HEARING ON VETERANS' AFFAIRS CONSTRUCTION PROCESS

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WEDNESDAY, JUNE 10, 2009

United States Senate,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to notice, at 9:33 A.M., in Room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Begich, Burris, Burr, Isakson, and Johanns.

OPENING STATEMENT OF CHAIRMAN AKAKA

Chairman Akaka. The Committee on Veterans' Affairs of the United States Senate will come to order.

Aloha. This morning we will take a look at the VA construction process, including how VA's vast infrastructure needs are managed. I also want to learn more about where we stand on the CARES effort--the now five-year-old plan to make sense of VA's capital assets.

VA is a large health care system with aging infrastructure and some new and growing needs. Planners have to balance large-scale construction projects with costs in the hundreds of millions, along with smaller projects and nonrecurring maintenance. VA's infrastructure must be adapted to meet the needs to today's veterans and prepare to

respond to the changes that will come.

VA has moved from a hospital-driven health care system to an integrated delivery system that emphasizes a full continuum of care. The lion's share of VA's infrastructure was designed and built decades ago under a different concept of health care delivery. Since then, VA health care has experienced a great shift from inpatient to outpatient services, and as a result, VA has a system which generally reflects yesterday's priorities, not today's.

The goal of CARES was a good one--shift resources from underused, inefficient, or obsolete buildings to support better ways of furnishing health care. However, the degree to which this has happened, as well as the extent to which this continues, remains unclear.

In terms of current projects, VA has requested over $1.9 billion for fiscal year 2010 construction programs. While this is significant, it is clear that there is an extensive backlog of major construction projects, which require far more funding with such high dollar figures dedicated to construction projects, the Committee must understand the basis for VA's decision process.

I see today's hearing as beginning a focused look at where VA is with respect to its capital infrastructure and how we might go forward. I hope that we will hear some compelling suggestions for expediting the construction

process and for improving it.

I would like to now call for the statement of our Ranking Member, after which I will introduce our colleagues here for their statements.

OPENING STATEMENT OF SENATOR BURR

Senator Burr. Thank you, Mr. Chairman. Aloha.

Chairman Akaka. Aloha.

Senator Burr. Senator Udall, good to have you here. I'll be brief.

Mr. Chairman, thank you for calling this hearing. Welcome to all the witnesses of all the panels.

Mr. Chairman, you have often heard me talk about the need to transform the VA's health care system to a 21st Century delivery system and organization. In his budget, the President states that he wants the VA to be veteran-centric, results-driven, forward-looking. And such transformation, and I quote "is determined by new times, new technologies, new demographic realities, new commitments to today's veterans."

This transformation includes technological advances, new pharmaceutical products, and an emphasis on preventative care that greatly reduces the need for lengthy hospital stays. That's a good thing. And I've talked to everyone who wanted to spend more time in a hospital.

The transformation also includes providing veterans

greater access to care closer to where they live; dislocating families less. Something we see or have seen with increasingly regularity is VA opens new outpatient clinics across the country and some with ambulatory units attached.

The President and Secretary Shinseki have also endorsed the HCC approach--the health care centers' approach to health care delivery. HCCs have the ability to provide 90 to 95 percent of the care veterans need, including primary care, specialized care, and ambulatory surgery. One of the first HCCs was opened in Columbus, Ohio last fall. To supplement the outpatient care provided at the HCC, VA has collaborated with inpatient providers in the community. Although more time is needed to fully evaluate the concept, one thing is clear so far. It has saved veterans living in Columbus from having to drive 144 miles to access their health care. I think that is a good thing. More HCCs are in the pipeline, including three that are in this year's budget for the state of North Carolina. I welcome those HCCs.

These state-of-the-art facilities will eliminate the need for many veterans to drive to faraway hospitals for their care and will stretch VA's construction dollars far more than it otherwise would. We all know that construction dollars are limited. There are 66 major medical facilities-

-construction projects vetted and approved by VA for the FY010 budget. However, appropriations were requested for the design of only seven of these facilities. Fifty-nine projects will have to wait until another year.

What this suggests is that the VA and Congress must continue to think of innovative ways to meet the vast needs that exist in the system. I am pleased we have a panel of witnesses today that can help us try and chart that path forward.

One last comment before I conclude, Mr. Chairman. It concerns the over $1.4 billion allocated to the VA on the part of the stimulus package passed last February, which included one billion dollars for maintenance projects. According to the Administration's website, the latest numbers indicate that just over three hundredths of one percent of these dollars has actually been spent to date. Three hundredths of one percent.

We are now in the fourth month since the stimulus package was signed into law. I am anxious to hear why there has been a delay in spending money that was meant to stimulate the economy and what the plan is going forward.

Mr. Chairman, I look forward to the testimony today and to being enlightened by our good friend, Senator Udall.

Thank you, Chair.

Chairman Akaka. Thank you very much, Senator Burr, for

your opening statement.

Now, I would like to first welcome two distinguished gentleman from Colorado, Senator Mark Udall and Congressman Ed Perlmutter. I understand that Senator Bennet is on his way here.

They are all supporters of a new VA standalone medical center at the former Fitzsimmons Army Base in Aurora, Colorado. I can safely say that having two, and possibly three of you, certainly gives us full coverage of the Denver issue.

So, let us begin with Senator Udall. Senator Udall.

STATEMENT OF HON. MARK UDALL, A UNITED STATES SENATOR FROM THE STATE COLORADO

Senator Udall. Thank you, Chairman Akaka, Ranking Member Burr, Senator Isakson, Senator Johanns.

I appreciate the opportunity to tell you a little bit about the history of the VA Hospital and also where we hope to go in the near and the medium future.

We have a new, and we hope a final plan for the VA Medical Center on the Fitzsimmons Campus in Aurora, Colorado. As some of you may know, the current facility is almost sixty years old. It is at full capacity, and it does not meet the needs of our veterans. Sometimes veterans, Mr. Chairman, have to wait months to see a doctor, and veterans with spinal cord injuries have to travel to other states for treatment. And that is why the development of a state-of-the-art veterans' facility at Fitzsimmons was a centerpiece of the VA's Capital Construction Plan under the Capital Asset Realignment for Enhanced Services, or as it is known, the CARES Program.

Five years ago, as part of this CARES Program, Denver was identified as a city in urgent need of a new VA center. Today there is still no hospital and the need is still urgent, as you can all imagine, as thousands of young veterans returning from Iraq and Afghanistan require care for their wounds, whether physical or mental, or both. We

also have an additional four hundred thousand veterans in the region who require care.

So, I am pleased to be able to say although there have been a few bumps along the road--three secretaries of the VA and numerous plans and many intervening years at Fitzsimmons--it is again one of the highest priorities for the VA.

As you know, Secretary Shinseki who came out of retirement--I think in the wonderful state of Hawaii--listened to the concerns of our delegation, our local veterans' community, and veterans' service organizations, and his own advisors. And earlier this year he concluded that a standalone facility with comprehensive specialty care services, including a 30-bed spinal cord injury center, is essential in order to meet the needs of veterans throughout the Rocky Mountain region.

We are excited that the plan also includes constructing new health care centers in Colorado Springs, Colorado and Billings, Montana, a number of new clinics in rural health sites, and an outpatient administrative building at the Buckley Air Force Base, which is in Colorado, as well.

Mr. Chairman, if I could turn to costs which are always, of course, very, very important, the new estimate for the total cost is $800 million dollars with $119 requested in this year's President's 2010 budget. So far,

we have allocated--authorized, Mr. Chairman, $568 million for the hospital, but this is not enough to get us all the way to the finish line. So, I look forward to working with the Committee to increase these levels.

I want to thank my colleague, Representative Perlmutter, for his hard work, and our former colleague, Senator and now Secretary Salazar, for leading the charge when it looked like the VA was going to back away from its promise to build a standalone hospital. Senator Bennet has quickly picked up where Senator Salazar left off and he is pushing hard to get the project underway.

In my notes here I am also encouraged to talk about my contribution. What I would say is I have been working on this for ten years, and I was working on this when Senator Burr, Senator Isakson, and I were all members of the House of Representatives--all those glorious years in the past.

So, I am delighted to be here today. I am delighted to be able to, I think, see the end of the light at the end of the tunnel.

There is a groundbreaking scheduled in August, and I want to thank the Committee for giving me an opportunity to speak to you today. I ask your support so that we can finish this project in the way that our veterans deserve.

Thank you, Mr. Chairman.

[The prepared statement of Senator Udall follows:]

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Chairman Akaka. Thank you for your statement, Senator Udall.

I am going to call on Representative Perlmutter for your opening statement and your statement about Denver and the hospital there.

Representative Perlmutter.

STATEMENT OF HON. EDWARD PERLMUTTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mr. Perlmutter. Thank you, Mr. Chairman, Senator Burr, and Distinguished Members. Thank you for inviting a member of the House to come testify before your committee.

This is a great opportunity for the veterans of Colorado. We have been dealing with this project, as Senator Udall said, for at least 10 years, sort of back and forth. And the issue that we are dealing with is the need for a new state-of-the-art Veterans Administration standalone medical center at the former Fitzsimmons Army Base in Aurora, Colorado.

