065	6002		H	1933	Conc. frm. w/ infill	N02	

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465.	20	Roseburg	17	Mental Health Building	OR	VH	6,480	2107	E	H	1933	Unreinforced masonry	N01	HR
466.	20	Roseburg	58	Clothing Room	OR	VH	3,914	1001			1970	Steel light frame	N01	
467.	20	Roseburg	63	HazMat	OR	VH	392	4009	C		1980		N01	
468.	20	Roseburg	82	Chiller Bldg.	OR	VH	2,400	5006			2002		N01	
469.	NC	Roseburg	3301	Flammable Storage Building	OR	VH	75	4008	C		1980	Wood, light frame	N01	
470.	21	Sacramento NCHCS	88	McClellan Dental Clinic	CA	MH	8,900	2105	C		1980	Concrete shear wall	N01	HR
471.	21	Sacramento NCHCS	650	Mather Main Hospital Building	CA	MH	132,208	2101	C		1967	Steel frm. w/-infill	N03	HR
472.	21	Sacramento NCHCS	722	Research	CA	MH	5,040	7001	E		1988		N01	HR
473.	21	Sacramento NCHCS	728	Physical Med and Rehab Serv.	CA	MH	8,628	2108	E		1965	Reinf. masonry bearing wall	N01	HR
474.	21	Sacramento NCHCS	800	Admin bldg	CA	MH	2,387	1001					N01	
475.	21	Sacramento NCHCS	803	Dental Administration	CA	MH	1,440	1002			1991		N01	
476.	21	Sacramento NCHCS	2880	Mental Health	CA	MH	5,361	2107	E		1953		N01	HR
477.	21	Sacramento NCHCS	RE1	Resident Engineer Bldg., Travis	CA	MH	1,440	1099			1994		N01	
478.	21	Sacramento NCHCS	RE2	Resident Engineer Bldg., Sacto.	CA	MH	1,440	1099			1989		N01	
479.	19	Salt Lake City	11	Human Resources	UT	VH	12,025	1001			1949	Wood, light frame	N02	
480.	19	Salt Lake City	12	VISN (Field Office)	UT	VH	2,824	1001			1949		N02	
481.	19	Salt Lake City	15	General Counsel	UT	VH	3,259	1001			1949	Wood, light frame	N02	
482.	19	Salt Lake City	29	Research	UT	VH	177	7001	E		1949	Unreinforced masonry	N01	
483.	19	Salt Lake City	37	Research	UT	VH	2,375	7001	E		1985		N01	HR
484.	19	Salt Lake City	11a	Fiscal	UT	VH	10,000	1099			1990		N02	
485.	19	Salt Lake City	C1	Concourse (Red-B.1 to B.3)	UT	VH	11,350	8031			1949	Concrete shear wall	N01	
486.	19	Salt Lake City	C2	Concourse (Blue-B.4 to B.2)	UT	VH	5,644	8031			1949	Concrete shear wall	N01	
487.	19	Salt Lake City	C3	Concourse (Green-B.1 to B.8)	UT	VH	5,507	8031			1949	Concrete shear wall	N01	
488.	19	Salt Lake City	CU	Credit Union	UT	VH	5,000	1005			1977	Precast conc frms w/ conc	N02	
489.	22	San Diego	1	Medical Center	CA	VH	854,900	2101	C		1972	Steel braced frame	N05	EHR
490.	22	San Diego	11	SCI	CA	VH	100,929	2102	C		1985	Steel braced frame	N02	EHR
491.	21	San Francisco	1	Research/Clinical/Admin.	CA	VH	37,765	2101	C	H	1933	Concrete shear wall	N04	EHR
492.	21	San Francisco	3	Engineering	CA	VH	5,756	2101	C	H	1933	Unreinforced masonry	N01	HR
493.	21	San Francisco	5	Prosthetics/Research	CA	VH	5,605	2101	C	H	1933	Concrete shear wall	N02	HR
494.	21	San Francisco	6	Research/Admin.	CA	VH	52,261	2101	C	H	1933	Concrete shear wall	N03	EHR
495.	21	San Francisco	7	Canteen/Auditorium/Chapel	CA	VH	36,128	8002		H	1933	Concrete shear wall	N03	HR
496.	21	San Francisco	8	Mental Health	CA	VH	25,522	2106	C	H	1933	Concrete shear wall	N03	EHR
497.	21	San Francisco	9	Mental Health Clinics	CA	VH	7,321	2106	C	H	1933	Concrete shear wall	N02	HR
498.	21	San Francisco	10	Quarters	CA	VH	7,321	2107	E	H	1933	Concrete shear wall	N02	HR
499.	21	San Francisco	11	Quarters	CA	VH	4,562	3002	E	H	1933	Concrete shear wall	N02	HR
500.	21	San Francisco	12	Research	CA	VH	38,910	7001	E	H	1933	Concrete shear wall	N02	EHR
501.	21	San Francisco	13	Engineering/Research	CA	VH	12,906	7001	E	H	1933	Concrete shear wall	N01	EHR
502.	21	San Francisco	15	Storage	CA	VH	350	6007	C		1933	Unreinforced masonry	N01	
503.	21	San Francisco	16	Clinical Svc Admin	CA	VH	3,587	1002					N01	
504.	21	San Francisco	18	Research/Admin.	CA	VH	9,600	1002	E	H	1934	Wood, comm. & industrial	N02	HR
505.	21	San Francisco	21	Animal Facility	CA	VH	1,900	7002	E	H	1933	Unreinforced masonry	N01	HR
506.	21	San Francisco	26	Hazardous Chemicals Storage	CA	VH	392	4008	C		1953	Unreinforced masonry	N01	
507.	21	San Francisco	203	Inpat Hospital/Clinic/Research	CA	VH	335,009	2101	C		1975	Concrete shear wall	N04	EHR
508.	NC	San Francisco	1001	Admin. Building	CA	VH	800	1001			1929	Unreinforced masonry	N01	
509.	NC	San Francisco	2001	Lodge	CA	VH	2,034	3003		H	1929	Unreinforced masonry	N01	
510.	08	San Juan	1	Main Hospital	PR	H	591,294	2101	C		1968	Steel moment frame	N11	EHR
511.	08	San Juan	7	Emergency Generator	PR	H	546	5003	C		1985		N01	
512.	08	San Juan	9	Credit Union	PR	H	3,920	1005			1977	Steel moment frame	N02	
513.	08	San Juan	18	District Counsel	PR	H	2,300	1099			1992		N01	
514.	08	San Juan	24	Chiller Plant	PR	H	2,530	5006			2000		N01	
515.	NC	Santa Fe	1301	Admin./Maint. Building	NM	MH	3,313	1001			1976	Reinf. masonry bearing wall	N01	
516.	NC	Santa Fe	2101	Lodge	NM	MH	1,134	3003		H	1895	Unreinforced masonry	N02	
517.	NC	Santa Fe	3001	Utility/Restroom Building	NM	MH	2,050	5006			1939	Unreinforced masonry	N01	
518.	NC	Santa Fe	3W01	Pump House	NM	MH	60	5006			1935	Concrete shear wall	N01	
519.	20	Seattle	7	Lodging	WA	VH	3,523	3003			1950	Wood, light frame	N01	
520.	20	Seattle	8	Research	WA	VH	8,892	7001	E		1950	Concrete shear wall	N02	HR
521.	20	Seattle	11	Animal Research	WA	VH	6,800	7002	E		1961	Reinf. masonry bearing wall	N02	HR
522.	20	Seattle	13	Medical Research	WA	VH	19,428	7001	E		1966	Reinf. masonry bearing wall	N02	EHR

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523	20	Seattle	18	Clinic/Administration Building	WA	VH	21,030	2103	C		1976	Wood, light frame	N02	EHR
524	20	Seattle	20	Retail Store	WA	VH	4,997	6003			1975	Wood, light frame	N01	
525	20	Seattle	22	Canteen Building	WA	VH	10,597	6002			1976	Wood, light frame	N01	
526	20	Seattle	30	canteen retail storage	WA	VH	770	6003			1979		N01	
527	20	Seattle	31	Magnetic Resonance Imaging	WA	VH	2,952	2103	C		1992	Fwd shr wall/Stl br frm	N01	HR
528	20	Seattle	35	Credit union	WA	VH	1,942	1005			2000		N01	
529	20	Seattle	100CC	Central Core	WA	VH	201,671	2101	C		1985	Steel braced frame	N01	EHR
530	20	Seattle	100D&T	Main Hosp. Diag & Treatment Wing	WA	VH	250,000	2101	C		1985	Steel braced frame	N04	EHR
531	20	Seattle	100EP	Energy Plant	WA	VH	21,648	5001	C		1985	Steel braced frame	N01	EHR
532	20	Seattle	100NHCU	NHCU	WA	VH	37,000	2101	C		1985	Steel braced frame	N02	EHR
533	20	Seattle	100NT	Nursing Towers	WA	VH	155,000	2101	C		1985	Steel braced frame	N07	EHR
534	22	Sepulveda	1	Admin/Research	CA	VH	54,236	1001			1954	Reinf. masonry bearing wall	N02	
535	22	Sepulveda	4	Clinical Care	CA	VH	79,312	1002	E		1954	Reinf. masonry bearing wall	N03	EHR
536	22	Sepulveda	5	Clinical Care	CA	VH	57,294	1002	E		1954	Reinf. masonry bearing wall	N03	EHR
537	22	Sepulveda	22	Recreation	CA	VH	27,400	8001			1954	Reinf. masonry bearing wall	N02	
538	22	Sepulveda	23	Gym/Swimming Pool	CA	VH	20,600	2108	E		1952	Steel frm. w/-infill	N01	
539	22	Sepulveda	24	Chapel	CA	VH	7,995	6004			1954	Reinf. masonry bearing wall	N01	
540	22	Sepulveda	25	Mental Health Offices	CA	VH	22,072	1002			1980	Other - describe	N01	
541	22	Sepulveda	45	Rehab Medicine & Warehouse	CA	VH	14,129	2108			1954	Reinf. masonry bearing wall	N02	
542	22	Sepulveda	47	Animal Research	CA	VH	2,797	7002	E		1954	Reinf. masonry bearing wall	N01	HR
543	22	Sepulveda	63	Vet Center	CA	VH	4,000	1004			1954	Reinf. masonry bearing wall	N02	
544	22	Sepulveda	99	Nursing Home	CA	VH	61,008	2102	C		1974	Reinf. masonry bearing wall	N01	
545	22	Sepulveda	103	Animal Research Facility	CA	VH	4,104	7002	C		1986	Reinf. masonry bearing wall	N01	HR
546	NC	Sitka	3301	Flammable Storage Building	AK	H	40	4008	C		1967	Wood, light frame	N01	
547	na	Somerville AMS	A	Administration	NJ	MH	25,188	1001			1942		N02	
548	03	St. Albans	69	Guard House	NY	MH	2,258	6008			1948	Steel frm. w/-infill	N01	
549	03	St. Albans	84	Boiler Plant	NY	MH	28,706	5001	C		1948	Steel frm. w/-infill	N01	HR
550	03	St. Albans	85	Nursing Home Care (C wng)	NY	MH	41,564	2102	C		1948	Steel frm. w/-infill	N03	HR
551	03	St. Albans	86	Nursing Home Care (D wing)	NY	MH	39,099	2102	C		1948	Steel frm. w/-infill	N03	HR
552	03	St. Albans	87	Nursing Home Care (B wing)	NY	MH	36,812	2102	C		1948	Steel frm. w/-infill	N03	HR
553	03	St. Albans	88	Subsistance Building	NY	MH	79,925	2101	C		1948	Steel frm. w/-infill	N03	HR
554	03	St. Albans	89	Nursing Home Care/Dom. (A)	NY	MH	132,243	2102	C		1948	Steel frm. w/-infill	N03	HR
555	03	St. Albans	90	Radiation Therapy	NY	MH	5,822	2103	C		1948	Steel frm. w/-infill	N01	HR
556	03	St. Albans	91	Nursing Home Care (E wing)	NY	MH	38,808	2102	C		1948	Steel frm. w/-infill	N03	HR
557	03	St. Albans	92	Nursing Home Care (F wing)	NY	MH	41,564	2102	C		1948	Steel frm. w/-infill	N03	HR
558	03	St. Albans	93	Nursing Home Care (F wing)	NY	MH	39,094	2102	C		1948	Steel frm. w/-infill	N03	HR
559	03	St. Albans	165	NYS Drug Treatment/J-CAP	NY	MH	24,454	2111	E		1960		N01	HR
560	03	St. Albans	166	NYS Drug Treatment/J-CAP	NY	MH	8,838	2111	E		1960		N01	HR
561	03	St. Albans	167	Generator Building	NY	MH	711	5003	C					
562	03	St. Albans	168	Generator Building	NY	MH	711	5003	C					
563	03	St. Albans	169	Electrical Substation	NY	MH	702	5006						
564	03	St. Albans	173	Laundry	NY	MH	63,335	6006			1948	Steel frm. w/-infill	N03	
565	03	St. Albans	176	Pump Station	NY	MH	1,540	5006						
566	15	St. Louis (JB)	4	Adm/Nurse Ed/Socl Wrk	MO	MH	27,411	1002			1923	Unreinforced masonry	N02	
567	15	St. Louis (JB)	27	Quarters	MO	MH	3,441	3003			1929	Wood, light frame	N01	
568	15	St. Louis (JB)	28	Quarters	MO	MH	3,559	3003			1929	Wood, light frame	N01	
569	15	St. Louis (JB)	29	Quarters	MO	MH	3,441	3003			1929	Wood, light frame	N01	
570	15	St. Louis (JB)	38	Main Switch Gear	MO	MH	228	5006			1951	Other - describe	N01	
571	15	St. Louis (JB)	48	Natl Media Develop.	MO	MH	10,670	1001			1952	Conc. frm. w/ infill	N01	
572	15	St. Louis (JB)	61	Rec./Auditorium	MO	MH	26,000	6001			1957	Conc. frm. w/ infill	N01	
573	15	St. Louis (JB)	63	Therap./Recreation-Pool	MO	MH	16,938	2108	E		1957	Unreinforced masonry	N01	
574	15	St. Louis (JB)	70	Boiler Plant	MO	MH	15,036	5001	C		1952	Steel frm. w/-infill	N01	HR
575	15	St. Louis (JB)	72	Dressing Room	MO	MH	31	8001			1952	Unreinforced masonry	N01	
576	15	St. Louis (JB)	88	Laundry	MO	MH	32,075	6006			1989	Reinf. masonry bearing wall	N01	
577	15	St. Louis (JB)	70A	Chiller Plant	MO	MH	2,971	5001	C		1965	Steel frm. w/-infill	N01	HR
578	15	St. Louis (JC)	1	Main Hospital	MO	MH	557,779	2101	C		1953	Steel frm. w/-infill	N11	HR
579	15	St. Louis (JC)	2	Research, Edu., Chapel, Med	MO	MH	29,498	2301			1953	Steel frm. w/-infill	N01	
580	15	St. Louis (JC)	3	IRM, Hypertension	MO	MH	13,779	2901	C		1953	Conc. frm. w/ infill	N02	

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581.	15	St. Louis (JC)	6	Research	MO	MH	7,287	7001	E		1953	Unreinforced masonry	N03	
582.	15	St. Louis (JC)	7	Research	MO	MH	6,399	7001	E		1953	Steel frm. w/-infill	N01	
583.	15	St. Louis (JC)	8	Boiler Plant	MO	MH	7,054	5001	C		1953	Steel frm. w/-infill	N01	
584.	15	St. Louis (JC)	11	Gas House	MO	MH	575	5006			1953	Concrete shear wall	N01	
585.	15	St. Louis (JC)	1A	Emergency Generator	MO	MH	689	5003	C		1953			
586.	15	St. Louis (JC)	6A	Research	MO	MH	7,722	7001	E		1969	Steel frm. w/-infill	N03	HR
587.	15	St. Louis (JC)	8A	Chiller Plant	MO	MH	6,388	5001	C		1962	Steel frm. w/-infill	N01	HR
588.	20	Vancouver	2	Laundry/Warehouse	WA	H	38,190	5005			1985	Wood, comm. & industrial	N01	
589.	20	Vancouver	3	Boiler Plant	WA	H	5,529	5001	C		1984	Reinf. masonry bearing wall	N02	HR
590.	20	Vancouver	11	Barnes Rehab Building	WA	H	133,263	2108	E		1992	Concrete shear wall	N04	EHR
591.	20	Vancouver	14	Gym	WA	H	12,659	8001			1943	Wood, light frame	N02	
592.	20	Walla Walla	1	Directors Quarters	WA	MH	6,134	3003		H	1877	Unreinforced masonry	N01	
593.	20	Walla Walla	2	Duplex Quarters	WA	MH	5,158	3003		H	1858	Unreinforced masonry	N01	
594.	20	Walla Walla	3	Duplex Quarters	WA	MH	4,846	3003		H	1858	Unreinforced masonry	N01	
595.	20	Walla Walla	4	Duplex Quarters	WA	MH	4,846	3003		H	1858	Unreinforced masonry	N01	
596.	20	Walla Walla	5	Duplex Quarters	WA	MH	5,116	3003		H	1858	Unreinforced masonry	N01	
597.	20	Walla Walla	7	Police	WA	MH	6,780	6007	C		1930	Unreinforced masonry	N01	HR
598.	20	Walla Walla	48	Quarters	WA	MH	3,898	3003		H	1888	Unreinforced masonry	N01	
599.	20	Walla Walla	49	Quarters	WA	MH	3,494	3003		H	1888	Unreinforced masonry	N01	
600.	20	Walla Walla	68	NHCU/Admin.	WA	MH	39,898	2102	C	H	1906	Unreinforced masonry	N03	HR
601.	20	Walla Walla	69	Mental Health	WA	MH	48,195	2106	C	H	1906	Unreinforced masonry	N03	HR
602.	20	Walla Walla	74	Ambulatory Care	WA	MH	21,500	2104	C		1922	Unreinforced masonry	N02	HR
603.	20	Walla Walla	75	Canteen	WA	MH	20,506	6002			1922	Unreinforced masonry	N02	
604.	20	Walla Walla	77	Human Resources	WA	MH	11,214	1001			1929	Unreinforced masonry	N01	
605.	20	Walla Walla	78	Theatre/Directors Suite	WA	MH	10,800	6001			1939	Unreinforced masonry	N02	
606.	20	Walla Walla	T7	Chapel	WA	MH	4,042	6004			1945	Wood, light frame	N01	
607.	22	West Los Angeles	23	Quarters	CA	VH	3,448	3003		H	1900	Wood, light frame	N03	
608.	22	West Los Angeles	63	Engineering M & O	CA	VH	720	1001			1959	Concrete shear wall	N01	
609.	22	West Los Angeles	90	Duplex Quarters	CA	VH	4,752	3003		H	1927	Wood, light frame	N02	
610.	22	West Los Angeles	91	Duplex Quarters	CA	VH	4,752	3003		H	1927	Wood, light frame	N02	
611.	22	West Los Angeles	111	Vacant Gate House (West Gate)	CA	VH	144	8018		H			N01	
612.	22	West Los Angeles	114	Research Lab	CA	VH	69,921	7001	E	H	1930	Conc. frm. w/ infill	N03	EHR
613.	22	West Los Angeles	115	Research Lab	CA	VH	60,314	7001	E	H	1930	Conc. frm. w/ infill	N03	EHR
614.	22	West Los Angeles	117	Research Lab	CA	VH	20,873	7001	E	H	1930	Concrete shear wall	N01	EHR
615.	22	West Los Angeles	205	Brentwood Hospital	CA	VH	53,047	2101	C	H	1937	Concrete shear wall	N03	EHR
616.	22	West Los Angeles	206	Brentwood Hospital	CA	VH	47,015	2101	C	H	1940	Concrete shear wall	N03	EHR
617.	22	West Los Angeles	207	Brentwood Hospital	CA	VH	47,015	2101	C	H	1940	Concrete shear wall	N03	EHR
618.	22	West Los Angeles	208	Brentwood Hospital	CA	VH	47,265	2101	C	H	1945	Concrete shear wall	N03	EHR
619.	22	West Los Angeles	210	Brentwood Hospital	CA	VH	39,677	1001		H	1945	Concrete shear wall	N03	
620.	22	West Los Angeles	211	Theater	CA	VH	11,490	6001		H	1946	Concrete shear wall	N01	
621.	22	West Los Angeles	212	Dom/Prosthetics	CA	VH	69,400	3001	E	H	1938	Concrete shear wall	N04	EHR
622.	22	West Los Angeles	218	Administration	CA	VH	75,121	1001		H	1941	Concrete shear wall	N04	
623.	22	West Los Angeles	220	Dental/Greco	CA	VH	29,876	1001		H	1939	Concrete shear wall	N04	
624.	22	West Los Angeles	222	Mail Out Pharmacy	CA	VH	26,565	2104	C		1938	Concrete shear wall	N03	EHR
625.	22	West Los Angeles	224	Laundry	CA	VH	29,257	5005			1946	Concrete shear wall	N02	
626.	22	West Los Angeles	226	Theater	CA	VH	20,875	6001		H	1940	Concrete shear wall	N01	
627.	22	West Los Angeles	233	HazMat	CA	VH	840	4008	C		0			
628.	22	West Los Angeles	236	Police HQ	CA	VH	7,018	6007	C		1945	Concrete shear wall	N01	HR
629.	22	West Los Angeles	256	Brentwood Hospital	CA	VH	47,675	2101	C	H	1946	Concrete shear wall	N02	EHR
630.	22	West Los Angeles	257	Brentwood Hospital	CA	VH	57,386	2101	C	H	1946	Concrete shear wall	N03	EHR
631.	22	West Los Angeles	258	Brentwood Admin.	CA	VH	64,715	2101	C	H	1946	Concrete shear wall	N04	EHR
632.	22	West Los Angeles	259	Com Work Therapy	CA	VH	9,400	2108	E		1945	Reinf. masonry bearing wall	N01	HR
633.	22	West Los Angeles	292	Water Treatment Plant	CA	VH	900	5001	C		1946	Concrete shear wall	N01	
634.	22	West Los Angeles	295	Steam Plant	CA	VH	5,720	5001	C		1947	Concrete shear wall	N01	HR
635.	22	West Los Angeles	298	Residential Treatment Center	CA	VH	4,187	3001	E		1935	Wood, light frame	N01	HR
636.	22	West Los Angeles	299	High Voltage Switchgear	CA	VH	550	5006			1980	Concrete shear wall	N01	
637.	22	West Los Angeles	300	Dietetics & ADP	CA	VH	66,824	2109	E		1952	Conc. frm. w/ infill	N03	EHR
638.	22	West Los Angeles	306	Cafeteria/Post Office	CA	VH	14,281	6002			1957	Concrete shear wall	N01	

No.	VISN	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	VA Occupancy Subcode	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code	Except: High Risk Code
639.	22	West Los Angeles	329	Golf Club House	CA	VH	265	8001						
640.	22	West Los Angeles	337	Research Animal House	CA	VH	6,772	7002	E		1962	Concrete shear wall	N01	HR
641.	22	West Los Angeles	500	Main Hospital	CA	VH	937,000	2101	C		1976	Steel braced frame	N06	EHR
642.	22	West Los Angeles	508	Laundry	CA	VH	45,000	6006			1998		N01	
643.	22	West Los Angeles	510	Transportation	CA	VH	4,782	1099			2002		N01	
644.	22	West Los Angeles	1001	Administration Building	CA	VH	3,524	1001			1970	Concrete shear wall	N01	
645.	20	White City	200	Administration	OR	H	12,936	1001			1942	Unreinforced masonry	N02	
646.	20	White City	202	Activities Building	OR	H	15,698	6008			1942	Unreinforced masonry	N02	
647.	20	White City	204	Domiciliary Bed	OR	H	19,015	3001	E		1942	Unreinforced masonry	N02	EHR
648.	20	White City	205	Domiciliary Bed	OR	H	18,248	3001	E		1942	Unreinforced masonry	N02	EHR
649.	20	White City	206	Domiciliary Bed	OR	H	19,015	3001	E		1942	Unreinforced masonry	N02	EHR
650.	20	White City	207	Domiciliary Bed	OR	H	19,095	3001	E		1942	Unreinforced masonry	N02	EHR
651.	20	White City	208	Domiciliary Bed	OR	H	18,596	3001	E		1942	Unreinforced masonry	N02	EHR
652.	20	White City	209	Phys.Medicine & Rehab, Group Clinics	OR	H	19,277	8001	E		1942	Unreinforced masonry	N02	EHR
653.	20	White City	210	Dom. Bed, Lib, Info. Mgt.	OR	H	19,070	1003			1942	Unreinforced masonry	N02	
654.	20	White City	211	Clin. Supp., Health Mgt.	OR	H	23,555	1002			1942	Unreinforced masonry	N02	
655.	20	White City	212	Dom. Bed, Psych., SPD	OR	H	19,178	2108	C		1942	Unreinforced masonry	N02	EHR
656.	20	White City	213	Domiciliary Bed	OR	H	18,405	3001	E		1942	Unreinforced masonry	N02	EHR
657.	20	White City	214	Domiciliary Bed	OR	H	18,495	3001	E		1942	Unreinforced masonry	N02	EHR
658.	20	White City	215	Domiciliary Bed	OR	H	18,240	3001	E		1942	Unreinforced masonry	N02	EHR
659.	20	White City	216	Domiciliary Bed	OR	H	18,439	3001	E		1942	Unreinforced masonry	N02	EHR
660.	20	White City	217	Domiciliary Bed	OR	H	18,495	3001	E		1942	Unreinforced masonry	N02	EHR
661.	20	White City	218	Domiciliary Bed	OR	H	19,070	3001	E		1942	Unreinforced masonry	N02	EHR
662.	20	White City	219	Canteen	OR	H	13,531	6002			1942	Unreinforced masonry	N01	
663.	20	White City	220	Theater, Canteen	OR	H	20,251	6001			1942	Unreinforced masonry	N02	
664.	20	White City	221	Domiciliary Bed	OR	H	18,991	3001	E		1942	Unreinforced masonry	N02	EHR
665.	20	White City	222	Voluntary Serv, Day Treatment, & Vac.	OR	H	19,045	1004			1942	Unreinforced masonry	N02	
666.	20	White City	223	Occupational & Compensated Work Tr	OR	H	19,358	2108	E		1942	Unreinforced masonry	N02	EHR
667.	20	White City	224	A&MMS, Social Work	OR	H	19,045	1002			1942	Unreinforced masonry	N02	
668.	20	White City	228	FMS Admin	OR	H	2,736	1001			1942	Unreinforced masonry	N01	
669.	20	White City	229	Facilities Management Office	OR	H	3,760	1001			1942	Unreinforced masonry	N01	
670.	20	White City	232	Boiler Plant	OR	H	13,419	5001	C		1942	Unreinforced masonry	N02	EHR
671.	20	White City	236	Nutrition & Food Services	OR	H	20,000	2109	E		1942	Unreinforced masonry	N01	EHR
672.	20	White City	238	Nutrition & Food Services	OR	H	2,006	6002			1942	Unreinforced masonry	N01	
673.	20	White City	239	Domiciliary Bed	OR	H	18,240	3001	E		1942	Unreinforced masonry	N02	EHR
674.	20	White City	240	Rogue Comm. College	OR	H	18,240	2399			1942	Unreinforced masonry	N02	
675.	20	White City	243	Community Resources	OR	H	18,240	8001			1942	Unreinforced masonry	N02	
676.	20	White City	245	Personnel Quarters	OR	H	26,000	3003			1942	Unreinforced masonry	N01	
677.	20	White City	248	Chapel	OR	H	5,793	6004			1942	Unreinforced masonry	N01	
678.	20	White City	249	Eagle Pt. Alt. Sch. / Stor.	OR	H	5,852	2399			1942	Unreinforced masonry	N01	
679.	20	White City	250	Personnel Quarters	OR	H	21,300	3003			1942	Unreinforced masonry	N02	
680.	20	White City	251	Transportation Center/DAV	OR	H	571	1004			1952	Unreinforced masonry	N01	
681.	20	White City	256	FMS WATER INTAKE	OR	H	146	5006			1942			
682.	20	White City	260	FMS WATER INTAKE	OR	H	181	5006			1942			
683.	20	White City	261	Nut. & Food Service	OR	H	1,282	6002			1955	Unreinforced masonry	N01	
684.	20	White City	269	Stadium	OR	H	7,020	8001			1957	Unreinforced masonry	N01	
685.	20	White City	273	FMS EMER.EQUIP.	OR	H	485	6007	C		1957			
686.	20	White City	274	NUTR&FS. BREAK-SMOKE	OR	H	330	6002			1990			
687.	NC	Willamette	1001	Administration Building	OR	H	3,300	1001			1973	Concrete shear wall	N01	
688.	NC	Willamette	2001	Lodge	OR	H	3,204	3003			1951	Wood, light frame	N01	
689.	NC	Willamette	3002	Utility Building	OR	H	2,130	5006			1984	Concrete shear wall	N01	
690.	NC	Willamette	3003	Employee Building	OR	H	1,900	1001			1950	Wood, light frame	N01	
691.	NC	Willamette	3W03	Pump House	OR	H	600	5006			1974	Reinf. masonry bearing wall	N01	

APPENDIX D

Medical Center Data

Medical Center Number	VISN	Medical Center Name	State	State (or Territory) Code	County Code	Zip Code	FEMA 178 Seismicity	FEMA 310 Seismicity	FEMA 2000 Seismicity	Soil Type - UBC 94	Soil Type - FEMA 310	USGS 2/50 - Ss	USGS 2/50 - S1	H-08-8 Amax	H-18-8 Modified Z	USGS 10/50 - PGA
915	NC	Abraham Lincoln	IL	017	197	60421	L	L	L			0.213	0.077			0.029
528A8	02	Albany	NY	036	001	12208	M	ML	ML	S4	E	0.271	0.090	0.070	0.150	0.043
501	18	Albuquerque	NM	035	001	87108	M	MH	MH	S3	D	0.619	0.184	0.200	0.200	0.117
502	16	Alexandria	LA	022	079	71301	L	L	L			0.140	0.069			0.019
825	NC	Alexandria	LA	022	079	71359	L	L	L			0.141	0.070			0.019
826	NC	Alexandria	VA	051	013	22301	L	L	L			0.178	0.063			0.026
553A	11	Allen Park	MI	026	163	48101	L	L	L			0.127	0.047			0.019
800	NC	Alton	IL	017	119	62002	M	MH	MH			0.475	0.162			0.079
503	04	Altoona	PA	042	013	16603	L	L	L			0.165	0.060			0.023
504	18	Amarillo	TX	048	375	79106	L	L	L			0.166	0.043			0.021
663A4	20	American Lake	WA	053	053	98498	H	H	H	S2	D	1.217	0.392	0.200	0.300	0.282
463	20	Anchorage	AK	002	020	99508	H	H	VH			1.504	0.562			0.500
506	11	Ann Arbor	MI	026	161	48105	L	L	L			0.122	0.046			0.018
801	NC	Annapolis	MD	024	003	21401	L	L	L			0.181	0.063			0.026
637	06	Asheville	NC	037	021	28805	M	MH	MH	S2		0.438	0.139	0.070		0.076
646A4	04	Aspinwall	PA	042	003	15215	L	L	L			0.128	0.057			0.020
508	07	Atlanta	GA	013	121	30033	M	ML	ML	S3	E	0.260	0.113	0.120	0.120	0.045
509	07	Augusta	GA	013	245	30910	M	MH	MH			0.421	0.151	0.150	0.150	0.068
509A0	07	Augusta (Lenwood)	GA	013	245	30910	M	MH	MH	S2	D	0.421	0.151	0.150	0.150	0.068
827	NC	Balls Bluff	VA	051	107	20175	L	L	L			0.185	0.064			0.026
512	05	Baltimore	MD	024	510	21201	L	L	L			0.195	0.064			0.029
802	NC	Baltimore	MD	024	510	21201	L	L	L			0.195	0.064			0.029
512GD	05	Baltimore/Loch Raven	MD	024	510	21201	L	L	L			0.195	0.064			0.029
828	NC	Barrancas	FL	012	033	32501	L	L	L			0.103	0.056			0.013
528A4	02	Batavia	NY	036	037	14020	M	ML	ML	S3	E	0.320	0.075	0.200	0.100	0.042
803	NC	Bath	NY	036	101	14810	L	L	L			0.187	0.064			0.028
528A6	02	Bath	NY	036	101	14810	L	L	L			0.187	0.064	0.050	0.080	0.028
829	NC	Baton Rouge	LA	022	033	70801	L	L	L			0.145	0.062			0.017
515	11	Battle Creek	MI	026	025	49015	L	L	L			0.118	0.050			0.017
516	08	Bay Pines	FL	012	103	33510	L	L	L			0.091	0.038			0.010
830	NC	Bay Pines	FL	012	103	33510	L	L	L			0.091	0.038			0.010
831	NC	Beaufort	SC	045	013	29901	M	MH	MH			0.702	0.215			0.087
517	06	Beckley	WV	054	081	25801	L	ML	ML			0.283	0.095			0.046
518	01	Bedford	MA	025	017	01730	M	ML	ML	S1	C	0.337	0.091	0.100	0.150	0.050
804	NC	Beverly	NJ	034	005	08010	L	ML	ML			0.330	0.082			0.048
519	18	Big Spring	TX	048	227	79720	L	L	L			0.110	0.033			0.015
520	16	Biloxi	MS	028	047	39531	L	L	L			0.143	0.061			0.017
832	NC	Biloxi	MS	028	047	39530	L	L	L			0.140	0.060			0.017
521	07	Birmingham	AL	001	073	35233	L	ML	ML	S3	E	0.316	0.115	0.110	0.080	0.047
884	NC	Black Hills	SD	046	093	57785	L	L	L			0.126	0.039			0.021
531	20	Boise	ID	016	001	83702	L	MH	MH	S3		0.385	0.120	0.150	0.200	0.072
549A4	17	Bonham	TX	048	147	75418	L	L	L			0.168	0.070			0.024
523	01	Boston	MA	025	025	02130	M	ML	ML	S2		0.314	0.088	0.100	0.150	0.048
673GA	08	Brevard	FL	012		32940		L	L			0.097	0.042			
523A5	01	Brockton	MA	025	023	02401	M	ML	ML	S1	C	0.285	0.084	0.100	0.150	0.044
526	03	Bronx	NY	036	005	10468	M	MH	MH			0.425	0.094	0.100	0.150	0.063
630A4	03	Brooklyn	NY	036	047	11209	M	MH	MH	S2		0.418	0.093			0.061
528	02	Buffalo	NY	036	029	14215	M	ML	ML	S1	C	0.325	0.070	0.070	0.080	0.043
529	04	Butler	PA	042	019	16001	L	L	L			0.127	0.055			0.020
805	NC	Calverton	NY	036	103	11933	M	ML	ML			0.255	0.075			0.036
806	NC	Camp Butler	IL	017	167	62701	L	ML	ML			0.256	0.117			0.041
833	NC	Camp Nelson	KY	021	113	40356	L	ML	ML			0.243	0.104			0.038
528A5	02	Canandaigua	NY	036	069	14424	L	L	L			0.222	0.070	0.050	0.080	0.032
620A4	03	Castle Point	NY	036	027	12511	M	ML	ML			0.336	0.090			0.050

Medical Center Number	VISN	Medical Center Name	State	State (or Territory) Code	County Code	Zip Code	FEMA 178 Seismicity	FEMA 310 Seismicity	FEMA 2000 Seismicity	Soil Type - UBC 94	Soil Type - FEMA 310	USGS 2/50 - Ss	USGS 2/50 - S1	H-08-8 Amax	H-18-8 Modified Z	USGS 10/50 - PGA
834	NC	Cave Hill	KY	021	111	40201	L	ML	ML			0.248	0.119			0.038
534	07	Charleston	SC	045	019	29401	M	H	VH	S4	E	1.388	0.399	0.250	0.150	0.165
835	NC	Chattanooga	TN	047	065	37401	M	MH	MH			0.547	0.143			0.086
442	19	Cheyenne	WY	056	021	82001	L	L	L			0.183	0.055			0.031
537GD	12	Chicago (Lakeside)	IL	017	031	60611	L	L	L			0.182	0.064			0.025
537	12	Chicago (Westside)	IL	017	031	60612	L	L	L			0.187	0.064			0.025
538	10	Chillicothe	OH	039	141	45601	L	L	L			0.178	0.076			0.030
539	10	Cincinnati	OH	039	061	45220	L	L	L			0.185	0.087	0.060	0.080	0.032
836	NC	City Point	VA	051	149	23860	L	L	L			0.223	0.075			0.032
540	04	Clarksburg	WV	054	033	26301	L	L	L			0.156	0.065			0.024
541A0	10	Cleveland/Brecksville	OH	039	035	44106	L	L	L			0.215	0.058			0.026
541	10	Cleveland/Wade Park	OH	039	035	44106	L	L	L			0.215	0.058			0.026
542	04	Coatesville	PA	042	029	19320	M	ML	ML			0.323	0.080			0.044
837	NC	Cold Harbor	VA	051	085	23111	L	L	L			0.247	0.076			0.035
544	07	Columbia	SC	045	079	29209	M	MH	MH	S3	D	0.622	0.201	0.100	0.150	0.097
589A4	15	Columbia	MO	029	019	65201	L	L	L			0.185	0.095			0.027
838	NC	Corinth	MS	028	003	38834	L	MH	MH			0.451	0.188			0.056
807	NC	Crown Hill	IN	018	097	46201	L	L	L			0.185	0.092			0.030
839	NC	Culpeper	VA	051	047	22701	L	L	L			0.230	0.075			0.033
808	NC	Cypress Hills	NY	036	047	11201	M	MH	MH			0.422	0.093			0.063
549	17	Dallas	TX	048	113	75216	L	L	L			0.118	0.058			0.017
916	NC	Dallas/Fort Worth	TX	048	113	75201	L	L	L			0.120	0.058			0.017
550	11	Danville	IL	017	183	61832	L	L	L			0.223	0.099			0.036
809	NC	Danville	IL	017	183	61832	L	L	L			0.223	0.099			0.036
840	NC	Danville	KY	021	021	40422	L	ML	ML			0.225	0.109			0.037
841	NC	Danville	VA	051	143	24540	L	L	L			0.232	0.095			0.036
552	10	Dayton	OH	039	113	45428	L	L	L			0.217	0.082	0.050	0.080	0.013
810	NC	Dayton	OH	039	113	45390	L	ML	ML			0.252	0.082			0.035
554	19	Denver	CO	008	031	80220	L	L	L			0.191	0.058			0.032
636A6	23	Des Moines	IA	019	153	50310	L	L	L			0.073	0.042			0.010
553	11	Detroit	MI	026	163	48201	L	L	L			0.123	0.045			0.019
557	07	Dublin	GA	013	175	31021	L	ML	ML			0.237	0.109			0.035
558	06	Durham	NC	037	063	27705	L	L	ML			0.212	0.100			0.032
906	NC	Eagle Point	OR	041	029	97524	M	H	H			0.626	0.302			0.133
561	03	East Orange	NJ	034	013	07017	M	MH	MH	S2	D	0.423	0.094			0.064
756	18	El Paso	TX	048	141	79925	L	MH	MH			0.367	0.111			0.060
562	04	Erie	PA	042	049	16504	L	L	L	S2	D	0.163	0.054	0.100	0.100	0.025
437	23	Fargo	ND	038	017	58102	L	L	L			0.072	0.019			0.008
564	16	Fayetteville	AR	005	047	72701	L	L	L			0.191	0.098			0.025
565	06	Fayetteville	NC	037	051	28301	L	ML	ML			0.298	0.131			0.036
842	NC	Fayetteville	AR	005	143	72701	L	L	L			0.191	0.098			0.025
811	NC	Finn's Point	NJ	034	033	08079	L	ML	ML			0.277	0.073			0.036
843	NC	Florence	SC	045	041	29501	M	H	H			0.841	0.260			0.074
911	NC	Florida	FL	012	119	33513	L	L	L			0.105	0.045			0.012
885	NC	Fort Bayard	NM	035	017	88036	M	ML	ML			0.289	0.086			0.055
886	NC	Fort Bliss	TX	048	141	79906	L	MH	MH			0.370	0.112			0.060
909	NC	Fort Custer	MI	026	077	49012	L	L	L			0.115	0.049			0.016
844	NC	Fort Gibson	OK	040	101	74434	M	L	L			0.183	0.084			0.026
436	19	Fort Harrison	MT	030	049	59635	M	H	H	S3	E	0.938	0.235	0.300	0.300	0.167
845	NC	Fort Harrison	VA	051	087	23230	L	ML	ML			0.281	0.081			0.037
512GF	05	Fort Howard	MD	024	005	21052	L	L	L			0.193	0.063			0.028
887	NC	Fort Leavenworth	KS	020	103	66027	M	L	L			0.126	0.057			0.018
888	NC	Fort Logan	CO	008	031	80201	L	L	L			0.199	0.059			0.034
567	19	Fort Lyon	CO	008	011	81038	L	L	L			0.127	0.043			0.016

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889	NC	Fort Lyon	CO	008	011	81038	L	L	L			0.127	0.043			0.016
890	NC	Fort McPherson	NE	031	111	69151	L	L	L			0.088	0.031			0.013
568	23	Fort Meade	SD	046	093	57735	L	L	L			0.189	0.051			0.030
891	NC	Fort Meade	SD	046	093	57735	L	L	L			0.189	0.051			0.030
908	NC	Fort Mitchell	AL	001	113	36875	L	L	L			0.160	0.084			0.025
910	NC	Fort Richardson	AK	002	020	99505	H	H	VH			1.503	0.560			0.500
892	NC	Fort Rosecrans	CA	006	073	92101	H	H	VH			1.548	0.749			0.307
846	NC	Fort Sam Houston	TX	048	029	78201	L	L	L			0.120	0.034			0.012
893	NC	Fort Scott	KS	020	011	66701	L	L	L			0.121	0.068			0.018
920	NC	Fort Sill	OK	040		73503		ML	ML			0.349	0.091			
847	NC	Fort Smith	AR	005	131	72901	L	L	L			0.198	0.094			0.027
894	NC	Fort Snelling	MN	027	053	55401	L	L	L			0.057	0.027			0.008
539A	10	Fort Thomas	OH	039	061	43085	L	L	L			0.169	0.065			0.027
610A4	11	Fort Wayne	IN	018	003	46805	L	L	L			0.163	0.063			0.025
570	21	Fresno	CA	006	019	93703	H	MH	MH	S3	D	0.448	0.202	0.230	0.300	0.122
573	08	Gainesville	FL	012	001	32608	L	L	L			0.118	0.058			0.015
848	NC	Glendale	VA	051	087	23230	L	ML	ML			0.281	0.081			0.037
895	NC	Golden Gate	CA	006	081	94066	H	H	VH			2.084	1.493			0.879
812	NC	Grafton	WV	054	091	26354	L	L	L			0.158	0.064			0.024
636A4	23	Grand Island	NE	031	079	68803	L	L	L			0.124	0.040			0.018
575	19	Grand Junction	CO	008	077	81501	L	MH	MH	S3	D	0.378	0.084			0.068
520A0	16	Gulfport	MS	028	143	39531	M	L	L			0.143	0.061			0.017
590	06	Hampton	VA	051	650	23663	L	L	L			0.137	0.061			0.019
849	NC	Hampton	VA	051	199	23661	L	L	L			0.141	0.061			0.020
850	NC	Hampton (VAMC)	VA	051	199	23661	L	L	L			0.141	0.061			0.020
578	12	Hines	IL	017	031	60140	L	L	L			0.193	0.064			0.026
201	03	Hines VBA	IL	017	031	60140	L	L	L			0.193	0.064			0.026
459	21	Honolulu	HI	015	003	96850	M	MH	MH			0.613	0.178		0.190	0.130
896	NC	Hot Springs	SD	046	047	57747	L	L	L			0.186	0.049			0.027
568A4	23	Hot Springs	SD	046	047	57747	L	L	L			0.186	0.049			0.027
580	16	Houston	TX	048	201	77030	L	L	L			0.104	0.043			0.013
851	NC	Houston	TX	048	201	77001	L	L	L			0.105	0.043			0.013
362	03	Houston VBA	TX	048	201	77030	L	L	L			0.104	0.043			0.013
581	09	Huntington	WV	054	011	25704	L	L	L			0.221	0.088			0.035
583	11	Indianapolis	IN	018	097	46202	L	L	L			0.186	0.092	0.020	0.080	0.031
583A4	11	Indianapolis (CS Rd)	IN	018	097	46202	L	L	L			0.186	0.092	0.020	0.080	0.031
813	NC	Indiantown Gap	PA	042	075	17003	M	L	L			0.244	0.070			0.035
636A8	23	Iowa City	IA	019	103	52246	L	L	L			0.100	0.054			0.014
585	12	Iron Mountain	MI	026	043	49801	L	L	L			0.064	0.025			0.008
586	16	Jackson	MS	028	049	39216	L	L	L			0.191	0.096			0.024
323	02	Jackson VBA	MS	028	049	39216	L	L	L			0.191	0.096			0.024
852	NC	Jefferson Barracks	MO	029	510	63101	M	MH	MH			0.590	0.186			0.100
853	NC	Jefferson City	MO	029	051	65101	L	ML	ML			0.226	0.110			0.032
589	15	Kansas City	MO	029	047	64128	M	L	L			0.121	0.060			0.018
814	NC	Keokuk	IA	019	111	52632	L	L	L			0.137	0.077			0.021
854	NC	Kerrville	TX	048	265	78028	L	L	L			0.080	0.031			0.009
671A4	17	Kerrville	TX	048	265	78028	L	L	L			0.080	0.031			0.009
855	NC	Knoxville	TN	047	093	37901	M	MH	MH			0.572	0.146			0.097
636A7	23	Knoxville	IA	019	125	50138	L	L	L			0.079	0.047			0.011
573A4	08	Lake City	FL	012	023	32055	L	L	L			0.137	0.070			0.018
593	22	Las Vegas	NV	032	003	89102	M	MH	MH			0.625	0.186			0.125
897	NC	Leavenworth	KS	020	103	66043	M	L	L			0.126	0.058			0.018
589A6	15	Leavenworth	KS	020	103	66048	M	L	L			0.128	0.057			0.018
595	04	Lebanon	PA	042	075	17042	M	ML	ML			0.264	0.073			0.036

Medical Center Number	VISN	Medical Center Name	State	State (or Territory) Code	County Code	Zip Code	FEMA 178 Seismicity	FEMA 310 Seismicity	FEMA 2000 Seismicity	Soil Type - UBC 94	Soil Type - FEMA 310	USGS 2/50 - Ss	USGS 2/50 - S1	H-08-8 Amax	H-18-8 Modified Z	USGS 10/50 - PGA
856	NC	Lebanon	KY	021	155	40033	L	ML	ML			0.222	0.115			0.036
857	NC	Lexington	KY	021	067	40510	L	ML	ML			0.243	0.102			0.037
596A4	09	Lexington (CD)	KY	021	067	40511	L	ML	ML			0.253	0.100			0.038
596	09	Lexington (LD)	KY	021	067	40511	L	ML	ML			0.253	0.100			0.038
636A5	23	Lincoln	NE	031	109	68510	M	L	L			0.176	0.049	0.100	0.100	0.022
598	16	Little Rock	AR	005	119	72205	L	MH	MH			0.461	0.174	0.050	0.080	0.059
858	NC	Little Rock	AR	005	119	72201	L	MH	MH			0.480	0.179			0.056
640A4	21	Livermore	CA	006	001	94550	H	H	VH	S2	D	1.516	0.600	0.250	0.440	0.519
605	22	Loma Linda	CA	006	071	92357	H	H	VH			1.710	0.620	0.600	0.600	0.876
600	22	Long Beach	CA	006	037	90822	H	H	VH	S3	D	1.913	0.760	0.390	0.480	0.518
815	NC	Long Island	NY	036	059	11735	M	MH	MH			0.362	0.087			0.051
898	NC	Los Angeles	CA	006	037	90001	H	H	VH			1.505	0.600			0.416
691GE	22	Los Angeles	CA	006	037	90012	H	H	VH	S2	D	1.500	0.600	0.250	0.400	0.546
816	NC	Loudon Park	MD	024	510	21201	L	L	L			0.195	0.084			0.029
603	09	Louisville	KY	021	111	40202	L	ML	ML	S1	A	0.245	0.118	0.100	0.100	0.037
561A4	03	Lyons	NJ	034	035	07940	M	MH	MH			0.407	0.093			0.061
607	12	Madison	WI	055	025	53705	L	L	L			0.113	0.045			0.015
608	01	Manchester	NH	033	011	03104	M	MH	MH	S2	E	0.403	0.103	0.120	0.150	0.063
859	NC	Marietta	GA	013	067	30060	M	ML	ML			0.279	0.116			0.048
610	11	Marion	IN	018	053	46952	L	L	L			0.156	0.074			0.025
817	NC	Marion	IN	018	053	46952	L	L	L			0.156	0.074			0.025
657A5	15	Marion	IL	017	121	62959	M	H	H	S3	E	1.194	0.334	0.110	0.150	0.180
674A5	17	Marlin	TX	048	145	76661	L	L	L			0.104	0.048			0.013
612	21	Martinez/NCSC	CA	006	013	94523	H	H	VH	S2	D	1.592	0.600	0.480	0.600	0.651
613	05	Martinsburg	WV	054	003	25401	L	L	L			0.193	0.065	0.070	0.080	0.026
818	NC	Massachusetts	MA	025	001	02532	M	ML	ML			0.255	0.072			0.036
612GH	21	McClellan	CA			95652		MH	MH			0.455	0.203			
614	09	Memphis	TN	047	157	38104	H	H	VH	S2	D	1.292	0.391	0.250	0.300	0.137
860	NC	Memphis	TN	047	157	38104	H	H	VH			1.292	0.391			0.137
640A0	21	Menlo Park	CA	006	081	94025	H	H	VH	S2	C	1.500	0.823	0.400	0.520	0.823
546	08	Miami	FL	012	025	33125	L	L	L			0.062	0.024			0.005
436GJ	19	Miles City	MT	030	017	59301	L	L	L			0.108	0.036			0.017
861	NC	Mill Springs	KY	021	199	42544	L	ML	ML			0.240	0.116			0.040
695	12	Milwaukee (Wood)	WI	055	079	53295	L	L	L			0.119	0.047			0.016
618	23	Minneapolis	MN	027	053	55417	L	L	L			0.056	0.027			0.008
862	NC	Mobile	AL	001	097	36601	L	L	L			0.123	0.060			0.017
619	07	Montgomery	AL	001	101	36109	L	L	L			0.169	0.084			0.026
322	02	Montgomery VBA	AL	001	101	36109	L	L	L			0.169	0.084			0.026
620	03	Montrose	NY	036	119	10548	M	MH	MH			0.397	0.093			0.055
863	NC	Mound City	IL	017	153	62963	H	H	VH			3.270	1.030			0.216
621	09	Mountain Home	TN	047	179	37684	M	MH	MH	S2	D	0.448	0.135	0.100	0.150	0.023
864	NC	Mountain Home	TN	047	179	37684	M	MH	MH			0.448	0.135			0.023
626A4	09	Murfreesboro	TN	047	149	37130	L	ML	ML			0.274	0.134			0.044
623	16	Muskogee	OK	040	101	74401	M	L	L			0.185	0.084			0.026
626	09	Nashville	TN	047	037	37212	L	MH	MH			0.322	0.145			0.047
865	NC	Nashville	TN	047	037	37115	L	MH	MH			0.315	0.143			0.047
866	NC	Natchez	MS	028	001	39120	L	L	L			0.152	0.078			0.019
786	NC	NCA Operations Support	VA					L	L			0.189	0.066			
867	NC	New Albany	IN	018	043	47150	L	ML	ML			0.253	0.120			0.037
868	NC	New Bern	NC	037	049	28560	L	L	L			0.175	0.085			0.022
629	16	New Orleans	LA	022	071	70146	L	L	L			0.131	0.057			0.016
630	03	New York	NY	036	061	10010	M	MH	MH			0.424	0.094	0.100	0.150	0.063
689A4	01	Newington	CT	009	003	06111	M	ML	ML			0.277	0.085			0.041
914	NC	NMCA	AZ	004	013	85001	M	L	L			0.226	0.065			0.055

Medical Center Number	VISN	Medical Center Name	State	State (or Territory) Code	County Code	Zip Code	FEMA 178 Seismicity	FEMA 310 Seismicity	FEMA 2000 Seismicity	Soil Type - UBC 94		Soil Type - FEMA 310	USGS 2/50 - Ss	USGS 2/50 - S1	H-08-8 Amax		H-18-8 Modified Z	USGS 10/50 - PGA
899	NC	NMCP	HI	015	003	96850	M	MH	MH				0.613	0.178				0.130
556	12	North Chicago	IL	017	097	60064	L	L	L				0.162	0.059				0.023
598A0	16	North Little Rock	AR	005	119	72114	L	MH	MH	S1		C	0.499	0.183				0.059
631	01	Northampton	MA	025	015	01060	M	ML	ML	S2		E	0.256	0.087	0.100		0.150	0.040
632	03	Northport	NY	036	103	11768	M	MH	MH				0.354	0.087				0.049
635	16	Oklahoma City	OK	040	109	73104	M	ML	ML	S1		B	0.349	0.086	0.100		0.100	0.048
636	14	Omaha	NE	031	055	68105	L	L	L				0.121	0.042				0.017
673BY	08	Orlando	FL	012	095	32803	L	L	L				0.113	0.047				0.012
640	21	Palo Alto	CA	006	085	94304	H	H	VH	S2		C	2.114	1.079	0.500		0.600	0.823
512A5	05	Perry Point	MD	024	015	21902	L	ML	ML				0.274	0.073				0.036
642	04	Philadelphia	PA	042	101	19104	M	ML	ML				0.329	0.081				0.047
819	NC	Philadelphia	PA	042	101	19040	M	ML	ML				0.336	0.083				0.049
644	18	Phoenix	AZ	004	013	85012	M	L	L	S2		D	0.234	0.068	0.050		0.080	0.049
646A5	04	Pittsburgh (HD)	PA	042	003	15206	L	L	L				0.128	0.057				0.020
646	04	Pittsburgh (UD)	PA	042	003	15240	L	L	L				0.128	0.057				0.020
657A4	15	Poplar Bluff	MO	029	023	63901	H	H	H	S2		D	1.116	0.312	0.250		0.250	0.147
870	NC	Port Hudson	LA	022	033	70791	L	L	L				0.144	0.063				0.018
648	20	Portland	OR	041	051	97204	L	H	H	S2		C	1.046	0.343	0.150		0.300	0.191
649	18	Prescott	AZ	004	025	86303	M	MH	MH	S2		D	0.494	0.134	0.150		0.150	0.090
900	NC	Prescott	AZ	004	025	86301	M	MH	MH				0.470	0.133				0.089
650	01	Providence	RI	044	007	02908	M	ML	ML	S2		C	0.268	0.081	0.100		0.150	0.038
871	NC	Puerto Rico	PR	092	---	00956	H	H	H				1.000	0.400				
872	NC	Quantico	VA	051	153	22172	L	L	L				0.187	0.065				0.027
820	NC	Quincy	IL	017	001	62301	L	L	L				0.175	0.090				0.025
873	NC	Raleigh	NC	037	183	27601	L	ML	ML				0.213	0.101				0.030
654	21	Reno	NV	032	031	89520	H	H	VH	S2		C	1.358	0.488	0.500		0.420	0.326
652	06	Richmond	VA	051	087	23230	L	ML	ML				0.281	0.081	0.070		0.080	0.037
874	NC	Richmond	VA	051	087	23230	L	ML	ML				0.281	0.081				0.037
901	NC	Riverside	CA	065	065	92501	H	H	VH				1.500	0.600				0.536
821	NC	Rock Island	IL	017	161	61201	L	L	L				0.130	0.063				0.019
653	20	Roseburg	OR	041	019	97470	L	H	VH	S2		C	1.131	0.511	0.080		0.300	0.183
902	NC	Roseburg	OR	041	019	97470	L	H	VH				1.131	0.511				0.183
612A4	21	Sacramento NCHCS	CA			95655		MH	MH				0.425	0.197				
655	11	Saginaw	MI	026	145	48602	L	L	L				0.080	0.037				0.012
658	06	Salem	VA	051	161	24153	M	ML	ML	S2		D	0.314	0.100	0.120		0.120	0.048
659	06	Salisbury	NC	037	159	28144	M	ML	ML	S2		D	0.293	0.127	0.070		0.080	0.048
876	NC	Salisbury	NC	037	159	28144	M	ML	ML				0.293	0.127				0.048
660	19	Salt Lake City	UT	049	035	84148	H	H	VH	S2		D	1.769	0.788	0.300		0.300	0.267
671	17	San Antonio	TX	048	029	78284	L	L	L				0.121	0.035				0.012
877	NC	San Antonio	TX	048	029	78201	L	L	L				0.120	0.034				0.012
664	22	San Diego	CA	006	073	92103	H	H	VH	S1		B	1.622	0.786	0.150		0.400	0.307
662	21	San Francisco	CA	006	075	94121	H	H	VH	S2		D	1.638	0.962	0.300		0.440	0.680
903	NC	San Francisco	CA	006	075	94101	H	H	VH				1.500	0.752				0.527
913	NC	San Joaquin Valley	CA	006	077	95322	H	H	VH				1.500	0.598				0.527
672	08	San Juan	PR	092	---	00927	H	H	H	S3		E	1.000	0.400	0.120		0.300	
904	NC	Santa Fe	NM	035	049	87532	M	MH	MH				0.628	0.198				0.084
917	NC	Saratoga	NY	036	091	12871	M	ML	ML				0.298	0.095				0.048
663	20	Seattle	WA	053	033	98108	H	H	VH	S2		D	1.513	0.524	0.200		0.300	0.331
691A4	22	Sepulveda	CA	006	037	91343	H	H	VH	S3		E	1.702	0.731	0.450		0.600	0.546
878	NC	Seven Pines	VA	051	087	23150	L	L	L				0.246	0.076				0.033
666	19	Sheridan	WY	056	033	82801	L	ML	ML				0.271	0.060				0.043
667	16	Shreveport	LA	022	017	71101	L	L	L				0.168	0.081				0.022
438	23	Sioux Falls	SD	046	099	57117	L	L	L				0.113	0.036				0.015
905	NC	Sitka	AK	002	220	99835	H	H	H				0.647	0.431				0.300

Medical Center Number	VISN	Medical Center Name	State	State (or Territory) Code	County Code	Zip Code	FEMA 176 Seismicity	FEMA 310 Seismicity	FEMA 2000 Seismicity	Soil Type - UBC 94	Soil Type - FEMA 310	USGS 2/50 - Ss	USGS 2/50 - S1	H-08-8 Amax	H-18-8 Modified Z	USGS 10/50 - PGA
796	Staff	Somerville AMS	NJ					MH	MH			0.381	0.089			
668	20	Spokane	WA	053	063	99205	L	ML	ML	S2	D	0.317	0.092	0.100	0.200	0.061
879	NC	Springfield	MO	029	077	65801	L	ML	ML			0.213	0.106			0.028
630A5	03	St. Albans	NY	036	081	11412	M	MH	MH			0.408	0.092			0.060
875	NC	St. Augustine	FL	012	109	32084	L	L	L			0.126	0.063			0.017
656	23	St. Cloud	MN	027	145	56303	L	L	L			0.075	0.019			0.008
657A0	15	St. Louis (JB)	MO	029	510	63125	M	MH	MH	S3	D	0.600	0.189	0.110	0.150	0.101
657	15	St. Louis (JC)	MO	029	510	63125	M	MH	MH	S3	D	0.600	0.189	0.110	0.150	0.101
317	02	St. Petersburg VBA	FL	012	103	33510	L	L	L			0.910	0.038			0.010
860	NC	Staunton	VA	051	087	24401	L	L	L			0.247	0.084			0.035
528A7	02	Syracuse	NY	036	067	13210	L	L	L	S3	F	0.194	0.078	0.050	0.080	0.032
919	NC	Tahoma	WA	053	033	98031	H	H	VH			1.264	0.426			0.305
673	08	Tampa	FL	012	057	33612	L	L	L			0.088	0.038			0.010
674	17	Temple	TX	048	027	76504	L	L	L			0.088	0.042			0.012
402	01	Togus	ME	023	011	04330	M	ML	ML	S3	E	0.318	0.095	0.100	0.100	0.049
822	NC	Togus	ME	023	011	04330	M	ML	ML			0.318	0.095			0.049
676	12	Tomah	WI	055	081	54660	L	L	L			0.070	0.034			0.009
589A5	15	Topeka	KS	020	177	66610	M	L	L			0.184	0.059			0.024
678	18	Tucson	AZ	004	019	85701	M	ML	ML	S2	C	0.327	0.098	0.050	0.150	0.058
679	07	Tuscaloosa	AL	001	125	35404	L	ML	ML	S2	D	0.262	0.107	0.060	0.080	0.037
619A4	07	Tuskegee	AL	001	087	36083	L	L	L			0.167	0.084			0.026
648A4	20	Vancouver	WA	053	011	98660	M	H	H	S2	D	1.026	0.342	0.150	0.300	0.191
674A4	17	Waco	TX	048	309	76711	L	L	L			0.094	0.047			0.013
687	20	Walla Walla	WA	053	071	99362	L	MH	MH	S3	E	0.462	0.137	0.150	0.200	0.084
688	05	Washington, DC	DC	011	---	20301	L	L	L			0.178	0.063			0.026
689	01	West Haven	CT	009	009	06516	M	ML	ML			0.288	0.084			0.045
691	22	West Los Angeles	CA	006	037	90073	H	H	VH	S2	D	1.905	0.646	0.250	0.400	0.465
548	08	West Palm Beach	FL	012	099	33410	L	L	L			0.072	0.029			0.007
523A4	01	West Roxbury	MA	025	025	02132	M	ML	ML	S2	D	0.308	0.088	0.100	0.150	0.047
512	NC	West Virginia	WV	054	091	26354	L	L	L			0.158	0.064			0.024
692	20	White City	OR	041	029	97503	M	H	H	S2	C	0.628	0.305	0.070	0.300	0.134
405	01	White River Junction	VT	050	027	05001	M	ML	ML			0.341	0.106	0.070	0.150	0.055
589A7	15	Wichita	KS	020	173	67218	L	L	L	S2	D	0.139	0.057	0.070	0.080	0.020
693	04	Wilkes-Barre	PA	042	079	18711	M	L	L			0.234	0.075			0.034
907	NC	Willamette	OR	041	051	97201	L	H	H			1.052	0.350			0.191
460	04	Wilmington	DE	010	003	19805	L	ML	ML			0.314	0.078			0.041
881	NC	Wilmington	NC	037	129	28401	L	ML	ML			0.315	0.129			0.033
882	NC	Winchester	VA	051	015	22601	L	L	L			0.193	0.068			0.027
823	NC	Wood	WI	055	079	53201	L	L	L			0.117	0.046			0.010
824	NC	Woodlawn	NY	036	015	14901	L	L	L			0.174	0.065			0.026
883	NC	Zachary Taylor	KY	021	111	40201	L	ML	ML			0.248	0.119			0.038

APPENDIX E

Revised Occupancy Categories

VA Occupancy Subcode	FEMA Occupancy Code	FEMA Occupancy Name	VA Occupancy Subname	Essential/Critical Building Code [1]	Reason for Exemption Code [2]
1001	10	Office	General Administration Offices		E0
1002	10	Office	Clinical Service Administration Office		E0
1003	10	Office	Information Systems (Office Space)		E0
1004	10	Office	Veterans Services		E0
1005	10	Office	Credit Union		E0
1099	10	Office	Other Office		E0
1401	14	Post Office	Post Office		E0
2101	21	Hospital	Acute Care - General	C	E0
2102	21	Hospital	Long Term Care	C	E0
2103	21	Hospital	Clinical Diagnostic/Treatment	C	E0
2104	21	Hospital	Ambulatory Care - Primary	C	E0
2105	21	Hospital	Ambulatory Care - Subspecialty	C	E0
2106	21	Hospital	Mental Health - Inpatient	C	E0
2107	21	Hospital	Mental Health - Outpatient	E	E0
2108	21	Hospital	Rehabilitation Medicine	E	E0
2109	21	Hospital	Dietetics	E	E0
2110	21	Hospital	Drug/Alcohol Rehabilitation - I/P	E	E0
2111	21	Hospital	Drug/Alcohol Rehabilitation - O/P	E	E0
2181	21	Hospital	Rehabilitation Medicine - Blind Center	E	E0
2182	21	Hospital	Rehabilitation Medicine - Occupational	E	E0
2301	23	School	Training, Education		E0
2302	23	School	Medical School		E0
2399	23	School	Other School		E0
2901	29	Other Institutional	Information Systems (Equipment)	C	E0
2902	29	Other Institutional	Communications Center	C	E0
2903	29	Other Institutional	Emergency Command Center	C	E0
3001	30	Housing	Domiciliaries	E	E0
3002	30	Housing	Transitional Housing	E	E0
3003	30	Housing	General Staff Housing/Quarters		E0
3004	30	Housing	Healthcare Staff Quarters		E0
3005	30	Housing	Student Housing		E0
3006	30	Housing	Single, Duplex Quarters, LSZ		E2
4001	40	Storage	Materials Management Storage (Warehouse)		E1
4002	40	Storage	Maintenance Storage (Maint. Equipment)		E1
4003	40	Storage	Medical Records	E	E0
4004	40	Storage	Medical Equipment Storage	E	E0
4005	40	Storage	Parking Garage		E1
4006	40	Storage	Waste Storage		E1
4007	40	Storage	Medical Gas Storage	C	E0
4008	40	Storage	Hazardous Material Storage	C	E0
4099	40	Storage	Other Storage		E1
5001	50	Industrial	Central Plant Building	C	E0
5002	50	Industrial	Maintenance Facility (Shops)		E1
5003	50	Industrial	Emergency Generator	C	E0
5004	50	Industrial	Biomedical Eng. (Equip. & Wheelchair Repair)		E1
5005	50	Industrial	Waste Management (Incinerator & Recycle)		E1
5006	50	Industrial	Plant Outbuildings		E0
5007	50	Industrial	Accessory Non-Building Structures		E9f
5099	50	Industrial	Other Industrial		E1
6001	60	Service	Auditorium		E0

VA Occupancy Subcode	FEMA Occupancy Code	FEMA Occupancy Name	VA Occupancy Subname	Essential/Critical Building Code [1]	Reason for Exemption Code [2]
6002	60	Service	Canteen-Cafeteria		E0
6003	60	Service	Canteen-Retail Store		E0
6004	60	Service	Chapel		E0
6005	60	Service	Child Care		E0
6006	60	Service	Laundry		E0
6007	60	Service	Fire/Police	C	E0
6008	60	Service	Security (Guard Houses)		E0
6009	60	Service	Security - Accessory Buildings		E1
6099	60	Service	Other Service		E1
7001	70	Research	Medical Research	E	E0
7002	70	Research	Animal Facilities	E	E0
7003	70	Research	Rehabilitation/Prosthetics	E	E0
8001	80	Other	Recreational		E0
8002	80	Other	Library/Museum		E0
8003	80	Other	Connecting Corridors (General)		E9d
8004	80	Other	Toilets (Outhouses)		E1
8005	80	Other	Misc. Outbuildings		E1
8006	80	Other	Cemetery Building		E1
8007	80	Other	Greenhouses		E1
8008	80	Other	Vacant		E1
8009	80	Other	Non-buildings		E1
8010	80	Other	Temporary Buildings		E8
8011	80	Other	Buildings to be demolished		E8
8018	80	Other	Vacant - Leased to other Agencies		E0
8031	80	Other	Connecting Corr.-Concourse, Bridges		E0

[1] **Essential Codes:**
C: "Critical" - Immediate Occupancy Performance Objective
E: "Essential" - Immediate Occupancy Performance Objective
Blank: "Non-Essential" - Life Safety Performance Objective

[2] **Exemption Codes:**
E0: Not Exempt Based on Occupancy Only
E1: Building is classified for agricultural use
E2: Detached one- or two-family dwelling in a low or moderate seismic zone
E3: One story building of steel light frame wood construction with an area less than 3,000 square feet
E4: Building has been rehabilitated to comply with all four compliance categories of RP4
E5: Post-benchmark building or Research and post-1995
E6: Pre-benchmark shown by evaluation to be life safe in all four compliance categories
E7: Building was designed after the date of adoption of Executive Order 12699 (January 5, 1990) and the building was designed in accordance with the ICSSC Guidelines.
E8: Remaining useful life of the building is less than five years
E9a: Construction date between 1977 and 1990 and essential and thus designed using the H-08-8 standard
E9b: Building is located in an area of low seismicity
E9c: Building is non-essential and is located in an area of moderate-low seismicity
E9d: Building is a connecting corridor
E9e: Building is a trailer
E9f: Building is a non-building structure
E9g: Building was E0 but has been shown by evaluation to be compliant in all four categories.
E9h: Building is located in an area of moderate-low seismicity and therefore exempt, per October 2003 VA Structural Advisory Board decision.

APPENDIX F

Boiler Plant List

Number	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code	Reason for Exemp. Code
1.	Albany	4	Boiler Plant	NY	ML	2,759	C		1951	Steel frm. w/-infill shear walls	N02	E9h
2.	Alexandria	14	Boiler Plant	LA	L	4,400	C	H	1929			E9b
3.	Altoona	3	Boiler Plant & Garage	PA	L	23,374	C		1950			E9b
4.	Amarillo	11	Boiler Plant	TX	L	6,505	C	H	1939			E9b
5.	American Lake	23	Boiler Plant	WA	H	3,535	C	H	1923	Conc. frm. w/ infill shear walls	N01	E4
6.	Asheville	63	Building 15 Boiler	NC	MH	400	C		1993			E7
7.	Aspinwall	52	Boiler Plant	PA	L	12,415	C		1994		N02	E9b
8.	Augusta (Lanwood)	81	Boiler Plant, UD	GA	MH	8,656	C		1978			E9a
9.	Batavia	11	Boiler	NY	ML	7,450	C	H	1933	Steel frm. w/-infill shear walls	N02	E9h
10.	Bath	31	Boiler Plant/Tech Med Shop	NY	L	2,400	C	H	1885			E9b
11.	Bedford	22	Boilerplant	MA	ML	8,675	C	H	1928	Steel frm. w/-infill shear walls	N01	E9h
12.	Big Spring	2	Boiler/Chiller Plant	TX	L	8,044	C		1950			E9b
13.	Boise	46	Boiler Plant/Eng. Shops	ID	MH	8,817	C	H	1906			E4
14.	Bonham	10	Boiler / Chiller Plant	TX	L	9,000	C		1948			E9b
15.	Boston	5	Boiler Plant	MA	ML	6,156	C		1952	Steel frm. w/-infill shear walls	N04	E9h
16.	Brockton	40	Boiler Plant	MA	ML	4,500	C		1955	Conc. frm. w/ infill shear walls	N02	E9h
17.	Butler	7	Boiler Plant	PA	L	11,821	C		1938			E9b
18.	Canandaigua	12	Boiler Plant	NY	L	8,844	C	H	1931			E9b
19.	Canandaigua	13	Boiler Plant Emergency Gen.	NY	L	1,282	C		1978			E9a
20.	Castle Point	35	Boiler Plant/Chiller Plant	NY	ML	14,423	C		1980			E9a
21.	Cheyenne	13	Boiler Plant	WY	L	4,896	C	H	1932			E9b
22.	Chillicothe	259	Boiler Plant	OH	L	6,900	C		1970			E9b
23.	Cleveland/Brecksville	40	Boiler Plant	OH	L	6,000	C		1961			E9b
24.	Cleveland/Brecksville	41	Boiler Plant Machinery	OH	L	5,500	C		1961			E9b
25.	Coatesville	14	Boiler Plant	PA	ML	6,700	C	H	1929	Unreinforced masonry	N01	E9h
26.	Columbia	8	Boiler Plant/Incinerator	SC	MH	8,110	C	H	1932	Steel frm. w/-infill shear walls	N01	E0
27.	Dallas	10	Boiler Plant	TX	L	4,198	C		1940			E9b
28.	Danville	100	Boiler plant & incinerator	IL	L	20,000	C		1964	Steel moment frame	N01	E9b
29.	Dayton	147	Boiler Plant	OH	L	10,267	C		1962			E9b
30.	Denver	8	Boiler Plant	CO	L	3,359	C		1951			E9b
31.	Des Moines	11	Boiler Plant	IA	L	11,400	C	H	1932			E9b
32.	Durham	7	Boiler Plant	NC	ML	4,750	C		1953			E9h
33.	East Orange	8	Boiler Plant	NJ	MH	10,320	C		1950	Concrete shear wall	N01	E0
34.	Erie	7	M&R/Boiler Plant	PA	L	15,280	C		1950			E9b
35.	Fargo	10	Boiler Plant	ND	L	6,174	C		1945			E9b
36.	Fayetteville	10	Boiler Plant	AR	L	4,333		H	1933			E9b
37.	Fayetteville	11	Boiler Plant	NC	ML	8,047		H	1939			E9c
38.	Fort Harrison	142	Boiler Plant	MT	H	5,427	C		1932	Steel frm. w/-infill shear walls	N01	E4
39.	Fort Howard	226	Boiler Plant/Eng. Shops	MD	L	8,350	C		1943			E9b
40.	Fort Meade	137	Boiler Plant	SD	L	6,393	C		1958			E9b
41.	Fresno	2	Boiler Plant	CA	MH	4,756	C		1949	Concrete shear wall	N01	E6
42.	Grand Island	7	Boiler Plant	NE	L	9,096	C		1950			E9b
43.	Grand Island	18	Boiler Plant Generator Building	NE	L	110	C		1987			E9a
44.	Grand Junction	9	Boiler Plant	CO	MH	2,913	C		1949	Concrete shear wall	N01	E0
45.	Gulfport	6	Boiler Plant	MS	L	4,546	C		1923			E9b
46.	Gulfport	245	Boiler Plant	MS	L	6,250	C		1986			E9a
47.	Hampton	15	Boiler Plant	VA	L	24,546	C	H	1901			E9b
48.	Hines	5	Boiler Plant	IL	L	24,800	C		1921			E9b
49.	Hot Springs	18	Boiler Plant	SD	L	11,000	C	H	1907			E9b
50.	Houston	105	Boiler Plant	TX	L	11,310	C		1945			E9b
51.	Huntington	3	Boiler Plant	WV	L	6,257	C	H	1932			E9b
52.	Iowa City	16	Boiler Plant	IA	L	8,381	C		1978			E9a
53.	Iron Mountain	2	Boiler Plant / Garage	MI	L	13,106	C		1948			E9b
54.	Kansas City	4	Boiler / Chiller Plant	MO	L	8,243	C		1950			E9b
55.	Knoxville	77	Boiler Plant	IA	L	7,076	C		1939			E9b
56.	Lake City	37	Boiler Plant	FL	L	6,250	C		1936			E9b
57.	Leavenworth	39	Boiler Plant	KS	L	17,000	C	H	1896			E9b
58.	Lebanon	10	Boiler/Chiller/Coal Boiler Bld.	PA	ML	11,590	C		1947	Unreinforced masonry	N01	E9h
59.	Lexington (LD)	39	Boiler Plant	KY	ML	8,304	C		1951	Steel frm. w/-infill shear walls	N01	E9h
60.	Livermore	6	Boiler House	CA	VH	6,300	C		1924			E4

Number	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code	Reason for Exemp. Code
61.	Louisville	8	Boiler Plant	KY	ML	4,844	C		1952	Steel frm. w/-infill shear walls	N01	E9h
62.	Lyons	14	BoilerHouse	NJ	MH	4,816	C		1930	Steel frm. w/-infill shear walls	N01	E0
63.	Madison	2	Laundry / Boiler Plant	WI	L	26,500	C		1951			E9b
64.	Manchester	7	Boiler Plant/Maintenance	NH	MH	13,500	C		1949	Unreinforced masonry	N01	E0
65.	Marion	14	Boiler Plant	IL	L	5,110	C	H	1941	Concrete shear wall	N01	E0
66.	Marion	76	Boiler Plant	IN	H	8,595	C		1934			E9b
67.	Marlin	6	Boiler Plant	TX	L	2,952	C		1948			E9b
68.	Martinsburg	320	Boiler Plant	WV	L	8,336	C		1943			E9b
69.	Menlo Park	114	Boiler House	CA	VH	6,200	C	H	1929	Concrete shear wall	N01	E0
70.	Miles City	10	Boiler Plant	MT	L	10,000	C		1948			E9b
71.	Montgomery	14	Boiler Plant	AL	L	4,712	C	H	1940			E9b
72.	Montrose	20	Boiler Plant	NY	MH	7,133	C	H	1950	Unreinforced masonry	N01	E0
73.	Mountain Home	108	Boiler Plant - To be Demoed	TN	MH	9,541			1970			E8
74.	Murfreesboro	16	Boiler Plant	TN	ML	4,816	C	H	1939	Steel frm. w/-infill shear walls	N01	E9h
75.	New Orleans	6	Boiler Plant	LA	L	4,976	C		1952			E9b
76.	Newington	3	Boiler Plant & FMS	CT	ML	44,219	C	H	1931	Conc. frm. w/ infill shear walls	N02	E9h
77.	North Little Rock	69	Boiler Plant	AR	MH	4,875	C		1936	Unreinforced masonry	N01	E0
78.	Northampton	15	Boiler Plant	MA	ML	9,500	C	H	1923	Unreinforced masonry	N01	E9h
79.	Northport	203	Boiler Plant	NY	MH	6,972	C		1972	Conc. frm. w/ infill shear walls	N01	E0
80.	Oklahoma City	5	Boiler Plant	OK	ML	12,092			1952			E9c
81.	Omaha	2	Boiler Plant	NE	L	8,984	C		1950			E9b
82.	Orlando	502	Boiler Plant	FL	L	8,253	C		1980			E9b
83.	Palo Alto	40	Boiler House	CA	VH	6,200	C		1960	Concrete shear wall	N01	E0
84.	Perry Point	315	Boiler Plant	MD	ML	9,500	C		1969	Steel braced frame	N01	E9h
85.	Philadelphia	8	Boiler Plant	PA	ML	5,650	C		1950	Steel frm. w/-infill shear walls	N01	E9h
86.	Pittsburgh (UD)	5	Boiler house	PA	L	9,667	C		1954			E9b
87.	Poplar Bluff	7	Boiler Plant	MO	H	4,010	C		1950	Conc. frm. w/ infill shear walls	N01	E4
88.	Prescott	111	Boiler Plant	AZ	MH	6,046	C		1955	Steel frm. w/-infill shear walls	N01	E0
89.	Providence	10	Boiler Plant	RI	ML	3,878	C		1948	Steel frm. w/-infill shear walls	N01	E9h
90.	Reno	8	Boiler Plant	NV	VH	7,752	C		1981			E9a
91.	Roseburg	7	Boiler Plant	OR	VH	3,600	C	H	1933	Steel frm. w/-infill shear walls	N01	E0
92.	Saginaw	6	Boiler Plant	MI	L	3,432	C		1950			E9b
93.	Salem	13	Boiler Plant	VA	ML	23,725	C		1933	Steel frm. w/-infill shear walls	N01	E9h
94.	Salisbury	18	Boiler Plant	NC	ML	13,426	C		1951	Steel frm. w/-infill shear walls	N02	E9h
95.	San Antonio	1A	Boiler Plant	TX	L	2,831	C		1973			
96.	San Francisco	205	Boiler Plant	CA	VH	8,207	C		1973	Concrete shear wall	N01	E9g
97.	San Juan	16	Boiler Plant	PR	H	3,036	C		1997		N01	E7
98.	Sepulveda	40	Boiler / Chiller Plant	CA	VH	5,551	C		1954			E8
99.	Sepulveda	202	Boiler Plant	CA	VH	4,000	C		1996			E7
100.	Sheridan	90	Boiler House	WY	ML	4,858	C	H	1949	Steel frm. w/-infill shear walls	N01	E9h
101.	Shreveport	3	Boiler Plant	LA	L	7,538	C		1950			E9b
102.	Sioux Falls	11	Boiler Plant	SD	L	7,600	C		1960			E9b
103.	St. Albans	64	Boiler Plant	NY	MH	28,706	C		1948	Steel frm. w/-infill shear walls	N01	E0
104.	St. Cloud	7	Boilerhouse	MN	L	13,770	C	H	1923			E9b
105.	St. Louis (JB)	70	Boiler Plant	MO	MH	33,468	C		1952	Steel frm. w/-infill shear walls	N01	E0
106.	St. Louis (JC)	8	Boiler Plant	MO	MH	3,901	C		1953	Steel frm. w/-infill shear walls	N01	E0
107.	Togus	238	Boiler Plant	ME	ML	5,638	C		1963	Unreinforced masonry	N01	E9h
108.	Tomah	415	Boiler Plant	WI	L	6,586	C		1946			E9b
109.	Topeka	40	Boiler Plant	KS	L	5,724	C		1958			E9b
110.	Tucson	17	Boiler Plant	AZ	ML	4,644	C		1928	Steel frm. w/-infill shear walls	N01	E9h
111.	Tuskegee	12	Boiler Plant	AL	L	6,515	C	H	1923			E9b
112.	Vancouver	3	Boiler Plant	WA	H	5,529	C		1984	Reinf. masonry bearing wall	N02	E0
113.	Waco	14	Boiler Plant	TX	L	4,408	C		1932			E9b
114.	Walla Walla	76	Boiler Plant	WA	MH	4,043	C		1922	Unreinforced masonry	N01	E4
115.	West Haven	16	Boiler Plant	CT	ML	13,500	C		1916	Steel frm. w/-infill shear walls	N01	E9h
116.	West Roxbury	8	Boiler Plant	MA	ML	5,594	C		1945	Unreinforced masonry	N03	E9h
117.	White City	232	Boiler Plant	OR	H	6,446	C		1942	Unreinforced masonry	N02	E0
118.	White River Junction	2	Boiler Plant / Warehouse	VT	ML	9,217	C	H	1938	Unreinforced masonry	N01	E9h
119.	Wichita	13	Boiler Plant	KS	L	3,819	C	H	1934			E9b
120.	Wilkes-Barre	11	Boiler Room & Laundry	PA	L	24,717	C		1950			E9b
121.	Wilmington	7	Warehouse and Boiler Plant	DE	ML	20,470	C		1948	Steel frm. w/-infill shear walls	N01	E9h

APPENDIX G

Research Facilities

Number	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code
1.	18	501	Albuquerque	10	Research	NM	MH	23,000	E	H	1932	Conc. frm. w/ infill	N02
2.	18	501	Albuquerque	11	Research - Rehabilitation	NM	MH	17,300	E	H	1932	Concrete shear wall	N02
3.	18	501	Albuquerque	12	Research	NM	MH	2,200	E	H	1932	Unreinforced masonry	N01
4.	18	501	Albuquerque	15	Research	NM	MH	8,700	E	H	1932	Unreinforced masonry	N01
5.	18	501	Albuquerque	T1	Research	NM	MH	2,700	E				N01
6.	18	501	Albuquerque	T2	Research	NM	MH	2,700	E				N01
7.	18	501	Albuquerque	T46	Research	NM	MH	960	E		1967		N01
8.	20	663A4	American Lake	18	Research/IRM	WA	H	20,700	E	H	1923	Concrete shear wall	N01
9.	20	663A4	American Lake	T3	Research	WA	H	1,850	E		1980		N01
10.	11	506	Ann Arbor	22	Research	MI	L	16,282	E		1971		
11.	11	506	Ann Arbor	31	Research	MI	L	43,695	E		1995		
12.	07	508	Atlanta	T13	Prosthetics Bldg	GA	ML	5,440	E		1987		
13.	08	516	Bay Pines	23	Research / Support	FL	L	32,627	E		1977		
14.	01	518	Bedford	17	Research Bld	MA	ML	16,385	E	H	1930	Conc. frm. w/ infill	N02
15.	01	518	Bedford	18	GRECC Bld	MA	ML	16,386	E	H	1928	Conc. frm. w/ infill	N02
16.	01	518	Bedford	70	IPCC/HSR&D	MA	ML	63,958	E	H	1946	Conc. frm. w/ infill	N02
17.	01	518	Bedford	78	Patient Care Building	MA	ML	126,416	E		1959	Conc. frm. w/ infill	N04
18.	20	531	Boise	45	Research	ID	MH	5,595	E	H	1909	Unreinforced masonry	N01
19.	20	531	Boise	109	Veterinary Medicine Unit	ID	MH	17,000	E		1991		
20.	01	523	Boston	1A	Research	MA	ML	40,400	E		1971	Conc. moment frame	N03
21.	01	523A5	Brockton	46	Research	MA	ML	5,016	E		1955	Unreinforced masonry	N01
22.	03	526	Bronx	105	Research Building	NY	MH	103,500	E		1980		
23.	02	528	Buffalo	20	Research Building	NY	ML	84,585	E		1990		
24.	03	620A4	Castle Point	8	Research	NY	ML	12,897	E		1922	Unreinforced masonry	N03
25.	07	534	Charleston	T13	Prosthetics Building	SC	VH	5,440	E		1987		
26.	12	537GD	Chicago (Lakeside)	9	Medical Research	IL	L	42,278	E		1950		
27.	10	539	Cincinnati	5	Research	OH	L	12,499	E		1951		
28.	10	539	Cincinnati	15	Research	OH	L	31,376	E		1951		
29.	04	542	Coatesville	11	Research	PA	ML	21,600	E	H	1931	Conc. frm. w/ infill	N02
30.	07	544	Columbia	9	Research	SC	MH	32,847	E	H	1932	Conc. frm. w/ infill	N02
31.	07	544	Columbia	28T	USC Research	SC	MH	20,000	E		1932		N02
32.	17	549	Dallas	3	Research Laboratories	TX	L	26,402	E	H	1940		
33.	17	549	Dallas	43	Research & Education	TX	L	77,180	E		1978		
34.	11	550	Danville	13	Research	IL	L	39,703	E	H	1900	Unreinforced masonry	N02
35.	10	552	Dayton	127	Research	OH	L	9,530	E	H	1921		
36.	10	552	Dayton	307	Health Science	OH	L	34,340	E		1977		
37.	10	552	Dayton	315	Basic Science	OH	L	145,200	E		1931		
38.	19	554	Denver	19	Research	CO	L	14,131	E		1954		
39.	19	554	Denver	21	Research	CO	L	15,785	E		1971		
40.	06	558	Durham	2	Research	NC	ML	5,846	E		1953		
41.	06	558	Durham	4	Research	NC	ML	10,064	E		1953		
42.	06	558	Durham	10	Research	NC	ML	2,660	E		1953		
43.	06	558	Durham	14	Animal Research Facility	NC	ML	23,543	E		1959		
44.	03	561	East Orange	7	Research Building	NJ	MH	25,156	E		1950		N02
45.	03	561	East Orange	11	Research Building	NJ	MH	10,969	E		1955	Unreinforced masonry	N02
46.	03	561	East Orange	11A	Research Building	NJ	MH	1,400	E		1994		
47.	05	512GF	Fort Howard	T239	Orthotics Lab	MD	L	2,250	E		1992		
48.	21	570	Fresno	24	UCSF Research	CA	MH	30,000	E		1983	Concrete shear wall	N03
49.	08	573	Gainesville	11	Animal Research	FL	L	5,921	E		1976		
50.	06	590	Hampton	72	Research	VA	L	14,668	E		1908		
51.	12	578	Hines	229	Animal Research Facility	IL	L	4,500	E		1991		
52.	16	580	Houston	109	Research	TX	L	74,000	E		1979		
53.	16	580	Houston	110	Research	TX	L	62,900	E		1945		

Number	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	Essential/Critical Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code
54.	09	581	Huntington	5	Research	WV	L	13,087	E	H	1932		
55.	09	581	Huntington	23R	New Research Building	WV	L	29,055	E		1998		
56.	11	583	Indianapolis	19	Research	IN	L	4,220	E		1955		
57.	11	583	Indianapolis	21	Research	IN	L	5,136	E		1955		
58.	11	583A4	Indianapolis (CS Rd)	7	Prosthetics/I-B/HU (CSR)	IN	L	16,656	E	H	1934		
59.	23	636A8	Iowa City	2	Animal Research Fac/Warehs	IA	L	21,054	E		1951		
60.	23	636A8	Iowa City	3	Research Building	IA	L	29,301	E		1951		
61.	23	636A8	Iowa City	28	Research Building	IA	L	5,888	E		1987		
62.	16	586	Jackson	5	Research & Education	MS	L	65,520	E		1979		
63.	15	589	Kansas City	15	Research / Education	MO	L	75,438	E		1973		
64.	09	596	Lexington (LD)	5	Administration, Reference Lab	KY	ML	24,003	E	H	1931	Conc. frm. w/ infill	N02
65.	22	600	Long Beach	138	Research Services	CA	VH	61,658	E		1985	Concrete shear wall	N02
66.	09	603	Louisville	12	Animal Research	KY	ML	7,865	E		1954	Unreinforced masonry	N01
67.	09	603	Louisville	19	Clinical Research	KY	ML	8,269	E		1952	Steel frm. w/-infill	N02
68.	12	607	Madison	12	Animal Research Facility	WI	L	11,300	E		1963		
69.	12	607	Madison	13	Research Lab.	WI	L	12,255	E		1970		
70.	15	657A5	Marion	T110	Prosthetics	IL	H	1,440	E		1979		
71.	21	612	Martinez/NCSC	5/R-1	Laboratory/Research	CA	VH	11,500	E		1980	Steel light frame	N01
72.	21	612	Martinez/NCSC	AB1	IRM/A&SP Research	CA	VH	5,690	E		1979		N01
73.	21	612	Martinez/NCSC	R-2	Research	CA	VH	1,440	E		1991		
74.	21	612	Martinez/NCSC	R-3	Animal Research	CA	VH	2,160	E		1992		
75.	21	612	Martinez/NCSC	R-4	Research	CA	VH	7,920	E		1991		N01
76.	21	640A0	Menlo Park	205	Medical Research	CA	VH	72,300	E	H	1929	Concrete shear wall	N02
77.	08	546	Miami	7	Research & Education	FL	L	122,456	E		1980		
78.	08	546	Miami	8	ARF Lab	FL	L	2,727	E		1983		
79.	08	546	Miami	9	ARF Lab	FL	L	4,162	E		1983		
80.	12	695	Milwaukee (Wom)	70	Old Hospital Bldg & Research	WI	L	209,214	E		1922		
81.	12	695	Milwaukee (Wood)	T45	Research	WI	L	8,200	E		1998		N01
82.	23	618	Minneapolis	49	Animal Research Building	MN	L	45,754	E		1966		
83.	09	621	Mountain Home	5	Geriatric and Gen. Research	TN	MH	38,136	E	H	1905	Unreinforced masonry	N03
84.	09	621	Mountain Home	178	EUL - ETSU Research	TN	MH	182,900	E		2002		
85.	09	626A4	Murfreesboro	1	Admin., Medical Wards	TN	ML	99,456	E	H	1939	Conc. frm. w/ infill	N04
86.	09	626A4	Murfreesboro	4	Auditorium and Recreation	TN	ML	27,271	E	H	1941	Conc. frm. w/ infill	N01
87.	09	626A4	Murfreesboro	5	Medical Wards	TN	ML	70,579	E	H	1946	Conc. frm. w/ infill	N02
88.	01	689A4	Newington	5	Research	CT	ML	27,769	E	H	1931	Conc. frm. w/ infill	N02
89.	01	689A4	Newington	43	Research	CT	ML	3,872	E		1985		
90.	12	556	North Chicago	1	Research/Education	IL	L	43,131	E		1925		
91.	16	598A0	North Little Rock	58	Research/LREERC/HS R&D	AR	MH	43,885	E		1931	Conc. frm. w/ infill	N04
92.	16	598A0	North Little Rock	75	Animal Research	AR	MH	21,170	E		1940	Unreinforced masonry	N01
93.	16	598A0	North Little Rock	176	Animal Storage	AR	MH	3,485	E		1975	Reinf. masonry bearing wall	N01
94.	03	632	Northport	61	Research	NY	MH	33,690	E	H	1937	Conc. frm. w/ infill	N03
95.	03	632	Northport	62	Research	NY	MH	36,787	E	H	1937	Conc. frm. w/ infill	N03
96.	16	635	Oklahoma City	19	Research	OK	ML	41,078	E		1955	Conc. frm. w/ infill	N04
97.	14	636	Omaha	15	Research Building	NE	L	48,900	E		1975		
98.	21	640	Palo Alto	4	Research	CA	VH	90,100	E		1960	Concrete shear wall	N03
99.	21	640	Palo Alto	51	Rehab/Research & Develop Cr	CA	VH	23,100	E		1980	Steel frm w/ conc	N02
100.	21	640	Palo Alto	54	Animal Research Facility	CA	VH	18,100	E		1981	Steel frm w/ conc	N02
101.	21	640	Palo Alto	MB4	Nat'l Ctr for HIV/Hepatitis Res.	CA	VH	10,100	E		1990	Steel moment frame	N01
102.	05	512A5	Perry Point	4	Research	MD	ML	17,220	E	H	1918	Steel frm. w/-infill	N03
103.	05	512A5	Perry Point	33	Animal Lab	MD	ML	517	E	H	1918	Unreinforced masonry	N01
104.	05	512A5	Perry Point	362T	RESEARCH	MD	ML	1,960	E		1995		N01
105.	05	512A5	Perry Point	363T	RESEARCH	MD	ML	1,365	E		1996		N01
106.	04	642	Philadelphia	15	Research	PA	ML	6,690	E		1981		
107.	04	642	Philadelphia	21	Medical Research	PA	ML	61,620	E		1992		
108.	18	644	Phoenix	4	Nursing Edu./Prosthetics	AZ	L	4,676	E		1952		

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109.	04	646A5	Pittsburgh (HD)	13	Research/Community Suppt.	PA	L	8,550	E		1953		
110.	04	646	Pittsburgh (UD)	2	Research	PA	L	11,089	E		1954		
111.	04	646	Pittsburgh (UD)	6	Research	PA	L	19,448	E		1954		
112.	04	646	Pittsburgh (UD)	28	Research	PA	L	6,100	E		2003		
113.	20	648	Portland	6	Research	OR	H	22,028	E		1928	Conc. frm. w/ infill	N02
114.	20	648	Portland	16	Administration/Research	OR	H	24,099	E		1928	Conc. frm. w/ infill	N02
115.	20	648	Portland	101	Administration/Research	OR	H	129,692	E		1987	Steel braced frame	N06
116.	20	648	Portland	103	Research/Parking Structure	OR	H	91,648	E		1999		N06
117.	20	648	Portland	104	Research/Clinical	OR	H	40,972	E		1999		N03
118.	01	650	Providence	7	Research & Engineering	RI	ML	4,000	E		1948	Unreinforced masonry	N01
119.	01	650	Providence	9	Research	RI	ML	6,100	E		1948	Unreinforced masonry	N01
120.	01	650	Providence	35	Research	RI	ML	16,778	E		1996		
121.	21	654	Reno	15A	Research Modular	NV	VH	2,280	E		1997		
122.	21	654	Reno	J	Research Modular	NV	VH	980	E		1995		
123.	21	654	Reno	K	Research Modular	NV	VH	350	E		1995		
124.	21	654	Reno	MI	Research Modular	NV	VH	4,560	E		1995		
125.	21	612A4	Sacramento NCHCS	722	Research	CA	MH	5,040	E		1988		N01
126.	21	612A4	Sacramento NCHCS	722A	Research	CA	MH	1,384	E		2000		N01
127.	21	612A4	Sacramento NCHCS	806	Prosthetics	CA	MH	1,440	E		1991		N01
128.	21	612A4	Sacramento NCHCS	808	Research	CA	MH	1,440	E		1999		N01
129.	19	660	Salt Lake City	26	Research	UT	VH	217	E		1949	Steel light frame	N01
130.	19	660	Salt Lake City	29	Research	UT	VH	177	E		1949	Unreinforced masonry	N01
131.	19	660	Salt Lake City	30	Research	UT	VH	696	E		1949	Steel light frame	N01
132.	19	660	Salt Lake City	35	Research	UT	VH	1,177	E		1949	Steel light frame	N01
133.	19	660	Salt Lake City	45	Research	UT	VH	4,370	E		1969		
134.	19	660	Salt Lake City	37	Research	UT	VH	2,375	E		1985		N01
135.	22	664	San Diego	23	RESEARCH MODULAR	CA	VH	2,840	E		2001		N01
136.	21	662	San Francisco	2	Research/Admin.	CA	VH	126,249	E	H	1933		
137.	21	662	San Francisco	12	Research	CA	VH	36,910	E	H	1933	Concrete shear wall	N02
138.	21	662	San Francisco	13	Engineering/Research	CA	VH	12,906	E	H	1933	Concrete shear wall	N01
139.	21	662	San Francisco	21	Animal Facility	CA	VH	1,900	E	H	1933	Unreinforced masonry	N01
140.	20	663	Seattle	8	Research	WA	VH	8,892	E		1950	Concrete shear wall	N02
141.	20	663	Seattle	11	Animal Research	WA	VH	6,800	E		1961	Reinf. masonry bearing wall	N02
142.	20	663	Seattle	13	Medical Research	WA	VH	19,428	E		1966	Reinf. masonry bearing wall	N02
143.	20	663	Seattle	23	Animal Research	WA	VH	6,153	E		1982		
144.	20	663	Seattle	34	Animal Research	WA	VH	11,669	E		1995		
145.	22	691A4	Sepulveda	7	Engineering / EMS / Research	CA	VH	64,359	E		1954		
146.	22	691A4	Sepulveda	47	Animal Research	CA	VH	2,797	E		1954	Reinf. masonry bearing wall	N01
147.	22	691A4	Sepulveda	60	Research	CA	VH	4,995	E		1954	Reinf. masonry bearing wall	N02
148.	22	691A4	Sepulveda	80	Animal Research	CA	VH	699	E		1954	Reinf. masonry bearing wall	N01
149.	22	691A4	Sepulveda	85	Research	CA	VH	1,514	E		1954	Reinf. masonry bearing wall	N02
150.	22	691A4	Sepulveda	103	Animal Research Facility	CA	VH	4,104	E		1986	Reinf. masonry bearing wall	N01
151.	16	667	Shreveport	16	Animal Research	LA	L	3,578	E		1970		
152.	16	667	Shreveport	33	Research	LA	L	6,121	E		1986		
153.	23	438	Sioux Falls	28	Research Building	SD	L	6,660	E		1976		
154.	15	657	St. Louis (JC)	6	Research	MO	MH	7,287	E		1953	Unreinforced masonry	N03
155.	15	657	St. Louis (JC)	7	Research	MO	MH	6,399	E		1953	Steel frm. w/-infill	N01
156.	15	657	St. Louis (JC)	6A	Research	MO	MH	7,722	E		1969	Steel frm. w/-infill	N03
157.	15	657	St. Louis (JC)	7A	Research	MO	MH	2,367	E		1987		
158.	02	528A7	Syracuse	16	Research	NY	L	3,130	E		1958		
159.	02	528A7	Syracuse	T17	Research	NY	L	1,040	E		1995		
160.	08	673	Tampa	2	Research	FL	L	65,073	E		1972		
161.	17	674	Temple	147	T.A.M.U. Lab	TX	L	13,352	E		1942		

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162.	18	678	Tucson	6	Research	AZ	ML	20,165	E	H	1928	Unreinforced masonry	N02
163.	18	678	Tucson	10	Research	AZ	ML	4,000	E		1928	Unreinforced masonry	N01
164.	18	678	Tucson	32	Research, Animal House	AZ	ML	872	E		1931	Unreinforced masonry	N01
165.	18	678	Tucson	33	Storage/Kennel	AZ	ML	3,608	E		1937	Unreinforced masonry	N01
166.	18	678	Tucson	51	Research, Animal Pens	AZ	ML	480	E		1985		
167.	18	678	Tucson	56	Animal Research Lab	AZ	ML	10,265	E		1978		
168.	18	678	Tucson	64	Animal Research Lab	AZ	ML	1,413	E		1991		
169.	05	688	Washington, DC	4	Research	DC	L	22,962	E		1972		
170.	01	689	West Haven	3	Research/Administration	CT	ML	4,750	E		1916	Conc. frm. w/ infill	N01
171.	01	689	West Haven	4	Research/Administration	CT	ML	14,754	E		1916	Conc. frm. w/ infill	N01
172.	01	689	West Haven	5	Research/Administration	CT	ML	49,045	E		1916	Steel frm. w/-infill	N03
173.	01	689	West Haven	6	Research/Clinical	CT	ML	15,000	E		1916	Steel frm. w/-infill	N01
174.	01	689	West Haven	7	Research	CT	ML	5,000	E		1916	Steel frm. w/-infill	N01
175.	01	689	West Haven	27	Research	CT	ML	2,786	E		1960	Steel frm. w/-infill	N01
176.	01	689	West Haven	34	Research	CT	ML	6,560	E		1988		
177.	22	691	West Los Angeles	113	Animal Research	CA	VH	60,000	E	H	1930		
178.	22	691	West Los Angeles	114	Research Lab	CA	VH	69,921	E	H	1930	Conc. frm. w/ infill	N03
179.	22	691	West Los Angeles	115	Research Lab	CA	VH	60,314	E	H	1930	Conc. frm. w/ infill	N03
180.	22	691	West Los Angeles	117	Research Lab	CA	VH	20,873	E	H	1930	Concrete shear wall	N01
181.	22	691	West Los Angeles	265	Animal Storage	CA	VH	2,400	E		1944	Wood, light frame	N01
182.	22	691	West Los Angeles	304	Research Med. Sup.	CA	VH	89,267	E		1957	Concrete shear wall	N02
183.	22	691	West Los Angeles	337	Research Animal House	CA	VH	6,772	E		1962	Concrete shear wall	N01
184.	01	523A4	West Roxbury	20	Research	MA	ML	3,626	E		1950	Unreinforced masonry	N01
185.	01	523A4	West Roxbury	22	Research	MA	ML	1,284	E		1960	Reinf. masonry bearing wall	N01
186.	01	523A4	West Roxbury	30	Research	MA	ML	1,540	E		1960		N01
187.	01	405	White River Junction	44	Research Building	VT	ML	52,370	E		1991		
188.	01	405	White River Junction	45	Research Building	VT	ML	400	E		1991		
189.	01	405	White River Junction	T44	Research Lab	VT	ML	3,677	E		1982		
190.	15	589A7	Wichita	5	Research	KS	L	18,487	E	H	1934		
191.	04	460	Wilmington	15	Research	DE	ML	13,325	E		1972	Conc. frm. w/ infill	N02

APPENDIX H

Domiciliaries

Number	VISN	Medical Center Number	Medical Center Name	Building Number	Building Name	State	Seismicity	Area (sqft.)	Essential Building Code	Historic Building Code	Date of Construction	Building Type - Description	Number of Stories Code
1.	02	528A8	Albany	56	Fisher House	NY	ML	4,120	E		1994	Wood, light frame	N02
2.	18	504	Amarillo	35	Lodge	TX	L	2,500	E		1997		
3.	20	663A4	American Lake	4	Domiciliary	WA	H	22,400	E	H	1923	Conc. frm. w/ infill	N02
4.	20	663A4	American Lake	6	Domiciliary	WA	H	19,950	E	H	1923	Conc. frm. w/ infill	N02
5.	20	463	Anchorage	3001	Domiciliary	AK	VH	34,100	E		1964	Wood, light frame	N01
6.	04	646A4	Aspinwall	8	Male Quarters	PA	L	14,574	E	H	1925		
7.	04	646A4	Aspinwall	23	Female Quarters	PA	L	14,955	E	H	1932		
8.	02	528A6	Bath	30	Domiciliary	NY	L	13,300	E	H	1885		
9.	02	528A6	Bath	33	Domiciliary	NY	L	12,500	E	H	1887		
10.	02	528A6	Bath	34	Domiciliary	NY	L	23,300	E	H	1877		
11.	02	528A6	Bath	35	Domiciliary	NY	L	12,000	E	H	1877		
12.	08	516	Bay Pines	102	Domiciliary	FL	L	112,234	E		1981		
13.	16	520	Biloxi	5	Dom	MS	L	12,000	E	H	1933		
14.	16	520	Biloxi	19	Dom	MS	L	75,200	E	H	1937		
15.	17	549A4	Bonham	24	Domiciliary	TX	L	99,675	E		1992		
16.	01	523	Boston	2	Huntington House	MA	ML	21,372	E		1952	Conc. moment frame	N02
17.	01	523A5	Brockton	7	Domiciliary	MA	ML	120,504	E		1955	Conc. frm. w/ infill	N02
18.	04	529	Butler	3	Domiciliary	PA	L	31,634	E		1938		
19.	02	528A5	Canandaigua	6	Patient Building	NY	L	60,595	E	H	1936		
20.	10	541A0	Cleveland/Brecksville	4	Domiciliary	OH	L	44,570	E		1961		
21.	04	542	Coatesville	7	Domiciliary	PA	ML	46,000	E	H	1933	Conc. frm. w/ infill	N02
22.	04	542	Coatesville	10	Domiciliary	PA	ML	17,500	E	H	1929	Conc. frm. w/ infill	N02
23.	10	552	Dayton	220	Hospitality House	OH	L	7,350	E	H	1885		
24.	10	552	Dayton	320	Domiciliary	OH	L	2,310	E		1981		
25.	10	552	Dayton	400	Miller Cottage	OH	L	39,750	E		1937		
26.	23	636A6	Des Moines	5	Domiciliary	IA	L	26,000	E	H	1932		
27.	07	557	Dublin	6	Dom, Nsg,Sur,EMS,	GA	ML	19,000	E		1943	Conc. frm. w/ infill	N02
28.	07	557	Dublin	8	Dom, Psy	GA	ML	19,000	E		1944	Conc. frm. w/ infill	N02
29.	07	557	Dublin	14	Dom,Rec	GA	ML	26,958	E		1945	Conc. frm. w/ infill	N02
30.	07	557	Dublin	16	Dom, Rec,Eng	GA	ML	24,358	E		1945	Conc. frm. w/ infill	N02
31.	07	557	Dublin	25	DAV	GA	ML	6,700	E		1943	Conc. frm. w/ infill	N02
32.	23	437	Fargo	32	Lodging	ND	L	3,742	E		1960		
33.	23	437	Fargo	36	Lodgers	ND	L	3,742	E		1960		
34.	19	436	Fort Harrison	2	Visitor Lodging	MT	H	20,312	E	H	1895	Unreinforced masonry	N02
35.	05	512GF	Fort Howard	10	Patient Lodging	MD	L	6,186	E	H	1900		
36.	05	512GF	Fort Howard	57A	Patient Lodging	MD	L	1,667	E	H	1932		
37.	06	590	Hampton	43	Domiciliary	VA	L	26,092	E	H	1912		
38.	06	590	Hampton	52	Domiciliary	VA	L	23,785	E	H	1912		
39.	06	590	Hampton	148	Domiciliary	VA	L	88,243	E		1987		
40.	23	568A4	Hot Springs	4	Domiciliary	SD	L	14,934	E	H	1907		
41.	23	568A4	Hot Springs	5	Dom Quarters, Canteen	SD	L	16,234	E	H	1907		
42.	23	568A4	Hot Springs	6	Dom Quarters, Warehouse	SD	L	16,206	E	H	1907		
43.	23	568A4	Hot Springs	7	Dom Quarters, Arts & Crafts	SD	L	15,245	E	H	1907		
44.	23	568A4	Hot Springs	8	Dom Quarters, Recreation	SD	L	15,147	E	H	1907		
45.	23	636A7	Knoxville	68	Patient Building	IA	L	49,269	E		1931		
46.	23	636A7	Knoxville	82	Patient Building	IA	L	35,783	E		1939		
47.	15	589A6	Leavenworth	160	New Domiciliary	KS	L	114,796	E		1995		
48.	03	561A4	Lyons	57	Domiciliary	NJ	MH	60,500	E	H	1946	Conc. frm. w/ infill	N02
49.	12	607	Madison	5	Hoptel	WI	L	7,319	E		1951		
50.	05	613	Martinsburg	205	Domiciliary	WV	L	9,356	E		1943		
51.	05	613	Martinsburg	207	Domiciliary	WV	L	9,236	E		1943		
52.	05	613	Martinsburg	209	Domiciliary	WV	L	9,208	E		1943		

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53.	05	613	Martinsburg	211	Domiciliary	WV	L	8,821	E		1943		
54.	05	613	Martinsburg	502	Domiciliary	WV	L	80,445	E		1982		
55.	21	640A0	Menlo Park	347	Domiciliary	CA	VH	59,358	E		1996		
56.	12	695	Milwaukee (Wood)	43	Domiciliary	WI	L	70,986	E		1932		
57.	12	695	Milwaukee (Wood)	123	Domiciliary	WI	L	90,521	E		1978		
58.	23	618	Minneapolis	10	Lodging/Visn Support	MN	L	28,818	E		1927		
59.	23	618	Minneapolis	74	Fisher House	MN	L	4,912	E		1995		
60.	03	620	Montrose	13	Domiciliary	NY	MH	48,084	E	H	1950	Conc. frm. w/ infill	N03
61.	03	620	Montrose	28	Domiciliary	NY	MH	19,360	E	H	1950	Conc. frm. w/ infill	N03
62.	03	620	Montrose	52	Domiciliary	NY	MH	30,290	E		1960	Conc. frm. w/ infill	N03
63.	09	621	Mountain Home	160	600 Bed Domiciliary	TN	MH	306,000	E		1992		
64.	12	556	North Chicago	66	Domiciliary	IL	L	35,662	E		1938		
65.	16	598A0	North Little Rock	39	Patient Dorm	AR	MH	5,200	E	H	1907	Unreinforced masonry	N01
66.	01	631	Northampton	6	Homeless Shelter	MA	ML	31,700	E	H	1926	Unreinforced masonry	N02
67.	03	632	Northport	11	Homeless Residence	NY	MH	50,399	E	H	1928	Conc. frm. w/ infill	N02
68.	08	673BY	Orlando	519	Future Domiciliary	FL	L	5,248	E		1987		
69.	08	673BY	Orlando	520	Future Domiciliary	FL	L	5,248	E		1987		
70.	08	673BY	Orlando	521	Future Domiciliary	FL	L	5,248	E		1987		
71.	08	673BY	Orlando	522	Future Domiciliary	FL	L	5,248	E		1987		
72.	21	640	Palo Alto	MB1	Modular Building	CA	VH	14,900	E		1990		
73.	05	512A5	Perry Point	1H	Domiciliary	MD	ML	26,772	E	H	1921	Unreinforced masonry	N02
74.	05	512A5	Perry Point	2H	Domiciliary	MD	ML	26,778	E	H	1921	Unreinforced masonry	N02
75.	04	646A5	Pittsburgh (HD)	5	Patient Care	PA	L	62,386	E		1953		
76.	18	649	Prescott	151	Domiciliary	AZ	MH	92,348	E		1990		
77.	19	666	Sheridan	24	ITATC	WY	ML	10,508	E	H	1905	Unreinforced masonry	N01
78.	23	438	Sioux Falls	15	Hoptel	SD	L	3,320	E		1950		
79.	23	656	St. Cloud	2	Domiciliary	MN	L	34,700	E	H	1923		
80.	23	656	St. Cloud	9	Domiciliary	MN	L	14,700	E	H	1924		
81.	17	674	Temple	202	Domiciliary	TX	L	159,361	E		1988		
82.	07	679	Tuscaloosa	39	Hoptel	AL	ML	67,455	E	H	1944	Conc. frm. w/ infill	N02
83.	07	619A4	Tuskegee	62	PTSD, Dom., SWS	AL	L	79,170	E	H	1932		
84.	20	648A4	Vancouver	12	Domiciliary	WA	H	12,345	E		1990		
85.	22	691	West Los Angeles	116	Homeless Vets	CA	VH	60,000	E	H	1930	Conc. frm. w/ infill	N03
86.	22	691	West Los Angeles	212	Dom/Prosthetics	CA	VH	69,400	E	H	1938	Concrete shear wall	N04
87.	22	691	West Los Angeles	214	Domiciliacy	CA	VH	53,000	E	H	1938		
88.	22	691	West Los Angeles	217	Domiciliacy	CA	VH	58,000	E	H	1941		
89.	22	691	West Los Angeles	298	Residential Treatment Center	CA	VH	4,187	E		1935	Wood, light frame	N01
90.	20	692	White City	204	Domiciliary Bed	OR	H	19,015	E		1942	Unreinforced masonry	N02
91.	20	692	White City	205	Domiciliary Bed	OR	H	18,248	E		1942	Unreinforced masonry	N02
92.	20	692	White City	206	Domiciliary Bed	OR	H	19,015	E		1942	Unreinforced masonry	N02
93.	20	692	White City	207	Domiciliary Bed	OR	H	19,095	E		1942	Unreinforced masonry	N02
94.	20	692	White City	208	Domiciliary Bed	OR	H	18,596	E		1942	Unreinforced masonry	N02
95.	20	692	White City	213	Domiciliary Bed	OR	H	18,405	E		1942	Unreinforced masonry	N02
96.	20	692	White City	214	Domiciliary Bed	OR	H	18,495	E		1942	Unreinforced masonry	N02
97.	20	692	White City	215	Domiciliary Bed	OR	H	18,240	E		1942	Unreinforced masonry	N02
98.	20	692	White City	216	Domiciliary Bed	OR	H	18,439	E		1942	Unreinforced masonry	N02
99.	20	692	White City	217	Domiciliary Bed	OR	H	18,495	E		1942	Unreinforced masonry	N02
100.	20	692	White City	218	Domiciliary Bed	OR	H	19,070	E		1942	Unreinforced masonry	N02
101	20	692	White City	221	Domiciliary Bed	OR	H	18,991	E		1942	Unreinforced masonry	N02
102	20	692	White City	239	Domiciliary Bed	OR	H	18,240	E		1942	Unreinforced masonry	N02
103.	20	692	White City	203	DOMICILIARY BED	OR	H	18,308	E		1942	Unreinforced masonry	N02

APPENDIX I

Early VA Studies,

Phases 1 and 2

No.	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Description	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Code	Historic Building Code	Except. High Risk Code	VA Phase 1 or 2 Evaluation[A]
1.	Albany	1	Main Hospital	NY	ML	Steel frm. w/-infill	33,517	N15	1951	C			1
2.	Albany	2	Engineering Shops	NY	ML	Steel frm. w/-infill	7,191	N01	1951				1
3.	Albany	3	Laundry/Incinerator	NY	ML	Steel frm. w/-infill	5,208	N03	1951				1
4.	Albany	4	Boiler Plant	NY	ML	Steel frm. w/-infill	2,759	N02	1951	C			1
5.	Albany	5	Day Hospital	NY	ML	Steel frm. w/-infill	9,894	N02	1951	E			1
6.	Albany	7	Network 2 Headquarters	NY	ML	Steel frm. w/-infill	932	N02	1951				1
7.	Albany	14	Emergency Generator Building	NY	ML	Concrete shear wall	7,746	N01	1951	C			1
8.	Albuquerque	2	VCS - Recreation	NM	MH	Steel frm. w/-infill	20,000	N02	1932		H		2
9.	Albuquerque	3	Psychiatry - RCU	NM	MH	Concrete shear wall	46,253	N02	1932	C	H	HR	1
10.	Albuquerque	4	Administrative	NM	MH	Concrete shear wall	22,400	N02	1932		H		2
11.	Albuquerque	5	Engineering shops	NM	MH		5,040		1932		H		1
12.	Albuquerque	6	Engineering shops	NM	MH	Unreinforced masonry	3,780	N01	1932		H		1
13.	Albuquerque	8	Admin. - Engineering shop	NM	MH	Unreinforced masonry	4,936	N01	1932		H		1
14.	Albuquerque	9	Laundry	NM	MH	Steel frm. w/-infill	8,675	N01	1932		H		2
15.	Albuquerque	11	Research - Rehabilitation	NM	MH	Concrete shear wall	17,300	N02	1932	E	H	HR	2
16.	Albuquerque	61	Booster pump house	NM	MH	Reinf. masonry bearing wall	290	N01	1958				2
17.	Albuquerque	62	Well pump house	NM	MH	Reinf. masonry bearing wall	204	N01	1958				2
18.	Albuquerque	63	Chlorinator house	NM	MH	Reinf. masonry bearing wall	130	N01	1958				2
19.	Albuquerque	T35	Paint shop	NM	MH	Steel light frame	1,200	N01	1958				1
20.	American Lake	4	Domiciliary	WA	H	Conc. frm. w/ infill	22,400	N02	1923	E	H		2
21.	American Lake	5	Blind Rehabilitation	WA	H	Conc. frm. w/ infill	6,705	N01	1923	E	H		2
22.	American Lake	7	P.T.S.D.	WA	H	Conc. frm. w/ infill	19,915	N02	1923	C	H		2
23.	American Lake	8	Administration	WA	H	Conc. frm. w/ infill	15,900	N02	1923				2
24.	American Lake	16	Social Work/Psychology	WA	H	Conc. frm. w/ infill	5,625	N02	1923		H		2
25.	American Lake	17	Engineering/Nursing Educ.	WA	H	Conc. frm. w/ infill	6,365	N02	1923		H		2
26.	American Lake	19	Warehouse	WA	H	Conc. frm. w/ infill	9,150	N01	1924		H		2
27.	American Lake	20	Fire Station/Transportation	WA	H	Conc. frm. w/ infill	5,355	N01	1924	C	H	HR	2
28.	American Lake	21	Warehouse	WA	H	Conc. frm. w/ infill	4,970	N01	1923		H		2
29.	American Lake	23	Boiler Plant	WA	H	Conc. frm. w/ infill	3,535	N01	1923	C	H		2
30.	American Lake	50	Maintenance Shops	WA	H	Conc. frm. w/ infill	7,800	N01	1923		H		2
31.	American Lake	62	Exercise Hall	WA	H	Conc. frm. w/ infill	13,800	N01	1932		H		2
32.	Augusta (Lenwood)	7	Engineering Storage	GA	MH	Unreinforced masonry	13,397	N01	1923		H		2
33.	Augusta (Lenwood)	14	Engineering Shops	GA	MH	Steel frm. w/-infill	6,723	N01	1923				2
34.	Augusta (Lenwood)	18	Administrative	GA	MH	Unreinforced masonry	26,197	N04	1913		H		2
35.	Augusta (Lenwood)	19	Administrative	GA	MH	Unreinforced masonry	48,477	N04	1913		H		2
36.	Augusta (Lenwood)	20	Administrative	GA	MH	Unreinforced masonry	34,571	N04	1913		H		2
37.	Augusta (Lenwood)	76	Shops/Storage	GA	MH	Conc. frm. w/ infill	48,926	N02	1945		H		2
38.	Augusta (Lenwood)	95	Laundry	GA	MH	Steel frm. w/-infill	36,251	N02	1954				2
39.	Batavia	1	Main Hospital	NY	ML	Conc. frm. w/ infill	106,126	N06	1933	C	H		2
40.	Batavia	2	Kitchen	NY	ML	Conc. frm. w/ infill	44,213	N02	1933	E	H		2
41.	Batavia	3	Administration	NY	ML	Conc. frm. w/ infill	14,636	N03	1933		H		2
42.	Batavia	4	Recreation	NY	ML	Conc. frm. w/ infill	21,801	N03	1933		H		2
43.	Batavia	5	Mental Health	NY	ML	Conc. frm. w/ infill	25,993	N03	1933	C	H		2
44.	Batavia	9	Laundry	NY	ML	Unreinforced masonry	6,870	N01	1933		H		2
45.	Batavia	10	Warehouse	NY	ML	Unreinforced masonry	8,173	N01	1933		H		2
46.	Batavia	11	Boiler	NY	ML	Steel frm. w/-infill	7,450	N02	1933	C	H		2
47.	Batavia	13	Garage	NY	ML	Unreinforced masonry	3,886	N01	1933		H		2
48.	Batavia	20	Maintenance	NY	ML	Unreinforced masonry	4,662	N01	1933		H		2
49.	Batavia	21	Pole Barn/Storage	NY	ML		5,000		1970				1
50.	Batavia	7a	Quarters	NY	ML	Unreinforced masonry	6,190	N02	1933		H		2
51.	Batavia	8b	Quarters	NY	ML	Unreinforced masonry	6,190	N02	1933		H		2
52.	Bedford	1	Administration Building	MA	ML	Conc. frm. w/ infill	13,784	N02	1928		H		2
53.	Bedford	2	Patient Care Building	MA	ML	Conc. frm. w/ infill	95,669	N03	1928	C	H		2
54.	Bedford	3	Dietetics Kitchen	MA	ML	Conc. frm. w/ infill	39,789	N02	1928	E	H		2

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55.	Bedford	4	Nursing Home	MA	ML	Conc. frm. w/ infill	102,575	N02	1929	C	H		2
56.	Bedford	5	Nursing Home	MA	ML	Conc. frm. w/ infill	53,689	N02	1932	C	H		2
57.	Bedford	6	Patient Care Building	MA	ML	Conc. frm. w/ infill	53,860	N02	1937	C	H		2
58.	Bedford	7	Patient Care Building	MA	ML	Conc. frm. w/ infill	63,088	N02	1937	C	H		2
59.	Bedford	8	CMOP/DSS	MA	ML	Conc. frm. w/ infill	48,011	N02	1930	C			2
60.	Bedford	9	Administration Building	MA	ML	Conc. frm. w/ infill	41,680	N02	1928				2
61.	Bedford	10	Library	MA	ML	Unreinforced masonry	17,575	N01	1928		H		2
62.	Bedford	12	Office Building	MA	ML	Conc. frm. w/ infill	16,770	N02	1928		H		2
63.	Bedford	17	Research Bld	MA	ML	Conc. frm. w/ infill	16,385	N02	1930	E	H		2
64.	Bedford	18	GRECC Bld	MA	ML	Conc. frm. w/ infill	16,386	N02	1928	E	H		2
65.	Bedford	19	Laundry	MA	ML	Conc. frm. w/ infill	19,230	N01	1928		H		2
66.	Bedford	20	Garage	MA	ML	Conc. frm. w/ infill	4,383	N01	1928				2
67.	Bedford	21	CMOP Warehouse	MA	ML	Conc. frm. w/ infill	11,608	N01	1928		H		2
68.	Bedford	22	Boilerplant	MA	ML	Steel frm. w/-infill	8,675	N01	1928	C	H		2
69.	Bedford	27	Electric Switchgear	MA	ML		458		1928		H		1
70.	Bedford	28	Storage	MA	ML		458		1928		H		1
71.	Bedford	29	Storage	MA	ML		458		1928		H		1
72.	Bedford	30	Pumphouse	MA	ML		293		1930		H		1
73.	Bedford	32	Garage	MA	ML	Unreinforced masonry	3,240	N01	1929		H		2
74.	Bedford	33	Fiscal Building	MA	ML	Unreinforced masonry	5,453	N01	1930		H		2
75.	Bedford	61	Administrative Building	MA	ML		52,249		1939		H		2
76.	Bedford	62	Patient Care Building	MA	ML		51,768		1939		H		2
77.	Bedford	70	IPCC/HSR&D	MA	ML	Conc. frm. w/ infill	63,958	N02	1946	E	H		2
78.	Bedford	78	Patient Care Building	MA	ML	Conc. frm. w/ infill	128,416	N04	1959	E			2
79.	Bedford	80	Amb Care/NHCU	MA	ML	Conc. frm. w/ infill	38,950	N01	1960	C			2
80.	Bedford	81	Chapel	MA	ML		8,350		1960				2
81.	Bedford	82	Gymnasium/Pool	MA	ML		35,580		1962				2
82.	Bedford	78A	Canteen/Theater	MA	ML		25,299		1960				2
83.	Bedford	CC	Connecting Corridors-tunnels	MA	ML		13,336		1930				2
84.	Birmingham	1	Main Hospital	AL	ML	Conc. frm. w/ infill	752,521	N09	1952	C			2
85.	Boise	1	Mental Health	ID	MH	Unreinforced masonry	3,472	N02	1863	C	H	HR	1
86.	Boise	4	Mental Health	ID	MH	Unreinforced masonry	2,247	N02	1870	C	H	HR	1
87.	Boise	6	Eye Clinic	ID	MH	Unreinforced masonry	4,166	N01	1863	C	H	HR	1
88.	Boise	8	Engineering Shops & Dorm.	ID	MH		8,946		1932		H		1
89.	Boise	13	Director's Suite	ID	MH		5,437		1886		H		1
90.	Boise	23	Mental Health	ID	MH	Unreinforced masonry	11,469	N01	1905	C	H	HR	1
91.	Boise	24	AHEC and District Counsel	ID	MH	Unreinforced masonry	9,623	N01	1905		H		1
92.	Boise	27	Ward 2M/S	ID	MH		38,008		1996	C	H		1
93.	Boise	28	Laundry	ID	MH		9,139		1906		H		1
94.	Boise	29	Library/Learning Resource Ctr	ID	MH		8,339		1907		H		1
95.	Boise	34	A&MM/Warehouse	ID	MH		20,636		1910		H		1
96.	Boise	43	IRMS/Warehouse	ID	MH		6,810		1909		H		1
97.	Boise	44	Subs. Abuse/Pharm/Research	ID	MH	Unreinforced masonry	13,313	N01	1909	E	H		1
98.	Boise	45	Research	ID	MH	Unreinforced masonry	5,595	N01	1909	E	H	HR	1
99.	Boise	46	Boiler Plant/Eng. Shops	ID	MH		8,817		1906	C	H		1
100.	Boise	50	Engineering Office	ID	MH	Unreinforced masonry	2,841	N01	1890		H		1
101.	Boise	67	Ward 2 and 3	ID	MH		66,774		1932		H		1
102.	Boise	77	Dietetics/Canteen	ID	MH		20,715		1950	E			1
103.	Boston	4	Research Admin	MA	ML	Wood, comm. & industrial	6,069	N01	1952				2
104.	Boston	7	Maintenance Garage	MA	ML	Conc. moment frame	5,161	N01	1952				2
105.	Boston	1A	Research	MA	ML	Conc. moment frame	40,400	N03	1971	E			2
106.	Brockton	1	Administration	MA	ML	Conc. frm. w/ infill	54,895	N02	1955		H		2
107.	Brockton	2	Patient Care	MA	ML	Conc. frm. w/ infill	183,100	N04	1955	C			2
108.	Brockton	3	Outpatient	MA	ML	Conc. frm. w/ infill	245,766	N06	1955	C			2

