ASSESSING CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES AND THE FUTURE OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS' HEALTH INFRASTRUCTURE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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ASSESSING CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES AND THE FUTURE OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS' HEALTH INFRASTRUCTURE

THURSDAY, JUNE 9, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:09 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Teague, Halvorson, Perriello, Brown of South Carolina, Boozman, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I call the Subcommittee on Health to order and while we are giving our opening remarks, I would ask the first panel to come forward.

I would like to thank everyone for attending this morning's hearing. Today's hearing marks the fifth anniversary of the CARES decision, otherwise known as the Capital Asset Realignment for Enhanced Services.

The purpose of this hearing is to assess the U.S. Department of Veterans Affairs' (VA's) implementation of CARES and to investigate the effectiveness of CARES as a capital planning tool.

In addition, today's hearing will explore whether CARES should continue in the future or if the VA should adapt to an alternative capital planning mechanism.

When the VA embarked on the CARES process 5 years ago, over 5 years actually, the VA's health infrastructure was thought to be unresponsive to the needs of current and future veterans.

While about 24 percent of the veterans' population was enrolled in the VA for health care, the CARES plan assumed the enrollment population would increase to 33 percent by the end of 2022.

In addition, there were concerns about the ability of the existing health care infrastructure to meet the demand of the aging veteran population who opt for warmer climates in the south and southwest.

CARES was intended to eliminate or downsize unused facilities, convert older, massive hospitals to more efficient clinics, and build hospitals where they are needed in more populated areas. In essence, CARES was to direct resources in a sensible way to increase access to care for many veterans and to improve the efficiency of health care operations across the VA facilities.

Over the years, there have been challenges of implementing the CARES decision in numerous locations. Most notably, the VA actually has reversed the CARES decision under the leadership of different VA Secretaries.

Too often we hear stories of veterans who have been waiting for new facilities for over 10 or more years.

In addition, there is a new concept of health care centers, which provide primary and specialty care and is a hybrid of a Community-Based Outpatient Clinic (CBOC) and full-fledged hospital. Because this is a relatively new concept the VA is rolling out, it is important that we fully understand how it fits into the overall CARES plan.

I look forward to hearing the testimony of our panels today as we determine the path forward to continue to build a strong health infrastructure for the VA system.

One of the reasons why this Committee continues to receive legislation dealing with contracting out VA health care services is because VA has not moved as aggressively as we would like to see them move forward under the CARES process. Hence, Members of Congress are concerned and they are trying to do what they can to make sure that veterans in their State have access to that health care that they need to take care of their needs.

I would now like to recognize Ranking Member Brown for an opening statement that he may have.

[The prepared statement of Chairman Michaud appears on p. 51.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman, and thanks to the panel for coming and sharing their knowledge with us this morning.

Today, more than 80 percent of the primary, specialty, and mental health care of our veterans' needs can be provided in an outpatient setting. Yet, much of the Department of Veterans Affairs' health care infrastructure was built more than 50 years ago when VA care meant hospital care.

A review of VA's real property by the U.S. Government Accountability Office (GAO) in 1999 found that VA was wasting a million dollars a day on the maintenance of outdated and underutilized health care facilities.

In response to this report and in recognition of the need to update facilities to deliver 21st century health care, VA established the Capital Asset Realignment for Enhancement Services (CARES) process.

CARES was designed to be the capital planning blueprint for the future, to modernize and better align VA health care facilities for the changing veterans' population.

The CARES Commission identified several ways to improve access and enhance quality of care, including increased collaboration and partnership with the U.S. Department of Defense (DoD) and VA's academic affiliates.

Specifically, in my home State of South Carolina, the CARES Commission supported a concept for a joint venture with the Medical University of South Carolina and the Ralph H. Johnson VA medical center in Charleston.

The Secretary's May 2004 CARES decision also stated that VA will continue to consider options for sharing opportunities with the Medical University of South Carolina.

Since the leadership of the Medical University came to VA with this proposal more than 6 years ago, I and this Committee have taken significant steps to study and move forward with this historic opportunity to establish a new innovative model of care.

The "Charleston Model" would ensure high-quality health care for veterans in the Charleston area and could be leveraged to improve access to care in other areas.

A significant milestone was reached in advancing the project with the passage of Public Law 109–461, the Veterans Benefit Health Care and Information Technology Act of 2006.

Section 804 of this law authorized $36.8 million for VA to enter into an agreement with the Medical University to design, construct, and operate a collocated, joint-use medical facility in Charleston, South Carolina. However, much to my dismay, the VA has not yet set aside any funding to implement the law.

As we evaluate the effectiveness of CARES, it is also vital that we reevaluate the importance of collaborative partnerships. Building on the close relationships that VA already has with medical schools across the Nation is a powerful tool that VA can use to achieve greater health care quality and further efficiencies while still preserving the identify of a veterans' health care system.

I look forward to our discussion today and yield back the balance of the time.

[The prepared statement of Congressman Brown appears on p. 51.]

Mr. MICHAUD. Thank you, Mr. Brown.

I would like to recognize the individuals on panel one: Joseph Wilson, who is with the American Legion; Carl Blake, the Paralyzed Veterans of America (PVA); Dennis Cullinan, who is with the Veterans of Foreign Wars of the United States (VFW); Rick Weidman, who is with the Vietnam Veterans of America (VVA); and Joy Ilem, the Disabled American Veterans (DAV).

So I want to thank all of you for coming here this morning. Look forward to your testimony. And we will start with Mr. Wilson.

STATEMENTS OF JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA; AND JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for this opportunity to present the American Legion's views on the future of the Department of Veterans Affairs' infrastructure.

It is the American Legion's position that Congress keep in mind the importance of continuity of care during a servicemember's transition from active duty to the community.

Within the VA medical system are various divisions that accommodate a high demand of services.

In 2004, the VA completed the Capital Asset Realignment for Enhanced Services or CARES process, which called for the critical construction needs for outdated VA hospitals and clinics throughout the Nation, throughout the VA system.

The Secretary of VA reported Congress would have to include $1 billion annually for 6 years to ensure the success of CARES. The American Legion has recommended the same figure in its annual budget recommendation since the CARES decision.

Due to lack of funding over the years, it is believed VA has been playing fiscal catch-up. Although the VA had begun implementing CARES decisions, a Government Accountability Office or GAO report found implementation was not being centrally tracked or monitored to determine the impact the CARES process has or has not had on the mission.

GAO was also tasked with examining how CARES contributes to the Veterans Health Administration (VHA) capital planning process, the extent to which the CARES process considered capital asset alignment alternatives and the extent to which VA had implemented CARES decisions and how the application has helped VA carry out its mission.

Through CARES, the VA developed a model to estimate the demand for health care services as well as ascertained the capacity or availability of infrastructure to meet the demand. It was the recommendation of the VA to meet future health care demand by building medical facilities and opening more community-based outpatient clinics or CBOCs.

GAO further examined the CARES process by other means such as conducting six site visits to VA facilities in Walla Walla; El Paso; Big Spring, Texas; Orlando, Florida; Pittsburgh, Pennsylvania; and Los Angeles, California, but they found critical infrastructure problems at the following facilities, Walla Walla, greater Los Angeles, Orlando, and Pittsburgh.

As a result of the GAO report, it was recommended that VA provide the information necessary to monitor the implementation and impact of CARES decisions.

It was also recommended VA provide outcome measures that report the progress of CARES as it relates to access to medical services for veterans.

Since fiscal year 2002, approximately 945,000 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans have left active duty and become eligible for VA health care. Approximately 51 percent of the returnees were active duty while 49 percent were Reserve and National Guard. Many are also returning with various injuries and illnesses to include traumatic brain injury (TBI), spinal cord injury (SCI), blind eye injury, post-traumatic stress disorder (PTSD), and loss of limbs to name a few.

The American Legion presents the above-mentioned numbers to evoke to the Congress and other pertinent stakeholders to determine the adequacy or lack thereof of care to veterans when there

is lack of funding and/or inadequate accommodations, namely infrastructure that houses VA services.

While the decision to assess and plan and construct or reconstruct VA medical facilities has been underway since the CARES decision in 2004, the aforementioned figures also suggest veterans' issues have and continue to increase.

With the average age of VA facilities remaining at 49 years, the American Legion questions whether these facilities can sustain new medical technology for years to come. During that time, we must remain conscious that veterans' issues are patterned to rise. It is, therefore, imperative Congress support the demand for timely construction of these facilities.

It is the position of the American Legion that during the improvement/enhancement of VA facilities, a base of health care services must not only be maintained but must be increased to accommodate influxes.

In order for the CARES plan to work successfully, there must be adequate funding to accommodate every project as implemented by the Commission. To play fiscal catch-up from this point would adversely affect the intent of the CARES project or VA infrastructure and all veterans who rely on VA health care.

The American Legion also supports the mission of the CARES initiative if it provides a continuous, up-to-date infrastructure for an ever-changing veterans' community. However, we express descent and concern if the intent is aimed at the effort to reduce VA expenditures under the pretext of cost savings without regard to the needs of the veterans' population.

Finally, the preparation to construct and/or reconstruct VA medical facilities must be planned in accordance with service alignment decisions to fulfill the promise of continuity of care and prevent other inadequacies such as fragmentation of care throughout the women veterans' population.

The American Legion maintains that the CARES implementation process must be an open and transparent process that continually and fully informs the veterans service organizations (VSOs) of CARES initiatives, criteria proposals, and timeframes.

This also includes an accurate assessment of the demand for all medical services which gauges how much infrastructure is required to accommodate this Nation's veterans.

Through this form of checks and balances, the maintenance of quality stands to uphold the effectiveness of CARES as it pertains to strategic planning and the future of the entire VA system.

Mr. Chairman and Members of the Subcommittee, the American Legion sincerely appreciates the opportunity to submit testimony. Thank you.

[The prepared statement of Mr. Wilson appears on p. 52.]

Mr. MICHAUD. Thank you, Mr. Wilson.

Mr. Blake.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Michaud and Ranking Member Brown, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today.

I will limit my comments to CARES recommendations as they directly impacted care for spinal cord injured veterans and veterans with spinal cord dysfunction.

In reflecting on the CARES report, we believe that the health care concerns of veterans with catastrophic disabilities and particularly veterans with spinal cord injury or dysfunction (SCI/D) were adequately addressed.

Emphasis was placed on expansion of the SCI hub-and-spoke delivery model to fill geographic gaps in SCI/D services. Specifically the CARES Commission called for the construction of four new SCI centers in the VA system. Those locations were targeted for new centers in Syracuse, New York, Veterans Integrated Services Network (VISN) 2; VISN 16, which was later pinpointed to Jackson, Mississippi, by the VA and PVA officials; Denver, Colorado located in VISN 19; and Minneapolis, Minnesota, which was previously in VISN 23.

With regards to Denver, the Subcommittee is probably aware that it has been a long and difficult process to determine what the health care infrastructure plan for this region would be. The CARES planning called for a 30-bed SCI center to be located at a new Denver VA medical center to be built on the Fitzsimons Campus. However, the larger facility planning process moved forward in bits and starts.

The plan for Denver has taken many controversial turns spread out over many years with no plan being more troublesome than the new plan that was released in early 2008 by then VA Secretary Peake.

Fortunately the VA finally announced in March that a new stand-alone hospital will be built on the Fitzsimons Campus and a new SCI center will be included in that facility.

PVA was pleased that the final CARES Commission report included several recommendations for the expansion of long-term care services directed at spinal cord injured veterans as well.

Prior to the CARES initiative, the VA system of care provided only 125 long-term care staff nursing home beds dedicated to veterans with spinal cord injury. These SCI long-term care beds were located in four VA facilities, at Brockton, Massachusetts; Hampton, Virginia; Castle Point, New York, and at the Hines VA medical center in Chicago, Illinois.

Interestingly, the VA had no institutional long-term care beds for SCI veterans located west of the Mississippi River at that time.

While some progress has been made to expand VA's capacity for dedicated SCI long-term care, much work remains to be done. Despite the CARES Commission recommendations to increase SCI long-term care capacity, we believe that particular emphasis needs to be placed on expansion into the western United States.

In 2007, VA released a copy of its long-term care strategic plan that in the opinion of the co-authors of the *Independent Budget* and outlined in the fiscal year 2010 *Independent Budget* was lacking in specific planning detail regarding the future direction of its long-term care program.

In 2008, PVA understood that VA was working on the development of a second more comprehensive long-term care strategic plan. However, to the best of our knowledge, no follow-up plan has

ever been released. We would encourage the Subcommittee to investigate this issue further.

The CARES Commission emphasized in its final report that strategic planning for aging veterans and veterans with serious mental illness will be essential going forward.

The Subcommittee has posed the question about the viability of CARES in assessing the future health care needs of veterans. As pointed out in the *Independent Budget* for fiscal year 2010, despite the fact that CARES was completed in 2004, the VA continues to assess its needs and priorities for infrastructure by using concepts derived from the CARES model.

PVA actually sees this question as being one about whether or not the CARES recommendations made then appropriately address new demands on the system, particularly as it relates to the younger generation of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom.

Moreover, the question seems to suggest that CARES did not take into account that new demands to be growing in rural communities and that the infrastructure changes outlined by CARES do not reflect this change.

While we certainly understand this concern, we believe that the CARES model appropriately addressed where the greatest demand for care comes from.

Moreover, the CARES model provided a blueprint for aligning VA's infrastructure to best meet the needs of the most veterans possible.

Recognizing that certain demand has changed since 2004, the VA has moved forward on other major and minor construction initiatives outside of the CARES recommendations.

Mr. Chairman, we would again like to thank you and the Subcommittee for examining this issue. We look forward to working with the Subcommittee going forward to assist the VA in accomplishing this difficult task. And I would be happy to take any questions that you might have.

[The prepared statement of Mr. Blake appears on p. 54.]

Mr. MICHAUD. Thank you, Mr. Blake.

Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you. Chairman Michaud, Mr. Brown, distinguished Members of the Subcommittee, on behalf of the men and women of the Veterans of Foreign Wars and our auxiliaries, I want to thank you for inviting us to participate in today's very important oversight hearing.

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

VA then developed a 5-year plan to update and modernize the system, including introduction of systemwide 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 comprehen-

sive, long-range assessment of the VA's health care system's infrastructure, since 1981.

CARES was VA's systematic, data-driven assessment of its infrastructure that evaluated the present and future demands for health care services, identified changes that would help meet veterans' need.

The CARES process necessitated the development of actuarial models to forecast future demand for health care and the calculation of the supply of care and the identification of future gaps in infrastructure capacity.

Throughout the process, we were generally supportive and we continue to emphasize our support for the ES or enhanced services portion of the CARES acronym. We wanted to see that VA planned and delivered services in a more efficient manner, it also properly balanced the needs of veterans. And for the most part, that process did just that.

The 2004 CARES decision document gave VA a broad road map for the future. It called for the construction of many new medical facilities over the 100 major construction projects to realign or renovate current facilities and the creation of 150 new CBOCs to expand health care in areas where the CARES process had identified gaps.

The strength of CARES in our view is not its resultant one-time blueprint, but in the decisionmaking framework it produced. 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 systemwide, taking into account what is best for the totality of health care and what its priorities should be.

We continue to have a strong faith that this basic framework serves the needs of veterans in most cases. Despite its strengths, there are certainly some challenges.

While a huge number of projects are underway, a number of these, they 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 Administration must continue to provide full funding for the major construction account to reduce this backlog, but also begin funding future construction priorities.

With the twin problems of funding and speed in mind, VA has recently been exploring ways to improve the process. Last year, they unveiled the Health Care Center Facility (HCCF) or leasing concept.

As we understand it, HCCF was intended to be an acute care center somewhere in size and scope between a large VA 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 *Independent Budget*. Primarily we are concerned that this concept, which relies heavily on wide-

spread contracting, would be done in place of needed major construction.

Acknowledging that with the changes taking place in health care VA needs to look very carefully before building new medical facilities, cost plus projected usage must justify full-blown medical centers, that leasing is the right thing to do only if the agreements make sense.

VA needs to do a better job explaining to veterans and the Congress what their plans are for every location based on the facts. The misconception 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 in care and VA has continued to refine its statistics, especially with the improved data it is receiving from DoD on OEF/OIF veterans.

Providing more 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 the construction process.

VA must better use its fee-basis care program and the recent initiatives passed by Congress such as the mobile health care vans or the rotating satellite clinics in some areas to fix some of the demand problems that these veterans face.

Mr. Chairman, that concludes my statement. I thank you very much for this opportunity.

[The prepared statement of Mr. Cullinan appears on p. 57.]

Mr. MICHAUD. Thank you very much.

Mr. Weidman.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Mr. Chairman, thank you for your leadership, yours and Mr. Brown's in holding this hearing today and to take a look at this process of CARES and the whole construction milieu within VA.

VVA supports the concept behind CARES given that it is a concept of stewardship and each Administration is a steward of the Nation's physical facility to care for veterans.

Unfortunately, that stewardship was not very well met during various periods since it was first constructed following World War II. And many of the facilities have become dilapidated when they started to change from outpatient to inpatient. In the early 1990s, they had renovated spaces that then lay dormant.

Frankly, we were always skeptical of GAO's estimate that it was as high as has been reputed to care for outmoded facilities. All of the projections at that point were that the veterans' population served by the Veterans Health Administration would continue to decline on into the future. That has not proven to be the case, however.

The veterans' population VA formula, which is for estimating workload in the future, which is based on many of the same formula from Milliman that was used in CARES, has consistently underestimated the number of veterans who are seeking services.

Five years in a row, they have grossly underestimated the number of OIF/OEF veterans who would be seeking services and they have underestimated the number of veterans of older generations who found need to and were eligible to seek services from the VA even before the Congress began easing the requirements for Category 8s to seek services at VA hospitals.

So the assumption, one of the key assumptions behind it, which was that there was a great deal of excess space and we had a declining veterans' population has proven not to be the case today.

The second major problem that we have with CARES that we have had from the very beginning was that the formula was a civilian formula that did not take into account that wounds, maladies, injuries, and conditions that derive from military service, particularly wartime service, and is detailed at VA, at the veterans health initiative, the 32 curricula that look into the special medical, long-range medical problems that veterans have as a result of their military service or the military history card that people say that we are fanatics about that, frankly, needs to be incorporated into the computerized patient treatment record and taken account of in the diagnosis and treatment modalities at VA.

All of those things lead to a problem with underestimating the number and types of resources that individual veterans will utilize.

Second, because the Milliman formula was a civilian formula, it estimates one to three presentations or things wrong with them that need to be addressed by a clinician of each person walking across the door sill. And, in fact, at VA hospitals, it ranges from five to seven presentations per person, not one to three.

In addition to that, it does not fully take into account the VA formulas of not only wartime exposures but who is in a geographic area. Many who can and who have the resources who are middle class, as they age, they move south when they retire. Those who are left are older and sicker and poorer, quite frankly, so that the burden rate, the number of presentations per person is going to go up in the north.

So both the Vera formula, which is not the subject of this particular hearing, but also the CARES formula are going to be somewhat askew when it comes to estimating what are going to be the future needs of the physical structure within which the health care is delivered.

There are four things that we recommend that be done from this point on. The first thing is that the basic CARES formula must be improved to take into account military service and things that happened to people in the course of that and to adjust that formula to the reality of who we see at VA hospitals in terms of the number of presentations.

Second, we believe that the whole process needs to be much more transparent. In the last 5 to 6 years, Veterans Health Administration has, in fact, become much less transparent if indeed not secretive and shown virtual contempt for the Congress, for the veterans service organizations, for the union and its members, and for virtually anyone outside who would dare question any of their decisions no matter how wrong-headed or how off base they were as an example in terms of the lack of preparation for dealing with PTSD among all generations but particularly OIF/OEF veterans.

Third, VVA urges that the major construction budget be set at a level of at least $1.5 to $2 billion a year and possibly even higher. This is the time to, for those who have the money, to invest in construction. Why? Because so many people cannot get financing, that the cost of material and labor is more competitive now than it will be in 4 or 5 years when the economy rebounds.

Number four, VVA strongly recommends that the Secretary and the Deputy Secretary review the lines of authority and accountability for CARES, who is responsible for what, define those roles, and make it clear who is going to be held accountable, a novel concept within the Veterans Health Administration, who is actually going to be held accountable for delivering what should be delivered and decisions on time that actually results in enhanced services for veterans.

Mr. Chairman, I thank you for the opportunity for VVA to present here today and for your leadership of you and your distinguished Committee in holding this hearing. Thank you.

[The prepared statement of Mr. Weidman appears on p. 60.]

Mr. MICHAUD. Thank you very much.

Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Mr. Chairman and Members of the Subcommittee, thank you for inviting DAV to testify at this oversight hearing. We appreciate the opportunity to offer our views on CARES and to discuss the future of VA's health care infrastructure.

DAV concluded at the completion of CARES it was a comprehensive and fully justified road map for VA's infrastructure needs. However, once the plan was released media backlash developed to the proposed recommendations affecting the operating missions of a number of VA facilities. Many veterans, fearful that they would lose VA health care services, opposed the plans for changes in their States and at their facilities irrespective of the validity of the findings or the value of the plan as a whole. Local and political pressure became intense and in many cases, the proposed CARES recommendations were abandoned.

Unfortunately, the past decade of deferred and underfunded construction budgets has meant that VA has not adequately recapitalized its facilities, now leaving the health care system with a large backlog of major construction projects totaling more than $6 billion, with an accompanying urgency to deal with this growing dilemma.

Recently VA began to discuss the necessity to consider alternative means to address the growing capital infrastructure backlog and the significant challenge of funding it. VA broached the idea of a new model for health care delivery, the Health Care Center Facility or HCCF leasing program.

VA has argued that this model in lieu of the traditional approach to major medical facility construction would allow VA to quickly establish new facilities that would provide 95 percent of the care and specialty services veterans will need. The HCCF model seems to offer a number of benefits in addressing this capital infrastructure problem.

However, while it offers some obvious advantages, we are concerned about the overall impact of this new model on the future of

VA's system of care, including the potential unintended consequences on continuity of care and delivery of comprehensive services, its biomedical research and development programs, and particularly the impact on VA's renowned graduate medical education and health professions training programs.

DAV is also concerned with VA's plan for obtaining inpatient services under the model and we question the ability for maintaining existing specialized services.

In November 2008, VA responded to a Senate request for more information on VA's plans for the newly proposed HCCF leasing initiative. In a letter, VA addressed a number of key questions that may be of interest to the Subcommittee, including whether studies have been carried out to determine the effectiveness of the HCCF approach, the full extent of the current construction backlog, the engagement of community health care providers in the proposal, the ramifications on the delivery of long-term care and inpatient specialty care, and whether VA would be able to ensure that needed inpatient capacity will remain available.

What is not clear is to the extent which VA plans to deploy the HCCF model. In areas where existing community-based outpatient clinics need to be replaced or expanded due to the need to modernize, add services, or increase capacity, the model would seem appropriate and beneficial to veterans.

On the other hand, if VA plans to replace the majority or even a large fraction of all VA medical centers with HCCFs, such a radical shift would pose a number of concerns for DAV.

Fully addressing these and other related questions are important, but we see this challenge as only a small part of the overall picture related to VA health care infrastructure needs in the 21st century. The emerging HCCF plan does not address the fate of VA's 153 medical centers that are on average 55 years of age or older.

As we grapple with the issue of health care reform in America, we must make every effort to protect the VA system for future generations of sick and disabled veterans. A well thought-out capital and strategic plan is urgently needed and the tough decisions must be made and not avoided as in the response to the seemingly stalled CARES process.

Congress and the Administration must work together to secure VA's future to design a VA of the 21st century. Regardless of the direction VA takes, first and foremost, we want to ensure VA's infrastructure plan maintains the integrity of the VA health care system and all the benefits VA brings to its enrolled population.

While we agree that the VA health care system is not its buildings, VA must be able to maintain an adequate infrastructure around which to build and sustain its patient care system.

Although it is a significant challenge and costly prospect, VA's infrastructure issues must be addressed now. Our Nation's veterans deserve no less than our best effort.

Mr. Chairman, thank you again for the opportunity to testify.

[The prepared statement of Ms. Ilem appears on p. 62.]

Mr. MICHAUD. Thank you very much.

Once again, I would like to thank all the witnesses for your testimony this morning.

Several of you expressed a concern with VA's health care center facilities (HCCF) leasing programs. What do each of your organizations believe that the health care delivery system for the VA should look like for the 21st century?

Mr. CULLINAN. Mr. Chairman, with respect to the HCCF model, we think that could be invaluable in providing health care access to veterans.

I guess we have two primary concerns with it. First that it not overreach in size and scope. I mean, at a certain point, it makes sense to build as opposed to leasing. The leasing option could really be invaluable in parts of the country where building just is not an option.

The other thing has to do with the quality of the care that is going to be provided through the HCCF model. And specifically referring to contracting issues, there was this situation, it was in Grand Island, Nebraska, where such a facility was established, a contract was established with a local health care provider hospital for the inpatient service, and then the contract was backed out of which left it adrift for a while.

Now, I understand that has been remedied at this point in time, but these are the kinds of things that we would want to carefully monitor.

Mr. BLAKE. Go ahead, Rick.

Mr. WEIDMAN. I was going to say that used in moderation, the HCCF can make some sense. Unfortunately, good ideas often are given to the VA and they are like an 18-year-old who gets a hold of a bottle of whiskey and they run amuck.

And the example would be so-called Project HERO where the Congress instructed VA to rationalize the contracting out. And instead, VA has tried to turn it into a fire sale of contracting out as opposed to increasing and strengthening the organizational capacity within the hospitals themselves. And there are still problems with that. And in some areas of the country, it is as much as 40 percent of the patients are involved in Project HERO or HCCF type activities.

We have a real problem with utilizing something that makes sense in some areas and then using that as a Trojan horse to try and undermine and destroy the overall veterans' health care system.

Mr. BLAKE. Mr. Chairman, what I would say is the question seems to suggest that there is a one-size-fits-all solution to meeting overall health care demand issues in the VA, and I am not sure that that is the case. I think that is part of the concern with HCCF is that, as Rick mentioned, there are places where it is meant to work or where it should be used. But I do not think you can apply that universally to the VA health care system.

Additionally, as rural health care sort of becomes a larger issue, I do not think you can just simply say we are going to do this or we are going to do this.

Honestly, I believe that the VA in its recent release as part of its rural health care initiative is starting to take the right tact in addressing that particular demand issue by using CBOCs, by using HCCF, by using direct contract. I mean, I think it is going to have

to be sort of a fluid delivery model. I do not think HCCF in and of itself is the answer to the whole problem.

Mr. WILSON. Mr. Chairman, HCCF would have to accommodate that respective particular venue. As I have traveled throughout VA facilities this year, I found so many different areas, I found variations in those areas when we are speaking of urban as opposed to rural areas. And we had issues with contracts out in—with contract issues out in Sepulveda as well.

I think overall the American Legion is concerned about the culture of care and the culture of care bringing about quality, quality of care, understanding the veteran. The uniqueness of the veteran must remain. And business as usual should not filter into the veteran, as I said, who is a unique patient.

Ms. ILEM. And I would just add to the remarks of all my colleagues, you know, we just want to make sure the integrity of the VA health care system, the type of care that is delivered, the high-quality care delivered is maintained. And, you know, there need to be changes for the future for the 21st century. And a one size, I think that I agree with Carl, you know, is not going to fit every place, but there needs to be an overall plan that is well thought out and can really take into account all of these specialized services VA has been able to provide to our Nation's veterans. We just want to make sure that those are there for the future veterans.

Mr. MICHAUD. Thank you.

My next question is for Mr. Wilson and Mr. Weidman. You both had talked about the importance of openness, transparency, and accountability in the CARES implementation process and, hopefully, the VA will be more open and transparent.

What do you think will have to be done for them to do that? What would you consider to be openness and accountability and transparency in the CARES implementation process?

Mr. WILSON. I think a continuous assessment. I think there is too much time in between inspections or assessments and not just—well, there is one inspection that the big group, Jayco, and I have gotten calls from VA employees who say, oh, we get through that because we plan for it. We know what they are going to do and we plan accordingly. We can respond to them with a general question.

So I am thinking, you know, throughout the American Legion's visits are they doing the same. So I am looking at some things within various VISNs. They are uniform questions. We can look at it. We have roundtables over this and we are looking at it.

And it is like, okay, this is just a general response that they have given us and they are not—we take them through a line of questioning and we find out more things are going on. We talk to employees. We find out something differently.

So we feel that it has to be more transparent because the bottom line is the veteran is going to suffer, you know, if they are trying to make the system look perfect when they know, you know, the system is fallible or it is—well, we have also discovered complacency as well because of shortage of employees and other things and space as well.

So we think and that is how we come to the conclusion that there needs to be more transparency, some type of system of checks and balances where they can pretty much open up.

Mr. MICHAUD. Thank you.

Mr. WEIDMAN. Mr. Chairman, we increasingly over the last 5 years have been able to find out a great deal more about what is going on by talking to union members around the country than we can find out by meeting with the Under Secretary for Health. And this is not the kind of partnership that certainly the veterans service organizations envisioned nor the Hill nor people who want to make this system work.

And it is not because we have all the answers. We do not. But we have significant input that make the decisions better. And so that is one aspect of the openness of starting to regard veterans at the local level and at the VISN level as well as at the national level as true partners, the veterans' organizations in the process of how do we build and continually rebuild, reinvent the best health care possible for our Nation's veterans. That is one.