I would like to acknowledge the work of former Senator Ken Salazar, as well as Senator Wayne Allard, both of whom were strong partners in moving this project forward. I am equally pleased that Mark Udall now is a member of your chamber and Senator Mike Bennet are also champions for this particular facility--one that has been long, long overdue. And Chairman, in your remarks, you talked about sort of the fits and starts within the CARES program, and this is one of those examples. But finally, I think with the concerted effort of the Congress, as well as the Administration, we can move forward and fulfill the promises that we made to these veterans a long time ago.

General Shinseki, two and a half months ago in a clear statement, said we are going to move forward with a standalone facility which will serve the Rocky Mount West and the Western Plains. So, Nebraska, Kansas, Colorado, Utah, Idaho, Montana, Wyoming all will be served and the 700,000 veterans within that region will be served as part of this effort.

Our veterans deserve this medical facility. This is one that is worthy of their service. We found, and the CARES report is clear, that the current facility that we have simply is obsolete; it is undersized and is not meeting the needs of our veterans.

The Commission had 38 public hearings and over 200,000 public comments, and was completed and accepted by Secretary Principi five years ago. We are on our fourth secretary of the VA, and we hope that this time things will move forward with the groundbreaking scheduled for the end of August.

The CARES Committee Report concluded that there was a space deficit of 242,000 square feet. So, as Senator Udall said, the Congress has authorized $568 million for the project, of which $188,300,000 has been appropriated. Property has been purchased and we are ready to turn dirt. So, Senator Burr, your question about the stimulus and moving forward for jobs now to help us within this recession--this project is ready to you.

The new medical center will provide a full range of medical, laboratory, research, and counseling services, including a new spinal cord injury unit recommended by the CARES report. Moreover, it will be a joint facility with the Department of Defense to provide care for personnel stationed at installations throughout Colorado and VISN-19. In order to accomplish this, the President's budget proposes $119 million be appropriated this year for the Fitzsimmons facility.

I applaud Secretary Shinseki and President Obama for bringing closure to this long-awaited decision to move forward with this project. The veterans of Colorado very much appreciate the support of this project that it has received from this committee. The VSOs have been involved from day one in this project and are very supportive and very determined to have this go forward as the Chairman knows from a visit he made to Colorado a few months ago.

I thank you for the opportunity to speak to you. This is a critical project for our state and for the Rocky Mountain West and for the Western Plains. I look forward to your questions and to your support of this project.

[The prepared statement of Mr. Perlmutter follows:]

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Senator Akaka. Thank you very much, Representative Perlmutter. Thank you for your statement.

Now, we will hear from our Senator Bennet from Colorado.

STATEMENT OF HON. MICHAEL F. BENNET, A UNITED STATES SENATOR FROM THE STATE OF COLORADO

Senator Bennet. Thank you, Mr. Chairman. I apologize for being late.

Mr. Chairman, Ranking Member Burr, and other members of the Committee, thank you very much for inviting me to be a part of today's hearing.

I want to start by thanking Senator Udall for his hard work on the Denver VA Hospital, and I would also like the Committee to know that Congressman Perlmutter, in particular, has been indispensable in getting this critically important project off the ground.

When I came to the Senate just a few months ago, one of the first things that I did was join Senator Udall, Congressman Perlmutter, and the rest of the Colorado delegation, many of whom had been working on getting this facility built for several years, and communicating to the new Administration my support for a standalone facility in the Denver area.

Secretary Shinseki told us he supported a standalone facility, and as you know, he and President Obama have included $119 million in funding for it in their request for the upcoming fiscal year. We were particularly proud that this was the first decision that the VA made in capital construction this year. This funding will put the $800

million, 200-bed facility, which will serve 400,000 Colorado veterans, on track to open in 2013. When it does, 92 percent of Colorado veterans will be within one hour of VA primary care, and 81 percent of Colorado veterans will be within two hours of a medical center or health care center.

The new Denver facility will set the bar high. It will bring together the best resources the VA has to offer and enable more veterans to access the high quality care they need and deserve. With capacity for addressing mental health needs and spinal cord injuries, it will be a shining example of how we can do right by our veterans--one that this Committee can point to for years to come.

As the Committee considers the President's budget for Fiscal Year 2010, I join my colleagues and ask on behalf of Colorado's veterans that you preserve the $119 million the Administration has requested for this important project. I would also ask that when the time comes, you increase the authorization of the project to reflect its full estimated cost of $800 million. As the Congressman said, the project is currently authorized at $568 million.

I want to just close by saying thank you for your consideration. Thank you for your leadership on these issues. To Congressman Perlmutter, everybody in Colorado knows and should know that his commitment to this project has been tireless over many, many years, and it is extremely

gratifying to see it finally being brought home. So, I want to thank you on behalf of all the citizens of Colorado for your tireless work on this.

Thank you, Mr. Chairman.

[The prepared statement of Senator Bennet follows:]

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Chairman Akaka. Thank you very much, Senator Bennet for your statement.

Before I ask for additional opening statements, I would like to take up Representative Perlmutter's words. There may be some questions that you need. Do you have any questions?

Well, thank you very much, Representative, for being here and for your statement.

Senator Bennet. Thank you very much.

Chairman Akaka. Now I will ask for further opening statements. Senator Isakson.

OPENING STATEMENT OF SENATOR ISAKSON

Senator Isakson. Thank you very much, Chairman Akaka. I will not make a statement, except unfortunately given the fact the Health Committee is getting ready to start marking up the Health Care bill I am going to have to leave, but I did want to raise a question for the panelists that hopefully they will be able to address to my office.

In Georgia, we are fortunately having a total renovation and completion of the VA Hospital on Clairmont Road. We are very grateful for that, and I am very grateful to the Committee members who helped me get the appropriation and the Appropriations Act to do that.

However, we have run across a great problem during the course of the construction, and that is we have lost almost

all of our accessible parking--or at least a significant amount of it. Clairmont Road is a very busy road that connects Interstate 85 with downtown Decatur. The VA is operating a shuttle from an offsite parking lot to get patients to there, but we have a number of people who are on oxygen who are being required, even with the shuttle, to walk extensive distances to get to the shuttle to get to the hospital. And we have expressed to the VA our concerns, and we have had some good attention. I am not complaining.

But, I do think when the discussion about logistics and planning for construction is done--and that is part of the purpose of this particular hearing--when there is a displacement of parking, which is oftentimes the case at a site when you do a renovation or improvement--we need to be very conscious in the planning to make parking a high consideration during that period of renovation or construction so as to minimize the amount of difficulty it causes our veterans and patients.

With that said, that is my principal question, Mr. Chairman. And I hope during the course of the discussion this morning, although I will not be here, that can be addressed and our office can get a response on the question.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you, Senator Isakson.

Senator Johanns.

OPENING STATEMENT OF SENATOR JOHANNS

Senator Johanns. Mr. Chairman and Ranking Member, thank you very much for putting this hearing together.

If I might just spend a moment talking, if I could, about the Nebraska-Western Iowa Veterans' Facility that is there. And I want to alert the panelists that, of course, I have an interest in that having worked my way through government for many, many years as a county commissioner, a city councilmember, a mayor, and governor, etcetera. I am very used to working with capital improvements processes and budgets, and I understand that there is a process that we need to go through.

But let me, if I might, cite some of the deficiencies we found in this veterans facility. There are--dust, contaminants, potential infectious vectors are distributed throughout much of the hospital via the HVAC system. The hospital could not support a pandemic flu outbreak, which, of course, is on everybody's mind these days.

The system was graded F in VA assessments dating back to 1999. In the electrical system, there is not enough emergency power that is available to support equipment requiring emergency power. Now in our state, like probably so many states, emergency power is absolutely necessary. Storms do come through this area and you need that power.

Plumbing and medical gas system repairs and renovations

require whole hospital shutdowns. For water and oxygen, piping is 50 years old. It is corroded. It fails on a recurring basis. Moisture is pulled into wall cavities because of the faulty HVAC system. It creates a perfect breeding ground for mold in that facility.

Over 4,000 square feet of hospital space is not occupied, even though we have a deficiency in space in this hospital because there is reactor water and concrete that has yet to be removed.

Now, I could go on and on. That is the bad news of what we are dealing with here. It is not a good situation for our veterans who need care. I really appreciate the work that Colorado is doing, but if you live on the eastern side of the state of Nebraska, that is a 10-hour drive to Colorado. Now, we love to visit Colorado--except when the football team beats us--but that is a long way away. And most of our population, as you know, is in Omaha, Lincoln--on that eastern one-third of the state. So, nothing I say here stands in the way of what they are trying to do. I applaud them for their efforts.

That is the tough news. The good news about this project is the community is pulling together. And the state is pulling together. And Western Iowa is pulling together to say how can we be helpful in bringing first class medical care to these veterans who have served our country so well.