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109.	Brockton	4	Nursing Home	MA	ML	Conc. frm. w/ infill	131,812	N03	1955	C			2
110.	Brockton	5	Outpatient / Psychiatry	MA	ML	Conc. frm. w/ infill	88,489	N02	1955	E			2
111.	Brockton	7	Domiciliary	MA	ML	Conc. frm. w/ infill	120,504	N02	1955	E			2
112.	Brockton	8	Spinal Cord Injury	MA	ML	Unreinforced masonry	77,422	N01	1955	C			2
113.	Brockton	20	Kitchen / Warehouse	MA	ML	Conc. frm. w/ infill	55,881	N02	1955	E			2
114.	Brockton	21	Theater	MA	ML	Steel frm. w/-infill	39,186	N01	1955				2
115.	Brockton	22	Recreation / Library	MA	ML	Conc. frm. w/ infill	47,657	N02	1955	E			2
116.	Brockton	23	Gym / Pool	MA	ML	Steel frm. w/-infill	47,657	N02	1955				2
117.	Brockton	24	Chapel	MA	ML	Unreinforced masonry	15,720	N01	1955				2
118.	Brockton	25	Work Therapy	MA	ML	Unreinforced masonry	33,978	N01	1955	E			2
119.	Brockton	40	Boiler Plant	MA	ML	Conc. frm. w/ infill	4,500	N02	1955	C			2
120.	Brockton	44	Station Garage	MA	ML	Unreinforced masonry	7,140	N01	1955				2
121.	Brockton	45	VISN Laundry	MA	ML	Unreinforced masonry	22,639	N01	1955				2
122.	Brockton	46	Research	MA	ML	Unreinforced masonry	5,016	N01	1955	E			2
123.	Brockton	47	Water Pump House	MA	ML	Unreinforced masonry	200	N01	1955				2
124.	Brockton	50	Sewer Pump House	MA	ML		150		1955				1
125.	Brockton	51	Storage	MA	ML		2,640		1960				1
126.	Brockton	60	Administration	MA	ML	Unreinforced masonry	17,185	N01	1920				2
127.	Brockton	61	IRM	MA	ML	Unreinforced masonry	13,536	N02	1955	C			2
128.	Brockton	62	Patient Care	MA	ML	Unreinforced masonry	6,784	N01	1955	E			2
129.	Buffalo	1	Main Hospital	NY	ML	Steel frm. w/-infill	881,482	N14	1949	C			1
130.	Buffalo	3	Office Building	NY	ML		7,351		1949				1
131.	Buffalo	5	Office Building	NY	ML		6,317		1949				1
132.	Charleston	1	Main Hospital	SC	VH	Conc. frm. w/ infill	453,616	N05	1966	C			2
133.	Columbia	2	USC Med School	SC	MH		18,480	N03	1932	C	H	HR	1
134.	Columbia	4	USC Med School	SC	MH		30,832	N03	1932	C	H	HR	1
135.	Columbia	5	Auditorium	SC	MH	Conc. frm. w/ infill shear wall	19,258	N03	1932		H		2
136.	Columbia	10	Administration	SC	MH	Conc. frm. w/ infill shear wall	22,620	N03	1932		H		1
137.	Columbia	11	Quarters	SC	MH	Unreinforced masonry	4,131	N03	1932		H		1
138.	Columbia	12	Quarters	SC	MH	Unreinforced masonry	4,644	N03	1932		H		1
139.	Columbia	13	Quarters	SC	MH	Unreinforced masonry	7,417	N03	1932		H		1
140.	Columbia	20	Shops/Engineering	SC	MH	Unreinforced masonry	9,414	N01	1932		H		2
141.	Columbia	22	Administration	SC	MH	Conc. frm. w/ infill	33,749	N03	1932		H		2
142.	Erie	1	Main Building	PA	L		286,345		1950	C			1
143.	Erie	5	Mental Hygiene Clinic	PA	L		6,060		1950	E			1
144.	Erie	6	CHEP/LAHEC	PA	L		3,170		1950				1
145.	Erie	7	M&R/Boiler Plant	PA	L		15,280		1950	C			1
146.	Erie	8	Substation	PA	L		980		1950				1
147.	Erie	10	Garage	PA	L		1,100		1950				1
148.	Fort Harrison	16	Fire Station	MT	H	Unreinforced masonry	1,952	N01	1895	C	H		2
149.	Fort Harrison	17	Fitness Center	MT	H	Unreinforced masonry	9,984	N02	1895		H		2
150.	Fort Harrison	20	Grounds Shops	MT	H	Unreinforced masonry	15,566	N01	1895		H		2
151.	Fort Harrison	31	Storage	MT	H	Unreinforced masonry	3,255	N01	1897		H		2
152.	Fort Harrison	35	Quarters	MT	H	Unreinforced masonry	9,092	N02	1895		H		2
153.	Fort Harrison	43	Storage	MT	H	Unreinforced masonry	4,698	N01	1905		H		2
154.	Fort Harrison	47	Storage	MT	H	Unreinforced masonry	9,600	N02	1908		H		2
155.	Fort Harrison	54	Hazardous Waste Storage	MT	H	Reinf. masonry bearing wall	480	N01	1947	C			1
156.	Fort Harrison	141	Administration Building	MT	H	Conc. frm. w/ infill	58,115	N03	1932				2
157.	Fort Harrison	142	Boiler Plant	MT	H	Steel frm. w/-infill	5,427	N01	1932	C			2
158.	Fort Harrison	150	Dietetics	MT	H	Unreinforced masonry	15,156	N02	1936	E			2
159.	Fresno	1	Main Hosptial	CA	MH	Concrete shear wall	246,974	N07	1949	C			2
160.	Fresno	2	Boiler Plant	CA	MH	Concrete shear wall	4,786	N01	1949	C			1
161.	Fresno	3	Facility Management Ad.	CA	MH	Concrete shear wall	7,622	N01	1949				2
162.	Fresno	10	Facility Management Ad.	CA	MH	Concrete shear wall	7,355	N01	1949				2

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163.	Fresno	11	Human Resource/EEO?Union	CA	MH	Concrete shear wall	4,370	N01	1949				2
164.	Fresno	14	Financial Resource	CA	MH	Concrete shear wall	7,584	N01	1949				2
165.	Livermore	62	MS&N	CA	VH	Concrete shear wall	74,200	N06	1949	C			2
166.	Livermore	64	Administration	CA	VH	Concrete shear wall	25,700	N02	1951				2
167.	Livermore	65	Administration	CA	VH	Concrete shear wall	12,100	N02	1953				2
168.	Long Beach	1	Admin Building Clinics	CA	VH	Concrete shear wall	89,500	N04	1943	C			2
169.	Long Beach	2	Canteen, Chapel, Clinic	CA	VH	Concrete shear wall	88,888	N03	1943				2
170.	Long Beach	3	Nurse Ed, Day Trmt.	CA	VH	Concrete shear wall	36,000	N02	1943	E			2
171.	Long Beach	5	Eng Admin, Shops, HTG Plant	CA	VH	Concrete shear wall	28,000	N01	1943	C			2
172.	Long Beach	6	A&MMS Warehouse #1	CA	VH	Wood, comm, & industrial	12,400	N01	1943				2
173.	Long Beach	8	Nursing, Med, Surg Admin	CA	VH	Concrete shear wall	36,000	N03	1943				2
174.	Long Beach	13	Engineering Shops	CA	VH	Wood, light frame	4,300	N01	1944				2
175.	Long Beach	46	Child Care, Minor Improv	CA	VH	Wood, light frame	4,625	N01	1944				2
176.	Long Beach	47	House Keeping Quarters	CA	VH	Wood, light frame	25,200	N02	1944				2
177.	Long Beach	50	Offices, Training	CA	VH	Wood, light frame	13,600	N01	1943				2
178.	Long Beach	53	VA Police	CA	VH	Wood, light frame	2,080	N01	1944	C			2
179.	Long Beach	122	Wards - To Be Demoed in 2002	CA	VH	Concrete shear wall	300,862	N03	1958				1
180.	Long Beach	126	Wards, Clinics, Admin	CA	VH	Concrete shear wall	352,566	N09	1967	C			2
181.	Louisville	1	Main Hospital	KY	ML	Steel frm. w/-infill	431,036	N09	1952	C			1
182.	Louisville	2	Fee Basis and Credit Union	KY	ML		1,605		1952				1
183.	Louisville	3	Fiscal	KY	ML		6,312		1952				1
184.	Louisville	4	Medical Media & Engineering	KY	ML		4,962		1952				1
185.	Louisville	5	Day Treatment Center	KY	ML	Unreinforced masonry	2,688	N01	1952	E			1
186.	Louisville	6	Engineering Shops	KY	ML		4,972		1952				1
187.	Louisville	7	Laundry	KY	ML		9,469		1952				1
188.	Louisville	8	Boiler Plant	KY	ML	Steel frm. w/-infill	4,844	N01	1952	C			1
189.	Louisville	10	Storage	KY	ML		418		1952				1
190.	Louisville	15	Meter House	KY	ML		40		1952				1
191.	Louisville	19	Clinical Research	KY	ML	Steel frm. w/-infill	8,269	N02	1952	E			1
192.	Louisville	21	Air Conditioning	KY	ML	Steel frm. w/-infill	3,242	N01	1972	C			1
193.	Louisville	T1	Storage	KY	ML		1,500		1952				1
194.	Manchester	6	Facility Service	NH	MH	Wood, light frame	3,400	N01	1949				2
195.	Manchester	7	Boiler Plant/Maintenance	NH	MH	Unreinforced masonry	13,500	N01	1949	C		HR	2
196.	Manchester	11	Smyth Tower- Historic Landmark	NH	MH	Unreinforced masonry	650	N03	1888		H		1
197.	Marion	1	Main Hospital	IL	H	Conc. frm. w/ infill	81,750	N04	1941	C	H		2
198.	Marion	2	Suppt Bldg(Kitchen, Canteen)	IL	H	Conc. frm. w/ infill	32,919	N03	1941	E	H		2
199.	Marion	15	Engineering Shops	IL	H	Unreinforced masonry	8,758	N01	1941		H		2
200.	Marion	16	Warehouse	IL	H	Unreinforced masonry	9,198	N01	1941		H		2
201.	Marion	23	Incinerator	IL	H		455		1988		H		1
202.	Memphis	1	Main	TN	VH	Concrete shear wall	654,118	N15	1967	C			2
203.	Menlo Park	8	Storage	CA	VH	Concrete shear wall	1,300	N01	1929		H		2
204.	Menlo Park	9	Paint Shop	CA	VH	Concrete shear wall	1,300	N01	1929		H		2
205.	Menlo Park	60	Quarters	CA	VH	Unreinforced masonry	2,900	N01	1929		H		1
206.	Menlo Park	114	Boiler House	CA	VH	Concrete shear wall	6,200	N01	1929	C	H	HR	1
207.	Menlo Park	116	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
208.	Menlo Park	117	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
209.	Menlo Park	118	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
210.	Menlo Park	119	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
211.	Menlo Park	120	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
212.	Menlo Park	121	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
213.	Menlo Park	122	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
214.	Menlo Park	123	Quarters	CA	VH	Unreinforced masonry	1,800	N01	1929		H		2
215.	Menlo Park	221	Engineering	CA	VH	Concrete shear wall	7,800	N01	1929		H		2
216.	Menlo Park	222	Quarters	CA	VH	Unreinforced masonry	3,400	N01	1929		H		2

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217.	Menlo Park	301	Bone Density Research	CA	VH	Concrete shear wall	14,200	N02	1929		H		2
218.	Menlo Park	303	Engineering	CA	VH	Steel moment frame	13,600	N02	1929		H		2
219.	Menlo Park	305	Quarters	CA	VH	Concrete shear wall	3,400	N01	1929		H		2
220.	Menlo Park	306	Quarters	CA	VH	Concrete shear wall	3,400	N01	1929		H		2
221.	Menlo Park	322	Chapel	CA	VH	Unreinforced masonry	5,200	N01	1960				2
222.	Menlo Park	329	Kitchen and Dining	CA	VH	Concrete shear wall	21,300	N01	1969	E		EHR	2
223.	Menlo Park	T44	Warehouse	CA	VH	Steel light frame	8,300	N01	1929		H		2
224.	Menlo Park	T45	Garage	CA	VH	Wood, light frame	3,500	N01	1929		H		2
225.	Menlo Park	T52	Paint Shed	CA	VH		700		1929		H		1
226.	Mountain Home	1	James H. Quillen Med.College	TN	MH	Unreinforced masonry	55,928	N03	1905		H		2
227.	Mountain Home	2	James H. Quillen Med.College	TN	MH	Unreinforced masonry	56,115	N03	1905		H		2
228.	Mountain Home	3	Nursing Educ./Admin. Space	TN	MH	Unreinforced masonry	38,136	N03	1905		H		2
229.	Mountain Home	4	Medical School Library	TN	MH	Unreinforced masonry	38,136	N03	1905		H		2
230.	Mountain Home	5	Geriatric and Gen. Research	TN	MH	Unreinforced masonry	38,136	N03	1905	E	H		2
231.	Mountain Home	6	Fut. Enh.-Use Lease to ETSU	TN	MH	Unreinforced masonry	38,136	N03	1905		H		2
232.	Mountain Home	7	Fut. Enh.-Use Lease to ETSU	TN	MH	Unreinforced masonry	38,136	N03	1904		H		2
233.	Mountain Home	8	A&MM, Fiscal Svc, Impact Sp.	TN	MH	Unreinforced masonry	49,391	N03	1932		H		2
234.	Mountain Home	10	Bandstand	TN	MH		1,015		1905		H		1
235.	Mountain Home	13	Protestant & Catholic Chapels	TN	MH	Unreinforced masonry	6,352	N01	1905		H		2
236.	Mountain Home	17	Carnegie Library & Conf.	TN	MH	Unreinforced masonry	5,380	N02	1904		H		2
237.	Mountain Home	20	Human Res./Admin. Space	TN	MH	Unreinforced masonry	6,544	N02	1904		H		2
238.	Mountain Home	34	ClkTower,Museum,VCS,Res	TN	MH	Conc. moment frame	64,423	N02	1902		H		2
239.	Mountain Home	35	Theater-To be En-Use Leased	TN	MH	Unreinforced masonry	16,595	N01	1904		H		2
240.	Mountain Home	37	Psychiatry Service	TN	MH	Unreinforced masonry	32,423	N02	1903	E	H		2
241.	Mountain Home	52	Med. School Admin. Offices	TN	MH	Unreinforced masonry	13,910	N02	1903		H		2
242.	Mountain Home	53	U.S. Post Office, Mt. Home	TN	MH	Unreinforced masonry	3,920	N01	1908		H		2
243.	Mountain Home	60	Vacant - To be Demolished	TN	MH	Unreinforced masonry	38,138	N03	1905		H		2
244.	Mountain Home	69	Psych., Nursing, Admin.	TN	MH	Unreinforced masonry	18,497	N03	1903		H		2
245.	Mountain Home	108	Boiler Plant - To be Demoed	TN	MH		9,541		1970				1
246.	Northampton	1	Multi-Use	MA	ML	Unreinforced masonry	171,700	N02	1923	C	H		2
247.	Northampton	2	Nursing Services & IRM	MA	ML	Unreinforced masonry	29,400	N02	1923	C	H		2
248.	Northampton	3	90,136, 04, 05 Offices	MA	ML	Unreinforced masonry	29,400	N02	1923		H		2
249.	Northampton	4	Ward	MA	ML	Unreinforced masonry	67,500	N02	1923	C	H		2
250.	Northampton	5	Main Kitchen	MA	ML	Unreinforced masonry	64,800	N01	1923	E	H		2
251.	Northampton	6	Homeless Shelter	MA	ML	Unreinforced masonry	31,700	N02	1926	E	H		2
252.	Northampton	7	Ward	MA	ML	Unreinforced masonry	29,400	N02	1923	C	H		2
253.	Northampton	8	Ward	MA	ML	Unreinforced masonry	22,300	N02	1923	C	H		2
254.	Northampton	9	Ward	MA	ML	Unreinforced masonry	30,900	N01	1923	C	H		2
255.	Northampton	11	Recreation Hall	MA	ML	Conc. frm. w/ infill	30,900	N02	1926		H		2
256.	Northampton	12	Ward / Administration	MA	ML	Unreinforced masonry	47,100	N02	1923		H		2
257.	Northampton	13	Garage	MA	ML	Unreinforced masonry	7,000	N01	1923		H		2
258.	Northampton	14	Laundry	MA	ML	Unreinforced masonry	20,800	N01	1923		H		2
259.	Northampton	15	Boiler Plant	MA	ML	Unreinforced masonry	9,500	N01	1923	C	H		2
260.	Northampton	16	Warehouse	MA	ML	Unreinforced masonry	9,786	N02	1923		H		2
261.	Northampton	25	Multi-Use	MA	ML	Unreinforced masonry	15,600	N02	1923		H		2
262.	Northampton	26	Ward	MA	ML	Unreinforced masonry	37,700	N02	1937		H		2
263.	Northampton	60	Chapel	MA	ML	Unreinforced masonry	14,500	N01	1959				2
264.	Oklahoma City	1	Main Hospital	OK	ML	Steel frm. w/-infill	847,780	N12	1952	C			2
265.	Oklahoma City	3	Day Clinic	OK	ML	Conc. frm. w/ infill	12,646	N02	1952	E			1
266.	Oklahoma City	4	Storage	OK	ML		3,468		1952				1
267.	Oklahoma City	5	Boiler Plant	OK	ML		12,092		1952				1
268.	Oklahoma City	8	Gas House	OK	ML	Unreinforced masonry	363	N01	1952	C			1
269.	Oklahoma City	18	Chiller Plant	OK	ML		2,741		1965				1
270.	Oklahoma City	19	Research	OK	ML	Conc. frm. w/ infill	41,078	N04	1965	E			2

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271.	Palo Alto	5	Outpatient	CA	VH	Concrete shear wall	94,200	N04	1960	C			2
272.	Palo Alto	7	SCI / Rehabilitation Medicine	CA	VH	Concrete shear wall	99,500	N01	1960	C			2
273.	Palo Alto	41	Engineering Shops	CA	VH		5,800		1960				1
274.	Palo Alto	42	Engineering Shops	CA	VH		8,900		1960				1
275.	Palo Alto	43	Engineering / Laundry	CA	VH		19,200		1960				1
276.	Palo Alto	54	Animal Research Facility	CA	VH	Steel frm w/ conc	18,100	N02	1981	E		EHR	1
277.	Phoenix	1	Main Medical Center	AZ	L		520,399		1952	C			1
278.	Phoenix	3	Volunteer	AZ	L		2,759		1952				1
279.	Phoenix	4	Nursing Edu./Prosthetics	AZ	L		4,676		1952	E			1
280.	Phoenix	5	Admin Space	AZ	L		3,916		1952				1
281.	Phoenix	6	Amb Care/HBHC	AZ	L		3,049		1952				1
282.	Phoenix	7	Day Treatment	AZ	L		2,100		1952	E			1
283.	Phoenix	14A	Eng/Fiscal Storage	AZ	L		3,275		1974				1
284.	Phoenix	2&10	Engineering/Laundry	AZ	L		30,787		1952	C			1
285.	Poplar Bluff	1	Medical / Nursing / PCC	MO	H	Conc. frm. w/ infill	137,718	N08	1950	C			2
286.	Poplar Bluff	2	Education	MO	H	Unreinforced masonry	4,720	N02	1950				2
287.	Poplar Bluff	3	Directors Quarters	MO	H	Unreinforced masonry	2,808	N01	1950				2
288.	Poplar Bluff	4	Human Resource / Hoptel	MO	H	Unreinforced masonry	3,300	N01	1950				2
289.	Poplar Bluff	5	Finance & AMMS	MO	H	Unreinforced masonry	5,280	N01	1950				2
290.	Poplar Bluff	6	Prop. For Suppt. Svc	MO	H	Unreinforced masonry	3,400	N01	1950				2
291.	Poplar Bluff	7	Boiler Plant	MO	H	Conc. frm. w/ infill	4,010	N01	1950	C			2
292.	Poplar Bluff	8	Fac. Mgmt. Shops	MO	H	Steel frm. w/-infill	6,075	N01	1950				2
293.	Prescott	12	Administration	AZ	MH	Unreinforced masonry	15,574	N02	1903		H		2
294.	Prescott	13	Administration	AZ	MH	Unreinforced masonry	16,250	N02	1908		H		2
295.	Prescott	14	Administration	AZ	MH	Unreinforced masonry	37,257	N02	1908		H		2
296.	Prescott	15	Theater	AZ	MH	Unreinforced masonry	11,115	N02	1908		H		2
297.	Prescott	16	Canteen	AZ	MH	Unreinforced masonry	4,946	N01	1908		H		2
298.	Prescott	17	Administration	AZ	MH	Unreinforced masonry	4,814	N02	1908		H		2
299.	Prescott	19	Warehouse	AZ	MH	Unreinforced masonry	2,334	N01	1903		H		2
300.	Prescott	20	Warehouse	AZ	MH	Unreinforced masonry	11,570	N02	1903		H		2
301.	Prescott	22	Engineering Administration	AZ	MH	Wood, light frame	4,832	N01	1920		H		1
302.	Prescott	23	Engineering Shops	AZ	MH		4,278		1910		H		1
303.	Prescott	28	Administration	AZ	MH	Unreinforced masonry	8,918	N02	1908		H		2
304.	Prescott	31	Engineering Shops	AZ	MH		7,774		1910		H		1
305.	Prescott	32	Engineering Shops	AZ	MH		1,830		1910		H		1
306.	Prescott	42	Warehouse	AZ	MH	Unreinforced masonry	3,838	N01	1908		H		2
307.	Prescott	70	Administration	AZ	MH	Unreinforced masonry	20,290	N02	1922		H		2
308.	Prescott	108	Dietetics/PM&RS	AZ	MH	Concrete shear wall	16,782	N02	1939	E		HR	1
309.	Prescott	112	Laundry Distribu/CWT Shops	AZ	MH	Concrete shear wall	9,493	N02	1957				1
310.	Providence	2	Administrative Office Bldg	RI	ML	Conc. frm. w/ infill	6,922	N02	1948				2
311.	Providence	3	Administrative Office Bldg	RI	ML	Unreinforced masonry	6,900	N02	1948				2
312.	Providence	6	Engineering Shop	RI	ML	Unreinforced masonry	3,780	N01	1948				2
313.	Providence	7	Research & Engineering	RI	ML	Unreinforced masonry	4,000	N01	1948	E			2
314.	Providence	8	Warehouse	RI	ML	Unreinforced masonry	5,000	N01	1948				2
315.	Providence	9	Research	RI	ML	Unreinforced masonry	6,100	N01	1948	E			2
316.	Providence	10	Boiler Plant	RI	ML	Steel frm. w/-infill	3,878	N01	1948	C			2
317.	Providence	26	Emergency Generator Bldg	RI	ML	Unreinforced masonry	1,227	N01	1960	C			1
318.	Reno	1	Main Hospital	NV	VH	Concrete shear wall	138,007	N07	1948	C			1
319.	Roseburg	3	Administrative Building	OR	VH	Conc. frm. w/ infill shear wall	12,394	N03	1933		H		2
320.	Roseburg	16	Canteen/Library/Chapel	OR	VH	Conc. frm. w/ infill shear wall	15,065	N02	1933		H		2
321.	Salem	1	Administration	VA	ML	Conc. frm. w/ infill	23,735	N03	1934		H		2
322.	Salem	2	NHCU/Dental/Nuclear Med.	VA	ML	Conc. frm. w/ infill	108,390	N04	1933	C	H		2
323.	Salem	4	N&F Svc/Canteen/Med Media	VA	ML	Conc. frm. w/ infill	75,196	N03	1933	E			2
324.	Salem	5	Education/Recreation	VA	ML	Conc. frm. w/ infill	31,181	N03	1934		H		2

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325.	Salem	7	Psych Units/Social Work Off	VA	ML	Conc. moment frame	58,112	N03	1933	C	H		2
326.	Salem	8	Acute Psych /Bio Med Shop	VA	ML	Conc. frm. w/ infill	58,316	N03	1938	C	H		2
327.	Salem	9	Psych Unit/PTSD Unit/Off	VA	ML	Conc. frm. w/ infill	62,768	N03	1941	C	H		2
328.	Salem	10	Substance Abuse O.P./Vacant	VA	ML	Conc. frm. w/ infill	62,514	N03	1940	E	H		2
329.	Salem	11	O.P. Psychiatry/Psych Off	VA	ML	Conc. frm. w/ infill	58,316	N03	1938	E	H		2
330.	Salem	12	R&D/AFGE/O.P./Supp. Space	VA	ML	Conc. frm. w/ infill	64,088	N03	1936		H		2
331.	Salem	13	Boiler Plant	VA	ML	Steel frm. w/-infill	23,725	N01	1933	C			2
332.	Salem	14	Laundry	VA	ML	Unreinforced masonry	15,172	N02	1933		H		1
333.	Salem	15	Research/CWT/Storage	VA	ML	Unreinforced masonry	18,694	N02	1933	E	H		1
334.	Salem	16	Engineering Offices/Garage	VA	ML		9,828		1933		H		1
335.	Salem	17	Student Quarters	VA	ML		15,273		1933		H		1
336.	Salem	18	Quarters	VA	ML		4,324		1933		H		1
337.	Salem	19	Quarters	VA	ML		6,744		1933		H		1
338.	Salem	25	Quarters	VA	ML		5,222		1885		H		1
339.	Salem	26	Garage	VA	ML		2,198		1937		H		1
340.	Salem	27	Garage	VA	ML		934		1937		H		1
341.	Salem	28	Garage	VA	ML		934		1937		H		1
342.	Salem	31	Paint Shop	VA	ML		1,649		1936				1
343.	Salem	34	Engineering Storage	VA	ML		1,378		1936				1
344.	Salem	35	Engineering Storage	VA	ML		1,360		1936				1
345.	Salem	46	Eng./Recreation Storage	VA	ML		1,184		1937				1
346.	Salem	72	Engineering Storage	VA	ML		1,344		1942				1
347.	Salem	74	Administration/Credit Union	VA	ML	Conc. frm. w/ infill	65,840	N03	1944		H		2
348.	Salem	75	Vacant/PM&RMS Clinics	VA	ML	Conc. frm. w/ infill	65,840	N03	1944		H		2
349.	Salem	76	ADHC/Vacant/Eng. Shops	VA	ML	Conc. frm. w/ infill	65,840	N03	1944	E	H		2
350.	Salem	77	Child Care Ctr./EMS/Stud. Qr	VA	ML	Conc. frm. w/ infill	65,840	N03	1944		H		2
351.	Salem	80	Greenhouse (West)	VA	ML		1,303		1943				1
352.	Salem	85	Sheet Metal Shop	VA	ML		960		1945				1
353.	Salem	97	Storage	VA	ML		3,408		1946				1
354.	Salem	102	Storage (Bulldozer)	VA	ML		365		1945				1
355.	Salem	116	Storage	VA	ML		228		1930				1
356.	Salem	117	Storage	VA	ML		2,426		1956				1
357.	Salem	121	Greenhouse (East) (Storage)	VA	ML		844		1956				1
358.	Salem	126	Toilet	VA	ML		451		1958				1
359.	Salem	130	Grandstand	VA	ML		9,648		1959				1
360.	Salem	131	Substation	VA	ML		483		1933				1
361.	Salem	132	Picnic Shelter	VA	ML		2,236		1960				1
362.	Salem	133	Golf Clubhouse	VA	ML		171		1962				1
363.	Salem	134	Transformer Vault	VA	ML		98		1963				1
364.	Salisbury	1	Administrative	NC	ML		26,888		1951				1
365.	Salisbury	2	General Medical	NC	ML	Conc. frm. w/ infill	215,858	N05	1951	C			1
366.	Salisbury	3	Psychiatry	NC	ML	Conc. frm. w/ infill	102,833	N04	1951	C			1
367.	Salisbury	4	Psychiatry	NC	ML	Conc. frm. w/ infill	108,081	N04	1951	C			1
368.	Salisbury	5	Kitchen/Library	NC	ML	Conc. frm. w/ infill	50,197	N02	1951	E			1
369.	Salisbury	6	Recreation	NC	ML		83,230		1951				1
370.	Salisbury	7	PM&RS	NC	ML	Conc. frm. w/ infill	24,784	N01	1951	E			1
371.	Salisbury	10	NHCU	NC	ML	Conc. frm. w/ infill	68,932	N03	1951	C			1
372.	Salisbury	11	NHCU	NC	ML	Unreinforced masonry	40,880	N02	1951	C			1
373.	Salisbury	12	Director's Quarters	NC	ML		3,239		1951				1
374.	Salisbury	13	Admin. Offices	NC	ML		12,356		1951				1
375.	Salisbury	15	Admin. Offices	NC	ML		6,559		1951				1
376.	Salisbury	16	Laundry	NC	ML		14,297		1951				1
377.	Salisbury	17	Warehouse	NC	ML		17,961		1951				1
378.	Salisbury	18	Boiler Plant	NC	ML	Steel frm. w/-infill	13,426	N02	1951	C			1

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379.	Salisbury	19	Chapel	NC	ML	Conc. frm. w/ infill	4,440	N03	1951				1
380.	Salisbury	21	Extended Care	NC	ML	Conc. frm. w/ infill	109,865	N03	1951	C			1
381.	Salisbury	23	Garage	NC	ML		1,250		1951				1
382.	Salisbury	24	PM&RS Storage	NC	ML	Wood, light frame	621	N01	1951	E			1
383.	Salisbury	25	PM&RS Storage	NC	ML	Wood, light frame	312	N01	1951	E			1
384.	Salisbury	28	Paint Shop	NC	ML		1,385		1951				1
385.	Salisbury	14E	Student Quarters	NC	ML		3,553		1951				1
386.	Salisbury	14W	Student Quarters	NC	ML		3,553		1951				1
387.	Salt Lake City	1	Main Hospital	UT	VH	Conc. frm. w/ infill	281,878	N07	1949	C			2
388.	Salt Lake City	2	Hospital	UT	VH	Conc. frm. w/ infill	146,506	N03	1949	C			2
389.	Salt Lake City	3	Hospital	UT	VH	Conc. frm. w/ infill	89,565	N03	1949	C			2
390.	Salt Lake City	4	Hospital	UT	VH	Unreinforced masonry	31,922	N01	1949	C			2
391.	Salt Lake City	5	Nutrition & Food	UT	VH	Unreinforced masonry	30,156	N01	1949	E			2
392.	Salt Lake City	6	Engineering	UT	VH	Conc. frm. w/ infill	19,112	N01	1949				2
393.	Salt Lake City	7	Laundry/Warehouse	UT	VH	Unreinforced masonry	54,570	N01	1949				2
394.	Salt Lake City	8	Recreation	UT	VH	Conc. frm. w/ infill	34,956	N01	1949				2
395.	Salt Lake City	9	National Media Development	UT	VH	Conc. frm. w/ infill	18,828	N01	1949				2
396.	Salt Lake City	10	Medical Education	UT	VH		11,032		1949				2
397.	Salt Lake City	11	Human Resources	UT	VH	Wood, light frame	12,025	N02	1949				2
398.	Salt Lake City	13	ChildCare	UT	VH		5,831		1949				2
399.	Salt Lake City	27	Engineering	UT	VH		3,581		1964				2
400.	San Francisco	2	Research/Admin.	CA	VH		126,249		1933	E	H		1
401.	San Francisco	4	Research/Admin.	CA	VH		7,127		1933		H		1
402.	San Francisco	7	Canteen/Auditorium/Chapel	CA	VH	Concrete shear wall	36,128	N03	1933		H		2
403.	San Francisco	13	Engineering/Research	CA	VH	Concrete shear wall	12,906	N01	1933	E	H	EHR	2
404.	San Francisco	18	Research/Admin.	CA	VH	Wood, comm. & industrial	9,600	N02	1934		H		2
405.	San Francisco	26	Hazardous Chemicals Storage	CA	VH	Unreinforced masonry	392	N01	1953	C			1
406.	San Francisco	200	AmbCare/Clinical Support	CA	VH		155,509		1965	C			1
407.	Seattle	1	Main Administration	WA	VH	Conc. frm. w/ infill	255,875	N09	1950				2
408.	Seattle	7	Lodging	WA	VH	Wood, light frame	3,523	N01	1950				1
409.	Sepulveda	4	Clinical Care	CA	VH	Reinf. masonry bearing wall	79,312	N03	1954	E		EHR	2
410.	Sepulveda	5	Clinical Care	CA	VH	Reinf. masonry bearing wall	57,294	N03	1954	E		EHR	2
411.	St. Louis (JB)	1	Clin/Adm/Diag/Research	MO	MH	Conc. frm. w/ infill	123,947	N03	1923	C			2
412.	St. Louis (JB)	2	Education	MO	MH	Conc. frm. w/ infill	26,372	N03	1923				2
413.	St. Louis (JB)	3	Education/student quarters	MO	MH	Unreinforced masonry	24,306	N02	1923				2
414.	St. Louis (JB)	4	Adm/Nurse Ed/Socl Wrk	MO	MH	Unreinforced masonry	27,411	N02	1923				2
415.	St. Louis (JB)	5	Engineering Shops	MO	MH		6,000	N01	1923				2
416.	St. Louis (JB)	6	Warehouse	MO	MH		5,279	N01	1923				2
417.	St. Louis (JB)	7	Engineering/EMS Shops	MO	MH	Unreinforced masonry	11,200	N01	1923				2
418.	St. Louis (JB)	8	Warehouse	MO	MH	Unreinforced masonry	11,346	N01	1926				2
419.	St. Louis (JB)	13	Storage	MO	MH		1,800	N03	1923				2
420.	St. Louis (JB)	17	Engineering Shops	MO	MH		1,000	N03	1935				2
421.	St. Louis (JB)	18	Administration	MO	MH	Conc. frm. w/ infill	44,476	N03	1939				2
422.	St. Louis (JB)	23	Shop/Clothing/Record	MO	MH		21,300	N01	1937				2
423.	St. Louis (JB)	24	Canteen/Lib/Audito.	MO	MH	Conc. frm. w/ infill	23,591	N02	1936				2
424.	St. Louis (JB)	25	Canteen/Gen. Coucil	MO	MH	Conc. frm. w/ infill	26,742	N03	1929				2
425.	St. Louis (JB)	27	Quarters	MO	MH	Wood, light frame	3,441	N01	1929				2
426.	St. Louis (JB)	29	Quarters	MO	MH	Wood, light frame	3,441	N01	1929				2
427.	St. Louis (JB)	35	Storage	MO	MH		3,680	N01	1939				2
428.	St. Louis (JB)	37	Storage	MO	MH		600		1935				2
429.	St. Louis (JB)	38	Main Switch Gear	MO	MH	Other	228	N01	1951				2
430.	St. Louis (JB)	48	Nat'l Media Develop.	MO	MH	Conc. frm. w/ infill	10,670	N01	1952				2
431.	St. Louis (JB)	50	Psychiatric	MO	MH	Conc. frm. w/ infill	110,044	N04	1952	C			2
432.	St. Louis (JB)	51	NHCU	MO	MH	Conc. frm. w/ infill	70,968	N01	1952	C			2

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433.	St. Louis (JB)	52	SCI/Domciliary	MO	MH	Conc. frm. w/ infill	102,178	N02	1952	C			2
434.	St. Louis (JB)	53	Medical/Geriatrics	MO	MH	Conc. frm. w/ infill	98,307	N02	1952	C			2
435.	St. Louis (JB)	60	Main Kitchen	MO	MH	Conc. frm. w/ infill	13,397	N01	1952	E			2
436.	St. Louis (JB)	61	Rec./Auditorium	MO	MH	Conc. frm. w/ infill	26,000	N01	1957				2
437.	St. Louis (JB)	63	Therap./Recreation-Pool	MO	MH	Unreinforced masonry	16,938	N01	1957	E		HR	2
438.	St. Louis (JB)	64	Chapel	MO	MH	Conc. frm. w/ infill	3,544	N01	1952				2
439.	St. Louis (JB)	65	Medical Rehab OT/PT	MO	MH	Conc. frm. w/ infill	13,998	N01	1952	E			2
440.	St. Louis (JB)	70	Boiler Plant	MO	MH	Steel frm. w/-infill	15,036	N01	1952	C		HR	2
441.	St. Louis (JB)	72	Dressing Room	MO	MH	Unreinforced masonry	31	N01	1952				2
442.	St. Louis (JB)	1CC	Connect Corridors	MO	MH	Unreinforced masonry	21,483	N02	1952				2
443.	St. Louis (JB)	70A	Chiller Plant	MO	MH	Steel frm. w/-infill	2,971	N01	1965	C		HR	2
444.	St. Louis (JC)	2	Research, Edu., Chapel, Med	MO	MH	Steel frm. w/-infill	29,498	N01	1953				1
445.	St. Louis (JC)	3	IRM, Hypertension	MO	MH	Conc. frm. w/ infill	13,779	N02	1953	C		HR	1
446.	St. Louis (JC)	4	Engineering	MO	MH		6,266		1953				1
447.	St. Louis (JC)	6	Research	MO	MH	Unreinforced masonry	7,287	N03	1953	E		HR	1
448.	St. Louis (JC)	7	Research	MO	MH	Steel frm. w/-infill	6,399	N01	1953	E		HR	1
449.	St. Louis (JC)	8	Boiler Plant	MO	MH	Steel frm. w/-infill	7,054	N01	1953	C		HR	1
450.	St. Louis (JC)	8A	Chiller Plant	MO	MH	Steel frm. w/-infill	6,388	N01	1962	C		HR	1
451.	St. Louis (JC)	11	Gas House	MO	MH	Concrete shear wall	575	N01	1953				1
452.	St. Louis (JC)	14	Garage	MO	MH		3,339		1953				1
453.	Syracuse	1	Main Hospital	NY	L		207,172		1945	C			1
454.	Syracuse	2	Support Services Center	NY	L		8,577		1945				1
455.	Syracuse	3	Day Care Center	NY	L		512		1945				1
456.	Syracuse	16	Research	NY	L		3,130		1958	E			1
457.	Togus	36	Grounds Unit	ME	ML		8,594		1900		H		1
458.	Togus	67	Paint Shop	ME	ML		1,774		1891		H		1
459.	Togus	200	GM & Hospital	ME	ML	Conc. frm. w/ infill	243,359	N07	1933	C			2
460.	Togus	201	Garage	ME	ML	Steel frm. w/-infill	9,842	N01	1933				2
461.	Togus	202	Utility Shop/Eng. Office	ME	ML	Conc. frm. w/ infill	21,605	N02	1933				2
462.	Togus	203	Administration Building	ME	ML	Conc. frm. w/ infill	24,004	N03	1935				2
463.	Togus	204	NP Kitchen/Dining Room	ME	ML	Conc. frm. w/ infill	49,060	N02	1936	E			2
464.	Togus	205	Administration	ME	ML	Conc. frm. w/ infill	81,069	N03	1936				2
465.	Togus	206	P & B Hospital	ME	ML	Conc. frm. w/ infill	81,034	N03	1936	C			2
466.	Togus	207	P & N Hospital	ME	ML	Conc. frm. w/ infill	88,824	N03	1937	C			2
467.	Togus	209	Medical Admin.	ME	ML	Conc. frm. w/ infill	23,220	N02	1937				2
468.	Togus	210	Theater	ME	ML	Steel frm. w/-infill	33,716	N02	1937				2
469.	Togus	211	Fire Station	ME	ML	Unreinforced masonry	3,206	N01	1935	C			2
470.	Togus	212	Laundry	ME	ML	Unreinforced masonry	13,247	N01	1936				2
471.	Togus	221	OT & Mat Shop	ME	ML	Unreinforced masonry	13,648	N01	1947	E			2
472.	Togus	222	Sewerage Plant	ME	ML	Unreinforced masonry	2,184	N01	1950	C			2
473.	Togus	223	Quonset Hut - Pipe Shed	ME	ML		1,170		1945				1
474.	Togus	224	Quonset Hut - SPD, Packaging	ME	ML		1,170		1946				1
475.	Togus	225	Quonset Hut - Paint Shed	ME	ML		1,170		1946				1
476.	Togus	226	Quonset Hut - Storage	ME	ML		1,170		1946				1
477.	Togus	227	Quonset Hut - Storage	ME	ML		1,170		1946				1
478.	Togus	228	Quonset Hut - Storage	ME	ML		1,170		1946				1
479.	Togus	232	Gymnasium, Pool Building	ME	ML		15,458		1956				2
480.	Togus	235	Chapel	ME	ML		6,856		1960				2
481.	Togus	238	Boiler Plant	ME	ML	Unreinforced masonry	5,638	N01	1963	C			2
482.	Togus	240	Supply Warehouse	ME	ML		17,573		1971				2
483.	Togus	T222	Quonset Hut - Eng. Shop	ME	ML		1,170		1945				1
484.	Tucson	1	Administration/Canteen	AZ	ML	Conc. frm. w/ infill	16,836	N01	1928		H		1
485.	Tucson	3	Kitchen/Canteen	AZ	ML	Conc. frm. w/ infill	35,654	N01	1928	E	H		1
486.	Tucson	4	Recreation,Lib./Auditorium	AZ	ML		13,650		1929		H		1

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487.	Tucson	5	Fac/Fiscal/Day Care/A&MMS	AZ	ML		23,106		1929		H		1
488.	Tucson	6	Research	AZ	ML	Unreinforced masonry	20,165	N02	1928	E	H		1
489.	Tucson	7	Day Care Psych	AZ	ML	Unreinforced masonry	2,708	N01	1928	E	H		1
490.	Tucson	8	SWBRC Housing Trng. Unit	AZ	ML	Unreinforced masonry	2,204	N01	1928	E	H		1
491.	Tucson	9	SWBRC Housing Trng. Unit	AZ	ML	Unreinforced masonry	2,204	N01	1928	E	H		1
492.	Tucson	11	SWBRC Housing Trng. Unit	AZ	ML	Unreinforced masonry	2,204	N01	1929	E	H		1
493.	Tucson	12	SWBRC Housing Trng. Unit	AZ	ML	Unreinforced masonry	2,204	N01	1929	E	H		1
494.	Tucson	13	Voc. Rehab.	AZ	ML	Unreinforced masonry	2,204	N01	1929	E	H		1
495.	Tucson	14	Warehouse	AZ	ML		6,854		1929				1
496.	Tucson	15	Grounds Storage	AZ	ML		5,334		1929				1
497.	Tucson	16	Laundary/Storage	AZ	ML		11,180		1928				1
498.	Tucson	17	Boiler Plant	AZ	ML	Steel frm. w/-infill	4,644	N01	1928	C			1
499.	Tucson	19	Gate House	AZ	ML		267		1928		H		1
500.	Tucson	22	Garage/Storage	AZ	ML		1,220		1930		H		1
501.	Tucson	30	S.Western Blind Rehab. Ctr.	AZ	ML	Conc. frm. w/ infill	54,147	N03	1931	E	H		1
502.	Tucson	31	Storage	AZ	ML		5,040		1935				1
503.	Tucson	32	Research, Animal House	AZ	ML	Unreinforced masonry	872	N01	1931	E			1
504.	Tucson	33	Storage/Kennel	AZ	ML	Unreinforced masonry	3,608	N01	1937	E			1
505.	Tucson	37	Oxygen Storage	AZ	ML	Unreinforced masonry	288	N01	1953	C			1
506.	Tucson	38	Clinical Building	AZ	ML	Concrete shear wall	90,884	N03	1958	C	H		1
507.	Tucson	40	A/C Plant	AZ	ML	Reinf. masonry bearing wall	4,495	N01	1962	C			1
508.	Tucson	T11	Grounds Shop/Storage	AZ	ML		1,120		1947				1
509.	Tucson	T8	Paint Shop	AZ	ML		1,195		1947				1
510.	Tuscaloosa	1	Intermediate Care	AL	ML	Conc. frm. w/ infill	97,874	N04	1931	C	H		1
511.	Tuscaloosa	2	Outpatient Care	AL	ML	Conc. frm. w/ infill	37,120	N03	1931	C	H		1
512.	Tuscaloosa	3	Dining/Kitchen/Boiler/ISS	AL	ML	Conc. frm. w/ infill	55,708	N03	1931	C	H		1
513.	Tuscaloosa	4	Auditorium/Q.A./Kin. Therapy	AL	ML	Unreinforced masonry	15,537	N02	1931	E	H		1
514.	Tuscaloosa	5	Administrative Office	AL	ML		24,292		1931		H		1
515.	Tuscaloosa	12	Warehouse	AL	ML		16,615		1931				1
516.	Tuscaloosa	13	Pump House	AL	ML		610		1931				1
517.	Tuscaloosa	14	Gas Meter House	AL	ML		128		1931				1
518.	Tuscaloosa	17	Engineering Shops	AL	ML		7,969		1933		H		1
519.	Tuscaloosa	18	Laundry	AL	ML		13,857		1933		H		1
520.	Tuscaloosa	27	Storage Garage	AL	ML		3,320		1932				1
521.	Tuscaloosa	28	Flammable Storage	AL	ML	Unreinforced masonry	280	N01	1936	C			1
522.	Tuscaloosa	38	Intermediate Care	AL	ML	Conc. frm. w/ infill	82,032	N02	1944	C	H		1
523.	Tuscaloosa	39	Hoptel	AL	ML	Conc. frm. w/ infill	67,455	N02	1944	E	H		1
524.	Tuscaloosa	40	IRMFO/Child Care	AL	ML	Conc. frm. w/ infill	73,348	N02	1944	C	H		1
525.	Tuscaloosa	41	CWT/Grounds/Transport.	AL	ML	Conc. frm. w/ infill	20,436	N02	1944	E	H		1
526.	Tuscaloosa	46	Chapel	AL	ML		4,363		1963				1
527.	Tuscaloosa	CC	Connecting Corridors	AL	ML		19,830		1933				1
528.	Vancouver	14	Gym	WA	H	Wood, light frame	12,659	N02	1943				2
529.	Vancouver	COR	Connecting Corridors	WA	H		29,775		1943				2
530.	Vancouver	T1819	Storage	WA	H	Wood, light frame	1,264	N01	1943				2
531.	Vancouver	T2107	Theater	WA	H	Wood, light frame	9,724	N02	1943				2
532.	Vancouver	T2113	Liver Lodgers	WA	H	Wood, light frame	5,162	N01	1943	E			2
533.	Vancouver	T2114	Liver Lodgers	WA	H	Wood, light frame	5,162	N01	1943	E			2
534.	Vancouver	T2115	Dom Office	WA	H	Wood, light frame	5,563	N01	1943				2
535.	Vancouver	T2116	Hospital	WA	H	Wood, light frame	5,225	N01	1943	E			2
536.	Vancouver	T2125	Vacant	WA	H	Wood, light frame	5,250	N01	1943				2
537.	Vancouver	T2126	CARS Outpatient	WA	H	Wood, light frame	5,250	N01	1943				2
538.	Vancouver	T2127	Transcription/Fee Basis	WA	H	Wood, light frame	5,250	N01	1943				2
539.	Vancouver	T2131	PTSD Outpatient	WA	H	Wood, light frame	5,225	N01	1943	E			2
540.	Vancouver	T2143	CARS Outpatient	WA	H	Wood, light frame	5,250	N01	1943	E			2

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541.	Vancouver	T2239	VISN	WA	H	Wood, light frame	11,744	N01	1943				2
542.	Vancouver	T2241	Vacant	WA	H	Wood, light frame	4,099	N01	1943				2
543.	Vancouver	T2243	Outpatient Clinic	WA	H	Wood, light frame	6,828	N01	1943	C			2
544.	Vancouver	T2263	Pharmacy	WA	H	Wood, light frame	5,250	N01	1943	C			2
545.	Vancouver	T2265	Records/Reproduction	WA	H	Wood, light frame	5,250	N01	1943	E			2
546.	Vancouver	T2267	Dental Hygene	WA	H	Wood, light frame	4,797	N01	1943	C			2
547.	Vancouver	T2279	Chapel	WA	H	Wood, light frame	4,082	N01	1943				2
548.	Vancouver	T2286	Prosthetics	WA	H	Wood, light frame	6,396	N01	1943	E			2
549.	Vancouver	T2287	Radiology	WA	H	Wood, light frame	5,139	N01	1943	C			2
550.	Vancouver	T2288	Facilities Storage	WA	H	Wood, light frame	5,169	N01	1943				2
551.	Vancouver	T2289	IRM	WA	H	Wood, light frame	5,169	N01	1943	C			2
552.	Vancouver	T2290	Admin Building	WA	H	Wood, light frame	5,169	N01	1943				2
553.	Vancouver	T2291	Dom West	WA	H	Wood, light frame	5,169	N01	1943	E			2
554.	Walla Walla	1	Directors Quarters	WA	MH	Unreinforced masonry	6,134	N01	1877		H		2
555.	Walla Walla	2	Duplex Quarters	WA	MH	Unreinforced masonry	5,158	N01	1858		H		2
556.	Walla Walla	3	Duplex Quarters	WA	MH	Unreinforced masonry	4,846	N01	1858		H		2
557.	Walla Walla	4	Duplex Quarters	WA	MH	Unreinforced masonry	4,846	N01	1858		H		2
558.	Walla Walla	5	Duplex Quarters	WA	MH	Unreinforced masonry	5,116	N01	1858		H		2
559.	Walla Walla	7	Police	WA	MH	Unreinforced masonry	6,780	N01	1930	C		HR	2
560.	Walla Walla	48	Quarters	WA	MH	Unreinforced masonry	3,698	N01	1888		H		2
561.	Walla Walla	49	Quarters	WA	MH	Unreinforced masonry	3,494	N01	1888		H		2
562.	Walla Walla	63	Plumbing Shop	WA	MH		2,200		1904		H		2
563.	Walla Walla	65	Carpenter Shop	WA	MH		8,680		1904		H		2
564.	Walla Walla	66	Laundry	WA	MH	Unreinforced masonry	7,416	N01	1937				2
565.	Walla Walla	77	Human Resources	WA	MH	Unreinforced masonry	11,214	N01	1929				2
566.	Walla Walla	78	Theatre/Directors Suite	WA	MH	Unreinforced masonry	10,800	N02	1930				2
567.	Walla Walla	80	Dietetics/Library	WA	MH	Unreinforced masonry	23,520	N02	1932				2
568.	Walla Walla	81	Warehouse	WA	MH		6,282		1928				2
569.	Walla Walla	82	Facilities Mgmt /Garages	WA	MH	Unreinforced masonry	7,860	N02	1932				2
570.	Walla Walla	86	Hospital	WA	MH	Unreinforced masonry	43,930	N03	1929	C			2
571.	Walla Walla	T1	AMMS	WA	MH		1,250		1947				1
572.	Walla Walla	T2	Fiscal	WA	MH	Wood, light frame	2,000	N01	1945				1
573.	Walla Walla	T6	Pharmacy/MCCR	WA	MH	Wood, light frame	4,915	N01	1945	C			1
574.	Walla Walla	T7	Chapel	WA	MH	Wood, light frame	4,042	N01	1945				1
575.	West Los Angeles	13	Storage	CA	VH	Concrete shear wall	52,604	N02	1929		H		2
576.	West Los Angeles	20	Chapel	CA	VH	Wood, light frame	8,758	N01	1900		H		2
577.	West Los Angeles	44	Engineering Shop	CA	VH	Steel frm. w/-infill	12,909	N01	1897		H		2
578.	West Los Angeles	46	Engineering Shop	CA	VH	Steel frm. w/-infill	11,034	N01	1922				2
579.	West Los Angeles	116	Homeless Vets	CA	VH	Conc. frm. w/ infill	60,000	N03	1930	E	H		2
580.	West Los Angeles	117	Research Lab	CA	VH	Concrete shear wall	20,873	N01	1930	E	H	EHR	2
581.	West Los Angeles	211	Theater	CA	VH	Concrete shear wall	11,490	N01	1946		H		2
582.	West Los Angeles	220	Dental/Greco	CA	VH	Concrete shear wall	29,876	N04	1939		H		2
583.	West Los Angeles	224	Laundry	CA	VH	Concrete shear wall	29,257	N02	1946				2
584.	West Los Angeles	226	Theater	CA	VH	Concrete shear wall	20,875	N01	1940		H		2
585.	West Los Angeles	264	Day Treatment Hospital	CA	VH	Wood, light frame	10,030	N02	1938	E	H		2
586.	West Los Angeles	266	Supply Warehouse	CA	VH	Wood, light frame	3,234	N01	1945				2
587.	West Los Angeles	267	Repair Shop	CA	VH	Wood, light frame	6,648	N01	1945				2
588.	West Los Angeles	295	Steam Plant	CA	VH	Concrete shear wall	5,720	N01	1947	C		HR	2
589.	West Los Angeles	297	Supply Warehouse	CA	VH	Steel frm. w/-infill	32,700	N01	1948				2
590.	West Los Angeles	298	Residental Treatment Center	CA	VH	Wood, light frame	4,187	N01	1935	E		HR	2
591.	West Los Angeles	300	Dietetics & ADP	CA	VH	Conc. frm. w/ infill	66,824	N03	1952	E		EHR	2
592.	West Los Angeles	301	AFGE Union	CA	VH	Steel light frame	2,643	N01	1951				2
593.	West Los Angeles	304	Research Med. Sup.	CA	VH	Concrete shear wall	89,267	N02	1957	E			2
594.	West Los Angeles	306	Cafeteria/Post Office	CA	VH	Concrete shear wall	14,281	N01	1957				2

No.	Medical Center Name	Building Number	Building Name	State	Seismicity	Building Type - Description	Area (sqft.)	Number of Stories Code	Date of Construction	Essential/Critical Bldg. Code	Historic Building Code	Except. High Risk Code	VA Phase 1 or 2 Evaluation[A]
595.	West Roxbury	1	Patient Care	MA	ML		203,000		1945	C			1
596.	West Roxbury	5	FMS	MA	ML		5,100		1977				1
597.	West Roxbury	7	Warehouse	MA	ML		10,600		1945				1
598.	West Roxbury	8	Boiler Plant	MA	ML	Unreinforced masonry	5,594	N03	1945	C			1
599.	West Roxbury	10	Garage	MA	ML		1,932		1945				1
600.	West Roxbury	17	Shops	MA	ML		1,800		1945				1
601.	West Roxbury	20	Research	MA	ML	Unreinforced masonry	3,626	N01	1950	E			1
602.	West Roxbury	22	Research	MA	ML	Reinf. masonry bearing wall	1,284	N01	1960	E			1
603.	White City	201	Primary Care Clinic	OR	H	Unreinforced masonry	27,069	N02	1942	C			2
604.	White City	219	Canteen	OR	H	Unreinforced masonry	13,531	N01	1942				2
605.	White City	225	Elec. Shop, Warehouse	OR	H	Unreinforced masonry	26,724	N02	1942				2
606.	White City	226	A&MMS Warehouse	OR	H		26,724		1942				2
607.	White City	227	Carp. Shop, Grounds	OR	H		26,724		1942				2
608.	White City	234	Plumbing Shop	OR	H		9,620		1942				2
609.	White City	235	Paint Shop, Refr Shop	OR	H		13,000		1942				2
610.	White City	241	PAP Supplies, Baggage	OR	H		18,240		1942				1
611.	White City	242	Facilities Management Storage	OR	H		18,240		1942				1
612.	White City	CC	Connecting Corridor	OR	H		104,418		1942				2
613.	Wichita	1	Wards Main Building	KS	L		119,136		1934	C	H		1
614.	Wichita	2	Kitchen	KS	L		22,443		1934	E	H		1
615.	Wichita	3	Administration	KS	L		20,644		1934		H		1
616.	Wichita	4	Auditorium	KS	L		22,351		1934		H		1
617.	Wichita	5	Research	KS	L		18,487		1934	E	H		1
618.	Wichita	7	SATU Outpatient	KS	L		7,296		1934	E	H		1
619.	Wichita	10	Engineering Garage	KS	L		4,359		1934		H		1
620.	Wichita	11	Safety Office	KS	L		1,564		1950		H		1
621.	Wichita	12	Engineering Warehouse	KS	L		5,834		1950		H		1
622.	Wichita	13	Boiler Plant	KS	L		3,819		1934	C	H		1
623.	Wichita	16	Laundry	KS	L		9,611		1950		H		1
624.	Wichita	17	Gas House	KS	L		130		1950		H		1
625.	Wichita	19	Wards	KS	L		23,518		1940	C	H		1
626.	Wichita	20	Engineering Shops	KS	L		4,950		1950		H		1
627.	Wichita	26	Outpatient Building	KS	L		53,905		1950	C			1
628.	Wichita	CC	Connecting Corridors	KS	L		11,817		1934				1

[A]VA Phase 1 or 2 Evaluation: "1" or "2" refers to VA Phase 1 or 2 evaluation during the 70's. These buildings have not been evaluated since then.

HOMELESSNESS

Question 26. The President's budget request notes that VA is developing research on health conditions and risk factors that relate to homelessness and on the effectiveness of VA homeless services. Are there any preliminary findings from this research that you can share with the Committee? When can Congress expect to see the results of these studies?

Response. The VA National Center on Homelessness Among Veterans (NCHV) has adopted a research agenda with a focus on the epidemiology of homelessness among Veterans and the effectiveness of services intended to prevent and end homelessness among Veterans. These studies are aimed at closing gaps in the research related to the prevalence of homelessness among Veterans, characteristics of Veterans who experience homelessness, and factors that predict homelessness among Veterans as well as Veterans' utilization of services and whether these services are both efficient and effective.

The initial studies conducted by the NCHV have focused on developing a definitive count of homeless Veterans. To this end, the NCHV collaborated with the U.S. Department of Housing and Urban Development (HUD) to develop Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report to Congress, which provides point-in-time and annual counts of homeless Veterans in the United States—75,609 and 135,334, respectively—as well as the characteristics and locations of homeless Veterans. An additional investigation of the prevalence and risk of homelessness among Veterans in a selection of communities provides more detailed analyses of homelessness risk. Taken together, these studies indicate that Veterans are overrepresented within the homeless population. Specifically, the multi-site investigation found that, after controlling for poverty, age, race, and geographic variation, female Veterans were three times as likely as female non-Veterans to become homeless, and male Veterans were twice as likely as male non-Veterans to become homeless.

There is another study underway to identify specific risk factors for homelessness among Veterans and to accurately prioritize prevention resources for those who are at imminent risk of homelessness. The NCHV is developing a Homelessness Risk Assessment, which will be piloted in a variety of settings and tested for reliability and validity. The instrument is a brief, two-stage assessment that first assesses whether a Veteran has a safe and stable place to stay for at least 90 days. If the Veteran appears to be at risk, the second stage of the instrument assesses the Veteran's current living situation, barriers to living independently, and supports that the Veteran may have or require to access and maintain safe and stable housing. The assessment will inform appropriate referrals to homelessness prevention or other services. In addition, data collected through the assessment process will guide decisions regarding need for and targeting of resources moving forward, including specific characteristics that may pose risk for homelessness.

While homelessness among Veterans in the OEF/OIF/OND service era is a priority concern, there is limited empirical data about the extent to which or dynamics whereby they do become homeless. To address this, the NCHV is examining the onset of homelessness among recent Veterans, including those returning from the OEF and OIF conflicts. Working in conjunction with the VA Office of the Inspector General and municipal shelter providers in Columbus, Ohio, New York City, New York and Philadelphia, Pennsylvania, researchers at the NCHV are compiling an array of data that will facilitate identifying risk factors for homelessness among OEF/OIF Veterans at the time of their separation from the military. This promises to inform prevention programs and increase their efficiency. Services use patterns among this group will also be examined to assess the extent to which they use VA services, community services, or a combination of the two. This will increase the understanding of how Veterans access the services available to them, and will facilitate better coordination of services between VA and mainstream homeless service systems.

The NCHV is also organizing a series of studies around the general topics of mortality, morbidity, and aging among homeless Veterans. The overall goal of this project is to assess the demographic trends among the homeless Veteran population to project future trends in the size and makeup of this population, and to anticipate future demand for services. Research conducted by study investigators has shown the overall single adult (i.e., not family) homeless population to be steadily aging. If these trends continue, this would lead to higher risk for early mortality and greater needs for long-term care. Research is currently underway to assess whether these trends also hold for homeless Veterans, and the impact that providing homeless Veterans with housing has on subsequent health and mortality.

Additionally, an examination of the intersection of suicide and homelessness has produced preliminary findings which show that 24 percent of Veterans in a registry of suicide attempters also had records of receiving VA homeless services.

Another project is examining the life course of elderly Veterans with records of homelessness, and their uses of VA and non-VA health care services.

Several of these studies are in the initial phases. We anticipate preliminary data on most of them to be available by the end of Fiscal Year 2011, and final reports by the end of Fiscal Year 2012.

Question 27. The Department has a number of programs with the goal of preventing veteran homelessness before it starts and ending it once veterans are on the streets. For each program, please share how many veterans are helped annually and how many have been helped since the program started. Of these programs, which have led to the largest reductions in homeless populations?

Response. The Department of Veterans Affairs (VA) operates the largest system of homeless treatment and assistance programs in the Nation. In 2010, VA's specialized homeless programs served more than 116,000 Veterans. The hallmark of VA's homeless programs are that they provide comprehensive care and benefits including medical, psychiatric, substance abuse, rehabilitation, dental care and expedited claim processing for these Veterans. In addition, VA case management and supportive services are focused on preventing and ending homelessness. The following programs represent VA's homeless continuum of care. All programs in the continuum are part of VA's plan to end homelessness and contribute to the overall reduction of the homeless Veteran population. Each program represents a different part of the continuum and no program is more efficacious than another.

Prevention Programs:

The primary VA prevention program, Supportive Services for Veteran Families (SSVF), is in the process of being implemented. The grant application period closed on March 11, 2011 and VA is in the process of reviewing these applications and awarding these grants. VA expects to announce these awards in June 2011.

A second prevention program is the Veterans Homelessness Prevention Demonstration (VHPD) also referred to as the HUD-VA Pilot. The HUD-VA Pilot program is designed to explore ways for the Federal Government to offer early intervention homeless prevention, primarily to Veterans returning from wars in Iraq and Afghanistan. This demonstration program will provide an opportunity to understand the unique needs of this new cohort of Veterans, and will support efforts to identify, outreach, and assist them to regain and maintain housing stability. This three year HUD-VA prevention pilot is a partnership among the Department of Veterans Affairs (VA), the Department of Housing and Urban Development (HUD), the Department of Labor (DOL), and local community agencies. VHPD will serve the following locations: MacDill Air Force Base in Tampa, Florida; Camp Pendleton in San Diego, California; Fort Hood in Killeen, Texas; Fort Drum in Watertown, New York; and Joint Base Lewis-McChord near Tacoma, Washington. As the lead agency, HUD is awarding grants for the provision of housing assistance and supportive services to prevent Veterans and their families from becoming homeless, or reduce the length of time Veterans and their families are homeless. HUD's Office of Special Needs Assistance Programs (SNAPS) executed the grant agreements with the pilot site Continuums of Care grantees on February 3, 2011. VA case management and outreach staff have been hired at each of the sites and are working with Department of Labor staff and the Continuum of Care grantees to implement the program. The HUD-VA pilot sites are expected to start delivering services to Veterans no later than March 2011.

The National Call Center for Homeless Veterans (NCCHV) was founded to ensure that homeless Veterans or Veterans at risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless Veterans and their families, VA medical centers, Federal, state and local partners, community agencies, service providers and others in the community. The NCCHV call number (1–877–4AID VET) was activated the week of December 21, 2009 and full implementation commenced on March 1, 2010. From March 1, 2010 to February 28, 2011, there have been 25,771 calls to the NCCHV. Of the calls received, 20,831 callers identified as Veterans; 6,578 Veteran callers identified as being homeless; and 11,769 Veteran callers identified as being at risk of homelessness.

As part of the Plan to End Homelessness Among Veterans, VA is focused on serving Veterans involved with the criminal justice system, who may be homeless or at risk for homelessness. Studies have shown that for adult males, incarceration is the most powerful predictor of homelessness (Burt et al., 2001). The Health Care for Reentry Veterans (HCRV) program provides outreach and linkage to post-release services for Veterans in state and Federal prisons; HCRV Specialists have provided re-

entry services to 24,244 reentry Veterans since Fiscal Year (FY) 2008, including 9,622 Veterans in FY 2010. The Veterans Justice Outreach (VJO) program focuses on Veterans in contact with law enforcement, jails, and courts, including the rapidly expanding Veterans Treatment Courts (VTC). VJO Specialists have served a total of 8,004 justice-involved Veterans since the start of the program, including 5,849 so far in FY 2011.

Rehabilitation, Treatment, Transitional Housing and Permanent Supportive Housing Programs:

Grant and Per Diem Program (GPD): The GPD program allows VA to award grants to community-based agencies to create transitional housing programs, and provides per diem payments to the programs to support operational costs. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VA medical centers by augmenting or supplementing care. The GPD program has provided services for 98,493 unique Veterans since 1995, including 15,706 Veterans in FY 2009, 17,305 Veterans in FY 2010, and 4,174 Veterans during the first quarter of FY 2011 (data from NEPEC annual report).

Health Care for Homeless Veterans (HCHV): The central goal of the HCHV programs is to reduce homelessness among Veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs. The HCHV Outreach program has served 383,362 unique Veterans since 1987; this includes 81,212 Veterans in FY 2009, 90,237 Veterans in FY 2010, and 36,371 Veterans during the first quarter of FY 2011.

The HCHV Contract Residential Treatment Program ensures that Veterans with serious mental health diagnoses can be placed in community-based programs which provide quality housing and services. HCHV provides "in place" residential treatment beds through contracts with community partners and VA outreach and clinical assessments to homeless Veterans who have serious psychiatric and substance use disorders. The HCHV Contract Residential Treatment Program has served 54,723 unique Veterans since 1987; this includes 2,870 Veterans in FY 2009, 3,541 Veterans in FY 2010, and 1,592 Veterans during the first quarter of FY 2011.

Domiciliary Care for Homeless Veterans (DCHV): The DCHV Program provides time-limited residential treatment to homeless Veterans with health care and social-vocational deficits. DCHV programs provide homeless Veterans access to medical, psychiatric, and substance use disorder treatment in addition to social and vocational rehabilitation programs. The DCHV program has served 76,289 unique Veterans since 1988; this includes 8,605 Veterans in FY 2009, 8,445 Veterans in FY 2010, and 3,267 Veterans during the first quarter of FY 2011.

Housing and Urban Development-VA Supported Housing (HUD-VASH): This is a collaborative program between HUD and VA where eligible homeless Veterans receive VA-provided case management and supportive services to support stability and recovery from physical and mental health, substance use, and functional concerns contributing to or resulting from homelessness. HUD-VASH is the Nation's largest supported permanent housing initiative. As of February 28, 2011, 19,834 Veterans are currently under lease, 6,667 Veterans have vouchers assigned to them, and are in process of getting housed and 3,936 vouchers are at the Public Housing Authority waiting to be assigned to a Veteran. Since 2008, a total of 23,011 Veterans have been housed through this program.

Question 28. The new homeless veteran call center is a vital tool for centralizing and standardizing the information VA provides to the public.

A. Who typically calls this center?

Response. From March 1, 2010 to February 28, 2011, there have been 25,771 calls to the NCCHV. As of February 28, 2011, there have been 20,831 callers identified as Veterans; 6,578 Veteran callers identified as being homeless; and 11,769 Veteran callers identified as being at risk of homelessness.

Additionally family members and friends of Veterans, community agencies, military/Veteran service providers and other interested parties have been identified as calling the National Call Center for Homeless Veterans (NCCHV) to help Veterans.

B. What type of information is provided to callers?

Response. Callers are provided the location of their nearest VA Medical Center as well as the names and phone numbers of the VA Medical Center's identified primary and secondary Homeless Program Points of Contact Callers are provided information, referral and intervention based on their presenting needs. Information re-

garding names and numbers of community agencies and local community resources are provided, as well as national Web sites and other hotline numbers.

C. What is the average wait time to reach a staff member?

Response. The National Call Center for Homeless Veterans (NCCHV) answers calls 24 hours a day, 7 days a week. All calls are answered immediately by trained responders at the NCCHV who conduct a brief screen to determine need and severity of need. Responders at the NCCHV then link those callers needing referral and linkage to the nearest VA Medical Center Homeless Program Point of Contact anywhere in the country. Emergency calls are linked immediately to the VA Medical Center's identified Homeless Program Point of Contact or after hour/weekend staff for assistance and intervention. Responders at the NCCHV can contact the Point of Contact or the after hour/weekend staff to consult on any call that may be urgent in nature to determine a course of action and develop a plan. For routine calls, the Point of Contact will respond within 24 hours or the next business day. All consult reports are completed by the Point of Contact within 5 business days and includes the Homeless Team's update on how they assisted the Veteran as well as any ongoing plan of care.

WOMEN VETERANS

Question 29. What funds are being specifically directed toward expanding hours at women's clinics?

Access to care, including making care available outside of typical operating hours, continues to be a part of the prospective changes to support ever increasing patient-centeredness of VA health care. According to information gathered in March, 2011, 29 facilities across 24 states currently offer extended primary care hours for women. Overall, 20.4% of facilities offer extended primary care hours (operating hours outside of usual operating hours 8am–4:30pm) for women and 24% offer extended primary care hours for men. It is anticipated that these numbers will continue to increase as the transformation to patient-aligned care teams and the focus on more patient-centered care continues. In FY 2011, the VISNs received approximately $410 million in Major Strategic Initiative/Transformation Initiative funds which could be used to expand primary care hours for women, among other purposes.

Question 30. Please provide detailed information on the childcare pilot program. Where will these pilots occur?

Response. VA recognizes that Veterans may need childcare options during health appointments and research confirms that lack of childcare may be a barrier to utilization of VA care by women Veterans. However, because childcare is not considered medical care, VA does not have authority to provide it. Currently, VA facilities may not use resources or personnel to provide childcare to Veterans attending appointments. Section 205 of Public Law 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010, signed May 5, 2010, requires VA to conduct a 2 year pilot program in at least three Veterans Integrated Service Networks (VISN) that offers eligible Veterans childcare when seeking a medical appointment. VA is currently working to determine the mechanism for pilot sites and to determine the definition of "primary caretaker" as provided in the legislation. We plan to initiate pilot childcare projects through three VISNs later this year, with initial pilot sites becoming operational this summer.

Question 31. VA's response to pre-hearing questions noted that $17 million in FY 2011 non-recurring maintenance funding has been budgeted for correcting patient privacy deficiencies. Is this amount sufficient to cover all of the construction recommendations identified in GAO's report, VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes? If not, please provide an estimate as to how much funding is needed to make VA facilities accessible to women veterans.

Response. The attachment follows.

Women's Projects from FY2012 SCIP Process

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
"Women" Specific Projects						
1	Augusta	ME	NRM	Women's Clinic Renovations	2012	1,612
1	White River Junction	VT	NRM	Construct a Women's Clinic	2012	1,086
3	Brooklyn	NY	NRM	Women Health Clinic Renovation	2012	1,320
4	Philadelphia	PA	NRM	Women's Imaging Center	2012	1,628
5	Martinsburg	WV	Minor Construction	Women's Wellness Center	2012	7,498
4	Philadelphia	PA	Other	Relocate Women's Health	2013-2021	900
6	Richmond	VA	Minor Construction	Women's Health/Primary Care Addition	2013-2021	8,250
9	Huntington	WV	NRM	Renovate Building 7 for Women's Health	2013-2021	1,900
11	Indianapolis	IN	NRM	Construct Women's Health Center	2013-2021	500
15	Topeka	KS	NRM	Women's Health Center B1, 1st Floor	2013-2021	300
16	Shreveport	LA	NRM	Women's Primary Care Clinic	2013-2021	2,300
19	Sheridan	WY	Major Construction	Construct Harmony House Women's Health Center	2013-2021	34,000
22	Long Beach	CA	NRM	B126 Women's Clinic Expansion	2013-2021	1,000
23	Sioux Falls	SD	NRM	Women's Health/Patient Privacy Improvements	2013-2021	3,750
					Sub-total	**66,043**
Indirect Women's Projects						
1	Augusta	ME	NRM	Mental Health Relocation to B206	2012	2,282
1	Bedford	MA	NRM	Correct Mental Health Deficiencies Inpatient 6B ward	2012	3,300
1	Brockton	MA	NRM	Replace Doors and Upgrade Hardware/ Card Access BK	2012	2,200
1	Brockton	MA	NRM	Ward Renovation Patient Privacy	2012	4,400
1	Newington	CT	NRM	Bathroom Upgrades Project PH 1	2012	1,200
1	West Haven	CT	NRM	In-Patient Unit Renovation for Patient Privacy, PH 2	2012	9,900
1	West Roxbury	MA	NRM	Ward Renovation Patient Privacy	2012	4,400
2	Albany	NY	NRM	Ward Renovations for Patient Privacy	2012	4,405
2	Bath	NY	NRM	Renovate Building 34 for Accessibility and Privacy	2012	2,681
2	Buffalo	NY	NRM	Renovate Ward 9C	2012	7,678
2	Syracuse	NY	NRM	Renovate 7 West for Patient Ward	2012	2,986
3	Manhattan	NY	NRM	Patient ward renovation ph1,2,3	2012	7,201
3	Manhattan	NY	NRM	Renovation of Patient Wards	2012	6,978
4	Altoona	PA	Minor Construction	Expand and Improve Behavioral Health clinic	2012	9,794
4	Clarksburg	WV	NRM	4A Mental Health	2012	6,600
4	Erie	PA	Minor Construction	Community Living Center Improvements Phase 1	2012	9,557
4	Philadelphia	PA	NRM	Rekey Medical Center	2012	2,200
4	Wilkes-Barre	PA	Minor Construction	Replace Community Living Center Phase 1	2012	9,722
4	Wilkes-Barre	PA	NRM	Emergency Room Expansion	2012	3,098
4	Wilmington	DE	Minor Construction	Construct New Medical Center Entrances (Community Living Center AND SW7)	2012	5,992
4	Wilmington	DE	Minor Construction	Domiciliary and Behavioral Health Building - Demolish Outbuildings	2012	9,800
5	Martinsburg	WV	NRM	Mental Health Domiciliary Building 502 Interior Renovations Ph.1	2012	3,685
5	Martinsburg	WV	NRM	Community Living Center Cultural Transformation to Renovate 5A Phase 2	2012	4,307

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
5	Washington	DC	NRM	Renovate Public Restrooms-Phase I	2012	2,749
6	Asheville	NC	NRM	Renovate Ward 1-West	2012	3,575
6	Fayetteville	NC	NRM	Bathroom Renovation	2012	1,925
6	Richmond	VA	NRM	Improve Patient Privacy 4D/4C - Phase 1	2012	3,073
6	Salem	VA	NRM	Renovate for Rural Health Program, Home Based Primary Care & CCHT	2012	1,320
6	Salisbury	NC	NRM	Renovate/Expand Building 11 for Residential Care Beds - Mental Health Renovations Phase 4	2012	8,226
6	Salisbury	NC	NRM	Construct Intensive Care Unit (ICU)	2012	9,126
7	Augusta	GA	NRM	Renovate Mental Health Wards A2	2012	6,000
7	Birmingham	AL	NRM	ER Urgent Care Improvements	2012	1,238
7	Dublin	GA	NRM	Renovate B34 to Outpatient Mental Health	2012	7,964
7	Montgomery	AL	NRM	Renovate Urgent Care/Radiology/Nuclear Med/Prosthetics	2012	3,001
8	Bay Pines	FL	NRM	Renovate Patient Wards B-100, 3C & 4A	2012	8,806
8	Bay Pines	FL	NRM	Renovate Community Living Center Phase II (Eden Concept)	2012	5,445
8	Gainesville	FL	Minor Construction	Additional Psychiatric Ward	2012	2,100
8	San Juan	PR	NRM	Emergency Expansion and Chest Pain Center	2012	6,654
9	Memphis	TN	NRM	Mitigate Security Risks	2012	2,531
10	Cincinnati	OH	Minor Construction	Relocate Community Living Center Phase IV	2012	8,534
10	Cleveland	OH	NRM	Renovate Mental Health Clinic	2012	1,699
10	Columbus	OH	Minor Construction	Construct Specialty Care Addition	2012	9,000
10	Columbus	OH	NRM	Expand Clinical Space, 4th Floor	2012	1,606
11	Saginaw	MI	NRM	Renovate Toilet Rooms for handicap access Building 1,2,3,4	2012	2,740
12	Iron Mountain	MI	NRM	Expand Mental Health 3-Center	2012	1,604
12	Iron Mountain	MI	NRM	Expand Medical/Surgery 4-West	2012	2,640
12	Tomah	WI	NRM	Renovate 2nd and 3rd Floors of Building 402	2012	9,504
12	Tomah	WI	NRM	Renovate 2nd and 3rd Floors of Building 406	2012	8,712
17	Dallas	TX	NRM	Patient Center Medical Home	2012	1,100
17	Dallas	TX	NRM	Renovate Medical Inpatient Nursing Unit for Privacy 5th Floor	2012	2,456
18	Albuquerque	NM	Minor Construction	New 30 Bed Community Living Center Phase 1	2012	9,597
18	Albuquerque	NM	Minor Construction	Construct New Acute Geriatric Psychiatry Unit	2012	9,714
18	Big Spring	TX	Minor Construction	New Community Living Center	2012	8,253
18	Phoenix	AZ	Minor Construction	Clinical Expansion	2012	9,945
18	Phoenix	AZ	Minor Construction	Community Living Center Cultural Transformation, Phase 2	2012	9,896
18	Tucson	AZ	Minor Construction	Mental Health Beds	2012	9,846
19	Cheyenne	WY	Minor Construction	CLC Additions	2012	7,773
19	Port Angeles	WY	Minor Construction	Domiciliary Expansion & Compensated Worth Therapy Transitional Residence	2012	9,105
19	Salt Lake City	UT	Minor Construction	New Specialty Clinic Building	2012	9,897
19	Salt Lake City	UT	Minor Construction	Prosthetics/Orthopedics/Neurology/Holistic Medicine Expansion	2012	9,964
20	Boise	ID	Minor Construction	Residential Mental Health Facility	2012	4,486
20	Portland	OR	NRM	Building 100 Ward 9D Remodel	2012	2,475
20	Vancouver	OR	Minor Construction	Construct New Primary Care Building	2012	9,300

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
21	Fresno	CA	Minor Construction	Expand the Community Living Center	2012	9,735
21	Menlo Park	CA	Minor Construction	Expand Homeless Domiciliary Outpatient and Therapy facilities	2012	9,800
21	Reno	NV	Minor Construction	Relocate/Upgrade/Expand Intensive Care Unit	2012	9,500
21	Sacramento	CA	Minor Construction	Construct Medical Specialties Building	2012	9,310
21	San Francisco	CA	Major Construction	Seismic Retrofit / Replace Exceptionally High-Risk Buildings	2012	224,800
22	Loma Linda	CA	Minor Construction	Intensive Care Unit Consolidation 2SE	2012	9,482
22	Loma Linda	CA	Minor Construction	Emergency Room Expansion	2012	9,593
22	Loma Linda	CA	Minor Construction	Community Living Center Expansion 15W	2012	9,994
22	Los Angeles	CA	NRM	Mental Health Inpatient Renovation	2012	8,019
22	Los Angeles	CA	NRM	Ambulatory Care Mental Health Medical Home	2012	2,200
22	Los Angeles	CA	NRM	B500 Renovate Bathrooms	2012	1,125
22	Los Angeles	CA	NRM	SACC Ambulatory Care Mental Health Medical Home	2012	2,198
22	San Diego	CA	NRM	Renovate Ambulatory Care Phase 2	2012	7,150
22	San Diego	CA	NRM	Renovate OEF/OIF Phase 2 & 3	2012	7,590
22	West Los Angeles	CA	Major Construction	New Essential Care Bed Tower / Seismic Correction and Renovation	2012	1,027,900
22	West Los Angeles	CA	NRM	Ambulatory Care Mental Health Medical Home	2012	9,394
23	Iowa City	IA	NRM	Renovate Inpatient Ward 5E for patient privacy	2012	4,554
23	Sioux Falls	SD	Minor Construction	Emergency Department Expansion With Relocation Of Oncology Center	2012	3,767
23	Sioux Falls	SD	Minor Construction	Expand Primary Care Space	2012	3,149
23	St. Cloud	MN	Minor Construction	Reconfigure/Expand Buildings 9 and 28 for Residential Rehabilitation Therapy Program	2012	8,069
23	St. Cloud	MN	NRM	Reconfigure for Medical Home Model, Building 4, First Floor	2012	5,257
1	Augusta	ME	Minor Construction	60 Bed Domiciliary	2013-2021	4,500
1	Augusta	ME	NRM	Upgrade Baths B200 (4S) for Patient Privacy	2013-2021	4,495
1	Augusta	ME	NRM	Upgrade Baths B200 (4S) or Patient Privacy	2013-2021	4,495
1	Bedford	MA	Major Construction	Construct New Community Living Center	2013-2021	35,340
1	Bedford	MA	Minor Construction	Relocate 6B Psychiatric Ward	2013-2021	9,000
1	Bedford	MA	Minor Construction	Expand Building 62 for Special Dementia Community Living Center	2013-2021	9,000
1	Boston	MA	NRM	Doors and Hardware/ Card Access JP	2013-2021	2,200
1	Boston	MA	NRM	Ward Renovation Patient Privacy	2013-2021	4,400
1	Boston	MA	NRM	Ward Renovation Patient Privacy	2013-2021	4,400
1	Brockton	MA	NRM	Mental Health Safety Improvements Ph 4	2013-2021	1,185
1	Manchester	NH	Major Construction	Construct New Clinical Care Building	2013-2021	114,070
1	Newington	CT	NRM	Bathroom Upgrades Project PH 2	2013-2021	1,200
1	Newington	CT	NRM	Primary Care Realignment Project PH 2	2013-2021	3,000
1	Newington	CT	NRM	Primary Care Realignment Project PH 1	2013-2021	3,500
1	Northampton	MA	Minor Construction	Primary Care Access Improvement	2013-2021	9,000
1	Northport	MA	Minor Construction	Renovate Emergency Room	2013-2021	9,570
1	Providence	RI	NRM	Renovate Mental Health Outpatient Services Wing 3B	2013-2021	7,660
1	Providence	RI	Major Construction	Construct Bed Tower Addition & Site Improvements	2013-2021	118,500

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1	Providence	RI	Minor Construction	Building 35 Expansion for Mental Health Research	2013-2021	3,618
1	Providence	RI	NRM	Renovate Ward 5A	2013-2021	500
1	Togus	ME	Major Construction	Construct New Community Living Center	2013-2021	18,600
1	Togus	ME	Major Construction	Construct New Consolidated Medical Building	2013-2021	351,826
1	Togus	ME	Minor Construction	Specialty Care Clinic Addition	2013-2021	9,900
1	West Haven	CT	Major Construction	Construct Clinical Tower Addition	2013-2021	447,863
1	West Haven	CT	Minor Construction	Mental Health Access Expansion	2013-2021	9,850
1	West Haven	CT	Minor Construction	Inpatient Bed Space Correction	2013-2021	9,890
1	West Haven	CT	Minor Construction	Surgical Intensive Care Unit Expansion	2013-2021	9,980
1	West Haven	CT	NRM	Handicap Accessible Bathrooms - Main Buildings Project PH 1	2013-2021	2,500
1	West Haven	CT	NRM	Handicap Accessible Bathrooms - Satellite Buildings Project PH 2	2013-2021	2,500
1	West Haven	CT	NRM	Primary Care Realignment Project PH 2	2013-2021	4,500
1	West Haven	CT	NRM	Primary Care Realignment Project PH 1	2013-2021	4,500
1	West Haven	CT	NRM	Bathroom Upgrades Project PH 2	2013-2021	6,000
1	West Haven	CT	NRM	Bathroom Upgrades Project PH 1	2013-2021	6,000
1	West Haven	CT	NRM	Specialty Care Realignment Project PH 2	2013-2021	9,000
1	West Haven	CT	NRM	Nursing Home Care Environment Up-Grade	2013-2021	9,000
1	West Haven	CT	NRM	Specialty Care Realignment Project PH 2	2013-2021	9,000
1	West Haven	CT	NRM	In-Patient Unit Rehabilitation Project PH 3	2013-2021	9,500
1	West Roxbury	MA	Major Construction	Construct West Roxbury Clinical Addition	2013-2021	280,375
1	West Roxbury	MA	NRM	Replace Doors and Upgrade Hardware/ Card Access WR	2013-2021	2,200
1	White River Junction	VT	NRM	Emergency Department Expansion and Renovation	2013-2021	500
1	White River Junction	VT	NRM	Renovate Inpatient Wards Ph 1	2013-2021	6,000
2	Albany	NY	Major Construction	Construct New Community Living Center and Parking Deck	2013-2021	93,500
2	Albany	NY	NRM	Renovate Primary Care on 4C and 8C	2013-2021	3,550
2	Bath	NY	NRM	Design, Renovate 104 for Community Living Center	2013-2021	750
2	Buffalo	NY	NRM	Renovate Space for Patient Privacy	2013-2021	875
2	Buffalo	NY	NRM	Clinical improvements	2013-2021	2,000
2	Buffalo	NY	NRM	Renovate Ward 9B for Patient Privacy	2013-2021	4,800
2	Buffalo	NY	NRM	Primary Care consolidation	2013-2021	5,000
2	Syracuse	NY	NRM	Renovate 6 west for Patient Ward	2013-2021	2,200
2	Syracuse	NY	NRM	Renovate 6E for Patient Ward	2013-2021	2,200
2	Syracuse	NY	Other	Replace Irving Street Entrance	2013-2021	850
3	Bronx	NY	NRM	Renovate Psych Ward	2013-2021	2,750
3	Bronx	NY	NRM	Renovate Community Living Center to Plane tree (First Floor)	2013-2021	3,500
3	Brooklyn	NY	Major Construction	Construct 2-Story Building Addition to Outpatient Clinic	2013-2021	130,000
3	Castle Point	NY	Major Construction	Construct 60-Bed Community Living Center	2013-2021	30,096
3	Castle Point	NY	Major Construction	Construct Castle Point, NY Psych & Community Living Center Integration	2013-2021	372,115
3	Castle Point	NY	NRM	Renovate E-2 for Patient Privacy	2013-2021	1,250
3	Castle Point	NY	NRM	Building 15H H-1 Community Living Center Renovations	2013-2021	3,200
3	Castle Point	NY	Other	Replace Locking System Ph. II	2013-2021	750

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3	Lyons	NJ	Minor Construction	Community Living Center Expansion and Renovation	2013-2021	9,500
3	Lyons	NJ	Minor Construction	Community Living Center Expansion and Renovation	2013-2021	9,700
3	Montrose	NY	Major Construction	Construct 100-Bed Community Living Center	2013-2021	46,564
3	Montrose	NY	Major Construction	Construct New Outpatient Building & Domiciliary	2013-2021	179,382
3	Montrose	NY	Minor Construction	Specialty Building Addition	2013-2021	8,700
3	Montrose	NY	NRM	Building 4 - Mental Health Addition	2013-2021	3,000
3	New York - Manhattan	NY	Major Construction	Construct 1-Story Outpatient Expansion	2013-2021	33,000
3	Northport	NY	Major Construction	Construct Mental Health Recovery Center	2013-2021	82,500
3	Northport	NY	Minor Construction	Relocate Ambulatory Surgery Unit	2013-2021	9,500
3	Northport	NY	Minor Construction	Relocate Community Living Center, Phase 4	2013-2021	9,900
3	Northport	NY	NRM	SARRPT Relocation	2013-2021	4,200
3	Northport	NY	NRM	Renovate Community living Center Bathrooms	2013-2021	4,200
3	Northport	NY	NRM	Renovate Inpatient Unit 33	2013-2021	4,200
3	Northport	NY	NRM	Renovate Inpatient Unit 34	2013-2021	4,200
3	Northport	NY	NRM	Renovate Mental Health Building 64	2013-2021	4,200
3	Northport	NY	NRM	Renovate Mental Health Building 63	2013-2021	4,200
4	Altoona	PA	Minor Construction	Outpatient Addition Floors 1/2 of BJ	2013-2021	10,000
4	Altoona	PA	Minor Construction	Community Living Center Improvements, Phase 2	2013-2021	10,000
4	Altoona	PA	Minor Construction	Specialty clinic addition 3rd floor	2013-2021	10,000
4	Altoona	PA	Minor Construction	Outpatient Clinic Expansion	2013-2021	10,000
4	Altoona	PA	Minor Construction	Community Living Center Improvements, Phase 1	2013-2021	10,000
4	Altoona	PA	NRM	Renovate Restrooms for ADA in Basement and 1st Floor, Building 7	2013-2021	500
4	Altoona	PA	NRM	Renovate 7th Floor to ADA bathrooms	2013-2021	600
4	Altoona	PA	NRM	Renovate Specialty Clinic	2013-2021	600
4	Altoona	PA	NRM	Replace Keying System	2013-2021	700
4	Altoona	PA	NRM	Renovate 1st Floor Building 1- Medical Home Model	2013-2021	750
4	Altoona	PA	NRM	Ward 4 Inpatient Behavioral Health	2013-2021	1,000
4	Clarksburg	WV	Minor Construction	Construct 8 Hospice Beds	2013-2021	312
4	Clarksburg	WV	Minor Construction	Medical/Surgical/Dental Clinic Replacement 2nd South Addition	2013-2021	900
4	Clarksburg	WV	Minor Construction	Consolidate Mental Health Residential Rehabilitation Program	2013-2021	3,822
4	Clarksburg	WV	Minor Construction	Ambulatory Care Support & Physical Security Improvements	2013-2021	8,388
4	Clarksburg	WV	Minor Construction	Primary Care/ Mental Health Renovation and Primary Care/Emergency Department/Basement Addition	2013-2021	10,042
4	Coatesville	PA	Major Construction	Construct Replacement Medical Center	2013-2021	357,500
4	Coatesville	PA	Minor Construction	Community Living Center Expansion	2013-2021	9,600
4	Coatesville	PA	NRM	Renovate Bath/Toilet facilities Buildings 10/16	2013-2021	680
4	Coatesville	PA	NRM	Improve Bath / Toilet Facilities Buildings 6 & 10	2013-2021	700
4	Coatesville	PA	NRM	ADA Upgrades, Access & Bathrooms, Buildings 19,26,27, & 28	2013-2021	1,090
4	Coatesville	PA	NRM	Renovate Building 2 Urgent Care/Emergency Mental Health	2013-2021	4,000

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4	Coatesville	PA	NRM	Seriously Mental Ill Group Homes	2013-2021	4,000
4	Coatesville	PA	NRM	Renovate Building 39 Dom/SATU.	2013-2021	6,000
4	Coatesville	PA	NRM	Renovate Building 8 - Dom	2013-2021	6,000
4	Erie	PA	Minor Construction	Community Living Center Improvements, Phase 2	2013-2021	8,850
4	Lebanon	PA	Major Construction	Replacement Facility	2013-2021	450,300
4	Lebanon	PA	Minor Construction	Construct new Intensive Care Unit and Medical/Surgical Unit	2013-2021	8,980
4	Lebanon	PA	Minor Construction	Construct Replacement Community Living Center/Behavioral Health Step Down Bed Unit	2013-2021	8,980
4	Lebanon	PA	Minor Construction	Construct Replacement Community Living Center/Hospice Building with Outside Access	2013-2021	8,980
4	Lebanon	PA	NRM	Building 17 Non-Surgical Specialty Clinic Renovation part 2	2013-2021	2,400
4	Philadelphia	PA	Major Construction	Construct Behavioral Health/Research Building	2013-2021	128,700
4	Philadelphia	PA	Major Construction	Construct Bed Tower	2013-2021	133,000
4	Pittsburgh	PA	NRM	UD, Update Public Restrooms	2013-2021	1,000
4	Pittsburgh	PA	NRM	Update Public Restrooms	2013-2021	1,800
4	Pittsburgh	PA	NRM	NHCU Modernization PH I	2013-2021	5,000
4	Pittsburgh	PA	NRM	NHCU Modernization PH II	2013-2021	5,000
4	Wilkes-Barre	PA	Minor Construction	Replace/Improve Community Living Center Phase II	2013-2021	9,900
4	Wilkes-Barre	PA	Minor Construction	OPC/Administration Building Phase I	2013-2021	9,900
4	Wilkes-Barre	PA	NRM	Restroom Renovations, Phase 2	2013-2021	750
4	Wilmington	DE	Minor Construction	Renovate/Expand Community Living Center for Patient Privacy	2013-2021	10,000
4	Wilmington	DE	Minor Construction	Clinical Service Building Expansion	2013-2021	10,000
4	Wilmington	DE	NRM	Renovate 6 West for Specialty Clinic	2013-2021	7,000
5	Baltimore	MD	Minor Construction	Expand Surgical & Mental Health 5B & 6B	2013-2021	7,700
5	Baltimore	MD	NRM	Public and Staff Restroom Repairs and Upgrade	2013-2021	550
5	Baltimore	MD	NRM	VISN-wide Integrated Security Access Control System	2013-2021	900
5	Baltimore	MD	NRM	Renovate Surgical Intensive Care Unit	2013-2021	990
5	Baltimore	MD	NRM	Renovate Cardiac Intensive Care Unit	2013-2021	990
5	Baltimore	MD	NRM	Renovate Medical Intensive Care Unit	2013-2021	990
5	Baltimore	MD	NRM	Renovate 6C/Backfill Mental Health	2013-2021	1,760
5	Baltimore	MD	NRM	Convert Semi Private Beds to Private 3B	2013-2021	3,000
5	Baltimore	MD	NRM	Convert Semi Private Beds to Private 3A	2013-2021	3,000
5	Fort Detrick	MD	Minor Construction	Expand Fort Detrick CBOC	2013-2021	6,350
5	Loch Raven	MD	Minor Construction	Construct Hospice Unit/Research Expansion	2013-2021	9,000
5	Loch Raven	MD	Minor Construction	Community Living Center Support Space Addition/Replace Building	2013-2021	9,100
5	Martinsburg	WV	Major Construction	Construct Outpatient Clinical Addition	2013-2021	33,880
5	Martinsburg	WV	Minor Construction	Relocate Inpatient Acute Mental Health Inpatient Unit	2013-2021	9,100
5	Martinsburg	WV	Minor Construction	33-Bed Community Living Center Unit	2013-2021	9,750
5	Martinsburg	WV	Minor Construction	Domiciliary Upgrades	2013-2021	9,750
5	Martinsburg	WV	NRM	Locked Mental Health Ward Corrections Phase 2	2013-2021	515
5	Martinsburg	WV	NRM	Community Living Center Parking Area Expansion	2013-2021	550
5	Martinsburg	WV	NRM	Building. 500, 3C Clinic Renovation	2013-2021	880

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5	Martinsburg	WV	NRM	Mental Health Domiciliary Building 502 Interior Renovations Ph.2	2013-2021	2,950
5	Martinsburg	WV	NRM	Renovate 4B for Intensive Care Unit	2013-2021	4,700
5	Perry Point	MD	Minor Construction	Construct Replacement Domiciliary Unit for 1H	2013-2021	8,500
5	Perry Point	MD	Minor Construction	Construct Replacement Domiciliary Unit for 2H	2013-2021	8,500
5	Perry Point	MD	NRM	Public and Staff Restrooms - Ph 2	2013-2021	500
5	Perry Point	MD	NRM	Public and Staff Restrooms - Ph 3 - Construction	2013-2021	500
5	Perry Point	MD	NRM	Renovate Clinical Space - 23A	2013-2021	900
5	Perry Point	MD	NRM	Card Key Access System	2013-2021	2,000
5	Washington	DC	Major Construction	120 Bed Community Living Center Replacement	2013-2021	77,000
5	Washington	DC	Minor Construction	Renovate 2D for Patient Privacy	2013-2021	9,300
5	Washington	DC	Minor Construction	Expand Surgical Intensive Care Unit	2013-2021	9,850
5	Washington	DC	Minor Construction	Construct 3B for Inpatient Mental Health	2013-2021	9,900
5	Washington	DC	NRM	Upgrade Community Living Center patio	2013-2021	750
5	Washington	DC	NRM	Renovate Outpatient Clinic Space- Phase II	2013-2021	1,000
5	Washington	DC	NRM	Convert Outpatient Space Vacated by HCC	2013-2021	1,000
5	Washington	DC	NRM	Renovate Outpatient Clinic Space-Phase I	2013-2021	2,000
5	Washington	DC	NRM	Renovate Public Restrooms-Phase II	2013-2021	2,750
6	Asheville	NC	Major Construction	Seismic Corrections & Outpatient Services Correction	2013-2021	75,800
6	Asheville	NC	Minor Construction	Demo Buildings 3-7/Construct Mental Health Center	2013-2021	9,900
6	Asheville	NC	NRM	Renovate Ward 3-East/West	2013-2021	400
6	Asheville	NC	NRM	Renovate Ward 5-East	2013-2021	5,940
6	Asheville	NC	NRM	Renovate Ward 4-East	2013-2021	5,940
6	Beckley	WV	Major Construction	Construct Nursing Home Care Unit	2013-2021	60,500
6	Beckley	WV	Minor Construction	Community Living Center Expansion	2013-2021	9,900
6	Beckley	WV	NRM	Renovate Mental health building	2013-2021	1,150
6	Beckley	WV	NRM	Nursing wards (inpatient) renovations	2013-2021	1,800
6	Durham	NC	Major Construction	Outpatient Care and Support Addition	2013-2021	92,500
6	Durham	NC	Minor Construction	Expand D-wing for Specialty Clinics	2013-2021	8,800
6	Durham	NC	Minor Construction	Community Living Center Expansion	2013-2021	8,890
6	Fayetteville	NC	Major Construction	Construct In-Patient Facility	2013-2021	66,000
6	Fayetteville	NC	NRM	Facility Door Replacement	2013-2021	1,000
6	Fayetteville	NC	NRM	Community Living Center Transformation Renovations	2013-2021	1,200
6	Fayetteville	NC	NRM	Rekey Medical Center	2013-2021	2,200
6	Hampton	VA	Major Construction	Community Living Center Renovation / Addition	2013-2021	49,500
6	Hampton	VA	Major Construction	Outpatient, Inpatient and Non-Clinical Care Addition	2013-2021	130,000
6	Hampton	VA	Minor Construction	Renovate/Expand Inpatient Medicine Bed Unit	2013-2021	6,380
6	Hampton	VA	Minor Construction	Renovate/Expand Domiciliary	2013-2021	7,700
6	Hampton	VA	Minor Construction	Construct New Clinical Building	2013-2021	9,350
6	Hampton	VA	Minor Construction	Primary Care Build out 2nd Floor 110B	2013-2021	9,925
6	Hampton	VA	NRM	Expand Medical Specialties	2013-2021	605
6	Hampton	VA	NRM	Renovate Building 110B for Outpatient Space	2013-2021	3,300
6	Richmond	VA	Minor Construction	Primary Care Addition, Phase 2	2013-2021	840
6	Richmond	VA	Minor Construction	Surgical Addition, Phase 2	2013-2021	840

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6	Richmond	VA	Minor Construction	Specialty Care Addition	2013-2021	4,950
6	Richmond	VA	Minor Construction	Construct New Administration/Clinical Building	2013-2021	8,250
6	Richmond	VA	Minor Construction	Community Living Center Expansion and Renovation, Phase 2	2013-2021	8,800
6	Richmond	VA	Minor Construction	SCI Enhancement Center, Phase 2	2013-2021	8,950
6	Richmond	VA	Minor Construction	Community Living Center Expansion and Renovation	2013-2021	9,020
6	Richmond	VA	Minor Construction	Primary Care Addition, Phase 1	2013-2021	9,240
6	Richmond	VA	Minor Construction	Surgical Addition, Phase 1	2013-2021	9,240
6	Richmond	VA	Minor Construction	Spinal Cord Injury Enhancement Center	2013-2021	9,264
6	Richmond	VA	NRM	Community Living Center Transformational Improvements	2013-2021	198
6	Richmond	VA	NRM	EOC Halls/Walls II	2013-2021	880
6	Richmond	VA	NRM	Door and Hardware Replacement-Phase 3	2013-2021	880
6	Richmond	VA	NRM	EOC Halls/Walls III	2013-2021	880
6	Richmond	VA	NRM	Door and Hardware Replacement-Phase 2	2013-2021	957
6	Richmond	VA	NRM	Modernize Public Restrooms	2013-2021	1,045
6	Richmond	VA	NRM	Renovate 5th Floor Clinics	2013-2021	2,200
6	Richmond	VA	NRM	ER Improvements	2013-2021	2,200
6	Richmond	VA	NRM	Renovate 2C Clinics	2013-2021	2,200
6	Richmond	VA	NRM	Renovate ICUs	2013-2021	2,420
6	Richmond	VA	NRM	Improve Patient Privacy 4C/4B - Phase 2	2013-2021	3,025
6	Salem	VA	Minor Construction	B-2A Expand/Renovate Emergency Department	2013-2021	6,600
6	Salem	VA	NRM	Renovate Mental health building	2013-2021	998
6	Salisbury	NC	Minor Construction	Renovate/Expand Building 42 Community Living Center - Phase 4	2013-2021	9,005
6	Salisbury	NC	NRM	Privacy Issues in Building 2	2013-2021	2,500
6	Salisbury	NC	NRM	B-42 Community Living Center	2013-2021	2,618
6	Salisbury	NC	NRM	Renovate MS&N unit on 2-3 for patient privacy	2013-2021	4,000
6	Salisbury	NC	NRM	B-3 Primary Care/Outpatient	2013-2021	9,095
6	Salisbury	NC	NRM	B-2 Medical-Surgical -Renovations	2013-2021	12,305
7	Atlanta	GA	NRM	Renovate Fort McPherson	2013-2021	1,268
7	Atlanta	GA	NRM	Security- Install Key Card Access Devices	2013-2021	2,500
7	Augusta	GA	NRM	Renovate Bathroom Facilities D1	2013-2021	2,000
7	Augusta	GA	NRM	Renovate Primary Care Clinics B3	2013-2021	3,000
7	Augusta	GA	NRM	Renovate Blind Rehabilitation Ward	2013-2021	3,000
7	Augusta	GA	NRM	Renovate Medical and Surgical Wards	2013-2021	9,000
7	Charleston	SC	Minor Construction	Convert Semi-private Rooms to Private	2013-2021	2,500
7	Charleston	SC	Minor Construction	Expand/Renovate Intensive Care Unit - 2nd Floor Addition on Mental Health Building	2013-2021	9,900
7	Charleston	SC	Minor Construction	Specialty Clinic Addition - 2nd Floor Addition on Research Building	2013-2021	9,900
7	Charleston	SC	NRM	Convert 5B/C for Inpatient Mental Health and Mental Health	2013-2021	900
7	Charleston	SC	NRM	Renovate Specialty Care Clinic Phase II	2013-2021	1,246
7	Charleston	SC	NRM	Expand and Renovate ED	2013-2021	2,750
7	Columbia	SC	Major Construction	Clinical Improvements and Patient Privacy	2013-2021	55,000
7	Columbia	SC	NRM	B100 Door Accessibility	2013-2021	1,338
7	Dublin	GA	NRM	Renovate 15A for Specialty	2013-2021	2,200
7	Dublin	GA	NRM	Renovate 5B for Amb Care	2013-2021	2,200

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7	Fort McPherson	GA	NRM	Renovate Fort McPherson Phase IV	2013-2021	550
7	Fort McPherson	GA	NRM	Renovate Fort McPherson Phase III	2013-2021	4,699
7	Montgomery	AL	Minor Construction	2nd Floor Build Out for Mental Health Beds	2013-2021	9,175
7	Montgomery	AL	NRM	Renovate Community Living Center	2013-2021	3,000
7	Montgomery	AL	NRM	Renovate Inpatient Medicine Unit	2013-2021	3,450
7	Montgomery	AL	NRM	Renovate Various Areas for Clinical Service to Improve Access	2013-2021	10,000
7	Tuscaloosa	AL	Minor Construction	Community Living Center Cottages, Phase III	2013-2021	9,973
7	Tuscaloosa	AL	Minor Construction	Community Living Center Cottages, Phase IV	2013-2021	9,973
7	Tuscaloosa	AL	NRM	Cultural Transformation B135, B63	2013-2021	2,000
7	Tuscaloosa	AL	NRM	Security/Access Control	2013-2021	2,020
7	Tuscaloosa	AL	NRM	Primary Care Clinic Upgrades	2013-2021	4,035
7	Tuscaloosa	AL	Other	Nursing Home Cultural Transformation: Outdoor Recreational Area	2013-2021	1,870
7	Tuscaloosa	AL	Other	Renovate Nursing Home Care Unit for Mental Health	2013-2021	5,600
8	Bay Pines	FL	NRM	Renovate B-22 for Specialty Clinics	2013-2021	850
8	Bay Pines	FL	NRM	Renovate For Urgent/Specialty Care B-100	2013-2021	1,500
8	Bay Pines	FL	NRM	Renovate Patient Wards B-100, 5A & 5B	2013-2021	8,800
8	Gainesville	FL	Major Construction	New Outpatient Building	2013-2021	250,000
8	Gainesville	FL	NRM	Doors / Hardware Renovations	2013-2021	500
8	Gainesville	FL	NRM	Renovate Ward 3C for Clinics	2013-2021	2,100
8	Gainesville	FL	NRM	Renovate Existing ICU's	2013-2021	2,800
8	Gainesville	FL	NRM	Additional MICU 4th Floor	2013-2021	8,800
8	Gainesville	FL	NRM	Additional SICU 2nd Floor	2013-2021	8,800
8	Lake City	FL	Major Construction	Community Living Center Privacy Initiative	2013-2021	45,000
8	Lake City	FL	Minor Construction	Expand Ambulatory Care Building - 25K SF	2013-2021	7,000
8	Miami	FL	Major Construction	Two Floor Addition to Ambulatory Care Building	2013-2021	16,000
8	Miami	FL	Major Construction	Construct Spinal Cord Injury Addition	2013-2021	17,220
8	Miami	FL	NRM	Renovate 1st Floor B10 for 30 Community Living Center Beds	2013-2021	6,670
8	Miami	FL	Other	Expand Primary Care Clinics Phase 1	2013-2021	2,172
8	Miami	FL	Other	Renovate Vacated Research Space for Outpatient Use	2013-2021	5,000
8	Orlando	FL	NRM	Viera Interiors Renovation	2013-2021	700
8	Orlando	FL	NRM	Lakemont Interiors Renovation	2013-2021	900
8	Orlando	FL	NRM	Community Living Center Renovation Phase II	2013-2021	950
8	San Juan	PR	Minor Construction	Community Living Center Expansion for Patient Privacy	2013-2021	9,800
8	San Juan	PR	Other	Renovate Community Living Center - Correct Patient Privacy, Ph 1	2013-2021	2,000
8	San Juan	PR	Other	Renovate Community Living Center - Correct Patient Privacy, Ph 2	2013-2021	2,000
8	San Juan	PR	Other	Correct Patient Privacy - Renovate Medical/Surgical Unit Ph 1	2013-2021	2,000
8	San Juan	PR	Other	Correct Patient Privacy - Renovate Medical/Surgical Unit Ph 2	2013-2021	2,000
8	San Juan	PR	Other	Correct Patient Privacy - Renovate Intensive Care Unit	2013-2021	2,000
8	Tampa	FL	Major Construction	Replace Community Living Center	2013-2021	18,230

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
8	Tampa	FL	Major Construction	Mental Health Consolidation	2013-2021	44,050
8	Tampa	FL	Major Construction	Bed Tower South/Outpatient Care and Consolidated Business/Admin Building	2013-2021	260,150
8	Tampa	FL	Minor Construction	Specialty Procedures expansion - 9K SF	2013-2021	10,000
8	Temple	TX	Minor Construction	Out-Patient PM&R Phase 2	2013-2021	9,800
8	Temple	TX	Minor Construction	Out-Patient PM&R Phase 2	2013-2021	9,800
8	West Palm Beach	FL	NRM	Community Living Center Phase II interior Finishes	2013-2021	500
8	West Palm Beach	FL	NRM	Community Living Center Phase I interior Finishes	2013-2021	500
8	West Palm Beach	FL	NRM	Interior Door Replacement Community Living Center,5,6,7	2013-2021	1,000
8	West Palm Beach	FL	NRM	Bathroom Renovations Phase1	2013-2021	1,000
8	West Palm Beach	FL	NRM	Bathroom Renovations Phase II	2013-2021	1,000
9	Chattanooga	TN	Major Construction	Construct Health Care Center	2013-2021	78,156
9	Huntington	WV	Minor Construction	Patient Privacy Inpatient Wards Building 1S	2013-2021	5,000
9	Lexington	KY	NRM	Renovate Radiology for Patient Privacy	2013-2021	1,200
9	Memphis	TN	Major Construction	Construct Health Care Center	2013-2021	122,326
9	Memphis	TN	Minor Construction	Expand Building 7 for Spinal Cord Injury Long-Term Care Unit	2013-2021	4,532
9	Memphis	TN	Minor Construction	Expand Building 7 for Additional Spinal Cord Injury Bed Unit	2013-2021	9,911
9	Memphis	TN	NRM	Expand Emergency Department	2013-2021	4,268
9	Mountain Home	TN	Major Construction	Construct Mental Health Wing	2013-2021	64,453
9	Mountain Home	TN	Major Construction	Construct New Floor in Main Hospital	2013-2021	81,592
9	Mountain Home	TN	Major Construction	Expand Community Living Center	2013-2021	99,880
9	Mountain Home	TN	Major Construction	Construct Health Care Center	2013-2021	107,628
9	Mountain Home	TN	NRM	Renovate & Expand ED in Building 204	2013-2021	1,744
9	Mountain Home	TN	NRM	Correct Patient Privacy Building 200 C1	2013-2021	9,419
9	Murfreesboro	TN	Major Construction	Construct Mental Health Services Center	2013-2021	35,281
9	Murfreesboro	TN	Minor Construction	Construct Community Living Center Residential Living Quarters	2013-2021	9,575
9	Murfreesboro	TN	NRM	Upgrade Ward PH1	2013-2021	4,000
9	Murfreesboro	TN	NRM	Upgrade Ward PH2	2013-2021	4,000
9	Nashville	TN	NRM	Upgrade Ward 4 North	2013-2021	4,000
10	Chillicothe	OH	Minor Construction	Relocate Specialty Clinics to Building 31	2013-2021	1,000
10	Chillicothe	OH	Minor Construction	Expand/Improve Mental Health Ward 26 East, Building 26	2013-2021	10,000
10	Chillicothe	OH	Minor Construction	Expand/Improve Mental Health Ward 26 West, Building 26 Phase 2	2013-2021	10,000
10	Chillicothe	OH	NRM	Renovate Space for Primary Care, Building 31	2013-2021	200
10	Chillicothe	OH	NRM	Install Security Access Locks	2013-2021	5,400
10	Cincinnati	OH	Minor Construction	Construct 3rd Floor Community Living Center Building	2013-2021	9,760
10	Cincinnati	OH	Minor Construction	Construct Inpatient Tower Addition Floors 5 & 6	2013-2021	9,900
10	Cleveland	OH	Major Construction	Primary Care Annex	2013-2021	120,000
10	Cleveland	OH	NRM	Renovate Mental Health South	2013-2021	1,815
10	Cleveland	OH	NRM	Ambulatory Care Medical Specialties Clinics	2013-2021	2,100
10	Cleveland	OH	NRM	Renovate Primary Care 1st Floor	2013-2021	3,850
10	Cleveland	OH	NRM	Renovate and Expand Endoscopy	2013-2021	3,850
10	Cleveland	OH	NRM	Spinal Cord Injury Suite Renovation	2013-2021	8,250
10	Columbus	OH	Minor Construction	Construct 23 Hour Short Stay Unit	2013-2021	9,900

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10	Fort Thomas	KY	NRM	Renovate Building 64 for Private Baths and 2 beds	2013-2021	3,810
11	Ann Arbor	MI	Minor Construction	Build Out Clinics in Prior ER/Urgent Care - PH1	2013-2021	250
11	Ann Arbor	MI	Minor Construction	Build out 2nd floor clinics - Phase 1	2013-2021	500
11	Ann Arbor	MI	Minor Construction	Build Out Clinics in Prior ER/Urgent Care - PH2	2013-2021	3,000
11	Ann Arbor	MI	Minor Construction	Build out 2nd floor clinics - Ph 2	2013-2021	4,000
11	Ann Arbor	MI	NRM	Construct Clinics in 2W	2013-2021	2,500
11	Battle Creek	MI	Minor Construction	Expand Domiciliary B-22	2013-2021	2,912
11	Battle Creek	MI	Minor Construction	Patient Privacy Renovation B-84	2013-2021	8,896
11	Battle Creek	MI	Minor Construction	Patient Privacy Renovation B-82	2013-2021	8,896
11	Battle Creek	MI	NRM	Install Keyless Entry System Station Wide	2013-2021	2,000
11	Danville	IL	Other	Complete Security System Upgrade Station Wide	2013-2021	850
11	Danville	IL	Other	Install Electronic Access System Station Wide	2013-2021	1,250
11	Detroit	MI	Lease	New Detroit Domiciliary	2013-2021	1,968
11	Detroit	MI	Minor Construction	Convert A2S from Inpatient to Outpatient usage	2013-2021	4,400
11	Detroit	MI	Minor Construction	Convert A4S from Inpatient to Outpatient usage	2013-2021	4,400
11	Indianapolis	IN	Lease	Lease 50 Bed Domiciliary	2013-2021	1,250
11	Indianapolis	IN	Major Construction	Expand Ambulatory Care and Surgery Suite	2013-2021	27,500
11	Indianapolis	IN	NRM	Renovate MICU for Private Rooms	2013-2021	500
11	Indianapolis	IN	NRM	Upgrade Restrooms for Accessibility	2013-2021	500
11	Indianapolis	IN	NRM	Replace and Upgrade Doors in Building 1	2013-2021	2,900
11	Marion	IN	Other	Renovate and Upgrade 4th Fl. Patient Areas	2013-2021	2,000
11	Saginaw	MI	Major Construction	Mental Health & Physical Therapy Building Consolidation	2013-2021	12,000
11	Saginaw	MI	Minor Construction	Specialty Clinic Expansion	2013-2021	16,500
12	Chicago	IL	Major Construction	Patient care Area Addition and Relocation of Loading Dock	2013-2021	38,000
12	Chicago	IL	Minor Construction	Add/Expand Outpatient Clinics to 3rd floor over Building 30	2013-2021	10,000
12	Chicago	IL	NRM	Relocate Mental Health (SRRTP) suite to 10 N&S	2013-2021	7,000
12	Iron Mountain	MI	Minor Construction	Expand Community Living Center (CLC)	2013-2021	8,580
12	Iron Mountain	MI	NRM	Renovate Outpatient Clinic	2013-2021	1,000
12	Madison	WI	Major Construction	Construct Ambulatory Care Center	2013-2021	50,000
12	Madison	WI	NRM	Home Based Primary Care Renovation	2013-2021	539
12	Madison	WI	NRM	Renovate 5A for Clinical Space	2013-2021	2,305
12	Madison	WI	NRM	Expand Ambulatory Surgery	2013-2021	2,565
12	Madison	WI	NRM	Expand Emergency Department/Admissions	2013-2021	3,400
12	Madison	WI	NRM	Renovate Outpatient Clinics	2013-2021	3,424
12	Madison	WI	NRM	Renovate Clinical Support - Community Living Center	2013-2021	6,600
12	Milwaukee	WI	Major Construction	Construct Bed Tower	2013-2021	223,000
12	Milwaukee	WI	Minor Construction	Specialty / Eye Clinic Consolidation	2013-2021	3,175
12	Milwaukee	WI	Minor Construction	Primary Care Consolidation	2013-2021	6,325
12	Milwaukee	WI	Minor Construction	Emergency Department Expansion	2013-2021	8,755
12	Milwaukee	WI	NRM	Mental Health Office renovations 3A	2013-2021	1,850
12	Milwaukee	WI	NRM	Renovate 4A for Mental Health	2013-2021	4,753
12	Milwaukee	WI	NRM	Intensive Care Unit Expansion East	2013-2021	7,967

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
12	North Chicago	IL	Major Construction	Modernize VA/DoD Inpatient Mental Health	2013-2021	73,700
12	North Chicago	IL	Major Construction	Modernize Community Living Center and Expand Ambulatory Care Clinics	2013-2021	95,700
12	North Chicago	IL	NRM	Interior Renovations Outpatient Buildings	2013-2021	5,000
12	North Chicago	IL	NRM	Renovate Specialty Clinics	2013-2021	9,300
12	Tomah	WI	NRM	Renovate east wing 2nd floor Building 400 for Amb Care	2013-2021	1,410
15	Columbia	MO	Lease	Community Living Center Lease	2013-2021	24,808
15	Columbia	MO	Minor Construction	Expand Ambulatory Care Building, Phase 2	2013-2021	5,400
15	Columbia	MO	NRM	Expand Card Access System	2013-2021	500
15	Columbia	MO	NRM	PRRT Beds	2013-2021	1,161
15	Kansas City	MO	Major Construction	Construct Building Addition	2013-2021	56,000
15	Kansas City	MO	Minor Construction	Mental Health Expansion	2013-2021	9,800
15	Kansas City	MO	Minor Construction	Addition to Expand Lab Services, Radiology & Specialty Clinics	2013-2021	9,800
15	Kansas City	MO	NRM	Repair/replace/upgrade restrooms in Building. 26	2013-2021	5,300
15	Kansas City	MO	NRM	Repair/replace/upgrade restrooms in Building. 1	2013-2021	5,300
15	Leavenworth	KS	Major Construction	VA DOD Joint Venture for Inpatient Wards, Operating Room Suite, and Support Services	2013-2021	75,000
15	Marion	IL	Minor Construction	B-2 Extension Tower for Inpatient Care	2013-2021	9,900
15	Poplar Bluff	MO	Minor Construction	Construct new Primary Care/Urgent Care and pharmacy space	2013-2021	8,800
15	Popular Bluff	MO	Minor Construction	Specialty Care Expansion	2013-2021	8,100
15	Saint Louis	MO	Major Construction	Replace Inpatient Mental Health Building	2013-2021	49,497
15	Saint Louis	MO	Major Construction	Clinical Expansion and Removal of Building 1	2013-2021	709,500
15	Saint Louis	MO	Minor Construction	Polytrauma Addition & Renovation, B-53, JB	2013-2021	9,950
15	Saint Louis	MO	NRM	Decrease Acute Inpatient Mental Health Beds, B-51	2013-2021	1,320
15	St. Louis	MO	NRM	Expand Inpatient Residential Rehab Mental Health Program, B-1	2013-2021	685
15	Topeka	KS	Minor Construction	Construct Primary Care Addition	2013-2021	9,800
15	Topeka	KS	NRM	OEF/OIF Primary Care Addition	2013-2021	550
15	Topeka	KS	NRM	Remodel Inpt Ward B1, 4th Floor	2013-2021	600
15	Topeka	KS	NRM	Remodel 2nd Floor Building 5 for Behavioral Health	2013-2021	827
15	Topeka	KS	NRM	Remodel in PT Ward B2, 3rd Floor (1/2)	2013-2021	6,000
15	Topeka	KS	NRM	Remodel Inpatient ward B1, 4th Floor (A wing)	2013-2021	6,000
15	Wichita	KS	Major Construction	VA/DoD Joint Venture - Relocate Existing Inpatient Wards, Operating Room Suite, and Support Services	2013-2021	154,000
15	Wichita	KS	Minor Construction	Expand Community Living Center for Patient Privacy	2013-2021	3,630
15	Wichita	KS	Minor Construction	Behavioral Health Minor	2013-2021	5,225
15	Wichita	KS	Minor Construction	Specialty Care Addition	2013-2021	5,940
15	Wichita	KS	NRM	Renovate for Mental Health	2013-2021	9,950
16	Alexandria	LA	NRM	Provide Private Bathrooms, B-7	2013-2021	2,250
16	Biloxi	MS	NRM	Renovate B-19 for PRRTP Use	2013-2021	6,400

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
16	Fayetteville	AR	Major Construction	Construct Replacement Bed Building to include Ambulatory Surgery Center and Cardiac Cath Lab	2013-2021	113,285
16	Houston	TX	Major Construction	Establish Ambulatory Care Center	2013-2021	42,900
16	Houston	TX	Major Construction	Construct Replacement 120 Bed Community Living Center and Hospice Care Center	2013-2021	125,000
16	Jackson	MS	Major Construction	Provide New Spinal Cord Injury Center	2013-2021	55,000
16	Jackson	MS	Major Construction	Construct New Clinical Addition	2013-2021	137,500
16	Jackson	MS	Minor Construction	Construct Outpatient Mental Health Addition	2013-2021	9,900
16	Jackson	MS	NRM	Renovate 3K for Mental Health Outpatient Clinic	2013-2021	2,500
16	Little Rock	AR	NRM	Security Internal devices/systems	2013-2021	510
16	Little Rock	AR	NRM	Improve Patient Environment	2013-2021	600
16	Little Rock	AR	NRM	Security Access System	2013-2021	873
16	Little Rock	AR	NRM	Renovation for private/Semi-private Bed Spaces	2013-2021	1,000
16	Little Rock	AR	NRM	Consol.Step-Down/Exp Telemetry	2013-2021	6,500
16	Muskogee	OK	Major Construction	Construct Medical Office Building	2013-2021	67,917
16	Muskogee	OK	NRM	Enhance Inpatient Ward - 4-East/4-West	2013-2021	7,500
16	Muskogee	OK	NRM	Enhance Inpatient Ward -5-West and Intensive Care Unit	2013-2021	7,500
16	Muskogee	OK	NRM	Renovate Armory for Ambulatory Surgery Center	2013-2021	9,652
16	North Little Rock	AR	Minor Construction	Primary Care Addition-NLR	2013-2021	9,500
16	North Little Rock	AR	NRM	Primary Care Expansion Into 3E	2013-2021	1,953
16	North Little Rock	AR	NRM	Primary Care Expansion Into 3C	2013-2021	2,354
16	North Little Rock	AR	NRM	Community Living Center - Patient Centered Care	2013-2021	3,000
16	North Little Rock	AR	NRM	Primary Care Expansion Into 3B	2013-2021	3,888
16	North Little Rock	AR	NRM	Expand Mental Health Outpatient Capacity	2013-2021	9,775
16	Oklahoma City	OK	Minor Construction	Renovate 7 North for Inpatient Beds	2013-2021	500
16	Oklahoma City	OK	Minor Construction	Renovate 5 East for Inpatient Beds	2013-2021	3,450
16	Oklahoma City	OK	Minor Construction	Expand Community Living Center	2013-2021	4,025
16	Oklahoma City	OK	NRM	Renovate 7East for Private Beds	2013-2021	2,580
16	Oklahoma City	OK	NRM	Expand Mental Health Beds	2013-2021	3,335
16	Oklahoma City	OK	NRM	Expand Community Living Center	2013-2021	4,025
16	Tulsa	OK	Major Construction	Construct New Outpatient Clinic - Tulsa	2013-2021	87,450
17	Bonham	TX	Minor Construction	Ambulatory Care Renovation & Expansion	2013-2021	5,000
17	Bonham	TX	Minor Construction	Community Living Center Patient Privacy Bonham	2013-2021	10,000
17	Corpus Christi	TX	NRM	Corpus Christi CBOC Renovation	2013-2021	6,750
17	Dallas	TX	Lease	Homeless Medical Domiciliary	2013-2021	5,700
17	Dallas	TX	Minor Construction	Herzog Clinic	2013-2021	10,000
17	Dallas	TX	Minor Construction	Community Living Center Patient Privacy	2013-2021	10,000
17	Dallas	TX	NRM	Renovate Medical Inpatient Nursing Unit for Privacy 7th Floor	2013-2021	2,500
17	Dallas	TX	NRM	Renovate Medical Inpatient Nursing Unit for Privacy 8th Floor	2013-2021	2,500
17	Dallas	TX	NRM	Inpatient Mental Unit Nursing Renovation	2013-2021	2,500
17	Dallas	TX	NRM	Community Living Center Bed Room Compliance	2013-2021	5,000
17	San Antonio	TX	Minor Construction	Domiciliary Replacement and Expansion	2013-2021	9,900