Second, the Milliman formula, no one has ever successfully explained to us how it works. And the Milliman technicians time and again said to us, well, we cannot really explain it to you, it is too complicated, to which my response is, young lady, contrary to what you seem to believe, those of us who served in Vietnam were not too stupid to know where Canada was. We served because we believe it was correct. Try us.

But we still have not gotten a successful iteration, if you will, of how it works within that black box. But one thing we do know is that it does not take into account the special experience of veterans and having to do with everything from toxic exposures to all the other kinds of things that one is subject to in military service in the projections of the formulas.

And we believe we need to have a task force appointed by Secretary Shinseki to look into this and involve the veterans' organizations as well as outside experts and not just folks within the VA in every step of the process.

When they first formulated the CARES formula, they met with the veterans' organizations a couple of times to say that they met with us. And they said we are not to the point where we can share any details with you, but we will call you together as soon as we can.

Then Dennis Duffy, then with the Office of Planning and Policy, called us all together and said this is what we are going to do based on the report from all of our consultants. And so a number of us had questions about it and said, once again, what about the special problems that veterans have ranging from SCI to much higher rates of visual impairment to all kinds of other things and prosthetics, et cetera, to which the response was it is too late, we are on a schedule, we have got to stick with what we have got now.

Whereupon, our response from VVA was when was the 1.2 seconds for the veterans service organizations to make their input into this process. Do not go back and tell the Secretary and the Congress that you consulted with the veterans service organizations when, in fact, all you did was inform us and said too bad, this is the way it is going to be, you folks.

That partnership, I am not sure how you can legislate that, Mr. Chairman. I do believe that Secretary Shinseki is going to approach this process differently because he and Deputy Secretary Gould understand that you make better decisions when you consult with labor, when you consult with the stakeholders, with the patients, and when you consult with people outside of the system who have a legitimate stake in seeing that we have the best health care for our Nation's veterans.

Mr. MICHAUD. Thank you very much.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman. I have enjoyed the testimony.

I am an optometrist, so those of you that are having problems with your eyes or whatever, I will be able to give you some free advice later.

But I was listening. My brother was an ophthalmologist, an eye surgeon. We went into practice many years ago, and one of the procedures he did was cataract surgery. Thirty years ago when he did that, it was probably about a 2-hour procedure. The results were not very good.

If that were still going on today as it was then, as I look out, many in the audience would have the big old cataract glasses. You know, the ones that magnified your eyes and restricted your vision.

The surgery was done and then you were put in the hospital for 3, 4, or 5 days with sandbags around your head. That procedure is now done in about 15 minutes. You immediately go home, and probably miss a day of work and then go back.

That procedure is that way and so many of our procedures are heading in that direction or have already headed in that direction. So, I think that we would all agree that there is a need for looking at the way that we do things and adapting.

I guess the key is that as we start doing that, when we talk to GAO just in visiting with you guys, visiting with the CARES Commission, whatever, there really is a resistance to change. In the communities, there is a fear. I agree that certainly the number one thing is the quality of care. That is without a given.

I understand also the culture. I think that is very, very important, the things that you all have mentioned. But I guess, and you mentioned the task force some ideas and things. Give me some more ideas or let us go further with that.

How do we, as we go forward, and I think we all agree that things are changing and we have got to get into the present, how do we break down the resistance to change? You know, how can you all be helpful in that?

You mentioned the transparency issue is so important. And I agree with that.

You know, again, on the other side, they are probably a little bit hesitant in the sense because there has been such a resistance to change sometimes that you immediately get shot down regardless of what you are doing.

So, if you all would discuss a little bit about maybe some other—kind of dwell a little bit on how we can get—transparency. You mentioned task force. What other things are out there? How can you guys help us, like I said, look without—to kind of break down

this both at the community level, the district level, and then at the VA level?

Mr. CULLINAN. Mr. Boozman, if I may, the VFW handles the construction portion of the IB. We have been doing it for a number of years and we are happy to do it. It is such an important issue.

A big concern of ours is that this be a highly dynamic process and we believe the CARES system is that. Yes, in the early stages of CARES implementation, there was a lot of murkiness.

I remember when the CARES document was finally released, I got a PDF version of it and a hard copy. And it was an avalanche of information. It really defied my ability and my staff's to even begin to entertain what was said in there. But over the years, with respect to the implementation, yes.

I talked about Denver earlier. There have been other places where the implementation has been murky. First something is going to be one thing, then it is going to be another and it changes back again.

But I have to say that with respect to our dealings with VA in dealing with trying to get the explanations of how the actuarial models work, the budget model, the Milliman, and then beyond because VA has gone quite beyond the—VA has been quite forthcoming actually formally and informally, I have to say that while their budget model certainly is beyond what I can really apprehend, it seems very accurate.

I spent a day over at VA with a colleague of mine and they went through an explanatory process. And they really have this refined to an art and it is not a static art. It is something that they continue to work on.

With respect to the construction needs outside of the modeling itself, again, we have had a positive experience with VA. So I just want to add that.

Ms. ILEM. I think some of the things that have been mentioned, that communication is the key, especially with CARES. Those of us that, have been around from the very beginning of CARES through now, one of the biggest problems was the communication issue.

When things came out and people realized that there may be a change or there was a proposed change, there was a panic. And oftentimes just being able to communicate beforehand, before all of a sudden you get something that is just sprung on you or seemingly sprung on you, you were not aware of, you know, working with Members of Congress, working with the local officials, the VISN, and, I mean, all the way down with veterans and really having a good understanding and that they play a key role.

And if you are talking, sometimes just the language, if they hear closure or realignment, they do not understand what that exactly means. They just think for me, my services are going away. This is what I want. It is here. It is where we need it.

And people are very protective which is a great thing about what you really saw. People really came to show you how important the VA is to them and what it really is able to provide.

But I think just with communication and a much better strategy, openness with the veterans service organizations, certainly we can help. I mean, we all have chapters and departments throughout the Nation. We can get people there, making sure that they are part

of the dialogue from the beginning rather than, as Rick mentioned, at the end, which is oftentimes, you know, then you are in a defensive position right from the get-go.

Mr. WEIDMAN. You also have to tell the truth. I mean, that is one of the problems with Denver was that there were people there and people within 810 Vermont who were not telling the truth to the Secretary. And so the Secretary got called out repeatedly, three different Secretaries, in what was going on with that process. And they did not tell the truth to the veterans.

The one thing that is, vets will sometimes get mad, but they will always accept it if you play straight. The one thing that will make veterans madder than hell is if you lie to them. And I do not blame them. And it makes me madder than the dickens. And when they lie to us, that makes us angry. But people have not been held accountable for that in the past.

The next panel has on it the Honorable Everett Alvarez, a true hero in war and in peace. And as Chair of the CARES Commission, it was Mr. Alvarez, Chairman Alvarez who took all the heat from all the places around the country and made the necessary change to CARES to avoid it being a debacle and he caught all the heat for the stupidities of people within the bureaucracy. And he actually did not have white hair until that point and the CARES process did it to him.

But we do not need to abuse our heroes in order to make steady progress in the future if we mandate that every hospital, as an example, have regular meetings with the veterans service organizations about the quality of care and the care service lines at that facility and not turn them into dog and pony shows where people have 15 minutes to ask questions. And the same thing is true at the network level to really assess consultation with the community.

If you call a Veterans Integrated Services Network, the idea was that somehow it is closer to the community, but by and large, that has not happened in many of the VISNs or at many of the facilities. And that is a step that needs to be taken.

And I think that the new Under Secretary for Health, that decision is really going to be key, that that be someone who is as open and direct and as straightforward and honest as Secretary Shinseki is and is committed to veterans' health care. So who that individual is is going to set the tone.

And, once again, I am going to hearken back to something Secretary Shinseki told the full Committee at his first hearing over here on the House side. When asked was there additional legislation needed, his answer was most of our problems have to do with leadership and accountability. And that is still the issue.

Together, if it was a leadership and accountability within the VA and proper respect not only for the individual veteran seeking services but for the veterans' organizations and expect us to do our part of the bargain of doing our homework before we come to meetings by sharing good information, then we can make some steady progress together and with that openness.

But I do not know that there are things that you can stipulate in statute to get people to act decently.

Mr. BLAKE. Mr. Boozman, if I might just quickly. You mentioned our resistance to change and our longstanding concerns about

broad-based contracting notwithstanding. Some of this idea of change, our resistance comes from us applying the does this make sense test to a recommended change.

You know, I will use as an example under HCCF, I think we have said here today that applied correctly, it is a good thing.

Early on when this was discussed, Salisbury, North Carolina, was put out as a possible HCCF facility. It was going to involve contracting for certain services that are already being provided in the Salisbury facility. And it is not like they were being contracted to an area 50 or 100 miles away. They were being contracted out into the local community.

So we asked ourselves does that really make sense. And from our perspective, the answer to that question is no. So then there is no other really explanation for why to then apply HCCF to a facility like that.

There was a Booz, Allen, Hamilton report that focused on a number of these HCCF designated facilities that came out last year, and if I can find it, I will be glad to submit it for the record, and it reads sort of like a multiple choice test. And it has, you know, example A and here are A, B, C, and D as the solutions to the problem. And you read that and if you pick the answer, at the end, the findings of the report completely go against what you think make sense.

So I think as we move forward with change, we have to apply a little bit of just common sense to the process and not simply, well, this is the model we want to make fit because we think it is a good model.

Mr. WILSON. Mr. Boozman, I think it is consistency when implementing policy, the communication as well throughout the VA system. For example, there was previously 1 million veterans that migrated to rural areas. Now it is 2 million. And that went up pretty quickly.

VA has to track better and they have to be consistent at tracking because we found even in our travels that some were tracking, for example, those 500,000 who had applied after 2003 who will be in the system now, but some have tracked and some have not tracked. That is inconsistent.

And so the American Legion, we think there should be a better tracking of veterans period from the time they leave DoD to the time they transition into the community. That is not something that is as difficult as if you were tracking nonmilitary simply because one issue that a veteran may have is the microcosm of many.

So when you, for example, as I said, you have 2 million who migrated to, who live in rural areas, and a high number of those recently migrated, not the full 2 million, but a high number of those did, so it is pretty much a pattern and it is in huge numbers, so it is trackable because we have had some systems who have tracked and some said they were unable to track. We need to know why.

Mr. BOOZMAN. Thank you, Mr. Chairman, very much.

Mr. MICHAUD. Thank you.

Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman.

Thank you, panelists, for being here.

Mrs. Ilem, you mentioned in your testimony that some of the facilities are outdated. One of them you mentioned is near my district, Hines in Chicago.

With the need and probably too much need basically to get it up to the 21st century needs, do you think that it might be better to put the money and the needs to expand more CBOCs because, as Mr. Boozman said, we need to adapt to change? And now people are not spending as much time in the hospitals and maybe we need to do more to the outpatient clinics.

So I do not know. Since you had it in your testimony, we can start with you. And I do not know if anybody else wants to mention that as we have more challenges in new health care, whether it be mental health or some of the other traumatic brain injuries or women challenges, should we be putting our emphasis more on the CBOCs?

Ms. ILEM. Well, I would just say one thing—I remember sticks out in mind from our *Independent Budget* were PVA has architects and people available within their organization who have expertise in construction issues. And when we have talked about renovating or updating or modernizing a facility, one of the things that sticks out is that they continue to say, oftentimes, that it costs more to try and renovate a place than to build a new facility.

And because of the new types of equipment that are available today, the rewiring, the ceiling heights, there is just a number of issues like that that come into play.

So the assessment, which was nice about CARES, was it really gave you—I mean, when you opened the books and as we said, we got volumes of books on each location, you can really get a feel, if you have not been there, for each of those facilities.

But certainly many of us travel around for our organizations. We visit the VA facilities. And they are doing the best that they can. They have retrofitted these almost outpatient clinics within medical facilities which used to be wards and different things. And they have tried the best they can to make renovations with the money that they have gotten.

And a lot of them have added new additions on.

I just came back from New Hampshire this weekend. I visited the VA facility and they showed me a new addition. They have not opened the new wing yet. It is just night and day between the original facility itself and just the look, the feel, the space confinement, and you go to the new addition, the new wing, which was just literally brand new, it has not even been furnished yet. They have the appropriate size doors, wheelchair accessible, it is very modern. It is like you are in another world. And they were talking about all the clinics that will be moving down there.

And I know in your facility, Tammy Duckworth was a big—I remember her testifying in the Senate way back when she first got back about her impression just of coming to the facility, the prosthetics department, and how, you know, dungeon-like things were there. And even regardless if you are getting good quality care, I mean, there gets to be a point where, you know, you have to look at the modernization of some of these facilities.

So I do not know that the HCCF model certainly will be a good model for many places. Again, we just have to have VA looking at

this big picture of the way care has been delivered for years and years with this inpatient capacity and what we lose when we go an HCCF model and we outsource care.

And the big thing that researchers tell us is when care is provided outside the VA, contracted out for it, we do not know what the quality of that care is. They tell us that with women's health especially.

So I think that stands as one thing that we really need to look at because that has been—VA has worked very hard to bring up the quality of its care and be renowned within our Nation for the care it provides. So we just want to ensure that that is maintained as these changes come about, whatever they are.

Mr. BLAKE. Mrs. Halvorson, one thing I would also mention as it relates to maybe indirectly Hines is Joy mentioned modernization and modernization of an aging major tertiary care facility does not necessarily equate to building 10 CBOCs or 10 super CBOCs or whatever because while you may expand capacity and access points through some sort of model like that, you may then ultimately diminish the scope of services that are available if you move out into that setting away from Hines.

I am not suggesting that maybe we need to just build a whole new hospital in place of Hines, but when you think about the fact that from PVA's perspective there is a spinal cord injury center there, but the scope of services that support that SCI center are far reaching beyond the immediate SCI delivery model. And if you move it out into the community into super CBOCs, which was something that was suggested under the Denver plan last year, I think you run the risk of diminishing more important services that are provided through that tertiary care hospital. And you put at risk probably the highest end users of the VA health care system.

Mr. WEIDMAN. The paradigm that we either have to go to CBOCs or live with an outmoded facility, I would suggest is a false dilemma. This is the United States of America and if we need a brand new hospital in order to properly care for veterans in a major urban center in our country, then we should do—I did not notice anybody with George Washington University Hospital over in Washington Circle suggesting that they open a bunch of community clinics. What they did instead was build a whole new hospital and blew up the old one. And if we need to do that in Hines, then we should do that.

And somehow we have gotten used to thinking that our best days as a Nation and our most powerful days when we can take care of the men and women in our democracy who put their lives on the line in a first-rate manner in brand new facilities that we cannot do that anymore. Frankly, at Vietnam Veterans of America, we reject that notion. And we need to move forward. And where we need to replace a whole new hospital, then we need to do it.

Mrs. HALVORSON. Well, I have a tendency to agree with that. However, that is why I am asking all of you where the future is and where it is that we need to go. And I have people call me every day that they are tired of going there and sitting there all day just to be turned away. And what are we going to do about that.

And so we need to do something. Our veterans deserve the best care ever. And if we need to build them a new hospital, then we

need to do that. There are all kinds of things that we could be doing for them.

Mr. CULLINAN. Mrs. Halvorson, I would just add to the conversation. I mean, again, we need a dynamic process to address these issues as has been pointed out. A new hospital is not always the answer. Sometimes it is a CBOC. CBOCs are very popular where they are established.

The HCCF model will remedy some of the problems where a hospital is not appropriate and a CBOC is not enough. And that is the key thing is to address all of the issues as best as possible.

One thing that is contained in our testimony, there are certain rural areas where the probability of an HCCF model is unlikely. There simply are not the assets in place to even construct something like that. There is certainly not the staff availability.

So then you need things like contract care. Mobile vans are another solution. There are other satellite type solutions to these kind of problems. And that is what needs to be done.

Years ago, we used to say that about VA medical centers and it certainly is still true of some of them, the only way to renovate one is by jackhammer. They were concrete bunker-like structures. They just do not lend themselves to modification for modern medical purposes. So there is that too.

And the final thing I will say with the shifting patient workloads, again a dynamic solution is the only way to go because veterans are going to continue to move around and new needs will arise.

Thank you.

Mrs. HALVORSON. Thank you.

Mr. WILSON. You know——

Mrs. HALVORSON. Go ahead. One last.

Mr. WILSON [continuing]. When we talk about facilities, facilities, and facilities and we must keep in mind the veteran at all times. I mean, if we have to write it on the paper 50 times just to keep in mind who we are serving, I mean, this is practical. We are talking about appropriate accommodations, is it adequate.

Those questions we have to continue to ask over and over again because now you also have women veterans. Forty-nine percent of women veterans are seeking care outside of VA. So there is a fragmentation of care amongst women veterans that is unprecedented. I mean, just within this past 6 months, it has grown. We do not know the numbers now, but that was about 3 or 4 months ago, we found out it was 49 percent.

We must keep that in mind when just not—just finishing a facility or how nice a facility looks or the location. It is a matter of, as I stated previously, the American Legion supports better tracking. We are contacting various posts out there, sending out various blasts and receiving the information as to how many veterans are in that area, what the pattern, you know, as far as the pattern and all.

But a concern when as far as accommodations and building these facilities, all those women veterans who for some reason are seeking care outside of VA because actually it was one of the reasons they are not receiving continuous care.

Mr. WEIDMAN. May I just add that is poor organization in the clinic. And, frankly, the clinic Director should be reprimanded. I mean, it should not ever happen anymore at VA that somebody—because we know of no guidelines any place in the country at any of the 153 medical centers where it is supposed to be done—the way they used to do it is you go in at 7 o'clock in the morning and you wait until whenever you get seen. There should be appointments and waiting no longer than 30 minutes.

And if it is not happening in Hines, then I would suggest that you may want to make a call to General Shinseki and say what is happening here that is—what is not happening here that is happening elsewhere where people are not being treated well in my district.

Mr. MICHAUD. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I have one question for the entire panel.

One of the shortcomings of CARES was the lack of long-term care in outpatient mental health services. Do you believe that VA has made progress in its ability to model demand for these services and improve access to these services?

That is for the entire panel again. Thank you.

Mr. CULLINAN. Mr. Bilirakis, I will just say one thing briefly about that. I think that VA is quite capable, and I know there are others who would agree, about modeling demand. The problem is actually answering that demand and it comes down to resources. It is an expensive proposition.

You have long-term care and mental care that still really are not properly accommodated under CARES. We do not believe that they cannot actually model them. We believe that they can. It is just where is the money going to come from.

Mr. BLAKE. Mr. Bilirakis, I would suggest that there have been instances in the past where I think VA senior leadership has shown the desire to get out of the business of long-term care as a whole. That can be reflected in some of the budget requests that were made in the past.

And I think if you read the GAO report that came out earlier this year about long-term care and the modeling and funding that, you will see that while it is something the VA needs to be doing, their approach to it is broken obviously.

And as I mentioned in my testimony, our concern remains about a long-term care strategic plan going forward. And that does not just apply to SCI veterans. That applies to all veterans.

And so if there is definitely a flaw, that would be it.

Mr. WILSON. You mentioned long-term care. When I think of long-term care, I think of the old nursing home care units in which VA is transitioning into community living centers.

We saw good things there because they are trying to acclimate the veteran back into the community. There are also active duty who are with those needs. If they request, they can receive it if it helps that active-duty member as well.

I think on behalf of the American Legion, I think there has been progress, but they have a ways to go because of the various injuries and the veterans with the various injuries, they are showing up at VA and either they are referring them to outside facilities still, so

it leaves a big question mark with us as to where they are going from here because to this point, we feel that they have been reactive.

Ms. ILEM. Yes. I would just mention long-term care has been one of the issues all of the organizations have really talked about over the years, that we just have not seen this strategic plan materialize, and it just seems to be put off, put off into the future.

When we go out to visit facilities, again I was just in New Hampshire, and they did have a nursing home component with an inpatient component there. And I asked the medical center Director, you know, how did they provide services to support the long-term care unit in terms of oftentimes elderly people have real hospital care needs and this is not a full scale hospital. So they do have to do a lot of the contract care and take them by ambulance to a nearby facility for that type of care.

So this is just another issue even though a lot of VA is pushed out like the Nation. You know, everybody wants to be provided care in their home to the largest extent possible. We have many elderly veterans who have either a spouse that is their same age in their mid 80s that cannot care for their spouse any longer and they do not have the support at home even if somebody is coming in a couple days a week. They really need inpatient bed care.

And, you know, these people have been in the VA system for their entire life, since they have gotten out of service and been a part of that system and they want to stay with VA. So we need better collaboration with the State Veteran Home community, which is another option in many States.

But this issue we do not feel has really been addressed and should be taken up as part of the infrastructure issue as it moves along.

Mr. WEIDMAN. A couple of things to add to that, if I may, Mr. Bilirakis.

Joy is absolutely correct as we have been waiting on that so-called strategic plan on long-term care for a very long time. And it needs to be addressed and it needs to be addressed in conjunction and cooperation and collaboration with the State Directors of Veterans Affairs and the State Homes because a lot of the solution in many parts of the country is going to be that need is going to be met through the State Homes more effectively and probably more efficiently.

And home health care has great promise for many people, but there are instances, as Joy just pointed out, where it is not in the cards because of the particular situation.

In regard to the second half of your question having to do with mental health, there are models where we can predict where we are going to need services, but they have not been employed. Frankly, we believe we need new national leadership in mental health and we need it soon.

There are the clinicians and certainly the folks at the National Center for Posttraumatic Stress Disorder who can help produce the models where we can make sure that between the Vet Centers or the readjustment counseling service and the inpatient services that are available that we have the inpatient services available when they are available in every network in the country and halfway in

between outpatient and inpatient is residential care which is appropriate to many folks, like Canandaigua is a good example of that or, excuse me, Batavia in upstate New York. It is much less expensive because you do not have 24-hour nursing and you have the patient where you need it.

VA has hired 3,800 new clinicians, 3,800 new mental health clinicians. And so we are asking where the heck are they, number one?

Number two, where is the in-service training to make sure that they are adhering in every one of the 153 hospitals to the best practices guidelines as outlined in the June 2006 report from the Institute of Medicine for diagnosis and assessment?

And, number three, where are the research projects and clinical trials to do what the Institute of Medicine said VA had been doing which is robust clinical studies to figure out what kind of treatment modalities work with what particular kinds of veterans because post-traumatic stress disorder, to say somebody has PTSD is like saying somebody has cancer? There are a zillion different kinds of it and you have got to have an accurate diagnosis in order to be able to effectively treat it.

So the modeling, I think, is there, but the question is overall leadership and assessment and accountability. Thirty-eight hundred new clinicians nationwide is a lot of people. And that may not be enough, but right now I am not sure that we know exactly how many more we need in order to adequately meet the need given the length of the wars where there is no end in sight in either Afghanistan or Iraq at the moment.

Mr. BILIRAKIS. Anyone else want to address the mental health services issue?

Ms. ILEM. I would just say one thing. This is a particular issue. I had a veteran call and they were looking for services. They were down in the Florida area. The brother called me and said my brother is under a bridge. He is enrolled in VA health care. He wants to get into a substance use disorder program. He has PTSD. He has some issues, but he needs to detox. He needs to get in a facility. He needs an inpatient bed.

The homeless coordinator went out and picked the veteran up, got the veteran. The family was very thankful for that. The problem was they were not going to have a bed available for this veteran. He was ready. He needed help then. The family called in panic and said if they allow my brother to go back out, he feels he will die, you know. He cannot make it.

After I cannot even tell you, I think 10 phone calls and it finally went up to Central Office level, they got this person into a detox bed and he was there for 24 to 48 hours. The family was expecting the veteran would go right into the substance use disorder or long-term inpatient program. They were told there is no room for that patient by the time he had detoxed. And they were going to try and send him out. They were trying to find accommodation in the community. They could not accommodate him.

Again, the family in a panic called, said can you please help. I was calling up and down the coast, this family said we will pay for him to go anywhere in VA. There was no coordination of inpatient services where anyone could tell me there is a bed available for this

person until, you know, again it was elevated to the Central Office level.

Eventually they found a bed in Florida. They were able to get this veteran in. But after a certain amount of time, he went out—I do not know if they did not have a residential unit for him to then transition into and the family called about 6 months later and said that—they really thanked me for the help, but that he had died, the veteran had died.

So, again, these kind of things, having the inpatient services when and where they are needed, especially when we have so many returning veterans from OEF/OIF that are having mental health issues that really need some sort of support. They are not, you know, getting it at home or in an outpatient setting.

So it is so critical within the VISN, as Rick mentioned, to be able to have the current services one after the other. Why bring them in to detox them to be able to send them out to the community again back under the bridge until a bed is available in 30 days?

I mean, we just hate to hear that kind of thing and that without any coordination throughout VA, even with different people very interested in helping, but not being able to tell me, well, there is a bed here or there.

Mr. WEIDMAN. May I add to that, Mr. Bilirakis. We have known for 25 years that Florida veterans' population was going to be where it is today in 2009. I can remember when then Governor Bob Graham was running for office and talking to him about what needed to happen in terms of expansion because by 2015, Florida, I think, is still projected to have more veterans than California. And 10 percent of all veterans in the country live in California.

So it is not that this came upon us as a sudden shock, but the expansion of services, particularly for neuropsychiatry within Florida, has not kept up with the need.

We have a hard time figuring out why people from VISN 8 to VISN 1 and 2 are telling us that they have a really tight budget this year when we got a 12-percent increase in the veterans' health care budget. I mean, we have talked to Mr. Edwards about it. We have asked VA repeatedly and get no straight answers about the 2009.

So some of the problem that you are alluding to is it is not just the overall resources, it is how well are we applying those resources within the VA structure itself. Are we getting the bang for the buck both on the construction side, but also on the services side?

And I think we have a right to expect some answers about where are we in the 2009 budget, where are we with the kind of services that Joy is talking about, particularly in an area that ostensibly is a quote, unquote winner under the Vera allocation model of where the health care dollars actually go. Why aren't there any services available?

I have gone through the same thing with the TBI problems in Florida of trying to find a bed and repeatedly having to go back at the behest of the family and intercede to keep a veteran who could not function on his own with bad TBI from hitting the street. I mean, something is wrong in VISN 8, but a lot of it has to do with overall organization and accountability.

Mr. BILIRAKIS. Thank you.

Mr. MICHAUD. Thank you very much. This has been really helpful.

Since the next panel has only two witnesses, I just have one last question. If you can please keep your answer brief.

A lot of the discussion this morning has been centered around creating new access points for our veterans. There has been talk about the current process and how it has to be open and transparent, including some of the decisions in Colorado.

My question is, by the same token, when you look at creating new facilities, politics sometimes get involved. But also the reverse is true, when you try to close facilities. I know when the VA asked PriceWaterhouseCoopers to look at 18 sites in VISN 1, which is my VISN, they recommended closing four medical centers. The VSOs in that region were outraged. They wanted their medical facilities there versus having a brand new one that could accommodate the needs.

So, while we want to create new facilities, if the old facilities are inefficient facilities and we have to close them, that puts the VSOs and elected officials in the awkward position of having to say, yes, it should be closed.

So my question then is, to be more transparent in deciding whether, where, and when we should either open or close facilities, should we establish a process similar to the Base Realignment And Closure (BRAC) process where they will make the decision of which facilities are inefficient and should be closed and where we should build new facilities?

Mr. BLAKE. I do not know if I can honestly answer that, Mr. Chairman, but I would say that, you know, even the BRAC process is not without flaws, I believe. I think politics still enters into even decisions made through BRAC. So I think you run a risk whether you create another commission that is going to say yea or nay on opening and closing facilities or not.

I think you point to the fact that all politics is local. Denver was a perfect example. The decisions there were ultimately made by the local population of veterans and the organizations there.

So it is a tough situation for us to be in. And I sympathize with you, Mr. Chairman, with the situation. I do not know. We do not have an official position on whether that would be a good idea or not. If you propose legislation, we would be glad to take a look at it and work on it from there.

Mr. WILSON. Also, Mr. Chairman, I would like to on behalf of the American Legion, I would like to reserve that response for a later date.

Mr. CULLINAN. Mr. Chairman, I would just certainly concur with my colleague here about the honesty portion of the BRAC Commission or a BRAC-like Commission.

I mean, one thing that needs to happen, though, VA has to clearly explain to local veterans what is going to take the place of a hospital. The VFW agrees that there are hospital facilities out there that need to be closed that are a waste of resources.

The way to do that, though, is to clearly explain to veterans, well, not all health care resources are going to go away. We may be closing this old, obsolete hospital, but we are going to replace

it with a CBOC or an HCCF that is going to take care of all your needs in a way that is even better than what you have got now because we are going to give you, for example, three CBOCs instead of one old hospital, and you are not going to have to travel as far. They will take care of all your needs and more serious inpatient type care is in line. We can take care of that too. Just explain the situation.

Mr. WEIDMAN. It is a difficult thing and I am not sure going to BRAC makes sense personally. And I do not think it is just because I am biased in favor of it as a former Army medic.

But the decision to close Walter Reed at its current location, given its history and centrality in American military medicine, is a bonehead move and hopefully will be undone. That is with all due respect to my good friend, Tony Principi and his colleagues who worked very hard on the BRAC Commission.