The good news is that in Omaha you have two medical centers--two medical schools--Creighton University, my alma mater, first class, and the University of Nebraska Medical Center. They want to join forces. They want to do everything they can to bring the best medical care to bear to help these veterans.

Now, again, I understand capital improvements processes. But these conditions are not good, and I am hoping that if we can all work together and cooperate on not only this project but other projects that have this awful list of problems, that we can work together to solve these problems. Hopefully, work together to get the funding and move these projects forward.

No one would like front page stories about these conditions. They are not good.

And so, Mr. Chairman, and Ranking Member, again, I just thank you so very much. This gives us a forum to debate and discuss how best to deal with these issues. The reassuring thing about this Committee and the people that come before the Committee is we share one common goal. And that is, how do we improve the conditions for our veterans? I am anxious to be a partner in that.

Thank you.

Chairman Akaka. Thank you very much, Senator Johanns.

And now, I want to welcome our principal witness from

VA, Donald Orndoff, who is the director of the Office of Construction and Facilities Management.

He is accompanied by Brandi Fate, Director of VHA's Office of Capital Asset Management and Planning Service; James Sullivan, Deputy Director of VA's Office of Asset Enterprise Management; and Dr. Lisa Thomas, Director of VHA's Office of Strategic Planning and Analysis.

I thank all of you for being here this morning. VA's full testimony will appear in the record.

STATEMENT OF MR. ORNDOFF, AIA, DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

Mr. Orndoff. Mr. Chairman and members of the Committee, I am pleased to appear today to discuss the status of the Department of Veteran Affairs facility infrastructure. I will provide a brief oral statement.

Current Medical Infrastructure. VA has a real property inventory of more than 5,400 owned buildings, 1,300 leases, 33,000 acres of land, and approximately 159 million gross square feet of occupied space, both owned and leased. Our aging facilities were not designed to meet the changing demands of clinical care for the 21st Century.

Continuing our recapitalization program is critical to providing world-class health care for veterans now and into the future.

Our Current Major Construction Program. VA continues the largest capital investment program since the immediate post-World War II period. Since 2004, VA has received appropriations totaling $4.6 billion in health care projects, including 51 major construction projects. These projects include new and replacement medical centers, poly-trauma rehabilitation centers, spinal cord injury centers, ambulatory care centers, and new inpatient nursing units.

Background: CARES. In 2000, the Veterans' Health

Administration embarked upon the Capital Asset Realignment and Enhanced Services program, or CARES. CARES assessed the veterans' health care needs and promoted strategic realignment of capital assets. In 2003, VA released its draft national CARES plan and created the CARES Commission for further analysis.

In May 2004, the Secretary published his CARES decisions and identified 18 sites whose complexity warranted additional study. The VA completed these studies in May 2008.

Today: Strategic Facilities Planning Process. The tools and techniques acquired through CARES are now incorporated into VA's Strategic Health Care Facilities Planning Process. VA no longer distinguishes between CARES and other project planning needs.

Our Goal. High performance medical facilities. VA new medical facilities contribute to world-class health care for veterans today, tomorrow, and into the 21st Century. Our designed goal is to deliver high-performance buildings that are functional, cost-efficient, veteran-centric, adaptable, sustainable, energy efficient, and physically secure.

Acquisition Strategies. VA uses a range of acquisition tools that are tailored to best satisfy the unique requirements of each project. We partner with industry leaders through architect engineer design contracts, design

bid build contracts, design build contracts, integrated design construct contracts, construction management contracts, and operating leases.

Our Fiscal Year 2010. VA's FY10 budget request continues our recapitalization effort supported by Strategic Facilities Planning Process. VA requests $1.1 billion in FY10 for major construction to replace or enhance VA medical facilities and $196 million authorization for 15 new medical facility leases. VA also requests $112 million for major construction to expand two national cemeteries.

In closing, I thank the Committee for its continued support to improve the Department's fiscal infrastructure to meet the changing needs of America's veterans. My colleagues and I stand ready to answer your questions.

[The prepared statement of Mr. Orndoff follows:]

Chairman Akaka. Thank you very much. I would like to now call on our Senator from Illinois for any opening statement he may have before we continue with the questioning.

Senator Burris: Not at the moment, Mr. Chairman. Thank you, sir.

Chairman Akaka. Thank you very much.

Mr. Orndoff, accompanying you are various officials involved in the construction process. At the onset, tell me what these other individuals do specifically and how do they interact with one another.

Mr. Orndoff. Yes, sir.

First, I'll begin with Ms. Lisa Thomas on my far left. She is in the VHA's Strategic Planning area, which basically defines our strategic requirements and ultimately identifies where areas of need are--gaps in veteran service need and capabilities. So that office basically defines initially the requirement that needs some type of a solution--a facility solution being potentially one of those.

Moving to my right, Ms. Brandi Fate. Her office then takes that output as input and plans projects, further defines requirements, and develops a project that would move forward. Of course, she works closely with the people at the regional level, at the VISN level, and at the local level at the medical centers to fully flush out the

requirements and make sure that a project coming forward is, in fact, a valid requirement and would be one that would make--hopefully make the priority list.

The total output of that effort is the list of projects that we have in our five-year capital plan, which is 66 projects that were identified earlier. And all of those projects have been validated and are on the list in a priority order.

Mr. Sullivan, to my left, is from our Office of Management, the Asset Enterprise Management Office. He is the key player in working with our Office of Management and our fiscal officer to develop the input of where we are in terms of prioritizing projects. His office takes the lead in developing the criteria that is used--certainly a recommendation that comes forward ultimately approved by the Secretary.

Using that established list of criteria against the list of projects, we then basically score them and come up with a priority order. The top of the priority list, of course, then is included in the Department's budget--the annual budget that would come forward.

So, basically, Mr. Sullivan's office sort of manages the process of getting the requirements prioritized and into the budget where the budget limits are and so forth working with the fiscal officer. So, it starts with strategic

requirements, project requirements, prioritization, budgeting. And then at the end I catch the result of all of that and I am the execution guy--the guy that delivers projects--the brick and mortar that we all know and love.

Chairman Akaka. Thank you for that explanation.

You have stated in your testimony that VA no longer distinguishes between CARES and non-CARES planning. Of all the projects approved by Secretary Principi and his CARES decision, how many were undertaken? And where do we stand on those?

Mr. Orndoff. Yes, sir. Since Fiscal Year 2004, basically when CARES was initiated, we have had a total of 58 projects identified. Nine of those are complete, 20 are under construction, 13 are in design, 15 are in planning.

Many of them are projects that are continuing to work through the process, as we said, in construction. Certainly, the Denver project that was discussed earlier is one of those projects that is moving forward. Many of the projects that we have partially funded today are a result of the CARES process. All of those requirements that have made the prioritization list as we continue to refresh it every year move forward.

Any time a project is partially funded, at that point there is no longer a prioritization of that project. It is automatically above the line, if you will, and moves forward

to completion. So, really, it is just project-specific as to where any particular project is in terms of scheduling and delivery, but in every case where we have a valid output from CARES they have moved forward.

Chairman Akaka. Thank you. Let me just--before I call on Senator Burr--what were the lessons learned from CARES?

Mr. Orndoff. Let me turn that one to Ms. Thomas, if I may.

Chairman Akaka. Ms. Thomas.

Ms. Thomas. Good morning, Mr. Chairman.

As you know, CARES is a data-driven assessment of our health care system and it was used to guide the strategic allocation of our assets to support health care delivery.

Our goals under CARES were to improve access and quality in the delivery of health care to make sure that it was done in a cost-effective manner and mitigated any impacts to our staffing or our communities.

We have several very good results as a result of our CARES program. It did help us identify our priorities and improve our physical infrastructure. It also helped us increase access to services to veterans. And one of the things it did is it really improved our strategic planning and capital facilities planning process in that it led to our first ever five-year capital plan, which now drives all of the capital requests from that point forward.

As Mr. Orndoff said in his statement, we no longer distinguish between CARES and non-CARES because we learned so many lessons as a result of CARES that we have now incorporated all of those tools and techniques that we have learned as a result of CARES into our regular standard operating procedures for strategic and facility capital planning.

We developed a 10-step health care model that replaced the 9-step CARES model that we used. It very much is similar to that model. It is a web-based portal whereby it increased our efficiency with identifying what our strategic needs are and it has greatly enhanced our ability to continue on the traditions that we learned during CARES.

Chairman Akaka. Thank you very much.

Senator Burr.

Senator Burr. Thank you, Mr. Chairman.

Just one thing on CARES. Did CARES take into account the demographic shift that has happened in America in military retirees?

Ms. Thomas. Absolutely, sir. What we built our planning upon is our Enrollee Health Care Projection Model, which identifies for us the number of enrollees that we have, where they are, the types and volume and kind of services that they--health care services that they need and the cost of those services. And that model is updated every

year.

Senator Burr. And when the CARES model originally came out, North Carolina was not projected to be the recipient of 3HCCs or whatever the equivalent would have been under that. Yet, I am not sure whether anything would fully encapsulate the demographic shift--the decision of retirees to choose North Carolina as home. And it does put tremendous stress and strain on the delivery system when the infrastructure is not there to deliver that much care to that many veterans. We appreciate them making the decision to retire in North Carolina; we just want to make sure we have got the capacity to deal with them.