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17	San Antonio	TX	Minor Construction	Community Living Center Expansion for Geriatric Primary Care and Acute Polytrauma Integration	2013-2021	9,900
17	San Antonio	TX	Minor Construction	Cardiothoracic Surgical Step-Down Expansion and Relocation of Pastoral Care	2013-2021	9,900
17	San Antonio	TX	Minor Construction	Acute Medical-Neurological Step-Down Unit Expansion - 4G	2013-2021	9,900
17	San Antonio	TX	Minor Construction	7G Expansion for Primary Cancer Care	2013-2021	9,900
17	San Antonio	TX	NRM	Renovate 1st floor space vacated in 5G project for Primary Care Mental Health	2013-2021	900
17	Temple	TX	Major Construction	Outpatient Clinic Expansion	2013-2021	123,333
17	Waco	TX	NRM	Renovate for Mental Health Phase 2	2013-2021	3,300
18	Albuquerque	NM	Major Construction	Spinal Cord Injury Expansion	2013-2021	25,300
18	Albuquerque	NM	Major Construction	Outpatient Center - Health Care Center	2013-2021	142,500
18	Albuquerque	NM	Minor Construction	Renovate B41 4B 20 Bed Ward for Patient Privacy	2013-2021	1,000
18	Albuquerque	NM	Minor Construction	Construct New PRRTP Building	2013-2021	6,850
18	Albuquerque	NM	Minor Construction	New 10 Bed Community Living Center Phase 2	2013-2021	7,700
18	Albuquerque	NM	Minor Construction	20 Bed Acute Psych B41 6th Floor	2013-2021	10,000
18	Albuquerque	NM	Minor Construction	Renovate B41 4A 20 bed Ward for patient privacy	2013-2021	10,000
18	Albuquerque	NM	Minor Construction	B3 Seismic/30 Bed SARRTP 2nd fl.	2013-2021	10,000
18	Albuquerque	NM	Minor Construction	Renovate/Expand B41 3A 20 Bed Step Down	2013-2021	10,000
18	Albuquerque	NM	Minor Construction	Renovate B41 4D 20 Bed Ward for Patient Privacy	2013-2021	10,000
18	Albuquerque	NM	NRM	Improve Outpatient Mental Health Environment, Building 1	2013-2021	750
18	Albuquerque	NM	NRM	Remodel Inpatient/Outpatient Bathrooms, Building 41, Phase II	2013-2021	750
18	Albuquerque	NM	NRM	Enhance Inpatient Environment, B-41	2013-2021	750
18	Amarillo	TX	Minor Construction	Primary Care Addition Phase I	2013-2021	9,700
18	Amarillo	TX	Minor Construction	Community Living Center Expansion Phase I	2013-2021	9,700
18	Amarillo	TX	Minor Construction	Community Living Center Expansion Phase 2	2013-2021	9,900
18	Amarillo	TX	Minor Construction	Primary Care Addition Phase 2	2013-2021	9,900
18	Amarillo	TX	NRM	Renovate Mental Health Program Area	2013-2021	900
18	Amarillo	TX	NRM	Create Step Down Unit	2013-2021	3,300
18	Big Spring	TX	Minor Construction	Community Living Center Expansion	2013-2021	3,960
18	Big Spring	TX	Minor Construction	Primary Care/Urgent Care Expansion	2013-2021	9,900
18	El Paso	TX	Major Construction	Replacement Ambulatory Health Care Facility (VA-DoD Joint Venture)	2013-2021	455,301
18	El Paso	TX	Minor Construction	Construct Day Treatment Center (DTC)	2013-2021	3,774
18	Lubbock	TX	Major Construction	New Lubbock Health Care Clinic	2013-2021	30,600
18	Phoenix	AZ	Major Construction	Construct Inpatient Tower	2013-2021	55,000
18	Phoenix	AZ	Minor Construction	New Outpatient Building	2013-2021	9,850
18	Phoenix	AZ	Minor Construction	Community Living Center Cultural Transformation, Phase 3	2013-2021	9,900
18	Phoenix	AZ	Minor Construction	Mental Health Expansion	2013-2021	9,900
18	Phoenix	AZ	NRM	Renovate Ward 4B	2013-2021	710
18	Phoenix	AZ	NRM	Renovate Restrooms Building 1 and Building 8, Phase 2	2013-2021	800
18	Phoenix	AZ	NRM	Renovate Restrooms Building 1 and Building 8	2013-2021	900
18	Phoenix	AZ	NRM	Renovate Outpatient Clinics – Phase 1	2013-2021	1,200

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18	Phoenix	AZ	NRM	Renovate In-Patient Ward, Phase 2	2013-2021	1,200
18	Phoenix	AZ	NRM	Retrofit Ward 4D Shower	2013-2021	1,250
18	Phoenix	AZ	NRM	Renovate Outpatient Clinics – Phase 2	2013-2021	1,300
18	Phoenix	AZ	NRM	Renovate In-Patient Ward	2013-2021	1,500
18	Prescott	AZ	Minor Construction	Expand Primary Care	2013-2021	5,500
18	Prescott	AZ	Minor Construction	Renovate for Community Living Center Private Bed & Bath- Phase 1	2013-2021	9,000
18	Prescott	AZ	Minor Construction	Renovate for Community Living Center Private Bed & Bath- Phase 2	2013-2021	9,000
18	Tucson	AZ	Major Construction	Community Living Center Addition	2013-2021	27,586
18	Tucson	AZ	Minor Construction	Clinic Addition for Medical Home Model (phase 2)	2013-2021	832
18	Tucson	AZ	Minor Construction	Expand Clinics for Medical Home Model (phase 1)	2013-2021	9,773
18	Tucson	AZ	Minor Construction	Clinical Support Building	2013-2021	9,800
18	Tucson	AZ	Minor Construction	Additional Med/Surg Beds	2013-2021	9,800
18	Tucson	AZ	NRM	Improve Inpatient Environment Phase 2	2013-2021	1,200
18	Tucson	AZ	NRM	Improve Inpatient Environment Phase 1	2013-2021	1,200
18	Tucson	AZ	NRM	Improve Inpatient Environment Phase 3	2013-2021	1,200
19	Aurora	CO	Major Construction	Renovate Space for Inpatient and Outpatient Space Efficiencies	2013-2021	50,813
19	Cheyenne	WY	Minor Construction	Community Living Center Addition	2013-2021	8,480
19	Cheyenne	WY	Minor Construction	Mental Health Addition	2013-2021	8,480
19	Cheyenne	WY	NRM	Patient Privacy Improvements	2013-2021	750
19	Cheyenne	WY	NRM	Ambulatory Care Backfill	2013-2021	2,832
19	Denver	CO	Lease	Denver Homeless Domiciliary	2013-2021	5,584
19	Denver	CO	Major Construction	Construct Domiciliary - Ph. II	2013-2021	19,150
19	Fort Harrison	MT	Minor Construction	New 3rd and 4th Floor Addition, B-154	2013-2021	9,400
19	Fort Harrison	MT	Minor Construction	New Addition to Ambulatory Care	2013-2021	9,400
19	Fort Harrison	MT	NRM	Urgent Care Expansion	2013-2021	2,000
19	Grand Junction	CO	Minor Construction	Community Living Center Renovation/Urgent Care	2013-2021	7,000
19	Grand Junction	CO	Minor Construction	Primary Care Expansion	2013-2021	10,000
19	Grand Junction	CO	Minor Construction	New Mental Health Building	2013-2021	10,000
19	Grand Junction	CO	Minor Construction	Community Living Center Expansion	2013-2021	10,000
19	Grand Junction	CO	Minor Construction	Surgical Clinics Expansion	2013-2021	10,000
19	Grand Junction	CO	Minor Construction	3rd Floor Surgery Center Expansion	2013-2021	10,000
19	Salt Lake City	UT	Minor Construction	Mental Health Outpatient Expansion	2013-2021	4,500
19	Salt Lake City	UT	Minor Construction	New Emergency Department Addition	2013-2021	9,900
19	Salt Lake City	UT	Minor Construction	Specialty Clinic Expansion	2013-2021	9,900
19	Salt Lake City	UT	NRM	B.14 1st flr. Primary Care Renovation	2013-2021	2,200
19	Salt Lake City	UT	NRM	Renovate 3A for Private Restrooms	2013-2021	2,500
19	Salt Lake City	UT	NRM	Outpatient Mental Health B.16 Renovation	2013-2021	4,000
19	Salt Lake City	UT	NRM	Electronic Lock System Expansion	2013-2021	4,000
19	Sheridan	WY	NRM	Renovate Ambulatory Mental Health Services	2013-2021	750
19	Sheridan	WY	NRM	Renovate Acute Mental Health	2013-2021	800
19	Sheridan	WY	NRM	Renovate Ambulatory Care	2013-2021	7,700
19	Sheridan	WY	Other	Keyless Entry System Installation	2013-2021	2,000
20	American Lake	WA	NRM	B81 FLR 1 Expand Urgent Care	2013-2021	1,500
20	Anchorage	AK	Major Construction	Construct Domiciliary Replacement	2013-2021	14,250
20	Anchorage	AK	Major Construction	Construct to Consolidate Business Functions & New Mental Health Facility	2013-2021	18,500
20	Boise	ID	Major Construction	Construct Clinical Building	2013-2021	119,161
20	Bremerton	WA	Minor Construction	Bremerton CBOC with Naval Hospital via JIF	2013-2021	9,350

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
20	Portland	OR	Major Construction	Construct New Medical Office Building	2013-2021	150,000
20	Portland	OR	Major Construction	Portland Bldg 100 & 101 Seismic Retrofit and Renovation	2013-2021	330,000
20	Portland	OR	NRM	Building 100 Ward 9C Remodel	2013-2021	2,400
20	Portland	OR	NRM	Building 100 Ward 5D Remodel	2013-2021	2,500
20	Roseburg	OR	Minor Construction	New Building to relocate Mental Health out of Seismically Deficient Building 2 - Phase 3	2013-2021	9,900
20	Roseburg	OR	Minor Construction	New Building to relocate Mental Health out of Seismically Deficient Building 2 - Phase 4	2013-2021	9,900
20	Roseburg	OR	NRM	Integrated Security System Ph 1	2013-2021	500
20	Roseburg	OR	NRM	Integrated Security System Ph 2	2013-2021	500
20	Seattle	WA	Major Construction	Inpatient Improvements	2013-2021	229,900
20	Seattle	WA	Minor Construction	Building 100 FLR 4, Expand Specialty Clinics Phase 2	2013-2021	6,812
20	Seattle	WA	Minor Construction	Building 100 FLR 3 New Surgical Intensive Care Unit/PCU	2013-2021	9,850
20	Seattle	WA	Minor Construction	Building 100 FLR 4 New Medical Intensive Care Unit/Cardiac Cath Unit/Primary Care Unit	2013-2021	9,850
20	Seattle	WA	NRM	B100 FLR 5W Seismic Relocate 25 Bed Ward	2013-2021	5,820
20	Seattle	WA	NRM	B100 FLR 4W Seismic Relocate 25-Bed Ward	2013-2021	6,039
20	Seattle	WA	NRM	B100 FLR 3E Seismic Med/Surg. Procedures	2013-2021	6,259
20	Spokane	WA	Major Construction	Construct Clinical Addition	2013-2021	88,000
20	Spokane	WA	Minor Construction	Specialty Care Building	2013-2021	7,814
20	Spokane	WA	Minor Construction	Primary Care Building	2013-2021	7,888
20	Spokane	WA	Minor Construction	Community Living Center Renovation and Expansion	2013-2021	9,412
20	White City	OR	Minor Construction	Expand Ambulatory Care, B201	2013-2021	9,430
20	White City	OR	Minor Construction	Infirmary Bed Expansion Building 211A	2013-2021	9,970
20	White City	OR	NRM	Outpatient Care Renov, B201	2013-2021	950
20	White City	OR	NRM	Outpatient Care Renov, B201 (Dental Backfill)	2013-2021	1,900
20	White City	OR	NRM	Outpat Care Renov, B201, Phase 2	2013-2021	2,140
20	White City	OR	NRM	Renovate B211LS	2013-2021	2,140
21	Fairfield	CA	Minor Construction	Consolidate/Expand Outpatient Mental Health and Neurosurgery Clinic, Fairfield	2013-2021	9,900
21	Fresno	CA	Major Construction	Construct New Health Care Center	2013-2021	110,000
21	Fresno	CA	Minor Construction	Expand Mental Health Substance Abuse Center Addition	2013-2021	5,500
21	Fresno	CA	NRM	7th Floor Renovation, Building. 1	2013-2021	2,200
21	Honolulu	HI	Other	Renovate In Patient Mental Health Ward for patient safety	2013-2021	1,200
21	Martinez	CA	Minor Construction	Expand Ambulatory Surgery Unit, Martinez	2013-2021	9,900
21	Martinez	CA	Minor Construction	Renovate & Expand Community Living Center for Patient Privacy, Martinez	2013-2021	9,900
21	Menlo Park	CA	Major Construction	Replace Building 331 Community Living Center	2013-2021	82,000
21	Menlo Park	CA	Minor Construction	Construct Community Living Center Therapy Addition	2013-2021	9,800
21	Mountain View	CA	Major Construction	Building 6 Replacement	2013-2021	40,020
21	Palo Alto	CA	Major Construction	Correct Building 100 for Patient Privacy	2013-2021	8,000

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
21	Palo Alto	CA	Major Construction	Establish Consolidated Outpatient Mental Health Center	2013-2021	64,000
21	Palo Alto	CA	Major Construction	Replace Spinal Cord Injury/Disorder Center	2013-2021	110,000
21	Palo Alto	CA	Minor Construction	Enhance Physical Security Project	2013-2021	800
21	Palo Alto	CA	Minor Construction	Consolidate Psychology Service	2013-2021	9,800
21	Redding	CA	Major Construction	Health Care Center, Redding Mega Clinic	2013-2021	48,296
21	Reno	NV	NRM	Patient Bathroom Expansion Main Entrance	2013-2021	500
21	Reno	NV	NRM	Key Security Ph 3	2013-2021	800
21	Sacramento	CA	Major Construction	Health Care Center, Sacramento Annex	2013-2021	105,210
21	Sacramento	CA	Minor Construction	Consolidate Home Based Primary Care/Mental Health Intensive Case Management (HBPC/MHICM)	2013-2021	2,400
21	Sacramento	CA	Minor Construction	Primary Care Expansion	2013-2021	9,900
21	Sacramento	CA	NRM	Renovate Building 700 4th Floor for Med/Surg	2013-2021	5,000
21	San Francisco	CA	Major Construction	HCC, Build New HCC and Parking Garage in Downtown SF to Replace Downtown SF Community Based Outpatient Clinic	2013-2021	655,000
21	San Francisco	CA	Minor Construction	PICU Renovation & Privacy Expansion	2013-2021	9,977
21	San Francisco	CA	Minor Construction	Mental Health Research Annex	2013-2021	10,000
21	San Francisco	CA	Minor Construction	Sausalito Center Expansion, Phase 2	2013-2021	10,000
22	Las Vegas	NV	Major Construction	Construct Domiciliary	2013-2021	14,520
22	Las Vegas	NV	NRM	Ambulatory Care Specialty Clinics 3W	2013-2021	8,800
22	Las Vegas	NV	NRM	Inpatient Expansion 5W	2013-2021	9,900
22	Loma Linda	CA	Minor Construction	4NW Ward Renovation for patient privacy	2013-2021	990
22	Loma Linda	CA	Minor Construction	Specialty Clinics Expansion Mod4	2013-2021	4,000
22	Loma Linda	CA	Minor Construction	Intensive Care Unit Consolidation 2SW	2013-2021	9,900
22	Loma Linda	CA	Minor Construction	Community Living Center/Rehabilitation Renovation/Expansion - Phase 1	2013-2021	9,900
22	Loma Linda	CA	Minor Construction	Community Living Center Renovation/Expansion 1SE for patient privacy - Phase 2	2013-2021	9,900
22	Loma Linda	CA	Minor Construction	4SE Ward Renovation for patient privacy	2013-2021	9,900
22	Loma Linda	CA	NRM	Construct 4 Family Bathrooms- Phase 2	2013-2021	500
22	Loma Linda	CA	NRM	Construct 4 Bathrooms for Clinics - Phase 2	2013-2021	500
22	Loma Linda	CA	NRM	4NE Ward Renovation	2013-2021	770
22	Loma Linda	CA	NRM	Neurology Renovation 2 NW	2013-2021	950
22	Loma Linda	CA	NRM	Remodel Public Restrooms	2013-2021	5,000
22	Long Beach	CA	Major Construction	Inpatient Privacy Bed Expansion and Space Reconfiguration	2013-2021	105,600
22	Long Beach	CA	Major Construction	Spinal Cord Injury Inpatient Privacy Bed Expansion, Consolidated Rehab & Imaging Center	2013-2021	231,000
22	Long Beach	CA	NRM	B126 Ward Bathing and Toilet HC Renovation Phase 2	2013-2021	2,000
22	Long Beach	CA	NRM	B126 Relocate and Renovate Ortho and Podiatry Clinic	2013-2021	2,750
22	Long Beach	CA	NRM	B126 Ward Renovations	2013-2021	3,300
22	Long Beach	CA	NRM	B126 Renovate/Consolidate Day Surgery and Endo	2013-2021	6,600
22	Los Angeles	CA	Major Construction	Construct New Community Living Center	2013-2021	359,000
22	Los Angeles	CA	Minor Construction	Renovate B500 Emergency Department	2013-2021	7,174

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
22	Los Angeles	CA	Minor Construction	Building 208 Homeless Interior Renovation	2013-2021	8,300
22	Los Angeles	CA	Minor Construction	Building 205 Homeless Interior Renovation	2013-2021	8,300
22	Los Angeles	CA	NRM	B304 Second Floor South Wing Renovation	2013-2021	500
22	Los Angeles	CA	NRM	Correct Security Deficiencies Various Buildings	2013-2021	650
22	Los Angeles	CA	NRM	Replace video security system	2013-2021	650
22	Los Angeles	CA	NRM	Replace Video System	2013-2021	660
22	Los Angeles	CA	NRM	Correct Security Deficiencies Various Buildings Phase 2	2013-2021	715
22	Los Angeles	CA	NRM	Renovate Primary Sub-Specialty Care	2013-2021	820
22	Los Angeles	CA	NRM	Mental Health Inpatient Renovation	2013-2021	825
22	Los Angeles	CA	NRM	Install Security Surveillance Camera System	2013-2021	8,800
22	Los Angeles	CA	NRM	Renovate Medicine Wards Phase 3	2013-2021	8,800
22	San Diego	CA	NRM	Renovate Dental to Ambulatory Care Phase 4	2013-2021	7,000
23	Des Moines	IA	Minor Construction	Spinal Cord Injury Addition for Community Living Center	2013-2021	3,500
23	Des Moines	IA	Minor Construction	Home Based Cottages	2013-2021	4,500
23	Des Moines	IA	Minor Construction	Expand Specialty Procedures/Clinics	2013-2021	7,500
23	Des Moines	IA	Minor Construction	Clinical Improvements	2013-2021	8,500
23	Des Moines	IA	Minor Construction	Outpatient Expansion	2013-2021	9,000
23	Fargo	ND	NRM	Mental Health Building	2013-2021	1,000
23	Fargo	ND	NRM	Building 9 First Floor West Renovation	2013-2021	2,600
23	Fort Meade	SD	NRM	Renovate for Inpatient and Intensive Care Unit	2013-2021	5,300
23	Grand Island	NE	NRM	Renovate for polytrauma	2013-2021	780
23	Hot Springs	SD	Minor Construction	Renovate Building 8 for Patient Privacy	2013-2021	5,000
23	Hot Springs	SD	NRM	Renovate 2 South for Clinics	2013-2021	850
23	Iowa City	IA	Minor Construction	Specialty Clinics Addition	2013-2021	9,804
23	Iowa City	IA	Other	Construct Specialty Clinics Addition	2013-2021	196
23	Lincoln	NE	NRM	Mental Health Modernization	2013-2021	825
23	Minneapolis	MN	Major Construction	Expanded Polytrauma Rehab and Community Living Center	2013-2021	187,108
23	Minneapolis	MN	Minor Construction	Consolidate and Enhance Patient Services	2013-2021	9,800
23	Minneapolis	MN	NRM	Realign Primary Care Phase 1	2013-2021	1,000
23	Minneapolis	MN	NRM	Realign Primary Care Phase 2	2013-2021	1,000
23	Minneapolis	MN	NRM	Construct Clinic Space, Ph. 1	2013-2021	2,000
23	Minneapolis	MN	NRM	Construct Clinic Space, Ph. 2	2013-2021	2,000
23	Rapid City	SD	Major Construction	Domiciliary Replacement	2013-2021	34,000
23	Saint Cloud	MN	Minor Construction	Expand Psycho-Social Rehab, Add Second Floor to Building 111	2013-2021	7,500
23	Saint Cloud	MN	Minor Construction	Expand for Acute Inpatient Medicine	2013-2021	9,100
23	Saint Cloud	MN	Minor Construction	Multidisciplinary Specialty Clinic	2013-2021	9,200
23	Saint Cloud	MN	Minor Construction	Renovate/Expand Building 2 Mental Health Residential Rehabilitation Therapy Program for Privacy	2013-2021	9,200
23	Saint Cloud	MN	Minor Construction	Renovate/Expand Building 50 Community Living Center for Privacy	2013-2021	9,501
23	Saint Cloud	MN	Minor Construction	Community Living Center Cottages	2013-2021	9,600
23	Saint Cloud	MN	Minor Construction	Renovate/Expand Building 51 Community Living Center for Privacy	2013-2021	9,750
23	Sioux Falls	SD	Major Construction	Sioux Falls VAMC Community Living Center Cultural Transformation	2013-2021	27,200

VISN	City	State	Project Type	Project Name	Funding Year	Total Estimated Cost ($000s)
23	Sioux Falls	SD	Minor Construction	Outpatient Specialty Medicine Addition	2013-2021	4,915
23	Sioux Falls	SD	NRM	Mental Health Outpatient Clinic Renovation	2013-2021	2,040
23	St. Cloud	MN	Minor Construction	Community Living Center Cottages	2013-2021	9,500
					Sub-total	16,084,903
					Total	16,150,946

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INFORMATION TECHNOLOGY

Question 32. The President's budget request includes $5 million for the development of both short-term and long-term Strategic Capital Investment Plan Automation tools. Please explain what functionalities will be included in each.

Response. Strategic Capital Investment Plan (SCIP) Automation Tool (SAT)

SAT Short Term Solution: The SAT Short Term tool is the first stage in automating the data collection that serves as the basis for developing the 10-year Action Plans. The tool also provides for more efficient collection and analysis of data due to tool business rules and criteria as well as the ability to auto generate reports, which assist in synthesizing gap mitigation based on Action Plan submissions. The implementation of the SAT Short Term tool significantly reduced the manual and redundant data collection process that was used during the first year of the SCIP process.

SAT Long Term Solution: The SAT Long Term tool will continue to enhance the automation of the Action Plan data collection process. The SAT Long Term is also a comprehensive tool that will continue to automate the collection of data during the Action Plan phase through the Business Case development and OMB budget formulation phases. The long term may also include modules for improved formulation and tracking of VA construction operating plans.

The SAT Short Term tool solution serves as a functionality bridge between data collection requirements during the Action Plan phase and the additional data collection/analysis requirements during subsequent SCIP process phases. The full implementation of the SAT Long Term tool solution will incorporate all Action Plan data collection requirements as a one of several modules included in the included SAT Long Term tool.

Question 33. The budget request includes two new IT systems: the Homeless Operations and Management Evaluation System and the VA Homeless Management Information System. Please explain the purpose of these new programs.

Response. The Homeless Operations and Management Evaluation System is a case management system which specifically addresses the needs of the Homeless Veteran. As a case management system, it will register and administer benefits to the Homeless Veteran. Included in this program is the pilot and implementation of handheld devices that will be used by field outreach and case workers to interact with Homeless Veterans.

The VA Homeless Management Information System program aims to gather information about Homeless Veterans receiving benefits and forwards that information to VA's Homeless Registry. The information gathered provides VA with information about the individual Veteran receiving benefits, and measures the effectiveness of various homeless programs.

Question 34. How much of the Veterans Benefits Management System's long-term success hinges on the success of other programs such as the Virtual Lifetime Electronic Record?

Response. One of the primary goals of the Virtual Lifetime Electronic Record (VLER) is to provide access to electronic health records, which are essential to VA's strategic goal of achieving the paperless administration of benefits. Capability to electronically access Veterans' health records through a secure, reliable, and accessible system will improve Veterans' experiences by increasing timeliness and predictability of claims decisions. In the short term, VBMS plans to scan the health records received as paper documents. In the longer term as VLER matures and approaches full operational capability, it will serve as a source of health and benefits data from not only VA but also from DOD, the Social Security Administration, other government agencies and the private sector, to make benefits delivery more efficient and convenient.

Question 35. Are there decisionmaking quality measures that exist in VBMS and how will this software track errors in the long-term and at what level of granularity?

Response. As VBMS moves VBA from paper-based to electronic claim processing, it will improve quality by ensuring adherence to processes, policies and procedures. Utilizing automated workflows and business-rules engines will prevent common errors, thereby improving overall claim quality. Error checking, data validation and checks for completeness will help ensure that the claim is correct before it is finished, thereby reducing the need for costly rework. Additionally, it will provide more discreet claim-level information to VBA quality systems, enhancing end-of-line quality controls.

Question 36. Please describe the major milestones for VBMS. For example, when will the system be truly paperless?

Response. The VBMS initiative involves business transformation efforts coupled with incremental technology releases to modernize the benefits adjudication process. There are three successive phases that are designed to develop and test process improvements and VBMS technology solutions in a production claims setting.

Phase 1 (November 2010–May 2011) delivers the first iteration of VBMS, including a new graphical user interface, an electronic claims repository and a scanning solution, which integrates with existing core business applications in the current legacy platform (VETSNET). The first iteration of the software is being tested at the VBA Regional Office in Providence, Rhode Island.

Phase 2 (May 2011–November 2011) and Phase 3 (November 2011–May 2012) are intended to provide capability and capacity for national deployment of an end-to-end paperless claims processing system. In addition to building out the core and a sustainable system, both phases will increase the number of regional offices, the number of users, the types of claims, and the number of claims processed using VBMS. Full national deployment is scheduled to begin in calendar year 2012.

VA will continue to accept paper claims. Paper claims received will be scanned and processed in VBMS.

Question 37. What efforts has VA planned, in working with DOD, to further articulate a shared set of goals for VLER?

Response. The Department of Defense (DOD) and Department of Veterans Affairs (VA), in collaboration with the Interagency Program Office, have agreed to implement VLER by four (4) functional areas, called VLER Capability Areas (VCAs). Completion of a VCA indicates the availability of specific information sets in electronic form for authorized users, Veterans who have provided their consent, Servicemembers, and their beneficiaries and/or designees.

VCA 1—represents the exchange and availability of clinical information needed for the delivery of health care in a clinical setting.

VCA 2—expands health information from the initial set exchanged in VCA 1 to include the exchange of additional electronic health information for disability adjudication.

VCA 3—completes the information needed for the delivery of the remaining benefits services, including other compensation, housing, insurance, education, and memorial benefits.

VCA 4—ensures online access to benefits information via a single portal.

Though work is progressing in all VCAs, DOD and VA are heavily focused on the implementation of VCA 1. The plan is to continue to expand pilot testing the exchange of subsets of clinical data, via the Nationwide Health Information Network, between DOD, VA and private health care providers, in 2011–2012. Lessons learned from these pilot tests will be used to determine scalability, usability, security, and reliability of the architecture for broader application, and implementation.

Question 38. In response to prehearing questions, VA stated, "In early calendar year 2010, VA undertook an extensive re-evaluation of its financial management challenges, risks and critical priorities. The re-evaluation, which included consideration of available resources, the clean audit opinions on VA's financial statements for 11 years in a row." Who performs these audits? Please provide the previous two years audits.

Response. In FY 2010, the Department of Veterans Affairs was pleased to have received our 12th consecutive unqualified ("clean") audit opinion on the Department's consolidated financial statements. The auditors were Clifton Gunderson LLP and their clean audit opinion is found on page III–59 of the Department's FY 2010 Performance and Accountability Report (http://www.va.gov/budget/report/). In FY 2009, the Department also received our unqualified ("clean") audit opinion (11th consecutive clean opinion) on the Department's consolidated financial statements. The auditors were Deloitte and their clean audit opinion is found on page III–52

of the Department's FY 2009 Performance and Accountability Report (http://www.va.gov/budget/report/) for this link, you will need to page down and click on the 2009 PAR).

Question 39. Is VLER under the Project Management and Accountability System and is it on target for meeting its goals for 2012 and beyond?

Response. In July 2009, the Veterans Affairs Chief Information Officer mandated that all funded information technology (IT) projects comply with Project Management and Accountability System (PMAS) guidelines. All VLER IT projects, including the VA adaptor to the Nationwide Health Information Network (NwHIN), which enable the VLER mission, are fully compliant with PMAS guidelines.

Yes, established goals are on target for being met.

Question 40. What role does DOD have in VA's recent public Request for Information on evolving VistA in an open source environment?

Response. VA and DOD have ongoing, extensive discussions regarding Electronic Health Records, including the possible use of open source models for the development of the VistA EHR. The Electronic Health Record Open Source Custodial Agent Request for Information, prepared and released by VA with the full awareness of DOD, was informed by those discussions.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Question 41. VA's budget request anticipates a 10 percent increase in the use of VR&E in FY 2012. Has this anticipated increase in workload taken into account the downturn in the economy and your planned outreach activities?

Response. Yes, the projected increase is based, in part, on the downturn in the economy and our planned outreach activities. However, these increases are also projected based upon new compensation presumptive conditions, VR&E's participation in the IDES process, and Congress's recent changes to the Post-9/11 GI Bill that will now allow Veterans eligible for both Chapter 31 and Chapter 33 benefits to elect the higher Chapter 33 housing allowance.

Question 42. Has VA designed outreach to specifically target Guard and Reserve units to educate them about VR&E?

Response. Yes, VR&E's Coming Home to Work Program provides services to active duty Servicemembers, to include National Guard and Reservists. The program provides opportunities for Servicemembers and Veterans to obtain work experience, develop skills needed to transition to civilian employment, determine potential career opportunities, and return to suitable employment. VR&E's Coming Home to Work Coordinators also provide outreach services specifically for Guard and Reserve through the Yellow Ribbon and Post-Deployment Health Reassessment (PDHRA) events, which occur at 30, 60, 90 day intervals for returning Guard members and Reservists.

Question 43. What effect, if any, do you expect the increased number of VR&E applicants will have on timely entitlement decisions? Will it have an effect on rehabilitation rates?

Response. With the increase in FTE requested, VR&E projects improvements in the national rehabilitation rate and the speed of entitlement decisions. VR&E's request for additional FTE to support expansion of IDES is expected to provide early engagement in services with Servicemembers by physically placing Vocational Rehabilitation Counselors (VRC) at IDES locations. This will result in a more timely entitlement decisions. Servicemembers will spend less time in the transition period from eligibility to entitlement services and will have more timely access to VR&E benefits.

Question 44. Are you confident that the increased staffing request will be sufficient to meet the higher demand for VR&E services?

Response. Yes.

Question 45. Please provide a copy of the VR&E work measurement study, for which the contract expired on February 25, 2011.

Response. The VR&E Work Measurement Study final contract deliverable was rejected by VR&E for being incomplete. The contractor submitted a revised deliverable on March 25, but the study was again rejected. VR&E Service continues to work with the contractor to revise the final deliverable. Once an acceptable deliverable is provided, VR&E will review report for final concurrence, brief VBA leadership on the results, and submit a copy of the study to the Committee.

Question 46. In response to a pre-hearing question on the Integrated Disability Evaluation System, the Department stated, "All IDES participants will receive a mandatory initial counseling session in which a VR&E counselor will work with the separating Servicemember to determine whether and how further program partici-

pation can benefit them in their transition process." For clarification, will all IDES participants receive the mandatory counseling session, or just those who apply for VR&E services?

Response. All IDES participants will receive the mandatory counseling session, not just those that apply for VR&E services. This face-to-face meeting will inform the Servicemember of the benefits available through the VR&E program. The Servicemember can then make an informed decision about whether or not to pursue VR&E program services.

OTHER

Question 47. The President's Budget reflects a substantial decrease in the amount of funding for advanced planning within the National Cemetery Administration—from over $25 million in FY 2011 to only $4.3 million in FY 2012. This reduction is proposed despite rather ambitious plans to expand operations in six different new cemeteries and to move forward with "urban satellite cemeteries" in four locations across the country. Are you satisfied that the budget will permit NCA to move forward to continue to plan to meet the needs of veterans and their families in their time of need?

Response. If the FY 2011 President's budget request is approved, we will have $23.4 million available in the Advance Planning Fund (APF). An additional $4.5 million is requested in FY 2012.

APF requirements are based on anticipated major construction needs. Available and requested APF funds are sufficient to cover the five new national cemeteries and planned gravesite expansion projects. The urban satellite cemeteries will be funded through minor construction.

Question 48. Implementation of the Post-9/11 Veterans Educational Assistance Program and the timely and accurate payment of benefits are critical. The President's budget, however, decreases the number of FTE for the Education Service by over 200—despite the fact that there is also a 73 percent projected increase in claims since the program's inception and that significant changes were made early this year with the 2010 Improvements Act that could easily impact the timeframe for implementing the long-term automated processing system. Please give me VA's commitment to advise the Committee at the very first sign that there might be problems with available staffing. There are concerns that by releasing more than 200 employees who have over the past two years have developed skills in processing education claims, VA will be losing valuable expertise that might be utilized elsewhere in the Department. To what degree will the reduction in FTE be achieved by attrition rather than by dismissal?

Response. To support Post-9/11 GI Bill claims processing, VA hired 530 term employees as GI Bill claims examiners in February 2009. The term employees were part of VA's short-term solution until the Office of Information and Technology delivered the Long-Term Solution (LTS) for Post-9/11 GI Bill claims processing. VA anticipated all term employees would be retained through the end of FY 2011.

The enactment of the Veterans Educational Improvements Act of 2010 (P.L. 111–377) has impacted the development of the LTS for processing Post-9/11 GI Bill claims and our ability to fully automate the delivery of benefits. The capability for automated end-to-end processing of some supplemental claims was planned for June 2011. This capability would create a subset of claims that do not require manual intervention. Implementation of the LTS was expected to address the increased workload and improve claims processing timeliness while negating the need for temporary claims processors. Because all LTS development efforts will now be directed to implementing the changes in the new law, we anticipate this LTS functionality will not be available until the third quarter of FY 2012.

The delay in the implementation of the enhanced functionality planned for the LTS impacts the number of FTE needed to process education claims. Our budget request of 1,429 FTE reflects the need to retain 324 of the 530 temporary claims examiners through FY 2012 to maintain current claims processing efficiencies. While there is a 73 percent projected increase in claims since the inception of the Post-9/11 GI Bill, VA anticipates only a 3.1 percent increase in claims from FY 2011 to 2012. We anticipate any reduction in FTE in FY 2012 will be accomplished through attrition.

VA is committed to providing the best possible service to our Veterans. We will carefully measure the impact the LTS has on our ability to accurately and timely process Post-9/11 GI Bill claims, and we will continue to engage in dialog with Congress on issues that impact our ability to effectively and efficiently administer the Post-9/11 GI Bill.

Question 49. The budget request notes that VA plans to increase teleworkers by 250 percent over the next two years to realize savings. How many teleworkers does VA have currently, and how does VA plan to increase the number of employees who choose to telework?

Response. VA records reflect a total of 4,669 employees' teleworking 1 or more days per week. VA has developed a multi-year strategy to increase telework to 16,636 employees' teleworking 1 or more days per week by the end of 2012. As part of this strategy, VA issued agency wide guidance in accordance with the Telework Enhancement Act of 2010 which includes the assignment of telework coordinators within each administration, all VISNs and VA's Central Offices. In addition VA has designed a multi-year strategy to promote the full utilization of telework through:

- a telework education program,
- promotion of best practices
- issuance of guidelines regarding suitability
- establishment of tracking mechanisms
- development of "touchdown space" guidelines; and
- assuring the necessary IT infrastructure is in place to support remote access users

Question 50. Under the acquisition reorganization, what is the procurement dollar level authority at the Centralized Mail Order Pharmacy level? Please also submit the outline of the plan that shifts the buying authority from lower level entities into National Acquisition Center.

Response. Currently the Office of Acquisition, Logistics, and Constructions' (OALC) National Acquisition Center (NAC) is providing acquisition support to the Consolidated Mail Outpatient Pharmacy (CMOP) and has warranted Contract Specialists supporting each of the seven CMOP facilities. Each of these contract specialists has senior level warrant authority which is unlimited. CMOP personnel will retain purchase card authority limiting purchases to $3,000 for goods; $2,500 for services; and $2,000 for construction. CMOP personnel also may be delegated "ordering officer" authority allowing them only to issue delivery and/or task orders against specific contracts awarded by a VA contracting officer. Limitations will vary based on the ordering officer delegation.

In that the NAC is currently providing buying authority to support CMOP operations, there is no plan that shifts buying authority.

Response to Posthearing Questions Submitted by Hon. Richard Burr to U.S. Department of Veterans Affairs

GENERAL

Question 1. The December 2010 report from the National Commission on Fiscal Responsibility and Reform included this recommendation:

> Reduce Federal travel, printing, and vehicle budgets. Despite advances in technology, Federal travel costs have ballooned in recent years, growing 56 percent between 2001 and 2006 alone. Government fleets, meanwhile, have grown by 20,000 over the last four years. Printing costs are still higher than necessary despite technological advancement. We propose prohibiting each agency from spending more than 80 percent of its [Fiscal Year (FY)] 2010 travel budget and requiring them to do more through teleconferencing and telecommuting. We also recommend a 20 percent reduction in the nearly $4 billion annual Federal vehicle budget, excluding the Department of Defense and the Postal Service. Additionally, we recommend allowing certain documents to be released in electronic-only form, and capping total government printing expenditures.

A. In fiscal year 2008, how much in total was expended by the Department of Veterans Affairs (VA) on travel costs; how much in total was expended on printing costs; and how much in total was expended to purchase, operate, or maintain vehicles?

B. In fiscal year 2009, how much in total was expended by VA on travel costs; how much in total was expended on printing costs; and how much in total was expended to purchase, operate, or maintain vehicles?

C. In fiscal year 2010, how much in total was expended by VA on travel costs; how much in total was expended on printing costs; and how much in total was expended to purchase, operate, or maintain vehicles?

D. For fiscal year 2011, how much in total is projected to be expended by VA on travel costs; how much in total is projected to be expended on printing costs; and

how much in total is projected to be expended to purchase, operate, or maintain vehicles?

E. For fiscal year 2012, how much in total is requested for travel costs; how much in total is requested for printing costs; and how much in total is requested to purchase, operate, or maintain vehicles?

Response.

Department of Veterans Affairs					
Employee Travel, Printing, and Fleet Services					
($ in millions)					
Appropriated	2008	2009	2010	2011	2012
Employee Travel	187	193	228	259	252
Printing	23	27	40	46	56
Fleet Vehicles	64	69	73	80	86
Total	$274	$289	$341	$385	$394

Question 2. In addressing the Commission on Fiscal Responsibility and Reform on April 27, 2010, President Obama stated, "Now, I've said that it's important that we not restrict the review or the recommendations that this commission comes up with in any way. Everything has to be on the table." The Commission, itself, reiterated that sentiment in their December 2010 report: "There is no easy way out. Everything must be on the table." (The Moment of Truth, page 6.)

A. How has VA taken this sentiment into account in formulating the fiscal year 2012 budget request?

Response. In developing the 2012 budget request VA was and remains, attentive to the themes of eliminating wasteful or unnecessary spending. VA has conducted a review of the efficiencies to be gained, and the savings to be achieved within the agency. These improvements are estimated to total $745 million in FY 2011. Similar improvements are included in VA's budget request for 2012 at estimated savings of $1.2 billion.

The VA is firmly committed to increasing the value of every dollar entrusted by the Congress and the American taxpayer to this Department for the delivery of benefits and services to Veterans, their families and survivors. For example, in 2011, we are implementing several operational improvements in our medical care programs that will save money while improving the quality of health care. These include:

- Reducing indirect costs by adopting uniform standards for administrative and support services;
- Reducing the costs of non-VA provided dialysis by implementing Medicare's standard payment rates;
- Reducing acquisition costs by consolidating contracting requirements, adopting strategic sourcing and other initiatives;
- Reducing improper payments and improving operational efficiencies in the administration of the medical fee program; and
- Reducing payroll costs by increasing capabilities and productivity of healthcare professionals through more appropriate alignment of the mix of physician and nursing staff, and other non-physician providers, to meet patient demand.

In developing the 2012 budget, we also carefully reviewed requirements in our non-medical programs. As a result, we will reduce spending by $1.1 billion below current 2011 estimates in several program areas. For example, by prioritizing our most critical safety and security capital infrastructure needs, funding for major and minor construction will be reduced. Investments in information technology will begin to pay dividends as deployment of the Veterans Benefits Management System (VBMS) begins in 2012, allowing for increased productivity and reduced operating costs in processing disability compensation claims in the Veterans Benefits Administration. In addition, we are adopting new acquisition strategies to make more effective use of our information technology resources, including consolidating requirements into 15 prime contracts that will allow VA to leverage economies of scale and reduce IT spending.

VA has also instituted a number of innovative practices to improve our energy efficiency and make more effective use of our resources. For example, the National Cemetery Administration (NCA) has implemented creative approaches to cemetery operations: the use of pre-placed crypts, that preserve land and reduce operating costs; application of "water-wise" landscaping that conserves water and other re-

sources; and installation of alternative energy products such as windmills and solar panels that supply power for facilities. NCA has also utilized biobased fuels that are homegrown and less damaging to the environment. NCA is developing an independent study of emerging burial practices throughout the world to inform its planning for the future.

In the past two years, we have established and created management systems, disciplines, processes, and initiatives that help us eliminate waste. Financial and performance metrics provide the foundation for monthly performance reviews that are chaired by the Deputy Secretary. These monthly meetings play a vital role in monitoring performance throughout the Department, and are designed to ensure both operational efficiency and the achievement of key performance targets. In addition, a new budget review cycle was established to further strengthen stewardship of our financial resources. This cycle has three components: pre-year review; mid-year review; and post-year review. The Secretary chairs meetings in each review cycle to assess budget and operational efficiency and effectiveness.

We also demonstrated our ongoing commitment to effective stewardship of our financial resources by obtaining our 12th consecutive unqualified (clean) audit opinion on VA's consolidated financial statements. In 2010, we were successful in remediating 3 of 4 longstanding material weaknesses, a 75 percent reduction in just one year.

Question 3. One of VA's integrated objectives is to "educate and empower veterans and their families through outreach and advocacy."

A. VA-wide, how much in total was spent on outreach activities during fiscal year 2010, how much in total is expected to be spent on outreach activities during fiscal year 2011, and how much in total is requested for purposes of outreach activities during fiscal year 2012?

Response. VA created the National Outreach Office within the Office of Public and Intergovernmental Affairs (OPIA) in FY 2010 to standardize how outreach is being conducted throughout VA. While we are not currently able to extract the total spending for outreach across the department for FY 2010 and FY 2011, we are working diligently toward that goal for FY 2012. VA has made considerable progress in researching and analyzing VA's outreach programs and activities and have developed a framework to guide us through creating a more efficient and effective approach to conducting outreach department-wide, in support of VA's major initiatives. Key to the final plan is building a process that helps VA's administrations (Veterans Health Administration, Veterans Benefits Administration and National Cemetery Administration) and program offices:

- provide Veterans with high-quality products and activities that are consistent,
- provide outreach coordinators with training,
- evaluate and measure the effectiveness of outreach programs,
- track costs associated with outreach programs.

B. What metrics are used by VA to gauge whether outreach efforts are effective?

Response. Currently, VA's administrations and program offices coordinate and conduct their own outreach efforts. This includes the use of numerous methods to ensure it reaches the greatest number of Veterans, including the use of: direct mail, news media, paid advertising, community-based activities, and partnerships with other Federal agencies; Internet and social media (such as YouTube, Facebook, and Twitter); phone centers; and personal briefings to Veterans, Veterans Service Organizations (VSO), Military Service Organizations (MSO), state, regional and local governments, 200,000 dedicated VA volunteers, and other interested stakeholders.

C. For fiscal year 2010, please provide VA's performance outcomes in terms of those metrics.

Response. As referenced in Question B, "What metrics are used by VA to gauge whether outreach efforts are effective?," the attached document, delivered to Congress December 2010, is the first step in analyzing VA's multitude of outreach activities and is serving as a baseline to develop a plan to yield the performance metrics necessary to determine the level of success of individual program efforts. What the report shows so far is the need to build a standard approach so each office conducting outreach can easily measure the value of their initiatives in serving Veterans. Again, building this process is necessary to providing data on VA's performance in outreach.

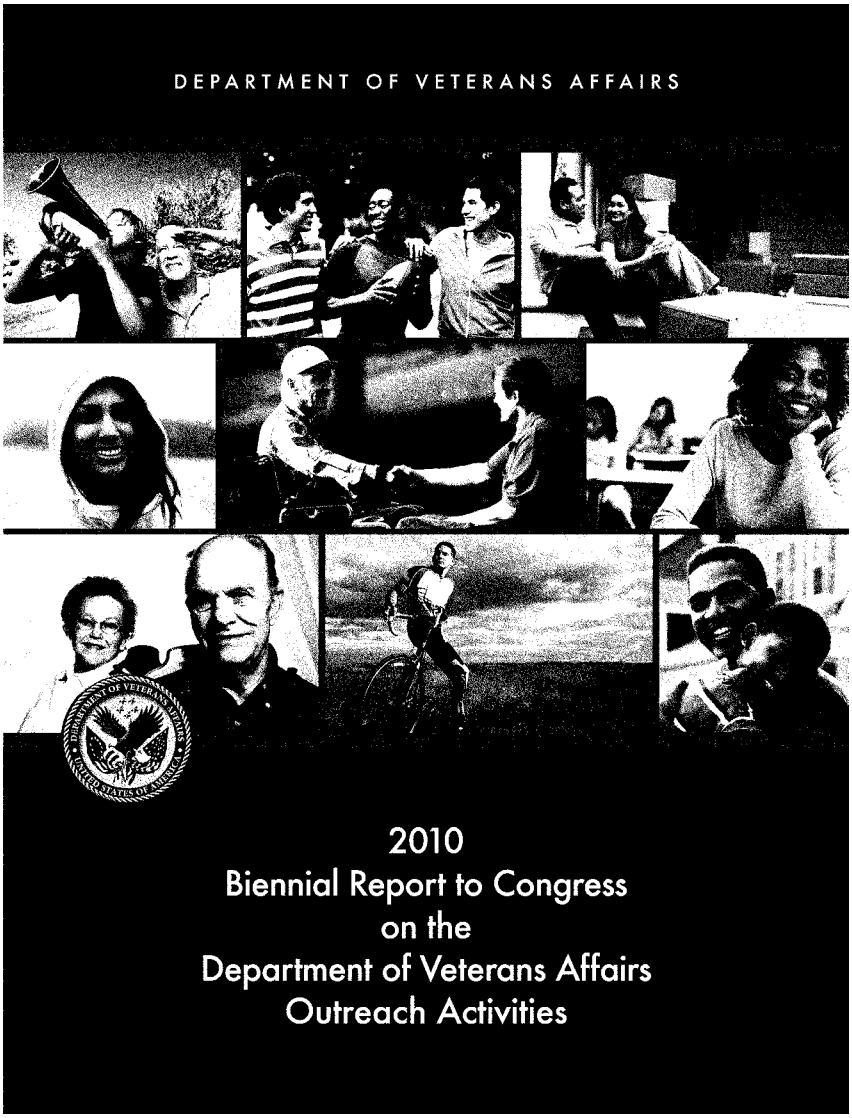
D. For fiscal years 2011 and 2012, please provide VA's projected performance outcomes in terms of those metrics.

Response. The Outreach Office established a workgroup made up of representatives from VHA, VBA and NCA and program offices like the Center for Women Veterans, OIF/OEF Case Management, Center for Minority Veterans, Small and Disadvantaged Business Utilization, Homeless Veterans and many others. The

workgroup holds monthly meetings to coordinate input, solicit ideas and build buy-in for development and implementation of the overall outreach plan. Additionally, to ensure future outreach program success, the National Outreach Office will hold "Outreach Day" at the 2011 National Office of Public and Intergovernmental Training Conference, to orient VA's directors responsible for outreach to the new standard—VA's outreach efforts are fiscally responsible, success is measurable and outreach efforts are based on sound research and well-planned strategies.

E. Does VA collect and analyze any data or information that would allow a comparison of the effectiveness of one outreach approach over another? If so, please explain what information or data has been collected, what conclusions have been drawn from that information, and what has been done with respect to any activities found to be ineffective.

Response. No. Currently, the only report on outreach available, the 2010 Biennial Report to Congress on the Department of Veterans Affairs Outreach Activities, was submitted December 2010.


DEPARTMENT OF VETERANS AFFAIRS
2010
Biennial Report to Congress
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Outreach Activities

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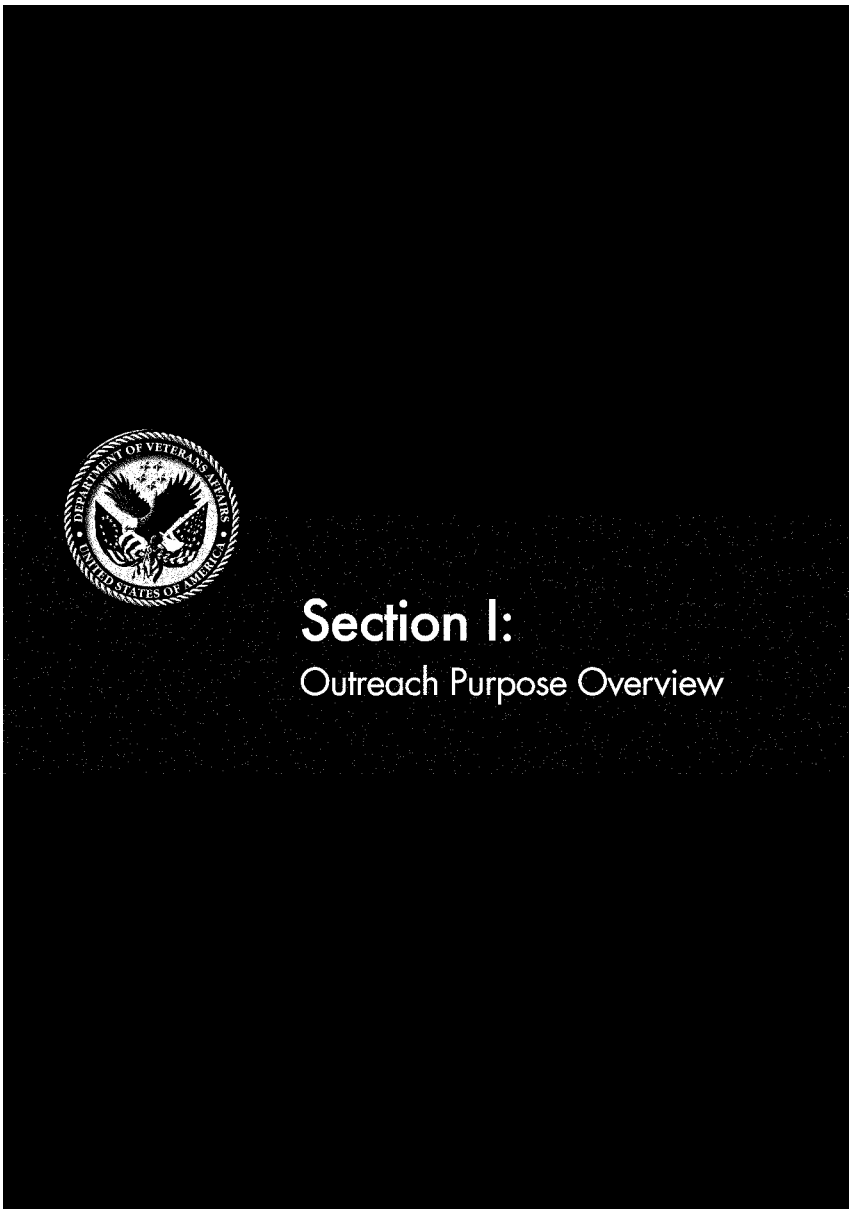

Section I:
Outreach Purpose Overview

SECTION I: OUTREACH PURPOSE OVERVIEW

The Department of Veterans Affairs (VA) is dedicated to improving the lives of Veterans of all eras and their eligible family members and survivors by providing them with the benefits and services they have earned. VA staff throughout the country are committed to fulfilling President Lincoln's promise: "To care for him who shall have borne the battle, and for his widow, and his orphan." Intrinsic in this promise is the need for the Department to actively engage our Nation's heroes and to educate them, their families, and their survivors about the benefits and services they may be eligible to receive. To achieve this, outreach must be a proactive and systematic effort providing important information and assistance on VA's services and benefits.

Wholeheartedly accepting President Barack Obama's challenge to transform VA and under the leadership of Secretary Eric K. Shinseki, the Department continues to make strides in becoming an accessible, responsive, and transparent 21st century organization. VA recognizes that outreach and awareness activities have a direct impact on achieving this mission. By adapting to new realities, embracing new technologies, and serving Veterans of every era with a renewed vigor, the Department is confident of its success. All activities of the Department, including outreach, are driven by a framework to support its transformation. As outlined by Secretary Shinseki, this framework has three fundamental principles: VA's focus must be people-centric, results-oriented, and forward-looking.

People-centric: Veterans are the centerpiece of our organization and of everything we do as we design, implement, and sustain programs to serve them. It is VA's mission to anticipate and address Veterans' changing needs over time and across the full range of support that VA is committed to providing.

Results-oriented: Now more than ever, the true measure of VA's success is the timeliness, quality, and consistency of the services and support we provide to our Nation's Veterans and their families. We will establish outreach performance standards that effectively address the needs of a diverse Veteran population now and into the future.

Forward-looking: VA will deliver the best service with available resources by leveraging best practices and combining our knowledge with emerging technologies to improve the quality and accessibility of benefits and services.

VA executes outreach activities primarily through our three Administrations: Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), and National Cemetery Administration (NCA), in addition to its many staff and program offices. The Administrations, staff, and program offices coordinate and conduct their own outreach efforts based on their unilateral missions; however, each also contributes to the overarching effort for all of VA. In addition, each Administration and staff office employs numerous methods to ensure it reaches the greatest number of Veterans, including the use of: direct mail, news media, paid advertising, community-based activities, and

partnerships with other Federal agencies; Internet and social media (such as YouTube, Facebook, and Twitter); phone centers; and personal briefings to Veterans, Veterans Service Organizations (VSO), Military Service Organizations (MSO), state, regional and local governments, 200,000 dedicated VA volunteers, and other interested stakeholders. This ensures Servicemembers, Veterans, and their families and survivors understand how to access and apply for VA benefits and services and that the necessary outreach activities and related communications are provided correctly; to the right beneficiary, at the right time, and in the right way. To achieve this, VA employs the following approaches:

1. Centralize outreach management and decentralize outreach execution by:

- Building a centralized corporate structure for outreach through the National Outreach Office
- Establishing benchmarks and measures for success
- Coordinating outreach activities and strategies Departmentwide
- Creating and deploying unified messaging and outreach materials

2. Leverage technology to reach Veterans by enhancing:

- My eBenefits – VA/Department of Defense (DoD) initiative
- My Health**e**Vet
- VA's Web sites
- Social media

3. Strengthen partnerships to maximize outreach efforts:

- Increase and enhance our work with other Federal Departments and agencies, State Directors of Veterans Affairs, Tribal government leaders, insular government leaders, County Veterans Service Officers (CVSO), Veterans, VSOs, MSOs, non-profits, businesses, philanthropic organizations, and educational institutions to maximize VA's outreach efforts.

To assist in the three-prong approach, VA created a National Outreach Office within the Office of Public and Intergovernmental Affairs (OPIA). In FY 2010, the new office awarded an Indefinite Delivery Indefinite Quantity contract to five marketing/public relations companies. Each company is now allowed to propose on VA's Veteran outreach campaigns. Specifically, in September 2010 the office awarded a variety of outreach campaign task orders that cover topics such as Paralympic sport, Veteran homelessness, and suicide prevention. Through these campaigns, OPIA plans to increase Veteran awareness, improve education, and increase client confidence using specific and targeted outreach activities and communication materials and products. The new office will also assist the Administrations and staff offices in developing outreach strategies and will begin to unify outreach communications using clear, accurate, consistent, and targeted messaging to inform our Veterans and their families of the health care services and benefits available to them. Knowing Veterans, like many Americans, receive their information from a variety of sources, it will also ensure

delivery of messages to our Veterans and their families by leveraging the latest media technology and critical partnerships with a multi-level of stakeholders to distribute outreach information. Finally, the office will ensure there are standard, Departmentwide performance measures in place, track outreach outcomes, and report on the success of these activities to Veterans, Congress, VSOs, other stakeholders, and the American public.

The new outreach office should result in significant cost savings by coordinating previously separate outreach functions, unifying messaging and eliminating duplicate communications, and sharing the costs of doing market research. It will also enhance VA's efforts to reach our Veterans, their families, and the stakeholders with whom VA collaborates and partners as well as the general public. The Administrations and staff offices will continue to execute outreach activities, but the strategy and messaging will be coordinated across the Department by OPIA's National Outreach Office.

President Obama stated the case succinctly when he said: "Whether you left the service in 2009 or 1949, we will fulfill our responsibility to deliver the benefits and care that you earned. And that's why I've pledged to build nothing less than a 21st century VA."

> *"President Obama has a vision for change at the Department of Veterans Affairs, and I am fully committed to helping him achieve it. That vision will require transforming VA into an agile, adaptive organization that is capable of leading change, not waiting around to be forced into it, or worse, risking irrelevance as we take on transforming the Department … The focal point of our efforts will be our Nation's Veterans and the fair and just treatment they deserve. I am your advocate, and I intend to represent you forcefully."*
>
> —Secretary Eric K. Shinseki, Department of Veterans Affairs, February 20, 2009

Outreach Highlights

Since the last Biennial Outreach Report submitted in FY 2008, VA has significantly improved its Veteran outreach activities across the Department and nation and it will continue to do so by adopting new technologies and seeking out Veterans. The Department will continue to integrate and coordinate outreach efforts, communicate using a single identity and consistent messaging, and begin to establish and implement Departmentwide standards for tracking and reporting successes and failures. It will also continue to foster its partnerships with Federal Departments and administrations, state, tribal, and local governments, VSOs and MSOs, and other national and community stakeholders who support or assist Veterans and their families. Finally, VA will continue to increase Veteran awareness and use of its benefits and services. Below are some of the Department's achievements over the last two fiscal years.

Secretary Shinseki's Five-Year-Plan to End and Prevent Veteran Homelessness Among our Nation's Veterans

The initiative of eliminating Veteran homelessness is built upon six strategies or pillars: outreach/education, treatment, prevention, housing/support services,

income/employment/benefits, and community partnerships. All Veterans at risk for homelessness or attempting to exit homelessness must have easy access to VA's programs and services. Since homelessness can be caused by a range of complex issues, VA offers a variety of resources, programs, and benefits including: prevention services such as the National Call Center for Homeless Veterans; housing support services such as the Grant and Per Diem Program; treatment such as health care, stand downs, and dental assistance; employment and job training such as VA's Compensated Work Therapy; and, homeless Veteran benefit assistance. Outreach is also conducted in community locations like shelters, soup kitchens, bus and train stations, rural camps, and other areas known for homeless congregation. Reaching out and engaging homeless Veterans who have been disenfranchised is one of the most critical steps for ending Veteran homelessness. These Veterans often require mental health and substance abuse treatment services, but will not avail themselves of such help without the encouragement of outreach workers. VA is taking proactive steps to seek out, engage, and assist all homeless Veterans.

Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) Seven Touch Points

Approximately 837,000 Servicemembers have been mobilized since 2002 and, of those, only 39 percent have used VA's VHA health care. For this reason, VA has initiated several outreach programs to provide OEF/OIF Veterans and their families with vital information about accessing available benefits and health care. VHA has adopted and is taking a proactive stance by providing information at a variety of venues to OEF/OIF Veterans about their earned care and benefits. The Department is working toward being more responsive and flexible as these Servicemembers continue transitioning back into civilian life. The new outreach approach adopted by VHA is called the Seven Touches of Outreach and engages National Guard and Reserve Veterans at least seven times during the deployment cycle, with targeted messages and face-to-face encounters with VA staff members. The names of the seven touch points are: 1) Demobilization Initiative, 2) Individual Ready Reserve (IRR) Muster; 3) Combat Veteran Call Center, 4) Yellow Ribbon Program (YRP), 5) Post-Deployment Health Reassessment, 6) Transition Assistance Advisors, and 7) the OEF/OIF Internet Web page.

eBenefits

VA and the DoD launched the eBenefits portal worldwide on October 22, 2009. The portal is a one-stop shop for benefits-related online tools and information for wounded warriors, Veterans, Servicemembers, and families of Servicemembers. The site allows for personalization by the user and will customize benefit information based on their profile. It also enables users to find tailored benefit information and services in one place, rather than scattered across a variety of Web sites. Through deployment of the eBenefits portal, VA and the DoD have fully embraced the recommendations of the Dole-Shalala Commission. In 2010, VA further enhanced the eBenefits portal to allow Servicemembers and Veterans to check the status of Compensation & Pension (C&P) claims and appeals, review payment history, obtain home loan certificates of eligibility, transfer educational entitlement, and request state benefit information. As

enhancements continue, targeted outreach messages will be further tailored to individuals.

National Veterans Awareness Campaign
To further enhance its outreach activities, VA has set aside $30 million for a National Veterans Awareness Campaign. In order to execute such a large campaign, OPIA implemented a two-phased approach to developing a national outreach strategy and executing a national media campaign to help bring Veterans to VA for benefits and quality health care. Phase I is currently underway (awarded July 15, 2010) and the Department is researching and collecting Veteran demographics and developing an outreach strategy and strategic media plan. VA will analyze the data and establish audience profiles to allow for targeted messaging. The profiles and data will also help the Department with paid media planning and buying. Phase I serves as the foundation for the advertising element of the national outreach campaign, which will occur during Phase II. Using the data, research and audience analysis, and metrics for success established during Phase I, VA will implement Phase II in 2011 Veterans and produce national advertising pieces.

Social Media
VA has embraced the use of Web 2.0 to engage younger Veterans and social media is now one of the primary methods VA uses to share news, updates, and general information and to collect comments and feedback. Currently, VA's Facebook page has over 65,000 subscribers--higher than the Facebook page of any other cabinet-level agency. In addition, VA now has 25 official Twitter feeds for both the Department and each of the Administrations, the primary feed having over 6,000 followers--more than any VSO. VA now reaches more Veterans each day through social media than through the entire VA Web site.

VA will continue to embrace video- and photo-sharing media with the use of YouTube and Flickr. VA has begun posting each segment of its EMMY award-winning news magazine program, *The American Veteran,* on YouTube, while showcasing a selection of them on the VA home page. The Department also has a health care-related YouTube channel, which showcases more than 90 videos, has 1,300 subscribers, and has had more than 58,000 views.

Finally, VA has hired its first official blogger professional, charged with communicating VA's message directly to Veterans and designed the Department's first official blog (with an anticipated October 2010 launch date).

Simpler, Faster Benefits Application Form
As part of VA's effort to "break the back" of the backlog, VBA has shortened application forms to reduce paperwork for Veterans. The forms are available online at www.va.gov/vaforms and include a shortened VA Form 21-526 for Veterans applying to VA for the first-time for disability compensation or pension benefits. There is also a more clear version of VA Form 21-526b for Veterans seeking increased benefits for conditions already determined to be service-connected and two new forms for Veterans

participating in the VA's new Fully Developed Claim Program, which is one of the fastest means to receive a claims decision. You can find the new forms at http://www.Veteransbenefitgroup.com/.

Building on VA's Success

VA's three Administrations and their staff and program offices will continue to build on the successes of their most effective outreach efforts with leadership from VA's National Outreach Office. The following is a comprehensive list of outreach activities VA completed in FYs 2009 and 2010, which is an excellent summary of our commitment and dedication to Veterans. Because VA launches new outreach efforts every day, the Department will closely monitor and adjust or replace those that do not meet their potential with more effective strategies. VA will continue improving its outreach efforts, making it possible to analyze and capture outcomes and key metrics of ALL outreach activities and provide them to interested stakeholders.

Section II:
Administrations' Outreach

SECTION II: ADMINISTRATIONS' OUTREACH

VA's Veterans Benefits Administration (VBA) Outreach

Overview
VBA outreach activities are designed to ensure benefit information is provided to the right beneficiary at the right time. The newly established Benefits Assistance Service (BAS) facilitates the cooperative outreach effort among all regional offices and VBA business lines making it easier for Veterans to access the benefits they have earned. VBA's outreach efforts are coordinated through the VBA Office of Field Operations, all field stations, and the Office of Policy and Program Management (OPPM), which consists of five business lines: C&P, Loan Guaranty (LGY), Insurance, Vocational Rehabilitation and Employment (VR&E), and Education. VBA conducts and coordinates a variety of outreach activities for VA benefits and services such as disability compensation and pension, LGY benefits, VR&E, education assistance, and insurance.

VBA championed new outreach initiatives over the past 2 years to ensure Servicemembers, Veterans, and their families and survivors can understand and access VA benefits and services. These new outreach initiatives include development of joint outreach campaigns for the eBenefits Web portal, the Post-9/11 GI Bill, a fully developed claim process, the availability of pre-discharge services, and data sharing programs that target outreach to specific potential clients.

VBA also engages in a wide range of outreach activities to ensure Servicemembers, Veterans, and their family members are aware of the benefits to which they are entitled. These include direct mailings, Web sites, transitional briefings, general benefits information booths, conferences, speaking engagements, presentations, and exhibitions, and social media tools, such as Facebook, Twitter, and YouTube.

Web Communications and Social Media
Target Audience: Veterans, Servicemembers, their dependents, and VA stakeholders
Description of Effort: In 2009, VBA, along with VA's three Administrations, released a redesigned Web site to provide more easily accessible information. Additionally, VBA launched pages on the social media sites Facebook and Twitter. Through these avenues, VBA can now release concise messages about benefits and services available to Servicemembers, Veterans, and their families. This also allows VBA to engage its clients in real time, with online conversations to better assist them.
Outcome/Metrics: As of August 2010, VBA had over 7,000 followers in over 20 countries.

VBA and DoD Joint Outreach
Target Audience: Veterans, Servicemembers, family members, and care providers
Description of Effort: Through deployment of the eBenefits Web portal, VBA and the DoD have fully embraced the recommendations of the Dole-Shalala Commission. The portal provides a single transparent access point to online benefits directly to

Servicemembers, Veterans, and their family members as well as care providers for the wounded, ill, and injured.
Outcome/Metrics: In 2010, the eBenefits portal was further enhanced to allow Servicemembers and Veterans to check the status of C&P claims and appeals, review payment history, obtain home loan certificates of eligibility, transfer educational entitlement, and request state benefit information. As enhancements continue, individual targeted outreach messages will be available for deliver.

Benefits Executive Council (BEC) Partnerships
Target Audience: Veterans, Servicemembers, and DoD
Description of Effort: VBA and the DoD coordinated through the BEC implementation of the eBenefits Web portal that allows users to receive targeted information regarding benefits and services relevant to their individual needs. Communication of VA and DoD benefits to Servicemembers throughout their military careers is coordinated within the BEC.
Outcome/Metrics: New accomplishments include placement of VA benefit information on leave and earning statements on the eBenefits Web portal as well as on military Web sites, social media outlets, and benefit video products.

Veterans Service Organization (VSO) Partnerships
Target Audience: VSOs
Description of Effort: To communicate outreach initiatives to VSO members and facilitate VBA ongoing weekly, monthly, and quarterly meetings.
Outcome/Metrics: N/A

US Army Warrior Transition Command
Target Audience: Army Veterans and their dependents
Description of Effort: In 2010, Benefits Assistance Service (BAS) assumed responsibility for supporting the US Army Warrior Transition Command, formerly known as the Warrior Care and Transition Office.
Outcome/Metrics: Through integration of personnel, BAS and OPPM provided training to over 1,100 Army nurse case managers, non-commissioned officer cadre, and approximately 180 Army wounded warrior advocates in 2009 and 2010.

Marine Corps and Marine Wounded Warrior Regiment (WWR)
Target Audience: Marine Corps Veterans and their dependents
Description of Effort: BAS works with the Marine Corps and Marine WWR to ensure that all severely injured Marines and their family members receive support as they transition back to active duty or into civilian life. By way of personnel integration, BAS staff is responsible for augmenting and integrating programs currently sponsored by the U.S. Marine Corps, WWR, the Marine for Life Injured Support Program, and other government entities. Additionally, the BAS staff assists the WWR in resolving inquiries through direct contact with VA personnel for quick results. Follow-up actions ensure benefits and services to Servicemembers, Veterans, and their families are provided in a responsive, timely, and compassionate manner. This successful program has ensured

that eligible beneficiaries receive disability compensation and health care benefits timely.
Outcome/Metrics: Through these partnerships, Servicemembers, Veterans, and their families and survivors are made aware of VA benefits while serving and after separation.

In-Service Outreach

VA Benefits
Target Audience: New Servicemembers
Description of Effort: VBA continues providing the VA Pamphlet 21-00-1, A Summary of VA Benefits, to anyone inducted into one of the five military branches through the Military Entrance Processing Stations. In addition, VBA distributes the pamphlet to graduates of the military service academies. These efforts ensure that inductees and graduates are aware of VA benefits and services for which they may become eligible during their service.
Outcome/Metrics: N/A

Servicemembers' Group Life Insurance (SGLI)
Target Audience: Servicemembers and their dependents
Description of Effort: Upon entering military service, military personnel inform the Servicemember about SGLI and family SGLI. Coverage for these benefits is automatic, unless declined by the Servicemember. SGLI Form 8286 also clearly summarizes VA insurance benefits available to Servicemember participants during and after service. At certain times during active duty--such as deployment--the DoD requires Servicemembers to thoroughly review their SGLI coverage and beneficiary designation.
Outcome/Metrics: N/A

Traumatic Servicemembers' Group Life Insurance (TSGLI)
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: TSGLI is automatic if a Servicemember has SGLI coverage. Each military branch has its own TSGLI claims processing office that conducts outreach at military medical conferences, unit commander trainings, etc. Each branch also has staff located at major military treatment facilities (MTFs) to personally assist injured Servicemembers in completing TSGLI claims. VA's VBA supplements these efforts by training TSGLI claims processing offices on the most up to date policies and procedures and has recently designed and released a Web-based training module to provide information to TSGLI stakeholders.
Outcome/Metrics: VBA staff is currently providing outreach to over 1,100 Servicemembers and Veterans identified through the Pentagon's medical records as being potentially eligible for TSGLI hospitalization benefits but having not yet applied. This important effort is designed to assist them in the application process.

Free Financial Counseling Service
Target Audience: Veterans, Servicemembers and their dependents

Description of Effort: VBA provides SGLI and TSGLI beneficiaries with information about the availability of free financial counseling with regard to benefits. VBA sends information on this benefit with the claim payment and follows-up at 120 days and then again at 1 year following payment. VBA is working to increase the frequency of the follow-up to 3, 6, 9, and 12 months after payment and develop outreach materials that are targeted to each demographic.
Outcome/Metrics: N/A

Transition Outreach

Transition Assistance Program (TAP) Reengineering
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: VA, the DoD, and the Department of Labor (DOL) have begun an end-to-end review process of the TAP to explore ways to enhance delivery to Servicemembers based on personalized transition goals and needs. Delivery will be through online resources and traditional methods. This will allow those already separated to review their TAP guidance materials online at any time.
Outcome/Metrics: N/A

TAP and Other Military Services Briefings
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: Currently, Servicemembers may participate in TAP and Army Career and Alumni Program workshops, which can range from 3 to 5 days in duration. During the workshops, which are conducted by the DOL and the DoD, VBA representatives provide briefings on VA benefits. Other transitional briefings include retirement briefings, separation briefings, pre- and post-deployment briefings for Reserve and National Guard members, and overseas briefings.
Outcome/Metrics: In FY 2009, over 8,600 briefings were provided to approximately 362,000 attendees. As of August 2010, approximately 277,000 Servicemembers attended over 6,300 briefings.

Disabled Transition Assistance Program (DTAP)
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: Provides Servicemembers with information about VA's VR&E program. The program is the first step to ensuring professional and personal success outside of the military for eligible Veterans with service-connected disabilities. Generally, DTAP is conducted in conjunction with TAP briefings.
Outcome/Metrics: During FY 2009, over 36,000 Servicemembers participated in 1,818 DTAP briefings around the world. There were 34,980 active duty personnel participating and 563 National Guard members and Reservists. As a result of these briefings, VR&E received 3,441 applications for benefits and services and 1,151 applications for educational/vocational counseling. The total applications received for both benefits represent a 10 percent Return On Investment (ROI). As of August 2010, approximately 29,000 Servicemembers participated in 1,354 DTAP briefings around the world. There were 27,656 active duty personnel participants and 513 participants from the National Guard and Reserve. As a result of the DTAP briefings thus far in FY 2010,

VR&E has received 2,278 applications for benefits and services and 651 applications for educational/vocational counseling. The total applications received for both benefits represent an 8 percent ROI.

Coming Home to Work (CHTW)
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: CHTW is part of VR&E's early intervention and outreach efforts to Servicemembers and Veterans. The primary purpose of this program is to establish contact with Servicemembers prior to discharge from active duty and with Veterans soon after discharge from active duty. CHTW outreach is provided at MTFs during Servicemembers' medical rehabilitation programs, DTAP sessions, VA's VHA medical facilities, Vet Centers, Post-Development Health Reassessment events, job fairs, and Welcome Home events.
Outcome/Metrics: In February 2008, the program expanded nationwide with 13 full-time Vocational Rehabilitation Counselors (VRCs) stationed at MTFs and a VRC in each regional office assigned as the point-of-contact for CHTW. CHTW provides access to all VR&E services and allows Servicemembers to begin thinking about future opportunities in the community and assists them with completing evaluation/planning activities before returning home. CHTW also coordinates with the receiving station to ensure a smooth transition and provides a seamless transition into the VR&E Program.

Pre-Discharge Outreach
The VBA Pre-Discharge Web site launched in June 2009. Posters and pamphlets were distributed along with other outreach materials to announce the new and improved pre-discharge programs available to Servicemembers who are within 180 days of separating from military service. Additionally, VA provides an easier way to file the pre-discharge claim with a new two-page application form (526c). The Joint BEC Benefits and Services Communications Working Group is in the process of developing an email system to notify Servicemembers approximately 1 year prior to discharge about both military and VA benefits and services using Defense Knowledge Online (DKO). This intranet system will eventually interface with VA's eBenefits and the emerging Virtual Lifetime Electronic Record. By leveraging DKO, VA can reach the entire fighting force--Active, Guard, and Reserve--via periodic, targeted emails on an as-needed basis. The site will also provide information on all Servicemembers' leave and earnings statements.

Benefits Delivery at Discharge (BDD)
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: VA established this initiative to provide seamless transition assistance and continuity of care to Servicemembers separating from active duty. Under the BDD Program, Servicemembers may begin the disability claims process through VA within 60 to 180 days of separation. VA and the DoD signed a Memorandum Of Agreement (MOA) in November 2004, establishing a Cooperative Separation Process/Examination under this program. The MOA stipulates that only one examination process is to be conducted and it will follow VA protocol and meet the requirements of VA and the DoD. BDD claims are now accepted at any intake site prior

to separation. Intake sites include all places that accept VA claims. Servicemembers unable to participate in the BDD Program may file a Quick Start claim.
Outcome/Metrics: Since 2006, the BDD outreach program has processed over 124,000 disability claims.

Quick Start
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: Quick Start is a joint VA/DoD initiative that was first introduced in July 2008 for Active Duty Servicemembers, National Guard members, and Reservists who are either within 1-59 days of separating from service or who do not meet BDD criteria thereby requiring availability to attend exams prior to leaving point of separation.
Outcome/Metrics: Eligible participants can submit Quick Start claims at any place that accept VA claims. Since 2008, Quick Start has processed over 55,000 disability claims.

Overseas Military Services Coordinator Program
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: Through the Overseas Military Services Coordinator (OMSC) Program, VBA places employees at military installations to support ADSMs stationed overseas. These employees serve temporary assignments to provide TAP, DTAP, and other transition briefings on VA benefits at military installations in Germany, the United Kingdom, Italy, Okinawa, and mainland Japan. Additionally, they provide transition briefing coverage in Belgium, the Netherlands, Spain, Portugal, Turkey, and Bahrain. OMSCs are available for personal interviews following their briefings and maintain office hours for one-on-one interviews.
Outcome/Metrics: In FY 2009, OMSCs participated in 698 outreach activities at approximately 60 different overseas locations. Of these outreach activities, 428 were TAP briefings and 148 were DTAP briefings and, combined, they reached 15,279 attendees, which included Servicemembers, family members, and other interested parties. Year-to-date for FY 2010, OMSCs participated in 446 outreach activities at over 50 locations. Of these outreach activities, 298 were TAP briefings and 94 were DTAP briefings and, combined, they reached 13,670 attendees.

Transition Case Management
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VBA has continued deploying benefit counselors at key MTFs where severely injured OEF/OIF Servicemembers are most frequently sent. These counselors work with designated regional office coordinators to seamlessly and expeditiously process claims from each seriously disabled OEF/OIF Servicemember or Veteran. Regional office and out-based counselors also participate in ongoing monthly conference calls, local partnerships, and community outreach events. VA social workers assist by coordinating the transfer of Servicemembers or Veterans from major MTFs to the VA medical center closest to their home of record or most appropriate for specialized services required as a result of their medical condition.
Outcome/Metrics: N/A

OEF/OIF Outreach
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: OEF/OIF coordinators at each VA Regional Office are responsible for tracking cases, participating in monthly conference calls, and providing outreach services.
Outcome/Metrics: As of August 2010, over 6,700 hours of outreach were designated for OEF/OIF Veterans and 76,606 Veterans were reached. These outreach events resulted in the submission of 2,055 claims.

Outreach to National Guard/Reserve
Target Audience: Veterans, National Guard/Reserve members, and their dependents
Description of Effort: In 2009 and 2010, VBA continued its important partnership with the National Guard. In May 2005, VA and the National Guard Bureau (NGB) signed a national MOA outlining their combined effort to identify and resolve problems and improve communication and information about VA benefits. As additional National Guard Reservists are activated and deployed and others redeployed to Southwest Asia, VA, in partnership with the DoD, has continued to conduct retirement, health care services, and benefits briefings at town hall meetings and for Family Readiness Groups. VA also conducts these briefings during unit drills near the homes of returning National Guard/Reserve Servicemembers. There is a continual emphasis on developing and maintaining regional and local partnerships among VA leaders, National Guard Adjutant Generals, and Directors of State Departments of Veterans Affairs. These important partnerships enhance access and services to Veterans and provide an avenue for sharing information about VA benefits and services through coalition meetings. VBA continues to actively support NGB to help train and support their Transition Assistance Advisors (TAAs, formerly called state benefits advisors). VBA has provided annual training to this group since the inception of the program and participates in the TAA monthly conference calls by having experts present information on specific topics and provide benefit updates.
Outcome/Metrics: TAAs serve all 50 states and four territories and serve as statewide points of contact and coordinators. Additionally, TAAs advise National Guard members and their families on VA benefits and services and assist in resolving problems with VA health care, benefits, and TRICARE.

Physical Examination Board List
Target Audience: Veterans, Servicemembers and their dependents
Description of Effort: VA and the DoD are collaborating to ensure VA is notified when Servicemembers who may be medically separated or retired and transitioning to VA and civilian life are referred to the Physical Examination Board (PEB). Under this initiative, the DoD provides VA with the names of Servicemembers entering the PEB process.
Outcome/Metrics: The monthly list enables VBA to contact Servicemembers who have not yet applied for disability compensation to ensure they are aware of VA benefits.

Integrated Disability Evaluation System
Target Audience: Veterans, Servicemembers and their dependents

Description of Effort: Integrated Disability Evaluation System (IDES) is a program VA and the DoD developed to reduce the overall time it takes a Servicemember to progress from referral to Medical Evaluation Board (MEB) to recipient of VA benefits. IDES is designed to close a critical gap where participants undergo a single examination and receive a single disability evaluation, which is binding on both agencies. IDES is currently operating at 27 military installations and VA maintains representatives at each. Military Service Coordinators (MSCs) serve as liaisons regarding VA benefits for the Servicemember and their family throughout the IDES process. During an initial interview, MSCs provide an overview of VA benefits and direct Servicemembers toward any other necessary information and resources. If a Servicemember is determined unfit for duty, MSCs will discuss all benefits and entitlements that the Servicemember may be entitled to as a Veteran.
Outcome/Metrics: IDES currently covers 47 percent of all Servicemembers who are undergoing disability evaluations. VA and the DoD plan to expand IDES worldwide to cover all Servicemembers referred to MEB by end of FY 2011.

Veteran Outreach Activities

Veterans Assistance at Discharge System (VADS)
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VBA enhances outreach efforts to all recently separated or retired active duty members (including National Guard/Reserve Servicemembers). VADS mails the "Welcome Home Package" that includes a letter from the Secretary, VA Pamphlet 21-00-1, and VA Form 21-0501, Veterans Benefits Timetable, to all recently separated or retired active duty members (including National Guard/Reserve Servicemembers). VADS generates a second mailing to the same Veterans that includes a 6 month follow-up letter and a summary of benefits information letter with similar information. The mailings contain specific information on VA benefits, including education. In addition, at the time of discharge, VADS sends a list of all recently discharged Veterans who were covered by SGLI to VBA's Insurance Service.
Outcome/Metrics: As of February 2010, VADS has sent over 73,000 VADS "Welcome Home Packages" to recently separated or retired Servicemembers.

First-Time Applicants
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VBA ensures all Veterans and beneficiaries are informed of other potential benefits when they submit an initial application for any VA benefit. VA Form 21-0760, *VA Benefits in Brief*, is included with all acknowledgment letters for compensation and pension claims, education claims, and insurance benefits. This includes special instructions for VR&E applicants. VBA identifies family members of deceased Veterans for separate, special outreach. Regional offices mail VA Pamphlet 21-03-1, VA Benefits for Survivors, to potentially eligible dependents who submit VA Form 21-2008, an application for a United Stated Flag for Burial Purposes.
Outcome/Metrics: Over the past 2 years, VBA has received approximately 927,000 burial flag applications.

BAS Outreach
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: The BAS, along with OPPM and the Office of Field Operations (OFO) conducts activities to meet VBA's strategic outreach needs and perform client-service activities. BAS supports all VBA services, staff members, and regional offices. BAS assumed primary responsibility for VBA's significant outreach efforts and has national program managers who assist and guide the regional offices' outreach coordinators. VBA has national program managers for the following targeted groups: Former Prisoners of War (FPOWs), homeless Veterans, women Veterans, elderly Veterans, and minority Veterans, and military Servicemembers and survivors. BAS staff members work closely with the DoD, the DOL, the Department of Homeland Security, and the Social Security Administration (SSA) to enhance the effectiveness of VBA's wide range of outreach efforts and reach the many varied targeted groups. VBA outreach personnel continuously liaison with national organizations to provide information about VA benefits for their members and the public.
Outcome/Metrics: N/A

Homeless Veterans
Target Audience: Homeless Veterans and their families, VA stakeholders
Description of Effort: VBA fully supports Secretary Shinseki's Five-Year-Plan to End and Prevent Veteran Homelessness. Each regional office has a designated Homeless Veterans Outreach Coordinator (HVOC) to provide benefit information and services to homeless Veterans and Veterans at risk of becoming homeless. In accordance with Public Law (PL) 107-95, 20 regional offices have full-time HVOCs, based on the Veteran population in those jurisdictions. The other VA Regional Offices (VAROs) have part-time HVOCs. HVOCs conduct outreach at homeless stand-downs and shelters, prisons and jails, and other areas where they may find homeless Veterans and those at-risk of becoming homeless. In November 2009, VBA attended the Homeless Veterans Summit in Washington, DC. The Summit signaled the beginning of Secretary's Shinseki's campaign to end Veteran homelessness in 5 years. Attendees included 1,300 VA clinicians and health care specialists, representatives from federal agencies, and 12 representatives from VBA. The national program manager facilitates monthly conference calls to inform HVOCs of changes to laws, regulations, and requirements. Guest speakers from VHA's homeless Veterans programs, the Center for Women Veterans (CWV), and the DOL's Veterans Employment and Training Service Program have assisted in providing important information to aid HVOCs in their outreach efforts. Due to the critical human element, VBA mandates that all homeless claims be expedited. HVOCs manage and monitor homeless Veterans' claims in their jurisdiction to ensure compliance with this mandate. In addition, the Homelessness Veterans Reintegration Program offers community grants to prevent homelessness from occurring. Primarily focused on those returning from the wars in Afghanistan and Iraq, the Department of Housing and Urban Development (HUD) and VA announced an investment of $15 million in five selected communities near military installations. This grant fund is intended to provide housing assistance and supportive services to Veterans who might otherwise be living in homeless shelters or on the streets. Finally, in October 2009, VA announced that 19 states, Washington DC, and Puerto Rico would

share more than $17 million in grants to community groups to create 1,155 beds for homeless Veterans.
Outcome/Metrics: Nationally, VBA maintains close oversight of this complex process, which resulted in an increased number of claims processed. Over the past 2 years, regional offices have processed 12,584 homeless claims. VBA's HVOCs collaborate with VHA's homeless program case managers and coordinators; and with VHA's Veteran justice outreach specialists in the courts, prisons, and jails to ensure all identified homeless Veterans receive information on benefits and procedures for applying when eligible. Annually, VBA's national program manager and selected HVOCs attend the National Coalition for Homeless Veterans (NCHV) Annual Conference in Washington, DC.

Casualty Assistance--In-Service Deaths
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: Regional Office Casualty Assistance Coordinating Officers (CACOs) visit surviving family members of military Servicemembers who die while on active duty. These visits are coordinated with military Casualty Assistance Officers. VA CACOs ensure that family members are aware of all VA benefits and services and assist them with applying for benefits. In FY 2009, CACOs provided outreach to the survivors of 303 OEF casualties, 143 OIF casualties, and 2,470 non-combat casualties. During FY 2009, VBA widely distributed the new fact sheet, 21-02-1, Benefits and Services for Survivors of Servicemembers Who Die on Active Duty. The two-page document is included in the DoD binder that Military One Source provides titled "The Days Ahead." This binder is provided to deceased Servicemembers' immediate next of kin. VBA supports this important effort by providing ongoing casualty assistance training and briefings to beneficiaries. Over the past two years, VBA's outreach personnel provided briefings and training sessions to the U.S. Marine Corps and the U.S. Coast Guard. VBA's national program manager assisted with the establishment of VA's Office of Survivor Assistance during FY 2009.
Outcome/Metrics: VBA's national program manager attended the annual congressional luncheon hosted by the Gold Star Wives in FY 2009. VBA and the DoD are joint sponsors of a quarterly survivors forum, which has 42 active members representing 18 organizations and agencies with a vested interest in survivors and survivor benefits. The BAS assistant director is a member of the Casualty Advisory Board (CAB), which meets quarterly to discuss how to work together to assist surviving family members. The program manager performs duties as an alternate. CAB members include individuals from the DOD, VA, and each branch of service; and DoD civilian personnel.

Elderly Veterans Outreach (EVO)
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VBA has designated an Elderly Veterans Outreach Coordinator (EVOC) at each VA Regional Office to conduct outreach to elderly Veterans and surviving spouses. EVOCs participate in outreach events at senior centers, assisted living facilities, nursing homes, and other locations where aging Veterans may be present. VBA's national program manager moderates conference calls every other

month to provide the EVOCs with new or revised laws, regulations, and requirements. The calls often include subject matter experts from different organizations to assist the EVOCs. Previous speakers have been from VHA's Geriatrics and Extended Care Unit and the National Council on Benefits Enrollment and Outreach (NCBOE). In months when conference calls are not conducted, the EVO program manager releases a newsletter with updates, reminders, and information on the program. The national program manager also participates in events that address the elderly Veteran and surviving spouse population. During the last 2 years, events included the United States Department of Agriculture's Aging Conferences in Washington, DC, and a Senior Information Fair. Additionally, the program manager participates in the NCBOE Advisory Group with other government and non-profit organizations who assist aging Americans. The Advisory Group allows multiple groups and organizations to collaborate in developing new ways and defining best practices on providing benefits and services to the elderly, including Veterans. In an effort to collaborate with other government organizations, VBA continues to provide VA benefits pamphlets in SSA offices nationwide and ensures SSA outreach material is available at all VAROs. Elderly Veterans are able to access information on SSA, VA, and other government benefits and services at either location.
Outcome/Metrics: In FY 2009, VBA conducted approximately 325 hours of outreach to elderly Veterans. The EVOCs have increased their outreach efforts to the aging Veteran population through informational tables, briefings, and one-on-one assistance. As of July 2010, outreach efforts have increased to 1,166 hours.

Women Veterans
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VBA has designated Women Veterans Coordinators (WVCs) at all regional offices, pension maintenance centers, and national call centers. WVCs conduct outreach and provide guidance on benefits and services to which women Veterans may be entitled. VBA representatives maintain cooperative relationships and continue to work closely with VA's program office, the Center for Women Veterans, VHA's Women Veterans Health Program, and the Secretary's Advisory Committee on Women Veterans to improve outreach to women Veterans. In August 2009, the Women Veterans program manager facilitated the first national training conference for VBA's WVCs in St. Paul, MN. The next conference is scheduled for 2011. In July 2010, representatives from BAS, including the Women Veterans program manager, participated in the 2010 Women Veterans Forum. BAS provided a subject matter expert and an information booth to address issues specific to women Veterans and provide general benefit information. In August 2010, a representative from BAS participated in the Veterans of Foreign Wars proficiency training in Indianapolis, IN. This training provided VSOs with a better understanding of the unique needs of women Veterans and was designed to foster a cooperative relationship between VSOs and VBA's WVCs.
Outcome/Metrics: In FY 2009, WVCs conducted 1,188 hours of outreach to women Veterans. The WVCs contacted 6,316 women Veterans and 7,348 other participants. These efforts generated 95 new claims for benefits from women Veterans. In addition, with the recent establishment of the Benefits Assistance Service Division, VBA's

outreach Intranet site will feature links to VA social media sites such as Facebook and Twitter that highlight women Veterans' issues.

Former Prisoners of War (FPOW)
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: There are approximately 15,030 FPOWs currently in receipt of compensation and pension benefits. Over 5,000 widows and widowers of FPOWs are also receiving VA benefits. Practically speaking, statistics show that World War II FPOWs are dying at a rate of 12-14 percent annually and Korean War FPOWs are dying at a rate of 8 percent annually. Each year the FPOW Program hosts two meetings of the Advisory Committee on Former Prisoners of War (ACFPOW). The ACFPOW advises VA's Secretary on the needs of FPOWs in the areas of service-connected compensation, health care, and rehabilitation. Annual meetings are held in the spring and fall. The spring meeting is held in Washington, DC, while the fall meeting location varies from year to year.
Outcome/Metrics: During FYs 2009 and 2010, VBA targeted outreach to FPOWs and their families through mass mailings, conferences, and town hall meetings. In June 2010, BAS staff and field station employees participated in the annual Rolling Thunder event in Washington, DC to honor FPOWs. VBA staffed an information booth to provide general benefit information and support during the event.

Minority Veterans Outreach
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VBA designated a Minority Veterans Program Coordinator (MVPC) at each VA Regional Office to conduct important outreach to minority Veterans. MVPCs provide support and outreach to this community of Veterans including Hispanic, Asian American, Pacific Islander, African American, and Native American Veterans. MVPCs conduct speaking engagements, provide VA benefits briefings, and conduct personal interviews. The MVPCs have a comprehensive knowledge of VA programs and attend town hall meetings to provide outreach to minority Veterans. MVPCs act as liaisons with federal, state and local agencies and community stakeholders and service providers to increase minority Veterans' awareness and respond to their unique needs Veterans. VBA is a sponsor of the Center for Minority Veterans' MVPC biennial conference. In June 2009, the MVPC conference was held in Atlanta, GA, and the next conference will be held in June 2011 in San Antonio, TX. VBA has also participated in outreach activities at non-traditional venues like the Tuskegee Airman National Convention (FYs 2009 and 2010) and the Nation Black Family Reunion (FY 2010).
Outcome/Metrics: In FY 2010, VBA is on track to achieve a 4 percent increase in the total number of targeted minority outreach hours. This increase will be a measurable indicator that minority Veterans are receiving equal access to benefits knowledge and services.

Foreign Service Program
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VBA ensures benefits information and assistance are available to Veterans and their families at American embassies and consulates worldwide

through the Federal Benefits Program. Foreign Service Nationals (FSNs) from various countries provide VA benefits information to our Veterans and their families living overseas. In conjunction with the SSA and the Department of the State, VBA provides annual benefits training to FSNs at the G.H. Fallon Federal Building in Baltimore, MD.
Outcome/Metrics: N/A

Compensation and Pension Service Outreach

Project 112/Shipboard Hazard & Defense (SHAD)
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: Between 2002 and 2007, VBA mailed outreach letters to 4,243 Veterans the DoD identified as having been exposed to shipboard hazards during tests conducted in the 1960s and early 1970s.
Outcome/Metrics: At this time, VBA has mailed outreach letters to all identifiable SHAD participants.

Chem-Bio Exposures
Target Audience: Veterans and their dependents
Description of Effort: As of August 2010, the DoD database contained 16,647 Chemical Biological Radiological Nuclear Explosive (CBRNE) records, 8,556 of which are complete enough for identification. VBA mailed notification letters to 3,291 of these test participants. In April 2010, VBA received an updated list from DoD and is currently working with the Internal Revenue Service to identify records that contain a social security or serial number.
Outcome/Metrics: Additional identification efforts are ongoing with the remaining 3,200 records, which do not contain identity-confirming information.

Mustard Agents and Lewisite (Mustard Gas)
Target Audience: Veterans and their dependents
Description of Effort: The DoD's database contains the names of 4,495 Mustard Gas research participants. Of those participants, the DoD was able to confirm that 2,157 are deceased. Since June 2008, the DoD has mailed 371 letters to the remaining presumed living Veterans and 118 letters to surviving spouses.
Outcome/Metrics: As of August 2010, there have been no additions to this database.

Agent Orange Fast Track Program and Presumptive Change Outreach
Target Audience: Vietnam Veterans and their families
Description of Effort: Well over 100,000 Veterans exposed to herbicides while serving in Vietnam and other areas will have an easier time qualifying for disability pay under a new regulation that adds three new entries to the list of illnesses found to be related to Agent Orange and other herbicide exposures. The illnesses are B-cell leukemia 9 (such as hairy cell leukemia), Parkinson's disease, and ischemic heart disease. The new rule will bring the number of illnesses presumed to be associated with herbicide exposure to 14.

Outcome/Metrics: Veterans who served in Vietnam and who have a "presumed" illness do not have to prove an association between their illnesses and their military service. This "presumption" simplifies and speeds up the benefits application process.

Amyotrophic Lateral Sclerosis
Target Audience: Veterans and their dependents
Description of Effort: VA established a presumption of service connection for Amyotrophic Lateral Sclerosis (ALS) for any Veteran who served at least 90 days of continuous active military service and who develops the disease at any time after separation from service. ALS (also called Lou Gehrig's disease) is a neuromuscular disease that affects about 20,000 to 30,000 people of all races and ethnic backgrounds in the United States. ALS is often relentlessly progressive and almost always fatal. VA based their decision to establish the presumption primarily on a November 2006 report by the National Academy of Sciences Institute of Medicine. The final regulation was published on September 23, 2008, at which time VA also issued a press release announcing the decision.
Outcome/Metrics: VA subsequently sent outreach letters to Veterans who may have been diagnosed with ALS or were denied for a previous ALS claim.

Traumatic Brain Injury (TBI)
Target Audience: Veterans, Servicemembers, and their dependents
Description of Effort: VA published a final rule revising the disability rating criteria for determining the severity of TBIs in Veterans on September 23, 2008, with an effective date of October 23, 2008.
Outcome/Metrics: VA sent outreach letters to approximately 32,000 Veterans identified as having a service-connected TBI as of April 2009. The letters invited Veterans to file claims with their regional offices asking to be reevaluated under the new rating criteria.

Atomic Veterans
Target Audience: Veterans and their dependents
Description of Effort: The Veterans Advisory Board for Dose Reconstruction recommended that VA provide outreach to Veterans with confirmed ionizing radiation exposure of five rems or greater as a result of participation in atmospheric nuclear testing between 1945 and 1962.
Outcome/Metrics: VA concurred with this recommendation and, in June 2009, sent letters to approximately 667 Veterans advising them of diseases that are presumed to have resulted from exposure to ionizing radiation. They sent Veterans information on how to file a claim for disability benefits and for how to enroll in VA's Ionizing Radiation Registry.

Insurance Service Outreach Veterans' Group Life Insurance (VGLI)
Target Audience: Servicemembers, Veterans and their dependents
Description of Effort: VBA provides a series of three staggered mailings to all separating Servicemembers who had Servicemembers' Group Life Insurance (SGLI) coverage informing them of their ability to convert their SGLI coverage to VGLI. VBA

sends two mailings within 120 days of separation to alert Veterans of their ability to convert their coverage without any health review during the 120-day period immediately following separation. VA sends a final letter 1 year after separation giving Veterans a final notice of their ability to convert their coverage before 1 year and 120 days after separation when their eligibility for VGLI is scheduled to end. From July 2008 through June 2009, over 190,000 separating Servicemembers were sent VGLI conversion mailings.
Outcome/Metrics: These mailings include clear and concise information about the SGLI disability extension and spousal conversion of family SGLI coverage. VGLI members are also able to use a new "web chat" service to ask questions about their coverage with a staff member in real time online.

Free Financial Counseling Service
Target Audience: Servicemembers, Veterans and their dependents
Description of Effort: VBA provides VGLI beneficiaries with easy to understand information about free financial counseling available to assist them in how to use their benefits. VBA sends information on this benefit with the claim payment and then follows up at 120 days and 1 year following payment. VBA is working to increase the frequency of the follow up to 3, 6, 9, and 12 months after payment and develop demographic–specific materials.
Outcome/Metrics: N/A

Special Outreach for Severely Disabled
Target Audience: Servicemembers, Veterans and their dependents
Description of Effort: VBA provides information to separating Servicemembers who incurred severe disabilities while serving about their potential eligibility for the SGLI disability extension, as well as for VGLI, Traumatic SGLI, Service Disabled Veterans Insurance, and Veterans' Mortgage Life Insurance. All separating Servicemembers with military disability ratings of 50 to 100 percent and OEF/OIF Veterans with unemployability ratings 50 to 100 percent (who separated from service within the last 2 years) who have not already taken insurance through SGLI's other outreach efforts or applied for VGLI or the SGLI disability extension are targeted for additional outreach. VA Insurance contacts these Veterans personally via telephone to inform them of their insurance benefits and assist them in applying for coverage.
Outcome/Metrics: As a result of an independent study of insurance outreach efforts promoting VGLI conversion, VBA will expand its outreach efforts in early 2011. This expanded effort will target a larger audience, based on military or VA rating conditions that impact insurability instead of rating percentage alone. This will substantially increase the number of Veterans VBA is reaching.

Service-Disabled Veterans Insurance (S-DVI)
Target Audience: Servicemembers, Veterans and their dependents
Description of Effort: This outreach program provides information about the 2 year eligibility period for service-connected Veterans. Information on the benefit and the application form are mailed to Veterans who have been approved for new service-related disabilities.

Outcome/Metrics: N/A

Veterans' Mortgage Life Insurance (VMLI) and Specially Adapted Housing (SAH)
Target Audience: Servicemembers, Veterans and their dependents
Description of Effort: This program provides information to certain Veterans about their eligibility for VMLI. Veterans who are eligible for an SAH grant are eligible for VMLI coverage. Computer matches identify eligible Veterans who Veterans are then sent information about the VMLI Program. The goal is to ensure that every eligible Veteran is aware of the program and has the opportunity to apply for coverage.
Outcome/Metrics: N/A

General Outreach
Target Audience: Servicemembers, Veterans and their dependents
Description of Effort: VBA's insurance program responds to Servicemembers' and Veterans' inquiries it receives by letter, telephone, or email. The program also maintains a Web site and a toll-free service to answer questions from enrolled Servicemembers, Veterans, and their families and has developed an outreach brochure, *Plan Today, Protect Tomorrow*, which discusses all VA insurance programs. The brochure is provided to separating Servicemembers and Veterans as part of TAP, DTAP, and other VA Regional Office briefings. In cooperation with the DoD, Insurance is also finalizing a program-wide communications plan to ensure comprehensive outreach to key stakeholders for all of its programs. Insurance will be hiring a specialized staff member to oversee the plan, develop communications, and ensure placement in military and Veteran media. Insurance has developed an electronic newsletter that provides information about VA insurance benefits to those who subscribe. Policyholders and members of all of the VA Insurance programs receive an annual statement or newsletter outlining the current status of their policy and informing them of any new or enhanced benefits being offered.
Outcome/Metrics: VA improved outreach activities after analyzing client feedback obtained from monthly, random surveys. Insurance forms and publications are tested for readability with focus groups consisting of Veterans and Servicemembers before they are finalized.

Vocational Rehabilitation and Employment (VR&E) Service Outreach
Target Audience: Servicemembers, Veterans, and their dependents
Description of Effort: As college is not for everyone, VA's VR&E is committed to providing early outreach and intervention to Servicemembers and Veterans for vocational rehabilitation and employment. VR&E is involved in several outreach activities including the DoD's YRP, Post-Deployment Health Reassessment (PDHRA) Program, CHTW, the Chapter 36 Program, and DTAP. VR&E has also partnered with many federal, private, state, and local employment agencies; and continues its partnership with faith-based and community organizations to increase program awareness.
Outcome/Metrics: N/A

Home Loan Guaranty Service Outreach
Target Audience: Servicemembers, Veterans, and their dependents
Description of Effort: VA's highly successful Loan Guaranty personnel reach out to Servicemembers and Veterans through training and information provided by financial stakeholders who provide home loans to Servicemembers and Veterans. Loan Guaranty personnel provide training via conferences, broadcasts, seminars, and briefings; and net meetings to local lenders, appraisers, real estate agents, and mortgage servicers.

In addition, they hold Information sessions with industry partners, the Mortgage Bankers Association, Fannie Mae, Freddie Mac, Ginnie Mae, the National Association of Realtors, and the National Association of Mortgage Brokers; and other government agencies, including the Federal Housing Administration and Rural Housing Service. Loan Guaranty conducts direct outreach to Servicemembers and Veterans through information sessions at DoD sites, homebuyer fairs, and HUD home buyer events. They also meet with seriously injured Servicemembers and their families at Walter Reed Army Medical Center to explain the SAH Program and other home loan benefits; hold information sessions with Native American Veterans, Tribal Veteran Representatives (TVRs), and other tribal officials about VA Native American Direct Loan Programs; and make briefings and presentations to Veterans Service Officers (VSOs), VHA and VBA OEF/OIF staff, and VBA customer service representatives.

Finally, they participate in panel discussions and distribute program information to representatives from national and local industries, VSOs, and County Veterans Service Officers. VBA conducts outreach mailings to individuals who recently obtained VA home loans and Servicemembers separating from active duty. The mailings provide Servicemembers and Veterans with information regarding VA assistance available to those who experience financial hardship and become unable to maintain their mortgage payments. Loan Guaranty responds to Servicemembers' and Veterans' inquiries they receive by letter, telephone, and e-mail and the office maintains a Web site (http://www.benefits.va.gov/homeloans/). Loan Guaranty produces and posts to this site a number of informational short videos directed at Veterans and recently targeting severely injured Veterans and Servicemembers who may be eligible for the SAH grant program, current or recent deployed Veterans and Servicemembers experiencing difficulty making mortgage payments, and those who need to be informed of their rights under the Servicemembers Civil Relief Act (SCRA), and of the options to avoid foreclosure that may be available from their loan servicers.

Loan Guaranty also has a robust loan-servicing program that requires VA-guaranteed loan holders to extend every reasonable forbearance to Veterans experiencing financial difficulty in maintaining their house payments. Even with the nation's long standing housing crisis, VA has helped over 107,000 Veteran home owners avoid foreclosure since 2002 because of VA's home mortgage program which has the lowest foreclosure and default rates of any mortgage system in America. VA guarantees nearly 1.3 million individual home loans with an unpaid balance of $175 billion. In 2008, VA promulgated

extensive regulatory changes to incentivize holders to arrange extended repayment plans on delinquent loans, to set up special forbearance agreements, or to modify loans to provide Veterans with fresh starts. Additionally, VA reviews all loans prior to foreclosure to be sure that the holders have provided adequate service, and VA initiates contact with Veterans to offer counseling and intervention with holders when appropriate. VA has a national toll-free number (1-877-827-3702) for Veterans to call for home loan assistance and provides counseling to Veterans whose loans are not guaranteed by VA, even though VA has no authority to intercede with the loan holders in those cases. Loan Guaranty also takes advantage of the Department's presence on Facebook, Twitter, and YouTube by posting relevant information and videos about the program.
Outcome/Metrics: N/A

Education Service Outreach
Target Audience: Servicemembers, Veterans, and their dependents
Description of Effort: In an effort to ensure that information about VA Education Benefits is made widely available, Education actively participates in national events held for congressional, military, Veteran, or higher education personnel. These events provide an opportunity for personalized contact and help ensure we meet the needs of all our customers. In FYs 2009 and 2010 Education employees participated in approximately 84 national, regional, and local events. Their role(s) included staffing information booths, giving presentations about education benefits, or participating in town hall type meetings. Some of these events included the Student Veterans of America Conference, the American Legion National Conference, the Congressional Black Caucus Veterans Braintrust Forum, and the U.S. Coast Guard College Education Fair. VA is second only to the Department of Education in providing educational benefits of $9 billion annually.
Outcome/Metrics: In addition, Education conducted nationwide outreach campaigns in FYs 2009 and 2010 to raise awareness about the Post-9/11 GI Bill.

Post-9/11 GI Bill
Target Audience: Servicemembers, Veterans, and their dependents
Description of Effort: In FY 2009 VA began a robust outreach campaign to make sure Servicemembers, Veterans, and their families knew about the Post-9/11 GI Bill and how to apply for the benefit. In February 2009, VA launched a 2-month, nationwide advertising campaign to assist student Veterans and Servicemembers applying for this benefit. The GI Bill advertising campaign included half-page ads in top college publications and online and social media; and print, radio, and outdoor advertising (such as posters and flyers). In addition, the Department delivered public service announcements on approximately 150 college radio stations and 750 local stations in areas with high numbers of students, as well as military installations; and placed Veterans posters in registrars' offices, dormitories, cafeterias, student union buildings, and other high-traffic areas. This comprehensive advertising campaign assisted VA in reaching student Veterans, Servicemembers, and educational administrators who needed help understanding the Post-9/11 GI Bill and their role in the benefits process. Finally, VA employed social media and online advertising to reach the younger

generation of student Veterans by placing banner ads on social media sites such as Facebook, Google, MySpace, and Yahoo. VA sent letters and notices to university presidents, school certifying officials, State Veterans Affairs Directors, VSOs, members of Congress, and other education stakeholders highlighting the importance of timely submission of school enrollment information. To date, VA has issued over $4.4 billion in Post-9/11 GI Bill benefit payments for more than 317,000 Veterans with service after 9/11/2001 who are enrolled in school. The Post-9/11 GI Bill fully covers the costs of Veterans' educational programs at all in-state public institutions of higher learning, as well as provides a monthly housing allowance and stipend for books and supplies.

VA also expanded its VetSuccess Campus Pilot program to two community colleges and three other four-year colleges and universities. VA counselors will help Veterans attending school under the Post-9/11 GI Bill make the most of their educational opportunities at Salt Lake City Community College, the Community College of Rhode Island, Rhode Island College, Arizona State University, and Texas A&M University. Under the pilot program already underway at the University of South Florida, Cleveland State University, and San Diego State University, experienced VA vocational rehabilitation counselors and outreach coordinators form VA's Vet Centers are assigned to campuses to provide vocational testing, career and academic counseling, and readjustment counseling services to ensure Veterans receive the support and assistance needed to successfully pursue their educational and employment goals.

Finally, in FY 2010, VA began a national campaign to increase overall awareness of and access to VA education programs, emphasizing the Post-9/11 GI Bill portion of the program and providing eligible participants with clear and easily accessible information through the VA GI Bill Web site; and print, Web, and video advertising. Some of the principal features of the FY 2010 fall campaign were establishing a basic strategy and a plan with a single cohesive message (branding) and pathway to the GI Bill Web site, revamping the Web site, targeting the message to direct customers (Veterans and Servicemembers), reaching advertising visibility targets of 20 percent for national general awareness and 80 percent for our direct customers, and enhancing existing social media platforms with campaign material. VA placed ads highlighting the Post-9/11 GI Bill in print and Web outlets (such as GIJobs.com and Military.com) to reach eligible participants and influencers like higher education personnel and in magazines such as Marine Corps Times and Chronicle of Higher Education. In addition, VA partnered with NASCAR and TRG Motorsports to increase awareness of the bill and placed the bill's new logo and Web address on the rear panel (TV Panel) of Bobby Labonte race car for the Coca-Cola 600 during one Memorial Day weekend. The Coca-Cola 600 was broadcast Sunday, May 30, 2010, on the Fox Network; and the Speed Channel broadcast the practice sessions live on Saturday, May 29, 2010. Finally, VA mailed all colleges and universities to advise them of the major provisions of the Post-9/11 GI Bill, most specifically the YRP. The YRP allows a school to enter into an agreement to pay tuition and fee expenses not covered by the Post-9/11 GI Bill. VA also worked closely with national organizations representing colleges and universities to provide them with information and training about the new GI Bill Program. VA continues

to provide information at VSO meetings, Department of Education student financial aid regional and national conferences, and Student Veterans of America meetings.
Outcome/Metrics: VA's ROI for participating in NASCAR was positive. An estimated 6.5 million people watched the race; 165,000 attended the race; and approximately 700,000 people deployed overseas watched and listened to the race broadcast over the Armed Forces TV and Radio Network. Hits to the GI Bill Web site increased by 29 percent the day before the race and 34 percent during the race. Additional coverage of the race mentioning the Post-9/11 GI Bill was also in USA Today and the New York Post; and on NASCAR.com, Motorsports.com, Twitter, and Facebook. In August 2010, VA entered into more than 3,200 agreements with over 1,100 schools for the upcoming academic year under the YRP.

Post-9/11 GI Bill and Montgomery GI Bill Mailings
Target Audience: Servicemembers, Veterans, and their dependents
Description of Effort: Benefit information about the Post-9/11 GI Bill and Montgomery GI Bill is mailed to Servicemembers upon enlistment. The information is sent again to those who complete 12 and 24 months of active duty, respectively. These mailings also include information about other VBA programs. VA also sends annual reminders and information to continuously encourage school participation in the YRP. Based on our annual outreach efforts, VA anticipates an increase in participation each year, which should result in additional training options for Veterans and their families.
Outcome/Metrics: N/A

Partnership with State Approving Agencies
Target Audience: Servicemembers, Veterans, and their dependents
Description of Effort: Education partnered with State Approving Agencies (SAAs) to ensure institutions of higher learning and training establishments understood VA education benefit programs and could easily and effectively assist Veterans who elect to attend their institutions while receiving benefits. Education shared all outreach materials produced on the benefits and provided training at the National Association of State Approving Agencies (NASAA) conferences. In addition, VBA coordinated regularly with NASAA to provide information to schools concerning their role in the benefit process.
Outcome/Metrics: N/A

VA's Veterans Health Administration (VHA) Outreach

VHA OEF/OIF Outreach Office Overview
The mission of VHA outreach is to increase access to VA health care and benefits by optimizing links to VA services for all new Veterans through targeted programs throughout the three stages of deployment. The Office of Outreach has seven ongoing initiatives that are strategic and proactive programs that have shown an increase in enrollment and use of VA health care for former Active Duty, National Guard members, and Reservists. These programs have changed the face of VA in terms of how to interact with Veterans by engaging Veterans and their families in face-to-face interviews encounters to deliver the One-VA message within the first 6 months of returning home

and as they separate from service. The so-called Seven Touches of Outreach are: 1) Demobilization Initiative, 2) Individual Ready Reserve Muster (IRR), 3) Combat Veteran Call Center, 4) Yellow Ribbon Program (YRP), 5) Post-Deployment Health Reassessment, 6) Transition Assistance Advisors, and 7) OEF/OIF Internet Web page.

Reserve Component (RC) Demobilization Initiative at 63 Demobilization Sites
Target Audience: Reservists and National Guard Component Servicemembers
Description of Effort: In May 2008, the VHA Outreach Office initiated a program to inform demobilizing RC combat Veterans of their enhanced VA health care and dental benefits during their mandatory separation briefings. The program assists with the completion of enrollment forms for VA health care. Servicemembers returning from the combat zone are introduced to VA during the out processing period at demobilization sites and receive a standard 46-minute briefing on VA services and benefits and are encouraged to enroll in VA health care as soon as possible. All members leave with the name of their local OEF/OIF program manager who will help set up their initial health and dental appointments at the closest VA Medical Center (VAMC). As of October 2009, this program has been implemented at 15 Army, 4 Navy, 5 Marine Corps, 36 Air Force, and 3 Coast Guard Reserve demobilization sites. In collaboration with VBA and VHA's Readjustment Counseling Services, the VHA OEF/OIF Outreach Office has developed a standardized presentation and VA staff provides educational materials to all new Veterans.
Outcome/Metrics: Since May 2008, VA has reached out to 126,860 Veterans and enrolled 118,027 of them in the VA health care system.

IRR Muster for United States Marine Corps, Air Force Reserve, Navy, and United States Army Reserve Veterans
Target Audience: Reserve and National Guard Component Servicemembers and their families
Description of Effort: In May 2009, the VHA Outreach Office initiated a program to inform IRR Army Reserve soldiers; and Navy, Air Force, and Marine members of their enhanced VA health care and dental benefits during their mandatory annual IRR Muster. Previous active duty members who are in the IRR are also introduced to VA during this event. VA staff provides a 20-minute brief on its services and benefits and offers assistance with associated enrollment forms. VA encourages 100 percent enrollment of all those attending the IRR Muster. All members leave the IRR Muster with the name of the local OEF/OIF program manager who will help them set up their initial health and dental appointments at the VAMC nearest their home.
Outcome/Metrics: Through this initiative, VA has reached out to 19,602 members and enrolled 5,785.

Post-Deployment Health Reassessment (PDHRA) Initiative for the Reserve Components
Target Audience: Reserve and National Guard Component Servicemembers
Description of Effort: In early 2005, the DoD mandated PDHRA, a health care screening (DD-2900), for all Reserve and National Guard Servicemembers returning from deployment. PDHRA is a global health assessment (with an emphasis on

behavioral health and service-related conditions) designed to be conducted 90-180 days post-deployment. The intent of PDHRA is to identify deployment-related physical health, mental health, and readjustment concerns; and to provide the opportunity for timely follow-up evaluation and treatment. VHA has been an active partner in this outreach initiative since 2005. Reserve Component Units conduct PDHRA through three primary modes: on-site events conducted by DoD contract health care providers, on-site call center events, and a 24/7 call center operation. VAMC and Vet Center staff conduct briefings, staff table-top information displays, enroll Veterans in VA health care, and arrange follow-up appointments at VAMCs and VHA Vet Centers as part of the Readjustment Counseling Service.
Outcome/Metrics: VA has supported over 2,200 PDHRA events and the DoD PDHRA 24/7 Call Center since November 2005 resulting in over 70,000 referrals to VAMCs and over 27,000 referrals to Vet Centers.

Combat Veterans Call Center Initiative
Target Audience: Reserve and National Guard Servicemembers and their families
Description of Effort: On May 1, 2008, the VHA Outreach Office began the Combat Veteran Call Center (CVCC) initiative to ensure OEF/OIF combat Veterans are aware of the services and benefits VA offers. These Veterans receive a call that provides important information about VA benefits, services, employment opportunities and offered the opportunity to be assigned a VHA care manager.
Outcome/Metrics: As of November 1, 2009, the VHA Outreach Office has called over 700,000 Veterans and VA staff has spoken with over 176,000 Veterans. More than 40,000 information packets have been mailed to these Veterans.

YRP Support Initiative for the RCs
Target Audience: Reserve and National Guard Servicemembers and their families
Description of Effort: The National Defense Authorization Act of 2008 established YRP for all Reserve and National Guard Servicemembers and their families. YRP events cover all phases of deployment from mobilization, deployment programs for families, and post-deployment at periods of 30-60-90 days. VHA is a major support partner in the YRP Initiative, with a staff that provides information on benefits and services, enrolls Veterans in health care programs, provides direct assistance and advocacy, and coordinates referrals to other services. VHA also provides specialized briefings on issues like PTSD and TBI.
Outcome/Metrics: Since FY 2009 VA has provided support at over 1,000 YPR events with over 130,000 Servicemembers and 75,000 family members in attendance.

VA Partnership with the National Guard and the Transition Assistance Advisors (TAA) Initiative
Target Audience: Reserve and National Guard Servicemembers and their families
Description of Effort: In order to ensure that OEF/OIF combat Veterans receive access to high-quality health care and coordinated VA services and benefits as they transition from the DoD system to VA, the Department and the National Guard developed a creative partnership. The National Guard hired 54 TAAs in 2006 (currently 62) to serve as VA/National Guard outreach coordinators in the field at the state level

and to answer National Guard Servicemembers' and their families' questions and provide assistance to accessing VA benefits and services at VAMCs and VBA Regional Offices.
Outcome/Metrics: Since January 2006, TAAs have reached out to 389,096 National Guard members/reservists and their families, enrolled 17,984 National Guard members/reservists, and referred 22,000 National Guard members/Reservists and their families to Vet Centers.

VHA OEF/OIF Internet Web Page
Target Audience: Reserve and National Guard Servicemembers and their families
Description of Effort: To support all of their programs and services, VHA Outreach staff has developed a new Internet Web page for OEF/OIF Veterans. In addition to providing information about VA benefits and services, the site uses blogs and other social media tools to engage this new generation of Veterans. There is also a section on the Web page for family members (www.oefoif.va.gov).
Outcome/Metrics: VHA outreach and communication staff members monitor Internet searches and visits to this site. Through blogs, VA Outreach staff gets feedback about access to its services and outreach initiatives.

Qarmat Ali Medical Surveillance Program
Target Audience: National Guard personnel from Oregon, South Carolina, West Virginia, and Indiana
Description of Effort: National Guard personnel from Oregon, South Carolina, West Virginia, and Indiana who served at the Qarmat Ali Water Treatment Facility near Basra, Iraq in 2003 may have been exposed while in country to sodium dichromate (SD) which contains hexavalent chromium Cr (VI). Exposure would have occurred by breathing in SD dust. Breathing high levels of VI over time is known to cause lung cancer, as well as asthma and nose and skin irritations. VA cannot predict who might have been sufficiently exposed to cause significant long-term health effects from exposure; therefore, it has established a medical surveillance program within the existing Gulf War Registry that will monitor these Veterans over time. The Office of Public Health and Environmental Hazards is the lead on this program, with support from the OEF/OIF Outreach Office. On July 6, 2010, the VHA Health Resource Center (HRC) began administering an outbound call campaign to contact the potentially affected National Guard personnel, informing them about this potential chemical exposure. The HRC staff developed scripting, a call flow process for transferring calls to local VAMC OEF/OIF offices and environmental coordinators and conducting follow-up procedures in anticipation of this campaign. The campaign was designed to call every potentially affected Veteran. VA staff was recruited to work Monday through Friday during business hours. Call agents were trained to document every outbound and inbound call to capture data specific to the Qarmat Ali project. VA could use this data to track the calls, determine which Veterans were called, and decide when and where to report results of the HRC's efforts. There will also be a letter sent to each National Guard personnel that is jointly signed by the Secretary of VA and DoD.
Outcomes/Metrics: On July 27, 2010, the HRC started calling individuals on the Qarmat Ali list. The HRC initiated a phased-in approach to calling these Veterans,

starting with Indiana, followed by Veterans in Oregon, West Virginia, and South Carolina. The HRC completed the initial calls to the 638 Veterans on July 31, 2010. The HRC made follow-up calls starting August 1, 2010, and repeated this daily on a staggered basis until they had made five attempts per unreachable Veteran. The HRC completed making calls on August 9, 2010, and continues to receive and process incoming calls from the affected Veterans.

Development of a National Veterans Outreach Reporting System for Tracking the Cost of Outreach Events
Target Audience: All National Guard members and Reservists as they participate in the Seven Touches of Outreach initiatives
Description of Effort: VA developed an outreach reporting system that tracks key data elements in real time for VA staff to record information throughout the deployment cycle on Veterans participating in the Seven Touches of Outreach. VA created individual modules and trained field staff to input data and analyze costs for supporting these events: demobilization, YRP, PDHRA, IRR Musters, and other outreach events conducted at local VAMCs. Costs for holding these events include FTE, equipment and supplies, and travel.
Outcomes/Metrics: Real-time data is generated to show the workload and costs needed to conduct outreach events.

Readjustment Counseling Service (RCS)

RCS OEF/OIF Combat Veteran Outreach Program
Target Audience: OEF/OIF combat Veterans and family members
Description of Effort: The RCS Vet Center Program has hired 100 OEF/OIF combat Veterans to conduct proactive outreach to returning combat Veterans and their families at military demobilization and National Guard and Reserve sites. Veteran-to-Veteran peer services go a long way in making a personal and empathic connection that helps fellow combat Veterans overcome stigmas and other barriers to care.
Outcome/Metrics: Since the beginning of combat operations in Afghanistan and Iraq, through March 31, 2010, the Vet Centers have seen 470,496 OEF/OIF Veterans, 353,907 of whom were outreach contacts seen primarily at military demobilization and National Guard and Reserve sites.

RCS Mobile Vet Center (MVC) Program
Target Audience: OEF/OIF Veterans and other eligible combat Veterans
Description of Effort: To promote geographical access to care, RCS has deployed 50 MVCs to extend outreach and readjustment counseling services to OEF/OIF combat Veterans and their families in remote, outlying areas. MVCs participate in a wide range of events including homeless stand-downs, military demobilizations, job fairs, and other community events where Veterans and family members are likely to be encountered in rural areas or where there is a critical need.
Outcome/Metrics: Cumulative from the onset of MVC operations in 2009 through the end of August 2010, MVCs have participated in over 3,000 distinct outreach events. Four MVCs were deployed in response to the Fort Hood tragedy in November 2009.

Working with other deployed Vet Center staff, the MVCs have provided assistance to over 8,000 Veterans, military service personnel, and their family members.

RCS New Vet Centers
Target Audience: OEF/OIF Veterans and other eligible combat Veterans
Description of Effort: The Vet Center Program is establishing new Vet Centers to ensure that successful readjustment counseling model is available to increasing numbers of new OEF/OIF combat Veterans without decreasing needed services to combat Veterans of previous wars and conflicts.
Outcome/Metrics: Currently, there are 270 Vet Centers in operation, which is an increase of 61 since 2007. Another 30 Vet Centers are authorized, which will bring the total number to 300 in 2011.

Vet Center Combat Veteran Call Center
Target Audience: OEF/OIF Veterans and other eligible combat Veterans and family members
Description of Effort: The Vet Center Program has established a 24/7 national call-in service for combat Veterans and their family members. Veterans who understand and value military service in a combat theater and have the knowledge of VA and other resources are trained as Vet Center counselors and assist Veterans and family members who call in.
Outcome/Metrics: The Vet Center Combat Veteran Call Center (877-927-8387, WAR-VETS) has recorded over 5,000 calls since becoming operational on March 17, 2010.

RCS Bereavement Counseling Program
Target Audience: OEF/OIF and other combat Veteran families
Description of Effort: The Vet Center Program has established a bereavement program for the survivors of active Servicemembers who died while on active duty. Services are available to all immediate family members.
Outcome/Metrics: To date services have been provided to over 2,150 fallen warrior family members, approximately 60 percent of whom were in-theater casualties of Iraq or Afghanistan.

Homeless Veteran Outreach

Community Homelessness Assessment, Local Education, and Networking Groups for Veterans (CHALENG)
Target Audience: Consumers, community providers, VA staff, and other interested stakeholders
Description of Effort: Each VAMC designates a point of contact to organize CHALENG meetings that include community participation. Through community outreach, CHALENG brings together homeless and formerly homeless Veterans ("clients"), providers, advocates, local officials, and concerned citizens to identify the needs of homeless Veterans and then work to meet those needs through proactive planning and cooperative community action.

Outcome/Metrics: There were 11,711 participants in FY 2008 and 16,512 participants in FY 2009--a 41 percent increase. CHALENG continues to emphasize consumer involvement and between FYs 2008 and 2009, Veteran participation increased 62 percent, from 6,613 in to 10,701.