The green eyeshade boys, if you will, that came up with the idea that somehow it would be cheaper to build a new tertiary medical facility in Bethesda, a very expensive location, versus renovating the current hospital and that they could build a new tertiary medical facility for $800 million, I began to laugh. I said you are not going to in Bethesda open the key to that front door for less than $2 billion plus. And that was even 5 years ago.

So I am very dubious of some of the, with all due respect, I am not going to pick on PriceWaterhouseCoopers, but the consultants, if you will. When they look at northern Maine and they say, well, you can travel from Togus down to here. Well, they have never been in northern New England during most of the year. And as they used to say in northern Vermont where I lived for a long time, you cannot get there from here at that time of year. And they simply do not understand the local situation. So you need to reconfigure and work with the community.

And, frankly, one of the smartest things was keeping Canandaigua open as opposed to closing it in upstate New York where it is now the home to the nationwide hotline and those jobs are great jobs in Canandaigua. And it does not matter whether the hotline is in Chicago or in Canandaigua or it would not matter if it was in Toga, Spain.

So rethinking the use of those facilities about how do you serve the overall need of the Nation's veterans in all 50 States, if we approach it from that point of view, then I think you can come up with politically palatable solutions that meets the needs of the local community and does not live in the past, sir.

Ms. ILEM. I would concur with many of the comments my colleagues made about concern over a BRAC scenario. It just may cause a lot of problems just to even use that term or that concept.

But maybe looking more individually, but really working on more transparency and communications with veterans in those States and the data that is really being used to come up with some decisions and why changes are being proposed and they feel changes need to be made.

But, of course, you need to take into account veterans' preferences and their concerns in local areas which each one is unique.

Mr. MICHAUD. Thank you very much once again for your testimony this morning. As you can see by the time, there has been a

lot of discussion and a lot of concern and a lot of interest in this very important issue. I really appreciate your willingness to come forward today to give us your thoughts and ideas on how we should proceed from here. Thank you very much.

I would like to now invite panel two to come forward. We have Everett Alvarez, Jr., who was Chairman of the CARES Commission, and Mark Goldstein, who is from the Government Accountability Office.

I want to thank both of you for coming here this morning and sitting through our first panel to hear the discussions and the questions for the first panel. I look forward to your testimony as well as an open dialogue on where we go from here when you look at providing access to our veterans throughout this great Nation of ours.

So without any further ado, Mr. Alvarez, would you please begin.

STATEMENTS OF HON. EVERETT ALVAREZ, JR., CHAIRMAN, CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES COMMISSION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND MARK L. GOLDSTEIN, DIRECTOR, PHYSICAL INFRASTRUCTURE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF HON. EVERETT ALVAREZ, JR.

Mr. ALVAREZ. Thank you. Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to be here this morning to discuss the work of the CARES Commission.

And I have provided the Subcommittee with my full statement and ask that it be accepted for the record.

Mr. MICHAUD. Without objection, so ordered.

Mr. ALVAREZ. Let me begin by saying that the CARES commissioners, many of whom are veterans themselves, were well aware of the enormous implications their efforts may have on the veterans and the VA health care system.

We knew we had a moral obligation to be objective and transparent because our review would serve as a blueprint for resource planning at the VA and an approach for medical care appropriations long after the Commission's work had ended.

Our efforts are documented in the CARES Commission report dated February of 2004.

Mr. Chairman, let me take a step back to provide some historical context that led to the creation of the CARES Commission and its body of work.

CARES was a multifaceted process designed to provide a data-driven assessment of the veterans' health care needs. Simply stated, the process used projected future demand for health care services, compared the projected demand against current supply, identified capital requirements, and then assessed any realignments the VA would need in order to meet future demand for services, improve the access to and quality of services, and improve the cost effectiveness of the VA's health care system.

The CARES process consisted of nine distinct steps and I have outlined these nine steps in my written testimony. It is one of these steps, step six to be exact, that the CARES Commission, after reviewing a draft national CARES plan and other information, con-

ducted its review and analysis and then issued its report to the Secretary with findings and recommendations for enhancing health care services through alignment of the VA's capital assets.

Since the CARES process was primarily a VA internal planning process, the CARES Commission was established by then Secretary Anthony Principi as an independent body to conduct an external assessment of the VA's capital asset needs and validate the findings and recommendations in the draft national plan.

The Secretary emphasized that the Commission was not expected to conduct an independent review of the VA's medical system. However, as we conducted our analysis of the draft national plan, we were expected to maintain a reliance on the views and concerns from individual veterans, veterans service organizations, Congress, medical school affiliates, VA employees, local government entities, affected community groups, Department of Defense, and other interested stakeholders.

The CARES Commission began its journey in February of 2003 and in fulfilling our obligation, the commissioners visited 81 VA and Department of Defense medical facilities and State Veterans Homes. We held 38 public hearings across the country with at least one hearing per VISN. We held 10 public meetings and analyzed more than 212,000 comments received from veterans, their families, and other stakeholders.

On February 12th, 2004, I presented the CARES Commission report to Secretary Principi. These findings were grounded on the compilation of information gathered at these site visits, public hearings, and meetings, as well as information obtained from the public comments at the VA.

Mr. Chairman, the Commission established several critical goals in order to sustain the highest standard of credibility to our efforts.

First, we maintained an objective point of view in order to give an effective external perspective to the VA CARES process.

We set goals to focus on accessibility, quality, and cost effectiveness of care that were needed to serve our Nation's veterans.

We held a clear line of sight on the integrity of the VA's health care mission and its other missions.

Additionally, since the VA is more than bricks and mortar, the Commission thoughtfully sought input from stakeholders to minimize any adverse impact on VA staff and affected communities.

It was the Commission's desire to make findings and recommendations that would provide the VA with a road map for strategically evaluating the VA's capital needs in the future.

During the development of the VISN planning initiatives and ultimately the draft national plan, the VA CARES model, demand model was the foundation for projecting the future enrollment of veterans, their utilization of certain inpatient and outpatient health care services, and the unit cost of such services.

The Commission did not participate in the development of the model or the application of the model at the VISN level. The Commission's role, however, was to review data and analysis based on the model.

And because the model was such an integral component in the development of the CARES market plans, we wanted a high level

of confidence in the reasonableness of the model as an analytical approach to projecting enrollment and workload.

For this reason and to foster the Commission's goal to sustain credibility, the Commission engaged outside experts to examine and explain the technical aspects of this model.

Based on the experts' analysis, the Commission found the CARES model did, in fact, serve as a reasonable analytical approach for estimating VA enrollment, utilization, and expenditures.

However, there were lingering concerns noted in the Commission's report relating to project utilization of specialized inpatient and outpatient services, notably outpatient mental health services, inpatient long-term care services, including geriatric and seriously mentally ill.

To note, the model projected only certain inpatient and outpatient services such as surgical services and primary care services. And as has been noted before, there were shortcomings in the model and these have been addressed in the report extensively.

I would also add that the Commission made numerous recommendations for immediate corrective action and development of new planning initiatives.

Mr. Chairman, I hope that my testimony today will help to inform the Subcommittee about the historical significance of the Commission and its work. I will be happy to answer any questions. Thank you.

[The prepared statement of Hon. Alvarez appears on p. 70.]

Mr. MICHAUD. Thank you.

Mr. Goldstein.

STATEMENT OF MARK L. GOLDSTEIN

Mr. GOLDSTEIN. Thank you, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to testify today on the subject of the Department of Veterans Affairs and our reports regarding the Department's Capital Asset Program and CARES.

Through its Veterans Health Administration, the Department of Veterans Affairs operates one of the largest integrated health care systems in the country.

In 1999, GAO reported that better management of VA's large inventory of aged capital assets could result in savings that could be used to enhance health care services for veterans.

In response, VA initiated a process known as Capital Asset Realignment for Enhanced Services, CARES. Through CARES, VA sought to determine the future resources needed to provide health care to our Nation's veterans.

My complete testimony describes, one, how CARES contributes to VHA's capital planning process; two, the extent to which VA has implemented CARES decisions; and, three, the type of legal authorities that VA has to manage its real property and the extent to which VA has used these authorities.

The testimony is based on GAO's body of work on VA's management of its capital assets, including our 2007 report on VA's implementation of CARES.

The findings from our recent work that addressed these questions are as follows.

First, the CARES process provides VA with a blueprint that drives VHA's capital planning efforts. As part of the CARES process, VA adopted a model to estimate demand for health care services and to determine the capacity of its current infrastructure to meet this demand. VA continues to use this model in its capital planning process.

The CARES process resulted in capital alignment decisions intended to address gaps in services or infrastructure. These decisions serve as the foundation for VA's capital planning process.

According to VA officials, all capital projects must be based on demand projections that use the planning model developed through CARES.

Second, VA has started implementing some CARES decisions, but does not centrally track their implementation or monitor the impact of their implementation on mission.

VA is in varying stages of implementing 34 of the major capital projects that were identified in the CARES process and has completed eight.

Our past work found that while VA had over 100 performance measures to monitor agency programs and activities, these measures either did not directly link to the CARES goals or VA did not use them to centrally monitor the implementation and impact of CARES decisions.

Without this information, VA could not readily assess the implementation status of the CARES decisions, determine the impact of such decisions, or be held accountable for achieving the intended results of CARES.

Third, VA has a variety of legal authorities available such as enhanced use leases, sharing agreements, and other items to help manage real property. However, legal restrictions and administrative and budget-related disincentives associated with implementing some authorities affect the VA's ability to dispose and reuse property in some locations.

For example, legal restrictions limit VA's ability to dispose of and reuse property in west Los Angeles. Despite these challenges, VA has used legal authorities to help reduce underutilized space.

In 2008, we reported that VA had reduced underutilized space in its buildings by approximately 64 percent from 15.4 million square feet in fiscal year 2005 to 5.6 million square feet in fiscal year 2007.

While VA's use of various legal authorities likely contributed to VA's overall reduction of underutilized space, VA does not track the overall effect of using these authorities on space reductions. Not having such information precludes VA from knowing what effect these authorities are having on reducing underutilized or vacant space or knowing which types of authorities have had the greatest effect.

According to VA officials, they plan to institute a system in 2009 that will track square footage reductions at the building level.

GAO is not making recommendations in this testimony, but has previously made a number of recommendations regarding VA's capital asset management. VA is at various stages of implementing those recommendations.

Mr. Chairman, this concludes my testimony. I would be happy to respond to any questions that you or the Subcommittee may have.

[The prepared statement of Mr. Goldstein appears on p. 73.]

Mr. MICHAUD. I want to thank both of you very much for your testimony this morning.

Mr. Alvarez, I want to especially thank you for your testimony and for the excellent historical content you provided the Subcommittee with under the original decisions of what CARES has done.

You noted explicitly that some of the CARES Commission findings may be outdated today because the information was based on data from 5 years ago.

Would you recommend that we need to update CARES with a new Commission? How should we update the original recommendations of CARES?

Mr. ALVAREZ. Mr. Chairman, thank you.

At the time, the CARES Commission's work reviewed what had been done and reviewed the model that was used. We felt it was the best objective effort to date that the VA had undertaken.

Also, at the time, we felt that our review really surfaced a lot of the current issues that were on the people's minds around the country, not only the veterans, but the VA employees and leadership as well.

There were a considerable number of recommendations that we recommended go forward. To this date, I have been watching for the last 5 years somewhat curiously as to the progress of the plans.

And when I look at this process and compare it with the BRAC process, the basic difference is that we were an internally appointed Commission. And with that, we really did not have much bite.

So my suggestion would be that if I compare that with the BRAC where decisions were made and were held, that if you are going to do this again, give the Commission's work to have some bite and effect on the outcome and be realistic about it.

I thought a lot of our recommendations were pretty solid and they were objective. But, again, without strong realistic backing, they are just not going to go anywhere.

Mr. MICHAUD. During your discussion, when you put forward the recommendation where some community-based outpatient clinics should be located, was there ever any discussion over the fact that the CBOC funding comes out of the VISN's operating budget? This may create a situation where a VISN Director might not want to lose operating money, and, therefore, will not put forward a plan to implement what was recommended under CARES? Was that ever part of the discussion of the Commission?

Mr. ALVAREZ. Oh, I am sure it was, Mr. Chairman. Given the discussions at the time with regard to the tremendous need for outpatient care, we definitely saw that that was the way to go in many parts of the country, particularly the rural areas.

And so there were many, many challenges that surfaced with regard to doing that. One, of course, was what you described as giving the local leadership the authority to go ahead and do that.

And then, of course, there was really no priority across the country in terms of the large requirement. The demand was and the

need was all over the country. It would have been perhaps good if there was some way to come up with a priority list, and if you had centralized funding construction, that would have been perhaps helpful. But I do not know if that is realistic or not either.

The other thing, of course, is that there was also the possibility of looking at combinations of leasing, contracting, and so forth with regard to the CBOCs. In addition, I am pleased to say that what has surfaced is this super CBOC.

The HCCF that people referred to is, I think, a step in the right direction in terms of meeting the challenges that you mentioned with regard to how to fund the local CBOCs, while addressing the local issues, the local hurdles, political, what have you.

Mr. MICHAUD. My other question is, when you look where we are today fiscally, with a debt limit to $12 trillion and with our huge trade deficit and where we are heading as a country, do you think it would make sense to, number one, look at the recommendations under CARES to see if they are still valid today and if not, update the recommendations? And after that is done, would you think it would make more economic sense to focus on the community-based outpatient clinics or access points in areas of the country that have federally qualified health care clinics so if you have an area where it is recommended we have a CBOC, but there is a federally qualified health care clinic using Federal dollars to build it, that it would make more sense to actually work jointly with the clinic or rural hospital?

Mr. ALVAREZ. I think it would be, to answer the first part of your question, it would be probably a good exercise to look at the basic work of the CARES Commission and update it to see which parts have held true in terms of the purpose and the analysis and to do this in an objective manner. I think that would be probably a good exercise.

With regard to looking at other options with regard to the CBOCs and outpatient care or perhaps a different form of funding these or expanding the outpatient capability around the country, it is probably good to look at that. I think what you are really looking at is maybe thinking outside of the box in terms of possibilities.

In addition to that, to what you mentioned with regard to federally qualified health clinics and other ways of funding it, we looked at this rural concept that was just surfacing at the time and we really did not understand. But I think that is something that has probably developed nicely now.

I think the important thing would be, which is what was mentioned by the previous panel, is to communicate. Once you have a good idea, communicate this with the stakeholders, the veterans service organizations, and explain to them exactly what your thoughts are and have an open dialogue on this.

We found this to be quite helpful in our meetings and in our hearings around the country. A lot of people at the time were very concerned that they were going to lose their hospital.

But when they realized that, as Mr. Boozman indicated, 80 percent of care is done on an outpatient basis and that we could take care of the individuals quite well in their communities and not require the lengthy travel back and forth and what have you, they were in general very positive.

This happened quite often in places in the western regions. Walla Walla, for example, is a good example of a sort of remote location in terms of talking about the local clinics, CBOCs type concept, what have you.

So I think that these other ideas in terms of rural health and other means of funding local clinics may work quite well, but it has to be well communicated and get the cooperation of the local veteran groups and other stakeholders.

Mr. MICHAUD. Thank you.

Mr. Goldstein, as you know, the VA continues to use the tools developed through the CARES as part of its capital planning process.

Do you think that the tools that they are using continues to serve their purpose or are there modifications that are needed within the VA to develop a more accurate tool to assess what is happening out there within the VA facilities?

Mr. GOLDSTEIN. We are aware that they are still using the tool that they developed some time ago and that it has been useful to managing the program. Whether it needs a revamping is not something that we have specifically studied at this point in time.

Mr. MICHAUD. When you do your reports, do you think outside the box? For instance, under the CARES process, as I mentioned earlier, they might recommend that it be located at point X and there might be a brand new federally qualified health care clinic that is going to be built at point X. So when you do your report, do you look at whether it makes more sense to have a joint facility at point X for VA as well as a federally qualified health care clinic or when you do your evaluation, do you just focus on that issue?

Mr. GOLDSTEIN. We tend to look at the processes that were undertaken by VA in conjunction with any of its partners, to determine whether the process that they have is an effective one for determining the best outcome.

We found in our work in Denver and Charleston that some of the challenges and difficulties occurred when the process that should have been used was not always used effectively.

So our approach would be to try and encourage the agencies to use effective processes that are transparent and bring in all the stakeholders so that agencies can make effective decisions.

Certainly in the CARES process, we did note that VA did look at most alternatives for most of the locations that they were examining, but quickly ruled many of them out. It is just a question of how that was adopted.

We noted in our report that in most instances, the Secretary tended to agree with any option where the recommendation was to either keep the facility open or to use an enhanced use lease. However, the Secretary agreed only in one case to close a facility. That was in Gulfport when both the original plan as well as the Commission had suggested that a greater number of facilities be closed.

And that may be a completely appropriate decision on the part of the Secretary, but there did appear to be a lack of transparency. In addition, it took a lot of time to make decisions, and this affected local communities while decisions were not being made.

Mr. MICHAUD. What would you recommend? How would we put forward a model for new facilities that is fluid enough to take into account the changing veterans' population as well as the service

needs out there and a model that would actually ensure that VSOs are part of the process. Yes, VA talked to the VSOs, but it was only to say that they talked to the VSOs. The VSOs really did not feel part of the process.

What would you recommend for a model from here on out that would really take into account the different issues that change every day between now and whenever we get a facility built or leased and that will actually really put the VSOs in a situation where they can have really good effective input?

Mr. GOLDSTEIN. Mr. Chairman, we did not do work looking at a specific model, but we did hear everywhere we went in all the locations that we visited for our work there were a lot of issues of communication.

These issues of communication were not just between the Department and veterans' groups. They were also between the Department and other stakeholders, local communities, universities, other hospitals, other places that VA might try to develop an effective health care solution, and that in many instances, the kinds of actions that needed to occur to at least get everyone in a room and suggest various ways to move forward took a very long time and required the input of other parties to ensure that VA was going to honestly come to the table.

Mr. ALVAREZ. Mr. Chairman, if I may, on that question about being heard, what we found in our experience is that giving the local veterans' groups around the country the opportunity to have input was not always a benefit because when you get into these discussions, the level of knowledge required to provide input was not always there as you see here in Washington and others where you see that level of expertise, in the veterans service groups themselves who have that tremendous level of expertise, but that level of expertise is not always present at the local level.

And, therefore, when they are invited to come in and participate, they really cannot participate much beyond the initial phases of these discussions. And that is one of the issues that we always dealt with when we were having our meetings and our hearings around the country.

Mr. MICHAUD. But by the same token—and actually it was brought up by Mr. Weidman—and I can attest to that coming from the State of Maine, where the Office of Rural Health was concerned about a mobile vet clinic, and really did not think that it was needed because when looking at a map, you could easily get from point A to point B when, in fact, you cannot get from point A to point B because of the distance and the way the transportation system is located.

Here, actually, the VA at Togus made very clear that, yes, it is a very rural area and you cannot get from point A to point B. So, therefore, we were able to get the facility. But it is that local input that really made the difference in that particular case.

I can understand from what you are saying that sometimes they might not know some other factors. But, quite frankly, if you do not have local input along with the other factors, I think you have to weed out some of the information that is brought forward. It is that local perspective that is very important.

Going through the CARES process now, I know there is one VISN where they are going to hopefully have a CBOC. You actually might be able to eliminate another access point that was originally recommended by CARES, just by moving it around a little bit. But it is that local input that definitely is helpful.

By that same token, as I mentioned to the previous panel, some of the concerns that I see are the political concerns, especially when it comes to closing facilities. It might make more sense to close facilities and reconfigure where the new facility might be. That is, when you get into some of the political problems in that particular area.

I am not sure how to really address that unless you have a BRAC type commission that does that, but I am not recommending it. That is just playing the devil's advocate for the first panel, to see how they would respond to that particular area.

But I understand what you had mentioned, Mr. Alvarez, and really appreciate your comments.

Mr. GOLDSTEIN. If I may, Mr. Chairman, VA, of course, is not the only agency that suffers from what GAO euphemistically calls competing stakeholder interests. Many agencies face this very same problem.

And it is among the reasons why GAO years ago put real property on the Federal high-risk list. It is one of five issues that informed us that it was important for the government to determine ways to deal with this because if it does not, we are always going to be caught in this bind whether it is VA, the Postal Service, or any other Federal agency.

Mr. MICHAUD. Thank you.

Once again, I want to thank both of you for coming. This has been extremely helpful. We may have additional questions in writing. I really appreciate your taking the time this morning to come here to give us your thoughts and to answer the questions. So, thank you both very much.

Mr. GOLDSTEIN. Thank you, Mr. Chairman.

Mr. ALVAREZ. Thank you, sir.

Mr. MICHAUD. I would like to ask the third panel to come forward. Donald Orndoff, who is the Director of Office of Construction and Facilities Management from the VA. He is accompanied by Brandi Fate from the VA as well as Jim Sullivan and Lisa Thomas.

I want to thank you very much for coming here this morning. I look forward to your testimony. Hopefully, we will be able to have an open dialogue as we move forward with the CARES process on how we make sure that veterans have access to health care facilities, regardless of where they live.

So, Mr. Orndoff, would you please begin?

STATEMENT OF DONALD H. ORNDOFF, AIA, DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY BRANDI FATE, DIRECTOR, OFFICE OF CAPITAL ASSET MANAGEMENT AND PLANNING SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JAMES M. SULLIVAN, DIRECTOR, OFFICE OF ASSET ENTERPRISE MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND LISA THOMAS, PH.D., FACHE, DIRECTOR, OFFICE OF STRATEGIC PLANNING AND ANALYSIS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. ORNDOFF. Mr. Chairman, I am pleased to appear here to discuss the status of the Department of Veterans Affairs health care infrastructure.

I will provide a brief oral statement and request that my full written statement be included in the record.

Mr. MICHAUD. Without objection, so ordered.

Mr. ORNDOFF. Joining me today is James M. Sullivan, Director of VA's Office of Asset Enterprise Management; Lisa Thomas, Director of VHA's Office of Strategic Planning and Analysis; and Brandi Fate, Director of VHA's Office of Capital Asset Management and Planning.

Current medical infrastructure. VA has a real property inventory of 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 challenging demands of clinical care of the 21st century. Continuing our recapitalization program is critical to providing world-class health care to veterans now and into the future.

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 for health care projects, including 51 major construction projects.

These projects include new and replacement medical centers, polytrauma rehabilitation centers, spinal cord injury centers, ambulatory care centers, and new inpatient nursing units.

Background CARES. In 2000, the Veterans Health Administration embarked on the Capital Asset Realignment and Enhanced Services study or CARES. CARES assessed veteran health care needs and promoted strategic realignment of capital assets.

In 2003, VA released the draft national CARES plan and created the CARES Commission for further analysis.

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

Today strategic planning facilities process. The tools and techniques acquired through CARES are now incorporated in the VA's strategic health care facilities planning process. VHA no longer distinguishes between CARES and other project planning needs.

Goal, high performance medical facilities. New VA medical facilities contribute to world-class health care for veterans today, tomor-

row, and well into the 21st century. Our design goal is to deliver high performance buildings that are functional, cost efficient, veteran-centric, adaptable, sustainable, energy efficient, and physically secure.

Our 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.

Fiscal year 2010 requirement. VA's fiscal year 2010 budget request continues our recapitalization effort supported by our strategic planning process. VA requests $1.1 billion in fiscal year 2010 for major construction to replace or enhance VA medical facilities. VA also requests $196 million authorization to provide 15 new medical facility leases.

In closing, I thank the Committee for its continuing support to improve the Department's physical 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 appears on p. 82.]

Mr. MICHAUD. Thank you very much for your testimony.

As you heard from panel one, there is a lot of concern about the lack of transparency in the capital planning process, especially as it pertains to CBOCs.

It is my understanding that CBOCs come out of the VISN's operating budget. That being the case, if you have a VISN Director who might have other plans on what he wants to do within his VISN, even though there is a need for a CBOC, they will not proceed forward with that CBOC.

I think that is a disincentive to help move forward on CBOCs, so my question is, number one, do you have any ways that we might be able to address that? Should the CBOC operating budget be a separate line item so we can actually move forward with CBOCs within the CARES process? What would you do to bring more transparency to the process?

As you heard from the first panel, they feel that they have not been part of the process. In Maine, for instance, we have the Department of Education where the Commissioner does not decide they are going to do new school construction. It is the State Board of Education that makes that decision.

Should we have an outside entity make the decision of where the VA will be moving on these facilities and the VA just will proceed forward with that recommendation?

Mr. ORNDOFF. Mr. Chairman, allow me to have Ms. Thomas respond to the requirement's generation part.

Ms. THOMAS. Mr. Chairman, I would like to address your questions regarding the community-based outpatient clinics.

As of the end of March of this year, VHA has over 750 community-based outpatient clinics and they have treated approximately 1.8 million veterans already. So I think that those numbers alone show that it is not essentially a disincentive for the Network Directors to use that tool to enhance services to veterans in their local communities.

Mr. MICHAUD. I might add, how many have been built recently?

Ms. THOMAS. I can tell you that in fiscal year 2009, 13 have already been activated and there is another 62 planned for this fiscal year.

Mr. MICHAUD. Another 62?

Ms. THOMAS. Yes, sir, for a total of 75 in fiscal year 2009.

Mr. MICHAUD. Okay. And how many are left under the CARES process to be moved forward?

Ms. THOMAS. Sir, we have almost completely implemented all of the CARES community-based outpatient clinics. We have 50 CBOCs that have opened in 13 networks and we have 78 of those CBOCs in 14 networks that will open between fiscal year 2009 and 2011.

One of the other things that I would like to mention is that we have over the past 2 years taken a national deployment plan for our community-based outpatient clinics. So we have more of a nationwide systemwide perspective. And the methodology that we employ looks at looking at those areas of the country that have limited access to care in combination with those areas that have the highest projected demand for services for both primary care and mental health services.

We then rank order those markets and present those to the networks and ask them for the highest ranking markets, if they could please develop a plan for how they are going to meet the needs of veterans in those areas.

And that is a combination of CBOCs in addition to other strategies that we have such as telehealth and mobile health clinics and outreach clinics. So we have over the last 2 years increased the rigor with which we look at where the CBOCs need to be placed.

Mr. MICHAUD. In that process, what have you done to involve the VSOs in those regions?

Ms. THOMAS. My understanding is that within every network, they have a structure in place to communicate with their veterans service organizations and their representatives both at the network level in terms of committees as well as the local medical center level. We encourage every single medical center and VISN to ensure that they are speaking with their VSOs and incorporating their input into their strategic planning processes.

Mr. MICHAUD. Is the process consistent among all the different VISNs in how they deal with this or is it left up to each VISN on how they are to involve the VSOs in their region?

Ms. THOMAS. There is variability within the networks. Different networks have varying governance structures. But I believe we can certainly take that for the record and get back to you with how each network does accomplish that.

Mr. MICHAUD. I did not mean to interrupt. If you could finish answering my original question, which I think you mostly answered.

Ms. THOMAS. Oh, the transparency issue? I will pass that back to Mr. Orndoff.

Mr. ORNDOFF. Well, the transparency issue, I think, is best addressed, as Ms. Thomas said, in that there is a dialogue with stakeholders at the local VISN and Central Office level. We do have a continuing process of evaluating requirements and setting the

priorities for which projects would move forward, as Ms. Thomas has talked about.

So it is always a challenge to communicate enough and we try very hard to do that. Could we do better? Sure. We will look for opportunities to do that.

Mr. MICHAUD. How are the concerns of local facilities conveyed to the VISN office?

For instance, I will use Maine as an example. VISN 1 is very large. You can put New England in the State of Maine. And you have your Director at Togus and then you have your VISN 1 Director in Boston.

How are the concerns from the very local level, say the Togus level, conveyed to the VISN level then ultimately conveyed to the Central Office? Does the Central Office have an opportunity to see what actually is really needed at the local level or does that get cut off at the VISN level? Is this dealt with consistently throughout the different VISNs?

Mr. ORNDOFF. Ms. Fate will answer, sir.

Ms. FATE. Thank you.

There are different programs that address the needs at the medical centers. We have our nonrecurring maintenance (NRM) program, which is a decentralized program that allows the VISNs the control as to what decisions are made for renovation within the existing medical centers. And each one of the VISNs has their own process by which they prioritize their projects.

For the minor construction and the major construction programs, those are at a centralized level where the needs are brought forward to Central Office for capital assets. And typically those mostly involve new construction. And we have a model set for the criteria where each project is scored and ranked.

And I do not know if, Jim, you want to present.

Mr. SULLIVAN. If we could, we have a large chart here that will show you the prioritization methodology that is applied to the major construction program as well as very similarly to the minor construction program.