Let me move to you, Donald, if I can. Relative to my opening statement where I made the reference that less than three hundredths of one percent of the stimulus money had actually gone out, I hope you are going to tell me that my numbers were wrong.

Mr. Orndoff. Sir, I am going to, if I may, refer to our subject matter expert, Ms. Fate.

As you mentioned, the funding was targeted at maintenance and repair-type projects. And that function is managed from Ms. Fate's area. So, if I may let her respond.

Senator Burr. I would be happy to.

Ms. Fate. Thank you, Don.

Sir, the number that we have today as of our

obligations is $27.5 million for the NRM stimulus funding. While that is a small percentage, it took us a while to get engaged because we changed our process to be 100 percent competitive in all of our contracting, as well as trying to engage in as many small businesses and 8(a) set-asides as we could for these contracts.

So, that took additional contract time to write these clauses, as well as the Buy American Act and a few other requirements that were put into the contract requirements from OMB.

Senator Burr. So, is the lesson to Congress that if we are looking at divvying out stimulus money that is more immediate from a standpoint of its need, we probably should not do maintenance projects?

Ms. Fate. No, absolutely, sir. We were ready to go with several of these facts. And, in fact, in March we had a substantial number of projects ready to go, but we wanted to be competitive to the local market so that everybody had an opportunity to get this stimulus funding. And within the next few months we anticipate to award about at least 40 percent of the stimulus funding.

So, we are gearing up to go. We just had a few stumbling blocks at the very beginning, but we are projected and targeted to end FY09 on a positive note.

Senator Burr. And I appreciate that and I appreciate

your diligence at making sure that communities get what, in fact, they deserve. I think the difficulty is the American people had expectations that stimulus money was going out immediately, and that is not exclusive to the VA. I think it is across the board, and I think they are shocked at the difficulty we are having pushing that money out the door, creating the jobs, having the impact that it was intended on. And I think it is just--it is absolutely vital that we know the reasons so that we can explain it to them.

Let me go on to another point. Let me go to Denver just real quick.

Mr. Orndoff, it has been a long process, and I, for one, have had objections with it at certain times. Under the original footprint, taking Senator Isakson's comments to heart, what is the parking conditions at the Denver facility as currently designed?

Mr. Orndoff. Sir, I do not know the specific numbers, but I assure you that the full requirement is part of the solution. We have both structured parking and surface parking as part of the schematic design solution. There is no limitation or, you know, tradeoff on parking. It will meet the full requirement.

Senator Burr. The last time I looked at the plan it was the billion dollars plus plan.

Mr. Orndoff. Yes, sir.

Senator Burr. And it has been scaled back to $800 million. At that time the parking for the Denver facility, because of the way the footprint was designed, meant that the parking was roughly a half a mile from the hospital and that every patient and visitor would have to be bused to the hospital. Do you know if that is currently still the configuration?

Mr. Orndoff. No, sir. It is not. The solution is that in the northern part of the site--and it is somewhat of a challenging site in that it is a relatively narrow, rectangular site, so it drives a linear facility solution to work on that site.

But the schematic design has, I think, an incredibly well thought out and design solution. I have personally been involved in reviews of all the phases of schematic design. The parking is located to the north, but it is on the site and it is connected literally by a pedestrian bridge. Some of the parking, as I mentioned, is structure, and that is actually embedded almost essentially within the facility itself at the southern part and the mid-part of the design solution.

So, there is not a long travel distance. It may be a little longer than in a perfect scenario where we had a site that was larger and a little bit more square in shape or round in shape, but I think there is certainly a lot of

attention in the design process to minimize the travel impacts and to look creatively on how to do that.

Senator Burr. Any concern by you or any of your colleagues that are with you today whether the $800 million threshold can be met?

Mr. Orndoff. In terms of working within that budget?

Senator Burr. Yes, sir.

Mr. Orndoff. That is a relatively recent estimation of the new solution. As was mentioned earlier, we changed the design solution when the Secretary made the decision to return to the standalone hospital concept. We did a re-estimation of the project based on that.

And, of course, part of that is that part of the design solution is growing in other areas. And as was mentioned, Colorado Springs and in Billings, Montana. So, part of the design solution is pushed out, so that's why the cost has come down a little bit from the one I believe you referred to earlier, which was about a $1.1 billion solution.

That is not to say we have less service. In fact, we have the same level or arguably a higher quality of service as it is closer to veterans that are served. But, in aggregate, it is the same capability. The Denver project, specifically, at $800 million will meet the requirement. That also includes an additional project scope issue of adding renewable energies into the design solution. So, it

will be--

Senator Burr. I am going to try to sneak one more question in.

Mr. Orndoff. Yes, sir.

Senator Burr. And I assure the Chairman if he gives me the latitude I will not have to have a second round.

There have been 36 major medical facility projects that have been completed since 2004. How many of those projects ended up costing more than the original projection?

Mr. Orndoff. Sir, I do not have the specifics on that. I could certainly get it for the record.

I think it is fair to say that all projects were delivered within ultimately what was the approved budget. In some cases, we had an extremely aggressive market in the construction industry. It is hard to believe with today's news, but in the not too distant past there was a very tough construction market. We had very difficult times getting competition on our projects. Incredible as it may seem to have multi-hundred million dollar projects out when in some cases we had one or two proposals on a project.

Senator Burr. Would you, for the record, provide me that number that went over budget?

Mr. Orndoff. Yes, sir.

Senator Burr. In addition, would you add to that how the VA tracks the accuracy of its construction budget

forecast?

Mr. Orndoff. Yes, sir.

Senator Burr. And more importantly, how the VA tracks delays in construction, as well.

Mr. Orndoff. Right.

Senator Burr. I appreciate it.

Mr. Orndoff. And just to be clear, sir, you are talking from the original budget?

Senator Burr. Of those 36 projects since 2004, I would like to know how many were over budget. From a standpoint of the ongoing process at VA, what your method is to track the budget relative to what was forecasted.

Mr. Orndoff. Yes, sir.

Senator Burr. And track delays in construction.

Mr. Orndoff. Yes, sir. Will do.

Senator Burr. Thank you. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Burr.

Senator Burris.

Senator Burris. Thank you, Mr. Chairman.

Mr. Chairman, I would like to indicate that we will be submitting some questions for the record because I have points that may not have all the data. What I was wondering if Mr. Orndoff is familiar with what is happening in Danville, Illinois at that facility. Have you had any direct contact with the VA Hospital in Danville?

Mr. Orndoff. Direct contact? Do we have a project there? I am not sure.

Senator Burris. Yeah, well, what the director is saying is that a lot of the buildings are old, and they are seeking to have this expansion program.

Mr. Orndoff. Yes, sir.

Senator Burris. And I just wondered whether any of that has been brought to your level as of yet. They have a great innovative program going on in Danville with reference to the housing where they are having community housing for our veterans. It is not really assisted living because it is almost independent living. And they have at least two of those housing developments up and working where at least 10 veterans can be served at these homes. And that has all been approved, which I thought was a very, very innovative program for some of our aging veterans.

But, they also have these older facilities because that is one of the best run--because I have visited several of the hospitals in Illinois, and I was very impressed with what is going on there. Except for the facilities. There is just a need to upgrade. Some of them are probably total reconstructions.

So, we will be submitting this information to you if you do not--Mr. Chairman, if you do not have that, we will certainly follow up.

Mr. Orndoff. Yes, sir. I would like to take that for the record and give you a full response.

Senator Burris. Thank you. And to Ms. Fate, you mentioned you are working on some 8(a) programs. Now, in any of this construction, are you all looking at any type of set-aside contracts for minorities and women in your construction process? What are the requirements there?

Ms. Fate. I do know that we have a lot of our contracts that focus on the set-asides, including minority and women. I do not have the specifics, but we have our targeted socioeconomic goals and we can take that for the record, again, back with you on what those are.

Senator Burris. I would like to know specifically what minorities have gotten any work on contracts or any of the VA projects. Minorities and women, and what is your percentage of that, and how is your process in reference to selecting those particular contractors.

Ms. Fate. We will take that for the record.

Senator Burris. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much. Senator Johanns.

Senator Johanns. I, as you know in my opening statement, went through some of the challenges we are facing in the Western Iowa-Omaha facility.

As I understand it, a feasibility study has started with that facility, and I think it has been completed. Does

anybody on the panel know the status of that?

Mr. Orndoff. Yes, sir. Ms. Fate would like to respond.

Senator Johanns. Great.

Ms. Fate. Thank you, Don.

Yes, sir. We received the feasibility study, the final recommendations, at the beginning of May. And so it is four volumes--a very thick book--very thick four books. And we are looking through that and we anticipate to have a recommendation for VA, hopefully by and within the next couple of months.