Health Care for Homeless Veterans (HCHV) Outreach
Target Audience: Homeless Veterans
Description of Effort: The core mission of HCHV is to perform outreach through VA social workers and other mental health clinicians, identify homeless Veterans who are eligible for VA health care, and assist these Veterans in accessing the appropriate levels of care. HCHV Programs provide outreach services in community locations such as shelters, soup kitchens, bus and train stations, rural camps, and other areas where the homeless congregate to engage homeless Veterans who have been underserved and disenfranchised. These Veterans often require mental health and substance abuse treatment services, but will not avail themselves of such help without the encouragement of outreach workers going to where the homeless Veterans live on the streets.
Outcome/Metrics: In FY 2009, over 340 HCHV outreach staff conducted 40,216 intake assessments. During the same time, over 77,696 Veterans were treated by HCHV staff. Based on most recent NEPEC data (3rd quarter), FY 2010 projects 40,664 intake assessments with 88,244 Veterans treated by HCHV staff.

VA Stand Down Events
Target Audience: Homeless Veterans
Description of Effort: Stand Down Events are one part of the Department's more successful efforts to assist homeless Veterans. They are typically 1-3 day events where staff members provide services to homeless Veterans such as food, information on shelters available, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services (such as housing, employment and substance abuse treatment). Stand Down Events are collaborative and coordinated among local VA facilities, other government agencies, and community agencies who serve the homeless. The first Stand Down was organized in 1988 by a group of Vietnam Veterans in San Diego, CA. Since 1994, Stand Downs have been used effectively in reaching out to more than 500,000 Veterans and their families.
Outcome/Metrics: In FY 2009, VA sponsored 190 Stand Downs, a 21 percent increase from the 157 held in 2008. Events were held in 46 states, the District of Columbia, and the U.S. Virgin Islands, including 22 sites reporting their first Stand Down. Two hundred seventeen have been held or are planned for FY 2010. As part of the Stand Down initiative, VA supports Operation New Hope, a nationally recognized effort that has shipped over $238 million worth of DoD surplus items to 2,457 outreach events since 1994.

National Call Center for Homeless Veterans (NCCHV)
Target Audience: Homeless Veterans and their families; VAMCs; federal, state and local partners; community agencies; service providers; and others in the community

Description of Effort: One of the new initiatives in VA's plan to end homelessness among Veterans is the creation of the Veterans NCCHV. Its purposes are 1) to provide homeless Veterans with timely and coordinated access to VA and community services and 2) to disseminate information to concerned family members and non-VA providers about all the programs and services available to assist these Veterans. It operates with the Suicide Prevention Hotline at the Canandaigua VA Medical Center and uses the information technology (IT) infrastructure already in place and the clinical expertise of their call responders. In a seamless effort, all staff currently operating the Suicide Prevention Hotline, along with newly hired staff, can respond to calls from either hotline. The NCCHV number (1-877-4 AID VET) was activated in March 1, 2010. The call center's Web site also allows anonymous online chat contact between NCCHV responders and homeless Veterans and was activated on March 15, 2010.
Outcome/Metrics: There have been approximately 7,500 calls to the NCCHV and approximately 4,800 of these callers have identified themselves as Veterans. Seven hundred forty-five Veterans have contacted the service, with 587 mentioning that they were homeless and 237 of those being transferred to a NCCHV responder.

VA Health Care for Re-entry Veterans (HCRV)
Target Audience: Incarcerated Veterans re-entering the community
Description of Effort: HCRV's goals are to prevent homelessness; reduce the impact of medical, psychiatric, and substance abuse problems upon community re-entry; and decrease the likelihood of re-incarceration for those leaving prison. Clinical outreach connects Veterans at risk of homelessness with appropriate VA services, especially homeless, mental health, and substance use services. Active national and state partnerships with the U.S. Departments of Justice (Bureau of Prisons, Bureau of Justice Statistics), the DOL, and Health and Human Services (Office of Child Support Enforcement); as well as with State Departments of Corrections and VA have been critical for successful implementation of the program.
Outcome/Metrics: Since October 2007, HCRV specialists have seen 21,962 reentry Veterans in 955 state and federal prisons.

Veterans Justice Outreach (VJO)
Target Audience: Justice-involved Veterans in jails and courts.
Description of Effort: The purpose of the VJO initiative is to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans. The initiative attempts to ensure that eligible justice-involved Veterans have timely access to VHA mental health and substance abuse services when clinically indicated as well as other VA services and benefits as appropriate. The program provides outreach, including an important component of homelessness prevention. Every VAMC has a VJO specialist, although many fulfill the role as a collateral duty.
Outcome/Metrics: 1) Between September 2009 and June 2010, VJO specialists served 3,166 justice-involved Veterans and 2) partnerships have been developed among the U.S. Departments of Justice (Bureau of Justice Assistance), the DOL, Health and Human Services (Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Mental Health Services National GAINs Center, and OCSE;

as well as with judicial, law enforcement, and jail administration officials in support of this mission.

VA Homeless Veterans Web Site (http://www1.va.gov/HOMELESS/index.asp)
Target Audience: Veterans, their families, health care professionals, and the general public
Description of Effort: Provides important outreach information and resources for Veterans, their families and others seeking information on the VA's integrated continuum of care in homeless programs. Links are provided to VA's programs, the NCCHV Veterans, the National Resource Directory (NRD), and 153 VAMCs.
Outcome/Metrics: From January 1, 2010 through September 21, 2010 there have been approximately 485,544 visits to the VA homeless Veterans website.

Women Veterans Outreach

Women Veterans Health Care Monthly Outreach Campaigns
Target Audience: The primary audience is women Veteran users of VA health care. Secondary audiences are Women Veterans Health staff as well as all VAMC and Community Based Outpatient Clinic (CBOC) staff who serve women Veterans. Tertiary audiences are non-enrolled women Veterans in the community. All of these audiences, to varying degrees, are not accustomed to high-impact promotion of women Veterans. Our visually attractive posters put women Veterans and their health issues in the spotlight and send the message that VA provides women with quality health care that is constantly evolving and improving.
Description of Effort: To guide the development of outreach materials for Women Veterans Program Managers (WVPM), the Women Veterans Health Strategic Health Care Group convened a national communications workgroup comprised of WVPMs from representative VAMCs. The workgroup meets monthly to consider tools and opportunities for inreach and outreach that will raise the visibility of women Veterans and their health care needs. The VA determined that the Women Veterans Health Awareness Outreach campaign would be an effective tool for this purpose. Each monthly poster reinforces the Women Veterans Health Care identity and motto: *You Served, You Deserve the Best Care Anywhere*. Each health topic is supported by a call to action, *Let VA Help*. Each monthly health message is checked against the National Institutes of Health and Centers for Disease Control for the latest and best guidance. Internal VA experts also review and collaborate to ensure the accuracy of the messages (Mental Health and Military Sexual Trauma, VA's National Center for Prevention, etc.).
Outcome/Metrics: Branded outreach materials are distributed to 153 WVPMs nationwide on a monthly basis

- Awards: VA was honored with a 2010 Ace Achievement Award

As an example of the outcome of one monthly campaign--flu prevention--a survey conducted by the Women Veterans Health Strategic Health Care Group found that, of 72 responding facilities, 98.6 percent were engaged in outreach to pregnant and lactating women Veterans. Many went beyond hanging posters, to calling patients, mailing reminders, and engaging in provider education. In Big Spring, TX, Women Veterans Health staff advertised in the local paper and traveled to rural areas to

distribute vaccinations. And the Long Beach, CA facility partnered with local VSOs and held a baby shower where new mothers and moms-to-be could get flu vaccinations. The event was a success and two more baby showers are planned for 2010.

Women Veterans Health Care Web site:
http://www.publichealth.va.gov/womenshealth/campaigns.asp

Branding of Women Veterans Health
Target Audience: Enrolled and non-enrolled women Veterans and their families; Veteran advocates, including VSOs; VA and Veterans Integrated Service Network (VISN) leadership as well as Executive and Congressional representatives; VA staff, including Women Veterans Health Program Managers (WVPMs); and non-VA women's health providers and social service communities.
Description of Effort: Based on market penetration rates, women Veterans are underserved by VA (16 percent of female Veterans compared to 22 percent of male Veterans). VA's Women Veterans Health Strategic Health Care Group (WVHSHG) has been charged with designing and leading a national initiative to improve health care to women Veterans, thereby enhancing VA's mission to serve all eligible Veterans. One way to improve care for women Veterans is to enhance the language, practice, and culture of VA to be more inclusive of women Veterans. Branding women Veterans health care with a powerful identity, including a visual logo and tagline--*You Served, You Deserve the Best Care Anywhere*--helped establish a consistent, nationally recognized symbol for high-quality services that women Veterans should expect at every VA facility. The identity was used to make templates for stationery, memos, and business cards; and was incorporated into brochures, fact sheets, videos, presentations, reports, white papers, posters, note cards, note pads, hand-outs, and giveaways.
Outcome/Metrics: In the first year (2009) of the 5-year campaign, the goals were to increase the visibility of women Veterans, professionalize the image of the VA women's health options, and support local efforts to connect with women Veterans in their catchment areas. A cursory search of VA Women Veterans Health Care on the Internet revealed significant use of the WVHC brand on VA Web sites across diverse VISNs:

- reno.va.gov
- chillicothe.va.gov
- cincinnati.va.gov
- sanfrancisco.va.gov
- northflorida.va.gov
- visn10.va.gov
- lasvegas.va.gov
- westpalmbeach.va.gov
- visn20.med.va.gov
- womenVeteransofnewmexico.com
- pittsburgh.va.gov

Women Veterans Health Video Series, Highlighting VA's Efforts to Improve Health Care for Women Veterans
Target Audience: Enrolled and non-enrolled women Veterans and their families; Veteran advocates, including VSOs; VA and VISN leadership as well as Executive and Congressional representatives; VA staff, including Women Veterans Program Managers (WVPMs); and non-VA women's health providers and social service communities.
Description of Effort: The videos highlight the growing population of women Veterans and how VA is constantly evolving and improving to meet their needs. A collection of interviews with women Veterans in facilities around the country, *You Served, You Deserve* documents the far-reaching changes underway across the VA system to care for this growing population. The video reflects progress since WVHSHG's 2008 production, *The Best Care Anywhere*, which focuses on the rise in women Veterans and the steps needed to ensure every Veteran receives the best care anywhere. The list of available videos is as follows:

- 2008: *The Best Care Anywhere*
- 2010: *You Served, You Deserve*
- Video dayton.va.gov
- Video lomalinda.va.gov

Outcome/Metrics: The videos were loaded on the Women's Veterans Health (WVH) thumb drive and distributed to nearly 200 women Veterans and Veteran advocates at the Forum on Women Veterans in July 2010. The videos are also available on the WVH Web site and have been promoted through VA Facebook and Twitter.

WVH Veterans Thumb Drive--Clearinghouse of Information and Resources for Women Veterans
Target Audience: Enrolled and non-enrolled women Veterans and their families and Veteran advocates, including VSOs
Description of Effort: The thumb drive was created specifically to distribute information on VA's programs and benefits for women Veterans and Veteran advocates attending the Forum on Women Veterans in Virginia in July 2010. The jump drive includes a user-friendly menu that directs users to VA applications and forms, information about VA benefits, and Women Veterans Health videos and brochures. WVHSHG intends to use the branded thumb drive--the first of its kind produced by a VA program office--for future outreach efforts.
Outcome/Metrics: The thumb drives were distributed to nearly 200 women Veterans and women Veteran advocates at the Forum on Women Veterans in July 2010. The helpful information is also posted on the WVH Web site for easy access.

July 2010 Forum on Women Veterans
Target Audience: Women Veterans, VSOs, and women Veteran advocates attending the forum
Description of Effort: The Veterans WVHSHG joined the Center for Women Veterans in co-sponsoring the Forum on Women Veterans on July 28, 2010 at the Women's Memorial at Arlington Cemetery. The event highlighted enhancements in VA care and services for women Veterans. Dr. Patty Hayes, Chief Consultant for Women Veterans Health Care, was the main speaker and opened the programmatic portion of the event.

Subject matter experts from almost every VA office briefed attendees and the Secretary opened the event with a tribute to a young Army Lieutenant who showed extraordinary courage in battle and was in the audience. The 2010 video, *You Served, You Deserve,* was debuted before the audience of nearly 200 women Veterans, advocates, and press. WVHSHG also staffed a table at the event's information booth. Attendees could collect materials provided by VA program offices, VSOs, and advocacy organizations. WVHSHG made copies of their health brochures available and handed out WVH-branded jump drives with important information about improvements to services.
Outcome/Metrics: Press coverage ranged from national newspapers to military press (including The Washington Post, Stars and Stripes, and the American Forces Press Service), local broadcast affiliates (NBC, ABC, etc.), and cartoonist Garry Trudeau. Registration for the event was filled within 20 minutes and the waiting list included more than 250 names. Because of demand and lack of available seats, the Center for Women Veterans moved its quadrennial Women Veterans Summit from 2012 to September 2011. The event will be held at a larger venue to accommodate more attendees. Feedback was gathered through an evaluation form and attendee feedback was positive. Out of a possible 5 points, the following averaged responses of 4.8: the forum was relevant to my needs and interests; overall, the presenters effectively communicated relevant, up-to-date information; and overall, the forum was worthwhile.

Women Veterans Health Web Site
Target Audience: Women Veterans, VSOs, women Veteran advocates, and family and friends of women Veterans.
Description of Effort: The Women Veterans Health Web site has undergone a significant overhaul, including two redesigns in the last two years, to ensure that visitors have easy access to critical information on women Veterans health. The site includes help finding facilities, up-to-date information about benefits, the latest news about women Veterans, and monthly health outreach campaign materials. All of this information is front-and-center on the women's health home page at http://www.publichealth.va.gov/womenshealth/index.asp. Specifically, the site enables visitors to learn about what VA is doing to meet the health care needs of the ever-increasing population of women Veterans, covering topics such as:

- Health care services available (including comprehensive primary care and specialty care)
- Rehabilitation
- Homelessness
- Mental health
- Treatment for military sexual trauma

Videos, women's health outreach posters for download, and resources for wellness and healthy living round out the site's offerings.
Outcome/Metrics: The Women Veterans Health Web site ranks among the most-visited VA public health Web sites.

Patient Care Services: Office of Mental Health Services (OMHS) Overview
The OMHS is the national program office that sets program and policy guidance for mental health services provided throughout VHA. OMHS aims to ensure that all

Veterans have easy access to needed mental health care. VA Mental Health Services advances the principle that mental health care is an essential component of overall health care and promotes mental health recovery. OMHS facilitates improvement of the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from mental and addictive disorders among Veterans and their families. VA conducts several outreach activities and programs throughout its homeless program continuum. Such activities and programs are the Health Care for Homeless Veterans Program, Stand Downs, the Veterans HCRV, VJO, the NCCHVVeterans, and Intranet sites. Outreach is a key strategy in VA's goal of ending homelessness among our nation's Veterans. The initiative of eliminating Veteran homelessness is built upon six strategies: outreach/education, treatment, prevention, housing/supportive services, income/employment/benefits, and community partnerships.

Substance Abuse and Mental Health Services Administration (SAMHSA) Policy Academy June 7-9, 2010
Target Audience: Eight to ten member teams of representatives from nine states and one territory, VA, the National Guard, and state and community health care providers
Description of Effort: In FY 2008 and again in FY 2010, SAMHSA hosted a Policy Academy for representatives from nine states and one U.S. Territory. The State/ Territorial Teams included VA, National Guard, State, and community health care providers. In FY 2010, seven of the States and one territory were new and two were returnee teams from the 2008 program sharing their experiences and enhancing their programs. The purpose of the conference was first to describe existing programs from VA, DoD, and successful State and community care providers to better identify and serve returning OEF/OIF Veterans and their families. The program involved presentations by panels of providers on a range of relevant topics such as VA health care and other benefits. The other feature of the conference involved intensive planning sessions by the State Teams. VA staff participated as program planners, presenters on the panels, and also as subject matter experts consulting with State Teams at their request on issues such as approaches to rural mental health care. VA also provided support materials on VA Suicide Prevention, Readjustment Counseling and other activities at a booth throughout the 2-day program.
Outcome/Metrics: Nine of the States have submitted their action plans, which SAMHSA plans to post on a Returning Warriors Web site that is anticipated for launch early this FY.

VA Mental Health Web Site
Target Audience: Veterans, their families, and health care and other professionals, including college professors and guidance counselors
Description of Effort: Provide extensive information and resources for care for Veterans, their families, and professionals, including resources for counseling Veteran students and important information about suicide prevention resources, vet centers, and VAMC locations (www.mentalhealth.va.gov).
Outcome/Metrics: In the past year, there have been 414,287 visits to the Web site.

Presentations to Non-VA Groups on VA Mental Health Services with Particular Focus on Care for OEF/OIF Veterans
Target Audience: Presentation to National Guard TAAs, January 2009; Presentation to Canadian Military health care providers, February 2009
Description of Effort: Provide information on VA clinical services for returning Veterans, with a focus on Post-Traumatic Stress Disorder (PTSD) and other war-related mental disorders, including treatment approaches and data on the number of Veterans treated.
Outcome/Metrics: Two presentations occurred, as noted above. The actual number of attendees is not available, as these programs were not sponsored by VA.

National Center for PTSD Web Site
Target Audience: Veterans, the public, providers, and researchers
Description of Effort: The National Center for PTSD Web site is an educational resource that offers Veterans and the general public psycho-education about trauma and PTSD, modules on understanding PTSD, returning from the war zone, videos, information on effective treatment for PTSD, and the new VA PTSD Program locator to help Veterans find treatment programs at local medical centers. For providers and researchers, the Web site offers educational materials on working with and treating those who have experienced trauma and PTSD, information on assessing trauma and PTSD, PTSD 101 online curriculum, two regular publications (Clinician's Trauma Update (online) and the *PTSD Research Quarterly*), the world's largest database of citations on trauma and PTSD (PILOTS), research articles by the National Center for PTSD, training videos, the Iraq War Clinician Guide, the Psychological First-Aid Manual, and the Wounded Spirits Ailing Hearts Manual for cross-cultural considerations in care (www.ptsd.va.gov).
Outcome/Metrics: FY 2009 data is not available due to major Web site transition. FY 2010 statistics show:

- Site homepage: 1,860,000 visits (average 155,000 per month)
- Veteran and public home page: 225,099 visits (average 16,400 per month)
- Providers and researchers homepage 156,927 visits (average 11,200 per month)

NOTE: Thousands of pages exist on the site and these totals are for a particular page, not overall use of a section.

PTSD Monthly Mailing List (Listserv) and Twitter
Target Audience: Veterans, the public, providers, and researchers
Description of Effort: A monthly listserv posting is sent out to 7,021 subscribers via email to keep people aware of new and existing information and resources on trauma and PTSD. Each month the content focuses on a specific topic. The content of this listserv posting is then "tweeted" to the National Center for Post-Traumatic Stress Disorder (NCPTSD) Twitter account: http://twitter.com/VA_PTSD_Info
Outcome/Metrics: FY 2009--6,000 subscribers; FY 2010--7,021 subscribers to mailing list; 560 followers on Twitter.

VA PTSD Program Locator
Target Audience: Veterans, the public, and providers

Description of Effort: Similar to the VA Facility Locator, this tool allows users to identify and locate various VA PTSD treatment programs across the country providing them with a contact to find out more information that is right for them. (http://www2.va.gov/directory/guide/ptsd_flsh.asp).
Outcome/Metrics: Similar to the VA Facility Locator, this tool allows users to identify and locate various VA PTSD Treatment programs across the country providing them with a contact to find out more information.

Interactive Online Modules: Understanding PTSD
Target Audience: Veterans and the public
Description of Effort: These products use Flash technology to provide engaging video of real stories of Veterans, their families, and others dealing with reintegration and trauma. The modules cover common reactions to trauma, how to identify problems, and where to get help and effective treatment. VA conducted outreach efforts to inform the public of these materials via a mailing list and outreach to VSOs.
http://www.ptsd.va.gov/public/pages/fslist-ptsd-overview.asp
http://www.ptsd.va.gov/public/reintegration/guides-rwz.asp)
Outcome/Metrics: Returning from the War Zone: *Guide for Families of Military Personnel* - 1,804 per month average visits; and, *Guide for Military Personnel* -1,234 per month average visits. Understanding PTSD just soft launched on 9/2010, so no data on visits are available yet

PTSD 101 Online Curriculum
Target Audience: Providers
Description of Effort: An online curriculum of 20 courses available for continuing education credits for all VA, DoD, and community providers. Employee Education Service (EES) has recently been notifying all DoD providers of this. Hundreds of CDs containing the courses are distributed annually at the VA mental health conference.
http://www.ptsd.va.gov/professional/ptsd101/ptsd-101.asp
Outcome/Metrics: In FY 2010, there were over 2,000 visitors to the list of courses per month.

Mental Health OEF/OIF Support
Target Audience: Returning Veterans and their families, community providers and organizations who serve as support for these populations, and DoD colleagues.
Description of Effort: Office of Mental Health Services (OMHS) outreach activities are carried out in support of Vet Center face-to-face outreach activities, including PDHRA, YRP presentations, visits to National Guard and Reserve meetings, and visits to active duty bases. VAMCs also hold Welcome Home and Stand Down events that provide outreach to returning Veterans and their families. VA Internet sites provide information for Veterans, their families, and community providers (e.g., the National Center for PTSD Web site, www.ncptsd.va.gov; and the new Web site targeting college provider/ Veteran populations, www.mentalhealth.va.gov/College/index.asp.). There have also been conferences for VA and joint VA/DoD clinician audiences (Evolving Paradigms 2 and Joint VA DoD conference September 2009).

Outcome/Metrics: VA does not have specific data on the numbers of veterans referred/ enrolled in VA care through the PDHRA process.

- The number of website visits to the NCPTSD site is 1,860,000, an average of 155,000 per month
- Over 3,000 VA and DoD attendees attended the Evolving Paradigms 2 conference in September 2009
- NCPTSD staff made 1,484 presentations in FY 2005-09
- For the Office of Mental Health Services College website, there have been 18,147 visits to the site in the past year

Native American Veterans Outreach
Target Audience: Native American Veterans and their families, community providers and organizations who serve as support for these populations, tribal governments, SAMHSA, Indian Health Service colleagues
Description of Effort: Face-to-face outreach activities including visits with Tribal Councils accompanied by VA-trained tribal Veterans' representatives, usually with Vet center colleagues. Distribution and use of a DVD on outreach to Native American Veterans designed for OEF/OIF and other service era Veterans. VISN 19 and 20 have robust Native American Veteran outreach programs. VA's Suicide Prevention team communicates with SAMHSA grantees who serve Native American Veterans. Local Suicide Prevention Coordinators (SPCs) provide outreach to SAMHSA tribal grantees as requested and the tribes make referrals for care to the SPCs for VA services as needed. Internet sites provide information for Native American Veterans, their families and community providers (e.g., the National Center for PTSD Web site, www.ncptsd.va.gov, which has materials such as the video "Wounded Spirits, Ailing Hearts: PTSD in Native American Veterans").
Outcome/Metrics: The VA National Director for Suicide Prevention has just started tracking specific outreach activities on a monthly basis. In the month of August 2010, there were 5 outreach activities to American Indian/Native American groups. VA will continue to track these on a monthly basis and will continue to work through our collaborative outreach plan for suicide prevention with IHS.

- Number of website visits and counts on NCPTSD website:
  - PTSD 101 Cross Cultural Considerations: 432 average visits per month
  - Wounded Spirits Ailing Hearts Manual for Clinicians: 278 average visits per month
  - Videos for Native American Veterans/Families: 768 average visits per year

Tribal Veterans Representative (TVR) Program
Target Audience: All Veterans and their families
Description of Effort: Provides outreach, communication, education, and development to individuals intended to assist the Department in providing information to tribal Veterans on VA programs, enrollment, and application for initial entry and application for VA services. Initially, the effort was designed to train volunteers to distribute VA program materials in rural and tribal communities not accessible to VA; however, it has evolved over the past years to a program recognized by tribal leaders as essential to the relationship between tribes and the VA for initiation of services through telehealth,

telemental health, and consultation for programs by VHA, VBA, and NCA. Training has expanded beyond tribal combat Veterans to include elected tribal leaders, VA employees, Indian Health Service, and state employees.
Outcome/Metrics: More than 200 individuals throughout the nation have been trained through the TVR Program since 2001. Significant increases in VHA enrollment, service-connected benefits, and burial assistance have occurred as a result of TVR efforts. TVRs have worked with tribal courts to get Veterans into VHA programs for treatment in lieu of confinement; initiation of benefit claims for processing by service officers; and application for NCA burials, headstones, and markers. Outreach has occurred at hundreds of local and national events in the past, resulting in a positive reflection on the Department for outreach efforts previously did not exist. The TVR Program has also developed training manuals, booklets, DVDs, and videos for distribution throughout the nation. TVRs have made presentations at state and national tribal and federal meetings, communicating the objectives of the program.

Suicide Prevention
Target Audience: Veterans and their families who have concerns about suicidal behavior and community providers and organizations who can support these populations
Description of Effort: VA's basic strategy for suicide prevention requires ready access to high-quality mental health (and other health care) services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high-risk patients. Effective initiatives include:

- A 24/7 Suicide Prevention Hotline, established with the help of the Substance Abuse and Mental Health Services Administration (SAMHSA). Veterans call the national suicide prevention hotline number (1-800-273-TALK/8255) and "push 1" to reach a trained VA professional who can deal with any immediate crisis. More than 245,000 callers have called the hotline and over 144,000 of these callers have identified themselves as Veterans or family members or friends of Veterans. There have been over 7,000 rescues of actively suicidal Veterans to date. An online Chat Service was initiated in July 2009 and, to date, there have been almost 4,000 chatters who have used the service. Several of them have been referred to the hotline for immediate care.
- Each VAMC has an SPC or team to ensure that the Veterans receive the appropriate services. Calls from the hotline are referred to the coordinators, who follow up with Veterans and coordinate care.
- A screening and assessment processes throughout the system to assist in identifying patients at risk for suicide and a chart "flagging" system to assure continuity of care and provide awareness among caregivers.
- Enhanced care for patients who have been identified as "high risk," including missed appointment follow-ups, safety planning, weekly follow-up visits, and care plans that directly address their potentially suicidal behavior.
- A reporting and tracking system that allows employees to learn more about Veterans who may be at risk and help determine areas for intervention.
- Employee education programs such as Operation S.A.V.E. (**S**igns of Suicidal thinking, **A**sk the questions, **V**erify the experience with the Veteran, and **E**xpedite

or **E**scort to help) and a Web-based clinical training module that is mandatory for VA employees.

- Two centers devoted to research, education, and clinical practice in the area of suicide prevention. VA's VISN 2 Center of Excellence in Canandaigua, NY develops and tests clinical and public health intervention strategies for suicide prevention. VA's VISN 19 Mental Illness Research Education and Clinical Center in Denver, CO focuses on: 1) clinical conditions and neurobiological underpinnings that can lead to increased suicide risk; 2) implementation of interventions aimed at decreasing negative outcomes; and 3) training future leaders in the area of VA suicide prevention.

Outreach

- VA has sponsored 3 Suicide Prevention Days to increase awareness of the problem and co-sponsored two conferences on suicide prevention with the DoD for clinicians in both systems.
- VA is sponsoring public service announcements (Gary Sinise/Deborah Norville), Web sites, and display ads designed to inform Veterans and their families of VA's Suicide Prevention Hotline (1-800-273-TALK/8255).
- VA has been distributing brochures, wallet cards, bumper magnets, key chains and wristbands to Veterans, their families, and VA employees to promote awareness of the hotline and educate its employees, the community, and Veterans on ways to identify and help Veterans who may be at risk.
- SPCs are required to do outreach activities in their local communities and are able to provide a community version of Operation S.A.V.E. to returning Veterans and their families, VSOs, or other community groups as desired.
- VA has developed family psycho-educational materials, including information sheets intended to serve as guides for adults to use when talking with children about a suicide attempt in the family; and the family Ask, Care, Escort (ACE) card.
- VA/VHA recently awarded a contract for suicide prevention outreach services and activities, which include outreach and audience analysis, graphics support, metrics support, video and multimedia development and support, media planning and buying, Web site support, and communication materials (brochures, posters, flyers, fact sheets). The contract will provide more effective outreach strategies and communications products and advance the strategic outreach plan and mission for the Suicide Prevention Program.

Outcome/Metrics:

- Number of callers to Suicide Prevention Hotline: 318,254 through August 2010
- Number of rescues from hotline calls: Over 10,000 as of July 31, 2010
- Number of conference presentations: Over 50 to date in FY2010
- Number of Chat Service contacts. 8,609 from July 2009 – August 2010
- Number of participants reached through community presentations: 581,000 participants were reached in 6,191 events in FY2010 through July 31, 2010.
- Number of letters sent per quarter: 87,524 mailings have been sent in FY2010 through July 31, 2010

Special Recognition: VHA is a finalist (5th place) in the 2010 Direct Marketing Association International ECHO Awards Competition in the Business and Customer Service Category.

Former Prisoners of War (FPOW)
Target Audience: FPOWs and their families, community providers, and organizations who can serve as support for these populations
Description of Effort:

- Face-to-face presentations by VA clinicians and VBA staff at VSO conventions, especially local and annual conventions of American Ex-POWs.
- Mailings to FPOWs and announcements of VAMC events through the media (for example on POW MIA day and Veterans Day)
- POW health care and benefits information provided to the Library of the National POW Museum, National Park Service Andersonville Historic Site, at their request.
- Training conferences on POW health care and benefits issues for VHA and VBA staff to facilitate effective outreach and care for this population

Outcome/Metrics: OMHS does not have information on the results of these efforts.

National Resource Directory: (NRD)
Target Audience: Wounded, ill, and injured Servicemembers; and Veterans, their families and those who support them.
Description of Effort: The NRD is a partnership among the DoD, DOL, and VA that provides access to services and resources at the national, state, and local levels to support recovery, rehabilitation, and community reintegration. Visitors can find information on a variety of topics including benefits and compensation, education and training, employment, family and caregiver support, health, homeless assistance, housing, transportation and travel, and other services and resources. The information on the site is from federal, state, and local government agencies; Veterans' service and benefit organizations; non-profit and community-based organizations; academic institutions; and professional associations that provide assistance to wounded warriors and their families. The VHA Homeless Programs Office collaborated with the NRD to enhance available information on resources for Veterans who are homeless or at risk of homelessness. This included adding information and a link to the Veterans NCCHV on to the initial page as well as a spotlight on the NCCHV. The NCCHV Call Center staff also uses NRD to provide location specific information to homeless Veterans (www.nationalresourcedirectory.gov).
Outcome/Metrics: Between January 2010 and August 2010, the NRD received roughly 500,000 visitors and approximately 5,739 page views. In February 2010, the NRD began using an e-mail marketing service called GovDelivery (www.GovDelivery.com). The service allows users to sign up for e-mail updates based on subject area or location. In just 8 months of use, the NRD has more than 9,000 subscribers who receive weekly updates regarding new content on the website. 5,112 subscribers to this service signed up to receive "Homelessness Assistance" information.

Spinal Cord Injury and Disorders Services

VA Spinal Cord Injury/Disorders (SCI/D) Patient Information Brochure and Briefings
Target Audience: Servicemember, DSMs, Veterans, families, VA and community stakeholders (e.g., federal recovery coordinators, VHA liaisons, VA Polytrauma nurse liaisons, VHA case managers at military treatment facilities)
Description of Effort: Developed and disseminated a VA SCI/D patient information brochure that provides comprehensive information about SCI/D programs and services throughout all SCI/D Centers.
Outcome/Metrics: Measurement of increased awareness by active duty Servicemembers, Veterans, families, stakeholders and the public regarding access to VA SCI/D health care and benefits.

VHA Office of Health Information (OHI) Communication
OHI is dedicated to providing the best health care for Veterans. OHI works closely with the frontline VA doctors, nurses, and other health care providers to determine how to improve VA's health care system for their patients. One of their primary services is to maintain the integrity, quality, security, and privacy of electronic health care information. One area of focus relates to working closely with the DoD to make electronic health information secure, yet available to the doctors, clinicians, and staff working with Veteran and active duty patients.

Outreach Events/Activities
Target Audience: Veterans, Servicemembers and their families, VSOVeteranss
Description of Effort: OHI participated in over 36 outreach events and activities that provided information on VA health and benefits information to Veterans, Servicemembers, and their families throughout FYs 2009 and FY 2010. Key services and programs promoted VA's award-winning Personal Health Record and My Health**e**Vet (www.myhealth.va.gov); and other nationally recognized IT applications such as VistA, the Computerized Patient Records System (CPRS), the Nationwide Health Information Network, the Bar Code Medication Administration, and the Compensation and Pension Record Interchange (CAPRI) for VSOs. Additionally, My Health**e**Vet educational training courses were presented at the National Association of County Service Veterans Officers stakeholder conferences.
Outcome/Metrics: 1) Positive exposure to key stakeholders about VA's ability to provide state-of-the-art health care to Veterans and Servicemembers and 2) a 19.5 percent increase in In-Person Authenticated My Health**e**Vet users from baseline as of the third quarter, FY 2010.

Communication Products
Target Audience: Veterans, Servicemembers and their families, and VSOs
Description of Effort: OHI publishes posters, brochures, and fact sheets to provide Veterans, Servicemembers, VSOs, and their family members with targeted and specific information about new and existing services and benefits; and circulates My Health**e**Vet publications nationally to all VAMCs to promote the accessibility and benefits of VA's electronic personal health record. Outreach products produced in FYs 2009 and 2010 include:

- Four online Healthy Living fact sheets for My Health**e**Vet, which various VA stakeholders and VA employees use;
- The OHI/VHA *"Heroes"* video showcasing the unique and complex nature of VA's patients, the dedication of their caregivers, and the technology they employ to assist our nation's heroes;
- A 2-minute video overview of My Health*e*Vet for VA stakeholders on the Content Distribution Network (also posted on YouTube);
- Three Bar Code Resource Office newsletters, The Messenger, to various stakeholders;
- Fact sheets relating to VistA/CPRS, Bar Code Medication Administration, and the Nationwide Health Information Network;
- The CAPRI for VSOs brochure detailing roll-out of VA's CAPRI software to accredited VSOs with power of attorney to view Veteran clients' electronic health records; and
- Three VA news releases on My Health*e*Vet's one millionth registrant milestone, Bar Code Medication Administration's 10-year anniversary, and VA's First eSharing Endeavor with Kaiser-Permanente, and VA San Diego.

Outcome/Metrics: NA

My Health*e*Vet Web Site
Target Audience: Veterans and their families and VSOs
Description of Effort: OHI produced and maintains VHA's My Health**e**Vet Web site. My Health**e**Vet is VA's award–winning, ehealth Web site, which offers Veterans, ADSMs, their dependents, and caregivers anywhere, anytime Internet access to VA health care information and services. My Health**e**Vet is a free, online Personal Health Record (PHR) that empowers Veterans to become informed partners in their health care. With My Health**e**Vet, America's Veterans can access trusted, secure, and current health and benefits information; and record, track and store important health and military history information at their convenience. Veterans who are enrolled in a VA facility can refill their VA prescriptions and more. In addition, the Web site also received a first honors award in the category of PHRs at the 2009 Toward an Electronic Patient Record (TEPR+) conference held in California and attended by a broad cross-section of private, public, local, state, and federal health care professionals. The Department competed against many nationally recognized health care organizations developing and providing PHR systems, including Kaiser Permanente, Microsoft Health Vault, and Google Health.
Outcome/Metrics:

- Over 43 million visits to My Health**e**Vet as of August 25, 2010
- Over 1,050,000 registrants as of July 28, 2010
- Over 220,000 in-person authentications as of August 20, 2010
- Over 16 million prescription refills as of July 04, 2010

OHI Exhibits, Conferences, and Conventions
Target Audience: Veterans, families, and community partners that serve Veterans
Description of Effort: The OHI sponsors exhibits at several Veteran-focused events throughout the year, including Veteran annual VSO conventions; as well as national,

state, and local government conferences. Each exhibit focuses on direct interaction with Veterans, increased awareness of VA benefits and services, and My HealthyeVet enrollment assistance. For the My HealtheVet campaign, Veterans are registered and authenticated for the program during the convention and given a short tutorial on how to use the application. This has been an effective way to reach a large number of Veterans, who have been overwhelmingly receptive to the program. Some of the key events where OHI sponsored exhibits in FYs 2009 and 2010 include:

- VA Winter Sports Clinics
- Golden Age Games
- National Association of County Veteran Service Officers Annual Conference
- National Veterans Wheelchair Games
- Disabled American Veterans (DAV) National Convention
- American Veterans (AMVETS) National Convention
- Veterans of Foreign Wars (VFW) National Convention
- Blinded Veterans Association (BVA) National Convention
- American Legion National Convention
- National Association of State Directors of Veterans Affairs (NASDAV) Annual Conference (participation planned as of the date of this report)

Office of Public Health and Environmental Hazards

Gulf War Review Newsletter and Special Poster
Target Audience: Gulf War Veterans
Description of Effort: The Gulf War Review newsletter and special poster were published in time for the 20th anniversary of the war and posted on the Web; and announced by email to multiple VA staff in VHA, VBA, and NCA and to electronic subscribers. It was also featured on Facebook and Twitter. The goal of the newsletter is to inform Veterans of ongoing research and programs of interest to Gulf War Veterans and the poster was designed to commemorate and honor Gulf War Veterans
Outcome/Metrics: Over 400,000 copies of the newsletter and nearly 300,000 copies of the poster were mailed to Veterans, VAMCs, Vet Centers, VBA Regional Offices, NCA Cemetery Directors, and VSOs

The Public Health Website
Target Audience: All Veterans
Description of Effort: Comprehensive Web site on all environmental exposures of interest to Veterans. To disseminate information pertaining to hazardous exposures, health concerns, compensation and other issues.
Outcome/Metrics: Total visits: 2,642,479

- Agent Orange visits: 1,739,466
- Gulf War Veterans' Illnesses visits: 296,757
- All Other Hazardous Exposures visits: 388,140
- War Related Illness and Injury Study Centers visits: 218,116

Agent Orange Review Newsletter
Target Audience: Vietnam Veterans

Description of Effort: The goal of the newsletter is to inform Veterans of ongoing research and programs of interest to Vietnam Veterans. The most recent edition of the newsletter was published in August 2010 and announced by email to VA health care facilities, VBA offices, NCA, and electronic subscribers; and featured on Facebook and Twitter.
Outcome/Metrics: 450,000 individual mailings to Veterans; 180,000 bulk mailings (including medical centers, vet centers, VBA, NCA, and VSOs); 631,000 total materials printed and distributed.

Ionizing Radiation Review Newsletter
Target Audience: Vietnam Veterans
Description of Effort: The goal of the newsletter is to inform Veterans of ongoing research and programs of interest to Veterans exposed to radiation in Vietnam Veterans. The most recent edition of the newsletter was published in March 2010.
Outcome/Metrics: The newsletter was mailed to Veterans, VA health care facilities, VBA offices, and VSOs. A total of about 60,000 newsletters were printed and distributed.

OEF/OIF Review Newsletter
Target Audience: Gulf War Veterans, their families, VSOs, and other community stakeholders
Description of Effort: Publication of a Veteran-focused newsletter to disseminate information pertaining to hazardous exposures, health concerns, compensation, and other issues pertaining to the identified cohort (e.g., enhanced enrollment opportunities for OEF OIF Veterans). The link to the most recent edition is provided here: http://www.publichealth.va.gov/docs/oefoif/OIF_OEF_Review_June_2008.pdf
Outcome/Metrics: 770,000 copies were printed and distributed to Veterans, VA health care facilities, VBA offices, and VSOs.

Hepatitis C Virus (HCV) Community Advisory Board (CAB)
Target Audience: Approximately 10-11 men and women Veterans living with a diagnosis of hepatitis C who represent the approximately 150,000 Veterans with chronic hepatitis C who are receiving care at VA.
Description of Effort: The Public Health Strategic Health care Group (PHSHG) has an annual face-to-face meeting to hear from Veterans about how VA's hepatitis C programs are meeting their needs and to allow VA staff to share new information with CAB members. Additionally, one or two teleconferences a year are held. A coordinator is available to CAB members 24/7. The CAB reviews and comments on any of our education materials. Current topics of discussion include Hepatocellular Carcinoma Screening, Hepatitis C Resource Center Products, Quality indicators for good hepatitis C care, and a discussion about the new hepatitis C drugs that are on the horizon.
Outcome/Metrics: Ten Veterans participate in the HCV CAB.

Human Immunodeficiency Virus (HIV) CAB

Target Audience: This is an audience of about 14-15 men and women Veterans living with a diagnosis of HIV who represent the approximately 22,000 Veterans living with HIV who are receiving care at VA.
Description of Effort: The PHSHG has an annual face-to-face meeting to hear from Veterans about how VA's HIV programs are meeting their needs and to share new information with the CAB. Additionally, one or two teleconferences a year are held as needed. A coordinator is available to CAB members 24/7. The CAB reviews and comments on any of our education materials. Current topics of discussion include the new policy regarding HIV testing, the HIV Care Survey, dental issues, and current research Quality Enhancement Research Initiative projects.
Outcome/Metrics: 13 Veterans participate in the HIV CAB.

Office of Rural Health
In January 2010, VA provided $21.7 million to regional health care systems to improve health care for Veterans in rural areas and provide health care services, which rural Veterans have earned. In May 2009, $215 million in competitive funding was allocated for projects to improve services for Veterans in rural and highly rural areas.

Mobile Health Care Clinics Pilot
Target Audience: Rural Veterans and their families:
- VISN 1: Togus VAMC
  - Areas of operation: North and Central Maine
- VISN 4: Clarksburg VAMC
  - Areas of operation: North and Central West Virginia
- VISN 19: Cheyenne VAMC
  - Areas of operation: Southeast Wyoming and Northeast Colorado
- VISN 20: Puget Sound VAMC
  - West Washington

Description of Effort: This pilot project, using specially outfitted large trailers or similar vehicles, was implemented to extend access to primary care and mental health services in rural areas where it is not feasible to establish a fixed clinic. The Mobile Health Care Clinics travel to rural and highly rural areas to provide access to VA health care to Veterans in those areas.
Outcome/Metrics: The Office of Rural Health (ORH) is in the midst of initiating a metrics program to collect data that will support assessing the effectiveness of the various initiatives and projects. Below is a sample of metrics associated with Mobile Health Care Clinics:
- Number of rural Veterans newly enrolled in VHA
- Service use/encounters
- Clinical quality indicators
- No-shows and cancellations
- Wait times
- Patient satisfaction
- Provider satisfaction

Outreach Clinic Expansion
Target Audience: The following lists the 42 Outreach Clinics ORH funded in FYs 2009 and 2010:

- VISN 1: Houlton, ME
- VISN 2: Wellsboro, PA
- VISN 4: Fort Indiantown Gap, PA
- VISN 7: Selma, AL
- VISN 7: Perry, GA
- VISN 8: Taylor County, FL
- VISN 8: Waycross, GA
- VISN 8: Vieques, PR
- VISN 8: Comerio, PR
- VISN 8: VA Caribbean – St. Johns, VI
- VISN 8: Utuado, PR
- VISN 9: Lee County, VA
- VISN 9: Smith County, CA
- VISN 9: Buchanna County, VA
- VISN 10: Wilmington, OH
- VISN 10: Georgetown, OH
- VISN 12: Manistique, MI
- VISN 17: La Grange, TX
- VISN 19: Hamilton, MT
- VISN 19: Salida, CO
- VISN 19: Price, UT
- VISN 19: Moab, UT
- VISN 19: Rawlins, WY
- VISN 19: Evanston, WY
- VISN 19: Worland, WY
- VISN 19: Glenwood Springs, CO
- VISN 19: Idaho Falls, ID
- VISN 19: Plentywood, MT
- VISN 19: Montezuma Creek, UT
- VISN 20: Libby, MT
- VISN 20: Newport, OR
- VISN 20: Grants Pass, OR
- VISN 20: Crescent City, CA
- VISN 20: Burns, OR
- VISN 20: Mountain Home, ID
- VISN 20: The Dalles, OR
- VISN 20: Juneau, AK
- VISN 20: Homer, AK
- VISN 21: Saipan, Commonwealth of the Northern Marianas
- VISN 21: Winnemucca, NV
- VISN 21: Yreka, CA
- VISN 22: Laughlin, NV

Description of Effort: Outreach clinics are fixed-site clinics intended to serve Veterans in rural and highly rural areas where there is not sufficient demand, or it is otherwise not feasible to establish a full-time Community Based Outpatient Clinic (CBOC). These part-time clinics use community resources to enhance access to primary care and mental health services for Veterans in rural and highly rural areas.
Outcome/Metrics: ORH is in the midst of initiating a metrics program to collect data that will support assessing the effectiveness of the various initiatives and projects. Below is a sample of metrics associated with outreach clinics.

- Number of rural Veterans newly enrolled in VHA
- Service use/encounters
- Clinical quality indicators
- Wait times
- Patient satisfaction

VISN Rural Consultants
Target Audience: ORH supports eight full-time VISN rural consultant positions, which are in VISNs 9, 11, 15, 16, 19, 20, 21, and 23
Description of Effort: This project was implemented in accordance with PL 109-461 to build an ORH community of practice that facilitates information exchange and learning across VISNs and the VA Central Office, and engages in rural planning efforts and outreach activities to enhance access to VA health care for Veterans residing in rural areas.
Outcome/Metrics: Metrics have been established:

- Rural Consultants are identified and positions are established in every VISN.
- Consultant positions remain filled and are not left vacant.
- Evaluate the potential to increase the number of full-time VISN Rural Consultant positions established nationally. Long term aim is at least one full-time VRC position established at each VISN.
- VISN Rural Consultants and program projects will be assessed in FY 2011 for effectiveness, efficiency and value in impacting Veterans in rural and highly rural areas.

Veteran Rural Health Resource Centers (VRHRCs)
Target Audience: The three VRHRCs are in the Eastern (White River Junction, VT), Central (Iowa City, IA), and Western (Salt Lake City, UT) regions of the United States
Description of Effort: VRHRCs serve as ORH satellite offices with the specific purpose of conducting policy studies and analyses and functioning as field-based laboratories for projects that will enhance delivery of services to Veterans in rural areas and serve as a repository for rural health care information. They extend ORH's outreach capabilities to localized areas.
Outcome/Metrics: Metrics have been established for each of the ORH funded projects established by the VRHRCs. Additionally in FY 2011, all three VRHRC programs will be evaluated for effectiveness, efficiency and value in impacting Veterans in rural and highly rural areas.

Community Based Outpatient Clinics (CBOC)
Target Audience: The following lists the 51 CBOCs funded in FY 2010. These CBOCs are located in counties with enrollees considered 100 percent rural:

VISN	Station Name	County	State
1	Brattleboro	Windham	VT
6	Lumberton	Robeson	NC
6	Rutherfordton	Rutherford	NC
6	Edenton/Elizabeth City	Chowan	NC
6	Emporia	Emporia City/Greensville	VA
6	Lewisburg	Greenbriar	WV
6	Staunton	Augusta	VA
6	Wytheville	Wythe	VA
7	Blairsville	Union	GA
7	Milledgeville	Baldwin	GA
7	Southwest Alabama	Monroe	AL
7	Guntersville	Marshall	AL
7	Wiregrass	Coffee	AL
8	Putnam County	Putnam	FL
9	Gallia County	Gallia	WV
9	Mt. Pleasant-Columbia	Maury	TN
9	Pulaski	Giles	TN
9	Harriman	Roane	TN
9	Athens	McMinn	TN
9	Jellico	Campbell	TN
11	Bad Axe	Huron	MI
11	Cadillac	Wexford	MI
11	Cheboygan	Cheboygan	MI
11	Grayling	Crawford	MI
11	Peru	Miami	IN
11	Charleston	Coles	IL
15	Carbondale	Jackson	IL
15	Harrisburg	Saline	IL
15	Washington-Sullivan	Franklin	MO
15	Sikeston	Scott	MO
15	Sedalia	Pettis	MO
16	Conway	Faulkner	AR
16	Russellville	Pope	AR
16	Ozark	Franklin	AR
16	Jay	Delaware	AR
16	Craig County (Vinita)	Craig	OK
16	Natchitoches	Houston	LA
16	Fort Polk (Leesville)	Vernon Parish	LA

VISN	Station Name	County	State
16	Franklin	St. Marys Parish	LA
16	Bogalusa	Washington Parish	LA
20	South Puget Sound	Lewis	WA
21	Susanville	Lassen	CA
21	Lake County	Lake	CA
23	Southern Central MN Border	None Named	MN
23	SW Metro	McLeod	MN
23	Decorah (Northeast Iowa)	Winneshiek	IA
23	Sterling	Whiteside	IL
23	Carroll	Carroll	IA
23	Marshalltown	Marshall	IA
23	Ottumwa	Wapello	IA
23	Wagner	Charles Mix	SD

Description of Effort: CBOCs are fixed health care sites that are geographically distinct or separate from the parent medical facility that is either VA-operated and/or contracted. The scope of service at CBOCs varies, based on the type of clinic and population served. In FY 2010, ORH provided funding to support previously approved CBOCs in rural and highly rural areas. CBOC funding will improve access to primary care and mental health services for Veterans residing in geographically remote communities. These CBOCs will be maintained predominately (80 percent) through leasing with only 4 percent being activated by construction and 16 percent by contract. Approximately 86 percent of these CBOCs will have, or are continuing to explore, the use of telehealth.

Outcome/Metrics: ORH is in the midst of initiating a metrics program to collect data that will help assess the effectiveness of the various initiatives and projects. Below is a sample list of metrics:

- Number of rural Veterans newly enrolled in VHA
- Number of new MyHealtheVet enrollees
- Service use/encounters
- Clinical quality indicators
- Wait times
- No-shows
- Number of ER visits
- Number of hospitalizations, bed days, and readmissions
- OQP measures performance
- Patient satisfaction
- Office of Telehealth quality measures

Veterans VHA Program Office and VISN Initiatives

Target Audience: Veterans and providers who have been targeted through the VHA program offices and VISN initiatives

Description of Effort: During FYs 2009 and 2010, ORH allocated funds to VHA program offices and VISNs to establish and implement rural health outreach and delivery initiatives for Veterans in geographically remote areas. Projects include, but are not limited to, expanding home-based primary care (HBPC), medical foster homes (MFH), telehealth services, transportation, and OEF/OIF outreach; and providing behavior health care services. Below is a sample list of currently funded outreach initiatives:

- Geriatrics and Extensive Care (GEC): HBPC Expansion: Indian Health Service (IHS) Collaboration
- GEC: HBPC Expansion: CBOC and Community Collaboration
- GEC: MFH Home Expansion
- VISN 2: Expanding Rural Veterans' Access to Behavioral Health Care
- VISN 4: OEF/OIF Outreach Clinic
- VISN 5: Mental Health Rural Outreach
- VISN 5: Rural Homeless and Homeless Prevention Services
- VISN 7: HBPC Expansion to Selma Outreach Clinic and Athens CBOC
- VISN 7: Enhancing Services for Rural Veterans--A Novel Approach Using a VA-Rural PACE
- VISN 16: The Virtual Outreach to Increase Collaborative Exchange Program
- VISN 16: Rural Health Access – Collaboration with IHS/Choctaw Nation
- VISN 20: Rural Health care Outreach Communications Packet
- VISN 21: Saipan, Commonwealth of Northern Marianas Islands Rural Health Coordinator
- VISN 22: Remote Access Coordination
- VISN 23: Imaging Equipment for the Brainerd, MN CBOC

Outcome/Metrics: ORH is in the midst of initiating a metrics program to collect data to support assessing the effectiveness of the various initiatives and projects. Below is a sample of metrics associated with VHA program office and VISN initiatives:

- Number of rural Veterans newly enrolled in VHA
- Number of new My HealtheVet enrollees
- Service use/encounters
- Clinical quality indicators
- Patient satisfaction

Physical Medicine and Rehabilitation Service Development of Internet Web Sites
Target Audience: Veterans and ADSMs participating in the VA Polytrauma/TBI/Amputation Rehabilitation process or who could benefit from these programs; caregivers; community health care providers; VSOs; other federal agencies
Description of Efforts: Development of the Polytrauma System of Care Web site (http://www.polytrauma.va.gov) that includes information on admission criteria, location of Polytrauma /TBI facilities, family support resources, and the Polytrauma Rehabilitation Center Family Care Map to guide caregivers through the rehabilitation process. Lectures on Polytrauma System of Care and available resources by Dr. David Cifu, National Director Physical Medicine and Rehabilitation Program Office, to various community venues:

- Brain Injury Association of New Jersey Annual Meeting (June 2010)--150 people (Veterans, caregivers, TBI community health care providers)
- Cornell University/Columbia University Departments of Physical Medicine and Rehabilitation (PM&R) Service (January 2010)--50 health care providers
- Shepherd Center (April 2010)--50 health care providers
- Ohio State University Department of PM&R (May 2010)--50 health care providers
- Fourth annual TBI Military Training Conference in Washington, DC (August 2010)--1000 military and VA health care providers

2010 Gulf War Reunion (August 2010) at which the Physical Medicine and Rehabilitation Program Office appeared to offer Polytrauma/TBI resource and offer immediate responses to Veterans attending this meeting. The *Amputation Patient Education Handbook* developed in partnership with the DoD to provide patient education and information both agencies will use to help guide Veterans and ADSMs through the amputation rehabilitation process. The ACA Peer Visitation Program, developed with VA to establish Peer Visitation Programs (which is a 'train-the-trainer' model), across each Regional Amputation Center and network site within the VA Amputation System of Care.

Outcome/Metrics: Patient and family satisfaction as measured by local VA medical centers and the national Survey of Health Experience of Veterans (SHEP), a patient-centered initiative of the VA's Office of Quality and Performance used to assess satisfaction, functional status, and health behavior information from Veterans who obtain care in VHA. No PM&R data to report pending release of SHEP data by Office of Quality and Performance.

Blind Rehabilitation Services Development of Blind Rehabilitation Service Internet Web Site

Target Audience: Veterans and ADSMs participating in the VA blind rehabilitation process or who could benefit from the programs, caregivers, VSOs, and other federal agencies.

Description of Efforts:

- Developed the Blind Rehabilitation Services Web site, which includes information on visual impairment and blindness rehabilitation services provided; and the locations of Blind Rehabilitation Centers and facilities with a Visually Impaired Service Team (VIST) and blind rehabilitation outpatient specialist to help Veterans, Servicemembers, caregivers, and family members identify services and resources available in their area (http://www1.va.gov/BLINDREHAB/index.asp).
- Partnered with VSOs, federal administrations and agencies, and other national, state, and community organizations that support or assist Veterans and Servicemembers. Blind Rehabilitation collaborates with numerous national, state, and community organization who assist Veterans and Servicemembers and support outreach and identification of those with visual impairment and blindness, including the Vision Serve Alliance, the National Council of State Agencies for the Blind, the Council of State Administrators for Vocational Rehabilitation, the Association for Education and Rehabilitation for the Blind and

Visually Impaired, the Academy for Certification for Vision Rehabilitation and Education Professionals, the Blinded Veterans Association, the Blinded American Veterans Foundation, the Council of the Blind, the American Foundation for the Blind, and the United States Association of Blind Athletes.

- Acted as military treatment liaisons and provided outreach to Veterans and Servicemembers at each military treatment facility in the U.S. via partnerships with VIST coordinators, the Federal Recovery Program, and OEF/OIF case managers at VA Medical Centers to further enhance outreach efforts.
- Participated in VA DoD Outreach--provides outreach to Servicemembers through deployment of Blind Rehabilitation Outpatient Specialists (BROS) at Walter Reed Army Medical Center and the Bethesda Nationals Naval Medical Center
- Lectured on Blind Rehabilitation Service Programs and available resources.
- Attended geriatric Research, Education and Clinical Center Geriatric Medicine Update: Vision and Hearing Rehabilitation in Older Adults: Little Rock, AR (February 2010); had an audience of 50 health care providers, case managers
- Meaningful Occupations, Jobs and Careers of Veterans with Visual Impairment, Center for Visual Impairment: Atlanta, GA (February 2010), Kansas City KS (June 2010)--75 health care providers, case managers, Veterans, caregivers, VSO members
- Led blind Rehabilitation Service Continuum of Care to provide outreach, case management comprehensive evaluation, treatment, blind and vision rehabilitation for Veterans and Servicemembers with any level of visual impairment. Outreach and provision of services is accomplished through a comprehensive system of care givers/facilities, including VIST coordinators (who provide care management and outreach), BROS (who provide in-home and in-community service, outpatient blind and vision rehabilitation clinics), and 10 inpatient Blind Rehabilitation Centers (with three additional inpatient centers planned for FY 2011).

Outcome/Metrics:

- Visual Impairment Service Team Coordinators: increased number of unique patients by 7.6% from FY09 to FY10
- Blind Rehabilitation Outpatient Specialist: increased number of unique patients by 39.9% from FY09 to FY10
- Intermediate Outpatient Low Vision Clinics: increased number of unique patients by 39.9% from FY09 to FY10
- Advanced Outpatient Low Vision Clinics: increased number of unique patients by 31.2% from FY09 to FY10
- Visual Impairment Services Outpatient Rehabilitation Program (VISOR) & Advanced Outpatient Blind Rehabilitation Clinics: increased number of unique patients by 43.2% from FY09 to FY10

Office of Research and Development (ORD) Office Overview

Effective external communication provides an opportunity to ensure Veterans and other VA Research stakeholders that VA is working to discover new therapies and treatments in direct response to their deployment-related ongoing health needs. As one Veteran stated: "Research offers hope for my illness and for others in similar situations."

Continued and greater awareness of the quality, relevance, and value of the VA Research Program on the part of stakeholders and decisionmakers fosters collaboration and program stability. Further, appropriately promoting VA research advancements creates a national venue for highlighting cutting-edge medical treatments available to Veterans through the VA health care system.

In recent years, there have been significant advancements in VA Research and Development outreach and communications. Activities include a branding initiative, toolkit and resource development, enhanced use of emerging communication technologies and social media venues, and development of venues for transparent conveying of timely and accurate information tailored to stakeholders' needs. To ensure responsiveness to target audience's needs, such as the academic and scientific community, VSOs, and Veterans and their families, stakeholders are involved in the development of key communications initiatives and play a significant role in their implementation.

ORD Brochure Series
Target Audience: Veterans, their family members, VSOs, the VA research and medical community, and other stakeholders
Description of Effort: Nearly 30 program and topic brochures have been developed to date, and new brochures are added as new needs are identified. Brochures cover specific health topics such as post-traumatic stress disorder, traumatic brain injury, prosthetic and related technology, mental health, women's health, and rural health. There are also overview brochures on topics such as the VA Research and Development Program, genomic research, personalized medicine, research focused on Afghanistan and Iraq, and federal agency collaboration. Material is being used in large quantities at VSO chapter meetings, VAMC events, and other venues that provide considerable opportunities for message "spread."
Outcome/Metrics: 1) More than 50,000 brochures were distributed in 2008 to Veterans and their family members, VSOs, research offices, and other stakeholders; 2) 140,000 brochures were distributed in 2009; and 3) 150,000 have been distributed to date in 2010.

VA Research Today
Target Audience: Veterans, their family members, VSOs, the VA medical and research community, and other stakeholders
Description of Effort: This 72-page magazine was produced in FY 2009 to help commemorate the 85th anniversary of VA Research. Copies were distributed at VA Research Week events in Washington, DC, and at VAMCs nationwide. The magazine included feature stories on topics ranging from advanced prosthetics to chronic disease management, along with inspiring personal stories of Veterans and researchers. Research and Development Communications will now produce *VA Research Today* on an annual basis, to coincide with Research Week.
Outcome/Metrics: 1) Over 10,000 copies of VA Research Today have been distributed nationally and 2) researchers within VA and other government and civilian agencies

have expressed great interest in this product with order requests coming in on a regular basis.

"Hope" Music Video
Target Audience: Veterans, their family members, VSOs, the VA research and medical community, VAMCs, and other stakeholders
Description of Effort: To help spread the message of "hope" through VA Research, ORD collaborated with country musician Stephen Cochran, his band The New Country Outlaws, and a Veteran choir to produce a song titled "Hope" and an accompanying music video.
Outcome/Metrics: The "Hope" music video has become one of our most sought-after resources and more than 20,000 copies have been distributed since April 2010, with more than 3,000 views on YouTube. The video won bronze statues in the *Government Relations* and *Music Video* categories at the 31st Annual Telly Awards, recognizing the finest video and film productions created for the Web.

85 Years of Advancement video
Target Audience: Veterans, family members, Veteran Service Organizations, VA medical and research community, VAMCs, and other stakeholders
Description of Effort: For more than 85 years, the Research and Development program has advanced health care for Veterans and other Americans through its innovations and discoveries. To convey this message and provide a glimpse of the historic accomplishments of VA investigators and the generous contributions of Veterans, a video was created—"Turning Hope into Reality"—featuring Veterans' stories and research examples from across the country in a broad array of areas.
Outcome/Metrics: The video premiered nationally during VA Research Week 2010, with more than 1,000 online views, and it is still being shown in VAMC reception areas and distributed as part of outreach materials. The video won bronze statues in the *Employee Communication*, *Government Relations*, and *Public Relations* categories in the 31st Annual Telly Awards, recognizing the finest video and film productions created for the Web.

Mini Research Program Videos
Target Audience: Veterans, their family members, VSOs, VA research and medical community, VAMCs, and other stakeholders
Description of Effort: To quickly convey program activities and research advancements in a transparent and compelling manner, ORD has started making video documentation of significant meetings, activities, or advancements and turning them into 2- to 3-minute videos that can be posted on the VA and VHA Web sites and YouTube pages. The first video of its kind highlighted a major women's health research conference and was posted within days of the mid-July event.
Outcome/Metrics: Postings of VA Research-related material on social media outlets continue to grow and proactively reach our intended audiences in what is becoming a very conventional method.

Direct Community-Outreach
Target Audience: Veterans, their family members, VSOs, and other stakeholders
Description of Effort: The VA ORD Direct Community-Outreach Program includes exhibits and presentations at VSO meetings, VA Research partner conferences, and scientific functions. Regular briefings are conducted with VSOs and other partners such as the Friends of VA Medical Care and Health Research. Further, ORD is working with VSOs to create a toolkit of resources that can be used by VSO chapter organization leadership during hometown meetings to spread the word about VA Research advances.
Outcome/Metrics: By meeting Veterans face-to-face, ORD outreach efforts build relationships with Veterans, their service organizations, and members VSO leadership. This close contact is invaluable in establishing long-held, professional relationships that foster the bond between ORD and the Veterans we serve. The demand for VA to exhibit at functions continues to increase each year.

As part of outreach efforts, over seven briefings to individual VSOs are conducted annually. In response to requests, ORD community outreach conducted 30 briefings in the hometown of a particular VSO, as well as attended 15 national VSO meetings. By meeting Veterans face-to-face, ORD outreach efforts build relationships with Veterans, their service organizations, and members VSO leadership. This close contact is invaluable in establishing long-held, professional relationships that foster the bond between ORD and the Veterans we serve. The demand for VA to exhibit at functions continues to increase each year.

Mass Media Outreach
Target Audience: Veterans, family members, Veteran Service Organizations, research and medical community, other stakeholders, and general public
Description of Effort: ORD regularly prepares and submits press releases to VA leadership and contributes articles to VAnguard and Hey VA. Also, content was recently provided for "An American Hero" and the Pentagon Channel. ORD has also prepared a series of Questions and Answers on "hot" research areas such as genomics, the DEKA prosthetic arm, and comparative effectiveness research. The number of "good news" stories has increased, with VA Research receiving prominent coverage in national media sources such as the *Washington Post*, 60 Minutes, and CNN. As a further way to make media outlets aware of VA Research accomplishments, ORD released video featuring various research topics, Veterans, and investigators as part of VA Research Week activities.
Outcome/Metrics: As of August 2010, 147 media outlets aired some sections of the video, with a viewing audience totaling more than three million and a broadcast value of $197,000.

VA Research Currents
Target Audience: VSOs, the scientific and medical communities, VAMCs, and other stakeholders
Description of Effort: ORD produces VA Research Currents to provide news about research results, new initiatives, major awards, research funding, and other matters of interest.

Outcome/Metrics: With a print run of nearly 6,000 copies, VA Research Currents is distributed to more than 5,000 readers via traditional mail and sent to more than 4,000 readers via email. It is also available on the VA's Web site. For 2 years running, VA Research Currents has been recognized as the VHA's top publication in the newsletter/magazine category. The publication was also awarded a 2010 ClearMark ranking from the Center for Plain Language.

Internet/Social Media
Target Audience: Veterans, their family members, VSOs, VA research and medical, the public, and other stakeholders
Description of Effort: VA Research implemented a national plan for promoting VA research advances through social media outlets such as Twitter, Facebook, and LinkedIn.
Outcome/Metrics: VA Research and Development has become a regular contributor to all VA and VHA social media venues, with the "Hope" video being among the top-viewed videos. VA Research contributes content for VA and VHA social media sites, such as Twitter and Facebook, as often as three times a week. Topics covered range from deployment related research, such as posttraumatic stress disorder and traumatic brain injury, to aging related conditions, such as Alzheimer's disease and cardiac care.

VA Research Week/Research Week Kick-Off Activities
Target Audience: Veterans, their family members, VSOs, academic and federal research partners, medical and scientific community, and other stakeholders
Description of Effort: VA Research Week is an annual event, which recognizes VA research discoveries and innovations that advance health care for Veterans and the nation. Research Week also celebrates the Veterans who make advancement possible through their participation in VA research studies. Research facilities around the country held a variety of activities as part of VA Research Week, ranging from open houses to Veteran appreciation activities to honor and thank Veterans for their participation in research. Kick-off activities were held in Washington, DC, including a Congressional reception sponsored by VSOs and the Friends of VA Research membership organizations; a research forum at the VA Central Office moderated by the VA's Chief Research and Development Officer, Joel Kupersmith, MD, and featuring a keynote address by Deputy Secretary of Veterans Affairs, M. Scott Gould; and a Veterans celebration at the Richmond VA Medical Center where Veterans learned about VA Research advances and were treated to a performance by Veteran and country music artist Stephen Cochran and his band, The New Country Outlaws.
Outcome/Metrics: Over 400 individuals participated in the first 2 days of events with an additional 400 Veterans attending the Richmond Veterans' celebration.

Workforce Management and Consulting Office, Health Care Retention and Recruitment Office (HRRO): VA Jobs for Vets
Target Audience: Transitioning Veterans
Description of Effort: VA Recruitment Brochure, VA Jobs for Vets, was distributed in July 2009 and will be redistributed in September 2010 to all state Transition Assistance Offices (TAO) and to all TAOs on installations worldwide. This distribution targets

transitioning Veterans to provide them with information on the VA as a preferred employer. Additionally, each VAMC will receive an additional shipment of brochures to distribute in their local communities and at local colleges. This brochure promotes "brand" awareness and results are measured through annual hiring of Veterans. **Outcome/Metrics**: Veteran hires have steadily increased from 21.13% of new hires in FY 2005 to 27.96% of new hires in FY 2009. This demonstrates an increase of 6.83% in hires over the last five years. As of August 30, 2010, there has been a significant increase in the percentage of Veteran Hires to 30.57% (7,778 out of 25,442 total hires). The Healthcare Retention and Recruitment Office has distributed over 100,000 "VA Jobs for Vets" brochures.

VA's National Cemetery Administration (NCA) Outreach

Overview
NCA attends national conventions, conferences, and similar events throughout the country each year. In some cases, when asked, NCA may also provide a speaker at these events. NCA also attends local events.

NCA 2009 Attendance at National and Local Outreach Events
Target Audience: Veterans, their dependents, the public, and other stakeholders
Description of Effort: Attendance at outreach events allows for face-to-face interaction with Veterans, their dependents, and other stakeholders interested in VA memorial benefits. In 2009 NCA attended national events with the following groups:

- 2009 AMVETS Spring National Executive Meeting
- VVA 2009 State Convention
- VBA Women's Veterans Coordinator Training
- International Cemetery Cremation and Funeral Association
- 2009 Public Service Recognition Week
- 2009 Camp Lejeune Maynia Festival
- National Image Incorporated
- TAPS National Convention
- 127th Annual Funerals Directors Association of Kentucky's State Convention
- 80th LULAC National Convention
- LULAC Summit, Federally Employed Women
- Vietnam Veterans of America Marine Corps League
- National Funeral Directors & Morticians Association
- 2009 American GI Forum
- AMVETS
- Veterans of Foreign Wars
- 2009 Women Veterans Coordinator Training Conference
- 2009 Cremation Association of North America
- 91ST Annual Convention, American Legion
- Disabled American Veterans
- Religion Newswriters Association
- 2009 Washington Women Veterans Summit

- 2009 Evolving Paradigms II Conference & Expo
- Fleet Reserve Association
- AARP National Event & Expo
- National Funeral Directors Association
- National Association of Estate Planners & Councils
- National Congress of American Indians 66th Annual Convention
- NAACP National Convention
- Veterans Appreciation Day
- Southern Regional Coalition Non-Profit & Faith-Based Convention
- Delaware State Funeral directors Association First Annual Convention

Outcome/Metrics:
Total number of national events: 32
Total number of local events: 2,762
Total number of estimated attendees: 468,948

NCA 2010 Attendance at National and Local Outreach Events
Target Audience: Veterans, their dependents, the public and other stakeholders
Description of Effort: Attendance at outreach events allows for face-to-face interactions with Veterans, their dependents, and other stakeholders interested in VA memorial benefits. In 2010 NCA attended national events with the following groups:

- Stony Brook University Government Career Fair
- Congresswoman Jenkins 2nd District Veterans' Resource Fair
- Cremation Association of North America & National Funeral Directors Association Cremation Symposium
- International Cemetery Cremation and Funeral Association
- AMVETS 2010 Spring NEC
- Delaware State Funeral Directors Association Annual Convention
- National Image Inc.
- LULAC National Women's Conference
- 130th Ohio Funeral Directors Association Annual Convention and Exhibit, Kansas, Missouri, Nebraska Funeral Directors Association (Tri-State Conventions)
- Public Service Recognition Week
- VVA State Convention
- Maynia Festival
- Caring For Our Seniors Expo
- TAPS National Convention, Career Fair @ National Naval Medical Center
- San Diego's Fourth Annual Veterans Job Resource Fair
- Special Forces Association National Convention
- SAIGE 7th Annual Training Conference
- NAACP VIP Day
- American GI Forum of California
- Funeral Directors Association of Kentucky State Convention
- NAACP 101st Annual Convention
- Caregivers Meeting
- Federally Employed Women (NTP)

- LULAC National Convention
- Gold Star Wives of America
- Indiana Black Expo
- 6th Annual National Veteran Small Business Expo
- American GI Forum
- National Urban League
- Forum on Women Veterans Conference
- National Funeral Directors & Morticians Association
- Senior Information Fair (sponsored by Congresswoman Donna Edward's office)
- Disabled American Veterans
- Cremation Association of North America 92nd Annual Conference
- AMVETS National Convention
- Marine Corps League
- Vietnam Veterans of America
- Blacks In Government 32nd Annual National Training Conference
  Veterans of Foreign Wars
- American Legion
- NOMAR National Training Conference
- Women's Marines Association
- National Council of Negro Women Black Family Reunion
- Fleet Reserve Association
- Congressional Black Caucus Convention
- La Plaza Fiesta Indianapolis
- Religion Newswriters Association
- AARP National Event & Expo
- National Funeral Directors Association
- Washington Women Veterans Summit
- Veterans Extravaganza
- Senior Center Health and Information Fair
- National Congress of American Indians 67th Annual National Convention
- National Association of Estate Planners & Councils
- Eligibility Fair for Women Veterans
- LULAC National Veterans Summit
- The Southern Regional Coalition/Nonprofit/Faith-Based Organizations

Outcome/Metrics:
Total number of national events: 58
Total number of local events: 1,738
Total number of estimated attendees: 563,522 (through July 2010)

2009 Special Event and Ceremonies
Target Audience: Veterans, their dependents, the public, and other stakeholders
Description of Effort: 2009 Memorial Day, Veterans Day, and other special event ceremonies.
Outcome/Metrics:
Total number of local ceremonies: 158
Total number of estimated attendees: 253,864

2010 Special Event and Ceremonies
Target Audience: Veterans, their dependents, the public, and other stakeholders
Description of Effort: 2010 Memorial Day, Veterans Day, and other special event ceremonies.
Outcome/Metrics:
Total number of local ceremonies: 151
Total number of estimated attendees: 277,764

2009 NCA Volunteers
Target Audience: Veterans, dependents, the public and other stakeholders
Description of Effort: Volunteer hours donated in support of VA national cemeteries in 2009.
Outcome/Metrics: Volunteer hours donated: 349,959

2010 NCA Volunteers
Target Audience: Veterans, dependents, the public, and other stakeholders
Description of Effort: Volunteer hours donated in support of VA national cemeteries in 2010. George Weiss, a VA volunteer at Fort Snelling National Cemetery, received the Citizen's Medal from President Obama on August 4, 2010 for more than 30 years of volunteerism serving Veterans at the Fort Snelling National Cemetery.
Outcome/Metrics:
Volunteer hours donated: 257,252 (through June 2010)
Citizen Medals received: 1

NCA National Gravesite Locator (NGL)
Target Audience: Veterans and their families
Description of Effort: The NCA's NGL is available online at http://www.cem.va.gov/ or on VA's mobile site at http://m.va.gov/. NCA came up with the idea to create an NGL in the early 90s to make it easier for anyone with Internet access to search for the gravesite locations of deceased family members and friends and to conduct genealogical research. The NGL was first available on the Internet in April 200 and in 2005, they added approximately 1.9 million records for Veterans buried primarily in private cemeteries to the nationwide locator. In 2006, NGL put cemetery maps online, which users were able to print them from home computers. Continuous technology and process improvements have been made since 2004. As new national cemeteries and state Veteran cemeteries have opened and used NCA's burial system, the NGL has added their gravesite location information. NGL also created a version optimized for hand-held devices in 2009. Currently the NGL includes all of VA's 131 national cemeteries and over 7 million burial records and updates it nightly with information on burials from the previous day, adding approximately 1,000 new records each day.

NCA Social Media
Target Audience: Veterans, their dependents, the public and other stakeholders
Description of Effort: NCA recently added a social media component to our communication efforts and has integrated this with our Internet sites. NCA has begun

using the popular social media site Facebook and the microblog Twitter. Since NCA has begun using these sites, we have experienced a continued increase in the number of viewers on both Facebook and Twitter. NCA also provides content for VA's presence on the social media sites YouTube and Flickr.
Outcome/Metrics:
Twitter followers: 368 (as of August 2010)
Facebook likes: 1,302 (as of August 2010)

NCA Printed Outreach Products
Target Audience: Veterans, their dependents, the public and other stakeholders
Description of Effort: 2009 and 2010 traditional printed outreach products such as fact sheets and brochures. Additionally NCA uses a wide variety of outreach give-away products such as pens, mini flag cases, sewing kits, wristbands and magnets etc.

Fact Sheets:
- Arranging Burial in a VA National Cemetery
- Government-Furnished Headstones and Markers
- Presidential Memorial Certificates
- Medallion Benefit
- Military Funeral Honors
- Burial Flags
- Burial in a Private Cemetery
- The National Cemetery Administration
- National Cemetery Development
- Consumer Affairs: What You Can Do
- Facts About the National Cemetery Administration
- History and Development of the National Cemetery Administration
- State Cemetery Grants Program
- Filming in a National Cemetery
- National Cemeteries Dates Established and First Burials

Brochures:
- NCA national brochure
- Individual cemetery brochures
- Scheduling center brochure

Information sheets:
- Interments in Department of Veterans Affairs National Cemeteries (VA-NCA-IS

Outcome/Metrics:
- NCA fact sheets: 15
- NCA national brochure: 1
- Individual cemetery brochures: 131
- Scheduling center brochure: 1
- Information Sheet for Interments in Department of Veterans Affairs National Cemeteries (VA-NCA-IS-1): 1

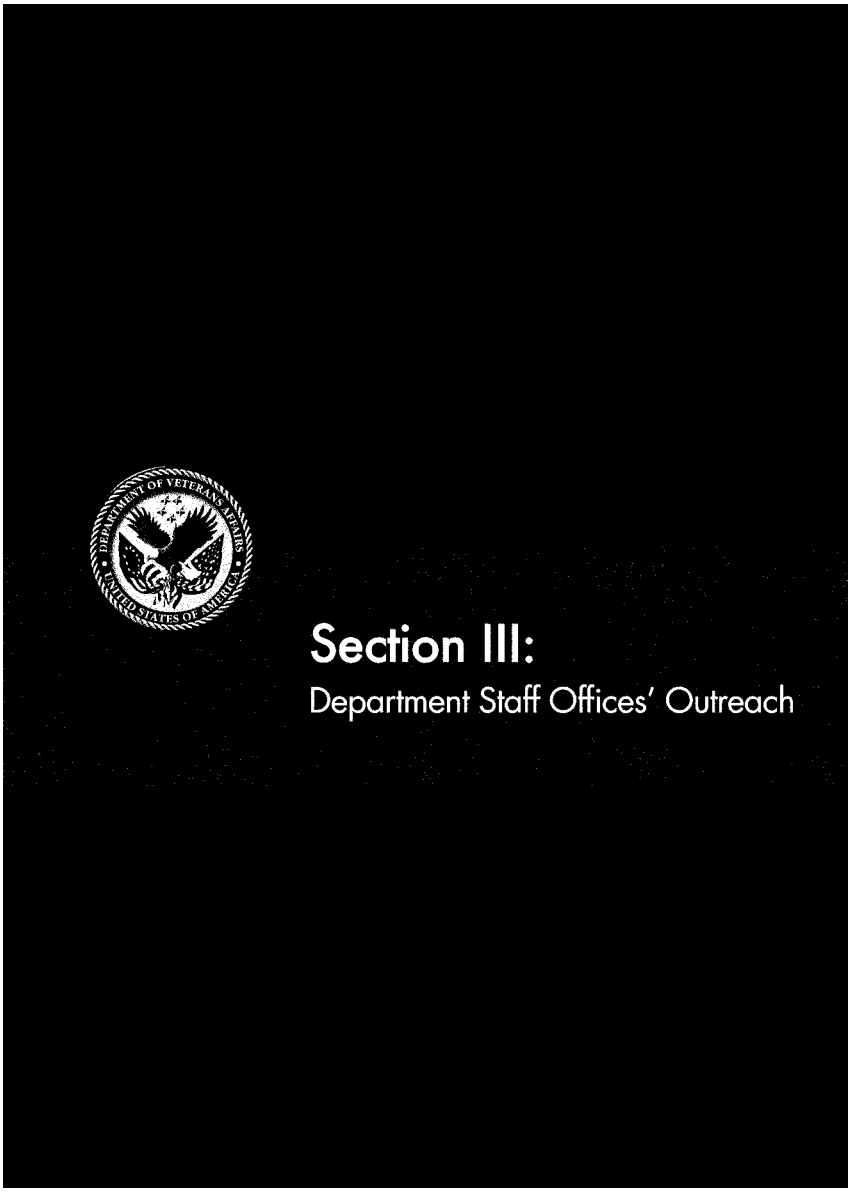
- NCA Input into the *2010 A Federal Benefits for Veterans, Dependents and Survivors*

2009 State Cemetery Grant "Big Check" Ceremonies
Target Audience: Veterans, dependents, the public, and other stakeholders
Description of Effort: 2009 – "Big Check" ceremonies attract state-wide media interest and are well attended by Veterans, the public and federal, state, and local officials.
Outcome/Metrics: Number of state cemetery grant "Big Check" events: 8 (2009)

2010 State Cemetery Grant "Big Check" Ceremonies
Target Audience: Veterans, dependents, the public, and other stakeholders
Description of Effort: 2010--"Big Check" ceremonies attract statewide media interest and are well attended by Veterans and the public; as well as federal, state and local officials.
Outcome/Metrics: Number of state cemetery grant big check events: 2 (2010)

NCA Medallion Benefit
Target Audience: Veterans and their families
Description of Effort: A new VA memorial benefit is now available to Veterans. Family members can now order bronze medallions to affix to an existing privately purchased headstone or marker to signify the deceased's status as a Veteran. The medallion depicts a three-dimensional folded flag surrounded by a laurel wreath with the word "Veteran" on the top and the Veteran's branch of service on the bottom. Eligible Veterans are entitled to either a traditional government-furnished headstone or marker or the new medallion, but not both. Instructions on how to apply for a medallion are located on NCA's Web site.

2009 and 2010 NCA Public Outreach Video
Target Audience: Veterans, their dependents, the public, and other stakeholders
Description of Effort: NCA's outreach video "A Sacred Trust" is the inspiring story of the NCA and its service to our nation's Veterans. Through personal interviews with dedicated NCA representatives, viewers learn of the many benefits available to them and their families in our nation's Veteran cemeteries. Through interviews with family members, viewers experience personal stories of the honorable and dignified process of their Veteran's burial--from application to interment and beyond. Stirring photography accompanies informative narration as viewers gain familiarity with the NCA and its efforts to provide burial benefits to those who gave so much for their country.
Outcome/Metrics: Public outreach video: 1 (2009 and 2010)


Section III:
Department Staff Offices' Outreach

SECTION III: DEPARTMENT STAFF OFFICES' OUTREACH

VA's Office of Public and Intergovernmental Affairs (OPIA) Outreach

Public Affairs

New Media
Throughout 2009 and 2010 the VA's OPIA transformed its outreach efforts by adopting 21st century interactive, personal communications technology enabled by Web-based new media.

VA Web Site
OPIA assumed editorial control and redesigned the VA.gov home page, providing daily content updates.

Social Media/Social Networking/Blogs
OPIA consolidated disparate social media operations across VA under a single authority and established a unifying social media policy for the Department by:

- Launching and providing oversight of 32 VA Facebook pages (including 25 administered by VA medical centers). In August 2009, VA's primary Facebook page had 879 subscribers and by the end of August 2010 it had over 50,000 subscribers--more than any other cabinet-level agency.
- Guiding the launch and overseeing 25 VA Twitter feeds (including 15 administered by VA medical centers). In August 2009, VA had no primary Twitter feed and by the end of August 2010, VA had a primary Twitter feed with over 6,000 followers--more than any VSO.
- Creating VA's first official blogger position, charged with communicating VA's message directly to Veterans and designing VA's first official blog (with an anticipated launch in October 2010).

VA now reaches more Veterans each day through social media than through the entire VA Web site.

The American Veteran Outreach Video
This monthly half-hour news feature format video program produced by OPIA was broadcast to military Servicemembers around the world by the DoD's Pentagon Channel throughout 2009-2010. The number of domestic local public cable outlets carrying the program doubled. The program is also viewed online at www.va.gov. During 2009-2010, the program received three Emmy awards. One of the program's segments on the new GI Bill garnered the most views of any video posted on VA's YouTube during this period.

Federal Benefits for Veterans, Dependents, and Survivors
OPIA edited, updated, and published this 170-page comprehensive guide to VA and other federal programs, services, and benefits for Veterans in 2009 and 2010. It is among the Government Printing Office's most in-demand publications with a distribution of more than 2 million in 2010. It is published in English and Spanish and both editions

are also available on the VA Web site at
http://www1.va.gov/opa/publications/benefits_book.asp.

Post-9/11 GI Bill Launch
OPIA played a major role in implementing and launching the new Post-9/11 GI Bill Educational Benefits Program in the fall of 2009 and throughout 2010. OPIA provided leadership and guidance in establishing an outreach ad campaign aimed at Veterans eligible for the new program and worked closely with VBA and the contracted marketing agency in planning an initial newspaper and Web campaign aimed at college campuses.

OPIA worked closely with the White House in planning President Obama's kick-off event for the new program at George Mason University in 2009. In 2010, as the fall school enrollment season approached, OPIA brought VA leadership, student Veterans, and NASCAR together in front of the VA's Central Office in an event featuring the roaring, smoking Chevrolet 71 stock car driven by NASCAR rookie of the year Landon Cassill and sponsored by "THE POST-9/11 GI BILL" prior to its race on the NASCAR circuit in Richmond, VA. The car became part of the Post-9/11 GI Bill marketing campaign to reach Veterans in and out of service with the message that the new GI Bill and VA were ready and waiting for them to start their race for success.

National Veterans Awareness Campaign
To further enhance VA's outreach activities, $30 million has been set aside for the *National Veterans' Awareness Campaign*. In order to execute such a large campaign, OPIA implemented a two-phased approach to develop a national outreach strategy and execute a national media campaign. To be successful and effective, outreach must be well-planned, researched, executed, and measured. For Phase I, the Department will collect Veteran demographic data and research and analyze targeted audiences for effective media placement. It will also develop an outreach strategy and strategic media plans. Phase I will serve as the foundation for the advertising element of the national outreach campaign, which will occur during Phase II. VA awarded a contract for Phase I on July 15, 2010. Using the data, research, audience analysis, and metrics for success established during Phase I, VA will implement Phase in 2011 and conduct the *National Veterans' Awareness Campaign* and produce and place various national advertising pieces.

VA.Gov Web Site Renovation Launched on Veterans Day 2009
On Veterans Day 2009 VA rolled out the first phase of a large-scale Web renovation to better serve America's Veterans. This first and most visible step of the renovation was changing the Web site's look to make it easier for Veterans and their families to navigate and to find information.

VA for Kids Web Site
This Web site is designed to provide historical information and learning materials related to VA and Veterans for children in kindergarten through 12th grade and their teachers.

M.va.gov via Mobile Devices
This link provides access to VA from your mobile device, enabling you to read and share featured VA news stories, watch videos, and find a VA facility on the go!

Outreach to Returning Veterans
VA launched a new "Returning Veterans" Web site to welcome home Veterans of the Iraq and Afghanistan conflicts with a social, Veteran-centric focus on their needs and questions. The Web site features videos, Veterans' stories, and a blog where Veterans are encouraged to post feedback.

Intergovernmental Affairs

National Outreach Office
VA takes outreach to all our nation's Veterans very seriously. The Department has created an outreach office within OPIA. The new National Outreach Office awarded an IDIQ contract in August 2010 to five marketing/public relations companies. Each company is now allowed to propose a distinct outreach campaign. In September 2010 VA awarded a variety of outreach campaign task orders that cover topics such as Paralympic sport, Veteran homelessness, and suicide prevention. Through these campaigns, OPIA aims to increase Veterans' awareness, education, and confidence using specific and targeted outreach activities and communication materials and products. In addition, the new office has begun assisting Administrations and staff offices with defining and constructing effective outreach strategies. Furthermore, the office has assisted subject matter experts in developing outreach materials and collateral and has helped Administrations and staff offices coordinate outreach efforts. This new approach by the Department ensures delivery of necessary and valuable information to Veterans and their families; leverages technology and partnerships with other stakeholders to distribute outreach information; unifies outreach messages; measures tangible outreach outcomes nationwide; and will report the success of outreach activities to Veterans, Congress, stakeholders, and the American public. We anticipate this office will be fully functional by the end of the year.

Tribal Government Outreach
In November 2009, President Obama tasked all federal departments with developing detailed plans to fully implement Executive Oder 13175 on "Consultation and Coordination with Indian Tribal Governments." VA developed their plan in 2010 and has been successful in meeting its objectives. The end result is to broaden communications between the Department and Native American tribal leaders to improve services to Native American Veterans. The following defines VA's actions during 2010:

- Sent an invitation to the tribal leaders of 564 federally recognized tribes to participate in listening sessions held in January 2010.
- Established a tribal consultation email address to improve the timeframe for communications between VA and tribal leaders.
- Completed the VA Native American Tribal Action Plan and updated it based on suggestions from tribal leaders.

- Attended conferences hosted by Native American organizations. VA staff had the opportunity to speak during conference events and present updates on programs at VA for Native American Veterans.
- Launched a Tribal Government Web site in March 2010.
- Defined their new Office of Tribal Government Engagement in March 2010.
- Attended listening sessions with tribal leaders and members of Native American organizations throughout the year to brief them on the status of the developing consultation policy and to receive a briefing from tribal leaders.
- Finalized the VA Native American Consultation Policy in August 2010.

VA expects the Office of Tribal Government Engagement to be operational in 2011.
Challenges: The 564 federally recognized tribes are located throughout the United States. Many are located in very rural areas and transportation and communications are in short supply. Many tribes lack funding and the ability to travel to VA facilities is limited.

State and County Outreach: For state and county outreach, VA has been successful in instituting new meetings to further their outreach activities:

- Quarterly meetings where state director representatives have the opportunity to meet with high-level VA officials (VA's Secretary, Under Secretaries, etc.) to discuss issues.
- Monthly conference calls where subject matter experts provide up-to-date information on their programs such as education, C&P, etc.

VA's Office of Policy and Planning (OPP) Outreach

The VA's Office of Policy and Planning's VA-DoD Collaboration Service continues to improve outreach to Veteran-related programs through its coordination of programs through the Senior Oversight Committee and Joint Executive Council, notably in coordination of outreach improvements in mental health, disability evaluations, and the Wounded Warrior Resource Center Call Center.

Mental Health

Mental health care provides different challenges for VA and the DoD, in that they serve a common population, but at different life stages. The Interagency Policy Committee Subcommittee on Military Family Mental Health will include other branches of government and community outreach in joint VA-DoD mental health services.
The VA-DoD Integrated Mental Health Strategy uses a public health model, coordinating outreach to the nation as a whole to address mental health as a public health concern. A strategic goal of this strategy directs the VA and the DoD to assist family members in identifying when Servicemembers and Veterans need help for mental health problems and knowing how to seek such help, provide coordinated resources to support families in helping Servicemembers and Veterans engage in care, and minimize mental health conditions as barriers to reintegration of Servicemembers and Veterans into their families, schools, work places, places of worship, and communities by engaging in new forms of partnerships with community organizations.

VA-DoD mental health outreach coordination ensures both entities convey consistent mental health messages; help reduce the stigma associated with mental health; offer education about military culture, mental health, and the readjustment needs of returning Servicemembers, Veterans, and their families; and create incentives for Servicemembers or Veterans who want to develop careers providing mental health services in DoD or VA facilities.

Disability Evaluation System
The expansion of the Disability Evaluation System includes a vocational rehabilitation and education component that focuses on helping Servicemembers plan for their civilian employment future. This outreach does not just employ Veterans, but also prevents underemployment and short-term employment. VA is evaluating the best practices of the military call centers, with special attention to the Marine Corps Call Center practice of making outreach calls to place a priority on personal engagement. The SOC behavioral health action plan to mitigate deployment impacts on Servicemembers and their families integrates a spectrum of psychological health services including outreach to community resources. Suicide prevention approaches use hands-on training in its family outreach to provide awareness and assessment skills to families. VA plans to expand "special outreach" to those who would be uninsurable if they did not convert to VGLI or uninsurable at standard rates, to maximize participation.

Call Centers
The Wounded Warrior Resource Center Call Center placed 11,286 outreach calls from June 2008 to January 2010. These calls assess needs, wellness, family status, financial wellness, employment needs, and health; and inform about rehabilitation opportunities and wounded warrior and reintegration events. The call centers include outreach measures in their performance measures. The 24/7 Defense Centers of Excellence (DCoE) Outreach Call Center provides confidential answers, tools, tips and resources about psychological health issues and TBI.

Outreach to Veterans on Employment
VA expanded its "VetSuccess.gov" Web site in March 2009 to make it easier for Veterans to navigate and for employers to post jobs and find qualified Veterans to fill vacancies. VA collaborated with the National Association of State Workforce Agencies and direct employers to include a Job Central data bank of over 500,000 jobs. Also, three "VetSuccess" videos were introduced via YouTube. These short, testimonial videos tell the inspirational stories of three Veterans who successfully completed their programs of rehabilitation.

VA's Center for Minority Veterans (CMV) Outreach
The Center for Minority Veterans (CMV) supports the Department's strategic effort to "Educate and empower Veterans and their families through outreach and effective advocacy." The CMV strives to develop and foster relationships with community organizations, VSOs, special emphasis groups, and other stakeholders to assist in creating an understanding of the unique needs of minority Veterans. The CMV provides briefings and panel presentations to minority Veterans and their family members,

educates staff and local communities, conducts town hall meetings, and attends national and local conventions.

The CMV identifies and assesses the needs of minority Veterans and conducts targeted outreach to increase awareness of minority Veteran related issues and develop strategies for increasing participation in existing VA benefit programs and services. Minority Veterans Program Coordinators (MVPCs) are located in VAMCs, regional offices, and VA national cemeteries nationwide. The CMV provides guidance to MVPCs and others upon request to maximize the effectiveness of outreach efforts. The CMV oversees the Web-based MVPC Quarterly Activity Reports, which provide the CMV with a systematic review and analysis of the effectiveness of the outreach programs conducted nationwide by the approximately 300 MVPCs. Analysis of the reports enables the CMV to identify and benchmark best practices to share among all MVPCs.

The CMV provides liaisons to targeted minority Veteran populations including Pacific Islanders, Asian Americans, African Americans, Hispanics/Latinos, and Native Americans, including American Indians, Alaska Natives, and Native Hawaiians. In addition, the CMV coordinates the outreach activities of the Advisory Committee on Minority Veterans (ACMV).

ACMV's responsibilities include:

- Meeting with VA officials, VSOs, and other stakeholders to assess the Department's efforts in providing benefits and outreach to minority Veterans.
- Making periodic site visits and holding town hall meetings with Veterans to address their concerns.

CMV outreach activities in FY 2009-2010 included the following:

Asian Pacific Islander

- FAPAC's Veterans Empowerment Workshop
- Nat'l Council of Asian and Pacific Islander Physicians Conference
- Governor's Commission on Asian Pacific American Affairs
- National Federal Asian Pacific American Council
- 6th Annual Fairfax Mega Jobs Fair/ Entrepreneur Expo
- National Alliance for Filipino Veterans Equality
- Filipino WWII Veterans Mira Mesa Senior Center
- DC Chapter National Association Asian American Professionals
- White House Initiative on Asian American and Pacific Islander
- National FAPAC Conference in National Harbor
- National Japanese American Civil League

African American

- Minority Veterans Health Summit, DC VAMC
- 2010 CBC Spring Health Braintrust/National Minority Quality Forum
- Veterans Workshop at the National Urban League 34th Annual Centennial Mid-Winter Professional Development Meeting and New Affiliate CEO Orientation
- Bolling Air Force Base Women Leadership Conference

- Fairfax Mega Jobs/Entrepreneurship Expo
- Caring for our Seniors Expo at the Shiloh Family Life Center
- Public Service Recognition week on the National Mall
- National Urban League 100th Anniversary Conference
- CMV African American Veterans Liaison staffs information booth during 100th Anniversary Conference
- Blacks In Government National Training Conference

Native American
- NCAI Executive Winter Session Conference
- United South & Eastern Tribes Mid-Year Conference

Hispanic American
- Stakeholder meeting with National Council of La Raza
- National Association of State Directors of Veterans Affairs Mid-Winter Conference
- VA/DoD Welcome Home Celebration
- National Council of La Raza National Convention
- American GI Forum National Convention

External Stakeholders
- National Association of County Veterans Service Officers
- Catholic Health Association

In addition, on February 12, 2009, the United South and Eastern Tribes (USET), Inc. Board of Directors supported the establishment of a Veterans Committee. This was a direct result of the outreach efforts of the VA Center for Minority Veterans. Efforts over several years helped USET realize that Veterans from their 25 federally recognized member tribes could use this committee to obtain vital information on VA services and provide the organization a voice.

VA's Center for Women Veterans (CWV) Outreach

The Veterans CWV conducts outreach to women Veterans and their advocates to improve awareness of entitlement to services and benefits offered by VA, as well as to ascertain and highlight the challenges faced by women Veterans as they seek to access these services and benefits. CWV performs this outreach Veterans through direct correspondence and phone contact; and through participation in briefings, town hall meetings, panels, workshops, and other government and community-based activities. The director and associate director also strive to keep those who work with women Veterans aware of what VA offers so they can assist women Veterans more efficiently. CWV staff performs outreach at the annual conference of the Association of Military Surgeons of the United States (AMSUS), a society of federal agencies targeting male and female Servicemembers, particularly those preparing to separate from the military.

As part of Women's History Month, CWV designed its own campaign, *Her Story*, to commemorate the 2009 national theme--"Writing Women Back into History." The

outreach campaign, which began in March and culminates in November 2010, acknowledges the contributions of women Veterans and includes women Veterans sharing their stories on VA's Web site. By posting these stories on VA's Web site, CWV enhances the image of women Veterans and reminds the nation of the sacrifices they have made. Each week, VA highlights one of its woman Veteran employees, discussing her military and civilian experiences. This campaign has received national accolades for recognizing VA women Veteran employees. During November, a *Her Story* documentary will be distributed to VA facilities for broadcast to Veterans at the facilities. The documentary highlights the diverse stories of 10 women Veterans from eras spanning World War II to those returning from Operation Iraqi Freedom.

In 2010, VA held an inaugural Women Veterans Forum to educate, engage, and empower over 225 women Veterans and women Veterans advocates about the enhancements to VA programs and benefits and services for women Veterans. This was a rare opportunity to hear from VA leadership on women Veteran's health, homelessness, benefits, and other issues. The expected outcome of the forum was to engage women Veteran advocates from many geographic locations and gain their stakeholder buy-in so they may assist with outreach in their respective communities. This event was held at the historical Women Veterans Memorial at Arlington National Cemetery. During the event, VA announced that the quadrennial National Summit on Women Veterans' Issues--originally scheduled for summer 2012--would be held in 2011 instead due to the overwhelming response to the Women Veterans' Forum. As in 2008, the 2011 summit will have updates from VA leadership; and hold plenary sessions on women Veterans' health care and mental health, DoD/VA initiatives for returning Veterans, research, employment, homeless programs, and benefits. Several VSOs and other federal agencies will assist VA with planning this event. VA expects to welcome over 500 participants and will invite Congressional staff, White House staff, collaborating federal, state and local agencies, VSOs, women Veterans, and members of the active duty military, National Guard, and Reserve.

VA's Center for Faith-based and Neighborhood Partnerships (CFBNP) Outreach

VA's CFBNP was established on June 1, 2004, by Executive Order 13342. The initial objective was to coordinate the Department's efforts for the elimination of regulatory, contracting, and other programmatic obstacles. Removal of these obstacles would enable faith-based and community organizations to access resources they need to provide social and community services.

The White House Office of Faith-Based and Neighborhood Partnerships coordinates the 12 federal centers for faith-based and neighborhood partnerships. Each center forms partnerships between its agency and faith-based and neighborhood organizations to advance specific goals.

In February 2009, President Obama issued Executive Order 13199 establishing the President's Advisory Council for Faith-based and Neighbourhood Partnerships. The White House Office of Faith-based and Neighborhood Partnerships also coordinate the work of the President's Advisory Council. The Advisory Council is a group of 25 leaders

from both faith-based and non-sectarian organizations, each serving a 1-year term. The Advisory Council recommends ways the federal government can more effectively partner with faith-based and neighborhood organizations.

The VA CFBNP will cultivate and develop partnerships with faith-based and secular organizations to serve our Veterans, their families, and survivors.

The VA CFBNP, through its outreach efforts, provides opportunities for external partners to expand their understanding of and participation in VA programs.

- Exhibited at VA's Women Veteran's Forum held at WIMSA
- Attended and presented at the Faith-Based Grant Summits hosted by Sen. Lindsey Graham in Greenville SC and Sen. Graham and Rep. James Clayburn in Columbia, SC
- Attended the Veterans Day National Ceremony
- Co-hosted and participated in Veterans Roundtables in collaboration with the VBA VR&E Regional Offices in Jackson, MS., Seattle, WA., Newark, NJ., and Waco, TX
- Conducted a workshop at the VA 2010 Caregivers Support Conference
- Hosted four "CFBNP Quarterly Conference Calls" to provide FBCOs with information on ways they can collaborate with VA programs and learn about VA services for Veterans
- Developed two DVDs about the successful partnerships between FBCOs and VA Homeless Providers Grant and Per Diem Program and VA Chaplains working with married couples post deployment and dealing with reintegration
- Upgraded CFBNP Web site to include: Outreach Toolkit, Guidance Materials, and FBNP Success Stories
- Exhibited at the Congressional Muslim Association Intern Day on Capitol Hill
- Participated and presented at the Society for American Indian Government Employee Event
- VA and White House Faith-based Centers co-hosted a Fatherhood Forum--A National Conversation on Responsible Fatherhood and Healthy Families in Fayetteville, NC
- Contributed VA outreach information on the Department of Health and Human Services
- Designed and developed a new CFBNP brochure to aid in outreaching to faith-based and secular organizations.

CFBNP will continue building collaborative relationships with government agencies and faith-based and community organizations to better serve our Veterans, their families, survivors and their communities. The Center will also continue to support the four priorities identified by President Obama and the White House Office of Faith-based and Neighborhood Partnerships:

- Strengthening the role of community organizations in the economic recovery
- Reducing unintended pregnancies, supporting maternal and child health and reducing the need for abortion
- Promoting responsible fatherhood and strong communities
- Promoting interfaith dialogue and cooperation

VA's Non-Government Organizations (NGO) Gateway Initiative Office Outreach

In July 2009, VA launched a new initiative to assist NGOs in their efforts to serve Veterans, their families, and survivors. This is accomplished by providing NGOs with consultation, Veteran data and statistics, and facilitating collaborative opportunities that enhance VA services. Over the past year the Office has conducted 173 meetings and discussions with NGOs; provided 122 referrals to 44 NGOs; developed a vibrant 186 member email distribution list; pushed 46 VA outreach communications on key topics of interest to NGOs, and other activities that have led to NGOs being better inform of, and connected to, VA programs, staff, and Veteran community issues.

VA's Office of Small and Disadvantaged Business Utilization (OSDBU) Outreach

The OSDBU administers VA's small business programs through advocacy, education, and oversight. The CVE promotes business ownership and expansion for Veterans and service-connected disabled Veterans through the use of Veteran targeted posters, briefings, newsletters, videos, and Web sites.

OSDBU encourages agency contractors to subcontract with Service-Disabled, Veteran-Owned Businesses (SDVOSB) by attending local outreach events sponsored by other organizations and participating with prime contractors in prime outreach events.

Veterans Enterprise Web Portal launched a Web site (www.vetbiz.gov) for Veterans in business as a platform that allows for the search of Veteran-owned business, registering Veteran businesses, and additional resources.

The Vendor Information site http://www.vip.vetbiz.gov/ is a database of Veteran and SDVOSBs and the verification program gives participating companies official VA verification of their company's Veteran status, ownership, and control.

PL 109-461, the Veterans Benefits, Health Care, and Information Technology Act of 2006, established SDVOSB as a priority, if such business concern also meets the requirements of the contracting preference. Veteran-owned small businesses (VOSB) shall be considered after SDVOSB. PL 109-461 and the establishment of SDVOSB and VOSB as first and second preference for all eligible procurements are applicable only to VA.

OSDBU began a Mentor Protégé Program to enhance the capabilities of SDVOSBs and VOSBs to perform prime contracts and subcontracts for VA. A large business or well-established small business agrees to provide developmental assistance to a SDVOSB or VOSB. The mentors are given proposal evaluation credit and large businesses may receive additional subcontracting plan credit toward a specific VA

contract. The pilot program was very popular with over 100 agreement submitted for the program.

In FY 2010 VA's small business programs produced outstanding results, with preliminary data indicating that SDVOSB firms received over 19 percent of all VA awards and VOSB firms received almost 23 percent. VA's socioeconomic goals for SDVOSBs and VOSBs in 2009 were 7 percent and 10 percent, respectively. In FY 2010, 36.7 percent of every dollar VA spent was awarded to a small business.

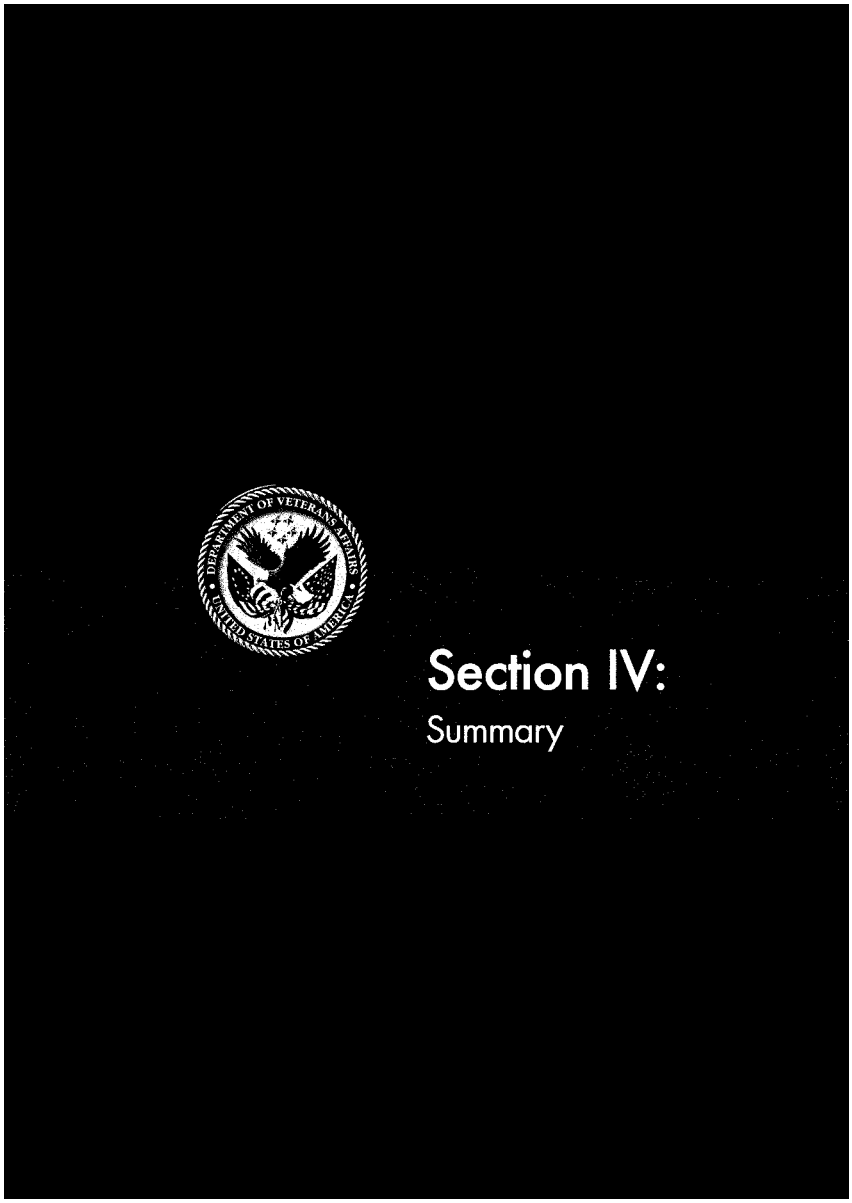
VA's Office of Survivors Assistance (OSA) Outreach

OSA conducts outreach to surviving spouses and family members of deceased Veterans as well as their advocates and the internal VA staff that serve them. The office's goal is to better educate these populations on available entitlement benefits, as well as to learn of the challenges faced by this community. Outreach within the community occurs on multiple levels, including correspondence, telephone, and face-to-face contact. In addition, e-resources such as web content and social media are being continually developed in order to best complete our outreach mission.

Utilizing the aforementioned tools, great strides have been made in bringing education and services to this community. In addition, OSA leadership and staff have participated in multiple meetings and events during this past year, including but not limited to:

- Interdepartmental outreach with the VA Health Administration Center (CHAMPVA)
- Tragedy Assistance Program for Survivors (TAPS) Memorial Day Seminar and Good Grief Camp
- DoD Military Health System 2010 Remembrance Ceremony
- American Gold Star Mothers National Convention
- Gold Star Wives of America National Convention
- Annual OSA / VSO meeting
- Annual Forum for Women Veterans held at the Women in Military Service for America Memorial at Arlington National Cemetery

Through these and future efforts, OSA intends on continuing to build relationships within the community, and develop partnerships in order to best meet the needs of the survivor community.


Section IV:
Summary

SECTION IV: SUMMARY

Through FY 2009 and 2010, VA unleashed a variety of new technologies, tactics, strategies, and activities, all with the hope of fulfilling the Department's vision and President Lincoln's promise.

A few of the outreach activities accomplished over the past 2 years include:

- Continued efforts by OPIA to coordinate all outreach activities through the National Outreach Office and develop effective outreach strategies; coordinate outreach activities; unify outreach messages; measure outreach outcomes Departmentwide; and report on outreach activities to interested stakeholders.
- The launch of eBenefits and continued enhancement by VA and the DoD to the Web portal, which provides Servicemembers, Veterans, their families, and care providers a single, transparent access point to VA benefits and services.
- Entry into the social media arena and its meteoric rise on sites such as Facebook, YouTube, Twitter, and blogs. The Department will continue to employ this successful technology to reach Veterans of all generations.
- Continued strengthening and establishment of new partnerships to achieve and maximize effectiveness, coordination and the interrelationship of services among programs and activities affecting Veterans and their families.
- Implementation of VA's 5-year plan to eliminate homelessness among Veterans, with a focal point of preventing homelessness from ever occurring. The plan focuses on outreach/education, treatment, prevention, housing/supportive services, income/employment/benefits, and community partnerships and both VHA and VBA have already achieved tremendous success in this area.
- Implementation of a new outreach approach for OEF/OIF Veterans called the Seven Touches of Outreach. The program engages National Guard and Reserve Veterans at least seven times during the deployment cycle, with targeted messages and face-to-face encounters with VA staff members. The Seven Touches are: 1) Demobilization Initiative, 2) IRR Muster, 3) Combat Veteran Call Center, 4) YRP, 5) Post-Deployment Health Reassessment, 6) TAAs, and 7) the OEF/OIF Internet Web page.

As this clearly demonstrates, VA is committed and dedicated to our Nation's heroes. From the outpatient clinics, medical centers, Vet centers, and mobile clinics to the Central Office, Administrations, and staff offices, the Department remains zealous, passionate, and unwavering in providing the best benefits and services to our Veterans. Educating and empowering Veterans through proactive outreach is only a fraction of what VA employees do every day, yet it plays a crucial role in reaching out and embracing those who do not use the services or collect the benefits they have so nobly earned.

Question 4. VA's FY 2010 Performance and Accountability Report reflects that independent auditors provided this assessment:

> Interest and administrative costs are required to be charged to VA's delinquent debtors * * *. However, for 87 sample items out of a total of 90 sample selections tested, [the Veterans Benefits Administration (VBA)] did not charge interest or administrative costs on delinquent payments * * *.

The auditors concluded that VA is "noncompliant with the Debt Collection Improvement Act of 1996" and recommended that VA "[i]implement policies and proce-

dures to assess applicable interest and administrative costs or propose a legislative remedy to request waiver of these requirements."

A. What actions has VA taken or does VA plan to take in response to that recommendation?

Response. In accordance with 31 U.S.C. § 3717 and 38 U.S.C. § 5315, as well as the Federal Claims Collection Standards (31 CFR Parts 900–904), VA has published both regulation (38 CFR § 1.915) and internal policy (VA Financial Policies and Procedures, Volume XII, Chapter 1A), which require that VA charge interest and administrative costs on all delinquent debts, including those that arise out of participation in VA benefit, medical care, or home loan programs. However, in 1992, the Deputy Secretary of Veterans Affairs made a decision not to implement the statutory interest and administrative charges on Compensation and Pension debts. This decision continues to be VA policy, which is referenced in Volume XII, Chapter 1A, and is also reported annually in VA's notes to the Consolidated Financial Statements. However, in 1992, the Deputy Secretary of Veterans Affairs made a decision not to implement interest and administrative charges on Compensation and Pension debts. This decision continues to be VA policy; it is referenced in Volume XII, Chapter 1A, and is also reported annually in VA's notes to the Consolidated Financial Statements.

B. Currently, what is the total amount of outstanding delinquent debts?

Response. At the end of FY 2010, VA's total outstanding delinquent debt was $1.3 billion. Of this total, $784 million was attributable to delinquent benefit debts.

As of Feb 28, 2011, the outstanding debt balance for the C&P account is $1,145,841,464; for the Readjustment Benefits account, the debt balance is $368,171,435.

As of December 31, 2010 the outstanding delinquent debt balance for the C&P account was $511,955,867. The majority of debts created for compensation are due to beneficiary death, incarceration and fugitive felons. The majority of pension debt is due to death of the beneficiary and change in income status. For the Readjustment Benefits account, the debt balance is $270,203,419. The majority of debt for the Readjustment account is due to changes in enrollment after tuition has been paid and delinquent debt on advance payments.

Question 5. It is my understanding that, if an individual receives an overpayment of VA benefits, those funds might not be recouped by VA for a number of reasons, such as in circumstances where the debt to VA is waived or if efforts to recoup the overpayment are not successful.

A. During fiscal year 2010, what was the total value of overpayments of benefits and what percentage of those overpayments were not recovered by VA for any reason?

Response. In FY 2010, VBA recorded $1,552,691,000 in new debt. Including overpayments that were still open from prior fiscal years, the total available for collection was $2,812,152,000. During FY 2010, VA collected $1,232,819,000. This leaves 57 percent of the total debt available for collection. Of the total amount remaining, 50 percent is considered delinquent where VA is not currently recouping these funds through payment plans or offsets. However, when a debt is delinquent, VA continues to take action to recoup the funds by referring the debt to the Treasury Offset Program.

B. For those overpayments of benefits that were not recouped by VA during fiscal year 2010, how many of the overpayments were the result of VA errors and what is the total value of un-recouped debts attributable to those errors?

Response. VA systems do not track the source of the overpayment with the resolution of the overpayment. However, when an administrative error generates an overpayment, typically VA would have the means to recoup the overpayment from future payments to the recipient. In the 2010 Performance and Accountability Report, VA reported 64 percent of our compensation improper payments and 34 percent of the pension improper payments were due to documentation and administrative errors. These percentages include both over and under payments.

C. During fiscal year 2011, what is the total value of benefit overpayments that are not expected to be recouped?

Response. For FY 2009 and FY 2010, around 20% of established debt for C&P has been deemed uncollectable. If this figure remains constant for FY 2011, this would be $234 million deemed uncollectable for C&P. For Education, the rate is around 8%, which would equate to $22 million. It should be noted that although a debt is currently deemed uncollectable, it can be re-established and collected if benefits resume.

D. Does the budget request for fiscal year 2012 include funding for benefits that are projected to be overpaid and not recouped? If so, what is that amount and where is it accounted for in the budget request?

Response. In the calculation for the FY 2012 President' Budget request, the Readjustment Benefits account is projecting a net increase of $7.2 million in obligations associated with overpayments. This projection is based on historical trends and updated each budget cycle. This $7.2 million obligation is included in the chapter 33-obligation estimate of $8,481.2 million found on page 2B–2 of the budget. While obligations for the net increase are incorporated into the budget, these amounts may be collected in the future and are not identified as funds that VA does not expect to recoup. Although there is no specific line item for overpayments in the budget request for the Compensation and Pension account, these payments are accounted for in the baseline budget estimates and are not identified as funds that VA does not expect to recoup.

E. Do any performance measures for claims processing staff, service center managers, or regional office directors take directly into account the amount of un-recouped benefit overpayments attributable to their errors or errors of their subordinates?

Response. No, VA systems do not track this information.

Question 6. VA's Central Office is located in Washington, DC, and houses a number of different entities, such as the Office of the Secretary, the Office of Congressional and Legislative Affairs, and other support offices.

A. How many employees were assigned or detailed to VA's Central Office during fiscal year 2008, during fiscal year 2009, and during fiscal year 2010?

Response. Employees assigned to VA's Central office. (Identified employees at station 101 or 101 with any duty station).

FY 08: 4991
FY 09: 4518
FY 10: 4997

The reasons for the drop from FY 2008 to FY 2009 is that OIT lost 249 employees at the VA Central Office and OIG had 462 employees transferred out of PAID because PAID/VA was no longer servicing them for H.R. or payroll. Note: FY 2009 and FY 2010 totals do not include OIG.

B. How many employees currently are assigned or detailed to VA's Central Office?

Response. As of the 3/13/2011 PAID Master File, there are 4861 employees assigned to VA's Central office.

C. If VA's fiscal year 2012 budget request is adopted, how many employees would be assigned or detailed to VA's Central Office during fiscal year 2012?

Response. VA does not project the number of employees that will be funded in budget requests, but rather estimates the number of full time equivalents (FTE) that can be supported by the budget. During FY 2012, VA estimates the General Administration Account will have 2,442 FTE at headquarters and 873 FTE in the field. In a normal year, one FTE generally equals 2,088 hours of work per year. The number of employees will be higher than the FTE reported in the budget due to the fact that VA employs both full time and part time employees.

D. In total, how many contractors and consultants are providing services directly to the staff offices at VA Central Office?

Response. The number of contractors that serve staff offices at VACO is 771.

i. What percentage and dollar amount of these contracts does VA Central Office award to veteran-owned small businesses and service-disabled veteran-owned small businesses?

Response to 6D and 6Di: At this time, VA is unable to provide a complete response to this question as a data analysis of VA's service contracts is currently underway as part of a requirement set by section 743 of the FY 2010 Consolidated Appropriations Act (Public Law 111–117), which require civilian agencies subject to the Federal Activities Inventory Reform Act of 1998 (Public Law 105–270; 31 U.S.C. 501) to prepare an annual inventory of their service contracts.

On November 5, 2010, the Office of Management & Budget's (OMB) issued guidance to Federal agencies on preparing their inventories of service contracts for fiscal year (FY) 2010 which included the requirement to analyze the inventory data to determine if contract labor is being used appropriately and effectively and if the mix of Federal employees and contractors is effectively balanced. VA identified 27,810 number of service contracts Nation-wide and summary information of FY 2010 inventory is currently available to the public at: www.va.gov/oamm/rlib/scainventory.cfm. The inventories include all service contract actions over $25,000 awarded in the specified fiscal year. The inventories consist of funded contract actions including contract actions made on the Department's behalf by other agencies.

Similarly, the lists exclude contract actions made by the Department on another agency's behalf with the other agency's funding.

The analysis of this data is ongoing and will be supplemented with the specific request of information regarding the VA Central Office awards to veteran-owned and service-disabled veteran-owned small businesses. In accordance with the OMB guidelines, VA expects this analysis to be complete by June 30, 2011."

E. I recently received a breakdown of each of the 89 positions within the Office of the Secretary, which includes an "Ombudsman/Non-Governmental Affairs" at a General Schedule (GS)–15 pay level, a non-career Staff Assistant (GS–11); three Special Assistants/Staff Coordinators at GS–9, 11 and 12; three Executive Correspondence Analysts at GS–15; two Executive Writers at GS–13 and 14; two Correspondence Analysts at GS–12 and 13; and a Supervisory Correspondence Analyst at GS–13.

i. For each of these positions, please describe their responsibilities.

Response. The Ombudsman/Non-Governmental Affairs position includes: serving as a primary access point for Non-Governmental Organizations (NGO's) to VA resources, departmental contacts, Veteran data, and VA needs; facilitating opportunities for collaborations with NGO's that supplement VA's services and supports for Veterans, their families, and survivors; promoting complimentary missions that reduce duplication; providing consultation to the Secretary and other Executive Leadership on key NGO matters; and maintaining an extensive network of NGO contacts.

As examples of the activities of this position, during FY 2011 to date, the Ombudsman/NGO has: provided over 174 consultations on, or to, NGO's about VA, NGO community awareness, public/private working relationships, Veterans and their families' needs, and many other related topics; provided 85 NGO's serving Veterans with 153 internal and external referrals to other key resources; worked with more than 10 NGO's serving Veterans to create collaborations that benefit VA, Veterans and their families; represented VA at 17 external Veteran community events; vetted 11 NGO's for senior leader meetings; conducted in-depth research on 43 NGO's; and developed and managed a 205 member NGO network distribution list.

The non-career Staff Assistant position includes: strategic communication planning for announcements, roll-out events, and initiatives to include video releases and video production; and special events to include briefing and staffing especially to support special communications projects planning and execution. As examples of the activities of this position, during FY 2011 to date, the Staff Assistant has: supported Caregivers legislation implementation plan distribution to VA stakeholders; served as executive producer of at least 5 videos used in both internal and external communications; oversaw and advised on various major communications initiatives; planned and coordinated several events for VA leadership to reinforce VA's homelessness program (e.g., DC VAMC Homelessness Stand Down, Homeless Point in Time Count) and a major Senior Leadership Conference.

Three Special Assistants/Staff Coordinators: This pivotal support team serves as a direct staff coordinating element for senior leadership of the Department. They are responsible for a variety of duties relative to planning, executing and recording the day-to-day operational activities for the Secretary of Veterans Affairs, Deputy Secretary and Chief of Staff. This team serves as a direct link between the Department leaders, principal staff, and key leadership throughout the Department. During FY 2010, this team was responsible for scheduling coordination, documenting and executing related follow-on tasks for approximately 1,300 meetings.

This team is also responsible for planning, staffing, and executing travel for the leaders in the Office of the Secretary. They develop complex schedules to meet the intent of senior leadership to achieve maximum efficiencies and ensure that the purpose and outcomes of the site visit is achieved. Coordination requires involvement of VA facility leadership throughout the Continental United States, and both national and local government officials, to include Members of Congress and their staff. Responsibilities include coordination and execution of travel to international locations. This team planned and executed more than 40 site visits in FY 2010 including two overseas.

The Office of the Secretary of Veterans Affairs' (OSVA) Executive Secretariat has a team of staff that is responsible for all business documents and correspondence that require action and signature by the Secretary, Deputy Secretary, and Chief of Staff. The Executive Secretariat positions described below fulfill many of these responsibilities for OSVA.

Three Executive Correspondence Analysts; two Executive Writers: This is a team of writers/reviewers that are responsible for the daily processing and preparation of Executive correspondence for the Office of the Secretary. These analysts and writers processed more than 1,800 documents, to include drafting approximately 400 writ-

ten responses on average in each of the last 3 years. Correspondence includes responses to Members of Congress, Federal, state and local officials, private sector organizations, and internal VA memorandums. The team assured accuracy for content, grammar and consistency of Department positions as well as proper coordination and vetting across all VA elements. This staff also conducted individual and group training for correspondence officials across VA—training more than 300 employees in 2010. In addition to correspondence and decision documents, these employees reviewed and edited all testimony and questions for the record.

Two Correspondence Analysts: These employees prepare, arrange and control correspondence packages for final presentation to Senior Officials. They assure the package contains the necessary information, in the correct order, and then process it after signature for dispatch. They also ensure the official record is complete and in each of the last 4 fiscal years averaged processing approximately1500 items.

One Supervisory Correspondence Analyst: This employee supervises 3 persons to include those that process and assign all incoming mail (approximately 12,000 items per year) and those that answer Office of the Secretary telephones (average more than 70 calls a day). This employee also serves as the Records Management Officer and FOIA Officer for the Office of the Secretary.

All of the employees in this section operate an electronic document management tracking system daily.

ii. Please explain how the staff is of direct benefit to veterans.

Response. Veterans directly benefit from the important work performed by each employee assigned to the Office of the Secretary of Veterans Affairs (OSVA). On a daily basis, the OSVA directly supports the Secretary's mission to transform the Department into a 21st Century organization that is people-centric, results-driven, and forward-looking. OSVA staff is responsible for facilitating effective coordination and cooperation between the Secretary's office and various organizations and stakeholders involved in Veterans' affairs. They implement and oversee various programs, communicate priorities and issues, and prepare correspondence on behalf of the Department.

The OSVA's overall size includes the staff positions described above, as well as other positions and congressionally established offices. The OSVA is compromised of the following:

• Center for Women Veterans Affairs (CWV)—this office was established by Congress in November 1994, and serves as the primary advisor to the Secretary on all matters related to policies, legislation, programs, issues, and initiatives affecting women Veterans. CWV's mission is to monitor and coordinate VA's administration of health care and benefits services and programs for women Veterans.

• Center for Minority Veterans (CMV)—CMV was mandated by Congress in 1994, under Title 38 Public Law 103–446, Section 509. It serves as an advocate for minority Veterans by conducting outreach activities to promote the awareness and use of Veteran benefits and services by evaluating the overall effectiveness of the provisions of VA benefits and services.

• Office of Survivors Assistance (OSA)—OSA was established by Public Law 110–389, Title II, Section 222, in October 2008. Its mission is to serve as the principal advisor to the Secretary on all policies, programs, legislative issues, and other initiatives affecting survivors and dependents of deceased Veterans and Servicemembers.

• Office of Employment Discrimination Complaint Adjudication (OEDCA)—OEDCA is an independent Department of Veterans Affairs adjudicatory authority created by Congress and established in February 1998. Its mission is to objectively review the merits of employment discrimination claims filed by present and former VA employees and non-agency applicants for employment.

• Center for Faith-based and Neighborhood Partnership (CFBNP)—This Center was established on June 1, 2004, by Executive Order 13342. Its mission is to develop partnerships and provide relevant information to faith-based and secular organizations and expand their participation in VA programs in order to better serve the needs of Veterans, their families, and survivors.

• Executive Secretariat—this office is responsible for all administrative operations for the OSVA. The Executive Secretariat serves as the process owner for administrative procedures in the Department of Veterans Affairs Central Office. In addition, the Executive Secretariat is responsible for all business documents and correspondence that require action and signature by the Secretary and Deputy Secretary, such as policy development, personnel actions centralized to the Secretary, review of congressional testimony and responses to pre- and post-hearing questions, spending proposals, regulations, reorganizations, and legislation; the Executive Secretariat is the business owner for the Department's electronic document management and tracking system.

• Office of the Secretary Special Staff—this special staff includes VA's senior leadership's special assistants and senior advisors. This special staff coordinates travel, meetings, and executive briefings; facilitates correspondence; conducts liaison with stakeholders, and assists in VA's transformation through analysis and oversight activity. The special staff also includes non-career staff and advisors such as the Chief Technology Officer, VA Innovation Initiative Program Director, and White House liaison.