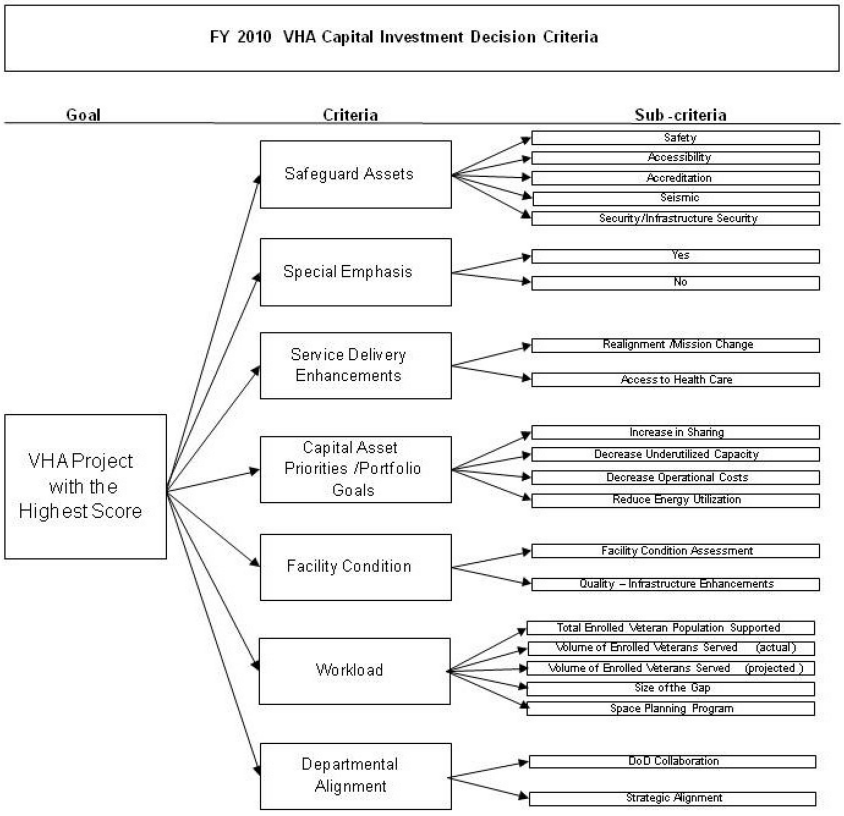
Mr. MICHAUD. Would it be possible if you could send that also to the Committee——

Mr. SULLIVAN. Absolutely, sir.

Mr. MICHAUD [continuing]. Electronically?

Mr. SULLIVAN. Yes.

[The VA chart follows:]



Mr. MICHAUD. Thank you.

Mr. SULLIVAN. This shows the criteria that is used to determine which is the highest priority. So you can see, there are seven parts of criteria starting with issues that address safety, special emphasis which would be TBI, seriously mentally ill, SCI needs, and then service delivery gaps, addressing where those gaps are, your portfolio goals, that is getting rid of unneeded space, vacant space, things along those lines.

The facility condition criteria references the large backlog of deficiencies. We have a facility condition assessment process that will tell you what each facility has, how many deficiencies, and then workload, how much of a workload gap is that investment addressing. And then last, is it in alignment with the strategic plan of the Department.

And a similar process is used for decentralized programs, which are minor construction and major construction.

Mr. MICHAUD. I wish I could say I could see it. The only thing I can see is this is the year 2010 VA decision criteria and that is it.

Mr. SULLIVAN. It is in the budget document.

Mr. MICHAUD. Okay.

Mr. SULLIVAN. But we will——

Mr. MICHAUD. Yeah. Thank you. I appreciate that.

My next question is, when you look at the CARES process, some of the concerns that I and the Subcommittee have heard are from our Members from all around the country and ever since I have been here, we have received legislation to require the VA to do more contracting out. The reason why we are seeing legislation to contract out is veterans all around the country are getting frustrated that they are not getting access to the health care that they really need. And, hence, we are seeing legislation to contract out.

I do not want the VA to become an insurance agency, that is all you do is pass through. Part of the problem, I feel, is because the CARES process has not been moved forward aggressively, that is not necessarily the VA's problem in that the previous Administration and previous Congress have never provided the adequate funding needed to move forward on the CARES process as originally recommended, the billion dollars a year. So that is the lack of foresight among Congress and the Administrations to move forward.

My question is, however, when you look at the CARES process, there are a lot of access points without huge costs to move forward. Has the VA looked at those access points where it was recommended that they work collaboratively with the federally qualified health care centers to move forward more aggressively and get these up and running so that we can help get the veterans the services that they need and hopefully prevent any more legislation dealing with contracting out? Has there ever been an overlay of where the needs are to CARES compared to where we currently have other federally qualified health care clinics?

Mr. ORNDOFF. Well, certainly the overall process of identifying requirements covers the waterfront, all the requirements. And where we have gaps, we certainly identify requirements and the highest requirements through the process that Mr. Sullivan just described would float up.

We have developed a comprehensive list of requirements for the capital investments. They are in the fiscal year 2010 budget submission. There are 66 projects listed in priority order as a result of this prioritization process.

What we have done is try to look for opportunities for leasing a facility so we can get more projects moving faster. So we have a two-pronged approach, capital investment as well as leasing.

In terms of creative solutions that you have addressed, certainly the opportunities as presented are explored and discussed.

If there are other thoughts on the panel about that, let me refer it to someone else.

Ms. THOMAS. Sure. I can address a portion of that, Mr. Chairman.

As we heard the gentleman from GAO report, they did a report on VA and criticized us for not centrally tracking and monitoring the implementation of CARES.

As a result of that, our Under Secretary for Health chartered a work group. And that work group was a VA-wide body that recommended a report be conducted annually to track both the implementation and the impact of the CARES decisions.

One of those items that we are currently looking at is the implementation of increased access points through contracted care for

any of those decisions that were identified in the CARES document as well as the 18 follow-on business care studies. So we will be tracking that and our first annual report will be out this month.

Mr. MICHAUD. If you make sure that the Committee receives a copy of that report——

Ms. THOMAS. Absolutely.

[The VA subsequently submitted the report entitled, "VA Health Care: Implementation Monitoring Report on Capital Asset Realignment for Enhanced Services," dated August 2009. The report will be retained in the Committee files.]

Mr. MICHAUD [continuing]. It would be very much appreciated. Under the process you mentioned, there are several new CBOCs coming online.

In moving forward, what are you doing to try to really get them aggressively moving forward? It is one thing to start the process and say you are going to do it. Are there ways that we can streamline that process to move them forward more aggressively? Do we need to change something statutorily or can you do it administratively? And if you can do it administratively, are there bumps in the road that we should look at administratively? How we can streamline that process to get these facilities up and running?

Ms. THOMAS. Mr. Chairman, I think there is always room for improvement in terms of effectiveness and efficiency. And I think that what I would like to do is take that question for the record and consult with my colleagues and identify those areas that can be streamlined. There are several levels of review that go on both within VHA with the Department and with OMB.

[The VA subsequently provided the following information:]

> The current Community Based Outpatient Clinic (CBOC) Planning process is aligned with the VHA Capital Planning and Budget cycles as approved by the Office of Management and Budget (OMB). Therefore, a 2-year planning scenario is required by which CBOC proposals are submitted 2 years prior to their planned activation date so that they are included in the appropriate budget formulation cycle. For example, right now, at the end of FY2009, the CBOCs that VHA plans to open in FY2011 are under the review by OMB with VHA's budget submission.
>
> The CBOC process begins with a national analysis of the underserved populations as defined by limited geographic access in areas with projected increases in primary care and mental health services. The Deputy Under Secretary for Health for Operations & Management (DUSHOM) issues a call memorandum to the Veterans Integrated Service Networks (VISNs) for CBOC Business plan submissions for those areas of the country that meet the national threshold for having underserved populations. A technical review of each of these business plan proposals is then completed. Those proposals meeting the technical requirements are then reviewed by a CBOC National Review Panel (NRP). The NRP reviews the proposed CBOCs against national operations criteria. By June of each budget formulation year, the National Review Panel recommendations are completed and forwarded to the Under Secretary for Health and ultimately the Secretary approval and inclusion into the Department Budget Submission.

Mr. MICHAUD. Thank you.

Mr. SULLIVAN. I think, Mr. Chairman, one of the biggest improvements has been the raising of the threshold that the Committee successfully got through on the lease threshold.

It used to be we had to get leases authorized at 600,000. For the first time with your help, it was raised to a million and I think that will speed the process of bringing leases online significantly quicker.

Mr. MICHAUD. I am sure it also will save time within the VA system because I know Members of Congress constantly call to find out where that project is in the system to try to move it along. The more streamlined it is, I think the more efficient it will be.

Actually, the first panel voiced serious concerns about the HCCF leasing concept. Can you share the rationale behind that leasing concept and the VA's plan to deploy that model? How does the concept fit into the overall CARES process?

Mr. ORNDOFF. Yes, sir. As was mentioned, I think by members of that panel, it is not a one size fits all or the ultimate solution. It is one of a range of facility solutions that VA intends to employ and address and tailor to the need at the particular location.

What we are seeing is there are opportunities with the shift in outpatient care that a very high percentage, as high as 95 percent of the health care needs of veterans, can be met in an HCCF environment as opposed to having full-blown hospitals at each of these locations.

So in most cases or in some cases where we do not have capabilities now, maybe the HCCF is the correct solution rather than a series of community-based clinics or a large medical center complex which can be, of course, from a capital investment point of view very expensive.

What we are also looking to do with the HCCF is to deliver these quicker than the normal capital process through leases. And the budget in fiscal 2010, there are seven HCCFs for authorization. Those projects would not be before you now if it was not for leasing of the HCCF. So it is an opportunity to reach down our priority list and move projects forward.

Because of limitations of leasing, operating leases, working within the guidelines and policies of the Office of Management and Budget, we do have some limits on leasing. And so we are basically pressing the envelope a bit with HCCFs in terms of getting leasing done for HCCFs within the leasing authorities that we have. But we are certainly working with all stakeholders to try to move forward on that.

Maybe Ms. Fate can embellish a little bit on when an HCCF is the right facility solution.

Ms. FATE. We are currently in the process of fully defining the HCC. While right now the services that are provided are primary care, specialty care, mental health, expanded diagnostics, and ambulatory surgery, we are using it as another mechanism to provide the services that we do in VA.

It can be either through construction or through leasing, but the avenue that we tested through the fiscal year 2010 was to take seven projects through the major construction project listing and try to push those forward through the leasing process so that they could be done quicker as opposed to sitting in priority 23 for the next several years and not getting funded from the major construction.

So that was just our attempt to address the needs so that our veterans do have a facility that is managed by VA health care and providing the quality health care that we do at our facilities.

Do you have anything?

Mr. SULLIVAN. Yes.

Mr. Chairman, I would like to add to that that the leases the HCCs proposed in the budget, five of them are leases that would normally show up in the construction list. With an $11 billion backlog, the theory behind this was to see if some of those could be leases. For example, at Loma Linda, it was an outpatient addition planned for construction.

The option here was to say could you lease a facility across the street in the neighborhood right next to the medical center where you could deliver that facility probably 6 to 8 years earlier than waiting for construction. That is one of the advantages of HCCF.

So it is a way to get facilities, new and adequate facilities quicker with our large backlog of facilities. Because I think as Mr. Orndoff referenced, we are at an $11 billion backlog. And we know that is not the full backlog, but that is probably a pretty good indicator of where we are.

And we have over $2.2 billion that are partially funded that we need to finish before we can start more. So this was a way to look at delivering facilities quicker and faster in this budget.

So, I mean, that was the goal of this now. And also the concept itself, as it applies to where we do not have facilities now, is still being fully developed.

Mr. MICHAUD. When you look at that huge backlog and when you look at the range in dollars from a CBOC to a large medical facility and you look at the rural issues concerning veterans, are you focused more on trying to build a brand new hospital or is the VA looking at taking care of a hundred different needs out there by doing CBOCs or access points? How do you judge that priority?

When you look at the huge amount of money it costs to build a multi-million dollar huge hospital, it makes a lot more sense to me to instead take care of a lot of the smaller access points out there where you can take care of a lot more veterans for fewer dollars.

Mr. SULLIVAN. Right. We separate our infrastructure needs out, that the $11 billion backlog is big, major, current facilities that exist today. The CBOC process which provides more flexibility is to address some of those smaller pockets of need through that process. And there is a separate process Ms. Thomas talked about in terms of how you prioritize those CBOCs. The $11 billion is just basically our current infrastructure stock and the repairs needed for that.

Ms. THOMAS. I think part of your question, sir, is also how do we identify what type of capital solution is appropriate for the care that veterans need. And that is based upon services and projected demand for those kinds of services.

So when you look at certain markets and you look for the demand and the utilization out into the out-years, if the predominant need of the veterans is for primary care or mental health services, then it would be appropriate to look toward a CBOC or a smaller access point to meet those needs.

If there is a large population of need for specialty care, inpatient care, then that would help dictate what type of infrastructure you would need, a larger health care center or a hospital in that case. And then through the capital process, we would work together to identify with the local network whether or not the most cost-effective way to meet that would be through a lease or construction.

Mr. MICHAUD. If you were to take care of all the needs that are currently out there under the CARES process or that came about after CARES—I am just talking about the smaller facilities—what would that total cost be approximately?

Mr. SULLIVAN. In terms of the non-CBOC, it is about $12 billion in the major program. I believe the minor program is $1.5 billion in terms of project backlog. And in the interim——

Mr. ORNDOFF. The FCA backlog is what, $8 billion?

Mr. SULLIVAN. Eight billion dollars. Now, there is some overlap between the project backlog and the facility deficiency backlog, but it is a large issue.

Mr. ORNDOFF. Sir, if I may address your point about either/or, I think we are making an effort to do both. And we have a different facility solution depending on the requirement.

I think there is a need to recapitalize the infrastructure even for the major medical centers. There is a veteran need for that level of care in certain high population areas. On the other hand, certainly we want to make access available to veterans in all locations, including rural areas.

So I think we are working all those fronts and the spectrum of different types of facilities and different acquisition strategies are all being put into play to try to address that with all the resources available.

Mr. MICHAUD. Thank you.

Also on panel one there were co-authors of the *Independent Budget* who had mentioned that VA's long-term care strategy plan, released in 2007, was lacking in specific planning details regarding the future direction in long-term care programs.

Could you inform us what you are doing to develop a more comprehensive, long-term care strategy plan? Where is that and what have you done thus far?

Mr. ORNDOFF. Mr. Sullivan or Ms. Thomas.

Ms. THOMAS. Mr. Chairman, VA is working on a population-based model to project the long-term care needs for both residential and noninstitutional long-term care services for the needs of our enrolled veteran population.

As is the cornerstone of our planning, the enrollee health care projection model or actuarial model, which the other panels had referenced is really the cornerstone for strategic planning. And VA has made progress to develop a long-term care model that is similar in rigor and assistance that those kinds of tools can provide us in planning.

I do know that there has been progress in the long-term care planning since the last time they had submitted an official plan to Congress. And we would be happy to get those experts to clarify exactly what steps they have made in terms of improving that.

[The VA subsequently provided the following information:]

> The Geriatrics and Extended Care (GEC) Strategic Plan was approved by the Acting Under Secretary for Health on September 2, 2009. The plan responds to the challenges facing VA given an increase in the age, number and medical complexity of elderly veterans, and the appearance of a younger, more health-savvy cohort of veterans with immediate and future extended care service needs; and a U.S. health care workforce underequipped to care for those with chronic diseases and disabling conditions.

The GEC Strategic Plan specifies four goals to be achieved through 10 strategies, and 82 recommendations. The most critical of these recommendations include: ensuring patient-centeredness of programs; analyzing the cost/benefit of long-term care policies; ensuring a focused and dynamic research program; building national partnerships; appointing a GEC lead for each VISN; developing a practical means of tracking veterans served by GEC programs; and appointing a GEC Workforce Advisory Council of senior VHA leadership to address workforce inadequacies. Implementation of the GEC Strategic Plan covers a 7-year planning horizon.

Mr. MICHAUD. When you do your planning, whether it is for CBOCs or long-term care planning, are you involving not only the VSOs but other State entities?

I am very pleased with the State Veterans Nursing Home in Maine. They have a facility. They have been approved for a brand new community-based outpatient clinic on the same campus. They are going to have a hospice facility there on the same campus as well as low-income housing for our veterans.

So, all on the same campus, you have a community that offers the whole continuum of care, and a lot of that was because of the leadership of the State Veterans Nursing Home.

When you are doing your planning process, are you not only involving the VSOs but also other entities that might be out there that could help move forward in a particular area?

Ms. THOMAS. Yes. The answer is yes, Mr. Chairman. Both at the local level and at the national level, our geriatrics and extended care service line does very much look to partner and learn from the private industry and our local communities.

One of the large changes that we recently made is we no longer refer to our nursing homes as nursing homes. They are now CLCs or community living centers. And looking toward the innovative strategies that others have developed in terms of a greenhouse and approaches like that where they are real living communities and a sense of a community and not an institutional-like setting for those of our veterans who need long-term care.

We are always looking for input from our partners, our veterans service organizations and all of the stakeholders. I think that is a very important ingredient to strategic planning, particularly for this population.

Mr. MICHAUD. Thank you.

Also on panel one, we heard some concerns about the lack of transparency and the lack of involvement from the VSOs.

What do you think that you can do better to make sure that all the stakeholders are at the table and that their concerns are heard in a meaningful way, not just to bring them in and say we have talked to them, that is the end of it? What can you do to address some of the concerns that we heard from panel one?

Mr. SULLIVAN. I think one thing, Mr. Chairman, on the major construction area that we will brief them and sit down with them and talk to them about our prioritization process, how projects get into it, why projects are where they are on the priority list so they can have an understanding of where things are for a particular project and how there is a straightforward prioritization process.

Congress required us to do it back in the early 1990s and we have refined it. Maybe it needs to be more fully briefed to the VSOs and others so they can see at least what the decision process is.

The process was put together to be transparent so you could find out why a project is ranked particularly higher than another or why one is not ranked higher. And maybe that is an education process that is incumbent on us to more fully explore with those elements. And we will do that.

Mr. MICHAUD. What you just described does not really involve them. It is pretty much here is the decision and here is how we came to that decision.

I think, if I understood correctly from panel one, they would like to be involved in that process, before you make the decision not to say "here is a decision, here is what we have, and this is how we arrived at the decision." I think they want to be part of that process in moving forward before the decision is made. That is the meaningful input that they want.

Mr. Sullivan, what you have told me is pretty much, I think, what they have been complaining about: here is a decision, take it or leave it. If you like our methodology, or dislike it, that is what you have to live with. I think they want to be part of that process, not after the fact. So——

Mr. SULLIVAN. Sir, we will take that back to the Secretary and discuss that option of finding a way to involve them in that process.

Mr. ORNDOFF. Sir, I think the opportunity to influence the project selection process is basically the process that we used to develop this chart over here which says, you know, what are the things that are important that should be weighted more heavily that float to the top.

So I think there is an opportunity that we could take to discuss that in the development process. It is an annual cycle of refreshing that to make sure it is aligned with the current strategic vision of the Secretary.

So as a step in that process, we could have a dialogue there that would influence the model that eventually produces the list. That way, we can all have some ownership in the outcome.

Mr. MICHAUD. I would appreciate it because some of the frustration that I have heard and seen over the years is a desire to really be part of that ownership.

I know at times, that probably might delay things a little bit or might be frustrating at times, but, quite frankly, I think any time that you can work with those that are involved in the process, it has long term benefits. And I think it gets rid of a lot of the frustrations that we have heard today and hopefully in the future.

As I mentioned earlier, I think part of the problem in the past has been that VA lacked the financial resources needed to move forward on this in an aggressive manner. It is my hope that with the new Administration and new Congress that we will definitely look forward in this particular area.

My only disappointment is in the stimulus package, the funding for the VA got cut. The additional increase actually got cut from the original request that we had. Hopefully we will be able to move forward with giving the VA the resources they need so you can move forward to take care of our veterans.

I guess my last question would be, if there is anything that Congress could do, other than provide additional resources to help

make your job a lot easier so we can move forward more aggressively as we look at the CARES process and how we can meet the facility needs? Is there anything that we can do or should do?

Mr. ORNDOFF. Sir, I am not aware of any legislative proposals that we have for specifically in the area of capitalization of projects. We do appreciate the raising of thresholds as was mentioned for leasing. That certainly facilitates that process moving forward.

We have a budget, a robust budget before you of $1.2 billion for major construction, which is a high watermark. And we, you know, of course, would appreciate support for that going forward.

Any other issues that anybody on the panel has?

[No response.]

That is all I have, sir.

Mr. MICHAUD. Well, once again, I want to thank you. There will be additional questions for the record.

I do want to thank you for your testimony this morning, for answering the questions. Hopefully, you will take seriously the comments made by the first panel about their involvement up front, not at the end, because I have been here 7 years and I hear a lot of concerns about the VSOs being able to meaningfully participate in the process.

Anything you can do to open that up to make it more transparent, would definitely be very helpful. I look forward to working with you, and I want to thank each and every one of you as well as your staff for what you do for our veterans in this great Nation of ours.

I think all too often elected officials tend to criticize the VA because of a lack of services for our veterans, but I want to thank you for what you do for our veterans, not only the four of you, but also your staff as well. I really appreciate it very much.

So without any further questions, I now adjourn the hearing. Thank you.

[Whereupon, at 12:49 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will now come to order. I would like to thank everyone for attending this hearing. Today's hearing marks the 5-year anniversary of the CARES decision, otherwise known as Capital Asset Realignment for Enhanced Services.

The purpose of this hearing is to assess the VA's implementation of CARES and to investigate the effectiveness of CARES as a capital planning tool. In addition, today's hearing will explore whether CARES should continue in the future or if the VA should adopt an alternate capital planning mechanism.

When the VA embarked on the CARES process 5 years ago, the VA's health infrastructure was thought to be unresponsive to the needs of current and future veterans. While about 24 percent of the veteran population was enrolled in the VA for health care, the CARES plan assumed that the enrollment population would increase to 33 percent by the end of 2022. In addition, there were concerns about the ability of the existing health infrastructure to meet the demands of the aging veteran population who opt for warmer climates in the south and the southwest.

CARES was intended to eliminate or downsize underused facilities, convert older massive hospitals to more efficient clinics, and build hospitals where they are needed in more populated areas. In essence, CARES was to direct resources in a sensible way to increase access to care for many veterans and to improve the efficiency of health care operations across VA facilities.

Over the years, there have been challenges of implementing the CARES decision in numerous locations. Most notably, the VA has reversed the CARES decision under the leadership of different VA Secretaries. Too often, we hear stories of veterans who have been waiting for new facilities for 10 or more years. In addition, there is a new concept of Health Care Centers which provide primary and specialty care and is a hybrid of a CBOC and a full-fledged hospital. Because this is a relatively new concept which the VA is rolling out, it is important that we fully understand how this fits in with the overall CARES plan.

I look forward to hearing the testimonies of our panels today, as we determine the path forward in continuing to build a strong health infrastructure for the VA.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you Mr. Chairman.

Today, more than 80 percent of the primary, specialty, and mental health care our veterans need can be provided in an outpatient setting. Yet, much of the Department of Veterans Affairs (VA) health care infrastructure was built more than 50 years ago, when VA care meant hospital care.

A review of VA real property by the Government Accountability Office (GAO) in 1999 found that VA was wasting a million dollars a day on the maintenance of outdated and underutilized health care facilities.

In response to this report and in recognition of the need to update facilities to deliver 21st century care, VA established the Capital Asset Realignment for Enhanced Services (CARES) process. CARES was designed to be a capital planning blueprint for the future—to modernize and better align VA's health care facilities with the changing veteran population.

The CARES Commission identified several ways to improve access and enhance quality of care including increasing collaborative partnerships with the Department of Defense and VA's academic affiliates.

Specifically, in my home State of South Carolina, the CARES Commission supported a concept for a joint venture with the Medical University of South Carolina (MUSC) and the Ralph H. Johnson VA medical center in Charleston. The Secretary's May 2004 CARES Decision also stated that "VA will continue to consider options for sharing opportunities with the Medical University of South Carolina."

Since the leadership of MUSC came to VA with this proposal more than 6 years ago, I and this Committee have taken significant steps to study and move forward with this historic opportunity to establish a new innovative model of care. The "Charleston Model" would ensure high-quality health care for veterans in the Charleston area and could be leveraged to improve access to care in other areas. A significant milestone was reached in advancing the project with the passage of Public Law 109–461, the Veterans Benefits, Health Care, and Informational Technology Act of 2006. Section 804 of this law authorized $36.8 million for VA to enter into an agreement with the MUSC to design, construct and operate a co-located, joint-use medical facility in Charleston, South Carolina. However, much to my dismay, the VA has not yet set aside any funding to implement the law.

As we evaluate the effectiveness of CARES, it is also vital that we re-evaluate the importance of collaborative partnerships. Building on the close relationships that VA already has with medical schools across the Nation is a powerful tool that VA can use to achieve greater health care quality and further efficiencies, while still preserving the identity of a veterans' health care system.

I look forward to our discussion today, and yield back the balance of my time.

Prepared Statement of Joseph L. Wilson, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the future of the Department of Veterans Affairs (VA) infrastructure. It is The American Legion's position that Congress keep in mind the importance of continuity of care during a servicemember's transition from active duty to the community.

Within the VA medical system are various divisions that accommodate a high demand of services, to include extended care and rehabilitation, mental health, pharmacy, primary care, research, social work, spinal cord injury (SCI), and women's health. Quality care throughout those divisions may be hindered when buildings that house them aren't equipped to accommodate and/or sustain modern technologies and medicines.

Since the late 1990s, VA has gone through a critical transformation in its shifting from primarily hospital-based care to outpatient care. As the transition occurred, VA's infrastructure surpassed obsolete. This brought about the Capital Asset Realignment for Enhanced Services (CARES) process in 1999. This process was implemented to enhance outpatient and inpatient care and special programs, to include SCI, blind rehabilitation, seriously mentally ill and long-term care through proper upgrading, sizing, and location of VA facilities. However, once CARES was underway, the Commission did not include mental health and long-term care needs in its final recommendations, due to the lack of sufficient data. As a result, all of the facilities identified for closure were providing nationally recognized mental health and long-term care services.

In 2004, the VA completed the CARES process, which called for critical construction needs for outdated VA hospitals and clinics throughout the Nation. The Secretary of VA reported Congress would have to include $1 billion annually for 6 years to ensure the success of CARES. The American Legion has recommended the same figure in its annual budget recommendation since the CARES decision. Due to lack of funding over the years, it is believed VA has been playing fiscal catch-up.

Although the VA had begun implementing CARES decisions, a Government Accountability Office (GAO) report found implementation was not being centrally tracked or monitored to determine the impact the CARES process has or hasn't had on the mission. GAO was also tasked with examining how CARES contributes to the Veterans Health Administration (VHA) capital planning process; the extent to which the CARES process considered capital asset alignment alternatives; and the extent to which VA had implemented CARES decisions and how the application has helped VA carry out its mission.

Through CARES the VA developed a model to estimate the demand for health care services, as well as ascertain the capacity or availability of infrastructure to meet the demand. It was the recommendation of the VA to meet future health care

demand by building medical facilities and opening more Community Based Outpatient Clinics (CBOCs).

GAO further examined the CARES process by other means such as conducting six site visits to VA facilities in Walla Walla, El Paso, Big Spring, Orlando, Pittsburgh, and Los Angeles.

They found critical infrastructure problems at the following facilities:

- **Walla Walla**–The facility was in poor and dilapidated condition, to include buildings that dated back to the early 1900s. They also discovered lead-based paint and seismic issues.
- **Greater Los Angeles**–Infrastructure and life safety issues were discovered as well as seismic structural deficiencies for some of the old buildings. Most of the buildings also required major repairs, including seismic and structural upgrades, with the main hospital building at "exceptional" high risk for earthquake damage.
- **Orlando**–The Orlando facility had the greatest infrastructure need of any "market" in the country. The new facility is transitioning from that which accommodated 90,000 veterans to a population of 400,000.
- **Pittsburgh**–Buildings at the Pittsburgh Highland Drive facility were found in poor condition and not designed for modern medical health care.

As a result of the GAO report, it was recommended that VA provide the information necessary to monitor the implementation and impact of CARES decisions. It was also recommended VA provide outcome measures that report the progress of CARES as it relates to access to medical services for veterans.

Since Fiscal Year (FY) 2002, approximately 945,423 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans have left active duty and become eligible for VA health care. Approximately 51 percent of the returnees were active duty, while 49 percent were Reserve and National Guard. Many are also returning with various injuries and illnesses, to include Traumatic Brain Injury (TBI), SCI, Blind Eye Injury, Post-Traumatic Stress Disorder (PTSD), and Loss of Limb(s), to name a few.

The American Legion presents the above-mentioned numbers to evoke to the Congress and other pertinent affiliates to determine the adequacy, or lack thereof, of care to veterans when there is lack of funding and/or inadequate accommodations; namely infrastructure that houses VA services.

While the decision to assess and plan, and construct or reconstruct VA medical facilities has been underway since the CARES decision in 2004, the aforementioned figures also suggests veterans' issues have and continue to increase. With the average age of VA facilities remaining at 49 years, The American Legion questions whether these facilities can sustain new medical technology for years to come. During that time, we must remain conscious that veterans' issues are patterned to rise. It is therefore imperative Congress support the demand for timely construction of these facilities.

It is the position of The American Legion that during the improvement/enhancement of VA facilities, a base for health care services must not only be maintained, but must be increased to accommodate influxes. In order for the CARES plan to work successfully, there must be adequate funding to accommodate every project as implemented by the Commission. To play fiscal catch-up from this point will adversely affect the intent of the CARES project, VA infrastructure, and all veterans who rely on VA health care.