In the meantime, though, due to concerns raised by Mr.--Senator Nelson of the potential patient safety concerns with the HVAC, working with GLHN, who is the contractor for it, they garnered enough information from their analysis to provide us a very basic project for just to replace the HVAC, which is $90 million. And VA--we were discussing this yesterday--VA is committed to ensure that that basic project at a minimum is submitted for or approved for VA in FY10 to ensure that we are being proactive to mitigate any patient safety potential issues that might occur at that facility.

But, we do want to fully vet that study to ensure that we are moving forward with the right plan--with the best plan for the veterans. We just haven't had a chance to go through all four volumes.

Senator Johanns. Okay. Once that is done, kind of walk me through the process of what happens next, and maybe even--I know it is hard to tell me timelines, but if you could help me understand kind of where we are in the process and where we go from here.

Mr. Sullivan. Sure, Senator. What will happen is once the need--excuse me. Once the need has been verified through the study and the best way to address services is made, a resulting capital project will more than likely come forward. If it is more of a maintenance issue in terms of HVAC and electrical, it may be handled through the nonrecurring maintenance program Ms. Fate spoke about, which was the $90-100 million dollar solution.

Should one of the options look at replacing the entire facility or moving the facility, that project then will be put through the 2011 budget formulation process where they will decide on an option and submit, if you will, a concept paper and application for that project. That project then will be evaluated against all the other projects that are coming in in the 2011 process.

In 2010, as Mr. Orndoff referred to where there are 66 projects that came in for full evaluation--it was a larger number than that, but that went through a full evaluation--that will go through that as well. That happens during the summer. In about a month or two that process will move

along for 2011. And as the budget formulation process continues through July and August, that listing will be submitted to the Secretary. There will be a decision made by the VA of what to submit to OMB for 2011, which usually happens in the first week of September. It goes through the OMB evaluation process sometime in December. Pass back will happen from OMB where VA will get either a list of projects approved by OMB or a funding allocation, and then that decision will then be wrapped into the present submission up to the Hill here in the first week of February.

Senator Johanns. Okay. Let me, if I might, just to wrap up my questioning here, focus on this hoped for relationship with the medical centers in Omaha and the VA. You know, I have such confidence in what Creighton does and the University of Nebraska Medical Center, and they really want to help here. They tell me every time I see the leader of those programs, "Gosh, we want to be on a team to help."

Do you see that as a positive? And just in terms of advice to the community, how does that interface with what you have just described for me?

Mr. Sullivan. I think the major--I will defer to Ms. Fate--the major positive in terms of working with the community would be on the services, and how those services will be delivered, and where those services will be delivered in terms of formulating the optimal solution.

So, in terms of them working with the medical center staff and the vision staff, that would be helpful in terms of determining where those services should be and what is the best service delivery vehicle. You know, whether it be in a VA-owned building, in a renovated VA-owned building, in a shared building. So, I mean, that is on the ground. When they define those requirements that is the best place for, I believe, that interaction to happen.

Senator Johanns. When you are ready for that, I hope you will reach out to Senator Nelson's office, my office, Congressman Terry's office for that matter because we--you know, in our state we just work together on these issues.

And the other thing I would say as I look through some of the challenges that we have here, they seem to be quite traumatic. Now, I think in what you are doing you are probably feeling like you do triage every day, you know, because there are old facilities out there. They do need complete replacement in many, many cases. This one dates back into the 50's. It is old. Its space requirements, its plumbing is a problem. You could probably say, you know, Mike, we've got a lot on the list like that.

But, what I want to say is this. The Medical Center, myself, others, are willing to try to put together working with you, working under your direction, a plan that I think really would provide first-class medical care. And we are

excited about Colorado and this and that, but 10 hours away for medical care is not a workable solution to this problem. We just simply need something here to try to deal with a facility that probably long ago outlived its useful life.

And the most important message I can deliver is as you are working through this, we do not want to interfere but we want to try to be a partner in what you are doing. Okay?

Mr. Sullivan. Yes, sir.

Senator Johanns. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Johanns.

Senator Begich.

Senator Begich. Thank you, Mr. Chairman. I apologize I will have to leave in a few minutes to go preside, and if these questions have been asked I apologize.

I just want to--I caught a little bit of what Senator Burr was talking about. I want to kind of follow up on it. And I want to first say thank you for the facility in Alaska--the new one that just opened up in the Matanuska Valley. The clinic there. It is kind of a partial clinic but it is a very good center and well received. People are very excited about it. I know you have others planned in Juno and elsewhere.

You know, I come from--after being five and a half years, almost six years as a mayor, and I am just trying to figure out how with the stimulus money you are going to

achieve--and if I get these numbers wrong I apologize because I just caught part of the conversation. You have spent maybe $27 million, $30 million and you are trying to get to 40 percent of the stimulus numbers expenditure by end of September/October 1st, give or take, somewhere right in there.

Reassure me--I know this discussion occurred a little bit--how are you going to do that? It is a sizeable amount. You have very diverse facilities all across the country. I know as a mayor what we do and how we have to do it in regards to our fees and we have to be very aggressive about it. And it means that you have to have full force focus, not just normal course of business. Give me a couple of comments on that and then I will have some additional follow up.

I do not know who wants to respond to that.

Mr. Orndoff. Maybe if I could just make an opening comment and I will let Ms. Fate speak to it, as well.

We have a network of acquisition professionals across VA that essentially supports every local medical center and certainly every VISN. That business model is ramping up fast and understands the requirement to execute within these timelines and has the strategy to do so. It is--as Ms. Fate was mentioning earlier, we are marshaling the troops. We had some initial start up issues, but we fully understand

the requirement and the need to execute not only to obligate the funds but also to get the output of those projects which will make our medical centers better for our veteran care.

So, we have the infrastructure in place. It was not, of course, sized to this to address this bow wave of requirement that came somewhat unexpectedly, but we are making--certainly, marshaling the troops and understand that those are the goals and objectives. And we certainly have a commitment to make that.

Let me see if Ms. Fate has additional thoughts.

Ms. Fate. Sure. Thank you, Don. Sir.

One of the tasks that were first given to us about a month ago--or two months ago, I'm sorry--was to ensure that NRMs--both the normal through the FY09, as well as the stimulus--are the contracting's first priority. And the contracting staff in the field have made it their first priority. They have been given overtime. They have been given comp time to work on the weekends and such to ensure that this is--that these obligations are on track and are very aggressive and pursuing obligations throughout the year.

And to ensure that by the end of this year we do not only meet the 80 percent rule for our normal interim which is, I guess, the 20 percent rule for obligations before August--in August and September--but it also ensures that we

have the stimulus funding obligated at least by 40 percent.

But, the contracting officers have also other responsibilities that they are working--that have been delegated down to them. It used to be that we had a lot of the projects coming forward. Once they passed a certain level--$500,000, $5 million dollars--a new process started back in the February/January timeframe that has delegated a lot of those tasks to the local level so it increases the efficiencies of them getting the jobs done and oversight. And they put additional taskings for senior contracting officers so that contracting officers were not burdened with all of the tasks, but that they leveled it out so that they could be more aggressive.

So, many steps have been taken at the local level to ensure that these projects have been the primary focus to ensure obligations.

Mr. Sullivan. And I would just say, Senator, that each of these projects were identified and submitted to Congress. Also, every week each project is updated and reviewed with the senior contracting official to ensure that the project is staying on schedule. Or if there is an issue with the project, whether it be legal or technical, that the appropriate resource from General Counsel or the Procurement side, as Mr. Orndoff said, is brought to bear so that they are tracked and reported on weekly and sometimes twice a

week.

Senator Begich. Let me--if I can just quickly end on this, and again, if you are repeating information, I apologize.

If I caught your word right, it is 40 percent obligated.

Mr. Sullivan. Yes.

Senator Begich. Not expended. Right? Because obligation and expenditure are two different things. So, you will have it associated with a project but not in the field necessarily working the project. Am I right?

Mr. Sullivan. No, obligated means an actual legal contract award. Someone is selected. They have been given notice to proceed.

Senator Begich. Proceed. Okay.

Mr. Sullivan. Expenditure would be actually paying the bill after the work is completed or put in place.

Senator Begich. So obligation--the 40 percent obligation level will mean that contracts have been awarded. I want to repeat what you said just to make sure we are clear. Awarded. Notice to proceed has been given, whatever that timetable is. But notice to proceed to the individual contractor or contractors. Yes?

Mr. Sullivan. Yes.

Senator Begich. And then last, if I can get at a later

time, I would be very curious to follow up Mr. Burris, and that is the component on the 8(a) components and how you utilize those. I know the Corps of Engineers utilizes--at least Alaska Natives 8(a)s very successfully in getting projects out and done quickly, because of weather conditions. And very efficiently and very cost effectively. And I would be very interested in how you utilize 8(a)s in the competitive process, but also a sole source process.

Again, the Corps has an incredible record--a positive record--of sole source 8(a)s because of weather conditions especially in Alaska and how they utilize 8(a)s. So I would be very curious of how you use that and the advantage or disadvantage. If you can share that with me at a later time.

Mr. Sullivan. We also use what is known in VA as SDVOs, the Small Disadvantaged Veteran Owned businesses also in that same category.