Since Secretary Shinseki's arrival in January 2009, the OSVA staff has been a significant contributor to this organization's programs and accomplishments on behalf of Veterans, their families, and survivors. They have been instrumental in establishing a more accountable, transparent and enterprise-wise culture within VA. Accomplishments at VA—with the help of OSVA—are many, but much work remains. VA has helped deliver benefits for the Post-9/11 GI Bill under a compressed timeline and has dramatically improved collaboration with DOD in many areas. From the development of Electronic Health Records to a continuously improving eBenefits system that gives Servicemembers and Veterans direct access to their records, VA is delivering for Veterans. OSVA is an indispensible part of the VA team.

Question 7. Last year, the President signed the Patient Protection and Affordable Care Act (PPACA) into law and that will affect all areas of health delivery in this country.

A. How will the PPACA affect the workload of the Veterans Health Administration (VHA)?

Response. VA has been carefully assessing the potential impact of the Affordable Care Act (ACA) since its enactment. VA's partnership with its consulting health actuary, Milliman, has positioned VA well to assess the potential impact of health reform on VA. Preliminary analyses have looked at understanding how the ACA could impact VA's health care system and to what extent various Model factors such as enrollment, reliance, and morbidity are expected to change. Based on our assessment of the Act, we believe that VA's Medical Benefit Package meets the minimum essential coverage provisions of the ACA. There are also administrative requirements in the Act that could increase VA's resource requirements such as those associated with data sharing with HHS.

B. What steps did VA take to reflect any increase or decrease as a result of the PPACA in this year's budget request?

Response. The ACA establishes the Indian Health Services (IHS) as the payer of last resort for all health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations. Section 10221 authorizes IHS to establish Sharing Arrangements with Federal Agencies. The cost of health care to IHS will be reduced and transferred to VHA. The FY 2012 budget submission includes $52 million in 2012 and $57 million in 2013 for reimbursement to IHS. At this time, VA does not have a clear view of the expected financial impact of this law, but will continue to monitor developments as additional information and clarification is received.

C. What will be the impact of the health care reform act on VA's budget in long term projection models?

Response. Beyond the funds requested in the 2012/2013 budget submission (response 7b above), VA does not have a clear view of the expected financial impact of this law, but will continue to monitor developments as additional information and clarification is received.

Question 8. Recently, VA announced the creation of two new offices—the Office of Patient Centered Care and Cultural Transformation under VHA and the Office of Tribal Government Relations.

A. In what way did VA take into consideration the current budgetary restraints the country finds itself in while creating these offices?

Response. The Patient Centered Care (PCC) effort is one of many transformation initiatives in the Department's Strategic Plan. These major initiatives are designed to improve the value of VA health care—safety, quality, efficiency, and the experience patients and their families have when they obtain VA health care services. A cost benefit analysis was attempted before undertaking our PCC initiative. A literature review suggested that many private sector organizations that have adopted similar patient care principles have realized economic returns on that investment. For example, patients tend to have shorter hospital stays and make different decisions about end of life care.

After reviewing the evidence, we felt that there was not enough specific data to do a formal return on investment analysis. On the other hand, patient centered care approaches are rapidly becoming the norm in private health care. The Joint Com-

mission has recently published proposed standards that will be incorporated into their accreditation requirements. Recognizing the evolving industry standards and the needs of Veterans, VA has undertaken this initiative to craft standards and programs that are best aligned with our unique mission and patient population. We do expect many of the necessary changes can easily be accomplished within existing resources and will improve patient satisfaction and quality outcomes.

OPIA's initiative to Enhance Partnerships with Tribal Governments is a cost effective way to build positive partnerships with tribal governments (i.e., partnerships equivalent to those VA engages in with state and local municipalities) with whom the Federal Government already has a unique political relationship. This effort will result in informed decisionmaking within VA when it comes to policy, program planning and priority setting as the agency serves this population of American Indian/Alaska Native (AI/AN) Veterans. Consequently, informed decisionmaking results in smarter use of fiscal resources and better outcomes for AI/AN Veterans. Twelve percent (12%) of AIANs in the US are Veterans, one of the highest per capita populations of Veterans in any ethnic group. Simultaneously with their exceptionally high rates of military service, AIANs are also one of the most vulnerable populations. Approximately 25% of AIANs live in poverty and they have higher obesity (23.9%) that any other racial/ethnic group (CDC, 2003). Thirty-three percent (33%) of AI/ANs had no health insurance coverage in 2007; of those with coverage, 24% relied on Medicaid (DHHS). Currently VA has one quarter of a single employee (.25 FTE) dedicated to Native American issues. VA has an opportunity to demonstrate its support of AI/AN populations with a relatively low cost through this OPIA office with five full time employees.

More importantly, VA has an opportunity to reduce AINA Veterans' reliance on Medicaid as well as to increase preventative care that reduces later VA medical costs. For example, one of OPIA's current efforts is to jointly coordinate access for VA's mobile clinics and mobile Vet Centers to tribal lands. This is key to fighting obesity among AI/AN populations. Obesity is associated with diseases such as diabetes, cardiovascular disease, hypertension, coronary heart disease and cancer (CDC). A 2003 study on diabetes estimates that it costs $13,243 per patient to treat diabetes compared to $2,560 for patients without diabetes

If OPIA can increase access for VA preventative healthcare and keep just 1% AIAN vets from developing diabetes, VA will save well more than the $800,000 cost for this initiative in OPIA's FY 2011 budget.

B. How many additional full-time equivalents (FTEs) and how much increased funding did VA request for each new office in this request?

Response. There are five FTEs. VA requested $800,000 to fund these offices.

C. Under whose direction will the Office of Tribal Government Relations operate?

Response. The Assistant Secretary for Public and Intergovernmental Affairs.

D. How many people will the office of Tribal Government Relations serve?

Response. According to the 2008 Census Bureau American Community Survey, there are 160,471 American Indian/Alaska Native Veterans. There are 565 federally recognized Tribes (tribal governments). The Office will be working with tribal governments as political entities on a Nation-to-nation (inter-governmental) basis to facilitate communication between the Department of Veterans Affairs and tribal governments.

E. Are there any other new offices currently in the planning stages to be rolled out this year? If so, please explain.

Response. There are no new offices in the planning stages to be rolled out this year in OPIA.

F. Can these services be met through any office currently in existence within VA? If so, please detail which offices and why was it not considered to expand an existing office rather than creating a new one.

Response. No, the Office of Tribal Government Relations (OTGR) office is located within the Office of Public and Inter-Governmental Affairs. The office serves the needs of the VA in relation to incorporating key stakeholder perspectives (in this instance tribal governments) as they apply to cross-cutting issues affecting all three Administrations in VA. Therefore, the best "home" for the OTGR is within an office located at the Departmental level.

Question 9. The Office of Congressional and Legislative Affairs (OCLA) is requesting funding for an estimated 52 FTEs in fiscal year 2012, which is a 44% increase over fiscal year 2010. In addition, each programs office under VHA and VBA has Congressional liaison staff also tasked with working with the Hill.

A. Please explain the functions performed by OCLA and the Congressional liaisons of VHA and VBA. In what areas do they overlap?

Response. The Office of Congressional and Legislative Affairs (OCLA) is the lead office responsible for maintaining open communications with Congress through

briefings, meetings, calls, hearings, site visits, written communications, reports, and responses to requests for information. OCLA also maintains constituent casework offices on Capitol Hill to support Congressional offices' Veterans, dependents, and survivors casework. Additionally, OCLA is responsible for liaison with the U.S. Government Accountability Office (GAO) and coordinates all meetings and correspondence with the agency. During FY 2010, OCLA supported 105 hearings, 322 information briefings, coordinated the responses to over 1,240 questions for the record, responded to over 7,100 written and over 15,000 telephonic requests for information, and countless e-mails, and supported approximately 100 oversight visits. In FY 2010, OCLA also coordinated the VA response to 50 GAO reports that focused on VA issues. In the FY 2012 budget request, OCLA will assume the funding for the Office of Advisory Committee Management, which is responsible for supporting the VA's advisory committees. The Office of Advisory Committee Management supported 23 advisories committees and 54 advisory committee meetings during FY 2010.

The Congressional liaisons assigned to VHA and VBA are the conduit for the flow of information between OCLA and the VA Administrations. Each liaison facilitates the accurate assignment within their respective Administration, manages their Administration's responses to Congress, and tracks actions until they are completed and delivered to Congress. There is no overlap of duties between the Administration Congressional liaisons and OCLA personnel.

Question 10. The deadline for full implementation of the caregivers program as mandated in the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163) has passed with only the plan for implementation presented to Congress a few weeks ago.

A. When does VA intend to move to full implementation of the family caregiver program?

Response. VA has identified below a general timeline with goals for implementing the family caregiver program required by title I of Public Law (PL) 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010. VA's planning and work on regulations has been ongoing since before the Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law. This work has continued throughout the time the Implementation Plan was under development. VA is working as quickly and responsibly as possible to deliver these enhanced benefits to eligible Veterans and their caregivers and will keep the Committee closely apprised of its progress.

Create Caregiver Support Line	February 1, 2011 (completed)
Hire All Caregiver Support Coordinators	April 2011
New State-of-the-Art Web Site	May 2011

On February 28, 2011, VA transmitted a draft Interim Final Rule to the Office of Management and Budget. We believe this measure will expedite the rulemaking process and set the path to begin delivering caregiver benefits as early as this summer.

B. How is the implementation reflected in the FY 2012 budget? How much funding is allotted for this program and under which accounts?

Response. VA will be updating the cost estimates for the implementation of the Caregiver Act. These costs cannot be finalized while the Interim Final Rule is pending. VA will continue to keep the Committee informed, including providing our final estimate, once the process is completed.

Question 11. VA recently announced that it plans to reorganize the Veterans Benefits Administration.

A. Will this reorganization result in the creation of additional positions or elimination of positions within VBA? If so, please specify the number of positions that will be created or eliminated and the nature of those positions.

Response. Eight new positions are created as a result of the reorganization:

- Director, Office of Strategic Planning
- Director, Veterans Benefits Management System
- Director, Veterans Relationship Management Program
- Deputy Chief of Staff
- Deputy Under Secretary for Economic Opportunity
- Director, Pension and Fiduciary Service
- Assistant Director for Pension
- Assistant Director for Fiduciary

No positions are eliminated as a result of the reorganization.

The following positions are re-titled under the reorganization:

• Deputy Under Secretary for Benefits now titled Principal Deputy Under Secretary for Benefits
• Associate Deputy Under Secretary for Policy and Program Management now titled Deputy Under Secretary for Disability Assistance
• Associate Deputy Under Secretary for Field Operations now titled Deputy Under Secretary for Field Operations
• Associate Deputy Under Secretary for Management now titled Director, Office of Management
• Director, Compensation and Pension Service, now titled Director, Compensation Service

B. What level of funding is needed for the reorganization effort?

Response. No additional funding is need for this reorganization. It will be carried out within existing funding levels.

C. Does the fiscal year 2012 budget request include any necessary funding to carry out this reorganization?

Response. No additional funding is requested in the FY 2012 budget to carry out this reorganization.

Question 12. In the General Administration budget request, Volume III page 5A–7, there is a chart entitled "Employment Summary—FTE by Grade," which breaks down proposed General Administration hiring for fiscal year 2012. The current request is for 3,315 General Administration employees, which would be almost 6% more than the 2011 Continuing Resolution (CR) level and 20% over the fiscal year 2010 actual level. Of the proposed 176 employee increase over last year, 148 of these jobs are at GS–12 or higher. This chart also breaks out Senior Executive Service (SES) employees. If VA's request is met, there will be 105 SES employees, an increase of 32 over a two-year period and seven more than last year.

A. How will these staffing increases be of direct benefit to our Nation's veterans?

Response. Half (88) of the 176 FTE increase between 2011 and 2012 is for resident engineers within the Office of Acquisition, Logistics & Construction, who will provide necessary oversight of construction projects at VA facilities nationwide. The remaining FTE increases fall primarily across four staff offices: the Office of Human Resources & Administration, Office of Policy & Planning, Office of Security & Preparedness, and the Office of Management. These FTE will support the Secretary's Transformation initiatives including: the Human Capital Investment Plan, VA DOD collaboration activities, Homeland Security Presidential Directives implementation and compliance, and financial audits of Non-VA Care (Fee) programs. These investments are expected to significantly improve how VA delivers services to Veterans and their families in the near term.

B. Please explain what specific functions these new SES employees will perform.

Response. Of the 32 SES level positions above 2010, 27 were positions approved prior to FY 2012, The distribution of these 32 SES level positions is as follows:

• 10 General Schedule positions within the Office of General Counsel converted to SES (Regional Counsels in the field)
• 9 positions within the Office of Policy and Planning including those of the Deputy Assistant Secretary (DAS) for Policy (1), DAS for Data & Evaluation (1), Chief Actuary (1), and the Enterprise Project Management Office (ePMO) (5)
• 6 positions within the Office of Management: Executive Director of Operations(1), Director, Office of Performance Management (1), Financial Operations (1), Office of Asset Enterprise Mgt.-Green Management (1), Office of Budget (2)
• 3 positions within the Office of Acquisitions, Logistics, and Construction to lead Facilities Acquisition (1), Facilities Programs and Plans (1), and Engineering Operations Support (1).
• 3 positions within the Office of the Secretary
• 1 position within the Office of Security and Preparedness: Director of Personnel Security & Identity Management; lead for Secretary's Preparedness Initiative

C. What is the additional cost for these additional FTEs?

Response. The average annual salary for General Administration FTE is about $93.7 thousand. However, for the 148 FTE (Grade 12 or higher) cited above the average annual salary is approximately $98 thousand. The additional cost for 148 FTE is:

148 FTE × $98 thousand × 1.27% (fringe benefits %) = $18.4 million per year.

Question 13. Another chart available in the budget, Volume III page 5-A8, has a breakout of fiscal year 2010 FTE in two categories, Field and Headquarters (HQ). According to this chart, in fiscal year 2010, 2,028 FTE within the General Administration worked at HQ and 725 in the Field. Please provide a similar breakdown for the requested FTE for fiscal year 2012.

Response:

Analysis of FTE Distribution Headquarters/Field				
Grade	2010 HQ- Actual	2010 Field-Actual	2012 HQ- Estimate	2012 Field-Estimate
SES	63	11	76	13
GS-15*	182	38	219	46
GS-14	629	215	755	260
GS-13	418	131	504	158
GS-12	157	98	189	118
GS-11	137	66	165	80
GS-10	6	0	7	0
GS-9	137	67	165	81
GS-8	47	8	57	10
GS-7	79	44	96	53
GS-6	30	22	36	27
GS-5	31	11	38	13
GS-4	32	7	39	9
GS-3	67	3	81	3
GS-2	12	1	14	1
GS-1	1	1	1	1
Total Number of FTE	2,028	725	2,442	873

READJUSTMENT BENEFITS

Question 1. The fiscal year 2012 budget request appears to reflect (in Volume 3, page 2B–3) that the average cost of automobile grants during fiscal year 2012 will be $11,000. Does this estimate take into account Public Law 111–275, which increased the automotive assistance allowance? If not, please provide a revised estimate including the impact of Public Law 111–275.

Response. The FY 2012 Budget Submission did not include the cost of the increased automobile grants provided by section 804 of Pub. L. 111–275. Including the impact of the increase from FY 2011 of $11,000 to FY 2012 of $18,900, the cost of the Automobile Grant Program will increase by $14.5M in FY 2012. These increased costs will be reflected in the Mid Session Review Readjustment Benefits model update.

Question 2. The fiscal year 2012 budget request reflects that changes made by Public Law 111–377, the Post-9/11 Veterans Educational Assistance Improvements Act of 2010, were "not incorporated into this budget." Please provide updated estimates of the workload, average cost, and total cost of readjustment benefits based on the changes made by that new law.

Response. The impact of Public Law 111–377 is currently being assessed by VA staff and will be fully incorporated into the release of the 2012 Mid Session Review Budget.

Question 3. The fiscal year 2012 budget request with respect to readjustment benefits includes this explanation: "The average cost per trainee is highest for chapter 33, reaching $16,527 in 2012. Chapter 30 average costs per trainee ($8,061 by 2012) are less than chapter 33, causing the majority of eligible trainees to transfer programs." To date, how many trainees have transferred to chapter 33 from chapter 30 and how many additional trainees are expected to transfer to chapter 33 during fiscal year 2012?

Response. We do not have data to identify the number of trainees that have transferred from chapter 30 to chapter 33. We do know that the number of chapter 30 trainees decreased by nearly 95,000 from FY 2009 to FY 2010. Additionally, we know that approximately 36,400 individuals used both chapter 30 and chapter 33 benefits during fiscal year 2010. At this time, we are unable to forecast the number of trainees expected to transfer to chapter 33 from chapter 30 during FY 2012.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Question 1. The fiscal year 2012 budget request reflects that the Vocational Rehabilitation and Employment (VR&E) program expects to spend $897,000 on equip-

ment during fiscal year 2011 and requests $2.4 million to spend on equipment during fiscal year 2012. What factors account for this over 168% increase?

Response. Equipment costs increase to support the hiring of additional FTE for the IDES and VetSuccess on Campus initiatives and for VR&E's share of infrastructure improvements for the co-location and relocation of VBA facilities.

Question 2. The fiscal year 2012 budget request reflects that the Vocational Rehabilitation and Employment program expects to spend $3 million on travel during fiscal year 2011 and requests $3.5 million to spend on travel during fiscal year 2012.

A. What factors account for this 16% increase in travel expenses?

Response. Increased travel costs support the training of new VR&E counselors hired for the IDES and VetSuccess on Campus initiatives and increased oversight to IDES and VetSuccess On Campus locations.

B. How many employees are expected to travel during fiscal year 2012, what is the purpose of the travel, and what is the expected average cost for each trip?

Response. Training requirements for new counselors hired for the IDES and VetSuccess on Campus initiatives will entail travel for approximately 119 new counselors. Approximately two or three oversight personnel will be required to travel to each of the 17 stations that are responsible for VetSuccess on Campus locations and comparably for the IDES locations. The cost of each trip will vary depending on the location of the new counselors and oversight staff and their destinations but the approximate average cost is $1,500 for one week.

Question 3. For fiscal year 2012, the Vocational Rehabilitation and Employment program requests additional employees in order to provide services in connection with the Integrated Disability Evaluation System (IDES). The budget request provides this description: "With mandatory counseling services, we will assist Servicemembers in developing vocational goals and commencing vocational rehabilitation services to support their successful transition from the military to their home communities."

A. Have VA and the Department of Defense (DOD) finalized a plan for including services from the Vocational Rehabilitation and Employment program in the IDES process? If so, please explain when the plan was completed and provide the specifics of that plan.

Response. VA and DOD are developing a plan for expansion of VR&E into the IDES process. The plan has not been finalized.

B. At what point during the IDES process would mandatory counseling take place?

Response. Servicemembers would participate in a mandatory counseling appointment when referred to the Physical Evaluation Board. Vocational Rehabilitation Counselors will receive referrals for appointment scheduling in collaboration with the Physical Evaluation Board Liaison Officers and Military Service Coordinators.

C. Would those counseling services be expected to add to the length of the IDES process?

Response. The counseling services are not expected to add to the length of the IDES process.

D. Would counseling be mandatory for servicemembers in regular components of the military who have already secured civilian employment for after they are discharged from service?

Response. The initial counseling appointment would be mandatory for every Servicemember referred to the Physical Evaluation Board through the IDES process.

E. Would counseling be mandatory for members of the Guard or Reserves in the IDES process who have civilian jobs?

Response. The initial counseling appointment would be mandatory for all Guard and Reserve members referred to the Physical Evaluation Board through the IDES process.

Question 4. In the fiscal year 2012 budget request, there is an increase of 60 FTE due to the realignment of funds currently used to purchase contract counseling services to hire additional vocational rehabilitation and employment counselors.

A. What metric was used determine it was more effective and efficient to hire the additional vocational rehabilitation and employment counselors?

Response. VA compared total costs and quality of service of FTE against that of contract counselors. FTE total costs and performance metrics such as average rehabilitation rate and Veteran feedback were compared against FY 2010 contracting rates and contractor quality of service analysis from case mangers. The analysis indicated savings to the government and better service to Veterans when VR&E counselors were used. Contract counselors are still used to supplement services VA provides to Veterans, including serving Veterans in remote areas.

B. What is the average caseload for FTE counselors versus contract counselors?

Response. Contractors in the last national contract were capped at a 125 Veterans per counselor. In FY 2010 VR&E counselors carried an average caseload of 136 cases.

C. Will the decrease in contract counseling services negatively impact veterans living in rural or underserved areas? Please explain.

Response. VR&E estimates the increased staffing levels and funding in the FY 2012 budget request for contract counseling services will help continue our high level of service to Veterans living in rural areas. Further, VR&E has successfully piloted remote counseling technology to enhance services provided to Veterans living in rural areas and/or who have difficulty with transportation due to disability. The success of remote counseling with both Veterans and counselors has prompted VR&E Service to begin national implementation in FY 2011.

D. What performance measures does VA use to evaluate the effectiveness of contract counseling services?

Response:

Coverage of Jurisdiction—Contractor shall have an adequate number of trained counseling staff to ensure provision of services for Veteran clientele throughout the Regional Office jurisdiction.

Responsiveness—Contractor shall submit accurate timely reports detailing services provided and additional service needs until rehabilitation or closure of the case. These reports must be in accordance with the M28 manual and the report format identified in the contract.

Customer Satisfaction—Contractor shall provide a level of service that is responsive to Veteran or eligible dependents' needs, as evidenced by positive feedback from clients, lack of complaints, and periodic contact of clients by VR&E to assess customer satisfaction.

Question 5. The Vocational Rehabilitation Assistance Study identified the need to incorporate VR&E services into the IDES. In the fiscal year 2012 budget request, VA seeks $16.2 million to employ 110 FTE at the largest IDES locations.

A. At what IDES locations will the FTE be employed?

Response. The IDES installations where VR&E FTE will be assigned have not been finalized. VA is coordinating with DOD to identify locations.

B. How does VA plan to monitor the effectiveness of this initiative?

Response. VA will keep data on all participants in the IDES process. Participation rates will be assessed by the number of Servicemembers that begin the IDES process and receive a rating in addition to those that participate in a rehabilitation and/or education benefit program.

Question 6. For the fiscal year 2012 request, the VetSuccess on Campus seeks almost $1.1 million for the continuation of the eight pilot campuses and nine additional campuses. Please list the additional nine campuses and explain how the additional sites were determined?

Response. The additional nine campuses for 2012 expansion of VetSuccess on Campus have not been identified. A list of schools that meet basic criteria such as number of Veterans on campus, proximity to VA resources, and availability of space on campus, will be used to select the nine campus locations.

HOUSING

Question 1. The fiscal year 2012 budget request reflects that the Housing program expects to spend over $29.9 million on Other Services during fiscal year 2011, which is $790,000 more than VA originally planned to spend on Other Services during fiscal year 2011. For fiscal year 2012, VA is requesting $32.8 million for Other Services. That increase is explained as follows: "Other services increases $6.7 million as a result of increases to the Appraisal Management Service/Automated Valuation Model contract, Housing's portion of contracts supporting the Veterans Relationship Management initiative, and must-fund contracts to internal and external customers."

A. What factors account for the increase in Other Services during fiscal year 2011?

Response. Payroll savings from elimination of the 2011 pay raise were realigned to Other Services to fund a job task analysis for loan production specialists. This supports VBA's strategic plan objective of defining competencies and providing national training products for nationally standardized positions.

B. Please provide a detailed itemized list of how these funds would be spent during fiscal year 2012. To the extent that these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response:

2012 Housing Other Services Increase over 2010

Appraisal Management Service/Automated Valuation Model Contract	$4.2M
Housing's share of the Veterans Relationship Management Initiative	0.1M
Must-fund contracts to internal and external customers management support*	2.4M
Total Increase	$6.7M

*VBA incurs obligations that are considered ''must-fund,'' such as contractual obligations to the Department of Homeland Security for guard services, the Department of the Treasury for mailing benefits payments, the National Archives and Records Administration for records storage, and several VA customers (Debt Management Center, Financial Services Center, etc.). This figure represents those obligations and other management support obligations, such as VBA infrastructure obligations for the collocation or relocation of facilities and equipment operating, maintenance, and repair service contracts, which are apportioned to the Housing program.

INSURANCE

Question 1. The fiscal year 2012 budget request reflects that the Insurance Service is requesting $1.1 million for Other Services. Please provide a detailed itemized list of how these funds would be spent during fiscal year 2012. To the extent that these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. The Insurance Service is requesting $1.1 million in Other Services in the fiscal year 2012 budget for the continuation of ongoing operations and to support the training needs of Insurance employees and stakeholders to assist in serving Veterans and Servicemembers more effectively.

Of this $1.1 million, $750 thousand is budgeted for shared overhead expenses for the Regional Office and Insurance Center, which includes building maintenance, guard services, maintenance and repairs of equipment/furniture, shredding contract, and the building security access system. $344 thousand is budgeted for ongoing training of our human capital, which includes tuition reimbursement, the maintenance of our internal electronic reference guide for system practices and procedures, the development of web-based training modules, and outside training courses.

COMPENSATION AND PENSION

Question 1. VA's FY 2010 Performance and Accountability Report reflects that VBA plans to "contract with vendors to collect medical records from private physicians/offices instead of direct requests to physicians by VA." Similarly, Secretary Shinseki's testimony for the March 2, 2011, hearing before the Senate Committee on Veterans' Affairs reflects that VA intends to use "a private contractor to retrieve the records from the provider, scan them into a digital format, and send them to VA through a secure transmission."

A. Has VA entered into any contracts for this purpose? If not, what is the expected timeline for entering into these contracts?

Response. The Department of Veterans Affairs (VA) entered into a contract with DOMA Technologies, LLC, in September 2010.

B. Through these contracts, how many contractors are expected to perform claims processing functions (i.e., evidence gathering)?

Response. VA has entered into one contract for services provided to seven Regional Offices. Upon expiration of the current contract, VA may seek to enter into another contract with terms that would provide services for additional Regional Offices.

C. Where will these contractors be located?

Response. DOMA Technologies, LLC is headquartered in Virginia Beach, VA.

D. When are contractors expected to be on board and how long is VA expecting to use contractors to gather evidence?

Response. Performance of work pursuant to the contract began in December 2010. The contract is scheduled to expire six months after work began, in June 2011. VA's evaluation of the performance is ongoing, and based upon the results, VA will determine whether a new contract is necessary at the end of the current contract.

E. How much in total does VA expect to spend on these contractors?

Response. VA has budgeted $384 thousand for this contract.

F. Will VA use fiscal year 2011 funds to pay for these contractors? If so, how much?

Response. If VA determines that the benefits of the contractor's services outweigh the costs, VA will use FY 2011 funds to cover the cost of a new contract. VA estimates that the cost of a nationwide contract will be $3 million for 2011.

G. How much is requested for this initiative for fiscal year 2012?

Response. VA has requested $16.4 million for this initiative in FY 2012.

H. What performance measures will be used to gauge the effectiveness of the contractors?

Response. In order to gauge the effectiveness of the current contract, VA is evaluating the timeliness of the seven regional offices using the contractor's services as compared to the timeliness of regional offices requesting medical records directly from private physicians.

I. What impact, in terms of increased productivity, does VA expect from using these contractors?

Response. VA expects this contract to improve the timeliness of claims decisions by reducing the time in the claims processing cycle that VA is awaiting receipt of medical evidence needed to determine eligibility for benefits. The current contract supporting seven regional offices will help VA assess the improvements in the timeliness of service delivery, as well as whether there is any potential for increased productivity through this contract.

Question 2. According to the fiscal year 2012 budget request, VA's goal is to "eliminate the disability claims backlog by 2015 such that no veteran has to wait more than * * * 125 days for a high quality decision." However, for fiscal year 2011 and 2012, VA expects to receive more claims than it decides and, by the end of fiscal year 2012, the inventory of claims is expected to be over 934,000, which is more than double the year-end inventory two years ago. Also, VA expects it to take on average 230 days to complete a claim in fiscal year 2012, which is 65 days longer than it took in fiscal year 2010.

A. Please provide specific details about VA's plan to bring the backlog under control by 2015, such as what level of increase in productivity VA expects once the Veterans Benefits Management System is rolled out, how many claims VA expects to receive in each of the next four years, and how many claims VA would need to decide in each of the next four years.

Response. VA's multi-tiered approach for balancing the attack on workflow includes a number of innovations. Improved access for Veterans will come with advances in increased internet capabilities such as: online access both for claim status and self-service options such as ordering copies of discharge records; this will improve customer satisfaction for Veterans of all time periods while freeing VA staff to work on claims. A 21st Century electronic processing solution will virtually put an end to lost paperwork and infuse new efficiencies through the Veterans Benefits Management System (VBMS). New evidence-gathering tools such as Disability Benefits Questionnaires, three of which are currently in use for Ischemic Heart Diseases, Hairy cell Leukemia, and Parkinson's Disease, will sharpen the focus in medical examinations to ensure all information needed to rate the claim is gathered the first time in the medical examination process and is presented during the development phase of adjudication. The Fully Developed Claims program puts Veterans in the driver's seat for developing a claim that will be ready to rate when submitted, along with features that preserve the earliest possible effective date for back payments upon approval.

In late 2012, VA estimates that production will begin to outpace receipts, the VBMS automated claims processing system simultaneously will be in a deployment phase, having completed a series of pilots currently under way. It will provide powerful new tools to claims examiners to boost efficiency and productivity. In addition to gains in accuracy which may reduce re-reviews and appeals, the rules-based processing and calculator tools also have a side benefit of speed in the rating process which will pay dividends in employee productivity and provide more staff hours to rate other claims.

Beyond the estimates submitted in the 2012 President's Budget, VA estimates receipts to be 1.39M, 1.46M, and 1.53M 2013 through 2015. Likewise, VA estimates production to be 1.40M, 1.61M and 1.85M in 2013–2015. Working under the assumption that the 2012 request for 14,320 C&P direct labor FTE remains constant, productivity due to the impact of the overall transformation plan (of which VBMS plays a part) will rise from 89 annual claims per C&P direct labor FTE in 2012 to 129 in 2015.

B. Please explain whether the fiscal year 2012 budget request would provide VA with the tools and resources needed to follow through with that plan.

Response. VBA's 2012 General Operating Expense budget request includes 14,320 direct FTE for compensation and pension claims processing as well as $72.7 million and 66 FTE for program management and oversight of transformation initiatives, to include the Veterans Benefits Management System and Veterans Relationship Management initiatives. We believe these are the resources necessary to continue to deploy important initiatives associated with the transformation plan in 2012.

Question 3. In discussing changes from the original fiscal year 2011 budget request, the fiscal year 2012 budget request for Compensation, Pensions, and Burial reflects that "[o]bligations increase $11.8 million for Other Services above the fund-

ing reallocated from FTE from the original budget estimate." The fiscal year 2012 budget request also reflects that VA is requesting $337 million for Other Services for fiscal year 2012.

A. During fiscal year 2011, how much was reallocated to Other Services from FTE and for what purpose?

Response. In FY 2011, VBA will realign approximately $57 million from personal services for exploration of alternatives to FTE to assist in breaking the back of the backlog.

B. What factors account for the $11.8 million increase in Other Services during fiscal year 2011?

Response. The $11.8M increase is a result of the realignment of personal services funding to be used for exploration of alternatives to FTE to assist in breaking the back of the backlog.

C. Please provide a detailed itemized list of how these funds would be spent during fiscal year 2012. To the extent that these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Compensation & Pensions (C&P) Service
2012 President's Budget—Other Services Funding Request

Medical Examinations	$226.7M
Veterans Benefits Management System	31.5M
Claims Transformation Plan	27.8M
Instructional Systems Development and Training—includes Challenge training, leadership, and employee development programs	18.2M
Pilots and Studies—includes work earnings loss study, pilot for sending checklists to Veterans for information needed from them to process their claims, Institute for Defense Analyses (IDA) contract to assess and implement changes to enhance the accuracy of the quality assurance program	4.0M
C&P Operations and Support*	28.5M
Total Other Services Funding Request	$336.7M

*This includes C&P Service's routine operational expenses, such as contracts for shredding, equipment maintenance, and travel requirements. It also includes C&P Service's portion of ''must-fund'' obligations, such as contractual obligations to the Department of Homeland Security for guard services, the Department of the Treasury for mailing benefits payments, the National Archives and Records Administration for records storage, and several VA customers (Debt Management Center, Financial Services Center, etc.). The remaining funds consist of C&P Service's portion of the Veterans Relationship Management initiative; VBA infrastructure investments, such as the co-location or relocation of facilities and associated equipment contract costs; and equipment operating, maintenance, and repair services contracts.

Question 4. In connection with the Committee's February 2010 hearing on VA's fiscal year 2011 budget request, VA reported that "[i]n fiscal year 2010 the estimated output per Compensation and Pension direct labor FTE is 78 processed claims" and "[i]n fiscal year 2011 the estimated output per Compensation and Pension direct labor FTE is 79 processed claims."

A. For fiscal year 2012, what is the projected output per Compensation and Pension direct labor FTE (including in that FTE total any contractors that will perform claims processing functions, such as evidence gathering)?

Response. VA estimates 14,320 Compensation and Pension direct labor FTE will produce ~1,274,000 disability compensation and pension claims for an output of ~89 claims per direct labor FTE in fiscal year 2012. This estimate does not include any additional contractors that may perform claims processing functions, such as evidence gathering, due to the fact that the only services VA contracts for currently is a pilot to retrieve medical evidence from private physicians. The goal of this contract is not to supplement direct labor FTE, but to expedite the retrieval of evidence.

B. As part of the plan to break the back of the backlog, will VA focus on increasing the average number of claims processed per employee? If so, please explain.

Response. Yes, VA's multi-tiered approach for eliminating the backlog includes a number of innovations. Improving online access for Veterans to obtain claim status information and perform self-service options, such as ordering copies of discharge records, improves customer satisfaction while freeing VA staff to work on claims. A 21st Century electronic processing solution will virtually put an end to lost paperwork and infuse new efficiencies through the Veterans Benefits Management System (VBMS). New evidence-gathering tools such as Disability Benefits Questionnaires, now rolling out, sharpen the focus in medical examinations to ensure all information needed to rate the claim is gathered in the medical examination and presented succinctly. The Fully Developed Claims program puts Veterans in the driver's seat for submitting a claim that will be ready to rate when received by VA.

At the projected late–2012 peak of the bridge span when decisions production begins to outpace claims receipts, we will begin national deployment of the VBMS

automated claims processing system. VBMS will provide powerful new tools to claims examiners to boost efficiency and productivity. In addition to gains in accuracy and reductions in rework and appeals, the rules-based processing and calculator tools will also speed the rating process and increase productivity.

Question 5. In connection with the Committee's February 2010 hearing on VA's fiscal year 2011 budget request, VA was asked to explain what would be a reasonable goal for rating-related claims processed per employee and VA provided this response: VA is currently undergoing a metric study associated with rating-related claims processed based upon employee experience levels. One key factor being analyzed is the average number of issues addressed for rating-related claims. We expect this study to provide us with baseline information that will enable us to establish appropriate measures and goals for claims processing employees.

A. What is the status of that initiative and how much in total has VA expended on this initiative?

Response. In 2009, the Institute for Defense Analyses (IDA) was contracted to conduct a study and provide an assessment of the current personnel requirements of the VBA. This study involved an analysis of rating-related claims processed based on employee experience levels and an assessment of the adequacy of the number of personnel assigned to each regional office for each type of claim adjudication position. VA paid $600,015 for this contract, which was mandated by section 104(b)(2) of Public Law 110–389, the Veterans Benefits Improvement Act of 2008. Results are being considered in the current revision of claims processors' performance standards, as discussed in response to question 5C below.

B. For fiscal year 2012, how much, if any, funding is requested for purposes of this initiative?

Response: No funding is requested in FY 2012 for this initiative.

C. For fiscal year 2012, will goals for claims processing employees be established based on this study? If so, please provide a list of the goals for claims processing employees with various levels of experience.

Response. Goals for claims processors have not been revised based on this study. However, VBA is currently reviewing and revising the current performance standards for each category of claims processors, including Veterans Service Representative, Rating Veterans Service Representative, and Decision Review Officer. VBA is engaged with our Union partners to develop revised standards that allow VBA to achieve our overall strategic goals while meeting the needs of our stakeholders and employees. We anticipate these standards to be implemented in early FY 2012.

Question 6. Since 2006, the level of claims processing staff has increased by more than 80%. In connection with the Committee's February 2010 hearing on VA's fiscal year 2011 budget request, VA was asked what metrics would be used to determine whether these hiring initiatives have been effective. VA responded that, "[w]hile VBA uses a combination of workload management indicators to gauge performance, we will closely monitor rating quality, inventory, and completed claims to determine the effectiveness of our recent hiring initiatives."

A. For fiscal year 2010, please explain whether those indicators (rating quality, inventory, completed claims) reflect that the large staffing increases have been effective.

Response. VA's recent staffing increases have been effective in decreasing the overall impact of external factors on performance. We increased our workforce in 2010 by converting 2,400 American Recovery and Reinvestment Act employees to full-time and by hiring an additional 600 new employees; these employees are assisting VA in taking on the challenge of a dramatically increasing workload.

VA's pending claims inventory is rising due to the unprecedented volume of disability claims being filed. In 2010, we received approximately 1.2 million disability claims, a 17.6% increase over the previous year. While the volume and complexity of claims have increased, so too has the overall production effort of our claims processing workforce. In 2010, VBA processed an historic 1.08 million claims, an increase of 10.2% over 2009.

VA continues to aggressively train claims processing staff across the Nation. Recognizing that it takes approximately two years for a new hire to become fully trained in claims processing, new employees are mentored and provided timely feedback from trainers, reviewers, and supervisors. Area offices are also providing increased oversight and support for those ROs whose national rating-related claims quality is below 85%.

VA currently employs over 11,000 full-time claims processors. Hiring more employees is not a sufficient solution. The need to better serve our Veterans requires bold and comprehensive business process changes to transform VBA, and therefore VA, into a high-performing 21st century organization that provides the best services

available to our Nation's Veterans, survivors, and their families; The Claims Transformation Initiative is VA's effort to achieve these goals and break the back of the backlog by 2015.

B. Please explain whether any measures of individual employee productivity currently are used to gauge the effectiveness of hiring initiatives and, if not, whether any such measures will be used during fiscal year 2012.

Response. VA is actively revamping individual employee performance standards to ensure that individual goals tie directly to national initiatives to reduce the backlog and process claims with a 98% accuracy rate. In April 2010, VA implemented the revised performance plan for Veterans Service Representatives (VSRs) nationwide. This plan no longer allows work credit for interim claims actions; VSRs now receive credit only for performing a series of actions that will advance the claim to the next stage of the claims life cycle. The quality element has been increased to align the individual goal with the national quality goal, and local quality reviews are now based on the same review checklist as the national quality reviews. The revised performance plan is also designed to align local station performance targets to employee performance in both the quality and quantity of individual workload output. Similar reviews and revisions are currently underway for the Rating Veterans Service Representative and Decision Review Officer performance plans.

Question 7. VA's FY 2010 Performance and Accountability Report reflects that VA has developed "an overtime tracker to allow for nationwide reporting of claims processing during overtime hours at the local and national level."

A. For fiscal year 2010, how many overtime hours were worked for purposes of claims processing, how much in total was expended to pay for those overtime hours, and how many claims were completed as a result of those overtime hours?

Response. In FY 2010, VBA expended $32 million for claims processing overtime. This is not broken down nationally by total overtime hours worked. Regional offices are allotted overtime funds based on local workload and support of national programs. VBA completed almost 250,000 actions related to rating claims in FY 2010 on overtime. This included development actions and preparation and promulgation of rating decisions. Because all actions associated with processing individual claims are rarely all completed during overtime hours, a measure of "claims completed during overtime hours" is not easily defined. All claim's steps processed on overtime are necessary and lead to the eventual completion of the rating claim.

B. For fiscal year 2011, how many overtime hours are expected to be worked for purposes of claims processing, how much in total is expected to be expended to pay for those overtime hours, and how many claims are expected to be completed as a result of those overtime hours?

Response. Because we are operating under a continuing resolution, our overtime spend level for FY 2011 is currently the same as FY 2010, $32 million for claims processing. We recently directed that overtime funds be specifically focused on completion of rating actions and promulgation of rating decisions, which will increase the number of rating claims completed on overtime. We continue to explore ways to integrate data across systems to better quantify work completed during overtime hours.

C. For fiscal year 2012, what level of funding is requested to pay for overtime hours for claims processing? How many claims are projected to be completed as a result of those overtime hours?

Response. In FY 2012, the VBA budget request includes the same level of funding for claims processing overtime, $32 million. For the reasons articulated in the previous responses, VBA does not have specific projections of overtime production. However, transformational initiatives such as Smart VA-Calculators and Disability Benefits Questionnaires (DBQs) will increase both efficiency and production of completed rating decisions. VBA expects to realize a resulting increase in production of rating claims completed on overtime.

Question 8. In connection with the Committee's February 2010 hearing on VA's fiscal year 2011 budget request, VA reported that the overall attrition rate for VBA claims processing staff was approximately 10% per year from fiscal year 2005 to fiscal year 2009. VA also reported that "Regional offices that have difficulties in meeting performance targets are predominantly in high-cost metropolitan areas with high employee turnover."

A. What was the overall attrition rate for compensation and pension claims processing staff in during fiscal year 2010?

Response. The attrition rate for VBA claims processors (permanent employees in GS–0996/0930 series positions) during FY 2010 was 6.05 percent.

B. Please identify the five VA regional offices that experienced the highest attrition rates during fiscal year 2010 and the rates of attrition at those offices.

Response. In FY 2010, the following regional offices had the highest attrition rates for claims processing personnel (permanent employees in GS–0996/0930 series positions):

Anchorage, AK: 25%
White River Junction, VT: 17%
Manchester, NH: 14%
Little Rock, AR: 12%
Albuquerque, NM: 12%

C. For those offices, please identify the key performance outcomes for fiscal year 2010, including timeliness and quality measures.

Response. Key performance measures for fiscal year 10 were Average Days Pending (ADP), Average Days to Complete (ADC), and Rating Quality.

	ADP	ADC	Rating Quality
National Average	116.9	165.5	83.8%
Anchorage	110.1	186.1	87.6%
White River Junction	156.2	208.0	82.4%
Manchester	116.3	168.6	84.4%
Little Rock	98.7	162.9	82.7%
Albuquerque	117.1	161.5	85.4%

D. During fiscal years 2011 and 2012, what level of staffing and funding will be provided to those offices and what measures will VA take to ensure that Veterans in those areas will receive timely, accurate decisions?

Response. The staffing levels for FY 2011 are as follows: 41 FTE in Anchorage, 25 FTE in White River Junction, 64 FTE in Manchester, 198 FTE in Little Rock, and 98 FTE in Albuquerque. Funding for FY 2011 has been provided to support these staffing levels. The regional office (RO) staffing and funding levels for FY 2012 will be determined after receipt of the FY 2012 appropriation and will be based on the latest workload and performance information available at that time.

For the past several years, VBA has used a brokering strategy to assist ROs experiencing high turnover and to balance the inventory of pending claims across ROs. Pending claims are sent from ROs with high inventories to offices with capacity to process additional workload. This strategy is being used in all five of these ROs in fiscal year 2011.

VBA monitors performance and develops specific action plans to improve performance. Oversight is provided through site visits conducted by both the Compensation Service and the Area Directors. RO directors are held accountable for performance though annual performance evaluations.

Question 9. Under current law, a VA claimant and an attorney or agent who is representing him/her before VA may enter into an agreement providing that, if past-due benefits are awarded to the claimant by VA, the attorney or agent's fee will consist of a percentage of those past-due benefits and the attorney or agent will be paid directly by VA from those past-due benefits. In January 2011, VA announced that it is developing new procedures to govern cases where "VA mistakenly fails to make a direct payment of fees to an accredited attorney or agent out of VA funds." VA provided this explanation: Current VA procedures note that, if VA fails to withhold a portion of past due benefits for direct payment of fees and the attorney or agent is eligible for fees, VA will pay the representative from VA funds. This procedure will remain the same. However, new procedures will provide that VA may recoup the amount of the fees by establishing an overpayment against the past due benefits paid to the claimant.

A. To clarify, before these new procedures are implemented, if VA pays both the attorney or agent and the claimant for the amount that should have been paid directly to the attorney or agent, does VA try to recoup the duplicate payment?

Response. No. Under the current procedures, if VA pays both the attorney or agent and the claimant the amount that should have been paid directly (and solely) to the attorney or agent, VA does not recoup the amount of the overpayment. The new procedures will provide that VA may recoup the amount of the fees from the claimant.

B. In fiscal year 2010, in how many cases did VA fail to make direct payment of fees to an eligible attorney or agent and how much in total was paid to attorneys or agents "from VA funds" as a result?

Response. The number of times VA fails to make direct payment of fees and the total amount paid to attorneys and agents from VA funds is not available, as this information is not electronically tracked.

C. To date, in fiscal year 2011, in how many cases did VA fail to make direct payment of fees to an eligible attorney or agent and how much in total has been paid to attorneys or agents "from VA funds" as a result?

Response. See the response to 9B.

D. What is the expected timeframe for developing the new procedures?

Response. The Fast Letter outlining the new procedures is in the final concurrence stages of VBA. Once approved, the field will immediately implement the new procedures.

Question 10. During 2010, VA was pursuing at least 40 pilots and initiatives in order to try to address the backlog of disability claims. As discussed at a July 2010 hearing, over 12 years ago, former Under Secretary for Benefits Joe Thompson said this about VA's efforts to improve claims processing:

> [The Veterans Benefits Administration] has undertaken a number of initiatives to bring about needed change * * *. The reasons for the lack of success * * * [include] inadequate planning, unclear goals and objectives, poor integration of interrelated efforts, a lack of coordination with other stakeholders, and insufficient implementation planning and follow-up.

A. Please provide a list of any current initiatives/pilots.

Response. See the attached document entitled "VA Claims Transformation—Claims Transformation Initiatives."

VA Claims Transformation

April 2011

Claims Transformation Initiatives

Claims Segmentation

Agent Orange Nehmer claims processing
Philadelphia, Huntington, Roanoke, St. Petersburg, Columbia, St. Louis, Togus, Lincoln, Muskogee, Waco, Phoenix, Seattle, and San Diego
Nationwide implementation completed (Inactive as pilot)
Consolidation of cases to 13 Resource Centers – Day-One Brokering Centers
Process Agent Orange Nehmer claims timely and accurately

Express lane for limited issue claims
Seattle, Nashville, Muskogee, St. Paul – Pilot ongoing
Segment single issue claims at each station
Remove one-issue claims from queue and process them with higher productivity, and analyze the impact and feasibility of this procedure nationwide

Specialize mental disorder claims
Huntington, Roanoke – Pilot ongoing
Create a dedicated team for pre-determination, rating, and authorization at VSCs to handle all claims with mental disorder issues
Review feasibility and impact if ROs were to assign the most difficult cases to high performing employees, develop expertise from specialization, and address the disincentive in existing performance standards for working on more difficult cases

Leadership and Culture

Integrated communications program
Central Office – Initiative under way
Create a strategic communications program to understand and address internal and external stakeholder concerns through updates on the transformation plan
Motivate internal stakeholders to transform the organization and instill confidence in external stakeholders

VHA/VBA Collaboration (Improve VHA coordination and exam time)
Western Area and Central Office
Nationwide implementation completed (Active as pilot)
Partner with VHA to improve coordination, process, and capacity to reduce turnaround time for exams and medical consults
Eliminate exam cancellations, reduce exam turnaround time, and look for other areas to collaborate better

Legislative and Regulatory

Extend Diaries for Routine Future Exams
Nationwide implementation completed (Inactive as pilot)
Extend routine future exams scheduled for less than 5 years to the maximum period of 5 years unless exam is required by statute.
Free up resources that would have been used for processing routine future exams for tackling other claims

Performance Management

Additional quality metrics
Central Office – Closed
Create a quality metric that is based on accuracy of adjudication decision and payment to Veteran, as opposed to accuracy of adjudication process

Improve performance management
Central Area – Initiative under way
Reduce station and employee performance variance by reviewing best practices regarding management, standards and incentives
This initiative will include conversations with high performing station managers to identify drivers of high performance

Improve quality management
Muskogee – Initiative under way
Improve local quality reviews to include identification and resolution of root causes adversely impacting quality
Consider shifting audit responsibility from coaches to dedicated quality officers at each VSC; improve mechanisms to address sources of error by offering targeted training to employees or stations that display consistent patterns in quality review; identify what high quality ROs are doing that is different from other ROs in terms of quality management, and share best practices

Recruiting and hiring best practices
Detroit Human Resources Center – Initiative under way
Implement recruiting and hiring best practices
Learn from ROs that are consistently successful at bringing in talent, share best practices with all ROs, provide support in terms of recruiting material, and reform hiring policy to give ROs more flexibility in picking the best candidates

Revise performance standards (3 Initiatives)
VSR – Togus – Nationwide implementation completed (Inactive as pilot)
RVSR – Hartford – Pilot in planning
DRO – Houston – Pilot in planning
Revise VSR, RVSR, and DRO performance standards to align them with station and VBA goals

"Who's Who" recognition program
Nationwide implementation completed (Active as pilot)
Create a national recognition program for the highest performing VSRs and RVSRs to include quality, production, and availability time
Recognize employees quarterly and annually

Comprehensive Screening
Hartford – Pilot ongoing
Division split into four teams, with each team completing all work in a "terminal digit" range. Mail identified as requiring action, or "pull mail," receives initial screening.
Improve claims processing timeliness by reducing the number of hand-offs and quickly taking action on "pull mail."

Process Design

Case management
Pittsburgh – Pilot ongoing
Experiment with several processes including phone development, physician statements, and queuing evidence to reduce the administrative burden on RVSRs, etc.
Identify improvements to current processes to reduce claims cycle time

Centralize outbound mail
Lincoln – Not implemented
Shift responsibility of sending outbound mail from VSRs to mailroom employees and test concept for potential vendor/contract assistance.
Reduce administrative burden on VSRs to increase their productivity

Walk-in concept
Wichita and Milwaukee – Pilot complete
Encourage veterans to bring ready-to-rate fully developed claims through incentive of same day rating
Improve quality and completeness of claims submitted to reduce processing time

Lean claims processing
Little Rock, Montgomery – Pilot complete; Chicago – Pilot ongoing
Use lean operations principles to reduce waste in process flow, including co-located teams for processing claims
Eliminate time lost from handoffs, improve communication between VSRs and RVSRs, and draw upon RVSR expertise during development

Disability Benefits Questionnaires
Nationwide implementation ongoing
Use of disability benefits questionnaires to provide medical exam evidence needed to provide an accurate and timely disability decision; partner with Veterans to obtain exams
Reduce the wait time for VHA exams, revise old exam templates

Proactive phone development
Nationwide implementation completed (Active as pilot)
Proactive phone development for collecting evidence from veterans, physicians, VHA and other sources
Reduce development cycle time through faster and better communication

Rapid evaluation of claims
Atlanta – Pilot complete
Create a fast-track process for increased compensation when a Veteran provides medical evidence supporting an existing condition and accurate rating. The evidence must support waiving the VA exam.
Increase quality of claims received and reduce processing time

Review process manual
Central Office – Initiative under way
Conduct a comprehensive review of the process manual to identify opportunities to reduce complexity, remove unnecessary steps, and address common sources of error
Eliminate unnecessary steps to reduce administrative burden on claims processors

Rules-based processing for pension/dependency
St. Paul – Initiative under way
Develop rules for auto adjudication of pension and dependency claims
Free up resources that would have been used for basic pension claims and use them to tackle more difficult disability claims

Smart VA: rules-based processing (hearing loss calculator)
Phoenix – Nationwide implementation completed (Inactive as pilot)
Develop rules for auto adjudication of basic compensation claims
Free up resources that would have been used for basic compensation claims and use them to tackle more difficult disability claims

Veteran interviews and education
Albuquerque – Pilot ongoing
Contact the Veteran telephonically and conduct a personal interview to clarify disabilities/benefits claimed and sources of medical records. Produce or video regarding claim process to help educate Veterans.
Increase advocacy for Veterans

Integration Lab
Indianapolis – Pilot ongoing
A single place to test multiple initiatives within a new end-to-end processing model. The I-Lab is bundling claims based on complexity and testing the following initiatives concurrently: lean claims, intake processing center, comprehensive screening, express lane, case management, and private medical records. The lab environment provides a place to test, monitor, and document dependencies and processes.
Testing a new model for claims processing

Disability Evaluation Narrative Text Tool (DENTT)
Nationwide – Pilot ongoing
DENTT is currently expanding on the tenets of the Hearing Loss Calculator to include joints (such as Ankle, Shoulder, Elbow, Knee, Back, etc.)
These tools guide claims decision makers through the process with intelligent algorithms similar to tax preparation software or through simple spreadsheet buttons and drop-down menus. Objective data and clearly defined rules render a clear recommendation for the VA decision maker's final adjudication.

Intelligent Work Queue (iWQ)
Nationwide - Currently in development
iWQ will provide managers and individual employees the ability to get "the right claim to the right person at the right time."
An electronic and intelligent workload management tool will assist in eliminating searching for the "right next case" to work and feed requirements to VBMS for the electronic/smart routing of cases to individuals and through the entire claims processing system.

Resource Capacity

Effective tracking of overtime – Pilot ongoing
Expand use of overtime in a judicious manner to increase production through establishment of policy for overtime eligibility and standards for overtime production. Developed additional tracking mechanism for overtime hours worked and accomplishments realized
Increase production to address the growth in receipts while new hires gain experience and become more productive

Hiring surge
Central Office – Pilot complete
Expand current workforce by 2,000 full-time employees to increase capacity to meet high growth in claims receipts
Increase production and use new resources to address process bottlenecks

Vendors for private medical records
Jackson, New York, St. Louis, Chicago, Indianapolis, Phoenix, Portland – Pilot ongoing
Use vendors to collect medical records from private physicians
Reduce average record collection time from 40 days to 7-10 days and substantially increase physician response rate

Technology

Agent Orange development assistance ("Fast Track")
Nationwide implementation completed (Active pilot)
Streamline process for development of AO claims
Outsource technology for development of AO claims and automate processes
Operating at http://www.fasttrack.va.gov

Business Transformation Lab
Providence – Pilot complete
Experiment with process innovations to build the process design for paperless workflow
Streamline process flow for reduced cycle time and better use of resources after VBMS is complete

MAP-D live
San Diego – Initiative under way
Enable visibility into claims status for Veterans by improving accuracy of claim data in MAP-D, linking Veterans, VBMS, VRM and claims processors, expanding Veterans' access online.
Provide better customer service to Veterans

Scan and store digital images
Records Management Center (St. Louis) – Pilot complete
Scan and store digital images of records at the Record Management Center
Reduce wait time through electronic transfer of service records that are currently mailed to ROs

SMC calculator
Nationwide implementation complete (Inactive as pilot)
Develop a special monthly compensation calculator online, then within RBA 2000
Enable claims processors to quickly determine correct payment

Veterans Benefits Management System (VBMS)
Central Office – Initiative under way
Develop paperless claims IT solution to improve future business process and integrate with Veteran Relationship Management and Virtual Lifetime Electronic Record
Enable more efficient claims process flow to reduce cycle time from elimination of transportation of paper claims and to support process changes like segmentation of complex claims and auto-adjudication

Interactive online assistance
Hartford – Initiative under way
Reduce backlog, improve timeliness, and increase transparency with chat and secure messaging capability online for Veterans and VBA employees to communicate
Online chat communication can increase transparency and quickly provide claims assistance

Virtual Regional Office
Baltimore – Initiative complete
Evaluate IT system requirements and business processes in virtual environment

Veterans Relationship Management (VRM)
Central Office – Initiative under way
Upgrade and expand communication capabilities with Veterans (e.g., web, phone, email, social media)
Improve the speed, accuracy, and efficiency of interacting with Veterans

Veteran Partnership

Improve contention quality
Chicago – Pilot complete
Partner with VSOs and veterans to improve the accuracy of contentions (disabilities identified) in the application.
Reduce application processing time taken up by collecting evidence needed to deny contentions without merit

Interim Ratings / Quick Pay
St. Petersburg – Initiative under way
Rate issues as quickly as possible without waiting for all evidence (even if VA can only grant a lower evaluation to start benefits, while continuing claim development to grant a higher evaluation)
Serve Veterans by making the first payment as quickly as possible

Fully Developed Claims (Public Law 110-389 pilots)
Nationwide implementation completed (Active as pilot)
In accordance with PL 110-389, Section 221, two pilots were: 1.) 10 stations tested the expedited processing of fully developed claims, now implemented as national policy, and 2.) 4 stations tested the use of a checklist mailed to assist the veterans in submitting evidence.
Streamline the claims process

VAMC-RO joint venture/medical officer
Louisville – Initiative under way
C&P physician from VAMC visits the RO to prepare medical opinions, provide exam clarification, and answer medical exam-related questions
Improve claims processing timeliness by reducing the time to obtain adequate medical evidence

VSR single signature pilot
Initiative Under Way
Experienced VSRs selected to process simple award actions with no second level review for claims that result no adjustments to benefits
Eliminate second level review of specific award actions without compromising quality

VA Innovation Initiative's (VAi2) Industry Innovation Competition

Integrated Business Accelerator #1 (Virtual Tools)
Partnership with private sector to improve a Veteran's success in achieving vocational rehabilitation through sustained self-employment within their industry of choice by providing virtual tools and mentorship to assist a Veteran in estabilishing a business
Awaiting contract award

Integrated Business Accelerator #2 (Physical Site)
Partnership with private sector to improve a Veteran's success in achieving vocational rehabilitation through sustained self-employment within their industry of choice by providing a physical office site, to include some basic infrastructure, as well virtual tools and mentorship to assist a Veteran in estabilishing a business
Awaiting contract award

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B. When will determinations be made as to whether to continue, expand, or disband these initiatives/pilots?

Response. We are accelerating to the extent possible the evaluation timelines, while also ensuring sufficient data are available to accurately assess the initiatives' operational impact and success. For many initiatives, we use a 90-day cycle. However, given the length and complexity of the claims processing cycles, some initiatives must run longer. For example, the Indianapolis Integration Pilot will run longer to accommodate adjustments and tests. Some of the longer-term initiatives will run for a year or more: Disability Benefits Questionnaires, Integrated Communication Plan, and Disability Evaluation Narrative Text Tool.

C. What efforts are being made to integrate the various initiatives/pilots?

Response. We have selected the Indianapolis Regional Office as the site of the Veteran Benefits Administration's Integration Lab (I-Lab). The purpose of I-Lab is to test multiple initiatives within a new end-to-end processing model. Our change initiatives are currently tested in separate regional offices. The I-Lab provides a place to test them concurrently, where we can define and document dependencies.

The I-Lab is currently testing the following initiatives: Intake Processing Center, Comprehensive Screening, Case Management, Lean Claims Processing, Express Lane, and Private Medical Records.

D. What level of funding is requested during fiscal year 2012 to support the ongoing initiatives/pilots?

Response. VBA's 2012 General Operating Expense budget request includes $72.7 million and 66 FTE for program management and oversight of transformation initiatives, to include the Veterans Benefits Management System and Veterans Relationship Management initiatives.

Question 11. During 2010, VA expanded nationwide its fully developed claim initiative, through which VA expedites claims that arrive with necessary evidence.

A. How many fully developed claims have been filed since this program was expanded and on average how long is it taking to provide a decision on fully-developed claims?

Response. Between June 2010 (pilot start date) and March 9, 2011, the FDC program produced 5,193 completed claims. The average length of time to complete the FDC claims is 84.7 days.

B. Please describe any outreach that has been conducted to alert veterans, their families, and their representatives about the fully developed claim process.

Response. VA has attracted national publicity by issuing a news release about the FDC program, and has efforts in progress to develop additional media products to seek more national attention. A Web site was launched at http://benefits.va.gov/fastclaims offering information and links to a detailed fact sheet and the forms for the program. The site has received more than 13,000 visits. The FDC program has been briefed to the major Veterans Service Organizations (VSOs), and VA recently had an intensive all-day meeting on FDC with a group of VSO representatives from around the country to discuss opportunities to expand Veterans' understanding and use of the program. VA has taken FDC flyers to events for distribution to Veterans, such as VSO conventions, a NASCAR exhibition, and game four of the World Series last fall.

C. What outreach activities will be undertaken with respect to this initiative in fiscal year 2012 and how much funding is requested for that purpose?

Response. VA continues to seek the best approaches to provide outreach on this program and is currently developing a pilot in the Los Angeles and Waco regional offices' catchments to gauge whether submission of FDC claims increases through a coordinated series of marketing efforts. In FY 2011, this is expected to involve online advertising, promotional events, and distribution of materials to local VSOs, as well as handouts, posters and banners for use at VA outreach events, VA medical centers, and other locations. Results from this pilot will guide VA outreach efforts for the FDC program in FY 2012. Funding for this initiative is not specifically identified as a line item in the FY 2012 budget request, but such resources would be included in the overall funds allocated for our transformational programs.

Question 12. For many years, experts have stressed the need to update the VA disability rating schedule. In connection with the Committee's February 2010 hearing on VA's fiscal year 2011 budget request, VA indicated that "VBA plans to dedicate $2.2 million (includes FTE) in FY 2011 to update the rating schedule" and that VA anticipated spending $750,000 in fiscal year 2010 and $750,000 in fiscal year 2011 on a contract for that purpose. Also, VA's Project Management Plan for revision of the rating schedule reflects that "econometric earnings loss data will be obtained through future contracts with econometric companies if funding can be procured."

A. How much was expended during fiscal year 2010 on a contract or contracts related to the review of the rating schedule and how much is expected to be spent during fiscal year 2011 for that purpose?

Response. In fiscal year 2010, VBA expended $196,000 for a contract physician to review and revise the current rating schedule. In the 2011 budget, VBA requested $750,000 for the work earnings loss study and has expended nearly $525,000.

B. What level of funding would be required during fiscal year 2012 to obtain "econometric earnings loss data * * * through future contracts with econometric companies?" Is funding for that specific purpose included in the fiscal year 2012 budget request? If so, how much is requested for that purpose?

Response. VBA requested $1 million in the 2012 budget for a work earnings loss study.

C. What is the current level of staffing dedicated to updating the rating schedule? What level of staffing will be dedicated to this effort during fiscal year 2012?

Response. Seven FTE and one contractor are currently dedicated to updating the rating schedule, and that level of effort is estimated to continue into 2012.

D. How much in total was expended during fiscal year 2010 to update the rating schedule? Please provide an itemized list of how that funding was expended.

Response. In 2010, VBA obligated $604,000 to update the rating schedule.

2010 Funding Dedicated to Updating the Rating Schedule
$000s

Payroll and travel	$327
Contract physician	196
Musculoskeletal, mental health, endocrine & hemic/lymphatic forums	81
Total Obligations	$604

E. During fiscal year 2011, how much in total does VA currently plan to expend to revise the rating schedule? Please provide an itemized list of how that funding is expected to be expended.

Response. VBA plans to spend $750,000 for a work earnings loss study, $387,000 for a medical consultation contract, and payroll resources of approximately $1.1 million for seven FTE.

F. How much funding in total from the fiscal year 2012 budget is requested for purposes of updating the disability rating schedule? Will that funding be specifically designated for the purpose of updating the rating schedule and under the control of the project manager who is leading that effort?

Response. In the 2012 budget request, VBA requested $1 million for a work earnings loss study, $391 thousand for a medical consultation contract, and payroll resources of approximately $1.1 million for seven FTE. This funding is designated for the rating schedule update and will be monitored by the project manager.

G. Does the fiscal year 2012 funding request include funding to reimburse experts for travel expenses or funding to plan and carry out any additional public forums? If so, what level of funding would be provided for those purposes?

Response. The budget request does include funding to reimburse subject matter experts for travel expenses and for contractors to plan and execute public forums in the amount of $120,000.

H. Does the fiscal year 2012 budget request contain sufficient funding for all employees, contracts, and other expenses necessary to update the rating schedule in accordance with the Project Management Plan?

Response. In the FY 2012 budget request, funding is sufficient to carry out the approved Project Management Plan, which includes two studies as well as other work necessary to update the rating schedule.

Question 13. At a Senate Committee on Veterans' Affairs hearing in September 2009, the Committee discussed a report prepared by Economic Systems, Inc., entitled "A Study of Compensation Payments for Service-Connected Disabilities," which in part included options for compensating veterans for loss of quality of life caused by their service-related injuries. The Under Secretary for Benefits at that time indicated that further study would be necessary before moving forward with most of the options in that report. After that, VA provided this information:

The Advisory Committee on Disability Compensation is currently reviewing and analyzing potential models for compensating for Quality of Life (QOL) loss * * *. Due to the on-going work of the Advisory Committee on Disability Compensation, VA does not believe that additional studies to create a separate system to compensate for [quality of life] loss should be considered at this time.

A. Has the Advisory Committee provided VA with any actionable recommendations regarding quality of life? If so, what actions does VA plan in response to those recommendations?

Response. The Advisory Committee on Disability Compensation provided VA with 12 recommendations. Two covered quality of life and non-economic (other than work) income loss. However, the term "quality of life" is absent from any and all VA regulations and statutes authorizing compensation, as is the term "non-economic" loss. VA's compensation statute at title 38 U.S.C. 1155 only authorizes disability compensation to Veterans for reductions in earning capacity due to disability resulting from injury or disease incurred in or aggravated by active military service. A new compensation scheme based on quality of life or some other system would require legislation.

B. Does VA plan to conduct any studies—separate from the Advisory Committee—on quality of life? If so, what level of funding is needed for that purpose during fiscal year 2011 and 2012?

Response. Completely separate from the Committee, the Compensation and Pension Service is contracting for an earnings loss study of the musculoskeletal section of the rating schedule. The purpose of this study is to evaluate the average earnings losses incurred by veterans due to service-connected musculoskeletal diseases or injuries as described within diagnostic codes within the schedule. Again, VA compensation statutes do not provide for compensation based on "quality of life" issues, but only average losses in earning capacities. Therefore, while this study will analyze compensation forms of earnings loss capacity outside the VA system (i.e. workers' compensation and social security disability compensation), it will not address quality of life, because such a study would exceed VA's compensation authority.

C. How much in total has VA expended with regard to the Advisory Committee on Disability Compensation and what level of funding is requested for fiscal year 2012?

Response. Approximately $260,000 was spent in 2010. We plan for the Advisory Committee members to actively participate in the scheduled forums for updating the VASRD. The 2011 and 2012 budget requests include $300,000 in each year for the Advisory Committee.

D. To date, what actions have been taken by VA in response to the Committee's recommendations?

Response. VA has acted upon most recommendations that fall within VA's statutory authority. In response to the Committee's recommendations, VA hired five additional personnel on the Compensation and Pension Service's Policy Staff. These new hires include an experienced disability rating specialist with hands-on expertise as well as four new medical doctors to lead the effort to update the VASRD so that it incorporates econometric earnings loss data and current medial science. As recommended by the Committee in connection with updating the VASRD, VBA is receiving direct support from VHA medical subject matter experts (SMEs), who made formal presentations at four public forums and continue to provide medical science information as part of working groups set up after the forums. Also as recommended, VA initiated an Earnings Loss Study with the George Washington University, via an inter-agency agreement with the Department of Health and Human Services, to empirically study lost earnings by Veterans who are service-connected with musculoskeletal disabilities. The current medical science information that is captured from VHA SMEs and the earnings loss findings form the basis for updating the VASRD.

Question 14. Last year, VA announced that claims based on exposure to contaminated water at Camp Lejeune would be consolidated at the VA regional office in Louisville.

A. How many employees at Louisville will handle Camp Lejeune claims during fiscal year 2011 and during fiscal year 2012?

Response. As of March 2011, the Camp Lejeune contaminated water (CLCW) caseload of 638 claims represents nearly 10 percent of the rating workload of the Louisville Regional Office (RO). At this time, the Veterans Service Center has 15 full-time employees devoted to processing these cases. The RO intends to maintain at the current level in FYs 11 and 12, provided CLCW receipts remain stable. The VSC will continue to monitor CLCW workload and make appropriate adjustment, as necessary.

B. Does the fiscal year 2012 budget request include sufficient funding to provide any necessary training for these employees, so they will be kept informed of new studies or information regarding the contaminates at Camp Lejeune? If so, please explain.

Response. The budget request for fiscal year 2012 contains sufficient funding to keep the Louisville Regional Office personnel fully trained and informed on the processing of Camp Lejeune-related claims. On January 11, 2011, VA Fast Letter 11–03, Consolidation and Processing of Disability Claims Based on Exposure to Contaminated Drinking Water at Camp Lejeune, North Carolina, was released to VBA field stations, explaining certain technical aspects of processing these claims. A training letter has also been developed to provide background information and explain the relationship between certain diseases and the volatile organic compounds known to have contaminated the Camp Lejeune water supply. This will assist adjudicators making rating decisions as well as VA medical examiners who may not be familiar with the specific science related to these contaminants. The training letter will be released in the near future.

Following release of the Fast Letter, Compensation and Pension Service provided in-person training to Louisville staff. C&P will continue to communicate with that office on a weekly basis. In-person training sessions will be provided as needed to ensure that all aspects of the claims process are understood. Additionally, VA will continue to monitor the studies currently underway by the Department of Health

and Human Services' Agency for Toxic Substances and Disease Registry (ATSDR) related to Camp Lejeune. This agency is developing computer modeling to recreate flow patterns of the contaminated water system as well as a survey questionnaire to assess long-term health effects among individuals who served at Camp Lejeune during the 1957 to 1987 period of water contamination. When results of these studies are received, VA will incorporate the findings into training sessions for the Louisville Regional Office to ensure that claims processing is up to date. These studies are projected to be completed in 2013.

VBA's budget request for 2012 provides sufficient funding to meet this training requirement.

Question 15. Since 2003, certain cases remanded by the Board of Veterans' Appeals have been handled at a centralized entity called the Appeals Management Center.

A. How much was spent on the Appeals Management Center during fiscal year 2010 and what level of staffing did that funding support?

Response. During fiscal year 2010, $16.3 million was spent for the Appeals Management Center. $14.2 million comprised payroll and supported a staffing level of 168 full-time employees.

B. How much is projected to be spent during fiscal year 2011 and what level of staffing will that funding support?

Response. At this time, Appeals Management Center on-board staffing level is projected to increase to 209 FTE, with 2011 funding at $18 million for both payroll and non-payroll expenditures.

C. In total, how much funding is requested for fiscal year 2012, and what level of staffing will that funding support?

Response. In 2012, the Appeals Management Center is expected to maintain the 2011 staffing level and the funding request estimate is $18.3 million, including payroll and non-payroll expenditures. The anticipated $1.8 million increase in funding over 2011 is attributable to scheduled payroll increases (career-ladder and within-grade increases) and inflation associated with shipping, supplies and other non-payroll, general operating expenses.

D. How many appeals are currently pending at the Appeals Management Center?

Response. There are 20,899 appeals pending at the Appeals Management Center as of March 15, 2011.

E. How many of those pending cases are ready-to-rate; how many employees are dedicated to handling ready-to-rate cases; and what steps are being taken to provide decisions on those cases before the evidence becomes outdated?

Response. 11,715 cases are ready-to-rate as of March 15, 2011. 27 Decision Review Officers, 5 Rating Veterans Service Representatives (RVSRs), and 6 newly selected RVSR trainees are dedicated to handling ready-to-rate cases. Additional hiring is anticipated. Workload management tools have been implemented that focus on expediting the oldest pending remands. In January 2011, the Appeals Management Center began brokering approximately 500 ready-to-rate cases per month to a special processing team in Cleveland.

F. What were the key performance outcomes for the Appeals Management Center in fiscal year 2010 (related to timeliness, accuracy, and inventory) and what are the expected performance outcomes for fiscal years 2011 and 2012?

Response. Significant improvements were made in timeliness outcomes over FY 2009. "Average days pending" improved from 383 days in FY 2009 to 233 days in FY 2010. "Average days to complete" improved from 477 days in FY 2009 to 428 days in FY 2010. Accuracy was 74 percent for FY 2010. The pending remand inventory at the end of FY 2010 was 19,649, which was higher than the 18,500 target.

Performance targets for fiscal year 2011 are 180 days for "average days pending," and 380 days for "average days to complete." The FY 2011 accuracy target is 90 percent. Additionally, the accuracy review for the Appeals Management Center has been adjusted to use a larger, statistically valid sample. For FY 2011, the end-of-year inventory target remains 18,500 claims.

The FY 2012 performance targets will be established near the end of FY 2011 based on the actual performance of the Appeals Management Center during FY 2011.

Question 16. As one strategy to deal with VA's backlog of disability claims, VA brokers claims between VA regional offices.

A. How many cases did VA broker during fiscal year 2010 and how many cases does VA expect to broker during fiscal year 2011 and during fiscal year 2012?

Response. In FY 2010, a total of 105,337 rating-related cases were brokered. Through February 2011, a total of 12,547 rating-related cases were brokered. The total expected FY 2011 brokering will be approximately 30,000 cases. The sharp de-

cline in brokering is a result of utilizing the thirteen resource centers to process Agent Orange claims that are subject to the provisions of the Nehmer litigation. It is expected that beginning in early FY 2012, the resource centers will return to adjudicating brokered rating workload. VBA has not projected the volume of brokered cases for 2012.

B. Has VA developed performance measures or collected data that would allow a comparison of the timeliness and quality of decisions rendered in brokered cases versus cases that are not brokered? If so, please explain.

Response. Comparative quality data is collected for both regional offices that send brokered workload and resource centers that complete brokered work. VBA is currently engaged in refining existing data systems and workload tracking mechanisms to compare timeliness between sites that broker work and sites that complete brokered work. It is expected that these enhancements will be in place in fiscal year 2012.

C. Has VA developed performance measures or collected data that would allow VA to determine the cost-effectiveness of brokering? If so, please explain.

Response. Measurements do not currently exist to determine the cost effectiveness of workload brokering. VBA is currently engaged in refining existing data systems and workload tracking mechanisms to allow appropriate data collection to support cost-effectiveness analyses.

Question 17. According to VA's fiscal year 2012 budget request, VA's fiduciary program supervises over 110,000 incompetent beneficiaries.

A. During fiscal year 2012, what level of funding would be used to support the fiduciary program and what level of staffing would that funding support?

Response. In 2012, approximately $48 million will support approximately 600 fiduciary staff.

B. What were the key performance outcomes for the fiduciary program during fiscal year (FY) 2010 and what are the expected performance outcomes for fiscal years 2011 and 2012?

Response. The key performance indicators for the fiduciary program are:

1. Quality—Quality of the fiduciary program increased from 81.5% in FY 2009 to 85.0% in FY 2010. The expected performance outcome for FY 2011 is 86.5% and 90.0% in FY 2012.

2. Timeliness of account audits—The timeliness of account audits increased from 92.1% in FY 2009 to 92.3% in FY 2010. The expected performance outcome for FY 2011 and FY 2012 is 93%.

3. Timeliness of field examinations—The timeliness of field examinations completed in FY 2010 was 81.4%. The expected performance outcome for FY 2011 and FY 2012 is 92%.

4. During FY 2011, VA initiated the performance outcome relating to the timeliness of accountings received—It is anticipated the performance outcome for FY 2011 and FY 2012 will be more than 95% of all accountings are received prior to becoming seriously delinquent.

C. Does VA's fiscal year 2012 budget request include funding to develop an online training program for fiduciaries? If so, how much is included for that purpose?

Response. The 2012 budget request does not include funds to develop an online training program for fiduciaries but we have conducted research to identify existing certification programs. We plan to develop a system in 2013.

D. How many incompetent beneficiaries now live overseas and will the requested funding allow VA to appropriately protect the interests of those beneficiaries? If so, please explain.

Response. The Fiduciary Program has 1,099 beneficiaries residing in 40 foreign countries. The funding requested in the 2012 budget will allow VA to appropriately protect the interests of those beneficiaries. Approximately 80 percent of these beneficiaries reside in the Republic of the Philippines and their welfare is monitored by a local VA fiduciary activity. VA leverages the support of our embassies to provide oversight of the remaining beneficiaries through periodic visits.

Question 18. The FY 2010 Performance and Accountability Report reflects that VA has recognized the need to replace the Fiduciary Beneficiary System and to that end a Request for Information was released during fiscal year 2010.

A. What level of funding is expected to be expended during fiscal year 2011 to replace the Fiduciary Beneficiary System?

Response. VA estimates it will spend $50 thousand in General Operating Expense funds in its effort to replace the Fiduciary Beneficiary System in 2011.

B. What level of funding is requested for fiscal year 2012 for this purpose?

Response. VA estimates it will spend $38 thousand in General Operating Expense funds in its effort to replace the Fiduciary Beneficiary System in 2012.

C. What is the expected timeline for completion of the replacement of the Fiduciary Beneficiary System?

Response. VA estimates the Fiduciary Beneficiary System will be replaced in 2013.

Question 19. A November 2010 Fast Letter (10–51) set forth procedures for VA regional offices to follow in handling requests for relief from the requirement that VA report to the National Instant Criminal Background Check System the names of beneficiaries who have been assigned a fiduciary. In part, that Fast Letter provides this guidance: "To grant relief, the record must show affirmatively, substantially, and specifically that the beneficiary is not likely to act in a manner dangerous to public safety, and that granting relief will not be contrary to the public interest."

A. How many of these requests for relief has VA received, how many have been decided, and how many remain pending?

Response. As of March 9, 2011, VA has received 101 requests and decided 13. VA has 88 requests for relief pending.

B. Of the requests for relief that have been decided, how many have been granted?

Response. VA has granted one request for relief.

C. What level of funding is requested for fiscal year 2012 to provide training for regional office employees on how to determine if a beneficiary is dangerous?

Response. VA included criteria to consider in evaluating public safety in Fast Letter 10–15, dated November 22, 2010. Training will be incorporated in our annual training curricula. No additional funding in 2012 is needed for this purpose.

Question 20. DOD and VA plan to roll out to 140 sites worldwide a joint disability evaluation system, called the Integrated Disability Evaluation System or IDES, through which an injured or ill servicemember, before being medically discharged from the military, completes both the DOD disability rating system and the VA disability rating process. While DOD and VA were piloting this concept, significant challenges came to light, including untimely medical examinations, logistical issues, and staffing shortages.

A. At the 27 original (pilot) IDES sites, are there currently sufficient VA personnel to meet all relevant staffing goals? If not, please identify the specific sites where staffing goals are not being met and a timeline for when those goals will be met.

Response. All 27 sites have sufficient staffing levels.

B. At the 28 additional sites that have certified readiness to begin the IDES process, are there currently sufficient VA personnel to meet all relevant staffing goals? If not, please identify the specific sites where staffing goals are not being met and a timeline for when those goals will be met.

Response. The 28 sites have sufficient staffing levels.

C. During fiscal year 2011, how much in total does VA expect to expend with respect to the IDES (including both mandatory and discretionary funds) and how many VA employees will be dedicated to the IDES process?

Response. The 2011 budget request includes approximately $23 million to support 285 FTE and $13 million for contract examinations.

D. During fiscal year 2012, how much in total does VA expect to expend with respect to the IDES (including both mandatory and discretionary funds) and how many VA employees will be dedicated to the IDES process?

Response. The 2012 budget request includes approximately $24 million to support 285 FTE and $20.4 million for contract examinations.

E. For each site that will use the IDES process during fiscal year 2011 and 2012, please provide the level of funding that specific site has been or will be allocated (from any source) to carry out that process.

Response. Expansion of the Integrated Disability Evaluation System is still in the planning phase with the Department of Defense. Therefore, no specific amount of money has been allocated for this population of servicemembers.

F. For each site that will use the IDES process during fiscal year 2011 and 2012, please provide the number of servicemembers expected to enter the IDES process at that specific site per year.

Response. Please see the attached spreadsheet, which contains a list of military treatment facilities and their anticipated annual caseload.

IDES Sites			
Military Treatment Facility/Installation	State	Service	MEBs / year
Andrews AFB	MD	Air Force	258
Bethesda NNMC	MD	Navy	299
Walter Reed AMC	DC	Army	435
Ft. Belvoir	VA	Army	100
Ft. Meade	MD	Army	71
San Diego NMC	CA	Navy	757
Ft. Stewart	GA	Army	529
Camp Pendleton	CA	Navy	332
Bremerton NH	WA	Navy	106
Vance AFB	OK	Air Force	11
MacDill AFB	FL	Air Force	81
Nellis AFB	CA	Air Force	167
Ft. Polk	LA	Army	513
Camp LeJeune NH	NC	Navy	570
Elmendorf AFB	AK	Air Force	92
Ft. Richardson / Wainwright	AK	Army	283
Ft. Wainwright	AK	Army	
Ft. Drum	NY	Army	505
Travis AFB	CA	Air Force	252
Brooke AMC	TX	Army	854
Ft. Carson	CO	Army	1030
Ft. Riley	KS	Army	492
Ft. Lewis (Madigan AMC)	WA	Army	1308
Ft. Hood	TX	Army	1486
Ft. Benning	GA	Army	850
Ft. Bragg	NC	Army	754
Portsmouth NMC	VA	Navy	598
Beale AFB	CA	Air Force	80
Charleston AFB	SC	Air Force	27
Edwards AFB	CA	Air Force	51
Eielson AFB	AK	Air Force	22
Fairchild AFB	WA	Air Force	89
Hickam AFB	HI	Air Force	230
Langley AFB	VA	Air Force	300
Los Angeles AFB	CA	Air Force	12
Maxwell AFB	AL	Air Force	43
McChord AFB	WA	Air Force	63
Moody AFB	GA	Air Force	68
Mountain Home AFB	ID	Air Force	137
Patrick AFB	FL	Air Force	98

IDES Sites			
Military Treatment Facility/Installation	State	Service	MEBs / year
Pope AFB	NC	Air Force	22
Robins AFB	GA	Air Force	160
Seymour Johnson AFB	NC	Air Force	163
Shaw AFB	SC	Air Force	
Vandenberg AFB	CA	Air Force	58
Tripler AMC	HI	Army	389
29 Palms Marine Hospital	CA	Navy	164
Beaufort NH	SC	Navy	171
Charleston NH	SC	Navy	63
Cherry Point NH	NC	Navy	131
Jacksonville NH	FL	Navy	333
Lemoore NH	CA	Navy	16
Oak Harbor NH	WA	Navy	59
Pearl Harbor NH	HI	Navy	166
Quantico NH	VA	Navy	78
Buckley AFB	CO	Air Force	40
Cannon AFB	NM	Air Force	35
Davis-Monthan AFB	AZ	Air Force	123
Dyess AFB	TX	Air Force	97
F.E. Warren AFB	WY	Air Force	56
Goodfellow AFB	TX	Air Force	50
Hill AFB	UT	Air Force	81
Kirtland AFB	NM	Air Force	23
Lackland AFB	TX	Air Force	398
Laughlin AFB	TX	Air Force	18
Luke AFB	AZ	Air Force	128
Malmstrom AFB	MT	Air Force	75
Peterson AFB	CO	Air Force	110
Randolph AFB	TX	Air Force	126
Sheppard AFB	TX	Air Force	162
Ft. Campbell	KY	Army	689
Ft. Eustis	VA	Army	283
Ft. Gordon	GA	Army	771
Ft. Jackson	SC	Army	317
Ft. Lee	VA	Army	146
Ft. Rucker	AL	Army	49
Corpus Christi NH	TX	Navy	176
BHC Ft Worth	TX	Navy	110
Altus AFB	OK	Air Force	34
Barksdale AFB	LA	Air Force	50

IDES Sites			
Military Treatment Facility/Installation	State	Service	MEBs / year
Bolling AFB	DC	Air Force	48
Columbus AFB	MS	Air Force	30
Dover AFB	DE	Air Force	61
Eglin AFB	FL	Air Force	123
Ellsworth AFB	SD	Air Force	102
Grand Forks AFB	ND	Air Force	37
Hanscom AFB	MA	Air Force	32
Holloman AFB	NM	Air Force	97
Hurlburt AFB	FL	Air Force	153
Keesler AFB	MS	Air Force	104
Little Rock AFB	AR	Air Force	104
McConnell AFB	KS	Air Force	29
McGuire AFB	NJ	Air Force	184
Minot AFB	ND	Air Force	86
Offutt AFB	NE	Air Force	139
Scott AFB	IL	Air Force	95
Tinker AFB	OK	Air Force	78
Tyndall AFB	FL	Air Force	68
US Air Force Academy	CO	Air Force	72
Whiteman AFB	MO	Air Force	46
Wright-Patterson AFB	OH	Air Force	273
Fort Bliss	TX	Army	602
Ft. Leavenworth	KS	Army	68
Ft. Leonard Wood	MO	Army	563
Ft. Sill	OK	Army	613
Redstone Arsenal	AL	Army	114
BMC Millington (NH Pensacola)	TN	Navy	4
BMC New Orleans, (NH Pensacola)	LA	Navy	9
Great Lakes NH	IL	Navy	278
New England NHC	RI	Navy	175
Patuxtent River NH	MD	Navy	9
Pensacola NH	FL	Navy	227
USNA Annapolis	MD	Navy	17
Andersen AFB	Guam	Air Force	28
Aviano AFB	Italy	Air Force	27
Incirlik AFB	Turkey	Air Force	7

IDES Sites			
Military Treatment Facility/Installation	State	Service	MEBs / year
Kadena AFB	Japan	Air Force	35
Kusan AFB	Korea	Air Force	7
Lajes AFB	Portugal	Air Force	3
Misawa AFB	Japan	Air Force	36
Osan AFB	Korea	Air Force	23
RAF Lakenheath	UK	Air Force	98
Ramstein AFB	Germany	Air Force	57
Spangdahlem AFB	Germany	Air Force	78
Yokota AFB	Japan	Air Force	43
Ft. Huachuca	AZ	Army	111
Ft. Irwin	CA	Army	224
Ft. Knox	KY	Army	989
West Point USMA	NY	Army	234
Camp Zama	Japan	Army	7
Ft. Buchanan	Puerto Rico	Army	137
Heidelberg MEDDAC	Germany	Army	142
Landstuhl AMC	Germany	Army	183
Vincenza	Italy	Army	35
Guam NH	Guam	Navy	13
Guantanamo NH	Cuba	Navy	5
Naples NH	Italy	Navy	8
Okinawa NH	Japan	Navy	59
Rota NH	Spain	Navy	2
Sigonella NH	Italy	Navy	7
Yokosuka NH	Japan	Navy	68

G. Is the requested level of funding for fiscal year 2012 sufficient for all necessary staff to meet staffing targets nationwide in general and specifically at the military bases in North Carolina?

Response. The requested funding level would provide sufficient funding for the necessary staffing in fiscal year 2012. This includes all military bases in North Carolina.

H. For fiscal year 2012, does the fiscal year 2012 budget request include sufficient funding for VA doctors or contractor services necessary to provide timely medical examinations for IDES participants nationwide in general and specifically at the military bases in North Carolina?

Response. VBA's fiscal year 2012 budget request included sufficient funds for the timely examination of IDES participants by contract examiners, where needed.

I. For each branch of military service, please provide the most up-to-date performance statistics with respect to the IDES process, including the number of servicemembers referred to the IDES process, the number of servicemembers who remain in the process, the average length of time they have been pending in the IDES process, the average time it takes to complete the total process, the average time for claim development, the average time to complete medical evaluations, the average time to complete the Medical Evaluation Board, the average time to complete the Physical Evaluation Board, and the average time to complete a VA rating.

Response. Please see the attached spreadsheet.

Source: VTA Weekly Data Pull 3/6/11

	Claim Development	Medical Evaluation Stage	VA Examination	PEB Phase	MEB Phase	Preliminary Rating Time	VA Benefits	Entire Process (incl. Pre-Seperation Leave)
Navy/MC	7	63	58	121	141	40	49	369
Army	9	76	66	62	167	25	35	312
AF	8	55	53	104	145	39	52	363
DoD	8	71	63	85	156	31	41	333

	# Referred to IDES	# current enr. *	average days enr. *
Navy	2419	1471	230
Army	12291	8189	215
AF	1214	712	222
CG	6	6	270
MC	3818	2446	257
DoD	19748	12824	226

* Includes cases that have been issued final VA Benefits Letters, but have yet to be disenrolled by WWCTP

J. For each military base in North Carolina that is using the IDES process, please provide the most up-to-date performance statistics, including for each base the number of servicemembers referred to the IDES process, the number of servicemembers who remain in the process, the average length of time they have been pending in the IDES process, the average time it takes to complete the total process, the average time for claim development, the average time to complete medical evaluations, the average time to complete the Medical Evaluation Board, the average time to complete the Physical Evaluation Board, and the average time to complete a VA rating.

Response. Please see the attached spreadsheet.

Source: VTA Weekly Data Pull 3/6/11

	Claim Development	Medical Evaluation	VA Examination	PEB Phase	MEB Phase	Preliminary Rating Time	VA Benefits	Entire Process (incl. Pre-Seperation Leave)
Lejeune	8	75	74	127	185	42	54	386
Ft. Bragg	4	36	34	85	78	49	53	267
Cherry Pt.	21	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Seymore Johnson	3	36	30	n/a	n/a	n/a	n/a	n/a
Pope AFB	7	n/a	n/a	n/a	n/a	n/a	n/a	n/a

	# Referred to IDES	# current enr.*	average days enr.*
Lejuene	1770	1246	269
Ft. Bragg	681	599	169
Cherry Pt.	35	35	31
Seymore Johnson	18	18	42
Pope	1	1	46

* Includes cases that have been issued final VA Benefits Letters, but have yet to be disenrolled by WWCTP

K. In total, how many servicemembers currently have been pending in the IDES process for longer than 295 days, VA and DOD's goal for completing the joint process?

Response. As of March 6, 2011, 3,796 of the 12,824 Servicemembers currently enrolled in IDES have been pending for more than 295 days.

Question 21. In a January 2011 report, the VA Inspector General OIG found that VA "is not correctly evaluating and monitoring 100 percent disability evaluations" and that, if corrective action is not taken, VA "will overpay veterans a projected $1.1 billion over the next 5 years." Please provide an update on any actions that have been taken in response to this report.

Response. VBA remains committed to paying Veterans correctly and assigning appropriate disability evaluations at all levels. We are actively working to address the recommendations of the report, and resolving the system errors that have contributed to future examination controls being removed from records.

VBA is currently testing a recent system modification to ensure that future diaries established through the rating process are not removed through other processing actions. Testing is scheduled through the end of March 2011, and VBA plans to implement this system modification by April 30, 2011; this will prevent the loss of future examination controls that are necessary to periodically reevaluate tem-

porary 100-percent evaluations. VBA is also working to establish appropriate future diary controls within the system for the population of cases identified by OIG.

In January 2011, VBA amended the training lesson for Veterans Service Representatives to address timely actions that must be taken on future examination notifications. Additionally, a new training lesson entitled Permanent & Total Ratings was made available for Rating Veterans Service Representatives in March 2011. VBA's National Training Curriculum mandates completion of this lesson in FY 2011. This lesson provides detailed information on evaluating permanent and total disability ratings, and allows participants to apply their knowledge in resolving actual case scenarios during training.

Question 22. It is my understanding that, as one initiative to bring down the backlog of disability claims, VA plans to extend routine future disability examination requests to the maximum period of five years.

A. Does VA track any data that would reflect how frequently those types of routine follow-up examinations reveal an improvement in the veteran's disability, how often they reveal a worsening of the disability, and how often there is no change? If so, please explain.

Response. This information is not currently captured in any VA systems.

B. Has VA calculated an estimate of how many Veterans might be overpaid or underpaid as a result of this policy or how much in total will potentially be overpaid or underpaid? If so, please explain.

Response. VA has not calculated the overpayments and underpayments per the explanation in 22a.

Question 23. In addition to processing claims in a timely manner, it is essential that decisions are accurate in order to avoid delays and frustrations for veterans and their families.

A. How many employees are currently dedicated to VBA's national quality assurance program?

Response. Compensation and Pension Service currently has 49 employees dedicated to VBA's national quality assurance program. In addition, under Section 224 under Public Law (PL) 110–389, Veterans' Benefits Improvement Act of 2008, VBA contracted with the Institute for Defense Analyses (IDA) over a three-year period to conduct an independent assessment of the quality assurance program carried out in the VBA. The final report is due to VBA in August 2011. VBA is also implementing dedicated quality teams at each of the regional offices. The dedicated Quality Review teams will conduct quality reviews as well as provide feedback and training on error trends.

B. For fiscal year 2012, how many employees would be dedicated to VBA's national quality assurance program?

Response. At this time there are no plans to increase the number of employees in the National Quality Assurance Program. However, VBA does plan to add dedicated quality reviewers within the regional offices, which will focus solely on the improvement of quality.

C. How many cases were reviewed in fiscal year 2010, how many are expected to be reviewed during fiscal year 2011, and how many are projected to be reviewed during fiscal year 2012?

Response. We reviewed 46,507 cases for quality in fiscal year 2010. We project that we will review over 47,000 cases in both FY 2011 and FY 2012.

GENERAL ADMINISTRATION

Office of the Secretary

Question 1. The fiscal year 2012 budget proposal reflects that the Office of the Secretary expended $3,000 on Other Services during fiscal year 2010, expects to spend $246,000 on Other Services during fiscal year 2011, and requests $122,000 for Other Services for fiscal year 2012.

Response. NOTE: The expended amount in 'Other Services' during fiscal year 2010 consisted of $227,000 in actual obligations and a reimbursement of $224,000 from Veterans Benefit Administration (VBA) to Office of Employment Discrimination Complaint Adjudication (OEDCA) for services rendered, which resulted in a net difference of $3,000. Because OEDCA is in the same account as OSVA, it is reflected as an expenditure adjustment and nets against the 'Other Services' line. The reimbursement from VBA was recorded against 'Other Services.'

A. Please provide an explanation of how these funds have been used or are expected to be used.

Response. The following are the more significant items covered under 'Other Services' in FY10:

• $85k—Office of the Secretary—Training (includes eight 4-day sessions with more than 80 employees from across VA participating)
• $17k—Center for Women Veterans (CWV)—A Women's Summit where more than 400 stakeholders attended
• $18k—CWV—stipends to cover the costs of its Advisory Committee.
• $16k—Center for Minority Veterans (CMV)—stipends to cover the costs of its Advisory Committee
• $18k—CMV Employee Training—including an employee participating in the Federal Executive Institute program.

The following are the more significant items covered under 'Other Services' in FY11:

• CWV has planned $108k in other services (including a committee meeting, a major biennial summit, advisory committee site visits, equipment, printing, and supplies)
• CMV has planned $38k in other services (including committee meetings and equipment, printing, and supplies)
• Office of the Secretary has planned $97k in other services (including equipment, printing, and supplies)

B. If these are contracted services, what metrics will be used to determine whether these services will be used effectively?

Response. The services are for meetings or events necessary by both the CWV and CMV in fulfilling as Advisory Committee requirements. In addition, equipment like copiers are leased and not purchased.

Question 2. Before the House Committee on Veterans' Affairs, Secretary Shinseki testified that recent increases in staff for this office are due in part to transitioning away from the use of detailed employees in that office.

A. Please provide a breakdown of how many detailed employees currently work in the Office of the Secretary, how many have worked in that office over each of the past five years, and how many are projected to work in that office during fiscal year 2012.

Response. As of March 30, 2011, two persons are currently on short-term detail to the Office of the Secretary. Over the past 5 years, 12 persons were on detail to the Office of the Secretary in 9 distinct positions. Duration of these details varied. Three of these detail positions were converted to full time positions in the Office of the Secretary, and six of the detail positions were eliminated. The 4-person Center for Faith-Based and Neighborhood Partnerships was also transferred from the Office of Public and Intergovernmental Affairs to the Office of the Secretary during this 5 year period. This transfer also involved temporary detailing of Center employees until funding adjustments were coordinated. All Center employees now work in, and are funded by, the Office of the Secretary.

B. How many positions have been converted in fiscal year 2010 and fiscal year 2011 from a detailed position to full time employee working for the Office of the Secretary? How many of these positions will be new FTEs to the Secretary's office in fiscal year 2012?

Response. Two detail positions were transferred and reassigned to the OSVA in FY 2010 and one in FY 2011. These positions were included in the OSVA FTE total for that fiscal year.

Office of the Secretary

1. Secretary of Veterans Affairs (PAS)
2. Executive Assistant (GS-15)
3. Staff Assistant (GS-13)
4. Staff Assistant/Scheduler (GS-14)
5. Deputy Secretary of Veterans Affairs (PAS)
6. Special Assistant (Non-Career GS-15)
7. Staff Assistant (GS-11)
8. Chief of Staff (Non-Career SES)
9. Executive Assistant (GS-15)
10. Staff Assistant (GS-13)
11. White House Liaison (Non-Career GS-15)
12. Deputy Chief of Staff Operations (Non-Career SES)
13. Deputy Chief of Staff Administration (Career SES) Vacant
14. Senior Advisor Strategy (Non-Career SES)
15. Staff Assistant (GS-13)
16. Senior Advisor, Medical (Non-Career SES)
17. Senior Advisor/Chief Technology Officer (Non-Career SES)
18. Senior Advisor, Budget (Non-Career SES)
19. Historian (GS-15)
20. Senior Advisor Strategic Communications (Non-Career SES)
21. Staff Assistant (Non-Career GS-11)
22. Staff Assistant/VSO Liaison (GS-13)
23. Staff Assistant (GS-13)
24. Special Assistant (GS-15)
25. Ombudsman/Non Governmental Organizations (GS-15)
26. Assistant Chief of Staff Support Operations(GS-15)
27. Special Assistant/Staff Coordinator (GS-9)
28. Special Assistant/Staff Coordinator (GS-11)
29. Special Assistant/Staff Coordinator (GS-12)
30. Program Management Officer (GS-15)
31. Staff Assistant (GS-13)
32. Special Assistant/Staff Coordinator (GS-9)
33. Executive Secretary to the Department (Career SES)
34. Deputy Executive Secretary to the Department (GS-15)
35. HR Liaison/Staff Assistant (GS-14)
36. Management Analyst (GS-13)
37. Staff Assistant (GS-13)
38. Executive Correspondence Analyst (GS-15)
39. Executive Correspondence Analyst (GS-15)
40. Executive Correspondence Analyst (GS-15)
41. Executive Writer (GS-14)
42. Executive Writer (GS-13)
43. Correspondence Analyst (GS-13)
44. Correspondence Analyst (GS-12)
45. Supervisory Correspondence Analyst (GS-13)
46. Program Specialist (GS-11)
47. Program Support Assistant (GS-7)
48. Office Automation Clerk (GS-4)

Subsidiary

Center for Minority Veterans

49. Senior Program Analyst (GS-14)
50. Program Analyst (GS-13)
51. Program Support Assistant (GS-9)
52. Director (Non- Career SES)
53. Program Analyst (GS-13)
54. Deputy Director, (GS-15)
55. Program Analyst (GS-13)

Center for Women Veterans

56. Senior Program Analyst (GS-14)
57. Program Analyst (GS-13)
58. Deputy Director (GS-15)
59. Program Support Assistant (GS-9)
60. Director (Non -Career SES)

Office of Survivors Assistance

61. Director (GS-15)
62. Program Analyst (GS-13)
63. Program Analyst (GS-13) (detailed to BVA)

Center for Faith Based & Neighborhood Partnerships

64. Program Specialist (GS-13)
65. Deputy Director (GS-14)
66. Director (Non-Career GS-15)
67. Program Specialist (GS-9)

Office of Employee Discrimination Complaint Adjudication

68. Secretary (GS-6)
69. Associate Director (GS-15)
70. Paralegal (GS-11)
71. Attorney (GS-14)
72. Attorney (GS-14)
73. Attorney (GS-14)
74. Attorney (GS-14)
75. Attorney (GS-14)
76. Attorney (GS-14)
77. Administrative Officer (GS-12)
78. Secretary (GS-6)
79. Attorney (GS-14)
80. Attorney (GS-14)
81. Paralegal (GS-11)
82. Attorney (GS-14)
83. Attorney (GS-14)
84. Attorney (GS-14)
85. Secretary (GS-6)
86. Attorney (GS-14)
87. Attorney (GS-14)
88. Attorney (GS-14)
89. Director (Career SES)

C. Once these detailees are shifted back to their original hiring offices, how are they reflected in the total number of FTEs in this year's budget? Are they reflected

as an increase to that office's FTEs count or were they always reflected in that office's FTE numbers in the past?

Response. Employees on detail are and continue to be reflected in the FTE numbers of their original office.

Board of Veterans' Appeals

Question 1. According to the fiscal year 2012 budget request, the Board of Veterans' Appeals (Board or BVA) experienced a 22% increase in case receipts from 2008 to 2010 and expects to receive 66,600 new appeals in 2012.

A. For fiscal years 2009 and 2010, what percentage of case receipts involved cases that previously had been remanded by the Board?

Response. In fiscal year 2009, 32.60% of case receipts (or 16,288 cases) involved cases previously remanded by the Board.

In fiscal year 2010, 30.93% of case receipts (or 16,224 cases) involved cases previously remanded by the Board.

B. With the requested level of funding for fiscal year 2012, how many decisions does the Board expect to issue during fiscal year 2012?

Response. The Board expects to issue 49,500 cases during fiscal year 2012.

C. Currently, what is the average case disposition time and what is the expected case disposition time during fiscal year 2012 if the requested level of funding is provided?

Response. The Board's current average case disposition time, referred to as "cycle time," is 110 days (fiscal year 2011 to date). Cycle time measures the time an appeal is physically received at the Board until a decision reached, excluding the time that the case is with a Veterans Service Organization representative for the preparation of written argument. The expected cycle time for fiscal year 2012 is 140 days.

Question 2. The December 2010 report from the National Commission on Fiscal Responsibility and Reform included this recommendation:

> Reduce Federal travel, printing, and vehicle budgets * * *. We propose prohibiting each agency from spending more than 80 percent of its FY 2010 travel budget and requiring them to do more through teleconferencing and telecommuting * * *.

A. Of the $1.3 million the Board is requesting for travel expenses for fiscal year 2012, what portion is attributable to the costs of travel (or field) hearings?

Response. Of the $1.3 million the Board is requesting for fiscal year 2012, the Board projects spending $1.1 million on travel associated with conducting in-person hearings at field offices.

B. What accounts for the 37% increase in travel costs since fiscal year 2010 (from $948,000 to $1.3 million)?

Response. The 37% increase in travel costs represents the rising costs of air and rail travel, as well as the rising costs of fuel, and other incidental travel expenses.

C. In total, how much was spent on travel hearings during fiscal year 2010 and how much is expected to be expended during fiscal year 2011?

Response. In fiscal year 2010, the Board spent $804,330 on travel for Veterans Law Judges (VLJs) to conduct in-person hearings with Veterans and Appellants in field offices. In fiscal year 2011, the Board anticipates spending $1,000,000 on travel for VLJs to conduct in-person hearings in the field, due to the rising costs of air and rail travel, as well as the rising costs of fuel, and other incidental travel expenses.

D. Please provide a comparison of the costs to conduct hearings via videoconference versus conducting travel hearings.

Response. The Board spends nearly $1,000,000 per year on travel costs for VLJs to conduct in-person hearings with Veterans and Appellants in the field. By comparison, there are no travel expenses associated with conducting hearings via videoconference. There are costs associated with the initial purchase of videoconference equipment, as well as minimal maintenance costs for the equipment, but those costs are not covered by the Board.

The increased use of video conference technology also creates a time savings. VLJs would have greater flexibility over time management because video hearings would be conducted more efficiently from the Board's offices in Washington, VLJs would not lose time in the field due to travel days or to appellants failing to attend scheduled hearings.

Question 3. According to the fiscal year 2012 budget request, the Board now expects to spend over $2.5 million on Other Services during fiscal year 2011, which is 177% higher than originally anticipated in the fiscal year 2011 budget ($923,000). For fiscal year 2012, the Board requests over $2 million for Other Services.

A. Please provide a detailed itemized list of how these funds would be spent in fiscal year 2011. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response:

(Dollars in Thousands)

Credit Card Purchases	
Training Credit Card Purchases	$29
Miscellaneous (locksmith, rental furniture)	$3
Customer Service Survey	$300
Office of Resolution Management (BVA shares operational cost of discrimination complaints)	$67
OGC Hein Online and CyberFed (Federal Register materials and Law Journal articles)	$5
Government Movers (miscellaneous task service (assemble/disassemble/repair workstation))	$70
West Group (legal database)	$244
OT Utilities (summer utilities for overtime on weekend)	$110
All-Shred (sensitive documents destruction)	$24
FaxPlus (maintenance contract for office fax)	$5
Promisel & Korn (electronic research tool)	$559
Independent Medical Expert (expert medical opinions)	$60
VA Franchise Funds (Financial Service Center)	$27
Payroll support services, fiscal services	
Security and Investigation Centers	$1
Investigative services	
Transcription services	
York	$250
Diaz	$250
Bell	$250

B. Please provide a detailed itemized list of how these funds would be spent in fiscal year 2012. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response:

(Dollars in Thousands)

Credit Card Purchases	
Training Credit Card Purchases	$35
Miscellaneous (services)	$4
Office of Resolution Management (BVA shares operational cost of discrimination complaints)	$67
OGC Hein Online and CyberFed (Federal Register materials and Law Journal articles)	$5
Government Movers (miscellaneous task service (assemble/disassemble/repair workstation))	$70
West Group (legal database)	$254
OT Utilities (summer utilities for overtime on weekend)	$110
All-Shred (sensitive documents destruction)	$24
FaxPlus (maintenance contract for office fax)	$7
Promisel & Korn (electronic research tool)	$450
Independent Medical Expert (expert medical opinions)	$60
VA Franchise Funds (Financial Service Center)	$28
Payroll support services, fiscal services	
Security and Investigation Centers	$1
Investigative services	
Transcription services	
York	$300
Diaz	$300
Bell	$300

Question 4. According to the fiscal year 2012 budget request, the Board now expects to spend over $400,000 on Supplies and Materials during fiscal year 2011, which is 89% higher than originally anticipated in the fiscal year 2011 budget. For fiscal year 2012, the Board requests $570,000 for Supplies and Materials, which is 169% higher than originally requested for fiscal year 2011 and 43% higher than the Board now expects to spend during fiscal year 2011.

A. What accounts for these increased expenditures during fiscal year 2011?

Response. In fiscal year 2010, the Board spent $650,000 on Supplies and Materials. The Board's original fiscal year 2011 request for only $212,000 for Supplies and Materials was in error, and was not enough to meet the Board's actual Supplies and Materials needs.

B. What accounts for the increase between fiscal year 2011 and 2012?

Response. The Board requested $570,000 for fiscal year 2012 in the Supplies and Materials category, which represents a 22.8% increase from fiscal year 2011 to fiscal

year 2010. This request would correct the error made by the Board in the 2011 budget request for Supplies and Materials.

Question 5. In fiscal years 2009 and 2010, the BVA published a Veterans Law Review using appropriated funds. In connection with the Committee's February 2010 hearing on VA's fiscal year 2011 budget request, the BVA stated that this law review "serves as a training function" and that the BVA expected to spend slightly more than $34,000 to publish the 2010 edition.

A. How much was actually spent during fiscal year 2010 on the operation and publication of the Veterans Law Review?

Response. In fiscal year 2010, the total expenditures on publication of the Veterans Law Review were $35,885, spent almost entirely on printing costs.

B. How much is expected to be expended on the operation and publication of the Veterans Law Review during fiscal year 2011 and how much is requested for this purpose in the fiscal year 2012 budget?

Response. In fiscal year 2011, the expected expenditure for the Veterans Law Review (again almost entirely for printing costs) is approximately $27,000. This decrease in funding reflects a more accurate view of the requisite supply of volumes to be printed.

In fiscal year 2012, the Board requested $90,000, which was an over-projection, based on actual costs and demand.

C. What specific goals does BVA expect to accomplish through this initiative and what metrics are in place to gauge whether this initiative is meeting those goals?

Response. The goal of the Veterans Law Review is to provide a forum to address the legal issues and policy concerns faced by an expanding universe of Veterans' benefits law. It also provides interested Board attorneys and Veterans Law Judges with additional experience in researching, editing, and writing legal articles, as well as experience with the management of a complex project. The training aspect of participation in the Veterans Law Review is of great value to the Board in accomplishing its mission.

It is important to note that the Board sponsors the publication of the Veterans Law Review by providing printing costs and occasional meeting space. All employees who contribute do so largely on their own time, without detriment to serving the Veterans whose appeals are before the Board. The Board's goal in sponsoring the Veterans Law Review is to increase scholarship in the area of Veterans law. It also provides an important and exciting learning opportunity for interested Board attorneys and Veterans Law Judges to explore areas of the law in a critical and in-depth manner that is not generally possible in the day-to-day operations of the Board. In an indirect way, this serves as an important supplement to the Board's other training programs to support the professional growth and development of our staff. The Board does not have any metrics in place to measure whether these goals are being met because these are not the types of goals that are subject to clear measurement. From the experience gained in publishing the first three volumes of the Veterans Law Review, however, the Board feels strongly that the very small costs of publishing the document are more than outweighed by the personal growth and development of our staff.

D. Does VA consider the publication of this law review to be a mission critical activity?

Response. The Board considers the legal scholarship created in the Veterans Law Review to play a critical role in the development of a robust legal community practicing Veterans law. The insight gained increases awareness in the Veterans bar and will increase the quality of the arguments before the Board, the United States Court of Appeals for Veterans Claims, the United States Court of Appeals for the Federal Circuit, and the Supreme Court in this unique area of law which, even after three decades of judicial review, is still in its relative infancy compared to most other areas of Federal jurisprudence.

E. Has BVA or VA approached any law schools, bar associations, or other entities to determine whether they would be willing to publish a Veterans Law Review?

Response. By creating the Veterans Law Review, the Board sought to fill an educational void in the increasingly complex world of Veterans' benefits appellate adjudication. To date, the Board has not approached any law schools, bar association, or other entities to determine if any of them would be willing to take over the publishing of this law journal.

Question 6. The fiscal year 2012 budget request includes $73.3 million to support 544 employees for the Board.

A. Please provide a breakdown of the positions that would be filled in fiscal year 2012 (such as members of the Board, professional staff, and administrative staff) and the number of staff for each type of position.

Response. The breakdown of the 544 positions in fiscal year 2012 is as follows:

Attorney Adviser	345
Veterans Law Judge	64
All Other	135

B. How many members of the Board (or Veterans Law Judges) currently are employed by the BVA?

Response. The Board currently employs 59 Veterans Law Judges, with five appointments currently pending at the White House.

C. Please provide a breakdown of the percentage of Board members who were existing Board employees when selected to become a Board member; the percentage who were selected from other VA offices; and the percentage who were selected from outside of VA.

Response. With respect to the Board's current 59 Veterans Law Judges, the percentage who were, or were not, already Board employees when selected is broken down as follows:

- Percentage of Board members who were existing Board employees (95%)
- Percentage who were selected from other VA offices (5%)
- Percentage who were selected from outside of VA (0%)

General Counsel

Question 1. Within the Office of General Counsel, Professional Staff Group (PSG) VII represents VA before the U.S. Court of Appeals for Veterans Claims.

A. How many employees currently are assigned to PSG VII?

Response. As of March 15, 2011, there are 119 FTEE assigned to PSG VII (one is currently serving on active duty with the Navy).

B. Currently, what is the average caseload handled by PSG VII attorneys?

Response. There are approximately 40 active cases per attorney on average. An active case is one in which the Secretary's dispositive pleading has yet to be filed.

C. For fiscal year 2012, what level of funding would be dedicated to supporting PSG VII and how many employees would that level of funding support?

Response. The FY 2012 budget request would allocate $17.1M in funding to PSG VII, which would support 131 FTEE.

D. With the requested level of funding for fiscal year 2012, what would be the average caseload for attorneys in PSG VII?

Response. Barring any unforeseen events, we anticipate that the caseload would average around 36 active cases per attorney at the projected FY 2012 funding level.

E. How many motions for extension of time did PSG VII file during fiscal year 2010?

Response. PSG VII filed 3,411 extension motions on behalf of the Secretary during FY 2010, which represented approximately 284 extension motions per month on average.

F. To date, how many motions for extension of time have been filed by PSG VII during fiscal year 2011?

Response. During the period extending from October 1, 2010 to February 28, 2011, PSG VII filed 642 extension motions on behalf of the Secretary, which represented approximately 128 extension motions per month on average.

Question 2. For many years, the Office of General Counsel has been involved in a project known as the VA Regulation Rewrite Project.

A. What is the status of that project?

Response. VA has published 20 Notices of Proposed Rulemaking (NPRMs), which encompass all of VA's compensation and pension regulations in Part 3 of 38 CFR. Because the Compensation and Pension (C&P) Regulation Rewrite Project is a major, comprehensive reorganization, updating, as well as redrafting of these regulations, VA compiled its responses to public comments submitted on all 20 of the proposed rules into a single final rule document. Due to the enormity of the project and based upon requests from several Veterans Service Organizations (VSOs), VA is giving the public and VSOs an additional opportunity to review and comment on the entire new Part 5 in a second, consolidated NPRM. Once this large NPRM is published and the public has had an opportunity to comment, VA will make final revisions and publish the Final Rule.

B. Please provide a timeline of the remaining milestones for this project.

Response. The current C&P Regulation Rewrite Project schedule calls for publication of the consolidated NPRM by November 1, 2011, and publication of the Final Rule by January 1, 2013. VA's Office of the General Counsel (OGC) will continue to oversee the transition to the new Part 5 CFR from the existing Part 3 provisions

for several years, until Part 3 provisions are no longer applicable to any Veterans' claims.

C. To date, how much has been expended in connection with this project and how much is requested for fiscal year 2012?

Response. The C&P Regulation Rewrite Project is not a separate entity nor is it separately funded. OGC's Office of Regulation Policy & Management (ORPM) is responsible for the project which consumes about 10% of its time.

ORPM's budget has ranged from $1.3M–1.4M a year. Therefore, the cost associated with the C&P Regulation Rewrite Project is approximately $130–140K per year and amounts to about $1M since 2004.

Consistent with previous fiscal years, OGC anticipates devoting approximately $140K to the project in FY 2012.

D. How many Office of General Counsel employees currently are dedicated to that project?

Response. Currently, two ORPM FTEE in OGC are assigned responsibilities associated with the C&P Regulation Rewrite Project. The Deputy Director for ORPM supervises the project and spends approximately 75% of his time managing that process. One additional ORPM employee spends about 10% of her time on the project. In addition, two attorneys—one from C&P Service and one from the Board of Veterans Appeals (BVA)—remain detailed to ORPM for the Project. ORPM uses unpaid student interns for academic credit. Other attorneys in OGC perform legal reviews for the proposed regulations, as they do for all VA regulations, but their time spent on this project is not tracked separately from their other rulemaking work.

E. With the funding requested for fiscal year 2012, how many Office of General Counsel employees would be dedicated to this project during fiscal year 2012?

Response. There would be no change in the number of OGC employees dedicated to the C&P Regulation Rewrite Project during fiscal year 2012.

Office of Management

Question 1. The fiscal year 2012 budget request for the Office of Management includes the following information:

> As a result of the centralization of certified invoice payments at the [Financial Services Center], continued improvements have been made in reducing interest penalty payments and increasing discounts. Centralization resulted in a decrease of 24% in interest penalties per million dollars disbursed to commercial vendors from $47 per million in 2009 to $35 per million in 2010.

A. In total, how much did VA spend on interest penalties during fiscal year 2010?

Response. VA spends $854.3K on interest penalties during fiscal year 2010.

B. In total, how much is expected to be spent during fiscal years 2011 and 2012 on interest penalties?

Response. During fiscal year 2011 $732.7K is expected to be spent and $696.0K in fiscal year 2012.

Question 2. According to the fiscal year 2012 budget request, the Office of Management now plans to spend over $50 million on Other Services during fiscal year 2011, which is 35% higher than the amount VA originally anticipated would be spent on Other Services during fiscal year 2011. For fiscal year 2012, the Office of Management is requesting over $42 million for Other Services.

A. What accounts for that increase in spending during fiscal year 2011?

Response. The 2011 current estimate for "Other Services" is $13.1 million above the amounts identified in the original 2011. This funding is for initiatives that were scheduled to be obligated at the end of 2010, but will now be obligated in 2011. These initiatives will help transform Department-level management by improving accountability, efficiency, and Veteran safety throughout the system.

Also contributing to the higher 2011 estimate is an increase in billing of $3.2 million for payroll services from the Defense Finance & Accounting Service (DFAS).

B. Please provide an itemized list of what expenditures would be made with these funds during fiscal year 2011 and fiscal year 2012. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response:

2011 "Other Services":

- $31.3 million for the Defense Finance & Accounting Services (DFAS) contract. DFAS provides VA with all of its payroll services.
- $3.9 million for Office of Business Oversight work in the areas of internal controls, contractual review, A–123 audits and Open Government.

• $4.3 million for contracts to support: Audit readiness contracts; Service Level Agreements (SLAs) for IT and H.R. support and services provided by the Financial Services Center (FSC); training; space, lease and moving expenses
• $11.4 million for transformation and financial management initiatives that will improve Department-level management, accountability, and efficiency, including development of an integrated operating model and cost accounting enhancements.

2012 "Other Services":

• $32.7 million for the Defense Finance & Accounting Services (DFAS) contract. DFAS provides VA with all of its payroll services.
• $3.6 million for Office of Business Oversight work in the areas of internal controls, contractual review, A–123 audits and Open Government.
• $1.5 million for contracts to support: Audit readiness contracts; Service Level Agreements (SLAs) for IT and H.R. support and services provided by the Financial Services Center (FSC); training; space, lease and moving expenses.
• $4.4 million for transformation and financial management initiatives that will improve Department-level management, accountability, and efficiency, including development of an integrated operating model and cost accounting enhancements.

Question 3. According to the fiscal year 2012 budget request, the Office of Finance within the Office of Management manages the financial operations at VA's Debt Management Center.

A. For the completeness of the record, please describe the scope of responsibilities of the Debt Management Center.

Response. The Debt Management Center (DMC) is responsible for collecting debts that arise from an individual's participation in any VA benefit program. If DMC is unable to affect collection, they are responsible for referring the debt to the Department of the Treasury for offset under the Treasury Offset Program or further collection action by collection agencies under contract with the Department of the Treasury.

B. How many telephone lines does the Debt Management Center currently operate and how many operators are dedicated to answering those telephones?

Response. DMC is currently operating 28 toll-free telephone lines with 37 operators. To provide expanded service to Veterans, the DMC increased the telephone service hours from 7:30 AM to 6:00 PM effective September 2010.

C. How many telephone operators are expected to be assigned to the Debt Management Center during fiscal year 2012?

Response. DMC expects to increase staffing levels to 40 operators within the next three months and maintain that staffing level into fiscal year 2012. DMC will continue to monitor workload throughout fiscal year 2011 and into fiscal year 2012 and will adjust staffing levels as needed.

D. During fiscal year 2010, how many debts were referred to the Debt Management Center, what was the total value of those debts, and how much did the Debt Management Center recoup?

Response. DMC provided collection services for all VA benefit programs, which include education, compensation, pension, and loan guaranty. Debts are automatically created and referred to DMC when an adjustment is made to a beneficiary's award that reduces his/her entitlement. During FY 2010, DMC received 595,354 new debts valued at $1,349,099,996. Collections/offsets for the fiscal year on all debts totaled $1,018,347,000.

E. How many debts are expected to be referred to the Debt Management Center during fiscal year 2011 and during fiscal year 2012?

Response. DMC experienced an increase of 37% in total number of new debts referred from fiscal year 2009 to fiscal year 2010. This is attributable, for the most part, to the implementation of the new Post-9/11 GI Bill Program, where an individual can have multiple debts on their record at any given time. For example, an individual could have an outstanding advance payment as well as tuition and fees overpayment and a housing allowance overpayment all at the same time. Based on the expected number of Post-9/11 GI Bill Program participants in receipt of benefits and the increase in related debts experienced in fiscal year 2010, the DMC expects the percentage of new debts will increase by similar amounts in fiscal years 2011 and 2012. Based on that percentage, DMC expects to have 815,881 new debts referred in fiscal year 2011 and 1,117,763 new debts referred in fiscal year 2012.

F. What performance measures are used to determine the effectiveness of the Debt Management Center?

Response. DMC currently has six performance measures they use to determine effectiveness of operations. They are:

(1) Timeliness of Deposits (Goal—Deposit within 2 business days)

(2) Timely Response to Congressional Inquiries (Goal—Respond within 5 business days)
(3) Timely Response to General Correspondence (Goal—Respond within 12 business days)
(4) Lost Call Rate (Goal—Maintain a lost call rate of less than 5%)
(5) Timely Application of Unapplied Funds (Goal—Identify and apply funds within 60 calendar days)
(6) DMC Efficiency and Effectiveness (Goal—Meet or exceed expected rate of return)

G. In terms of those metrics, please explain the performance of the Debt Management Center during fiscal year 2010 and to date during fiscal year 2011.

Response. During FY 2010, DMC performed accordingly:

Timeliness of Deposits—Averaged deposits within 1 day measured against a goal of 2 business days.
Timely Response to Congressional Inquiries—Averaged responses within 4.21 days measured against a goal of 5 business days.
Timely Response to General Correspondence—Averaged responses within 11.12 business days measured against a goal of 12 business days.
Lost Call Rate—Averaged a 2.28% lost call rate against a goal of less than 5%.
Timely Application of Unapplied Funds—Averaged application within 49 calendar days measured against a goal of 60 calendar days.
DMC Efficiency and Effectiveness—Achieved a rate of return of $114.25 for every dollar spent measured against a goal of $80.88.

During FY 2011 to date, DMC performed accordingly:

Timeliness of Deposits—Averaged deposits within 1.2 days measured against a goal of 2 business days.
Timely Response to Congressional Inquiries—Averaged responses within 4.74 business days measured against a goal of 5 business days.
Timely Response to General Correspondence—Averaged responses within 11.5 business days measured against a goal of 12 business days.
Lost Call Rate—Averaged a lost call rate of 2.22% measured against a goal of less than 5%.
Timely Application of Unapplied Funds—Averaged application within 52 calendar days measured against a goal of 60 calendar days.
DMC Efficiency and Effectiveness—For first quarter, achieved a rate of return of $136.24 for every dollar spent measured against a goal of $125.00.

H. What would be the expected performance outcomes for the Debt Management Center during fiscal year 2012?

Response. DMC plans to maintain current performance measures and expects to meet or exceed those performance measures during fiscal year 2012.

Office of Human Resources and Administration

Question 1. In connection with the Committee's February 2010 hearing on VA's Fiscal Year 2011 budget request, VA provided the following explanation for the $14 million difference between what had been requested for travel for fiscal year 2010 ($2.4 million) for the Office of Human Resources and Administration and the amount then expected to be spent on travel by that office ($16.8 million):

> Under VA's new corporate level training program, all travel and training are managed, obligated and reported by the [Human Capital Investment Plan (HCIP)] at the corporate level. Costs that previously may have been obligated and reported at the field level are now reported at the corporate level under HCIP.

A. Please explain in more detail the change in the reporting methods for travel and training costs.

Response. Last year, VA Learning University assumed responsibility for managing all Human Resources and Administration sponsored training related travel. This effectively centralized this function and created a level of efficiency in support of VA's training goals.

During the first quarter of FY 2011, VALU has provided over 54,000 training opportunities (Functional Specific Training, Leadership and Management, Project/Program Manager Training, Transformation Training, Customer Service, and Union Training for Managers/Leaders) utilizing various modalities.

B. As a result of this corporate level reporting of travel training costs, were there decreases in the travel budgets for other offices during fiscal year 2010? If so, please identify any such decreases.

Response. VA believes that as we implement more VALU on-line training, travel budgets will decrease and VA has incorporated this trend in its estimates. VA estimates VA-wide travel of $252 million which is expected to decrease by $7 million or 2.7% from the 2011 estimated level.

C. What metrics are used to determine which staff needs to travel?

Response. Our travel cost is executed against VALU sponsored training programs derived from a requirements process that identifies critical training needs and fills training gaps identified by the VA Administration(s) and VA Staff Offices. VALU also provides training to the field in centralized locations where there are areas of high concentration of VA employees allowing for a reduction in expected travel that would have been incurred to support the training efforts.

D. What options (such as video conference, webinars, or local options) were explored to reduce the costs to the taxpayer?

Response. The vast majority of training conducted by VALU (HRA) is conducted through its online Learning Management System (LMS) which is the most cost effective way to train thousands of VA employees. Training is also being conducted through various modalities, including non-LMS online training, video conferencing, training hubs/clusters in the field, and at various existing training facilities (such as the VA Acquisition Academy, IT Training Academy, Office of Personnel Management, etc.) This technical training supports our VA professional employees deployed in very small numbers in any specific facility, and needing very specific training targeted to their profession. The training venues offer highly interactive, case study and scenario-based training to large numbers of a specific professional group (i.e. financial management professionals). This training modality is an efficient and effective means of targeting our professional career fields.