The American Legion also supports the mission of the CARES initiative, if it provides a continuous up-to-date infrastructure for an ever-changing veterans' community; however, we express dissent and concern if the intent is aimed at an effort to reduce VA expenditures under the pretext of cost-savings without regard to the needs of the veterans' population.

In response to a recent GAO report, VA concluded it did not have sufficient information to complete decisions throughout VA for various services like long-term care and mental health. In order to assess the need for the appropriate infrastructure, VA must collect actual numbers of veterans' demand for health care and services.

Other shortcomings included, specifically, the lack of sufficient information on the numbers of veterans who were to seek long-term care and mental health services from VA on a daily basis. Since 2004, VA has maintained that its models were inadequate to forecast demand. In order to be successful, VA must address key challenges, to include developing information to complete various service alignment decisions.

Finally, the preparation to construct and/or reconstruct VA medical facilities must be planned in accordance with service alignment decisions to fulfill the promise of

continuity of care and prevent other inadequacies, such as fragmentation of care throughout the women veterans' population.

The American Legion maintains that the CARES implementation process must be an open and transparent process that continually and fully informs the Veterans' Service Organizations of CARES initiatives, criteria, proposals and timeframes. This also includes an accurate assessment of the demand for all medical services which gauges how much infrastructure is required to accommodate this Nation's veterans.

Through this form of checks and balances, the maintenance of quality stands to uphold the effectiveness of CARES as it pertains to strategic planning and the future of the entire VA system.

Mr. Chairman and Members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on the above-mentioned matters and issues of similarity. Thank you.

Prepared Statement of Carl Blake,
National Legislative Director, Paralyzed Veterans of America

Chairman Michaud, Ranking Member Brown, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views today on the Capital Asset Realignment for Enhanced Services (CARES) report. Given that it has been 5 years since the CARES report was released, we believe this is a good benchmark period to review the progress that the Department of Veterans Affairs (VA) has made in implementing its recommendations. We also recognize the need to assess whether or not those recommendations remain an appropriate tool to align VA's health care infrastructure to meet the current and future demands on the system.

PVA would like to focus much of our discussion on how the CARES recommendations targeted the needs of our members—veterans with spinal cord injuries or dysfunctions (SCI/D), such as Multiple Sclerosis. We will outline the current status of CARES Commission recommendations with regards to SCI/D. Finally, we will discuss the outcomes of the CARES report regarding the realignment of VA infrastructure to meet changing demand for care and the value of the CARES methodology for determining current and future medical care workload and future demand for services.

Delivery of Care Through the SCI System

In reflecting on the CARES report, we believe that the health care concerns of veterans with catastrophic disabilities, and particularly veterans with spinal cord injury or dysfunction, were adequately addressed. The report included recommendations that significantly improved the capacity for VA to meet this demand while addressing barriers to access at the same time. Emphasis was placed on expansion of the SCI hub-and-spoke delivery model to fill geographic gaps in SCI/D services. Additionally, the report made timely recommendations for SCI/D long-term care designed to be a first step toward meeting the demands of aging veterans with SCI/D.

Specifically, the CARES Commission called for the construction of four new SCI centers in the VA system. Locations targeted for new SCI centers were Syracuse, New York (VISN–2); VISN–16 (this location was later pinpointed to Jackson, Mississippi by VA and PVA officials); Denver, Colorado (VISN–19); and, Minneapolis, Minnesota (previous VISN–23).

As to the status of these projects, the Syracuse SCI center is currently in the planning phase. A 30-bed unit is being planned for this location. We feel confident that this new SCI center will be a state-of-the-art facility that will certainly meet the needs of veterans in that region. PVA is also extremely pleased that the new 30-bed Minneapolis SCI center officially opened last fall and became fully operational in February 2009.

The CARES plan also called for a 30-bed facility in VISN–16. Prior to the release of the final CARES report, the Draft National Cares Plan (DNCP) supported the North Little Rock VA facility in VISN–16 for location of an SCI center. However, the Commission recognized that North Little Rock did not provide the full range of tertiary care services required by VA to be a proper site for an SCI center. Since that time, Jackson, Mississippi, has been identified as the optimal location for that VISN. While this recommendation has not been advanced at this time, PVA's Architecture Department has been informed by the VA that it intends to request funding to begin this project in FY 2011.

With regards to Denver, the Subcommittee is probably aware that it has been a long and difficult process to determine what the health care infrastructure plan for this region would be. The CARES plan called for a 30-bed SCI center to be located at a new Denver VA medical center to be built on the Fitzsimons Campus. However, the larger facility planning process moved forward in fits and starts. The plan for Denver has taken many controversial turns, spread out over many years, with no plan being more troublesome that the new plan released in early 2008 by then VA Secretary James Peake. Secretary Peake's plan would have used Denver as the model for the new Health Care Center Facility (HCCF) Leasing Program.

Fortunately, significant pressure from the VSO community in Colorado along with strong support from the Congressional delegation put a hold on this program in Denver. PVA was very pleased with the VA's announcement in March that a new stand-alone hospital will be built on the Fitzsimons Campus, and a new SCI center will be included in that facility. Current VA Secretary Eric Shinseki also pledged in March to see that this project is completed by 2013.

The CARES report also called for the relocation of the SCI center located in Castle Point, New York (VISN–2) to the Bronx. However, this relocation was contingent upon the VA expanding the infrastructure at the Bronx SCI center. The plan then called for Castle Point to become an SCI long-term care facility. Currently, the Castle Point facility is under renovation. Meanwhile, the Bronx facility is being replaced with a 92-bed SCI center that will include 46 SCI long-term care beds.

Additionally, CARES called for the placement of an SCI outpatient clinic in VISN–4. SCI outpatient clinics, such as the one recommended, serve as spokes in the hub-and-spoke SCI system model. The VA embraced this recommendation and has since opened an SCI outpatient clinic in Philadelphia, Pennsylvania.

Finally, the CARES report called for adding 20 additional SCI acute care beds in Augusta, Georgia (VISN–7). Under this plan, the VA was to add 11 acute care beds immediately with 9 beds to be added by FY 2012. Our Architecture Department has informed us that the additional 11 beds are currently under construction and should be operational within the next few months. The additional 9 beds have not been formally designed, and no funding for this expansion has currently been requested. While the VA did not move on this recommendation as quickly as we would have liked, PVA is pleased to see that the VA is finally addressing this issue.

Long-Term Care Considerations

PVA was pleased that the final CARES Commission report included several recommendations for the expansion of long-term care services directed at spinal cord injured veterans. Prior to the CARES initiative, the VA system of care only provided 125 long-term care staffed nursing home beds dedicated to veterans with spinal cord injury. These SCI long-term care beds were located in four VA facilities—Brockton, Massachusetts; Hampton, Virginia; Castle Point, New York; and, Hines VA medical center in Chicago, Illinois. Interestingly, the VA had no institutional long-term care beds for SCI veterans located west of the Mississippi River.

While some progress has been made to expand VA's capacity for dedicated SCI long-term care, much work remains to be done. The CARES report called for an additional 100 SCI long-term care beds systemwide to expand capacity and improve admission wait times experienced by SCI veterans. Despite the CARES recommendations to increase SCI long-term care capacity, we believe that particular emphasis needs to be placed on expansion into the western United States.

The CARES Commission recommended 30 SCI long-term care beds to be located in VISN–8. PVA is pleased to report that 30 SCI long-term care beds have been placed adjacent to the SCI center located at the Tampa VA medical center and they are fully operational.

The Commission also recommended 20 SCI long-term care beds to be located at the SCI Center in Memphis, Tennessee (VISN–9); 20 SCI long-term care beds at the Cleveland VA medical center (VISN–10); and 30 SCI long-term care beds in Long Beach, California (VISN–22).

These three sites are in various stages of the planning process. The long-term care beds at Cleveland are currently under construction, and the final project will actually include 26 beds. This facility is anticipated to be operational by late 2010. The VA is also moving forward with the Memphis recommendation and is currently in the planning phase. Preliminary architectural plans have been reviewed and commented on by PVA.

The 30-bed long-term care plan for Long Beach has faced significant delays primarily related to space restrictions. However, PVA's Architecture Program has developed a conceptual plan to convert a currently unused portion of the existing facility into a 17-bed SCI long-term care unit. While this is actually a PVA recommended solution to part of the demand problem at Long Beach, we believe it is

a step in the right direction. We remain hopeful that VA will agree with this recommendation while working aggressively to establish the entire 30-bed unit recommended by CARES. We would encourage the VA and Congress to conduct aggressive oversight to ensure that the VA is moving forward on these critical projects expeditiously.

Additionally, PVA would like to revisit a significant problem concerning the difference between acute SCI center care and SCI long-term residential care that evolved as the CARES Commission process moved forward. As the Commission continued its fact finding work it became clear to PVA that the Commission had blurred the distinction between acute SCI care and SCI long-term residential care.

As the Commission made investigative visits throughout the VA health care system, some members of the Commission were concerned with their observations concerning low occupancy rates at SCI Centers. In fact, the Special Disability Program section of the Executive Summary of the Commission's final report quoted current occupancy rates among VA facilities with SCI/D units as ranging from approximately 52 percent to 98 percent. PVA felt at the time that this impression led the Commission to concoct ways of filling unused SCI acute care beds with SCI long-term care patients.

One of the significant problems identified during the early stages of the CARES process was the exclusion of long-term care, including nursing home, domiciliary and non-acute inpatient and residential mental health services, in its projections due to the absence of an adequate model to project future need for these services. This problem can still be seen in the flawed budget development for long-term care identified by the Government Accountability Office in its report released in January 2009: *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement* (GAO–09–145). Despite the lack of adequate data the CARES Commission made several recommendations regarding VA long-term care:

1. Prior to taking any action to reconfigure or expand long-term care capacity or replace existing facilities, VA should develop a long-term care strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the long-term care of the seriously mentally ill.
2. An integral part of the strategic plan should maximize the use of State Veterans Homes.
3. Domiciliary care programs should be located as close as feasible to the population they serve.
4. Freestanding long-term care facilities should be permitted as an acceptable care model.
5. VA should implement the VISN-specific recommendations for upgrading existing long-term care and chronic psychiatric care units, recognizing that some renovations are needed to improve the safety and maintenance of the facilities' infrastructure and to modernize patient areas.

In 2007, VA released a copy of its Long-Term Care Strategic Plan that, in the opinion of the co-authors of *The Independent Budget*, was lacking in specific planning detail regarding the future direction of its long-term care program. In 2008, PVA understood that VA was working on the development of a second, more comprehensive, Long-Term Care Strategic Plan; however, to the best of our knowledge that followup plan has never been released. We would encourage the Subcommittee to investigate this issue further. The CARES Commission emphasized in its final report, that strategic planning for aging veterans and veterans with serious mental illness will be essential going forward.

Meeting Future Health Care Demand

The Subcommittee has posed the question about the viability of CARES in assessing the future health care needs of veterans. As pointed out in *The Independent Budget* for FY 2010, despite the fact that CARES was completed in 2004, the VA continues to assess its needs and priorities for infrastructure by using concepts derived from the CARES model.

PVA actually sees this question as being one about whether or not the CARES recommendations made then appropriately address new demands on the system, particularly as it relates to the younger generation of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom. Moreover, the question seems to suggest that CARES did not take into account that new demand seems to be growing in rural communities and that the infrastructure changes outlined by CARES do not reflect this change.

While we certainly understand this concern, we believe that the CARES model appropriately addressed where the greatest demand for care comes from. Moreover, the CARES model provided a blueprint for aligning VA's infrastructure to best meet

the needs of the most veterans possible. Existing statutory authority, particularly Fee-for-Service, allows the VA to address health care demand and need outside the immediate infrastructure alignment. Furthermore, recognizing that certain demand has changed since 2004, the VA has moved forward on other major and minor construction initiatives outside of the CARES recommendations.

Recent activities of the VA seem to suggest that it might like to address health care demand outside of its infrastructure alignment, whether justified or not. As mentioned earlier, PVA, and many of its VSO partners, expressed serious concerns about the VA's HCCF leasing program developed under Secretary Peake. Under the HCCF, the VA would lease larger outpatient clinics (often referred to as super-CBOCs) instead of investing in new major construction initiatives. These large clinics would provide a broad range of services, including primary and specialty care as well as outpatient mental health services and same-day surgery. This proposal seemed to outline a different approach that some senior leadership in VA wanted to take in expanding health care capacity in the future.

However, as expressed in *The Independent Budget*, the HCCF leasing program has serious flaws that do not necessarily address the future health care needs of veterans. As explained in *The Independent Budget*:

> CARES required years to complete and consumed thousands of hours of effort and millions of dollars to study. The IBVSOs believe it to be a comprehensive and fully justified road map for VA's infrastructure as well as a model VA can apply periodically to assess and adjust those priorities. Given the strengths of the CARES process and the lessons VA learned and has applied from it, why is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one? We have yet to see evidence that it is and until we see more convincing evidence that it will truly serve the best interests of veterans, the IBVSOs will have a difficult time supporting it.

PVA also realizes that facility closures were a part of the CARES report recommendations. We certainly understand the focus on reducing excess capacity, particularly if it is clearly demonstrated that space is significantly underutilized. However, we must emphasize that careful thought must go into these decisions. Facility closures may have an adverse impact on certain SCI veterans as well as those other veterans with specialized health care needs and that rely so heavily on the VA for care. For some PVA members who live long distances from an SCI hub or spoke facility, particularly in rural areas, these VA hospitals represent their only health care option. If facility closures become necessary, VA must take action to ensure the availability of inpatient hospital care to meet the specialized health care needs of these affected veterans.

Mr. Chairman, PVA would again like to thank the Subcommittee for examining this issue. We all agree that the VA of the future must be aligned in such a fashion to best meet the demands of a changing veterans' population while ensuring that those same veterans receive the absolute best care possible. We look forward to working with the Subcommittee going forward to assist the VA in accomplishing this difficult task. I would be happy to answer any questions that you might have.

Prepared Statement of Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today.

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

With passage of that bill, VA developed a 5-year plan to update and modernize the system, including the introduction of systemwide managed care principles such as the uniform benefits package. As part of the overall plan, VA increasingly began to rely on outpatient medical care. Technological improvements, improved pharmaceutical options and management initiatives all combined to lessen the need for as many inpatient services. Additionally, the expansion of VA clinics—notably the Community Based Outpatient Clinics (CBOCs)—brought care closer to veterans.

These widespread changes represented a management challenge for VA, GAO argued:

> "VA's massive, aged infrastructure could be the biggest obstacle confronting VA's ongoing transformation efforts. VA's challenges in this arena are twofold: deciding how its assets should be restructured, given the dramatic shifts in VA's delivery practices, and determining how a restructuring can be financed in a timely manner."

GAO also testified before the House Veterans' Affairs Committee's Subcommittee on Health in March 1999 on VA's capital asset planning process. They concluded that, "VA could enhance veterans' health care benefits if it reduced the level of resources spent on underused or inefficient buildings and used these resources, instead, to provide health care, more efficiently in existing locations or closer to where veterans live." Further, GAO found that VA was spending about 1 in 4 Medical Care dollars on asset ownership with only about one-quarter of its then-1,200 buildings being used to provide direct health care. Additionally, the Department had over 5 million square feet of unused space, which GAO claims cost VA $35 million per year to operate.

From these findings, VA began the Capital Asset Realignment for Enhanced Services (CARES) process. It was the first comprehensive, long-range assessment of the VA health care system's infrastructure needs since 1981.

CARES was VA's systematic, data-driven assessment of its infrastructure that evaluated the present and future demands 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 the supply of care and the identification of future gaps in infrastructure capacity.

The plan was a comprehensive multi-stage process.

- February 2002–VA announced the results of the pilot program of VISN–12.
- August 2003–Draft National CARES Plan submitted to the Under Secretary for Health.
- February 2004–16-member independent CARES Commission submits recommendations based upon its review of the Draft Nationals CARES Plan.
- May 2004–VA Secretary announces releases final CARES Decision Document, but leaves several facilities up for further study.
- May 2008–Final Business Plan Study released, completing the CARES process.

Throughout the process, we were generally supportive. We continuously emphasized that our support was contingent on the primary emphasis being on the "ES"—enhanced services—portion 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.

Our main concern with the plans as they unfolded was the lack of emphasis on mental health care and long-term care. The early stages of the CARES process excluded many of these services for the most part because they lacked an adequate model to project the need for these services in the future.

The CARES Commission called for VA to develop a long-term care strategic plan, to address the needs of veterans and all care options available to them, including State veterans homes. As we discussed in the *Independent Budget*, VA's 2007 Long-Term Care Strategic Plan did not address these issues in a comprehensive manner; going forward, this must be rectified.

The 2004 CARES Decision Document gave VA a road map for the future. It called for the construction of many new medical facilities, over 100 major construction projects to realign or renovate current facilities, and the creation of over 150 new CBOCs to expand cares into areas where the CARES process identified gaps.

Since FY 2004, 50 major construction projects have been funded for either design or actual construction. Eight of those projects are complete. Six more are expected to be completed by the end of FY 2009, and 14 others are currently under construction. So CARES has produced results.

The strength of CARES in our view is not the one-time blueprint it created, but in the decisionmaking framework it created. 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 systemwide, taking into account what is best for the totality of the health care system, and what its priorities should be.

VA's Capital Investment Panel (VACIP) is the organization within the department responsible for these decisions. VA's capital decision process requires the VACIP to review each project and evaluate it using VA's decision model on a yearly basis to

ensure that potential projects are fully justified under current policy and demographic information. These projects are assigned a priority score and ranked, with the top projects being first inline for funding.

It is a dynamic process that depoliticizes much of the decisionmaking process. The projects selected for funding are by and large the projects that need the most immediate attention. Because it is a dynamic process, some of the projects VA has moved forward with were not part of the original CARES Decision Document, but they were identified, prioritized and funded through the methodology developed by CARES. We continue to have strong faith that this basic framework serves the needs of the majority of veterans. Despite its strengths, there are certainly some challenges.

First is that the very nature of the report required a large infusion of funding for VA's infrastructure. 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.

This has resulted in a sizable backlog of construction projects that are only partially funded. Were the Administration's construction request to move forward, VA would have a backlog in funding for major construction of nearly $4 billion. This means that to just finish up what is already in the pipeline, it would take approximately 5 full fiscal years of funding—based on the recent historical funding levels—just to clear the backlog.

This Congress and this Administration must continue to provide full funding to the Major Construction account to reduce this backlog, but also to begin funding future construction priorities.

Another difficulty has been the slow pace of construction. Major construction projects are huge undertakings, and in areas—such as New Orleans or Denver—where land acquisition or site planning have presented challenges, construction is slower than we would like. There are, however, many cases where there have been fewer challenges, and when the money was appropriated, construction has moved quickly.

With these twin problems of funding and speed in mind, VA has recently been exploring ways to improve the process. Last year, they unveiled the Health Care Center Facility (HCCF) leasing concept.

As we understand it, the 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.

We expressed our concerns with the HCCF concept in the *Independent Budget* (IB). Primarily, we are concerned that this concept—which heavily relies on widespread contracting—would be done in lieu of an investment of major construction.

Acknowledging that with the changes taking place in health care, VA needs to look very carefully before building new facilities. Cost plus occupancy must justify full-blown medical centers. But leasing is the right thing to do only if the agreements make sense.

VA needs to do a better job explaining to veterans and the Congress what their plans are for every location based on facts. The ruinous miscommunication that plagued the Denver construction project amply demonstrates this point.

While promising, the HCCF model presents many questions that need answers before we can fully support it. Chief among these is why, given the strengths of the CARES process and the lessons VA has learned and applied from it, is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one?

We also have major concerns with the widespread contracting that would be mandated by this type of proposal. The lessons from Grand Island, NE—where the local hospital later canceled the contract, leaving veterans without local inpatient care—or from Omaha—where some veterans seeking specialized services are flown to Minneapolis—show the potential downfall of large-scale contracting.

Leasing clinical space is certainly a viable option. It does provide for quicker expansion into areas with gaps in care, and it does provide the Department with flexibility in the future.

But when it is combined with the contracting issue, and presented without information and supporting documentation that is as rigorous or comprehensive as CARES was, it will be difficult for the VFW and the veteran's community to support it.

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 in care, and VA has

continued to refine its statistics, especially with the improved data it is getting from the Department of Defense about OEF/OIF veterans.

Providing care to these rural veterans is the latest 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 the construction process. VA must better use its fee-basis care program, and the recent initiatives passed by Congress—such as the mobile health care vans or the rotating satellite clinics in some areas—are going to fix some of the demand problems these veterans face.

We can always certainly do more, but thanks to the CARES blueprint, VA has greatly improved the ability of veterans around the country to access the care they earned by virtue of their service to this country. And with the annual adjustments and reassessments that account for changes within the veterans' population, we can assure that veterans are receiving the best possible care long into the future.

The VFW thanks you and the Subcommittee for looking at this most important issue.

Prepared Statement of Richard F. Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America

Good morning, Mr. Chairman, Ranking Member Brown and distinguished Members of this Subcommittee, on behalf of Vietnam Veterans of America (VVA) National President John Rowan and all our officers we thank you for the opportunity for VVA to present our views on Assessing CARES and the Future of VA's Health Infrastructure. I ask that you enter our full statement in the record, and I will briefly summarize the most important points of our statement.

VVA has long advocated for proper stewardship of our Nation's veterans health care system. By this we mean stewardship in the sense that one is conscious of leaving the physical plant as well as the quality and the quantity of medical services delivered therein better than one found it. Our first National President was on a dirty, rat infested ward for Spinal Cord Injured veterans at the old Bronx VA medical center that was the cover story of an issue of *LIFE* magazine in 1970. As a result of the publicity and furor generated by that article, the momentum was created that led to the construction of a brand new modern and much larger VA facility in Bronx, New York, and led to the antiquated one being torn down.

The concept of the Capital Asset Realignment for Enhanced Service (CARES) is ostensibly one of stewardship, and therefore VVA endorses the concept. However, VVA continues to be very concerned about the actual process that is currently in place. Many of the most gross mistakes and errors created by the process created by VHA and their outside contractor were corrected by the good work and intrepid efforts of the Honorable Everett Alvarez and his distinguished colleagues who served on the CARES Commission some 5 years ago.

Other particularly poor recommendations of the initial report from VHA were corrected by the Secretary of Veterans Affairs when he accepted the report of the CARES Commission. However the basic formula and process remain basically for the future, and therein lays the core of the problem. The formula developed by the Milliman-USA people is a civilian formula designed for basically healthy middle class people that can afford to purchase access to an HMO or PPO. It does not take into account the wounds or diseases that are attendant to military service, particularly for those deployed overseas and/or in a war zone.

Despite common sense that would mandate it, and despite earnest entreaties from VVA and others, the VA Veterans Health Administration (VHA) still does not take a military history from each veteran, make it part of the veteran's medical record on the Central Patient Records System (CPRS) in the VISTA system at VHA, and use it as a significant part of the basis for the diagnosis procedure or in the process of crafting a successful treatment modality (or modalities). Because of this, the VA constantly underestimates the chronic diseases and long term health care problems that veterans are likely to experience. It is not that VA does not know what the wounds, maladies, injuries, and conditions are that veterans, depending on when and where they served, are more likely to experience than their civilian cohort. As Attachment I please find enclosed the title page to www.va.gov/vhi that leads one to the Veterans Health Initiative (VHI), which is a set of curricula in many of the conditions for which veterans face increased risks. So VA knows what most of these increased risks are, and even distributes the "pocket card" to new medical residents and interns at VA medical centers and other VHA facilities, as well as providing

it to others (see Appendix II or go to http://va.gov/oaa/pocketcard/), as well as having had it in the M1A1 Medical Procedures Manual since 1982.

What bearing does all of this have on the CARES formula? Well, the Milliman formula, which as noted above is basically a civilian formula, does not take any of these special conditions that veterans are subject to into account. Further, the Milliman formula is based on one to three "presentations" per individual who comes to the medical facility for service, whereas VA medical centers average between five and nine "presentations" per individual. What this means is that each unique individual consumes more resources per person than the Milliman formula allows for in its computations. Therefore, the formula, which has come to affect all of resource planning at the VHA, will perennially leave the VHA short of the needed resources to deliver timely, quality medical care to each veteran eligible and seeking such services. The same holds true when it comes to estimating what will be needed in the way of physical facilities to deliver health care in the future.

CARES was funded on the premise that there was a great deal of unutilized space at VA facilities across the Nation, and that because the population of veterans eligible for services who were likely to seek such services, that the census of patients would be in precipitous decline from 2000 to 2020 (later changed to 2002 to 2022). That has proven to be an erroneous assumption. Not only have the ranks of veterans risen because of the wars in Iraq, Afghanistan, and elsewhere, but even the size of our standing force of active duty military has been increased for the foreseeable future.

Using all of the supposedly great tools of projection, VHA has dramatically underestimated the number of OIF/OEF veterans who would seek medical services from VA in each of the last 5 years. Further, even before the new Administration and the Congress began easing the restrictions on so-called category 8 veterans, the VA underestimated the number of veterans of earlier generations who would seek and receive medical services. Some of that increase comes from previously service connected disabled veterans who lost eligibility for other private sector medical options as a result of job loss or retirement, or their employer could no longer afford to have medical insurance for their employees. For others, they are "new" older veterans who after years of delay were finally awarded service connected disabled status, and therefore access to medical care. All of these have led to an increase not only in the gross number of veterans seeking help from VHA, but at most VHA facilities the number of veterans seeking services has remained constant or risen in the past 7 years. Even at those facilities where the number seeking services has remained essentially constant (mostly in the northern climates of the Nation), the number of medical needs has risen because those who could afford to move to a warmer climate as they got older and/or retired did so. Those that stayed were/are older, poorer, and sicker, and therefore need more resources to take care of per person than those who had the ability to move.

It is time to re-examine all of the original assumptions of the CARES process now that it is clear that the number of veterans seeking services is not generally declining, and that the needed services per individual will likely continue to rise, at least for another decade or so, as the average age of the Vietnam veterans rises (currently the mean average age of Vietnam veterans, who constitute 60% of VA patients, is 63 years old, while the median age of Vietnam veterans is almost 61 years old). What the growth of the younger cohorts, and the increase in use by the Vietnam cohort means is that the notion of many empty buildings across America that are not needed just is not the case. In most cases, that space is needed and more. Further, the notion advanced by the now former Under Secretary of Health that "we cannot afford any more new hospitals for veterans" is a notion that was out of step with both the clear and apparent need, and was clearly not in keeping with fulfilling the obligation of the American people to "care for he (and she) who hath borne the battle."

The 2007 GAO Report (GAO–07–408) from March 2008 criticized VA for not following through on making the goals, objectives, and timetables for the CARES implementation plan clear to all. It also sharply criticized VA for CARES not being a transparent process at every step. GAO noted that VA did not build meeting the specific goals of CARES into the set of metrics by which managers are rated and scored on their performance ratings within the VHA, which meant that it was unclear who is supposed to be doing what to get on track with upgrading the physical structures of VHA. VVA also criticized VA for a lack of clarity in just who was in charge of implementation, and the role of the many players in the process.

VVA would also note that until the 110th Congress, there was nowhere near the minimum of $1 billion per year upon which the CARES plan was predicated which was actually provided to VA in the appropriation. This means that the schedule is

seriously behind because it was not fully funded in the early years of implementation.

So, where are we today? VVA recommends the following steps to ensure that the physical plant needed for the effective and efficient provision of quality medical services to veterans is in place for those currently in need of these services, and for the future:

1. **VVA strongly believes that the basic CARES formula must be improved by making it a "veterans' health care formula" that takes into account the actual situation of veterans, and likely rate of use of resources per person, so that it provides for the request for resources it will take to properly serve all of the needs, of the veterans population that seeks medical services at VHA, particularly the conditions that are a direct or indirect result of military service.**
2. VVA believes that the entire process, like much of the rest of activities and planning at VA, needs to be much more transparent, with respect to involvement at every level of ALL of the stakeholders. The previous Administration, and particularly those who have occupied the top leadership positions of VHA in the past 7 years, showed veritable contempt for the Congress, for veterans service organizations, for the VA labor unions and their members, and for individual veterans by the secretive and patronizing manner in which business was all too often conducted. This must be dramatically changed, and the process and the way of doing business transformed.
3. VVA urges that the major construction budget be set at a level of at least $1.5 billion to $2 billion per year for the next few years to begin to make up for all that did not happen during the previous decades, and particularly in the first few years of the CARES process. As imperfect as the formula and the process are, at least we know that what has been recommended is the bare minimum that is needed to properly care for veterans. Even while work goes on to improve both the formula and the overall process, we can speed up the pace of implementation. Because of the financial crisis, we can frankly get buildings built today for much less than will be the case in a few years with worldwide liquidity.
4. VVA recommends that the Secretary and the Deputy Secretary review the lines of authority and accountability for implementing CARES is clear to all parties, and the role of each is clear, from the Office of Policy & Planning in the central VA office to the VISN Directors and VAMC Directors.

While there are no doubt other useful steps that can and should be taken to improve the CARES process, these are in the view of VVA the four most important steps. Mr. Chairman, thank you for the opportunity to provide our brief remarks. I will be happy to answer any questions.

Prepared Statement of Joy J. Ilem,
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this oversight hearing of the Subcommittee on Health. We appreciate the opportunity to offer our views on progress by the Department of Veterans Affairs (VA) in delivering on the recommendations outlined in the 2004 Capital Asset Realignment for Enhanced Services (CARES) report, and to discuss the future of VA's health care infrastructure.