Senator Begich. Great. Maybe just add--and I'll leave on that--and that is could you give me an update in response to this question on 8(a)s, what is your percentage of hit on that. Is it three percent you are trying to hit? Is that--what is--

Mr. Sullivan. The Agency goal?

Mr. Orndoff. Yeah.

Senator Begich. That's okay. You can just give me--I

do not want to burn up time, Mr. Chairman. But if you could give me that along with the 8(a) information that would be greatly appreciated.

Mr. Sullivan. Yes, sir.

Senator Begich. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Begich.

Mr. Orndoff.

Mr. Orndoff. Yes, sir.

Chairman Akaka. Let me ask my last question on CARES.

Mr. Orndoff. Yes, sir.

Chairman Akaka. CARES was a very data-rich, multi-layered process that involved a great deal of community input and outside review. How much community output and outside review do you seek presently?

Mr. Orndoff. Well, I think the main source of outside input happens at the local level. The stakeholders locally, the veteran support organizations, other veteran patients--veteran patients, excuse me--there is a process of a continual dialogue in different forms that are developed to try to get input from veterans in the veteran support organization of what are the real priorities that the local medical centers should be focused on in order to provide better care for veterans.

That input very much influences the development of projects coming forward. Once it gets to the central office

level here in D.C., the headquarters of VA, we look at that list in aggregate, of course, and go through a prioritization process. Yesterday, there was discussion in a hearing about more involvement of VSOs in the prioritization process, and we are going to look at how we might do that.

But, I think the real dialogue happens locally. I have been personally involved and in the room where giving briefings to local Veteran Service Organizations on projects. New Orleans is a good example. And it is a very spirited discussion and you get lots of good input. I think it definitely helps shape the direction we move and our facility solutions to support veterans.

Chairman Akaka. Thank you. I have many more questions which I will submit in writing reflective of how important good construction planning is.

So, Senator Burr, do you have any? Senator Burris?

Senator Burris. Yes, Mr. Chairman. To Ms. Fate.

I just hope that that data I requested of you will be broken down by categories--Blacks, Hispanics, Asians, women--in terms of their ability to have received--and you can select a period of time--these projects.

Ms. Fate. Yes, sir.

Senator Burris. Just how many of those projects are going to minority contractors.

Ms. Fate. Yes, sir. We will break it down as far as we can.

Chairman Akaka. Thank you.

Senator Burris. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Burris.

I want to thank the panel for your responses. We certainly want to continue to work with you and try to move these programs.

I would like to welcome our second panel.

First, I welcome Davis Wise, who is Director of Physical Infrastructure Issues at the GAO.

Next, we have Mr. Dennis Cullinan, Director of National Legislative Service at the Veterans of Foreign Wars.

And I also welcome J. David Cox, National Secretary Treasurer of the American Federation of Government Employees.

Thank you so much for being here. Mr. Wise, we will please begin with your statement.

STATEMENT OF DAVID WISE, DIRECTOR PHYSICAL INFRASTRUCTURE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

David Wise. Chairman Akaka, Ranking Member Burr, and members of the Committee. Thank you for the opportunity to discuss the Department of Veterans' Affairs application of enhance used leases which allows third parties to use government property in return for consideration in cash or in kind.

As GAO noted in its June 9th testimony before the House Committee on Veterans' Affairs, subcommittee on Health, enhance use leasing is one of a variety of legal authorities available to help VA manage real property and reduce underutilized space. With more than 32,000 acres of land and over 6,200 buildings on about 300 sites, VA is one of the Federal Government's largest property holders.

However, many VA properties are aged and not particularly well-suited to providing care in the current VA system. As a result, VA holds a significant amount of property that is underutilized or vacant because of age, condition, location, and other factors. Maintaining this property requires VA to spend funds that could otherwise be used to provide direct care and other medical services to veterans. In a report we issued in 2008, we estimated the VA spent $175 million in Fiscal Year 2007 operating

underutilized or vacant space at medical facilities.

My testimony has three parts. I will discuss: (1) VA's authority to enter into EULs; (2) how VA has used its EUL authority; and (3) the relationship between VA's authorities and the amount of real property retained or sold.

My statement is based upon our report entitled "Federal Real Property: Authorities and Actions Regarding Enhanced Use Leases and Sale of Unneeded Real Property" issued February 17, 2009.

On the first point, VA may enter into EULs for underutilized or unutilized real property for up to 75 years in exchange for cash and/or in-kind consideration, such as provision of office space or construction of facilities. After covering the cost of the EUL, VA may use the remaining proceeds for a variety of purposes, including medical care, construction, facility improvement, and other EULs without further Congressional appropriation or change in law. VA's current EUL authority will terminate on December 31, 2011.

On the second point, VA has used its EUL authority to reduce the amount of underutilized and unutilized property. In its FY2010 budget submission, VA reported disposing of 50 buildings and land in FY2008 using EUL authority. VA currently has 52 EULS, including housing, health care facilities, mixed use, and other projects.

In one example in 2006, VA entered into an EUL that will use almost 300,000 square feet of vacant space at Fort Howard, Maryland to develop a retirement community with priority placement for veterans. While many EULs result in direct services to veterans, in some instances the relationship is less clear. For example, VA is leasing property in Hillsboro, New Jersey to a company that subleases the property to a variety of commercial interests needing warehouse or light manufacturing space, as well as the County government.

On the third point, in addition to EUL authority, VA may sell unneeded property and retain the proceeds under its Capital Asset Fund or CAF authority. However, to do so VA must determine that the property is not needed to carry out its function and is not suitable for providing services to the homeless. Additionally, VA's use of these proceeds is subject to further congressional appropriation or change in law.

Despite this authority to sell property, VA has not sold any real property through its CAF authority. VA has sold only one property in Chicago, and that sale occurred under its EUL authority. According to VA officials, EULs are more attractive compared to disposal and sale under CAF, in part because VA can enter into EULs with fewer restrictions and has more flexibility on how it can use the

proceeds. For example, VA can use EUL proceeds for medical care but cannot after selling a property.

VA officials said that implementing an EUL can take anywhere from nine months to two years. EULs may also be complex due to issues such as land, due diligence, public hearings requirements, and lease drafting and negotiations. VA officials said that they are working to streamline the process.

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions you or members of the Committee may have.

[The prepared statement of Mr. Wise follows:]

Chairman Akaka. Thank you very much, Mr. Wise. Mr. Cullinan.

STATEMENT OF DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Cullinan. Chairman Akaka, Ranking Member Burr, aloha and good morning.

On behalf of the men and women of the Veterans of Foreign Wars, I want to thank you very much for inviting us to participate in today's very important oversight hearing.

In April 1999, GAO issued a report on the challenges VA faced in transforming the health care system. At the time, VA was in the midst of reorganizing and modernizing after the passage of the Veterans' Health Care Eligibility Reform Act of 1996.

The VA then developed a five-year plan to update and modernize the system, including introduction of system-wide managed care principles, such as the Uniform Benefits Package. In response to the enormous challenges brought about in implementing this plan, VA began the Capital Asset Realignment for Enhanced Services or CARES process. It was the first comprehensive, long-range assessment of the VA Health Care System's infrastructure needs since 1981.

CARES was a VA systematic dated revenue assessment of its infrastructure that evaluated the present and future demand for health care services, identifying changes that would help meet veterans' needs. The CARES process

necessitated the development of actuarial models to forecast future demand for health care and the calculation of supply of care in the identification of future gaps in infrastructure capacity. Throughout the process we continuously emphasize that our support was contingent upon the primary emphasis being in ES, or Enhanced Services, of the CARES acronym.

We wanted to see that VA planned and delivered services in a more efficient manner that also properly balanced the needs of veterans, and for the most part the process did just that. The 2004 CARES decision document gave a broad and comprehensive roadmap for the future.

The strength of CARES in our view is not in its result into a one-time blueprint but in the decision-making framework that produced it. It created a methodology for future construction decisions. VA's construction priorities are reassessed annually all based on the basic methodology created to support the CARES decisions. These decisions are created system wide, taking into account what is best for the totality of VA health care and what its priorities should be.

We continue to have strong faith that this basic framework serves the needs of the majority of veterans. Despite its strengths there are certain challenges. While a huge number of projects are underway, a number of these are

still in the planning and design phase. As such, they are subject to changes but they have also not received full funding. The Congress and this Administration must continue to provide full funding for major construction account to reduce this backlog but also to begin funding future construction priorities.

With the twin problems of funding a speed of mind, VA has recently been exploring ways to improve the process. Last year they unveiled the HCCF leasing concept. As we understand it, an HCCF was intended to be an acute care center somewhere in size and scope between a large medical center and a CBOC. It is intended to be a leased facility--enabling a shorter time for it to be up and running--that provides outpatient care. Inpatient care would be provided on a contracted basis, typically in partnership with a local health care facility.

While supportive of more quickly providing greater health care access to veterans on a cost-effective basis, we expressed our concerns with the HCCF concept in the IB. Primarily, we are concerned that this concept--which relies heavily on widespread contracting--would be done in place of needed major construction.