Question 2. In connection with the Committee's February 2010 hearing on VA's fiscal year 2011 budget request, VA projected that, during fiscal year 2011, 8,800 employees would take trips and that each trip would cost on average $2,000, at a total cost of $17.6 million in travel expenses for the Office of Human Resources and Administration. According to the fiscal year 2012 budget request, the Office of Human Resources and Administration now expects to spend over $27 million on travel during fiscal year 2011, which is nearly $10 million more than this office requested for travel funds in VA's fiscal year 2011 budget proposal. For fiscal year 2012, this office is requesting over $28 million for travel expenses.

A. To date, how many employees have traveled during fiscal year 2011 and what was the average cost per trip?

Response. Through February 2011, VALU has expensed travel cost for 2,194 VA employees taking training and the average cost for fiscal year 2011 is $1,196.82 per trip. Some employees have travelled more than once. The total cost of VALU sponsored travel is $3.8 million through February 2011.

B. Has this office made any changes in light of this recommendation of the National Commission on Fiscal Responsibility and Reform: "Reduce Federal travel." If so, please explain.

Response. Yes. We are addressing this by providing training conference venues where we are able to reach a larger number of VA employees in a centralized location and reduce the number and frequency of smaller scale technical training events. We are also providing the vast majority of our training courses via VA's online LMS.

C. During fiscal year 2011, how was the additional $10 million now allocated for travel originally expected to be spent?

Response. The $10 million reflected in the current budget for travel was originally requested in FY 2011 to fund VA staff training.

D. What factors account for the over $1 million increase in expected travel expenses between fiscal year 2011 and fiscal year 2012?

Response. The 4.7 percent increase in travel cost from FY 2011 to FY 2012 is primarily due, in part, to anticipated inflation.

E. For fiscal year 2012, how many trips is the $28 million expected to support?

Response. We expect that $28 million would support the travel of over 13,000 trips to training courses

Question 3. For fiscal year 2012, the Office of Human Resources and Administration is requesting over $309 million for Other Services.

A. Please provide a detailed itemized list of how these funds are expected to be spent.

Response. The majority of the Other Services category of obligations is for contracts ($308.6 million) and is detailed in the response to 3B. The remaining $790 thousand is for maintenance and repair services, including the repair of furniture and equipment.

B. To the extent any of these funds will be spent on contracts, please explain the expected nature of the contract and the expected outcomes.

Response. The Other Services category of obligations includes the contracts detailed below.

Training, Development and Management:

Corporate Senior Executive Management Office ($9.5 million): The Corporate Senior Executive Management Office (CSEMO) centrally manages the recruitment actions for all 407 executive positions, has oversight of the VA-wide corporate Executive Resources Board, oversees and manages Executive Performance Management, leads the new VA SES Orientation Program and provides formalized SES On-Boarding. Initiatives under the Corporate Management Office include executive coaching and leadership development, the creation of a new performance management system that makes meaningful distinctions in performance, and the development of a collaborative Web site for VA executives.

Leadership Assessment/Competency ($1 million): Targeting senior leaders, managers and supervisors, this contract is aimed at assessing and developing leaders across VA to foster and support a strong, capable leadership corps, and ensure that VA leaders have the skills and proficiency to effectively lead people and programs. Program evaluation elements will complement organizational leadership evaluation and assessments performed by the National Center for Organizational Development. Evaluation activities will include a review and acceptance of proposed certification and standards by VA and OPM general counsel.

Leadership Infusion ($4.3 million): This initiative procures seats in pre-designed and custom leadership and management training programs through the U.S. Office of Personnel Management (OPM) Center for Leadership Capacity Services (CLCS). These pre-designed training programs are designed to increase proficiency in each leadership competency and improve performance at the supervisor, manager, and executive levels of across the Department.

Basic/Advanced Supervisory Management Training ($30.5 million): To Reach nearly 22,000 managers and supervisors, VA has implemented an enterprise-wide, corporate university approach to supervisory and management training. This initiative includes development of all aspects of competency-based basic and advanced supervisory and management training programs, development and delivery of training using multiple modalities and production of documents and materials needed to conduct instructor-based training, and analysis, design, and development support to VA production staff to produce video, VA knowledge network satellite, graphics, and eLearning materials. In addition, the project will include the testing of training materials and implementation of training programs and evaluations.

Transformational Leadership ($10 million): This contract will enable design, development, and delivery of training programs that result in increased proficiency in each competency and enable optimization of performance for leaders at the supervisor, manager, and executive levels of leadership. The proposal reflects five major facets of work: (a) development of a Transformational Leadership Competency Model, (b) a framework for senior leader training identified as the Senior Leadership Academy, (c) options for manager and supervisor training, (d) objectives for program related assessment and evaluation through engagement with the National Center for Organizational Development and (e) linkages with the VA Transformation Communication Strategy.

National Center for Organizational Development (NCOD) ($3.6 million): NCOD will evaluate the effectiveness of the VA's Human Capital Improvement Plan (HCIP) initiatives through the development of an HCIP performance tracking dashboard, 360 degree assessments of managers, supervisors and executives, and onsite Organizational Assessments for identified VA Organizations to assess specific areas of focus (e.g., Information Technology, Human Resources). NCOD will conduct assessments utilizing multiple measures (surveys, focus groups, interviews, etc.) to objectively evaluate organizations within VA, including employees and leadership. Results from the assessments will guide and support ongoing HCIP initiatives and training development to ensure that curriculum meets identified gaps. NCOD will also implement the Civility, Respect, and Engagement in the Workforce (CREW) initiative across all of VA. CREW was created to improve employee satisfaction and success in meeting performance measures while decreasing conflict in the workplace. Finally, NCOD will expand the VHA All Employee Survey (AES) to encompass all VA employees once per year and will provide the necessary coordinator training, organizational mapping, marketing activities, administration coordination, data analysis and presentation, and support for action plan development.

Office of Information and Technology (OI&T) Workforce Training Program ($28.7 million): Contractor support is needed to both maintain VA's OI&T Supervisor com-

petency model and implement it for CIOs and application software developers. The scope of the required role-specific professional development activities covers the following primary tasks:

• Provide administrative support for the establishment of a program office to establish processes and provide administrative support for program review, development of program milestones, resource allocation, and monitor milestone progress;
• Provide operations and maintenance support for the Information Security Officer (ISO) Competency Model and develop courseware to fill gaps in the supervisor curriculum;
• Implement the CIO Professional Development Program;
• Initiate and implement Application Software Developers Professional Development Program;
• Provide operations and maintenance support for the OI&T Supervisory Program and develop courseware to fill gaps in the Supervisory Training Program curriculum;
• Develop and implement an On-Boarding Program to orient and integrate new employees into the Office of Information and Technology;
• Develop and implement an intern program to begin building bench strength and a labor pool in newer technologies; and
• Develop and implement a vendor-supplied certification and voucher program that includes IT-related technical and professional development certification.

HR Academy ($5.8 million): The H.R. Academy will support the more than 3,800 VA H.R. professionals ranging from GS–7 to GS–15 in their career development, skills, and abilities. A gap analysis of 22 core competencies and specialized skills determined several areas in need of improvement. By closing the known gaps through a standardized, organized H.R. Academy and associated curricula, VA H.R. professionals will gain the ability to advance their proficiencies in order to provide improved service to clients and customers. Academy plans call for the implementation of certification programs as well the creation of a cadre of exemplary H.R. professionals who can provide consultation and operational service at the highest levels of industry standards. The H.R. Academy will be a virtual "Academy" that provides course curricula at three levels of practice: Practitioner, Expert Practitioner, and Advanced/Leader. The curricula will consist of online and classroom training programs that are easily available through a variety of vendors and modalities, cost-effective, and demonstrably able to close proficiency gaps.

VA Acquisition Academy ($19.9 million): Specifically mandated by the Office of Federal Procurement Policy, is the requirement to establish Federal Acquisition Certification-Program/Project Managers (FAC-P/PM) as a structured career development program for P/PMs throughout Federal civilian agencies. The Academy will be designed to address gaps in program and project management skills critical to the success of major departmental initiatives. In particular, it will train the Acquisition and Information Technology workforce and other employees requiring project and program management training and/or certification to meet the FAC-P/PM competencies. The project will acquire commercial or government training in support of Supply Chain Management (SCM) and other acquisitions and logistics management curricula, provide training for employees requiring Contracting Officer's Technical Representative (COTR), and support the formation of the VA Facilities Management Academy program. The development of Project Management skills meets another goal: the shortage of project management skills among IT and other critical mission occupations have resulted in costly and poorly managed programs in the past.

Program Based Training ($32.7 million): The purpose of this project is to design, develop, and implement program based training for approximately 40,000 employees in cross-cutting career fields not previously identified for action. Examples of career fields include all VA Staff Offices and new groups set up to implement the 13 major initiatives, which represent the Department's highest priorities and include Management Analysts, Program Analysts, Budget Analysts, Accountants, Auditors, Executive and Staff Assistants, Human Resources Liaisons, Paralegals and Legal Assistants, Project Managers, and Contracting Officers Technical Representatives. These training programs shall be offered in a wide variety of training methodologies including e-Learning, facilitated and instructor-led group events, and independent study.

Workforce Planning and Career Broadening ($26.2 million): Focused on ensuring that the VA is prepared for the future and on the development and retention of a skilled workforce, these initiatives will first target 44,000 VA employees in mission-critical positions. The VA will create a workforce planning program to centrally coordinate the development and retention of a critical staff throughout the entire Department.

VA Learning University ($7.7 million): VA Learning University (VALU) contracts will cover program expenses associated with providing educational programs to the Department's employees through established learning technology infrastructure. While core programs rely heavily on remote and on-line training delivery through the Department's Learning Management System to minimize costs, VALU will also utilize Leadership VA, Mentor Training to support the VA Central Office Leadership Development Mentoring Program, the Aspiring Leaders Program and other special emphasis training programs.

Skillsoft License renewals ($1.6 million): This ongoing contract will continue to provide VA employee access to online courses and digital online books, job aids, educational reference materials and other courseware through OPM's Government On-line Learning Center. The content is available to VA employees through the VA Learning Management System.

Improvements to Human Resources Processes and Systems:

Hiring Reform: Improving VA Central Office H.R. Service (COHRS) and Knowledge Management ($5.5 million): One of the major goals of this initiative is to streamline the VA's processes for recruiting and hiring qualified personnel. This contract will support H.R. business process reengineering, service level agreements, new standard operating procedures, employee competency assessments and the creation of individual development plans. It will include the development of libraries of up-to-date position descriptions and functional statement for core positions, the design and implementation of an on-boarding tool, workload tracking tool, redesign the COHRS Web site, and the development of universally applicable position descriptions/functional statements for identical work performed Department-wide, and the development of a Knowledge Management system.

Human Resources Information System ($53.5 million): This project is the central component of an overall VA H.R. enterprise-level initiative that will upgrade the VA's antiquated COBOL-based H.R. processing systems. The new Human Resources Information System (HRIS) will replace the existing paper driven Personnel and Accounting Integrated Data System (PAID) with an "off-the-shelf" solution that will be provided by an approved OPM Human Resources Line of Business Shared Service Center (SSC). The SSC provider will offer proven modern HRIS services to VA for a fee, based on the nature of the services provided and the number of employees serviced in a year. This service will eliminate the manually laden basic transactional and maintenance work by current H.R. staff associated with PAID, paper driven processes, and disconnected applications.

Recruitment/Centralized Intern Hiring Projects ($8.2 million): To meet VA's succession planning needs into the future, VA will need to strengthen its employment pipeline by consolidating its various internship programs. Focused recruitment will ensure new talent by increasing the number of Presidential Management Fellows and other student/graduate appointments. Other recruitment contracts will improve the process and tools for hiring, the on-boarding process, and retention of acquired talent.

Veterans Employment Initiatives ($16.4 million): Contract funds will support the implementation of VA's Veterans Employment Strategic Plan to support increased hiring of Veterans at VA and support the President's Executive Order on Veterans employment. The recruiting, retention, and reintegration program is designed to recruit from a pool of 23 million Non-VA Veterans, retain the 90,000 VA Veteran employees currently working for the Department, increase the percentage of Veterans employed to VA established goals, and provide reintegration assistance for the 7,000 VA Military Servicemembers who are eligible for deployment. The contract funds will be used to stand up a new Veteran recruiting, retention, and reintegration office and maintain a virtual career assessment center to assist in transitioning the military employee back to the workplace.

Safety and Health:

Worklife and Health and Wellness Initiatives ($5.3 million): Collectively, these initiatives address the quality of the work environment and are designed to improve employee performance, lower sick leave usage and increase productivity by promoting a positive life-style and a healthful working environment. Based on an agreement between VA and the Department of Health and Human Service, Federal Occupational Health (FOH), the objective of this program is to provide a range of options to help employees and their families balance personal and workplace responsibilities at every life stage. The FOH Wellness/Fitness Program includes access for all VA employees to an on-line health information program offering: a comprehensive lifestyle management center, on-line health risk assessment, tracking programs, personal improvement programs, and an online health encyclopedia.

Occupational Safety and Health ($4.1 million): Occupational Safety and Health (OSH) will implement initiatives contained in the Worker's Compensation and Safety Strategic Plans, recommendations made by the Office of Inspector General in collaboration with Administration members of the VA Worker's Compensation and Safety Steering Committees. Initiative contracts will be dedicated to improving safety and workers' compensation program management (e.g., developing and implementing worker's compensation case management), educational products, and safety surveys to provide improved program support and oversight. OSH expects to reduce program costs through the prevention of injuries and illnesses and by the reduction in employee injury costs, saving VA dollars and returning employees to work.

Other Program Initiatives:

Alternative Dispute Resolution ($1.5 million): Increased emphasis on the VA's ADR program is expected to reduce conflict in the workplace and decrease the amount of time and money spent on EEO complaints and grievances. In order to promote leadership skills in the areas of effective communication, negotiation and problem solving, ORM has developed Department-wide curriculum for VA leaders on managing conflict. Ongoing Alternative Dispute Resolution (ADR) contract funds will enable ORM to continue implementation of a program that promotes leadership skills and conflict competency to include awareness of behaviors that escalate conflict, and skill in resolving disputes at the earliest stage possible. Contract funding will also support continued operation of the Resolution Support Center (RSC), a full-service hotline established to serve as an additional resource to managers, employees and Veterans through which questions can be raised and consultative services and referrals provided by subject matter experts. In FY 2010, this program saved VA an estimated $80 million in costs associated with protracted EEO complaints.

EEO and Diversity Programs ($10.8 million): The VA processes Equal Employment Opportunity (EEO) complaints for VA employees, applicants for employment, and former employees. Statutorily mandated complaint processing services include counseling, mediation, procedural determinations, and investigations. These services are provided through a nationwide network of ORM field operations offices. Contract funds are used for contract investigators, as well as, transcription services to capture the testimony of witnesses. VA will also continue to implement the Department-wide Diversity and Inclusion Strategic Plan for FY 2009—2013. This Plan represents a major transformation of the diversity management function in VA to a broader, more inclusive paradigm. Contract funds in the Office of Diversity and Inclusion (ODI) will support the implementation of the Plan's strategies such as employee training, leadership development, and compliance oversight in the areas of diversity and disability program management to avoid costly liability associated with non-compliance with statutory obligations and EEOC requirements. ODI will expand its diversity-focused internship program, fully implement an EEOC-compliant Reasonable Accommodations Case Management System and expand the use of its centralized account to fund reasonable accommodations in support of the Americans with Disabilities Act Amendments Act of 2008 (ADAAA).

Labor-Management Relations ($5.6 million): LMR promotes successful labor-management relationships that allow the Department to effectively manage its workforce while meeting its labor relations obligations. This contract effort will improve the relationship between labor unions and management by providing training to encourage and establish cooperative and productive labor-management partnerships. A range of training delivery strategies, including classroom and web-based training, may be utilized. Training may include establishment and maintenance of effective labor management forums.

Emergency Employee Accountability ($2.8 million): This contract effort will develop an enterprise-wide personnel accountability system (PAS) to allow communications with and accounting for VA employees during a natural disaster, act of terrorism or other emergency. This initiative will improve VA ability to provide continuity of benefits and Veterans services as well as to serve the community in areas such as health care, in compliance with VA's fourth mission to "Increase VA Capability to Support the Nation in Time of Need." PAS will provide the capability for VA to alert andnotify employees and contractors by name and obtain responses as to their safety and ability to work during and immediately after declaration of the emergency.

Office of Administration ($6.2 million): The Office of Administration (OA) serves as the VA's hub for all building and facility related services for the VACO campus, comprised of eleven Washington area office buildings. On-going contract funds are required to support a clean, safe, attractive and accessible environment. Contract funding is requested to support the VACO Health Unit and Transit Benefits Program for employees. Funds will also be used to support the operations of OA's leas-

ing and space functions, simplified acquisitions, transportation and labor services, and audio/visual and media services needs.

Strategic Operations ($7.4 million): The Strategic Management Group provides effective management and oversight over the Department's Human Capital Improvement Plan initiatives. This contract funds administrative support for the establishment of a program review, development of program milestones, resource allocation, and for monitoring milestone progress. Contract activities include overall coordination and management of VA transformation and HCIP initiatives, assistance with the management of change and ongoing support of a project management office (PMO) support organization and staff.

Question 4. The fiscal year 2012 budget request for the Office of Human Resources and Administration shows an increase of $288,000 or 136% over fiscal year 2010 for printing and reproduction.

A. What accounts for that 136% increase in printing costs from fiscal year 2010?

Response. The fiscal year 2012 budget request includes printing requirements that were not made during FY 2010 due to delays in employee relocation for the Lafayette Building renovation. HR&A is responsible for several administrative functions related to the VACO campus including printing and distributing customer service guides, Occupancy Emergency Response Guides, and Emergency Evacuation Procedures to all VACO campus employees. The FY 2012 printing costs will include publication of guides to employees in new VA spaces. The requested increase will also cover the printing of several new HR&A publications listed in response 4B.

B. Please provide an itemized list of how these funds will be expended.

Response. The increase request for FY 2012 printing funds is attributed to printing the following materials:

- Customer Service Guide, Occupancy Emergency Response Guide, Emergency Evacuation Procedures.
- Strategic Human Capital Plan. This Report is to be shared with VA senior leader and serves as a "roadmap" for the accomplishment of VA Strategic goals, objectives, and initiatives using our human capital resources.
- Human Capital Management Report (jointly with the Office of Oversight & Effectiveness). This Report has a similar audience to the above. The Report indicates on an annual basis what VA was (or was not) able to accomplish using their human capital resources.
- Knowledge Management (KM) User Guide and Overview. These two documents (the second being two-side laminated) will be used to educate our H.R. professional community and others on what Knowledge Management is and how to use the new KM program.
- Workforce Planning Fact Sheet. This two-sided laminated document will serve a similar role, educating VA workforce planners on the Department's new corporate-wide Workforce Planning Program.

Question 5. The fiscal year 2011 budget request included $3 million for a "Health and Wellness initiative," which would fund a contract to an outside vendor. The "Health and Wellness initiative" was again mentioned in the FY 2012 budget under the Human Capital Investment Plan.

A. How much has been budgeted for FY 2012 for continuation of the "Health and Wellness initiative?"

Response. In FY 2012, $3.04 million has been budgeted for the continuation of this initiative.

B. How much of the $3 million was obligated to an outside vendor to support the initiative? Who was the outside vendor and how does VA evaluate their job performance?

Response. In FY 2011, $2.7 million was obligated to Federal Occupational Health (FOH) via Inter-Agency Agreement with the Department of Health and Human Services. Performance is measured through:

i. Employee Participation—The percentage of VA employees who sign up/register for the program and complete an online Health Risk Assessment (HRA). The Web site is designed and maintained by the vendor (FOH) and usage rates, drop off rates, etc. are monitored monthly through Executive Summary Reports. This measure provides quantitative data for the number and type of recognized health risk behaviors in VA. This data allows VA to focus on these behaviors and address them. The database also provides us with the demographic areas where high risk health behaviors exist and provides an overall "snapshot" of the state of wellness of VA employees.

ii. Feedback Surveys—Volunteer feedback surveys will be available through the Web site. Surveys will contain questions on all program areas and results will be used to identify program strengths and weaknesses to improve upon.

The results of this data will be both qualitative and anecdotal, allowing for more detailed feedback on areas for program improvement.

a. Using the performance metrics outlined by VA last year in response to Senator Burr's questions for the record in connection with the February 2010 budget hearing, how effective has this program been in "promoting healthier employees?"

Response. The program is still in its "Baseline Year." Only quantitative data on levels of utilization and participation have been collected. Program effectiveness measures will be reviewed at six months and at the end of the fiscal year to assess for program modifications to better meet employee needs. The official VA-wide program launch took place September 23, 2010. As of March 3, 2011, 6.5 percent of VA employees had signed up and completed an HRA. Program effectiveness results will also be identified with the Employee Feedback Survey which is scheduled for dissemination at approximately the six-month point of the program (April 2011) and will be available continuously so employees may provide feedback at any time.

b. Please outline the number of personal health coaches and active program coordinators, how they are chosen, and how their performance is measured.

Response. There are 120 Lifestyle Coaches. Coaches were selected after completing the Healthy Lifestyle Coach requirements (Bachelors degree or higher in health promotion, health education background, counseling or other health related field and at least one year of experience in coaching). Coaches go through initial training and then will have ongoing evaluation and training. Measurement of FOH coach utilization and goals set by the employee will be ongoing. Employee health risk assessments will be reviewed by the coaches and then discussed with the employee to identify significant changes that merit tailoring of program elements to meet their needs.

There are 330 Local Wellness Representatives who serve as program coordinators. This position is a voluntary and collateral position within the VA; representatives volunteer for this position in addition to their regular duties. They must have an overall interest in health and wellness promotion and be committed to serving as the liaison between the Health and Wellness Team, who oversee the VA-wide wellness program, and the on-site employee. The most direct measure for Wellness Representatives' performance is the overall participation rate at their respective sites.

Office of Policy and Planning

Question 1. For fiscal year 2012, the Office of Policy and Planning is requesting over $20.7 million to support 125 employees. This would be an 87% increase in staffing since fiscal year 2010, a 21% increase over fiscal year 2011 staffing levels, and a 127% increase over fiscal year 2008 staffing levels.

Response. For clarification, the Office of Policy and Planning (OPP) is requesting a total of 105 full time equivalent (FTE) ($17.6 million) in the fiscal year (FY) 2012 budget authority, an increase of 2 FTE over the FY 2011 request and 12 FTE over the FY 2010 request. The additional 20 FTE ($3.1 million) would be assigned to the Enterprise Program Management Office (ePMO). The ePMO was attached to OPP in late 2010, after the FY 2011 budget submission, as a pilot program. It is responsible for developing Department-wide program management standards/doctrine; supporting the execution of the Department's $2.5 billion portfolio of the 16 major initiatives, and assisting the Department's 20 supporting initiatives. The ePMO brings program management capabilities to large scale programs; is helping VA develop a program management culture; and will facilitate the successful development of future programs throughout the Department. In the last month alone, the ePMO has led a concentrated effort that has resulted in the awarding of $63.3 million in contracts and the preparation of $104.5 million of actionable contract packages in support of 16 major initiatives (see list of initiatives following response to question 3D). Since the ePMO provides Department-wide services, the operating expenses of the ePMO will be paid via reimbursements from the Veterans Benefit Administration (VBA), the Veterans Health Administration (VHA), and the Office of Information and Technology (OIT) in FY 2011 and FY 2012. The ePMO currently consists of a small cadre of six FTE and contract support. As the ePMO is proving to be successful in helping the Department to develop more effective program management capabilities, it is anticipated that the ePMO will be incorporated into OPP's budget authority request for FY 2013, subject to the approval of the Department's leadership.

A. What measurable performance outcomes would suggest whether the previous staffing increases have been effective?

Response. Since 2009, staffing increases have allowed OPP to establish the Office of Corporate Analysis and Evaluation (CA&E) and the Transformation and Innovation Service (TIS). We have also dedicated additional resources to the National Center for Veterans Analysis and Statistics (NCVAS) and the VA/DOD Collaboration

Service. As a result of these additional resources, OPP has been able to improve outcomes to Veterans during FY 2010 and FY 2011 in support of the four key integrated strategies articulated in the VA Strategic Plan.

Enhance our understanding of Veterans' and their families' expectations by collecting and analyzing client satisfaction data and other key inputs.

• Completed the National Survey of Veterans, a comprehensive nationwide survey of Veterans, active duty servicemembers, activated National Guard and Reserve members and family members and survivors. Data collected through the National Survey enables VA to compare characteristics of Veterans who use VA benefits and services with those of Veterans who do not; and study VA's role in the delivery of all benefits and services Veterans receive.

• Established VA data governance policy and processes to ensure VA enterprise data and information are available, current, reliable, readily accessible, and useful. Developed and implemented business intelligence capabilities and tools to transform data into information to support data-driven planning, analysis, and decisionmaking activities.

Anticipate and proactively prepare for the needs of Veterans, their families, and our employees.

• Improved VA policy toward Gulf War Veterans by advocating for the implementation of recommendations made by the Advisory Committee on Gulf War Veterans. Produced a comprehensive annual report on the use of selected VA benefits and services by pre-9/11 Gulf War Era Veterans. The recommendations included presumptive criteria for a number of serious illnesses for which Veterans will now be eligible to receive treatment from VA.

• Completed the Program Evaluation of VA's Mental Health Program. This study provided VA with information about the services it provides, the impact on Veterans, how VA compares to the private sector, patient outcomes, and costs. Study findings and recommendations are used to refine and improve VA services by suggesting policy and operating changes.

Create and maintain an effective, integrated Department-wide management capability to make data-driven decisions, allocate resources, and manage results.

• Began the implementation of planning, programming, budgeting, and evaluation (PPBE) capabilities to implement multi-year strategic resource allocation system across the Department and independent analysis to inform senior level decisionmaking on resource options. CA&E is an independent body dedicated to aligning VA resource allocations with investments that best serve our Veterans, their families, dependents, and survivors.

• Implemented the new strategic management process for VA. This process uses strategy to drive the budget and performance plans, and aligns the execution of VA strategy with performance management and organizational and individual accountability in an iterative way. This process centers on implementing the strategic goals, integrated objectives, and integrated strategies throughout VA.

• Ensured the success of Departmental transformation initiatives via collaboration, oversight, and monitoring of the $2.5 billion portfolio of 16 major transformation initiatives and 20 supporting initiatives. This included assisting in the development of operating plans, intensive mid-year reviews, and problem solving sessions with the 16 major initiatives that provided independent assessment of progress, identified barriers to success, helped define solutions, and elevated issues to senior leadership, as required.

Create a collaborative, knowledge-sharing culture across VA and with DOD and other partners to support our ability to be people-centric, results-driven, and forward-looking at all times.

• Contributed to transforming VA/DOD Collaboration by coordinating the development and implementation of joint programs such as the expansion of the virtual lifetime electronic record (VLER) pilots; the expansion of the integrated disability evaluation system (IDES) pilot to worldwide deployment; the development of the integrated mental health strategy (IMHS) and its 28 joint strategic actions; the increased access of servicemembers to VA benefits and service information through e-Benefits; the development of joint policy for the implementation of separation health assessments for all servicemembers; and significant improvements to the transition assistance program (TAP).

Additionally, OPP continued to provide ongoing services and capabilities to the VA and to Veterans that included the following outcomes:

• Provided statistical and geospatial analysis to support recurring and ad-hoc reporting. Examples of these statistical products include the Geographical Distribution of VA Expenditures Report, the Unemployment Rate of Veterans Report: 2000 to

2009, the Labor Force Participation Rates of Veterans Report: 2000 to 2009, The VA Information Pocket Guide; the Gulf War Era Veterans: pre-9/11 Report, and the VA/DOD Disability Evaluation System Trend Analysis.

• Provided actuarial services to the Department on an ongoing basis. FY 2010 efforts included development of the VA compensation and pension liability model.

• Updated VA's official estimates and projections of the Veteran population by State, county and congressional district from 2009 to 2039. Veteran population estimates are projected with characteristics such as: age, gender, period of service, race, ethnicity, rank (officer/enlisted), and branch of service.

Conducted a nationwide management analysis/business process reengineering study of sanitation operations (8,831 FTE) and biomedical engineering (990 FTE) services across VHA and monitored the implementation of the recently reengineered plant operations and grounds maintenance (7,269 FTE) functions.

B. What indicators would suggest whether additional staffing increases are warranted?

Response. Despite the outcomes described above, additional capabilities are needed in FY 2012. The nine FTE within CA&E are not enough to implement a Departmental-wide programmatic alignment of the VA's $132 billion budget, conduct independent assessments of resource requirements needed to meet planned Veteran outcomes, and fully integrate PPBE across a 300,000 person organization with three distinct administrations (VBA, VHA, and NCA). Additional resources are also required to fully engage with DOD and the military services in the growing number of activities required to ensure effective transition from active duty to Veteran status. Finally, there is a recognized gap in the strategic planning ability of the VA to conduct long-term policy analysis and consider alternative futures that will impact Veterans and the Department in the long-term.

The additional 12 FTE to bring the budget authority FTE to 105 in FY 2012 are requested to meet the emerging requirements identified above. First, to fully integrate and establish the PPBE methodology in the Department, it is necessary to expand the CA&E office from nine to 13 personnel. CA&E is still an exceptionally lean, and efficient, operation in relation to comparable governmental agencies. The desired CA&E staffing of 13 would provide strategic resource management and independent analysis and oversight of a program budget in excess of $132 billion and a workforce in excess of 300,000. By comparison, the Office of Program Analysis and Evaluation (PA&E) at the Department of the Army is staffed with approximately 100 personnel and supports a similar sized program/budget of $149 billion in FY 2012. The VA/DOD Collaboration Service is expanding from 13 to 16 personnel to address the growing number of issues associated with VA/DOD collaboration including IDES, VLER, electronic health records, IMHS, TAP, etc. Finally, we are establishing a new capability within the Office of Policy to conduct long-term policy analysis and alternative futures development in coordination with DOD and other Federal agencies.

C. Please list the specific positions that would be added to the Office of Policy and Planning during fiscal year 2012 with this level of funding and the expected paygrades for those positions.

Response. Most of the additional 12 FTE requested for FY 2012 will be management analyst grades 12/13/14. We will also hire statisticians and operational research personnel at the 13/14 level.

D. Please explain the outcomes or achievements that are expected to be attributable to these additional employees.

Response. As noted, the additional FTE are requested for 2012 to enhance capabilities primarily in three areas:

• The Office of Corporate Analysis and Evaluation will continue implementation of a Departmental-wide strategic resource management system to help inform VA leadership with analysis and options for future funding of Veterans needs. CA&E provides the Secretary, VA and senior leadership with independent and objective analysis of resource requirements and options for funding Veterans needs across the spectrum of health care, benefits, and memorial services. Through independent analysis and evaluation, CA&E provides an added level management insight on the effectiveness and efficiency of VA programs and budgets and measurable impact to the Veteran.

• The Office of VA/DOD Collaboration will expand its development and monitoring of joint policies and programs such as the expansion of the VLER pilots; the expansion of the IDES pilot to worldwide deployment; the development of the IMHS and its 28 joint strategic actions; the increased access of servicemembers to VA benefits and service information through e-Benefits; the development of joint policy for the implementation of separation health assessments for all servicemembers; and

significant improvements to TAP. These activities will protect the equity of Veterans as they transition from servicemembers; producing better outcomes in health care delivery and benefit service for Veterans, servicemembers, military retirees, and eligible dependents.

• Finally, we are establishing a new capability within the Office of Policy to conduct long-term policy analysis and alternative futures development in coordination with DOD and other Federal agencies. It will provide policy analysis capability to a evaluate range of future policy issues and requirements, i.e. policy challenges due to population trends, changing demographics and implications to VA infrastructure and capabilities such as the impact of health care reform on Veterans, and implementation of Caregivers Legislation.

Question 2. The fiscal year 2012 budget request for the Office of Policy and Planning shows an increase of $395,000 for travel over the amount ($112,000) expended in fiscal year 2010 for travel.

Response. OPP is requesting $300,000 in travel budget authority for FY 2012. OPP only expended $110,000 in travel during FY 2010 because there was there were very few senior leaders assigned to the office during much of the year. The Assistant Secretary, for example, was not confirmed until March 2010 and the Principal Deputy Assistant Secretary was not appointed until September 2010. The Executive Director for CA&E and the Deputy Assistant Secretary for Policy were not appointed until the fall of 2010. The increased travel funding is also requested to support the additional functions and staff assigned to OPP, to include travel to support VA/DOD activities, PPBE functions, and operational oversight of the transformation initiatives.

The remaining requests for $207,000 in travel funds for FY 2012 are from the ePMO ($120,000) and the VA Innovation Initiative (VAi2) ($87,000), both of which are paid via reimbursing agreements by VBA, VHA, and OI&T. The ePMO, which supports program management activities across the Department, is involved with Major Initiatives across the country. VAi2 is involved with working with the private sector entrepreneurs, academia, and internal VA employees to identify and prototype cutting edge solutions to assist in solving VA's most challenging issues.

A. What metrics are used to determine which staff needs to travel?

Response. Travel is approved at the Deputy Assistant Secretary level for mission essential requirements. Senior executive service employees' travel is approved by the Assistant Secretary. These decisionmakers approve travel when it supports:

• Field operations
• Technical training required for mission essential skills development
• Planning and policy implementation
• Management oversight to include on-going assessments of VLER pilot expansion, IDES pilot and deployment sites, IMHS development, and major initiatives development.

B. What options (such as video conference, webinars, or local conferences) were explored to reduce the costs to the taxpayer?

Response. Whenever possible, we will use technology (video conference, and webinars) to reduce the cost of our travel. For example, most recently, the ePMO used extensive video teleconferencing over a three week period to synchronize contracting activities between the VA acquisition centers in New Jersey, Texas, and Maryland with activities here in Washington.

Question 3. According to the fiscal year 2012 budget request, the Office of Policy and Planning now expects to spend $4.5 million more on Other Services than is estimated in the fiscal year 2011 budget. For fiscal year 2012, the Office of Policy and Planning is requesting $21.4 million for Other Services, which would be a 27% increase over the amount that the office now plans to spend during fiscal year 2011 and 94% more than this office originally requested for fiscal year 2011.

A. Please provide a specific itemized list of how these funds would be spent during fiscal year 2011 and fiscal year 2012. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. The FY 2012 budget authority request for OPP is only $10.6 million for "Other Services," which is actually a decrease of approximately $500,000 from our 2011 request. The remaining $10.8 million is being requested to support the ePMO ($10.1 million) and VAi2 ($0.7 million), which will be funded via reimbursements from VBA, VHA, and OI&T.

B. What factors account for the nearly $6 million increase during fiscal year 2011?

Response. Since OPP plans to actually spend less in FY 2011 than originally requested, the increase in spending is fully reflective of the additional responsibilities assigned to the ePMO and VAi2.

C. How was that $6 million originally intended to be spent?

Response. VBA, VHA and OIT intended to spend the $6 million on transformation initiatives.

D. What factors account for the over $4.5 million increase between fiscal year 2011 and 2012?

Response. This increase is due to the additional responsibilities assigned to the ePMO and VAi2. The ePMO will develop project management standards, methodologies and processes to govern the management of the major transformational initiatives in VA; share best practices; help major initiative teams to define requirements and get the resources (people, money, contracts, and space) they require to effectively execute; review operating plans to determine whether the proposed resources will achieve the intended outcomes; and identity opportunities for re-engineering VA process to institutionalize change and improve VA's long term capacity to execute large cross cutting programs. This activities are all directed at improving the quality and accessibility of health care, benefits, and memorial services for Veterans while optimizing value. VAi2 is responsible for using joint public-private sector collaboration in order to improve health care, benefits and memorial services for Veterans.

16 Major Initiatives

1 Eliminate Veteran homelessness.
2 Enable 21st century benefits delivery and services.
3 Automate GI Bill benefits.
4 Create Virtual Lifetime Electronic Records.
5 Improve Veterans' mental health.
6 Build VRM capability to enable convenient, seamless interactions.
7 Design a Veteran-centric health care model to help Veterans navigate the health care delivery system and receive coordinated care.
8 Enhance the Veteran experience and access to health care.
9 Ensure preparedness to meet emergent national needs.
10 Develop capabilities and enabling systems to drive performance and outcomes.
11 Establish strong VA management infrastructure and integrated operating model.
12 Transform human capital management.
13 Perform research and development to enhance the long-term health and well-being of Veterans.
14 Optimize the utilization of VA's Capital Portfolio by implementing and executing the Strategic Capital Investment Planning (SCIP) process.
15 Health Care Efficiency: Improve the quality of health care while reducing cost.
16 Transform health care delivery through health informatics.

Office of Operations, Security, and Preparedness

Question 1. For fiscal year 2012, the Office of Operations, Security, and Preparedness requests $4.4 million for Other Services. Please provide an itemized list of how these funds would be spent. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. In fiscal year 2012, The Office of Operations, Security, and Preparedness is requesting $4.4 million for contract support for the Department of Homeland Security (DHS) Guards contract at VACO for the security of our employees in the work place ($2.8 million), Program Support for the Homeland Security Presidential Directive 12 (HSPD–12) Program Office ($1.0 million), Funding for the VA Continuity of Government (COG) site ($0.25 million), and Maintenance and Support Contracts (access control systems, security cameras etc.) ($35 million).

The DHS Guards contract helps to ensure that VACO employees, veterans, and visitors have a safe and secure workspace. Additionally, in a crisis situation the Federal Protective Service uniformed officers provide emergency response force. The program support for the HSPD–12 Program Office is necessary to assist in the establishment and maintenance of the Agency-wide HSPD–12 Program. The COG site allows VA senior leadership to have a space to continue to function in the event of a crisis.

Question 2. For fiscal year 2012, the Office of Operations, Security, and Preparedness requests $13.7 million for 107 employees. This would amount to an 84% increase in staffing since fiscal year 2008 and a 41% increase since fiscal year 2010.

A. What measurable performance outcomes would suggest whether the previous staffing increases have been effective?

Response. OSP's mission has significantly increased in scope since fiscal year 2008. During fiscal year 2010 the Office took on responsibility for the Department's Personnel Security and Suitability Program as well as the operation of the VACO

Personal Identity Verification (PIV) badging office (11 FTE). The Office of Emergency Management (OEM) increased staffing in mandated programs in Exercise, Test and Evaluation and Planning and National Security (7 FTE). The Office of Security and Law Enforcement (OS&LE) increased staffing to provide more Oversight of field activity, VA police units, and critical infrastructure protection planning activities (6 FTE). The Office of the Assistant Secretary identified a requirement for a Human Resources official (1 FTE).

Going from fiscal year 2010 to fiscal year 2012, OSP is requesting an increase of 12 FTE. These are identified for the HSPD–12 Program Office (7 FTE), VA internally authorized in the fiscal year 2011 President's Budget submission. The fiscal year 2012 President's Budget identifies an additional 5 FTE for the following functions; 1 each for the Director Personnel Security and Identity Management (PS&IM), Director for PSS, Director of the Integrated Operations Center (IOC), a Special Security Representative (SSR) for a remote site, and one FTE in the Assistant Secretary's office to support required functions such as a Privacy Officer, a FOIA support role, and Records Management functions.

B. What indicators would suggest whether additional staffing increases are warranted?

Response. OSP is the Executive Lead for the VA Major Initiative Preparedness. This required an SES incumbent to function as the Initiative Lead (position also is the Director of PS&IM). This initiative is in direct support of the Secretary's transformation of the VA into a 21st century organization.

The VA Integrated Operations Center has evolved into a fusion center with representatives from 15 organizations that gather information from all sources, not just VA, who then analyze; generate predictions and recommendations for senior leadership. This allows VA to fully participate in the interagency arena in response to real time events.

The Director of National Intelligence signed the Intelligence Community Directive (ICD) 705 (Effective May 26, 2010), which requires a Special Security Representative (SSR) for each operational Sensitive Compartmented Information Facility (SCIF). In FY 2012, VA will operate a VA Reconstitution Planning Site that contains a SCIF, thus requiring an additional SSR staff member.

The Personal Security and Suitability Service (PSS) was established to standardize the method in which VA processes security and suitability requirements for the Department. The increased staff is to support additional training, oversight and audit functions that have not been fully operational.

The Resource Management Office was established to ensure compliance of Financial Management, Human Resource Management and Administrative and Logistics Management, to ensure procedures, laws, regulations, and policies in the Office of Operations, Security and Preparedness.

Office of Public and Intergovernmental Affairs

Question 1. For fiscal year 2012, the Office of Public and Intergovernmental Affairs requests $13.6 million for 93 employees. This would amount to a 35% increase in staffing since fiscal year 2010 and a 48% increase in staffing since fiscal year 2008.

A. What measurable performance outcomes would suggest whether the previous staffing increases have been effective?

Response. New Media Team—VA's main Facebook page now has over 100,000 subscribers who we reach on a daily basis—more than any other cabinet-level agency and among the top 10 of all Federal organizations (to include the White House and military services).

- Among Veterans who use Twitter, more get their information from VA than from any VSO or Veterans organization. With over 14,000 Twitter followers, VA has more followers than IAVA, the VFW, and the American Legion combined.
- Nearly 34,000 people are now receiving information directly each day from one of 79 VA medical centers now on Facebook.
- Over 7,000 people are now receiving information directly each day from one of 43 VA medical centers now on Twitter.
- VA's 250 YouTube videos have been viewed over 463,000 times.
- VA's 5,300 photos on Flickr have been viewed over 395,000 times.

OPIA established the Homeless Veterans Initiative Office to end homelessness in 5 years. The initiative began in 2009 with 131,000 homeless Veterans. In 2011, that number has fallen to 75,000. One of the most innovative efforts has been to implement a new strategy to prevent and rapidly end homelessness for those at highest risk. We expected to award funding by July 2011 that will aid 10,000 Veteran families who have lost housing or those at serious risk to maintain housing. This effort

will, for the first time, effectively reduce those Veterans at low income with a nationwide community based intervention.

B. What indicators would suggest whether additional staffing increases are warranted?

Response. The new employees will be supporting the Office of Tribal Government Relations; Paralympic Program Office; Homeless Veterans Initiatives and Outreach Program offices.

Question 2. For fiscal year 2012, the Office of Public and Intergovernmental Affairs requests $100,000 for a staff assistant to "coordinate schedules and write speeches/correspondence."

A. Please explain how adding a staff assistant to write speeches will help improve the lives of veterans or their families.

Response. VA is charged with informing Veterans, dependents, and survivors of the benefits and services to which they may be eligible. The Office of Public and Intergovernmental Affairs (OPIA) builds confidence in VA and its readiness to serve America's Veterans of all generations. OPIA accomplishes this by developing, maintaining and communicating the Department's message through media relations and public, intergovernmental and Veteran engagement to empower Veterans and their families.

The Staff Assistant to the Assistant Secretary will coordinate schedules and write speeches/correspondences for the Assistant Secretary and senior level principals. As a representative of the Secretary and of the President, the Assistant Secretary is responsible for conducting outreach and communications with Veterans, dependents, survivors, and stakeholders throughout the country. This results in a highly complex schedule with events, meetings and speaking engagements throughout the country with a diverse set of audiences. OPIA requires a staff member to manage the travel and scheduling logistics for the Assistant Secretary and, at times, travel with the Assistant Secretary as an aide and a representative of VA. Further, OPIA requires a staff member who can ensure that the messages from the Assistant Secretary, through speeches and presentations, are coordinated and in line with other key outreach and strategic communications efforts from the Department. It is imperative that OPIA be staffed appropriately to ensure that Veterans and their families receive consistent and regularly benefit information from the Department.

The Staff Assistant will also be writing responses to inquiries from the White House, Congressional inquiries, Veterans and family members of veterans which we receive on a daily basis. This will also include all the telephone inquiries we receive. The Assistant Secretary receives on average 25–30 requests from Veterans daily.

B. Please provide a list of the type of engagements for which speeches would be written.

Response. The Staff Assistant coordinates messaging on speeches for VA principals which include all Assistant Secretaries. In 2010 alone, the Assistant Secretary for Public and Intergovernmental Affairs received at least 312 requests for speaking engagements (regretted 246, accepted 66). VA principals such as the Assistant Secretary for Public and Intergovernmental Affairs speak at events for women groups, military branches, veteran service organizations, VA offices and administrations, healthcare specialists, the legal community, Federal and state agencies, universities, private corporations, and non-profit assisting Veterans and servicemembers.

Question 3. In the fiscal year 2012 budget request, the Office of Public and Intergovernmental Affairs requests $800,000 and 5 FTE to enhance VA's partnership with Tribal Governments. The Office of Tribal Government Relations is in the process of being stood up at this time. In correspondence between the Committee on Veterans' Affairs and the Office of Congressional and Legislative Affairs, VA justified the new office by stating that employees in the new office will do the following:

> The new employees will serve as the regional Office of Tribal Government Relations representatives responsible for developing ongoing positive collaborative relationships and partnerships with tribal officials, the Veterans Benefits Administration, the Veterans Health Administration and National Cemetery Administration and other key partners in assisting with facilitating policy and program consultation initiatives, communication plans, program promotion and access to health care services, benefits and funding or special project opportunities offered by the VA. The employees will be responsible for developing annual work plans and providing quarterly and annual accomplishment reports to both VA leadership and the tribes within their regional service area. The Director and employees will establish a five year strategic plan for the office that aligns with the Departmental strategic plan with meaningful input from the tribes from each region.

A. VA has had a long-standing relationship with the Indian Health Service (IHS), which required coordination with many Indian tribes throughout the United States. Who was previously in charge of forging those relationships between VA, IHS, and Indian tribes?

Response. There was previously no lead office designated within VA to work with tribal governments on cross-cutting issues involving all three Administrations. Relationships were formed on an ad-hoc basis within the programs, with tribal governments, but nothing was formally dedicated to be the primary point of contact interfacing with tribal governments on behalf of the Secretary.

B. Please explain the rationale used to determine whether or not to stand up a new administrative office within VA to strengthen tribal government relations versus increasing the ability of a standing office in VA to meet the same goals.

Response. There are 565 federally recognized tribes located across the United States. The United States and Indian Tribes have a unique political relationship that is distinct from any other ethnic group or governmental entity. It was determined that if the office was housed within a VA Administration, it would not reach across all programs and services offered by VA that affect Indian Tribes. Therefore, it would be best suited to be housed at the Departmental level. Additionally, given the high rates of military service amongst American Indian/Alaska Native tribal members, given the large number of federally recognized tribes, the complexity of issues, and the predominantly rural and far reaching geographic locations where most tribal governments are situated, the importance of tribal the tribal consultation process in informed decisionmaking, it was determined that sufficient workload existed to dedicate the office specifically to focus on the needs and concerns tribal governments have in accessing services, benefits and funding opportunities to serve the needs of American Indian/Alaska Native Veterans.

Question 4. According to the fiscal year 2012 budget request, the Office of Advisory Committee Management is tasked with the responsibility of serving as VA's liaison with VA's 25 advisory committees and setting uniform procedures for the Committees. In fiscal year 2011 the office charged with overseeing all of VA's advisory committees had a budget of $249,000 and two associated FTE. There is apparently no budget request for funds or FTE in fiscal year 2012.

A. Please provide the names and descriptions for all 25 official VA advisory committees and any other councils or committees under the auspices of VA.

Response. Currently the VA has only 23 advisory committees. The following list of VA advisory committees includes 15 that have been established by statute (with an asterisk *) and 8 non-statutory panels designed to provide advice on selected VA programs and policies. The advisory committees listed below are arranged alphabetically according to key words **[bold print]** in their titles. Immediately following the list of committees are summaries of the Committees' objectives.

*1) Advisory Committee on **Cemeteries** and Memorials
2) Clinical Science Research and Development Service **Cooperative Studies** Scientific Evaluation Committee
*3) Advisory Committee on **Disability Compensation**
*4) Veterans' Advisory Committee on **Education**
*5) Veterans' Advisory Committee on **Environmental Hazards**
*6) Advisory Committee on **Former Prisoners of War**
7) **Genomic Medicine** Program Advisory Committee
*8) **Geriatrics and Gerontology** Advisory Committee
*9) Research Advisory Committee on **Gulf War Veterans' Illnesses**
10) **Health Services Research and Development** Service Merit Review Board
*11) Advisory Committee on **Homeless Veterans**
12) **Joint Biomedical Laboratory** Research and Development and Clinical Science Research and Development Services Scientific Merit Review Board
*13) Advisory Committee on **Minority Veterans**
14) **National Research** Advisory Council
*15) Advisory Committee on **Prosthetics and Special Disabilities** Programs
*16) Advisory Committee on the **Readjustment** of Veterans
*17) Veterans' Advisory Committee on **Rehabilitation**
18) **Rehabilitation Research and Development** Service Scientific Merit Review Board
19) Veterans' **Rural Health** Advisory Committee
*20) **Special Medical** Advisory Group
*21) Advisory Committee on **Structural Safety** of Department of Veterans Affairs Facilities

22) Department of Veterans Affairs **Voluntary Service** National Advisory Committee

*23) Advisory Committee on **Women Veterans**

Advisory Committee on **Cemeteries** *and Memorials (Statutory)*

To provide advice to the Secretary of Veterans Affairs on the administration of national cemeteries, the selection of cemetery sites, the erection of appropriate memorials, and the adequacy of Federal burial benefits.

Clinical Science Research and Development Service **Cooperative Studies** *Scientific Evaluation Committee*

To provide advice on VA cooperative studies, multi-site clinical research activities, and policies related to conducting and managing these efforts while ensuring that new and ongoing projects maintain high quality, are based upon scientific merit, and are efficiently and economically conducted.

Advisory Committee on **Disability Compensation** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on establishing and supervising a schedule to conduct periodic reviews of the VA Schedule for Rating Disabilities (VASRD).

Veterans' Advisory Committee on **Education** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on the administration of education and training programs for Veterans and Servicepersons, Reservists, and dependents of Veterans under Chapters 30, 32, 35, and 36 of Title 38, and Chapter 1606 of Title 10, United States Code.

Veterans' Advisory Committee on **Environmental Hazards** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on adverse health effects that may be associated with exposure to ionizing radiation, and to make recommendations on proposed standards and guidelines regarding VA benefit claims based upon exposure to ionizing radiation.

Advisory Committee on **Former Prisoners of War** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on the administration of benefits for veterans who are former prisoners of war, and to assess the needs of such veterans in the areas of service-connected compensation, health care, and rehabilitation.

Genomic Medicine *Program Advisory Committee*

To provide advice on the scientific and ethical issues related to the establishment, development, and operation of a genomic medicine program within the Department of Veterans Affairs.

Geriatrics and Gerontology *Advisory Committee (Statutory)*

To provide advice to the Secretary of Veterans Affairs on all matters pertaining to geriatrics and gerontology by assessing the capability of VA health care facilities to meet the medical, psychological, and social needs of older veterans , and by evaluating VA facilities designated as Geriatric Research, Education, and Clinical Centers.

Research Advisory Committee on **Gulf War Veterans' Illnesses** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on proposed research studies, research plans, or research strategies relating to the health effects of military service in Southwest Asia during the Gulf War.

Health Services Research and Development *Service Merit Review Board*

To provide advice on the fair and equitable selection of the most meritorious research projects for support by VA research funds. The ultimate objective of the Board is to ensure the high quality and mission relevance of VA's legislatively mandated research and development program. Board members advise on the scientific and technical merit, originality, feasibility, and mission relevance of individual research proposals. They also advise on the adequacy of protection of human and animal subjects.

Advisory Committee on **Homeless Veterans** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on benefits and services provided to homeless veterans by the Department of Veterans Affairs.

Joint Biomedical Laboratory *Research and Development and Clinical Science Research and Development Services Scientific Merit Review Board*

To provide advice on the scientific quality, budget, safety, and mission relevance of investigator-initiated research proposals submitted for VA merit review consideration. The proposals to be reviewed may address research questions within the general area of biomedical and behavioral research or clinical science research. The Board also advises VA research officials on program priorities and policies, as well as administration of VA's intramural program.

Advisory Committee on **Minority Veterans** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on the administration of VA benefits for veterans who are minority group members in the areas of compensation, health care, rehabilitation, outreach, and other services.

National Research *Advisory Council*

To provide advice to the Secretary of Veterans Affairs on research and development sponsored and/or conducted by the Veterans Health Administration, to include policies and programs of the Office of Research and Development.

Advisory Committee on **Prosthetics and Special Disabilities** *Programs (Statutory)*

To provide advice to the Secretary of Veterans Affairs on VA prosthetics programs and the rehabilitation research, development, and evaluation of prosthetics technology. The Committee also assesses VA programs that serve veterans with spinal cord injury, blindness or vision impairment, loss of or loss of use of extremities, deafness or hearing impairment, or other serious incapacities.

Advisory Committee on the **Readjustment** *of Veterans (Statutory)*

To provide advice to the Secretary of Veterans Affairs on policies, organizational structures, and the provision and coordination of services to address veterans' post-war readjustment to civilian life, with particular emphasis on Post Traumatic Stress Disorder, alcoholism, other substance abuse, post-war employment, and family adjustment.

Veterans' Advisory Committee on Rehabilitation (Statutory)

To provide advice to the Secretary of Veterans Affairs on the rehabilitation needs of disabled veterans and the administration of VA's rehabilitation programs.

Rehabilitation Research and Development *Service Scientific Merit Review Board*

To provide advice on the fair and equitable selection of the most meritorious research projects for support by VA research funds, and to provide advice for research program officials on program priorities and policies. The ultimate objectives of the Board are to ensure that the VA Rehabilitation Research and Development program promotes functional independence and improves the quality of life for impaired and disabled veterans.

Veterans' **Rural Health** *Advisory Committee*

To provide advice to the Secretary of Veterans Affairs on health care issues affecting enrolled veterans residing in rural areas.

Special Medical *Advisory Group (Statutory)*

To provide advice to the Secretary of Veterans Affairs and the Under Secretary for Health on matters relating to the care and treatment of veterans and other matters pertinent to the operations of the Veterans Health Administration (i.e., research, education, training of health manpower, and VA/DOD contingency planning).

Advisory Committee on **Structural Safety** *of Department of Veterans Affairs Facilities (Statutory)*

To provide advice to the Secretary of Veterans Affairs on structural safety in the construction and remodeling of VA facilities, and to recommend standards for use by VA in the construction and alteration of facilities.

Department of Veterans Affairs **Voluntary Service** *National Advisory Committee*

To provide advice to the Secretary of Veterans Affairs and the Under Secretary for Health on how to coordinate and promote volunteer activities within VA health care facilities.

Advisory Committee on **Women Veterans** *(Statutory)*

To provide advice to the Secretary of Veterans Affairs on the needs of women veterans regarding health care, rehabilitation benefits, compensation, outreach, and other programs administered.

B. Please explain which office will be serving as liaison to the VA advisory committees in fiscal year 2012.

Response. In FY 2012, the Office of Congressional and Legislative Affairs will support the Office of Advisory Committee Management. The funding for the Office of Advisory Committee Management has been incorporated into OCLA's overall budget request. It was not specifically highlighted as a separate entity.

C. In the last two years, how many recommendations or findings made by advisory committees have been implemented by the Secretary to change VA procedures or improve its delivery of care or benefits to veterans?

Response. In the last two years VA advisory committees made 220 recommendations. VA has implemented, or is in the process of implementing, 87% of them.

D. Of the 25 advisory committees noted in the fiscal year 2012 budget request, do any of them have a termination or sunset date other than those listed in the summary volume of the fiscal year 2012 budget request? If so, please list the end dates and whether the Committees have been dissolved.

Response. VA Advisory Committees with termination or sunset dates are:

Veterans' Advisory Committee on Education—December 31, 2013
Advisory Committee on Homeless Veterans—December 30, 2011
Advisory Committee on Minority Veterans—December 21, 2014

E. What is the operational cost of these committees for fiscal year 2012?

Response. Estimated operational cost for VA's advisory committees for fiscal year 2012 is $6 million which includes personnel payments to non-Federal members (stipend), Federal members, non-member consultants, and Federal staff (salary of Federal staff(s) who provides support to the Committee); travel and per diem; and other costs (court reporter, conference space, etc.).

Costs for VA's advisory committees have been controlled. Committees meet on an average of twice a year. Over the last two of years we have made several procedural and process changes designed to improve the management of VA's advisory committees, to include, where statutorily permissible, limiting membership and stipends and requiring an annual operations plan and annual assessment to enhance operations planning. Actual costs for the last three fiscal years are:

Actual Costs
FY 08—$5,422,621
FY 09—$5,870,115
FY 10—$5,870,972
FY 11—$5,925,000 (estimate)

Office of Congressional and Legislative Affairs

Question 1. For fiscal year 2012, the Office of Congressional and Legislative Affairs requests $6.1 million for 52 employees. This would amount to a 44% increase in staff since fiscal year 2010 and a 58% increase since fiscal year 2009.

A. What measurable performance outcomes would suggest whether the previous staffing increases have been effective?

Response. OCLA has a critical role in keeping Congress informed of VA's work on behalf of Veterans as well as responding to Member and Committee inquiries on legislation, policy initiatives, on behalf of constituents, and many other areas. OCLA's efforts in providing Members of Congress with the information they require is people-intensive, and for a number of years OCLA was not staffed sufficiently to keep pace with Congress' increasing requests for information. OCLA's budget request is intended to put additional personnel toward meeting the needs of Congress.

In October 2010, OCLA produced its Operating Plan which defined performance measures and metrics for the office for FY 2011–2013. These measures and metrics were created to improve OCLA's responsiveness to Congressional requests for information and set goals for the office that support VA's Strategic Plan. These measures and metrics will be the standard to measure OCLA's progress and are reviewed on a monthly, quarterly, and annual basis. OCLA also published a new Standing Operating Procedures (SOP) Manual following a comprehensive review of all of the office's internal processes. Since the implementation of the Operating Plan, and publication of the SOP, OCLA has improved its responsiveness to Congressional requests for information. As an example, OCLA has revitalized the questions for the record (QFR) process. OCLA assigned new program analysts to assist with implementing the new collaborative processes outlined in the SOP that streamlined the overall QFR process and turned an underachieving performance throughout FY 2010 into

a process that is exceeding its targeted goal in FY 2011. In FY 2010, OCLA submitted 16% of the QFRs on time. Through the first five months of FY 2011 OCLA has submitted a 100% of the QFRs on time. OCLA supported 322 congressional briefings in FY 2010. Through the first five months of FY 2011, OCLA coordinated 173 briefings, which is a 60 percent increase over the same period last FY. The added briefings were a result of the greater depth and breadth on issues staffed by the additional congressional relations officers and congressional liaison officers. These new personnel have also contributed to ensuring OCLA improved its performance in submitting VA witness written testimony on time. In FY 2010, OCLA submitted only 60% of testimony on time. Through the first five months of FY 2011, OCLA has submitted 100% of testimony on time. VA is committed to providing Congress accurate and timely information and the increase in personnel are necessary to achieve that goal.

B. What indicators would suggest whether additional staffing increases are warranted?

Response. There are two main indicators that suggest increased staffing is required. OCLA monitors the feedback Members of Congress and Congressional staff provide on the timeliness and accuracy of the information VA provides to Congress. While OCLA has made significant improvement, there are still additional improvements to be made to decrease the time it takes to respond to requests for information. The other main indicator is OCLA's All Employee Survey results. These results indicate additional personnel are needed to balance workload within the office. The results of the survey indicated employees realize the importance of their jobs, but are impacted by the high volume of work and the very dynamic environment they operate in. These factors were considered in reorganizing OCLA's structure to provide greater depth and breadth on issues, adding positions to support the most overworked areas, and rebalancing existing duties and responsibilities. OCLA requested additional funding and staff to accomplish these actions. However, in FY 2009 and FY 2010, OCLA was unable to achieve its authorized number of employees due to high employee turnover. In FY 2009, OCLA was authorized 38 FTEs, only 34 were obligated. In FY 2010, OCLA was authorized 42 FTEs, and only obligated 36. As of March 2011, OCLA has increased the number of personnel to 43 and should be able to achieve our authorized strength of 46 employees before the end of the fiscal year. In FY 2012, OCLA requests additional funding to support three additional personnel, which includes the Office of Advisory Committee Management. As a result of the office's grade structure, FY 2012's requested funding would increase the office's overall FTE to 49 vice 52.

C. Please provide a list of the specific positions that have been or will be added to the office since fiscal year 2009 and the pay-grades for those positions.

Response. In FY 2010, OCLA added four positions to its organizational structure.

Congressional Relations Officer—GS–14
Congressional Relations Officer—GS–14
Congressional Liaison Officer—GS–13
Congressional Liaison Officer—GS–13

In FY 2011, OCLA will add four positions to its organizational structure.

Director, Benefits Legislative Affairs—GS–15
Program Analyst—GS–9
Program Analyst—GS–9
Congressional Liaison Assistant—GS–8

In FY 2012, OCLA is requesting to add three positions to its organizational structure.

Director, Health Legislative Affairs—GS–15
VA Advisory Committee Management Officer—GS–14
VA Advisory Committee Program Analyst—GS–11

Question 2. The Office of Congressional and Legislative Affairs requested an 80% increase in travel over the same period.

A. What metrics are used to determine which staff needs to travel?

Response. OCLA personnel travel in support of Members of Congress and Congressional Staff. Staffs are primarily assigned to support Congressional travel by their respective portfolios. Every OCLA request for travel is approved at the deputy assistant secretary level. Requests for travel in support of organizational meetings/conferences or training are also approved at the deputy assistant secretary level to ensure a requirement exists for attendance and there is sufficient return to support the expenditure of travel funds. OCLA's travel budget also pays for Members of Congress and Congressional staff oversight travel.

B. What options (such as video conference, webinars, or local conferences) were explored to reduce the costs to the taxpayer?

Response. During October 2010, OCLA completed installation of video teleconferencing equipment that enables the office to participate in teleconferences vice traveling to the conference/meeting sites out of the Washington, DC area. OCLA will offer Congressional staff the option of conducting a video teleconference for meetings with out of town VA personnel versus having VA personnel travel to Washington, DC for the meeting. OCLA staff also participates in webinars when possible to reduce travel costs. OCLA has coordinated staff training with VA's Learning University utilizing conference facilities adjacent to VA headquarters on Vermont Avenue.

Office of Acquisition, Logistics, and Construction

Question 1. For fiscal year 2012, the Office of Acquisition, Logistics, and Construction requests $36 million for Other Services, which includes funding for the President's Acquisition Improvement Initiative.

A. Please provide an itemized list of how these funds would be spent. To the extent any of these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. The table below shows the major contracts and expenses the Office of Acquisition, Logistics, and Construction plans during FY 2012 in the Other Services account.

General Operating Expense (GOE) Other Service Items	
Acquisition Improvement Initiative	$23,854,000
Service Level Contracts for Hoteling	$2,700,000
National Institute of Building Standards (NIBS) Contracts	$2,931,000
NIBS Membership and Design Guide	$170,000
Seismic Maintenance Interagency Agreement	$61,000
Federal Facilities Council Contract	$30,000
National Park Service Portal Interagency Agreement	$20,000
Financial Service Center Service Level Agreement	$500,000
Historical Preservation Contracts and Interagency Agreements	$824,000
Moving Cost Related to Regional Office Relocations	$180,000
Training	$132,000
Permanent Change of Station Moves	$479,000
Repair of Furniture and Equipment	$44,000
Strategic Planning Support	$131,000
Maintenance and Repair Services	$38,000
Subtotal for GOE	$32,094,000
Other Service Amounts Included Under Reimbursements	
Other Service Costs for 140 FTE Reimbursed from Major Construction	
Permanent Change of Station Moves	$869,078
Training	$70,000
Contracts—reimbursement prorated portion NIBS, Historical, FFC, etc.	$1,771,922
Total for Major Construction Reimbursement	$2,711,000
Others Service Costs for 51 FTE Reimbursed from Medical Facility	
Permanent Change of Station Moves	$377,860
Training	$25,500
Contracts—reimbursement prorated portion NIBS, Historical, FFC, etc.	$681,640
Total for Medical Facility Reimbursement	$1,085,000
Other Service Costs for 6 FTE Reimbursed from Supply	
Repair of Furniture & Equipment	$1,000
Maintenance & Repair Services	$1,000
Contracts—including prorated portion of FSC contract	$131,000
Training	$5,000
Total for Supply Reimbursement	$138,000
Subtotal Reimbursements	$3,934,000

Grand Total	$36,028,000

The information below provides details on funds that will be spent on contracts.

Acquisition Improvement Initiative: Part of the President's Acquisition Improvement Initiative to increase the capacity and capability of the acquisition workforce. This funding will specifically support 1) improvements in the VA Acquisition Academy Training Model; 2) enhancement of VA's program management culture; 3) the Warrior to Workforce (W2W) Program—which strives to develop and implement a formalized training program for wounded veterans to obtain the positive education requirement for entry into the GS–1102 Contracting Series and completion of the VAAA's Acquisition Internship School program and curriculum; 4) the acquisition intern program—which continues to implement a formalized and holistic training program to provide additional entry level contract specialists for VA and other Agencies. Contract Specialist Tuition Reimbursement—which supports the VA in developing its existing contracting workforce by providing $2.5M in funding toward tuition reimbursement.

Contracts will specifically support the development and implementation of the required curriculum and training programs associated with aforementioned programs.

Service Level Contracts for Hoteling: Provides temporary locations for three new regional offices as part of the implementation of phase II of the VAFM Transformation Initiative until GSA long term leases are put in place.

Federal Facilities Council: Support facilities engineering related studies and identify best-practices.

Financial Service Center Service Level Agreement: The Financial Service Center contract is a Service Level Agreement between Department of Veterans Affairs (VA) Financial Services Center (FSC) and the Office of Acquisition, Logistics and Construction (OALC). OALC reimburses FSC for services provided to OALC including construction accounting, credit card processing, payment services, customer support help desk services, payroll services, permanent change of station travel processing services, etc.

National Institute of Building Standards (NIBS) Contracts/NIBS Membership and Design Guide: NIBS was authorized by the U.S. Congress in the Housing and Community Development Act of 1974, Public Law 93–383 to address the need for an organization that could serve as an interface between government and the private sector. The Institute provides an authoritative source of advice for both the private and public sector of the economy with respect to the use of building science and technology.

Seismic Maintenance Interagency Agreement: Seismic Maintenance Interagency Agreement (IAA): The agreement is between the U.S. Geological Survey (USGS) and VA, signed on April 20, 2009. It includes the installation of multi-channel systems for recording earthquake shaking at VA hospitals and to provide earthquake damage alerts. USGS will install multi-channel instruments in 27 buildings in a period of four (4) years. The final year of the IAA is 2012. To date, 13 hospital buildings were completed. Instrumentation of the remaining 14 hospitals will be completed in FY 2011 and FY 2012 The instruments and engineering support will provide specific information on potential damage to VA facilities within minutes.

Historical Preservation Contracts and Interagency Agreements: Provide "on-call" historic preservation compliance assistance to medical centers and cemeteries. Work can include archaeological surveys, historic structure assessments, historic American building documentation, and consultation with consulting parties, drafting agreement documents, and assistance with curating artifacts.

National Park Service Portal Interagency Agreement: VA supports the NPS Historic preservation portal which hosts the VA historic preservation checklist and provides key information on preservation laws and regulations to VA field personnel.

Strategic Planning Support: OALC long range planning to align organizational goals to the Secretary's long range vision for the Department. Strategic planning support will also implement a process to track development, implementation, and completion of initiatives.

B. What metrics will be used to gauge the effectiveness of the Acquisition Improvement Initiative?

Response. The following are the metrics used to measure VA's acquisition processes. Execution of the acquisition improvement initiative is expected to have a positive impact on these measures.

Metrics for VA Acquisition Improvement Initiatives

Balanced Scorecard Quadrant	Measure
Business Processes	Procurement Customer Satisfaction
Financial	Federal Procurement Data System Accuracy
Customer Satisfaction	Procurement Savings
Customer Satisfaction	Unauthorized Commitments
Business Processes	FPDS Verification
Business Processes	Procurement Action Lead Time (PALT)
Business Processes	High Risk Contracting Reductions
Learning and Growth	Socio-Economic Program Goal Performance
Customer Satisfaction	Electronic Contract Management System (eCMS) Usage
Business Processes	Contracting Competition

EDUCATION

Question 1. In 2009, VA provided $356 million in emergency payments of education benefits to approximately 122,000 individuals. In connection with the February 2010 budget hearing, VA acknowledged that "[a]pproximately $120 million was issued to advance payment recipients who had not established their benefits eligibility for the fall enrollment period." According to a November 2010 report from the VA Office of Inspector General, "the emergency payments resulted in an estimated loss of about $87 million in unrecoverable debts."

A: To date, how much of the $356 million has been recouped by VA?

Response. As of March 5, 2011, VA has collected $259,411,399.

B: To date, how much of the $356 million has been determined to be uncollectable and why?

Response. As of March 10, 2011, none of these debts have been determined to be uncollectable. Any emergency payment debts that do not have a current re-payment plan have been referred to Treasury for offset from other Federal payments. Treasury can also refer these debts to third party collection agencies.

Question 2. VA's fiscal year 2011 budget proposal requested funding for various contracts, including a contract with MITRE Corporation's Center for Enterprise Modernization, a contract for an Outcome and Customer Satisfaction Survey, a contract for Training Performance Support Systems, a contract for National Student Clearinghouse Match, and a contract for Education State Approving Agency Contract Review.

A: Please provide an update on those contracts, including the amount of funds that have been expended and the results achieved.

Response. The following FY 2011 funds have been expended during the continuing resolution.

1. MITRE Corporate Center for Enterprise Modernization

Funds expended: $1.4 million.

Results achieved: During FY 2011, MITRE has provided User Acceptance Testing (UAT) Support for four releases (3.0, 4.0, 4.1, and 4.2) of the Post-9/11 GI Bill Long-Term Solution (LTS). MITRE developed test scripts and test cases for each release, which were used by Veteran Claims Examiners to successfully test the LTS. In addition to UAT Support, MITRE has provided strategic management support to Education Service to include strategy development and planning; Integrated Master Schedule planning; and organizational strategic support, analysis and recommendations.

2. Customer Satisfaction Survey

Funds expended: $2.7 million.

Results achieved: VBA's Benefits Assistance Service (BAS) leads the customer satisfaction survey effort for all VBA programs including education programs. Under

this contract with J D Power and Associates (JDPA), the survey questionnaires have been finalized and are awaiting the selection files for the survey participants. BAS and JDPA are in the process of finalizing the data transfer agreement and developing the reporting site. JDPA is requesting the data files by the end of April for a May deployment of the surveys. The initial survey results are expected by September 2011.

3. State Approving Agency Contract Review

Funds expended: No funds have been expended for this contract in FY 2011.

Results achieved: This contract generated recommendations for greater efficiency in the State Approving Agency (SAAs) contract and contract processes. A thorough review and analysis were completed to ensure compliance with all laws and regulations. A contract deliverable made recommendations for funds distribution that take into account the differences amongst SAAs and would allow VA to consider factors not addressed in the current funding allocation methodology. The deliverable provided recommended improvements to current contracting processes. As VA is focused on implementing SAA-related changes resulting from Public Law111–377, recommendations from this contract have not been implemented at this time, and will be revisited at a later date.

4. National Student Clearinghouse Match

Funds expended: VA anticipates expending $40,625 relating to this contract in FY 2011.

Results achieved: Contractor is expected to provide student data reports that will show degree attainment characteristics for VA education beneficiaries and graduation rates compared to a randomly selected student population.

5. Training Performance Support Systems—TPSS

Funds expended: To date, no funds have been expended for this contract in FY 2011. However, a task order package has been submitted for Lifecycle Maintenance and additional task orders may be submitted subject to training needs and funds availability for FY 2011.

Results achieved: VA anticipates that the contractor will provide Lifecycle Maintenance and fulfill any additional training module requirements subject to training needs.

B: Does the fiscal year 2012 budget proposal include any funding to continue these contracts? If so, please provide the amounts and expected achievements.

Response. VA requested the following FY 2012 funds to fulfill the listed contracts:

1. MITRE Corporate Center for Enterprise Modernization

Funds requested: $5.1 million.

Expected achievements: VA anticipates that MITRE will continue to develop test scripts and test cases for each release as we look forward to the full automation and implementation of the LTS in 2012. MITRE will also continue to provide UAT support and strategic management support to Education Service.

2. Customer Satisfaction Survey

Funds requested: $5 million.

Expected achievements: JDPA is expected to provide similar services to the BAS during fiscal year 2012 and produce a survey that will convey customer satisfaction results to the Education Service.

3. State Approving Agency Contract Review

Funds requested: No funds were requested for this contact for FY 2012.

Expected achievements: VA does not anticipate extending this contract.

4. National Student Clearinghouse Match

Funds requested: $53,000

Expected achievements: Contractor is expected to provide student data reports that will show degree attainment characteristics for VA education beneficiaries and graduation rates compared to a randomly selected student population.

5. Training Performance Support Systems—TPSS

Funds requested: $586,000

Expected achievements: The contractor is expected to begin work on training modules for the Education Liaison Representative (ELR), Education Compliance Survey Specialist (ECSS), Equal Opportunity Compliance Surveys and State Approving Agency Contract Management. The contractor will continue to work on existing training modules for Veterans Claims Examiners and Education Case Managers, TIMS Clerks, and ELR/ECSS compliance surveys. These modules will be updated as part of a routine maintenance to incorporate new legislation, policy, and procedures.

C: Does the fiscal year 2012 budget proposal include any funding to secure contract services to help process education claims?

Response. VA's FY 2012 budget proposal does not include a request for funding to secure contract services to help process education claims.

Question 3. VA's fiscal year 2011 budget proposal for the Education Service included $3.1 million for Supplies and Materials. VA indicated that $1.2 million of that amount would be spent on printer cartridges in connection with an initiative to provide printers for individual employees. Since then, VA has indicated that the printer initiative was canceled. How is that $1.2 million now expected to be spent?

Response. This funding requirement is no longer applicable. Funds for the printer cartridges initiative were eliminated from VBA's budget.

Question 4. According to VA's Web site, individuals with questions about education benefits may call VA's 1–888-GIBILL–1 phone number but they should "[b]e advised this line only accepts calls from 7:00 AM–7:00 PM central time Monday–Friday and you may experience long hold times."

A. Currently, how many employees are dedicated to answering calls to that telephone number?

Response. There are currently 280 employees working in the Education Call Center (ECC) in Muskogee, Oklahoma. Of those 280 employees, 140 are call agents permanently assigned to the ECC. An additional 45 employees are term appointments (expiration date is Sept. 30, 2011) and 18 are temporary appointments (expiration date is Sept. 30, 2011). Currently, 34 agents are temporarily detailed from the Muskogee National Call Center (NCC) to the ECC to assist with the high volume of calls. The ECC also has 32 Education Case Managers (dedicated 5 hours/day to call handling) and 11 Senior Case Managers (handling call escalations) to assist with technical questions and call handling.

B. Currently, what is the average "hold time" for an individual calling that telephone number?

Response. The average "hold time" for fiscal year 2011 to date is four minutes and one second.

C. For fiscal year 2012, what level of funding is requested for purposes of handling these telephone calls and how many employees will that level of funding support?

Response. VA's FY 2012 budget submission identifies the overall staffing level for administration of the education programs. Funding levels for specific functions supporting education claims processing, such as managing the Education Call Center, are allocated during the budget execution year. We therefore do not have this information available.

D. With the requested level of fiscal year 2012 funding, what is the expected hold time for callers?

Response. VBA's current performance measures for call centers are based on abandoned and blocked call rates. To improve customer service, we are in the process of analyzing data and establishing goals to replace the abandoned call measures with measures for wait times. Analysis of the impact of workload and staffing fluctuations during peak enrollment periods on wait times is critical to establishing appropriate measures and improving customer service. At this time, we do not have sufficient data available to project expected hold time.

Question 5. In connection with the February 2010 hearing on VA's fiscal year 2011 budget proposal, the Education Service indicated that it planned to expend $1.2 million during fiscal year 2011 on "[o]utreach pamphlets and letters."

A. How much has VA expended so far during fiscal year 2011 on outreach pamphlets and letters?

Response. Approximately $55,000 has been expended in FY 2011 (Qtr 1).

B. How much is requested for this purpose in the fiscal year 2012 budget proposal?

Response. VA has requested approximately $1.9 million to fulfill all outreach efforts in FY 2012, which include the mailing of letters and pamphlets.

C. What metrics are used to determine if these pamphlets and letters are effective?

Response. There are currently no metrics that gauge the effectiveness of outreach materials; however, VBA's Benefits Assistance Service is conducting an outreach assessment. As part of this assessment, VBA intends to address metrics for this area.

We do monitor usage of our Web site pages using Google Analytics to determine most visited Web sites. We also monitor usage of our Frequently Asked Questions and Facebook comments to evaluate what areas of information require clarification.

In FY 2009, we enlisted MITRE assistance in conducting focus groups on communication to our stakeholders and made changes to our outreach strategy based on that information. MITRE will be conducting follow-up sessions with key stakeholders and Veterans to determine the effectiveness of our communications plan.

D. In terms of those metrics, please explain the performance outcomes to date during fiscal year 2011.

Response. See response to 5c.

VETERANS HEALTH ADMINISTRATION

Question 1. The President's Commission on Fiscal Responsibility and Reform's December 2010 report recommended that Federal agencies "reduce Federal travel, printing and vehicle budgets." (Recommendation 1.10.5) However, in the fiscal year 2012 budget request Appendix for Medical Services there is listed an increase of 8% or $6 million for employee travel over the fiscal year 2010 actual level. Over the same period, there is listed an increase of 61% or $14 million for the "transportation of things."

A. How did VHA take into account the President's commission's recommendation to reduce travel when formulating this budget?

Response. The eight percent increase in travel is over a 2 year period from FY 2010 to FY 2012. While there is an increase in Employee Travel from FY 2010 through FY 2014, VHA took the President's commission's recommendation to reduce travel and directly applied it to the preparation of the 2012 President's Budget by limiting the amount of growth to only the inflationary rate per year from FY 2011 to FY 2013 (see chart below). This is a reduction from the FY 2009 to FY 2010 increase of 19.75 percent.

	2009 Actual	2010 Actual	2011 Estimate	2012 Estimate	2013 Advance Approp.
21 Travel & Trans of Persons:					
Employee	$64,592	$77,349	$79,900	$82,700	$85,700
Percent of Change		19.75%	3.30%	3.50%	3.63%

The 61 percent increase in Transportation of Things is over a 2 year period from FY 2010 to FY 2012. Estimates for Transportation of Things are made up of several components that are highly variable and are outside of the control of VA, such as Shipment of Bodies, Declared Emergency Shipment of Bodies, and Other Shipments which include shipment of personal effects of deceased beneficiaries.

	2009 Actual	2010 Actual	2011 Estimate	2012 Estimate	2013 Advance Approp.
22 Transportation of Things	$9,512	$22,697	$28,900	$36,800	$46,900
Percent of Change		27.33%	27.34%	27.45%	27.45%

B. Please explain the assumptions used to formulate the budget for employee travel and transportation of things.

Response. VHA used the Administration's inflationary assumptions for the formulation of Employee Travel. VHA used an historical four year average to formulate the Transportation of Things because of the dramatic change in year-to-year actuals for this budget line.

Question 2. The number of veterans who have served in the Armed Forces of the United States has been on a steady decline. The total veteran population has declined by 2.4 million since September 30, 2006, and VA estimates it will decline by 427,793 veterans from 2011. However, VHA estimates their unique patients will increase by 85,567 in fiscal year 2012 over fiscal year 2011 and will increase further by another 116,607 in fiscal year 2013.

A. If the overall veteran population is decreasing, what accounts for the steady increase in unique patients?

Response. While the Veteran population is decreasing, the Veteran enrollment rates are holding fairly steady. Thus, in spite of the declining Veteran population, the enrolled Veteran population is projected to increase by approximately 465,900 from FY 2010 to FY 2013. This increase in Veteran enrollees results in a projected increase of approximately 274,000 Veteran patients from FY 2010 to FY 2013. However, the proportion of enrollees who are patients remains constant at 65 percent during this period. The likelihood of an enrollee becoming a patient is correlated with enrollee age, priority, gender, morbidity, special conflict status (OEF/OIF/OND status versus other), reliance on VA health care, and whether the enrollee used VA before or after Eligibility Reform. Also, new enrollees tend to have a higher likelihood of being a patient in the first year of enrollment.

B. Of the unique patients, which period of veterans is expected to start utilizing the VHA system in greater numbers?

Response. VA does not have the data on period of service for all enrollees that would allow a comparison of utilization of the VA health care system by period of service.

Question 3. In the Budget Message of the President accompanying the fiscal year 2012 budget request, he writes:

> America is emerging from the worst recession in generations. In 2010, an economy that had been shrinking began to grow again. After nearly 2 years of job losses, America's businesses added more than one million jobs. (The Budget, page 1)

With that in mind, the FY 2012 budget shows a contingency fund of close to $1 billion to cover a potential increase in demand due to our current economic conditions.

A. If the President believes that the economy is getting better, why does VA need a contingency fund?

Response. The $953 million contingency fund, estimated in the VA's Enrollee Health Care Projection Model, was created to address the potential demand increase for medical care services due to changes in economic conditions. Recent studies have shown that unemployment rates among Veterans are approximately double those of non-Veterans. As Veterans lose access to other health care options, such as employee health insurance, they increasingly seek VA care. These funds will only become available for obligation if the Administration determines that the estimated need due to economic conditions materializes in 2012.

B. What is the threshold that needs to be reached for VA to use this additional funding? And what are the mechanics to releasing the fund?

Response. Section 226 of the Administrative Provisions states that "* * * such funds shall only be available upon a determination by the Secretary of Veterans Affairs, with the concurrence of the Director of the Office of Management and Budget, that:

(a) The most recent data available for:

(1) National unemployment rates,

(2) Enrollees' utilization rates, and

(3) Obligations for Medical Services,

validates the economic conditions projected in the Enrollee Health Care Projection Model, and

(b) Additional funding is required to offset the impact of such factors."

C. Should this increase in demand not materialize what is VA's alternate plan for this funding?

Response. If the increase in demand does not materialize, these funds would not become available for obligation and they would be used for deficit reduction.

Question 4. In the VA budget justification books under Medical Services there is a category that shows a savings of just over $1 billion for "operational improvements." The previous administration also sent to the Hill a budget request in fiscal year 2007 which included management efficiencies. In a Senate Committee on Veterans' Affairs (SVAC) hearing on the fiscal year 2007 VA budget, then-Senator Obama stated:

> The VA had made management efficiency claims which make up over $1 billion in this year's budget, but the [Government Accountability Office (GAO)], at least, says haven't been and can't be proven. So one of the concerns, and I am sure you will hopefully have a chance to respond directly to this is, if those savings prove illusory, what happens and how are you planning that possibility? (SVAC hearing, Feb. 16, 2006.)

A. Should these savings not materialize, how has VA planned for that risk?

Response. These savings estimates are in six separate areas of operations and represent modest, achievable goals unlike the unspecified savings referenced above.

Question 5. The Medical Care Collections Fund was established by the Balanced Budget Act of 1997 and has shown a steady increase in what has been collected from first party and third party payers over the years. Originally, VA estimated it would collect $3.2 billion in fiscal year 2012. According to a conversation my staff had with VA's Chief Business Officer, that figure has been downgraded to $2.8 billion.

A. How much of this down grade is due solely to a change in the actuarial model and has VA also assumed changes to the economy in this revision?

Response. The down grade was not due to a change in the VHA Office of Policy & Planning's Enrollee Health Care Projection actuarial model. The reduction is a result of VA revising several assumptions from CBO's collections model to incorporate economic market conditions, in addition to a number of other factors, to project MCCF collections in FY 2012. These factors include:

• Poor economic conditions—Growth in national unemployment (from 7.7 percent in the First Quarter of FY 2009 to 9.8 percent at the end of the First Quarter of FY 2011) will continue to impact both first party collections (Veteran out-of-pocket costs) and third party collections (unemployment and resultant loss of health insurance coverage).

• Hardship waivers and exemptions from copayments are increasing—Veteran first party copayment economic hardship waivers and exemptions were at their highest levels in FY 2010 (the most recent completed year) than in any prior year, and this is expected to continue with the current economic conditions.

• Third party "Collections to Billings" (CtB) ratios are down nationally—CtB ratios are expected to continue a downward trend, reducing third party collections. CtB decreased from 43.1 percent in January 2009 to 39.1 percent in January 2011, and was influenced by the continued shift by insurers of payment responsibility to the patient (i.e., higher deductibles, increased copayments, etc.). Section 1729 of title 38 prevents VA from billing the Veteran if the insurance company does not pay. Each one percent decrease in CtB represents a $55 million loss in revenue.

• Veterans aging to 65 years and older—FY 2012 begins to reflect the shift in workload for Vietnam Era Veterans aging to 65 years and older. Once a Veteran is Medicare-eligible, Medicare becomes the primary insurance coverage and VA can bill insurance companies only for the portions Medicare does not cover (typically their deductibles). This significantly reduces the amount VA can collect.

• Priority Group migration from lower to higher status—National Priority Group migration over the past two years has shown a sharp decrease in collections for Veterans in Priority Group 8, which are the primary drivers of both first and third party collections.

• Shift in Service Connected Workload vs. Non-Service Connected Workload As Veterans migrate from lower to higher status, there is also a shift in workload from Non-Service Connected (Non-SC) care (which could be billable if the Veteran has insurance) to Service Connected (SC) care (regardless of insurance coverage VA does not bill for SC care). From FY 2009 to FY 2011 the total number of outpatient encounters has seen an increase of two percent nationally in SC care, with an equal decrease of two percent in Non-SC care, which has impacted Third Party collections.

Question 6. The fiscal year 2012 budget request calls for savings of $150 million through medical and administrative support savings.

A. What will be the total loss of FTE?

Response. There are no discrete reductions in FTE included in this cost savings estimate. Total FY 2012 FTE is estimated to actually increase by 524. The savings are achieved through clinically appropriate substitution of less costly staff for more expensive predecessors, for example the replacement of a physician with a nurse practitioner, or the replacement of a registered nurse with a licensed practical nurse, in positions where there will be no degradation in either the quality or quantity of health care services provided to Veterans. There may be other occupations where care extenders may be utilized and, in each case, VHA will do appropriate assessments to ensure care to Veterans is not compromised.

B. Please explain what type of positions fall within this category?

Response. Please see response to 6. A.

C. Will these cuts be realized at individual VA facilities or at Veterans Integrated Service Network (VISN) headquarters and VA Central Office?

Response. The cost savings of $150 million will be achieved by more efficiently employing the resources in various medical care, administrative, and support activi-

ties at each medical center and will be achieved by targeting the following areas to improve overall operational efficiency:

- High missed outpatient appointments/no show rates
- Observed to Expected Length of Stay
- Diagnostic colonoscopy (CPT code 45378) cost per procedure
- Cardiac catheterization cost per procedure
- Primary care cost per encounter

Question 7. The FY 2012 budget request proposes a change in current law to remove the requirement for VA to reimburse certain employees appointed under title 38, section 7401(1), for expenses incurred for continuing professional education. Under current law, the Secretary shall reimburse for up to $1000 per year for full time physicians and dentists for continuing education. The budget states that the change in law could have a potential cost savings annually of $325 million and $3.25 billion over ten years.

A. How will VA guarantee that doctors and dentists have the ability to receive all of the continuing education needed to maintain their requirements under their licenses, specifically at facilities in rural areas without access to major academic institutions?

Response. VHA health care professionals, including physicians, are solely responsible as a condition of employment for maintaining their professional licensure and for completing the associated continuing medical education requirements. VHA's Employee Education System (EES) provides training to support VHA's mission and pursues opportunities for accrediting these training programs for professional continuing education credits wherever feasible and advisable. Some training, education, or conference events may not be professionally appropriate for continuing education accreditation.

Question 8. The FY 2012 budget request asks for $451 million for reimbursement to eligible veterans of emergency services pursuant to the Veterans Millennium Health Care Act. This represents an increase of $87.5 million since FY 2010 or 24%. The FY 2013 advanced appropriation calls for an additional $52.5 million, which is an 11.6% increase over FY 2012.

A. What accounts for the 24% increase in the amount for reimbursed emergency services? To what extent is this attributable to Public Law 111–137?

Response. The 24 percent increase in the amount for reimbursed emergency services is not attributable to Public Law 111–137. Public Law 110–387, Section 402 is responsible for this increase. The change in the law, which allows for payment of emergency inpatient care beyond the point of stabilization if VA facilities are not available, is the primary reason for the significant increase in projected budget requirements. Other reasons contributing to this increase in projected costs include the increase in unique Veterans served, overall economic conditions impacting Veteran eligibility and utilization, and increased billing rates reflecting medical costs inflation.

B. VA is currently rolling out the Patient Aligned Care Team (PACT) model with one of the goals of limiting the necessity of readmissions and hospitalization. If the PACT model will limit the growth of reimbursement for emergency services under the Millennium bill, what accounts for this increase in FY 2013?

Response. The goal of limiting the necessity of readmissions and hospitalizations applies to those that occur in VA medical facilities. It will not reduce the cost of emergency admissions to civilian hospitals which are estimated to increase. The costs in FY 2013 are projected to increase when compared with FY 2012 but these costs will be less than what VA would have incurred without this initiative. Factors beyond VA's control, such as the proximity of Veterans to facilities (VA or non-VA) and rising health care costs influence the need for and cost of emergency care.

Question 9. The fiscal year 2012 budget request for the Energy/Green Management Program shows the program funding decreased 82% between FY 2010 and 2012. According to the budget request, the program is to be increased 15.5% between FY 2012 and 2013.

A. With the fluctuations in the budget for the Energy/Green Management Program, how will VA have the necessary funding to meet the performance benchmarks set forth in Executive Order 13514?

Response. VA contracted to implement a large number of green building, renewable energy, and energy/water efficiency improvement projects in FY 2010, which are scheduled to come on-line as late as FY 2012. We also funded a number of feasibility studies for additional projects and are conducting energy assessments of 25% of our facilities annually. Performance improvements related to the FY 2010 investments are projected to be significant and to move VA successfully forward through FY 2013. In the meantime, we continue to incorporate renewable energy and other

sustainable features into our new construction projects and to select future projects at existing facilities based on results of feasibility studies and energy assessments. To continue progress toward EO 13514 goals in the face of fluctuating direct funding, VA will be making use of third-party financing mechanisms—energy savings performance contracts (ESPC) and utility energy savings contracts (UESC)—to procure some of these projects. Using these instruments will allow VA to implement projects without up-front investment, with costs paid for out of the stream of resulting operational savings. With a centralized contracting activity dedicated to the Energy/Green Management Program, VA is well-positioned to accelerate the use of ESPC/UESC to meet EO 13514 performance benchmarks. In addition, VA is pursuing a number of low cost/no cost initiatives as part of this program. For example, we are instituting a "stoplight" style reporting process to evaluate how facilities are addressing EO 13514 requirements. We created a "Green Routine" program that encourages and supports all employees in everyday practices such as turning off lights and double-sided copying. And, we established two new internal awards programs, one covering "green" professionals such as environmental managers and one covering all other employees who make innovative contributions to greening their facility.

Question 10. The fiscal year 2012 budget request shows an increase of 2,589 between FY 2011 and 2012 for contract hospital (psychiatric) workload and an additional increase of 2,143 between FY 2012 and 2013. At the same time, the budget request shows a decrease of 2,990 for psychiatric residential rehabilitation within VA over the same timeframe.

A. Please explain the justification for eliminating internal psychiatric residential rehabilitation capacity with contract hospitals outside VA?

Response. Psychiatry Average Daily Census levels have trended upwards over the last several years and out year projections indicate continued increases but at a slower rate. The experience with Residential Rehabilitation is different. VA Mental Health Service views Psychiatric Residential Rehabilitation (PRRT) and Domiciliary care as equivalent care options, and are both Residential Rehabilitation care. In recent years there has been a decrease in PRRT with a commensurate increase in Domiciliary Residential Rehabilitation Treatment. The budget for FY 2012 and FY 2013 forecasts an increase for the combined workload of PRRT and Domiciliary care, the two forms of Residential Rehabilitation care, as shown in the following table.

Description	2010 Actual	2011 Estimate	2012 Estimate	2013 Estimate	2011 to 2012 Change	2012 to 2013 Change
Psychiatric Care Total						
Acute Psychiatry	96,032	96,801	97,749	98,458	948	709
Contract Hospital (Psych)	14,795	17,504	20,093	22,236	2,589	2,143
Psy. Residential Rehab	14,450	13,642	12,186	10,652	(1,456)	(1,534)
Dom Residential Rehab	31,324	34,404	38,242	42,131	3,838	3,889
Subtotal	45,774	48,046	50,428	52,783	2,382	2,355
Overall Total	156,601	162,351	168,270	173,477	5,919	5,207

Question 11. The fiscal year 2012 budget request estimates savings of $315 million in FY 2012 and $362 million in FY 2013 by moving the fee care program payments to be consistent with those of the Centers for Medicare and Medicaid Services (CMS) rates.

A. What are the underlying assumptions for these estimated savings?

Response. The underlining assumptions for these savings were based on use of the multiple pricing schedules covered under the regulation. VA has had authority to pay inpatient hospital claims and physician services utilizing the Centers for Medicare & Medicaid Services (CMS) payment methodologies for many years. Effective for non-VA treatment on or after February 15, 2011 VHA adopted CMS payment methodologies for outpatient services. This aligns VHA with standard Federal payment schedules and assures all payments from VA utilize the same structure. Prior to adopting CMS payment methodologies VHA processed payment for outpatient services for facility charges using a "VA Fee Schedule" which is based on billed charges and reimbursement was based on the 75 Percentile of those charges, significantly higher than standard CMS pricing. The estimated savings was developed using the difference between the 75 Percentile from the VA Fee Schedule and the CMS rates extrapolated from actual payment data from the first six months of calendar year 2008. VHA contracted with an outside vendor to complete a comparison

to identify cost savings under this legislation. The analysis compared CMS rates with VA Fee Schedule rates to make this estimate. A sampling of lab, ESRD, and other Medicare methodologies to estimate an average savings based on these rates.

B. VA is currently in the process of upgrading the IT infrastructure to process the new fee payments at the Medicare rate. What is VA's timeline for completing these upgrades? Will VA be able to realize savings in FY 2012 if systems are not fully in place to handle the move to the CMS rate?

Response. The current claims processing system, Fee Basis Claims System, is scheduled to be updated with CMS rates by mid-year FY 2012. To assure accurate pricing, VA developed an interim solution utilizing a contract service to price claims submitted to VHA for authorized services by non-VA providers. This service will initially be manual, with a move to a web-based solution by the end of April. The VA will continue to utilize this service until such time as the appropriate technology is in place to accurately price these claims.

C. How do the savings in the FY 2012 budget request compare to the estimates that VA provided in the regulations moving the purchased dialysis program to CMS rates? Please explain any changes in assumptions that led VA to adjust the savings estimate.

Response. The FY 2012 budget request utilizes the same cost savings estimates documented in the Final Rule.

D. How are the anticipated savings in the FY 2012 budget request affected by contracts that VA currently has in place with private dialysis facilities or from replacing these contracts with payments at the Medicare rate?

Response. VA is currently assessing the impact of continued use of contracts in relation to the new regulation. This assessment will include a specific market analysis and a determination on impact to access for health care, assuring access is not negatively impacted while also assuring a cost effective program.

E. Please explain the estimated savings VA will accrue from dialysis contracts and Basic Ordering Agreements compared to the former regulation that required VA to pay at the 75th percentile of billed charges?

Response. Cost savings in FY 2011 were estimated based on use of contracts and blanket ordering agreements (BOA). The contract and BOA rates and payments are compared with prior year payments. Prior to use of contracts/BOAS VA was required to pay at the 75th percentile of billed charges.

Question 12. The FY 2012 budget request calls for clinical staff and resource realignment which will presumably save VA $150.8 million. To reach that projected savings, VA states it will cut 313 doctor and 1,133 registered nursing positions. The lost FTE will be replaced by non-physician providers and LPNs. Due to the economic down-turn, thousands of skilled registered nurses have reentered the workforce. It would seem that we should be trying to entice these skilled clinicians to work at VA; however, VA has decided to cut the number of RN positions for FY 2012.

A. Registered nurses are the backbone of any well operated hospital or clinic. What will be the effect to both institutional knowledge and patient care if VA is successful in cutting the numbers of doctors and registered nurses and replacing them will less trained and skilled positions?

Response. VA is replacing positions through attrition, not designated elimination of staff, so there will be no acceleration of loss of institutional knowledge. Only those positions identified as clinically appropriate will be used for substitution of more cost effective specialties, so there is no anticipated impact on patient care.

B. Will these cuts in RN and physician FTE result in the loss of actual personnel at facilities or are these FTE not currently filled? If not, why does the budget include positions that are not filled?

Response. These estimates are based on substitution of positions with less costly and more clinically appropriate specialties when they become vacant. There is no associated loss of total FTE. Positions that have not historically been filled are not included in the budget estimates.

C. Please explain the decisionmaking process that led VA to make this cut in RN positions.

Response. In response to anticipated resource constraints and to exercise good stewardship of VA resources, the executive leadership at each VA medical center or program office will determine if a physician or registered nurse position that becomes vacant requires a replacement with the same clinical skills or may appropriately be filled with a less costly alternative specialty without any degradation of quality or capacity of health care for Veterans.

Question 13. VA has taken a number of steps over the last two years to try and limit the number of hospital or clinic visits which are needed for veterans. The PACT model is only one facet of VA's strategy to better coordinate care between pri-

mary and specialty care, with the ultimate goal of allowing veterans to receive all of their needed treatment and consultations in one visit. In order to better understand how veterans are currently utilizing VA services, please provide the following information.

A. VA has stated that by realigning the primary care model used at their facilities, scheduling of appointments will be focused on veterans' wishes and will eliminate the need for multiple visits. Please define what VA believes constitutes unneeded multiple visits.

Response. Unneeded multiple visits are those where patient concerns can be addressed by means other than face-to-face clinic visits e.g., telephone care, secure messaging, My Health*e*Vet, and/or mail. In addition, VA data suggests return visit intervals can be increased resulting in a reduction of clinic visits without a decrease in quality by using other means as well.

B. Assuming there have been unneeded multiple visits, how many unneeded multiple visits took place in FY 2010, how many took place in FY 2011, and how many are forecasted for FY 2012?

Response. Currently, this data is not available in the VA scheduling package.

C. VA currently has performance metrics for both primary care and specialty care appointments completed within 14 days of the desired date. How does VA measure the interrelation between scheduling primary and specialty care appointments on the same date?

Response. When making appointments, schedulers are instructed to coordinate appointments for patients as much as possible. However, VHA Directives do not require that appointments for primary and specialty care be scheduled to occur on the same date. For that reason, VHA does not monitor the number of primary and specialty care appointments scheduled to occur on the same date. The wait time for each appointment is purely the measurement of the number of dates from the desired date for that specific appointment and the date that appointment is completed. However, if a Veteran were to specify that his desired date for an appointment is on the same date another appointment is scheduled to occur, he scheduler would be expected to enter that date as the desired date for the appointment being scheduled, and if possible offer an appointment on that date.

Question 14. In recent months, the Committee has been approached by senior former employees at VA medical centers from across the country claiming they were targeted by their superiors for raising concerns about improper facility practices. They raised concerns specifically with the use of what VA calls "Administrative Investigations Boards."

There is an obvious need for Medical Directors to investigate malfeasance and fraud in VA facilities. However, Medical and VISN directors do not always have the ability to terminate or punish those who have been found to put veterans' lives at risk or who have become a liability to the organization. Yet some senior level former VA employees suggest that certain senior leaders have found ways to abuse the process and have used it as a tool to retaliate.

A. VA has previously indicated there is no centralized oversight of AIBs by the VISNs or VA Central Office. In fact, VA has stated that the guidelines for AIBs are almost at the complete discretion of the senior leader who convenes an AIB. How does VA conduct oversight and provide guidance from the VISN and Central Office to ensure the AIB's are used properly?

Response. VA Directive 0700 establishes policy within the Department of Veterans Affairs (VA) regarding administrative investigations. It establishes uniform standards for the conduct, reporting, and review of administrative investigation boards, and clarifies the responsibilities of those involved. VA Handbook 0700 establishes operational requirements and procedures for convening, conducting, reporting, and reviewing administrative investigations. The General Counsel (GC) is responsible for the contents of both documents. However, GC does not typically oversee local administrative investigations.

Determining the facts and the appropriate response to matters within their areas of responsibility is an inherent duty of VA executive leadership. Generally, the decision to order an investigation, and the appropriate scope of the investigation, is a matter within the discretion of the Convening Authority. These actions are expected to be consistent with VA Directive/Handbook 0700 and any other governing requirements. Retaliation by any VA employee against any person for cooperating with an investigation or providing truthful testimony is prohibited. In some cases, employees are entitled to specific protections against retaliation, such as those established under the Whistleblower Protection Act. Witnesses who believe they are being reprised against can report the matter to the Convening Authority and they may also report the matter to the Office of Special Counsel (OSC) or VA's Office of Inspector General (OIG). Employees who believe the investigation was convened for

the purpose of harassment following their participation in protected activity may also report their concerns to OSC, the VA OIG, or other senior officials in the employee's supervisory chain of command.

The VA Secretary's memorandum dated July 30, 2009 entitled "Senior Management Conduct Issues" requires specific procedures for investigation of allegations of serious misconduct involving senior managers. Senior managers include all members of the Senior Executive Service; Associate and Assistant Directors; Chiefs of Staff, Nurse Executives at VHA facilities, heads of other VA facilities; including National Cemeteries, Network Offices, and Regional Offices; any GS–15 position or Title 38 equivalent in VA Central Office; and all other positions centralized to the Secretary. All Administrative Investigative Boards that concern VHA senior managers are attended by or reviewed by the VHA Human Resource Management Group, which has a reporting alignment to the Under Secretary for Health through VHA's Workforce Management and Consulting Office. To assure consistency throughout the Agency, any decisions involving occupants of these covered positions require the concurrence of the Office of General Counsel and VA Office of Human Resources Management. The reviews by these other offices also occur even when determinations are made that no action is necessary or counseling or training is recommended.

The Office of Human Resources Management in VA Central Office provides regular training in the conduct of administrative investigations for potential board members. Additionally, VHA's Senior Executive Orientation recently added a session addressing "When to convene an AI?"

B. Which office in VA has direct responsibilities for ensuring fair procedures are being followed in the AIB process?

Response. As indicated above, OGC is responsible for implementing the requirements found in VA Directive/Handbook 0700, but does not directly oversee each investigation. Employees who have concerns regarding unfair procedures during the conduct of an AI may report their concerns to the Convening Authority or other senior management officials. In addition, employees who believe an investigation is being used to harass them for engaging in protected activity may contact the OSC or the VA OIG.

VHA Performance Plan

Question 1. In the FY 2012 budget request there is a performance indicator listed with the stated major institutional goal to "design a veteran-centric health care model and infrastructure to help veterans navigate the health care delivery system and receive coordinated care." The only associated performance measure for this is the non-institutional long term care average daily census, which has a limited scope dealing directly with long term care. With the roll out of the PACT model, what performance measures will VA utilize to measure both PACT and the major institutional goal of designing a veteran-centric health care model and infrastructure?

Response. Currently, VA uses the Primary Care Staffing ratio to monitor and measure PACT infrastructure implementation and patient and employee satisfaction scores to measure satisfaction with implementation. In addition, VA also monitors access, coordination, and continuity as indicators of PACT implementation progress.

Veterans Canteen Service Revolving Fund

Question 1. In the FY 2012 budget request, the current estimate for FY 2011 shows personnel costs totaling $12.1 million while only estimating $11 million in fiscal year 2012. In addition, in the Summary of Employment section there is a projected increase of 25 employees from FY 2011 Current Estimate to FY 2012.

A. What accounts for the increase in average employment while decreasing the amount of money obligated to the costs of personnel?

Response. Projected personnel increases are the result of new or upgraded canteen operations in CBOCs and outpatient clinics. Most Canteen Service personnel are hourly rate workers, employed either full-time or part-time. Consequently, the estimated annual cost for these employees is considerably less than it would be for 25 full-time employees.

The original cost estimate for FY 2012 would have shown a slight increase from the FY 2011 estimate due to the new hires and an assumed increase in the cost-of-living allowance. However, the estimate was revised downward as a result of the pay freeze to a figure that is slightly less than the original estimate for FY 2011.

Question 2. In the program description of the Veterans Canteen Service, the FY 2012 budget request mentions that "provisions of the Veterans' Benefits Act of 1988 * * * eliminated the requirement that excess funds be paid to the Treasury and authorized such funds to be invested in interest bearing accounts."

A. What type of interest-bearing accounts have the excess funds been invested in?

Response. The Veterans Canteen Service (VCS) invests only in Treasury bills.

B. Please detail the invested funds performance since the ability to do so was authorized.

Response. Over the past 10 years, VCS investment income has varied due to market-based fluctuations in interest rates. Before September 11, 2001, VCS earned $1.5 to $2 million per year. Since September 11, 2001, rates were dramatically lower as interest income ranged from $381,000 to $800,000 per year through 2008. Since 2008, interest rates have been zero and VCS proceeded with significant capital and technology investment thus reducing funds invested. In FY 2012 VCS expects capital and technology investments to slow and investment income begins to grow.

Question 3. The fiscal year 2012 budget request shows a decrease in the Cost of Merchandise Sold from $24.5 million in FY 2011 to $15 million in FY 2012.

A. Please outline the reasons for a projected decrease of $9.5 million in Cost of Merchandise Sold.

Response. There has not been a decrease in Cost of Merchandise Sold from FY 2011 to FY 2012 which is presented in the "Analysis of Increases and Decreases—Obligations" table in the President's FY 2013 Budget Submission, Vol. 2, page 4A–3 (below).

The table shows an overall estimated increase of $62,547, 000 in obligations for FY 2011, of which $24,500,000 is an increase in Cost of Merchandise Sold. For FY 2012, the table shows an overall estimated increase of $41,000,000, of which $15,000,000 is an increase in Cost of Merchandise Sold.

The question assumes that the total Cost of Merchandise Sold fell from $24,500,000 to $15,000,000 between FY 2011 and FY 2012 when in fact the amount increased each year by those amounts.

Analysis of Increases and Decreases - Obligations
(dollars in thousands)

	2011 Current Estimate	2012 Estimate
Prior Year Obligations	$370,853	$433,400
Increases and Decreases:		
Cost of Merchandise Sold	$24,500	$15,000
Personnel Cost	$12,106	$11,000
Other Operating Expenses	$7,500	$4,000
Indirect Expenses	$5,000	$5,000
Equipment, Inventory, Open Orders	$13,441	$6,000
Net Change	$62,547	$41,000
Obligations Estimate	$433,400	$474,400

HOMELESS VETERANS

Question 1. The President has made ending homelessness among veterans a top priority of his administration. The FY 2012 budget request includes $939 million, a 51% increase from FY 2010, for specific programs to prevent and reduce homelessness among veterans.

A. Do the fiscal year 2012 request and the fiscal year 2013 advance funding request anticipate or require changes in the law to release funding for homeless veterans' programs?

Response. There are two specific programs for which changes in law are requested the Grant and Per Diem (GPD) Program and the Support Services for Veterans Family (SSVF) Program. VA's FY 2012 budget submission includes increased funding for both the GPDSSVF programs for FY 2012 and FY 2013

Section 2013 of title 38, United States Code, currently authorizes the appropriation of up to $150,000,000 per fiscal year for the GPD Transitional Housing program. The GPD Program FY 2012 and FY 2013 budget anticipates an increased level of spending in order to increase program capacity to serve approximately 20,000 homeless Veterans. The budget request for FY 2012 and FY 2013 is $224,117,000 per fiscal year. To accommodate this anticipated increase, a legislative change in the authorized spending amount is requested.

The SSVF Program currently is authorized to spend up to $60 million over three years ending in FY 2011. FY 2012 and FY 2013 budgets anticipate a $100 million annual appropriation. Such an appropriation contemplates modification of the SSVF

Program's current funding authority. Approximately 19,000 Veterans and their families will receive services in 2012 and 2013.

Question 2. Even though the administration has made ending homelessness among veterans a top priority, the Domiciliary Care for Homeless Veterans and the Compensated Work Therapy programs have a reduction in their budgets. The FY 2012 request has a 10% decrease for Domiciliary Care for Homeless Veterans and an 11% decrease for the Compensated Work Therapy/Vocational training program from FY 2010.

A. What is the justification for the reductions in these programs' budgets? How do the reductions in these programs align with VA's overall strategy to end homelessness?

Response. The Domiciliary Care for Homeless Veterans (DCHV) and Compensated Work Therapy (CWT) budget projections are based on historical program costs plus additional program cost that are part of the initiative to end homelessness among Veterans. The FY 2010 President's budget costs were estimated at $119 million and did not contain any new program costs related to the homeless initiative. The actual FY 2010 DCHV costs were $175 million. The increase in FY 2010 actual costs is related to program expansion and initiatives to improve workload capture and cost reporting.

The FY 2011 and FY 2012 figures are estimates based on historical costs plus planned expansion related to the homeless initiative. The Veterans Health Administration (VHA) will continue to monitor budget estimate verses actual costs to further refine budget submissions. The FY 2012 CWT and DCHV budget requirements will be reevaluated and addressed within the total Homeless program budget as FY 2011 Actuals become finalized and VA's FY 2013 President's budget costs are submitted.

Question 3. The Housing and Urban Development-VA Supported Housing (HUD-VASH) Program is one of the signature VA initiatives to provide permanent housing to homeless veterans with case management services. Since 2008, Congress has funded approximately 30,050 vouchers. As of December 31, 2010, only 21,078 formerly homeless veterans are currently living in permanent housing. The President's request for FY 2011 and FY 2012 includes additional funding for 10,000 vouchers each year.

A. Of the remaining 9,422 vouchers, only 7,419 have been issued to veterans. What is the status of vouchers that have not been issued to veterans? When does VA believe that all vouchers will be issued and leased?

Response. HUD has received approximately 30,000 HUD-VASH vouchers since 2008 (approximately 10,000 per year in 2008, 2009 and 2010). HUD is responsible for allocating these vouchers to local Public Housing Authorities (PHA) and VA's role in the program is to screen, case manage, and refer eligible Veterans to PHAs for distribution of these vouchers.

The data referenced above reflect cumulative numbers starting in 2008.

As of February 28, 2011, 19,834 Veterans are currently under lease. Of the vouchers not leased up, approximately 6,667 are in the hands of Veterans who are in the housing search process. Approximately 3,936 Veterans have been referred to the PHA to undergo the process of background checks to ensure the referred Veterans are not on any sexual offender registry and that they qualify for income eligibility.

It is important to note and understand that these numbers are dynamic and that Veterans leased up today could not be leased up tomorrow due to "graduation" or "falling out" of the HUD-VASH program for a variety of reasons. This response provides a point-in-time snapshot of HUD-VASH voucher status as of February 2011.

VA is working diligently with HUD and local PHAs to ensure that Veterans receive supportive services during this process. VA is working with the PHA to ensure that vouchers are assigned expeditiously and to ensure the maximum number and Veterans are placed into permanent housing.

Additionally, vouchers can be re-issued and have been re-issued to other homeless Veterans. VA, through its case managers, is working diligently with the PHAs to issue these vouchers. It is important to note that the number of vouchers available for issue at any given time fluctuates as a result of Veterans who "graduate" or discontinue the program and no longer need their voucher. These vouchers are able to be redistributed.

Once a Veteran is referred to the HUD-VASH program, it takes an average of 126 days for the Veteran to get housed. During this time, Veterans are referred to the PHA to complete the application process, begin identifying and locating suitable and affordable housing, arranging for the inspection of the selected unit, signing the lease with the landlord, and making arrangements to move into their housing. Addi-

tionally, Veterans are engaging in clinical services that assist them in enhancing their skills to live a full and productive life.

Many VA facilities are working closely with their PHA partners, landlords and other community groups to streamline the process and improve the timeliness of distributing vouchers to Veterans and moving them into rental units. Significant improvements have already occurred. In the first year, the mean cumulative lease up rate was 548 Veterans housed each month. In 2010, the mean cumulative lease up rate increased to 929 Veterans per month, and thus far in FY 2011, the mean cumulative lease up rate is 992 Veterans per month. VA believes it can maintain this rate, and will have approximately 90% of the Veterans permanently housed by September 30, 2011.

B. Of the remaining vouchers, what VA medical facilities were these vouchers allocated to? How is VA ensuring there is not a systematic problem resulting in issuing the remaining vouchers?

Response. As of February 28, 2011, the attached list of the medical centers have vouchers that still need to be assigned.

VA Medical Centers With Unallocated Vouchers
As of February 2011

VISN	Parent Facility
1	BEDFORD
1	BOSTON
1	MANCHESTER
1	NORTH HAMPTON
1	PROVIDENCE
1	TOGUS
1	WEST HAVEN
1	WHITE RIVER JCT
2	ALBANY
2	BUFFALO
2	CANANDAIGUA
2	SYRACUSE
2	UPSTATE NY (BATH VAMC)
3	BRONX
3	EAST ORANGE
3	LYONS
3	MONTROSE
3	NEW YORK HARBOR (BROOKLYN)
3	NEW YORK HARBOR (MANHATTAN)
3	NORTHPORT
4	ALTOONA
4	BUTLER
4	CLARKSBURG
4	COATESVILLE
4	ERIE
4	LEBANON
4	PHILADELPHIA
4	PITTSBURGH
4	WILKES BARRE
4	WILMINGTON
5	BALTIMORE
5	MARTINSBURG
5	PERRY POINT
5	WASHINGTON DC
6	ASHVILLE
6	BECKLEY
6	DURHAM
6	FAYETTEVILLE, NC
6	HAMPTON
6	RICHMOND
6	SALEM
6	SALISBURY
7	ATLANTA

VA Medical Centers With Unallocated Vouchers
As of February 2011

VISN	Parent Facility
7	AUGUSTA
7	BIRMINGHAM
7	CENTRAL AL HCS
7	CHARLESTON
7	COLUMBIA, SC
7	DUBLIN
7	TUSCALOOSA
7	TUSKEGEE
8	BAY PINES
8	GAINESVILLE
8	MIAMI
8	ORLANDO
8	SAN JUAN
8	TAMPA
8	WEST PALM BEACH
9	HUNTINGTON
9	LEXINGTON
9	LOUISVILLE
9	MEMPHIS
9	MOUNTAIN HOME
9	NASHVILLE (TN VALLEY)
10	CHILLICOTHE
10	CINCINNATI
10	CLEVELAND
10	COLUMBUS, OH
10	DAYTON
11	ANN ARBOR HCS
11	BATTLE CREEK
11	DETROIT
11	ILLIANA HCS (DANVILLE)
11	INDIANAPOLIS
11	N. INDIANA
11	SAGINAW
12	CHICAGO HEALTH CARE SYSTEM
12	HINES
12	IRON MOUNTAIN
12	MADISON
12	MILWAUKEE
12	N. CHICAGO
12	TOMAH
15	COLUMBIA, MO
15	KANSAS CITY
15	LEAVENWORTH

VA Medical Centers With Unallocated Vouchers
As of February 2011

VISN	Parent Facility
15	SAINT LOUIS
15	TOPEKA
15	WICHITA
16	ALEXANDRIA
16	FAYETTEVILLE, AR
16	GULF COAST HEALTH CARE SYSTEM
16	HOUSTON
16	JACKSON
16	LITTLE ROCK
16	MUSKOGEE
16	NEW ORLEANS (SE LA HEALTH CARE SYSTEM)
16	OKLAHOMA CITY
16	SHREVEPORT
17	CENTRAL TEXAS HEALTH CARE SYSTEM
17	DALLAS
17	SAN ANTONIO (S. TEXAS HEALTH CARE SYSTEM)
18	AMARILLO
18	EL PASO HEALTH CARE SYSTEM
18	NEW MEXICO HEALTH CARE SYSTEM
18	PHOENIX
18	PRESCOTT
18	TUCSON
18	WEST TEXAS HEALTH CARE SYSTEM
19	CHEYENNE
19	EASTERN CO (DENVER)
19	EASTERN CO (SO. CO.)
19	GRAND JUNCTION
19	MONTANA HEALTH CARE SYSTEM
19	SALT LAKE CITY
19	SHERIDAN
20	ALASKA HEALTH CARE SYSTEM
20	AMERICAN LAKE (PUGET SOUND)
20	BOISE
20	PORTLAND
20	ROSEBURG
20	SEATTLE
20	SPOKANE
20	WALLA WALLA
20	WHITE CITY
21	CENTRAL CA HEALTH CARE SYSTEM
21	NORTHERN CA HEALTH CARE SYSTEM

VA Medical Centers With Unallocated Vouchers
As of February 2011

VISN	Parent Facility
21	PACIFIC ISLAND HEALTH CARE SYSTEM (GUAM)
21	PACIFIC ISLAND HEALTH CARE SYSTEM (HAWAII)
21	PALO ALTO HEALTH CARE SYSTEM
21	SAN FRANCISCO
21	SIERRA NEVADA HEALTH CARE SYSTEM
22	GREATER LOS ANGELES
22	LOMA LINDA
22	LONG BEACH
22	SAN DIEGO
22	SOUTHERN NEVADA HEALTH CARE SYSTEM
23	BLACK HILLS HEALTH CARE SYSTEM (FT. MEADE)
23	CENTRAL IOWA HEALTH CARE SYSTEM (DES MOINES)
23	FARGO
23	IOWA CITY
23	LINCOLN, NE
23	MINNEAPOLIS
23	OMAHA (NEB W/ W. IOWA)
23	SIOUX FALLS
23	ST CLOUD
23	VA BLACK HILLS HEALTH CARE SYSTEM (HOT SPRINGS)

To clarify, the local Public Housing Authority (PHA) receives the vouchers and awards them to eligible Veterans referred by HUD-VASH case managers at the local VA medical center.

Note: This list is dynamic and will change based on the productivity and activity of the medical center. The number of vouchers available at any given time fluctuates as a result of Veterans leaving or discontinuing the program and no longer needing vouchers. These vouchers are able to be redistributed.

VA is confident that delays are not systemic and is working with these Medical Centers to ensure they are assisting homeless Veterans as expeditiously as possible. VISNs and Medical Centers submit to the VA National Homeless Program Office at least monthly reports of voucher issuance and lease up rates. The National Program Office has been able to determine where sites are experiencing delays. As of the end February 2011, 20 of the 132 medical centers awarded vouchers account for 90% of the underutilized vouchers. A total of 98 sites have fully implemented their vouchers. Reasons for delays vary and include clinical decisions to have Veterans treated in a more acute treatment setting to address mental health and medical concerns prior to referring them for permanent supportive housing with the Public Housing Authorities, hiring delays at the local Medical Center, the need for better collaboration with the community in identifying homeless Veterans and streamlining the application process, reconciling poor credit histories for Veterans and obtaining access to funding to help Veterans with move in expenses. Delays have also occurred due to difficulties in finding and approving suitable affordable housing in certain high cost areas. VA will continue to put emphasis on incorporating the Housing First model into its HUD-VASH program, allowing Veterans more timely access to housing, while providing them with needed supportive services to ensure that they are able to maintain housing. VA is also actively pursuing the use of

shared contracted community case management services in those communities with VA medical centers that have been slow to hire case managers.

C. Of the veterans who have received a HUD-VASH voucher, how many are gainfully employed and have been able to return the voucher because they no longer need the program?

Response. As of February 2011, homeless program evaluation data indicates that there are 752 Veterans whom have exited HUD-VASH because they met program goals, exceeded the income limits and no longer need the program to remain in permanent housing, or found and obtained alternative housing.

Specific gainful employment data is not directly collected at this time.

D. How is VA ensuring that homeless veterans living in rural and underserved areas are able to participate in the HUD-VASH program?

Response. In the voucher selection processes for past years, HUD and VA were able to target approximately 11% of the allocated vouchers to rural and underserved areas in recognition of the fact that identifying and serving rural homeless is a priority. VA and HUD work closely to disseminate housing choice vouchers where they are most needed. Furthermore, when vouchers are not being appropriately utilized by a local Public Housing Authority (PHA), HUD has taken proactive measures to relocate those vouchers to another PHA that has Veterans with unmet housing needs. VA will continue to monitor this issue and coordinate with HUD to get vouchers to locations where there is unmet need.

Question 4. HUD-VASH case managers play a vital role in the operation and success of the HUD-VASH program. Case managers are on the front lines working with veterans, landlords, and other community organizations to assist homeless veterans in obtaining and maintaining permanent housing. In the President's request, the HUD-VASH case management account receives a 183% increase from FY 2010.

As of December 31, 2010, VA has funded 1,230 HUD-VASH positions; however, only 897 have been filled.

A. Is VA contracting with local organizations to ensure that homeless veterans are receiving case management services? If not, does VA need legislative authorization to contract these services?

Response. VA is able to contract with local organizations to ensure that homeless Veterans receive case management services. In FY 2010, The DC VA Medical Center contracted with the District of Columbia to provide community case management services for 150 Veterans. All 150 Veterans were placed in housing within 6 months, and because of the success with this initiative, the contract was extended. Sites in California, Florida, New York City and Denver are currently exploring a targeted shared contracted case management model.

B. How many additional case managers will be needed to ensure that the additional vouchers are effectively and efficiently received by homeless veterans?

Response. VA is funded for 1,207 case managers rather than 1,230. VA expects to continue using a staff to Veteran funding ratio of 1 case manager for every 25 Veterans whom are utilizing a voucher. Therefore, if HUD receives funding for an additional 10,000 vouchers, VA would anticipate hiring another 400 case managers. It is important to note that the number of case managers that will be needed is dependent upon the number of vouchers allocated.

Question 5. On May 20, 2010, the Senate Appropriations Subcommittee on Transportation, Housing and Urban Development, and Related Agencies and the Subcommittee on Military Construction, Veterans Affairs and Related Agencies held a hearing regarding ending veterans' homelessness."

Secretary Donovan testified as follows: "For FY 2011, HUD did not request funding for HUD-VASH. While the need for homeless veterans' assistance is great, with the significant level of resources that we have been provided by Congress in recent years, we want to ensure that these resources are used as effectively and efficiently as possible."

A. Planned program expansions will provide an additional 10,000 new vouchers in 2011 and 2012. How is VA ensuring that these additional resources will be used effectively and efficiently? What is VA's justification for the additional vouchers when HUD did not request additional vouchers in FY 2011?

Response. VA has several processes in place to ensure resources are used effectively and efficiently. VA and HUD have a shared Office of Management and Budget high priority performance goal for which both agencies have committed to reducing the number of homeless Veterans on any given night to 59,000 by June 2012. A primary strategy for achievement of this goal involves utilizing the HUD-VASH program to provide homeless Veterans with vouchers so they can access permanent housing. This high performance goal provides an opportunity for both agencies to improve performance.

VA has established performance monitors that promote timely hiring of case managers and timely lease-up rates of awarded vouchers by medical centers. Medical Centers that are having implementation issues have been asked to provide action plans. In regards to hiring, all medical centers that have not filled these positions are required to submit action plans and progress toward hiring until all positions are filled. VA anticipates all positions will be filled by June 30, 2011. Medical Centers have been instructed to detail appropriate staff into any vacant case management positions to ensure Veterans have timely access to case management services. The National Homeless Program Office is providing oversight to medical centers that are encountering difficulty with hiring; and in some cases, VA is working with medical centers to contract case management services with known and proven community partners.

In instances where there have been low leasing rates, site visits have been made and technical assistance has been provided. Medical Centers have been asked to provide corrective action plans which are being closely monitored by the VA National Homeless Program Office. As VA addresses the issues that have caused delays at these sites, they should be well positioned to more quickly process any additional vouchers that may be forthcoming.

Both HUD and VA have also conducted consultative site visits with communities experiencing implementation delays. These visits have assisted in reducing barriers and promoting greater coordination between VA, Public Housing Authorities (PHA) and community partners. VA plans to continue this process through FY 2011.

VA and HUD plan to continue the performance component, instituted in FY 2010, to the voucher award allocation process that incentivizes high performers and challenges low performers to increase their productivity as a pre-condition to receiving additional vouchers. VA and HUD will continue to conduct training for both VA case managers and for PHA staff. Additionally, VA and HUD will continue to conduct satellite broadcasts to inform and train staff. Finally, in response to extreme situations, HUD has reassigned vouchers to other PHAs.

VA is promoting the utilization of a Housing First Model in several large cities. Housing First promotes rapid and direct placement of homeless individuals (in some cases with accompanying family members) into housing, and offers treatment and supportive services with variable intensity and frequency as an integrated component of the service. The Housing First approach represents a change from linear models that seek to prepare individuals for permanent housing by requiring completion of treatment in residential rehabilitation or transitional housing, and often require demonstrated sobriety before moving into permanent independent housing.

VA requested additional funds to hire case managers that would support HUD VASH vouchers to ensure the Department was poised to implement programming should additional vouchers be awarded to HUD.

In FY 2008 and in FY 2010, HUD did not request in the President's budget additional vouchers but received 10,000 vouchers each of those years in the HUD-VASH Program. Based on this prior history, the Department requested additional case mangers to handle any additional vouchers.

VA continues to review and refresh its plan to end Veteran homelessness as new information and data is obtained. The Veteran Supplemental Report to the 2009 Annual Homeless Assessment Report (AHAR) to Congress reports 75,609 homeless Veterans on any given night. The total annual count of sheltered and unsheltered homeless Veterans exceeded 160,000 of which 38% or 60,000 were chronically homeless. This estimate of Veteran homelessness and unmet need, demonstrates to VA that obtaining additional permanent housing resources would be valuable.