As we near the end of the first decade of the 21st century, we find ourselves at a critical juncture with respect to how VA health care will be delivered and what the VA of the future will be like in terms of its health care facility infrastructure. Although admittedly this vision is yet to gain clarity, one fact is certain—our Nation's sick and disabled veterans deserve and have earned a stable, accessible VA health care system that is dedicated to their unique needs and can provide high-quality, timely care where and when they need it.

CARES BEGINS

Mr. Chairman, based on preliminary work by the professional staff of this Subcommittee, VA initiated CARES in 1999 with a pilot program in Veterans Integrated Service Network (VISN) 12, through the auspices of a contract with the firm of Booz Allen Hamilton. In 2001, that contract was canceled and VA integrated the CARES process within its own staff and other resources. The process took years to

complete and required tens of thousands of staff-hours of effort and millions of dollars in studies. At its conclusion, with issuance of the so-called "Draft National CARES Plan," the VA Secretary chartered and appointed a CARES Commission to independently evaluate and consider its outcomes and recommendations. These processes were largely conducted and reported in public.

As a general principle, the *Independent Budget* Veterans Service Organizations (IBVSOs), DAV, AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States, concluded that CARES was a comprehensive and fully justified road map for VA's infrastructure needs, as well as a model that VA could apply periodically to assess and adjust those priorities. However, once the Draft National CARES Plan was released in 2004, an immediate backlash developed to the proposed recommendations affecting the operating missions of a number of VA facilities. Many veterans, fearful that they would lose VA health care services, and selected Members of Congress, opposed the plans for changes in *their* States—and in *their* VA facilities, irrespective of the validity of the findings or the value of the plan as a whole. Local political pressure became intense, and in many cases the proposed CARES recommendations were scuttled. In one respect, it became clear that veterans and their Members of Congress were passionate and committed in keeping targeted VA facilities intact. Unfortunately, this passionate defense of the status quo stymied the CARES implementation phase, and caused VA to become much more reserved about sharing information about any strategic infrastructure planning.

CARES STALLED

Upon completion of the Draft National CARES Plan in 2004, then-VA Secretary Anthony Principi testified before this Subcommittee. His testimony noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care." VA reports that through fiscal year (FY) 2009, Congress actually has appropriated $4.9 billion for construction projects since FY 2004.

On July 18, 2008, then-VA Secretary James Peake wrote to two Members of Congress that the planned Denver, Colorado replacement VA medical center was "... not affordable ..." as a traditional government-owned, VA-operated facility of the size, scope and price that had been designed. That same day, while not declaring CARES officially "dead," Secretary Peake spoke before a large audience at the National Press Club and indicated, in answer to a question, that VA would be looking at factors beyond CARES to determine its future capital infrastructure planning needs.

For nearly a decade, the IBVSOs have argued that the VA must be protected from deterioration of its health infrastructure, and the consequent decline in VA's capital asset value. Year after year, we have urged Congress and the Administration to ensure that appropriated funding is adequate in VA's capital budget so that VA can properly invest in its physical assets, protect their value, and ensure health care in safe and functional facilities long into the future. Likewise, we have stressed that VA's facilities have an average age of more than 55 years; therefore, it is essential that funding be routinely dedicated to renovate, repair, and replace VA's aging structures, capital, and plant equipment systems as needed.

CAPITAL FUNDS DEFICIT WORSENED UNDER CARES

Mr. Chairman, unfortunately, the past decade of deferred and underfunded construction budgets has meant that VA has not adequately recapitalized its facilities, now leaving the health care system with a large backlog of major construction projects totaling between $6.5 billion to $10 billion, with an accompanying urgency to deal with this growing dilemma.

One of the reasons VA's construction backlog is so large and growing today is because both VA and Congress, by agreement with the two prior Administrations, allocated little to no capital construction funding during the pendency of the CARES process, over a 6-year period. Agreeing with VA, the Appropriations Committees in both chambers provided few resources during the initial review phase, preferring to wait for CARES results, a decision the IBVSOs repeatedly opposed. We argued that a *de facto* moratorium on construction was unnecessary because a number of these projects obviously warranted funding and would almost certainly be validated through the CARES review process. The House agreed with our views as evidenced by its passage of H.R. 811, the "Veterans Hospital Emergency Repair Act." That bill passed unanimously on March 27, 2001, about 2 years into the CARES process. Let me quote, in part, what the bill's sponsor, then Chairman Christopher H. Smith, had to say in introducing H.R. 811 over 8 years ago:

Mr. Speaker, for the past several years, we have noted that the President's annual budget for VA health care has requested little or no funding for major medical facility construction projects for America's veterans. As we indicated last year in our report to the Committee on the Budget on the Administration's budget request for fiscal year 2001, VA has engaged in an effort through market-based research by independent organizations to determine whether present VA facility infrastructures are meeting needs in the most appropriate manner, and whether services to veterans can be enhanced with alternative approaches. This process, called "Capital Assets Realignment for Enhanced Services," or "CARES," has commenced within the Department of Veterans Affairs, but will require several years before bearing fruit. In the interim, Mr. Speaker, some VA hospitals need additional maintenance, repair and improvements to address immediate dangers and hazards, to promote safety and to sustain a reasonable standard of care for the Nation's veterans. Recent reports by outside consultants and VA have revealed that dozens of VA health care buildings are still seriously at risk from seismic damage. The buildings at American Lake [Washington] damaged in yesterday's earthquake were among those identified as being at the highest levels of risk.

Also, Mr. Speaker, a report by VA identified $57 million in improvements were needed to address women's health care; another report, by the Price Waterhouse firm, concluded that VA should be spending from 2 percent to 4 percent of its "plant replacement value" (PRV) on upkeep and replacement of its health care facilities. This PRV value in VA is about $35 billion; thus, using the Price Waterhouse index on maintenance and replacement, VA should be spending from $700 million to $1.4 billion each year. In fact, in fiscal year 2001, VA will spend only $170.2 million for these purposes.

While Congress authorized a number of major medical construction projects in the past 3 fiscal years, these have received no funding through the appropriations process. I understand that some of the more recent deferrals of major VA construction funding were intended to permit the CARES process to proceed in an orderly fashion, avoiding unnecessary spending on VA hospital facilities that might, in the future, not be needed for veterans. I agree with this general policy, especially for those larger hospital projects, ones that ordinarily would be considered under our regular annual construction authorization authority. We need to resist wasteful spending, especially when overall funds are so precious. But I believe that I have a better plan.

To our regret, the Senate never considered the proposed bill, Congress did not appropriate supportive funding, and the construction and maintenance backlog continued to grow unabated for the next several years. Incidentally, the needed infrastructure improvements for women veterans (for privacy, restroom accommodations, etc.) mentioned by Representative Smith were largely never made. The VA projects that the number of women veterans turning to VA for care will likely double in the next 2–4 years; therefore, it is essential that these infrastructure needs are addressed now.

Another area of concern is VA research capital infrastructure. Over the past decade, minimal funding has been appropriated or allocated to maintain, upgrade or replace aging VA research facilities. Many VA facilities have run out of adequate research space. Plumbing, ventilation, electrical equipment and other required maintenance needs have been deferred. In some urgent cases, VA medical center Directors have been forced to divert medical care appropriations to research projects to avoid dangerous or hazardous situations.

The 2003 Draft National CARES Plan (DNCP) included $142 million for renovation of existing research space and to cover build-out costs for leased research facilities. However, these capital improvement costs were omitted from the VA Secretary's final report on CARES, the so-called "CARES Decision Memorandum." According to Friends of VA Medical Care and Health Research (FOVA), over the past decade, only $50 million has been spent on VA research construction or renovation in VA's nationwide research system. Additionally, FOVA noted in its fiscal year 2010 budget proposal, endorsed by DAV, that VA was congressionally directed to conduct a comprehensive review of its research facilities and report to Congress on the deficiencies found, with recommended corrections. During FY 2008, the VA Office of Research and Development initiated a 3-year examination of all VA research infrastructure to assess physical condition, capacity for current research, as well as program growth and sustainability of the space to conduct research. We urge the Subcommittee to consider this report when completed, and for Congress to address VA's research facilities improvement needs as part of a separate VA research infra-

structure appropriation. VA's Medical and Prosthetic Research program is a national asset to VA and veterans—it helps to ensure the highest standard of care for veterans enrolled in VA health care, and elevates health care practices and standards in all of American health care. That program cannot continue its record of achievement without adequate maintenance of the capital infrastructure in which it functions.

CARES PROJECTION MODEL

One of the strengths of the CARES process was that it was not just a one-time snapshot of needs. As part of the process, VA developed a health care projection model to estimate current and future demand for health care services, and to assess the ability of its infrastructure to meet this demand. VA uses this projection model throughout its capital planning process, basing all projected capital projects upon the results of the demand model.

VA's model, was also relied on for VA health care budget, policy and planning decisions, produces 20-year forecasts in demand for VA health services. It is a complex and sophisticated model that adjusts for numerous factors, including demographic shifts, morbidity and mortality, changing needs for health care based on aging of the veteran population, projections to account for health care innovations, and many other relevant factors.

In a November 2007 hearing before this Subcommittee, VA's testimony summed up the process:

> *Once a potential project is identified, it is reviewed and scored based on criteria VA considers essential to providing high-quality services in an efficient manner. The criteria VA utilizes in evaluating projects include service delivery enhancements, the safeguarding of assets, special emphasis programs, capital asset priorities, departmental alignment, and financial priorities. VA considers these new funding requirements along with existing CARES decisions in determining the projects and funding levels to request as part of the VA budget submission. Appropriate projects are evaluated for joint needs with the Department of Defense and sharing opportunities.*

VA uses these evaluation criteria to prioritize its projects each year, releasing these results in its annual 5-year capital plan. The most recent one, covering fiscal years 2009–2013, is part of the Congressional budget submission in "Volume III: Construction Activities." This plan is central to VA's funding requests and clearly lists the Department's highest construction priorities for the current year, as well as for the immediate future. The Partnership for VA Health Care Budget Reform, in testifying before your full Committee on April 29, 2009, provided detailed information and our opinion about VA's projection model in support of our proposed reforms in VA health care funding. We refer the Subcommittee to that testimony for our comments on the model.

VA MOVING IN NEW DIRECTION

Mr. Chairman, over the past several years, VA began to discuss with the veterans service organization community, its desire to address its health infrastructure needs in a new way. VA acknowledged its challenges with aging infrastructure; changing health care delivery needs, including reduced demand for inpatient beds and increasing demands for outpatient care and medical specialty services; limited funding available for construction of new facilities; frequent delays in constructing and renovating space needed to increase access, and particularly the timeliness of construction projects. VA has noted, and we concur, that a decade or more is required from the time VA initially proposes a major medical facility construction project, until the doors actually open for veterans to receive care in that facility. VA indicated to us a necessity to consider alternative means to address the growing capital infrastructure backlog and the significant challenge of funding it.

Given these significant challenges, VA has broached the idea of a new model for health care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF proposal, in lieu of the traditional approach to major medical facility construction, VA would obtain by long-term lease, a number of large outpatient clinics built to VA specifications. These large clinics would provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

VA noted, that in addition to its new HCCF facilities, it would maintain its VA medical centers (VAMCs), larger independent outpatient clinics, community-based outpatient clinics (CBOCs) and rural outreach clinics. VA has argued that the HCCF model would allow VA to quickly establish new facilities that will provide 95

percent of the care and services veterans will need in their catchment areas, specifically primary care, and a variety of specialty services, mental health, diagnostic testing and same-day ambulatory surgery. According to VA, veterans' inpatient hospital service needed by these HCCFs would be provided through additional leases, VA staffed units, or other contracts or fee-for-service options with academic affiliates or in available community hospitals.

We concur with VA that the HCCF model seems to offer a number of benefits in addressing its capital infrastructure problems including more modern facilities that meet current life-safety codes; better geographic placements; increased patient safety; reductions in veterans' travel costs and increased convenience; flexibility to respond to changes in patient loads and technologies; overall savings in operating costs and in facility maintenance and reduced overhead in maintaining outdated medical centers.

CHALLENGES TO HCCF MODEL

Nevertheless, Mr. Chairman, while it offers some obvious advantages, the HCCF model also portends obvious challenges. Outside the CBOC environment, contract management in complex leased health care facilities is an untested practice in VA. This Subcommittee has spent years overseeing efforts to improve VA's contracting performance across a range of activities, including obtaining contract health care for eligible veterans. Also, we are deeply concerned about the overall impact of this new model on the future of VA's system of care, including the potential unintended consequences on continuity of high-quality care, delivery of comprehensive services, VA's electronic health record (EHR), its recognized biomedical research and development programs, and particularly the impact on VA's renowned graduate medical education and health professions training programs, in conjunction with longstanding affiliations with nearly every health professions university in the Nation. Additionally, we question VA's ability to provide alternatives for maintaining its existing 130 nursing home care units, homeless programs, domiciliaries, compensated work therapy programs, hospice, adult day health care units, the Health Services Research and Development Program, and a number of other highly specialized services including 24 spinal cord injury centers, 10 blind rehabilitation centers, a variety of unique "centers of excellence" (in geriatrics, gerontology, mental illness, Parkinson's, and multiple sclerosis), and critical care programs for veterans with serious and chronic mental illnesses. We question if VA has seriously considered the probable impact on these programs in developing the HCCF concept.

In general, the HCCF proposal seems to be a positive development, with good potential. Leasing has the advantage of avoiding long and costly in-house construction delays and can be adaptable, especially when compared to costs for renovating existing VA major medical facilities. Leasing options have been particularly valuable for VA as evidenced by the success of the leased space arrangements for many VA community-based outpatient clinics and Vet Centers. However, VA has virtually no experience managing as a tenant in a building owned by others, for the delivery of complex, subspecialty VA health care services.

INPATIENT SERVICES: A MAJOR CONCERN

The IBVSOs are also concerned with VA's plan for obtaining inpatient services under the HCCF model. VA says it will contract for these essential inpatient services with VA affiliates or community hospitals. First and foremost, we fear this approach could negatively impact safety, quality and continuity of care, and permanently privatize many services we believe VA should continue to provide. We have testified on this topic numerous times, and the IBVSOs have expressed objections to privatization and widespread contracting for care in the "Contract Care Coordination" and "Community-Based Outpatient Clinics" sections of the Fiscal Year 2010 *Independent Budget*. We call the Subcommittee's attention to those specific concerns.

In November 2008, VA responded to a Senate request for more information on VA's plans for the newly proposed HCCF leasing initiative. A copy of VA's response is attached to this testimony and I ask that it be made a part of the record of this hearing, Mr. Chairman. To summarize that response, VA advised it originally identified 22 sites that could potentially be considered appropriate for adoption of the HCCF concept. Following additional analysis, that number was reduced to 8 potential sites for review, including Butler, Pennsylvania; Lexington, Kentucky; Monterey and Loma Linda, California; Montgomery, Alabama; and Charlotte, Fayetteville and Winston-Salem, North Carolina.

VA also addressed a number of other specific questions in the November 2008 letter including whether studies had been carried out to determine the effectiveness

of the current approach; the full extent of the current construction backlog of projects and its projected cost over the next 5 years to complete; the extent to which national veterans organizations were involved in the development of the HCCF proposal; the engagement of community health providers related to capacity to meet veterans' needs; the ramifications on the delivery of long-term care and inpatient specialty care; and whether VA would be able to ensure that needed inpatient capacity will remain available.

I will comment on some of the key responses from VA related to these noted questions. Initially, it appears VA has a reasonable foundation for assessing capital needs and has been forthright with the estimated total costs for ongoing major medical facility projects. For this year, VA estimated $2.3 billion in funding needs for existing and ongoing projects. The Department estimated that the total funding requirement for major medical facility projects over the next 5 years would be in excess of $6.5 billion. Additionally, if the new HCCF initiative is fully implemented, VA indicated it would need approximately $385 million more to execute seven of the eight new HCCF leases.

We agree with VA's assertion that it needs a balanced program of capital assets, both owned and leased buildings, to ensure demands are met under the current and projected workload. Likewise, we agree with VA that the HCCF concept could provide modern health care facilities that would not otherwise be available due to the predictable constraints of VA's major construction program.

VA indicated in its letter that the eight sites proposed for the HCCF initiative were chosen to ensure there would be little impact on VA specialty inpatient services or on delivery of long-term care. However, VA made a statement with respect to the HCCF model for the proposed sites that is somewhat confounding (VA's response to question 5), as follows: "By focusing the outpatient needs through HCCF's, major construction funding could then shift to the remaining capital needs." What is not clear to us is the extent to which VA plans to deploy the HCCF model. In areas where existing CBOCs need to be replaced or expanded with additional services due to the need to increase capacity, the HCCF model would seem appropriate and beneficial to veterans. On the other hand, if VA plans to replace the majority or even a large fraction of all VAMCs with HCCFs, such a radical shift would pose a number of concerns for DAV.

Mr. Chairman, before the HCCF concept is permitted to go forward on a larger scale, and with a major private sector component as described by VA, we believe VA must address and resolve a number of challenges. Among these questions are:

- Facility governance, especially with respect to the large numbers of non-VA employees who would be treating veterans;
- VA directives and rule changes that govern health care delivery and ensure safety and uniformity of the quality of care;
- VA space planning criteria and design guides' use in non-VA facilities;
- VA's critical research activities, most of which improve the lives not only of veterans but of all Americans;
- VA's electronic health record, which many observers, including the President, have rightly lauded as the EHR standard that other health care systems should aim to achieve; and
- Continuity of care within the mix of public/private facilities, as well as for those VA-enrolled veterans who relocate to other areas from the HCCF environment.

Fully addressing these and related questions are important, but we see this challenge as only a small part of the overall picture related to VA health infrastructure needs in the 21st century. The emerging HCCF plan does not address the fate of VA's 153 medical centers located throughout the Nation that are on average 55 years of age or older. It does not address long-term care needs of the aging veteran population, treatment of the chronically and seriously mentally ill, the unresolved rural health access issues, or the lingering questions on improving VA's research infrastructure.

HISTORY AS A LESSON FOR THE FUTURE

Today's VA largely was built during and immediately following World War II, to become an exalted place of care for over 500,000 injured war veterans. Some of those wounded remained hospitalized in VA for the remainder of their lives. VA's spinal cord injury, blind rehabilitation and prosthetics and sensory aids programs got their genesis or major expansions from World War II veterans' needs. In 1946, Congress established the Department of Medicine and Surgery (DM&S), now the Veterans Health Administration, and gave many independent powers that other Federal agencies lacked, in order to care for those wounded heroes. DM&S Memo-

randum No. 2 formed the VA-medical school affiliation relationships, to guarantee the young and energetic physicians-in-training of that age would turn their full attention to wounded and ill veterans. In conjunction with new affiliations, VA made a collective decision to locate its new post-war VA hospitals nearby or alongside existing medical schools' academic health centers for the potential symbiotic effect and to help ensure a high-quality physician workforce remained available to sick and disabled veterans. VA's biomedical research and development programs and its remarkable academic training programs we see in practice today emerged out of these seminal decisions and have become instrumental in both aiding VA with stronger academic credentials, advancing evidence-based treatments, and promoting a higher standard of care for wounded and sick veterans. Even with the advent of primary care and VA's other transformations during the past decade, this cooperative VA-academic system of care is still largely intact more than 60 years after World War II.

Mr. Chairman, as this Subcommittee and Congress at large consider the future of VA's infrastructure, and VA's future overall, it is good to remember our history, and to learn from it. Today, the Nation confronts two wars that, when concluded, will have likely produced over 2 million new veterans. While early in the process, we know from VA that already more than 400,000 of them have contacted VA for health care, for conditions ranging from post-deployment mental health conditions to minor musculoskeletal problems to severe brain injury with multiple amputations. No less than earlier generations and probably more so, these veterans will need VA to be sustained for them. The question that confronts the Subcommittee today is—what that VA system is going to be, what it will offer, and how it will be managed and sustained. We in the veterans service organization community cannot plan the future VA, and we would not expect your Subcommittee to do so independently. Given the President's pledge to create the VA of the 21st century, and Chairman Filner's commitment to aid VA in that endeavor; however, we do expect that VA should be mandated to establish its plan in a transparent way, vet that plan through our community and other interested parties, and provide its plan to Congress. We hope that all our communities (both inside and outside VA) share our concerns and want to help VA mold a strategic capital plan that all can accept and help collectively to accomplish. However, until this process materializes, we fear that VA's capital programs and the significant effects on the system as a whole and on veterans individually, will go unchanged, ultimately risking disaster for VA and for America's sick and disabled veterans.

AVOIDING THE OBVIOUS

As we grapple with the issue of health care and insurance reform in America, we must make every effort to protect the VA system for future generations of sick and disabled veterans. A well thought-out capital and strategic plan is urgently needed, and the tough decisions must be made, not avoided as in the response to the seemingly aborted CARES process. We are pleased the current Administration has committed to building the VA of the 21st century. However, we are not sure what this may mean, nor do we have the value of a VA comprehensive infrastructure plan. Regardless of the direction VA takes, we must insist there is consideration of all the elements we have described throughout our testimony. Critical elements in VA make up what are considered by all accounts the "best care anywhere" in the United States. We want to ensure VA's infrastructure plan maintains the integrity of the VA health care system, and all the benefits VA brings to its enrolled population. We want to ensure care is not fragmented and that high-quality, safe health care remains the bulwark of VA's programs.

CARES: AN UNFULFILLED VISION

Mr. Chairman, hitting its apex in 2004, we at DAV believe CARES provided a solid foundation for, and a valuable assessment of, what VA had in its health care infrastructure portfolio and where VA needed to go, but we ask today, what substantive action has been taken since the release of the CARES report to overhaul the system to make way for the 21st century? Currently VA is planning construction of five major VA medical centers, in Orlando, Florida; Denver, Colorado; Las Vegas, Nevada; Louisville, Kentucky; and New Orleans, Louisiana. None of the decisions to build these facilities was affected by the CARES process in any way but the most marginal sense. However, the decisions were unquestionably affected by the political process. While VA is addressing these political demands, it is still ignoring similar deficits at facilities such as in Togus, Maine; Sheridan, Wyoming; Wichita, Kansas; East Orange, New Jersey; Hines, Illinois; Mountain Home, Tennessee; Battle Creek,

Michigan; and more than 100 other older VA medical centers, some of which are in, or are reaching, dire need for infusion of major infrastructure funding.

VA: AT RISK

At this juncture, we believe VA soon may be in a very precarious situation. Operations Iraqi and Enduring Freedom continue. Each day we see growth in future health care, rehabilitation and post-deployment mental health needs in our newest generation of war veterans, and record demand for VA care by previous generations of disabled veterans. As a Nation, we must be good stewards of taxpayer dollars, yet we must also fulfill the commitment of the Nation to care for those who have suffered illness or injury as a result of military service and combat deployment. Concurrently, the American economy is unstable, Social Security, Medicare and Medicaid are seen by many to be unsustainable if not changed, and the new Administration and Congress are trying to formulate a plan to ensure access to basic health care services for every U.S. resident, and simultaneously reform the private insurance system. Changes coming from those trends, and that work, will undoubtedly affect the viability of VA in the future, but it is impossible to know the depth of that impact or its nature. Unfortunately, from what we do know, VA is largely uninvolved in the health care reform debate, and therefore, VA may be negatively impacted by those larger reforms. In our opinion, the VA, as a Cabinet agency, cannot be permitted to sit on the sideline of health care reform, but must be proactive and fully engaged in the debate.

ADVOCATES WANT A 21ST CENTURY VA

As advocates for veterans, we do not accept VA's contention that replacing outdated VA facilities is "... not affordable." VA's infrastructure needs have been deferred, neglected and delayed for far too long, to the advantage of other consumers of Federal dollars; therefore, without question facility replacements and updating are going to be costly, and both Congress and the Administration are confronted with that reality. The FY 2008 VA Asset Management Plan provides the most recent estimate of VA's needs. Using the guidance of the Federal Government's Federal Real Property Council, the value of VA's infrastructure is just over $85 billion. Accordingly, using industry standards as a yardstick, VA's capital budget should be between $4.25 billion and $6.8 billion annually in order to maintain its infrastructure at that value. VA's capital budget request for FY 2009—which includes major and minor construction, maintenance, leases, and equipment—was $3.6 billion.

The IBVSOs greatly appreciate that Congress provided funding above that level this year by an increase over the Administration's request of $750 million in Major and Minor Construction alone. That higher amount brought the total capital budget for FY 2009 inline with industry standards. We strongly urge that these targets continue to be met and we would hope that future VA requests use standard guidelines as a starting point without requiring Congress to add additional funding. We also are mindful that Congress included nearly $1 billion in the recent economic stimulus package that will fund VA infrastructure improvements and represents a significant re-payment to VA of capital funds it should have received years ago while CARES was underway.

DESIGN THE FUTURE

Congress and the Administration must work together to secure VA's future to design a VA of the 21st century. It will take the joint cooperation of Congress and the Administration to support this reform, while setting aside resistance to change, even dramatic change, when change is demanded and supported by valid data. Accordingly, we urge the Administration and the Congress to live up to the President's words by making a steady, stable investment in VA's capital infrastructure to bring the system up to match the 21st century needs of veterans.

COMMUNICATIONS WILL BE KEY TO SUCCESS

Finally, one of our community's pent-up frustrations with respect to VA's infrastructure is lack of information and communication. Communications have been sorely lacking for the past several years, and VA has seemingly resisted keeping us informed of its planning. In the spirit of the President's very first Executive order, on the transparency of government, we ask VA do a better job of communicating with our community, enrolled veterans, labor organizations and VA's own employees, local government and their affected communities, and other stakeholders, as the VA capital and strategic planning processes move forward. It is imperative that all

of these groups understand VA's "big picture" and how it may affect them. Talking openly and discussing potential changes will help resolve the understandable angst about this complex and important question of VA health care infrastructure. While we agree that VA is not its buildings, and that the patient should be at the center of VA care and concern, VA must be able to maintain an adequate infrastructure around which to build and sustain its patient care system. The time to act is now—our Nation's veterans deserve no less than our best effort.

Thank you, Mr. Chairman and Members of the Subcommittee. I will address any questions you may have for the DAV.

Prepared Statement of Hon. Everett Alvarez, Jr., Chairman, Capital Asset Realignment for Enhanced Services Commission, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee,

Thank you for the opportunity to appear before the Subcommittee to discuss the extraordinary work of the Capital Asset Realignment for Enhanced Services (CARES) Commission.

Let me begin by saying that the Commission believed its mission was pioneering—not just in terms of an external board assessing allocations of the VA's capital assets and making recommendations how these assets should be used, but also doing so while honoring and preserving the VA's health care and related missions. The Commissioners, many of whom are veterans themselves, were well aware of the enormous implications their efforts may have on veterans and the state of their health care system. We knew we had a moral obligation to be objective and transparent, because our review would serve as a blueprint for resource planning at the VA and an approach for medical care appropriations long after the Commission's work ended. We were guided, gratefully, by leadership and participation from VA officials, VA employees across the country, many hundreds of veterans, family-members, stakeholders, including Members of Congress, medical and nursing affiliates and communities at large.

Our efforts are documented in the CARES Commission Report to the Secretary of Veterans Affairs (VA) dated February 2004. Before I discuss key components of the Commission's Report, let me take a step back to provide some historical context that led to the creation of the CARES Commission and its body of work.

Retrospective Observations

VA CARES Process:

At the time of the Commission's involvement in the VA CARES process, the Commission believed the CARES process itself was the most comprehensive assessment ever undertaken by the VA to determine the capital infrastructure needed to provide modern health care to veterans.

CARES was a multi-faceted process designed to provide a data-driven assessment of veteran's health care needs. The process used projected future demand for health care services, compared the projected demand against current supply, identified capital requirements and then assessed any realignments the VA would need in order to meet future demand for services, improve the access to and quality of services, and improve the cost effectiveness of the VA's health care system.

Integrated in the overall CARES process was the reliance on input from the individual Veterans Integrated Service Networks (VISNs) and local veterans and stakeholders, followed by reviews of the National CARES Program Office (NCPO), the Under Secretary for Health, the CARES Commission, and the Secretary of VA.

The CARES process consisted of nine distinct steps. To give you a sense of the comprehensiveness of the CARES process, briefly let me outline the nine steps of the CARES process:

Step 1: The NCPO and VISNs created "markets" for planning purposes within each VISN. Markets were based on veteran population, enrollment, and market share data provided by the NCPO, as well as local knowledge of transportation and other factors unique to the community.

Step 2: The VISNs conducted an analysis of the current health care needs of veterans to identify markets. Future health care needs of veterans in those markets were projected using the CARES model.

Step 3: The VISNs identified "planning initiatives" to describe the difference between current resources and projected demand.

Step 4: The VISNs developed market-specific plans to address identified initiatives. A planning decision support system was developed that included forecasted demand and operating, contracting, and capital costs derived from the facilities and markets to create a national methodology for costing alternative approaches. Veteran and stakeholder input was sought and occurred at the national and field levels.

Step 5: The Under Secretary for Health reviewed market plans and developed the Draft National CARES Plan (DNCP), which was issued on August 4, 2003.

Step 6: The CARES Commission, after reviewing the DNCP and other information, conducted its review and analysis and then issued its report to the Secretary with findings and recommendations for enhancing health care services through alignment of VA's capital assets.