Acknowledging the changes taking place in health care, VA needs to look more carefully before building facilities. Cost plus projected usage must justify full blown medical

centers. Leasing is the right thing to do only if the agreements make sense. VA needs to do a better job of explaining to veterans and to Congress what their plans are for every location based on the facts. The ruinous miscommunication that plagued the Denver construction project amply demonstrates this point.

We have seen the importance of leasing facilities with certain CBOCs and Vet Centers, especially when it comes to expanding care to veterans in rural areas. CARES did an excellent job of identifying locations with gaps and care, and VA has continued to refine its statistics, especially with the improved data it is getting from DOD about OEF and OFI veterans.

Providing care to rural veterans is a major challenge for the system, and the expansion of CBOCs and other initiatives can only help. We do believe, however, that much of what will improve access for these veterans will lie outside of the construction process. VA must better use its fee-based care programs, and the recent initiatives passed by Congress, such as the mobile health care vans or the rotating satellite clinics in some areas, are helping to fix the demand problems facing veterans and VA.

Mr. Chairman, this concludes my statement. Again, I thank you and Ranking Member for inviting us to testify here today.

[The prepared statement of Mr. Cullinan follows:]

Chairman Akaka. Thank you very much, Mr. Cullinan. Now we will hear from Mr. Cox.

STATEMENT OF J. DAVID COX, R.N., NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Mr. Cox. Chairman Akaka and Ranking Member Burr, I greatly appreciate the opportunity to discuss AFGE's concerns about the VA's health care center facility leasing program. I also want to thank the Chairman and Senator Rockefeller for their efforts last year to make the information about this program available to the public.

The leasing program was introduced by former Senator Peake last year, and it appears that the VA considers leasing as an alternative to construction of new and replacement VA Medical Centers. The leasing program poses the greatest threat to the VA Health Care System since its creation. If Congress does not investigate and put the brakes on this program, VA Medical Centers as we know them today will disappear. Maybe not next year or the year after, but this unique source of health care for our veterans will become extinct by leasing slow erosion of its core.

How can a 13-page PowerPoint about enhanced leases and large outpatient facilities have a devastating effect on VA Medical Centers? Because the leasing program is not really about leases; it is about permanently diverting major construction dollars and patient care dollars away from

standalone VA hospitals and shifting them to private hospitals. And doing it without Congressional authority. It is about starving VA Medical Centers of staff, beds, and maintenance in order to support health care centers. An untested model that has never been used in the public or private sector. It is about an entirely new organizational chart for the VA, one that has these outpatient facilities reporting to private hospitals instead of a VA Medical Center.

I will focus the rest of my remarks on how the leasing program is hurting the facility in my hometown that is especially near and dear to my heart--the W.G. Heffner VA Medical Center in Salisbury, North Carolina, the facility where I worked as a registered nurse for 23 years caring for America's veterans. What happened in Salisbury is a useful roadmap for how not to adapt VA health care to veterans' changing needs.

First, secrecy and exclusion do not work. When Medical Center Carolyn Adams announced last year that the acute care, intensive care, and emergency services were being cut, the veterans would be getting most of the inpatient care from private hospitals that do not specialize in veterans' conditions and are already struggling to treat growing numbers of uninsured. The news came as a complete surprise to veterans, employees, and even some members of Congress.

The facility had recently invested in new operating rooms and intensive care units and had recruited more physicians and nurses. And veterans in Winston-Salem and Charlotte, the proposed sites for health care centers already had large outpatient clinics. Neither Ms. Adams, nor VISN-6 Network Director, Daniel Hoffman, who also played an active role in the proposed plans, included stakeholders in the planning process. When the VA contracted for a study to consider different options for the facility, the study team did not talk to a single veteran using the facility or a single employee providing care.

Second, hospitals with uncertain futures lose staff. And I would refer to that as the Walter Reed Syndrome. Upon receiving the news of proposed cuts in core inpatient services, many of the recently hired physicians and nurses left for more secure jobs.

Third, do not write promises to veterans. After the huge outcry from North Carolina veterans and labor last fall, the VA put its leasing plans on hold promising no cuts in services or staff reductions until 2013. Yet, almost immediately, hiring slowed, renovations stopped, and services were stopped. Management is still talking about closing the ER and replacing it with an urgent care facility.

I would like to close by urging this Committee to

investigate the impact of the leasing program on the Salisbury VA and other facilities before they are irrevocably weakened and the only remaining option for other veterans is a network of contract hospitals and providers.

As for Salisbury specifically, it is clear that Mr. Hoffman and Ms. Adams are not serving the interests of North Carolina veterans. North Carolina is home to the fourth largest veterans population in this country. Clearly, none of us--and I am sure including the Ranking Member--are interested in having one less VA Medical Center in the state of North Carolina. Yet, management insists on implementing policies that are weakening a full-service, nearly 500-bed VA Medical Center that serves as a hub in North Carolina.

It is far better to plan for the future needs of North Carolina veterans by including lawmakers, veterans receiving this care, and the employees providing this care in the planning process.

Thank you, Mr. Chairman. I will be glad to take any questions.

[The prepared statement of Mr. Cox follows:]

Chairman Akaka. Thank you very much, Mr. Cox, for your statement. And since you have been mentioning North Carolina, let me call on Senator Burr for his questions.

Senator Burr. Thank you, Mr. Chairman. I expressed to the Chairman I have a mark-up in three minutes down at Armed Services that I need to be on some appointments that need to be made, and the Chairman was gracious enough to let me go first.

I am not going to ask questions. I am going to make a statement relative to specifically HCCs because they have been raised. It has been of great interest. I have spent a tremendous amount of time. I have worked with General Peake. I have worked with General Shinseki. I have worked with most at the VA.

What I have got here is the budget submission. I think it was referred to earlier that seven of the projects that were ranked got funding this year, and that is pretty much--that is not out of the ordinary. That is the available money to handle the maintenance requests.

Now, you are too impassioned, please. One for my colleague from Nebraska; one for my colleague from Atlanta. The Nebraska project ranks number 16. That is clearly not one through seven. The Atlanta project ranks number 51. That is clearly not one through seven.

Does that lessen what they said? No, we have got

veterans that in some cases are hauling oxygen across a parking lot. But let me assure you that under the process that all of us agrees has to be followed because there are projects on here, 51, it is going to be--I'm sorry that we have not got the last panel up. They could tell me how many years it is going to be, but I think we all know probably not while I am here.

Now, where have we benefitted the delivery of health care for veterans if we just queue people in this system without using the flexibility that, in fact, was the CARES recommendation. Let me read it because everybody has referred to CARES.

A finding. "Contracting for CARE provides VA with the flexibility to quickly add and subtract services to meet the changing veterans' needs contingent on the availability of viable alternatives in the community."

What have we screamed about, those of us from states that have a demographic shift of veterans? Jeez, VA, Mr. Secretary, what can you do short-term to address the need that we have to deliver care to all these veterans that have moved in? If we had a stagnant population, I agree. Let us do exactly what we are doing and we will get exactly the same outcome.

But, in North Carolina, in other states, we have conditions that are different than they were last year--not

10 years ago. And to be honest, Mr. Cox, when you say there is a new model--referring to the HCCs--never been used in the public or private sector, my god, what is an outpatient clinic with an ambulatory unit attached to a hospital? That is exactly what a HCC is. It is set up to take individuals out of an inpatient setting where health care can deliver a higher quality for less money because there is a higher percentage likelihood that they do not need inpatient care connected to the outpatient procedure.

But in the unlikely nature that a surgeon who does the outpatient procedure says "something during this process led me to believe I would like to use 24 hours to observe somebody in a controlled setting, let me use the facility here versus transferring him to Asheville, or to Salisbury, or to Durham, or to Fayetteville."

Now, in the case of Fayetteville where there is a new HCC, the referral is not going to be to a community hospital when we have a VA hospital in that community. The likelihood is it is going to be to the VA facility. It doesn't lessen the need for Salisbury, or Asheville, or Durham, or Fayetteville. It begins to compliment the 21st Century delivery system that this Administration, the last Administration, and every Secretary of the Veterans' Administration have strived for. And I believe it is the mission of those that have a career at the VA to make sure

that our veterans have the best possible care.

If doing something different is wrong, then I am guilty because I have pushed every Secretary since I have been here in this capacity to do everything we can possibly do to meet the needs of veterans across the country. In some cases it is by contracting and using that flexibility because there is no service provided in that rural marketplace. In some cases it is to create new entities like HCCs because we can provide that care closer to where they live, displacing them from their family, not arguing over what the mileage reimbursement rates are. We can't keep up with the price of gasoline so we are never going to hit it in an optimal way.

But at the end of the process having the infrastructure needed, whether it is in Denver where I may have had some disagreements--not on whether we did it or not but how we did it. Not on whether Salisbury is still an integral part of the structure of North Carolina. It is how we build out to compliment the system that we have got.

If just building standalone hospitals was the delivery of care for the 21st Century, why would every community in the United States be doing it differently? Why would they be building out these entities that provide a higher level of care?