B. With the rapid increase of vouchers in 2011 and 2012, how does VA plan to effectively allocate the vouchers to local VA medical centers and local public housing authorities to ensure that veterans receive the vouchers in a timely manner?

Response. Housing and Urban Development is ultimately responsible for allocating vouchers to local public housing authorities.

In past years, VA has conferred with HUD in determining relative need, using data provided by the Continuums of Care Point in Time data and VA homeless outreach data. Input from the respective Medical Centers is solicited and previous performance data is also considered. As plans for allocations approach finalization, facilities were notified to submit staffing plans for expedited approval so they could either commence hiring, or utilize contracted services which are already being set up in some locales.

To ensure that Veterans receive vouchers in a timely manner, VA continues to transform its HUD-VASH program to the Housing First model. This allows Veterans quicker access to housing while providing them with needed supportive services to ensure that they are able to maintain housing. VA is also actively pursuing

the use of shared contracted community case management services in those communities with VA medical centers that have been slow to hire case managers.

VA also instituted a performance measure regarding the number of vouchers issued to the medical center/facility that result in a homeless Veteran achieving resident status in PHA. As of February 28, 2011, the cumulative HUD-VASH achieving resident status rate was 77%.

C. How is VA working to ensure the local partnerships between VA medical centers, public housing agencies, and community organizations in rural and underserved areas are effectively working together to end homelessness among veterans?

Response. At the National Forum on Homelessness Among Veterans Conference held in December, 2010, each Medical Center was charged with holding a Homeless Veteran Summit to confer with key partners in VA's efforts to end homelessness among Veterans. Key partners included local Public Housing Authorities, Continuums of Care, HUD, Department of Labor, State VA Departments other key Federal, state and local organizations. The goal of these meetings was to determine ways to more efficiently and effectively assist homeless Veterans in accessing needed supportive services and suitable permanent housing in order to achieve and maintain stabilization. There were over 170 Summits held locally. These summits have improved existing partnerships and assisted in building new partnerships.

Also at this conference, each VA Medical Center was directed to participate in the 2011 Point in Time Count of the homeless held in January, and in their local Continuums of Care. These directives have served to foster closer cooperation and collaboration between VA staff and community providers in rural areas. These meetings will continue and further strengthen the ability of VA and other housing and service provider partners to effectively work together to end homelessness among Veterans.

In a further effort to expand partnerships in rural communities, the VA National Center on Homelessness among Veterans has developed a model of case management that combines homeless and mental health case management teams to improve access and engagement of homeless Veterans and Veterans with serious mental illness in rural communities. The model is currently being implemented in 16 VISNs across the country with a primary objective of identifying and engaging Veterans in treatment while also increasing their access to homeless and other supportive services both within the VA and with other community partners. The combined homeless and mental health intensive case management teams are engaged in outreach and treatment helping to increase both mental health and homeless services for Veterans in rural America. Results from this project will be available by the end of this fiscal year.

Question 6. Under the Operational Improvement section of the VA Real Property Cost Savings and Innovation Plan, the President proposes a $66 million cost savings through the VA Real Property Cost Savings and Innovation Plan. Under this plan, VA has identified 17 vacant or underutilized buildings to repurpose for homeless housing and other enhanced-use lease initiatives.

A. VA must maximize the utilization of the buildings identified. Please list where the 17 buildings are located. Has VA engaged the local community in these areas to determine what types of homeless facilities are needed, such as transitional or permanent housing?

Response. VA continues its efforts toward achieving the goals set forth in the President's Memorandum on Real Property. VA has engaged local communities at key decision points in the process of repurposing its vacant and underutilized assets through enhanced-use leasing (EUL)—i.e., during a) the upfront planning phase to determine feasibility and need by conducting a market assessment for each campus to match supply (buildings and land) and demand among Veterans for the following housing types: Supportive Housing—housing with on-campus supportive services for homeless and at-risk Veterans and their families; Senior Independent Living—housing with limited on-campus supportive services for low-income Veterans who are 62 and older and capable of living independently; and Non-Senior Assisted Living—housing with limited on-campus supportive services for disabled low-income Veterans—and b) the EUL project implementation phase through a public hearing to solicit stakeholder and local community input into each project.

17 Vacant or Underutilized VA Buildings

Network	Station Name	Building Number	Total GSF
1	Newington, CT	5	17,799
1	Newington, CT	43	3,872

17 Vacant or Underutilized VA Buildings—Continued

Network	Station Name	Building Number	Total GSF
7	Augusta, Uptown	18	28,530
7	Augusta, Uptown	7	4,420
7	Augusta, Uptown	76	56,712
10	Chillicothe	10	6,750
12	North Chicago	48	26,496
12	Hines	48	39,546
12	Hines	51	58,000
7	CAVHCS, Tuskegee	62	72,203
21	Menlo Park	301	15,200
12	Milwaukee	2	133,730
23	Minneapolis	229	9,000
23	Minneapolis	211	19,160
15	Topeka, KS	261	1,369
15	Topeka, KS	263	1,376
15	Topeka, KS	265	1,526
	Total	.....	495,689

B. How does VA plan to proceed with this initiative to ensure that the maximum amount of homeless veterans can be reached? Has VA worked to strengthen community partnerships in these communities to provide the most beneficial and successful alliances for all stakeholders?

Response. VA has included this initiative in the five-year plan to end homelessness among Veterans . Information has been disseminated to VA senior management at VA medical centers, VHA Network Homeless Coordinators', VA national conferences and calls. VA's Homeless Veterans Initiative Office and the Office of Asset Enterprise Management has meet with local community organizations interested in providing housing for homeless Veterans on VA property to assist with development issues.

Strengthening partnerships with communities is a major pillar of VA's plan to end homelessness among Veterans. The Homeless Veteran Initiative Office is the lead office and is developing and maintaining strategic external partnerships and socializing VA's Plan to End Veteran Homelessness.

Question 7. Within the Office of Public and Intergovernmental Affairs, VA has established the Homeless Veterans Initiative Office (HVIO), which "is responsible for policy development, inter and intra-agency coordination, developing/maintain strategic external partnerships and socializing VA's plan to end Veteran homelessness." In addition, VA has also created the National Center on Homelessness among Veterans, "whose mission is to develop, promote and enhance policy, clinical care, research and education to improve homeless services."

A. How do these offices align with VA's five year plan to end homelessness? How do these offices function with other offices responsible for overseeing homeless programs?

Response. The Office of the Assistant Secretary for Public and Intergovernmental Affairs (OPIA) is the Executive Sponsor for the Homeless Veteran Initiative. This office serves as the departmental lead for coordination, communications and monitoring of VA's Plan to End Homelessness Among Veterans. The Homeless Veteran Initiative Office (HVIO) serves as the lead point of contact with the White House and other Federal agencies, including the U.S. Interagency Council on Homelessness, and with State and local government officials.

Implementation and execution of the Plan is a responsibility shared by the Homeless Veterans Initiative Office (HVIO), Veterans Health Administration (VHA), and Veterans Benefits Administration (VBA). VHA is responsible for building and executing an operational budget, monitoring performance and oversight of regional and local health operations. Within the Veterans Health Administration, The National Center on Homeless Veterans was created to promote recovery-oriented care for Veterans who are homeless or at-risk for homelessness by developing, promoting, and enhancing policy, clinical care research, and education to improve homeless services. The Center's goal is to establish a national forum to exchange new ideas; provide education and consultation to improve the delivery of services; and disseminate the knowledge gained through the efforts of the its Research and Model Development Cores to VA, other Federal agencies, and community provider programs that assist homeless populations.

B. With similar missions, how is VA ensuring that these offices are working cohesively together and do not become duplicative in nature? What oversight mechanism is in place to ensure funds are being spent in an effective and efficient manner?

Response. The Homeless Veterans Initiative Office (HVIO) has lead responsibility to ensure the Plan to Eliminate Veteran Homelessness is continually reviewed and revised as needed to achieve the goal of ending Veteran homelessness. HVIO provides policy coordination and takes the lead in the monthly oversight of the plan by senior VA leadership. This oversight includes a monthly Operational Management Review meeting chaired by the Deputy Secretary. Topics addressed include a detailed review of expenditures in each of the programs that constitute the Plan. Both HVIO and VHA Homeless Program leads participate, and review specifics related to their program activities. Independently of these monthly reviews, the HVIO and VHA Homeless Program leads meet weekly both one on one and with a representative of the Secretary's office to monitor ongoing program activities and address emerging issues. As of February 2011, the HVIO and VHA Homeless Programs' physical offices are co-located, facilitating ongoing communication and coordination of efforts.

Question 8. The Office of Research and Development plans to expand research on homelessness, focusing specifically on intervention, risk factors, health care usage patterns and other areas to assist with VA's plan to end homelessness.

A. How is the HVIO and the National Center for Homelessness among Veterans working with the Office of Research and Development to ensure that their efforts to end homelessness are not being duplicated? How are the HVIO, the National Center on Homelessness among Veterans, and the Office of Research and Development ensuring that VA's efforts to end and prevent homelessness among veterans are effective?

Response. The Homeless Veteran Initiative Office (HVIO), the VA National Center for Homelessness among Veterans (NCHV) and the Office of Research and Development (ORD) are in close collaboration. Efforts to address homeless among Veterans in each of these offices are discussed at regular meetings with senior leadership.

The NCHV has worked very closely with ORD, most specifically the Health Services Research and Development Office (HSR&D), to create a homeless portfolio that would be coordinated with the Federal Strategic Plan to Prevent and End Homelessness and with the VA Plan to End Veteran Homelessness.

The ORD recently funded four prominent researchers to study homelessness. These studies will inform leadership of the effectiveness of VA's efforts to end and prevent homelessness.

The projects include:

Homeless Solutions in a VA Environment (H-SOLVE)

The purpose of this study is to determine whether VA implementation of Housing First can serve the chronic homeless population with serious mental illness.

Aligning Resources to Care for Homeless Veterans (ARCH)

The purpose of this study is to evaluate ways to best organize and deliver primary care for homeless Veterans. ARCH will assess 4 different adaptations of the PACT primary care model in a mixed methods study that includes multicenter, randomized-controlled trials of embedded peer-mentoring within different iterations of the PACT model, focus groups of study participants assessing satisfaction, treatment engagement and self-efficacy within the different care models and a cost-utility analysis to determine the most cost-efficient approach to organizing care for this population. Findings from this study will help determine optimal care approaches for reducing emergency department visits and acute hospitalizations, increasing patient satisfaction, and improving chronic disease management.

Population-based Outreach Services to Reduce Homelessness among Veterans with Serious Mental Illnesses (SMI).

The purpose and aims of this study are to develop a Navigator outreach program to identify Veterans with SMI and a lifetime history of homelessness to determine whether contact by the Navigator is associated with increased health services use, housing or other social services as well as decreased mortality.

Addiction Housing Case Management for Homeless Veterans Enrolled in Addiction Treatment

This randomized, controlled trial will develop and test a model for homeless Veterans entering addiction treatment with aims of evaluating: (1) addiction

treatment with addiction/housing case manager (experimental); or (2) addiction treatment with weekly housing group (time and attention control) and assessed for two years to determine if addiction/housing case management results in earlier transition to and higher retention in stable housing among homeless Veterans entering addiction specialty care.

In addition to the above-noted efforts the NCHV and HSRD have funded an evidence based treatment manual, Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION) that can assist VA case managers better meet the needs of homeless veterans with co-occurring mental health and substance use treatment needs. The ORD is also considering funding a trial to study how this evidence based treatment manual can be disseminated with the VA Homeless services. Additionally, the NCHV and HSRD are evaluating how they can collaborate to initiate research related to homeless Women Veterans. The close collaboration between the VA National Center and ORD will ensure VA is efficiently researching the issues that will be most effective in ending homelessness among Veterans.

CONSTRUCTION

Question 1. According to a September 2010 GAO report entitled *The FY 2009 Federal Real Property Report*; the Federal Government had 10,327 excess buildings in FY 2009 with an operating cost of $133.7 million. This is an increase of 187 buildings and $600 million in operating costs from the fiscal year 2008 report. Across the country, VA has about 1,100 buildings that are vacant or underutilized.

A. Exactly how many excess and underutilized buildings does VA have across the country? Please list their previous functions prior to abandonment.

Response. The VA currently estimates we have 895 buildings that are vacant or underutilized. Of these approximately 296 are vacant, the remaining 599 are considered underutilized, but are still in use providing support to Veterans. The underutilized buildings are not used at capacity and may not be operating as efficiently as possible, but cannot be easily disposed of without consolidating operations to make them fully vacant. Below is a breakout of the GSA Usage code for the 895 vacant or underutilized buildings.

Number of Vacant and Underutilized Buildings by GSA Usage Code

All Other	198
Dormitories/Barracks	1
Hospital	34
Housing	126
Industrial	29
Laboratories	15
Office	118
Other Institutional Uses	68
Post Office	1
Service	154
Storage	3
Warehouses	148
Grand Total	895

The VA currently has plans for reuse or disposal of 350 of these buildings. After those actions, there will be approximately 96 vacant buildings and 451 underutilized buildings remaining in the inventory. Many of these buildings are very small (340 of the 545 are <5,000 GSF) and have little reuse potential. VA continues to look for consolidation opportunities to make available for reuse a portion of the 451 underutilized buildings, but until consolidation occurs those building remain in use providing Veteran services.

B. When a new construction project is proposed, does VA take into account the excess buildings owned by VA?

Response. Yes. A primary gap used to evaluate the need for additional space under SCIP is space. A facilities space gap is calculated as the projected space needs to total currently existing building space, resulting in either additional space need or excess space. In cases of excess space, VISNs are required to reuse or dispose

of excess space before requesting new construction. This requirement ensures that there is a plan for excess space, either renovating to put back into service, reusing in other VA administrations, repurposing for homeless housing, or disposing of the asset. Each VA administration and office is part of the review of each SCIP action plan, providing a review for potential reuse opportunities as well.

C. How many of these buildings can be re-utilized for other purposes within VA, and thereby save the taxpayers in construction costs?

Response. Of the currently identified 895 vacant or underutilized buildings, 184 are planned for internal reuse or repurposing via VA's Enhanced-Use Leasing (EUL) Program. The Building Utilization Review and Repurposing (BURR) initiative is a strategic effort to identify and repurpose unused and underutilized VA land and buildings nationwide in support of the Secretary's goal to end Veteran homelessness. The Department's EUL authority allows VA to match supply (available buildings and land) and demand among Veterans for housing with third-party development, financing, and supportive services. Other potential reuse opportunities will continue to be explored.

D. How many of these buildings can be sold to a private entity or transferred to another Federal agency?

Response. There are currently 19 buildings planned for sale or transfer. The majority of the buildings with reuse value are being repurposed in support of ending Veteran homelessness. The remaining buildings are generally being planned for demolition or deconstruction due to their size (more than 1/3 less than 5,000 GSF), location, lack of reuse potential, or poor condition. For example, many buildings are located in the center of VA medical center campuses; such that they are not attractive business opportunities for private partners who rely on customer traffic that could disrupt patient care.

Question 2. As stated in your budget justification for Construction, VA notes that "VA has undergone a profound transformation in the delivery of health care over the past 20 years." The VHA infrastructure was developed in a period of time when delivery of health care was more in-patient focused. What this left the VHA with were capital assets that "often do not fully align with current health care needs." (Volume 4, page 2–3.)

A. What is VA's strategic plan to balance the vast needs in infrastructure while taking into consideration the tight budget restraints we are operating under?

Response. VA's strategic plan to balance during budget constraints is to focus capital investments on the most critical infrastructure needs. Through the Strategic Capital Investment Planning (SCIP) process, the most critical needs within the construction (major and minor) and non-recurring maintenance programs are funded in priority order. VA infrastructure needs are first prioritized against each other to develop one integrated list of capital requirements.

Question 3. In the fiscal year 2012 budget Appendix for Construction, Minor Projects, there is a line item titled "other services from non-Federal sources," which will be funded at $37 million in FY 2012. This would be an increase of 131% or $21 million from FY 2010 actual and equal to the continuing resolution level.

A. What accounts for a doubling of this account in one year?

Response. While the 2012 estimate for this is $21 million higher than the 2010 actual, it is important to note that the 2012 request is actually $10 million less the 2009 actual.

2009 Actual: $47 million
2010 Actual: $16 million
2011 Estimate: $37 million
2012 Estimate: $37 million

Actual spending year to year can vary depending on the requirements, as well as the timing, of the actual construction schedules. The estimate for 2011 and 2012 is equal to the average of the last 4 years of actuals for this activity.

B. Please explain what services are being provided to the Federal Government under this line item?

Response. This line item largely consists of contracts for maintenance, certification, inspection, repair of equipment and land planning associated with construction contracts.

Question 4. VA has an unfunded liability in medical construction which seems to grow larger every year. Currently, this backlog stands at roughly $6 to 8 billion in projects waiting for funding. Simultaneously, the costs of individual projects are also increasing, with the current estimate of the VA hospital in New Orleans at just under $1 billion.

A. What is VA's strategic plan to secure funding for individual projects in order to get this list to a more manageable size?

Response. VA is comprised of over 5,000 buildings and 30,000 acres. VA infrastructure needs are prioritized against each other to develop one integrated list of capital requirements and construction requests are also weighed against other VA priorities to determine the appropriate level of funding each fiscal year. In order to maximize resources, and fund additional projects, VA requests funding for larger, individual projects in phased sections. Each phase is a stand-alone project or phase that can be obligated within the fiscal year of request, without any extenuating circumstances.

B. How has VA taken into account the long term patient demand projection and needs when considering what types of facilities to build and where?

Response. VA relies on the Enrollee Health Care Projection Model (EHCPM) to project the demand for care by specific categories of care over a 20-year planning horizon. The EHCPM is an actuarial model that is updated each year that takes into account Veteran demographics and illness complexities to project long-term patient demand for inpatient and outpatient care. The EHCPM uses previous utilization and referral patterns to inform VA on health care demands based on where enrollees live and which VA facilities they will likely go to for care. In making long-term projections, the EHCPM takes into account Veteran reliance on VA vs. non-VA care, and incorporates the same assumptions as other Federal agencies regarding future discharges of Iraq and Afghanistan Veterans.

The EHCPM projections serve as the foundation for VHA's Health Care Planning Model (HCPM). Veterans Integrated Service Networks (VISN) use the HCPM's standard methodology to systematically analyze gaps between current and projected demand for care in each market over the next five, ten, and twenty years to plan strategic initiatives to best address the anticipated gaps in services. This information is then used to inform what types of facilities VA will need in the future, as well as well as where they should be built. VA's rigorous planning ensures that Veterans receive the highest quality care in the most appropriate locations for inpatient and outpatient environments.

C. Has VA performed a business case study on the benefits of leasing or buying to consider the long term needs of VA to ascertain which would be more financially advantageous to VA? If so, what were the results?

Response. Many factors are evaluated when considering leasing or buying. An example of some factors include, the need for additional space, the capacity to build on medical center campuses or renovate existing buildings, the requirement for quick implementation or flexibility to terminate a contract, budget constraints, the most cost effective alternative, all go into the buy versus lease determination. Each acquisition decision is considered and reviewed on an individual basis.

VA Policy, the OMB A–11, Capital Programming Guide and OMB A–94 requires a detailed cost benefit analysis be completed for all Major initiatives. The VA Strategic Capital Investment Planning (SCIP) process expanded this requirement to all capital initiatives via a cost-effectiveness analysis (CEA). The CEA provides a life cycle cost comparison of alternatives including: build, renovate, lease, and contract out for services. A cost effectiveness analysis must be completed for each capital solution to compare costs and provided as part of a completed business case application.

In addition, each business case is required to conduct an alternatives analysis, including a comparison of the net present value (NPV) of four options: status quo; construct new/renovate; lease space; and contract out services. Project business case applications are scored and ranked on several SCIP Criteria, one of the main criterion is called the "Best Value Solution," which provides an analysis of which option has the best net present value (NPV). If the chosen option does not have the best NPV, an explanation of why it is the chosen option is required.

INFORMATION AND TECHNOLOGY

Question 1. The Office of Information and Technology (OI&T) has asked for an increase of $25.8 million over fiscal year 2010 levels for Research and Development (R&D). The VA has 16 Major Transformational Initiatives to improve collaboration and integration among the various VA departments. The R&D initiative focuses on the genomic medicine, point of care research, medical informatics and Information Technology (IT) and VA Central Office field research.

A. What accounts for a $25.8 million increase in two years?

Response. The Research & Development transformational initiative receives funding from the Medical and Prosthetics research budget for business needs and the Office of Information and Technology (OI&T) for IT needs. Fiscal Year 2010 is the baseline for this question so it is important to state that in Fiscal Year 2010, Research & Development did not receive any transformational initiative funds from ei-

ther the business or OI&T budgets. Hence, all subsequent transformational initiative funds appear as an increase in funding. In Fiscal year 2011, $17.1 million of OI&T funding is budgeted, pending congressional action, to fund the following: the Veterans Affairs Research and Development lead role in personalized medicine, including the Million Veteran Program and the Genomic Informatics System for Integrative Science [GenISIS]; comparative effectiveness research [Point of Care research]; new tools to mine VA electronic medical records to optimize strategies for Veteran care, including Veterans Affairs Informatics and Computing Infrastructure [VINCI] and Consortium for Healthcare Informatics Research [CHIR]; and new tools to improve research administrative oversight while decreasing costs in the future, including the Research Administrative Management System [RAMS]. The Fiscal Year 2012 funding level is forecast at $30 million from OI&T funding and $0 from business funding.

B. How much in total will be expended on this initiative?

Response. Outyear funding levels for this initiative will be developed as future needs are analyzed.

Question 2. Assistant Secretary Baker recently informed the Hill of OI&T's intention to hire 705 new employees. According to a spreadsheet provided to Committee staff on February 14, 2011 (copy attached), it appears that a substantial amount of these employees are to be located in the Washington, DC, area or VA Central Office. Please reconcile the staffing levels outlined in that document with the staffing levels requested in the fiscal year 2012 budget request.

Priority	Series	Grade	Recruitment Functional Title	Primary Location
P1	343	13	Program Analyst (Program Mgt Policy)	Washington DC Metro Area
P1	2210	13	IT Specialist	Washington DC Metro Area
P1	2210	14	IT Specialist	Washington DC Metro Area
P1	2210	13	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	2210	13	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	2210	13	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	2210	13	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	2210	13	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	343	13	Program Analyst (PMSA Reports and Data Mgts)	Washington DC Metro Area
P1	343	13	Program Analyst (Program Assessment)	Washington DC Metro Area
P1	343	13	Program Analyst (Program Assessment)	Washington DC Metro Area
P1	343	13	Program Analyst (Program Mgt Policy)	Washington DC Metro Area
P1	343	14	Program Analyst (Collaboration & Communication Liaison)	Washington DC Metro Area
P1	2210	14	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	2210	14	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	2210	14	IT Specialist (Engineer (New Systems Engineering))	TBD
P1	2210	15	Supv, IT Specialist (Dir, Current Systems Engineering)	TBD
P1	2210	15	Supv, IT Specialist (Dir, Enterprise Engineering Service)	TBD
P1	2210	15	Supv, IT Specialist (Dir, New Systems Engineering)	TBD
P2	2210	13	IT Specialist (Lead)	Washington DC Metro Area
P2	2210	13	IT Specialist (Lead)	Washington DC Metro Area
P2	343	13	Program Analyst	TBD
P2	2210	13	IT Specialist (Lead)	Austin, TX
P2	2210	13	IT Specialist (Lead)	Washington DC Metro Area
P2	2210	14	IT Specialist	Washington, DC or Falling Waters, WV
P2	2210	14	IT Specialist (Lead)	Washington, DC or Falling Waters, WV
P2	2210	14	IT Specialist (Lead)	Washington, DC or Falling Waters, WV
P2	2210	14	IT Specialist (Lead)	Washington DC Metro Area
P2	2210	14	Supv, IT Specialist (Deputy Director (ESSS))	Washington DC Metro Area
P2	2210	14	Supv, IT Specialist	TBD
P2	2210	15	Supv, IT Specialist (Director, Business Continuity)	Washington DC Metro Area
P2	2210	15	Supv, IT Specialist (Director, Incident Res (RMIR))	Falling Waters, WV
P2	2210	15	Supv, IT Specialist (Director, Risk Management (RMIR))	Washington DC Metro Area
P2	2210	15	Supv, IT Specialist	Washington DC Metro Area
P2	343	15	Supv, Program Analyst	Washington DC Metro Area
P2	343	15	Supv, Program Analsyst (NTE 400 days)	Washington DC Metro Area
P2	343	15	Supv, Program Analyst	Washington DC Metro Area
P2	301	7T 8T 9	Program Support Assistant	Washington DC Metro Area
P2	343	12T 13	Program Analyst	Washington DC Metro Area
P2	2210	11T 12T 13	IT Specialist	Hines, IL
P2	2210	12T 13	IT Specialist	Washington DC Metro Area
P2	343	7T 9T 11T 12	Program Analyst	Washington DC Metro Area
P2	343	7T 9T 11T 12	Program Analyst	Washington DC Metro Area
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Supulveda, CA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	San Diego, CA

P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Martinsburg, WV
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Austin, TX
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Denver, CO
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Philadelphia, PA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Pittsburgh, PA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Atlanta, GA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Nashville, TN
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Salt Lake City, UT
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Big Spring, TX
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	East Orange, NJ
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Cleveland, OH
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	St. Petersburg, FL
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Brockton, MA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Menlo Park, CA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Canandaigua, NY
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Washington DC Metro Area
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Fresno, CA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	New Orleans, LA
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Lake City, FL
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Murfreesboro, TN
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Muskogee, AL
P2	2210	9T 11T 12	IT Specialist (Information Security Officer)	Frederick, MD
P1	560	15	Director - IT Budget Execution	VACO, Station 101
P3	301	7T 9T 11	Program Specialist	VACO, Station 101
P1	2210	14	Supv, IT Specialist	VACO, Station 101
P1	301	13T 14	Program Support	VACO, Station 101
P1	2210	13	IT Specialist	VACO, Station 101
P1	340	15	Director	Bay Pines, FL
P1	2210	13	IT Specialist (Project Manager)	Dayton, OH
P1	343	13	Management and Program Analyst (Planner)	TBD - Bay Pines, FL or Salt Lake City, UT or Hines, IL, etc
P1	560	13	Budget Analyst	Bay Pines, FL
P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	301	14	Management Analyst	
P1	340	15	Director	Albany, NY
P1	343	14	Management Analyst	Eatontown, NJ
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	560	13	Budget Analyst	Bay Pines, FL
P1	343	14	Management Analyst	Eatontown, NJ
P1	301	9	Staff Assistant	Eatontown, NJ
P1	2210	13	IT Specialist (Application Software)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc

P1	343	14	Management Analyst	Eatontown, NJ
P1	343	15	Director	Bay Pines, FL or Washington, DC
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	340	14	Project Manager	Falling Waters, WV
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	343	14	Management Analyst	Bay Pines, FL
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	1102	13	Contract Administrator	Eatontown, NJ or Bay Pines, FL
P1	2210	13	IT Specialist (Application Software)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	2210	13	IT Specialist (Technical Analyst)	Bay Pines, FL
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	2210	13	IT Specialist - Support	TBD - Development Center or Remote
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	343	14	Management Analyst	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc

P1	2210	13	IT Specialist (Application Software)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P2	2210	15	Director	Oakland, CA
P2	2210	12T 13	IT Specialist - Support	TBD - Development Center or Remote
P2	2210	12T 13	IT Specialist - Support	TBD - Development Center or Remote
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P2	2210	12T 13	IT Specialist - Support	TBD - Development Center or Remote
P2	2210	12T 13	IT Specialist - Support	TBD - Development Center or Remote
P2	2210	12T 13	IT Specialist - Support	TBD - Development Center or Remote
P2	2210	12T 13	IT Specialist - Support	TBD - Development Center or Remote
P2	2210	11T 12	IT Specialist - Support	TBD - Development Center or Remote
P2	2210	15	Supv, IT Specialist (Competency Director)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	11	IT Specialist (Application Software)	Denver, CO
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	340	14	Program Manager	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	560	13	Budget Analyst	Bay Pines, FL

P1	340	14	Program Manager	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	1102	13	Contract Administrator	Eatontown, NJ or Bay Pines, FL
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	340	15	Initiative Lead	Washington, DC or Eatontown, NJ
P1	340	14	Program Manager	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	301	12	Staff Assistant	Eatontown, NJ
P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc

P1	340	14	Project Manager	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P2	2210	13	IT Specialist - Support	Hines, IL
P1	301	7T 9T 11T 12	Staff Assistant	Washington DC Metro Area
P2	2210	13	IT Specialist - Support	Hines, IL
P2	2210	13	IT Specialist - Support	Hines, IL
P1	2210	12	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	12	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	1102	13	Contract Administrator	Eatontown, NJ or Bay Pines, FL
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	340	14	Program Manager	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc

P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	343	14	Management Analyst	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	343	14	Management Analyst	Eatontown, NJ
P1	343	13	Management and Program Analyst (Planner)	TBD - Bay Pines, FL or Salt Lake City, UT or Hines, IL, etc
P1	343	14	Management Analyst	Eatontown, NJ
P1	2210	12	IT Specialist (Application Software)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	343	14	Management Analyst	Eatontown, NJ
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	2210	12	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	12	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc

P1	2210	12	IT Specialist (Functional Analyst)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	343	14	Management Analyst	Washington DC Metro Area
P1	343	14	Management Analyst	Eatontown, NJ
P1	301	11T 12	Staff Assistant	Eatontown, NJ
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P3	343	14	Management Analyst	Austin, TX
P1	301	7T 9T 11T 12	Staff Assistant	Eatontown, NJ
P1	2210	11	IT Specialist (Project Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	13	IT Specialist (Application Software)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	343	11T 12T 13	Management Analyst	Bay Pines, FL
P1	343	11T 12T 13	Management Analyst	Bay Pines, FL
P1	343	11T 12T 13	Management Analyst	Bay Pines, FL
P1	2210	14	Supv, IT Specialist (Competency Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P1	2210	14	IT Specialist (Program Manager)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	14	Supv, IT Specialist (Competency Manager)	TBD
P2	2210	12T 13	IT Specialist - Support	TBD

P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	14	Supv, IT Specialist (Competency Manager)	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	12T 13	IT Specialist - Support	TBD
P2	2210	13	IT Specialist (Data Manager-HL7/Messaging)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P2	2210	13	IT Specialist (Data Dictionary lead)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P3	2210	13	IT Specialist (Enterprise Architect)	Virtual
P3	2210	15	Supv, IT Specialist (Director, Business Intelligence)	Virtual
P3	2210	13	IT Specialist (Project Manager)	Virtual
P3	2210	12T 13	IT Specialist (Project Manager)	Washington DC Metro Area
P3	2210	12T 13	IT Specialist (Project Manager)	Washington DC Metro Area
P2	2210	13	Supv, IT Specialist (Chief, Enterprise Connectivity Section)	Austin, TX
P2	2210	12	IT Specialist (Network Administrator)	Philadelphia, PA
P1	2210	12	IT Specialist (Systems Analyst)	Austin, TX
P1	2210	13	IT Specialist (Project Manager)	Austin, TX
P1	2210	13	IT Specialist (Application Software Manager)	Austin, TX
P3	2210	7T 9T 11	IT Specialist (Customer Support)	Hines, IL
P3	2210	7T 9T 11	IT Specialist (Customer Support)	Hines, IL
P3	2210	7T 9	IT Specialist (Customer Support)	Waco, TX
P2	2210	12	IT Specialist (VistA Imaging Coordinator)	Charleston, SC
P1	2210	12	IT Specialist (VistA Manager)	Columbia, SC
P1	2210	12	IT Specialist (Systems Analyst)	Columbia, SC
P1	2210	11T 12	IT Specialist (VistA Imaging Coordinator)	Columbia, SC
P3	2210	13	Supv, IT Specialist (Assistant FCIO)	Salisbury, NC
P1	2210	13	IT Specialist (Systems Analyst)	Austin, TX
P1	2210	11T 12	IT Specialist	Austin, TX
P1	2210	11	IT Specialist (Security)	Martinsburg, WV
P1	2210	12T 13	IT Specialist	Austin, TX
P2	2210	11	IT Specialist (Customer Support)	Seattle, WA
P2	2210	9T 11	IT Specialist (Sys Admin/Customer Support)	San Diego, CA
P1	2210	11	IT Specialist (PACS Admin)	East Orange, NJ
P1	2210	12	IT Specialist (Network Admin)	East Orange, NJ
P1	2210	9	IT Specialist (CRC Support)	East Orange, NJ
P1	2210	9	IT Specialist (CRC Support)	East Orange, NJ
P2	335	5	Computer Assistant	Indianapolis, IN

P2	2210	12	IT Specialist (Application Software)	Cincinnati, OH
P2	2210	9	IT Specialist (Web Developer)	Cincinnati, OH
P1	2210	13	Supv, IT Specialist (Systems Analyst)	Washington DC Metro Area
P2	2210	9	IT Specialist (Custspt/PlcyPln/Internet)	Augusta, GA
P2	2210	11	IT Specialist (Telecommunications Manager)	White River Junction, VT
P2	2210	11	IT Specialist (Network Support)	Memphis, TN
P2	2210	11	IT Specialist (Network Support)	Memphis, TN
P2	2210	11	IT Specialist (Network Support)	Memphis, TN
P2	2210	11	IT Specialist (Application Software)	Milwaukee, IL
P2	2210	12T 13	Supv, IT Specialist	Leavenworth, KC
P2	2210	11T 12	IT Specialist (Network Services)	Jackson, MS
P2	2210	11T 12	IT Specialist (Network Services)	Jackson, MS
P2	2210	9	IT Specialist (Customer Support)	Mt. Home, AR
P1	2210	11	IT Specialist (Network Manager)	San Juan, Puerto Rico
P2	2210	11	IT Specialist (Hardware Technician)	San Juan, Puerto Rico
P2	2210	11	IT Specialist (Hardware Technician)	San Juan, Puerto Rico
P2	2210	11	IT Specialist (Hardware Technician)	San Juan, Puerto Rico
P2	2210	12	IT Specialist (Project Manager)	New Orleans, LA
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Myrtle Beach, SC
P3	2210	13	IT Specialist (Core Systems)	Little Rock, AR
P1	2210	9	IT Specialist (Customer Support)	Hampton, VA
P2	341	11T 12	Administrative Officer	Virtual
P1	2210	12	IT Specialist (Customer Support)	Hampton, VA
P2	2210	9	IT Specialist (Customer Support)	Dallas, TX
P2	2210	11T 12	IT Specialist (VistA Manager)	Huntington, WV
P2	2210	9	IT Specialist (Customer Support)	Dallas, TX
P1	2210	9	IT Specialist (Telecommunications Specialist)	Columbia, SC
P3	2210	5T 7T 9	IT Specialist (Customer Support)	New Port Richey, FL
P2	2210	9	IT Specialist (Customer Support, Desktop Support)	Huntington, WV
P1	2210	13	IT Specialist (Application Software)	Durham, NC
P3	2210	5T 7T 9	IT Specialist (Customer Support)	Tampa, FL
P2	2210	5T 7T 9	IT Specialist (Desktop Support)	Nashville, TN
P2	2210	11	IT Specialist	Danville, IL
P2	2210	5	Computer Operator	Danville, IL
P2	2210	12T 13	Supv, IT Specialist	Dallas, TX
P3	2210	13	IT Specialist (Network)	Virtual
P2	2210	11	IT Specialist (Network Support)	Louisville, KY
P2	2210	9	IT Specialist (Customer Support)	Virtual
P2	2210	9	IT Specialist (Customer Support)	Virtual
P2	2210	11T 12	IT Specialist (Operation Systems)	Virtual
P2	2210	14	Supv, IT Specialist	Indianapolis, IN
P2	2210	9T 11	IT Specialist (Network - Voice/Video)	Virtual
P3	2210	15	Supv, IT Specialist (NCIO)	Minneapolis, MN
P3	2210	5T 7T 9	IT Specialist (Customer Support)	Indianapolis, IN
P3	2210	5T 7T 9	IT Specialist (Customer Support)	Indianapolis, IN
P2	2210	12	IT Specialist (Application Software)	Ann Arbor, MI
P2	2210	9	IT Specialist (Desktop Support)	Baltimore, MD
P2	2210	12	IT Specialist (I-Net web programmer)	Baltimore, MD
P2	2210	11	IT Specialist (System Administrator) Hardware	Memphis, TN

P2	2210	11	IT Specialist (Application Software)	Battle Creek, MI
P2	2210	13	Supv, IT Specialist (Network)	Orlando, FL
P1	2210	13	IT Specialist (Internet)	Philadelphia, PA
P1	2210	13	IT Specialist - Web Logic Administrator	Austin, TX
P1	2210	14	Supv, IT Specialist (Internet)	Falling Waters, WV
P3	2210	14	Supv, IT Specialist (Program Manager)	Virtual
P3	2210	14	Supv, IT Specialist (Program Manager)	Virtual
P3	2210	14	Supv, IT Specialist (Program Manager)	Virtual
P3	2210	14	Supv, IT Specialist (Program Manager)	Virtual
P3	2210	14	Supv, IT Specialist (Program Manager)	Virtual
P2	2210	13	IT Specialist (Application Software)	Dallas, TX
P2	2210	9	IT Specialist (Voice/Data))	Dallas, TX
P3	2210	9	Program Specialist (Customer Support)	Arlington, TX
P2	2210	9	IT Specialist (Customer Support)	Dallas, TX
P2	2210	11	IT Specialist (Voice/Data/Network)	San Antonio, TX
P2	2210	5	IT Specialist (Customer Support)	San Antonio, TX
P2	2210	5T 7T 9	IT Specialist (Customer Support)	San Antonio, TX
P2	2210	12	IT Specialist (VistA Imaging Coordinator)	Atlanta, GA
P2	2210	12	IT Specialist (Customer Service & Logistics, Telecomm Service)	San Diego, CA
P1	2210	5T 7T 9T 11	IT Specialist (Customer Support)	Washington DC Metro Area
P2	2210	5T 7T 9T 11	IT Specialist (Customer Support)	Washington DC Metro Area
P3	2210	9T 11T 12	IT Specialist (Customer Support)	Pittsburgh, PA
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Birmingham, AL
P1	2210	13	IT Specialist (Network Services)	Austin, TX
P3	391	12	Telecommunications Specialist Lead	San Francisco, CA
P2	2210	13	Supv, IT Specialist (Customer Support, Desktop PC/Printer Support)	San Francisco, CA
P2	2210	11	IT Specialist (Network Svc/Customer Support)	Amarillo, TX
P2	2210	12	IT Specialist (Application Software)	Alexandria, LA
P2	2210	11T 12	IT Specialist (VistA Applications)	Jackson, MS
P2	2210	12	IT Specialist (Customer Support)	New Orleans, LA
P2	2210	11	IT Specialist (Customer Support)	Oklahoma City, OK
P2	2210	11	IT Specialist (Pol/Planning)	Dallas, TX
P2	2210	11	IT Specialist (Customer Support)	Central Iowa, IA
P2	2210	9	IT Specialist (Customer Support)	Virtual
P2	2210	9	IT Specialist (Customer Support)	Central Iowa, IA
P2	2210	11T 12	IT Specialist (Network Services)	Fargo, ND
P3	2210	14	Supv, IT Specialist (System Administrator)	Virtual
P2	2210	13	Supv, IT Specialist (Facility Deputy CIO)	Battle Creek, MI
P2	2210	12	IT Specialist (VistA Applications)	Philadelphia, PA
P3	2210	13	IT Specialist (System Administrator)	Virtual
P3	2210	13	IT Specialist (System Administrator)	Virtual
P3	2210	13	IT Specialist (System Administrator)	Virtual
P3	2210	13	IT Specialist (System Administrator)	Virtual
P3	2210	13	IT Specialist (System Administrator)	Virtual
P3	2210	13	IT Specialist (System Administrator)	Virtual
P3	2210	13	IT Specialist (System Administrator)	Virtual

P3	2210	13	IT Specialist (Requirements Analyst)	Eatontown NJ; Albany, NY; Bay Pines, FL; Birmingham, AL; Tuscaloosa, AL; Dallas, TX; Hines, IL; Martinsburg, WV; Oakland, CA; Salt Lake, UT; Silver Spring, MD
P3	2210	13	IT Specialist (Requirements Analyst)	Eatontown NJ; Albany, NY; Bay Pines, FL; Birmingham, AL; Tuscaloosa, AL; Dallas, TX; Hines, IL; Martinsburg, WV; Oakland, CA; Salt Lake, UT; Silver Spring, MD
P3	2210	13	IT Specialist (PKI Technical Specialist	Eatontown, NJ or Hines, IL
P3	2210	12T 13	IT Specialist (Campus Support (Team 3))	Silver Springs, MD or Salt Lake City, UT
P3	2210	12T 13	IT Specialist (Campus Support (Team 3))	Silver Springs, MD or Salt Lake City, UT
P3	2210	12T 13	IT Specialist (Campus Support (Team 3))	Silver Springs, MD or Salt Lake City, UT
P3	2210	12T 13	IT Specialist (Campus Support (Team 3))	Silver Springs, MD or Salt Lake City, UT
P2	2210	12	IT Specialist (Lead Customer Support Technician)	Northport, NY
P2	2210	11	IT Specialist (Application Software)	Boston, MA
P3	2210	12	IT Specialist (Customer Support)	Austin, TX
P3	2210	12	IT Specialist (Application Software)	Denver, CO
P2	2210	11	IT Specialist (Database Administrator)	Atlanta, GA
P3	2210	11	IT Specialist (Application Software)	Ann Arbor, MI
P3	2210	11T 12	IT Specialist (Network Services)	Hines, IL
P2	2210	12	Supv, IT Specialist (Application Software)	Milwaukee, IL
P2	2210	12	IT Specialist (Serv Supt)	Harlingen, TX
P2	2210	11	IT Specialist (Prog Analyst)	Arlington, TX
P2	2210	9	IT Specialist (Customer Support)	Bay Pines, FL
P2	2210	9	IT Specialist (Customer Support)	Bay Pines, FL
P2	2210	9	IT Specialist (Customer Support)	Bay Pines, FL
P3	2210	12T 13	IT Specialist (Project Manager)	Virtual
P3	2210	12T 13	IT Specialist (Project Manager)	Virtual
P2	2210	9	IT Specialist (Customer Support)	Bay Pines, FL
P3	335	7	Computer Assistant	Sacramento, CA
P2	2210	9	IT Specialist (Customer Support)	Redding, CA
P2	2210	9	IT Specialist (Customer Support)	Dallas, TX
P2	2210	9	IT Specialist (Customer Support)	Dallas, TX
P2	341	11	Administrative Officer	Dallas, TX
P2	2210	12	IT Specialist	San Antonio, TX
P2	2210	9	IT Specialist (Customer Support)	Dallas, TX
P2	2210	13	Supv, IT Specialist	San Antonio, TX
P2	2210	9	IT Specialist (Customer Support)	Virtual
P2	2210	9	IT Specialist (Customer Support)	Minneapolis, MN
P2	2210	9T 11	IT Specialist (Network Services)	Virtual

P3	2210	14	IT Specialist (Network Engineer)	Eatontown NJ; Raleigh NC; Durham NC; Winston-Salem NC; Greensboro NC
P2	2210	7T 9T 11	IT Specialist (VIE Messaging Specialist)	Eatontown, NJ; CA; OR; UT; WY; WA; CO; AZ; ND; SD; TX; NB; KS; OK
P2	2210	7T 9T 11	IT Specialist (VIE Messaging Specialist)	Eatontown, NJ; CA; OR; UT; WY; WA; CO; AZ; ND; SD; TX; NB; KS; OK
P2	2210	5T 7T 9T 11	IT Specialist (VistA Application Support)	Mountain Home, TN
P2	2210	5T 7T 9T 11	IT Specialist (VistA Application Support)	Mountain Home, TN
P1	2210	13	IT Specialist (Customer Support) Lead	Philadelphia, PA
P1	2210	11	IT Specialist (Telecommunications Specialist)	Brooklyn, NY
P2	2210	11	IT Specialist (Customer Support)	Denver, CO
P1	2210	11	IT Specialist (Customer Support, Tier II)	Brooklyn, NY
P1	2210	12	Supv, IT Specialist (Lead)	St. Albans, NY
P1	2210	13	Supv, IT Specialist (Site Manger)	East Orange, NJ
P1	2210	9	IT Specialist (Standard Tier II)	East Orange, NJ
P1	2210	9	IT Specialist (Standard Tier II)	East Orange, NJ
P1	2210	13	IT Specialist (Project Manager)	Austin, TX
P1	2210	13	IT Specialist (Project Manager)	Austin, TX
P1	2210	12	IT Specialist (Systems Analysis)	Austin, TX
P2	2210	12	IT Specialist (Network Services)	Atlanta, GA
P2	2210	12	IT Specialist (VistA Manager)	Birmingham, AL
P1	2210	5T 7T 9	IT Specialist (Customer Support)	Columbia, SC
P3	2210	5T 7T 9	IT Specialist (Customer Support)	Tuscaloosa, AL
P3	2210	12T 13	IT Specialist (Corporate Database Programmer)	Augusta, GA
P3	2210	13	Supv, IT Specialist (Assistant Chief)	Bay Pines, FL
P3	2210	13	IT Specialist (Data Warehouse Administrator)	Virtual
P2	2210	9	IT Specialist (Customer Support)	Newington, CT
P3	2210	5T 7T 9	IT Specialist (Customer Support)	Erie, PA
P1	2210	13	Supv, IT Specialist (Supply Systems Analyst)	Austin, TX
P1	2210	11	IT Specialist (Customer Support)	Washington DC Metro Area
P2	2210	11	IT Specialist (Customer Support)	Colorado Springs, CO
P2	2210	14	Supv, IT Specialist	Fayettville, AR
P2	2210	11	IT Specialist (Network Services)	Houston, TX
P3	2210	12	Supv, IT Specialist	Fayettville, AR
P3	2210	12	IT Specialist (Windows System Administrator)	Hampton, VA
P2	2210	11	IT Specialist (Customer Support)	Cheyenne, WY
P2	2210	9	IT Specialist (Tier II)	Portland, OR
P2	2210	9	IT Specialist (Tier II)	Portland, OR
P2	2210	9	IT Specialist (Tier II)	Portland, OR
P2	2210	11	IT Specialist (Tech Support)	Seattle, WA
P2	391	9	Telecommunications Specialist	Spokane, WA
P2	2210	9	IT Specialist (Customer Support)	Spokane, WA
P2	2210	9	IT Specialist (Customer Support)	McClellan (Sacramento), CA
P2	2210	12	IT Specialist (Tier II)	San Francisco, CA
P2	2210	12	IT Specialist (Tier II)	San Francisco, CA
P2	2210	11	IT Specialist (Telecommunications - Tier I/II)	Amarillo, TX

P2	2210	11	Supv, IT Specialist (Tier I/II)	Albuquerque, NM
P2	2210	11	IT Specialist (Tier I/II)	Albuquerque, NM
P1	2210	11	IT Specialist (Business Systems)	Chillicothe, OH
P2	2210	9	IT Specialist (Customer Support)	Cleveland, OH
P2	2210	9	IT Specialist (Customer Support)	Cleveland, OH
P2	2210	11	IT Specialist (System Administrator) Windows Admin	Dayton, OH
P2	2210	11	IT Specialist (Network)	Indianapolis, IN
P1	2210	11T 12	IT Specialist (Systems Analysis)	Austin, TX
P1	2210	7T 9T 11	IT Specialist (Customer Support)	Austin, TX
P3	344	7	Management and Program Analyst	Austin, TX
P3	2210	13	IT Specialist (Project Manager)	Virtual
P3	2210	13	IT Specialist (Project Manager)	Virtual
P3	2210	13	IT Specialist (Project Manager)	Virtual
P2	2210	12	Supv, IT Specialist	Little Rock, AR
P3	2210	12T 13	IT Specialist (Policy/Plng)	Little Rock, AR
P2	2210	14	Supv, IT Specialist (Facility CIO)	Atlanta, GA
P2	2210	9T 11	IT Specialist (System Administrator)	Atlanta, GA
P2	2210	12	IT Specialist (System Administrator)	Birmingham, AL
P1	2210	5T 7T 9	IT Specialist (Customer Support)	Columbia, SC
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Dublin, GA
P2	2210	12	IT Specialist (Network)	Tuscaloosa, AL
P3	2210	7T 9T 11	IT Specialist (Customer Support)	Iron Mt, MI
P2	2210	9T 11	IT Specialist (PC Support)	North Chicago, IL
P2	2210	9T 11	IT Specialist (PC Support)	North Chicago, IL
P2	2210	5T 7T 9	IT Specialist (PC Support)	North Chicago, IL
P2	2210	5T 7T 9	IT Specialist (Customer Support)	North Chicago, IL
P3	2210	12	IT Specialist (System Administrator)	North Chicago, IL
P2	2210	9	IT Specialist (Mac Tech)	North Chicago, IL
P2	2210	11	IT Specialist (PC Support)	Hines, IL
P2	101	13	Supv, IT Specialist (VIRec Technical Director)	TBD
P2	2210	13	Supv, IT Specialist (Chief Appl Dev & Tng)	San Antonio, TX
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Birmingham, AL
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Dublin, GA
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Dublin, GA
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Dublin, GA
P2	2210	11	IT Specialist (Application Software)	Northampton, MA
P2	2210	11	IT Specialist (System Admin / Application Software)	Bedford, MA
P1	2210	13	Supv, IT Specialist	Austin, TX
P2	2210	7T 9	IT Specialist (Customer Support)	Tucson, AZ
P2	2210	9	IT Specialist (PC Team)	Phoenix, AZ
P2	2210	9	IT Specialist (Customer Support)	Prescott, AZ
P2	2210	9	IT Specialist (PC Specialist - Walk-in Support)	Phoenix, AZ
P2	2210	9	IT Specialist (Customer Support)	Amarillo, TX
P2	2210	11	IT Specialist (Customer Support)	Denver, CO
P2	2210	9T 11T 12	IT Specialist (VistA Imaging/App Support)	Cheyenne, WY
P2	2210	11	IT Specialist (Customer Support)	Denver, CO
P2	2210	11	IT Specialist (PC Team)	Grand Junction, CO
P2	2210	11	IT Specialist (Customer Support)	Fort Harrison, MT
P2	2210	5T 7T 9	IT Specialist (Customer Support, Telecomm)	Portland, OR

P2	2210	11	IT Specialist (Team Lead)	Portland, OR
P2	2210	9	IT Specialist (Customer Support)	Spokane, WA
P2	2210	9	IT Specialist (PC & Printer Team)	Fresno, CA
P2	2210	13	IT Specialist (VistA App & Programming Team)	San Francisco, CA
P2	2210	11	IT Specialist (M&O, Service/Repair, Cust Sup)	Los Angeles, CA
P2	2210	9	IT Specialist (Customer Support, Desktop PC/Printer Support)	San Francisco, CA
P3	341	12T 13	Administrative Officer	Albany, NY
P2	2210	11	IT Specialist (VistA Imaging/PACS Admin)	Clarksburg, WV
P2	2210	11	IT Specialist (Customer Support, Desktop Support)	Baltimore, MD
P3	343	13	Management and Program Analyst	Eatontown, NJ or Albany, NY
P2	2210	7T 9T 11	IT Specialist (Campus Support (OAL) Team 2)	Virtual
P2	2210	7T 9T 11	IT Specialist (Campus Support (OAL) Team 2)	Virtual
P3	2210	13	IT Specialist (Platform Engineer)	Eatontown, NJ or Albany, NY
P3	2210	13	Supv, IT Specialist (Business Office Manager)	Virtual
P3	2210	14	Supv, IT Specialist (Benefits Systems)	Eatontown, NJ; Washington, DC metro; Austin, TX; Hines, IL; Philadelphia, PA
P3	2210	13T 14	IT Specialist (VBA Benefits Engineer)	Eatontown, NJ; Washington, DC metro; Austin, TX; Hines, IL; Philadelphia, PA
P2	2210	9T 11T 12	IT Specialist (Tech Writer)	Eatontown, NJ or Albany, NY or Hines, IL
P3	2210	13	IT Specialist (Telehealth-Network Engineer)	Eatontown, NJ
P3	2210	13	IT Specialist (Telehealth-Network Engineer)	Eatontown, NJ
P3	2210	13	IT Specialist (VISTA Tech)	Denver, CO; Muskogee, OK; Columbus, OH; Silver Spring, MD, Oakland, CA; Albany, NY; Hines, IL
P3	2210	13	IT Specialist (VISTA Tech)	Denver, CO; Muskogee, OK; Columbus, OH; Silver Spring, MD, Oakland, CA; Albany, NY; Hines, IL
P2	2210	12	Supv, Assistant FCIO	Beckley, WV
P3	2210	13	Supv, IT Specialist (Associate Facility CIO)	Asheville, NC
P3	2210	12T 13	IT Specialist (OPP)	Virtual
P3	2210	12T 13	IT Specialist (OPP)	Virtual
P3	343	13	IT Specialist (Tech Writer)	Eatontown, NJ; Oakland CA; San Francisco CA; Albany NY; Hines, IL
P3	343	13	IT Specialist (Tech Writer)	Eatontown, NJ; Oakland CA; San Francisco CA; Albany NY; Hines, IL
P3	343	13	IT Specialist (Tech Writer)	Eatontown, NJ; Oakland CA; San Francisco CA; Albany NY; Hines, IL

P2	391	13T 14	Telecommunications Specialist (Call Center Engineer)	Portland, OR; Eatontown, NJ; Washington, DC; Dallas, TX; Austin, TX; San Antonio, TX; San Jose, CA; Boston, MA; Chicago, IL; Kansas City, MO; Anchorage, AK; Raleigh-Durham, NC
P2	391	13T 14	Telecommunications Specialist (Call Center Engineer)	Portland, OR; Eatontown, NJ; Washington, DC; Dallas, TX; Austin, TX; San Antonio, TX; San Jose, CA; Boston, MA; Chicago, IL; Kansas City, MO; Anchorage, AK; Raleigh-Durham, NC
P2	391	13T 14	Telecommunications Specialist (Call Center Engineer)	Portland, OR; Eatontown, NJ; Washington, DC; Dallas, TX; Austin, TX; San Antonio, TX; San Jose, CA; Boston, MA; Chicago, IL; Kansas City, MO; Anchorage, AK; Raleigh-Durham, NC
P2	391	14	Supv, Telecommunications Specialist (Call Center)	Portland, OR; Eatontown, NJ; Washington, DC; Dallas, TX; Austin, TX; San Antonio, TX; San Jose, CA; Boston, MA; Chicago, IL; Kansas City, MO; Anchorage, AK; Raleigh-Durham, NC
P3	391	5T 7T 9	Telecommunications (VANTS Operators)	Martinsburg, WV
P2	2210	13	IT Specialist (Assistant CIO)	Orlando, FL
P2	2210	9	IT Specialist (Customer Support)	Columbus, OH
P2	2210	9	IT Specialist (Customer Support)	Columbus, OH
P2	2210	11	IT Specialist (System Administrator) Telecom	Columbus, OH
P2	2210	13	Supv, IT Specialist (Customer Support)	Denver, CO
P2	2210	12	Supv, IT Specialist (Desktop PC/Printer Support)	Fresno, CA
P2	2210	9	IT Specialist (Desktop & Walk-In Support Team)	Honolulu, HI
P3	2210	13	Supv, IT Specialist (FCIO)	Manila, PI
P2	2210	13	Supv, IT Specialist (Customer Support)	Los Angeles, CA
P3	2210	11T 12	IT Specialist (ITSS, Ops Svc Ctr IT Analyst)	Virtual
P2	391	7	Telecommunications Specialist (Communications Clerk)	Lexington, KY
P3	303	7	Administrative Officer	Virtual
P3	2210	11	IT Specialist (Web Developer)	Denver, CO
P2	2210	9	IT Specialist (Desktop Support)	Atlanta, GA
P3	2210	9	IT Specialist (Desktop Support)	Atlanta, GA
P2	2210	9	IT Specialist (Data Validation/Customer Support)	St. Louis, MO
P2	2210	7T 9	IT Specialist (Customer Support)	Virtual
P2	2210	9	IT Specialist (Customer Support)	Biloxi, MS
P2	2210	9	IT Specialist (Customer Support)	Virtual
P3	2210	12	IT Specialist (Network)	Jackson, MS
P3	335	5T 6T 7	Computer Assistant	Virtual

P2	2210	12	IT Specialist (Network Admin)	Dayton, OH
P3	2210	12	IT Specialist (Project Manager)	Ann Arbor, MI
P2	2210	9	IT Specialist (Desktop Support)	Saginaw, MI
P2	2210	12	IT Specialist (Network Services)	Austin, TX
P3	2210	13	IT Specialist (Data Management)	TBD - Washington, DC or Salt Lake City, UT or Albany, NY, etc
P3	301	9T 11	Staff Assistant	Eatontown, NJ
P3	2210	13	IT Specialist (Requirements Analyst)	Eatontown NJ; Albany, NY; Bay Pines, FL; Birmingham, AL; Tuscaloosa, AL; Dallas, TX; Hines, IL; Martinsburg, WV; Oakland, CA;
P3	2210	13	IT Specialist (Requirements Analyst)	Eatontown NJ; Albany, NY; Bay Pines, FL; Birmingham, AL; Tuscaloosa, AL; Dallas, TX; Hines, IL; Martinsburg, WV; Oakland, CA;
P3	2210	13	IT Specialist (Requirements Analyst)	Eatontown NJ; Albany, NY; Bay Pines, FL; Birmingham, AL; Tuscaloosa, AL; Dallas, TX; Hines, IL; Martinsburg, WV; Oakland, CA;
P3	2210	13	IT Specialist (Requirements Analyst)	Eatontown NJ; Albany, NY; Bay Pines, FL; Birmingham, AL; Tuscaloosa, AL; Dallas, TX; Hines, IL; Martinsburg, WV; Oakland, CA;
P3	2210	13	IT Specialist (Requirements Analyst)	Eatontown NJ; Albany, NY; Bay Pines, FL; Birmingham, AL; Tuscaloosa, AL; Dallas, TX; Hines, IL; Martinsburg, WV; Oakland, CA;
P3	2210	13	IT Specialist (Project Planner)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL
P3	2210	13	IT Specialist (Project Planner)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL

P3	2210	13	IT Specialist (Project Planner)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL
P3	2210	13	IT Specialist (Project Planner)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL
P3	303	7	Program Support Assistant	Ann Arbor, MI
P3	2210	13	IT Specialist (Project Manager)	Ann Arbor, MI
P2	2210	11T 12	IT Specialist (Customer Support)	Clarksburg, WV
P2	2210	13	Supv, IT Specialist (Facility CIO)	Lebanon, PA
P2	2210	9	IT Specialist (Customer Support)	Wilmington, DE
P2	2210	13	Supv, IT Specialist (Chief Operation Officer)	Bronx, NY
P2	2210	11	IT Specialist (Customer Support)	Bronx, NY
P1	2210	9	IT Specialist (Customer Support)	Virtual
P2	2210	11	IT Specialist (Systems Analyst)	Baltimore, MD
P2	2210	7T 9T 11	IT Specialist (Customer Support) Intern	Martinsburg, WV
P2	2210	13	IT Specialist (Network Services)	Austin, TX
P1	2210	12T 13	IT Specialist (Customer Support)	Austin, TX
P2	2210	7T 9T 11	IT Specialist (Customer Support)	Hines, IL
P1	2210	11	IT Specialist (Customer Support)	Washington DC Metro Area
P3	2210	14	Supv, IT Specialist (Assistant Chief, Technical Support Div)	Philadelphia, PA
P2	2210	9	IT Specialist (Customer Support)	Coatesville, PA
P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA
P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA
P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA
P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA
P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA

P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA
P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA
P3	2210	13T 14	IT Specialist (IT Project Manager)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL; Northern VA
P3	2210	14	Supv, IT Program Manager	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL
P3	2210	14	Supv, IT Specialist (Tech Writer)	Eatontown, NJ; Albany, NY; Silver Spring, MD; L'Enfant Plaza, DC; Martinsburg, WV; Birmingham, AL; Bay Pines, FL; Tuscaloosa, AL; Dallas, TX; Oakland, CA; Salt Lake City, UT; Hines, IL
P2	2210	9	IT Specialist (Infrastructure Spt - Customer/Network)	El Paso, TX
P2	2210	9	IT Specialist (Customer Support)	Prescott, AZ
P2	2210	9	IT Specialist (Customer Support)	Tucson, AZ
P2	2210	9T 11	IT Specialist (VistA Apps/Accounts)	Cheyenne, WY
P2	2210	11	IT Specialist (Video Conf Coordinator)	Seattle, WA
P2	2210	9	IT Specialist (Customer Support)	Palo Alto, CA
P3	2210	9	IT Specialist (Desktop Support, App/Cust Sup)	Loma Linda, CA
P2	2210	9	IT Specialist (Desktop Support, App/Cust Sup)	Loma Linda, CA
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Augusta, GA
P2	2210	9T 11	IT Specialist (Network Services)	Charleston, SC
P2	2210	12	IT Specialist (Systems Manager)	Augusta, GA
P2	2210	11	IT Specialist (LAN Manager)	Augusta, GA
P2	2210	9	IT Specialist (Desktop Support)	Augusta, GA
P2	2210	11	IT Specialist (Application Software)	Boston, MA
P2	2210	11	IT Specialist (Customer Support)	New Orleans, LA
P3	2210	5T 7T 9	IT Specialist (Customer Support)	Tampa, FL
P2	2210	11	IT Specialist (Customer Support)	Bay Pines, FL
P2	391	11	IT Specialist (Customer Support)	Bay Pines, FL
P2	2210	13	Supv, IT Specialist (Assistant FCIO)	Salem, VA
P2	2210	12	Supv, IT Specialist	Salem, VA
P2	341	12T 13	Administrative Officer	
P2	2210	11	IT Specialist (PC Team)	Phoenix, AZ
P2	2210	9	IT Specialist (PC & Printer Team)	Fresno, CA
P2	2210	11T 12	IT Specialist (Backoffice Telecomm Team)	Phoenix, AZ
P2	2210	7T 9	IT Specialist (PC Team)	Salt Lake City, UT
P3	2210	7T 9	IT Specialist (Help Desk)	Pittsburgh, PA
P2	2210	12T 13	Supv, IT Specialist (FCIO)	Coatesville, PA
P2	2210	11	IT Specialist (Hardware Technician)	Lexington, KY
P3	2210	13	Supv, IT Specialist (Policy and Planning)	Arlington, TX
P3	2210	12T 13	IT Specialist (Project Manager)	Virtual
P3	2210	12T 13	IT Specialist (Project Manager)	Virtual
P3	2210	12T 13	IT Specialist (Project Manager)	Virtual
P2	2210	11T 12	IT Specialist (Operation Systems)	Virtual
P3	2210	14	Supv, IT Specialist (Facility CIO)	West Haven, CT
P2	2210	13	Supv, IT Specialist (FCIO)	Big Spring, TX
P3	2210	9	IT Specialist (Customer Support)	Indianapolis, IN

P2	2210	9	IT Specialist (Budget/Help Desk)	Saginaw, MI
P2	2210	9	IT Specialist (Customer Support)	Tucson, AZ
P2	2210	9	IT Specialist (Customer Support)	White City, OR
P3	2210	13	Supv, IT Specialist (FCIO)	Portland, OR
P2	2210	12	IT Specialist (Customer Support)	Cincinnati, OH
P2	2210	12	IT Specialist (VistA Imaging Manager)	Louisville, KY
P2	2210	11	IT Specialist (Application Software) VistA	Louisville, KY
P2	343	12	Management and Program Analyst	
P2	303	5	Program Support Assistant	
P2	2210	13	Supv, IT Specialist (Office Support)	Ann Arbor, MI
P2	2210	5T 7T 9	IT Specialist (Desktop Support)	Mountain Home, TN
P1	2210	11	IT Specialist (Interface Administrator)	Lexington, KY
P2	2210	13	Supv, IT Specialist (Chief Operation Section IT Specialist)	Philadelphia, PA
P2	2210	11	IT Specialist (Technical Security Specialist)	Philadelphia, PA
P2	2210	13	Supv, IT Specialist (Operations Section)	Philadelphia, PA
P2	2210	9	IT Specialist (Customer Support)	Ann Arbor, MI
P2	2210	11	IT Specialist (Network)	673
P2	2210	11	IT Specialist (LAN Administrator)	Beckley, WV
P1	2210	11	IT Specialist (Customer Support)	East Orange, NJ
P1	2210	11	IT Specialist (Customer Support)	East Orange, NJ
P2	2210	11	IT Specialist (Application Software)	Perry Point, MD
P2	2210	11	IT Specialist (Customer Support)	San Diego, CA
P3	2210	11	IT Specialist (Customer Support)	Seattle, WA
P3	2210	11	IT Specialist (Customer Support)	Seattle, WA
P2	2210	11	IT Specialist (Application Software)	Muskogee, OK
P2	2210	11	IT Specialist (Customer Support)	Nashville, TN
P1	2210	13	IT Specialist (System Administrator)	Quantico, VA
P3	2210	12	IT Specialist (Customer Support)	Boston, MA
P1	2210	14	Supv, Oracle and UNIX Support Div	Quantico, VA
P1	343	7T 9	Management and Program Analyst	
P1	2210	11T 12T 13	IT Specialist (UNIX Engineer)	Quantico, VA
P1	2210	11T 12T 13	IT Specialist (System Administrator)	Quantico, VA
P1	2210	12T 13	IT Specialist (Oracle DBA)	Quantico, VA
P3	2210	14	Supv, IT Specialist (Network)	Philadelphia, PA
P3	2210	13	IT Specialist (Internet)	Philadelphia, PA
P2	391	12T 13	IT Specialist (Telephone Voice Engineer)	Eatontown, NJ or Washington, DC
P2	391	12T 13	IT Specialist (Telephone Voice Engineer)	Eatontown, NJ or Washington, DC
P2	2210	14	Supv, IT Specialist	Minneapolis, MN
P3	2210	14	IT Specialist (Test Center Operations)	TBD
P3	2210	14	IT Specialist (Systems Analysis) Performance Tester	TBD
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Charleston, SC
P2	2210	14	IT Specialist (Collaborative Service)	Eatontown, NJ or Washington, DC
P1	343	13	Management and Program Analyst	Virtual
P2	2210	13	IT Specialist (Business Office Manager)	Virtual
P2	2210	13	IT Specialist (Campus Support Team Lead)	Hines, IL

P3	2210	13	IT Specialist (Performance Tester)	Eatontown NJ; Albany, NY; Bay Pines, FL; Washington Metro area DC
P3	2210	13	IT Specialist (Performance Tester)	Eatontown NJ; Albany, NY; Bay Pines, FL; Washington Metro area DC
P3	2210	13	Supv, IT Specialist	Denver, CO
P2	343	14	Supv, Management and Program Analyst	Washington DC Metro Area
P2	2210	11	IT Specialist (Web Developer)	Denver, CO
P2	2210	11	IT Specialist (Customer Support)	Billings, MT
P1	2210	13T 14	IT Specialist (Project Manager)	Washington DC Metro Area
P1	2210	13T 14	IT Specialist (Project Manager)	Washington DC Metro Area
P1	2210	13T 14	IT Specialist (Project Manager)	Washington DC Metro Area

P1	343	14	Management and Program Analyst	Washington DC Metro Area
P1	301	9T 11	Staff Assistant	Washington DC Metro Area
P1	2210	12	IT Specialist (System Administrator)	Virtual
P1	2210	12	IT Specialist (System Administrator)	Virtual
P1	2210	12	IT Specialist (Database Manager)	Virtual
P3	341	12	Supv, Administrative Officer	Durham, NC
P2	2210	7T 9T 11	IT Specialist (Desktop Support)	Washington DC Metro Area
P2	2210	7T 9T 11	IT Specialist (Desktop Support)	Washington DC Metro Area
P2	2210	9T 11	IT Specialist (PC Support)	North Chicago, IL
P2	2210	7T 9T 11	IT Specialist (Desktop Support)	Baltimore, MD
P1	301	7T 9T 11	Staff Assistant	Bay Pines, FL
P2	2210	7T 9T 11	IT Specialist (Help Desk Support)	Baltimore, MD
P1	2210	13	IT Specialist (Functional Analyst)	Washington DC Metro Area
P1	2210	13	IT Specialist (Data Architecture)	Washington DC Metro Area
P3	2210	13	IT Specialist (Project Manager)	Eatontown, NJ; Northern VA; Washington DC metro; Albany, NY; Martinsburg, WV; Silver Spring, MD; L'Enfant Plaza; Birmingham, AL; Dallas, TX; Hines, IL; Oakland, CA; Salt Lake City, UT; Tuscaloosa, IL
P2	2210	8	IT Specialist (Customer Support)	Jackson, MS
P2	2210	9	IT Specialist (Customer Support)	Jackson, MS
P2	2210	13	IT Specialist (Health Solutions)	TBD
P2	2210	13	Supv, IT Specialist	Jackson, MS
P2	2210	9	IT Specialist (Customer Support)	Jackson, MS
P2	335	7	Computer Assistant	St. Louis, MO
P2	2210	12	IT Specialist (Application Software)	Virtual
P2	2210	12	IT Specialist (Server Mgmt Spt)	Harlingen, TX
P2	2210	11	IT Specialist (Customer Support)	Harlingen, TX
P2	2210	11	IT Specialist (Network)	Harlingen, TX
P2	2210	7T 9	IT Specialist (Customer Support)	Temple, TX
P2	2210	7T 9	IT Specialist (Customer Support)	Temple, TX
P2	2210	11T 12	IT Specialist (Network)	Des Moines/Iowa City, IA
P2	2210	9	IT Specialist (Customer Support)	Virtual
P2	2210	9	IT Specialist (Customer Support)	Minneapolis, MN
P2	2210	13	Supv, IT Specialist	Des Moines, IA
P1	2210	13	IT Program Analyst	Virtual
P3	2210	13	IT Specialist (Data Management)	Virtual
P3	301	7T 9	Program Specialist (Video-conferencing Specialist)	Durham, NC
P2	2210	5T 7T 9	IT Specialist (Customer Support)	Grand Junction, CO
P2	2210	9	IT Specialist (Customer Support)	Tampa, FL
P2	2210	9	IT Specialist (Customer Support)	Tampa, FL
P2	2210	9	IT Specialist (Customer Support)	Tampa, FL
P2	2210	9	IT Specialist (Customer Support)	Tampa, FL

Response. OI&T request for FY 2012 does not request an increase in FTE. OI&T is currently understaffed and faces employment turnover rates of about 10%. The effort to hire 705 new employees is intended to bring staffing levels to where they should be. This effort would get OI&T hiring on track, not increase FTE.

Question 3. The Virtual Lifetime Electronic Record (VLER) is one of the President's initiatives for VA/DOD. According to the fiscal year 2012 budget request: "Both VA and DOD have agreed that the objective for VLER is to establish a coherent, lifetime electronic record that will capture Servicemember/Veteran information from accession into military service to interment and until the last benefit is administered. VLER will include all information necessary to provide medical care, services, benefits, and compensation to the Veteran, eligible family members, or eligible beneficiaries."

A. What steps will be or have been taken by VA to improve upon the program, as recommended in the February 2011 GAO Report on Electronic Health Records?

Response. The Virtual Lifetime Electronic Record (VLER) program has often been so closely linked to the Electronic Health Record (EHR) modernization initiative as to become synonymous. It is important to understand that VLER is closely aligned with but unique from the EHR initiative. VLER is an interoperable and communication environment where by health, benefits and administrative information may be electronically accessed by every Servicemember, Veteran and/or their beneficiaries. The VLER environment is structured to support the secure exchange of health, benefits and administrative information between public and private partners. Health, benefits and administrative information resides in many DOD and VA systems. VLER ensures that regardless of the information source, policies, regulations, and

procedures are put into place to secure and protect the information accessed or exchanged, and the terminologies, definitions, and terms are clearly presented.

NATIONAL CEMETERY ADMINISTRATION

Question 1. The budget request for fiscal year 2012 under Operations and Maintenance for Other Services is $86 million. Please provide a detailed itemized list of how these funds would be spent during fiscal year 2012. To the extent that these funds will be spent on contracts, please explain the nature of the contract and the expected outcomes.

Response. The following chart provides a list of projects funded under Other Services:

Category	Cost ($M)	Description
National Shrine Projects	$32.9	Contracts to raise, realign, and clean headstones/markers and repair sunken graves.
Road and Grounds Maintenance	33.6	Contracts to maintain and repair roads, sidewalks, and other property. Contracts for mowing and trimming, snow removal from streets and sidewalks, and tree pruning.
Non-Recurring and Recurring Maintenance and Projects.	2.5	Contracts to maintain and repair buildings and other structures.
Equipment Maintenance	0.5	Maintaining and repairing cemetery and office equipment.
Operational and Other Services	12.7	Contractual services for cemetery operations, including security services, trash removal, and pest control. Contractual services for customer satisfaction surveys. Also includes payments to other VA staff offices for centralized support activities and to the Defense Finance and Accounting Service for payroll processing costs.
Janitorial Services	1.4	Contracts for janitorial and cleaning services.
Compensated Work Therapy	0.8	Payments made for participation in the Compensated Work Therapy program.
Franchise Fund Payments	0.7	Payments based on service level agreements for centralized financial services and security services (background investigations, ID badges, etc.).
Employee Relocations	0.5	Payments for storage of household goods and relocation services.
Training	0.4	Tuition for attendance at training courses.
Total	$86.0	

Question 2. In Volume III page 1B–10, there is a chart entitled "Employment Summary-FTE by Grade." The request for fiscal year 2012 for SES employees is 11, an increase of 4 SES employees over fiscal year 2011 and an increase of 7 over fiscal year 2010.

A. Please explain why the National Cemetery Administration (NCA) needs 4 additional SES level employees.

Response. The new SES positions reflect the growing scope and complexity of NCA operations. We are not requesting any additional funding or FTE for the positions.

Five of the seven positions are for our regional office directors. Workload has increased considerably in the field. For example, in the last decade NCA has opened 15 new national cemeteries, a national training center, and a national scheduling center.

Another of the new positions is for the Memorial Program Service director. In FY 2010, this office processed nearly 400,000 headstone/marker applications and over 800,000 Presidential Memorial Certificates. Its responsibilities have expanded to include the First Notice of Death function and the new medallion benefit.

The final position restores an SES management slot that was available to NCA prior to FY 2010.

B. What functions will they perform?

Response. These new positions are necessary to reflect current management requirements and will ensure the recruitment and retention of top managers.

Question 3. For fiscal year 2012, the amount requested for travel for NCA is the same as the current expected travel expenditures during fiscal year 2011, over $2.7 million. How often do and how many people are eligible for travel?

Response. NCA's 2012 travel budget is straight-lined from the 2011 request, despite increased costs associated with all modes of transportation. NCA is a national organization with 131 cemeteries in 39 states and Puerto Rico; oversight of grants made to states for state Veterans cemeteries in 38 states, Guam and Saipan; a national training center; and a national scheduling center. Travel funding is critical to ensure appropriate operational oversight, training, and organizational communication. Employee travel is approved based on program and training requirements. Approximately 480 NCA employees travel in a year. Some employees travel once a year, while others travel several times a year.

Question 4. In Volume III page 1B–15, the explanation for the budget line Transportation of Things reflects that "costs include the transportation of household goods as part of permanent change of station moves of transferring employees." For fiscal year 2012, what percentage of the Transportation of Things budget would be used for employee relocation costs?

Response. In FY 2012, an estimated 26 percent of the Transportation of Things budget line will be used for employee relocation costs.

Response to Posthearing Follow-up Questions Submitted by Hon. Richard Burr to U.S. Department of Veterans Affairs

Question 1. Question 1 regarding VA's Housing program asked VA to explain why the Housing program was projecting to spend $790,000 more on Other Services during fiscal year 2011 than VA had originally requested for Other Services for that fiscal year. In response, VA indicated that "Payroll savings from elimination of the 2011 pay raise were realigned to Other Services to fund a job task analysis for loan production specialists."

a. Was the purpose of the pay freeze to reduce the deficit and, if so, is this use of funds consistent with that purpose?

Response. The President's memorandum of December 22, 2011, regarding the freezing of Federal employee pay schedules states its purpose, "as the first of a number of difficult actions required to put our Nation on a sound fiscal footing." The 2011 estimates included in the 2012 budget reflect the Department's best estimates consistent with the guidance and funding levels appropriated to the Department by Congress in the Continuing Resolution in effect at that time.

b. How much in total does VA expect to realize in payroll savings during fiscal year 2011?

Response. The 2011 advance appropriation for VA medical care included $237 million for the employee pay raise, and $49 million of this amount was rescinded in Public Law 112–10. VBA reallocated $16 million in pay savings across all business lines. Those allocations were primarily for contract services to improve delivery of benefits and services to Veterans. All other payroll accounts were ultimately funded at the 2010 level by Public Law 112–10, which did not include funding for an employee pay raise and was at levels substantially lower than the 2011 President's Budget request; thus, there are no other payroll savings in 2011.

c. VA-wide, how much in total of the fiscal year 2011 payroll savings were realigned for other purposes?

Response. Please see the response to 1.b., above.

d. Please provide a detailed account of how any payroll savings expected to be realized in fiscal year 2011 have been or will be spent.

Response. Please see the response to 1.b., above.

Question 2. Under the category "General," question 5(D) asked VA whether the fiscal year 2012 budget includes funding for benefits that are projected to be overpaid and not recouped. In part, VA responded: "In the calculation for the FY 2012 President's Budget request, the Readjustment Benefits account is projecting a *net increase* of $7.2 million in obligations associated with overpayments. This projection is based on historical trends and updated each budget cycle." (Emphasis added.)

a. What is the total amount included in the Readjustment Benefits account for fiscal year 2012 associated with overpayments?

Response. The total cumulative overpayments for the Readjustment Benefits account are estimated to be $390.7 million at the end of fiscal year (FY) 2012. This cumulative amount includes overpayments from prior fiscal years.

b. Please explain the relevant historical trends over the past 5 years.

Response. From FY 2006 to FY 2009, the cumulative overpayments ranged from $111 million to $121 million for the Readjustment Benefits account. Cumulative overpayments increased to $375 million FY 2010, primarily resulting from one-time advance education payments, most of which have already been recouped. The estimated FY 2012 overpayments of $390.7 million are also cumulative. Overpayments occur more frequently and in larger amounts under the Post-9/11 GI Bill program because of the way the program is designed. Tuition and fee payments are made at the beginning of the academic term, often before students have adjusted their courses. For example, if a student withdraws from a course after VA issued a payment, an overpayment is created. When changes like this occur, overpayments are unavoidable. While adjustments like this are inherent in the program, overpayments may be collected in the future and are not identified as funds that VA does not expect to recoup.

Question 3. Under the category "General," question 5(E) asked whether any performance measures for regional office personnel take into account the amount of unrecovered benefit overpayments attributable to their errors. VA responded that "VA systems do not track this information."

a. Will any planned technological improvements include the ability to track this type of information? If so, when will this type of information be available?

Response. Almost all compensation and pension awards have been converted to VETSNET. Currently, no adjustment reasons exist in VETSNET to record administrative error awards or the adjustment period. Compensation Service is developing new business rules that will allow award adjustments due to administrative errors to be specifically identified. These changes will be part of future VETSNET Awards releases targeted for 2012.

The goal of this VETSNET Awards design change is to add details regarding any amount of benefits incorrectly paid for a specific period.

b. In the meantime, what steps will VA take to hold employees accountable for unrecoverable overpayments resulting from their errors?

Response. Secretary Shinseki has set an aggressive goal to achieve 98 percent accuracy for all rating decisions by the end of FY 2015. Compensation Service is dedicated to meeting this aggressive goal for our Veterans. However, due to the complexity of the claims process, there will always be a certain number of human errors.

Currently, errors are tracked through historical data collection in our computer applications and through claims quality assurance provided by Systematic Technical Accuracy Review (STAR). STAR reviews individual claims and identifies employee errors using established VA employee performance standards for Veterans Service Representatives, Rating Veterans Service Representatives, and Decision Review Officers. As part of these reviews, STAR identifies specific errors in claims processing so individual employees may receive additional training and guidance in those specific areas. STAR reviews also examine administrative decisions and the approval process for those decisions, which may include possible overpayments. Compensation Service is dedicated to meeting the Secretary's goal for accuracy by providing the best possible training and guidance for our VA employees, both collectively and as individuals.

Question 4. Under the category "Compensation and Pension," questions 22(A) and (B) asked VA about an initiative to extend routine future disability examination requests to five years. In response to those questions, VA indicated that it does not have information about how often these types of examinations reveal a change in the veteran's level of disability or about how many veterans would potentially be overpaid or underpaid as a result of this initiative. Please explain what factors were considered in determining to move forward with this initiative.

Response. In 2010, Compensation Service issued Fast Letter (FL) 10–14, Procedural Change Regarding Routine Future Examinations, which modified Compensation Service claims-processing procedures for scheduling Veterans' routine future examinations. Routine future examinations are now scheduled at five-year intervals instead of two-year intervals. Factors considered in determining to move forward with this initiative included:

- Eliminating over 80,000 routine future examinations over the course of three years; and
- Freeing resources to improve the timeliness of processing of other Veterans' claims.

Question 5. Under the category "Board of Veterans' Appeals," VA was asked in question 5 about VA's publication of an annual Veterans Law Review. VA indicated that "employees who contribute [to the Law Review initiative] do so *largely* on their

own time" (emphasis added). In response to questions on VA's fiscal year 2011 budget request, VA indicated that "[a]pproximately 70 attorneys and Veterans Law Judges volunteer their *non-duty* time to edit and publish the Veterans Law Review each year" (emphasis added).

a. Please clarify whether employees of the Board of Veterans' Appeals use duty-time to perform activities related to the law review.

Response. Employees of the Board of Veterans' Appeals do not use duty time to perform writing or editing for the Veterans Law Review (VLR); all writing and editing is voluntary and is conducted on non-duty time.

With respect to other VLR activities, to include planning meetings and forms/citations training, the use of duty time is nominal to none, as these activities are largely scheduled during non-duty time. Approximately 5 times per year, the lead team of VLR editors, which consists of approximately 10 individuals, must meet to discuss scheduling, the selection of pieces for publication, and other issues that may arise, for which the Board provides meeting space. The three supporting teams of editors, consisting of the remaining 60 volunteers, must also meet approximately 2–3 times during the year. Finally, VLR provides a forms and citation training once annually. VLR is committed to scheduling these meetings and the training during non-duty time, e.g., during lunch breaks, although, at times, these activities may carry over to or fall within duty time for brief periods.

b. If so, how much time on an individual and total basis do VA employees devote to this activity?

Response. The approximately 70 employees involved with the VLR spend no hours of duty time on writing or editing for the VLR. With respect to the other VLR activities, the 10 lead editors devote no more than 5–6 hours annually to their meetings, and the three supporting teams of editors devote approximately 1–2 hours annually to their meetings. The forms and citations training is conducted over a 1 hour period annually. As noted above, nominal to no duty time is devoted to the VLR, as the activities are to be scheduled for non-duty time, although, on occasion, these activities may briefly carry over to or fall within duty time.

Question 6. Under the category "General," VA was asked in question 2 about the sentiment from the Commission on Fiscal Responsibility and Reform that "[e]verything has to be on the table" with regard to fiscal reform. VA's response indicated that, "[i]n the past two years, we have established and created management systems, disciplines, processes, and initiatives that help us eliminate waste."

a. How much has VA saved as a result of these "management systems, disciplines, processes, and initiatives?"

Response. Please see the chart below for an accounting of the estimated savings included in VA's budget submission. Descriptions that further detail each item are included in Volume 2 of VA's congressional budget submission beginning on Page 1A–14.

VHA Operational Improvements ($M)	2011	2012	2013
Fee Care Payments Consistent with Medicare	($275)	($315)	($362)
Fee Care Savings	($150)	($200)	($200)
Clinical Staff and Resource Realignment	($44)	($151)	($151)
Medical & Administrative Support Savings	($100)	($150)	($150)
Acquisition Improvements	($177)	($355)	($355)
VA Real Property Cost Savings & Innovation Plan	$0	($66)	($66)
Subtotal, Operational Improvements	($746)	($1,237)	($1,284)

b. Did the funds realized from these savings go to deficit reduction? If not, for what purposes were these funds realigned?

Response. The estimated savings identified above are a vital component of VA's multi-year budget planning, and contribute to deficit reduction efforts.

Question 7. In the category "Office of Human Resources and Administration," VA was asked in question 1(C): "What metrics are used to determine which staff needs to travel?" VA responded:

Response. Our travel cost is executed against [VA Learning University (VALU)] sponsored training programs derived from a requirements process that identifies critical training needs and fills training gaps identified by the VA Administration(s) and VA Staff Offices. VALU also provides training to the field in centralized loca-

tions where there are areas of high concentration of VA employees allowing for a reduction in expected travel that would have been incurred to support the training efforts.

When it is necessary for staff to travel, what metrics are used to determine which staff needs to travel?

Response. VALU provides training venues and travel resources to support the Veterans Affairs mission and business objectives through high quality, continuous learning, development that enhances leadership, occupational proficiencies, and personal growth. Individuals are designated for training based on individual development plans (IDP), specific functional training needs identified by department or administration and also may select cross cutting core competency training and leadership training which collectively address most of the VALU portfolio. The number of training events offered by VALU depends on several factors including courses identified through the requirements process, technical training conferences, transformational leadership and supervisor/manager training needs. Total course load is built based on resourcing and need. Individuals fill the available seats by registering thru Talent Management System and getting supervisor approval. The number of train ings an individual may attend is based on availability and approval. Total number of individuals training during a year is compared to targets set by leadership. Technical training conferences and leadership training typically require face to face training which dictates travel. Increasingly VALU is introducing virtual training and social media to reduce need for travel.

Question 8. Also in the category "Office of Human Resources and Administration," VA was asked in question 5(C) about the effectiveness of the Health and Wellness initiative in "promoting healthier employees." VA stated that the program is still in the baseline year and the program's effectiveness will be evaluated in six months and at the end of the fiscal year. What metrics will be used to determine if the program is "promoting healthier employees?"

Response. While still in the baseline year, during the past six months VA Wellness Is Now (WIN) has implemented several aggressive promotional campaigns, organized a national event, and developed partnerships with the national unions, nursing services and the National Partnership Council. Metrics used to evaluate the program come from the online database which tracks many key elements such as health risks (smoking, obesity, hypertension and others). There has been a steady rise in completion of the online Health Risk Assessment (HRA) with 30,000 employees completing them (11% of the VA population, up from 5% in the last quarter). VA WIN's first national "2K Walk & Roll" event, which was led by the VA's Deputy Secretary, had 155 sites and over 16,847 employees participating in the event. VA WIN has developed useful "tools" for employees such as guidebooks to help motivate, get employees exercising and moving and to support their emotional well-being. A new satisfaction survey is being added to the database so we can better evaluate if the program is meeting our goals for employee satisfaction and promoting healthy employees. A complete update on the program will occur at the end of the fiscal year incorporating all elements of VA WIN.

Question 9. Under the category "Office of Public and Intergovernmental Affairs," VA was asked in question 1(B): "What indicators would suggest whether additional staffing increases are warranted?" VA responded:

> The new employees will be supporting the Office of Tribal Government Relations; Paralympic Program Office; Homeless Veterans Initiatives and Outreach Program offices.

Please clarify what indicators VA uses to determine whether additional staffing increases are warranted for this office.

Response. The National Veterans Outreach Office (NVO) was established within the Office of Public and Intergovernmental Affairs in 2010. NVO's mission is to assess, standardize and coordinate outreach activities for the entire Department of Veterans Affairs. The office is developing outreach plans, web resources and training to assist VA administrations and program offices in unifying outreach communications through clear, accurate, consistent and targeted messaging. The Office is also providing project management of significant marketing and advertising contracts to ensure Veterans and their families are aware of benefits and services, and is working to develop a system to track department-wide performance measures for VA's outreach programs. In addition, the office is responsible for coordinating an annual Outreach summit; the report on the outcomes of VA outreach programs to the Secretary of Veterans Affairs, Congress, Veterans Service Organizations, and other interested stakeholders, and the American people.

When NVO was initially set up, the Office was authorized a total of three FTE which include a GS–15 director; a GS 13/14 Program Specialist, serving as deputy director; and a GS 12/13 program specialist. It has quickly become apparent that the size and complexity of the office's workload is greater than initially anticipated. Departments and offices throughout VA are relying on NVO for support, approvals and advice for their advertising and marketing initiatives, and Members of Congress, the news media and others are expecting considerable information about VA's outreach efforts—frequently with short turnaround times. Because much of this information is both time-sensitive and proprietary to the enterprise, it should not be provided by contractors, but only by VA staff. In addition many of the decisions and recommendations NVO has been required to make cannot be delegated to contractors. The two existing staff members are working tirelessly to ensure all deadlines and expectations are met, however, once many of these plans are implemented, the workload will grow exponentially.

The VA Parlaympic Office is responsible for the monthly allowance to Veterans who are eligible and meet the qualifications. To process these applications the VA must work closely with the United States Olympic Committee (USOC) and Veterans Benefit Administration. This requires checks and balances to ensure that claims are processed in a timely manner and meet the intent of the law. This not only requires working with VBA but also the Veteran athlete and the coaches at the USOC. The VA Paralympics Program Office needs to verify that the Veteran is training on a daily/weekly basis and meets the standards set forth by USOC and its governing bodies to be a Paralympic athlete. The VA Paralympic Program office also manages the grant program that was established by Pub. L. 110–389. This requires that the office ensures that the grants are administrated in accordance with VA and other Federal regulations.

The Office of Tribal Government Relations (OTGR) engages in intergovernmental efforts focused on increasing American Indian and Alaskan Veterans' access to health care and benefits (enrollment, interagency collaboration for health care service delivery), promoting economic sustainability through outreach focused on awareness of Veteran-owned small business opportunities, the Native American Direct Home Loan program, the Post-9/11 GI Bill, and facilitating increased access to compensation and benefits. OTGR has a geographically, culturally and politically diverse mandate to work with 565 distinct political entities. American Indians and Alaska Natives serve in the United States military at a rate higher than any other ethnic group. Estimates are that of 1% of the US population are Veterans while approximately 15% of American Indians and Alaska Natives are Veterans. There are 565 federally recognized Tribes located in 38 states. The increase in FTEs would enable VA to expand its responsiveness in developing intergovernmental relations with tribal governments and improve efforts to extend VA's reach to Veterans living in Indian Country, much of which is located in rural or remote areas.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. As you continue to focus more on rural veterans and their unique needs. I wanted to stress to you the Alaska Native Health Care system. They have hospitals and clinics in very remote areas in my state and are very willing to provide health care and provide space for VA. I know your Department is working on the MOU with tribes. What is the status of the MOU and is it ready to be negotiated with the Alaska Native health entities?

Response. The VA-IHS Memorandum of Understanding (MOU) was signed by Dr. Robert Petzel, Under Secretary for Health, and Dr. Yvette Roubideaux, Director, Indian Health Service, on October 2, 2010. A number of areas are addressed in the MOU, including improving the delivery of care by sharing programs, increasing access to services and benefits, improving coordination of care, and increasing efficiency through sharing contracts and purchasing agreements. The MOU also focuses on the joint development of applications and technologies, as well as the implementation of new technologies such as tele-health. Additionally, this agreement focuses on increasing the quality of care through training and workforce development, attention to cultural competency, joint credentialing of staff, and sharing of contingency planning and preparedness efforts for emergencies and disasters. In order to accomplish the main goals of the MOU, 12 work groups have been established that have representation from both the VA and IHS. All of the work groups have met and most have developed action items and timelines for accomplishing their items. An implementation work group, led by Dr. Mary Beth Skupien, Director, Office of Rural Health, and a yet to be determined designee from IHS, will meet soon to dis-

cuss the submitted action items and procedures for administering the work groups. At this time, the MOU can be used in negotiations with Alaska Native health entities.

Question 2. Last February, I conducted Veterans' Affairs Committee hearing in Alaska, we heard from the VSO's about the time it was taking to get a response. Are you continuing to Broker the ratings to other states? I am hearing that this is still causing delay and hardship for veterans waiting for their benefits.

Response. The Anchorage Regional Office is currently brokering out claims for service-connected compensation benefits to the Salt Lake City, UT, and Ft. Harrison, MT, VA Regional Offices. Between the two offices, cases are brokered at a rate of approximately 145 per month. Anchorage has experienced a 32 percent increase in its pending workload since the beginning of FY 2011. Comparatively, the nationwide inventory has increased by 49 percent. These increases are due in significant part to the Secretary's decision to add three additional disabilities to the list of conditions presumed to be related to Agent Orange exposure for Veterans who served in the Republic of Vietnam. VA anticipates that as the Agent Orange-related claims are completed, both in Anchorage and nationwide, VA will reduce the pending inventory.

Question 3. As you are aware, VISN 20, more specifically Alaska has had a rural demonstration pilot project for outreach to rural veterans. Object of pilot was to reach veterans and inform them about veteran's benefits. The pilot was pulled to reaccess, focus groups were conducted, I have asked for the report and what the follow up will be on getting these vets information. Will you please tell me the status of the pilot in Alaska?

Response. The pilot was not pulled, but concluded at the end of FY 2010. The Veteran Focus Groups were completed in August 2010, and the report was received in September 2010. As a result of the August Congressional Delegation visit, it was determined that focus groups should also be conducted with the vendors. These were completed in December 2010, and the final report was received in late January 2011 evaluating both Veteran and provider results. Alaska leadership has met with the Director of the Alaska Area Native Health Service, IHS, DHHS and the CEO of the Alaska Native Tribal Health Consortium to begin a consultative process for the next steps to provide services to Alaska Native rural Veterans. In addition, a meeting is scheduled with the President/CEO of the Alaska Native Health Board which has experience with conducting tribal consultation between Federal and tribal entities. The report that you requested was forwarded to your staff via e-mail on March 10, 2011.

Question 4. VISN 20 is one of the fastest growing VISNs, our facilities in Alaska are seeing an increase in use, does the budget take into account the growing population of veterans and does the VISN believe that they have the adequate resources to serve Veterans?

Response. As the table indicates, both VISN 20 and Anchorage have higher growth than the VHA average when comparing unique patient growth from January 2010 to January 2011.

January 2010 to January 2011

Access Point	% Change in Unique Veterans Served
VHA	2.20%
VISN 20	4.80%
Anchorage	3.90%

The VHA budget takes into account the growing population of both Alaska and VISN 20. The FY 2011 Alaska operating budget was supplemented over $18M ($10 million from VHA; $8 million transferred internally from VISN 20) due to Alaska's purchased care cost structure. With this additional support, VISN 20 leadership believes it has adequate resources to serve Alaska's Veterans for FY 2011. However, with increased referral to the local community in the provision of oncology and other specialty care in the last few months, VISN 20 is currently evaluating what additional resources will be necessary to sustain this care in future years.

Question 5. My question is regarding the HUD VASH vouchers and the need to look at increasing them. In our newest CBOC in Juneau, there is a need for VASH vouchers; I am told they do not have a case manager to manage the vouchers. I recently cosponsored a Bill that will give the Secretary authority to contract with nonprofits to conduct the case management. The pilot in DC seems to be a good exam-

ple. Can you tell me what the obstacles are in utilizing legitimate non-profits and tribal agencies in supplying the needed case management?

Response. VA is able to contract with local organizations to ensure that homeless Veterans receive case management services. There are a few obstacles in utilizing outside agencies to provide case management services:

- In some geographic areas, particularly rural areas, VA medical centers are having difficulty finding viable partners to contract with for case management services.
- Ensuring that contract agencies have the same qualifications and meet the same performance standards as VA employees, that the services they provide are comparable to VA's, and that prospective community partners are knowledgeable about VA treatment and benefit services.

Question 6. What can Congress do to help you eliminate the benefits backlog?

Response. Congressional support of VA's FY 2012 budget request is essential to achieving our goal of eliminating the claims backlog. Funding is requested to support critical Claims Transformation initiatives designed to streamline our business processes and develop and deploy powerful 21st century IT solutions to simplify and improve claims processing for timely and accurate decisions. The cornerstone of VA's Claims Transformation Strategy is the Veterans Benefits Management System (VBMS). VBMS integrates a business transformation strategy to address process and people with a paperless claims processing system. Combining a paperless claims processing system with improved business processes is the key to eliminating the backlog and providing Veterans with timely and quality decisions.

VA's 2012 budget request also includes funding for the Veterans Relationship Management (VRM) initiative, another of VA's major transformation initiatives. VRM will provide Veterans, their families, and survivors with direct, easy, and secure access to the full range of VA programs through an efficient and responsive multi-channel program, including phone and Web services. VRM will provide VA employees with up-to-date tools to better serve VA clients, and empower clients through enhanced self-service capabilities.

As the incoming volume of claims continues to rise, it is also vitally important that Congress appropriate funds to support VBA's requested FTE level of 20,321. The disability claims workload from returning war Veterans, as well as from Veterans of earlier periods, is increasing each year. Annual claims receipts increased 51 percent when comparing receipts from 2005 to 2010 (788,298 to 1,192,346). We anticipate claims receipts of nearly 1.5 million in 2011 (including new Agent Orange presumptive claims) and more than 1.3 million in 2012.

Funding to support the requested FTE level and these innovative systems and initiatives will put VA on a path to achieving our ultimate goal of no Veteran waiting more than 125 days for a quality decision on his/her claim.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MIKE JOHANNS TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. My state staff often deals with veterans who have been waiting in the appeals process for over five years. These veterans are typically pre-9/11 veterans, with many from the Vietnam era. It appears that regional offices have specific goals for processing initial claims, but no such metric seems to exist for claims in the appeals process. Does the Department of Veterans Affairs establish singular management responsibility for a claim once it enters the appeal process?

Response. Regional Offices have nationally established goals for different stages of the appeals process. Goals are set in the following areas:

- Notice of disagreement (NOD) inventory: The total number of NODs pending at the end of the month.
- NOD average days pending: The average number of days from receipt of the NOD to current end of month.
- Form 9 timeliness: The average number of days from receipt of a substantive appeal until certification to the Board of Veterans' Appeals (BVA).

Achievements under these goals are measured and included in the regional office directors' yearly performance evaluations.

To ensure direct management responsibility for the appeals process, each regional office has a team of employees dedicated to processing the appeals workload. The composition of the local appeals team may vary, but typically includes Decision Review Officers (DRO), Rating Veterans Service Representatives (RVSRs), and Veterans Service Representatives (VSRs).

The DRO is a senior technical expert who is responsible for processing appeals. DROs hold many responsibilities including:

- Holding informal conferences and formal hearings with Veterans
- Evaluating the evidence of record including the need for additional evidence as a result of information obtained during the hearing
- Making direct contact with the appellants and their representatives
- Providing feedback to RVSRs on their initial decisions
- Playing a central role in employee development, including mentoring new rating specialists, participating in the training of RVSRs, and coordinating training opportunities with BVA and local medical centers
- Certifying appeals to the BVA and coordinating their transfer to BVA.

VBA's Appeals Management Center (AMC) has jurisdiction over most appeals remanded to VBA for additional action by BVA and the Court of Appeals for Veterans Claims. The AMC has approximately 180 employees whose sole focus is to process appellate remands.

Question 2. Additionally, how will new technology and a paperless system help resolve these longstanding claims that are stuck in the appeals process?

Response. The Veterans Benefits Management System (VBMS) is utilizing smart-scanning technology, which provides searchable PDFs and electronic data. Enhanced search capability allows for easy identification of key words to aid in the quicker review of evidence. Future functionality will support the linking of evidence to specific disabilities/key words, providing the reviewer with the capability to better organize documents/images for subsequent reviews. Utilizing business rules, VBMS will have tools to assist the reviewer with identifying gaps in the claim development process, consequently reducing premature advancement of a claim to the next step in the claims process. More significantly, the planned advanced rules-engine technology will assist decisionmakers with assigning disability evaluations based on predefined embedded evaluation criteria for disabilities in the current 38 CFR, Part 4, Schedule for Rating Disabilities. Incorporating these rating tools will support consistent and accurate disability decisions, which may reduce the number of cases entering the appeals process. These tools and capabilities will also directly support Decision Review Officers in carrying out their decisionmaking responsibilities on appealed claims decisions.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SCOTT BROWN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. I met with members of Massachusetts Chapter of Disabled American Veterans in my Boston office recently and listened to their concerns about the inadequate facilities at the VA Hospital in West Roxbury. It serves veterans from the entire North East Region, and is the highest level of care within its regional Veterans Integrated Service Network.

West Roxbury VA Hospital serves veterans from all over New England, but its operating room is too small for modern surgical equipment. As a result, the facility is in need for significant upgrades.

I am concerned that with a proposed 40% cut in VA construction in FY 2012 that the facility that has needed these improvements for many years will be one of the projects pushed to the side. Please provide me with an indication of where the West Roxbury VA Hospital stands on the list of modernization/recapitalization priorities for the VA and why.

Response. VA Boston HCS submitted, and Veterans Integrated Service Network 1 endorsed, a major construction project for consideration in fiscal year (FY) 2012 to modernize and enhance the West Roxbury campus, a tertiary care VA facility serving Veterans throughout New England.

The multi-story project would co-locate such critical as: operating rooms; intensive care units; emergency department; radiology (including a magnetic resonance imaging unit and computed tomography); instrument sterilization (supply, processing and distribution); and other ancillary services. The proposed addition would renovate existing building space to increase capacity to accommodate workload increases and improve clinical access. At present, the West Roxbury facility provides and will continue to provide safe, appropriate, and skilled care to our Veterans. Additionally, investments have been made to further enhance the facility's services. In the past three years, more than $20 million has been spent in improvements and repairs to the infrastructure and $36 million in equipment.

The proposed project was evaluated during the FY 2012 Strategic Capital Investment Planning (SCIP) review, along with other capital investment proposals submitted for consideration. The project was ranked seventh of the major construction. The four highest ranking major construction projects are included in the FY 2012 budget request. The West Roxbury project and the other projects not selected during

the FY 2012 SCIP process must be resubmitted in FY 2013 for funding consideration.

Chairman MURRAY. Thank you very much, Mr. Secretary. As you know, we have been called to vote. We have a few minutes to get to the Floor. I am going to call a short recess, approximately 10 minutes, and when I return we will begin with questions.

[Recess.]

Chairman MURRAY. We will reconvene this hearing. A number of Members are still on the Floor voting, and they will be returning shortly. We will now move to the question period with the Secretary.

Mr. Secretary, I have a great deal of respect for the work that you have done on homeless and women's issues, and I know you are working diligently in a number of ways, but I wanted to bring up an issue that I am very concerned about.

I have already discussed the caregiver issue with you. I have talked about it with Jack Lew. I have talked with senior staff at the White House, and I have spoken directly with the President of the United States. VA's plan on the caregivers' issue was overdue, and once submitted, it hardly resembled the bill that unanimously cleared this Congress. Three weeks ago, my Committee staff requested information on how that plan was developed, and to date, no information has been provided.

Rather than following the law, the Administration set forth some overly stringent rules, bureaucratic hurdles that would essentially deny help to caregivers.

Sarah and Ted Wade, who were staunch advocates and worked hard with us to get this passed, were invited by the President to attend the bill signing at the White House. Ironically, they will not be eligible for the new program under the plan that the Department submitted.

We are also hearing from a lot of other veterans and caregivers from across the country who fall outside of this new line in the sand the VA has drawn or who have been left in limbo and now do not know if this benefit that they advocated and worked so hard for will support them.

Mr. Secretary, it appears that your Department is not complying with the law as written. Can you please tell this Committee why?

Secretary SHINSEKI. Chairman Murray, let me begin by expressing my regret that the implementation plan was late getting to you. We did our best. We are looking forward at this point on how to accelerate the process.

I would also add that the importance of family in caring for our Nation's injured veterans has been a long-standing concern and issue for the VA; and, as you know, we have about eight decades of history of caring for the caregivers.

We have demonstrated this dedication to them in a wide range of ways over the years. Benefits that are already offered include education, training, homemaker, home health services, respite care, and family support services. But more than programs, we see it in the thousands of acts of compassionate care provided by VA employees on the front lines.

Through the caregivers bill enacted last year, thanks to the leadership—your leadership specifically but the leadership of Congress

as well—Congress and the President built on this foundation by establishing landmark new benefits for post-9/11 veterans that for the first time provide direct financial and broad health care support directly to the caregiver. We have not done this before, and we are working through the complexity of what this means.

Implementation of the more unprecedented features of the law has taken longer than I anticipated or would have liked. We understand the frustration that has been expressed on the part of some.

We have responded by greatly expediting the required regulatory process through the use of what I described as the interim final regulation, transmitted to the Office of Management and Budget on Monday.

I assure veterans and the Congress that the Administration will move quickly and, we plan to have direct-to-caregiver benefits in place this summer, early this summer.

We also understand the concerns that have been expressed with the scope of the benefit, as we have proposed, in our implementation plan. We have an obligation to get this right, to get this benefit right, and that means meeting the requirements of the law and also making sure that those VA employees on the front lines of caring for our veterans have a clear and consistent set of guidelines to apply.

It has been a challenging exercise. I will state that. It is my personal obligation to be able to explain to an injured veteran why he or she would not be eligible for this benefit while someone else in his or her company with similar injuries would be, and that is the standard we are trying to establish here.

That standard has guided our efforts to this point, and I hope remains in whatever standard we finally establish.

That said, I want to be clear we are absolutely open to suggestions for different places to draw that line than what we have put forward. What we put forward was a starting place, but the standard must work in the real world on the clinical front lines where differences exist; and combinations of injuries, mental and physical, are as unique as the veterans themselves.

To that end, Madam Chairman, VA is willing and I am willing to work with you and Members of this Committee and your staff and all the veterans and families who are represented and have a stake in this. I welcome the input both from you, Ranking Member Burr, and others in trying to develop clear, clinical guidelines for this program.

OMB is now reviewing the regulation. I will take this opportunity to encourage all with a stake in this important new program to provide us the benefit of their insights and their comments, and I will provide feedback to you at the appropriate time.

Chairman MURRAY. Thank you very much, Mr. Secretary. I know this is a new law. We considered that as we prepared it and wrote it and worked with many, many people to get it done. But I think it is absolutely imperative that in this time of war with OIF and OEF soldiers coming home seriously disabled, a generation of soldiers that are facing very long-term care with spouses, siblings or parents caring for them, that we make this right and make it right soon.

I am deeply concerned, first of all, in the lack of communication and the lateness in getting this to us. We are past that now, but we are at a very unfortunate stage. The rules have gone to OMB and may be out in a few months. Then implementation takes a while, and you are only now offering to let us look at different ways of writing the law.

So, we have a real challenge in front of us to be able to write it in the way Congress intended. If the rules come out as we saw the draft with the narrow definition, it will not be in keeping with the intent of Congress.

We are happy to work with you now to tell you what we feel should be implemented, but we are facing a seriously difficult challenge because of where it is today.

So I am very concerned about that and will have more to say about it. I think it is important to remember why we wrote this. We know that in every war soldiers come home and need care; but in this war, in particular, where we have saved the lives of many, many soldiers, they have come home with very seriously challenging issues to deal with, and their spouses or their parents are now required to quit their job, lose their income, and care for them. That was the reality behind the intent of Congress.

The narrowness we saw in your rules excludes many people who we believe Congress wrote the law to cover. So we are going to have to work on this.

But I wanted to ask you today, of $180 million that the budget submission specifies for the Caregivers and Veterans Act, how much is going to be actually allocated for the implementation of the family caregiver program?

Secretary SHINSEKI. In the 2012 budget, it is $66 million.

Chairman MURRAY. $66 million for the implementation.

The legislation authorized an average of $308.4 million for this program each year. Can you tell us why the VA is only planning to use about 21 percent of that?

Secretary SHINSEKI. Madam Chairman, I would just say that that again is where we established the start point. We expect this program will grow.

Chairman MURRAY. Pardon me.

Secretary SHINSEKI. We expect that this program will grow. The $66 million was based on our estimate of going through the veterans who are in various categories of serious and severe injuries, and the numbers on which $66 million are based was that initial eligibility start point, roughly about 1,000.

Chairman MURRAY. Very narrowly redefined though; not defined as the law was.

Secretary SHINSEKI. That is correct.

Chairman MURRAY. It was the intent of Congress that the law not be narrowly defined. So we have an issue between us on that one.

Secretary SHINSEKI. OK.

Chairman MURRAY. Let me ask one other question, and I will then turn to the Ranking Member, but we will have a lot more discussion about this caregiver bill.

I recently saw a newsletter written by the director of the Indianapolis VA medical center, talking about a variety of cost savings

initiatives that the VAMC will undertake. He indicated that he intended to seriously reduce bonuses but he also would be slowing the hiring of additional and replacement staff.

Will those types of cost savings actually result in the degradation of quality?

Secretary SHINSEKI. Madam Chairman, I am going to call on Dr. Petzel to address the specific issue there at Indianapolis. But what I would offer up front is that we now have a year-long budgeting dialog—the beginning of the year, midyear, and end of year—and there are adjustments made.

No VISN director of the 21 VISNs has come in and said they are unable to execute their program for the year, and we hold them responsible for balancing resources and requirements.

Dr. PETZEL. Thank you, Mr. Secretary.

Madam Chairman, the estimate, the letter that you read, which I also read, was an early estimate of what their budget might look like. Those estimates are refined almost weekly as medical centers begin to spend their money. If you were to look, in fact—we have asked what the estimate is now; it is substantially reduced.

As the Secretary has said, we review—here in Washington, he personally reviews with each one of the networks, their budgets, and how well their medical centers are doing.

We have no evidence that any medical center is not going to be able to meet their obligations and not going to be able to provide the kind of care that you and I expect.

Chairman MURRAY. Well, the Indianapolis director said that they were facing an $18 million budget gap this fiscal year.

Dr. PETZEL. That was the difference between what they wanted and what they got. It does not represent the difference between what they need and what they got.

So if you were to look, if we were to ask what is that gap now, we would find that is not $18 million. It has been substantially reduced, if not actually disappeared.

In addition to that, if that were true, if there were an $18 million shortfall between what they got and what they needed, the networks are able to make up those differences. They have reserve funds. The Secretary has a reserve fund. We have, as I said, reviews at least three times a year here in Washington of the financial state of each one of the medical centers. There would be money to take care of that.

Chairman MURRAY. How many VISNs currently are facing a budget shortfall?

Dr. PETZEL. None.

Chairman MURRAY. Quickly, on the issue of bonuses, I was surprised at the number of bonuses that were awarded last year. Among them, actually, was the director of the medical center in Dayton, OH, where there have been serious problems we have been hearing about: with respect to a dentist failing to practice basic hygiene and overall poor management of human resources in the dental clinic and other areas.

Apparently, he received more than $11,000 this year and $64,000 since 2006, with problems going on the entire time. Executives from other troubled medical centers received significant bonuses as well.

Mr. Secretary, I wanted to ask you. Are you going to be seriously reducing the number of bonuses paid the same way that the director of Indianapolis was forced to do?

Secretary SHINSEKI. Madam Chairman, let me start and then call on Dr. Petzel for any details.

I would offer that for the past 2 years, we have paid specific attention to the way bonuses are paid. Without making any statements about how it was run prior, I just did not find as close a connection between performance and bonuses.

I do believe bonuses have a real role to play in the compensation programs designed to encourage best behaviors, superior performance; and where that happens, I think there is justification for that.

For the past 2 years we have looked very closely at it and I am happy to provide you the details. You will see the "outstandings" and the number of bonus payments actually adjusted quite significantly.

To your direct question about Dayton, I cannot justify the performance of what happened at Dayton. I think there is a failure of leadership, and therefore, I am not going to try to describe why a bonus was sensible.

But suffice it to say, this issue came up because VA workers thought we had a problem. This went on for an extended period of time where it was not brought to the attention of leadership and, again, I attribute that to a failure in the leadership, that the climate was not conducive for the workforce to believe they could raise the issue and get a satisfactory response. I own that, and my responsibility is to correct that, and that is what we are doing.

Chairman MURRAY. OK. I appreciate that. Thank you.

Senator Burr.

Senator BURR. Thank you, Madam Chairman.

I have got a number of questions, Madam Chairman, and I am going to ask unanimous consent that I have the opportunity to send them all to the VA and have them respond for the record.

Mr. Secretary, I am going to spend my time now talking about the caregivers bill. I did not intend to do this, and there will not be questions.

I would like to tell you a story this morning. On an evening when the U.S. Senate alarms for some type of bio- or chemical-detection went off, all the doors were shut down, and Members and staff were hustled into the Russell garage for hours until we got the all-clear, that night I had an opportunity to meet a young man. He could hardly function.

He was a warrior back from Iraq, a kid that when they made the decision at Landstuhl to put him on a plane and fly him to the United States, there was not a health care professional in the room that believed he would live through that trip; and for that reason, he was discharged before he left because it was perceived that it would be advantageous to the family to have him discharged before.

There was only one problem; they never told Ted Wade. Ted lived. Ted got back because of an unbelievable spouse and family support. Ted continues to make progress every day. He will never get back to the kid he was.

It was Ted Wade and Sarah Wade that I think played the biggest part in the creation of the Caregiver Act. When we talked about passing the caregiver bill, I do not think that there was a Republican or Democrat on this Committee who did not look around and see Sarah and Ted Wade.

Sarah was tireless in her contributions to crafting the legislation to get it right so that at the end of the day we could look at the product we had produced and be proud, not just today but for the future, that this was going to affect families in ways that provided them the opportunity to invest in their family members who had committed so much.

Until this morning, it really was not raised to this level on my radar and when we wrote the legislation, we wrote it in a way that was pretty clear.

I have got to tell you, if I were you, I would pull it back from OMB; I would ask them not to comment. If I were you, I would go back and rewrite this rule. I say to you and your staff of great professionals, if you insist on moving this as currently written, it will be one hell of a fight because the way I read this, unless somebody otherwise is institutionalized, a caregiver gets no benefits. That was not the intent of the Committee Members.

If there is something that we are missing from a standpoint of the ability to administer or the funding needed, then it is a conversation we need to have, and I am ready to have it.

But to suggest that only the veterans that otherwise would be institutionalized qualify for this is to take a kid whose medical assessment was that he would never live to make the trip back to the United States and then say, you know, "You've got a loving, caring wife, who is going to take care of you. She will change her entire life to be able to be there to take care of you. But because she does that and you continue to improve, your only other option would not be to be institutionalized."

We were trying to make sure that was not the only option that was left for kids, to institutionalize them, and now all of a sudden it has become the threshold for participation in the program.

Let me suggest that the effort is misguided right now, and I would implore all of you go back to the table. Read the bill again. What is not clear might be influenced by our intent, and we will help you move from where we are today to where we need to be for these veterans in the future.

I thank you for your commitment.

Thank you, Madam Chairman.

Chairman MURRAY. Thank you very much, Senator Burr, and I look forward to working with you on that.

Senator Rockefeller.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Madam Chair.

One of the reasons I am here, not the most important reason, but one of the reasons I am here is that this is your first day chairing, and I think that is extraordinarily good news for the Veterans' Committee, very good news for General Shinseki, and very good news for veterans as a whole. So I wanted to say that.

Chairman MURRAY. Thank you.

Senator ROCKEFELLER. That is on the record, is it not?

Chairman MURRAY. It is.

Senator ROCKEFELLER. OK. The other reason I am here is parochial, which is very untypical of me, actually. But I have a point that bothers me.

I had a conversation with the head of the National Science Foundation recently. They had a very important program that affected a lot of the research that we were doing at West Virginia University.

It emanated actually from EPSCoR. It was a philosophy matter because it used to be that science research was given to the Harvards, the Stanfords, the Yales, you know, all of those. But the smaller universities, or you could say smaller States, that do not have the high ranking, that are not as prestigious, just never got a grant from the National Science Foundation.

They were peer-reviewed so that you could say that we did bad grants but I do not think we did because I helped invent that program, EPSCoR.

I got the head of the National Science Foundation to agree that rather than accumulate all of the secondary programs in his office, as opposed to committing them to a general sciences fund which would then mean that money would go to other institutions such as West Virginia University, such as—I do not know in Washington you do not have a small university, do you?

Chairman MURRAY. We have great universities.

Senator ROCKEFELLER. You just have great universities, and we are aspiring to that, too.

What comes into play is the fairness doctrine on the Beckley nursing home situation.

West Virginia is not a big State. The Beckley nursing home—the case that I could make to you for that is lengthy and goes back a number of years. Senator Byrd and I worked on that very, very hard. Senator Murray remembers this herself I know. Anyway, WVU is on a sort of secondary list.

Now, you are overwhelmed with all kinds of things. You are going to be facing budget cuts, I mean, all kinds of things that you are overwhelmed with, and I know that. I have enormous respect for you, as you know.

But when I see that we are lumped in with all other construction projects in one massive category from which some will emerge and some will not—being from Appalachia and having that degree of fatalism which is necessary to have if you are from Appalachia and also necessary to overcome if you are from Appalachia—I have this feeling that we are not going to get funded.

Now, we would have the funding had the omnibus appropriations bill passed last year, but that was stopped at the last moment.

So my question to you is what can we do? I am just in the wilderness on this. It is so important to our State, to our veterans, and yet we are not high enough on the list, and we have been ranked in another category. I do not know what it is that we can hope to expect. I also want to know what it is that I do about trying to improve our circumstance, because if you are from Appalachia you have to be skeptical. You have to assume that you are going to be

left behind, that others will be picked because they have more people, they have, you know, more criteria.

So, I admit that is a fairly self-serving project but it serves veterans with dementia and all kinds of other problems. This is something that you and I have actually talked about and I have written to you about it.

But I just wondered what can I look forward to doing or what should I be doing? I mean this hearing is a darn good first step. But what should I be doing to improve the opportunity for that project to succeed?

Secretary SHINSEKI. Senator, you and I have discussed this. I am going to call on Dr. Petzel here to give us an update of where we think we are. We thought we had this issue addressed.

Senator ROCKEFELLER. Right.

Secretary SHINSEKI. We are now adjusting to the current situation.

Senator ROCKEFELLER. I understand that.

Secretary SHINSEKI. But let us give you the state of play here from our side.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Rockefeller, I do not know specifically where this sits right now on the construction list, so what I would like to do is have the time to go back and look to see what the order of priority is with nursing-home construction. As I am sure the Secretary could tell you and Mr. Grams could tell you, we have a huge need in terms of construction.

Senator ROCKEFELLER. Of course.

Dr. PETZEL. This is special from a number of different perspectives. One, it talks about an Alzheimer/dementia unit which is something that we desperately need within the VA.

So what I would like to do is beg your indulgence, go back and take a look at the list, and we will communicate after I have had a chance to look at it.

Senator ROCKEFELLER. Completely satisfactory.

Secretary SHINSEKI. I would just add, Senator, that in my opening comments, I talked about something called SCIP, which is our Strategic Capital Infrastructure Program where we look at all of our assets: medical centers and outpatient clinics, both leased and ones we run, to make sure that we have, looking forward, a good plan for what we expect out of each of those.

I would offer that constructing a nursing home care unit at Beckley was submitted as part of that 2012 SCIP process for consideration as a future budget request. It is not in the 2012 budget, but we anticipated we were not going to have this issue to deal with in 2012.

We are now adjusting. In our 2012 study, this nursing home is addressed as a requirement for a future budget request. That is sort of the current state of play. The project is about an 80,000-square-foot facility which I think we have costed, so we have a pretty good idea of what that is going to be. It will give us a way to make sure that it gets addressed here in the future.

Senator ROCKEFELLER. I thank you.

Thank you, Madam Chairman.

Chairman MURRAY. Thank you, Senator Rockefeller.

I want to welcome to our Committee Senator Boozman. We are delighted to have you. Do you want to give an opening statement and ask questions? Either one.

STATEMENT OF HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Madam Chair. I want to congratulate you on being Chairman. I look forward to working with you and Senator Burr as we all push forward and work really hard to get a lot of stuff accomplished for veterans.

I guess really the only questions I would have—I appreciate having the opportunity to work with you, Secretary Shinseki, on the House side on the Veterans' Affairs Committee—I know that you really are working hard for our veterans. We just have a lot of issues out there that we have to deal with.

One of the things that I was really involved with was a GI Bill implementation. I really feel kind of bad in the sense, you know, there for a while I literally—as being Chair and then Ranking Member on the Veterans' Employment Subcommittee, Economic Opportunity—it seemed like, you know, we were meeting every month, getting updated. So I would really like a bit of an update there; making sure that we have got the resources. Then, the other thing that I was really concerned about was putting veterans to work. In this difficult time of employment, it is hard on everyone and yet, with these multiple deployments, I am very concerned that perhaps employers are starting—maybe psychologically or whatever, sometimes willfully, it is difficult. Many of these individuals are from small towns. They get called up and it is hard sometimes to go back to work.

So if you could comment on those things, I would appreciate it.

Secretary SHINSEKI. Senator, let me begin with GI Bill processing. I think a lot has transpired since we went through that first initial fall where everything was done pretty much by hand.

We have automation tools that are now in place and there have been successive drops. One more drop to go—a program to be inserted to give us a long-term automated solution to the GI Bill processing.

I will call on Secretary Baker to describe for you what that is, and then I will address the other pieces of your question.

Senator BOOZMAN. The other thing, Mr. Secretary, is in the course of that, and here today again we have limited time, but I would be interested if you have a process in place that would make it more efficient for us to legislatively adjust it somewhat. That would be very helpful also.

Mr. BAKER. Thank you, Senator. On the efficiencies I am going to defer to Mr. Walcoff to talk potentially about those.

We are working hard right now on the technology to implement the upgrade to the law. This weekend we will install the IT changes for the 60-day requirements from that law.

On June, I believe it is about the 14th, we will install all the IT changes necessary to support the August 1st requirements of law. So we are processing well there.

We have many optimizations we can do in the processing of those claims that are scheduled for the release after the new law is put

in place. So that is actually deferred while we implement the new law. But we are on track with the program and very pleased with the new technology that is in place, with the long-term solution and its flexibility for us.

Let me ask Mr. Walcoff to talk about efficiencies from a legislative standpoint.

Mr. WALCOFF. Thank you, Secretary Baker.

Senator Boozman, it is good to work with you again. I am really pleased to be able to say that we have come a long way since those days that you were referring to, the first semester that we had the new GI Bill.

A lot of that progress is due to the technology that has been developed by Secretary Baker and his people. I just want to give you an example of how effective this technology is.

In the processing of a supplemental claim—say it is not the first time a veteran has come in but once he has been enrolled, he comes in semester after semester; they are called supplemental claims.

Under the manual system, the one that caused us to have such a big backlog 2 years ago, it took about 40 minutes to work a supplemental claim. With the new technology that has been delivered by our IT people, we now do a supplemental claim in about 7 minutes. They are the largest number of the claims that we receive.

So with that type of efficiency gain from the technology, it has enabled us to be in much better shape in terms of the delivery of benefits.

Senator BOOZMAN. Thank you.

Secretary SHINSEKI. To the issue of jobs, it is something we work on. I am part of an interagency effort to increase the number of veterans hired into the Federal Government departments.

We just had the latest meeting yesterday and the vast majority of a number of departments have increased veteran hiring inside their own organizations. The VA is probably just around 30 percent. We were several points less 2 years ago. So we have begun to make the move in the right direction.

Other things we have underway, small businesses that are owned by veterans, disabled veterans, are a high priority with us. We look for the opportunity to give them a veteran's first competition opportunity for contracts that VA controls. We encourage other departments to do the same.

We invite in small business owners once a year, take them through a training program where we encourage them to start businesses primarily because veterans tend to hire other veterans and that creates the churn we are looking for.

Senator BOOZMAN. Thank you, Madam Chairman.

Chairman MURRAY. Thank you very much.

Mr. Secretary, last week I had a number of listening sessions with veterans in my homestate, and I heard a lot of concern about the elimination of interval pay during breaks in schools.

I know the President's Fiscal Year 2012 Budget does not completely reflect the implementation of the recently enacted improvements legislation. But I wanted to ask you today if you have any more information on the number of students we have that might be affected by the elimination of interval pay: how many are vet-

erans; how many are active duty; how many are transferees; and what is the average amount of living allowance that they are going to be losing?

Secretary SHINSEKI. Madam Chairman, I am going to call on Mr. Walcoff to provide some of that detail. Some of that data I think we will have to provide for the record, and I am happy to coordinate that with you.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. The Department of Veterans Affairs (VA) provided education benefits to more than 800,000 students in fiscal year (FY) 2010. Of these, approximately 366,000 students trained under the Post-9/11 GI Bill. During this period, approximately 278,000 Post-9/11 GI Bill students qualified for interval payments—235,000 Veterans and 43,000 transferees. While there were 18,000 servicemembers, these individuals are not entitled to interval pay under the Post-9/11 GI Bill. Based on the recently enacted legislation, 278,000 individuals would no longer qualify for an interval payment, which currently provides an average housing allowance of $1,348.84.

For the other VA education programs, such as the Montgomery GI Bill—Active Duty, Montgomery GI Bill—Selected Reserve, Reserve Educational Assistance Program, and the Dependents' Educational Assistance Program, there were approximately 311,000 individuals who would no longer qualify for interval payment based on FY 2010 data.

Chairman MURRAY. That would be fine.

Secretary SHINSEKI. I would say we have enrolled in the GI Bill program right now about 427,000 veterans and family members, and the elimination of interval pay applies to all of them.

Chairman MURRAY. Right.