Step 7: Secretary's decision was made to accept, reject, or ask for additional information on the Commission's recommendations.

Step 8: The VISNs prepared detailed implementation plans and submitted them to the Secretary for approval.

Step 9: In the final step, VISN planning initiatives and solutions were refined and integrated in the annual VA strategic planning cycle.

CARES Commission:

Since the CARES process was primarily a VA-internal planning process, the CARES Commission was established by the Honorable Anthony J. Principi, former VA Secretary, as an independent body to conduct an external assessment of the VA's capital asset needs and validate the findings and recommendations in the DNCP. The Secretary emphasized that the Commission was not expected to conduct an independent review of the VA's medical system. However, as we conducted our analysis of the DNCP, we were expected to maintain a reliance on the views and concerns from individual veterans, veterans service organizations, Congress, medical school affiliates, VA employees, local government entities, affected community groups, Department of Defense (DoD), and other interested stakeholders.

The CARES Commission's journey began in February, 2003. Even from the onset it was clear to the Commission that the goal of CARES was to enhance services to veterans; not to save money—rather, to spend appropriated funds wisely.

In fulfilling our obligation, Commissioners:

- visited 81 VA and DoD medical facilities and State Veterans Homes;
- held 38 public hearings across the country, with at least one hearing per VISN;
- held 10 public meetings; and
- analyzed more than 212,000 comments received from veterans, their families, and stakeholders.

At the public hearings, the Commission had the opportunity to hear from approximately 770 invited local speakers, including VISN leadership, veterans and their families, veterans service organizations, State directors of veterans' affairs, local labor organizations, medical schools, nursing schools and other allied health professional affiliates, organizations with collaborative relationships including the DoD, and local elected officials. Seven Governors and 135 Members of Congress participated or provided statements for Commission hearings.

On February 12, 2004, I presented The CARES Commission Report to Secretary Principi. The Commission's findings were grounded on the compilation of information gathered at the site visits, public hearings, and meetings as well as information obtained from the public comments and the VA. It represented the best collective judgment of the Commissioners, who applied their diverse expertise in making decisions related to the future of the VA's infrastructure.

Mr. Chairman, with this historical perspective in mind, I would like to now focus my testimony on two key areas that formed the foundation, I believe, of the Commission's efforts and that enabled us to present the independent assessment demanded by our charter. These foundation areas are: the Commission's goals and the review of the VA CARES model by outside experts.

Commission's Goals:

Mr. Chairman, the Commission established several critical goals in order to sustain the highest standard of credibility to our efforts. First, we maintained an objective point-of-view in order to give an effective external perspective to the VA CARES process. We set goals to focus on accessibility, quality, and cost effectiveness of care that were needed to serve our Nation's veterans. We held a clear line of sight on the integrity of VA's health care mission and its other missions. Additionally, since the VA is more than bricks and mortar, the Commission thoughtfully sought input from stakeholders to minimize any adverse impact on VA staff and affected communities. Moreover, it was the Commission's desire to make findings and recommenda-

tions that would provide the VA with a road map for strategically evaluating VA's capital needs into the future.

VA CARES Demand Model:

During the development of the VISN planning initiatives and ultimately the DNCP, the VA CARES demand model was the foundation for projecting the future enrollment of veterans, their utilization of certain inpatient and outpatient health care services, and the unit cost of such services. The Commission did not participate in the development of the model, or the application of the model at the VISN level. The Commission's role, however, was to review data and analyses based on the model.

Because the CARES demand model was such an integral component in the development of the VA's CARES market plans, the Commission wanted a high level of confidence in the reasonableness of the model as an analytic approach to projecting enrollment and workload. For this reason and to foster the Commission's goal to sustain credibility, the Commission engaged outside experts to examine and explain the technical aspects of the model. With the help of outside experts the Commission sought assurance that the CARES model was:

- Logical: internally consistent and coherent;
- Auditable: open to scrutiny and examination;
- Comparable: consistent with known methods or techniques in common analytical practice;
- Defendable: given the range of alternatives available;
- Robust: flexible to use for projecting uncertain future scenarios;
- Timely: data used are applicable to the current environment; and
- Verified and Validated: tested to ensure data used were not skewed in some way.

Based on the experts' analyses, the Commission found the CARES model did, in fact, serve as a reasonable analytical approach for estimating VA enrollment, utilization and expenditures. However, there were lingering concerns noted in the Commission's report relating to projecting utilization of specialized inpatient and outpatient services, notably outpatient mental health services, and inpatient long-term care services (including geriatric and seriously mentally ill care).

Let me elaborate. The CARES demand model projected only certain inpatient and outpatient services, such as surgical services and primary care services. During the Commission's assessment we found that the initial CARES projections underestimated the demand for outpatient mental health services as well as long-term mental health services. Additionally, the Commission noted that projections for long-term care, including nursing home, domiciliary, and non-acute inpatient and residential mental health services, were not included in the CARES projections due to the absence of an adequate model to project future need for these services. In the case of these noted areas the Commission made recommendations for immediate corrective action and development of new planning initiatives.

Prospective Observations

Mr. Chairman, to this point I have provided you and the Subcommittee with a retrospective look at CARES and have highlighted key areas of the Commission's efforts. In discussing the Commission's efforts today, I need to remind everyone that the Commission's findings and recommendations were based on data, analyses and information that are more than 5 years old. As you can appreciate veterans' medical needs, when combined with advances in medicine, psychiatry, medical technology and health care in general, could make some of the Commission's findings outdated.

As you are aware, veterans returning home from the wars in Iraq and Afghanistan often go to the VA for specialized inpatient and outpatient medical care to facilitate their physical and emotional recovery. The experience in recent years as a result of the nature of the Iraq and Afghanistan wars, and with the advances in combat medicine, have meant that VA is caring for patients with injuries far more complex than ever before, such as traumatic brain injuries (TBI) and polytraumatic injuries. For these visible wounds of war the VA has responded by establishing state-of-the art Polytrauma Rehabilitation Centers and a diverse supportive system of care that approaches the limits of modern medicine and knowledge in treating and caring for these patients.

Of equal significance, the nature of the Iraq and Afghanistan conflicts has placed an emphasis on improving combat and VA health care to treat PTSD, suicide prevention, and other mental health concerns—the invisible wounds of war. Because symptoms of PTSD, suicide and other mental illness may manifest over time, effec-

tive mental health treatment requires appropriate access to a full continuum of mental health services. The DoD and VA are responding by enhancing psychiatric and mental health programs and policies, particularly for PTSD and suicide prevention.

I would suggest that if a "CARES Commission" were chartered today, it would likely assess how the VA integrates advancements in medicine, psychiatry, science, and health care in the strategic and resource planning processes. Reflecting on the importance of the CARES demand model in earlier planning efforts, a "CARES Commission" would likely verify that VA has addressed previously noted shortcomings in estimating outpatient mental health and inpatient long-term care services to ensure that the infrastructure planning is keeping pace with mental health demand and that VA and DoD are capitalizing on shared treatment capabilities. A Commission might also review the modeling of polytrauma care, including long-term rehabilitation care to validate that VA long-term care facilities are being transformed to embrace the long-term care for younger generation of veterans with young families while maintaining a strong sense of commitment to geriatric long-term care.

Closing

Mr. Chairman, this concludes my testimony. I again want to thank you for allowing me to address the Subcommittee.

Prepared Statement of Mark L. Goldstein, Director, Physical Infrastructure, U.S. Government Accountability Office

VA HEALTH CARE: OVERVIEW OF VA'S CAPITAL ASSET MANAGEMENT

GAO Highlights

Why GAO Did This Study

Through its Veterans Health Administration (VHA), the Department of Veterans Affairs (VA) operates one of the largest integrated health care systems in the country. In 1999, GAO reported that better management of VA's large inventory of aged capital assets could result in savings that could be used to enhance health care services for veterans. In response, VA initiated a process known as Capital Asset Realignment for Enhanced Services (CARES). Through CARES, VA sought to determine the future resources needed to provide health care to our Nation's veterans.

This testimony describes (1) how CARES contributes to VHA's capital planning process, (2) the extent to which VA has implemented CARES decisions, and (3) the types of legal authorities that VA has to manage its real property and the extent to which VA has used these authorities. The testimony is based on GAO's body of work on VA's management of its capital assets, including GAO's 2007 report on VA's implementation of CARES (GAO–07–408).

What GAO Recommends

GAO is not making recommendations in this testimony, but has previously made a number of recommendations regarding VA's capital asset management. VA is at various stages of implementing those recommendations.

What GAO Found

The CARES process provides VA with a blueprint that drives VHA's capital planning efforts. As part of the CARES process, VA adapted a model to estimate demand for health care services and to determine the capacity of its current infrastructure to meet this demand. VA continues to use this model in its capital planning process. The CARES process resulted in capital alignment decisions intended to address gaps in services or infrastructure. These decisions serve as the foundation for VA's capital planning process. According to VA officials, all capital projects must be based on demand projections that use the planning model developed through CARES.

VA has started implementing some CARES decisions, but does not centrally track their implementation or monitor the impact of their implementation on its mission. VA is in varying stages (e.g., planning or construction) of implementing 34 of the major capital projects that were identified in the CARES process and has completed 8 projects. Our past work found that, while VA had over 100 performance measures to monitor other agency programs and activities, these measures either did not directly link to the CARES goals or VA did not use them to centrally monitor the implementation and impact of CARES decisions. Without this information, VA could not readily assess the implementation status of CARES decisions, determine the impact of such decisions, or be held accountable for achieving the intended results of

CARES. VA has recently created the CARES Implementation Working Group, which has identified performance measures for CARES and will monitor the implementation and impact of CARES decisions in the future.

VA has a variety of legal authorities available, such as enhanced-use leases, sharing agreements, and others, to help it manage real property. However, legal restrictions and administrative- and budget-related disincentives associated with implementing some authorities affect VA's ability to dispose and reuse property in some locations. For example, legal restrictions limit VA's ability to dispose of and reuse property in West Los Angeles and Sepulveda. Despite these challenges, VA has used these legal authorities to help reduce underutilized space (i.e., space not used to full capacity). In 2008, we reported that VA reduced underutilized space in its buildings by approximately 64 percent from 15.4 million square feet in fiscal year 2005 to 5.6 million square feet in fiscal year 2007. While VA's use of various legal authorities likely contributed to VA's overall reduction of underutilized space since fiscal year 2005, VA does not track the overall effect of using these authorities on space reductions. Not having such information precludes VA from knowing what effect these authorities are having on reducing underutilized or vacant space or knowing which types of authorities have the greatest effect. According to VA officials, VA will institute a system in 2009 that will track square footage reductions at the building level.

Mr. Chairman and Members of the Subcommittee:

We appreciate the opportunity to testify on the Department of Veterans Affairs' (VA) management of its capital assets. As you know, VA operates one of the largest health care systems in the country. VA, through its Veterans Health Administration (VHA), provided health care to almost 5.5 million veterans in 2008.[1] To support its mission, VA has a large inventory of real property—including over 150 medical centers and over 900 outpatient and ambulatory care clinics. However, many of VA's facilities were built more than 50 years ago and are not well suited to providing accessible, high-quality, cost-effective health care in the 21st century. In 1999, we reported that with better management of its large, aged capital assets, VA could significantly reduce the funding used to operate and maintain underused, unneeded, or inefficient properties.[2] We further noted that the savings could be used to enhance health care services for veterans. Thus, we recommended that VA develop market-based plans for realigning its capital assets. In response, VA initiated a process known as Capital Asset Realignment for Enhanced Services (CARES)—a comprehensive, long-range assessment of its health care system's capital asset requirements. The CARES process included nine distinct steps and required the time and expertise of many VA officials at the departmental and network levels.[3] (See table 1.)

Table 1: Steps of the CARES Process

Step 1:	VA officials at the departmental and network level develop market areas and submarkets as the planning units for analyzing veterans' needs.
Step 2:	VA officials at the departmental level conduct market analyses of veterans' health care needs using standardized forecasts of enrollment and service needs and actuarial data.
Step 3:	VA officials at the departmental level identify planning initiatives that addressed apparent gaps between supply and demand in resources for each market area.
Step 4:	VA officials at the Network level consider different alignment alternatives and develop specific plans for individual markets that addressed all the planning initiatives identified by VA officials at the departmental level.

[1] VHA is primarily responsible for VA's health care delivery to the veterans enrolled for VA health care services and operates the majority of VA's capital assets.

[2] GAO, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T–HEHS–99–83 (Washington, D.C.: Mar. 10, 1999).

[3] VA's health care delivery system is divided into 21 health care delivery networks. For example, one network serves veterans in Alabama, Georgia, and South Carolina.

Table 1: Steps of the CARES Process—Continued

Step 5:	The Under Secretary of Health uses the market plans to prepare a Draft National CARES Plan (DNCP) and recommendations.
Step 6:	The Secretary of Veterans Affairs appoints a commission composed of non-VA executives to make recommendations to the Secretary to accept, present alternatives to, or reject the recommendations contained in the DNCP.
Step 7:	The Secretary of Veterans Affairs decides whether to accept, reject, or modify the commission's recommendations concerning the DNCP.
Step 8:	Network officials implement the Secretary's decisions.
Step 9:	VA officials at the departmental level refine and incorporate CARES planning initiatives into the annual strategic planning cycle.

Source: VA.

According to VA, the CARES process was a onetime major initiative. However, its lasting result was to provide a set of tools and processes that allow VA to continually determine the future resources needed to provide health care to our Nation's veterans. In May 2004, the Secretary stated that implementing CARES decisions will require an additional investment of approximately $1 billion per year for at least the next 5 years, with substantial infrastructure investments then continuing for the indefinite future, to modernize VA's aging infrastructure. Although CARES will require substantial investment, the Secretary noted that not proceeding with CARES would require funding to maintain or renovate obsolete facilities and would leave VA with numerous redundant, outmoded, or poorly located facilities. The Secretary further stated that through the CARES process, VA had developed more complete information about the demand for VA health care and a more comprehensive assessment of its capital assets than it had ever done before. The Secretary noted that this information, along with the experience gained through conducting CARES, positioned VA to continue to expand the accuracy and scope of its planning efforts.

In my statement today, I will discuss (1) how CARES contributes to VHA's capital planning process, (2) the extent to which VA has implemented CARES decisions, and (3) the types of legal authorities that VA has to manage its real property and the extent to which VA has used its authorities to reduce underutilized and vacant property. My comments are based on our extensive body of work on VA's management of its capital assets, including recent reviews of VA's implementation of CARES and management of real property, as well as updated information from VA officials.[4]

Background

Over the past decade, VA's system of health care for veterans has undergone a dramatic transformation, shifting from predominantly hospital-based care to primary reliance on outpatient care. As VA increased its emphasis on outpatient care rather than inpatient care, it was left with an increasingly obsolete infrastructure, including many hospitals built or acquired more than 50 years ago in locations that are sometimes far from where veterans live.

To address its obsolete infrastructure, VA initiated its CARES process—the first comprehensive, long-range assessment of its health care system's capital asset requirements since 1981. CARES was designed to assess the appropriate function, size, and location of VA facilities in light of expected demand for VA inpatient and outpatient health care services through fiscal year 2022. Through CARES, VA sought to enhance outpatient and inpatient care, as well as special programs, such as spinal cord injury, through the appropriate sizing, upgrading, and locating of VA facilities. Table 2 lists key milestones of the CARES process.

[4] GAO, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, T–HEHS–99–83 (Washington, D.C.: Mar. 10, 1999); GAO, *VA Health Care: VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions*, GAO–07–408 (Washington, D.C.: Mar. 21, 2007); GAO, *VA Health Care: Additional Efforts to Better Assess Joint Ventures Needed*, GAO–08–399 (Washington, D.C.: Mar. 28, 2008); and GAO, *Federal Real Property: Progress Made in Reducing Unneeded Property, but VA Needs Better Information to Make Further Reductions*, GAO–08–939 (Washington, D.C.: Sept. 10, 2008). These performance audits and our updated work were conducted in accordance with generally accepted government auditing standards.

Table 2: Key CARES Milestones

Date	Milestone	Description
February 2002	VA announced the results of a pilot CARES study.	The pilot study assessed current and future use of health care assets in the three markets of Network 12, which includes parts of five States: Illinois, Indiana, Michigan, Minnesota, and Wisconsin. It resulted in decisions to realign health care services and renovate or dispose of several buildings consistent with VA's mission and community zoning issues.
August 2003	VA Under Secretary for Health presented the DNCP.	The Under Secretary's DNCP included recommendations about health care services and capital assets in VA's remaining 74 markets. These recommendations reflected input from managers of VA's health care networks.
February 2004	An independent CARES Commission issued recommendations.	An independent 16-member commission appointed by the Secretary of Veterans Affairs issued recommendations to the Secretary based on its review of the DNCP and related documents and information obtained through public hearings, site visits, public meetings, written comments from veterans and other stakeholders, and consultations with experts.
May 2004	VA Secretary announces the CARES decisions.	The Secretary based his decisions on a review of the CARES Commission's recommendations.
January 2005	CARES follow-up studies.	VA awarded a contract for additional studies at 18 VA facilities. These studies included evaluating outstanding health care issues, developing capital plans, and determining the best use for unneeded VA property consistent with VA's mission and community zoning issues.
May 2008	CARES follow-up studies.	All 18 studies are completed.

Source: GAO analysis of VA data.

We have previously reported that a range of capital asset alignment alternatives were considered throughout the CARES process, which adheres to capital planning best practices.[5] Moreover, there was relatively consistent agreement among the DNCP prepared by VA, the CARES Commission appointed by the VA Secretary to make alignment recommendations, and the Secretary as to which were the best alternatives to pursue. Although the Secretary tended to agree with the CARES Commission's recommendations, the extent to which he agreed varied by alignment alternative. In particular, the Secretary always agreed with the Commission's recommendations to build new facilities, enter into enhanced use leases, and collaborate with the Department of Defense and universities, but was less likely to agree with the CARES Commission's recommendations to contract out or close facilities. The decisions that emerged from the CARES process will result in an overall expansion of VA's capital assets. According to VA officials, rather than show that VA should downsize its capital asset portfolio, the CARES process revealed service gaps and needed infrastructure improvements. We also reported that a number of factors shaped and in some cases limited the range of alternatives VA considered during the CARES process. These factors included competing stakeholder interests; facility

[5] GAO–07–408.

condition and location; veterans' access to facilities; established relationships between VA and health care partners, such as DoD and university medical affiliates; and legal restrictions.

The challenge of misaligned infrastructure is not unique to VA. We identified Federal real property management as a high-risk area in January 2003 because of the nationwide importance of this issue for all Federal agencies. We did this to highlight the need for broad-based transformation in this area, which, if well implemented, will better position Federal agencies to achieve mission effectiveness and reduce operating costs. But VA and other agencies face common challenges, such as competing stakeholder interests in real property decisions. In VA's case, this involves achieving consensus among such stakeholders as veterans service organizations, affiliated medical schools, employee unions, and communities. We have previously reported that competing interests from local, State, and political stakeholders have often impeded Federal agencies' ability to make real property management decisions. As a result of competing stakeholder interests, decisions about real property often do not reflect the most cost-effective or efficient alternative that is in the interest of the agency or the government as a whole but instead reflect other priorities. In particular, this situation often arises when the Federal Government attempts to consolidate facilities or otherwise dispose of unneeded assets.[6]

CARES Process and Modeling Tools Drive VHA's Capital Planning Efforts

Through the CARES process, VA gained the tools and information needed to plan capital investments. As part of the CARES process, VA modified an actuarial model that it used to project VA budgetary needs. According to VA, the modifications enabled the model to produce 20-year forecasts of the demand for services and provided for more accurate assessments of veterans' reliance on VA services, capacity gaps, and market penetration rates.[7] The information provided by the model allowed VA to identify service needs and infrastructure gaps, in part by comparing the expected location of veterans and demand for services in years 2012 through 2022 with the current location and capacity of VA health care services within each network. In addition to modifying the model, VA conducted facility condition assessments on all of its real property holdings as part of the CARES process. These assessments provided VA information about the condition of its facilities, including their infrastructure needs. VA continues to use the tools developed through CARES as part of its capital planning process. For example, VA conducts facility condition assessments for each real property holding every 3 years on a rotating basis. In addition, VA uses the modified actuarial model to update its workload projections each year, which are used to inform the annual capital budget process.

The CARES process serves as the foundation for VHA's capital planning efforts. The first step in VHA's capital budget process is for networks to submit conceptual papers that identify capital projects that will address service or infrastructure gaps identified in the CARES process.[8] The Capital Investment Panel, which consists of representatives from each VA administration and staff offices, reviews, scores, and ranks these papers. The Capital Investment Panel also identifies the proposals that will be sent forward for additional analysis and review, and may ultimately be included as part of VA's budget request. According to VA officials, all capital projects must be based on the CARES planning model to advance through VHA's capital planning process. On the basis of CARES-identified infrastructure needs and service gaps, VA identified more than 100 major capital projects in 37 States, the District of Columbia, and Puerto Rico.[9] In addition to these projects, the CARES planning model identified service needs and infrastructure gaps at other locations throughout the VA system. The model is updated annually to reflect new information.

VHA's 5-year Capital Plan outlines CARES implementation and identifies priority projects that will improve the environment of care at VA medical facilities and ensure more effective operations by redirecting resources from the maintenance of vacant and underutilized buildings to investments in veterans' health care. In VA's fiscal year 2010 budget submission, VA requested about $1.1 billion to fund 12 VHA

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[6] GAO, *High-Risk Series: Federal Real Property*, GAO–03–122 (Washington, D.C.: January 2003) and GAO, *Federal Real Property: Progress Made Toward Addressing Problems, but Underlying Obstacles Continue to Hamper Reform*, GAO–07–349 (Washington, D.C.: April 2007).

[7] We did not evaluate the reliability of the model or its projections.

[8] CARES conceptual papers are created at the network level and provide a detailed description of the project, the problem the project will address, and other relevant information.

[9] The term "major capital project" refers to a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $10 million. (See 38 U.S.C. § 8104.) In contrast, a "minor capital project" refers to the construction, alteration, or acquisition of a medical facility involving a total expenditure of $10 million or less.

major construction projects and about $507 million for VHA minor construction projects.

Some CARES Decisions Implemented, But Additional Information Needed to Fully Assess Status and Impact of Decisions

VA has begun implementing some CARES decisions. Specifically, VA is currently in varying stages (e.g., planning or construction) of implementing 34 of the major capital projects that were identified in the CARES process. Eight major capital CARES projects are complete.

Although VA is moving forward with the implementation of some CARES decisions, we previously reported that a number of VA officials and stakeholders, including representatives from veterans service organizations and local community groups, view the implementation process as too lengthy and lacking transparency.[10] For instance, stakeholders in Big Spring, Texas, noted that it took almost 2 years for the Secretary to decide whether to close the facility. During this period, there was a great deal of uncertainty about the future of the facility. As a result, there were problems in attracting and retaining staff at the facility, according to network and local VA officials. We also previously reported that a number of stakeholders we spoke with indicated that the implementation of CARES decisions has been influenced by competing stakeholders' interests—thereby undermining the process.[11] In its February 2004 report, the CARES Commission also noted that stakeholder and community pressure can act as a barrier to change, by pressuring VA to maintain specific services or facilities.

In 2007, we reported that VA does not use, or in some cases does not have, performance measures to assess its progress in implementing CARES or whether CARES is achieving the intended results. Performance measures allow an agency to track its progress in achieving intended results. Performance measures can also help inform management decisionmaking by, for example, indicating a need to redirect resources or shift priorities. In addition, performance measures can be used by stakeholders, such as veterans service organizations or local communities, to hold agencies accountable for results. Although VA has over 100 performance measures to monitor other agency programs and activities, these measures either do not directly link to the CARES goals or VA does not use them to centrally monitor the implementation and impact of CARES decisions.[12] We also reported that VA lacked critical data, including data on the cost of and timelines for implementing CARES projects and the potential savings that can be generated by realigning resources.

Given the importance of the CARES process, we previously recommended that VA develop performance measures for CARES. Such measures would allow VA officials to monitor the implementation and impact of CARES decisions as well as allow stakeholders to hold VA accountable for results. In responding to our recommendation, VA created the CARES Implementation Monitoring Working Group. This working group has identified performance measures for CARES and the group will monitor the implementation and impact of CARES decisions.

VA Has a Variety of Legal Authorities to Manage Real Property, But Does Not Track How Using Them Contributes to the Reduction in Underutilized Property

VA has a variety of legal authorities available to help it manage real property. These authorities include enhanced-use leases (EUL), sharing agreements, and outleases. (See table 3 for descriptions of these authorities.) VA uses these authorities to help reduce underutilized and vacant property. For example, in 2005, in Lakeside (Chicago), Illinois, VA reduced its underutilized property at the medical center by nearly 600,000 square feet by using its EUL authority with Northwestern Memorial Hospital. VA also uses these authorities to generate financial benefits. For example, the VA Greater Los Angeles Healthcare System enters into a number of sharing agreements with the film industry. VA officials told us that these agreements are typically temporary arrangements—sometimes lasting a few days—during which film production companies use VA facilities to shoot television or movie scenes. According to VA officials, these agreements generate roughly $1 million to $2 million a year.

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[10] GAO–07–408.

[11] GAO–07–408.

[12] Officials from the Office of Asset Enterprise Management told us that they had information on the status of CARES projects that were included in the 5-year capital plan, but that they did not track the status of all CARES decisions.

Table 3: Major Types of Authorities Available to VA

Authority	Definition	Proceeds
Enhanced-use leases (EUL) 38 U.S.C. §§ 8161–8169	VA leases underutilized or vacant property to a public or private entity for up to 75 years if the agreement enhances the use of the property or results in an improvement of services to veterans in the network in which the property is located. The EUL shall be for fair consideration, and lease payments may be monetary or be made for in-kind consideration, such as construction, repair, or remodeling of Department facilities; providing office, storage, or other usable space; or for services, programs, or facilities that enhance services to veterans.	Proceeds generated from the EUL are used to pay for expenses incurred by VA in connection with the EUL and can be used for any expense incurred in the development of future EULs. Any remaining funds are to be deposited in the VA Medical Care Collections Fund. At the discretion of the VA Secretary, proceeds also may be deposited into construction major project and construction minor project accounts to be used for construction, alterations, and improvements of any medical facility.
Sharing agreements 38 U.S.C. §§ 8151–8153	VA may enter into sharing agreements to provide the use of VHA space (including parking, recreational facilities, and vacant land) for the benefit of veterans or nonveterans in exchange for payment or services if VA's resources would not be used to their maximum effective capacity and would not adversely affect the care of veterans. Sharing agreements do not convey an interest in real property and can be entered into for up to 20 years, with the initial term not to exceed 5 years.	Proceeds generated from sharing agreements are to be credited to the applicable Department medical appropriation of the facility that furnished the space.
Outlease 38 U.S.C. § 8122 38 U.S.C. § 2412	VA's outlease-related authorities include the following: *Outlease:* VA may lease real property to public or private interests outside of VA for up to 3 years, or up to 10 years for a National Cemetery Administration (NCA) property. Lease payments may be made for maintenance, protection, or restoration of the property as part of the consideration of the lease. *License:* Gives a nonfederal party permission to enter upon and do a specific act or series of acts upon the land without possessing or acquiring any estate therein. A license can be revoked at any time.	Proceeds generated from outleases of VHA space, minus expenses for maintenance, operation, and repair of buildings leased for building quarters, are deposited into the Department of the Treasury as miscellaneous receipts. Proceeds generated from outleases of NCA property are to be deposited into the NCA Facilities Operation Fund and are available for costs incurred by NCA for operations and maintenance of NCA property. Proceeds generated from licenses and permits are deposited into the Department of the Treasury.

Table 3: Major Types of Authorities Available to VA—Continued

Authority	Definition	Proceeds
	Permit: Gives another Federal agency permission to enter upon and do a specific act or series of acts upon the land without possessing or acquiring any estate therein. The permit can be revoked at any time.	

Source: GAO.

However, legal restrictions associated with implementing some authorities affect VA's ability to dispose of and reuse property in some locations. For example, legal restrictions limit VA's ability to dispose of and reuse property in West Los Angeles and North Hills (Sepulveda) California. The Cranston Act of 1988 precluded VA from taking any action to dispose of 109 of 388 acres in the West Los Angeles medical center and 46 acres of the Sepulveda ambulatory care center.[13] In 1991, when EUL authority was provided to VA, VA was prohibited from entering into any EUL relating to the 109 acres at West Los Angeles unless the lease was specifically authorized by law or for a childcare center.[14] The Consolidated Appropriations Act of 2008 expanded the EUL restrictions to include the entire West Los Angeles medical center.[15] The Consolidated Appropriations Act of 2008 also prohibits VA from declaring as excess or otherwise taking action to exchange, trade, auction, transfer, or otherwise dispose of any portion of the 388 acres within the VA West Los Angeles medical center.