Mr. Chairman, let me end with this. And I have overshot my time.

Health care in the 21st Century has to be about educating people how to stay well--even veterans who are susceptible to needing treatment for certain things. A hospital setting is not a place to do that. It is done through outpatient facilities. It is done through medical homes. Medical homes are not created through emergency rooms. Medical homes are established with the confidence that an individual has with a health care professional. And when that bond is established, the education begins.

I think we all know that if we want to bring down the overall cost of health care and raise the outcome, then we have got to bring prevention and wellness and disease management into the VA system, just like we do the private sector. You are not going to do that through an emergency room, though trauma facilities are important to this country's veterans and we will have them.

But do not throw something overboard that fills out and compliments the health care system just because we have got a concern that it is leased and not owned. Or we have a concern that we are duplicating an area that already has a CBOC. As a matter of fact, we just completed the Charlotte CBOC less than a year ago. And the amazing thing is on the day that I was down there to shove the first pound of dirt, we all knew that it was not big enough. When we decided to build the CBOC in Charlotte, we estimated there were 125,000

underserved veterans in the metropolitan area of Charlotte, some 45 miles to Salisbury. We could not get them to Salisbury.

Today, the 290,000 square foot HCC in Charlotte, North Carolina will not replace the CBOC; it is going to be in addition to the CBOC. And I would be bold enough to say today that 290,000 square feet plus the CBOC is not enough to meet the needs of the veterans' population that we are going to reach out to in northern South Carolina and southern North Carolina. And it is not going to have an effect on how many people end up utilizing Salisbury. It is going to mean that we are delivering care to that many more veterans. And hopefully, we are doing it in the most effective way that we can.

I want to thank all three of you for your willingness to be here today. I want to thank the Chairman for what I think is a vital hearing. And I want to thank him for his generosity of letting me go first.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you, Senator Burr, for your statement.

I would like to ask all of you--the three of you--this question. And it has to do with BRAC. BRAC has its own identity. The question is would VA benefit from a BRAC-like process which would bundle a variety of recommendations into

one package?

I would like to hear from each of you. Mr. Wise, would you begin?

Mr. Wise. Mr. Chairman, the subject of our report that I testified about really dealt with the issue of property management among a number of federal agencies of which VA is one. We did not really get into qualitative aspects of realignment of VA resources and that sort of thing, but from the Enhanced Use Lease perspective, it is reasonable to assume that if you can reallocate resources from maintenance of unneeded or underutilized property and then transfer them into providing services to veterans that should be a plus for overall care for the veteran population.

Chairman Akaka. Mr. Cullinan.

Mr. Cullinan. Thank you, Mr. Chairman.

The VFW certain agrees that there are facilities out there that are not doing the job anymore--they are outdated. In fact, they bog down the system. They consume resources that could be better applied. However, at this stage we would continue to argue that the best course of action would be to go on a case-by-case basis in addressing these facilities. A key element here is to communicate to the veteran population.

In an instance where VA is going to do away with an outdated medical center, for example, what is essential then

is for VA to determine what is necessary to take that facility's place with respect to appropriately providing health care services to veterans and then letting that veteran population know about it. Tell them in advance. Before it is announced that something is going to be taken away, let them know what is coming. In place of this outdated VA medical facility, we are going to provide three CBOCs or two HCCs to provide better care in a more accessible manner. And we think that would go a long way to addressing this. We are not quite at the BRAC stage yet, we hope.

Thank you.

Chairman Akaka. Mr. Cox.

Mr. Cox. Mr. Chairman, AFGE would be opposed to some process that--like for BRAC, like has been used for the military, for VA, we agree also that you need to look state by state, facility by facility, the needs of those veterans. Obviously, I believe, the needs of veterans in Alaska and with the vast population is going to vary with the needs of veterans in North Carolina. I mean, what is happening in North Carolina is, yes, we are building a large health center in Charlotte at the expense of closing a full pledged VA Medical Center in Salisbury.

Those are real issues that I think have to be looked at. How do you close VA Medical Centers and create

outpatient clinics when a medical center is a hub of the operations of any health care system?

Chairman Akaka. Thank you. Mr. Cullinan, I know that VA's construction process is something that you have been keeping your eye on for quite a while.

Mr. Cullinan. Yes, sir.

Chairman Akaka. What are the biggest challenges for VA at this time? And how should those challenges be addressed?

Mr. Cullinan. It is one of the things that we just talked about really. It has to do with VA letting veterans know what it is going--I am referring to VA as if it were a sentient being--but letting the veterans know what they intend to do for them to provide proper health care services.

The other issue, of course, is what to do with facilities that have served their purpose because they are outdated, because of shifting demographics. You know, the patient loads have moved elsewhere.

Another huge issue, of course, is providing for rural veterans. I mean, that is something right now--there are parts of the country where not only is there not the infrastructure; there simply are not the providers. The responses to this has to do with providing satellite clinics, you know, vans, all the rest of it. But the key issue is letting veterans know what it is going to do--what

VA intends to do for them.

Chairman Akaka. Thank you. Mr. Cox, VA has requested over $1.9 billion for Fiscal Year 2010 for its construction projects, and also faces a huge backlog of projects yet to be completed. What recommendations would you make to Congress about building versus leasing facilities?

Mr. Cox. Mr. Chairman, I would make the same recommendation I believe about homeownership. We all prefer to own our homes versus to rent homes. And when the VA builds medical centers, owns these clinics and various things of that nature, it is the VA's property. They have a pride in it. They take care of it. It is operated for veterans, and probably about 50 percent of the people that work in it are veterans. It creates that community that veterans so often seek. Many studies have shown that.

We need to be building and owning VA facilities. The leasing--you lose sight of the veterans and they are just mainstreamed into a health care system that is already struggling greatly in this country. And the care of veterans is very, very unique. And I also believe veterans deserve first priority when it comes to care in this country, sir.

Chairman Akaka. Thank you for that response.

Mr. Wise, what are the pros and cons of using enhanced use leases? And how does VA's use of them compare with that

of other federal agencies?

Mr. Wise. Mr. Chairman, I think from the perspective of the Veterans Administration, the pros for using enhanced use leasing is it gives the Agency a bit more flexibility compared to other forms of property disposal or trying to get rid of property that is underutilized or unutilized due to the way the law is structured. So, there are some advantages from the Agency's perspective in that they give more flexibility in what they can do with the proceeds and ability to do more with the retention of the proceeds.

As far as it compares to other agencies, it is kind of all over the map. Each agency is governed by a different law, and so the majority of the agencies we looked at do have some authority to retain proceeds. But it varies somewhat from agency to agency.

As you may know or probably know, there is a bill that has been introduced in the House of Representatives that is currently in committee that is looking at trying to unify the proceeds retention procedures for agencies that will try to do away with these disparities between the large federal property holders.

Chairman Akaka. I thank you for that. Let me ask my final question. I have other questions that I will submit.

For each of you, how significant of a role should community input and outside review play in the VA

construction process? We have been talking about transparency and you have mentioned this. And what are the potential pitfalls of a system that is not completely transparent?

Mr. Wise?

Mr. Wise. Mr. Chairman, from the perspective of enhanced use leasing, there are requirements and provisions that go into developing these leases that take into account certain community needs and other areas that are relevant to leases for the Veterans' Administration.

Chairman Akaka. Mr. Cullinan?

Mr. Cullinan. Thank you, Mr. Chairman.

We believe that local involvement is essential to the process, both with respect to determining true need. Who knows better what their needs are than those--the potential patients or customers of the VA system.

It also has to do with expectations--letting the veteran population in this case know what they can expect--what the outcome will be of a new facility, of an alteration, of a mission change in a facility.

And finally, it helps very much in the end once all of these things are done in the political process. You are not going to have the outcries and outrage that are sometimes expressed due to not to a bad plan necessarily but of the fact that it is just misunderstood. So, in terms of

establishing true need and involving them in the process early on to avoiding unnecessary problems, we think it vital.

Chairman Akaka. Thank you.

Mr. Cox?

Mr. Cox. Seeking the input of the veterans, the employees who take care of the veterans, is essential to any process, as well as the community. And also, from members of Congress.

I have to share with you, Mr. Chairman, Congressman Mel Watt read in the newspaper about the Salisbury VA Medical Center and that was the first time he was informed that a medical center in his district was being closed and turned into an outpatient clinic. He had no knowledge. And I think certainly involving the members of Congress is very, very important to the process, and it does create a transparency.

Chairman Akaka. Well, I want to thank all of our witnesses for appearing today. The VA's construction process and priorities are important to all of us. There is a lot of money at stake in these decisions, and the system needs to be transparent to the public.

VA construction projects have a great impact on so many of our veterans, and therefore, your input is very, very much appreciated.

As a follow up to this hearing, I will be asking GAO for a global review of the CARES process with a detailed analysis of all of the proposals.

Again, I want to say thank you very much for being here.

[Recess.]

[Whereupon, at 11:16 a.m., the Committee was adjourned.]