Secretary SHINSEKI. So, if we add to the GI Bill program, the Montgomery GI Bill voc rehab students, that number is 800,000; and the elimination of interval pay applies to all of those students.

Mr. WALCOFF. I do not have anything more specific in terms of numbers. The Secretary gave the numbers that I have with me. But I will tell you that one of the things that we are very concerned about is that veterans are in the know about all the changes, including that change, because a lot of plans were made based on the fact that they expected that they would get paid for the intervals.

So, we basically have an outreach plan to veterans to make sure that they know about all the changes. As a matter of fact, there is a letter that is going out——

Chairman MURRAY. They not only know, they are panicked.

Mr. WALCOFF. I know. It is a serious situation for some who had, in their planning, had it down to the point where they need every payment that they were expecting. But we are sending a letter out to every veteran who is receiving the GI Bill to make sure that if they had not known, that they are at least now aware of it; and we acknowledge that it is going to have a negative effect on some veterans.

Chairman MURRAY. Mr. Secretary, would the Department consider using any authority for emergency payments, like it did during the period of time when difficulties were first encountered with this program, to use some kind of help for financial hardship for some of these students?

Secretary SHINSEKI. Madam Chairman, I think the answer is yes. I mean, there are opportunities for the Secretary to exercise a judgment in specific cases. We tend not to write a blanket policy that applies to everyone but deal on a case-by-case basis.

Yes, the emergency route is available. I do know the other side of that is the requirement to also later collect and that presents a challenge for some. So we want to be judicious here and provide it to the most strenuous cases where we know there is no other alternative, and then after that waive whatever difficulty there might be. Manage the problem, not create another one.

Chairman MURRAY. OK. I completely respect the complexity of it, but I do think there are some very significant financial hardships for some of these folks that would be very much helped by that, so I would like to work with you on that.

Secretary SHINSEKI. OK.

Chairman MURRAY. Let me ask about claims processing. It is a perennial question but it is as serious today as when I first started working on this Committee a long time ago.

It is one of the most common issues and heartfelt issues I hear from veterans. It will be one of the top priorities I have as chair of this Committee and I know that you are willing to work on that too, and I want us to both work from our respective positions because our veterans deserve no less.

So, I want to ask a few questions about VBA. Can you account for the decrease from last year's level in discretionary spending for VBA?

Secretary SHINSEKI. Mr. Walcoff.

Mr. WALCOFF. Yes. When you look at the 2011 budget—as you know, there was a big increase in the 2011 budget and that included the hiring of a lot of people. To support that hiring, there was a lot of money put in there for the training of all those people: the travel involved with that; all the support mechanisms that are needed to support the hiring of a large number of people.

We are not planning on doing that kind of hiring in 2012 for a lot of reasons that we can get into. But to answer your question directly, a lot of that money that was in the 2011 budget to support the hiring of new people and the training of those people is taken out because we are not going to have that influx in 2012. That is the primary reason; and there is no pay raise. There are a few other reasons but that is the primary reason.

Chairman MURRAY. OK. What specifically is included in the VA's budget that is intended to ensure more timely and accurate resolution of claims?

Secretary SHINSEKI. We have a number of pilots underway that deal in three areas: people, process, and technology; and it takes all three to attack this claims backlog issue that has built up over years.

Just a little history. When I arrived to 2009, VBA produced 977,000 claims decisions that year, a high watermark for them. Everyone was very excited about it, and then realized that they got a million claims in return.

In 2010, they produced a million claim decisions, and got 1.2 million claims in the door. We expect this year that the number of claims we receive are going to be 1.4–1.5 million claims.

It is a large number issue, and merely hiring more people will not get us out ahead of it. So we must automate. As I say over in VA, IT is the elephant in the house. We must do this, and we must do it quickly.

In the meantime there is a crossover point. We have been investing heavily in IT, and we are looking for that crossover point at which we can begin to stop the investments in personnel and have what we have invested in automation take over.

That crossover point we intend to be in 2012. Counting on IT drops that are going to produce what we have invested, spent monies for, that is to be determined. We are going to see that happen over the next year.

I have a high degree of confidence that this will go with Secretary Baker leading the way on this and creating a structure for doing these things—a high degree of confidence. But again, we will know it when we see it. But 2012 is our target, and this budget for 2012 is an important crossover point.

Chairman MURRAY. Thank you very much.

Senator Sanders.

Senator SANDERS. Senator Murray asked the question that I wondered about, the processing of claims. Let us go to another area. How are we doing on homelessness? It appears to me we are making some progress. Can you give us some background on that?

Secretary SHINSEKI. I would say from the Secretary's seat I have reached out and pinned a rose on an individual who is seated to my right. Dr. Petzel is the lead on our homeless program primarily because 85 percent of the homeless issue is a health-related issue. It is health care in general. It is depression. It is other mental health issues. Substance-abuse.

The individual we have resourced with the capabilities to do something about that is our VA health care system. So Dr. Petzel has the lead for that, and through him every VISN director and every medical center director also has a responsibility to treat homelessness as a priority, not when someone walks in the door who happens to be homeless but reaching out to the communities they live in, touching base with folks from across the Nation that do this day-in and day-out: Catholic Charities, Salvation Army, Volunteers of America, Swords-to-Plow Shares, etc.

As I have described them in the previous testimony, they are really the creative geniuses here who, with very little, have done so much. It is time for us to link in with them. We have, and advantaged what they know to help us build a registry of the names of homeless veterans, at the same time looking at building a registry of at-risk veterans because whatever we see of the homeless situation—today the estimate is about 76,000, down from 107,000 previously.

It is still an estimate. So, building a registry here is important to get us out of rescue mode, getting people off the streets, into prevention as well, and that is what we intend here, heavy effort in rescue today.

We know that they are out there. We need a registry so we can focus on them, but at the same time, we need to develop some appreciation for the protection requirements.

Senator SANDERS. So what I am hearing, General, is that we are working with other organizations, we are making some significant progress.

Secretary SHINSEKI. Absolutely.

Senator SANDERS. That is my impression.

Let me ask you a more general question, and if Dr. Petzel wants to jump in, that is fine. As I understand it, you run the largest medical system in the United States?

Secretary SHINSEKI. That is correct.

Senator SANDERS. Let me ask you a general question. We talk about health care a whole lot, with many debates. In fact, I just was talking to some young people from the United Kingdom and asked them about their system.

In your judgment, compared to other systems in the United States of America, how does the VA rank? Is it a good system? Does it compare well to other systems? What would you say?

Secretary SHINSEKI. Senator, I am going to answer that with 2 years of hindsight. As I have testified before, I did not grow up in VA. Did not know much about it when I arrived to this position, and I am not a clinician. So, much of what I know today has been learned here by going and visiting our various facilities, and relying on the great expert guidance here by Dr. Petzel among others.

I would categorize the VA health care system as excellent, and I compare that to a 38-year history of being in another very large health care system which took very good care of me day-to-day and also in the more serious moments, and I always thought it was an excellent system.

Senator SANDERS. You are referring to the military.

Secretary SHINSEKI. The military health care system. I would put VA very much in that category, and in a number of ways superior to that.

Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Sanders, just a couple of comments to elaborate on what the Secretary said. We are actually the largest integrated health care delivery system in the country, and that is where the physicians, the hospitals, et cetera, all work under the same kind of organization. I think it is an important distinction to make.

When you look at our performance, we have a very deep array of performance measures, particularly around quality, about 170 of them. When you look at those measures that we can compare with the private sector, which is quite limited because there are not as many things being measured there and published right now, we rank very well.

When you look at our performance on HEDIS and the ORYX measures—one, HEDIS looks at outpatient; ORYX looks at inpatient, which are nationally collected on every single medical center in the country—and compare the Medicare population performance of these medical centers with us, we rank way above.

Senator SANDERS. It's my understanding—somebody was telling me in terms of information technology, you guys are pretty close to the top. Are you not?

Dr. PETZEL. Our medical records, certainly at this point in time rank one of the best, if not the best, in the country. Of course, the

private sector is playing catch-up right now and they are breathing down our neck. But, yes, we do have an excellent medical records ranking.

Senator SANDERS. If my memory serves, and please correct me if I am wrong, but there is obviously a lot of concern about infections in hospitals. You guys were doing pretty well in that, are you not?

Dr. PETZEL. A little background, Senator. The overall infection rate is a hard thing to measure across the country, not just within the VA. There has been disagreement as to what constitutes an infection, et cetera. The one place that there is a standard way of looking at this is with methicillin-resistant staph aureus or MRSA. VA has done a remarkable job over the last four and one-half years of reducing its hospital-acquired MRSA infection rate. I would say we are doing as well as any hospital system in the country right now.

Senator SANDERS. These are my last questions, Madam Chair.

Everybody is concerned about the high costs of health care in the United States. We spend almost twice as much as any other country on health care. How cost-effective is the VA health care system?

Secretary SHINSEKI. I would just point out that the effectiveness of the VA health care system is excellent, and one of the ways we look at this is comparing what it costs to take care of a patient during the course of a year and compare it to what our known costs are for taking care of a homeless veteran who comes to us on those occasions when they need help. The cost of taking care of the homeless veteran is three and one-half times the cost of other health care we deliver.

Therefore, it is in our interest to get our homeless population in, cared for, and off the streets. So, it is both a health care issue for them and a cost factor for us to give them the excellence that VA provides.

Senator SANDERS. But you would argue that at a time of great concern about health care costs, you are running a cost-effective operation?

Secretary SHINSEKI. We are.

Senator SANDERS. Madam Chair, thank you.

Chairman MURRAY. Thank you.

Let me follow up on the issue of homelessness. It is one near and dear to my heart. I notice that the House continuing resolution would end the expansion of the HUD-VASH program, and I wanted to ask you today how many eligible veterans do you have on the waiting list to participate in that program?

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. Just to review the HUD-VASH situation right now, in 2008 we received 10,000 vouchers. We received 10,000 vouchers in 2009 and 10,000 vouchers in 2010. To date, we have assigned 29,000 of those vouchers. They have actually been acted on by HUD in 22,000 cases.

I am not aware at the present time of a waiting list for HUD-VASH vouchers. That does not mean there is not one. I just am not aware of it.

Chairman MURRAY. If you could check for me and find out.

Dr. PETZEL. We will.

Chairman MURRAY. I would really appreciate that.

Dr. PETZEL. Yes, Madam Chairman.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

According to VA officials, there is no master HUD-VASH List. Facilities are allowed to locally keep a list of veterans who might be eligible, but not all facilities keep these lists, and an overall list or count is not tracked nationally.

Chairman MURRAY. And the budgetary implications if the government does not continue running. I just heard the Secretary say that caring for a homeless veteran costs three and one-half times that of one that we have in the system, and the budgetary implications of that too. If you could get that back to me, I would appreciate it.

Chairman MURRAY. I want to ask about women veterans. We have talked about it a number of times. I wanted to ask what funds in this budget are directed toward expanding operating hours in women's clinics to make sure that women get the care they need.

Secretary SHINSEKI. Let me comment, Madam Chairman, and I will turn to Dr. Petzel for specifics.

In the 2012 budget, we intend to spend $270 million on gender specific care. It is more than a 25 percent increase over previous budgets.

We have also dedicated $12 million to specific women's issues research. To this point in 2011, we have invested $29 million in clinical enhancements and another $21 million in facility improvements. Those are things that will occur this year in preparation for these other budget data for 2012 that I have provided to you.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Murray, I cannot specifically identify money that is in the budget directed at enhancing the hours for women veterans. We do have a program in a general sense of enhancing the available hours for clinics, primary care, specialty clinics, et cetera, including the women's clinics. But I will go back and look to see if we can break this out, but I could not do that for you now.

Secretary SHINSEKI. Let me just add, we do not have a specific answer here. This is trying to build for the 2012 numbers, but we have initiatives under way in which we are studying how to extend operating hours to include evenings and Saturdays for female veterans, especially if they bring children with them.

Chairman MURRAY. To that point, what is the status of the childcare project—the pilot program that we put in?

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. That was part of the caregiver legislation. We are creating a request for proposals and hopefully are going to have pilots out there by the summer so that we can quickly see what the implications might be for the entire system.

Chairman MURRAY. That is really a huge barrier for women veterans today.

Dr. PETZEL. We absolutely agree with you. It is a barrier for male veterans in many cases as well.

Chairman MURRAY. That is true.

Senator Burr, do you have any additional questions?

Senator BURR. No additional questions.

Chairman MURRAY. OK. I have a number of other questions I will submit for the record. But before I let you go, Mr. Secretary, I did want to ask you, on January 5th, President Obama nominated Allison Hickey to be Under Secretary of Benefits and Steve Muro to be Under Secretary of Memorial Affairs.

We, in this Committee, do not yet have the questionnaire from Mr. Muro or the other documents we need from these nominees in order to proceed.

When can this Committee expect those documents?

Secretary SHINSEKI. Madam Chairman, it is a priority with me. I have been working on this for over year. I will get you the documents. I was not aware there was a hold up. I will get the documents you need.

Chairman MURRAY. OK. I appreciate that very much.

I thank you very much for your testimony. I look forward to working with you on this budget, and as Senator Burr and I both have talked to you specifically about, the caregivers' issue, which is not going to go away. This is something we feel very strongly about. Thank you.

If the second panel could move forward to the table. While they are coming up, I am going to go ahead and introduce them in order to expedite the time.

We have a number of witnesses who are here to speak on behalf of *The Independent Budget*.

It will be Carl Blake, National Legislative Director of the Paralyzed Veterans of America; Joe Violante, the National Legislative Director for the Disabled American Veterans; Christina Roof, National Acting Legislative Director of AMVETS; and Ray Kelley, National Legislative Director for Veterans of Foreign Wars.

I also want to welcome to our table Tim Tetz, Director for the National Legislative Commission of The American Legion, and Dr. Maryann Hooker, Lead Neurologist at the Wilmington, Delaware, VA Medical Center, representing the American Federation of Government Employees.

Beginning with Mr. Blake, we will move down the table in order. *The Independent Budget* witnesses will have 20 minutes total to make their presentation. The American Legion and AFGE will each be recognized for 5 minutes.

I want to remind all of you that your prepared remarks will be made part of the record, and thank you all for joining us today.

Mr. Blake, we will begin with you.

STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Madam Chairman, Ranking Member Burr, and Members of the Committee, on behalf of the co-authors of *The Independent Budget*, the Paralyzed Veterans of America is pleased to be here today to present the views of *The Independent Budget* for the Department of Veterans Affairs on the fiscal year 2012 health care budget.

Before I begin, I would just like to take the opportunity to thank the majority and minority staffs of the Committee for allowing the

IB to sit down with them in advance of the President's Budget actually being released to discuss the budget recommendations that *The Independent Budget* ultimately provided on February 14 and 15.

As you know, last year the Administration recommended an advance appropriation for fiscal year 2012 of approximately $50.6 billion in discretionary funding for VA medical care. The House supported this recommendation in H.R. 1 as well.

When combined with the $3.7 billion for medical care collections previously projected by the Administration, the total available operating budget recommended for 2012 is approximately $54.3 billion.

However, included in the President's budget request for fiscal year 2012, the Administration revised the estimates for medical care down by $713 million due to the proposed Federal pay freeze, a factor that was not included in H.R. 1.

However, *The Independent Budget* did choose to mirror the zero pay raises for fiscal year 2012 in our recommendations across all of the accounts of the VA.

I would like to say the *IB* appreciates the increases that the Administration has recommended for fiscal year 2012 in its medical care budget request. However, we do have some real concerns with the methods that the Administration uses to get to those projected increases.

Of particular concern to *The Independent Budget* is an ill-defined contingency fund that would provide $953 million more for medical services for fiscal year 2012. Moreover, we are especially concerned that the VA presumes "management improvements", a gimmick that was commonly used by previous administrations under the term "management efficiencies" of approximately $1.1 billion to be directed toward fiscal year 2012 and fiscal year 2013.

The VA has explained that these management improvements provide $1.1 billion that the VA would like to carryover, and yet if the VA is not authorized to carryover this additional money, its Fiscal Year 2012 Budget request and 2013 advance appropriations request will be insufficient to meet the health care demand of veterans it serves.

Finally, we have real concerns about the revised estimates in medical care collections from the originally projected amount as also mirrored in the advance appropriations language, $3.7 billion. So now what is projected is only $3.1 billion for fiscal year 2012. Given this revision in estimates, the VA budget request may arguably be short $600 million in additional budget authority for next year.

For fiscal year 2012, the Administration recommends $53.9 billion for total medical care spending. *The Independent Budget* recommends approximately $55 billion for total medical care. This includes approximately $43.8 billion for medical services.

Our medical services recommendation includes $41.3 billion for current services, $1.5 billion for the increase in patient workload, and $1 billion for additional medical care program costs.

Each of these areas is explained in more detail in my full written statement and even greater detail in *The Independent Budget for Fiscal Year 2012*.

For medical support and compliance, *The Independent Budget* recommends approximately $5.4 billion, and finally, for medical facilities the *IB* recommends approximately $5.9 billion. While our recommendation does not include an additional increase for non-recurring maintenance above current services levels, it does reflect a fiscal year 2012 baseline of approximately $1.1 billion, and I would point out that the Administration's non-recurring maintenance request is approximately $850 million, up from fiscal year 2012.

We are also concerned about the steep reduction in spending for medical and prosthetic research. *The Independent Budget* recommends $620 million, approximately $111 million more than the Administration's request. As you know, research is a vital part of veterans' health care and an essential mission of the national health care system.

The Independent Budget is pleased to see that the Administration has proposed an increase in the medical care accounts for fiscal year 2013. However, we urge Congress, and this Committee in particular, to remain vigilant to ensure that the proposed funding levels for fiscal year 2013 are, in fact, sufficient to meet the continued growth in demand on the VA health care system.

Madam Chairman, that concludes my statement. I will be happy to answer any questions.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, CONCERNING *THE INDEPENDENT BUDGET*

Chairman Murray, Ranking Member Burr, and Members of the Committee: As one of the four co-authors of *The Independent Budget* (*IB*), Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for FY 2012.

With the newly elected 112th Congress just beginning to conduct business, it is important to once again review and assess the efforts of the 111th Congress to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs (VA), particularly the VA health-care system. The first session of the 111th Congress laid the groundwork for a historic year in 2010. In 2009 the President signed Public Law 111–81, the "Veterans Health Care Budget Reform and Transparency Act," which required the President's budget submission to include estimates of appropriations for the Medical Care accounts for fiscal year (FY) 2012 and thereafter (advance appropriations) and the VA Secretary to provide detailed estimates of the funds necessary for these accounts in budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget*, the law also required a thorough analysis and public report by the Government Accountability Office (GAO) of the Administration's advance appropriations projections to determine whether that information is sound and accurately reflects expected demand and costs to be incurred in FY 2012 and subsequent years.

The Independent Budget veterans service organizations (IBVSOs) were pleased to see that in February 2010 the Administration released a detailed estimation of its FY 2011 funding needs as well as a blueprint for the advance funding needed for the Medical Care accounts of VA for FY 2012. It is important to note that last year was the first year that the budget documents included advance appropriations estimates. Unfortunately, due to differences in interpretation of the language of Public Law 111–81, the GAO did not provide an examination of the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model. *The Independent Budget* was informed that the GAO was not obligated to report on the advance appropriations projections of VA until at least 2011. The IBVSOs look forward to working with Congress to ensure that the GAO fulfills its responsibility this year.

For FY 2011, Congress provided historic funding levels for VA in the House and Senate versions of the Military Construction and Veterans Affairs appropriations bill that matched, and in some cases exceeded, the recommendations of *The Independent Budget*. Unfortunately, as has become the disappointing and recurring proc-

ess, the Military Construction and Veterans Affairs appropriations bill was not completed even as the new fiscal year began October 1, 2010. Although the House passed the bill in the summer, the Senate failed to enact the bill in a timely manner. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past few years, the larger appropriations process continues to break down over matters unrelated to VA's budget due to partisan political gridlock.

Fortunately, this year, the enactment of advance appropriations has temporarily shielded the VA health-care system from this political wrangling and legislative deadlock. However, the larger VA system is still negatively affected by the incomplete appropriations work. VA still faces the daunting task of meeting ever-increasing health-care demand as well as demand for benefits and other services.

In February 2010, the President released a preliminary budget submission for VA for FY 2011. The Administration recommended an overall funding authority of $60.3 billion for VA, approximately $4.3 billion above the FY 2010 appropriated level but approximately $1.2 billion less than *The Independent Budget* recommended. The Administration's recommendation included approximately $51.5 billion in total medical care funding for FY 2011. This amount included $48.1 billion in appropriated funding and nearly $3.4 billion in medical care collections. The budget also included $590 million in funding for Medical and Prosthetic Research, an increase of $9 million over the FY 2010 appropriated level.

For FY 2011, *The Independent Budget* recommended that the Administration and Congress provide $61.5 billion to VA, an increase of $5.5 billion above the FY 2010 operating budget level, to adequately meet veterans' health-care and benefits needs. Our recommendations included $52 billion for health care and $700 million for medical and prosthetic research.

The Administration also included an initial estimate for the VA health-care accounts for FY 2012. Specifically, the budget request calls for $54.3 billion in total budget authority, with $50.6 billion in discretionary funding and approximately $3.7 billion for medical care collections. Unfortunately, because work on the FY 2011 appropriations bill was not completed, advance appropriations funding for FY 2012 remains in limbo.

Moreover, recent actions by VA suggest that the FY 2011 advance appropriations funding levels (which were affirmed in the President's budget request) may not be sufficient to support the health-care programs managed by VA. In a letter sent to Congress on July 30, 2010, VA Secretary Eric Shinseki explained that he believes the advance appropriations levels provided for FY 2011—that virtually match the Administration's request for FY 2011—will be insufficient to meet the health-care demand that VA will face this year. He also emphasized that the passage of Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act," and Public Law 111–148, the "Patient Protection and Affordable Care Act," will increase workloads for VA. Unfortunately, the House version of the FY 2011 Military Construction and Veterans Affairs appropriations bill did not fully address this projected current year demand. Likewise, the Senate version of the appropriations bill is apparently insufficient to meet the new demand the Secretary projects.

While we appreciate the funding levels that are provided by the appropriations bills, we believe that the Secretary's letter sends a clear message that, absent some unclear "management action" by VA, more funding will be needed for FY 2011 for VA Medical Care accounts. We hope that as the House and Senate finally complete work on the FY 2011 Military Construction and Veterans' Affairs appropriations bill, proper consideration must be given to this concern.

FUNDING FOR FY 2012

Last year the Administration recommended an advance appropriation for FY 2012 of approximately $50.6 billion in discretionary funding for VA medical care. The House Committee on Appropriations supported this recommendation in H.R. 1 as well. When combined with the $3.7 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2012 is approximately $54.3 billion. However, included in the President's Budget Request for FY 2012, the Administration revised the estimates for Medical Care down by $713 million due to the proposed Federal pay freeze (a factor not included in H.R. 1).

The Independent Budget appreciates the increases that the Administration has recommended for FY 2012 in its Medical Care budget request. However, we have some real concerns with the methods that the Administration uses to get to those projected increases. Of particular concern to *The Independent Budget* is an ill-defined contingency fund that would provide $953 million more for Medical Services for FY 2012. Moreover, we are especially concerned that the VA presumes "manage-

ment improvements" of approximately $1.1 billion to be directed toward FY 2012 and FY 2013. The use of management improvements or efficiencies was a gimmick commonly used in the past to reduce the requested level of discretionary funding; and yet, rarely did the VA realize any actual savings from those gimmicks. Additionally, we are concerned that the VA does not clearly define the relationship between the contingency fund and the "management improvements" that it proposes. Finally, we are concerned about the revised estimate in Medical Care Collections from the originally projected $3.7 billion (included in last year's advance appropriations recommendation and supported by Congress) to now only $3.1 billion. Given this revision in estimates, the VA budget request may arguably be short at least $600 million in budget authority for next year simply based on the revised collection estimate.

For FY 2012, the Administration recommends $53.9 billion for total Medical Care spending. *The Independent Budget* recommends approximately $55.0 billion for total medical care, an increase of $3.4 billion over the FY 2011 operating budget level currently proposed in H.R. 1, the "Continuing Resolution for FY 2011." The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health care funding level. For FY 2012, *The Independent Budget* recommends approximately $43.8 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$41,274,505,000
Increase in Patient Workload	1,495,631,000
Additional Medical Care Program Costs	1,010,000,000
Total FY 2012 Medical Services	$43,780,136,000

Our growth in patient workload is based on a projected increase of approximately 126,000 new unique patients—Priority Group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $1.0 billion. The increase in patient workload also includes a projected increase of 87,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans at a cost of approximately $306 million.

Finally, our increase in workload includes the projected enrollment of new Priority Group 8 veterans who will use the VA health care system as a result of the Administration's continued efforts to incrementally increase the enrollment of Priority Group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new Priority Group 8 veterans who will enroll in the VA should increase by 125,000 between FY 2010 and FY 2013. Based on the Priority Group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately $148 million.

Last, *The Independent Budget* believes that there are additional projected funding needs for the VA. Specifically, we believe there is real funding needed to restore the VA's long-term care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of the VA), to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service), and to meet the new projected demand associated with the provisions of Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act." In order to restore the VA's long-term care average daily census (ADC) to the level mandated by Public Law 106–117, the "Veterans Millennium Health Care Act," we recommend $375 million. In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $250 million. This increase in prosthetics funding reflects the significant increase in expenditures from FY 2010 to FY 2011 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures for FY 2012.

Finally, we believe that there will be a significant funding need in order for the VA to address the provisions of Public Law 111–163, specifically as it relates to the caregiver provisions of the law. During consideration of the legislation, the costs were estimated to be approximately $1.6 billion between FY 2010 and FY 2015. This included approximately $60 million identified for FY 2010 and approximately $1.54 billion between FY 2011 and FY 2015. However, no funding was provided in FY 2011 to address this need. As a result, the VA will have an even greater need for funding to support Public Law 111–163 between FY 2012 and FY 2015 in order to fully implement these provisions. While the Administration claims to have provided an additional $208 million for implementation of Public Law 111–163, we remain concerned about the lack of action by the VA thus far to actually implement the

law. Moreover, it is not clear where that additional funding is included in the FY 2012 Medical Care budget request. With this in mind, *The Independent Budget* recommends approximately $385 million to fund the provisions of Public Law 111–163 in FY 2012.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $5.4 billion, approximately $50 million above the FY 2011 appropriated level. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.9 billion, approximately $160 million above the FY 2011 appropriated level. While our recommendation does not include an additional increase for nonrecurring maintenance (NRM), it does reflect a FY 2012 baseline of approximately $1.1 billion. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended two to four percent of plant replacement value. In fact, the VA should actually be receiving at least $1.7 billion annually for NRM (Refer to Construction section article "Increase Spending on Nonrecurring Maintenance).

For Medical and Prosthetic Research, *The Independent Budget* recommends $620 million. This represents a $39 million increase over the FY 2011 appropriated level. We are particularly pleased that Congress has recognized the critical need for funding in the Medical and Prosthetic Research account in the last couple of years. Research is a vital part of veterans' health care, and an essential mission for our national health care system.

ADVANCE APPROPRIATIONS FOR FY 2013

As explained previously, Public Law 111–81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2012 and subsequent fiscal years. With this in mind, the VA Secretary is required to update the advance appropriations projections for the upcoming fiscal year (FY 2012) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2013. Moreover, the law also requires a thorough analysis and public report of the Administration's advance appropriations projections by the Government Accountability Office (GAO) to determine if that information is sound and accurately reflects expected demand and costs.

The Independent Budget is pleased to see that the Administration has proposed an increase in the Medical Care accounts for FY 2013. We simply urge Congress to remain vigilant to ensure that the proposed funding levels for FY 2013 are in fact sufficient to meet the continued growth in demand on the health care system. Moreover, it is important to note that this is the first year that the GAO will examine the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model. *The Independent Budget* looks forward to examining all of this new information and incorporating it into future budget estimates.

In the end, it is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this Nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of *The Independent Budget*.

This concludes my testimony. I will be happy to answer any questions you may have.

Chairman MURRAY. Thank you very much.

Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VIOLANTE. Thank you, Madam Chairman.

On behalf of the Disabled American Veterans, I am here today to present the recommendations of *The Independent Budget for the Fiscal Year 2012* in the area of veterans' benefits.

First, however, I want to congratulate you, Chairman Murray, on your selection to lead this great Committee. I also want to welcome back Ranking Minority Member Burr. The DAV looks forward to working together with both of you and all Members of the Committee and your staff to improve the lives of our Nation's veterans, particularly disabled veterans, their families, and survivors.

I also want to extend a special "Aloha" to former Chairman Akaka. His leadership over the past 4 years contributed to historic achievements for veterans.

Madam Chairman, for fiscal year 2012, *The Independent Budget* recommends only modest increases in personnel levels for the Veterans Benefits Administration, and those increases are targeted primarily at Vocational Rehabilitation and Employment Service and the Board of Veterans Appeals.

The voc rehab program is one of the most important benefits provided to disabled veterans. However, a 2009 study by the Government Accountability Office found that 54 percent of Veterans Affairs Regional Offices reported they had fewer voc rehab counselors than needed. The current caseload target is one counselor for every 125 veterans, but that ratio is reported to be as high as 1 to 160.

Therefore, the *IB* supports an increase of 100 new counselors and an additional 50 FTEE dedicated to management and oversight of the growing number of contract counselors and service providers.

The Board of Veterans Appeals workload has consistently averaged about 5 percent of the total number of claims before VBA. So as claims rise, so too do the number of appeals. To meet that new demand and to avoid creating an even larger backlog of appeals, the *IB* recommends funding increases for the Board that are commensurate with the increased workload.

Madam Chairman, the *IB* once again calls on Congress to completely end the ban on concurrent receipt for all disabled veterans and eliminates the SBP/DIC offset for veterans, widows, and dependents.

Madam Chairman, VA is at a critical junction in its efforts to reform an outdated, inefficient, and overwhelmed claims processing system. Secretary Shinseki has made clear his intention to, "break the back of the backlog," as a top priority; and while we welcome this goal, we would caution that eliminating that backlog is not necessarily the same as reforming the claims process system.

To achieve real and lasting success, the VA must focus on creating a veteran's benefits claims processing system designed to decide each claim right the first time.

Undoubtedly, the most important new initiative underway is the Veteran's Benefits Management System, VBMS, their new IT program being designed to provide a paperless and rules-based method of processing and awarding claims.

We would urge Congress to carefully monitor and oversee this work and recommend considering an independent outside expert review of the VBMS.

However, regardless of the IT solutions, VBA must ensure that they have a properly trained workforce and a comprehensive quality control system.

That concludes my statement. I will be happy to answer any questions the Committee may have.

[The prepared statement of Mr. Violante follows:]

PREPARED STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, ON BEHALF OF *THE INDEPENDENT BUDGET*

Chairman Murray, Ranking Member Burr and Members of the Committee: On behalf of the Disabled American Veterans and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to be here today to present the recom-

mendations of *The Independent Budget* for the fiscal year 2012 budget in the area of veterans' benefits. As you know, *The Independent Budget* is a collaboration amongst the DAV, AMVETS, Paralyzed Veterans of America and Veterans of Foreign Wars.

First, however, I want to congratulate you, Chairman Murray, on your selection to lead this great Committee. I also want to welcome back the Committee's Ranking Minority Member, Richard Burr. The DAV looks forward to working together with both of you, as well as all of the returning and new Members of the Committee, to improve the lives of our Nation's veterans, particularly disabled veterans, their families and survivors.

I also want to extend a special "Aloha" to former Chairman Akaka. Your leadership over the past four years contributed to historic achievements for veterans, including enactment of the Veterans Health Care Budget Reform and Transparency Act of 2009 and the Caregiver and Veterans Omnibus Health Services Act of 2010.

For the past 25 years, *The Independent Budget* has provided Congress and the Administration with budget and policy recommendations to strengthen programs serving America's veterans. I note with appreciation that Public Law 111–275, the Veterans Benefits Act of 2010, which was enacted in the last Congress, contained a number of provisions addressing recommendations made to this Committee by *The Independent Budget*. In particular, the new law includes an increase in the automobile grant from $11,000 to $18,900; an expansion of eligibility for Aid and Attendance benefits for veterans suffering from Traumatic Brain Injury; an increase in Supplemental Service-Disabled Veterans' Insurance (SDVI or "RH") from $20,000 to $30,000; and an increase in Veterans Mortgage Life Insurance (VMLI) for disabled veterans from $90,000 to $150,000 effective October 1, 2011, with a 2012 increase to $200,000. Each of these and many other provisions in this new law will make a real difference in the lives of thousands of disabled veterans and their families and we thank this Committee for helping to enact this legislation.

SUFFICIENT STAFFING FOR THE VETERANS BENEFITS ADMINISTRATION

Madame Chairman, for fiscal year 2012, *The Independent Budget* recommends only modest increases in personnel levels for the Veterans Benefits Administration (VBA), and those increases are targeted at Vocational Rehabilitation and Employment (VR&E) and the Board of Veterans Appeals (BVA). Over the past couple of years, with strong support from Congress, VBA's Compensation and Pension (C&P) Service has seen a significant increase in personnel to address the rapidly rising workload they face. It is important to note that this large increase in claims processors could actually result in a short-term net decrease in productivity, due to experienced personnel being taken out of production to conduct training, and the length of time it takes for new employees to become fully productive. While we do not recommend additional staffing increases at this time, we do recommend that VBA conduct a study on how to determine the proper number of full-time employees necessary to manage its growing claims inventory so that claims are decided accurately and in a timely manner.

The Independent Budget does, however, recommend that Congress authorize at least 160 additional full-time employees for the VR&E Service for fiscal year (FY) 2012, primarily to reduce current case manager workload. A 2009 study by the Government Accountability Office (GAO) found that 54 percent of Department of Veterans Affairs Regional Offices (VAROs) reported they had fewer counselors than they needed and 40 percent said they had too few employment coordinators. VR&E officials indicated that the current caseload target is 1 counselor for every 125 veterans, but that ratio is reported to be as high as 1 to 160 in the field. An increase of 100 new counselors would address that gap. Given its increased reliance on contract services, VR&E also needs an additional 50 full-time employee equivalents (FTEE) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. In addition, VR&E has requested at least 10 FTEE in FY 2012 to expand its college program—"Veteran Success on Campus," and we support that request.

With the number of claims for benefits increasing over the past several years, so too is the number of appeals to the BVA. On average, BVA receives appeals on 5 percent of all claims, a rate that has been consistent over the past decade. With the number of claims projected to rise significantly in the coming years, so too will the workload at BVA, and thus the need for additional personnel. Funding for the BVA must rise at a rate commensurate with its increasing workload so it is properly staffed to decide veterans' appeals in an accurate and timely manner.

CLAIMS PROCESSING REFORM: GET IT RIGHT THE FIRST TIME

The VBA is at a critical juncture in its efforts to reform an outdated, inefficient, and overwhelmed claims-processing system. After struggling for decades to provide timely and accurate decisions on claims for veterans' benefits, the VBA over the past year has started down a path that may finally lead to essential transformation and modernization, but only if it has the leadership necessary to undergo a cultural shift in how it approaches the work of adjudicating claims for veterans benefits.

The number of new claims for disability compensation has risen to more than 1 million per year and the complexity of claims have also increased as complicated new medical conditions, such as Traumatic Brain Injury, have become more prevalent. To meet rising workload demands, *The Independent Budget* has recommended, and Congress has provided, significant new resources to the VBA over the past several years in order to increase their personnel levels. Yet despite the hiring of thousands of new employees, the number of pending claims for benefits, often referred to as the backlog, continues to grow.

As of January 31, 2011, there were 775,552 pending claims for disability compensation and pensions awaiting rating decisions by the VBA, an increase of 289,081 from one year ago. About 41 percent of that increase is the result of the Secretary's decision to add three new presumptive conditions for Agent Orange (AO) exposure: ischemic heart disease, B-cell leukemia, and Parkinson's disease. Even discounting those new AO-related claims, the number of claims pending rose by 171,522, a 37 percent increase of pending claims over just the past year. Overall, there are 331,299 claims that have been pending greater than VA's target of 125 days, which is an increase of 147,930, up more than 80 percent in the past year. Not counting the new AO-related, over 50 percent of all pending claims for compensation or pension are now past the 125-day target set by the VBA.

Worse, by the VBA's own measurement, the accuracy of disability compensation rating decisions continues to trend downward, with their quality assurance program, known as the Systematic Technical Accuracy Review (STAR) reporting only an 83 percent accuracy rate for the 12-month period ending May 31, 2010. Moreover, VA's Office of Inspector General found additional undetected or unreported errors that increased the error rate to 22 percent. Complicating the Department's problems is its reliance on an outdated, paper-centric processing system, which now includes more than 4.2 million claims folders.

Faced with all of these problems, VA Secretary Shinseki last year set an extremely ambitious long-term goal of zero claims pending more than 125 days and all claims completed to a 98 percent accuracy standard. Throughout the year he repeatedly made clear his intention to "break the back of the backlog" as his top priority. While we welcome his intention and applaud his ambition, we would caution that eliminating the backlog is not necessarily the same goal as reforming the claims-processing system, nor does it guarantee that veterans are better served.

The backlog is not the problem, nor even the cause of the problem; rather, it is only one symptom, albeit a very severe one, of a much larger problem: too many veterans waiting too long to get decisions on claims for benefits that are too often wrong. If the VBA focuses simply on getting the backlog number down, it can certainly achieve numeric success in the near term, but it will not necessarily have addressed the underlying problems nor taken steps to prevent the backlog from eventually returning. To achieve real success, the VBA must focus on creating a veterans' benefits claims-processing system designed to "get each claim done right the first time." Such a system would be based upon a modern, paperless information technology and workflow system focused on quality, accuracy, efficiency, and accountability.

Recognizing all of the problems and challenges discussed above, we have seen some positive and hopeful signs of change. VBA leadership has been refreshingly open and candid in recent statements on the problems and need for reform. Over the past year, dozens of new pilots and initiatives have been launched, including a major new IT system that is now being field-tested. The VBA has shared information with the veterans service organizations (VSOs) about its ongoing initiatives and sought feedback on these initiatives. These are all positive developments.

Yet despite the new openness and outreach to the VSO community, we remain concerned about VBA's failure to fully integrate service organizations in reforming the claims process. VSOs not only bring vast experience and expertise about claims processing, but our local and national service officers hold power of attorney for hundreds of thousands of veterans and their families. In this capacity, VSOs are an integral component of the claims process. We make the VBA's job easier by helping veterans prepare and submit better claims, thereby requiring less time and resources to develop and adjudicate them. VBA leadership must commit to a true

partnership with service organizations, and infuse this new attitude throughout the VBA from central office down to each of the 57 regional offices.

Madame Chairman, the VBA must also change how it measures success and rewards performance in a manner designed to achieve the goal of "getting it right the first time." Unfortunately, most of the measures that the VBA employs today, whether for the organization as a whole, or for regional offices or employees, are based primarily on measures of production, which reinforces the goal of ending the backlog. VBA must change how it measures and reports progress and success so that there are more and better indicators of quality and accuracy. VBA must also continue to review employee performance standards to ensure that it creates incentives and accountability to achieve quality and accuracy, not just increased speed or production.

PILOT PROGRAMS

As the VBA moves forward with dozens of pilots and initiatives designed to modernize and streamline the claims-processing system, it is imperative that the VBA have a systematic method for analyzing and integrating "best practices" that improve quality and accuracy, rather than just those that may increase production. One of the most important new initiatives is the use of templates for medical evidence, which VBA calls Disability Benefits Questionnaires (DBQs). There are currently three DBQs that have been approved for use in claims for the three new presumptive conditions associated with Agent Orange exposure: ischemic heart disease, Parkinson's disease, and B-cell leukemia. An additional 76 DBQs are in various stages of the development and approval process. We support the use of DBQs as a method to streamline and improve the quality and timeliness of decisions; however, it is crucial that DBQs are properly completed, either by VA or private medical examiners. VBA employees must be properly trained so they understand that DBQs are but one piece of evidence that must be considered in the development and decisionmaking process. VBA's rating specialists must properly consider the evidentiary weight and value of all evidence related to the claim and address it adequately in the reason and bases of the subsequent decision.

One of the major new claims process reform initiatives is the Fully Developed Claims (FDC) program, which began as a pilot program mandated by Public Law 110–389, and was rolled out to all VAROs last year. We were pleased that VBA modified the FDC application process at our request so that a veteran could make an informal notification to the VBA of his or her intention to file a FDC claim, thereby protecting the earliest effective date for receipt of benefits. However, we have been hearing numerous reports from the field that local ROs are not allowing such informal claims to be made. We have also been told that the participation level of veterans in the FDC program remains low. We continue to believe in the FDC program and urge this Committee to work with us and VBA to address the obstacles to its success.

In order to synthesize the "best practices" from all of the ongoing pilots, VBA recently started a new Integration Laboratory at their Indianapolis Regional Office. Given all of the pressure to "break the backlog" by increasing production, we have concerns about whether the VBA will successfully extract and then integrate the best practices from so many ongoing initiatives. Given the enormous pressure to reduce the backlog, we are concerned that there could be a tendency to focus on process improvements that result in greater production rather than those that lead to greater quality and accuracy.

Congress must continue to provide aggressive oversight of the VBA's myriad ongoing pilots and initiatives to ensure that practices adopted and integrated into a cohesive new claims process are judged first and foremost on their ability to help VA get claims "done right the first time."

TRAINING AND QUALITY CONTROL

Madame Chairman, two longstanding weaknesses of VBA's claims adjudication process are training and quality control, which should be linked to create a single continuous improvement program, both for employees and for the claims process itself. Quality control programs can identify areas and subjects that require new or additional training for VBA employees and better training programs for employees and managers should improve the overall quality of the VBA's work.

VBA's primary quality assurance program is the STAR program. The STAR program was last evaluated by the VA Office of Inspector General (OIG) in March 2009, with the OIG finding that STAR does not provide a complete assessment of rating accuracy. Although the STAR reviewers found that the national accuracy rate was about 87 percent, the OIG found additional errors and projected an overall accuracy

rate of only 78 percent. In addition to rectifying errors found by the OIG, we recommend that the VBA establish a true quality control program that looks at claims "in-process" in order to determine not just whether a proper decision was made, but how it was arrived at in order to identify ways to improve the system. The data from all such reviews should be incorporated into the VBA's new information technology systems being developed so that analysis can provide management and employees important insights into processes and decisions. This in turn would lead to quicker and more accurate decisions on benefits claims, and most important, the delivery of all earned benefits to veterans, particularly disabled veterans, in a timely manner.

Training is essential to the professional development of an individual and tied directly to the quality of work they produce, as well as the quantity they can accurately produce. Veterans service organization officers have been told by many VBA employees that meeting production goals is the primary focus of management, whereas fulfilling training requirements and increasing quality is perceived as being secondary. An overemphasis on productivity must not interfere with the training of new employees who are still learning their job.

The Government Accountability Office (GAO) recently conducted a study to determine the appropriateness of training for experienced claims processors and the adequacy of VBA's monitoring and assessment of such training. Of particular interest are GAO findings that experienced claims processors' had concerns with the training received—specifically the hours, amount, helpfulness, methods, and timing of training. Likewise, as the GAO report pointed out, there is very little done by the VBA to ensure the required training is completed or to assess the adequacy and consistency of the training, nor to properly ascertain the total number of employees who have met the annual training requirement. In fact, only one VARO met the annual training requirement and nine VAROs had less than half their employees meet the annual training requirement. It is simply unacceptable to have only one VARO meeting the most basic requirement of ensuring that all its employees complete 80 hours of training. VBA must place greater emphasis on training by implementing stricter monitoring mechanisms for all VAROs and ensuring that they are held accountable for failure to meet this minimal standard.

Madame Chairman, Public Law 110–389, the "Veterans' Benefits Improvement Act of 2008," required the VBA to develop and implement a certification examination for claims processors and managers; however, today there are still gaps in the implementation of these provisions. While tests have been developed and piloted for Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs), additional tests need to be developed and deployed for Decision Review Officers and supervisory personnel. None of these certification tests are mandatory for all employees, nor are they done on a continuing basis.

The VBA cannot accurately assess its training or measure an individual's knowledge, understanding, or retention of the training material without regular testing. It is important, however, that all testing and certification be applied equally to employees and to the people who supervise and manage them. All VBA employees, coaches, and managers should undergo regular testing to measure job skills and knowledge, as well as the effectiveness of the training.

Equally important, testing must properly assess the skills and knowledge required to perform the work of processing claims. Many employees report that the testing does not accurately measure how well they perform their jobs, and there have been reports that significant numbers of otherwise qualified employees are not able to pass the tests. VBA must ensure that certification tests are developed that accurately measure the skills and knowledge needed to perform the work of VSRs, RVSRs, decision review officers, coaches and other managers.

Successful completion of training by all employees and managers must be an absolute requirement for every VARO and must be a shared responsibility of both employees and management. Managers must be held responsible for ensuring that training is offered and completed by all of their employees. However it is also the responsibility, as well as part of the performance standard, for employees to complete their training requirements. Managers must provide employees with the time to take training and employees must fully and faithfully complete their training as offered. Neither should be able or pressured to just "check the box" when it comes to training.

NEW VBA INFORMATION TECHNOLOGY SYSTEMS

Madame Chairman, undoubtedly the most important new initiative underway at the VBA is the Veterans Benefits Management System (VBMS), which is designed to provide the VBA with a comprehensive, paperless, and ultimately rules-based

method of processing and awarding claims for VA benefits, particularly disability compensation and pension. Following initial design work, the VBMS had its first phase of development in Baltimore last year where a prototype system was tested in a virtual regional office environment. The first actual pilot of the VBMS was begun in November 2010 at the Providence, Rhode Island Regional Office. The six-month pilot program began with simulated claims and was scheduled to begin working on actual "live" claims early this year. A second six-month pilot is expected to begin in May 2011 at the Salt Lake City Regional Office, which will build on the work begun at Providence. A third pilot is scheduled to begin in November 2011 at an undesignated location, and the final national rollout of the VBMS is schedule to take place in 2012.

Although the development and deployment of a modern information technology (IT) system to process claims in a paperless environment is long overdue, we have concerns about whether the VBMS is being rushed to meet self-imposed deadlines in order to show progress toward "breaking the back of the backlog." While we have long believed that the VBA's IT infrastructure was insufficient, outdated, and constantly falling further behind modern software, Web, and cloud-based technology standards, we would be equally concerned about a rushed solution that ultimately produces an insufficiently robust IT system.

Given the highly technical nature of modern IT development, we would urge Congress to fully explore these issues with the VBA and suggest that it could be helpful to have an independent, outside, expert review of the VBMS while it is still early enough in the development phase to make course corrections, should they be necessary.

To be successful, the VBMS must include the maximum level of rules-based decision support feasible at the earliest stages of development in order to build a system capable of providing accurate and timely decisions, as well as include real-time, quality control as a core component of the system. VBA must also commit to incorporating all veterans' legacy paper files into the paperless environment of the VBMS within the minimum amount of time technically and practically feasible.

DISABILITY COMPENSATION AND QUALITY OF LIFE

The Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation published a report in 2007, "A 21st Century System for Evaluating Veterans for Disability Benefits," recommending that the current VA disability compensation system be expanded to include compensation for nonwork disability (also referred to as "noneconomic loss) and loss of quality of life. Nonwork disability refers to limitations on the ability to engage in usual life activities other than work. This includes ability to engage in activities of daily living, such as bending, kneeling, or stooping, resulting from the impairment, and to participate in usual life activities, such as reading, learning, socializing, engaging in recreation, and maintaining family relationships. Loss of quality of life refers to the loss of physical, psychological, social, and economic well-being in one's life.

The IOM report stated that, "* * * Congress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the Rating Schedule and other ways. Modern concepts of disability include work disability, nonwork disability, and quality of life (QOL) * * *" The congressionally-mandated Veterans Disability Benefits Commission (VDBC), established by the National Defense Authorization Act of 2004 (Public Law 108–136), spent more than two years examining how the rating schedule might be modernized and updated. Reflecting the recommendations of the IOM study, the VDBC in its final report issued in 2007 recommended that the, "* * * veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss of quality of life."

The IOM Report, the VDBC (and an associated Center for Naval Analysis study) and the Dole-Shalala Commission (President's Commission on Care for America's Returning Wounded Warriors) all agreed that the current benefits system should be reformed to include noneconomic loss and quality of life as a factor in compensation.

The Independent Budget recommends that Congress finally address this deficiency by amending title 38, United States Code, to clarify that disability compensation, in addition to providing compensation to service-connected disabled veterans for their average loss of earnings capacity, must also include compensation for their noneconomic loss and for loss of their quality of life. Congress and VA should then determine the most practical and equitable manner in which to provide compensation for noneconomic loss and loss of quality of life and then move expeditiously to implement this updated disability compensation program.

ELIMINATION OF CONCURRENT RECEIPT FOR ALL DISABLED VETERANS

Madame Chairman, many veterans retired from the Armed Forces based on longevity of service must forfeit a portion of their retired pay, earned through faithful performance of military service, before they receive VA compensation for service-connected disabilities. This is inequitable—military retired pay is earned by virtue of a veteran's career of service on behalf of the Nation, careers of usually more than 20 years. Entitlement to compensation, on the other hand, is paid solely because of disability resulting from military service, regardless of the length of service.

A disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing a service obligation can receive full VA compensation and full civilian retired pay—including retirement from any Federal civil service. A veteran who honorably served and retired for 20 or more years and suffers from service-connected disabilities due to disability should have that same right.

Congress should enact legislation to repeal the inequitable requirement that veterans' military longevity retired pay be offset by an amount equal to their rightfully earned VA disability compensation if rated less than 50 percent.

REPEAL OF OFFSET AGAINST SURVIVOR BENEFIT PLAN

When a disabled veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive Dependency and Indemnity Compensation (DIC) from VA. This benefit indemnifies survivors, in part, for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

Career members of the Armed Forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the Survivor Benefit Program (SBP), deductions are made from the member's retired pay to purchase a survivors' annuity. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died of other than service-connected causes or was not totally disabled by service-connected disability for the required time preceding death, beneficiaries receive full SBP payments. However, if the veteran's death was a result of his or her military service or followed from the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. Where the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose all entitlement to the SBP annuity.

We strongly believe this offset is inequitable because no duplication of benefits is involved. Payments under the SBP and DIC programs are made for different purposes. Under the SBP, a dependent purchases coverage that would be paid in the event of the death of the servicemember. On the other hand, DIC is a special indemnity compensation paid to the survivor of a servicemember who dies while serving or a veteran who dies from service-connected disabilities. In such cases, VA indemnity compensation should be added to the SBP, not substituted for it.

We note that surviving spouses of Federal civilian retirees who are veterans are eligible for dependency and indemnity compensation without losing any of their purchased Federal civilian survivor benefits. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay. Congress should repeal the offset between DIC and the SBP.

In addition, Congress should lower the age required for survivors of veterans who died from service-connected disabilities who remarry to be eligible for restoration of dependency and indemnity compensation to conform with the requirements of other Federal programs. Current law permits the VA to reinstate DIC benefits to remarried survivors of veterans if the remarriage occurs at age 57 or older or if survivors who have already remarried apply for reinstatement of DIC at age 57. Although we appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is arbitrary. Remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55. We believe the survivors of veterans who died from service-connected disabilities should not be further penalized for remarriage and that equity with beneficiaries of other Federal programs should govern Congressional action for this deserving group.

VA SCHEDULE FOR RATING DISABILITIES

The amount of disability compensation paid to a service-connected disabled veteran is determined according to the VA Schedule for Rating Disabilities (VASRD), which is divided into 15 body systems with more than 700 diagnostic codes. In 2007, both the VDBC, as well as the IOM Committee on Medical Evaluation of Veterans for Disability Compensation in its report "A 21st Century System for Evaluating Veterans for Disability Benefits," recommended that VA regularly update the VASRD to reflect the most up-to-date understanding of disabilities and how disabilities affect veterans' earnings capacity.

In line with these recommendations, the VBA is currently engaged in the process of updating the 15 body systems, beginning with mental disorders and the musculoskeletal system. Additionally, it has committed to regularly updating the entire VA Schedule for Rating Disabilities every five years.

In January 2010, the VBA held a Mental Health Forum jointly with the Veterans Health Administration (VHA), which included a VSO panel. In August 2010, the VBA and VHA held a Musculoskeletal Forum, which also included a VSO panel. Just a few weeks ago, a series of four public forums were held in Scottsdale, Arizona over the course of two weeks on four additional body systems. The Arizona sessions in particular, were far removed from the public and offered little opportunity for most VSOs to observe, much less offer any input.

While we are appreciative of such efforts, we are concerned that except for these initial public forums, VBA is not making any substantial efforts to include VSO input during the actual development of draft regulations for the updated rating schedule. Since the initial public meetings, the VBA has not indicated it has any plans to involve VSOs at any other stage of the rating schedule update process other than what is required once a draft rule is published, at which time they are required by law to open the proposed rule to all public comment. We strongly believe that the VBA would benefit from the collective and individual experience and expertise of VSOs and our service officers throughout the process of revising the rating schedule. In addition, since the VBA is committed to a continuing review and revision of the rating schedule, we believe it would be beneficial to conduct reviews of the revision process so that future body system rating schedule updates can benefit from "lessons learned" during prior body system updates.

Madame Chairman and Members of the Committee, this concludes my statement and I would be happy to answer any questions you may have.

Chairman MURRAY. Thank you very much.

Ms. Roof.

STATEMENT OF CHRISTINA M. ROOF, NATIONAL ACTING DEPUTY LEGISLATIVE DIRECTOR, AMVETS

Ms. ROOF. Chairman Murray, Ranking Member Burr, and distinguished Members of the Committee, on behalf of AMVETS, I would like to thank you for inviting me and the other *Independent Budget* organization representatives to share with you our recommendations on the Department of Veterans' Affairs Fiscal Year 2012 Budget. We believe our recommendations will prove to be the most fiscally responsible way of ensuring the quality and integrity of the care and benefits our veterans community depend on and receive today.

As a partner of *The Independent Budget*, AMVETS devotes a majority of our time to the concerns and matters of VA's National Cemetery Administration, or NCA, and to VA entrepreneurship, as well as Federal procurement. Today I will briefly be speaking to these issues.

The most important obligation of NCA is to honor the memory of America's brave men and women who have served in the Armed Forces.

As of late 2010, NCA maintained more than three million graves at 131 national cemeteries in 39 States and in Puerto Rico.

With the anticipated opening of several new national cemeteries, annual internments are projected to increase to approximately 116,000 in 2013 and maintain at that level through 2015.

The *IB* recommends a total operating budget of $275 million for NCA for fiscal year 2012. This is so that NCA may meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

Furthermore, due to the challenges that the State Cemetery Grants Program is experiencing in meeting the growing demand for their services, the *IB* recommends Congress appropriate $51 million to the State Cemetery Grants Program for fiscal year 2012.

This funding level will allow SCGP to establish new State cemeteries at their current rate of need and will provide burial options for veterans that otherwise would have no reasonably access to a State or national cemetery.

In 1973, NCA established a burial allowance that provided partial reimbursements for the costs of funerals. However, while the cost of funerals has risen over 700 percent since 1973, the VA benefit has only been raised 250 percent.

We call on the Administration and Congress to provide the resources required to meet the critical nature of NCA's mission and to fulfill this Nation's commitment to all veterans who have served their country so honorably and faithfully.

AMVETS' second focus in the fiscal year 2012 *IB* is on veteran entrepreneurship and Federal procurement, as it relates to service-disabled veteran-owned small businesses and veterans-owned small businesses. While I do note that a majority of the proceeding information is focused on policy rather than hard fiscal numbers, we believe that identifying broken policies, duplication of efforts, and lack of oversight are key factors in determining a fiscally responsible budget.

Supporting service-disabled veteran-owned small businesses and veteran-owned small businesses contributes significantly in sustaining a veteran's quality of life, while also contributing to the success of transitioning from military life to civilian life.

Given the current state of our economy, now more than ever, Federal agencies must be held accountable to meeting the 3 percent Federal procurement goal as outlined by Executive Order 13360 and Section 36 of the Small Business Act.

Furthermore, Congress must ensure adequate resources are available to effectively monitor and recognize those agencies not meeting the 3-percent goal, and hold them accountable to their failure.

Another critical part of protecting our veterans in the Federal procurement system is through a centralized vendor verification system.

Thus far VA has been awarded $1.4 billion in Recovery Act funds to aid our veterans in their entrepreneurial endeavors. According to VA, of the Recovery Act funds they have received, $538 million have been awarded to veteran-owned small businesses.

However, we have really serious concerns due to the lack of verification processes at VA on how many of those awarded contracts were to legitimate veteran-owned businesses. Even though changes were made to the CFR regarding the verification process

last year, we believe the minor updates still leave the veteran-owned business verification system and VA open to fraud.

A continued lack of clarity and inconsistent status verification processes will continue to cause the same unwanted results of many service-disabled veteran-owned small businesses and veteran-owned small businesses not receiving the protections they are entitled to under the law.

In closing, I want to encourage each of the Committee Members to review my full written testimony which will outline all of the *IB*'s concerns and recommendations regarding NCA, veteran entrepreneurial and Federal procurement.

Again, Chairman Murray, Ranking Member Burr, and Members of the Committee, we thank you for inviting us to share with you our recommendations, and I am ready to answer any questions that you may have.

[The prepared statement of Ms. Roof follows:]

PREPARED STATEMENT OF CHRISTINA M. ROOF, NATIONAL DEPUTY LEGISLATIVE DIRECTOR, AMVETS

Chairman Murray, Ranking Member Burr and Distinguished Members of the Committee: On behalf of AMVETS I would like to thank you for allowing myself and representatives of the other member organization authors of the *Independent Budget* to share with you our recommendations on the Department of Veterans Affairs Fiscal Year 2012 budget, in what we believe to be the most fiscally responsible way of ensuring the quality and integrity of the care and benefits our veterans community receive.

AMVETS is honored to join our fellow Veterans' Service Organizations in presenting the *Independent Budget's* recommendations on the Fiscal Year 2012 Department of Veterans Affairs Budget Request. AMVETS testifies before you as a co-author of The FY 2012 Independent Budget. This is the 25th year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America and the Veterans of Foreign Wars have combined our expertise, experiences and resources to produce this unique and in-depth document; one that has stood the test of time.

In developing the *Independent Budget* we are always guided by the same set of principles. These principles include, first, our belief that veterans should not have to wait for the benefits to which they are entitled through their service to our country. Second, every veteran must be ensured access to the highest quality medical care available. Third, specialized care must remain a top priority and focus of the Department of Veterans Affairs (VA). Furthermore, we believe veterans must be guaranteed timely access to the full continuum of health care services, including, but not limited to, long-term care. Finally, veterans must be assured accessible burial in a state or national cemetery regardless of their location.

As a partner of the *Independent Budget*, AMVETS devotes a majority of our time to the concerns and matters of the Department of Veterans Affairs National Cemetery Administration (NCA) and to all of the aspects of veteran entrepreneurship and Federal procurement. Today I will be speaking directly to these two issues.

By way of background, the stated mission of The National Cemetery Administration (NCA) is to honor veterans with final resting places in national shrines and with lasting tributes that commemorate their service to our Nation. Their vision is to serve all veterans and their families with the utmost dignity, respect, and compassion and ensure that every national cemetery will be a place that inspires visitors to understand and appreciate the service and sacrifice of our Nation's veterans. Furthermore, many states have established state veterans cemeteries. Eligibility is similar to that of the Department of Veterans Affairs (VA) national cemeteries, but may include residency requirements. Even though they may have been established or improved with government funds through VA's State Cemetery Grants Program, state veterans cemeteries are run solely by the states.

As of late 2010 the Department of Veterans Affairs National Cemetery Administration (NCA) maintained more than 3 million graves at 131 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 71 are open to all interment; 19 will accept only cremated remains and family members of those already interred; and

41 will only perform interments of family members in the same gravesite as a previously deceased family member.[1]

VA estimates nearly 23 million veterans are living today. They include veterans from World Wars I and II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the newly planned national cemeteries, annual interments are projected to increase to approximately 116,000 in 2013, and are projected to maintain that level through 2015. Historically, only 12 percent of veterans opt for burial in a state or national cemetery, although these numbers are rising.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the Armed Forces. Therefore, the purpose of these cemeteries as national shrines is one of NCA's top priorities. Many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that must be protected, respected and cherished.

The Independent Budget Veterans Service Organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families. We call on the Administration and Congress to provide the resources needed to meet the changing and critical nature of NCA's mission and fulfill the Nation's commitment to all veterans who have served their country honorably and faithfully.

In FY 2010, $250 million was appropriated for the operations and maintenance of NCA, with approximately $2 million in carryover. NCA awarded 47 of its 50 minor construction projects that were in the operating plan. Additionally, the State Cemetery Grants Service (SCGS) awarded $48.5 million in grants for 12 projects.

NCA has done an exceptional job of providing burial options for the nearly 91 percent, about 170,000, of veterans who fall within a 75-mile radius threshold model. However, the NCA realized that, without adjusting this model, only one area, St. Louis, would qualify for a cemetery within the next five years and that the five highest veteran population concentrated areas of the country would never qualify if the threshold remained unchanged.

In 2010, the IBVSOs recommended several new threshold models for NCA to consider in an effort to best serve a veterans population declining in number. The IBVSOs are pleased to see that NCA has adjusted its model and will begin factoring in 80,000 veterans within a 75-mile radius for future cemetery placement. This modification will allow NCA to continue to provide burial options for veterans who would otherwise be limited geographically for this benefit.

NATIONAL CEMETERY ADMINISTRATION (NCA) ACCOUNTS

The Independent Budget recommends an operations budget of $275 million for NCA for fiscal year 2012 so it can meet the increasing demands of interments, gravesite maintenance and related essential elements of cemetery operations.

NCA is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a Presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

However, the national cemetery system continues to face serious challenges. Though there has been significant progress made over recent years, NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to national cemeteries are still likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the Nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

NCA has worked tirelessly to improve the appearance of our national cemeteries, investing $45 million in the National Shrine Initiative in FY 2010 and approxi-

[1] http://www.cem.va.gov/cem/cems/listcem.asp

mately $25 million per year for the three previous years. NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. In 2006 only 67 percent of headstones and markers in national cemeteries were at the proper height and alignment. By 2009 proper height and alignment increased to 76 percent. NCA is on target to reach 82 percent this fiscal year. To ensure that NCA has the resources to reach its strategic goal of 90 percent, the IBVSOs recommend that NCA's operations and maintenance budget be increased by $20 million per year until the operational standards and measures goals are reached.

In addition to the management of national cemeteries, NCA is responsible for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107–103 and 107–330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries. Public Law 110–157 gives VA authority to provide a medallion to be attached to the headstone or marker of veterans who are buried in a private cemetery. This benefit is available to veterans in lieu of a government-furnished headstone or marker.

THE STATE CEMETERY GRANTS PROGRAM

The State Cemeteries Grant Program (SCGP) faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the SCGP is to develop a true compliment to, not a replacement for, our Federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery. Currently there are 48 state and tribal government matching grants for cemetery projects.

The Independent Budget recommends Congress appropriate $51 million for SCGP for FY 2012. This funding level would allow SCGP to establish new state cemeteries at their current rate that will provide burial options for veterans who live in regions that currently has no reasonably accessible state or national cemeteries.

BURIAL BENEFITS

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potter's fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the means test was removed. In its early history the burial allowance was paid to all veterans, regardless of their service connectivity of death. In 1973 the allowance was modified to reflect the status of service connection. The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery.

In 1973, NCA established a burial allowance that provided partial reimbursements for eligible funeral and burial costs. The current payment is $2,000 for burial expenses for service-connected (SC) death, $300 for non-service-connected (NSC) deaths, and $300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a non-service-connected death, and 54 percent of the burial plot cost. In 2007 these benefits eroded to 23 percent, 4 percent, and 14 percent respectively. It is time to restore the original value of the benefit.

The IBVSOs are pleased that the last Congress acted to improve the benefits, raising the plot allowance to $700 as of October 1, 2011. However, there is still a serious deficit in original value of the benefit when compared to the current value.

While the cost of a funeral has increased by nearly 700 percent, the burial benefit has only increased by 250 percent. To restore both the burial allowance and plot allowance back to their 1973 values, the SC benefit payment should be $6,160, the NSC benefit value payment should be $1,918, and the plot allowance should increase to $1,150.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that VA separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model, and those who live outside the threshold. For those veterans who live outside the threshold, the SC burial benefit should be increased to $6,160, NSC veteran's burial benefit should be increased to $1,918, and plot allowance should increase to $1,150 to match the origi-

nal value of the benefit. For veterans who live within reasonable accessibility to a state or national cemetery that is able to accommodate burial needs, but the veteran would rather be buried in a private cemetery, the burial benefit should be adjusted. These veterans' burial benefits will be based on the average cost for VA to conduct a funeral. The benefit for a SC burial should be $2,793, the amount provided for a NSC burial should be $854, and the plot allowance should be $1,150. This will provide a burial benefit at equal percentages, but based on the average cost for a VA funeral and not on the private funeral cost that will be provided for those veterans who do not have access to a state or national cemetery.

In addition to the recommendations we have mentioned, the IBVSOs also believe that Congress should enact legislation to adjust these burial benefits for inflation annually.

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the Nation's commitment to all veterans who have served their country so honorably and faithfully.

NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 3 million servicemembers who died in every war and conflict are honored through internment in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans; they are hallowed ground to those who died in our defense, and a memorial to those who survived.

AMVETS' second focus in the FY 2012 *IB* is on veteran entrepreneurship and Federal procurement as it relates to Service Disabled Veteran Owned Small Businesses (SDVOSB) and Veterans Owned Small Businesses (VOSB). We believe that both of these issues play a vital rule in the success of transitioning servicemembers and the quality of life for veterans. And while I do note that a majority of the proceeding information is focused on policy rather than hard fiscal numbers, we believe that broken policy, duplication of efforts and lack of oversight are key factors in determining fiscally responsible budgets.

VETERAN PREFERENCE IN FEDERAL HIRING AND PROCUREMENT

Supporting Service-disabled Veteran-owned Small Businesses (SDVOSBs) and Veteran-owned Small Businesses (VOSB) contributes significantly in sustaining a veteran's quality of life, while also contributing to the success and ease of transitioning from active duty to civilian life. Often in these tough economic times, self employment and entrepreneurship are the only ways many veterans are able to earn a living wage. Given the circumstances, now more than ever, Federal agencies must be held accountable to meet the Federal procurement goals outlined by Executive Order 13360, Sections 15 (g) and 36 of the Small Business Act and the numerous other published Federal regulations outlining veterans' preference and SDVOSB set-aside laws.

The Government Accountability Office's (GAO) most recent review of interagency agreements found that VA is still lacking an effective process to ensure that interagency agreements include the required language instructing all Federal agencies comply with VA's contracting goals and preferences for SDVOSBs and VOSBs. While it is noted that VA issued guidance to all contracting officers on managing interagency acquisitions in March 2009, the numerous interagency agreements still did not even include the required language addressing VA's contracting goals and preferences until it was amended on March 19, 2010. This serves as an example of how VA is clearly lacking an established hierarchy or clear delegation of duties in oversight activities. This lack of oversight is continuing to contribute to VA having no assurance or metrics in place to conduct proper oversight that agencies have made maximum feasible efforts to contract with SDVOSBs or VOSBs. This lack of oversight only stands to hurt those in which the laws were established to protect, the veterans.

We recommend stronger oversight, outreach and enforcement by all Federal agencies tasked with ensuring the success of our veteran entrepreneur community. This includes, but is not limited to, the U.S. Department of Labor (DOL), Office of Small Business Programs (OSBP), Small Business Administration (SBA), Office of Federal Contract Compliance and Procurement (OFCCP) and all other Federal agencies committing to reaching their 3 percent goal. All Federal agencies must make a high priority of assisting in the development and implementation of stronger strategies and accountability in reaching the three-percent goal of veteran employment and contracting.

Congress must ensure adequate resources are available to effectively monitor and recognize those agencies that are not meeting the three-percent goal and hold them

accountable for failure. The annual reports filed by all Federal agencies, reporting the prior fiscal years' actual percentage of goal achieved, should serve as guidance as to which agencies need the most assistance in the development and implementation of stronger contracting plans and oversight.

CENTER FOR VETERAN ENTERPRISE

Another critical aspect in ensuring the success of our veteran entrepreneur community is promoting and assisting veterans in their entrepreneurial endeavors through programs such as the Center for Veteran Enterprise (CVE). CVE was established to assist all veterans with the numerous aspects of establishing and maintaining a small business. CVE is a subdivision of the Office of Small and Disadvantaged Business Utilization that extends entrepreneur services to veterans whom own or who want to start a small business. CVE is also tasked with aiding other Federal contracting offices in identifying VOSBs in response to Executive Order 133600. In the past, VA has faced many obstacles, from lack of leadership to best practices with their entrepreneurship programs, which have directly resulted in and prevented the success of veteran owned businesses. For this reason, VA established the program entitled the Center for Veterans Enterprise (CVE) with the passage of the Veterans Entrepreneurship and Small Business Development Act of 1999. Furthermore, on Dec. 22, 2006, President Bush signed Public Law 109–461, the Veterans Benefits, Health Care, and Information Technology Act of 2006 in an effort to successfully identify and grant status to SDVOSBs. Effective June 20, 2007, this legislation authorized a unique "Veterans First" approach, specific to VA contracting.

As we move through the 21st century, during a time of war on multiple fronts, the VOSB and SDVOSB population continues to rise at a rate not seen since the end of World War II. As America's war-fighters transition back into civilian life, many are choosing to pursue lives as entrepreneurs. Given the almost 35 percent influx of VOSB and SDVOSB, it is vital that the Center for Veterans Enterprise be ready and able to meet the growing demand for their services. However, the IBVSOs do not believe that CVE is serving the needs of those veterans it was originally designed to help. Due to a lack of leadership over the past year, we have seen CVE slowly move from the role of assisting VOSB and SDVOSBs to that of an information and referral agency for other Federal and state agencies. We believe the Center for Veteran Enterprise must be brought back up to par with what it was originally tasked to do: assisting our veteran population in all aspects for their entrepreneurship endeavors. In order to effectively accomplish this Congress must provide dedicated funding and strong oversight in ensuring CVE is properly staffed, trained and funded.

VENDOR VERIFICATION SYSTEMS

Another key part of protecting our veterans in a successful Federal procurement system is through a centralized vendor verification system. We believe it to be vital for all Federal agencies to utilize a continually updated, single centralized source database in the verification of all businesses claiming preferred status as a VOSB or SDVOSB.

At present, vendors desiring to do business with the Federal Government must register in the Central Contractor Registration (CCR) database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. Public Law 109–461 required VA to establish a Vendor Information Page (VIP) database to accurately identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. This database was originally designed to act as a reliable, centralized database enabling all Federal agencies a single source in the identification of possible SDVOSB and VOSB for consideration during their procurement processes. Furthermore, both contractors and subcontractors involved in the procurement process of any government award is then required to provide the Secretary of Labor a specific breakdown of all information required by the VETS 100 and VETS 100-A filed on an annual basis, demonstrating their continued compliance with the contracts terms regarding veterans preference and status. As of April 15, 2009, approximately 18,000 SDVOSBs were registered in the Central Contractor Registration, however, due to lack of oversight and an inconsistent, self-reported status verification processes, many non-veteran-owned businesses are not receiving the protections they are entitled to under the law.

On February 8, 2010, the final CFR rules regarding "VA Veteran-Owned Small Business Verification Guidelines" were published. The document affirms as final, with changes, an interim final rule that implements portions of the Veterans Benefits, Health Care, and Information Technology Act of 2006. This law requires the

Department of Veterans Affairs (VA) to verify ownership and control of veteran-owned small businesses, including service-disabled veteran-owned small businesses. This final rule declares to define the eligibility requirements for businesses to obtain verified status, explains examination procedures and establishes records retention and review processes. However, the newly published rule fails to outline any solid changes or improvements to the SDVOSB verification process. We further believe the newly published rules on the verification process focused on control and ownership definitions, yet provided no clarification on the specifics of the verification process. The IBVSOs believe these updates to 38 CFR, Part 74 regarding Public Law 109–461 still leave the integrity of the SDVOSB and VOSB verification system open to fraud. This continued lack of clarity and non-uniformed inconsistent status verification processes will cause the same unwanted results of many veteran owned businesses not receiving the protections they are entitled to under the law.

VA has thus far been awarded $1.4 billion in recovery act funds to aide in the employment and contracting opportunities available to SDVOSB and VOSB. To date $538 million has been used on awards to SDVOSB and VOSB, according to VA. However, we have very serious concerns on how much of these appropriated funds were actually awarded to legitimate SDVOSB and VOSBs, due to the lack of verification processes in place at VA.

In an effort to resolve this issue we recommend that all Federal agencies should be required to certify veteran status and ownership through the VA's VIP program before awarding contracts to companies claiming veteran status. We also recommend the database be maintained and updated on a regular basis to avoid backlogs of vendors waiting to be certified or re-certified.

Furthermore, Congress must take the necessary actions in requiring all Federal agencies to use a single source database in all verifications of veteran ownership statuses before unknowingly awarding contracts to companies on the basis of claiming SDVOSB or VOSB preference. Finally, internal promotion and education on proper usage of the database should coincide with implementation of databases use.

VETERAN SET-ASIDES

Protecting veteran set-asides within the Federal procurement system is a matter that must be addressed more rigorously within VA's training and personnel programs. Public Law 109–461, the "Veterans Benefits, Health Care and Information Technology Act of 2006," was signed Dec. 22, 2006, and went into effect on June 20, 2007. The law allows VA special authority to provide set-aside and sole-source contracts to small businesses owned and operated by veterans and service-disabled veterans. This legislation is codified in Title 38, United States Code, sections 8127 and 8128. After more than three years since its enactment, no significant change has been implemented with regard to how Federal contracting officers are trained. VA personnel involved in the acquisition process need to be trained and familiarized with all current and new authorizations and responsibilities under P. L. 109–461, as well as all other procurement directives regarding VOSBs and SDVOSBs. Our service-disabled veterans who own small businesses cannot afford to wait any longer for VA to enforce compliance with the law.

Under current policy, no proof of compliance is required, nor do random labor audits occur. OIG has issued more than 10 reports illustrating these deficiencies in recent years. Most recently, in October 2009 the U.S. Government Accountability Office (GAO) issued their report on "Service-Disabled Veteran-Owned Small Business Program: Case Studies Show Fraud and Abuse Allowed Ineligible Firms to Obtain Millions of Dollars in Contracts" to the Committee on Small Business. This report outlines how millions of dollars in set-aside contracts were awarded to non-SDVOSB businesses due to the gross lack of program controls in place to detect and prevent fraud. The report identified 10 case-study examples of firms that did not meet the basic SDVOSB program eligibility requirements, but yet received over $100 million in SDVOSB set-aside contracts. VA, DOL, SBA and the OFCCP must exercise better oversight and stronger enforcement with consequences for any government agency or nongovernment business claiming to be awarding set-asides to veteran-owned businesses when, indeed, they are not. There needs to be an immediate focus on proactive measures to eliminate untruths, such as "rent a vet," and cease only exercising "reactive" strategies. VA, the DOL, SBA, and OFCCP should pool all their resources and successful strategies to ensure swift action and to avoid duplication of efforts.

Furthermore, we believe VA must develop and implement uniformed training processes for all staff involved with the Federal procurement process, especially contracting officers. VA must also provide systems and metrics to identify the strengths and weaknesses in its procurement processes, as well as continued training and

evaluations of contracting staff in efforts of successfully identifying weaknesses and strengths within the program as a whole.

Last, VA, DOL, SBA, OFCCP and the Employment and Training Administration must collaborate in developing and implementing a single-source database for employer outreach programs for the promotion of veterans' entrepreneurship at local and national levels. This system must allow all employers to locate veterans for employment as well as provide an updated listing of employment opportunities.

Again, Chairman Murray, ranking Member Burr and Members of the Committee, we thank you for inviting us to share with you our recommendations and stand ready to answer any questions you may have.

Chairman MURRAY. Thank you very much.

Mr. Kelley.

STATEMENT OF RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. KELLEY. Madam Chairman, on behalf of the 2.1 million members of the Veterans of Foreign Wars and its auxiliary, congratulations on your appointment to the chairmanship and thank you for the opportunity to testify today.

As a partner of *The Independent Budget*, the VFW is responsible for the construction budget. So I am going to limit my remarks to that subject today.

A vast, growing, and aging infrastructure continues to create a burden on VA's overall construction and maintenance requirements. These facilities are the instruments that are used to deliver the care to our injured male veterans.

Every effort must be made to ensure that these facilities are safe and sufficient environments to deliver that care. A VA budget that does not adequately fund facility maintenance and construction will reduce the timeliness and quality of care to our veterans.

This is why the *IB* partners are recommending an overall construction budget of $2.8 billion, $2.2 billion for the major construction accounts, and $585 million for the minor construction accounts.

Last fall, the VA provided the *IB* partners with an overview of the new strategic capital investment plan, or SCIP. After the briefing and upon reviewing VA's Fiscal Year 2012 Budget submission, the *IB* partners were pleased with the improved transparency of the capital planning.

VA has advised the *IB* partners that SCIP is intended to identify capital acquisition needs ranging from nonrecurring maintenance and leasing to major and minor construction projects, and to close the currently identified performance gaps.

All told, these gaps will require between $53 and $65 billion in funding over the next 10 year. However, at the Administration's requested level, it will take between 18 and 22 years to achieve this 10-year Plan.

Underfunding VA's capital plan in its infancy will only exacerbate the ongoing construction and maintenance needs. We are happy to see that the VA's Fiscal Year 2012 Budget request for medical facilities in New Orleans, Denver, and along with three other major construction sites will be fully funded. However, only seven of the 23 partially-funded major construction projects will continue to be funded in fiscal year 2012, leaving well over $4 bil-

lion remaining in partially-funded projects dating back to fiscal year 2007.

These projects include: improving seismic deficiencies; providing spinal cord injury centers; completing a polytrauma blind rehab and research facility; as well as expanding mental health facilities. These projects have a purpose and should be funded as quickly as possible to fulfill the promise of care to our wounded and ill veterans.

The VA is requesting approximately $545 million to continue construction on seven existing projects and to begin work on four new projects. At this pace, VA will not reach its strategic capital investment 10-year plan.

Therefore, the *IB* partners request Congress provide funding of $1.85 billion for VHA major construction accounts. This will allow VA to complete all current partially-funded major construction projects within 5 years, begin providing funding for 15 new projects and fund the four currently partially-funded seismic correction projects at a level that will have them completed in 3 years.

The *IB* partners are pleased with VA's funding requests for VHA minor construction accounts. This level of funding will allow VA to fully fund more than 75 projects.

The Administration's requests for NCA construction projects totals nearly $80 million. The *IB* is requesting $161 million. This will allow NCA to complete nearly all of its minor construction projects and begin three major projects, expanding veterans' access to cemeteries in Hawaii, Florida, and Colorado.

The *IB* partners are also requesting an increase in funding for research facilities, funding at the level of $150 million will allow work to begin on the five highest priority research projects.

Again, it is critical to the care of our veterans that we fully fund VA construction.

Madam Chairwoman, I thank you again for this opportunity and look forward to any questions you or the Committee may have.

[The prepared statement of Mr. Kelley follows:]

PREPARED STATEMENT OF RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

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 healthcare 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 healthcare 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

Major Construction—Continued

Category	Recommendation ($ in thousands)
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 sizable 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.

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.

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 shortsighted 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 MPROVEMENTS:

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 equip-

ment 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.

Chairman MURRAY. Thank you very much.
Mr. Tetz.

STATEMENT OF TIM TETZ, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. TETZ. Madam Chair, Ranking Member Burr, thank you for opportunity to come before you and testify on behalf of the American Legion.

As a parent of an 8- and 10-year-old, I am continually presented with tears and crying. As every parent knows, all crying is not the same. All tears do not have the same weight. There is a reason for the water works, the crying. Your task as a parent is to find it, find the base reason, then you have a much better chance of having a peaceful evening; but if you are successful in finding only one of the reasons, your evening is bound to be less than enjoyable.

Crying might have been what brought her pain to your attention but the underlining symptom might be a fever of 104. Your first response has to be to get that fever down; but ultimately, if you want to have a lasting success, you need to understand the underlying causes of the fever. Crying is one symptom. The fever is another. The true problem is an infection.

Congress, the VA, and the veterans' service organizations have presented with or demonstrated on a number of occasions some of this crying, some of these symptoms. We have all had our moments of crying. Our task must now focus on treating those symptoms of that underlying infection. This infection manifests itself in many ways.

We have all spoken to the backlog of claims. VA processes over a million claims a year. Over the past years we have thrown money at IT solutions in the form of VBMS, personnel, and wave after wave of new hires, and a multitude of new pilot programs. Yet have we treated the symptom or the root infection?

The VA claim system is broken because VA places an undue stress on the numbers of claims processed and a minimal stress on accuracy. New IT tools that are used to implement the old system will just allow us to make these mistakes faster. It will not unclog the system because the cycle of improper denials and appeals will not go away.

This budget gives VA quite a bit of money to implement the IT programs and initiatives. But does it fix it all the way? Does it establish a system that incorporates rules-based processing to enhance accuracy? VA must build a system that tracks individual error and holds stations accountable for not only the volume of work they accomplish but also the accuracy of that work.

Treat the root of the problem, not the symptom. Spending money to prevent symptoms and infection from rising is just as important as treating them once they arise.

Investment in infrastructure and facilities ensures that today's cough does not turn into tomorrow's infection. Infrastructure, modernization, and facilities adequate to meet the needs of our Nation's veteran population—these are foundational expenditures.

Construction money is money you have to spend now or you will surely spend it later. When you spend it later, you always spend more.

The American Legion is troubled to see the proposed major construction has dropped from $1.1 billion in 2010 to less than half that figure in 2012 with minor construction also seeing a nearly $200 million decrease.

We have seen firsthand in our annual System Worth Saving (SWS) visits, the need for such expansion and infrastructure to meet the needs of the growing veterans community, and we strongly urge Congress to at least meet the previous level of funding.

This cannot be an area to cut corners when so many rural veterans are hungry for access to the VA health care, when urban facilities lack the adequate needs, and when cities like Denver, New Orleans, and Las Vegas await new medical centers to serve the veterans in a manner they deserve.

The American Legion remains cautiously optimistic that the Fiscal Year 2012 Budget proposal will meet the needs of our Nation's veterans.

We appreciate the effort the VA has made toward addressing the symptoms and issues that currently face our Nation's veterans. We challenge their reduction of funding in programs and budgets that have long-term consequences.

Full funding of the VA to meet the needs of veterans is essential. Regardless of politics, if there is a cost to be met to care for veterans who have borne the battle of this Nation, we must bear that cost. To do so requires sacrifice, but the American Legion understands the importance of insuring there is no waste in that sacrifice.

Be vigilant and keep oversight over the VA to ensure that the money "we the people" give is spent as wisely as possible without waste and with efficiency and consistency.

I thank you again for the opportunity to provide this testimony and will gladly answer any questions.

[The prepared statement of Mr. Tetz follows:]

PREPARED STATEMENT OF TIM TETZ, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Madam Chairman and Members of the Committee: The American Legion welcomes this opportunity to comment on the President's Department of Veterans Affairs (VA) budget request for fiscal year (FY) 2012 and 2013.

The American Legion is pleased to see the budget, at a proposed 10.6 percent increase over 2010 levels, recognizes many of the needs faced by veterans and that this continues to be an area where we must ensure proper funding. The nation is facing many difficult challenges, and the veterans of America face many of their own challenges. Not only do we see the return of large numbers from two overseas wars, we also face the challenges of an aging veterans' population from previous wars. Unemployment strikes veterans at a rate two thirds higher than the general population and medical challenges are only now beginning to be understood in the form of Traumatic Brain Injury (TBI) and long term issues such as the effects of

environmental exposures in Vietnam and the Gulf War Theater and the psychological effects of war from Posttraumatic Disorder (PTSD).

Not only do external challenges such as these affect veterans, but internal obstacles within VA also represent significant challenges to be met by a budget. VA is transforming to 21st century "paperless" technology through the Veterans Benefits Management System (VBMS.) Will it be enough to turn the tide against a rising backlog when VA is awash in a sea of claims that has topped one million each of the past two years? This is a major concern. VA facilities, be they medical, administrative or for the purposes of our national cemeteries are much in need of upgrades and expansion to properly serve the veterans' community.

These all point to the importance of a fully funded VA to meet the needs of the growing numbers of veterans. It is vital to ensure that the mission set forth by President Lincoln, "To care for him who shall have borne the battle, and for his widow and his orphan," must not be given short shrift despite the economic woes. This debt must be honored.

However, this is also a time of fiscal responsibility. The American Legion believes there should never be a wasted dollar spent in the service of veterans and that a maximum amount of the money spent must find its way down to the veteran on the street level. If there is a cost to be paid to care for the veterans of this country we must pay it, but the money must be used efficiently and prudently. This is a time for smart money.

Smart money is investing in infrastructure. Infrastructure is construction money wisely spent and research to stay ahead of medical conditions before the most devastating lasting effects can be felt. Smart money is avoiding duplicative spending and making sure the money saved goes to places where even a small shortfall can be a major setback. Smart money is ensuring the Information Technology (IT) transformation of VA does more to transform the operational mindset and less to give electronic tools that repeat the errors of the past—but with greater speed.

It is also important to recognize investment in veterans is not investment in a vacuum or isolated community that has little impact on the rest of America. It was once noted that if you wanted to "reach the veterans of America" you should simply speak to the whole of America, for they have integrated into near every community. Urban or rural, from Washington state to Puerto Rico and Maine to Hawaii veterans are an integral part of the community and money invested in veterans shores up these communities.

A simple example is VA's Home Loan program, which provides low interest loans to veterans with no down payment and minimal closing costs. In a time where foreclosures have crippled the American housing markets, VA Home Loans have performed better than any other class of loans. In fact, according to the Mortgage Bankers Association, in 2010, the VA's percentage of loans that are seriously delinquent or in foreclosure is the lowest of all measured loan types—lower even than prime loans. In this way it is clear to see that investing in veterans can provide stability to communities that help all citizens in the difficult economy. It is all the more important that vital, community stabilizing programs such as the VA Home Loan program, receive full funding and are not curtailed in a short sighted aim of trimming a budget that only creates greater costs in the future.

There are, however, two issues the American Legion urges Congress to address that will make this program fully functional and as effective as it deserves to be: first—the extension of the VA's maximum guaranty amount which is currently set to snap back at the end of this fiscal year; and second—providing a fee structure that is not over-burdensome but ensures that the program is self-sustaining. Surely a self sustaining program that provides stability to America's housing market while returning the investment that veterans have made to their country is about as smart money as Congress can provide.

This is not a line-by-line excoriation and examination of a budget. This is an attempt to recognize the important areas The American Legion believes Congress must consider while determining the overall budget. Washington DC has a reverence for the new. Part and parcel of this reverence is often to roll out sexy new programs to solve the errors of the past, while letting the old programs languish in the background, still on the books and draining money, yet broken and creating drag on operations like a jammed chain on a bicycle. Sometimes the smarter choice is to ensure what you already have is working. It can be better to make fundamental repairs that bolster the existing system rather than throw the baby out with the bath water and reinvent the wheel.

The VA has a unique medical system that is tailor-made to push cutting edge research, but it must be bolstered and funded to do so. The VA is expanding medical facilities and programs to provide outreach to rural veterans who are a more difficult community to serve. As more veterans move to rural areas, this must be con-

tinued to help meet their needs. VA has dedicated doctors and health care professionals who work hard to treat the veterans of this country; they must have the best facilities we can provide them. Veterans must have basic amenities at their health care facilities like parking and child care, or they cannot make use of the excellent system that serves their health care needs. There is an extensive network of state veterans' homes, yet duplicative evaluation of these homes by both VA and SMS leads to millions of dollars of waste that could be better applied elsewhere, and this is only one example of overlap. VA has spent millions of dollars on dozens and dozens of pilot programs to fix the model of operations that has led to a multiyear backlog for veterans' disability claims. It's time to make the most of the lessons gleaned from these pilots and Congressional studies; it's time to stop studying and start implementing.

MEDICAL AND PROSTHETIC RESEARCH

While the President's proposed budget points to $6.2 billion in funds to care for TBI and PTSD, the vast majority of this money is directed solely at care and not at funding the research that will improve care and reduce the future costs incurred in treating these conditions.

The American Legion believes VA's focus in research must remain on understanding and improving treatment for medical conditions that are unique to veterans. Servicemembers are surviving catastrophically disabling blast injuries due to the superior armor they are wearing in the combat theater and the timely access to quality combat medical care. The unique injuries sustained by the new generation of veterans clearly demand particular attention. It has been reported that VA does not have state-of-the-art prostheses like DOD and that the fitting of prostheses for women has presented problems due to their smaller stature.

There is no reason that VA should not be the preeminent source of research in the world in the treatment of PTSD, TBI and prosthetic and amputee medicine.

There is a need for adequate funding of other VA research activities, including basic biomedical research and bench-to-bedside projects. Congress and the Administration should continue to encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans, such as prostate cancer, addictive disorders, trauma and wound healing, Post Traumatic Stress Disorder, rehabilitation, and other research that is conducted jointly with DOD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

As challenging health concerns such as the long term effects of TBI, exposures to environmental hazards in domestic and overseas deployment, and the mental health impact of exposure to combat conditions as well as sexual trauma and assault develop, it is essential that VA lead the way in research and development to combat and treat these conditions. Servicemembers affected by these conditions will have a deep and lasting effect on the economy through their ability to contribute if these conditions are not treated and mitigated. Learning to attack these conditions early can very often be the difference between manageable symptomatology and more devastating and less treatable levels in the future. Quite simply, the more that can be learned about diagnosing and treating these conditions, the more likely this Nation can avert catastrophic impact in the future.

Yet this proposed budget cuts funding from this vital area. The FY 2010 Final Budget saw an allocation of $581 million in this area, slashed by $72 million to $509 million in the proposed FY 2012 Budget. In a budget seeing increases in many other areas, a reduction to this critical area cannot be overlooked.

Truly, investing in research at the onset is investing in the future. While The American Legion applauds the VA budget's stated research priorities of Mental Health, Gulf War Illness and Environmental Exposures, Prosthetics, and Traumatic Brain Injury and Spinal Cord Injuries, the allocated $509 million should be made more robust. As the lesson learned from Agent Orange exposure in Vietnam should have taught us, research delayed into developing residuals of war can have devastating economic impact down the road. Money invested now in this research has the potential to not only save this Nation money in the long run, but also ameliorate and alleviate the suffering of veterans at a time when the long-term impact can be minimized.

CONSTRUCTION—MAJOR AND MINOR

As a part of the preparation for the annual System Worth Saving (SWS) reports, The American Legion has seen firsthand the structural deficiencies and challenges faced with the infrastructure of the VA health care system. During those site visits, many VA Medical Center staff have informed Legion personnel that they are unable

to dedicate needed funds toward construction projects due to the funding needs of actual medical care. Furthermore, many VA construction projects were only made possible through the use of funding from the America Reinvestment and Recovery Act. Such money is no longer available to meet the construction needs to shore up VA infrastructure in areas such as seismic criteria, aging electrical systems, insufficient parking and space utilization, and other needed areas. Therefore, the need to fully fund this area of the budget is even more apparent.

Recent reports of the VA Regional Office in Roanoke, VA noted that the floors of the building were in danger of collapsing due to the aggregate weight of the files. While this highlights yet another major implication of the claims backlog, it further underlines that this is not an area where VA can afford to scrimp and save. Substandard facilities do not serve the veterans of this country.

Construction is money that must be spent, either now or later. When the choice is made to spend later, the cost is always much higher.

If we are to truly invest in the future of this country, there are few more sound decisions to be made than investing in infrastructure. Just as the roads and bridges of America must be shored up to support the crumbling infrastructure and prevent even greater costs down the road, so too must the infrastructure of VA be solidified to meet the needs of the growing veterans' community.

Whether it is much needed medical facilities to the rural regions of the country, repairs to aging urban hospitals, proper laboratory facilities, adequate parking, or other needs, it is short sighted to see opportunities to cut here, for cuts to this area now will only bring greater costs down the road. The wise fiscal decision is to invest carefully now to head off ballooning costs in the future.

IT SYSTEMS

Since the data theft occurrence in May 2006, VA has implemented a complete overhaul of its Information Technology (IT) division nationwide. The American Legion hopes VA continues to take the appropriate steps to strengthen its IT security to regain the confidence and trust of veterans who depend on VA for the benefits they have earned.

As acknowledged by the GAO Report 11–265, "Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs" there are still major hurdles to be overcome to achieve the goals set forth of a Virtual Lifetime Electronic Record for servicemembers from induction through the rest of their lives as active duty and veteran. The President's budget sets aside monies for this purpose, but it is vitally important to ensure that this component is not left behind, nor allowed to falter. Achieving this goal should remain a major priority of both DOD and VA in cooperation with one another.

The American Legion supports the centralization of VA's IT. The amount of work required to secure information managed by VA is immense. The American Legion urges Congress to maintain close oversight of VA's IT restructuring efforts and fund VA's IT to ensure the most rapid implementation of all proposed security measures.

Obviously, with VA's transformation of the Veterans Benefits Administration (VBA) to a "paperless" processing system through the Veterans Benefits Management System (VBMS) this can be an area of great savings overall for VA as VBA moves out of the research and piloting stage of this system and into regular operations. Startup costs can now be eliminated and hopefully VA will be vigilant in ensuring that this new system offers the speed and accuracy promised.

FISCAL RESPONSIBILITY

Fiscal responsibility is, of course, a vital concern in the difficult times we are facing as a Nation. The American Legion believes strongly money spent must be utilized wisely. To this end, all aspects of operation must be scrutinized, and where waste and mismanagement needlessly contribute to an inflated budget, these must be eliminated. Rather than wholesale cutting of necessary infrastructure, areas of redundancy must be sought, and targeted cuts to those areas serve a far better purpose in managing the budget of VA.

Better coordination with outside evaluations can help reduce internal costs of evaluation. State veterans' homes are evaluated not only by VA internal evaluation, but also by outside CMS evaluation. Better coordination and standardization of evaluation could result in reduced costs of VA evaluations of millions of dollars by reducing this level of redundancy. The American Legion has similarly called for some time for VA to accept outside, third party evaluation of accuracy and quality rates in the benefits management and claims system. Such outside evaluation could

further reduce costs where areas of redundancy with VA's own evaluative process can be found.

To be sure, such savings may seem small in comparison to the entirety of the budget. Elimination of the above redundancy could provide savings on the level of around $10 million. However, when considered against the balance of small areas where a little money goes a long way, the impact of such savings and the proper redistribution of this money could be great.

VA's funding of State Cemetery Grants contributes in many ways to a vital task, providing for the respectful repose of our Nation's veterans in conjunction with the National Cemetery Administration (NCA.) The grants cover everything from major construction to basic irrigation and bringing these state cemeteries to National Shrine Standards. As the horrifying situation played out over the last few years across the river in Arlington National Cemetery has proven, or tales of missing headstones or grounds gone to seed and disrepair in other locations attest, there are few more unconscionable acts than to give substandard service to the families of veterans in their interment. NCA takes such failings seriously, and works tirelessly to preserve their status as one of the top two organizations in service and satisfaction in the entire Nation. We cannot fall short in meeting these National Shrine Standards. A mere $5 million dollars has been estimated to be the difference between fully funding the available projects and letting some projects slide to backlog status. Some projects may cost as little as a few hundred thousand dollars or even less. VA has already let our living veterans down by allowing claims service to fall into backlog status, they cannot afford to allow a similar lapse in our veterans' cemeteries.

Better Central Office oversight is further needed at the local level to ensure that money directed to the VISNs and Regional Offices are being spent in accordance with the direction of the administration. All too often in The American Legion's visits to local areas as a part of the System Worth Saving (SWS) Reports and Regional Office Action Review (ROAR) sees wide variances in execution from region to region. To truly manage the budget of VA most effectively, developing uniform consistency is vital across the country.

The President's budget includes vastly rising costs in administrative areas, such as increases ranging from 41% in the Office of the Secretary to nearly 100% in the Office of Policy Planning and well over even that for the Office of Public and Intergovernmental Affairs. Certainly VA has struggled to meet demands, and has been woefully late in compliance with implementation of Public Laws enacted. A HVAC DAMA Subcommittee meeting last year regarding Public Law 110–389 that found nearly half of the provisions short of implementation well over a year and a half past the passage of the law. Delays in implementation and publication of new Agent Orange regulations are well documented. Certainly we must not overlook the recent tardiness in an implementation plan for the Caregivers' Act. If VA is short staffed and unable to comply with basic regulations for operations, they should be given adequate staffing. Congress has generously provided VA with additional staffing for their claims processors that Acting Undersecretary for Benefits Michael Walcoff has recently stated in testimony is now sufficient for VA to reduce the backlog and meet the Secretary's stated goal of no claims languishing longer than 125 days at a 98 percent accuracy rate. If the Central Office truly needs this plus up of numbers to adequately manage the ability of VA to complete their daily tasks, then this funding is welcomed.

The American Legion does underline the need to ensure that this staffing is essential. As belts are tightened in budget season, not only in Washington but in every household across the country, we cannot afford wasteful spending. Every penny spent must be to the good cause of helping the veteran at ground level.

CONCLUSION

Madame Chairwoman and Members of the Committee, The American Legion believes it is absolutely critical that the entire military and veterans' community (active-duty, Reserve Component, and veterans) continue to remain supportive of honorable military service. No servicemember should ever doubt:

- the quality of health care he or she will receive if injured;
- the availability of earned benefits for honorable military service upon discharge; or
- the quality of survivors' benefits should he or she pay the ultimate sacrifice.

A true investment in the future means investing in key areas of infrastructure now and not making short sighted cuts to vital areas that will only bring greater costs down the road.

Full funding of essential projects such as research in emerging health risks and disabilities, as well as the physical infrastructure of VA facilities will be the prudent choice now to stave off even greater financial burdens down the road. VA must meet these challenges with an adequate budget to fund these necessary aims.

VA MEDICAL DISCRETIONARY PROGRAMS

	P.L. 111–117 FY 2010 VA Final Funding	P.L. 111–322 FY 2011 VA Funding	President's FY 2012 VA Budget Proposal	FY 2013 Proposed Advance Appropriations	American Legion's FY 2013 Request
Medical Services	$34.7 billion	$37.1 billion	$39.5 billion	$41.3 billion	$38.1 billion
Medical Support & Compliance	$4.9 billion	$5.3 billion	$5.4 billion	$5.7 billion	$5.3 billion
Medical Facilities	$4.8 billion	$5.7 billion	$5.4 billion	$5.4 billion	$6.2 billion
Medical/Prosthetic Research	$581 million	$581 million	$509 million		$600 million
Medical Care Collections Fund	[$2.9 billion]	[$2.9 billion]	[$3.1 billion]		
Total Medical Care	$47.9 billion	$51.6 billion	$53.9 billion	$52.4 billion	$50.2 billion

VA NON-MEDICAL DISCRETIONARY PROGRAMS

	P.L. 111–117 FY 2010 VA Final Funding	P.L. 111–322 FY 2011 VA Funding	President's FY 2012 VA Budget Proposal	American Legion's FY 2012 Request
Major Construction	$1.2 billion	$1.2 billion	$590 million	$1.2 billion
Minor Construction	$703 million	$703 million	$550 million	$800 million
State Veterans' Homes Construction Grants	$100 million	$100 million	$85 million	$100 million
State Veterans' Cemeteries Construction Grants	$46 million	$46 million	$46 million	$60 million
General Operating Expenses	$2.1 billion	$2.5 billion	$2.5 billion	$2.6 billion
Information Technology	$3.3 billion	$3.3 billion	$3.2 billion	$3.5 billion
National Cemetery System	$250 million	$250 million	$251 million	$260 million

Chairman MURRAY. Thank you very much.
Ms. Hooker.

STATEMENT OF MARYANN D. HOOKER, M.D., LEAD NEUROLOGIST, WILMINGTON, DELAWARE, VA MEDICAL CENTER, REPRESENTING AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Dr. HOOKER. Thank you very much, Madam Chairman, Ranking Member Burr, and other Members of the Committee in absentia. Thank you for the opportunity to testify on behalf of AFGE regarding clinical staff and resource realignments mentioned in the VA's budget request.

I joined VA in 1991. Prior to that, I rotated through several VA hospitals during medical school, internship, and residency. I greatly appreciate the education I received during my training years.

I wonder how the proposed realignment will impact medical education and academic affiliations if physicians are shifted away from patients.

As a neurologist, I work with a number of special patient populations: patients with spinal cord injury; multiple sclerosis; Traumatic Brain Injury; amyotrophic lateral sclerosis; dementia; and Parkinson's disease to mention a few.

The veterans I see for second level Traumatic Brain Injury screens are sent to be evaluated for those subtle changes that cannot be picked up on routine examinations. Those changes that lead

to many years of lost work, lost relationships, and lost lives due to missing the diagnosis.

Parkinson's disease is another entity where specialty expertise is invaluable both in making the correct diagnosis and in developing the proper treatment in concert with the patient.

I see a lot of women veterans who suffer from migraine and other pain syndromes where specialty care also lessons the burden of suffering and allows patients to lead more productive lives.

Without knowing the specifics of VA's proposed changes, I can only speak from direct experience in saying that the substitution of other providers for physicians or LPNs for RNs may, in some cases, have very negative effects to the health care team—patient and provider alike.

Each member serves a unique role. Indeed, the patient care center initiative of which Patient Aligned Care Teams or PACT is, but one aspect, if properly implemented, perfectly illustrates the symbiotic relationships inherent in providing good medical care.

I have to tell you, though, because some of these initiatives have already begun, that I am seeing patients who have not seen their primary care provider in over 2 years.

They are already lost to the VA system either through frustration with having to repeatedly call for appointments because there are no real openings or through the lack of adequate support staff to notify them of the need to make appointments, either by sending out the letters or making the telephone calls or even printing the reports to show who is missing from the system.

Gaming strategies such as these to show the achievement of 30-day access to providers will be even more egregious as VA implements 14-day access performance measures.

Realignment leading to less care providers will only exacerbate these problems. Primary care providers already are overburdened by the constant need to document completion of ever increasing numbers of clinical reminders.

They frequently are shifted among teams or clinical locations to cover staff shortages. They no longer know which patients are on their panels and patients no longer know their primary care provider.

Rather than addressing failures in the current system, we are moving on to the next great thing that will not be fully funded at the facility level.

All this constant shuffling of patients and care providers leads to high levels of staff turnover which is very costly. Nurses forced to work at the top of their scope, such as in the emergency department or intensive care unit, frequently are asked to work outside their scope. This leads to more stress, more burn out, more staff turnover, and more medical misadventures.

Patients feel this stress too as they identify very strongly with their VA care providers.

In our behavioral health service, 12 providers have left in less than 2 years. Only four have been replaced. For patients receiving behavioral health care services—our most fragile population, they are expected to cope, manage, and navigate themselves through a fractured system of care that is not integrated with primary care that itself is also fractured.

Care Coordination Home Telehealth, is another program under the Patient Centered Care initiative, though this one with the goal of keeping patients out of the hospital and away from the clinics, also is not well-integrated with primary care.

The nurses in this program work from templates and standardized order sets to manage the care of patients with complex problems such as diabetes, hypertension, and PTSD, all without the direct input of the patient's primary care provider.

I view my work at VA as an avocation more than a vocation. I have a deep respect for the men and women who served and have served in the Armed Forces. My father was in the Army and was awarded the Bronze Star. It is in his honor that I serve; and it is in the honor of the servicemembers past and present, with them in mind on behalf of AFGE that I express concern over these proposed changes.

Thank you.

[The prepared statement Dr. Hooker follows:]

PREPARED STATEMENT OF MARYANN D. HOOKER, M.D., LEAD NEUROLOGIST, WILMINGTON, DELAWARE, VA MEDICAL CENTER, SECRETARY, AFGE LOCAL 342

Chairman Murray, Ranking Member Burr and Members of the Committee: The American Federation of Government Employees (AFGE) and the AFGE National VA Council (NVAC) (hereinafter "AFGE") appreciate the opportunity to testify today on the Fiscal Year (FY) 2012 budget for the Department of Veterans' Affairs (VA). AFGE represents more than 200,000 VA employees, including nearly 120,000 Veterans Health Administration (VHA) employees providing direct medical services to veterans.

AFGE's testimony focuses primarily on the portion of the VA's FY 2012 budget request that relates to "Clinical Staff and Resource Realignment". The budget request assumes yearly savings of $151 million (in FY 2012 and FY 2013) based on three realignments:

- Conversion of selected physician to non-physician providers;
- Conversion of selected registered nurses (RN) to licensed practical nurses (LPN); and
- More appropriate alignment of required clinical skills with patient needs.

The lack of details in this proposal leaves many questions unanswered: which physician duties will be assigned to an RN? Will LPNs replace RNs in both inpatient and outpatient settings? Will staff be realigned in behavioral health and specialized medical services?

Without more specifics, it is difficult to assess whether these proposed conversions to lower skilled positions will result in a more efficient use of scarce VA medical dollars, or a harmful deskilling of the care we provide to veterans, many of whom are chronically ill or severely disabled. We urge the Committee to consider the following:

- How will the proposed staff realignment impact the quality of care that our veterans receive?
- How will it impact veterans' access to care?
- Will this realignment actually produce anticipated savings for taxpayers over the short run or the long run?
- Perhaps most important: Is the pursuit of these modest savings worth the risk of unintended consequences to veterans?

Fortunately, AFGE's assessment need not be purely theoretical; the VA is already attempting to achieve efficiencies through staff realignment, telehealth, team-based care, group appointments and shorter appointments, among other cost containment strategies. Unfortunately, what AFGE has learned so far from our gives us cause for concern. Too often, these realignments and cost containment strategies are implemented without proper oversight or advance planning, resulting in reduced access and quality of care. Also, rather than saving money, they sometimes cost the taxpayer more, in the form of costly contract care, less continuity of care and higher staff turnover. We also note that every time patients are reassigned, care coordination may suffer, clinicians have to spend additional time to learn the needs of a new patient, and veterans have to build relationships with new providers.

The impact of staff and resource realignment also will depend in part on whether it was planned or merely the unintended byproduct of budget shortfalls and hiring freezes. Yes, shortfalls and hiring freezes have not disappeared from the VHA landscape despite advance appropriations for FY 2011. AFGE recently received reports of shortfalls and hiring freezes from several VISNs. At the Wilmington VA, the Director just announced that no one can be hired on a permanent basis and the medical center budget is frozen.

This news is both puzzling and troubling. AFGE joins the *Independent Budget* veterans service organizations (IBVSOs) in urging Congress, the Administration and GAO to ensure that this critical funding reform law is fully and properly implemented.

Staff and resource realignment can and should be used in certain instances. For example, in some facilities, RN tasks such as administration of flu vaccines and B12 injections, are being reassigned to LPNs. In addition, many VA clinicians are unnecessarily burdened by administrative duties, due to new initiatives and reporting requirements. These clinicians already have extremely limited face time with patients; many primary care providers cannot spend a lot more than 30 minutes with new patients, and rumors of 15 minute new patient appointments have resurfaced. Therefore, AFGE urges the Committee to take a close look at the growing administrative burdens placed on VA clinicians that divert scare appointment time away from patient interaction. We also hope the VA will reconsider its current efforts to downgrade the Patient Support Assistant positions that provide critical backup to clinicians.

Clearly, the impact of staff realignments will also vary greatly depending on which medical services are targeted. At the Wilmington VA, the Pain Clinic Nurse Practitioner (NP) has had to run the clinic without the backup of an anesthesiologist. Like so many other VA initiatives, inadequate funding is provided for proper implementation of the VA's National Pain Initiative. As a result, the Wilmington has to send veterans out to non-VA facilities for their pain injections, resulting in delays and fractionated care. If RN positions such as these were converted to LPNs, the adverse impact on care could be significant.

A report from a VISN 1 facility reveals similar realignment problems: That facility's Pain Team has a physician who mostly does back injections and an NP is in charge of medication management. For the more difficult and complex pain patients, it may be better and safer to have a physician perform medication management, especially when narcotics are involved.

Realigning that increases the portion of specialty care delivered by a non-physician can also lead to delayed and fractionated care. When orthopedic patients see an NP or physician assistant for their first visit, they often have to return for a second appointment or go elsewhere in order to be examined by an orthopedist.

At the Wilmington VA, realignment has adversely impacted veterans seeking emergency care for behavioral health problems. At the Wilmington VA, the first oncall for emergency behavioral health patients is a licensed clinical social worker. In this type of setting, physician extenders are placed under enormous pressures to carry out the duties and schedules designed for a physician, resulting in further burnout and higher attrition. They may also be forced to perform duties outside their scope of practice. More generally, AFGE urges the Committee to look at the attrition rate among social workers and psychologists who are expected to carry out many of the duties of a psychiatrist.

Realignment-related problems may be especially difficult to detect and monitor in certain settings. For example, the Patient Aligned Care Team (PACT) is a laudable initiative that was recently described by Secretary Shinseki as an "historic step in redefining medical care". Unfortunately, implementation of PACT has been hindered by short staffing and poor coordination. Physicians and nurses already handling enormous workloads are required to take on new PACT duties. In some facilities, the only way to staff a PACT team is to transfer clinicians away from departments that are severely short-staffed.

Our members report that some PACT teams operate without the regular participation of a physician. Then, the remaining team members are forced to "realign" themselves to cover the gap. AFGE has received several reports of RNs having to work outside their scope of practice as a result of these hard-to-detect realignment problems.

We also share the concern of the IBVSOs that PACT could adversely impact specialty care if not implemented properly; staffing and coordination problems are likely to worsen the impact.

Again, AFGE believes that PACT has great potential to improve VA care. We urge this Committee to investigate implementation problems and ensure that front line

practitioners and their representatives have the opportunity to provide regular input into the evaluation process.

We also urge greater oversight of VA's Telehealth program. Here too, staffing problems that may be difficult to detect are hindering implementation of a valuable VA initiative. We are troubled by reports from several facilities that physicians are pressured to refer and keep veterans in telehealth programs, even when, in their professional judgment, another form of care would better serve the patient. (Some physicians have been offered cash incentives to divert patients to telehealth.)

In VISN 4, rural health care dollars were used to hire an NP at the Philadelphia VAMC. Then the VISN notified Wilmington's CBOC primary care providers that consults for cardiology, endocrinology and hematology/oncology could be placed through the coordinator at Philadelphia. If, after reviewing the consult, the specialist wants to see the patient, the patient would be required to bypass the Wilmington VA to go to the Philadelphia VA, even though Wilmington has the very cardiology, endocrinology and hematology/oncology specialty services the patient needs. (It is also troubling that the Philadelphia VA can only run an orthopedic surgery clinic one-half morning every other week, even though back and neck pain are among the top complaints causing veterans to seek care.)

Diagnostics is another area where conversion to lower skilled positions could be problematic. For example, depending on the medical need, an NP substituting for an internist may be required to work outside of his or her scope of practice.

As mentioned above, emergency care has suffered tremendously because of inadequate staffing. The goal is no longer to provide care to the veteran in the emergency department, but to refer the patient outside the VA system for care. At Wilmington, VA, we recently learned that the emergency department is slated to increase its maximum capacity from six to fourteen patients, yet administration wants to provide zero increase in nursing or physician staff. Recently, five patients each spent over 48 hours in the emergency department, including one who received two blood transfusions while he lay on a stretcher for two days. Meanwhile a 25-bed ward has sat idle for the past three years because of too few floor nurses.

Other concerns:

AFGE is disappointed to see the return of VA's proposal to eliminate all continuing medical education (CME) reimbursement for physicians and dentists. The VA recruits prospective clinicians with the promise of professional growth, but is reluctant to comply with the 1991 law that entitles clinicians to a modest sum for courses required to maintain certification and professional licenses.

The justification provided (without any supporting data) in the FY 2012 budget request is that physicians and dentists no longer need this recruitment/retention benefit because the pay system enacted in 2004 has made the VA competitive with other employers. If VA is sufficiently competitive, why do so many facilities have trouble recruiting these clinicians, and why does the VA continue rely so heavily on more costly fee basis care to fill the gaps? Furthermore, the 2004 pay law (P.L. 108–445) made no linkage to lower CME costs, but it did link better pay with less fee basis care—a desired outcome the VA has still not documented.

Rather than arbitrarily cut this modest CME benefit, AFGE urges this Committee to first conduct comprehensive oversight of VA physician and dentist issues, including: ongoing problems with the base, market and performance pay provisions in the 2004 law, its impact on VA's use of fee basis care, whether AFGE's CME program (again, still at 1991 levels) is competitive with other health care employers, the CME needs of other VA clinicians, and the impact of the physician/dentist "24/7" scheduling rule on recruitment and retention.

In addition, it would be valuable to finally understand why medical centers that run out of money to hire more front line practitioners usually find other funds to contract for more expensive non-VA care to fill the gap.

Perhaps, instead of looking for modest savings through realignment and the use of fewer physicians and RNs, the VA may want to examine the enormous growth of staff and resources at the VISNs, and the percentage of VISN staff that do not provide or support direct patient care.

Thank you.

POSTHEARING ADDITIONAL INFORMATION FROM MARYANN D. HOOKER, M.D., LEAD NEUROLOGIST, WILMINGTON, DELAWARE, VA MEDICAL CENTER, SECRETARY, AFGE LOCAL 342

E-Mail Viewer

Message Details Attachments Headers Source

HTML

From: "no-reply@murray.senate.gov" <no-reply@murray.senate.gov>
Date: 3/3/2011 7:29:07 AM
To: "webmail@murray-iq.senate.gov" <webmail@murray-iq.senate.gov>
Cc:
Subject: Testimony at 3-2-11 VA Budget Hearing

Dear Chairman Murray,

Thank you for allowing me to testify at the 3/2/11 hearing on the President's budget for the Department of Veterans Affairs.

You invited additional information to be submitted. What follows is from a presentation given by one of the members of the National VA Leadership Board regarding "VA Legacy Programs." One VA hospital in Iowa already has been converted to a Community Based Outpatient Care Clinic

VHA should study 3 categories of low volume inpatient hospitals:
Category 1: Facilities with 30 or less acute beds and/or utilization that would support less than 30 beds in 2010 and Acute Med/Surg utilization requiring < 30 Beds in FY 2019 AND has less than 20 acute psychiatric beds on the campus.

Category 2: Facilities with 30 or less acute beds and/or utilization that would support less than 30 beds in 2010 and Acute Med/Surg utilization requiring < 30 Beds in FY 2019 AND have greater than 20 acute psychiatric beds on campus, thereby making a closure of the facilities more complex as the mental health needs of these patients must be taken into account in a closure analysis.
Category 3: Facilities designated as Veterans Rural Access Hospitals.

The presence of other services and programs on the campuses of these category 1-3 sites such as Domiciliaries and Community Living Centers will need to be taken into account.

In order to successfully implement any recommendations, VHA would need BRAC-like legislation

If I may be of any further service, please do not hesitate to contact me.

Sincerely,

Maryann Hooker, MD
Secretary, AFGE Local 342

Close

Chairman MURRAY. Thank you very much. Thank you all for the work you put into providing this information for all of us, and excellent testimony from everybody.

I do have follow-up questions for all of you. We are running out of time here today at the hearing. Everybody has been very patient.

So I am just going to ask one or two questions and then turn to Senator Burr. I'll submit the rest to you and to ask you to respond.

Mr. Violante, I do want to ask you—because claims backlog is a top issue everywhere we go, and you spoke a little bit about it in your testimony. I saw that the amount of funding in the President's Budget request for VBA in the GOE account is significantly less than the funding recommended by the *IB*.

Can you elaborate on the *IB*'s request and comment on the Administration's?

Mr. VIOLANTE. Sure. First of all, if you look at the level that is being considered for 2011, the *IB* is roughly just a little less than $200 million more from 2011, roughly about $246 million above what the President is requesting.

Most of that increase is for what we believe to be increased costs in supplies, and there is a modest increase for vocational rehabilitation counselors, which account for about 150 individuals, and increases in the Board of Veterans' Appeals, roughly about 30 employees there.

We believe that what we are asking for is just a very modest increase above 2011.

Chairman MURRAY. Any comment on the Administration's request?

Mr. VIOLANTE. We think it is a little low.

Chairman MURRAY. That is sufficient. OK.

Mr. VIOLANTE. I do not agree with Mr. Walcoff on the training part of it. We believe there needs to be much more training involved, especially when we are looking at the problems that the VA is facing.

Chairman MURRAY. His testimony was that they would not be hiring as many so they did not need the training dollars. Tell me why you disagree with that.

Mr. VIOLANTE. We do not believe that they are adequately trained at this point, that there needs to be additional training provided to the employees that they do have, and we believe that more funds should be expended on training those individuals.

Chairman MURRAY. OK. Let me ask if anybody wants to comment on this. I think we all recognize these are very tough economic times and discretionary funding is going to be really hard to come by this year.

I want to ask if anybody wants to comment, if you believe that the VA's proposed operational improvements are appropriate and will help VA to spend taxpayer dollars in a more efficient and cost-effective manner.

If you all want to comment back for the record, you can do that.

I see you are willing to jump in.

Dr. HOOKER. It is always dangerous to give me a microphone and a platform from which to speak.

My concern would be losing the veterans that we have now that we have already lost and providing the care that they so desperately need; the efficiencies and the resources, I think, can be better utilized in fixing what it is we have now rather than promoting new initiatives that we have not tested at this point, as far as clinical care.

Chairman MURRAY. Others? Go ahead, Carl, jump in.

Mr. BLAKE. Joe and I are sitting here thinking, I think you would have to better define operational improvements. I mean, I know that they have a number of different areas where they identified projected savings. I think that is what you are referring to.

Chairman MURRAY. Right.

Mr. BLAKE. We could probably better answer that with a statement.

Chairman MURRAY. If you could get back to me with some comments on that I would really appreciate it. Great.

Chairman MURRAY. Senator Burr.

Senator BURR. Once again, I want to thank all of you for your commitment to participate in *The Independent Budget*, more importantly, your willingness to come in here and share thoughts with us.

The Chairman has pretty well spoken in what I think will be a protracted period of very difficult discretionary spending, not to just be encompassed in the next fiscal year but several to come.

It is going to be vitally important that the decisions that are made at the VA do not lose focus on what the VA mission is and that is to provide the care that our veterans were promised.

I have listened to some of additional requests that deal with training, that deal with expediting disability claims, that deal with construction needs. All of these are important.

I guess my question to anybody that would like to take it is: you are seeing a massive expansion of FTEs within the central office of the VA. Is anybody asking why, and more importantly, how that affects the mission and the things that are of most concern to each and every one of you?

My staff earlier in the week had just thrown down some things for me that we wanted to share with you to sort of set the stage for this.

In the Fiscal Year 2012 Budget request for general administration, it breaks down the proposed number of FTEs. It calls for an increase of 562 employees over fiscal year 2010, most of whom are at a GS–12 or higher level.

Now, I do not have to tell the veteran service organizations what they should be outraged about. But when you bring up the issues of construction, training, claims, the way I have broken it down I do not think that any of your issues are being addressed in the increase of 560 FTEs over fiscal year 2010.

It has got to be a particularly skilled person at a GS–12 or higher, and before any of you have the opportunity to weigh in, I hope you understand that these people come with a long-term obligation to the VA. There is a benefit package that extends far past their employment. It is not like you can bring them in without something that, for a foreseeable future, does not take away from our ability to provide the funding to deliver the care.

So, would anybody like to tackle that one?

Mr. BLAKE. Senator Burr, I would start by pointing out for basis of comparison that *The Independent Budget* for general administration was significantly less than what the Administration recommended.

From the broader perspective of the *IB*, we sort of took the perspective that we would apply the basics for inflation, which still exists out there, and not a lot else in our recommendations, health care side notwithstanding, because growth in demand is continuing. So it has its own little unique perspective.

But your concerns are not lost on us, and I think our recommendations reflect that on some level.

Senator BURR. Let me add one thing, if anybody else would like to chime in on this, in the 2012 budget request VA's Office of Information and Technology, which I say up front needs some more in-

vestment, needs some more personnel, has a request for an additional 128 FTEs.

The VA also indicates that they have plans to hire 705 new employees in the coming months, many of these are at levels of GS–12 and higher.

I think you could make the case out of information and technology that we are getting into the claims processing. Right there you have got 850 new FTEs. These are not claims processors. These are looking at the software, the hardware needs to try to facilitate the claims.

I might add to that if anybody would like to comment, I just introduced a bill yesterday that I think, Joe, you are aware of, maybe all of you are aware of, that provides for any veteran that sends in an application, a claim that has all the documentation they need, that they get an additional year's worth of benefits.

In other words, an attempt to try to create an incentive so that we get claims that are accurate when they come in the door so that they go forward with all the information.

If we screw it up then, we know we have something that we can look at that we can try to fix. But from the standpoint of the delays, waiting for all of the information that they have got to have to give the veterans the benefits.

Fully develop these claims. Do not bring them in until they are fully developed and we will give you the benefit of an extra year's benefits.

Tell me what you think of that. Joe, I will put you on the spot.

Mr. VIOLANTE. I have not read the language of the bill. I saw the information that you introduced a bill. I mean, it has been something that DAV and I think the other organizations here have talked about.

Veterans are put at a disadvantage to begin a fully-developed claim if they are not allowed to protect that earlier effective date.

From the sounds of the language of your bill, I mean, it would make that an incentive to wait that extra time to gather all your information, which then makes it easier for the VA.

Senator BURR. Anybody got any other comments on any of this?

Mr. VIOLANTE. I do. I agree with you also. As Carl said, we do not have the ability to peek behind the curtain as much as we would like to at VA. Yesterday, DAV's national commander testified before the Joint Committees and basically called on these Committees to do some more oversight of VA.

In talking to Secretary Shinseki, I know that he would like to know—it is a big bureaucratic agency—what is going on. He said before that he cannot fix the problem until he knows about it.

So I would like to encourage the Committee to do more oversight, to look at some of the situations where they are adding personnel that are not really helping the hands-on services, either on the health care side or on the benefits side, to ensure that these claims and services are provided as quickly as possible.

Senator BURR. Joe, I have said this to the Secretary, from the stand point of me personally, so this is not a shot at the Secretary or any of his professional staff. I believe that they are all multi-talented and passionate about the job that they do. I think there

is tremendous pressure from you, and from the Congress to fix things that are not always easy to fix.

I would hate to be in Dr. Petzel's position where he is the most liked guy if you've got something on his list. But it is not always something he can bump up to number 1 or this year or next year from the standpoint of funding.

Quite frankly, it has got to be frustrating for all of them to walk in and have the task of building an IT system, of having the task of fixing somebody else's problem that they left where some of the opportunities were not fully developed.

But that realization is why we are all here, to hold each other accountable to make the best decisions that we can. So, I think it is important that we call into question increases like this if, in fact, they do not pass the smell test; what is the outcome, and will it benefits us? I hope VA will take that back.

Anybody else?

Ms. ROOF. The longer I sit here the more I think about it; and you brought up the FTEs. Something you had said earlier is you asked the VA what money was appropriated for women's programs and then again someone asked why is so much of what we appropriated for the caregivers bill, why is that not all being used.

So those are the questions that pop into my mind. If there is money for things like speech writers and some of the positions you are talking about, something seems off there.

I do not have all the facts. That would be a conversation I would have, to sit and talk to VA directly, but those are the kind of things that bother us as a veterans' service organizations.

Dr. HOOKER. I can tell you from the clinical perspective that all those increases in positions come out of our hides. They do not come down to the facility level; we are shorted and then it is a question of robbing Peter to pay Paul.

So then the initiative is, say, polytrauma. Staff goes in, and then the next new initiative is women's health. So, staff comes out of polytrauma and goes into women's health. It is a constant shifting to meet what the latest performance measure is with no real addition to staff at the lower levels.

Mr. TETZ. Senator, I would say that the American Legion agrees with many of the counterparts here in the fact that, one, we do not have the open veil that we would like to have and be able to say truly what is there.

So we cannot get in the trenches and fight that and say absolutely 100 percent we agree with it. But, ultimately, at the end of the day what we should ask ourselves, whether we are a VA employee or a VSO, is this: has that employee, that team member who is at a hospital, a VBA center processing claims, what did they do for a veteran today?

If they did not have direction action, direct help with a veteran, then truly we need that person to join the team; and that is the question we must ask ourselves.

Senator BURR. I thank all of you. The Chairman has been awfully kind for letting me go over. I think this is a vital area; and we have the discretionary spending side even tighter next year. The question is, where does it come from?

My fear is that it would address even further the concern that Dr. Hooker has on the clinical side and eventually we find ourselves not talking about disability claims, we find ourselves talking about things we discussed two decades ago.

I thank you, Madam Chairman.

Chairman MURRAY. Thank you very much, Senator.

I want to thank all of our witnesses for appearing before the Committee today, especially the VA folks who stayed for our second panel. I appreciate your sitting here so long.

The President's Budget is a good place for us to start our work this year. We have got work to do on research, construction, the IG office, and a number of areas that we have talked about today.

This hearing will really help the Committee form its opinion of the Administration's request as we offer our views and estimates to the Budget Committee later this month.

I appreciate everybody's participation.

Thank you very much. This hearing is now adjourned.

[Whereupon, at 1:14 p.m., the Committee was adjourned.]

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