Budgetary and administrative disincentives associated with some of VA's available authorities may also limit VA's ability to use these authorities to reduce its inventory of underutilized and vacant property. For example:

- VA cannot retain revenue that it obtains from outleases, revocable licenses, or permits; such receipts must be deposited in the Department of the Treasury.[16] VA has said that, except for EUL disposals, restrictions on retaining proceeds from disposal of properties are a disincentive for VA to dispose of property.[17]
- In 2004, VA was authorized until 2011 to transfer real property under its jurisdiction or control and to retain the proceeds from the transfer in a capital asset fund for property transfer costs, including demolition, environmental remediation, and maintenance and repair costs.[18] In our previous work, we reported several administrative and oversight challenges with using capital asset funds.[19] Moreover, VA officials told us that this authority has significant limitations on the use of any funds generated by disposal. For example, VA officials we spoke with reported that the capital asset fund is too cumbersome to be used, and VA does not have immediate access to the funds because they have to be reappropriated before VA can use them.
- The maximum term for an outlease, according to VHA law, is 3 years; according to VA officials, this time limit can discourage potential lessees from investing in the property.
- Implementing an EUL agreement can take a long time. According to VA officials, EULs are a relatively new tool, and every EUL is unique and involves a learning process. In addition, VA officials commented that the EUL process can be complicated. According to VA officials, the average time it takes to implement an EUL can range generally from 9 months to 2 years. The officials noted that land due diligence requirements (such as environmental and historic reviews), public hearings, Congressional notification, lease drafting, negotiation, and other phases contribute to the length of the overall process. VA has taken actions to reduce the time it takes to implement an EUL agreement, but despite changes to streamline the EUL process, some officials stated that it is still time consuming and cumbersome.

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[13] P.L. No. 100–322, Section 421(b)(2), 102 Stat. 487, 553 (1988).
[14] 38 U.S.C. § 8162(c).
[15] P.L. No. 110–161, Section 224(a), 121 Stat. 1844, 2272 (2007).
[16] 38 U.S.C. § 8122.
[17] 38 U.S.C. § 8164.
[18] 38 U.S.C. § 8118.
[19] GAO, *Capital Financing: Potential Benefits of Capital Acquisition Funds Can Be Achieved through Simpler Means*, GAO–05–249 (Washington, D.C.: Apr. 8, 2005).

- VA can dispose of underutilized and vacant property under the McKinney-Vento Act to other Federal agencies and programs for the homeless.[20] However, VA officials stated that disposing of property under the McKinney-Vento Act also can be time-consuming and cumbersome.[21] According to VA officials, the process can average 2 years. Under this law, all properties that the Department of Housing and Urban Development deems suitable for use by the homeless go through a 60-day holding period, during which the property is ineligible for disposal for any other purpose. Interested representatives of the homeless submit to the Department of Health and Human Services (HHS) a written notice of their intent to apply for a property for homeless use during the 60-day holding period. After applicants have given notice of their intent to apply, they have up to 90 days to submit their application to HHS, and HHS has the discretion to extend the timeframe if necessary. Once HHS has received an application, it has 25 days to review, accept, or decline the application.

Furthermore, according to VA officials, VA may not receive compensation from agreements entered into under the McKinney-Vento Act.

Despite these challenges, VA has used these legal authorities to help reduce its inventory of unneeded space. In 2008, we reported that VA reduced underutilized space (i.e., space not used to full capacity) in its buildings by approximately 64 percent from 15.4 million square feet in fiscal year 2005 to 5.6 million square feet in fiscal year 2007.[22] Although the number of vacant buildings decreased over the period, the amount of vacant space remained relatively unchanged at 7.5 million square feet. We estimated VA spent $175 million in fiscal year 2007 operating underutilized or vacant space at its medical facilities.[23]

While VA's use of various legal authorities, such as EULs and sharing agreements, likely contributed to VA's overall reduction of underutilized space since fiscal year 2005, VA does not track the overall effect of using these authorities on its space reductions. Without such information, VA does not know what effect these authorities are having on its effort to reduce underutilized or vacant space or which types of authorities have the greatest effect. We concluded that further reductions in underutilized and vacant space will largely depend on VA developing a better understanding of why changes occurred and what impact these agreements had. Therefore, we recommended in our 2008 report that VA track, monitor, and evaluate square footage reductions and financial and nonfinancial benefits resulting from new agreements at the building level by fiscal year in order to better understand the usefulness of these authorities and their overall effect on VA's inventory of underutilized and vacant property from year to year.[24] The officials said that tracking financial benefits will require a real property cost accounting system which VA is in the process of developing. According to VA officials, VA will institute a system in June 2009 that will track square footage reductions at the building level, but the system will not track financial benefits at this level.

Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to questions from you or other Members of the Subcommittee.

GAO Contact and Staff Acknowledgments

For further information on this statement, please contact Mark L. Goldstein at (202) 512–2834 or goldsteinm@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony were Nikki Clowers, Hazel Gumbs, Edward Laughlin, Susan Michal-Smith, and John W. Shumann.

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[20] VA properties that are leased to another party under an EUL are not considered to be unutilized or underutilized for purposes of the McKinney-Vento Act (see 38 U.S.C. § 8162).

[21] We have reported elsewhere on this process. See GAO, *Federal Real Property: Most Public Benefit Conveyances Used as Intended, but Opportunities Exist to Enhance Federal Oversight*, GAO–06–511 (Washington, D.C.: June 21, 2006).

[22] See GAO–08–939. The underutilized square footage numbers that we report are different from those that VA reports. Our analysis only included underutilized square feet, whereas when VA measures its rate of utilization, it adds together underutilized square feet and overutilized square feet (additional square feet needed at a facility).

[23] GAO developed this estimate because VA does not track the cost of operating underutilized and vacant building space at the building level and has not developed a reliable method for doing so.

[24] GAO–08–939.

Prepared Statement of Donald H. Orndoff,
AIA Director, Office of Construction and Facilities Management,
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Mr. Chairman and Members of the Committee, I am pleased to appear today to discuss the status of the Department of Veteran Affairs' (VA) health care infrastructure, our strategic facilities planning process, our facility design objectives, our acquisition strategies, and our proposed Fiscal Year 2010 budget. Joining me today are Brandi Fate, Director of the Veterans Health Administration's (VHA's) Office of Capital Asset Management and Planning Service; James M. Sullivan, Director of VA's Office of Asset Enterprise Management; and Lisa Thomas, Ph.D., FACHE, Director of VHA's Office of Strategic Planning and Analysis.

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 (owned and leased). The average age of VA facilities is well over 50 years. Our older facilities were not designed to meet the changing demands of clinical care in the 21st century. Therefore, VA's continuing program of recapitalization of these aging assets is very important to providing world-class health care to veterans now and into the future.

Current Major Construction Program

The Department is currently implementing its largest capital investment program since the immediate post-World War II period. Since 2004, VA has received appropriations totaling $4.6 billion for health care projects, including 51 major construction projects for new or improved facilities across the Nation. These projects include new and replacement medical centers; polytrauma rehabilitation centers, spinal cord injury centers; ambulatory care centers; new inpatient nursing units; and projects to improve the safety of VA facilities. Thirty-six of the 51 projects have been fully funded at a total cost of approximately $3.1 billion. The remaining 15 projects have received partial funding totaling $1.6 billion against a total estimated cost of $4.5 billion. For these larger projects, VA requests design and construction funding in increments aligned with the projected multi-year acquisition schedule.

Background: CARES

In 2000, the Veterans Health Administration (VHA) embarked on the Capital Asset Realignment for Enhanced Services (CARES) process to provide a data-driven assessment of veterans' health care needs and to guide the strategic allocation of capital assets to support delivery of health care services over the next 20 years. The CARES program assessed veterans' health care needs in each Veterans Integrated Service Network (VISN), identified service delivery options to meet those needs, and promoted strategic realignment of capital assets to satisfy identified needs. The goal was to improve access and quality of health care in the most cost effective manner, while mitigating impacts on staffing, communities, and on other VA missions.

VA began the CARES process in 2000 with a regional pilot, then in 2002 expanded nationally. In 2003, VA released its Draft National CARES plan and created the CARES Commission, an independent panel established to review VA's plans. The Secretary published his decisions in May 2004 and identified 18 sites whose complexity warranted additional study. VA completed these studies in May 2008. One output of the CARES process is the development of a Five-Year Capital Plan that lists and ranks specific major construction projects.

Today: Strategic Facilities Planning Process

The lessons learned through CARES are now incorporated into VA's strategic health care and facilities planning process. VHA no longer distinguishes between CARES and non-CARES planning as the tools and techniques acquired through CARES have become part of our standard operating procedures for strategic planning within our health care system.

VA uses a multi-characteristic decision methodology in prioritizing its capital investment needs. Appropriate "joint" VA–DoD projects are evaluated to promote sharing and efficiency opportunities. Through this strategic facilities planning process, VA annually updates its Five-Year Capital Plan, which supports the development of VA's annual capital acquisition funding request.

VHA employs its Health Care Planning Model to strategically assess demographic data, anticipated workload, and actuarial projections for health care services. VHA compares this data to its capital asset inventory to identify gaps in capability. To close gaps, VHA develops investment solutions that may become capital infrastruc-

ture projects. All proposed projects undergo thorough cost effectiveness, risk, and alternatives analyses.

The Department's Capital Investment Panel (CIP) reviews, scores, and priority ranks potential projects based on criteria considered essential to providing high-quality health care services. The scoring criteria include enhancement of service delivery, meeting workload projections, safeguarding assets, supporting special emphasis programs, addressing capital asset management priorities, promoting department alignment, and eliminating facility deficiencies. The CIP integrates both new and existing program requirements into a single prioritized project list.

The CIP reports its analysis to the Strategic Management Council (SMC) for review. The SMC is VA's governing body responsible for overseeing VA's capital programs and initiatives. The SMC submits its recommendations to the Secretary, who makes the final decision on which projects to include in the budget.

Project Design Goal: High-Performance Medical Facilities

New VA medical facilities will contribute to world-class health care for veterans today, tomorrow, and well into the 21st century. Our design goal is to deliver high-performance buildings that are:

- Functional, providing cutting-edge clinical spaces that leverage the latest medical technologies to produce the highest possible health care outcomes.
- Cost efficient, incorporating evidence-based design for clinical spaces that are efficiently sized and configured to maximize clinical capability for invested capital.
- Veteran-centric, placing special emphasis on design that is veteran patient and family centered. Buildings welcome patients and visitors with effective way finding, open circulation and waiting areas, and expected amenities.
- Adaptable, creating buildings that will serve generations of veterans not yet born. Our buildings must be flexible to adapt and support continual changing clinical practices, advancing technology, and medical research. Buildings are designed with engineering systems organized in interstitial levels between occupied floors to enable rapid and less expensive reconfiguration of clinical spaces.
- Sustainable, setting a standard of designing our medical centers to a minimum Leadership in Environmental and Energy Design (LEED) Silver level as defined by the U.S. Green Building Council, and following all relevant Executive Orders, including the High Performance & Sustainable Buildings Guidance required under E.O. 13423.
- Energy efficient, designing new facilities to meet or exceed energy reduction targets of the Energy Policy Act of 2005 and related Executive Orders, shrinking energy use 30 percent below American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards. VA is committed to incorporating renewable energy technologies in the design of new or renovated facilities.
- Physically secure, ensuring medical facilities are designed to fully comply with stringent physical security guidelines for mission critical, high-occupancy Federal facilities. This includes hardened structures, perimeter and access control, redundancy and modularity. Water storage, emergency power, and fuel supplies are sized to enable continued health care operations for 4 days in the face of natural or man-made disaster.

Acquisition Strategies

VA uses a range of acquisition tools that are tailored to best satisfy the unique requirements of each project.

For design acquisition, VA selects partners through a targeted Architect/Engineer (A/E) contract solicitation. Our selection process values past performance and experience on health care projects of similar complexity. We carefully evaluate the experience and capabilities of the key members of the proposed design team. We require our design partners to leverage the power of Building Information Modeling (BIM) as a common communication and collaboration tool. We engage peer review from separate A/E firms to assist the owner's review of proposed design solutions in meeting required design criteria and standards.

For construction acquisition, VA uses a range of contract vehicles, including:

- Design-Bid-Build, where we fully develop the project design and use best value selection process, which assesses both technical and cost proposals. We typically use this contract vehicle for large, complex medical facility projects, such as large medical clinics.

- Design-Build, where a single contractor performs both the design development and the construction. We typically use this approach for smaller, less complex projects, such as parking structures.
- Integrated Design-Construct, where we bring the general contractor on board early in the design process, initially performing construction management functions, then construction work as design packages become available. This is VA's version of CM@Risk approach that is widely used in the private sector of the construction industry. We plan to use this use approach on our largest, most complex projects, such as new medical centers.
- Operating Leases, where we engage a developer to act as owner, designer, and constructor of "build to suit" leases. VA pays annual lease payments for terms up to 20 years. We typically use this strategy for smaller projects where VA does not currently own property, such as outpatient clinics.
- Construction Management, where we augment our capacity to perform the important owner role for cost analysis, schedule control, and field testing. We typically use CM support on larger, more complex projects, such as new medical centers.

VA is a leader among Federal agencies in meeting socio-economic goals for small business categories. We place special emphasis on contracting with veteran-owned businesses, especially service disabled veteran-owned businesses.

Fiscal Year 2010 Request

VA's FY10 budget request continues our recapitalization effort supported by our strategic facilities planning process.

VA requests $1.1 billion in FY 2010 for major construction to replace or enhance VA medical facilities. Of this amount, $649 million provides construction funding for five ongoing projects at Denver, CO; Orlando, FL; San Juan, PR; St. Louis (JB), MO; and Bay Pines, FL. Another $211 million will design seven new projects at Livermore, CA; Canandaigua, NY; San Diego, CA; Long Beach, CA; St. Louis (JC), MO; Brockton, MA; and Perry Point, MD. The remainder of the major construction request will provide funds for advance planning, facility security, judgment fund and land acquisition needs.

VA requests $196 million authorization for 15 new major medical leases. Lease projects are located at Anderson, SC; Atlanta, GA; Bakersfield, CA; Birmingham, AL; Butler, PA; Charlotte, NC; Fayetteville, NC; Huntsville, AL; Kansas City, KS; Loma Linda, CA; McAllen, TX; Monterey, CA; Montgomery, AL; Tallahassee, FL; and Winston-Salem, NC.

Conclusion

In closing, I thank the Committee for its continued support to improve the Department's physical infrastructure to meet the changing needs of America's veterans. We look forward to continuing to work with the Committee on these important issues. Thank you for the opportunity to appear before the Committee today. My colleagues and I stand ready to answer your questions.

POST–HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 18, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Shinseki:

Thank you for the testimony of Donald H. Orndoff, Director of the Office of Construction and Management at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Oversight Hearing on "Assessing CARES and the Future of VA's Health Infrastructure" that took place on June 9, 2009.

Please provide answers to the following questions by July 30, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. How does VA collaborate and coordinate with Federal Qualified Health Care Centers to increase the access points for obtaining health care?
2. In their testimony, GAO highlighted that VA has a variety of legal authorities to manage real property, but does not track how using them contributes to the reduction in underutilized property. What is your response?
3. Since the release of the May 2004 CARES report, has VA delivered on the CARES promise?
   a. Which decisions has VA implemented and which have yet to be implemented? What are the reasons for the delay in moving forward with the decisions which have not been implemented, to date?
   b. Which CARES decisions has VA changed course on? What are the reasons for this reversal?
4. The prolonged implementation process leads to a great deal of uncertainty about the future of the facility so that it leads to staff retention issues and, more importantly, leaves our veterans without access to a health care facility. What is your response to these concerns? What steps is VA taking to ensure timely construction of VA medical facilities?
5. How much did VA spend to develop the CARES report? At the time of the CARES report, did VA estimate the funding needed to fully implement each of the capital planning decisions for inpatient and outpatient care? How much has VA spent, to date, on the implementation of the CARES decision? What additional funding is needed to complete the implementation of the CARES decision?
6. VA's testimony states that "the tools and techniques acquired through CARES" have been integrated into VA's standard operating procedure with regard to strategic planning. How has this process changed from before CARES?
7. VA's testimony stresses the importance of ensuring that VA facilities are adaptable so that they may seamlessly accommodate the development of new clinical practices and technology. Can you elaborate on how VA ensures that its facilities meet this standard of flexibility?

Additionally, please answer the following question from Congressman Joe Donnelly for Lisa Thomas, Director of the Veterans Health Administration's Office of Strategic Analysis and Planning.

Dr. Lisa Thomas, I am a firm believer in optimizing health care and making sure veterans get the most accessible, highest-quality care we can give them with the resources with which we are entrusted. Accessibility to specialty care is an issue of particular concern to my district and to many districts nationwide. For example, St. Joseph County in my district has a population of more than a quarter million people, yet area veterans must too often drive more than 2 hours each way to get to

the nearest VA hospital for specialty care. While there is an excellent outpatient clinic in South Bend, it is unable to provide many needed services.

I am very pleased that the VA will open a new expanded health center in South Bend for outpatient and specialty care in 2012. The authorized facility will be 60–70,000 square feet and more than 10 times bigger than our current CBOC. The outpatient facility will provide comprehensive examination services in cardiology, podiatry, outpatient surgery and other medical specialties, wellness programs and ultrasound exams. Special services will also be available for newly returning veterans from Iraq and Afghanistan. Further, VA will contract with local hospitals in the South Bend area to provide inpatient services for area veterans.

I would like to know if the arrangement announced for South Bend might be a model that constitutes future health care that the VA plans to expand on as it looks in the near and long-term for opportunities to provide enhanced quality care and greater access to veterans?

What is the future of enhanced use lease agreements as it pertains to strategic planning and please elaborate on these agreements' worth to VA and possible uses in the future?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by July 30, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
The Honorable Michael H. Michaud, Chairman
Subcommittee on Health, House Committee on Veterans' Affairs
June 9, 2009

Accessing CARES and the Future of VA's Health Infrastructure

Question 1: How does VA collaborate and coordinate with Federal Qualified Health Care Centers to increase the access points for obtaining health care?

Response: When the Department of Veterans Affairs (VA) identifies an area with a demonstrated health care need and engages to expand care in that area, the method for care delivery is determined at the local level, and avenues for delivery of care are considered to close the service gap. The range of initiatives include providing direct care through VA staffed clinics and telehealth, as well as purchasing services with local providers. When the decision is made to purchase care, VA considers all eligible available health care provider options, including Federal Qualified Health Centers (FQHC), to meet the health care needs of veterans living in rural and highly rural areas. In the majority of instances, service delivery decisions are made at the local level.

Although the service delivery decisions are made at the local level, Office of Rural Health (ORH) has collaborated with the Veterans Integrated Service Networks (VISN) and recently funded two projects (in executing of appropriations provided under Public Law 110–329) that collaborate with FQHCs to increase access points to health care.

The Veterans Health Administration (VHA) Office of Geriatrics and Extended Care (GEC) was awarded funding to implement a national initiative to expand Home-Based Primary Care (HBPC) to Community-Based Outpatient Clinics (CBOC). This initiative will support implementation of HBPC in rural and highly rural CBOCs and non-VA community clinics, located across VA's health care system. The expanded service delivery will help to address issues of access and quality of health care for some of our most medically complex veterans. Of the chosen sites, GEC proposes to co-locate their HBPC satellite team in FQHCs and cooperatively recruit staff when feasible.

ORH also awarded funding to VISN 1 for an initiative to extend telemental health in rural Vermont. This initiative will create a partnership with non-Federal entities through a community-based telemental health program and provide access to specialized VA mental health services for veterans where travel to a CBOC is difficult or prohibitive. Services will be provided within existing non-VA community primary care practices in the most rural and inaccessible areas of Vermont and New Hampshire. Interactive audiovisual telecommunications will be used to provide direct care to veterans as well as educate local providers to enhance their ability to recognize

veteran-specific psychological difficulties. The first year will pilot a telemental health link between the White River Junction VA medical center to a FQHC and a community mental health center in Northern Vermont. During the second year, another FQHC will be added in Northern Vermont along with an additional site in New Hampshire. Application of the model to other clinics will be assessed during the second year.

ORH fully supports increasing access points and has implemented several other initiatives to address the needs of veterans in rural areas. Ongoing initiatives include the four rural mobile health clinics located in VISNs 1, 4, 19, and 20, as well as the network of outreach clinics that serve to increase the access to health care for thousands of veterans across the country.

VA and ORH will continue to develop relationships with experts in rural health and in veterans' health to explore, assess, and develop collaborative approaches to providing services for veterans in rural areas.

Question 2: In their testimony, GAO highlighted that VA has a variety of legal authorities to manage real property, but does not track how using them contributes to the reduction in underutilized property. What is your response?

Response: VA uses its various legal authorities for managing its real property, such as enhanced-used leasing (EUL) and disposal authority. VA then tracks the property reductions through the EUL report and the EUL and disposal sections of the capital plan in the annual budget submissions.

GAO in its report entitled *Federal Real Property: Progress Made in Reducing Unneeded Property, but VA Needs Better Information to Make Further Reductions* (GAO–08–939) recommended that VA track, monitor, and evaluate square footage reductions and financial and non-financial benefits when recording new agreements as of FY 2008. VA agreed with GAO's recommendation and VA does track revenue generated, square footage reductions, and services received through agreements, although this is not accomplished systematically. VA produces an annual report on EULs for Congress that describes the financial and non-financial impacts of its EULs. The report includes estimates of the amount of money VA saves on purchasing energy and parking and the value of new services available to veterans or employees as a result of EULs. However, VA does not conduct a similar analysis for other types of agreements, which greatly outnumber the EULs and VA's data systems do not provide information on the non-financial benefits it receives from those agreements. VA will track, monitor, maintain and evaluate square foot reductions and financial and non-financial benefits resulting from agreements for FY 2008 and beyond second quarter FY 2009 to ascertain the cumulative effect of its authorities on underused and vacant property square footage. We will identify baseline space for the buildings and metrics for reductions resulting from agreements.

Milestone	Planned Complete	Actual Complete	Status
Identify buildings and agreements for tracking	3/3/2009	3/30/2009	Complete
Establish baseline space and costs for buildings to be tracked	5/30/2009	5/30/2009	Complete
Establish reporting and analysis for building impacts resulting from agreements	9/30/2009		Pending BI release 1.5 and CAI upgrade
Collect detailed building level costs for tracking agreement impact	9/30/2012		Pending FLITE implementation

Disposal of underutilized space is a major focus area in VA 5-year disposal plans. VA issues a yearly call for disposals, identifying underused and non-mission dependent buildings as potential disposals to the field/Administrations. As summarized below, over the period FY 2009 through FY 2013, VA plans to dispose of 414 buildings (7,145,741 square feet) and 313.5 acres of land.

VA Disposal Plan FY 2009–2013					
FY	**Planned Buildings Total #**	**Total Planned GSF**	**Total # Land Parcels**	**Total Acres**	**Planned Disposals Total #**
2009	139	2,109,466	7	175.46	146
2010	78	765,853	2	66.00	80
2011	111	1,678,038	1	60.00	112
2012	55	827,293	1	12.00	56
2013	31	1,765,091	0	0	31
Total:	**414**	**7,145,741**	**11**	**313.46**	**425**

Question 3(a): Since the release of the May 2004 CARES report, has VA delivered on the CARES promise? Which decisions has VA implemented and which have yet to be implemented? What are the reasons for the delay in moving forward with the decisions which have not been implemented, to date?

Response: VA has made significant progress since 2004 and continues to plan for health care delivery improvements. Since the publication of the Capital Asset Realignment for Enhanced Services (CARES) Decision document in 2004, VA has increased access to primary care, decreased the amount of excess space, and increased the number of special disability programs for veterans. CARES decisions have been delayed for the purposes of additional study and as limited resources have required the prioritization of projects based on service delivery goals.

Further information on the status of individual CARES decisions will be provided in the CARES Implementation Monitoring Report, which is pending release.

Question 3(b): Which CARES decisions has VA changed course on? What are the reasons for this reversal?

Response: CARES identified capital and program requirements at a macro level using health care demand projections for services such as inpatient medicine, surgery and psychiatry, and outpatient primary care, mental health, and specialty care. As analyses of the decisions continued from an operational perspective using updated data, some CARES decisions changed based on feasibility and access improvements where the need was greatest. Further information on the status of individual CARES decisions will be provided in the CARES Implementation Monitoring Report.

Question 4: The prolonged implementation process leads to a great deal of uncertainty about the future of the facility so that it leads to staff retention issues and, more importantly, leaves our veterans without access to a health care facility. What is your response to these concerns? What steps is VA taking to ensure timely construction of VA medical facilities?

Response: Once major construction projects are approved for design, VA is committed to fully funding to completion. There are various reasons the construction appears and realistically is delayed:

- The design phase takes approximately 18 to 24 months; therefore, the construction funds typically follow 2 years after the design year.
- Based on the complexity of the construction and associated equipment, contractors may require the project to be broken into phases, with each phase being funded in annual increments.
- It is expected that the phases listed in VA's major construction budget submission be awarded by year's end. This requires only those buildings and structures that can be obligated by September 2009 be included, which is why we have projects that only construct the energy center and/or parking garage.

It is VA's intent to fully fund all major construction projects as quickly as possible to ensure the most economical cost for each project.

Question 5: How much did VA spend to develop the CARES report? At the time of the CARES report, did VA estimate the funding needed to fully implement each of the capital planning decisions for inpatient and outpatient care? How much has VA spent, to date, on the implementation of the CARES decision? What additional funding is needed to complete the implementation of the CARES decision?

Response: VA engaged in six contracts to assist the agency in developing the CARES process and report. The total cost of these contracts was approximately $18 million. The additional costs of staff resources spent on CARES were not tracked; therefore a total of VA resources spent to develop the CARES report are not available.

In the 2004 CARES Decision document, it was estimated that implementing CARES decisions would require an additional investment of approximately $1 billion per year for at least the next 5 years. Through FY 2008, VA has obligated approximately $2.4 billion on implementing construction projects identified in the 2004 CARES Decision document and in 17 business plan study decisions. An estimate for additional funding needed to complete the implementation of these decisions is approximately $3 billion.

Question 6: VA's testimony states that "the tools and techniques acquired through CARES" have been integrated into VA's standard operating procedure with regard to strategic planning. How has this process changed from before CARES?

Response: Through the CARES process, VA adapted its actuarial model to produce 20-year forecasts of the demand for veteran health care services. Ongoing updates allow for more accurate projections of veteran reliance on VA services. The data from the model is used to identify gaps between current and projected demand in services within each market using the health care planning model (HCPM) implemented as part of the 2008 VHA strategic planning guidance cycle. The 10-step HCPM planning model facilitates the planning of strategic initiatives to address the projected gaps. The initiatives include contracting for services, facility expansions, Department of Defense (DoD) collaboration, and other initiatives developed as a result of the CARES process.

As part of the annual VHA strategic planning guidance cycle, a methodology was developed to identify strategic locations for CBOCs and other health care delivery approaches across the system. The methodology evaluates the convergence of low access (measured by drive time guidelines for primary care services as established by the CARES process) and increasing projected demand for primary care and mental health services. The methodology guides the initial step in the CBOC approval process and/or in planning for the provision of health care through other solutions.

Question 7: VA's testimony stresses the importance of ensuring that VA facilities are adaptable so that they may seamlessly accommodate the development of new clinical practices and technology. Can you elaborate on how VA ensures that its facilities meet standards of flexibility?

Response: Although health care facilities are inherently more complex and less adaptable than other building types such as office buildings, VA makes every effort to plan for the inevitable change that occurs due to new advances in health care, technology, and changes in patient populations that occur over the life of a VA medical facility. VA has instituted a rigorous focus on the planning phase of new projects, so that projected change and growth over the next 20 years is accounted for at the beginning. This planning reviews the requirements for accommodating the changes in functional space use within the building as well as land for expansion so that its new facilities can accommodate future needs.

VA's design and construction specifications require that mechanical systems, equipment rooms, component arrangements, and pipe and ducts be sized for change and to accommodate future growth. Where possible, VA incorporates the VA hospital building system, which provides for greater flexibility by modular design with accessible interstitial mechanical space in a level above occupied space for distribution of engineering services, allowing maintenance, repair, and mechanical system changes to be made without disrupting activities on the occupied floor below.

The Honorable Joe Donnelly

Question 1: Dr. Lisa Thomas, I am a firm believer in optimizing health care and making sure that veterans get the most accessible, highest-quality care we can give them with the resources with which we are entrusted. Accessibility to specialty care

is an issue of particular concern to my district and to many districts nationwide. For example, St. Joseph County in my district has a population of more than a quarter million people, yet area veterans must too often drive more than 2 hours each way to get to the nearest VA hospital for specialty care. While there is an excellent outpatient clinic in South Bend, it is unable to provide many needed services. I am very pleased that the VA will open a new expanded health center in South Bend for outpatient and specialty care in 2012. The authorized facility will be 60–70,000 square feet and more than 10 times bigger than our current CBOC. The outpatient facility will provide comprehensive examination services in cardiology, podiatry, outpatient surgery and other medical specialties, wellness programs and ultrasound exams. Special services will also be available for newly returning veterans from Iraq and Afghanistan. Further, VA will contract with local hospitals in the South Bend area to provide inpatient services for area veterans. I would like to know if the arrangement announced for South Bend might be a model that constitutes future health care that the VA plans to expand on as it looks in the near and long-term for opportunities to provide enhanced quality care and greater access to veterans?

Response: VA has a comprehensive strategic planning process for actively identifying and appropriately planning for the full continuum of veteran health care needs. The expanded health care center in South Bend is just one example of VA initiatives that enhance the quality of and access to health care for veterans.